Open Council 25 November 2026

MEETING

25 November 2026 10:00 GMT

Meeting of the Council

To be held in person at 10:00 on Wednesday 25 November 2026 at 23 Portland Place, London W1B 1PZ

Agenda

Ron Barclay-Smith
Chair of the Council

Jacqueline Maunder
Council Secretary

1	**Welcome and Chair's opening remarks**	NMC/26/229	**10:00**
2	**Apologies for absence**	NMC/26/230	
3	**Declarations of interest**	NMC/26/231	
4	**Minutes of the previous meeting** Chair of the Council	NMC/26/232	
5	**Summary of actions** Secretary	NMC/26/233	

Matters for Discussion

6	**Quarterly Corporate Performance Report (Q2)** Chief of Staff	NMC/26/234	**10:10-10:30** *(20 mins)*
7	**Quarterly Risk Exposure Report (Q2)** Chief of Staff	NMC/26/235	**10:30-10:50** *(20 mins)*
8	**Financial Performance Report (Q2)** Executive Director, Finance	NMC/26/236	**10:50-11:10** *(20 mins)*

Refreshment Break (15 mins)

9	**Quarterly Safeguarding Update** Executive Director, Professional Practice	NMC/26/237	**11:25-11:45** *(20 mins)*

Matter for Approval

10	**Annual Health and Safety Report 2025-2026** Executive Director, Finance	NMC/26/238	**11:45-12:00** *(15 mins)*

Matters for Assurance*

12:00-12:10
(10 mins)

11	**Audit and Risk Committee Report** Interim Chair of the Committee	NMC/26/239	
12	**Planning and Performance Committee Report** Chair of the Committee **12.1 Report for the meeting of 8 October 2026** **12.2 Report for the meeting of 12 November 2026**	NMC/26/240	
13	**Finance and Resource Committee Report** Chair of Committee	NMC/26/241	

Refreshment Break (15 mins)

Matters for Discussion

14	**Thirlwall Inquiry** Executive Director, Strategy and Insight	NMC/26/242	**12:25-12:45** *(20 mins)*
15	**Practice Learning Review Outcome** Executive Director, Professional Practice	NMC/26/243	**12:45-13:15** *(30 mins)*
16	**Executive report** Chief Executive and Registrar/Executive	NMC/26/244	**13:15-13:30** *(15 mins)*
17	**Observer questions (oral)**	NMC/26/245	**13:30-13:45** *(15 mins)*

**Members should notify the Chair a minimum of two days prior to the meeting should they wish to discuss any 'For assurance' items. If not, then it is assumed that Council notes the reports and actions, without discussion.*

CLOSE **13:45**

Item 4
NMC/26/232
26 November 2026

Meeting of the Council
Held on Wednesday 23 September 2026 at the Stormont Hotel, Belfast

Minutes

Ron Barclay-Smith	Chair
Eileen McEneaney	Member
Hussein Khatib	Member
Flo Panel- Coates	Member
Nadine Pemberton Jn Baptiste	Member
Margaret McGuire	Member
Rhiannon Beaumont-Wood	Member
NMC Officers	Chief Executive and Registrar
Paul Rees	Executive Director of Finance
Christopher Kinsella	Executive Director, Professional Regulation
Lesley Maslen	Executive Director, People and Culture
Ravi Chand	Executive Director, Strategy and Insight
Emma Westcott	Executive Director, Communications and Engagement
Julia Corkey	Executive Director, Professional Practice
Chris Dzikiti	Executive Director of Transformation and Technology Services
Richard Cartland	Deputy General Counsel
Miranda Stotesbury (for Alice Hilken)	Chief of Staff
Ben Wesson	Secretary to the Council
Jacqueline Maunder	Senior Governance Manager
Sharon Dawson	Deputy Director, Professional Practice
Glenn Mathieson	
For item 9:	Assistant Director for Midwifery
Tracey MacCormack	Independent Chair, Midwifery Strategic Advisory Group
Birte Harlev-Lam	

A list of observers is at Annexe A.

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Minutes

NMC/26/211 **1. Welcome and Chair's opening remarks**

The Chair welcomed all attendees and observers to the meeting in Northern Ireland. The Chair noted that Council meetings and visits outside London provided an opportunity to engage more directly with the professions, partners, and stakeholders across the devolved nations and England, as well as giving Council and Executive colleagues a better understanding of local perspectives and issues. Council members and members of the Executive had visited various sites across a breadth of different health and social care services and met with a range of colleagues and partners the previous day. The Chair thanked everyone who took time out of their busy schedule to talk about their work and the challenges and achievements for nursing and midwifery in Northern Ireland.

The Chair extended a special welcome to Maria McIlgorm, the Chief Nursing Officer (CNO) for Northern Ireland, who would present to the Council later on the agenda.

The Chair reminded attendees of the NMC's values; integrity, fairness, respect, equity and effectiveness and how, within the context of these values, the fundamental role of the Council was to protect the public.

NMC/26/212 **2. Apologies for absence**

Apologies were received from Anna Walker, Julia Mundy and Lindsay Foyster, Council members, and Alice Hilken, General Counsel.

NMC/26/213 **3. Declarations of interest**

No declarations of interest were made.

NMC/26/214 **4. Minutes of the previous meeting**

The minutes of the meeting held on 21 July 2026 were received and agreed as an accurate record of the meeting and would be signed by the Chair.

NMC/26/215 **5. Summary of actions**

The Council received the summary of actions.

