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Aims and principles for fitness to practise

Reference: FTP-1 Last Updated: 25/03/2026

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 public 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.

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

It involves listening to what people receiving care, 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 people receiving care and members of the public to feel supported and listened to in our fitness to practise proceedings. Putting people receiving care, 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.

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 people receiving care 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.

Transparency is crucial to an effective fitness to practise process. All the people involved in a case, including people receiving care, 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 people receiving care and members of the public safe.

Employers are closer to the sources of risk to people receiving care 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 people receiving care 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.

In the small number of cases where employers can't put the right controls in place to keep people receiving care 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.

take account of the context

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.

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 people receiving care 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 open and professional culture that's been shown to keep people safe.

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 people receiving care 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.

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 people receiving care, 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.

We know that the public take concerns which raise fundamental questions about the standards and values set out in the Code particularly seriously, because they pose the highest risk to public protection. These cases are likely to be seen by the public as serious breaches of professional standards. We will always need to consider whether a concern raised about conduct outside professional practice raises fundamental questions about the ability of the professional to uphold the standards and values set out in the Code. Examples of concerns that could raise fundamental questions of this kind include:

- criminal convictions
- violent behaviour
- discrimination
- harassment
- sexual misconduct
- abuse of children or vulnerable adults, domestic abuse or any other conduct involving cruelty, exploitation or predatory behaviour

These are examples of commonly raised concerns. This is not intended to be an exhaustive list.

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.

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, midwife or nursing associate to our register
- Allegations about the fitness to practise of nurses, midwives or nursing associates.

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: 20/05/2026

In this guide

The Code sets the professional standards of practice and behaviour for nurses, midwives and nursing associates, and the standards that the public tell us they expect from those professionals.

Nurses, midwives and nursing associates must act in line with the Code. If their conduct falls short of the requirements of the Code, what they did or failed to do could be serious enough for us to take action.

Where concerns are raised, we'll need to consider the allegation to identify whether there is a risk to the public, or whether the behaviour is likely to undermine our professional standards or public confidence in the professions we regulate.

When does poor practice become serious professional misconduct?

Not all breaches of the Code or issues with practice will be a matter of regulatory concern. We should only take regulatory action where there is evidence of serious professional misconduct.[1]

Many instances of misconduct are better dealt with by employers in the first instance. Employers are closer to the sources of risk to people receiving care 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 only need to become involved if the nurse, midwife or nursing associate poses a risk of harm to people in their care 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. For example, one-off clinical incidents won't usually require regulatory action if there is evidence that the professional has reflected and learned from their mistake and we consider that the risk of repetition is low.

Some concerns are more serious because they may lead to people receiving care or members of the public suffering harm or losing trust and confidence in the professionals we regulate.

Serious professional misconduct is more likely to occur in professional practice – that is, when a professional is:

- acting in the course of their professional practice, such as providing direct care to individuals, groups or communities, or
- undertaking activities closely related to their professional practice, such as leadership, education, or research.

To determine whether activity is closely related to professional practice, we will look to the nature and setting. For example, the exercise of specific clinical skills, such as infection control or administration of medication, is likely to be closely linked to professional practice, whether or not the professional was performing a nursing or midwifery role at the time.

There may also be other concerns which are related to professional practice or to the nurse, midwife or nursing associate's role as a registered professional. This includes bullying or harassing colleagues (including sexual harassment), abusing their position as a registered nurse, midwife or nursing associate or other position of power

to exploit, coerce or obtain a benefit, failing to maintain clear professional boundaries with people receiving care, and dishonesty about qualifications or employment history. A more extensive list can be found in our screening guidance.

Fitness to practise is about keeping people safe, rather than punishing nurses, midwives and nursing associates for past mistakes. Even where there has been serious harm to people receiving care as a result of a clinical error, provided there is no longer a risk to those receiving care, and the nurse, midwife or nursing associate has been open about what went wrong and can demonstrate that they have learned from it, we will not usually need to take action.

Some concerns about harm to people receiving care will be so serious that they can't be addressed. In cases like this, we will usually only need to take action if it's clear that the nurse, midwife or nursing associate deliberately chose to take an unreasonable risk with the safety of people in their care.

We may also need to take action if the incident suggests a deep-seated attitudinal issue that could put people receiving care at risk of harm or where the incident is so serious that it requires action on the grounds of maintaining professional standards or upholding public confidence in the professions we regulate. Where behaviour suggests deep-seated attitudinal issues that could put people receiving care at risk, it is less likely that the nurse, midwife or nursing associate will be able to remediate and take steps to address the underlying concerns. When we are looking at safety incidents which relate to people receiving care involving nurses, midwives or nursing associates, we will always look carefully at the context in which they were practising. Even poor practice by a nurse, midwife or nursing associate might actually have happened because of underlying system failures.

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

Please see our screening guidance for more information.

Concerns outside professional practice

Nurses, midwives and nursing associates should keep to the standards and values set out in the Code and consider the requirement to “uphold the reputation of [their] profession at all times” to help maintain the public’s trust and confidence.[2]

When considering their behaviour outside professional practice, nurses, midwives and nursing associates should be mindful, in particular, of the need to:

- act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment (20.2)
- be aware at all times of how their behaviour can affect and influence the behaviour of other people (20.3)
- keep to the laws of the country in which they are practising (20.4)
- treat people in a way that does not take advantage of their vulnerability or cause them upset or distress (20.5)

Sometimes the way a nurse, midwife or nursing associate conducts themselves outside their professional practice can be serious professional misconduct and will require us to act. We will take action when a professional’s conduct:

- either indicates deep-seated attitudinal issues which could pose a risk to the public in professional practice, or
- is capable of undermining public trust and confidence in the profession, raising fundamental questions about the nurse, midwife or nursing associate’s ability to uphold the values and standards set out in the Code.

As a professional regulator we would be unlikely to investigate if a nurse borrowed a small sum of money from a friend and subsequently failed to pay them back. However, if the scenario involved exploitation of someone in their care or the professional had committed a crime and received a sentence of imprisonment for such behaviour (for example, fraud), we are more likely to take action.

We recognise that our involvement in behaviour outside professional practice has the potential to engage a nurse, midwife or nursing associate’s right to respect for private and family life.[3] However, these rights are not absolute.

Concerns outside professional practice can involve diverse situations, settings and relationships, including the relationship between a professional and their partner or child. For example, domestic abuse could involve a range of behaviours, such as harassment and sexual misconduct, which could raise fundamental questions about a professional's ability to uphold the standards and values set out in the Code.

Guided by our statutory objectives and close attention to the seriousness of the case, we will always consider whether any regulatory action that may interfere with a professional's right to respect for private and family life is necessary and proportionate in the circumstances.

We will only interfere with disputes in someone's private or family life or make requests for information when it is necessary and proportionate to do so to protect the public, uphold professional standards or maintain public confidence in the professions we regulate.

Just because a matter is of concern to us, that does not mean that we will be able to progress the case. Such cases often involve evidential challenges. Our Case Examiners will only refer a concern to a panel hearing where the evidence available means that there is a realistic possibility the Fitness to Practise Committee would find the incidents did happen.

More information about the different evidential tests that we apply throughout our fitness to practise process can be found in our screening, case examiner and our decision making guidance. For more information on how we approach evidence, please refer to our guidance on evidence.

Risk of Harm

In some circumstances, the way a professional conducts themselves outside professional practice could indicate deep-seated attitudinal issues which could pose a risk to colleagues and people in the professional's care.

Professionals must be able to work with and care for the public, including those who are vulnerable. They exercise skills, have access to personal and sensitive information and materials, and undertake responsibilities that give them access to people who are vulnerable to abuse. Professionals need to be able to provide care for a diverse range of people and to work as part of diverse teams. Discriminatory attitudes can have a direct impact on the quality of care provided.[4]

To determine whether conduct outside professional practice could impair fitness to practise, we will consider all the facts involved. Examples of important factors include:

- the duration or frequency of the conduct in question
- the professional's relationship or position in relation to those involved
- the vulnerabilities of anyone subject to any alleged conduct.

Long-term or repeated misconduct is more likely to suggest risk of harm, together with conduct involving imbalances of power, cruelty, exploitation and predatory behaviour. We will assess how likely the nurse, midwife or nursing associate is to repeat similar conduct or failings in the future, and if they do, if it is likely that people in their care could come to harm, and in what way.

Broadly speaking, the following behaviours are *more likely* to suggest a risk of harm to the public and impaired fitness to practise, regardless of where they take place:

The Code says that nurses, midwives and nursing associates must treat people fairly without discrimination, bullying or harassment. It also states that individuals should be aware of how their behaviour can affect and influence the behaviour of others, be sure not to express personal beliefs inappropriately and use all forms of communication responsibly.[5]

The NMC takes concerns about bullying, harassment, discrimination and victimisation very seriously.[6] Although bullying is not included as a prohibited behaviour under the Equality Act, it can have a serious effect on workplace culture, and therefore the safety of people receiving care, if it is not dealt with.

If found proved, concerns relating to discriminatory behaviour, are likely to be regarded as misconduct, and will very often result in a finding of impaired fitness to practise.[7]

To be satisfied that discriminatory conduct has been addressed, we'd expect to see comprehensive insight, remorse and strengthened practice from an early stage, which addresses the specific concerns that have been raised. In addition, we must be satisfied that discriminatory views and behaviours have been addressed and are not still present so that we and members of the public can be confident that there is no risk of repetition.

Not every finding of misconduct about these concerns will result in a finding of impaired fitness to practise, even though it will be likely with concerns relating to discrimination, such as racism, sexism, homophobia or other discriminatory behaviour. Conduct of these types can be more difficult to address as they suggest an attitudinal problem.

To be satisfied that conduct of this nature has been addressed, we'd expect to see comprehensive insight, remorse and strengthened practice from an early stage, which addresses the specific concerns that have been raised. In addition, we must be satisfied that discriminatory views and behaviours have been addressed and are not still present so that we and members of the public can be confident that there is no risk of repetition.

Both anti-Jewish hate and anti-Muslim hate are types of racism, as well as religious discrimination. This means that individuals who identify as Jewish or Muslim, or who are perceived as Jewish or Muslim, can be discriminated against for either their race or religion or both. As with all forms of discrimination, they may raise questions about the ability of the perpetrator to treat people in their care with kindness, respect and compassion, and also pose risks to public confidence in the professions we regulate.

The right to engage in public debate about political and religious matters is part of the fundamental right to freedom of expression; when considering whether any particular conduct constitutes anti-Jewish or anti-Muslim hate, we will always consider our freedom of expression guidance and ensure that our decisions to do not unduly restrict legitimate freedom of expression.

We consider anti-Jewish hate to be a serious matter and likely to be a breach of the Code. When considering concerns about anti-Jewish hate our starting point will be the International Holocaust Remembrance Alliance [IHRA]'s working definition of antisemitism, as adopted by the Government,[8] which states that:

> "Antisemitism is a certain perception of Jews, which may be expressed as hatred toward Jews. Rhetorical and physical manifestations of antisemitism are directed toward Jewish or non-Jewish individuals and/or their property, toward Jewish community institutions and religious facilities."

IHRA's working definition of antisemitism is supported by contemporary examples of antisemitism (included in the link above), which may, "taking into account the overall context", constitute antisemitism. In the case of *Husain v SRA*, the High Court made clear that when considering actions that may fall within the scope of the contemporary examples listed by the IHRA, the decision-maker should consider the language used and the context of what was said, informed by a reasonable understanding of the main historical and cultural manifestations of antisemitism.[9] The fact that conduct falls within the scope of one of the contemporary examples does not mean that the conduct will automatically and necessarily be deemed antisemitic.

Example 1

A nurse on a hospital ward identifies that one of the patients on the ward is wearing a Star of David. The nurse asks the patient if they are Jewish, and they confirm that they are. As a result, the nurse starts making comments loudly that are critical of the policies of the Israeli government, which are clearly directed at the Jewish patient. Targeting a Jewish patient in this way will clearly be antisemitic even if the actual comments made about the policies of the Israeli government might, in a different context, not be regarded as antisemitic. This is because the nurse is assuming that the Jewish person is in some way connected to or responsible for the actions and decisions of the State of Israel. This conduct falls squarely within one of the contemporary examples of antisemitism cited by the IHRA (namely "holding Jews collectively responsible for actions of the State of Israel").

The High Court's decision in Husain v SRA also emphasised that statements criticising the historic formation, existence or policies of the contemporary State of Israel will not, in and of themselves, be antisemitic. Whether or not such statements are antisemitic will depend on analysing the language used and the context in which the statement is made. For example, proposing a 'one-state solution' where Israelis and Palestinians share a unitary state is not necessarily antisemitic, because it does not necessarily imply hatred towards Jewish people.

Example 2

A nursing associate is socialising with colleagues after work. The conversation turns to the situation in the Middle East. The nursing associate is highly critical of the policies and actions of the Israeli Government, but at no point does she attack Judaism or the Jewish community generally, either within or outside Israel. This would not be deemed antisemitic and, on its own, would not raise fitness to practise concerns, because she is not discussing Israel any differently than another state might be discussed. Such comments are within her right to freedom of expression.

As with anti-Jewish hate, we consider anti-Muslim hate to be a serious matter and likely to be a breach of the Code. When considering concerns about anti-Muslim hate, our starting point will be the UK Government's definition of anti-Muslim hostility:

"Anti-Muslim hostility is intentionally engaging in, assisting or encouraging criminal acts – including acts of violence, vandalism, harassment, or intimidation, whether physical, verbal, written or electronically communicated – that are directed at Muslims because of their religion or at those who are perceived to be Muslim, including where that perception is based on assumptions about ethnicity, race or appearance.

"It is also the prejudicial stereotyping of Muslims, or people perceived to be Muslim including because of their ethnic or racial backgrounds or their appearance, and treating them as a collective group defined by fixed and negative characteristics, with the intention of encouraging hatred against them, irrespective of their actual opinions, beliefs or actions as individuals.

"It is engaging in unlawful discrimination where the relevant conduct – including the creation or use of practices and biases within institutions – is intended to disadvantage Muslims in public and economic life."

The accompanying text emphasises that the definition is not statutory, should not be confused with legislation and must not be used in any way that is inconsistent with the law. It also explains how this definition fits into the context of the right to freedom of expression[10], and in particular makes clear that criticism of any religion is, in and of itself, protected by law. We will also bear in mind any emerging caselaw relating to the new definition.

