

How We Investigate and Support Professionals with Health Issues

Reference: FTP-2d Last Updated: 30/10/2026

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Overview

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We often receive referrals alleging that a professional's physical or mental health is impacting their ability to practise safely and effectively. Where concerns have been raised about a professional's health condition, this does not automatically mean they pose a risk to the public. Our [Fitness to Practise](#) (FtP) principles set out that there will often be context when incidents of poor practise happen. These can often be because of system failures, or in the context of a professional's health, because the particular setting or role presents challenges for them (for example, where a professional is neurodivergent, which affects how a person processes information, learns and thinks), but doesn't necessarily mean that their practise is impaired. Similarly, for many health conditions and disabilities, there is a responsibility on the employer to provide the reasonable adjustments to enable the professional to safely carry out their role. Regulatory action should be used sparingly, particularly in relation to disability, which is defined as where a person

- a) has a physical or mental impairment and;
- b) the impairment has a substantial and long term adverse effect on a person's ability to carry out normal day to day activities¹

We know that being subject to a fitness to practise investigation is likely to be detrimental to a professional's wellbeing and recovery. This means that we'll only carry out a full investigation into someone's health where there is evidence that the health condition is likely to continue to put people at risk because the professional and/or employer is unable to manage their condition safely.

In assessing whether a full investigation is necessary, our screening enquiries will need to be proportionate. Ordinarily, they will be limited to establishing whether there is evidence of a current unmanaged risk and will generally not seek to obtain medical evidence, resolve disputed factual issues or undertake a detailed investigation into the management of a professional's health condition. The exploration of these matters would fall under the remit of our investigation teams.

Referrals about a professional's health should ordinarily be closed at Screening where:

- there is no evidence that the professional worked whilst unable to practise safely;
- there is no evidence of an unmanaged risk to patients;
- the professional is engaging with treatment or support; and
- any risks can be managed locally.

Whilst not an exhaustive list, factors that might mean we'd need to carry out a full investigation are:

- Evidence the professional worked (or intends to work) while a health condition affects their ability to practise safely and effectively (this includes where a professional lacks capacity to understand the impact of their condition on their ability to practise safely).
- Evidence of recurring errors or incidents plausibly linked to a health condition where the risk can't be appropriately managed at a local level.

In all cases where we investigate health, our primary focus will be on risks to public safety. It would be unusual for a health condition to pose risks to public confidence or professional standards alone.

Our approach

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Each referral that raises concerns about a professional's health will be considered on a case by case basis. No two cases are the same and a health condition can impact in various ways and can be both situation and setting dependent. Our [culture of curiosity](#) helps to make sure that we fully understand the circumstances that led to a referral involving a professional's health. There are various aspects that will need to be considered as part of this – aspects which can surface at any point in our process. Whilst not an exhaustive list, these include:

- Whether the concern relates to a disability and whether the concerns raised in the referral have been caused or contributed to by barriers at work, for example physical features in the workplace, informal policies, rules or practices, (the social model of disability recognises that individuals are disabled by barriers such as physical features and not by their condition) and whether a different employer might have been able to provide more, or alternative support.
- Whether any misconduct was caused or influenced by a health condition.
- Whether the professional is engaging with the NMC, their employer and/or any support services
- Any reasons why the professional has not engaged or is not engaging, including whether the professional has capacity to make specific decisions in relation to our process, and whether any lack of capacity is temporary or permanent
- The seriousness of the misconduct (see our guidance on [exceptional circumstances](#) for when we'll proceed with misconduct allegations despite the presence of a health condition)
- Whether there is evidence that the professional has ever posed a risk on account of their health condition, such as attending work whilst intoxicated where there are reasonable grounds to suspect that this was due to a health condition (for example, where colleagues may have previously raised concerns about the professional smelling of alcohol)
- Whether the professional has been provided with the right support by their employer, such as reasonable adjustments, and whether that support is continuing
- Whether our approach to assessing concerns about a professional's ability to practise safely, where these relate to physical or mental health, is consistent with the Equality Act. This means we must ensure that a professional is not treated unfavourably because of something arising from their disability (this applies as much to our work as a regulator as it does to an employer), unless that treatment is a proportionate means of achieving a legitimate aim.² In the context of our Fitness to Practise process, we must be able to clearly demonstrate that the professional's disability has placed, and continues to place the public at risk of harm. We must also show that the risk is not being managed by the professional themselves and cannot be managed at a local level, including through the use of reasonable adjustments.