Members noted:

a) There were 14 actions in total with two categorised as completed and the remaining actions due between October and December 2026,
b) Members were asked to note the progress on the open actions and

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agree to close the actions that were categorised as completed,

c) An oral update was provided for action NMC/26/142 - the Executive Director for People and Culture had attended a meeting of the Diaspora Registrant Association Forum (DRAF). Each member had been sent an invitation letter to give to their employer to recover costs which could now be reimbursed under the NMC claim and expenses policy. Travel and time compensation were also noted, and that this would be integrated into the registrant strategy; and

d) It was felt the action log did not reflect the true representation of progress of actions in the action summary, with a suggestion that action closures should be described.

The Secretary agreed to review the description of action progress in the action log.

NMC/26/216 **6. Presentation from the Chief Nursing Officer, Northern Ireland**

The Chief Nursing Officer (CNO), Northern Ireland welcomed the Council to Belfast and provided a brief oral presentation covering the state of the nursing and midwifery profession in Northern Ireland, and current challenges and opportunities.

The following areas were highlighted:

- There are 28,746 Nurses,1,379 Midwives & 344 Dual Registrants on the NMC register with an address in Northern Ireland,
- Northern Ireland's unique position, due to its proximity to the Republic of Ireland, has resulted in cross-border working,
- The significant health inequalities and high number of mental health needs in Northern Ireland were noted, alongside the 2023-2028 vision and key priorities for healthcare, including education and training, workforce planning, and patient safety,
- Progress on the Health and Social Care Reset Plan, focusing on care closer to home and early intervention, was reported,
- A workforce sustainability priority had been launched in March 2026 with an evidence-based approach to workforce planning being implemented regionally,
- The development of career pathways, such as for cancer care and care homes, was highlighted, along with a regional Nursing and Midwifery research framework; and
- The necessity for professional frameworks to keep pace with new opportunities and technological advancements was emphasised, with the NMC's work on the Code being welcomed.

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Council members noted:

a) Prevention, early intervention, and anticipatory care were central to the reset plan, with significant work being undertaken in Northern Ireland to enable nurses to deliver more preventative care,

b) The valuable contribution of overseas professionals to the social care system in Northern Ireland was acknowledged,

c) The NMC's work on the Code was welcomed. It was essential that the Code continued to support professional judgement, effective team working and enabled people to live their best lives,

d) The key elements of implementing a single digital system were having the right people to build, develop and lead the transformation and optimisation of the system. The system was now three years in, and it was exciting to have real time intelligence which was providing benefits for improving health care outcomes; and

e) The Council thanked the CNO, Northern Ireland for the useful insight provided into developments in Northern Ireland and the important collaboration with the NMC.

The Council:

- **Noted** the verbal update.

NMC/26/217

7. Northern Ireland Health and Care site visits – reflections

Members noted that the previous day, NMC Council members and the Executive Board had visited a range of health and social care sites and services in Northern Ireland. Reflections from the visits were provided by Council members as follows:

a) Midwifery-led Maternity Unit and Neonatal Unit, Antrim

Council member Margaret McGuire gave the update and advised that a calm and relaxed atmosphere was observed, alongside a strong team approach of compassion and care. The roles of advanced neonatal nurse practitioner and enhanced neonatal nurse practitioner were well evidenced. The importance of getting the Practice Learning Review (PLR) right was clear. The approach of the trust to midwife led and obstetric units had been impressive, demonstrating one of continual care and a fluid approach on decisions. There was evidence of multidisciplinary and multi-professional working and respect with a positive and strong approach to improvement and working collaboratively with staff and families. A good mechanism for critical incidents was particularly noted. The approach to governance and managing risk was evident. It had been a wonderful experience and made

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Council member Margaret McGuire even more proud to be a midwife.

b) Pond Park Care Home

Council member Hussein Khatib gave the update and members noted that the care home had 51 beds offering a range of services in a beautiful setting. NMC colleagues were met with a warm welcome. Nursing was a key feature in many of the senior posts, thus ensuring a professional focus on operational and strategic decisions. All the staff were courteous and caring towards the residents and relatives expressed their satisfaction with the home's approach to care.

The Northern Ireland Practice and Education Council had produced a career pathway book for staff, which Pond Park participated in. There was clear evidence between the strategic plan and the delivery at local levels for the nurses. A challenge for the care home is to afford the time for staff to attend training. A strong focus on career pathways and a comprehensive preceptorship programme was noted.

In conversation with nurses, both internationally trained and others, the work of the NMC and its plan to update the Code, revalidation, and practice learning was discussed.

c) KN Cheung SK InterSim Centre, Queen's University

Council member Eileen McEneaney gave the update and members noted at the interdisciplinary centre at Queen's University, the state-of-the-art simulation training facilities were observed. The highly supportive learning environment and the promotion of empathetic care were highlighted. The scaffolding approach to student learning was noted, and the value of education was advocated by Dr. Billy Jo Rice. The Northern Ireland response to the PLR consultation was endorsed by all. It was concluded that the high standard of midwifery and education in Northern Ireland was created by the people, academic team values, commitment, care, and scaffolding of students, alongside the Open University.

d) Emergency Department, Mater Infirmorum Hospital

Council member Flo Panel-Coates gave the update and members noted the history of the Mater Infirmorum Hospital and its place within the community it served was particularly interesting. There was a very strong sense of the Mater being not simply a hospital located within the community, but genuinely part of that community. There was real pride from staff in being part of the

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"Mater family", alongside a clear commitment to serving everyone in the community, regardless of their background or beliefs. Time was spent across a number of services, including the Patient Assessment and Treatment Hub (PATH) - a unique mental health facility - a respiratory and endocrine ward, and emergency and urgent care. This demonstrated the breadth of care being provided and some of the significant pressures experienced across the emergency care pathway, inpatient services, primary, voluntary and into the neighbourhood's spanning health and social care.

