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Aims and principles for fitness to practise

Reference: FTP-1 Last Updated: 26/11/2018

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 and midwives 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 and midwives' 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 and midwives 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 or midwife 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 and midwives involved, those people may be distressed if we don't take action against nurses and midwives 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 and midwives, 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 or midwife'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 or midwife'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 or midwife poses a risk of harm to patients or the public that the employer can't manage effectively (perhaps because the nurse or midwife has left), meaning the nurse or midwife'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 or midwife 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 or midwife's ability to practise, or remove it.

6. We take account of the context in which the nurse or midwife 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 or midwife may not stop similar incidents happening again in the future. Regulatory action against an individual nurse or midwife 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 or midwife has been open about what went wrong and can demonstrate that they have learned from it.

Encouraging nurses and midwives 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 and midwives. We want to assure nurses and midwives 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 and midwives 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 and midwives 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 remedied.

If the nurse or midwife has fully remedied 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 or midwife as a professional.

We know that the public take concerns which affect the trustworthiness of nurses and midwives 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 and midwives and require action to uphold standards or public confidence include, where related to professional practice, dishonesty, bullying and harassment. Within a nurse or midwife'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 or midwife's professionalism, can't be remedied 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 and midwives to be able to remedy 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 or midwife 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

Allegations we consider

Reference: FTP-2 Last Updated: 28/07/2017

Our statutory powers to carry out investigations are limited to two kinds of allegation:

- Allegations of fraudulent or incorrect entry of an individual nurse or midwife to our register
- Allegations about the fitness to practise of nurses or midwives.

Allegations about fitness to practise can be based on:

- misconduct
- lack of competence
- criminal convictions and cautions
- health
- not having the necessary knowledge of English
- determinations by other health or social care organisations

Misconduct

Reference: FTP-2a Last Updated: 31/08/2018

The Code sets the professional standards of practice and behaviour for nurses and midwives, and the standards that patients and public tell us they expect from nurses and midwives. While the values and principles can be interpreted for particular practice settings, they are not negotiable.

If nurses and midwives fall short of the Code, what they did or failed to do may be serious professional misconduct. We'll need to investigate and take action if this is the case.

When does poor clinical practice become serious professional misconduct?

There are certain kinds of clinical concerns we think are the most serious because they may lead to patients or members of the public suffering harm.

Because fitness to practise is about keeping people safe, rather than punishing nurses and midwives for past mistakes, one-off clinical incidents won't usually be considered serious professional misconduct.

Even where there has been serious harm to a patient or service-user, provided there is no longer a risk to patient safety, and the nurse or midwife has been open about what went wrong and can demonstrate that they have learned from it, we will not usually need to take action.

However, some concerns about patient harm will be so serious that they can't be remedied and we will need to take action to protect public confidence or to uphold professional standards. In cases like this, we will usually only need to take action if it's clear that the nurse or midwife deliberately chose to take an unreasonable risk with the safety of patients or service users in their care.

When we are looking at patient safety incidents involving nurses or midwives, we will always look carefully at the context in which they were practising. Even poor practice by a nurse or midwife might actually have happened because of underlying system failures.

In these circumstances, taking regulatory action against a nurse or midwife would not only be unfair, but it may not stop similar incidents happening again in the future, and might not keep people safe.

Our guidance about seriousness uses parts of the Code to explain what kinds of clinical concerns we think are the most serious.

What other kinds of misconduct are there?

Actions or failings which are related to clinical practice, but not a direct part of it, can be serious professional misconduct, as can issues about the nurse or midwife's role as a registered professional.

Bullying and harassment of colleagues, dishonesty about qualifications or employment history, are just some examples. A more extensive list is in our guidance about seriousness.

Sometimes, even the way a nurse or midwife conducts themselves in their private life could be serious professional misconduct.

This will usually only happen if the concerns raise fundamental questions about their trustworthiness as a registered professional. This is a high threshold, because it means we may need to take action to protect public confidence in all nurses and midwives, or uphold professional standards.

Comparing misconduct in a nurse or midwife's private life, to our approach to criminal convictions, we would say that only convictions for specified offences or ending with a sentence of imprisonment would be serious enough to raise fundamental questions about a nurse or midwife's trustworthiness as a registered professional.

We don’t need to become involved in issues like bad timekeeping, or minor breaches of a local disciplinary policy, because they won’t put patients or members of the public at risk of suffering harm, and they don’t raise fundamental questions about a nurse or midwife’s trustworthiness as a registered professional.

Lack of competence

Reference: FTP-2b Last Updated: 28/07/2017

We recognise that nurses and midwives sometimes make mistakes or errors of judgement. Unless it was exceptionally serious, a single clinical incident would not indicate a general lack of competence on the part of a nurse or midwife.

Substandard care that calls into question a nurse or midwife's competence would usually involve an unacceptably low standard of professional performance, judged on a fair sample of the nurse or midwife's work, which could put patients at risk, . For instance when a nurse or midwife demonstrates a lack of knowledge, skill or judgement showing they are incapable of safe and effective practice.

Criminal convictions and cautions

Reference: FTP-2c Last Updated: 31/08/2018

In this guide

Overview

Criminal offending can affect the fitness to practise of nurses and midwives in a number of ways.

This page sets out when a nurse or midwife's criminal offending may be relevant to their registration or fitness to practise.

We also explain how we assess the seriousness of criminal convictions and what we do when possible criminal conduct does not end with a caution or conviction.

We have separate guidance on the types of criminal offending we can't investigate.

Considering criminal conviction or caution declarations

Nurses or midwives must declare any cautions or convictions, unless these are for a protected caution or conviction, when they apply to join our register or renew their registration with us.

They also need to let us know if they become involved in criminal offending while they're on our register.

Not telling us about a conviction or caution is a clear breach of the Code.

If there's evidence the nurse or midwife was dishonest about criminal offending when they applied to join our register or renew their registration, we'll have to carry out a full investigation into the circumstances to determine if this affects their registration.

If a nurse or midwife is involved in criminal offending after they joined the register, or renewed their registration, it won't affect their entry in the register, but it may affect their fitness to practise if they kept the fact they were charged, accepted a caution, or were convicted, from us.

This is because we have a clear expectation, as set out under the Code, that nurses and midwives should let us know if they are involved in criminal offending as soon as they can.

In all these cases we'll consider the possible effect on the nurse or midwife's registration, or their fitness to practise, even if the offending itself was not serious.

