Aims and principles for fitness to practise

Reference: FTP-1 Last Updated: 14/04/2021

Our overarching objective as an organisation, is the protection of the public. It's central to everything we do.

In order to achieve our overarching objective, our legal framework[1] says we need to:

- protect, promote and maintain the health, safety and wellbeing of the public
- promote and maintain public confidence in the nursing and midwifery professions
- promote and maintain proper professional standards and conduct for members of the nursing and midwifery professions.

Our aims for fitness to practise

We have two clear aims for fitness to practise:

- A professional culture that values equality, diversity and inclusion, and prioritises openness and learning in the interests of patient safety
- Nurses, midwives and nursing associates who are fit to practise safely and professionally.

We designed a set of principles to help us deliver these aims.

Our principles for fitness to practise

We'll use these 12 principles to make sure we're consistent and transparent in the way we work and in the way we make decisions about nurses, midwives and nursing associates' fitness to practise.

Read about each principle below and how we apply it to what we do.

1. A person-centred approach to fitness to practise.

A person-centred approach helps us to put patients, families and the public at the heart of what we do.

It involves listening to what patients, their families and loved ones tell us about their experiences so that we can understand what the regulatory concerns about nurses, midwives and nursing associates might be and are better placed to act on those concerns. Sometimes, they provide vital information that shows we need to scrutinise the conclusions others have reached.

We want patients and members of the public to feel supported and listened to in our fitness to practise proceedings. Putting patients, families and the public at the centre of what we do helps us to make sure we are in the best place to protect the public.

2. Fitness to practise is about managing the risk that a nurse, midwife or nursing associate poses to patients or members of the public in the future. It isn't about punishing people for past events.

If professionals see us as being punitive, those professionals are more likely to hide things going wrong or act defensively. This will make it difficult to achieve the kind of open and learning culture that's most likely to keep patients and members of the public safe.

If we are seen by the people affected by unsafe care, as being there to discipline the nurses, midwives or nursing associates involved, those people may be distressed if we don't take action against nurses, midwives or nursing associates who are no longer a risk.

3. We can best protect patients and members of the public by making final fitness to practise decisions swiftly and publishing the reasons openly.

Transparency is crucial to an effective fitness to practise process. All the people involved in a case, including patients, members of the public, and nurses, midwives and nursing associates, expect fitness to practise processes to be efficient and joined up.

They need to understand clearly and as quickly as possible what we have done about the concerns, and the reasons for our decisions. Those reasons may help others in similar situations make decisions that will help keep patients and members of the public safe.

4. Employers should act first to deal with concerns about a nurse, midwife or nursing associate's practice, unless the risk to patients or the public is so serious that we need to take immediate action.

Employers are closer to the sources of risk to patients and members of the public, and better able to recognise and manage them. If they need to, they can intervene directly and quickly in a nurse, midwife or nursing associate's practice, and do so in a targeted way dealing specifically with the risks.

We are further away from the sources of possible harm, and have a more limited range of options to prevent it.

We only need to become involved early on if the nurse, midwife or nursing associate poses a risk of harm to patients or the public that the employer can't manage effectively (perhaps because the nurse, midwife or nursing associate has left), meaning the nurse, midwife or nursing associate's right to practise needs to be withdrawn or restricted immediately.

5. We always take regulatory action when there is a risk to patient safety that is not being effectively managed by an employer.

In the small number of cases where employers can't put the right controls in place to keep patients and members of the public safe, then we will need to become involved. This can often happen when the nurse, midwife or nursing associate practises in more than one setting, or doesn't have an employer, although these aren't the only examples. We may need to consider putting conditions on the nurse, midwife or nursing associate's ability to practise, or remove it.

6. We take account of the context in which the nurse, midwife or nursing associate was practising when deciding whether there is a risk to patient safety that requires us to take regulatory action.

When incidents of poor practice actually happen because of underlying system failures, taking regulatory action against a nurse, midwife or nursing associate may not stop similar incidents happening again in the future. Regulatory action against an individual nurse, midwife or nursing associate may give false assurance, direct focus away from a wider problem and cause a future public protection gap.

7. We may not need to take regulatory action for a clinical mistake, even where there has been serious harm to a patient or service-user, if there is no longer a risk to patient safety and the nurse, midwife or nursing associate has been open about what went wrong and can demonstrate that they have learned from it.

Encouraging nurses, midwives and nursing associates to learn from mistakes, including mistakes with serious consequences, is more likely to promote a learning culture that keeps patients and members of the public safe, than taking regulatory action to 'mark' the seriousness of the consequences.

Negative stories about regulation have a harmful effect on nurses, midwives and nursing associates. We want to assure nurses, midwives and nursing associates that they won't be punished if they admit to, and show they have learned from, past mistakes because this will support them in positively engaging with their professional duty of candour and help promote, rather than discourage, the kind of professional culture that's been shown to keep people safe.

8. Deliberately covering up when things go wrong seriously undermines patient safety and damages public trust in the professions. Restrictive regulatory action is likely to be required in such cases.

The duty of candour requires nurses, midwives and nursing associates to be open and honest when things go wrong. It stops them from trying to prevent colleagues or former colleagues from raising concerns.

We know that if professionals don't speak up when things go wrong, significant numbers of people can suffer harm, and have done in the past. Nurses, midwives and nursing associates who try to cover up problems in their

own practice deny patients and members of the public the honest explanation and apology they deserve when they have been put at risk of harm. It can also put other people at risk of suffering harm if organisations are prevented from investigating wider problems.

9. In cases about clinical practice, taking action solely to maintain public confidence or uphold standards is only likely to be needed if the regulatory concern can't be addressed.

If the nurse, midwife or nursing associate has fully addressed the problem in their practice that led to the incident, and already poses no further risk to patients, we won't usually need to take action to uphold public confidence or professional standards. Only those clinical concerns that are so serious that they can't be put right will prompt us to take regulatory action to promote public confidence or uphold standards.

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

We know that the public take concerns which affect the trustworthiness of nurses, midwives and nursing associates particularly seriously. Our research told us that these cases are likely seen by the public as serious breaches of professional standards. Conduct that could affect trust in nurses, midwives and nursing associates and require action to uphold standards or public confidence include, where related to professional practice, dishonesty, bullying and harassment. Within a nurse, midwife or nursing associate's private life, convictions that relate to specified offences or result in custodial sentences are also likely to require regulatory action for the same reason.

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

Conduct that calls into question the basics of someone's professionalism raises concerns about whether they are a suitable person to remain on a register of professionals. It's more difficult for nurses, midwives or nursing associates to be able to address concerns of this kind, and where they cannot, it will be difficult to justify them keeping their registered status.

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

Full public hearings are not always required to reach a decision that protects the public. Their adversarial nature often has a negative impact on people, and they are slow and resource intensive.

1 See article 3(4) and (4A) Nursing and Midwifery Order 2001