Nursing & Midwifery Council

Employer Link Service Regulation Adviser Manual

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Introduction

This manual sets out operational guidance for the Employer Link Service (ELS). The primary audience for this document is the Regulation Advisers (RAs), the Head of Service Delivery (HoSD), Employer Link Officer (ELO) and Employer Link Administrator (ELA), for whom it provides guidance on how the service is delivered.

It is also a document that will inform other Fitness to Practise (FtP) staff and the wider NMC of the services that the ELS provides, the 'customers' that it serves, and the key internal relationships and processes that are involved in delivering the service.

Companion documents

There are a range of documents that provide further details on specific processes mentioned within this manual:

- Employer Link Support Team Manual: outlines the operational processes followed by ELOs.
- Investigation Team Manual: outlines the operational processes followed by investigation teams within FtP.
- Revalidation Guidance: links to a range of revalidation documents including further information about procedures, forms and communications
- Quality Meetings: outlines the operational processes for Regional Quality Surveillance Groups, Risk Summits and Quality Summits.
- CQC and NMC operational protocol and Memorandum of Understanding: provide an operational model for staff of both organisations outlining key contacts at each organisation; when and how the NMC and CQC will share and record information and how each team at each organisation are involved.
- ELS Disclosure Guidance: outlines disclosure policies for sharing FtP information
- Freedom of Information Policy: outlines how the NMC manages FoI requests.

About the Employer Link Service

Purpose

The purpose of the ELS is to facilitate closer working between the NMC and healthcare providers, predominately around FtP. Specifically, the NMC is seeking to work in partnership with healthcare providers to improve patient safety and ensure higher standards of care through providing advice on NMC thresholds and revalidation recommendations; improving the quality of FtP referrals; and encouraging robust local investigation, performance management and clinical governance.

Principles

- The ELS integrates with and improves existing services. It works in a co-ordinated, consistent and coherent way across all teams and directorates of the NMC.

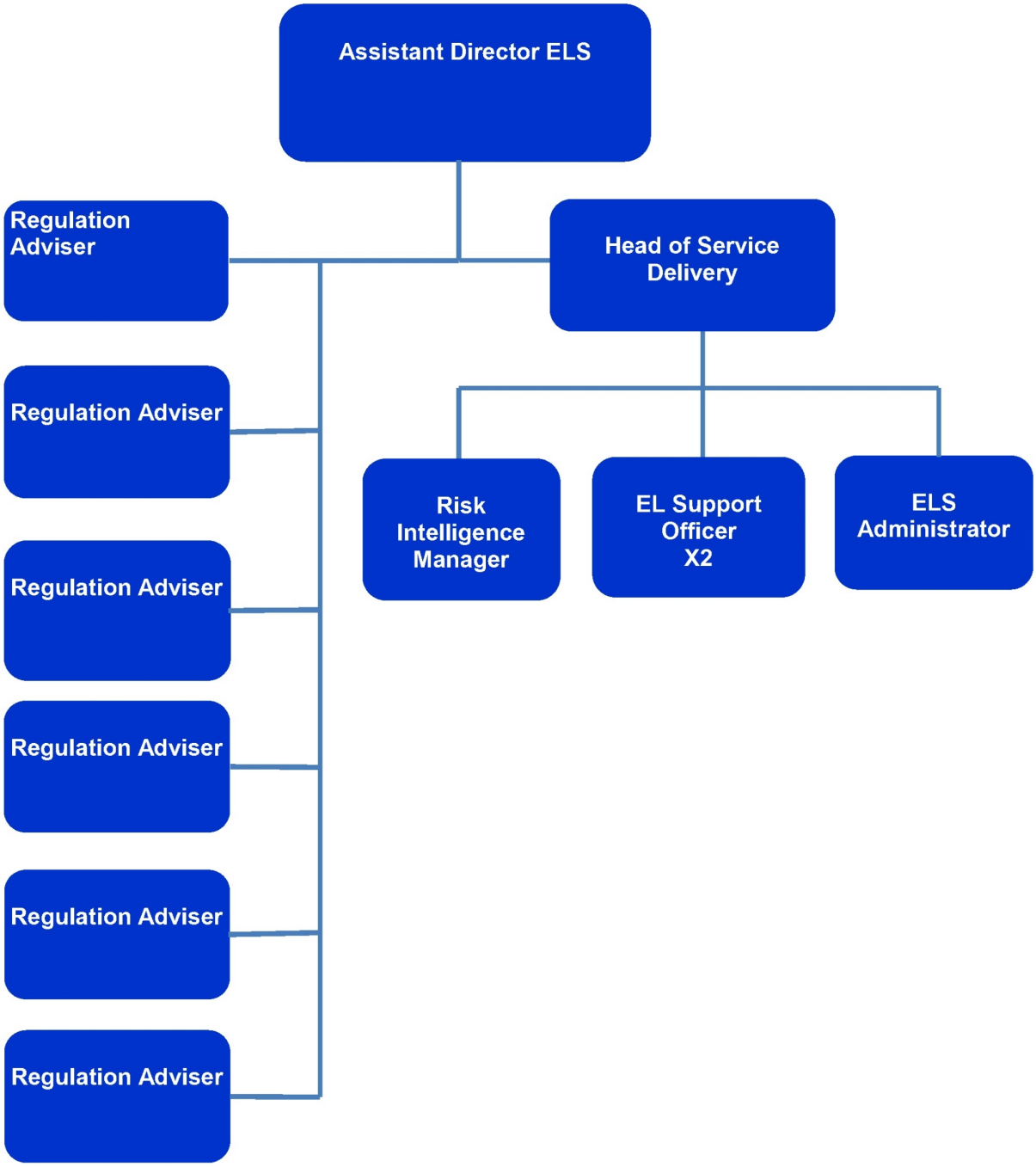
- RAs are a first point of contact for Directors of Nursing (DoNs) and their teams on NMC issues.
- RAs are highly professional in internal and external interactions and establish relationships built on trust. They are senior NMC staff empowered to engage with DoNs and senior employers of nurses and midwives.
- RAs actively promote the commitment to fairness, equality and diversity that characterises NMC procedures and culture.

Objectives

- To build and maintain relationships between the NMC and healthcare providers including the NHS and Independent Sectors.
- To improve the understanding of NMC FtP procedures including raising awareness of patient safety issues and the thresholds for referral to the NMC.
- To improve the quality of referrals and supporting evidence provided to the NMC.
- To improve the NMC's awareness of local handling of underperforming nurses and midwives in order to support the local resolution of lower level concerns.
- To support employers as they consider revalidation of nurses and midwives.
- To share data on performance with local healthcare decision-makers in order to develop a mutual understanding around key themes and emerging trends in poor performance.
- To work with other agencies on quality initiatives including systems regulators and the NHS.

Employer Link Service structure

RAs report to the Assistant Director ELS (AD ELS) who then reports to Director of FtP.



Who do we engage with?

Director of Nursing, Chief Nurse and Head of Midwifery

The vast majority of nurses and midwives practising in the UK are linked to a NHS trust or board with a Director of Nursing (DoN), Chief Nurse (CN) or Head of Midwifery (HoM).

Most NHS trusts or boards have a Director of Nursing who is usually a member of the executive team. Some larger organisations have multiple Directors of Nursing reporting to a Chief Nurse. The Chief Nurse is usually the executive team member and the Directors of Nursing are not members of the executive but assigned to lead nursing teams in a clinical practice area or hospital.

The DoN, CN or HoM is usually responsible for monitoring the fitness to practise of nurses and midwives within their organisation. A nurse or midwifes revalidation confirmer is usually their direct line manager rather the DoN/HoM or CN unless they are also the line manager of the nurse or midwife.

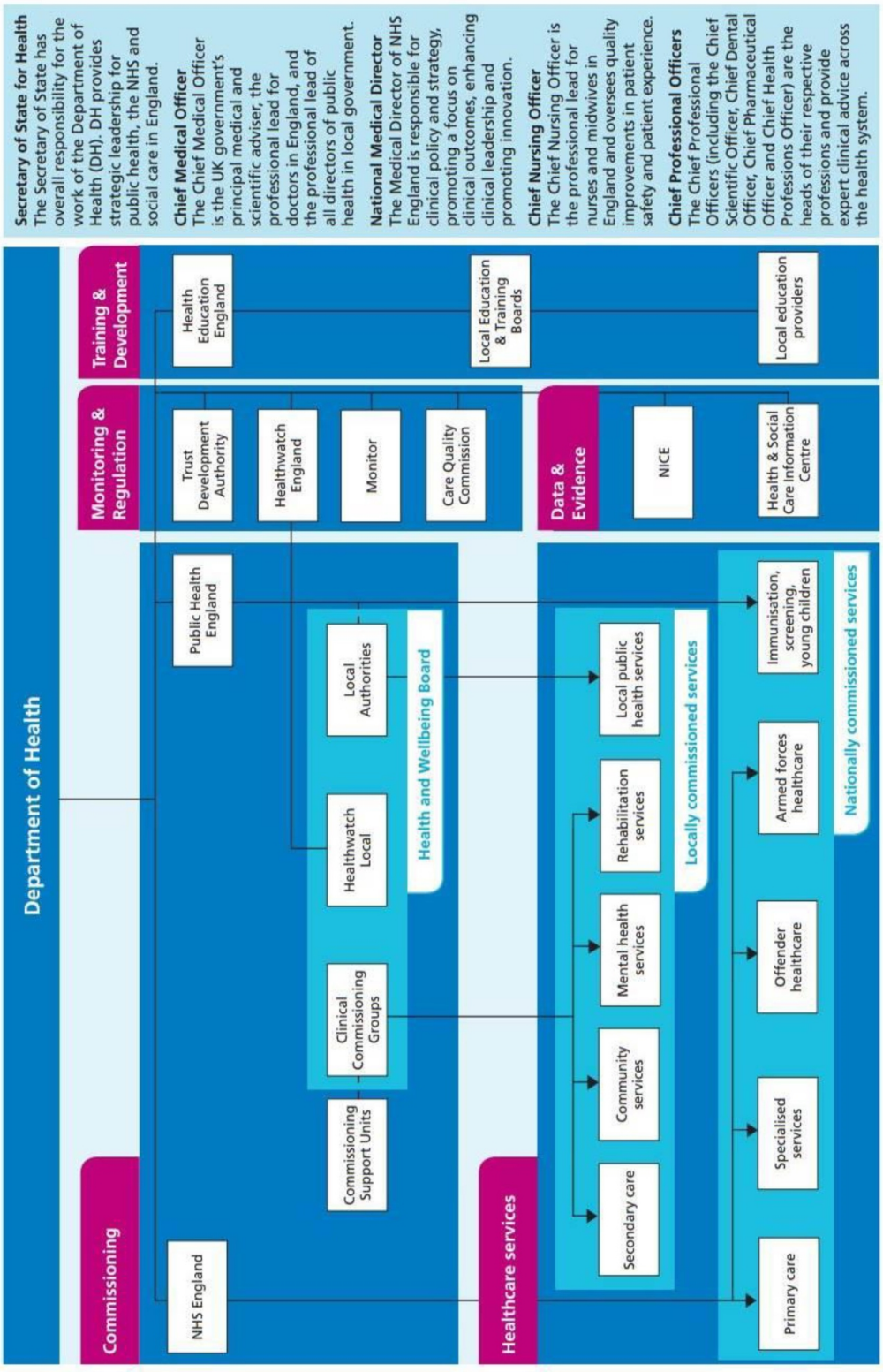
The DoN/CN or HoM is responsible for the systems of clinical governance in relation to nurses and midwives in their organisation. This includes appraisal, complaints management, incident reporting and processes for managing poorly performing nurses and midwives, all of which are required for robust revalidation. DoN/CN/HoM are also the individuals with the greatest influence over the FtP referrals made by healthcare providers to the NMC. RAs are responsible for ensuring regular communication, and a two-way flow of information between the NMC and the DoN/CN or HoM about poorly performing nurses and midwives and patient safety risks.

The success of the ELS is largely determined by the soundness of the advice and guidance that the RA provides and the level of confidence they instil in the DoN/CN or HoM. These same factors heavily influence the providers' perception of the NMC. DoN/CN or HoMs should perceive the RA as an accessible and expert adviser on FtP referral thresholds, revalidation and NMC policies. RAs should be a trusted source of support in discussing poorly performing nurses and midwives and difficult cases.

In larger employer organisations there may be other people beyond the DoN/CN or HoM with whom the RA will build a relationship, for example Deputy or Assistant Directors of Nursing, Deans or HR staff. The RA should obtain explicit assurance that these individuals have delegated authority from the DoN/CN/HoM and this should be rechecked and updated on a regular basis.

How is the NHS structured?

England



The day-to-day operations of the NHS can be split into two major functions; commissioning services for patients and providing services for patients. NHS England is an independent organisation and one of its primary tasks is overseeing local clinical commissioning groups (CCGs). The CCGs commission services from a range of providers to cover services such as accident and emergency, elective hospital care and community health services in their area.

Once commissioned, NHS services are delivered by provider organisations, which in England are predominantly known as Trusts. There are two types of trust, NHS foundation Trusts and NHS Trusts. The key differences are as follows:

	NHS Foundation Trust	**NHS Non-Foundation Trust**
Government involvement	Not directed by government therefore more freedom to make strategic decisions	Directed by government
Financial regulation	NHS Improvement (formally Monitor and TDA)	Health
Quality regulation	CQC	CQC
Finance	Free to make own financial decisions according to an agreed framework set out in law and by regulators. Surpluses can be retained and reinvested	Financially accountable to government

- Acute trusts
  Provide secondary care and specialised services. The majority of acute trusts are commissioned locally by CCGs although a few are commissioned centrally by NHS England.

- Primary care services
  Delivered by a wide variety of providers including GP practices, walk in centres, and NHS 111.

- Ambulance trusts
  Manage emergency care for life threatening and non-life-threatening illnesses including the NHS 999 service.

- Mental health trusts
  Provide community, in-patient and social care services for psychological and psychiatric illnesses.

- Community health services
  Delivered by foundation and non- foundation health trusts and includes amongst others, district nurse services, school nursing and health visitors.