These situations, where we have to take regulatory action in relation to a disability, are likely to be rare.

We've included examples below to demonstrate some of the common factors that our decision makers would take into account when assessing whether a referral requires a full investigation, or needs to be considered at a fitness to practise hearing.

Example A

Nurse A was involved in an incident where they had made a number of medication errors. It was found that the errors were caused by a health condition.

Nurse A was receiving treatment for the condition through their GP, but the treatment was having limited success.

The employer arranges for an Occupational Health assessment, which Nurse A attends. The assessment report recommends a number of reasonable adjustments be put in place. The employer decides to only implement a few of these and Nurse A continues to struggle, eventually leaving on the basis of a lack of support from the employer.

In this scenario the employer hasn't provided all reasonable adjustments that were recommended. It would be unfair to assume that the nurse's mistakes in this context indicate impaired fitness to practise, particularly as another employer may be better placed to provide the support that the professional needs. Additionally, it is important that any support or adjustments that have been put in place by an employer must be designed to address the barriers experienced by the professional and therefore must be effective at removing disadvantage and/or meeting the professional's needs.

Example B

Nursing Associate B was referred to the NMC by their employer as they were concerned about the effect that their mental health was having on their practice following a diagnosis of bipolar disorder.

Nursing Associate B has been supported by their GP throughout and was periodically signed off as being unfit for work.

Nursing Associate B has managed any risk to patients by taking sick leave when they are unwell, and is receiving support from their GP. This is unlikely to require regulatory action at this time as any potential risk is being well managed.

Example C

Nurse C was involved in an incident where they were responsible for several medication errors within a care home. Nurse C tells their manager that they are peri-menopausal and that they are experiencing intermittent bouts of 'brain fog' which have been becoming progressively worse. The manager says that they'll keep an eye on things and monitor the nurse's performance.

A few weeks later Nurse C makes similar low level medication errors, with no harm being caused. This is unlike Nurse C, who has worked for the company for eight years without concern.

Following these further medication errors, the manager refers Nurse C to the NMC, raising concerns about Nurse C's focus and memory impacting on their ability to practise safely. We're told that Nurse C has been suspended pending a full investigation, however remains employed. The referral makes it clear that no additional support or adjustments were made following the first medication error.

Menopause and peri menopause symptoms can have a long term and substantial impact on some women's ability to carry out day-to-day activities. These symptoms could be considered a disability. In this scenario, the employer hasn't put any measures in place to support the nurse before referring the matter to the NMC. Our [FtP](#) data tells us that disabled professionals are referred to the NMC in disproportionately high numbers.

In the event that the peri-menopause symptoms do amount to a disability the employer will be under a legal obligation not to directly or indirectly discriminate because of the disability or subject Nurse C to discrimination arising from disability. They will also be under an obligation to put in place reasonable adjustments to support Nurse C to carry out their duties effectively. Additionally, women experiencing menopause or peri menopause symptoms may also be protected from discrimination, harassment and victimisation, on the grounds of age and sex.

For these reasons, we wouldn't need to be involved at this stage as we'd expect the employer to manage the risks at a local level by putting in place support measures, including reasonable adjustments where necessary.

Example D

A referral is received from a member of the public raising concerns about Midwife D. The referrer, an expectant mother, says that Midwife D was abrupt during an antenatal appointment, gave short answers, and did not acknowledge her anxiety. As a result, she felt dismissed and unsupported. When contacted by the NMC, Midwife D denies being rude or uncaring and explains that they were focused on providing accurate clinical advice and keeping the appointment on track. The NMC also contacts Midwife D's employer, an NHS Trust, which confirms that several similar concerns have previously been raised about Midwife D. The Trust also confirms that it is aware Midwife D has recently been diagnosed with autism. However, it has not yet sought advice on how to support Midwife D, although it plans to do so.