Assessing the seriousness of convictions and cautions

If the criminal offending was directly linked to the nurse or midwife's professional practice, it's very likely this would be serious enough to affect their fitness to practise.

For example, offences that involved neglecting, exploiting, assaulting or otherwise harming patients are so serious that it may be harder for the nurse or midwife to remediate. In these cases it's more likely that we'll need to take regulatory action to maintain professional standards and public confidence in nurses and midwives.

If the criminal offending took place in the nurse or midwife's private life, and there's no clear risk to patients or members of the public, then it is unlikely that we'll need to take regulatory action to uphold confidence in nurses and midwives, or professional standards.

We'd only need to do that if the nurse or midwife was given a custodial sentence (this includes suspended sentences), or the conviction was for a specified offence.

Once we decide that the conviction, and any information we've gathered about the surrounding circumstances, would be serious enough to affect the nurse or midwife's fitness to practise, we'll seek police information to verify the details of the conviction or caution referred to us.

Find out more about how we determine seriousness.

Referring serious convictions directly to the Fitness to Practise Committee

We may pass the case directly to the Fitness to Practise Committee for their decision[1] if:

- a nurse or midwife has been sentenced to immediate imprisonment, or
- the conviction was for a 'specified offence'.

The nature of these convictions would raise fundamental questions about the nurse or midwife's trustworthiness as a professional, which means the Fitness to Practise Committee will probably need to take some action to restrict their registration as the possible outcomes imposed by case examiners are unlikely to be sufficient.

Police investigations that result in no conviction

Criminal investigations into possible offending by nurses and midwives can end with the police, prosecutors, or the courts taking no action.

The nurse or midwife may be found not guilty in court, or the investigation could end before the case gets to court.

For example, the court may give the nurse or midwife a conditional or absolute discharge.

Sometimes, the police may choose not to investigate following the findings of other organisations, such as safeguarding or social services, that the nurse or midwife has done something that is against the law.

We would only reinvestigate the facts of these cases if the concerns they raise put patients or members of the public at risk of being harmed, or could affect the public's trust in all nurses and midwives or their professional standards.

When we would reinvestigate

When deciding if we would need to reinvestigate, we would need to consider if the nurse or midwife's alleged actions could be serious professional misconduct.

We would reinvestigate the facts of a case if:

- the offence took place in a clinical or care setting or context,
- the alleged victims were patients, service users or people in the nurse or midwife's care, or
- there is a clear link to professional practice[2] (which includes respecting boundaries with patients and colleagues).

Before we reinvestigate alleged offending in a care, clinical or professional context we first carefully assess why there was not a conviction, or why the police decided not to investigate.

We will look carefully at whether, and if so why, the courts or the police rejected the accounts of people who would give evidence in any fitness to practise case.

We'll consider discussing any previous criminal trial with those people and assess very carefully how willing or able they would be to attend to give evidence in any future fitness to practise case.

When we wouldn't reinvestigate

If a nurse or midwife is accused of offending in their private life, based on incidents that have no connection with

their practice as a registered professional, and they are not convicted, we are far less justified in reinvestigating the facts.

The allegations wouldn’t really be connected with our role as a professional regulator, and the investigation would not need the specialist knowledge of our regulatory investigators or case examiners.

Nurses and midwives’ fitness to practise can be affected by very serious offending in their private life for which they are convicted. But if they aren't convicted, it's not our role to fill in any perceived gaps in the criminal justice system by taking regulatory action against them if there isn't a clear link to patient safety, clinical practice, or professional standards.

For example, if a nurse or midwife is investigated for an alleged mortgage fraud against a bank, but the prosecution collapses, it wouldn’t be our role to reinvestigate whether they acted dishonesty as part of a possible misconduct case.

1 Article 22(5)(b)(ii) requires us to refer allegations (as soon as reasonably practicable after they are received in the form required) to a Practice Committee. This includes referral directly to the Conduct and Competence Committee without consideration by our Case Examiners.

2 Ashraf v General Dental Council [2014] EWHC 2618 (Admin)

Serious offending and specified offences

Reference: FTP-2c-1 Last Updated: 05/09/2018

We'll usually refer the most serious cases of criminal offending straight to the Fitness to Practise Committee. These cases include those where the courts gave the nurse or midwife a sentence of immediate imprisonment, or if the nature of their offending was particularly grave.

We call convictions of that level of seriousness 'specified offences'. We will always take into account how long ago the offending happened when we decide whether to send it directly to the Committee.

What are specified offences?

For us, specified offences include:

- hate crimes
- sexual offences
- offending previously known as 'serious arrestable offences'

Hate crimes

We consider that a hate crime includes any criminal offence which is perceived by the victim or any other person, to be motivated by hostility or prejudice based on a person's race or perceived race; religion or perceived religion; sexual orientation or perceived sexual orientation; disability or perceived disability and any crime motivated by hostility or prejudice against a person who is transgender or perceived to be transgender.[1]

Sexual offences

Sexual offences include any offences which involve sexual activity or sexual motivation. They also include any involvement with child pornography.

Former serious arrestable offences

Certain offences were previously defined in section 116 of the Police and Criminal Evidence Act 1984 as 'serious arrestable offences'. The full list includes, in addition to various forms of sexual offending, various extremely serious crimes[2].

The definition also includes less serious offences (arrestable offences), if they led to, were intended or threatened to lead to, or were likely to lead to any of the following consequences:

- serious harm to the security of the State or to public order,
- serious interference with the administration of justice or with the investigation of offences,
- the death or serious injury of any person, or a substantial financial gain or serious financial loss to any person.

1 This definition was used by the CPS and the former Association of Chief Police Officers.
2 The list included treason, murder, manslaughter, kidnapping, causing an explosion likely to endanger life or property, certain offences under the Firearms Act 1968, causing death by dangerous driving, hostage taking, torture and many drug-related offences, and a variety of hijacking offences.

Criminal offences we don't investigate

Reference: FTP-2c-2 Last Updated: 31/08/2018

In this guide

Protected cautions and convictions

Nurses and midwives need to let us know if they receive a caution or conviction, unless this is for a protected offence.

Protected cautions and convictions are defined differently across the UK.

Cautions

Cautions in **Scotland and Northern Ireland** are not protected.

A caution in **England and Wales** is protected if six years have elapsed since the date of the caution (or two years if the person was under 18 at the time of the offence).