NHS Improvement (previously Monitor and the Trust Development Agency (TDA))

Due to a recent merger, Monitor and the TDA no longer exist. The functions of both now fall to a new organisation named 'NHS improvement'.

Monitor regulated solely in England ensuring that independent NHS foundation trusts were well-led so that they can provide quality care on a sustainable basis. This role included making sure that essential services were maintained if a provider got into serious difficulties. They also worked to promote quality and efficiency in the NHS payment system and that procurement, choice and competition operated in the best interests of patients. Further information can be found on their website at: https://www.gov.uk/government/organisations/monitor

The TDA was responsible for providing leadership and support to the non-Foundation Trust sector of NHS providers. This included 90 NHS Trusts.

The TDA oversaw the performance management of these NHS Trusts, ensuring they provided high quality sustainable services, and provides guidance and support on their journey to achieving Foundation Trust status.

The Trust Development Authority's key functions included:

- Monitoring the performance of NHS Trusts, and providing support to help them improve the quality and sustainability of their services
- Assurance of clinical quality, governance and risk in NHS Trust
- Supporting the transition of NHS Trusts to Foundation Trust status
- Appointments to NHS Trusts of chairs and non-executive members and trustees for NHS Charities where the Secretary of State has a power to appoint.

Health and Social Care in Northern Ireland

In Northern Ireland the NHS is referred to as Health and Social Care (HSC). Like the NHS it is free at the point of delivery but it also provides social care services like home care, day care and social work. Healthcare is one of Northern Ireland's devolved powers.

The Department of Health, Social Services and Public Safety has authority for all health and social care services. Services are commissioned by the Health and Social Care Board (HCSB) and then provided by five Health and Social Care Trusts namely Belfast, South Eastern, Southern, Northern, Western and the NI Ambulance Trust. Within the HCSB there are also local commissioning groups similar to those in England. They focus on the planning and resourcing of services.

Healthcare Boards in Scotland

Healthcare in Scotland is a devolved power and is provided by NHS Scotland. It differs from England in that healthcare staff work across one of fourteen regional NHS Boards or one of seven Special NHS Boards. Each NHS Board is accountable to Scottish ministers supported by the Scottish Government Health and Social Care Directorates. The regional Boards are responsible for the protection and improvement of their population's health and the delivery of frontline health services. Special NHS Boards support the regional Boards by providing a range of important specialist and national services.

Local Health Boards and Trusts in Wales

Healthcare in Wales is a devolved power and is provided by NHS Wales. It has seven Local Health Boards that are responsible for delivering all healthcare services within a geographical area. There are also 3 NHS Trusts, namely the Welsh Ambulance Services Trust, Velindre NHS Trust offering specialist services in cancer care, and finally Public Heath Wales.

Local Supervisory Midwifery Officers

Local Supervising Authority (LSA) arrangements differ across the United Kingdom. In England the LSA is the Commissioning Board (NHS England), in Scotland they are the Health Boards, in Wales the Health Inspectorate and in Northern Ireland, the Public Health Agency.

Each LSA has an appointed LSA Midwifery Officer (LSAMO) to carry out the LSA function. They are all practising midwives with experience in statutory supervision and provide a focus for issues relating to midwifery practice within each area. They also contribute to the wider NHS agenda by supporting public health and inter-professional activities at Commissioning Board, Board, Inspectorate or PHA level.

The LSAMO does not represent the interests of either the commissioners or providers of NHS maternity services. Each LSA is responsible for ensuring that statutory supervision of all midwives, as required in the Nursing and Midwifery Order (2001) and the Nursing and Midwifery Council's (NMC) Midwives rules and standards (2012) is exercised to a satisfactory standard within its geographical boundary.

The functions of the LSA, as discharged by the Midwifery Officer include:

- providing a framework of support for supervisory and midwifery practice
- receiving intention to practise data for every midwife practising in that LSA
- ensuring that each midwife meets the statutory requirements for practice
- accessing initial and continuing education and training for supervisors
- leading the development of standards and audit of supervision
- determining whether to suspend a midwife from practice, in accordance with Rule 14 of the Midwives rules and standards (NMC 2012)
- investigating cases of alleged misconduct or lack of competence
- being available to women if they wish to discuss any aspect of their midwifery care that they do not feel had been addressed through other channels

Each LSAMO compiles an annual report for the NMC, in accordance with Rule 13 of the Midwives rules and standards (NMC 2012), which outlines supervisory activities over the past year, key issues, audit outcomes and emerging trends affecting maternity services. This report is signed off by the LSA and is available to a wide range of stakeholders, including all Supervisors of Midwives, to facilitate effective commissioning and delivery of maternity services.

RAs are responsible for ensuring regular communication between the NMC and the LSAMOs about poorly performing midwives and patient safety risks. The RAs are the first point of advice for LSAMO on matters relating to the fitness to practise of midwives. In practice this means providing advice and guidance on thresholds and making referrals.

Who are the System regulators

There are a number of areas of work where information gathered by the NMC or other UK systems regulators can help the work of the other. The following section outlines the processes for managing relationships with the Care Quality Commission (QCQ) in England. There is ongoing work to develop similar processes and agreements with NHS Improvement (previously Monitor and the Trust Development Agency) in England. We are currently working on developing information sharing protocols with the other systems regulators in the devolved countries. The Employer Link Service currently shares pre-inspection aggregate data reports on FtP cases with CQC and Health Improvement Scotland (HIS).

System regulation in England

Care Quality Commission

The NMC and CQC have set out their intention to work together and share information in a CQC and NMC operational protocol and Memorandum of Understanding. The NMC and CQC share information with each other through planned activity and when there is a need to respond to emerging, urgent concerns. The majority of the information shared is about systems or aggregate data, rather than information about individual cases. There are five planned ways that we share information and these are: routine information sharing; local liaison meetings; coordination of on-going activities; risk summits; and strategic collaboration.

Any emails sent from the ELS to the CQC should be sent to: enquiries@ **I&S** and copied to intelligence@ **I&S** for the support team to log. The email should note who the RA spoke with and what the outcome was, for example, when dealing with a referral. Emails from the CQC are received via the joint email address and the support team will put the CQC enquirer in touch with the relevant RA.

RAs should adhere to the following set of principles when discussing queries with the CQC, particularly where the CQC are seeking to discuss a local concern with the RA. In some instances they want to check what a nurse or midwife has told them, or to understand any restrictions, in others they are considering making a referral.

- Do not confirm that we have an open case or enquiry, or share any non-public information about any nurse or midwife.
- If we do have an open case, do not confirm but welcome a referral. In some cases, the CQC material will be useful additional or adverse information.
- If the nurse or midwife has public restrictions on their registration, do not discuss the case, but explain our processes in general, the purpose of our restrictions and remind them that a nurse or midwife is fit to practise within those restrictions. If the CQC want to send some information about that nurse or midwife, then this should be accepted, but without discussing the case or confirming that we already have that information.
- The RA should make a telephone note, share the note with the CQC caller so that there is a joint record of the discussion and ensure it is sent to the Employer Link mailbox for logging in NMC electronic recording and management systems (known as CMS).

System regulation in Scotland

Healthcare Improvement Scotland (HIS)

HIS conducts approximately 30 inspections per year. HIS do not grade individual NHS boards; it conducts inspections and reports on individual hospitals run by the providers (NHS boards). Inspections are conducted by the Health Environment Inspectorate (HEI). HIS do not provide an overall rating for hospitals they use a system of requirements and recommendations. HIS are also responsible for regulating independent hospitals, voluntary hospices, and private psychiatric hospitals.

The ELS support team share aggregated information on fitness to practise cases with HIS prior to hospital inspections.

Care Inspectorate Scotland

Care Inspectorate is the systems regulator in Scotland for care services. Care inspectorate use a grading system based on the Scottish government's national care standards. There is no overall rating for inspected organisations. Each organisation is graded against four standards; quality of care and support; quality of environment; quality of staffing and quality of management and leadership.

We are currently in discussions with the systems regulators in Scotland around developing information sharing and operational protocols.

System regulation Wales

Care and Social Service Inspectorate Wales (CSSIW)

CSSIW inspect social care facilities in Wales. Most of the settings regulated by CSSIW are unlikely to employ nurses or midwives. The settings regulated by CSSIW that are

likely to employ nurses are adult care homes with nursing (younger and older) and nursing agencies.

Healthcare Inspectorate Wales (HIW)

Healthcare Inspectorate Wales is the independent inspectorate and regulator of all health care in Wales. HIW inspect both NHS and independent providers of health care. As such it is similar in function to the CQC in England and HIS in Scotland, except it does not cover those settings which are regulated by CCSIW.

System regulation in Northern Ireland

Regulation and Quality Improvement Agency (RQIA)

The Regulation and Quality Improvement Authority (RQIA) is Northern Ireland's independent health and social care regulator. Like CQC, it regulates health and social care services through a programme of planned and unplanned inspections of nursing homes, care homes and nursing agencies.

Advisers will need to be familiar with the above agencies as they are a rich source of data which ELS uses for prioritisation. A memorandum of understanding exists in relation to data sharing between these regulators and the NMC (save RQIA where one is presently under development).

Local liaison meetings

Local liaison meetings provide a structured, scheduled way for the GMC, NMC and CQC to share information at the local level and to monitor how effectively this is working. Local liaison meetings should take place twice a year between CQC Regional Leads, GMC ELAs and their NMC Regulation Advisers in each of the four NHS England regions. Depending on the agenda, colleagues from other directorates may also attend. Attendees are responsible for sharing relevant information from the meeting with colleagues. The secretariat and support for each meeting should alternate between organisations. The agenda and meeting note should be sent to the contact email address: *enquiries@* I&S (NMC staff approaching CQC) or *intelligence@* I&S I&S CQC staff approaching NMC) for logging.

The meeting is an opportunity to build relationships between local teams across the two organisations. Each meeting should cover:

- any local or operational changes at each organisation
- analysis of trends and statistical data for each organisation, if available
- a local stocktake of key concerns and activities within the region that each organisation should be aware of and any actions taken in response to these concerns.

Key relationships in Fitness to Practise

The RAs closest internal working relationship, outside of that of the support team, will involve working with the Case Investigation Teams (CIT). RAs will also work closely with the Screening Team and Case Preparation Team (CPT). The RA will need to liaise regularly with Case Investigation Officers (CIOs) and Case Investigation Managers (CIMs) to understand the progress of cases and to feedback information received from providers. RAs should also seek advice from Case Examiners (CEs) when appropriate. During these interactions, as elsewhere, the RA and investigations staff should be mindful of each other's time commitments and obligations; with the common aim of working together. In addition, utilising regular feedback and insights from DoN/CN/HoM and LSAMOs on NMC cases, the RA should be working with CIMs and the AD ELS to try to improve the efficiency of the investigation and adjudication processes.

The Fitness to Practise (FtP) directorate is responsible for dealing with complaints and allegations made about registered nurses or midwives. This includes the initial assessment of an allegation, investigation and where appropriate, taking action to protect the public. It is the largest Directorate in the NMC.

Being fit to practise means that a nurse or midwife has the skills, knowledge, good health and good character to do their job safely and effectively and is able to work without any restriction on their practice.

When someone considers that a nurse or midwife's fitness to practise is impaired they can bring these concerns to us. We investigate various allegations including:

- Misconduct
- Lack of competence
- Criminal convictions or cautions
- Physical or mental health
- A determination by another UK regulator that the nurse or midwife is impaired

If a nurse or midwife fails to comply with the standards we set, this does not automatically mean that their fitness to practise is impaired – we have to look at all the circumstances involved.

We also investigate cases where it appears that someone is on our register fraudulently.

We can only investigate complaints about a nurse or midwife who is on our register.

We cannot consider complaints about

- healthcare assistants or other healthcare workers
- complaints relating to non-FtP issues, such as neighbour disputes and employment contractual issues
- concerns about a nurse or midwife that are not related to fitness to practise should normally be resolved by the employer or some other authority.

The Fitness to Practise Directorate consists of a number of teams which manage the process of screening and investigating cases where allegations have been made against registered nurses and midwives.

What happens to a Fitness to Practise referral?

Initial processing

When a referral is made to the NMC it is first assessed by a member of the screening team, based in investigations. Screening officers will review all new cases to identify high risk and interim order cases. They will determine whether the case should be progressed to investigation, if further information is required before a decision can be taken, or if the matter should be closed.

Where there are risk factors present, the screening officer may refer the matter to a panel of the Investigating Committee who will decide whether or not to make an interim order restricting the registrant's practice. The NMC has the power to put in place interim measures to restrict a registrant's practice whilst the allegations they face are investigated.

Interim order hearings are an emergency measure because of the risk identified and therefore matters are listed to be heard before a panel within 28 days. This is to ensure the NMC properly fulfils its statutory duty to protect the public and the public maintain confidence in the professions and the NMC as the regulator.

The screening team arrange interim orders hearings as soon as possible and therefore reviews of referrals where interim order risk factors are identified are prioritised by the Investigations Legal Team (ILT).

If particular risk factors are identified, a case may be referred to an interim order hearing. The grounds for imposing an interim order are that it must be **necessary to protect the public; otherwise in the public interest or in the registrant's own interests** and only cases where one or more of these criteria are felt to be met should be referred to a hearing.

These cases can be varied as they may include cases of lack of competence, repeated poor clinical practice, serious convictions or imprisonment and health.

The investigation continues while the interim order is in effect. Interim orders are reviewed by a panel after six months and then every three months.

The panel can impose the following orders:

- **Interim suspension order**: the panel suspends the nurse or midwife's registration, for up to 18 months.
- **Interim conditions of practice order**: the panel imposes conditions on the nurse or midwife, for up to 18 months.

Assessing the need for an interim order is an ongoing process. The case holder at any given time will have to revisit decisions on the receipt of relevant new material. This is to ensure that serious cases where the registrant may pose a real risk are not missed.

Threshold for interim order

Interim orders are considered and imposed to protect the public where there is a real risk of harm if an order were not imposed.

An interim order can prevent a registrant from working or restrict their practise. The bar therefore for imposing an interim order is, as case law prescribes, a high one.