Autism can affect how a person recognises, interprets, and responds to emotional cues, including when someone may need reassurance. This may be relevant to understanding how the interaction with Midwife D was experienced. However, autism should not be relied on to make assumptions or stereotypes about Midwife D, nor should it mean the concern is dismissed automatically.

In this context, it is important to consider the impact of Midwife D's communication on the referrer. It is also relevant that Midwife D's employer has not yet sought advice or put support in place to understand and meet Midwife D's needs. This is a matter that should be addressed through appropriate workplace support and reasonable adjustments, rather than regulatory action.

Decision makers should actively consider whether unconscious bias, discrimination, or a lack of understanding of neurodiversity may have contributed to concerns being raised. This is particularly important given the evidence that neurodivergent professionals can be disproportionately subject to capability and disciplinary processes.

Example E

Nurse E attends work smelling of alcohol. Nurse E's manager is made aware of this and speaks to Nurse E who admits to having been drinking heavily the previous night. A conversation takes place whereby the manager makes it clear that patient safety is paramount, as is the confidence that patients have in their care. Nurse E accepts this and promises that it won't happen again. Nurse E is then sent home.

A week later the same manager is made aware that Nurse E smells of alcohol again and seems unsteady on their feet. The manager again speaks to Nurse E, who smells strongly of alcohol and appears to be intoxicated. In conversation Nurse E admits that they have developed a dependence on alcohol over a period of several months following their partner leaving them.

An Occupational Health referral is arranged, however Nurse E doesn't attend and shortly afterwards resigns.

The concern here hasn't been addressed. Despite assurances that they wouldn't attend work while intoxicated, Nurse E has attended work again whilst intoxicated. Local support and intervention has not been possible as Nurse E has resigned before support could be put in place. There remains a clear risk to the public, particularly as the nurse could seek a nursing role elsewhere, having demonstrated little insight into the risks posed by attending work whilst intoxicated. Regulatory action would therefore be justified in this example.

We often receive referrals after a professional has left an employer following concerns being raised about their practice. This may indicate increased risk where there is a clear link between a health condition and risk to the public, and the professional shows little or no insight. It would be unfair to treat the professional leaving employment as an increase in risk unless there is evidence they lack insight into the risks posed by their health condition, and/or haven't been open and honest with their employer, such as a previous lack of candour about a health condition.

Example F

Nurse F, an Advanced Nursing Practitioner (ANP) is found to have been accessing the Omnicell on numerous occasions over a number of months. When asked about this, Nurse F admits to taking the medication, but says that this was to help alleviate their pain from a chronic back injury as they were unable to obtain sufficient pain killing medication from their GP. A GP letter is obtained which confirms that Nurse F suffers from chronic back pain and states that there are no concerns about any dependency issues.

In this example, Nurse F hasn't disclosed any information that would suggest that they are dependent on any medication, and their GP has confirmed that they're unaware of any dependency. Additionally, chronic back pain is not something that would amount to a regulatory concern in relation to Nurse F's health. Instead, this would be treated as theft of medication and would amount to a misconduct matter that would require a full investigation.

Example G

We receive an employer referral about Nurse G, who is an inpatient at an acute mental health service following an intentional overdose. Nurse G has an existing diagnosis of bipolar affective disorder and emotionally unstable personality disorder. The referral tells us that during their time at the hospital Nurse G informed their treating team that they had a long term addiction to opiates and other medications. Additionally, Nurse G informed their employer that they did bank shifts as this allowed them to only undertake shifts when they felt safe and able to do so.

When asked by the NMC, the referrer could provide no evidence that Nurse G, who had been working with them for a number of years, had ever attended work whilst under the influence.

It is important that we remain led by the evidence and do not allow the apparent or perceived seriousness of a health condition to distract us from the facts of the case. In this example, while concerns about dependency and mental health are understandable, particularly in this context, there is no evidence that Nurse G has ever attended work while under

he influence. Nurse G is also managing any potential risk by only working when they feel safe and able to do so, and importantly there's no evidence to suggest that Nurse G's health condition adversely affects their ability to identify when they are safe to undertake shifts. Overall, there is no evidence linking any health condition to a risk to patients.