Example 1

A nurse posts on social media calling for the deportation of "anyone who undermines British values and the British way of life". The post includes an image depicting women with headscarves, men with long beards and a mosque in the background. We would be likely to regard this as an example of anti-Muslim hate that would impair fitness to practise. The images are a stereotypical depiction of Muslims and, when combined with the text of the post, treat Muslims as a collective group defined by fixed characteristics with the intention of encouraging hatred against them (i.e. that Muslims "undermine British values and the British way of life"). This would be in breach of paragraph 1.3 of the Code because the nurse has made assumptions and failed to recognise diversity.

Example 2

A community midwife complains that she is struggling to get to some appointments on Fridays because

parking is difficult near the local mosque during prayer times. She is critical of the mosque for not having better provision in place for parking. However, her complaints are only about the parking and not the people praying, nor does she make any stereotypical or prejudicial comments about those attending the mosque. This would not amount to anti-Muslim hate and, on its own, would not raise fitness to practise concerns.

To be satisfied that discriminatory conduct has been addressed, we'd expect to see comprehensive insight, remorse and strengthened practice from an early stage, which addresses the specific concerns that have been raised. In addition, we must be satisfied that discriminatory views and behaviours have been addressed and are not still present so that we and members of the public can be confident that there is no risk of repetition.

Not every finding of misconduct about these concerns will result in a finding of impaired fitness to practise, even though it will be likely with concerns relating to discrimination, such as racism,10 sexism, homophobia or other discriminatory behaviour. Conduct of these types can be more difficult to address as they suggest an attitudinal problem.

To be satisfied that conduct of this nature has been addressed, we'd expect to see comprehensive insight, remorse and strengthened practice from an early stage, which addresses the specific concerns that have been raised. In addition, we must be satisfied that discriminatory views and behaviours have been addressed and are not still present so that we and members of the public can be confident that there is no risk of repetition.

A person against another person under the Equality Act 2010 if they treat them less favourably than they would treat others because of a protected characteristic[11] that is:

- age
- gender reassignment
- being married or in a civil partnership
- being pregnant or on maternity leave
- disability
- race including colour, nationality, ethnic or national origin
- religion or belief
- sex
- sexual orientation

Discriminatory behaviours of any kind can negatively impact public protection and the trust and confidence the public places in nurses, midwives, and nursing associates. We therefore take concerns of this nature seriously regardless of whether they occur in or out of the workplace. These concerns may suggest a deep-seated problem with the nurse, midwife or nursing associate's attitude, even when there's only one reported complaint.

When a professional on the register engages in these types of behaviours, the possible consequences are far-reaching. Members of the public may experience less favourable treatment, or they may feel reluctant to access health and care services in the first place. We know that experiences of discrimination can have a profound effect on those who experience it[12] and that fair treatment of staff is linked to better care for people.[13]

Where a professional on our register displays discriminatory views and behaviours, this usually amounts to a serious departure from the NMC's professional standards.

In such cases where displaying discriminatory views and behaviours is proved, some level of sanction will likely be necessary unless there's been insight at the most fundamental level and the earliest stage. However, if a nurse, midwife or nursing associate denies the problem or fails to engage with the fitness to practise process, it's more likely that a significant sanction, such as removal from the register, will be necessary to maintain public trust and confidence.

The research conducted as part of our Ambitious for Change[14] work indicated that some groups with protected

characteristics, such as black nurses and midwives, are more likely to be referred for fitness to practise concerns. As part of the work that we do to understand the wider context of a referral, we ask the person being referred whether they believe that a protected characteristic played a part in the referral. If someone who we are investigating tells us that they have been discriminated against, or discrimination has led to them being referred to us, we will take it very seriously. Where there is evidence to support this, we'll take this into account as set out in our guidance on context.

The environment that all health and social care professionals work in should be safe and free from bullying, harassing (including sexual harassment) and victimising behaviours, as well as any abuses of power to exploit, coerce or obtain a benefit (for example sexual or monetary) from people receiving care, colleagues or students.[15]

The Code sets out that nurses, midwives and nursing associates must maintain effective communication with colleagues and act with honesty and integrity at all times, treating people fairly and without discrimination, bullying and harassment. The presence of bullying, harassment (including sexual harassment) and victimisation in the workplace can have an extremely negative effect on the work environment, performance and attendance.[16] This in turn can have an effect on the delivery of care and if not dealt with can affect trust and confidence in the professions.

Even when they occur outside professional practice, such concerns can raise fundamental questions about the ability of a nurse, midwife or nursing associate to uphold the standards and values set out in the Code.

can be described as unwanted behaviour from a person or a group of people that is either offensive, intimidating, malicious or insulting. It can be an abuse or misuse of power that undermines, humiliates, or causes physical or emotional harm to someone. It can be a regular pattern of behaviour or a one-off incident and can happen face-to-face, on social media or over emails or telephone calls.[17] Usually bullying would be a pattern of behaviour, but an example of when it could be a one off incident could be if a member of the public felt that they had been bullied into agreeing to a do not resuscitate decision by a healthcare professional.

is defined under the Equality Act 2010 as treating someone else less favourably because they have brought proceedings, given evidence in proceedings or done any other thing in relation to the Equality Act.[18] It will also be victimisation if someone is treated less favourably by a person for making an allegation that someone has broken the Equality Act. Giving false evidence or information or making a false allegation is not protected if it's done in bad faith.

Where bullying and victimisation has been raised as a concern in a professional context, in line with our principles for fitness to practise, we consider that employers should act first to deal with the issues, unless there is an immediate risk to public safety.

We will usually only get involved after there has been a local investigation into the nurse, midwife or nursing associate's behaviour and where we feel the nurse, midwife or nursing associate has not taken adequate steps to address the issues identified with their practice. This is more likely to be necessary where the individual has not reflected on their behaviour or taken steps to change their behaviours in the future.

Evidence of repeated poor behaviour which has not been adequately resolved following action at a local level is more likely to require regulatory action, than isolated instances of poor conduct which are unlikely to be repeated.

Example

A number of complaints are made about a midwife shouting and using offensive language towards more junior members of staff over the course of several months. These issues are raised with the midwife and a local investigation is started. The midwife resigns before the conclusion of the local investigation. We'd need to seek assurance that the midwife has reflected and demonstrated they would not act in the same way again if they found themselves in a similar working environment. Without this evidence, regulatory action is likely to be required to stop the concern from happening again.

- Sexual misconduct is unwelcome behaviour of a sexual nature, or behaviour that can reasonably be interpreted as sexual, that degrades, harms, humiliates or intimidates another. It can be physical, verbal or visual. It could be a pattern of behaviour or a single incident. As a healthcare regulator, it is not our role to pursue or punish potential criminal activity in place of the police. However, sexual misconduct outside professional practice could indicate deep-seated attitudinal issues which could put the public at risk, as well as raise fundamental questions about the professional's ability to uphold the standards and values set out in the Code. Whether regulatory action is required will be considered on a case-by-case basis. In some circumstances we may need to investigate such concerns arising outside professional practice where there is no criminal conviction.

Example 1

> The conduct here falls within the definition of sexual misconduct. Even though it occurred outside professional practice, the nature of these acts, together with the reasons provided by the professional, could indicate deep-seated attitudinal issues capable of posing a risk to colleagues and people in the professional's care.

Example 2

> While the concerns relate to behaviour outside professional practice, sharing explicit messages with others about the sexual abuse of children suggests a sexual interest in children which could pose a risk to the public in the course of professional practice. Such expression could also seriously undermine public trust in the profession. This concern is capable of impairing fitness to practise and is likely to result in regulatory action.

- Safeguarding and protecting people from harm, abuse and neglect is an integral part of providing safe and effective care. It is also a key principle embedded throughout our Code.

  The Code says that nurses, midwives and nursing associates must 'take all reasonable steps to protect people who are vulnerable or at risk of harm, neglect or abuse'. Professionals are also expected to make sure that people's physical, social and psychological needs are assessed and responded to, which includes acting as advocates for the vulnerable and challenging poor practice and behaviour related to a person's care.

  Protecting people from harm, abuse and neglect goes to the heart of what nurses, midwives and nursing associates do. Failure to do so, or intentionally causing a person harm, will always be treated very seriously due to the high risk of harm to those receiving care, if the behaviour is not put right. Where professionals are shown to be involved in serious neglect or abuse outside their professional practice, there is likely to be a risk of harm to people receiving care. Such behaviour also has the potential to seriously undermine the public's trust and confidence in the professions we regulate.

See our sanctions guidance for our approach to sanctions in cases involving abuse or neglect of children or vulnerable people.

Example 1

> The serious and repeated abuse of someone in the professional's care could indicate a risk to people who receive care, whether through direct abuse or the failure to properly safeguard people in their care/children or vulnerable adults.

- Harassment is defined by the Equality Act 2010 as someone engaging in unwanted conduct that's related to a protected characteristic or is of a sexual nature.[19] The behaviour has the purpose or effect of violating an individual's dignity or creating an intimidating, hostile, degrading, humiliating or offensive environment. It's necessary to take the perception of the person who's the subject of the conduct and any other circumstances into account. As well as harassment linked to a protected characteristic as defined by the Equality Act, harassment can also be unwanted conduct that is unrelated to a protected characteristic which someone finds offensive or which makes someone feel intimidated or humiliated.

  We recognise that concerns of this nature can have a profound effect on those subjected to the behaviour and could negatively affect public protection and the trust and confidence that the public places in nurses, midwives and nursing associates, especially where it occurs within professional practice.

  We will always consider the seriousness of the individual concerns raised with us, but in circumstances where the concerns relate to sexual harassment we may need to take action when there has been just one reported incident.

Example

A nursing associate sends a number of abusive and harassing text messages to a colleague and makes inappropriate comments at work following the breakup of their relationship. A complaint is made and the matter is raised with the nursing associate by their employer. The nursing associate acknowledges their behaviour was inappropriate and stops immediately. They are issued with a formal warning and there are no other incidents. The matter has been dealt with locally and there's no need for us to become involved unless there are further incidents.

- Depending on the particular facts, violent behaviour can be serious enough to indicate a risk to the public and seriously undermine public confidence in the professions we regulate, irrespective of where it occurs. This includes in a domestic setting. Factors to consider include the nature of violence or abuse (for example, violence towards a child or vulnerable adult is likely to impair fitness to practise; discriminatory features or motivation will also be significant), the harm caused, and its frequency.

Example 1

> Whilst the conduct occurred in a domestic setting, the professional's treatment of their spouse involves serious violence and could suggest potential risk to those within their care, as well as seriously undermining public confidence in the profession. Healthcare professionals are entrusted to safeguard others and evidence demonstrates that people directly affected by domestic abuse will often seek their support. In addition, the discriminatory words could suggest a deep-seated attitudinal issue towards

> women and girls that could impact the standard of care provided.

Example 2

> Whilst this is not behaviour we would condone, it is not the kind of behaviour that is likely to require us to take action to restrict someone's ability to practise. The situation could be different, for example, if there was more serious violence, a link to discrimination, the professional received a sentence of imprisonment or, depending on the facts, was alleged to have conducted a prolonged campaign of violence or intimidation against a vulnerable neighbour.

Our Public Sector Equality Duty (PSED)

Alongside our professional standards, as a public authority, we have wider legal obligations which ensure equality is at the heart of what we do. The public sector equality duty (PSED) was created by the Equality Act 2010 and requires us to have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010
- Advance equality of opportunity between people who share a protected characteristic and those who do not
- Foster good relations between people who share a protected characteristic and those who do not

When a concern is raised with us, and there's evidence that a professional on the register has engaged in harassing, discriminatory or victimising behaviours, we'll always thoroughly investigate, taking into account our professional standards and the aims of the public sector equality duty.

Public confidence

Nurses, midwives and nursing associates hold an important position of trust. They are responsible for caring for and protecting people when they are at their most vulnerable, and for acting as an advocate on their behalf. Due to their unique position, members of the public expect nurses, midwives and nursing associates to uphold the rights of those they care for and to act in their best interests at all times. They must work, and be trusted to work, with and alongside diverse groups of people without discriminating unfairly against them or exploiting them. Failure to uphold these expectations could seriously undermine the public's trust and confidence in the profession and could make the public reluctant to access health and care services.

We are likely to take action to uphold public confidence where a nurse, midwife or nursing associate's conduct raises fundamental questions about their ability to uphold the standards and values set out in the Code.

Many behaviours which are likely to indicate a risk to people who use health and social care services are also likely to justify regulatory action on the grounds of upholding public confidence and maintaining professional standards. Examples include expressing discriminatory views or behaviours, sexual misconduct (including assault or harassment), serious violence (including in a domestic setting) and abuse or neglect of children and/or vulnerable adults.

Example 1

> Nurses midwives and nursing associates are expected to provide person-centred, non-discriminatory care to people of all backgrounds. While the concerns relate to behaviour outside professional practice,

> the underlying behaviours could indicate a risk to people in the professional's care. Discriminatory behaviours also raise fundamental questions about the professional's ability to uphold the values and standards set out in the Code. A failure to take any action is likely to impact the public's trust and confidence the profession.

Example 2

> Nurses, midwives and nursing associates are responsible for the care and protection of the vulnerable. Whilst the concerns relate to behaviour outside professional practice, the failure to safeguard and protect a child is serious enough to raise fundamental questions about the professional's ability to uphold the values and standards set out in the Code and undermine public trust and confidence in the profession.
>
> In situations such as this, we will always carefully consider the context to understand how it may have contributed towards the professional's behaviour – for example considering whether a professional was subject to coercive control by an abusive partner.

Example 3

> This serious and repeated violence raises fundamental questions about the ability of the nurse, midwife or nursing associate to uphold the standards and values set out in the Code. We are likely to consider these concerns further.
>
> Domestic abuse does not always involve violence. It can also take the form of controlling, coercive, threatening or degrading behaviour, including sexual misconduct. Depending on the facts, all of these behaviours are capable of undermining public confidence in the professions we regulate.

Misconduct that could also be a crime

If an allegation has not been reported to the police or relevant third party, this will not prevent us from investigating it, provided it could amount to serious professional misconduct.

We will exercise some caution when bringing cases of this kind, particularly when the conduct occurred outside professional practice. It is not our role to fill any perceived gaps in the criminal justice system. When deciding whether to investigate concerns that could have been reported to the police, but have not, we will carefully consider:

i) whether an investigation is necessary to fulfil our statutory duties; and
ii) whether it would be more appropriate for the concerns to be considered by the police or another third party

organisation such as the Family Court.