There are three statutory grounds for imposing an interim order. An order may be made on one, two, or all three grounds. These are:

- An interim order is necessary for the protection of the public.
- An interim order is otherwise in the public interest.
- An interim order is in the registrant's own interests.

For an order to be necessary for the protection of the public a panel must be satisfied that there is a real risk to patients, colleagues or other members of the public if an order is not made. It is not enough for the panel to consider that an order is merely desirable. The ILT must consider whether an order is therefore necessary.

The panel will consider the seriousness of the **risk** to members of the public if the registrant were allowed to continue practising without restriction. The ILT must therefore consider the:

- Seriousness of the allegation.
- Risk to the public
- Nature of the evidence
- Likelihood of the alleged conduct being repeated if an interim order were not to be imposed

The primary purpose of an order is to protect members of the public. It will be relatively rare for an interim order to be made on public interest grounds alone (for example, to maintain confidence in the profession). The bar for public interest orders will nearly always be met however in cases which involve criminal sanctions for non-patient related incidents relating to, for example, sexual misconduct such as rape, accessing child pornography and serious child abuse.

There must be a prima facie case in order to refer a matter for an interim order hearing. In considering whether to impose an interim order the panel will not be making findings of fact. The panel must be of the view there is a prima facie case, having regard to such material as is put before them. In relation to the amount of evidence before the panel, the High Court has indicated that it would expect the allegation to be made in writing,

whether or not it has yet been reduced to a formal witness statement. The panel will also consider the source of the allegation and its potential seriousness. An allegation that is trivial or clearly misconceived should not be given weight.

Referrals from the Local Supervisory Authority in relation to midwives who have been suspended are sent straight for interim order consideration.

The NMC will usually awaits confirmation from the police that a suspect has been charged, and not merely arrested, before referring for interim order, however this is again something which should be considered on a case by case basis, considering all the relevant factors and the context of the referral.

Progressing a case

If it is decided in Screening that a case ought to be progressed, it will be referred to investigations where the allegations in question will be investigated in house by a case investigations officer (CIO), or sometimes by an external legal firm. The Investigations Legal Team will assist with the investigation by approving case investigation plans and providing legal advice to progress the case.

A similar process is followed in cases where a registrant's fitness to practise may be impaired by reason of health, in which case the investigation will consist of the NMC instructing an expert to examine the registrant and a medical report being prepared. Examples of ill health that the NMC may consider include:

- The registrant has made a self-referral stating that their fitness to practise is impaired citing a serious health problem.

- A referral has been made by a NHS employer following a capability hearing, or a hearing of a similar nature; where ill-health was the substance of the allegations and where findings were made in relation to ill-health having a clear impact on the ability of the individual to carry out their work as a nurse or a midwife.

- The referral provides evidence of a serious and chronic condition which is likely to impair someone's fitness to practise such as manic depression, or substance misuse.

The Case Examiners

The primary role of the Case Examiner (CE) is to decide whether or not there is a case to answer and if there is, to refer the matter on to the appropriate practice committee, that is, the Conduct and Competence Committee (CCC) or the Health Committee (HC). In some circumstances, for example where a registrant has been convicted of a serious criminal offence, the investigations team can bypass the case examiners and refer directly to the conduct and competence committee.

Case Examiners will reach this decision by considering the evidence and information gathered during the course of any investigation by screening and investigation staff,

together with any response from the nurse or midwife who has been referred in the case.

Each case must be considered by a Lay and Registrant Case Examiner who must come to a joint decision about the appropriate outcome.

Having considered the investigation report and supporting evidence, Case Examiners may decide that there is

- A Case to Answer
- No Case to Answer, or
- Recommend further investigation

Case to answer

Both Case Examiners must satisfy themselves that there is a case to answer before a case can be referred to a panel of the relevant practice committee. This means that both Case Examiners must be satisfied that there is a real prospect that:

- The facts of an allegation can be proved, and that if proved,

- Those facts could lead to a finding that the nurse or midwife's fitness to practise is currently impaired.

No case to answer

If the test for a case to answer is not satisfied, the Case Examiners will decide that on the evidence they have seen, there is no case to answer. In these circumstances, the Case Examiners will close the case.

Recommend further investigation

If the Case Examiners cannot reach a joint decision on the basis of the information and evidence available, they may return the case to the investigation team and suggest that further enquiries are made. This could include asking for further information from the relevant employers, or recommending that medical tests are conducted.

Case Examiners cannot *order* the investigation team to carry out such enquiries, as they have no power to control or direct the operational activities of the NMC.

Unable to agree a decision

In cases where the Case Examiners are unable to reach a joint decision, the case will be referred to a panel of the Investigating Committee (IC) for determination.

Interim Orders and other issues arising during case consideration

The primary role of a Case Examiner is to decide whether or not there is a case to answer which should be referred to a practice committee.

If the Case Examiner considers that an Interim Order could be appropriate, but there is no order in place, they can recommend that the investigation team consider applying for an order.

Conduct and Competence Committee

This committee considers cases where a nurse or midwife's fitness to practise is alleged to be impaired due to:

- Misconduct;
- Lack of competence;
- A criminal offence;
- A finding by any other health or social care regulator or licensing body that fitness to practise is impaired.

Panel hearings are held in public to reflect our public accountability. The panel may agree to hold parts of or all of the case in private, to protect the anonymity of the alleged victim, or if confidential medical evidence is disclosed.

Composition

Conduct and Competence Committee panels are made up of lay members and a nurse or midwife. Hearings are held in public unless the panel determine all of part of the case should be heard in private. This could be for example if there is a particularly sensitive matter concerning the registrant that should not be put into the public domain.

Decisions

Panels use the civil standard of proof to decide whether the facts of an allegation are proved. This means that a panel will consider a fact proved if they find that it is more likely than not to have happened.

When deciding on impairment, panels look for the level of conduct and competence expected of a nurse or midwife ordinarily working at that level of practice – not for the highest possible level of practice. When deciding on impairment, panels will also look at the standards and guidance set out by us. Even if there has been a breach of a standard set out in the Code or failure to follow guidance, it does not automatically mean that a nurse or midwife's fitness to practise is impaired, that is for the panel to decide.

The process

Hearings follow a three-stage process:

- are the facts proven or not?
- do the facts found proven amount to misconduct or a lack of competence
- is the fitness to practise of the nurse or midwife impaired?
- what sanctions (restrictions) are required to safeguard the health and wellbeing of the public?

Sanctions

The panel uses the Council's indicative sanctions guidance to choose which of the available sanctions is most appropriate. First, the panel must consider whether it is appropriate to take no further action. If the panel decides this option is not appropriate, it can:

- issue a caution for a period of between one and five years
- impose conditions of practice for a period of up to three years
- suspend the nurse or midwife's registration for up to one year, or
- strike off the nurse or midwife from the register. (In lack of competence cases this option is available only if the nurse or midwife has been continuously suspended or under conditions of practice for the previous two years.)

The available sanctions above are considered one-by-one, increasing in severity, until the panel is satisfied that the appropriate sanction in order to protect the public has been reached.

Health committee panels

This committee decides whether or not a nurse or midwife's fitness to practise is impaired by physical or mental ill health and, if so, what is the appropriate sanction required to protect the public.

Composition

Health Committee panels are made up of nurses or midwives and lay members. Due to the confidential nature of the medical evidence being considered, panel hearings are held in private.

Decisions

Panels use the civil standard of proof to decide whether the facts of an allegation are proved (see explanation of the civil standard above).

The process

Hearings follow a three stage process:

- are the facts proven or not?
- is the fitness to practise of the nurse or midwife impaired?
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- impose conditions of practice for a period of up to three years
- suspend the nurse or midwife's registration for up to one year
- strike off the nurse or midwife from the register. (This option is available only if the nurse or midwife has been continuously substantively suspended or under conditions of practice for the previous two years.)

Continued Practice Directorate

The Continued Practice directorate is responsible for oversight of nursing and midwifery education, the supervision of midwives, setting standards, and developing and implementing the NMC's approach to revalidation.

Understanding Education

Our role is to ensure that pre-registration education programmes provide students with the opportunity to meet the standards needed to join our register. We also ensure that programmes for nurses and midwives already registered with us meet standards associated with particular roles and functions.

Providers of higher education and training can apply to us for approval to deliver programmes that enable students to meet the *Standards for Pre-Registration Nursing Education (2010)* and *Standards for Pre-Registration Midwifery Education (2009).*

There are currently approximately 80 Approved Education Institutions (AEIs) which offer programmes of nursing and midwifery education and there are around 1,000 approved programmes. Most of the programmes we regulate (in terms of student numbers) are pre-registration education although we also approve various post-registration programmes.
We set requirements for AEIs. These are the requirements needed to deliver programmes that meet our standards. All standards have to be met before AEIs can run programmes; however, we can also recommend improvements and follow up on how these have been acted upon.

Our standards for programmes are a threshold standard, which means they are either met or not met. This is necessary for our regulatory functions as we must have a basis on which to make judgments about joining or being removed from the register. However, when we approve programmes we may judge it to be partially met with mandatory conditions. Therefore, our monitoring must clearly indicate whether our standards continue to be met.

Responsibility for the day-to-day management of quality lies with AEIs in partnership with practice-placement partners who offer 'hands on' practice experience to students. Practice placement partners include hospitals, surgeries, community health services and care homes or any other setting in which nursing or midwifery is delivered.

It is not within our remit to go beyond our standards into the verification of academic standards more generally. That is the responsibility of the providers themselves through their own internal quality assurance and of the Quality Assurance Agency for Higher Education (QAA).

RAs should work with the Education team to understand where there may be concerns around the provision of training and to provide feedback to and from employers on education related activities. In response to intelligence or sector forum discussions

(such as risk summits), RAs may also need to discuss with colleagues in the Education team the suitability of a setting as a learning environment for student nurses and midwives.

Understanding midwifery supervision

Our role in the supervision of midwives is to ensure compliance with the rules and standards we set for the supervision of midwives and the practice of midwifery. These are set out in the Midwives rules and standards (2012). These rules and standards set out the rules governing the practice of midwifery and the supervision of midwives, specifically the standards for the LSA's supervisory role.

As previously stated, RAs are the first point of advice for LSAMO on matters relating to the fitness to practise of midwives. In practice this means providing advice and guidance on making referrals.

Understanding quality assurance of education and midwifery supervision

We ensure that education and midwifery supervision standards are met through a programme of QA.

The objectives for QA include the following:

- ensuring new entrants to the register are capable of meeting the standards we set for safe and effective practice
- ensuring that everyone involved in education and the supervision of midwives, including students, service users and carers, knows how and when to raise a concern
- ensuring that AEIs or LSAs act swiftly and effectively when there are questions about the fitness to practise of a student or registered midwife.

We focus on the outcomes of education and the supervision of midwives as a means of being assured that the public are protected rather than on specifying how those outcomes should be achieved. We operate a risk-based approach to education and supervision of midwives. This includes:

- increasing the focus in education QA on aspects of provision where risk is anticipated or known, with particular reference to the practice-placement aspect of programme delivery
- promoting reporting by exception (that is, proactive self-reporting of concerns as they arise) for AEIs and LSAMOs
- establishing processes for responding to concerns.

However, our QA activity is not solely based on risk. We see all AEIs and LSAs in a review cycle.

We deliver QA through a process of self-assessment and review. The operational delivery of quality assurance of education and supervision of midwives is currently outsourced to Mott MacDonald.

AEI QA

Review is the process by which we assure ourselves that AEIs continue to meet our standards for the programmes they run. Review teams also look at how an AEI manages any risks associated with delivering the programme. The review takes into account an AEI's annual self-assessment report to us and intelligence from other sources, which contain information about the quality or risk of the AEI or its practice-placement partners. We publish a schedule of planned review visits and every year it will include a sample of AEIs selected on a risk basis. We will also make unscheduled visits if required in response to any emerging public protection concerns. There may be a thematic or a geographical element to a cycle of reviews.

Review teams consist of a managing reviewer, nurse and midwife reviewers (where possible drawn from education and practice) and a lay member. Nurse and midwife reviewers will be selected according to the particular programmes under scrutiny.

A review will always take into account feedback from students, service users and carers involved with programmes under scrutiny. We do not currently use students, service users or carers as reviewers but do require AEIs to fully involve them in a review. Draft outcomes of reviews are shared with the provider for comments on fact and finalised reports are published on our website.

LSA QA

QA visits are informed by annual self-assessment by the LSA and intelligence from other sources. There may be a thematic or geographical element to a cycle of reviews. The LSA review team will always include a managing reviewer, an LSAMO, a midwife who may also be a SoM, and a lay member.

Reviews will draw on feedback from maternity service users, student midwives and midwives practising in the LSA in question. Reports of review visits are shared with the LSA for comments on fact and are published on our website.

The full requirements for QA can be found in our Quality Assurance Framework.

The work of the standards team

The standards development team are responsible for developing and revising the Code and the standards for nursing and midwifery practice.

The Code contains the professional standards that registered nurses and midwives must uphold. UK nurses and midwives must act in line with the Code, whether they are providing direct care to individuals, groups or communities or bringing their professional

knowledge to bear on nursing and midwifery practice in other roles, such as leadership, education or research. While you can interpret the values and principles set out in the Code in a range of different practice settings, they are not negotiable or discretionary.

When joining our register, and then renewing their registration, nurses and midwives commit to upholding these standards. This commitment to professional standards is fundamental to being part of a profession. We can take action if registered nurses or midwives fail to uphold the Code. In serious cases, this can include removing them from the register.

In 2015 we launched a revised Code (effective from 31 March 2015), this Code reflects the world in which we live and work today, and changing roles and expectations of nurses and midwives. It is structured around four themes – prioritise people, practise effectively, preserve safety and promote professionalism and trust. Developed in collaboration with many who care about good nursing and midwifery, the Code can be used by nurses and midwives as a way of reinforcing their professionalism. Failure to comply with the Code may bring their fitness to practise into question.