Example H

Midwife H is overheard in the changing room at the start of their shift saying that they think they might have inadvertently brought cocaine into the hospital following their attendance at a music event at the weekend. This is reported to their manager and it is raised with the professional themselves who allows a search of their bag, which proves negative. The employer conducts a drug test (saliva) and the test is positive, although the drug can remain detectable for 2-3 days after having been taken. Midwife H is suspended and the matter is referred to the NMC. Within the referral it is made clear that there have never been any concerns about Midwife H being intoxicated at work, or that they were intoxicated on the day in question, which was 2 days after the music event. The referral also tells us that, when asked, midwife H disclosed that they sometimes take controlled drugs recreationally, but that they are in no way dependent.

In this example there is nothing to suggest that there are any health concerns linked to the use of cocaine, and no evidence to suggest that Midwife H has ever been intoxicated in any way whilst at work, including the day of the event that led to the referral. Without cogent evidence pointing to a health concern, or evidence of a risk to patients, this should be managed at a local level.

Example J

Nurse J is referred to the NMC by their employer following various concerns being raised by several colleagues about their competence in basic nursing tasks. We're told that Nurse J disclosed that they have a diagnosis of ADHD and autism. The employer sought Occupational Health advice and put in place all recommended reasonable adjustments, however the concerns around record keeping, medication administration and quality of handovers still remained despite a prolonged period of support and ongoing assessment. A further Occupational health assessment was undertaken and further adjustments were recommended and implemented to make sure that the support remained appropriate, however the issues remained and Nurse J was unable to demonstrate improvement when independently assessed. At this point the employer referred the matter to the NMC, although Nurse J remained employed by them on a supernumerary basis.

In this example, the employer has supported Nurse J and fulfilled their duties under the Equality Act 2010 (or in Northern Ireland the Disability Discrimination Act 1995) by providing reasonable adjustments that were appropriate, relevant and reviewed over time to confirm whether they remained relevant or needed to be changed or updated. It's key that any reasonable adjustments had the effect of putting Nurse J on an equal footing with other colleagues carrying out the same role. However, despite this being the case, the concerns about basic nursing tasks remain. In this example the regulatory concern would be about a lack of competence or misconduct, with neurodiversity being considered as context only.

Example K

We receive an employer referral that raises concerns about Nurse K who has worked for them for a period of 5 years. The referral tells us that for 4 years Nurse K worked without issue, however Nurse K suffered a bereavement which we're told impacted on their mental health. They were subsequently prescribed antidepressants by their GP. The referral sets out that it was around the time of the bereavement that concerns about Nurse K's practice started to arise. These related to a lack of patient documentation and observations. This led to an eight week performance plan, which Nurse K successfully passed. However, soon after this the same issues reappeared. Following the issues re-emerging, Nurse K disclosed that their GP thinks that they have ADHD, although this is undiagnosed.

In this example, where there is no formal diagnosis of ADHD, we'd treat this as a contextual factor, rather than a health regulatory concern. This would not prevent the professional from providing evidence of a formal ADHD diagnosis or other evidence in support of their case or in mitigation, which we will take into account in considering the concerns raised.

Our principles for how we approach referrals involving health

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As the regulator of nurses, midwives and nursing associates our primary purpose is the protection of the public.

We've created nine principles to help guide our approach to referrals involving health issues and the decisions we make in relation to those referrals. These are aimed at making our FtP process fair, compassionate, and supportive, whilst always aligning with our overarching duty to protect the public. It also helps to make sure that our decisions are clear, considered and consistent.

1. We understand that the way we communicate can't be 'one size fits all'

We'll always aim to tailor our communication with professionals who have a health condition in a way that is compassionate and responsive to their individual circumstances. Where appropriate, we'll be guided by their treating professional as to how and when we should contact the professional. We'll also take reasonable steps to make sure that professionals are given the time, space and support they need to engage meaningfully with us.

