Taking account of context

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In this guide

Overview

Back to top

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

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

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

Our approach

Back to top

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

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

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

- Is there evidence to suggest that there is a risk to public safety, public confidence or professional standards that could require us to take regulatory action to protect the public?
- If so, why did this happen and do we think it could happen again?
- If so, what action do we need to take to protect the public?

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

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

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