The opportunity to meet nurses and other professionals and to hear directly about what matters to them and where the NMC could support them was valuable. A strong reminder of the invaluable contribution made by internationally educated nurses was noted. It was a powerful reminder of the international nature of our professions and of the importance of ensuring that all registrants feel valued, supported and able to thrive throughout their careers. The breadth of the contribution that registrants were making was evident, across care, digital health, research, education, mental health, learning disability and advanced practice, with professionals leading innovation and working across traditional professional and organisational boundaries to improve care. There was a strong sense of the pressures facing services but also the commitment, professionalism and pride of the people working within them. It reinforced the importance of the NMC continuing to listen to registrants and the people they care for, understanding the particular context in which they practise, and making sure that its work as a regulator supports learning, improvement and high-quality care.

e) Primary and Community Care Seminar

Council member Rhiannon Beaumont-Wood gave the update and members noted that the Council and Executive Board had attended a seminar on Primary and Community Care which had provided context in terms of the health and social care strategy in Northern Ireland.

It was clear that what mattered to people about care closer to home was having the right care, in the right place, at the right time. The development of a digital coordination system was key to all of this. The focus on prevention and early intervention had been strongly demonstrated. While there existed an inequality between affluent and more deprived areas in Northern Ireland, it was evident that investing in early years helped to improve outcomes in later years.

Guest speaker, Brendan Casey, and his mother, Margaret, presented a moving account of their lived experience of nursing

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care. Brendan expressed his plea for greater opportunities for delivery of care through his team, to give him more independence and give his mother time for some respite.

It was acknowledged that the NMC has a part to play in terms of the revision of the Code and balancing safe delegation with patients' needs.

The multi-disciplinary approach was clearly effective and using the NIPEC framework to constantly review and consider the delegation of care. There was more for the NMC to do to see if it could help with that.

A helpful, informative and interesting perspective was presented by nurses working in the community and how they work with their service users.

The shift to a focus on primary and community care was important and was key for all four nations and right that the NMC should help to plan for that through its work on the Code, education and Advanced Practice.

The Council acknowledged that the visits to the broad range of health and social care sites in Northern Ireland, as well as the presentations by professionals and service users at the seminar, had been valuable and interesting. Thanks were conveyed to the organisers and those who kindly hosted the informative visits, for their warm welcome and for so generously giving their time.

The Council:

- **Noted** the reflections from the site visits and the primary and community care seminar.

NMC/26/218 **8. Executive report**

The Executive report was received, and the Chief Executive and Registrar gave a summary of activity since the last Council meeting.

Members noted:

a) It was important that the NMC held its Open meetings across the four nations periodically. The CER thanked colleagues in Northern Ireland for their hospitality and also for their support alongside NMC colleagues in running a successful visit to Northern Ireland.

b) There had been a notable increase in registrants with a Northern Ireland address with 30,471 professionals now on the NMC register, an increase of 805 on last year.

c) The findings of the Lady Justice Thirlwall report regarding Lucy Letby had highlighted past failings across many bodies in

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healthcare and in the NMC's processes and procedures, which were acknowledged with regret. Changes to strengthen the NMC's culture, professional curiosity, and multi-disciplinary peer review processes were outlined, alongside an improved intelligence-sharing pathway to provide a clearer escalation process.

d) Engagement was ongoing with harmed and bereaved families with learnings from reviews and ongoing collaboration with Donna Ockenden. New public information regarding the role of the NMC when there are failings in maternity care, and for fathers, had been published. The NMC's significant improvements in engaging with reviews and families had been recognised.

e) The CER had attended the London Maternity and Neonatal Excellence Awards which were noted as a means to celebrate excellent midwifery and neonatal care.

f) The professional practice roadmap continued to make progress.

g) A draft version of the new Code was due to be published for public consultation in November 2026, with final publication anticipated in October 2027.

h) It had been decided to defer the revalidation consultation to give time to reflect on the lessons from the Thirlwall report.

i) The standards for Advanced Practice would be published in October 2027.

j) A deep dive into the Employer Link Service would be helpful to understand how well it was working and delivering. This linked also to the Thirlwall recommendations. It was agreed that an audit would be conducted and a report brought back to the Council.

k) A meeting with the Chief Nursing Officers would discuss the drop in overseas registrants and to discuss workforce planning across the four nations.

l) With the closure of two OSCE centres, with three remaining in a stronger position, and ongoing monitoring of this challenge was confirmed.

The Council:

- **Noted** the report; and
- **Discussed** the key developments, updates and engagements up to 16 September 2026.

NMC/26/219 **9. Midwifery update and strategy launch**

The Midwifery update and strategy launch report was received. The Executive Director, Professional Practice introduced the item and the

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Assistant Director for Midwifery, and the Independent Chair of the Midwifery Strategic Advisory Group (MSAG) presented the update and strategy.