Convictions

A conviction in **England, Wales or Northern Ireland** is protected if:

- eleven years have elapsed since the date of conviction (or five and a half years if the person was under 18 at the time of the offence),
- it is the person's only offence,
- it did not result in a custodial sentence, a sentence of imprisonment or service detention, and
- it is not for a 'listed' offence.

There are separate groups of 'listed' offences (serious violent and sexual offences) in England and Wales, and in Northern Ireland.

A conviction in **Scotland** is protected if:

- it is spent, and
- appears in the list of offences to disclose subject to rules, and either:
- the sentence imposed by the court was an admonition or an absolute discharge, or
- fifteen years have passed since the date of the offence (or seven and a half years if the person was under 18 at the time of the offence).

Under Scots law, there is an additional list of convictions which cannot be protected because they are too serious.

Driving offences and penalty fares

We will not investigate referrals for motoring offences such as:

- parking and other penalty charge notices contraventions
- fixed penalty (and conditional offer fixed penalty) motoring offences
- penalty fares imposed under a public transport penalty fare scheme.

We will assess other motoring offences on a case by case basis, but will only take regulatory action if this is closely linked to the nurse or midwife's professional practice, or it suggests there may be a concern about their health.

Drink-driving offences

Drink-driving offences will only call into question a nurse or midwife's fitness to practise if:

- the offence occurred either in the course of a nurse or midwife's professional duties, driving to or from those duties, or during on-call or standby arrangements
- there are aggravating circumstances connected with the offence, or
- it is a repeat offence.

If a nurse or midwife has been convicted of a drink-driving offence, decision makers should consider whether we need to explore any underlying alcohol issues that indicate the nurse or midwife's fitness to practise is impaired because of their health.

In such cases the nurse or midwife's employer, general practitioner or occupational health department should be contacted for additional information.

Conditional discharges, absolute discharges and admonitions

We can't argue that the nurse or midwife's fitness to practise is impaired by reason of that conviction if a nurse or midwife has received the following:

- a conditional discharge
- an absolute discharge
- an admonition in Scotland.

However, we may investigate the underlying misconduct that led to the conviction where the facts suggest particularly serious misconduct, including dishonesty, violence, or sexual offending, especially if it relates to a nurse or midwife's professional practice.

Health

Reference: FTP-2d Last Updated: 28/07/2017

We often receive referrals alleging that a nurse or midwife has a health condition. We will not normally need to intervene in a nurse or midwife's practice due to ill health unless there is a risk of harm to patients or a related risk to public confidence in the profession.

There are very few circumstances where we decide that a nurse or midwife who has (or used to have) a health condition, but is currently able to practise safely without any risk to patients, is impaired on the basis of public confidence in the professions alone.

A nurse or midwife may have a disability or long-term health condition but be able to practise with or without adjustments to support their practice. Equally, a nurse or midwife may be signed off as 'unfit for work' due to ill health, but this does not necessarily mean their fitness to practise is currently impaired.

Cases of ill-health are likely to be better managed with the support of an employer to safely reduce any risk to patients, and not require a regulatory investigation where:

- the nurse or midwife has demonstrated good insight into the extent and effect of their condition
- the nurse or midwife is taking appropriate steps to access treatment and is following any advice from the health professionals treating them
- occupational health (where available) is providing support through the employer
- the nurse or midwife is managing his or her practice appropriately, for example by taking sickness absence.

Referrals which indicate long-term, untreated (or unsuccessfully treated), or unacknowledged physical or mental health conditions will be of particular concern if they suggest a risk to public protection.

Even where a health condition appears to be well managed, the nurse or midwife may be at risk of relapse, which could affect their ability to practise safely. In such cases some form of restriction may be required to make sure there is no risk of harm to patients or others.

When we assess whether concern about a nurse or midwife's health is serious enough to become involved in their practice, we will consider the nature of the concern and whether there is sufficient evidence to justify seeking further information from third parties, such as the nurse or midwife's GP or occupational health department. We will balance the nurse or midwife's right to privacy with our overarching duty to protect the public.

Not having the necessary knowledge of English

Reference: FTP-2e Last Updated: 06/11/2017

In this guide

Knowledge of English and patient risk

When first assessing the seriousness of concerns about whether a nurse or midwife has the necessary knowledge of English, the first question will be whether patients are placed at potential or actual risk of harm.

Examples of language concerns that could place the public at risk of harm include:

- poor handover of essential information about patient treatment or care to other health professionals because of an inability to speak English
- serious record keeping errors or patterns of poor record keeping because of an inability to write English
- serious failure(s) to give appropriate care to patients because of an inability to understand verbal or written communications from other health professionals (or patients themselves).
- drug error(s) caused by a failure to understand or inability to read prescriptions.

Not every language concern raised will trigger the need for us to carry out an investigation. If decision makers are considering regulatory concerns that are only about spelling, difficulty in understanding regional slang or English colloquialisms without any suggestion of clinical impact, the case is unlikely to involve possible impairment of fitness to practise.

English language testing and fitness to practise decisions

In cases about a nurse or midwife's knowledge of English, decision makers will consider language testing results as the primary measure of whether the nurse or midwife has the necessary knowledge of English to practise safely. Both case examiners deciding whether a nurse or midwife has a case to answer, and panel members of the Fitness to Practise Committee, deciding whether the facts at a final hearing are proved, will base their decision on test results. A properly signed certificate from the test provider will be conclusive evidence of the test result the nurse or midwife achieved.[1]

If the nurse or midwife has not achieved the minimum scores we specify in each of the four language skills (reading, writing, listening and speaking), then decision makers are likely to find that the nurse or midwife does not have the necessary knowledge of English to practise safely. We explain our minimum scores and the kinds of language tests we will accept to demonstrate them in our guidance on accepted language tests.

If the nurse or midwife fails to comply with a direction to take a language test, decision makers can take this into account in assessing possible impairment of the nurse or midwife's fitness to practise through their knowledge of English.

In addition to language testing results, decision makers are also able to consider other evidence when assessing cases based on a nurse or midwife's knowledge of English. Such evidence will be particularly relevant if the nurse or midwife has averaged just below the minimum scores we require, because the Fitness to Practise Committee may be less likely to make a final finding of current impairment. Other evidence that can be taken into account includes:

- any written responses or evidence the nurse, midwife or employer has submitted which seems to demonstrate they have the necessary knowledge of English to practise safely
- any evidence that the nurse or midwife has trained or practised in an English speaking environment for a

period of time
- any evidence that the nurse or midwife had previously completed a language assessment to the required standard (for example, as part of a previous application to the our register)
- any evidence that the nurse or midwife has recently obtained a qualification that has been taught and examined in English.

