

## About the NMC

The Nursing and Midwifery Council (NMC) regulates the practice of nurses and midwives in the UK, and nursing associates in England. It has **850,707** professionals on its register (as at 31 December 2024).








# Snapshot 2023/24

## Nursing and Midwifery Council | Annual review of performance

### About the NMC's performance for 2023/24

For this review, the NMC met 11 out of 18 of our Standards of Good Regulation. These Standards provide the benchmark against which we review performance. Meeting or not meeting a Standard is not the full story about how a regulator is performing. Our report provides more detail about the NMC's performance.

### Standards of Good Regulation met for 2023/24 performance review

	<b>General Standards</b>	<b>2 out of 5</b>
	<b>Guidance and Standards</b>	<b>2 out of 2</b>
	<b>Education and Training</b>	<b>1 out of 2</b>
	<b>Registration</b>	<b>3 out of 4</b>
	<b>Fitness to Practise</b>	<b>3 out of 5</b>

<b>Total Standards</b>	<b>11 out of 18</b>
------------------------	---------------------

### Standards met 2021-23

<b>2022/23</b>	<b>17 out of 18</b>
<b>2021/22</b>	<b>17 out of 18</b>

# Key findings

Nursing & Midwifery Council  
**2023/24**

## Context for this report

This is our report on the performance of the NMC in 2023/24. We were originally due to publish it by September 2024. However, in Autumn 2023 the NMC commissioned three independent reviews to look into issues raised in whistleblowing disclosures. We delayed our report to take the findings of these three reports into account.

The first of the three independent reviews, the Independent Culture Review (ICR), was published in July 2024. Its findings included serious concerns about the NMC's culture and governance. It made 36 recommendations, which the NMC has accepted. In response, we set up the Independent Oversight Group (IOG) to monitor the NMC's work to address these findings and recommendations. The IOG includes senior representatives from all four UK governments, professional bodies, and relevant experts (including from patient and service-user groups).

Publication of the two reviews being conducted by Ijeoma Omambala KC, has been delayed. We believe it is in the public interest for us to report on the NMC's performance in a timely way and have therefore decided to publish our report without the evidence from these two reviews. We are clear that the findings and any recommendations from the Omambala reviews are important. We will consider them in detail when they are available, including deciding how we can most appropriately report on what they tell us and whether there is further action we need to take.

## Key findings and areas for improvement

### ● Response to whistleblowing disclosures

The NMC has been working to respond to serious concerns raised in whistleblowing disclosures. As mentioned above, it commissioned three independent reviews, two of which had not been published by the time we completed our review. The published ICR made numerous critical findings about the NMC's organisational culture, and the NMC accepted all its recommendations. We note that the concerns are serious, and we had regard to the findings of the published ICR where relevant, alongside the other evidence available to us. We will consider the findings of the other two reviews when they are available.

### ● Equality, Diversity and Inclusion (EDI)

The whistleblowing concerns included concerns about discrimination and the organisational culture of the NMC. We saw that the NMC has processes in place to promote EDI, but given the findings of the ICR, we could not be assured that these processes were working effectively. The NMC has acknowledged that it needs to develop its capability in EDI, and has begun work on a range of improvement actions. We saw that the NMC's standards and guidance promote non-discriminatory, respectful, compassionate, and kind care. However, we were not assured that the NMC has effectively embedded EDI into its work. Therefore Standard 3 was not met.

## ● Education quality assurance

We noted some serious concerns about the NMC's work to assure the quality of education and training. Having identified issues about a training provider's compliance, the NMC carried out a mandatory self-reporting exercise where it required all training providers to send information about compliance with its standards. In our view, the need for such an exercise illustrated a failure of the NMC's routine monitoring. The NMC had also carried out an internal review of its education quality assurance work, which identified a number of serious risks, and limitations on the NMC's ability to mitigate them. The NMC started work on an improvement plan, but this was still in development by the end of our review period. Therefore Standard 9 was not met.

## ● Accuracy of the register

Around 350 graduates from a university training course were added to the NMC's register when they had not completed the required practice hours. When it became aware of the issue, the NMC contacted the affected graduates to request information about further practice learning they may have undertaken; most but not all had responded by the end of the review period. A number of other people may have joined the register fraudulently in relation to instances of large-scale fraudulent applications. The NMC is investigating these matters and has taken steps to improve its fraud prevention processes. However, maintaining an accurate register is a core function of a regulator, and a large number of people were added to the NMC's register without meeting its requirements. Therefore Standard 10 was not met.

## ● Fitness to Practise

The NMC is still taking too long to deal with fitness to practise cases. It has been working to an action plan to clear its backlog but had made only limited progress during the review period, partly because it had received more referrals than expected. Therefore Standard 15 was not met.

Concerns about the NMC's safeguarding capability were identified through the whistleblowing disclosures. Safeguarding is identified as the NMC's highest strategic risk, and it has taken action to improve its ability to detect and address cases. However, an internal audit identified that there had been cases where the NMC had not taken action that was necessary from a safeguarding perspective. Even a small number of safeguarding failings could amount to a serious risk to the public. Therefore Standard 17 was not met.

The evidence we saw from our audit of a sample of cases did not give us serious concerns about the NMC's routine decision-making. One of the independent reviews into whistleblowing disclosures will be reviewing a sample of fitness to practise cases, and we will consider the outcomes of the review when available.



Find out more about our performance reviews, including:

- the Standards of Good Regulation
- our performance reviews
- the NMC Independent Oversight Group