To underpin the Code we have developed a set of standards. There are currently 14 sets of standards:

- Standards for medicines management
- Prep handbook
- Midwives rules and standards
- Standards for competence for registered nurses
- Standards of competence for registered midwives
- Standards of proficiency for specialist community public health nurses
- Standards of proficiency for pre-registration nursing education
- Standards for pre-registration nursing education
- Standards for pre-registration midwifery education
- Standards to support learning and assessment in practice
- Standards for specialist education and practice
- Standards for the preparation of supervisors of midwives
- Standards of proficiency for nurse and midwife prescribers
- Standards for adaptation to midwifery in the UK

The standards development team also publish guidance which sets best practice for nurses and midwives. We currently have three guidance documents:

- Raising concerns: Guidance for nurses and midwives
- Social networking guidance
- Guidance on the professional duty of candour

As RAs are providing advice to employers on potential breaches of the Code, it is essential that they have a good understanding of the requirements set out in the Code and the standards.

Registrations Directorate

RAs should work closely with the Registrations Directorate to share and any feedback from DoN/CN or HoM about revalidation or registration processes and policies.

There will no doubt be contact from employers relating to revalidation as it is a new process and they may be unfamiliar with it. Advisers will therefore need to be familiar with revalidation processes so that they can assist or signpost as necessary.
It is important to note that whilst revalidation is currently owned by Continued Practice, it will move to Registrations upon its full launch.

RAs are also likely to be asked about the revised overseas registration process as there is currently an overseas recruitment campaigned within the NHS. Changes to the NMC process for registering overseas nurse and midwives has resulted in an increase in the time it takes to process applications from overseas (non-EU). This is still a relatively new process and we are fully aware that its introduction coincides with a time of particular pressure on frontline services, existing shortages and increased demand. We have therefore sought to be flexible and responsive in the introduction and operation of the process, but within the overarching remit of patient safety.

Revalidation

The purpose of revalidation is to improve public protection by making sure that nurses and midwives continue to remain fit to practise throughout their career.

Revalidation is built on existing arrangements and adds requirements which encourage nurses and midwives to seek feedback from patients and colleagues, reflect upon the Code by having a professional discussion with another registrant and, importantly, seek confirmation that they have met those requirements from a third party.

Revalidation reinforces the duty on nurses and midwives to maintain their fitness to practise within the scope of their practice and incorporate the Code in their day to day practice and personal development. Revalidation will encourage engagement in professional networks and discussions, and reduce professional isolation.

Revalidation will enhance employer engagement by increasing their awareness of our regulatory standards, encouraging early discussions about practice concerns before they escalate or require referral to us, and increasing access and participation in appraisals and professional development.

Through revalidation we want to create an interactive, career-long relationship with nurses and midwives, and increase our understanding of practice and the nursing and midwifery population more broadly.

How does revalidation relate to the Code

Revalidation supports professionalism through a closer alignment with the Code.

The revalidation model aligns to the four themes of the Code:

- **Prioritise people** by actively seeking and reflecting on any direct feedback received from patients, service users and others to ensuring that their needs are fulfilled.

- **Practise effectively** by reflecting on professional development with colleagues, identifying areas for improvement in practice and undertaking professional development activities.

- **Preserve safety** by practising within competency for the minimum number of practice hours, reflecting on feedback, and addressing any gaps in practice through continuing professional development (CPD).

- **Promote professionalism and trust** by providing feedback and helping other NMC colleagues reflect on their professional development, and being accountable to others for professional development and revalidation.

An overview of revalidation

In the three years preceding the date a nurse or midwife's application for renewal for registration, they need to meet a range of revalidation requirements designed to show that they are keeping up to date and actively maintaining their fitness to practise. These include undertaking a range of continuing professional development activities and ensuring that they do a minimum amount of practice.

Nurses and midwives work across a wide range of roles, functions and settings. For example, these include roles in front line clinical care both in acute and community settings, roles in nursing and midwifery education and research, policy advisory roles and management and leadership roles specific to nursing or midwifery. The activities they undertake to meet the requirements will reflect their individual scope of practice as a nurse or midwife.8

Once they have met the requirements, they will need to discuss their revalidation with a third party. As part of this discussion, they need to demonstrate that they have complied with the revalidation requirements.

Every three years every nurse and midwife on the register will be asked to apply for revalidation using NMC Online. As part of that application, they need to declare to the NMC that they have complied with the revalidation requirements.

Each year we select a sample of nurses and midwives to provide us with further information to verify the declarations that they made as part of their revalidation application. Such a request does not necessarily mean that there are any concerns about their application, and they can continue to practise while we review the information provided.

Revalidation requirements

Practice Hours

Nurses and midwives must practise a minimum number of hours over the three years preceding the date of their application for renewal of their registration. These are:

Registration	Minimum total practice hours required
Nurse	450
Midwife	450
Nurse and SCPHN	450
Midwife and SCPHN	450
Nurse and midwife (including Nurse/SCPHN and Midwife/SCPHN	900 (to include 450 hours for nursing, 450 hours for midwifery)

If a nurse or midwife has practised for less than the required number of hours in the three years preceding the date of their application for renewal, then they must successfully complete an appropriate return to practice programme approved by the NMC before the date of their application for renewal of registration.

Continuing professional development

Nurses and midwives must also undertake 40 hours of continuing professional development (CPD) relevant to their scope of practice, over the three years prior to the renewal of their registration.

Feedback

Nurses and midwives must obtain at least five pieces of practice-related feedback over the three years prior to the renewal of their registration.

We recommend that they obtain feedback from a variety of sources for example, feedback directly from patients, service users, carers, students, service users or colleagues. They can also obtain feedback through reviewing complaints, team performance reports and serious event reviews. They may also use feedback received through annual appraisals. Alternatively, feedback can be on their team, unit, ward or organisation's performance. However, they will need to be clear about the specific impact that the feedback had on their own practice.

Reflection and discussion

Nurses and midwives must record a minimum of five written reflections on the Code, their CPD, and practice-related feedback over the three years prior to the renewal of their registration.

They must have a professional development discussion with another NMC registrant, covering their reflections on the Code, CPD, and practice-related feedback.

They must ensure that the NMC registrant with whom they have had their professional development discussion signs a form recording their name, NMC Pin, email, professional address and postcode, as well as the date of the discussion.

Health and good character

Nurses and midwives must provide a health and character declaration as part of the revalidation process. They must declare if they have been convicted of any criminal offence or issued with a formal caution over the three years prior to the renewal of their registration.

Professional indemnity

They must also declare that they have, or will have when practising, appropriate cover under an indemnity arrangement.

Confirmation from a third party

The final requirement is for revalidation declarations to be confirmed by a third party known as a "confirmer".

This will be a declaration that the nurse or midwife has demonstrated to an appropriate third party that they have complied with the revalidation requirements.

They are required to provide the name, NMC Pin or other professional identification number (where relevant), email, professional address and postcode of the appropriate third party.

An appropriate third party confirmer is their line manager. We strongly recommend that they obtain confirmation from their line manager wherever possible. A line manager does not have to be an NMC registrant.

If they do not have a line manager, they will need to exercise judgment to determine who is best placed to provide confirmation. Wherever possible we recommend that the third party they obtain confirmation from is an NMC registrant.

If that is not possible, they may seek confirmation from another healthcare professional they work with and who is regulated in the UK. For example, they could ask a doctor, dentist or a pharmacist.

If the confirmer is an NMC registrant, they must have an effective registration with the NMC. We will not be able to verify applications if the confirmation was provided by a person who was subject to any kind of suspension, removal or striking-off order at the time of making the confirmation.

The process for overseas registration

The revised overseas registration process was implemented with effect from 1 October 2014. This process uses an online application system and is based around a two phase Test of Competence. Phase one is a Computer Based Test (CBT) – undertaken at secure test centres globally and operated on our behalf by Pearson Vue. Phase two is the objective structured clinical examination (OSCE) that is currently operated in the UK by University of Northampton under contract with the NMC.

Although the new process applied to applications received after 1 October 2014, it was not until April 2015 that the first applicants completed the OSCE. This is because prior to that point, applicants were completing the CBT, obtaining and submitting the required supporting documentary evidence and obtaining appropriate UK visas.

Test of Competence Based Process

Test of competence – part one

Once applicants have passed the eligibility assessment, they sit the first part of the test of competence. This is a computer based test of theoretical practice-based knowledge. The test format is multiple choice and can be taken in test centres around the world. Applicants have two attempts at the test. If an applicant fails to achieve the required minimum score after both attempts, they will be unable to retake the test for six months. Once an applicant has successfully completed the test, the results are passed to us and the application is progressed to the next stage.

Assessment

Applicants need to provide the following evidence in order for us to complete an assessment.

- A valid passport. This same document must also be presented at the test centre.
- Birth certificate.
- A qualification certificate for each qualification being submitted as part of the application.
- Registration certificates from each jurisdiction where the applicant has practised and/or been registered. If the applicant's country operates state registration, they will need to have registered in each state where they practised.
- Two employment references confirming the applicant's post-registration practice of at least 12 months, their competence and character.
- Verifications from all jurisdictions where the applicant practised or where the applicant has been previously registered.
- Transcript of training for all relevant nursing or midwifery programmes completed by the applicant. These must be calculated in hours or be accompanied by a letter from the training institution with a key to how the credits translate to hours.
- A good health declaration from the applicant's general practitioner or the occupational health department at their place of work.
- A police clearance certificate from all countries where the applicant has lived since the age of 18.

Once all the evidence has been submitted, an assessment officer reviews the full application to ensure that it meets the requirements for registration. Providing all documents are correct and the criteria are met, the application is progressed to the next stage.

Where further information is required from the applicant and provided separately, a full new assessment and decision will be conducted. This allows the complete application to be reassessed in its entirety to ensure that all documents are consistent. Timescales of applications vary and some will take longer if the correct documents are not included with the initial application.

Test of competence – part two

The second part of the test of competence assesses an applicant's clinical knowledge. The test is an objective-structured clinical examination (OSCE) and can only be

completed in the UK. The test is administered by the University of Northampton who administers their own test fee in agreement with us. Applicants need to contact the university directly to book and pay for the test.

The OSCE simulates a clinical environment and patient scenarios which registered nurses and midwives are likely to encounter when they assess, plan, implement and evaluate care. The OSCE contains nursing or midwifery scenarios along with separate skill stations. Each separate clinical examination is known a 'station' and candidates circulate through all the stations within a set timeframe.

Each of the six stations has standardised marking criteria against which all candidates are assessed. Candidates are assessed by a panel of examiners and will be filmed for quality assurance purposes.

Candidates are expected to demonstrate competence through safe and effective practice. The test of competence is based on current UK pre-registration standards.

ID check

After completing part two of the test of competence, the applicant has a face-to-face ID check. They are required to bring all the original documents that they have uploaded as supporting evidence for their application. The ID check takes place at the OSCE location. If applicants cannot produce the documents required, they have to rebook an ID check at our London office before they can complete the last stage of the process and receive their registration number.

Final registration

Once we have received notification that an applicant has successfully completed part two of the test of competence and the ID check, they are invited to complete their final declaration and payment for registration online. Once both have been received, we will send the applicant their registration number (Pin).

OSCE Capacity

The registration directorate continues to monitor the mix of applications received and we are especially mindful of this in the run up to the introduction of language controls under the EU Directive from Jan 2016. This is bound to have an adverse impact on EU registration.

We are aware of concern that periodically arises from there being only one UK based test centre (University of Northampton) as anxiety has been expressed the about capacity meeting potential demand. The quality, consistency and control of the OSCE is key to the assurance that can be derived from any such test, therefore the model has always been to have a very small number approved test centres (more than one for resilience) based on projected demand. The current facility is provided under a contractual arrangement and provides capacity for over 4000 OSCEs per year, with contingency plans to increase that capacity if required. This is over 4 times the current overseas (non-EU) registration and exceeds the projections of DH and UKVI (in terms of the number of UK visas they expect to issue).
Once we have evaluated both the current model and its operation, we intend to go out to tender for an additional test centre(s) later in 2015.

The process for UK registration

The NMC received between 8,000–9,000 names from education institutes every September and 2,000 every March, so it is important that you work with us to reduce any delays in the application process.

Once a student has completed their course, the university will upload to the NMC database all course details and personal information (such as name, address and date of birth). After confirming the qualification details, the NMC will tell the applicant by post within 7–10 working days. The university will also return a declaration confirming your good health and good character.

To join the register, applicants are advised to create an account with NMC Online, pay the registration fee of £120 and complete an application form online. Any police cautions or criminal convictions must be declared. A registrations officer will review the documents and if everything is completed correctly the application will be processed and they will be on our register within 2–10 working days.

If an application is made six months or more after completing the nursing or midwifery programme, a separate application is required. It is important that an application is made within five years of the course completion date or it will not be possible to register and pre-registration programme will need to be completed. Potential employers can use the online confirmation service to check registration. On the initial application an applicant is required to declare that they have or are intending to have an indemnity arrangement before commencing practice.

Further information for midwives

If the applicant is a midwifery graduate they must submit the intention to practise (ItP) form to the local supervising authority midwifery officer before commencing practice. The ItP form is provided with the initial application documents.

Strategy Directorate

The Strategy directorate sets the framework for how we conduct our business and make decisions, how we communicate with internal and external stakeholders, how we manage information and how we monitor business performance and improvement.

Responsibilities include internal and external communications, stakeholder engagement, Council services, business planning and governance, quality assurance, continuous improvement and complaints handling, research and evidence and policy, legislation compliance and strategy.

RAs will work with Strategy in a number of areas, for example, colleagues will share information from risk summits or regional quality surveillance group meetings. It is also important for RAs to communicate regularly with the strategic engagement team about sector events which may be of interest at a wider corporate level such as NHS confederation events or systems regulator engagement meetings.

RAs should proactively raise any emerging potential high profile issues or referrals with the media team, ideally with the contact details for the healthcare provider. The AD and Head of Service Delivery should also be copied into these emails.

Corporate Services

The Corporate Services directorate has responsibility for HR and OD, finance, procurement, estates and ICT.

What services does the ELS provide?

The work of the RAs covers a range of activities designed to support to DoNs/CNs or HoMs in delivering their responsibilities. In addition, the ELS play a key role in providing NMC representation and input on a range of quality initiatives and meetings.