In all cases, decision makers should exercise their judgement and balance the individual features of the case and any actual harm or risk of harm to patients.

1 Rule 31(4A) of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004

Determinations by other health or social care organisations

Reference: FTP-2f Last Updated: 28/07/2017

Nurses and midwives may be registered members of other health or social care professions, which are regulated by different legal bodies in the UK, or may be registered with licensing bodies overseas.

Decision makers sometimes receive referrals from these other organisations either in the UK or abroad, suggesting that a person also registered with us as a nurse or midwife has previously been impaired in their practice. When decision makers are looking at such referrals, they need to consider the potential impact on this person's nursing or midwifery practice in the UK.

We will consider the scope and nature of the other organisation's determination and the factual background. We will assess how closely the issues relate to the practice of nursing or midwifery in the UK and the underlying facts or issues. We will consider if, in light of these facts, the nurse or midwife could present a risk to members of the public by continued nursing or midwifery practice, or if the other body's finding could affect public confidence in the nursing or midwifery professions.

Cases about determinations of other regulators will generally need us to take regulatory action. The only exceptions to this are:

- where it is clear to us that the nurse or midwife presents no current risk of harm to patients
- the determination involves no potential impact on public confidence in the nursing or midwifery professions
- there is no need, in the particular case, to take action to maintain proper professional standards and conduct.

Fraudulent or incorrect entry to the register

Reference: FTP-2g Last Updated: 15/12/2017

In this guide

Nurses and midwives are only entitled to practise if they are on our register. For this reason, allegations that a nurse or midwife entered the register incorrectly or by fraud are extremely serious. They also raise public protection concerns. For example, if someone enters the register without the required qualification, they may lack the skills needed to carry out their nursing or midwifery role. This means they pose a risk to patient safety.

It is in the public interest for us to investigate these allegations and take action where needed. Not doing this could affect public confidence in the integrity of the register and the nursing and midwifery professions.

When looking into an allegation that someone was entered on the register incorrectly or through fraud, we examine how the nurse or midwife entered the register, not their fitness to practise.

When we investigate if a person's entry onto our register was incorrect or fraudulent, we can consider applications for:

- first time registration
- registration renewal
- readmission to the register.

Incorrect entry

If our decision to register, renew or readmit someone onto the register was based on wrong or inaccurate information about whether the person met the relevant requirements, it is an incorrect entry. For example, if someone wrongly declared that they had carried out the required number of hours of registered practice because they made a mistake when calculating them, their entry in the register is incorrect.

An entry is also incorrect if we made a mistake during the application process. For example, if we entered the wrong person's name onto the register due to an administrative error.

Fraudulent entry

An entry on the register is fraudulent if any of the information submitted as part of the registration, readmission or revalidation process was deliberately misleading about whether the person meets the relevant requirements.

For example, if a person provides a false certificate in order to be registered, we will have been deliberately misled. The entry is fraudulent. In this example, it doesn't matter who falsified the certificate. A nurse or midwife's entry on the register may be fraudulent even if they were not personally responsible for the fraud or even aware that deliberately misleading information was used.

This means that if the evidence shows it was a third party who deliberately produced false documents or statements, and that the person who is registered with us did not know about it, that person's entry is still fraudulent, even if they did not behave in a fraudulent or dishonest way themselves.

This is likely to happen only in a small number of cases. Decision makers should focus on whether the entry on our register was gained by fraud. They should not focus on whether the person on our register was directly at

fault themselves. In those cases, whoever did produce the document or make the statement deliberately misled us and this makes the entry fraudulent.
For example, if someone steals the identity of another person who was previously registered as a nurse or midwife and makes a false declaration, the entry is fraudulent, even though the former nurse or midwife is not aware of the fraud.

Another example would be if a nurse or midwife doesn't know whether they meet the requirements for renewing their registration but their employer tells them that they do. The employer then signs to confirm that the nurse or midwife meets the requirements even though they know this is not the case.

It doesn't matter whether or not the person whose name was entered on the register was able to meet the relevant criteria to be successfully registered or if they are currently able to practise safely. The key issue is whether we made the entry based on deliberately misleading information.

Types of incorrect or fraudulent entry cases

Reference: FTP-2g-1 Last Updated: 15/12/2017

In this guide

Approved qualification

Everyone applying to join the register must prove to us that they hold an approved qualification and that the course was completed within five years of the application for registration.

If the qualification was not awarded within the five year period, the person applying must have done additional education, training and experience in order to be registered.

An entry on the register may be fraudulent or incorrect if there is evidence that the person concerned:

- didn't hold an approved qualification when they were registered
- didn't complete their course within five years of their application for registration and didn't do the required additional education, training and experience.

Indemnity arrangement

Everyone on the register must have appropriate cover under an indemnity arrangement or have an arrangement in place when they practise as a nurse or midwife. To meet this requirement, when someone applies to join or come back onto the register, or renew their registration, they must sign a self-declaration confirming that they have appropriate indemnity insurance. This can include insurance their employer holds on their behalf.

If we find that the declaration was wrong because the applicant didn't have cover in place when they applied or when they started practising, the entry is incorrect. If the declaration was deliberately misleading, the entry is fraudulent.

When we decide whether or not to carry out a full investigation in this kind of case, we look at the particular circumstances in which the declaration was made. If the nurse or midwife made reasonable enquiries and had no reason to doubt that their employer had appropriate cover in place when they applied, we may decide not to carry out a full investigation.

Declaration of good health and good character

People will only be registered as nurses or midwives if they prove to us that they are capable of safe and effective practice. This includes showing that they meet the good health and good character requirements.

If any of the information about the applicant's health or character was wrong or deliberately misleading, the entry is incorrect or fraudulent.

When deciding if the entry is fraudulent or incorrect, decision makers aren't looking at whether new information about the nurse or midwife's health or character shows they would have been capable of safe and effective practice when they entered the register. That is a registration decision for the Registrar and is not relevant to the question of whether the entry in the register was fraudulent or incorrect.

In our process, decision makers are only assessing whether we were given wrong or misleading information about the health or character of that person when deciding whether they were capable of safe and effective practice.

Non-payment of fee

It is the professional responsibility of every nurse and midwife to ensure that they have paid the registration or renewal fee. If someone enters the register or stays on the register without paying the right fee, they were incorrectly entered onto the register. If the payment of the fee was done by a deliberate fraud, then the entry is fraudulent.