For example, if we received a referral where it is alleged that a sexual assault against a person receiving care had taken place, but the person concerned did not wish to report it to the police, we would still look into this. Where a professional is alleged to have carried out a sexual assault outside their professional practice, but the person subject to the assault does not wish to report it to the police, we would carefully consider whether there was any proper basis for us to take any regulatory action.

Example

> As the behaviour here could constitute serious sexual misconduct and potentially involves serious and repeated violence, it is likely to suggest a risk of harm to the public or is likely to undermine public trust and confidence in the professions. We would be likely to refer this matter for investigation and will consider carefully whether there is a realistic prospect of the allegations being proved at a panel hearing.

If the information we receive about a nurse, midwife or nursing associate's conduct potentially discloses a criminal offence or suggests a safeguarding risk to children or vulnerable people, we may determine that it is in the public interest to share information with the police or relevant third parties.[20] This is discussed in more detail in our information handling guidance. If the police or third party organisations decide to investigate the relevant conduct, we will decide whether we need to delay our consideration of the matter pending the outcome of that investigation.

If we believe that another organisation is best placed to investigate the concern, we will always let the referrer know why we believe this to be the case. If the referrer does not wish to report the matter to the police or progress an investigation with another organisation, we will decide whether to open our own investigation applying our usual screening test. Where a matter is referred for investigation, our Case Examiners will, once our investigation is concluded, consider whether there is a realistic prospect of the allegations being proved at a panel hearing, taking into account all the available evidence.

We need to be kind and fair to everyone involved in our regulatory process. Even when we proceed to investigate, such concerns will not always progress to a final hearing. We don't have the same extensive powers or specialist expertise as the police to investigate behaviour and therefore there may be limits to the evidence we are able to obtain. For example, we do not have access to forensic testing and data regarding the geographic location of mobile phones, nor are we able to search, seize evidence or compel someone to be interviewed.

Where we feel we're able to progress with a case, we will explain to the referrer any potential issues we're likely to face taking the case forward. The referrer can then make an informed decision about whether they wish to continue assisting us. We will look at how we can support people through our processes which includes identifying and signposting to external agencies when needed.

1 Meadow v General Medical Council [2006] EWCA Civ 1390; Roylance v General Medical Council [2000] 1 A.C. 311

2 The NMC Code, Standard 20

3 See Article 8 of the Human Rights Act 1998

4 A person discriminates against another person under the Equality Act if they treat them less favourably than they would treat others because of one or more of a protected characteristic. It includes discrimination on the basis of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race,

religion or belief, sex and / or sexual orientation. The Professional Standards Authority's September 2022 report Safer Care for All highlighted the impact that discrimination can have on the safety of people receiving care. In the PSA's report Perspectives on discriminatory Behaviours in health and care, members of the general public and health service users themselves highlighted the risk of mental and physical harm due to discrimination.

5 The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates 20.2, 20.3, 20.7, 20.10

6 The Equality Act 2010 states that harassment, discrimination and victimisation is prohibited in respect of the listed protected characteristics, age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion and belief; sex and sexual orientation.

7 See PSA v HCPC and Roberts [2020] EWHC 1906 (Admin) for a case where the use of racist language did not lead to a finding of impairment. However, the Court emphasised that cases of this type will be 'rare'.

8 Government leads the way in tackling anti-Semitism - GOV.UK

9 Husain v SRA Approved Judgment

10 PSA v HCPC and Roberts [2020] EWHC 1906 (Admin)

11 Equality Act 2010 s.13 - s.19.

12 Ross S, Jabbal J, Chauhan K, Maguire D, Randhawa M & Dahir S (2020) Workforce race inequalities and inclusion in NHS providers, The King's Fund.

13 West M, Dawson J, Admasachew L & Topakas A (2011) NHS Staff Management and Health Service Quality. Results from the NHS Staff Survey and Related Data.

14 Ambitious for change – research into NMC processes and people's protected characteristics, 20 October 2020

15 Harassment at work. A Unison Guide, December 2016

16 In addition to undermining public confidence, such concerns can also impact care. The Professional Standards Authority's September 2022 report Safer Care for All and its 2018 report Sexual behaviours between health and care practitioners: where does the boundary lie? highlight the impact that breaches of sexual boundaries between colleagues can have on the safety of people receiving care.

17 ACAS bullying definition

18 Equality Act 2010 s.27.

19 Equality Act 2010 s.26.

20 For example, other organisations who are responsible for safeguarding children or vulnerable adults, or who may be involved in safety investigations which relate to people receiving care, or in preventing or detecting criminal activity.

Freedom of expression and Fitness to Practise

Reference: 2ai Last Updated: 25/03/2026

> Following a number of reported cases around protected beliefs and freedom of expression, we have decided to provide consolidated guidance in these areas. To help nurses, midwives and nursing associates to practise and express themselves as professionals without issue, we have used examples based on real cases and set out the limited grounds on which we would consider taking action.

Everyone enjoys the right to freedom of thought, conscience and religion and freedom of expression.[1]

This includes:

- the freedom to share and receive information and ideas
- the freedom to express religious, political and philosophical beliefs.

It's unlawful to discriminate against someone because of their religion or belief or because they do not hold a belief.[2] These are called 'protected beliefs.'[3] In addition to religious beliefs, other examples of 'protected beliefs' are veganism and gender-critical beliefs.

Our role as a regulator

Everyone has the right to freedom of expression, but there may be some circumstances where what someone says or does could impact their fitness to practise.

We're not looking to regulate what professionals on our register say, particularly when they express protected beliefs.

Nurses, midwives and nursing associates should always be guided by the Code.

The Code

When expressing your views you should be particularly mindful of the need to

- treat people with kindness, respect and compassion (1.1);
- listen to people and respond to their preferences and concerns (2);
- deal with differences of professional opinion with colleagues by discussion and informed debate, respecting their views and opinions and behaving in a professional way at all times (9.3).
- act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment (20.2);
- be aware at all times of how your behaviour can affect and influence the behaviour of other people (20.3);
- make sure you do not express your personal beliefs (including political, religious or moral beliefs) to people in an inappropriate way (20.7);
- act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to (20.8);
- use all forms of spoken, written and digital communication (including social media and networking sites) responsibly, respecting the right to privacy of others at all times (20.10).

We recognise that the use of online communications and social networking platforms raise particular questions so

we have produced Guidance on Using Social Media Responsibly.

Our Approach

We respect the right to freedom of speech and will only interfere with its exercise when it is strictly necessary and proportionate to our aims as a healthcare regulator.

We will consider whether what a registered professional has said or done

discrimination, bullying, harassment and victimisation

It is particularly relevant to look at:

-
-
-

We take broadly different approaches where:

> 1. A professional makes comments outside work unrelated to their practice or registered status;

Nurses, midwives and nursing associates are free to express themselves and their protected beliefs outside of work. It is not our role to monitor what people say outside of, or unrelated to, professional practice. We won't take action simply because something a professional has said or done has shocked, disturbed or caused offence to someone. We will only do so in those rare cases where:

- the way a professional conducts themselves suggests they have a deep-seated attitudinal problem,
- what the professional did or said is so serious that a finding of impairment may be necessary to protect the public and/or maintain the public's confidence and trust in the professions and to uphold professional standards,
- what the professional did or said results in a criminal conviction[5] that could mean they pose a risk of harm to the public or undermine confidence in the profession.

So, for example, a professional might campaign for curbs to immigration or discuss online their religious belief (protected in law) that same sex marriage is sinful.[6] However, were they to use racist, homophobic, sexist or other discriminatory language, target people using health and care services or suggest that they would discriminate against others as a result of these views, especially in a professional context, their fitness to practise could be impaired. Professionals who share content from others or links to such content might reasonably appear to be supporting the views or language found there. When sharing, they should consider the Code and whether it would be appropriate to say they disagree with the content or explain their purpose for sharing it.

> 2. A professional makes comments outside work related to their practice or their position as a nurse, midwife or nursing associate;

Professionals can express opinions and ask challenging questions about their work and associated topics. These actions can strengthen our regulated professions. For example, provided they do not breach patient confidentiality, a registered nurse involved in end-of-life care might feature in a campaign for or against the legalisation of assisted dying, broadly sharing their experiences whilst doing so.

We won't take regulatory action just because a nurse, midwife or nursing associate has attended a lawful march or protest or is taking lawful industrial action. For example, a midwife might attend a rally opposing abortion without questions arising as to their fitness to practise. Professionals enjoy a right to protest and manifest their personal beliefs. However, if a professional assaulted someone at a rally or gave unsafe unsolicited clinical advice, we're likely to investigate the matter.

When a professional promotes a position on a medical or professional matter, especially where they rely on their registered status (for example, as a nurse) to do this, they should keep in mind the relevant provisions of the Code (for example para 20.3: "be aware at all times of how your behaviour can affect and influence the behaviour of other people"). Whilst we won't take action simply because they have expressed a controversial opinion on an

issue relating to nursing or midwifery practice, professionals should be aware of how their behaviour can affect and influence the behaviour of others, as well as undermine public confidence in their profession.[7] They should consider if they may need to qualify what they say, for example by pointing out that it is just their opinion or setting out the limitations of their experience in an area.

Example 1

Registered professionals are entitled to hold and express opinions about their work and politics, including in public, provided they do not act contrary to the Code. Sometimes such expression can be heated and passionate. In this scenario there is no evidence of behaviour contrary to the Code, such as racism, discrimination, harassment or breach of confidentiality, so we won't take regulatory action here. Had the professional, for example, described their manager using a racial slur or indicated that they would treat patients differently based on their political views or other characteristics, then we would be likely to take action

Example 2

We are likely to take regulatory action against this professional. Regardless of the nature of any underlying beliefs, the professional's words create risk to the public and are likely to fundamentally call into question their practice or the knowledge expected of a registered professional. The advice is public, given to someone aware of the nurse's registered status and there is no evidence that the nurse has made reasonable qualifications to what they have said.

Example 3

We are likely to take regulatory action against this professional. A registered professional should be aware of how their behaviour can affect and influence the behaviour of others, as well as undermine public confidence in their registered profession. The language used is inflammatory and abusive, their speech is public and goes far beyond a reasoned debate on the pros and cons of vaccination.

> 3. A professional expresses themselves in the course of work or an activity related to their practice;

We don't expect professionals to conceal their personal beliefs at work. Yet, we may find their practice impaired, if they express a personal belief in a way that:

- constitutes discrimination, harassment, bullying or victimisation of others,
- means that they are not delivering the fundamentals of care effectively, or are not listening to people and responding to their preferences and concerns, or
- conflicts with the Code's requirement to treat patients and people who use services with 'kindness, respect and compassion'.

Nurses, midwives or nursing associates may practise in accordance with a protected belief, provided it is within the law and does not deny people who use services access to appropriate medical care or otherwise contravene

the NMC Code. Please see our Guidance on Conscientious Objection for more information on this particular issue, including the statutory right of professionals to refuse to take part in procedures relating to both the achievement and termination of pregnancy.

Example 1

We are likely to take action against this professional. They have targeted their colleague in a discriminatory and harassing manner. Their conduct could undermine confidence in the profession as well as raise public protection concerns. Even if the nursing associate could demonstrate that the underlying beliefs that motivated their conduct are themselves protected, that protection does not give them licence to harass others or to discriminate against them.[8]

Example 2

We are likely to take action against this nurse. Persistently and deliberately misgendering a trans person is contrary to the requirements of the Code to treat people with kindness and respect. The nurse's beliefs do not justify a clear departure from the provisions of the Code. Although gender-critical beliefs are protected under the Equality Act, this does not mean that those with gender-critical beliefs can 'misgender' trans persons with impunity.[9]

Example 3

We are unlikely to take action on the basis of these facts alone. The Employment Appeal Tribunal has decided that Gender-critical views protected beliefs.[10] We will not take action against professionals unless the way their beliefs are expressed fundamentally calls into question a nurse, midwife or nursing associate's practice or professionalism. Though the nurse's beliefs may cause offense to others, there is no evidence in this example that they have expressed them in a way that could undermine public confidence in the profession. Nor is there any indication that the professional's belief is affecting their ability to practise safely and according to the Code – for example, that the midwife in this example has failed to treat a transgender patient with kindness and respect or has harassed or discriminated against trans people.

Example 4

There is no evidence at any point that the nurse has acted contrary to the Code.

Example 5

We are likely to take action in these circumstances. Even if the nurse's underlying beliefs were protected, by seeking to actively interfere with treatment on that basis they are acting contrary to the Code. This conduct is likely to impact on care and public health, as well as undermine confidence in the profession.

For details of how Freedom of Expression is considered in Interim Order applications, see our Guidance on Freedom of expression and Interim Orders.

1 Article 9 and 10 of the European Convention on Human Rights, or 'ECHR'

2 Under the Equality Act 2010 in England, Wales and Scotland; under the Fair Employment and Treatment (Northern Ireland) Order 1998 in Northern Ireland

3 Examples of beliefs that courts or tribunals have found to be protected include religious beliefs and beliefs closely linked to or based on those beliefs, lack of religion, veganism and gender-critical beliefs (that is, a belief that sex is binary and cannot be changed, for example in Forstater v CGD Europe and others UKEAT 0105/20)

4 Our legal framework sets out our duty to pursue these aims. See article 3(4A) Nursing and Midwifery Order 2001

5 For more detailed guidance on which convictions would be relevant, please see our FTP guidance on Criminal Convictions and Cautions

6 See Ngole v The University of Sheffield [2019] EWCA Civ 1127

7 Mohammad Adil v General Medical Council [2023] EWCA Civ 1261

8 See Forstater v CGD Europe [2021] 6 WLUK 104 where a "gender-critical" belief that sex was biologically immutable, and that sex rather than gender identity was fundamentally important, was held to be a philosophical belief protected under s.10 of the Equality Act 2010. The Court stressed that such a finding does not amount to an expression of support for particular view in debates about transgender issues, nor does it mean that (i) those with gender-critical beliefs can 'misgender' trans persons with impunity', (ii) trans persons do not have the protections against discrimination and harassment conferred by the [Equality Act 2010]' or (iii) 'employers and service providers will not be able to provide a safe environment for trans persons'

9 See the case of Forstater, above.

10 See the case of Forstater, above.

Lack of competence

Reference: FTP-2b Last Updated: 14/04/2021

Lack of competence would usually involve an unacceptably low standard of professional performance, judged on a fair sample of their work, which could put patients at risk. For instance when a nurse, midwife or nursing associate also demonstrates a lack of knowledge, skill or judgement showing they are incapable of safe and effective practice.