First point of NMC contact

The RA is the first point of contact for the DoNs/CNs or HoMs when they wish to discuss urgent issues, escalates concerns, or seeks advice and guidance. If an RA is unable to assist the DoNs/CNs or HoMs, they should discuss the matter with colleagues internally before providing the DoNs/CNs or HoMs with a response, or sign post the DoNs/CNs or HoMs to an appropriate member of staff who can deal with their query.

Regular meetings

The RA maintains relationships with the DoNs/CNs or HoMs through regular face to face or telephone meetings. At each meeting the RA will provide a general update about the wider work of the NMC; update the DoNs/CNs or HoMs on any open and recently closed FtP cases; review recent press cuttings; discuss any local issues or concerns the DoNs/CNs or HoMs has about nurses or midwives in the organisation; and discuss any queries. By providing updates on current and recently closed NMC cases and an overview of the process beneath it, the RA is able to reinforce and develop the DoNs/CNs or HoMs understanding of FtP referral thresholds and processes. During discussions, the RA will provide informal benchmarking for the DoNs/CNs or HoMs through discussing examples of what actions others have taken on similar issues including remediation and local conditions. The RA follows up on actions agreed during these regular meetings with the DoNs/CNs or HoMs. A more detailed explanation of the RA meeting process is provided in section 5 of this manual.

Ad-hoc telephone and email advice

The RA is available on an 'as needed' basis to provide expert advice on how to deal with patient safety risks, FtP thresholds for referral and queries about revalidation. The RA uses both phone and email communication to manage issues and follow-up on actions agreed during regular meetings with the DoNs/CNs or HoMs. Much of the value of the ELS is providing the DoNs/CNs or HoMs access to the RA to discuss the action to be taken around a local nurse or midwife in difficulty.

The RA must make an accurate telephone note (Annexe A) of the salient points of the discussion, particularly any advice, and send to the ELO for logging in CMS. The note should include reasons for the advice offered and any equality and diversity issues referenced. Emails which include advice about a nurse or midwife must also be sent to the ELO for logging in CMS. It is important to have an audit trail to satisfy any Freedom of Information requests or review of ELS involvement with an organisation or on a case. The ELO should also enter any action as an alert in CMS.

Participation in networks, workshops, induction and training sessions

Health sector networks have been formed across the UK and RAs may be required to actively participate in these networks. The RA is expected to provide guidance/advice on FtP, present local performance data (where available), deliver NMC communications and provide updates on revalidation during these meetings. The RA should maintain regular contact with the coordinator/secretariat for their networks to ensure that they are a regular participant at these sessions. RAs should provide cover if they can't attend a network meeting.

The ELS undertakes a 6-monthly internal review of how the networks are structured and functioning across the regions/devolved administrations which is shared with the Revalidation and Registrations Directorate.

RAs may also host, participate in or present at local networks, workshops or training sessions. These events give the RA an opportunity to update on or reinforce the role of the NMC and can provide access the wider networks such as HR and other staff. Presentations could include information on FtP procedures; thresholds; referral trends; poor performance issues; discussion around anonymised cases; revalidation; and other key themes and emerging trends. RAs should provide the description and date of any participation at such events to the ELO.
A key part of the adviser role is to be proactive so that Directors of Nursing are equipped to make the best decisions about referring cases. Therefore the advisers will provide induction and training sessions to new DoNs/CN or HoM as required.

Regional Quality Surveillance Groups

RQSGs were developed in England to provide a proactive forum for collaboration across the healthcare economy to: develop a common view of risks to quality through sharing intelligence; act as an early warning mechanism of risk about poor quality; and provide opportunities to coordinate actions to drive improvement. NMC objectives around RQSGs are to contribute to the delivery of high quality care and patient safety through: developing good working relationships with organisations across the region; sharing NMC information where appropriate; using stakeholder information to enhance our understanding of the local health economies and to identify areas or concerns that require NMC consideration or action.

RAs are involved in the RQSGs through direct attendance, preparation of data, sharing intelligence and follow-up actions. It is important that the ELS track attendance at

RQSGs. This information is included in FtP and ELS reporting. RAs should inform their ELO of any RQSGs to which they are invited. The ELO is responsible for keeping an accurate and up to date log following receipt of this information. A link to further detailed guidance was provided in section 1.1 of this manual.

Risk Summits

Risk summits generally refer to the NHS England-led process put in place to discuss and monitor potentially serious concerns identified in a healthcare provider. Risk summits are meetings where information is shared by a range of stakeholders and discussions seek to achieve a consensus about the situation under scrutiny and the actions required to mitigate the identified risks. A risk summit is generally triggered as a result of: routine monitoring and surveillance; at the instigation of an RQSG; regular clinical quality review meetings between commissioners and providers; or following reviews undertaken by commissioners, regulators or peer review. They may also be triggered by new information and intelligence from an unexpected source, for example, a whistle-blower, patient, or significant media exposure.

The NMC prioritises attendance at relevant risk summits. Where possible attendance should comprises an RA who has had previous involvement with the healthcare provider that is the subject of the meeting. Risk summits for organisations that have very limited nurse or midwife involvement; such as ambulance trusts, may not require NMC representation. Each invitation will be assessed on a case by case basis. We have agreed a process with NHS England where they will give us a steer as to whether we should attend. It is important that the ELS track attendance at risk summits. This information is included in FtP and ELS reporting. RAs should inform an ELO of any risk summits to which they are invited. The ELO is responsible for keeping an accurate and up to date log following receipt of this information.

CQC Quality Summits

CQC Quality Summits form part of the new process for inspecting healthcare providers in England. CQC inspection findings will inform the basis of a discussion at a quality summit. This summit is a meeting of organisations that are responsible for commissioning or providing scrutiny of health and social care services in the local area. The purpose of the quality summit is to develop a plan of action and recommendations based on the inspection team's findings as set out in the inspection report.

The NMC prioritises attendance at relevant quality summits. Where possible attendance should comprises an RA who has had previous involvement with the healthcare provider that is the subject of the meeting. Some quality summits may not raise any concerns or issues associated with NMC responsibilities. Each invitation will be assessed on a case by case basis. It is important that the ELS track attendance at quality summits. This information is included in FtP and ELS reporting. RAs should inform the ELO of any quality summits to which they are invited. The ELO is responsible for keeping an accurate and up to date log following receipt of this information.

Reviewing Never Events and Significant Incidents

Never Events (NEs) are a subset of serious incident reporting particular to England and Wales (see the Department of Health England Never Events for further information). NEs are formally investigated and reported within trusts and numbers/themes go to NHS England and the Care Quality Commission. Incidents are considered to be NEs if:

- the incident either resulted in or had the potential to cause severe harm or death
- there is evidence that the NE has occurred in the past and is a known source of risk
- there is existing national guidance or safety recommendations, which if followed, would have prevented the incident from occurring
- occurrence of the NE can be easily identified, defined and measured on an ongoing basis.

RAs may become aware of NEs through direct notification by the DoNs/CNs or HoMs and from reports such as those to the RQSGs. It is not appropriate to review documentation tabled in a meeting but the RA should take it away to review in detail. RAs should ask to see copies of the reports for any NE where a nurse or midwife has been directly involved and ask the DoNs/CNs or HoMs about how any actions/recommendations were implemented, and if there are any other concerns about the nurse or midwife. Sharing the report of an NE does not equate to making a referral to the NMC. In most cases, if local processes are robust and there is no presenting patient safety risk, the matter can be left locally.

The NE report should be reviewed and any potential issues about the FtP of any nurses or midwives involved identified. Having reviewed a report, the RA can discuss it with the DoNs/CNs or HoMs including whether any referral is required. If referral is required, the report itself forms part of a referral in the usual way. If referral is not necessary, the report should be stored along with the phone/email note in the meetings tab and is subject to our information retention policy in the same way as other non case material.

It is important the ELS tracks NEs which are discussed between DoNs/CNs or HoMs and RAs, so we can monitor numbers, including those which may translate into referrals, and report accordingly. RAs must email details of NEs to the ELO.

Supporting NMC engagement priorities

RA's contribute to the delivery of NMC priorities through supporting colleagues to promote our work, engaging with healthcare providers, and participating in project groups both within FtP and across the organisation.

Sharing Information

The FtP publication and disclosure policy and guidance should be read in conjunction with this section.

DoNs/CNs or HoMs can have access to a range of information relevant to their role. To reduce the risk of an information security breach, ELOs will check the list of nurses and

midwives with open cases ahead of each RA meeting or call to ensure that disclosure has taken or can place for all listed cases.

- You must **not disclose** details of health issues to employers.
- Cases closed (historically) in Screening or no case to answer by case examiners should **not be** disclosed
- You should **not disclose** cases relating to nurses or midwives employed by another organisation
- Cases closed (historically) at adjudication **can be** disclosed.

This means RAs should not discuss cases where the nurse or midwife is not employed by the organisation and the organisation has received only general employer disclosure. A case summary will still be produced where only basic disclosure occurred so the RA is aware of the detail of the case – although the RA does not divulge any of the information to the employer in the meeting.

Disclosure in terms of discussing specific pre-adjudication case details should only take place with DoNs/CNs, HoMs and LSAMO's where we have confirmed the callers identify and the contact sheet indicates that disclosure can take place (see section on Information Security in Support Team Manual). For all other employers specific case details should not disclosed unless the information is in the public domain or the case is at the adjudication stage and is not a health case.

It is acceptable to discuss cases with an employer in general terms or if the employer is already aware of the case or issues, for example a member of the public referral whereby the employer is also dealing with the case at the local level.

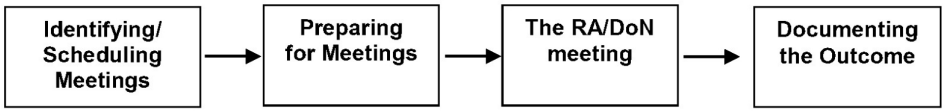
RAs can provide this information direct but should ensure that they are clear that they are disclosing to a DoNs/CNs or HoMs or their delegate. In respect of the nurse or midwife the name **and** PIN should be obtained to ensure disclosure is only made regarding the correct registrant.

In time, RAs will be able to provide formal benchmarking information to the DoNs/CNs or HoMs in the form of regional and sub-regional level data on FtP issues and sharing regional or national best practices. This service will be delivered when NMC data collation systems are sufficiently mature to deliver the information and subject to NMC data sharing strategy.

If an RA receives any requests for NMC statistics for external use, they should clear this with the Head of Service Delivery in the first instance. The NMC is reviewing some aspects of how the FtP statistics can be shared externally, particularly trust by trust/board by board material.

The ELS Meeting Process

The purpose of this section is to provide guidance on how to deliver an RA meeting. It should be noted that timelines are expressed in working days.



Identifying and scheduling meetings

If a new DoNs/CNs or HoMs is identified, a letter or email introducing the ELS should be sent to introduce the ELS and propose an initial meeting.

It is the responsibility of the RA to ensure meetings are scheduled in line with their meeting plan (Annexe B). The RA and ELO should agree who is responsible for booking the meeting and also try to avoid booking meetings in those weeks where 2 or more RA/DoN meetings are scheduled. RAs who book their own meetings must send an outlook invitation to the ELO so that a meeting record is created in CMS.

Preparing for meetings

The meeting preparation process should begin approximately **eleven** working days prior to each RA meeting. The ELO is responsible for performance managing this process and will ask for regular feedback from the RA as part of monitoring the provision.

At least **five** RA working days in advance of the meeting the administrator sends the DoNs/CNs or HoMs the meeting agenda (Annexe C), the meeting note from the preceding meeting and a list of identified nurses and midwives with open and recently closed cases where the DoNs/CNs or HoMs organisation is listed as the place of incident in CMS, a past employer if within the last 6 months or where the DoNs/CNs or HoMs organisation made the initial referral. An exception is if a nurse or midwife has left the organisation more than 6 months ago, in which case the case remains on the list until the RA instructs the ELO to remove it from the case list via the meeting note.

RAs must be aware of information security considerations and the list will not include the names of those nurses of midwives with new cases where employer disclosure has not occurred. RAs should follow the steps identified in the disclosure guidance when determining if a case can be disclosed to a DoNs/CNs or HoMs. Where a case must not be discussed or disclosed, the ELOs will provide case information in the covering email when they send them the link to the case list. It is not shared with the DoNs/CNs or HoMs.

Five RA working days in advance of each meeting, the ELO will e-mail the RA confirming the final pack of material for the meeting. The pack includes the information

sent to the DoNs/CNs or HoMs and a case summary (Annexe D) for each case to be discussed. The material should be presented as a pdf, with the summaries in the same order as the case list. The RA may agree with their ELO to receive the final meeting pack later than the 5 day SLA, for example, if they have scheduled their preparation day the day before the meeting takes place. An email confirming the revised due date should be sent to the ELO for logging in CMS.

The RA will prepare for the meeting by:

- downloading the 'bundle' to their laptop/iPad
- reviewing the note of the previous meeting and completing any actions
- reviewing any telephone notes since the previous meeting and completing any actions
- noting any on-going local concerns that they plan to discuss with the DoNs/CNs or HoMs reviewing any press cuttings sent to the employer that they will want to follow up at the meeting
- identifying any issues or wider NMC updates that they want to discuss with the DoNs/CNs or HoMs
- familiarising themselves with each case using the case summary and CMS. RAs may further discuss the case with the CIO or the CIM to understand the rationale for decisions and reasons for any delays. Where an information delay is due to the DoNs/CNs or HoMs or their organisation, the RA should make a note to secure an update on progress that can be shared with the CIO/CIM.

If an RA edits a case summary, this should be returned to the ELO along with a request that the revised text replaces the existing summary in CMS. This ensures the most up to date summary is held in CMS.

Minimising information security risks is a key priority for the NMC. RA/DoN meetings based on hard copy documentation containing highly sensitive information represent a significant potential risk. In order to mitigate this risk, the ELS deliver external meetings with nurse or midwife identifiable content on a paperless basis. You should refer to the Information Security Considerations section of this manual for further guidance on Paperless Working.