Registered practice hours

During revalidation, nurses and midwives must declare that they have done the required number of hours of registered practice.

A nurse or midwife is incorrectly entered onto the register if their declaration was wrong. If there is evidence that a wrong declaration was made with the deliberate intention to mislead us then the entry is fraudulent.

Continuing professional development

When renewing their registration a nurse or midwife must self-declare that they have done the required number of hours of continuing professional development (CPD).

A nurse or midwife is incorrectly entered onto the register if there is evidence that the CPD declaration was wrong. If there is evidence that a wrong declaration was made with the deliberate intention to mislead us, the entry is fraudulent.

Identity fraud

If the registration application contained deliberately misleading information about the identity of the applicant, the entry is fraudulent. This usually means that the person who applied and intended to practise using the registration deliberately made the application in the name of another person.

There is no need for the Investigating Committee to see evidence that the person who made the application has been convicted of a criminal offence in order to find the allegation proved.

Dual registration

Reference: FTP-2g-2 Last Updated: 15/12/2017

Nurses and midwives can apply to be on more than one part of the register as long as they meet the relevant entry requirements for each part. For example, they may be on the nursing part of the register and the midwifery part of the register.

Someone who entered one part of the register by fraud and was removed can still practise if they are on another part of the register.

Where someone has acted fraudulently there is likely to be public interest in making a fitness to practise referral. This is because the Investigating Committee's decision that a nurse or midwife fraudulently gained entry to one part of the register is likely to call into question their fitness to practise on the other part of the register. If the Investigating Committee decides it would be appropriate for such a referral to be made, it can say so as part of the reasons for its decision on what action to take.

How we determine seriousness

Reference: FTP-3 Last Updated: 31/08/2018

In this guide

What we mean by seriousness

Seriousness is an important concept which informs various stages of our regulatory processes.

When assessing whether a concern is serious, we look at what risks are likely to arise if the nurse or midwife doesn't remedy or put this concern right. This could be risks to patients or service users or, in some cases, to the public's confidence in all nurses and midwives.

It's vitally important that we encourage nurses and midwives to try to put problems right where they can, because we want to promote a learning culture that keeps patients and members of the public safe.

By focusing on how risks could arise if concerns aren't put right, we can see what the nurse or midwife may need to do to remedy the problems in their practice, or what action we may need to take if they don't.

When our decision makers are looking at overall fitness to practise, they'll always consider what the nurse or midwife has done to remediate the concerns.

The guidance below helps us assess the seriousness of concerns by looking at how easy they are to put right, what could happen if they aren't, and what the role of public confidence and professional standards is.

Factors that indicate the seriousness of a case

Decision makers across our fitness to practise process look at factors of a case to identify the types of concern which, unless put right, will usually mean a nurse or midwife's right to practise needs to be restricted.

These factors indicate the seriousness of the case and we use these as a framework for the way we investigate cases and present cases before panels of the Fitness to Practise Committee.

The factors can be broken down into three broad categories:

- Serious concerns which are more difficult to put right
- Serious concerns which could result in harm to patients if not put right
- Serious concerns based on the need to promote public confidence in nurses and midwives

Serious concerns which are more difficult to put right

Reference: FTP-3a Last Updated: 10/01/2020

A small number of concerns are so serious that it may be less easy for the nurse or midwife to put right the conduct, the problems in their practice, or the aspect of their attitude which led to the incidents happening.

In cases like this, we will be keen to hear from the nurse or midwife if they have reflected on the concerns and taken opportunities to show insight into what happened. Because concerns of this nature, when they aren't put right, are likely to lead to restrictive regulatory action, if we don't hear from the nurse or midwife we will usually focus on preparing the case for the Fitness to Practise Committee at the earliest possible opportunity.

We will need to do this where the evidence shows that the nurse or midwife is responsible for:

- breaching the professional duty of candour to be open and honest when things go wrong, including covering up, falsifying records, obstructing, victimising or hindering a colleague or member of staff or patient who wants to raise a concern, encouraging others not to tell the truth, or otherwise contributing to a culture which suppresses openness about the safety of care
- sexual assault, relationships with patients in breach of guidance on clear sexual boundaries, and accessing, viewing, or other involvement in child pornography
- deliberately causing harm to patients
- deliberately using false qualifications or giving a false picture of employment history which hides clinical incidents in the past, not telling employers that their right to practise has been restricted or suspended, practising or trying to practise in breach of restrictions or suspension imposed by us
- exploiting patients or abusing the position of a registered nurse or midwife for financial or personal gain
- being directly responsible (such as through management of a service or setting) for exposing patients or service users to harm or neglect, especially where the evidence shows the nurse or midwife putting their own priorities, or those of the organisation they work for, before their professional duty to ensure patient safety and dignity

Serious concerns which could result in harm to patients if not put right

Reference: FTP-3b Last Updated: 10/01/2020

Assessing the risks presented by an individual nurse or midwife's practice means carefully considering the evidence about those risks.

Our evidence will need to clearly explain whether patients were put at risk by the nurse or midwife's conduct or failings in the past, and what harm did or could have happened to patients because of those failings.

We will need to assess how likely the nurse or midwife is to repeat similar conduct or failings in the future, and if they do, if it is likely that patients would come to harm, and in what way.

Conduct or failings that put patients or service users at risk of harm will usually involve a serious departure from standards. Standards, such as our Code, are intended to ensure that nurses and midwives practise safely and effectively.

We've used the Code to identify some examples below of the kinds of failings which are likely to cause risk to patients if they are not addressed.

We wouldn't usually need to take regulatory action for isolated incidents of these failings, but a pattern of incidents is more likely to show risk to patients or service users which would require us to act.

Prioritise people

The evidence shows that the nurse or midwife has failed to:

- uphold people's dignity, treat them with kindness, respect and compassion, deliver treatment care or assistance without undue delay, or deliver the fundamentals of care (including hydration, nutrition, bladder and bowel care and ensuring people receiving care are kept in clean and hygienic conditions).
- make sure the physical, social and psychological needs of patients are responded to.
- respect people's right to privacy and confidentiality.

Practise effectively

The evidence shows that the nurse or midwife:

- has not maintained the knowledge and skills for safe and effective practice.
- is unable to communicate clearly, work cooperatively, keep clear and accurate records, without falsification.
- failed to be accountable for decisions to delegate tasks and duties to other people and/or failed to ensure they are adequately supported.