Unless it was exceptionally serious, a single clinical incident would not indicate a general lack of competence on the part of a nurse, midwife or nursing associate.

We recognise that nurses, midwives and nursing associates sometimes make mistakes or errors of judgement. Our starting position is that the nurse, midwife or nursing associate is usually a safe and competent professional but something may have happened that got in the way of them delivering safe care.

If concerns are raised about the general competence of a nurse, midwife or nursing associate we'll seek to understand the circumstances at the time. We'll also look at their practising history and not just at the period of time when the concerns arose. This will help us understand if there is a particular area of practice where there may be concerns or whether they are more general in nature.

Where we identify a gap in the nurse, midwife or nursing associate's knowledge or training we'll try to help them understand what they can do to address this gap and demonstrate they're safe to practise.

It's important that we find out how this gap occurred and in particular if it raises a concern about the quality or availability of support and supervision at a particular setting or whether there's evidence of discrimination or victimisation. If there is such evidence we may need to take some additional action, such as sharing information with other regulators or employers.

Criminal convictions and cautions

Reference: FTP-2c Last Updated: 06/05/2025

In this guide

Overview

This page sets out when a nurse, midwife or nursing associate'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.

Considering criminal conviction or caution declarations

Nurses, midwives or nursing associates 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 are charged with a criminal offence, are convicted or receive a caution while they're on our register.

the Code

If there's evidence the nurse, midwife or nursing associate 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, midwife or nursing associate 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, midwives or nursing associates should let us know if they are charged with a criminal offence or receive a caution, conditional discharge or criminal conviction as soon as they can.

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

Assessing the seriousness of convictions and cautions

Specified offences and custodial sentences

We will almost always take concerns to a fitness to practise panel when a professional

- has been convicted of any of the serious crimes we classify as specified offences and/or
- has been given a custodial sentence (including suspended sentences).

That is because this offending is considered to be so serious that it is likely to undermine our professional

standards and public confidence in the professions we regulate.

In all other cases we will look closely at the underlying circumstances of offending to determine whether there is a risk to the public that we need to act on, or whether it is likely to undermine our professional standards or public confidence in the professions we regulate.

Offending in professional practice

When offending has occurred in professional practice[1], it's very likely this would be serious enough to affect fitness to practise.

Offences which involve neglecting, exploiting, assaulting or otherwise harming people receiving care provide particularly strong evidence of risk to the public and are so serious that we are also likely to take regulatory action to maintain public confidence in nurses, midwives or nursing associates. Such concerns are more difficult to put right and are likely to require us to take regulatory action.

Offending outside professional practice

Whilst it is less likely that we will need to take action when offending occurs outside professional practice or isn't closely related to it, and it is neither a specified offence nor involves a custodial sentence, sometimes the underlying behaviour will be so serious as to:

- indicate deep-rooted attitudinal issues which could pose a risk to people in the professional's care or to the professional's colleagues, or
- be capable of undermining public trust and confidence in the profession or raise fundamental questions about the person's ability to uphold the standards and values set out in the Code.

We will always consider each case on its facts.

For example, depending on the particular facts and context, we might take action against professionals who receive non-custodial sentences for

- coercive control;
- serious and/or repeated violence against others;
- stalking or harassment offences.

When considering risk to the public, we will need to assess how likely the nurse, midwife or nursing associate is to repeat similar conduct or failings in the future and, if they do, if it is likely that people in their care or colleagues would come to harm, and in what way.

Outside specified offences[2], we are more likely to identify deep-rooted attitudinal issues which indicate a risk to the public, and/or consider that the conduct raises fundamental questions about the professional's ability to uphold the values and standards in the Code, where there is serious and/or repeated mistreatment, and/or the behaviour targets children or vulnerable people.

The sentence passed by a criminal court is likely to be a relevant consideration when deciding the seriousness of a professional's behaviour; however, it won't always be a reliable guide to how seriously the conviction affects a professional's fitness to practise. In the criminal courts, one of the purposes of sentencing is to punish people for offending. In contrast, our overarching objective is public protection and maintaining confidence in the professions we regulate.

Once we decide that the conviction, and any information we've gathered about the surrounding circumstances, would be serious enough to affect the nurse, midwife or nursing associate'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 screen cases.

Offences reported to the police that don't result in a conviction

As a professional regulator, we do not carry out criminal investigations or decide when a crime has been committed. The police investigate crime; our role is to protect the public from harm, promote professional standards and maintain public trust and confidence in the professions we regulate.

To fulfil these duties we sometimes need to investigate incidents that the police have investigated but have not resulted in a conviction, or conduct or circumstances that are closely related. We will only do so when it is necessary for us to take action as a regulator. For example, where the underlying conduct or wider behaviour raises fundamental questions about a person's ability to uphold the values and standards set out in the Code.[3]

After police investigation, it may emerge that a crime has not been committed. For example, in an offence of theft the police or jury may not be satisfied that a professional wanted to permanently deprive a hospital of medication they took. That does not always mean that the conduct does not concern us as a regulator. The systematic misplacing or removal of medication itself could raise questions about the professional's fitness to practise and require us to take regulatory action. Similarly, in an offence of racially aggravated common assault, the police or jury may not be satisfied that the professional assaulted someone. Nevertheless, there might be evidence that they did use racist language. Given their discriminatory behaviour we could well have concerns about the professional's fitness to practise which could require us to take regulatory action.

Example 1

> While the police have investigated these concerns already and concluded that no criminal offence has been committed, we're very likely to need to investigate this behaviour and take this matter forward. Sharing explicit messages with others about the sexual assault of women suggests a dangerous and potentially discriminatory view towards women and girls, which could pose a risk to the public in the course of
>
> professional practice
>
> . This conduct could also undermine public trust and confidence in the profession. We're not responsible for carrying out criminal investigations and deciding whether a criminal offence has been committed, but we have a responsibility to keep people safe, to promote professional standards and maintain public trust and confidence in the professions we regulate.

Example 2

Sometimes we may also need to investigate, and even take to a panel, allegations that the police have decided not to pursue. For example, the police investigate an allegation that a professional has assaulted a person who was receiving care whilst they were recovering from an operation and decide there isn't sufficient evidence to bring criminal proceedings. As the nature of the allegation indicates a potential risk to people receiving care and could also undermine public confidence in the profession, we will apply our screening guidance and, depending on the circumstances, may decide we need to conduct a full investigation.

Our approach

We will consider such cases under our standard guidance on Misconduct.

However, we need to be kind and fair to everyone involved in our regulatory process and be clear about the nature and limitations of regulatory investigations from the outset.

We will exercise considerable caution when bringing cases of this kind. When deciding whether to investigate the alleged behaviour after police involvement, we will first carefully assess:

- why there wasn't a conviction, or why the police decided not to investigate;
- 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;
- whether the nature of the allegation or the underlying behaviour indicates a need for us as a regulator to take action to protect the public, uphold standards or maintain public confidence in the professions we regulate;
- the likelihood of us obtaining sufficient evidence to prove the allegations at a panel hearing. In deciding this we'll need to consider our obligation to act fairly towards all involved.

The standard of proof for regulatory action (the balance of probabilities or "more likely than not") is lower than the standard used for criminal proceedings, where decision-makers need to be "sure". This means that we may sometimes be able to prove relevant underlying facts even where the evidence wasn't considered sufficient to do so in criminal proceedings.

Nevertheless, it's not our role to fill any perceived gaps in the criminal justice system. We will only take action if it is necessary to do so to fulfil our statutory duties.

For example, if a nurse, midwife or nursing associate is investigated for an alleged domestic mortgage fraud against a bank, but the prosecution collapses, it wouldn't be our role to investigate whether they acted dishonestly as part of a possible misconduct case. This type of offence does not raise a risk to people receiving care and would not cross the threshold for damage to public confidence in the profession.

We also need to be realistic about the limits of our investigatory powers. We don't have the same extensive powers or specialist expertise as the police to investigate allegations. There are limits to the evidence we are able to obtain. For example, we do not have access to forensic testing and data regarding the geographic location of mobile phones, we do not have powers to search or seize evidence and we're not able to compel someone to be interviewed.

Where we decide it is necessary and realistic for us to investigate, we will be open with those who might be involved in the investigation about the possible outcomes, and the potential issues we're likely to face taking the case forward, so they can make an informed decision about whether they wish to continue assisting us. We will look at how we can support people through our processes which includes identifying and signposting to external agencies when needed. 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.

1 As defined in 'Misconduct: When does poor practice become serious professional misconduct?'

2 Which include hate crimes and sexual offences

3 Ashraf v General Dental Council [2014] EWHC 2618 (Admin); for a more recent example of a case where a police investigation did not result in a prosecution but the regulator brought proceedings see Roy v GMC [2023] EWHC 2659 (Admin)

Directly referring specified offences to the Fitness to Practise Committee

Reference: FTP-2c-1 Last Updated: 27/02/2024

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

- a nurse, midwife or nursing associate has been sentenced to imprisonment (including a suspended prison sentence), and/or
- the conviction was for a .

Specified offences are offences which are, by definition, particularly serious. The nature of these convictions would raise fundamental questions about a nurse, midwife or nursing associate's ability to uphold the standards and values set out in the Code.

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?

In our guidance 'specified offences' means:

- hate crimes
- sexual offences
- serious offences involving children
- other serious offences listed below

Hate crimes

We consider that a hate crime is any criminal offence in which a professional has:

- demonstrated hostility based on race, religion, disability, sexual orientation or transgender identity or
- been motivated by hostility based on race, religion, disability, sexual orientation or transgender identity.[1]

Sexual offences

Sexual offences are offences which involve sexual activity or sexual motivation. They include crimes such as rape or sexual assault, any sexually motivated crimes against children including child sexual abuse or grooming, the taking or sharing of indecent images of children, and crimes that exploit others for a sexual purpose, whether in person or online.

Serious offences involving children

In addition to sexual offences involving children, this includes:

- Cruelty to a child – assault and ill treatment, abandonment, neglect, and failure to protect
- Causing or allowing a child to suffer serious physical harm or causing or allowing a child to die
- Offences under the Female Genital Mutilation Act 2003 including: female genital mutilation; assisting a girl to mutilate her own genitalia and assisting a non-UK person to mutilate overseas a girl's genitalia

Other serious offences

- murder

- manslaughter
- offences that relate to the death or serious injury of any person, or a substantial financial gain or serious financial loss to any person
- offences that relate to:
    - 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
- human trafficking
- slavery, servitude and forced or compulsory labour
- extortion
- blackmail
- kidnapping
- causing an explosion likely to endanger life or property
- serious offences under the Firearms Act 1968
- hostage taking
- torture
- serious drug-related offences
- hijacking offences
- causing death by dangerous driving, causing death by driving when disqualified from driving, and causing death by careless driving when under the influence of drink or drugs.

1 This definition was used by the CPS and the former Association of Chief Police Officers.

Criminal offences we don't investigate

Reference: FTP-2c-2 Last Updated: 17/12/2021

In this guide

Protected cautions and convictions

Nurses, midwives and nursing associates need to let us know if they receive a caution or conviction, unless the caution or conviction is protected.

Protected cautions and convictions are defined differently across the UK.

Cautions

Cautions in are not protected.

A caution in England and Wales is protected if:

- the person was under 18 years at the time the caution was given; or
- the person was 18 years or older at the time the caution was given, it wasn't for a listed offence, and six years have passed since the date of the caution.

Convictions

A conviction in is protected if all of the below bullet points apply:

- eleven years have passed since the date of conviction (or five and a half years if the person was under 18 at the date of conviction),
- it did not result in a custodial sentence (including a suspended sentence) 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 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 conviction(or seven and a half years if the person was under 18 at the date of conviction).

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'll assess other motoring offences on a case by case basis, but will only take regulatory action if this is closely linked to the nurse, midwife or nursing associate'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, midwife or nursing associate's fitness to practise if:

- the offence occurred either in the course of a nurse, midwife or nursing associate'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, midwife or nursing associate 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, midwife or nursing associate's fitness to practise is impaired because of their health.

In such cases the nurse, midwife or nursing associate'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, midwife or nursing associate's fitness to practise is impaired by reason of that conviction if a nurse, midwife or nursing associate 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, midwife or nursing associate's professional practice.

Health

Reference: FTP-2d Last Updated: 06/05/2025

We often receive referrals alleging that a nurse, midwife or nursing associate has a health condition. We will only need to intervene in a nurse, midwife or nursing associate's practice due to ill health if 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, midwife or nursing associate 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, midwife or nursing associate 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, midwife or nursing associate 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, midwife or nursing associate has demonstrated good insight into the extent and effect of their condition
- the nurse, midwife or nursing associate is taking appropriate steps to access treatment and is positively engaging with health professionals treating them
- occupational health (where available) is providing support through the employer
- the nurse, midwife or nursing associate is managing his or her practice appropriately, for example by taking sickness absence.

Example

> Nursing associate A was referred to the NMC by their employer as they were concerned about the effect that a health condition was having on their practice.
>
> Nursing associate A has been supported by their GP throughout and was signed off as being unfit for work during each of the prolonged periods of absence that they have taken. They agreed with their employer to engage with the occupational health department to plan a phased return to work and agree suitable adjustments to their working pattern.
>
> Nursing associate A has shown good insight into their condition and is receiving support from their GP, and more recently the occupational health department. They have also shown that they have managed their condition by taking sickness absence when they were unwell. This is unlikely to require regulatory action at this time as any potential risk is being well managed.

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, midwife or nursing associate 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.

Example

> Nurse B was involved in an incident where they had made a number of medication errors. It was found that the errors were caused due to a health condition that they had been suffering from.
>
> Nurse B was receiving treatment for the condition through their GP, but the treatment was having limited success and some further errors were found to have occurred which were again related to the health condition.
>
> As the concern hasn't been fully addressed and there is an ongoing public protection risk, regulatory action is likely to be required.