Members noted:

a) The NMC approach to strengthening midwifery regulation across the four countries and the progress in governance, oversight and team structures,

b) A new three-year strategy implementation plan for strengthening midwifery regulation across four nations was presented for Council approval along with a supporting action plan,

c) The strategy and action plan identified areas where further work is underway to ensure midwifery regulation is systemic, evidence informed and aligned to public protection priorities,

d) The strategy, developed through workshops and consultations with CNOs and Chief Midwifery Officers (CMidOs), would be supported by an implementation plan,

e) The Midwifery Regulatory Oversight Group (MROG) had been refreshed and there was a distinct separation between this and the Midwifery Strategy Advisory Group (MSAG),

f) Key findings concerning regulatory mapping and current standards related to racism, discrimination, inequality, and safety, had been identified as key areas of focus,

g) Part one of the strategy was high-level and forward-facing, with the implementation plan (Part 2) to be developed with users and stakeholders from September 2026 to March 2030,

h) The strategy's five priority areas, including learning from national reviews, fair and just processes, UK-wide leadership, and intelligence on risk, were outlined,

i) Plans included annual reviews and progress mapping through MSAG, alongside quarterly reports to the Council,

j) The importance of this work was emphasised, alongside the need for clearer reporting structures to the Council and the critical role of learning from investigations.

k) Updates on the registrant workplan were requested for Council,

l) Principles for supporting women's choices had been published and would be part of this work,

m) A toolkit had been developed for decolonising the curriculum with clear principles on anti-racism training in midwifery,

n) The plan needed to be live and responsive, with a clear direction of travel,

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o) For assurance it was necessary to understand the strength of the evidence base being drawn on,

p) Regarding the financial implications of delivering the strategy, a business case would be run alongside it, with two posts awaiting approval,

q) The framework was not fully formed yet, and this would be brought back to the Council; and

r) Maternity and perinatal services across the four countries of the UK continue to be subject to significant scrutiny, including the ongoing work in Scotland, Northern Ireland and Wales; forthcoming investigations in Leeds and Sussex; and the work of the National Maternity and Neonatal Taskforce in England alongside the English department of Health's recent publication of its maternity 10-point plan. In this context, the NMC recognises that strong, visible and responsive midwifery regulation must form part of the wider system response to improving equity, safety, quality and public confidence.

The Council:

- **Noted** the report,
- **Approved** the midwifery strategy and supporting action plan,
- **Noted** the progress made to strengthen governance, oversight and regulatory intelligence across midwifery regulation; and
- **Endorsed** the proposed direction of travel and the next phase of work to implement the strategy.

Action: **Provide updates on the registrant workplan to the Council.**

For: **Executive Director, Professional Practice**

By: **25 November 2026**

NMC/26/220 **10. Observer Questions**

The Chair invited questions and comments from observers (see Annexe B).

The Chair reminded everyone that the NMC was unable to provide responses to any questions relating to individual cases or situations. The Chair invited questions and comments from observers received via email in advance of the meeting and during the meeting.

Twenty questions had been submitted in advance of the meeting, and there was insufficient time to answer them all during the meeting. To balance responses to these questions with opportunities for observers attending in person to ask questions, three of the questions submitted in advance were answered. The remaining time was allocated to

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questions from those attending the meeting.

All of the questions received in advance of the meeting would be responded to via email in due course following the meeting.

There was an extended opportunity for observers to speak to NMC colleagues in the break.

NMC/26/221 **11. Historical Reviews update**

The Historical review report was received and the Executive Director, Strategy and Insight presented the update.

Members noted:

a) In October 2023 the NMC commissioned two independent reviews in response to allegations arising in media coverage of the concerns of an NMC whist blower. One review related to Fitness to Practise (FtP) cases that the whistleblower alleged had not been handled appropriately, and the other review looked at our handling of the whistleblower. These reviews were published in September 2025,

b) The Council had formally received and commented on the review reports on 21 October 2025 and received an update on progress against the recommendations in May 2026,

c) The NMC had completed 22 of the 25 recommendations from the historical reviews. The three outstanding recommendations all related to FtP,

d) Actions and delivery dates for recommendation 10 were agreed,

e) Regarding recommendations eight and nine, further dialogue was required with the author, Victoria Butler-Cole KC, to ensure a clear understanding of the actions; and

f) In relation to action 24, concerning the Council Raising Concerns leads, and the Empowered to Speak Up (ETSU) leads, these were two different roles. The Chief of Staff agreed to review and amend this action.

The Council:

- **Noted the report**

Action: Review and amend action 24 to clarify the difference between Council Raising Concerns leads and Council Empowered to Speak Up (ETSU) leads.
For: Chief of Staff
By: 25 November 2026

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NMC/26/222

12. Council and Committee Cycle of Business 2027-2028 and 2028-2029

The Council and Committee Cycle of Business 2027-2028 and 2028-2029 report was received. The Secretary to the Council presented the report.

Members noted:

a) To ensure effective governance a schedule of NMC Council meetings is agreed in advance of each calendar year,

b) Date mapping and sequencing had been undertaken to ensure appropriate reporting into the Council. The timing of the Planning and Performance Committee (PPC) meetings had been carefully considered to ensure they took place ahead of Council meetings,

c) The removal of one of the July Open Council meetings needed to be clarified as the report stated there was now only one meeting in July when in fact this was detailed as 30 June 2027. The Secretary agreed to review this; and

d) There had not been an opportunity to confirm dates with all committee chairs and dates would be confirmed and reviewed if necessary.

The Council:

- **Noted** the report; and
- **Approved** the Council meeting dates for 2027-2028 and 2028-2029, subject to any date amendments required to Committee dates following further consultation with the committee chairs.

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13. Adroddiad monitro blynyddol Safonau'r Iaith Gymraeg 2025-2026

Welsh Language Standards Regulations Annual Monitoring Report 2025-2026

The bilingual Welsh Language Standards Regulations Annual Monitoring Report 2025-2026 was received. The Executive Director, People and Culture presented the report.