Preserve safety

The evidence shows that the nurse or midwife has failed to:

- recognise and work within the limits of competence, accurately assess signs of normal or worsening physical or mental health, or make timely and appropriate referrals where needed.
- be open and candid with all service users, or act immediately to put right, explain and apologise when any mistakes or harm have taken place.
- offer help if an emergency arises in practice.
- act without delay if they believe there is a risk to patient safety or public protection.

- raise or escalate concerns.
- advise, prescribe or administer medicines in line with training, law and guidance.
- be aware of, or reduce as far as possible, any potential for harm associated with practice, including controlling and preventing infection, taking precautions to avoid potential health risks to colleagues, patients and public.

Promote professionalism and trust

The evidence shows that the nurse or midwife has failed to:

- uphold the reputation of the profession, by not acting with honesty and integrity, treating people fairly, without discrimination, bullying or harassment, in a way that does not take advantage of their vulnerability or cause them upset or distress.
- maintain the level of health needed for safe and effective practice.
- avoid asking for or accepting loans.
- cooperate with investigations and audits, including requests to act as a witness.
- tell us as soon as they could have about cautions or charges, conditional discharges or convictions for criminal offences.

Serious concerns based on public confidence or professional standards

Reference: FTP-3c Last Updated: 10/01/2020

Sometimes we may need to take regulatory action against a nurse or midwife not because their practice presents a risk of harm to patients, but because of our objectives to promote and maintain professional standards and public confidence in nurses and midwives.

This means we may need to take action even if the nurse or midwife has shown that they have put serious clinical failings right, if the past incidents themselves were so serious they could affect the public's trust in nurses and midwives.

We're more likely to need to do this if the clinical failings suggest an underlying issue with the nurse or midwife's attitude to people in their care.

We may also need to take action in cases where the concerns were not directly related to the care the nurse or midwife provided to people, but which call into question the basics of their professionalism. This may cover things that have happened in the nurse or midwife's private life, but this will usually only happen if they've committed serious criminal offences.

A need to take action because the public may not feel able to trust nurses and midwives generally is a high threshold. It suggests that members of the public might take risks with their own health and wellbeing by avoiding treatment or care from nurses or midwives.

We may need to take restrictive regulatory action against nurses and midwives whose conduct has had this kind of impact on the public's trust in their profession, who haven't made any attempt to reflect on it, show insight, and haven't taken any steps to put it right. This may mean they can't stay on the register.

Why we screen cases

Reference: FTP-4 Last Updated: 31/08/2018

We screen cases to assess whether a case is for us or not. Screening cases helps us to identify risk, then understand how serious it is and think about whether regulation is the right way to address it.

First we check if the concern is about a nurse or midwife on our register. Then we check if the case could raise questions about their registration with us, or their fitness to practise as a registered professional.

If the case is for us, we need to decide, quickly, the seriousness of a case, and whether an interim order should be put in place.

We use thresholds to help us make these decisions.

This also ensures that we focus our resources on the right cases, where employers can't manage the risk effectively.

If regulatory action is required, we need to make sure we are proportionate and apply only the right amount of regulatory force to achieve our desired outcome of public protection.

Find out about the different stages of our screening process and more.

When we use interim orders

Reference: FTP-5 Last Updated: 31/08/2018

We use interim orders to protect the public from risk by restricting or suspending a nurse or midwife's practice. We use them:

- during our investigation,
- before the allegation against the nurse or midwife has been decided, and
- sometimes, after a panel makes an order against them, but before it takes effect.

Interim orders can have very restrictive effects on nurses and midwives, so we need to make sure we only use them when it's proportionate to do so.

We'll need good evidence of the possible harm to patients, or be able to explain why an order is otherwise in the public interest or the nurse or midwife's own interests.

Find out more about interim orders.

Our investigations

Reference: FTP-6 Last Updated: 19/09/2018

We investigate serious concerns about a nurse or midwife's fitness to practise which could place patients at risk, or negatively impact public confidence in the nursing and midwifery professions.

We also investigate concerns about whether the entry of an individual nurse or midwife on our register may be incorrect, or may have been made as a result of fraud.

Find out more about what we investigate and how, in our section on Investigations.

Examining cases

Reference: FTP-7 Last Updated: 31/08/2018

Once our investigations team has completed their investigation into the concerns about a nurse or midwife, our case examiners decide whether or not a nurse or a midwife has a case to answer, and if they do, what should happen to the case.

They can recommend that we need to do further investigation before they can decide whether or not there is a case to answer.

In our fitness to practise process, case to answer has a precise meaning.

It means whether or not there is a realistic prospect that our Fitness to Practise Committee would find a nurse or midwife's fitness to practise to be currently impaired using the evidence we've gathered so far.

Decisions case examiners may reach

If case examiners decide there is **no case to answer**, they can:

- give the nurse or midwife advice,
- issue the nurse or midwife with a warning, or
- simply close the case.

If case examiners decide there is a **case to answer**, they can:

- recommend undertakings to be agreed with the nurse or midwife, or
- refer the case to the Fitness to Practise Committee.

Case examiners can also decide that the case should be referred to the Fitness to Practise Committee to consider whether an interim order should be imposed. If case examiners don't make this recommendation, the Investigating Committee can make an interim order at any point, until the Fitness to Practise Committee starts its consideration of the case.

Find out more about how we examine cases.

How we manage cases before a hearing

Reference: FTP-8 Last Updated: 26/11/2018

After the case examiners have made the decision to send the case to the Fitness to Practise Committee, our legal team will review it.

They may decide that there needs to be further investigation before it is passed to the committee.

Once the investigation is complete, we'll prepare for a hearing or meeting.

Where the nurse or midwife is represented, we'll consider whether to arrange a telephone conference with the representative to discuss the proposed hearing bundle and resolve any legal difficulties.

Find out more about how we manage cases before a hearing.

Meetings and hearings

Reference: FTP-9 Last Updated: 31/08/2018

The Fitness to Practise Committee holds meetings and hearings to consider fitness to practise matters.

About the committee

The committee is a three person panel, one of whom is a nurse or a midwife. The panel can hear matters at a meeting or a hearing, and has the same powers whether the matter is considered at a hearing or a meeting.

Find out who sits on our panels.

Dealing with cases at meetings and hearings

Once the case examiners have sent a case to be dealt with by a committee, we'll write to the nurse or midwife and give them 28 days to tell us if they would like their case to be dealt with at a hearing or a meeting.

We'll arrange for the case to be heard at a meeting if the nurse or midwife requests this, or if they don't tell us what they would prefer, or has no contact with us.