When we assess whether a concern about a nurse, midwife or nursing associate's health is serious enough to become involved in their practice, because we've assessed it poses a risk to either public safety or to the public's confidence in the professions generally or to professional standards, 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, midwife or nursing associate's GP or occupational health department. We will balance the nurse, midwife or nursing associate'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, midwife or nursing associate 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, midwife or nursing associate's knowledge of English, decision makers will consider language testing results as the primary measure of whether the nurse, midwife or nursing associate has the necessary knowledge of English to practise safely. Both case examiners deciding whether a nurse, midwife or nursing associate 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, midwife or nursing associate achieved.[1]

If the nurse, midwife or nursing associate 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, midwife or nursing associate 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, midwife or nursing associate 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, midwife or nursing associate'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, midwife or nursing associate's knowledge of English. Such evidence will be particularly relevant if the nurse, midwife or nursing associate 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, nursing associate or employer has submitted which seems to demonstrate they have the necessary knowledge of English to practise safely
- any evidence that the nurse, midwife or nursing associate has trained or practised in an English speaking environment for a period of time
- any evidence that the nurse, midwife or nursing associate 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, midwife or nursing associate 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: 14/04/2021

Nurses, midwives and nursing associates 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, midwife or nursing associate 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 or nursing associate practice in England.

We will consider the scope and nature of the other organisation's determination and the factual background.[1] We will assess how closely the issues relate to the practice of nursing or midwifery in the UK or nursing associate practice in England. We will also assess the underlying facts or issues, including any contextual factors and whether these have been considered by the other regulatory body when making their decision. We will consider if, in light of these facts, the nurse, midwife or nursing associate could present a risk to members of the public by continued nursing, midwifery or nursing associate practice, or if the other body's finding could affect public confidence in the nursing, midwifery or nursing associate 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, midwife or nursing associate presents no current risk of harm to patients
- the determination involves no potential impact on public confidence in the nursing, midwifery or nursing associate professions
- there is no need, in the particular case, to take action to maintain proper professional standards and conduct.

1 NMC (Fitness to Practise) Rules 2004 R 31 (4) states that a signed certificate is "admissible as prima facie evidence of the facts referred to in the determination"

When we use interim orders

Reference: FTP-5 Last Updated: 25/03/2024

We use interim orders to protect the public, and occasionally the professional themselves, from risk by placing conditions on, or suspending a nurse, midwife or nursing associate's practice. We use them:

- during our investigation,
- before the allegation against the nurse, midwife or nursing associate 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, midwives or nursing associates, so we need to make sure we only use them when it's proportionate to do so.

Find out more about interim orders.

Our investigations

Reference: FTP-6 Last Updated: 06/05/2025

We investigate concerns about a nurse, midwife or nursing associate'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, midwife or nursing associate 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: 25/03/2026

Once our investigations team has completed their investigation into the concerns about a nurse, midwife or nursing associate, our case examiners decide whether or not a nurse, a midwife or a nursing associate 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 possibility that our Fitness to Practise Committee would find a nurse, midwife or nursing associate'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 , they can:

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

If case examiners decide there is a , they can:

- recommend undertakings to be agreed with the nurse, midwife or nursing associate, 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, midwife or nursing associate 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, a midwife or a nursing associate. 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, midwife or nursing associate 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, midwife or nursing associate 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, midwife or nursing associate has asked for one, or if we think there is a 'material dispute'. A material dispute is a disagreement between us and the nurse, midwife or nursing associate 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, midwife or nursing associate 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, midwife or nursing associate.

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, midwife or nursing associate'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, midwives or nursing associates.

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.

Taking account of context

Reference: FTP-12 Last Updated: 06/05/2025

In this guide

Overview

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

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.

Commitment 1: We'll approach cases on the basis that most people referred to us are normally safe

Reference: FTP-12a Last Updated: 06/05/2025

Unless evidence shows that someone deliberately caused harm or acted recklessly, our starting position will be to assume the nurse, midwife or nursing associate is usually a safe and competent professional, but something got in the way of them being able to deliver safe care. Examples of things that might get in someone's way include:

- gaps in their knowledge or training
- widespread practices or cultures
- issues in the working environment
- someone's personal context such as health issues or personal circumstances.

Our initial enquiries and investigations will seek to understand what got in the way of someone delivering safe care. To do this we'll routinely make enquiries about the contextual factors identified in our research to see if these could have played a part in what went wrong.

We'll take an objective approach to the cases we look into, and our decisions in respect of what action is required will be evidence based. This may mean taking action against the individual referred to us if the evidence suggests that there's a serious concern regarding their fitness to practise. However, the evidence may suggest that some other action is required instead of, or in addition to action against the individual, in order to protect the public.

Where there's evidence of deliberate harm or recklessness, we'll follow the approach in our list of 'matters we'll always investigate further'. We'll need to ask questions about the culture of the team or setting, and what other people knew and did. However, causing deliberate harm or acting recklessly is more likely to call into question fundamental aspects of the individual's practice and require us to take regulatory action.

Commitment 2: We'll seek to build an accurate picture about the nurse, midwife or nursing associate's practising history

Reference: FTP-12b Last Updated: 29/03/2021

We'll always seek to build up, take account of and present an accurate picture of someone's practising history, rather than viewing an incident or concerns in a vacuum. A person-centred approach means looking at things that have gone well, not just the period of time when a concern has arisen.

Before deciding on someone's fitness to practise, it would be helpful to know if they'd encountered a similar situation before, knew the right thing to do and would usually do it. This could tell us if the incident we're looking at is out of character, part of a pattern or because of a gap in their knowledge or training.

Where our information shows what the nurse, midwife or nursing associate did was out of character, we'll focus our efforts on understanding what caused them to act differently on this occasion. The nature and extent of any further involvement by us will be informed by what that was.

We will aim to find out why the person did what they did and what prevented them from acting in the right way. This will help us decide if they represent a future risk to people who use services and the public (and if so, in what way) or whether something else was responsible for what went wrong.

If something else was responsible, we'll consider if we need to take other steps to stop it from happening again which don't involve taking regulatory action against the person.

Where the information shows a pattern of concerns, we'll look at why that might be the case. It's more likely that we'll need to take some kind of fitness to practise action if the concerns haven't been successfully addressed.

Commitment 3: We'll always carefully consider evidence of discrimination, victimisation, bullying or harassment

Reference: FTP-12c Last Updated: 06/05/2025

We value the diversity of the nurses, midwives and nursing associates on our register as an asset to the health and social care sector.

Data from the NHS staff survey in 2019 demonstrates that in England staff from an ethnic minority background are more likely to experience harassment, bullying or abuse both from members of the public and colleagues. When concerns are raised with us about people on our register, we'll take account of the links between these unacceptable behaviours, poor cultures and the safety of people who use services. We'll also recognise the impact discrimination, victimisation, bullying or harassment can have on someone's health and wellbeing and the significant part they can play in allegations of poor practice. We'll do this in the following ways.

Where we receive a complaint that a nurse, midwife or nursing associate may have been responsible for discriminating, victimising, bullying or harassing people and there's some evidence to support the complaint, we'll treat this as a potentially serious breach of the NMC Code. Our screening guidance sets out why cases of this nature are more likely to require regulatory action. We'll look to understand why the individual behaved in this way and concentrate on taking action to minimise the risk of the same thing happening again.

This may mean taking regulatory action against the nurse, midwife or nursing associate as well as against others where there's evidence they were involved in the same or similar conduct.

For those on our register, this means considering whether to open a referral about their fitness to practise. Where our enquiries show individuals not on our register were involved in the same or similar conduct, we'll consider sharing this information proactively with other regulators and employers. This is because other regulators and employers might be able to take action to address the issue and to help set clear expectations that the environment that all health and social care professionals work in is free from bullying, discrimination, victimisation and harassment and safe for everyone.

In all other cases, we'll ask at the beginning of our investigation whether discrimination, victimisation, bullying or harassment played a part in the referral. Where there's evidence the nurse, midwife or nursing associate referred to us was subjected to this kind of treatment, we'll need to decide whether this caused or contributed to what happened and if so, in what way. This could tell us if there's an issue with their practice that needs to be addressed or if what happened was purely the result of how they were treated and would be unlikely to happen again.

> A newly qualified nurse is referred to the NMC as their employer is concerned that they have a health condition that isn't being adequately managed. The nurse was found to be persistently crying whilst at work and had a high level of sickness absence. They refused to engage with occupational health because they said they had been bullied at work and were dismissed from their post. Upon investigation it is found that the senior nurse on the ward had been bullying a number of junior staff, which caused the sickness absence of the individual concerned.
>
> We would not need to look into the newly qualified nurse's fitness to practise as the issues came about as a direct result of an unacceptable working environment. We would however need to communicate the cultural issues we had uncovered to the Trust and see whether the bullying behaviour of the senior nurse was

> subsequently addressed. Unless the senior nurse has reflected and demonstrated that they would not act in this way again, we would need to start an investigation into the senior nurse's fitness to practise.

If we find evidence that a nurse, midwife or nursing associate who has been referred to us was discriminated against, victimised, bullied or harassed we'll also consider if we need to open any new referrals to look into the fitness to practise of those responsible. If those responsible are not on our register, we'll consider sharing information with other regulators and employers.

The research conducted as part of our Ambitious for Change[1] work has told us that groups with certain protected characteristics, such as black nurses and midwives, are more likely to be referred for fitness to practise concerns. If we receive information to suggest that discrimination has led to the referral being made, we will take it very seriously. Where there is evidence to support this, we will take this into account as part of our investigation.

1 Ambitious for change – research into NMC processes and people's protected characteristics, 20 October 2020

Commitment 4: Where risks are caused by system and process failures, we'll concentrate on the action we can take to help resolve the underlying issues

Reference: FTP-12d Last Updated: 06/05/2025

The evidence is clear that even one-off events or errors are usually caused by multiple contributing factors coming together.[1] Wrongly blaming an individual won't change these factors, won't stop underlying issues happening again and ultimately won't help keep people safe.

Where systemic issues prevent nurses, midwives and nursing associates from delivering safe care, the system should be accountable. Taking action against an individual in these circumstances doesn't lead to a culture of openness and learning, may give false assurance, direct focus away from a wider problem, and cause a future public protection gap.

Genuine mistakes and errors caused by problems in the working environment are unlikely to be issues that call into question someone's fitness to practise. If the evidence shows that a similarly qualified nurse, midwife or nursing associate would have done the same thing this may indicate the root cause of the incident is not the person's fitness to practise. Examples of this could be not completing a task when staffing levels meant it would have been impossible for anyone to do it or giving out the wrong medication when the root cause was actually because of how the medication was stored or labelled.

If we know that problems in the working environment are the real source of risk, our safeguarding responsibilities may mean we'll need to work with other agencies or professionals that are better placed than us to put these problems right. This is likely to involve sharing information, which we'll always do in a proportionate way that allows us to meet our legal responsibilities and objectives.

Where the information shows system issues contributed to an incident but the actions of the nurse, midwife or nursing associate still poses a risk to either public safety, public confidence or to professional standards we may need to share information as well as take action to address the fitness to practise concerns.

1 This is often explained in the 'Swiss Cheese' model developed by Professor James Reason. See Reason JT, Carthey J, de Leval MR. Diagnosing "vulnerable system syndrome": an essential prerequisite to effective risk management BMJ Quality & Safety 2001;10:ii21-ii25.

Commitment 5: In cases where a nurse, midwife or nursing associate was required to use their professional judgement we'll respond proportionately

Reference: FTP-12e Last Updated: 06/05/2025

Sometimes problems in the working environment will be outside the nurse, midwife or nursing associate's control. We'll take account of this. Examples include problems with systems, processes, equipment or staffing but could also involve issues about culture and leadership.

Where individuals are forced to make difficult choices, we'll focus on how they tried to escalate their concerns, if they did so before the incident or after, and how they exercised their professional judgement with reference to the Code.

Examples of such situations could be choosing to prioritise certain tasks or people over others due to short staffing or other kinds of problems in the working environment. We'll want to see any written records the nurse, midwife, or nursing associate made at the time (or after the event if they were acting in response to an emergency) as well as any relevant policies, documents on processes, or guidance documents in place at the time. We'll look for evidence that the professional was able to think critically and draw on their experience to make evidence-informed decisions, recognise and address any personal or external factors that influenced their decision-making, and explained the rationale for their choices.

We'll also ask questions about those in management positions to find out what their role was in the situation and how they acted on any concerns that were escalated to them. There may be issues relating to bullying and harassment that we need to consider. Where those in management positions have been required to make difficult decisions, we'll also look at what action they took to escalate concerns, and if they're also on our register, how they exercised their professional judgement with reference to the Code. If they're not on our register, we'd want to know if they took the steps they should have done as we might need to share that information with others.

When dealing with cases where someone has had to exercise their professional judgement, we won't apply an artificially high standard by judging what should have happened with the benefit of hindsight. Instead, we'll look at what the individual did in the context of the pressures they were working under at the time (which we know might involve life and death situations). We'll consider if recurring situations or a sense of perpetual challenge may have impacted on their professional judgement.

If there's evidence a nurse, midwife or nursing associate (either front line staff or those in management positions) didn't take the steps they clearly should have done under the Code, and this amounts to a risk to either public safety, public confidence or to professional standards , then they'll need to show us they've put the concern right so that this risk has been reduced.

Commitment 6: We'll look for evidence of steps the nurse, midwife or nursing associate has taken to address serious concerns caused by a gap in knowledge or training or personal context factors

Reference: FTP-12f Last Updated: 29/03/2021

Where we identify a gap in the nurse, midwife or nursing associate's knowledge or training, we'll try to help them understand what they can do to address this gap and demonstrate they're safe to practise.

It's important that we find out how this gap occurred and in particular if it raises a concern about the quality or availability of support and supervision at a particular setting or if there's evidence of discrimination or victimisation. If there is such evidence we may need to take some additional action, such as sharing information with other regulators or employers.

Where personal contextual factors, such as health issues or personal circumstances were the root cause of the concerns about someone's practice, our key consideration will be how they relate to the risk of harm to people who use services in the future. We'll need to look at the insight shown by the nurse, midwife or nursing associate into the extent and effect of the personal contextual factors on their practice and the steps they've taken to keep their practice safe in the future.

Commitment 7: We'll always look into whether group norms or culture influenced an individual's behaviour before taking action

Reference: FTP-12g Last Updated: 29/03/2021

When things go wrong there will usually be a number of people and different factors involved which contributed to some degree. Holding one individual to account where group norms or culture played a part in what happened may be unfair. It may also give false assurance and direct focus away from a wider problem.

Often incidents, errors or risks to safe care can happen through particular ways of doing things or because of a wider culture within an organisation. Workarounds can sometimes initially be developed because of problems in the working environment. Over time, these may become normalised and turn into a culture of this is how we do it here. Examples of this could be checking controlled drugs for multiple people at once, or pre-potting medication. Other norms can arise that result in unacceptable behaviour occurring in a working environment, such as inappropriate sexual banter.