Members noted:

a) The report demonstrated the NMC's compliance with the Welsh Language Standards (No 8) Regulations 2022, and the NMC's commitment to the Welsh language; and

b) The Annual report will be published on the NMC website and shared with the Welsh Language Commissioner by 30 September 2026.

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Following discussion members queried:

a) Section 2.8 of the report, relating to the Standard 20 challenge application concerning the development of a Welsh language version of the UK-trained registration system, and the Welsh Language Commissioners acceptance that standard 20 will no longer apply if the NMC provide a downloadable version of the registration form in Welsh. It was suggested that this sounded passive rather than an active offer, and it was asked whether more would be done to signpost. It was agreed that consideration would be given to how the website could be used to promote further to demonstrate the NMC's commitment to the Welsh "Active Offer" policy in Wales that meant providing services in Welsh without a person having to ask for them.

The Council:

- **Noted** the report.

NMC/26/224 **14. Finance and Resource Committee reports**

The Finance and Resource Committee reports of the meetings held on 28 July and 9 September 2026 were received.

The Council:

- **Noted** the Finance and Resource Committee Reports.

NMC/26/225 **15. People and Culture Committee report**

The People and Culture Committee annual report 2025-2026 and the reports of the meetings held on 14 May, 30 June and 2 September 2026 were received.

The Council:

- **Noted** the People and Culture Committee Report.

NMC/26/226 **16. Audit and Risk Committee report**

The Audit and Risk Committee Report of the meeting held on 7 September 2026 was received.

The Council:

- **Noted** the Audit and Risk Committee Report.

NMC/26/227 **17. Planning and Performance Committee report**

The Planning and Performance Committee Report of the meeting held on 27 July 2026 was received.

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The Council:

- **Noted** the Planning and Performance Committee Report.

NMC/26/228 **18. Chair's actions taken since the last meeting**

There had been two Chair's actions taken since the last meeting:

- **05/2026** Transfer of one Panel Member from the Fitness to Practise Committee to the Investigating Committee
- **06/2026** the removal of six Panel Members and two Legal Assessors as a result of resignations and retirement.

The Council:

- **Noted** and **Ratified** the Chair's actions to:
    - **Approve** the recommendation of the Appointments Board for the transfer of one Panel Member in Table 1 of Annexe 3 from the FtP Committee to the Investigating Committee (05/2026); and
    - **Accept** the recommendation of the Appointments Board for the removal of six Panel Members and two Legal Assessors set out in Table 2 of Annexe 3 (06/2026).

Closing remarks

On behalf of the Council and the Executive Board, the Chair expressed thanks to colleagues in Northern Ireland for their warm welcome and the interesting and informative health and care site visits which had provided valuable insight into healthcare provision in Northern Ireland.

The Chair thanked all attendees and observers for joining the meeting, noting that the next scheduled Open Council meeting would be on 25 November 2026.

Confirmed by the Council as a correct record:

SIGNATURE: .....

DATE: .....

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Janine	Compston	RCN Steward Belfast Health and Social Care Trust	
Foteini	Kourakou	Nurse Manager Town and Country Care Homes	
Carmel	McKeegan	Senior Inspector Regulation and Quality Improvement Authority (RQIA)	
Donna	Keenan	Executive Director of Nursing, Midwifery and AHPs Western Health and Social Care Trust	
Jessica	Scott	West Belfast General Practice Federation General Practice Nurse (GPN)	
Sarah-Joy	Hamilton	West Belfast General Practice Federation General Practice Nurse (GPN)	
Theresa	Morey	West Belfast General Practice Federation (Eastern Federation Support Unit) General Practice Nurse (GPN)	
Dale	Spence	Royal College of Midwives Director Royal College of Midwives NI	
Olga	O'Neill	Belfast Health and Social Care Trust Executive Director of Nursing	
Angela	McLernon	Eastern General Practice Federation Support Unit Director of Nursing	
Linda	Graham	Spa Nursing Home Group Regional Manager	
Chris	Wilkinson	Department of Health, Northern Ireland Head of Workforce Development	
Neal	Cook	Ulster University Professor of Nursing, Head of School	
Grace	Hamilton	Southern Health and Social Care Trust Executive Director of Nursing	
Caroline	Keown	Department of Health, Northern Ireland Chief Midwifery Officer	
Heather	Watson	Belfast Health and Social Care Trust Divisional Midwife and Head of Midwifery (Interim)	
Susanne	Thomas	Belfast Health and Social Care Trust Lead Midwife	
Laura	Stewart-Maunder	Belfast Health and Social Care Trust Lead Midwife	
Shirley	Stronge	Clinical Education Centre, Business Services Organisation Senior Education Manager	
Amy	Eakin	Public Health Agency Midwife Consultant	
Ann	Kerrin	Business Services Organisation Assistant Head HSC Clinical Education Centre	
Darren	McCabe	Quilter Financial Advisers Financial Adviser for HSC Pension	
David	Munday	Unite the Union Lead Professional Officer	
Anna	Harding	NHS England Regional Operations	
Carolyn	Donohoe	Nursing and Midwifery Board of Ireland	Chief Executive Officer
David	Robinson	South Eastern Health and Social Care Trust	Deputy Chief Executive
Paula	Matthews	North Down General Practice Federation	Mental Health Lead