The RA/DoN meeting

The standard agenda for RA meetings is provided in Annexe C and includes items on: open and recently closed cases, local concerns and press cuttings.

Outcomes of open/closed case discussions

There are three possible outcomes of discussion on open NMC cases:

1. Additional information has been provided about the nurse or midwife or case. The RA should inform the CIO managing the case and email them the relevant part of the meeting note that summarises the new information. Following receipt of the information, the CIO may decide to seek further advice as to whether the

new information constitutes a new allegation against the nurse or midwife and should be sent to Screening as a new referral.
2. DoNs/CNs or HoMs no longer has a relationship with the nurse or midwife and agrees that the case can be removed from the list for discussion at the next meeting. The RA should record this in the action column of the meeting note.
3. Review the case at next meeting.

On occasion, the DoNs/CNs or HoMs may provide feedback on some aspect of a closed case. This feedback should be logged in the notes section of the meeting note and the RA share the feedback with an appropriate internal NMC colleague.

Local issues

One of the key services that the RA provides is discussions about individual nurses or midwives where concerns are being handled locally or where the DoNs/CNs or HoMs is considering action. These discussions provide the DoNs/CNs or HoMs with an opportunity to discuss local problems, thresholds for referral to the NMC, local management and patient safety issues.

RAs should discuss all instances of nurses of midwives causing concern and work with the DoNs/CNs or HoMs to identify issues that can be managed locally and limit inappropriate or poorly timed referrals to the NMC. In both commenting on how to deal with nurses and midwives that are below the NMC threshold for referral and in discussing the DoNs/CNs or HoMs clinical governance arrangements, the RA is an adviser and not in a position to provide formal decisions. The RA does *not* have a role in quality assuring the DoNs/CNs or HoMs local governance or investigation processes however they should encourage the DoNs/CNs or HoMs to reflect on whether their local systems are effective and if they have taken appropriate action in individual cases. The responsibility for taking action on issues, whether referring to the NMC or dealing with the matter locally, sits firmly with the DoNs/CNs or HoMs.

The outcomes of these conversations will be that the RA advises the DoNs/CNs or HoMs to:

1. refer the nurse of midwife to the NMC for investigation. The RA should encourage the provision of appropriate evidence, remind the DoNs/CNs or HoMs of the importance of continuing local action and manage expectations around outcomes
2. deal with the issue locally, with monitoring and review, for future update with the RA
3. deal with the issue locally

In all cases the RA should exercise caution and provide advice based on the best available information. The RA should consider the RA case referral checklist (Annexe E) when discussing a potential case with the DoNs/CNs or HoMs. The RA should not make 'snap decisions' when considering how to deal with a potential case and should not rely on anecdote. If the RA is unable to advise about referral at that time, RAs should request DoN/CN or HoMs send them further information about the local issue (for example a local report) which they can review before providing further advice. This information would not constitute an official referral, but would be used by the RA to

consider whether to advise referral. The RA should discuss the potential case with the AD ELS if they are still unsure once they have received the information.

If the RA advises not to refer, they should discuss what steps the DoNs/CNs or HoMs could take, which may include liaising with HR or Occupational Health to produce an internal action plan for dealing with the concern. The RA should record the proposed action in the meeting note and follow up with the DoNs/CNs or HoMs at subsequent meetings. There will be instances where the threshold for referral is not reached initially but is met as a result of subsequent actions by the nurse or midwife and the RA should pick these up through ongoing monitoring.

New referral to NMC

There will be occasions where the RA advises that a referral to the NMC is required. The RA should note the advice to refer in the meeting or telephone record and at subsequent meetings the case should be on the RA/DoN case list for follow-on discussions. The RA should also request that the DoNs/CNs or HoMs email the referral to newreferrals@ I&S (copying in the RA).

An RA forwarding referral correspondence can either send it to newreferrals@ I&S I&S or use the internal email address in Outlook titled 'New Referrals'. Both feed into the same mailbox but it is important RAs are consistent and ask DoN/CNs HoM to send to newreferrals@ I&S .RAs should include the following text in the subject line of the email - 'New referral – ELS involved'. The RA should alert the ELO to add a case note indicating that the referral was made after ELS advice.

Where a referral is received in writing addressed to the RA via the general mail, the correspondence is picked up by the support team and sent to the scanning team for ad hoc scanning. A copy will also be sent to the relevant RA. RAs should review their alerts in CMS on a regular basis to check no tasks have been assigned to them. If an RA identifies an unexpected alert assigned to them in CMS, they should contact the support team or Head of Service Delivery or ELO who will clarify what to do.

RAs might be involved in managing a referral which is high profile, for example a nurse/midwife or organisation receiving significant media coverage. In this situation, RAs should copy in the following people to the referral: Screening, Head of Investigations; Head of Service Delivery; and the AD ELS so that it has the best chance of being prioritised.

Questions or complaints raised by the DoNs/CNs or HoMs about NMC processes

The RA may need to deal with concerns or complaints raised by DoN/CN or HoM in respect of NMC processes and decisions. When a complaint is received the RA needs to work to improve the responsiveness of the NMC and/or provide an explanation for any delay, decision or NMC process. In cases where the DoN/CN or HoM has a process complaint relating to a lack of NMC communication or delays in the progression of a case, the RA needs to consider whether they can work with colleagues to improve the situation. The RA should also spend time with the DoN/CN or HoM explaining the process so that at a minimum the DoN/CN or HoM understands the perspective of the NMC. RAs should escalate serious or persistent problems to the AD ELS.

More difficult scenarios are the instances where the DoN/CN or HoM has a concern/complaint about the decision by the NMC to investigate a complaint or the outcome of a case. These scenarios may represent a potential threat to the RA relationship with DoN/CN or HoM and reputation of the NMC and need to be managed carefully. While the RA has a responsibility to provide feedback to other FtP teams, it is generally unlikely that the RA can alter the course of an investigation. As such, the RA needs to have an expert understanding of the case and the related DoN/CN or HoM complaint and attempt to clearly articulate the rationale behind the decision. In these instances the RA should feel comfortable relying on the support of experienced RAs and/or their AD ELS on how to respond to the DoN/CN or HoM concern. The RA should record the complaint on the meeting note and initiate follow-on discussions at subsequent meetings as appropriate.

Documenting meetings

The RA should make a record of the discussion in the form of a meeting note (Annexe Fi). The note will document the issues and cases discussed, nurses and midwives who the ELO does not need to include in any future case lists, actions agreed, advice provided, and any other information that either the RA or DoN/CN or HoM may need to reference. It is particularly important that the note captures advice to refer/not refer and instances where the RA may need to escalate the case within the NMC as a result of a disagreement with a DoN/CN or HoM over their decision not to refer.

The RA should undertake any actions within the agreed timescales and produce a draft meeting note within **five** RA working days of the meeting. If the five day deadline is not possible, the RA should provide a brief reason for the delay within the email that the meeting note is attached so we can understand reasons for delays. The RA should also share a copy of the draft note with the DoN/CN or HoM requesting that they notify them of any corrections or amendments within 14 working days. The covering email should include standard minimum wording to ensure the DoN/CN or HoM is aware of the 'disclosability' of the meeting notes (see Annexe G).

In the event a draft meeting note is amended following feedback from the DoN/CN or HoM, the RA sends a final copy to the ELO for filing in the meeting record in CMS. The RA should also resend the final note to the DoN/CN or HoM if any amendments were made to the earlier draft. The final note should be sent to the Link mailbox within 10 working days of the meeting. Once the note of the meeting has been emailed to the ELO, the RA should delete it from their local folder, along with the bundle and any other documentation stored to support the meeting. If the draft note has not been amended it will be saved as the final copy in CMS.

A separate meeting note for each Trust should be saved in CMS. For those meetings with a DoN/CN or HoM who covers multiple Trusts or quality summits where multiple trusts/boards are discussed, the meeting note includes a section covering general discussion and annexes for any cases discussed according to each Trust (Annexe Fii). The main note and relevant annexe for each Trust should be saved in CMS.

If there is information pertinent to an ongoing investigation the RA may wish to share the relevant section of the meeting note with the CIO/CIM. Full meeting notes should

not be shared with CIO/CIMs or other FtP colleagues as they may hold information about more than one registrant's case. Only the section of information relevant to an FtP colleague should be shared. This reduces the risk of a colleague saving the meeting note in an unrestricted section of CMS, minimising risk of an information security breach.

The ELO records all actions for the RA, ELO or the DoNs/CNs or HoMs arising from the meeting in the Notes section within the meeting record in CMS and sends an alert to the appropriate RA or ELO. The ELO along with the RA monitors completion of these actions. Actions may be identified by the RA as having already been completed prior to receipt of the meeting note by the ELS support team. The ELO must still add the action to CMS but it can be set immediately to 'complete'. It is the RA's responsibility to regularly check their alerts in CMS and set them to complete as and when they have been actioned. A monthly exception report is run by the ELO to identify and chase up any actions which are overdue.

Logging activity in CMS

All ELS activity including telephone calls in and out need to be logged in CMS. The activity needs to be recorded against the party organisation in CMS using the communication log. The process for recording activity is:

- go to the parties section of CMS and select party type: 'Organisation',
- if you have the ODS code (or NHS code) you can enter this in the 'party name' section and click search
- if you do not have the ODS (NHS code) you can enter the employer name or part of it in the 'alias' section and select search
- if the organisation does not appear it will need to be added by the ELO prior to the activity being recorded
- to record activity you need to select "communication log"
- select 'new' from the task bar
- enter the date of the activity

There are two data fields in the communication log that need to be completed. The first field is the 'Communication Type' field. This field is used to record the activity and the customer type for example "Call In (DoN)". The second field is the 'Communication Outcome' field. This is used to record the outcomes of ELS activity for example 'Potential referral (advised to refer)'.

Where there are multiple issues discussed they must be recorded as separate outcomes. The first outcome recorded should be the activity and the customer type for example "Call In (DoN)". All subsequent outcomes recorded should have a communication type: "ELS – multiple issues". **For reporting purposes it is essential**

that the activity and customer type is only recorded once per activity and all other outcomes and themes are recorded as "ELS - multiple issues".

If an outcome or activity is not covered in the pre-existing options you should inform the Head of Service Delivery.

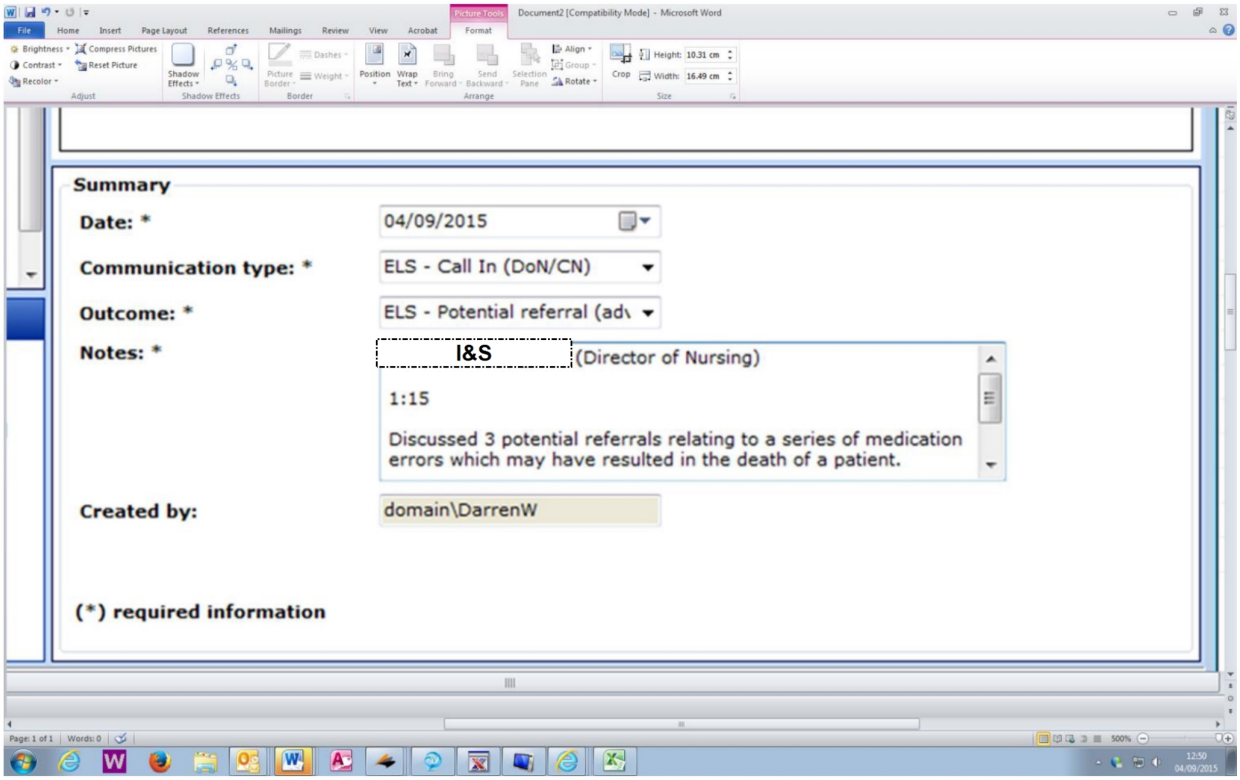
In the notes section you should record:

- Name of caller and role title
- Time engaged in the following format: H:MM
- High level description of the issues discussed