Before deciding on someone's fitness to practise, we'll explore what role others played (including managers) to establish if there were any group norms or cultural issues that may have influenced their actions or behaviour. It will be important that we know how widespread the poor practice was in the setting (particularly if other health or social care professionals were routinely doing it), and how this came to be the case.

We'll also look at whether people felt safe to speak up, whether the person or others had attempted to raise concerns previously, and at any organisational pressure not to do so. If concerns were raised and dismissed or not responded to it might indicate that a working environment existed which prevented people from doing the right thing. Where there's evidence of this, we'll need to consider sharing information with others who also have a role in preventing future harm to people who use services.

Commitment 8: Where an incident has occurred because of cultural problems, we'll concentrate on taking action to minimise the risk of the same thing happening again

Reference: FTP-12h Last Updated: 06/05/2025

While we expect nurses, midwives and nursing associates to comply with the Code at all times, we recognise the psychological evidence about how hard it can be to speak up or to disobey group norms, even if that means people acted in a way that looks unacceptable with hindsight. If the evidence shows that an incident occurred because of a poor culture we'll take this into account when deciding what action we need to take.

As we explain in our screening guidance, some concerns are likely to require us to take regulatory action because the professional's behaviours and conduct raise clear risks to public safety, public confidence and professional standards. Such concerns include things like causing deliberate harm to people who use services, concerns of discrimination that have taken place either inside or outside the workplace, or a person breaching the professional duty of candour, for example by falsifying records or covering up their mistakes. For these concerns we'd follow the approach in our screening guidance 'matters requiring full investigation by the NMC'. We'd still look into the impact of poor culture or group norms, and evidence of these would be considered as part of our assessment of the case. However, concerns such as these are more likely to call into question fundamental aspects of the individual's fitness to practise, and require us to take regulatory action.

Where cultural problems are at the heart of the concern, we'd need to seek assurance that the individual has since reflected and demonstrated that they can act appropriately if they found themselves in a similar working environment. Without this evidence, regulatory action may be required to stop the problem from happening again.

Where there's evidence that other individuals on our register took part in the same poor practices as the person referred to us, we'd need to consider what other action to take to keep people safe. This might mean opening referrals against them. We are less likely to open a new referral if we're confident that the individual has reflected on the incident and demonstrated that they can act appropriately if they found themselves in a similar working environment. We'll also consider sharing information with other regulators and employers via our regulation advisors.

In these types of situations, the people leading or fostering poor cultures should be held accountable as well as and not instead of the people who carry the behaviours out. We'll need to consider whether we need to take any action against those in senior positions who were responsible for the poor culture and for ensuring correct processes were in place, known about, understood and adhered to.

If managers knew poor practices were happening and did nothing, it might call their management arrangements and the level of support they provided into question. It might also be a concern if managers didn't know of a widespread cultural issue. Again, we may need to consider opening referrals against people on our register or sharing information with other regulators or employers who also have a role in preventing future harm to people who use services.

What context factors we think are important to know about when considering a case

Reference: FTP-12i Last Updated: 14/04/2021

We carried out research to help us identify what factors we should take into account when we're thinking about the context an incident occurred in. We've listed these below. We've created specific context questions based on these factors to help people tell us their perspective.

During the investigation of our cases we'll routinely ask the nurse, midwife or nursing associate and their employer (if the incident happened at their place of work) these questions. We'll also think about who else can tell us about the context an incident happened in. This is particularly important if the employer and nurse, midwife or nursing associate have different views.

The factors we identified relate to three areas of context:

- The nurse, midwife or nursing associate themselves

We want to know whether there were any personal factors that may have impacted the nurse, midwife or nursing associate and how these may have affected them. Although sometimes these questions may be harder for an employer to answer, we want to give the employer the opportunity to tell us what they can.

- The working environment and culture

System pressures or the working environment can prevent nurses, midwives and nursing associates from delivering safe care. We need to understand what the environment was like and whether it was a contributing factor to an incident.

- Learning, insight and any steps the nurse, midwife or nursing associate's taken to strengthen their practice

This will help us understand how the nurse, midwife or nursing associate has responded and how this may affect our consideration of the referral. We also want to hear from the employer about what they have done to resolve any issues within a workplace. This will help us think about if we need to take wider regulatory action, such as making a referral to another regulator.

Not all context factors will be present in every case. There may also be other factors that contribute to an incident that aren't listed. If someone tells us about factors that aren't on this list, our decision makers will take them in to account by considering how these fit in with our context commitments.

We code each of the factors as this helps us analyse the information we get. We can then think about whether there are systemic issues that may need wider regulatory action.

NMC1
Past Performance
Understanding how someone has performed in the past will help us consider whether the concerns are 'out of character'.
NMC2
Health and Addiction
Physical or mental health issues could provide relevant context, and those affected may not always recognise the impact or effect.
NMC3

Protected characteristics
Discrimination, harassment or victimisation can affect people's behaviour, or be a factor in their referral.
NMC4
Communication problems
Communication problems between people can be barriers to providing the right level of care.
NMC5
Factors affecting attention
Distractions in the work environment or personal lives may mean people are unable to focus on what they are doing properly.
NMC6
Tiredness/Sleep deprivation
Excessive tiredness due to sleep deprivation can affect people's behaviour or ability to concentrate.
NMC7
Lack of breaks
Everyone needs to take breaks for their wellbeing and if they cannot, this may affect their ability to carry out tasks or concentrate.
NMC8
Emotions/Mood
Personal factors or stress can distract people from performing their roles.
PC9
Contributory factors
Sometimes a nurse, midwife or nursing associate may have to make a difficult decision or prioritise tasks or people in their care. They may feel that their actions were the only thing they could have done under the circumstances.
MA10
Analysis and impact
We want to know if the nurse, midwife or nursing associate understands what went wrong, the consequences and have taken steps to prevent this from reoccurring (if relevant).
PC11
Learning
Does the nurse, midwife or nursing associate understand what could and should have been done differently and/or how to act differently in the future to avoid similar problems happening? If so, this may reduce the risk of it happening again.
PC12
Insight and Remediation
If a nurse, midwife or nursing associate has reflected and taken steps to address any gaps in their skills, knowledge or training, they may be less likely to be an ongoing risk to people in their care.
N13
Workload
Workload or work pressures can sometimes get in the way of people providing the ideal level of care or stop them from doing the

right thing.
N14
Distractions
What was the environment like at the time of the incidents? Was it particularly busy or loud compared to normal, and could this have been distracting?
N15
Substitution
Would another trained person have done the same thing? Ifso, this suggests the act may not be the fault of the nurse, midwife or nursing associate but the situation or environment.
N16
Training and supervision
Was the nurse, midwife or nursing associate adequately trained and supported for the job they had to do?
N17
Equipment
We need to know whether equipment or systems may have contributed to an incident. It may be that the right systems or equipment weren't available, or weren't in working order.
N18
Relationships
Were there poor relationships between professional groups and what impact did this have on how people acted
N19
Custom and practice
Was there a poor team culture or were poor practices or widespread workarounds part of the working environment.
N20
Raising concerns
Could concerns be raised by staff and were they appropriately responded to.

Our culture of curiosity

Reference: FTP-13 Last Updated: 02/12/2024

In this guide

The aim of this guidance is to set out our approach when considering fitness to practise concerns. It will be applied by all NMC colleagues, regardless of which Directorate they work in. Having a culture of curiosity makes sure we have the information we need in relation to potential fitness to practise concerns and that we make decisions that protect the public and are consistent with our fitness to practise policy principles.

Overview

As an independent regulator we need to understand what happened when we receive a concern about someone's fitness to practise. Understanding what happened and why helps us decide if there is any action we need to take to protect the public, or if a referral can be closed. We will listen to and fairly consider the accounts of relevant people involved where this is appropriate, reasonable and proportionate to understand what happened; for example, this may include a person receiving care or a family member, the professional, a Director of Nursing or employer. This guidance seeks to encourage a culture of curiosity and to clarify when we can seek information and when we cannot.

What is a culture of curiosity?

Having a culture of curiosity means we consider who has information that can assist us. We won't accept a single source of information at face value where it is appropriate, reasonable and proportionate for us to make other enquiries.

We'll listen carefully to what people tell us about their experience and will take their account seriously. Sometimes we will be told very different accounts of what happened from the person receiving care, the professional being investigated or the professional's employer. Where necessary we will have the confidence to ask sensitive questions or respectfully challenge what we're being told.

We avoid making assumptions and take steps to ensure that bias (whether conscious or unconscious) doesn't impact our decision making. We will consider all the evidence without preconceived ideas of whose account is most likely to be accurate. We may need to scrutinise the conclusions others have reached. Where necessary we'll consider if there are other reasonable and proportionate investigative steps we're able to take to clarify what happened.

We seek advice from our clinical advice team where this is necessary to understand the concerns raised and any response to those concerns. Understanding if similar concerns have been raised in relation to the same organisation can help us weigh up the concerns and the wider context. For example the risks identified may be caused by systemic issues or as a result of group norms or culture and our guidance on context explains why it's important to understand this.

By following this approach we can be satisfied we have fairly assessed the concerns that have been raised.

Who it's important we hear from

As set out in our guidance on engaging with your case and insight and strengthened practice where we're dealing with a referral which may require regulatory action by us it's really important that we hear from the professional involved. This is so we can understand the professional's perspective, including any wider context issues, to fairly assess if they pose a risk to people in the future.

We know that listening to the experience of people receiving care and their wider families can be essential to make sure we protect the public. It is important they are heard and their perspectives are understood, and also because their accounts can be crucial in understanding what happened and provide insights about the culture within a particular organisation. It's therefore important that where it's relevant to our investigation we make all reasonable efforts to contact people receiving care or their families.

People receiving care and their families are less likely to have access to all of the documentation that may be relevant and therefore it's really important we listen to what they have to say and consider if there's any documentation or information we're able to request which may help us assess the information we've received. For example, people receiving care and their families won't usually have access to staff rotas which may support their version of what happened. Equally, they may not have access to information which explains the care provided and why this was appropriate. We should clearly explain the conclusions we have reached as a result of assessing the various sources of evidence so those involved can understand our decision.

Organisations and professionals must comply with the duty of candour which includes being open and honest with people receiving care and their families and embracing a culture of learning from mistakes. Where organisations aren't listening to the experience of people receiving care and their families, they are missing the opportunity to learn from this. This may be something we need to investigate further or refer to other organisations, such as systems regulators including the Care Quality Commission, Care Inspectorate Scotland, Care Inspectorate Wales and Regulation and Quality Improvement Authority in Northern Ireland or another regulator. If we find the experiences of people receiving care and their families are being dismissed or ignored, this may reflect a poor culture within an organisation.

Most organisations and employers make sure concerns are appropriately dealt with and assist our investigations. There may be occasions where an organisation seeks to assure us that there isn't a serious issue for us to consider. These assurances may not always be reliable. This could be for a number of reasons; for example, they have investigated but, as they have a different remit to us, this doesn't cover everything we would need to consider. Whilst less frequently the case, there are occasions where organisations are aware of concerns and want to avoid outside scrutiny. This means we cannot always be satisfied there is nothing for us to investigate solely on the assurance of an organisation. Where another organisation or body has carried out an investigation, our guidance on Findings of other organisations and bodies explains how we should approach the evidence and any findings of the other investigation. However, where we have made enquiries and are satisfied that there isn't a fitness to practise issue we need to investigate, we cannot make further enquiries in order to respond to complaints or wider concerns raised by parties that don't relate to any individual's fitness to practise as that isn't our role. Where appropriate, we may refer concerns to other organisations, such as the systems regulator for the relevant country[1] or another regulator.

Our legal framework

When we're considering a referral relating to a professional's fitness to practise we have specific legal powers to carry out appropriate enquiries and investigations. These include the power to require information from someone other than the professional concerned where that information appears relevant for the purpose of our fitness to practise proceedings. Where a person fails to supply that information they are committing a criminal offence[2]. We cannot require disclosure of information which is prohibited by other legislation including the General Data Protection Regulation.

We're obliged to exercise these powers fairly and proportionately. We must therefore restrict our enquiries to what is appropriate and relevant to the assessment of whether the professional's fitness to practise is impaired.

Screening concerns

Closing straightforward referrals

Some concerns raised with us will be straightforward. It will be clear that they do not require regulatory action to protect the public and further enquiries will be neither necessary nor proportionate. Where this is the case, it is in everyone's best interests that we close these referrals as soon as possible. For example, where concerns are raised which are not sufficiently serious to suggest a concern about a professional's fitness to practise, we should not make further enquiries. A culture of curiosity does not mean looking to see if there is any evidence of other alleged wrongdoing by a professional regardless of what has been raised in the referral. This would be unfair, unreasonable and disproportionate.

We must be clear we understand the concerns before deciding not to investigate

However, when we're considering referrals which may concern us, we want to be satisfied we have an accurate and complete understanding of the concerns raised before we make a decision that we do not need to investigate further. This includes making sure we have a full understanding of the perspectives of the person raising the concern with us. Where we're considering closing a referral we will consider if we've been sufficiently curious and whether there are any further enquiries we should make. This may include seeking clinical advice where this might assist the decision maker to understand the nature of the concerns raised.

Example 1

The daughter of a resident in a care home refers a concern to us about the care their mother received from a number of professionals at the Home. They say they are concerned that the Home is not being open with them about what happened when their mother's health seriously deteriorated, requiring an ambulance to be called and her being admitted for a lengthy stay in hospital. They explain they are a former nurse and that they have looked at their mother's care records and noted these include observations and checks which were not carried out. They explain that they kept their own records of any checks which were carried out on their mother when they were visiting.

We make enquiries with the relevant Home and they provide the care records for the referrer's mother and tell us they have no concerns about any of the professionals involved.

The referrer tells us that she is aware that another family were concerned about the care provided and accuracy of the care records kept and have recently referred their concerns to us. We locate the other referral and raise both concerns with the Home and ask for the care records for the residents for both referrals to be provided along with any material relating to the complaints that were raised. We also ask for staff rotas which reveal that the people making entries into the Home's care records do not match the staff rotas and there are occasions where there are not sufficient staff. We request the records the referrer said they kept about their mother's care and see that their records match the staff rota, but not the records kept by staff at the Home.

We make further enquiries with the Home to identify the staff who have recorded observations when they were not on shift and those who were responsible for investigating the complaints and managing the Home.