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Niamh	Hardy	Down General Practice Federation	Advanced Nurse Practitioner (ANP)
Louise	Irvine	Ards General Practice Federation	General Practice Nurse (GPN)
Melissa	Strain	Down General Practice Federation	Trainee Advanced Nurse Practitioner (ANP)
Marian	Robertson	Southern General Practice Federation	Lead Nurse
Michelle	Knight	East Belfast General Practice Federation	Advanced Nurse Practitioner (ANP)
Jessica	Dyche	Southern General Practice Federation	General Practice Nurse (GPN)
Joanne	Maguire	Belfast Health and Social Care Trust	Advanced Nurse Practitioner (ANP)
Michelle	McErlean	East Belfast General Practice Federation	Advanced Nurse Practitioner (ANP)
Peter	Bates	NMCWatch Community Interest Company	Director
Jenni	Townsley	East Belfast General Practice Federation	Advanced Nurse Practitioner (ANP)
Corinne	Power	NHS England	Deputy Director of Nursing
Lynn	Long	Regulation and Quality Improvement Authority (RQIA)	Director
Amanda	Jackson	Regulation and Quality Improvement Authority (RQIA)	Assistant Director
Caroline	Hughes	General Practice Federation	General Practice Nurse (GPN)
Hazel	Walsh	Belfast Health and Social Care Trust	Bank Nurse Manager
Angela	Mooney	General Practice Federation	Advanced Nurse Practitioner (ANP)
Philip	Rodgers	Department of Health, Northern Ireland	Director of Workforce Policy
Anne	Spence	Northern Health and Social Care Trust	Revalidation and Workforce Facilitator
Yvonne	Eddis	Northern Health and Social Care Trust	Revalidation and Workforce Facilitator
Orla	Coady	Nursing and Midwifery Board of Ireland	Governance and Secretariat Manager
Ruth	Thompson	Royal College of Nursing	Associate Director
Sonia	Glendinning	Department of Health CNOG	Nursing Officer
Norman	Wylie	Springwell Renewable Energy Limited	Director
Mildred	Wylie	Springwell Renewable Energy Limited	Director
Barbara	Tate	Department of Health, Northern Ireland	Nursing Officer Learning Disability
Caroline	Riddell	Department of Health, Northern Ireland	Nursing Officer for Workforce
Colette	Higham	Professional Standards Authority	Scrutiny Officer
Jijo	Kavumkal Iype	North Down General Practice Federation	Senior Mental Health Practitioner
Katy	Rennick	Department of Health, Northern Ireland	Deputy Chief Nursing Officer
Codrina	Aioanei	Rose Lodge Care Home	Nurse Manager
Clara	Sogunro-Koko	MyHealthnet	Executive Nurse
Brenda Ann	Ckeland		
Claire	Johnston	Armagh and Dungannon General Practice Federation	General Practice Nurse (GPN)
Niall	McKenna	Queen's University Belfast	Senior Lecturer (Education)
Toluwalope	Aderibigbe	Belfast Health and Social Care Trust	Deputy Ward Sister
Roisin	Sheahan	South Eastern Health and Social Care Trust	Trainee Advanced Nurse Practitioner (ANP)
Alison	Smart		
MaryJo	Maxwell	South Eastern Health and Social Care Trust	Trainee Advanced Nurse Practitioner (ANP)
Angely	Alimbuyao	Healthcare Ireland	Staff Nurse

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Rebeca	Bamisile	Belfast Health and Social Care Trust	Staff Nurse
Caroline	Klisa	South Eastern Health and Social Care Trust	Staff Nurse
Romini	Joseph	Belfast Health and Social Care Trust	Registered Nurse Ward Manager
Oluwaseun	Mojeed	Electus Care Home	Staff Nurse
Eliz	Bannon	Queen's University Belfast	Senior Lecturer (Honorary)
Nasirudeen	Munirudeen	N & S Healthcare Consults Ltd	Registered Nurse
Eimear	Lawlor	Belfast Health and Social Care Trust	Staff Nurse
Niall	Mullan	Northern Health and Social Care Trust	Professional Lead
Clare Marie	Kearney	Northern Health and Social Care Trust	Clinical Nurse Specialist
Marian	Robertson	East Belfast General Practice Federation	Lead Nurse
Danielle	Small	Belfast Health and Social Care Trust	Staff Nurse / Nurse Bank
Thom	Hinds	Cedar Foundation	Deputy Manager, Registered Nurse
Roisin	Devlin	South Eastern Health and Social Care Trust	Assistant Director of Nursing
Theres	Srikanth	Belfast Health and Social Care Trust	Nursing Development Lead
Beena	Tharun	Belfast Health and Social Care Trust	Lead Nurse
Martina	Fay	Belfast Health and Social Care Trust	Community Psychiatric Nurse (CPN)
Maria	Loughran	Northern Health and Social Care Trust	Head of Nursing Workforce
Gill	Murphy	Northern Health and Social Care Trust	Executive Director of Nursing
Tracie	Fleming	Northern Health and Social Care Trust	Assistant Director of Nursing
Henry	Sproule	Ulster University	Lecturer in Nursing
Latoya	Toffa	Belfast Health and Social Care Trust	Senior Healthcare Assistant
Debi-Lee Aine	Lynch	Nursing and Midwifery Board of Ireland	President of Nursing and Midwifery Board of Irelan
Niamh	Mullan	Southern Health and Social Care Trust	Student Nurse (HCA)
Nicole	McPolin		
Vania	Santos	Ulster University	Student Nurse
Michelle	Lyne	Royal College of Midwives	Professional Advisor Education
Martha	Anyanta-Wilson	Ulster University	Student Mental Health Nurse
Stephanie	Foster Black	The Open University	Professional Lead for Nursing, OU NI
Zamuda	Namukuye	Ulster University	Student
Mary Frances	McManus	Department of Health, Northern Ireland	Deputy Chief Nursing Officer
Kerry	Bannister	West Belfast General Practice Federation	General Practice Nurse (GPN)
Caroline	Diamond	Northern Health and Social Care Trust	Assistant Director of Women's Health
Elaine	Colhoun	Down General Practice Federation	Advanced Nurse Practitioner (ANP)
Ashleigh	Smyth	Ards General Practice Federation	General Practice Nurse (GPN)
Kirsty	Honeyford	East Belfast General Practice Federation	Advanced Nurse Practitioner (ANP)
Sandra	McKimm	General Practice Federation	Advanced Nurse Practitioner (ANP)
Kim	Tait	General Practice Federation	General Practice Nurse (GPN)
Maureen	McVeigh	Belfast Health and Social Care Trust	Clinical Nurse Specialist
Mairead	Donnelly	Southern Health and Social Care Trust	Assistant Director Specialist Child Health & Disab
Ignatius	Mazibuko	Lucas Love Healthcare	Registered Nurse
Ciara	Millar	Belfast Health and Social Care Trust	Bone Bank Co-ordinator
Michelle	McGrath	The Open University	Student Nurse