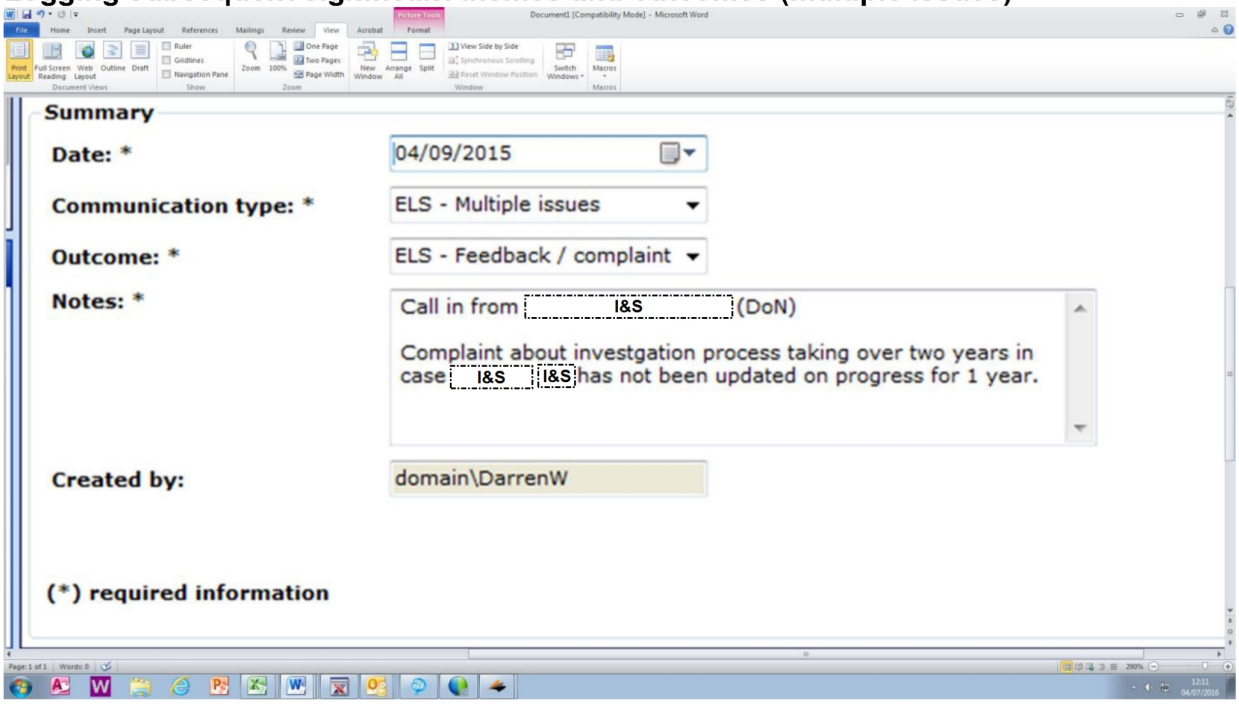
For advice calls you must record

- Time engaged in the following format: H:MM
- Name, designation, Tel no and email of caller:
- Name, DOB and PIN of Registrant under discussion:
- Brief reason for call:
- History (inc previous ELS/RA involvement) to call:
- Background:
- Matters arising from call/outcome:

Logging the initial activity and customer type



Logging subsequent significant themes and outcomes (multiple issues)



Internal operational activities of the ELS

RA Team meetings

RAs should attend the monthly team meetings. Meetings are half day sessions designed to share experiences, learning and gain an understanding of policy developments, high profile cases and strategic issues for the NMC. Each RA is expected to be an active contributor to these sessions and to work in between sessions with their fellow RAs to collaborate and share information. The RA should also be using these sessions to identify areas for learning and follow-up with other FtP staff. Through these engagements, the AD ELS will observe the RA's performance and provide regular and ongoing feedback to the RA, encouraging strong performance and helping identify areas for improvement.

Logging RA involvement in referrals

The ELS support team will log and monitor ELS involvement in referrals. In order to ensure that this log is capturing the correct information, DoN/CN or HoM should be asked to copy the RA into any referrals they make to the NMC following a discussion with or advice from the RA. In addition, RAs should notify Screening colleagues directly if they notice that a referral or promoted case, with which they had direct involvement, seems to be absent from the log.

Press cuttings

Although it is the responsibility of the High Profile Investigations team to approach and follow up Trusts for the majority of press cuttings, there will be certain issues that the individual RA will feel best placed to raise themselves, either by email or during meetings. The procedure around press cuttings is detailed below.

1. High Profile Investigations team will send the RA any new press cuttings about organisations they are visiting
2. The RA should review the cutting within two working days and advise:
    a. whether there are any particular cuttings that they would like to take forward personally with the DoN/CN or HoM, for example if the cutting references an issue they have already discussed.
    b. which DoN/CN or HoM should be contacted, if this is unclear from the cutting.
    c. of the need to refer the press cutting to the relevant system regulator if it appears to involve wider system failures.
    d. to close the enquiry if the issue is already known to NMC or relates to an open case but offers no new information.
3. If the RA advises that High Profile Investigations team should take forward the press cutting, the High Profile Investigations team will copy the RA into the email sent to the DoN/CN or HoM.
4. If the RA has selected to take forward the press cutting themselves, they should inform High Profile Investigations team of any information they receive about the issue.

5. The RA should forward cuttings to the ELO to ensure they are included in meeting papers and the ELO logs the cuttings under each Trust in CMS.

Notification and tracking of NMC investigations

Prior to contact with a DoN/CN or HoM, the RA should be informed of all new NMC investigations in the Trust/Board and kept up to date on the progress of cases. RAs should review reports for an overview of cases when preparing for meetings.

RAs will need to decide what, if any, information about case status changes are communicated to the DoN/CN or HoM taking into consideration NMC employer disclosure processes, rules and associated timescales. In discussion with the DoN/CN or HoM, the RA will have identified which cases are of particular interest and can notify at appropriate points if required. Other factors in deciding whether to notify the DoN/CN or HoM will include the seriousness of the case and possible media or other interest.

Managing Feedback from DoN/CN or HoM

RAs regularly receive feedback about NMC processes and policies from DoN/CN or HoM and other stakeholders with whom they have regular contact. This feedback is important information for the NMC as part of the continual review and improvement of policies and operational systems.

RAs act as the primary liaison between the ELS and other directorates/teams within the NMC. On receipt of feedback, RAs should forward this to the 'Lead RA' responsible for liaising with the relevant team within the NMC. 'Lead' RAs are responsible for:

- owning the issue until a suitable response is provided including logging it on the Lead RA log
- being aware of key developments in the area and sharing them within the ELS
- supporting the AD ELS in handling issues with senior NMC colleagues and keeping them updated on key issues as appropriate
- acting as a source of expertise for the lead area within ELS.

Six lead RA roles have been identified to provide the broad coverage of NMC functions. These are:

RA	Internal relationship	Specialist lead
Tony Newman	Registrations	Independent healthcare sector
David Porter	Screening & investigations	Risk intelligence
Michele Harrison	Revalidation	Midwifery, children's services and community
Amanda Halliwell	Adjudications	NMC Order & Rules, including Section 60 when it comes into force
Kristian Garsed	Education, Standards & Policy	UK healthcare regulatory reform, including Section 60 in terms of impact for employers

The ELO will regularly provide the AD ELS with a summary of the feedback received and responses for wider dissemination and discussion within NMC. Annually the ELO will also work with each 'Lead RA' to develop a summary of for their lead area. This will identify themes and issues captured during the year demonstrating where there has been positive change and where issues remain for further development and discussion. These will form the basis of a summary annual report to be agreed with the AD ELS.

Managing concerns about revalidation

An RA may receive information that raises a concern about the judgement of a revalidation confirmer or the quality of the systems to support revalidation processes. If such a concern arises, the RA should discuss it with the AD ELS and also notify the Revalidation Team, if appropriate.

Escalation of cases to the AD ELS

RAs need to be able to identify issues requiring escalation and act on these at appropriate points in time by notifying the AD ELS. There will generally be four situations which require escalation:

1. the DoN/CN or HoM identifies a case of a poorly performing nurse or midwife but does not want to refer to the NMC despite the RA's advice to do so

2. the DoN/CN or HoM displays a pattern of behaviour in dealing with FtP and Revalidation issues that RA believes poses a risk to patient safety
3. the DoN/CN or HoM has an open case with the NMC. The RA must not enter into discussion with the DoN/CN or HoM around the case, which should only be discussed with the DoN/CN or HoM's line manager
4. concerns over wider organisational governance or revalidation systems.

The RA should raise issues with the AD ELS, so they can jointly determine the most appropriate action to take. This may involve a combination of the following:

- direct contact to the DoN/CN or HoM by the AD ELS or Director of FtP
- direct contact from the NMC CEO to the DoN/CN or HoM's CEO
- contact with and discussion about the DoN/CN or HoM with their line manager
- opening an investigation about the nurse or midwife without a referral from the DoN/CN or HoM, but based on the information they have provided.

The NMC has the power under Article 22(6) of the Nursing and Midwifery Order 2001 to open cases of its own volition. This applies for example where the NMC becomes aware of a case in the media which raises public protection issues but no referral has been received. It also means that the NMC has power to open cases even where the DoN/CN or HoM does not want to refer. There is specific guidance for RAs on what steps to take in these circumstances which is contained in a separate document.

Whistleblowing or individual nurses or midwives raising concerns

RAs should raise any whistle-blowing issues with the AD ELS with a view to the issues being passed to the appropriate team or external stakeholder organisation if the issue is not one for the NMC.

Planning and Scheduling RA Meetings

Every December and May, RAs should develop a meeting plan for employers for the next six months and agree it with the Head of Service Delivery. A meeting plan template and guidance is provided at Annexe B.

Other operational processes relevant to the ELS

Information security considerations

The vast majority of ELS working documents are of a highly confidential nature. RAs must take care when emailing lists of nurses and midwives and meetings notes to ensure that the correct recipient has been identified. The RA is equipped so that they can minimise the use of paper and should use their iPad/laptop, for meeting purposes and not travel to meetings with the meeting briefing notes or other documents of a confidential nature. Where possible, documents should not be stored on the laptop

'desktop' but in the RA's local drive 'documents'. All documents of a confidential nature should be deleted from the RA's local drive as soon as the document has been saved to CMS.

Information security policies and guidance

Please see the intranet page which details information security policies and guidance and the intranet page detailing the information security user guide, home working checklist, clear desk policy and guidance to report data protection breaches and security incidents.

How to report an information security breach

You must inform the Head of Service Delivery (HoSD) of any potential breach of information security as soon as you become aware of it. The HoSD will log the incident as an SER and will contact the Information and Data Governance Manager.

Secure transfer of information (Egress switch)

Egress switch should be used by the ELS team for secure communications with employers. All confidential and sensitive **must be** sent by Egress.

Please see the http://mynmc.nmc-uk.org/org/how-to/Pages/Egress-email-encryption.aspx for users and detailed guidance.

Telephone security in ELS

When you receive a telephone call from someone who is looking to discuss a nurse or midwife's case, it is important not to share fitness to practise information and to ask yourself two questions before progressing the call any further:

1) Do I know this caller?

Yes – If you speak with the caller regularly and you have no doubts about their identity, proceed with the call as normal.

No – If you are not familiar with the caller, proceed to question 2 (below) and then follow the security check below.

2) Is the caller an interested party in a specific case?

No – Refer them to the relevant team depending on the query (this could be the screening team or the call centre)

Yes – Apply the security check below before continuing with the call.

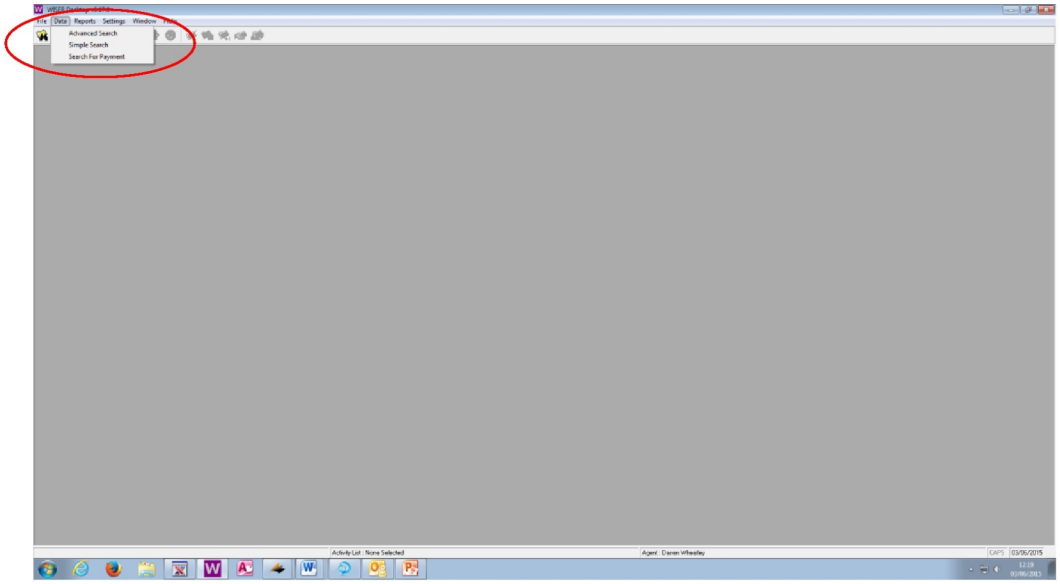
Security check to verify a callers identity

1. If a Director of Nursing or an NMC registrant request their NMC PIN Number and check in WISER

    - Open WISER
    - click the 'Data' tab
    - select 'simple search' (if given a NMC PIN number)
    - search of the PIN number (if searching a NMC PIN number)
    - proceed to step 2 (below).

    Or:

    - Open WISER
    - click the 'Data' tab
    - click on the 'Advance search' tab (if given an address or postcode)
    - search by surname and postcode
    - proceed to step 2 (below).



2. Check WISER to see if you have any personal details you can ask the caller to verify.

    When verifying personal details, try to ask for 2 out of the following:

    - DOB
    - email address
    - telephone number or (if a nurse/midwife)
    - the name of the training institute where they first qualified for entry on to the register

If you **do not** have personal details for the caller stored in WISER, proceed to Step 3.

Note: If the caller can provide the requested information at any stage of the security check, proceed with the call.

3. Ask the caller if they have a switchboard that you can ring them back on to verify their place of work.

   Finally, if you cannot use any of the above measures to identify the caller, proceed to Step 4.

4. Take a contact number for the person and report the call to the Head of Service Delivery who will help find an alternative way to verify a caller's identity.

   The security process is reflected in the checklist on the template we use for recording phone calls with substantial content – information that we need to record.

   Telephone notes should be stored in CMS as detailed below because it is important to have an audit trail to satisfy any Freedom of Information requests or review of ELS involvement with an organisation or on a case.