Were we to assume that the assurances the Home have given and the documentation the Home provided are more likely to be accurate than the concerns the family of the person receiving care have raised without making any further enquiries, we risk failing to identify a pattern of similar referrals in relation to the Home and wider concerns about the way it is operating. As we investigate the case, we may decide that there are other professionals who need to be investigated. We may also need to refer concerns about safe staffing or the way the Home is operating to the systems regulator.

Example 2

An employer refers a professional to us in relation to a concern where a person receiving care unexpectedly died after a routine operation. The employer explains they have made the referral because the professional made some significant errors in the administration of medication to the patient but that they did not have wider concerns about the professional's practice and the death could not have been anticipated or prevented. They explain that the family raised a number of concerns throughout the time the person was in their care.

We're aware that the person receiving care had family who were involved in their care and had visited them at the hospital and that they had raised concerns with the employer about whether sufficient monitoring and checks were carried out after the operation given their medical history. We should ask for contact details for the family and arrange to speak with them to make sure we fully understand their account of what happened and what they

think may have gone wrong before making a decision on whether further investigation is necessary.

We would also ask to see any organisational investigation or learning and would ask our clinical advisers to look at the patient's records to clarify if the treatment and care were appropriate and if there was any cause for concern. We may also ask our clinical adviser for their view on any investigation carried out by the Trust.

Example 3

A professional makes a referral about their line manager who has management responsibilities for a team of professionals who work on the same ward in a hospital. The allegations are that they bully and discriminate against members of staff, show favouritism to white members of staff and target staff who are black, Asian or from other ethnic minorities as they make excessive demands of them and scrutinise their performance more closely.

The Trust tell us they have investigated the concerns and decided the allegations of racism were not proved and that the professional has shown insight into the areas of concern raised. We ask to see the report, its terms of reference and consider the evidence within the report ourselves. When considering the report we see that the Trust acknowledges that they did not interview any staff who are black, Asian or from other ethnic minorities. We also see that the report identified that the professional made comments that could be considered offensive on the grounds of culture or ethnicity and that the professional fostered a culture where some staff felt excluded, particularly those from black, Asian and minority backgrounds. We also see that the reflective statement the professional provided does not reflect on the allegations of discrimination, and only covers the stress and challenges they had faced as a manager.

We decide to open an investigation based on the content of the report. Had we not looked more closely at what the Trust identified we may have decided there were no concerns for us to investigate.

Example 4

We receive a referral from a professional we're currently investigating. We're investigating concerns about the professional's clinical practice as a result of a referral from their employer. The professional has referred a senior colleague who works for their employer as they say they have been bullied, harassed and discriminated against by them on the basis of their skin colour. They do not provide any further details.

We take allegations of discrimination, bullying and harassment very seriously. However, we don't have any detail on what happened and therefore we will need to make further enquiries before deciding if an investigation is necessary. We'll want to get the referrer's account of the incidents they have raised to understand who was involved, or may have witnessed the incidents, where and when they took place, what happened and why. We'll also want to speak to the employer to see if they were aware of these concerns, whether they have investigated these and if they are able to supply any information which may assist us in assessing these.

We speak to the employer who says that no concerns have ever been raised about the senior colleague by the referrer or anyone else and they have spoken to the senior colleague and looked at records and can find no evidence to support the concerns raised. They believe this referral has been made in retaliation to the referral they made about the professional. In these circumstances it will be really important what further information the referrer provides us. If we speak to them and they say they can't provide any detail on particular incidents but they feel they were discriminated against and that is why the referral was made, and there isn't evidence to suggest the referral was discriminatory in itself, for example as another colleague who was white was also referred for the same behaviour, we're unlikely to investigate further. However, if we speak to them and they provide us with information about specific incidents, we'll consider if there are concerns we need to investigate or if there are any enquiries we can make which may assist us in making that decision.

Example 5

We receive a referral from a family about a professional who was involved in the care of their mother on a general ward in hospital just before their condition deteriorated and they ended up being transferred to the intensive care unit. The family allege that the professional failed to carry out appropriate checks and sufficient monitoring of their mother which meant that the deterioration in her condition was only noticed once it had reached a critical stage. We speak to the family and they explain their concerns that their mother would not have ended up in the intensive care unit had more frequent monitoring been carried out.

We request the medical records from the Trust which includes the printouts from the machines used to carry out the monitoring checks on the referrer's mother. These checks were carried out an hourly intervals. We ask our clinical advisors to review these records and they confirm that the regularity of the checks was in accordance with National Institute of Clinical Excellence ('NICE') guidance based on the person's medical history and age.

We close the referral as there is no evidence to support the concerns that have been raised about the professional. We explain to the family that the monitoring checks carried out on their mother were automatically recorded on the system and that the frequency of the checks was in accordance with the guidance that was in place and therefore there is no evidence to support the concerns they have raised about the standard of care the professional provided.

Deciding to close a referral where we can't get further information

We should close the referral where the following set of circumstances apply:

- it isn't clear what the concerns are, and therefore if there could be a fitness to practise concern, and
- we have made numerous attempts to contact the person who raised them by various means without success, and
- there are no other potential sources of information.

Concerns investigated by employers

Where a concern has been appropriately managed by an employer or where the employer is still dealing with the concerns, it's unlikely we will need to open our own investigation unless we need to take immediate action to protect the public. There will be some concerns which can only be appropriately managed by our wider regulatory powers.

Where an allegation is serious enough to suggest there may be a risk to the public but the employer has investigated, we will need to consider the concerns and the employer's investigation and may need to ask further questions before we can decide if a concern has been appropriately managed; this may be where they have upheld all of the concerns and have taken action, or where some or all of the concerns have not been upheld.

Where the employer is still dealing with the concerns, we'll carefully consider the ongoing risk and whether it is necessary to apply for interim restrictions on the professional's practice.

Extent of enquiries and managing risk

We must take care to get the balance right. We can make appropriate, reasonable, proportionate enquiries based on concerns raised with us and any information in our possession. We should not go beyond that. We will consider what is appropriate, reasonable and proportionate based on the nature and seriousness of the concerns raised; the more serious the concerns are, the more likely it is that more extensive enquiries will be appropriate, reasonable and proportionate. We will also keep in mind that fitness to practise is about managing the risk a professional poses to people, not punishing them for past events.

Steps we might take when we decide to close a referral

Where we decide not to investigate, we may still need to take steps to alert others of the situation. We'll consider[3] if there is a need to refer to others, for example:

- another regulator where other health care professionals are involved,
- a systems regulator where we feel there a wider organisational issue,
- the police,
- safeguarding services such as local authority social services teams.

Investigating concerns

Getting a holistic perspective

Where we decide to investigate a concern, we'll need to make appropriate enquiries so we're in the best position to understand what happened and why. We want to have a holistic picture. This will mean looking at available sources of evidence, asking questions, following up on answers and reflecting on the information we've received. Having "a culture of curiosity" means that when we consider the concerns raised with us, we:

- weigh up what the information is telling us,
- assess whether there are further enquiries we need to make,
- consider who may be able to assist us in providing information about what happened,

- make reasonable attempts to contact them to ask about the concerns raised,
- listen carefully and ask appropriate questions, which may include asking sensitive questions or challenging some of the answers provided when this is necessary and proportionate,
- Consider the information and any views or perspectives about what we've obtained and what they tell us about what happened and what we need to do to keep people safe,
- are open, alert to and follow up on information suggesting other concerns or risks that we haven't previously identified,
- use our context commitments to help us identify what other enquiries or actions we might need to take.

The examples set out in the screening section may also be helpful once we've decided to investigate a referral.

People we may need to speak to

When concerns are raised about a professional, we may need to speak to a number of people. This is particularly important in cases where there is a dispute of fact between the parties; for example, where someone else involved in the case provides a different version of events to that provided by the professional. Where we have contradictory information from different sources, we do not make assumptions about the likely accuracy of what we've been told based *solely* on who has provided the information. We seek to assess what the information tells us by appropriately considering all sources of information. The people we may need to speak to could include:

- their employer,
- any person who was receiving care who may be involved,
- any family members of the person receiving care,
- colleagues who were working alongside the professional at the time,
- any person who may have witnessed or have knowledge of the matter(s) that have been alleged
- other organisations who may have investigated the concerns raised, such as the police or social services.

We will also consider if it will be appropriate for us to get clinical advice from one of our internal clinical advisers so we're satisfied we understand the concerns raised and any response to those concerns. They may also be able to suggest additional enquiries that we need to make.

Support for people

We recognise that people may need support so they are able to provide the information we need. We will consider if we need to offer support and may ask people what support they need or how we can best support them.

If we have made enquiries with a member of the public or referrer and have not received an appropriate response, we'll want to consider if we need to try another approach; for example, we may want to try to speak to the person concerned rather than send them an email, we may want to ask if there is support they might need in order to engage with us.

We may also consider if we might be able to find the information we need from another source.

Extent of enquiries

We will assess what enquiries are appropriate, reasonable and proportionate. This will vary depending on the circumstances but appropriate considerations include:

- the seriousness of the allegations,
- the likely relevance of the evidence the witness can provide,
- the likely weight of the evidence and whether there are other sources of evidence,
- if there are other more serious allegations where we have obtained sufficient evidence.

1 In England the Care Quality Commission, In Scotland, Care Inspectorate (Scotland). In Wales, Care Inspectorate Wales. In Northern Ireland, Regulation and Quality Improvement Authority (NI).

2 Rule 2A(4) of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004 and Article 25 and 26 of the nursing and Midwifery Order 2001 sets out the power to require information and Article 44(4) of the Order makes the failure to provide information, without reasonable excuse, a criminal offence.

3 Screening colleagues should consider referring to our safeguarding team, Regulatory Intelligence Unit or a Regulation adviser in our Employer Link Service.

Clinical advice

Reference: FTP-14 Last Updated: 25/03/2026

In this guide

Why we use clinical advice

Clinical advisers are experienced nurses and midwives with a wide range of clinical knowledge who provide broad, general advice to assist decision makers in understanding the clinical context in which something happened and any clinical risks posed, whether by the professional themselves, or wider systemic issues. Clinical advisers provide guidance on clinical issues raised by a particular concern within the boundaries of their professional expertise. Clinical advisors may also suggest further enquiries such as determining what policies, guidance or training were in place at the time. Their input is one of several sources considered by decision makers when evaluating whether regulatory action is necessary to protect the public.

Clinical advice is based on the information provided in the referral, professional knowledge, experience and relevant contemporaneous guidance and policies related to the referral. Where required clinical advisers can also support the appropriate teams to identify the correctly qualified expert witness in a case (see our guidance on expert witnesses). This is typically when we need very specific clinical expertise.

When clinical advice shouldn't be used

- Clinical advice shouldn't replace independent expert advice.
- Clinical advice isn't admissible evidence. It doesn't express any view regarding the strength of any evidence or make a decision that a decision maker should make.
- Clinical advice shouldn't assist in resolving disputes; it is solely to help in assessing the clinical issues raised in a referral.
- Clinical advisers can't be asked to make a decision on next steps in a case; that is for the relevant decision-maker to make.

Decisions of the Disclosure and Barring Service (DBS) and Disclosure Scotland

Reference: FTP-15 Last Updated: 06/05/2025

The Disclosure and Barring Service (DBS)[1] helps employers to make safer recruitment decisions and bars individuals it deems pose a risk to vulnerable groups from working in certain roles[2].

The NMC recognises that a decision to bar a registrant raises a question about fitness to practise, namely public protection, and therefore the NMC needs to consider what steps it needs to take as a regulator to protect the public independently of the DBS.

The DBS' approach is to place restrictions automatically where an individual is convicted of certain criminal offences (automatic barring[3]). At the NMC, we will always consider the appropriate action to take when we become aware that a professional on our register has received a criminal conviction. Serious convictions could lead to immediate restriction from practice as well as eventual striking off.

The DBS also bars individuals on a discretionary basis in other types of cases[4] (non-automatic barring[5]). The tests and processes for DBS decisions are different to the tests and processes the NMC follows. For example, the DBS cannot call witnesses or hold a hearing. It is possible for the NMC and DBS to reach different assessments of the facts, risk and how to mitigate it.

A DBS non-automatic barring decision will lead us to look into the underlying conduct ourselves and consider any action we need to take to protect the public and maintain professional standards and the public's trust and confidence in nurses, midwives and nursing associates. When assessing risk, the facts and seriousness of conduct, we will take into consideration both the DBS decision and any information secured from them, in addition to any other evidence we gather. We cannot, however, rely on a DBS decision alone to prove the underlying facts or assess the seriousness of the conduct. There may be cases where we are not satisfied of the facts, or we conclude either that the conduct is not serious enough to impair or that the professional's practice is no longer impaired.

The existence of a DBS barring decision will be a legitimate consideration when approaching sanction – for example, when addressing the workability of conditions of practice. Where a fitness to practise panel is satisfied of the facts but decides that a professional subject to a barring decision shouldn't be struck off or suspended, it will need to explain carefully how it has reached that decision, with reference to public protection, public confidence and maintaining proper professional standards in the profession.

1 The Disclosure and Barring Service ('DBS') covers England, Wales, the Channel Islands and the Isle of Man and applications for DBS checks are made through them. In Scotland the relevant body is Disclosure Scotland. In Northern Ireland applications for DBS checks are made through Access NI but the Disclosure and Barring Service are responsible for the barring of individuals. We refer to the Disclosure and Barring Service ('DBS') throughout this document for ease of reference.
2 Regulated activity with children and/or vulnerable adults
3 In Scotland a similar provision is termed, 'Automatic listing' .
4 If the individual: (i) has engaged in relevant conduct; (ii) presents a risk of harm through their thoughts or beliefs and (iii) has previously worked in is currently working in, or might in the future work in regulated activity. In Scotland, Disclosure Scotland must be satisfied that the individual is unsuitable to work with children/protected adults because they have: caused harm to a child or protected adult, placed a child or protected adult at risk of harm, engaged in inappropriate conduct involving pornography, engaged in inappropriate conduct of a sexual nature involving a child or protected adult or given inappropriate medical treatment to a child or protected adult (s.2 of The Protection of Vulnerable Groups (Scotland) Act 2007)
5 In Scotland, a similar provision is "the inclusion in Child/Adult list after consideration".

Insight and strengthened practice

Reference: FTP-16 Last Updated: 14/04/2021

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

Evidence of the nurse, midwife or nursing associate's insight and any steps they have taken to strengthen their practice will usually be central to deciding whether their 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, midwife or nursing associate being referred to us will usually have happened some time previously.