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Roisin	Curran	Marie Curie	Clinical Nurse Specialist
Janine	Stockdale	Queen's University Belfast	Lead Midwife for Education
Meabh	Lewsley	Queen's University Belfast	Student Midwife
Chloe	Higgins	Queen's University Belfast	Student Midwife
Emma	Cruikshank	Queen's University Belfast	Student Midwife
Raluca	Dubei	Queen's University Belfast	Student Midwife
Siobhan	Johnston	The Open University	Staff Tutor
Megan	Harper	Ulster University	Student Nurse
Danielle	Gallagher	Ulster University	Student Mental Health Nurse
Karen	Devenney	Department of Health, Northern Ireland	Nursing Officer, Primary Care & Older People
Olga	Bruijniks	Queen's University Belfast	Student Midwife
Ethel	Rodrigues	Unite the Union	Lead Professional Officer
Josephine	Todd	Healthcare Ireland	Staff Nurse
Rodney	Morton	Regulation and Quality Improvement Authority (RQIA)	Authority Member, Non-Executive Director (Nursing)
Sharon	Burnside	Chief Nursing Officer Group (CNOG) Department of Health, Northern Ireland	Nursing Officer Education and Regulation
Alex	Garrett	Queen's University Belfast	Student Midwife
Tam	Koko	MyHealthnet	ICT and HR Manager
Jessica	Sharp	Belfast Health and Social Care Trust	Student Nurse
Sarah	Gallagher	DoH	CNOG Group Policy Team
Claire	Faulkner	Chief Nursing Officer Group, Department of Health NI	Deputy Principal Civil Servant
Oluwaseun	Mojeed	Electus healthcare	Registered Nurse

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Annexe B: Observer questions

Mildred Wylie

Question:

Panel Retraining and Legal Competence: *In light of the severe legal and procedural errors identified by Mr Justice O'Hara in my case, what immediate quality-assurance steps is the Council taking to ensure Fitness to Practise (FtP) panels understand fundamental legal standards?*

Response:

The NMC accepts the High Court's judgment and is sorry for the irregularities in this case.

The NMC takes the quality, consistency and legal robustness of decision-making within its fitness to practise processes extremely seriously. We are reviewing and learning from the findings and taking action to strengthen and improve our processes. The findings in Mrs Wylie's case have reinforced the importance of ensuring that panels have access to appropriate legal expertise and that all panel members are held to consistently high standards.

We are appointing legally qualified chairs to chair the majority of NMC fitness to practise hearings and provide legal advice to panels. Their legal expertise and case management experience will strengthen the consistency and quality of hearings, particularly where cases involve complex legal issues or require proactive case management.

This is just one of a number of changes being introduced to strengthen quality assurance and make the process fairer and more robust and to continue to maintain public protection.

Mrs Wylie was referred to us in 2013 and struck off in 2024. This reflects a very difficult period in the NMC's history and we offer our sincere apologies to Mrs Wylie.

Bradley Dawson

Question:

Staffing and management within Fitness to Practise

Given the continuing growth of the Fitness to Practise caseload and the NMC's acknowledgement to external oversight bodies of recruitment and capacity pressures, what assurance can Council provide that current staffing levels, experience and retention within Fitness to Practise are sufficient to deliver timely and consistently high-quality regulatory decisions, and what workforce modelling supports that assurance?

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Response:

The Council receives regular updates and assurance regarding the performance, capacity and ongoing improvement of the Fitness to Practise function. Ensuring that the NMC has the capability and capacity to deliver timely, proportionate and high-quality regulatory decisions remains a key area of focus.

As part of our FtP improvement programme, we are working with a partner to develop new ways of working that will enable us to create a more sustainable operating model that results in more timely and high quality decisions. We are currently piloting pathways which ensure we take more targeted and proportionate investigative approaches that reduce rework and avoid delays in case progression. A key component of this work is also ensuring we are using our current resources in the right way to ensure timely and safe case progression.

We are using a workforce modelling expert to review our current staffing levels alongside our current and projected case load and that, together with the evaluation of our new ways of working project, will create a robust workforce model for our current and future state.

Through this work, the NMC aims to ensure that its workforce planning is evidence-based, aligned to current and future demand, and supports the delivery of effective, proportionate and high-quality fitness to practise decisions.

Dr Penelope Ballinger

Question:

What safeguards does the NMC have to identify and address fitness-to-practise referrals that may be retaliatory in nature and arise from a registrant raising concerns about patient safety, staffing, or standards of care?