We also recognise that being contacted by multiple people at different stages of our process can be challenging for those going through it. Wherever possible, we'll work to maintain continuity in how we communicate with professionals who are involved in our process on account of their health.

We'll also focus on making sure that our requests are reasonable. For example, if we know a professional is experiencing a period of crisis, wherever possible we'll agree to any requests for an extension of a deadline and only ask for information that is relevant and necessary.

In doing so, we aim to make engaging in our process as accessible as we can to reach outcomes that protect the public and are fair to everyone, including the professionals on our register.

2. We'll keep compassion at the heart of everything we do

We recognise that being subject to a FtP investigation is stressful and can negatively affect the health of those referred to us.

This is especially true for professionals whose referral relates to their health, or to incidents linked to their health.

We also know that the duration and nature of our investigations can cause significant harm to those involved. We also understand that we can reduce any negative impacts on those professionals by communicating with them in a way that suits them.

It's therefore essential that we remain mindful of the impact our process can have, and do everything we can to make it clear, supportive and compassionate, while still fulfilling our statutory duty to protect the public. For example, we know that hearings can be particularly stressful and can often be times of crisis. To reduce this impact, we'll avoid imposing short timescales or deadlines in the lead up to a hearing wherever possible.

3. We'll focus on fairness by doing what we can to allow the professional to fully participate

Where the professional who is going through our process is very unwell, or lacks capacity to engage in the process, we'll work together to find ways, within our rules, to allow the professional the time to recover so that they can engage with our process. In certain circumstances this can mean placing a pause on our investigation to allow a professional the time to recover, or signposting the professional or their supporters to our agreed removals process. Where the professional is unable to do so (for example where they lack mental capacity), their supporters³ may be able to apply for agreed removal on behalf of the professional (while there is no prescribed list of people who may apply on the professional's behalf, this could include representatives, family members or close friends). Any such application would need to be supported by medical evidence, as well as clear evidence as to why the person is applying on the professional's behalf.

When we consider a professional's ability to engage with our process we'll always presume capacity unless we encounter information that suggests that the professional is unable to:

- understand information relevant to the decision in question
- retain that information

- use the information to make their decision
- communicate a decision⁴

In these situations, we may look to engage with others, for example the professional's family or healthcare team, to confirm that the professional does have capacity to continue (this is important as capacity can be both time and decision specific). We may also work with our safeguarding team to ensure we move forward appropriately.

Wherever possible, where there's evidence that a professional lacks capacity on a permanent basis, we'll seek to bring our process to a conclusion as early as possible as long as we can balance this with our need to fulfil our overarching objective (protecting the public).

4. Our decisions will be clear and proportionate

We'll never investigate health, or request that a professional undergoes medical testing or assessment, unless there's cogent evidence indicating a link between their health and a risk to the public.

Where we do assess that there is a link between a health condition and risk, wherever possible, we'll obtain information from treating professionals to help make sure that our decisions are the right ones, where we take the least restrictive action possible that still protects the public. This includes medical assessments, particularly where the professional is already under the care of a relevant specialist or general practitioner (who may be better placed to provide the information we need) and they are able to provide sufficient information to enable us to understand any link between the professional's health, their misconduct and any ongoing risk. This means that wherever we can bring a case involving a professional's health to a close, or support the professional back to safe practice whilst limiting the need for that professional to undergo a medical assessment arranged by us, we should.

In practice, this might mean our Case Examiners offering undertakings without the need for a medical assessment to inform these, or the use of warnings in certain circumstances, such as where the professional stole medication due to dependence or addiction, but there no longer exists a risk of repetition. In this particular instance, we'd primarily regard such cases as misconduct cases involving dishonesty, with health as context, rather than health being the head of impairment.

However, if a professional's health has, and continues to present a risk to public protection, and the case is likely to proceed to a hearing, testing and/or assessment may be necessary so that members of the FtP Committee are able to fully understand the link between the professional's health and any ongoing risk.

5. We'll only ever ask for the information we absolutely need

We know that investigating someone's health can be intrusive. When we need to access any medical records for the purposes of an investigation, we'll only ever request, or share records (for example when we need to share medical records with our medical assessment services) that are directly relevant to the concern(s) that we're looking into.