Before considering the nurse, midwife or nursing associate's insight and any steps they have taken to strengthen their practice, decision-makers should consider the context in which the incident occurred. This is because it may help them to understand what the concerns are with the nurse, midwife or nursing associate's fitness to practise and what sort of steps may be needed to address those concerns.

When assessing evidence of the nurse, midwife or nursing associate's insight and the steps they have taken to strengthen their practice, decision makers will need to take into account the following questions:

- Can the concern be addressed?
- Has the concern been addressed?
- 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, midwife or nursing associate's fitness to practise is currently impaired.

Can the concern be addressed?

Reference: FTP-16a Last Updated: 27/02/2024

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 addressed. 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 addressed. That is, are there steps that the nurse, midwife or nursing associate can take to address 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 addressed by taking steps, such as completing training courses or supervised practice.

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, midwife or nursing associate 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, midwife or nursing associate's attitude, it is less likely the nurse, midwife or nursing associate will be able to address their conduct by taking steps, such as completing training courses or supervised practice.

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

- criminal convictions for specified offences or convictions that led to custodial sentences
- inappropriate personal or sexual relationships with people receiving care or other vulnerable people or abusing their position as a registered nurse, midwife or nursing associate or other position of power to exploit, coerce or obtain a benefit
- incidents of discrimination that have taken place either inside or outside professional practice
- incidents of harassment, including sexual harassment, and other forms of sexual misconduct, whether it occurs inside or outside professional practice
- dishonesty, particularly if it was serious and sustained over a period of time, or is directly linked to the nurse, midwife or nursing associate's professional practice
- incidents of violence towards, or neglect or abuse of people receiving care, children or vulnerable adults.

Generally, issues about the safety of clinical practice are easier to address, 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, midwife or nursing associate has practised safely since they occurred.

Has the concern been addressed?

Reference: FTP-16b Last Updated: 25/03/2026

In this guide

Demonstrating insight

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

Where a nurse, midwife or nursing associate denies some or all of the facts alleged, this can be taken into account by decision-makers when assessing the quality of insight shown, but it is not necessarily a bar to demonstrating insight. A professional is, for example, entitled to say “I don’t accept that this incident took place in the manner alleged, but I understand why, if it had taken place, it would have been a serious departure from professional standards”.

A nurse, midwife or nursing associate 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 (but decision-makers must recognise that denial of some or all of the facts alleged is not necessarily a bar to demonstrating insight)
- 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, midwife or nursing associate 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, midwife or nursing associate’s right to practise, even if they have shown ‘some’ insight into what happened.

Where a nurse, midwife or nursing associate is alleged to be responsible for incidents that they denied (or continue to deny), this should not bar the nurse, midwife or nursing associate from being able to show insight. They may not accept that particular events have occurred, but they may still 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. Panels facing this situation may also find our sanctions guidance “The purpose of and approach to sanctions” and “Sanctions for the highest risk cases” of assistance in this regard.

Assessing whether insight is sufficient

It is important to carefully assess whether the insight shown by the nurse, midwife or nursing associate 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 may 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, midwife or nursing associate cooperate with their employer's or any other local investigation into the concerns?
- Did the nurse, midwife or nursing associate accept the concerns against them when first raised by their employer?
- Did the nurse, midwife or nursing associate, voluntarily or without prompting, draw any failings or inappropriate conduct to the attention of their employer?
- Did the nurse, midwife or nursing associate 'self-report' to the NMC, when a referral might otherwise not have been made by someone else?
- Does the nurse, midwife or nursing associate accept the of our regulatory concern, and accept responsibility for any failings or inappropriate conduct?
- Has the nurse, midwife or nursing associate done so since the early stages of our investigation?
- Does the nurse, midwife or nursing associate demonstrate a comprehensive understanding of:
    - any harm or risk of harm, to patients presented by the concerns?
    - any damage to public confidence in the professions that the concerns could present? For example, does the professional show genuine insight into how the concerns may have had a wider impact on the specific patient in question, or other patients in their care, in respect of the trust they have in healthcare professionals? Do they show an understanding of how colleagues may have been affected by the concerns?
- Does the nurse, midwife or nursing associate acknowledge:
    - how far their conduct or practice fell short of professional standards? For example, do they demonstrate a clear understanding of how the concerns relate to their obligations under the Code.
    - their own responsibility for the problem, without seeking to blame others or excuse their actions?

The decision-maker should bear in mind that these factors are not an exhaustive list, and that presence or absence of any of these factors does not automatically mean that they should conclude insight is sufficient or not. As stated above, ultimately the sufficiency of the insight is likely to involve a judgement by the decision-maker based on the particular facts of each case.

If a nurse, midwife or nursing associate admits concerns that they had previously not accepted or had disputed, decision makers should consider this carefully. They should carefully assess the nature of what it was that was disputed or not accepted, and whether it was possible for the nurse, midwife or nursing associate to make admissions earlier on by considering the information that was given to the nurse, midwife or nursing associate during their employer's investigation, other earlier local investigations, or our own investigation:

> For example, we receive an allegation from Patient B that Nurse A slapped them. Initially the only witness to the incident appears to be Patient B, and Nurse A maintains during the local investigation and in her initial response to the NMC that Patient B is fabricating the allegation. Nurse A only changes her position and admits to slapping Patient B when Witness C comes forward with a video recording that they took of the incident, and which clearly shows Nurse A slapping the patient.
>
> By contrast, the NMC receive a very general referral that Nurse B, the nurse in charge of a hospital ward, has been bullying more junior staff. Nurse B initially denies the allegations and in her response to the NMC says she doesn't understand why colleagues would say this about her. The NMC takes detailed statements from the specific colleagues in question, and in which they explain how they considered they were being bullied. When Nurse B receives and reads these statements, it causes her to reflect and recognise how in fact her behaviour had impacted on colleagues. She provides a detailed reflection to the NMC in which she accepts the allegations and explains how the statements have helped her to understand what was being alleged.
>
> Whilst the decision maker would need to take into consideration the initial denial/ lack of acceptance in respect of both examples, the initial denial in the first example is likely to be a more significant hurdle for the professional to overcome than the lack of acceptance in the second example.

The duty of candour

All registered nurses, midwives or nursing associates 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, midwives or nursing associates 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.
- Apologise and 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, midwife's or nursing associate'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, midwife or nursing associate has complied with the duty of candour and the requirements it places on professional practice when they consider issues of current impairment.

Apologies and insight

Apologising for mistakes or failings should be encouraged. A decision maker may take an apology into account as evidence that the professional understands and has complied with the duty of candour, and may view an apology as evidence of insight.

An apology may be expected in certain circumstances, such as when something goes wrong with a patient's treatment or care that causes or has the potential to cause harm or distress. However, there may be circumstances that prevent a nurse, midwife or nursing associate from offering an apology.

For instance, some may be discouraged from apologising by their employer or be encouraged to express the apology in a certain way. The employer may be concerned that an apology could be perceived as an admission of guilt and that this could have implications for any separate legal proceedings[1]

This can affect what a nurse, midwife or nursing associate feels able to do. We will consider our context principles when deciding how to approach the employer's actions in these circumstances.

Cultural differences or English being a second language may also affect the nurse, midwife or nursing associate's ability to provide a reflective statement and how they express insight, including whether they offer an apology.

Decision makers should consider whether these factors might be relevant when a nurse, midwife or nursing associate has not offered an apology.

Sufficient steps to address the concern

What is 'sufficient' to address the concern 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 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, midwife or nursing associate was made aware of the problem, or where other steps put in place to address the risks did not prevent problems from recurring.

Key considerations for decision makers in assessing the steps taken by a nurse, midwife or nursing associate to address 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, midwife or nursing associate 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 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, midwife or nursing associates 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, midwife or nursing associate 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, midwife or nursing associate'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 insight and the steps taken to address the concerns is insufficient, decision makers should consider whether further steps could be taken. For example, if a nurse, midwife or nursing associate has stated that they have attended a course or undertaken additional training, we could request evidence of this.

Assessing evidence

Decision makers must consider how much weight to place upon any evidence a nurse, midwife or nursing associate 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 will usually 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 of the reference/testimonial is aware of the full details of the allegations against the nurse, midwife or nursing associate.
- 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, midwife or nursing associate to demonstrate understanding.
- Little, if any, weight should be placed on character references and testimonials that do not provide informed comment on the nurse, midwife or nursing associate's clinical practice, skills or competence.

1 The NMC and GMG guidance on duty of candour says the following: "Apologising to a patient does not mean that you are admitting legal liability for what has happened. This is set out in legislation in parts of the UK (Section 2 of the Compensation Act 2006 (England and Wales)) and NHS Resolution also advises that saying sorry is the right thing to do".

Is it highly unlikely that the conduct will be repeated?

Reference: FTP-16c Last Updated: 14/04/2021

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

Decision makers will consider whether the nurse, midwife or nursing associate is likely to repeat the conduct that caused the concerns. When doing this, they should take into account whether the nurse, midwife or nursing associate 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, midwife or nursing associate has demonstrated sufficient insight and has taken appropriate steps to address any concerns arising from the allegations.
- The behaviour in question arose in unique circumstances. While this may not excuse the nurse, midwife or nursing associate's behaviour, this may suggest that the risk of repetition in the future is reduced.
- The nurse, midwife or nursing associate 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, midwife or nursing associate has engaged with us throughout our processes.

Early engagement

Reference: FTP-17 Last Updated: 25/03/2026

In this guide

Benefits of engaging early

We encourage professionals to engage with us as early as possible and at every stage of the process.

Early engagement can work in a professional's favour. If information is provided that demonstrates that their fitness to practise isn't impaired that will allow us to conclude our investigation. Early engagement also gives a professional a chance to give us their side of what happened, including anything that might have in some way caused or influenced what happened. They can also tell us about any training they have done to strengthen their practice and learning they have taken from the event(s).

Examples of information that we would be interested in receiving from a professional are:

- Whether they're currently employed and any steps their employer may be taking to manage any risk
- Information about the context in which the incident occurred
- Evidence of any steps they've taken to address the concerns raised about their fitness to practise (such as completing courses or retraining)
- Evidence of any insight they have or any reflection they've undertaken so far about the concerns raised (we recognise that insight and reflection can develop over time and may also depend on how any investigation progresses).

Early engagement also allows us to understand what we need to investigate (including knowing what is and what isn't in dispute) and can help prevent delays at the investigation and hearings stages due to receiving information at a late stage of the process.

What can happen if a professional doesn't engage, or engages at a late stage?

There may be instances where a professional can't engage with us for reasons such as ill health. We'll always take factors like these into account when making decisions on the case. However, professionals are required to co-operate with any investigation about their conduct in line with the Code.[1] A failure to cooperate, particularly if repeated and without a valid reason, such as ill health, may be considered especially serious. For example, not responding to a medical testing request that would help us understand a health condition could be viewed as a failure to cooperate and may also be raised as an additional concern.

Raising issues at a late stage in proceedings

If a professional raises an issue at a late stage (such as the final hearing) that could impact their case and could have been raised at an earlier stage, a panel may consider whether there's a reasonable explanation for this and whether to adjourn the matter for further investigation. One example of this could be the discovery of a key clinical document at a final hearing that has an impact on the facts of the case. We have further guidance on directing further investigation during a hearing.

If the panel considers that there's no reasonable explanation for the issue being raised late, it may, subject to it being fair, decide to take that into account when assessing the professional's credibility in relation to the matter

raised.

Providing materially different accounts

If a professional provides a materially different version of events in relation to the concerns raised than the version of events they provided at an earlier point in time, the panel may take this into account when considering their credibility. We may invite the panel to consider the professional's credibility in relation to that issue.

Not giving evidence at the final hearing

A panel may draw a negative conclusion about a professional if the professional doesn't give evidence that would normally be expected at a hearing and has no good reason for not giving evidence[2]. This is called an adverse inference.

A panel's decision on whether to draw an adverse inference will depend on the circumstances of the case. Panels must always ensure that the professional is treated fairly. We shouldn't draw an adverse inference based on the failure to give evidence unless:

1. We've put forward sufficient evidence that the professional has been involved in misconduct or that their fitness to practise is impaired for some other reason.[3]
2. The professional has been given an appropriate warning that an adverse inference may be drawn if they do not give evidence. The professional must be given an opportunity to explain why it wouldn't be reasonable for them to give evidence and, if it is found that there is no reasonable explanation, be given an opportunity to give evidence.
3. There is no reasonable explanation for the professional not giving evidence (for example, not giving evidence due to illness may be reasonable).
4. There are no other circumstances that would make it unfair to draw an adverse inference. (For example, if the professional becomes upset whilst giving evidence and is unable to continue, it would be unfair for the panel to consider drawing an adverse inference without offering them time to recover and an opportunity to continue to give evidence.)

If a witness provides written evidence but doesn't attend the hearing to provide oral evidence and be cross-examined, the panel can take this into account when considering whether to admit the written evidence and the weight to attach to it. You can read about the panel's approach to a witness not providing oral evidence at a hearing by looking at our general guidance on evidence.

Cultural factors

Our professionals come from a wide range of cultures and backgrounds, with diverse cultural norms and communication styles. These differences do not change their obligations as required in the Code, but the panel should consider how they might affect the professional's presentation of personal factors, such as apologies and insight. For further information, see our guidance on context.

A Muslim midwife is alleged to have provided poor care at the birth of a baby and disputes the allegations. The day before the multi-day hearing her relative dies. Many Muslims believe that burial should take place as soon as possible, and so the funeral is scheduled for the next day, and the midwife decides that they cannot attend the first day of the hearing. It would not be fair to draw any adverse inference based on the midwife's non-attendance in these circumstances.

Health cases

Where the professional's fitness to practise is alleged to be impaired because of health, the panel may also take into account any refusal by them to submit to an assessment of their current health.[4]

We would require some engagement from the professional or other confirmed source to explain why their health condition is preventing them from engaging with the investigation, otherwise the failure to engage may amount to an additional concern.

English language cases

Where the professional is alleged to be impaired because of not having the necessary knowledge of English, the panel may take into account the fact that they have failed to take or failed to provide evidence of an English language test that we've required them to undertake[5].

1 Standard 23, The Code – Professional standards of practice and behaviour for nurses, midwives and nursing associates (2018)
2 See e.g. R (Kuzmin) v General Medical Council (GMC) [2019] EWHC 2129 (Admin)
3 The legal term for this is that a 'prima facie' case to answer has been established
4 Rule 31(5)(a) NMC Fitness to Practise Rules 2004
5 Rule 31 (6A) NMC Fitness to Practise Rules 2004