Freedom of Information Requests

This section explains what to do if you are approached by a third party contact for assistance in responding to a request received under the Freedom of Information Act 2000 (FOI).

The Freedom of Information Act 2000 came into force in January 2005. Under the Act, anyone has the right to request any recorded information held by a public authority, which will include bodies such as NHS Trusts. Any person making a request for information must:

a. be told whether the authority holds that information, and

b. be provided with that information (unless it is excluded under one of a number of exemptions.

On occasion ELS team may be asked for assistance in responding to FOI requests by third party contacts.

In order to expedite matters, the team should route all requests for assistance to the FOI Team to coordinate on behalf of the NMC.

FOI/DPA team

The Freedom of Information Team/ Data Protection Act Team is located within the Strategy directorate and is responsible for responding to information requests made to the NMC under FOI. They provide a point of contact for all NMC staff that may require advice on what to do with an information request raised directly with them should an applicant raise queries directly with them.

FOI/DPA related policies / procedures

The Freedom of Information Policy

Process

If you are approached for assistance regarding an FOI request received by a third party organisation, the process to follow is described below.

Please send any request directly to the FOI/DPA team at foirequest@ I&S
Please remember to include contact details of the person who has approached you.

If you have been asked for assistance verbally, then please ask the information requester to email a copy of the FOI request to foirequest@ I&S

The FOI/DPA team will acknowledge receipt of the request to the applicant. They will respond to the applicant as soon as possible and within 20 working days.

The FOI/DPA team will make contact with information holders within the NMC where necessary. For example, the team may contact the Fitness to Practise Investigation Team to request assistance around disclose in live cases.

The FOI/DPA team will respond directly to the information requester.

Any subsequent queries from either the RA or the applicant can be directed to the named FOI/DPA team officer responsible for dealing with the request.

Sharing information about non-registered nurses and midwives

RAs may occasionally become aware of information about individuals practising without registration or when their registration has lapsed. The RA should try to obtain the name and any further information about the individual. Cases in which unregistered practice appears to have happened should be referred in the first instance to the registration directorate.

Reviewing the performance of the ELS

Given that the RAs are senior members of staff, a number of additional activities to those undertaken for all NMC staff take place to evaluate RA performance and ensure they receive the right feedback to succeed in their role.

QA reviews will be undertaken to ensure that the meeting management and document management processes are in line with the guidance in this document. The ELS will also undertake its own quality assurance work, monitoring timelines and quality. The AD ELS will also shadow each RA at least once a year to observe their work in the field. Feedback about the service will also be obtained through an annual customer satisfaction survey.

Administrative Processes

Cover when the RA is on leave

Leave should be requested by entering the dates into HR self-service and submitting for line management approval. The RA should update the holiday tracker and send a calendar invite to the AD ELS – a simple ‘all day’ recurring invite is sufficient for the duration of the leave. Cover must be arranged before going on holiday and the support team informed of the name(s) of the RA covering. The RA should have an out of office message directing people to contact the ELO and details of how to do so. They should ensure their phones are diverted or they have a voicemail message directing the call through to their ELO.

Emergency arrangements

If an RA has an emergency or an urgent query, including out of hours, they must contact the AD ELS as soon as possible.

Arranging telephone conferences

A conference call can be set up using the ELS team's BT conference details or through the conference facility on your desk phone.

BT conference call

Order a teleconference pod from ICT Support and notify them of the room date and time or call from your desk phone.

You can meet with up to 40 delegates with this facility since they need only call a free phone number and a password.

It is imperative that you, setting up as chairperson (this is BT's description which effectively means that you facilitate the conference call), have to phone in first.

Firstly, you will have to log into the teleconference pod as you would do or your own NMC phone – so it will be your user name and the usual password e.g. 11223344.

Then:

The Chairperson's dial in number is (dial 9 for outside line): 08 I&S
Followed by passcode: I&S then #

(Please note that if you are working at home on NMC business you can still chair a teleconference from your home phone by using the chairperson's dial in details given above).

The Chairperson (which will usually be an NMC staff member) should phone in about five minutes before the start time of teleconference and will then be joined by each participant – it will be announced when each participant joins the teleconference and similarly when they leave the teleconference.

The participants' free phone dial in number is: 08 I&S
The participant's passcode is: I&S then #

Telephone conferencing from your desk telephone

If you need to have a telephone call with more than one person, it is possible to do this using our phones rather than booking a teleconference facility.

- Step 1 – dial the extension of the first person
- Step 2 – press the CONF button
- Step 3 – dial the extension of the second person
- Step 4 – press the JOIN button
- Step 5 – press the ADD button
- Step 6 – dial the extension of the third person

- Step 7 – press the JOIN button

Repeat Steps 6 and 7 for as many additional people you want to join the call.

RA personal conflict of interest

An RA may encounter a conflict of interest when responding to a DoN/CN or HoM concerns about a nurse or midwife including where:

- there is or has been a personal, business or family relationship (partnership, friendship)
- there is a known and long-standing personal animosity
- the nurse or midwife works at in a setting at which the RA and/or their immediate family are patients
- the nurse or midwife is currently treating or has recently treated the RA or their immediate family
- the RA has made, at any time, a formal complaint in a personal capacity about the nurse or midwife or has been involved in such a case
- the RA has been involved in performance management, disciplinary or grievance issues in respect of the nurse or midwife.

In such situations the RA must advise the AD ELS who may appoint another RA to provide advice on the case or take other action short of replacing the RA. Where the AD ELS decide a conflict of interest does not exist, she/he will make a record of this decision.

Annexe A – Telephone Note Template

TELEPHONE NOTE

1.	**DATE:**		**TIME:**	
2.	**Name of Contact and Organisation:**			
3.	**TO:**			
4.	**RE:**			

SECURITY CHECK (Please mark appropriate statement)	**Y / N**
I know the caller, no security check required	
No confidential information was disclosed to the caller	
The caller was able to verify personal details	
The caller provided a switchboard number	
The caller failed the security check / was referred back to the contacts centre / advice sought from the Information Team	

5. For named nurse/ midwife only	PIN No, CMS case reference and CMS check on FTP history?
6. Main Note	**FTP CASES ONLY**: Breach of NMC Code/standards identified? Equalities issues identified? Local investigation? Current stage and timescale? Local restrictions in place/remediation? Other organisations involved? Description of nurse or midwife's practice, private practice, locum work? Other local concerns?
7. Agreed actions/ next steps	
8. TIME ENGAGED:	

Annexe B – RA Annual Meeting Schedule

RAs should develop a meeting schedule. The schedule is meant to be indicative of the number and types of meetings planned by the RA for the six months. When determining the frequency of meetings, RAs should assess, based on their experience with the organisation, the degree of risk the organisation carries in relation to patient safety and fitness to practise concerns. This assessment includes consideration of:

- The type of services the organisation provides - this may impact on the number of cases an organisation has open with the NMC or the likelihood of local concerns.
- The number of nurses and midwives employed - organisations with small numbers of midwives may not need to be met as frequently.
- The number of open cases with the NMC - organisations with a high proportion of cases may need more frequent meetings for updates.
- The wider system of regulation and routine monitoring by other regulators – some organisations operate in highly regulated fields that include inspections or routine reporting of their activities to a number of regulators.
- The level of experience of the DoN/CN or HoM and their awareness of FtP processes - organisations with a new DoN/CN or HoM may need more frequent meetings in the short term.

The schedule only includes regular RA and DoN/CN or HoM meetings, however it is recognised that a number of additional meetings will arise throughout the year including networks, risk and quality summits, regional quality surveillance groups, workshops and the like.

RA Name:
Year:

Organisation Name	Freq (per annum)	Multi Org (Y/N)	Meeting 1		Meeting 2		Meeting 3	
			Month	Type	Month	Type	Month	Type

Meeting Type Key

- IP – In Person
- TC – Telephone Conference

Annexe C – Meeting Agenda Template

Employer Link Service

[Date]

[Time]

[Location]

Agenda

1. NMC update
2. Local update
3. Update on non-case actions from the last meeting
4. Nurses and midwives with current NMC cases
5. Nurses and midwives with cases closed since previous meeting
6. Local issues
7. Press cutting enquiries
8. Any other business
9. Next meeting date

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Annexe D – Case Overview Template

Case Number:	**IO?: Yes/No**
Case Name:	**PIN:**
Gender: M/F	
Investigation/Criminal Conviction (delete as appropriate)	**Nurse / Midwife** (delete as appropriate)
Opened (date):	**Registrant Disclosure** (date):
Current FTP status: Conditions/Suspended	**Upcoming hearings (next 6 months):**
Revalidation Date and Status:	**Employer:**

Case Overview

Meeting Location:
Meeting date:
Document created on:
Author:
Version:

The details of each update will be recorded in the one line preceding each update e.g.

Case Update: dd mm yy (ELO Name, Latest meeting name)

Index Complaint (Screening Decision t)

- Name of complainant/referrer
- Date of complaint/referral
- Description of allegations including date and location of incident (if relevant)

Case Progression

- Employer Disclosure – name of employer and date
- Adverse Information
- Description of our investigation to date (delete as appropriate)
    - Medical Records
    - Is the case being managed by the enhanced case management team?
    - Expert Report – date and outcome
    - Health Assessment – date and outcome
    - Performance Assessment – date and outcome
    - Police/Court reports or findings – date and outcome
    - Witness Statements
- Case Examiner Decisions (summarised)
- Hearings – type of hearing, date of hearing, outcome
- Panel Decisions

Current Position

- What is left on the investigation plan?

RESTRICTIONS

- Wording of the current conditions

Annexe E – RA Case Referral Checklist

	Considerations
1.	Has there been a breach of NMC Code/standards?
2.	If yes, how serious? In the event there has been a breach of NMC Code/standards, which specific NMC Code/standards have been breached?
3.	If no, does it require any follow up?
4.	Are there any other organisations involved in the case? For example, police; NHS Counter Fraud; CQC. If so, how does it affect our need to take action?
5.	What is the risk to patients/public in allowing the nurse or midwife to continue to practise unfettered?
6.	Has any local investigation taken place and what has been the outcome?
7.	What arrangements are in place to minimise the risk to patients? For example, local conditions, contingent removals, supervision etc.
8.	What arrangements are in place for remediation?
9.	Does the local investigation and management satisfy you that the issue is being appropriately managed?
10.	Are there any reputational risks to the NMC such as significant press coverage or if the case involves a high profile nurse/midwife?
11.	Does the nurse/midwife have any FtP history with the NMC?

Annexe Fi – Meeting note template (standard)

Employer Link Service Meeting

Meeting Note –

Date and Time:
Meeting Location:
Attendees:

1	**NMC update**	**Notes**	**Actions**
2	**Local update**	**Notes**	**Actions**
3	**Update on non-case actions from last meeting**	**Notes**	**Actions**
4	**Registrants with current NMC cases**		**Actions**
5	**Registrants with cases closed since the last meeting**	**Notes**	**Actions**
6	**Local issues**	**Notes**	**Actions**
8	**Press Cuttings**	**Notes**	**Actions**
9	**AOB**		
10	**Next meeting date**		

Notes:

1. The meeting note is not a minute but a record of matters covered and actions agreed. The information captured in the meeting note should be concise and accurate.
2. The name and PIN of each registrant should be recorded for items 4, 5, and 6 where possible.
3. When the discussion does not add any new information or result in an action, the notes and action columns should not be populated.
4. For closed cases, it is reasonable to record any action taken
5. Particular care should be taken to ensure that any references to a registrant's health at any point in the meeting note are recorded appropriately.
6. Actions can be for the RA, in which case the ELO will add to the Alerts in CMS. When the action is for the DoN/CN or HoM, the RA action, to be recorded in CMS, is that the RA will follow up the DoN/CN or HoM action.

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Annexe Fii – Meeting note template (multiple employers)

Meeting Note – *List employers covered in meeting*

Date and Time:
Meeting Location:
Attendees:

1	NMC Update	Notes	Actions
2	**Local Update**	**Notes**	**Actions**
3	**Update on non-case actions from last meeting**	**Notes**	**Actions**
4	**Next Meeting**		
5	**Employer Annexes**		
		List all employers where an annexe has been completed	

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Annexe A to multiple employer meeting note– *List employers covered in Annexe*

6	Registrants with current NMC cases	Notes	Actions
7	**Registrants with cases closed since the last meeting**	**Notes**	**Actions**
8	**Press cuttings enquiries**	**Notes**	**Actions**
9	**Local Issues**		
10	**AOB**		

Notes:

1. The meeting note is not a minute but a record of matters covered and actions agreed. The information captured in the meeting note should be concise and accurate.
2. The name and PIN of each registrant should be recorded for items 4, 5, and 6 where possible.
3. When the discussion does not add any new information or result in an action, the notes and action columns should not be populated.
4. For closed cases, it is reasonable to record any action taken.
5. Particular care should be taken to ensure that any references to a registrants health at any point in the meeting note are recorded appropriately.

a. Actions can be for the RA, in which case the ELO will add to the Alerts in CMS. When the action is for the DoN/CN or HoM, the RA action, to be recorded in CMS, is that the RA will follow up the DoN/CN or HoM action.

Annexe G – DoN/CN/HoM Email Templates

1. EMAIL TO DoN/CN/HoM - RA MEETING NOTE

Dear XXX

Thank you for the helpful meeting on XXX

I attach a draft meeting note. Please let me know of any errors, omissions or changes you would like to make before I save them onto our system.

Please note that these notes are potentially disclosable and the content has to be accurate, fair and relevant. This note is intended purely as a record of the meeting; in the event that the note is shared for audit or appraisal purposes, the content should be completely anonymised.

I look forward to meeting with you again on xxxx

Many thanks

2. EMAIL TO DoN/CN/HoM – TELEPHONE NOTE

Dear

Thank you for your telephone call of the XXXX

I attach a draft note of our conversation. Please let me know of any errors, omissions or changes you would like to make.

Please note that these notes are potentially disclosable and the content has to be accurate, fair and relevant. This note is intendedly as a record of our conversation; in the event that the note is shared for audit or appraisal purposes, the content should be completely anonymised.

Many thanks