We should avoid hypothetical inquiries based on the possibility that a condition could give rise to risk in circumstances where that risk has never materialised. Conducting an investigation in the absence of cogent evidence of risk could constitute unlawful discrimination on the grounds of disability.

6. We'll always consider what support has been provided by an employer

Employers have a duty of care to their staff and are responsible for meeting the requirements of the Equality Act. Additionally, public authorities and other organisations that carry out public functions must also comply with the Public Sector Equality Duty (whilst not an exhaustive list, this includes the NHS, local authorities, education bodies and the armed forces), or in Northern Ireland, section 75 of the Northern Ireland Act 1998. These duties include providing reasonable adjustments where needed and eliminating discrimination and advancing equality of opportunity.

More often than not, cases of ill health can be managed in the workplace with the support of an employer, because they can put measures in place to support the professional at work. The onus is on employers to support professionals, particularly in relation to disability. It should be rare that regulatory action will be required in relation to a disability.

We also recognise that the level of support available can vary between employers and across different settings. Where there is evidence that a professional with a disability or health condition may not have received appropriate support, we may raise this with the relevant employer through our Employer Link Service.

7. We'll work together to reach an outcome as quickly as we can

There are several stages and teams involved in our fitness to practise process, and we'll work collaboratively to find the most efficient route to a timely outcome. If it becomes clear that a professional has a health condition that prevents them from engaging with the process, or makes their return to practice unlikely, we'll coordinate closely to identify the quickest outcome that is both fair and protects the public. For example, this may include finding ways to fast track a referral with a case to answer to our Case Preparation and Presentation Team so that the [cancelling hearings](#) process can be used. This means that in certain circumstances (such as terminal illness or where a professional does not have the mental capacity to engage in our proceedings) a panel chair can cancel the hearing, and in effect close the matter before it reaches a hearing.

In other instances, we may choose to delay the progression of the referral in order to allow the professional the time and space to recover from a serious illness or treatment, or regain capacity (in circumstances where this is not believed to be permanent) so that they are better able to engage with the process.

8. We'll be both proportionate and pragmatic when assessing a professional's insight and steps to recovery

We recognise that people recover from mental and physical illness, including dependency, in different ways and over different timescales. This means that the way we assess whether a professional's health poses an ongoing risk needs to be on a case by case basis. Wherever possible, we'll work with the professional, their health team and their employer to look for ways in which the professional and/or their employer can put measures in place to manage any risk that their health poses. This can be shown where one or more of the following apply:

- the professional has demonstrated good insight into the extent and effect of their condition
- the professional 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 professional is managing his or her practice appropriately, for example by taking sickness absence.

9. Our focus will be on the root cause of any concerns with a professional's practice

Within the context of our fitness to practise process we refer to these as regulatory concerns.

Where our inquiries tell us that what went wrong in a professional's practice (which we refer to as misconduct) arose directly from a health condition, and there's a clear link between that health condition and an ongoing risk, our regulatory focus will be on the health condition itself. This means that we won't treat the associated misconduct as a standalone concern.

However, where a professional is cautioned or convicted in relation to a criminal offence, we'll treat any link between the caution or conviction and their health as context, rather than treating this as a separate regulatory concern.

Where there is an absence of cogent evidence linking a health concern with the misconduct, our focus will be on the misconduct. However, if a health condition may have played some part in the misconduct, though not the root cause of the misconduct, we'll refer to this as a contextual factor.

Where the professional themselves wishes to raise health as mitigation, or a contextual factor, (including where no diagnosis exists), it'll be up to the professional to provide evidence of a diagnosis and/or how their health played a part in the incident(s) or behaviours that led to the referral.

1. Article 6(1) of the Equality Act 2010

2. Section 15 of the Equality Act 2010

3. Education Registration and Registration appeals rules 2004 r.14(1) which sets out that the Registrar may remove a registrant's name from the register upon written application made by or on behalf of that registrant but is silent on who may apply on the registrant's behalf

4. Section 3 Mental Capacity Act 2005