We'll only arrange for a case to be heard at a hearing if a nurse or midwife has asked for one, or if we think there is a 'material dispute'. A material dispute is a disagreement between us and the nurse or midwife about an important issue in the case.

Resolving cases by agreement

Reference: FTP-10 Last Updated: 31/08/2018

We would much rather avoid unnecessary hearings for the sake of all involved. So when we can, we use consensual panel determination to resolve cases by agreement or consent.

If a nurse or midwife wants to resolve their case by consent, they must accept the facts of the allegation and they must also accept that their fitness to practise is impaired.

We will then agree an appropriate level of sanction with the nurse or midwife.

The panel makes the final decision about the outcome of the case.

What sanctions are and when we might use them

Reference: FTP-11 Last Updated: 31/08/2018

A Fitness to Practise Committee panel can impose sanctions (restrictions) if they decide that a nurse or midwife's fitness to practise is impaired.

They would do this to make sure we protect patients, maintain confidence in the nursing and midwifery professions, and uphold the standards we expect of nurses and midwives.

How we decide which sanction to impose

The panel will consider the seriousness of the concern and the facts of the case to find a sanction that is enough to achieve public protection.

The available sanction outcomes, starting from the least severe, are:

- taking no further action
- a caution order of between one and five years
- a conditions of practice order of up to three years
- a suspension order of up to twelve months
- a striking-off order.

Find out more about how we decide which sanction to impose.

Remediation and insight

Reference: FTP-12 Last Updated: 28/07/2017

Decision makers across our fitness to practise process will always need to consider the level of risk the nurse or midwife presents to members of the public, looking at the facts of the case.

Remediation will usually be central to deciding whether a nurse or midwife's fitness to practise is currently impaired. This is because whether fitness to practise is being considered at a final hearing, or at an earlier stage of our process, the events that led to the nurse or midwife being referred to us will usually have happened some time previously. When assessing remediation, decision makers will need to take into account the following questions:

- Is the concern remediable?
- Has the concern been remedied?
- Is it highly unlikely that the conduct will be repeated?

These factors are key points for decision makers to consider, but they are not a definitive test of whether a nurse or midwife's fitness to practise is currently impaired.

Is the concern remediable?

Reference: FTP-12a Last Updated: 28/07/2017

Decision makers should always consider the full circumstances of the case in the round when assessing whether or not the concerns in the case can be remedied. This is true even where the incident itself is the sort of conduct which would normally be considered to be particularly serious.

The first question is whether the concerns can be remedied. That is, are there steps that the nurse or midwife can take to remedy the identified problem in their practice?

It can often be very difficult, if not impossible, to put right the outcome of the clinical failing or behaviour, especially where it has resulted in harm to a patient. However, rather than focusing on whether the outcome can be put right, decision makers should assess the conduct that led to the outcome, and consider whether the conduct itself, and the risks it could pose, can be remedied.

Decision makers need to be aware of our role in maintaining confidence in the professions by declaring and upholding proper standards of professional conduct. Sometimes, the conduct of a particular nurse or midwife can fall so far short of the standards the public expect of professionals caring for them that public confidence in the nursing and midwifery professions could be undermined. In cases like this, and in cases where the behaviour suggests underlying problems with the nurse or midwife's attitude, it is less likely the nurse or midwife will be able to remedy their conduct.

Examples of conduct which may not be possible to remedy, and where steps such as training courses or supervision at work are unlikely to address the concerns include:

- criminal convictions that led to custodial sentences
- inappropriate personal or sexual relationships with patients, service users or other vulnerable people
- dishonesty, particularly if it was serious and sustained over a period of time, or directly linked to the nurse or midwife's practice
- violence, neglect or abuse of patients.

Generally, issues about the safety of clinical practice are easier to remedy, particularly where they involve isolated incidents. Examples of such concerns include:

- medication administration errors
- poor record keeping
- failings in a discrete and easily identifiable area of clinical practice
- concerns about incidents that took place a significant period of time in the past, especially if the nurse or midwife has practised safely since they occurred.

Has the concern been remedied?

Reference: FTP-12b Last Updated: 28/07/2017

In this guide

Demonstrating insight

Before effective steps can be taken to remedy concerns, the nurse or midwife must recognise the problem that needs to be addressed. Therefore insight on the part of the nurse or midwife is crucially important.

A nurse or midwife who shows insight will usually be able to:

- step back from the situation and look at it objectively
- recognise what went wrong
- accept their role and responsibilities and how they are relevant to what happened
- appreciate what could and should have been done differently
- understand how to act differently in the future to avoid similar problems happening.

Decision makers do more than simply look at whether a nurse or midwife has shown ‘any’ insight or not. They need to assess the quality and nature of the insight. There may still be a public interest in restricting a nurse or midwife’s right to practise, even if they have shown ‘some’ insight into what happened.

Where a panel has found that a nurse or midwife was responsible for incidents that they denied (or continue to deny), this should not bar the nurse or midwife from being able to show insight. They may not have insight into the particular events that occurred, but they may be able to show insight by having an understanding of the need to minimise the risk of similar events occurring in the future, and the steps that might be taken to achieve this.

Assessing whether insight is sufficient

It is important to carefully assess whether the insight shown by the nurse or midwife is enough to address the specific concerns that arise from their past conduct, rather than simply identifying whether ‘any’ or ‘some’ evidence of insight is present. What is sufficient insight will depend on the circumstances of the case.

Decision makers must always consider each case on its own facts and circumstances. However, the following factors will be useful when considering whether the evidence of insight is sufficient to address the concerns in the case.

- If they had the opportunity to do so, did the nurse or midwife cooperate with their employer's or any other local investigation into the concerns?
- Did the nurse or midwife accept the concerns against them when first raised by their employer?
- Did the nurse or midwife, voluntarily or without prompting, draw any failings or inappropriate conduct to the attention of their employer?
- Did the nurse or midwife ‘self-report’ to the NMC, when a referral might otherwise not have been made by someone else?
- Does the nurse or midwife accept the substance of our regulatory concern, and accept responsibility for any failings or inappropriate conduct?

- Has the nurse or midwife done so since the early stages of our investigation?
- Does the nurse or midwife acknowledge:
    - any harm or risk of harm, to patients?
    - any damage to public confidence in the professions?
    - how far their conduct or practice fell short of professional standards?
    - their own responsibility for the problem, without seeking to blame others or excuse their actions?

If a nurse or midwife shows insight when they had previously not accepted responsibility for their actions , decision makers should consider this carefully. They should assess whether it was possible for the nurse or midwife to make admissions earlier on by considering the information that was given to the nurse or midwife during their employer's investigation, other earlier local investigations, or our own investigation.

Apologies and insight

While a willingness to apologise for mistakes or failings should be encouraged, there is no requirement for the nurse or midwife to make admissions at an early stage. Decision makers should be sensitive to circumstances which may prevent a nurse or midwife from offering a clear apology. Offering an apology may be perceived as an admission of guilt, which could have implications for any separate legal proceedings.

Similarly, cultural differences or the use of English as a second language may also affect the nurse or midwife's ability to provide a reflective statement and how they express insight, including whether they offer an apology. While an apology may be expected in certain circumstances, it is not necessary to demonstrate insight.

The duty of candour

All registered nurses and midwives must comply with the duty of candour guidance which arises from the requirements set out in the Code and Raising concerns: Guidance for nurses and midwives.

To comply with this professional duty, nurses and midwives must:

- Be honest, open and truthful in all their dealings with patients and the public.
- Never allow organisational or personal interests to outweigh the duty to be honest, open and truthful.
- Act with integrity and give a constructive and honest response to anyone who complains about the care they have received.
- Act without delay and raise concerns if they experience problems that prevent them from working within the Code. Also act without delay and raise concerns if they or a colleague, or any other problems in the care environment, are putting patients at risk of harm. 'Doing nothing' and failing to report concerns is unacceptable.
- Explain fully and promptly what has happened and the likely effects if someone in their care has suffered harm for any reason. 'Near misses', where a nurse's or midwife's act or omission puts a patient at risk of harm, must also be escalated as a point of concern.
- Cooperate with internal and external investigations.

Decision makers should take into account whether the nurse or midwife has complied with the duty of candour and the requirements it places on professional practice when they consider issues of insight and remediation.

Sufficient remedial steps

What is 'sufficient' remediation in a case will depend on the specific details, including the nature of the alleged failings or behaviour. The scale of the concerns will determine what remedial steps are required. For example, the reassurance a decision maker will be looking for will be less for a single clinical incident in an otherwise unblemished career than it would be if a number of errors had taken place over a period of time, and they continued to happen after the nurse or midwife was made aware of the problem, or where other remedial steps did not prevent problems from recurring.

Key considerations for decision makers in assessing the steps taken by a nurse or midwife to remedy concerns in their practice will be whether the steps taken are:

- relevant, in that they are directly linked to the nature of the concerns
- measurable (for example, where the nurse or midwife says they have been on a training course, information

should be provided to help the decision maker understand the scope of the course, the topics covered and the results of any assessments)
- effective, addressing the concerns and clearly demonstrating that past failings have been objectively understood, appreciated and tackled.

Sufficient and appropriate remedial steps may include the following.

- Attending a training course. Decision makers should assess whether the course content is relevant to the concerns in the case and whether the course was sufficiently comprehensive, ideally including a practical element and some form of assessment, with results available.
- Reflection. Reflective work by the nurse or midwife will be of more weight where they are able to give examples not only of what they have learned following the concerns being raised, but also how they have applied this learning in their practice.
- Developing and successfully completing an action plan.
- Successfully completing a period of supervised practice targeted at the concerns arising from the alleged behaviour.
- Periods of employment during which the nurse or midwife has practised in similar clinical fields, or carried out similar procedures to those where the original failings or concerns arose. Decision makers should look for clear evidence that the employer was aware of the areas of concern within the nurse or midwife's practice and what has been observed or assessed regarding these.
- Periods of unemployment (whether in the past or present) or periods working without having had the opportunity to demonstrate that the problematic task or tasks can be successfully completed without difficulty, will usually be of limited relevance.

Decision makers should only rely on the evidence that is actually available at the time they consider the case. They must not speculate about what other information might be available.

However, if a case is being considered before a final hearing or meeting, and the evidence of remediation is insufficient, decision makers should consider whether further steps could be taken. For example, if a nurse or midwife has stated that they have attended a course or undertaken additional training, we could request evidence of this.

Assessing evidence of remediation

Decision makers must consider how much weight to place upon any evidence a nurse or midwife provides. In particular:

- A reflective piece can be considered 'evidence', although the decision maker should consider at what stage in the proceedings it was produced.
- Testimonials from a manager or supervisor should carry more weight than those from friends or colleagues. References or testimonials should be signed by the author, dated, on letter-headed paper, and include contact details so we are able to verify the contents of the reference or testimonial.
- It should be clear that the author is aware of the full details of the allegations against the nurse or midwife, and of the nurse or midwife's acceptance of the charges.
- The content of the reference or testimonial should be relevant to the issues being considered by the decision maker.
- Evidence of training courses should be carefully considered. Decision makers should look at the duration of the course and the amount of time or focus placed on topics which address the relevant concerns. Courses with a practical element and formal assessment (with results available), can carry more weight than courses completed online or those without any means for the nurse or midwife to demonstrate understanding.
- Little, if any, weight should be placed on character references and testimonials that do not provide informed comment on the nurse or midwife's clinical practice, skills or competence.

Is it highly unlikely that the conduct will be repeated?

Reference: FTP-12c Last Updated: 28/07/2017

When considering how likely it is that conduct will be repeated, decision makers will assess the extent of the nurse or midwife's insight into the concerns, and will also consider whether the steps taken to remedy concerns are sufficient.

Decision makers will consider whether a repeat of the conduct that caused concerns. When doing this, they should take into account whether the nurse or midwife has been practising in a similar environment to where the conduct took place. If they have, and have therefore been exposed to occasions when there was a risk of past conduct being repeated, then the absence of repetition will be significant. If they have not been practising in a similar environment (whether because restrictions have been placed on their practice or for any other reason), the absence of repetition will be of little or no relevance.

Decision makers can also take into account the full circumstances of the case. The likelihood of the conduct being repeated in the future may be reduced where:

- The nurse or midwife has demonstrated sufficient insight and has taken appropriate steps to remedy any concerns arising from the allegations.
- The behaviour in question arose in unique circumstances. While this does not excuse the nurse or midwife's behaviour, this may suggest that the risk of repetition in the future is reduced.
- The nurse or midwife has an otherwise positive professional record, including an absence of any other concerns from past or current employers and of any previous action by us or another regulatory body.
- The nurse or midwife has engaged with us throughout our processes.