Response:

The NMC recognises that concerns may be raised in a variety of circumstances and that the context surrounding a referral may be relevant when considering how a case should proceed.

However, the NMC's statutory role is to assess whether there are concerns about a registrant's fitness to practise and whether there is any associated risk to the public.

Our role is to consider whether a registrant is fit to practise. We have to consider and weigh the evidence, regardless of whether the intention of the referrer was vexatious. That might be a contextual factor that is relevant to the decision about whether the referral should proceed, but we still have a duty to assess the risk to the public and to assess the evidence.

We are currently reviewing our guidance library to see whether this point could be clearer.

Whistleblowers have statutory protections against suffering a detriment as a result of whistleblowing.

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The NMC seeks to ensure that fitness to practise decisions are based on an assessment of the available evidence and the relevant context of each case, while continuing to review and improve its guidance where appropriate.

David Munday, Lead Professional Officer, Unite the Union

Question:

In the recent consultation on proposals to change nursing and midwifery practice learning education standards the NMC correctly identified the disparity faced by black and Asian women, and their babies, and made proposals to address this by increasing the length of midwifery programmes.

Why didn't the consultation address other significant health disparities that face people being cared for by adult, child and learning disability registered nurses, for example: Mental Health Act detention rates "for 'Black or Black British' people is four times those of White people"?

And how will these disparities be addressed by cutting registered nursing courses by 22%?

Response:

The purpose of the practice learning review consultation was to seek views around the quality of practice placements and to engage with our partners and stakeholders about what they want to see in the updated education and training standards, to inform any final proposed changes. The consultation had an incredible 6,000 responses.

The Council will now be making a decision on what steps to take forward following analysis of the consultation outcome.

Regarding EDI, we looked particularly at the issue of racism in midwifery and nursing ensuring consistency with our anti-racism principles. Sadly, Black women are two times more likely to die in childbirth and Asian women 1.5 times more likely. These statistics are a main driver for the NMC and we fully intend to continue to explore issues of health inequality on an ongoing basis and do more to help tackle these very serious issues.

Mary Frances McManus, Deputy Chief Nursing Officer, Northern Ireland

Comment:

The NMC is the regulator for all four of the UK nations and it has been a pleasure to welcome the NMC's Council and Executive Board and to be able to showcase the work of registrants in Northern Ireland.

Response:

The Chief Executive and Registrar (CER) thanked Mary Frances and colleagues from the DoH and commented that it had been a privilege for Council members and Executive Directors to participate in the healthcare site visits and the Primary and Community Care Seminar. The moving presentation from Brendan and his mother Margaret had demonstrated the challenges faced by being differently

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abled. The issue of delegation had been a block to this family being able to ensure the appropriate care to enable Brendan to lead a more independent life and for his mother, who provides care 24/7, to be able to enjoy some respite. The Code needed to be updated and the NMC needed to address the matter of delegation to help service users like Brendan and his mother.

The CER encouraged registrants and stakeholders to participate in the proposals within the Code consultation.

Lady Clara Sogunro-Koko, MyHealthnet Youth Health Service and the Lagos State Schools of Nursing and Midwifery Alumni International Association (LSSNMAIA)

Question:

Given the PSA findings, what governance, safeguarding, and data-protection standards would the NMC require before formally recognising and signposting nurses to LSSNMAIA? With the PSA's call for improvement, LSSNMAIA is committed to being part of the solution and wishes to collaborate constructively to support internationally educated nurses and strengthen regulatory confidence

Response (provided outside the meeting by email)
We recognise the important role that professional associations and diaspora-led organisations play in providing pastoral, professional and wellbeing support to nursing and midwifery professionals, and in helping us better understand the experiences and challenges they may face.

We are currently reviewing our approach for signposting registrants involved in our regulatory processes to other external organisations for support, including those who may be involved in our Fitness to Practise (FtP) proceedings. This work will help us develop a clear and consistent organisational approach to the organisations we signpost to, the nature of the support they provide and the information we make available to registrants.
In the meantime, we would welcome connecting Lady Clara Sogunro-Koko, representing the LSSNMAIA, with our established Diaspora Registrant Associations Forum (DRAF), which brings together representatives from diaspora nursing and midwifery associations to strengthen engagement, share experiences and raise awareness of the issues affecting internationally educated professionals.

We will follow up with Lady Clara Sogunro-Koko directly to provide further information about the Forum and our wider work.

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Item 5
NMC/26/233
25 November 2026

Report to:	Open Council	Meeting Date:	25 November 2026 2026

Summary of Actions	
Publication Status	Open
Presenting the Report	Jacqui Maunder, Secretary to the Council
Executive Director	Ben Wesson, Chief of Staff
Report Author	Jacqui Maunder, Secretary to the Council

PURPOSE OF REPORT AND REASON FOR RECOMMENDATIONS:

The purpose of this report is to provide an update on progress against actions from previous Council meetings.

RECOMMENDATION:

The Council is asked to:

- **Note** the report.

ANNEXES:

None

REPORT APPROVAL [mandatory for all Council/Committee Reports]	
Executive Director: Insert Name	N/A
Director of Finance:	N/A
General Counsel:	N/A
Chief Executive and Registrar (CER):	N/A

Secretary to the Council:	**Approved** 18 November 2026

External Engagement (undertaken to date		
Committee / Group	Date	Outcome
N/A		

Consideration at Committee/Group		
Committee / Group	Date	Outcome
N/A		

Nursing & Midwifery Council

Council Action Log

For Meeting 25 November 2026

Minute Ref	Minute Ref and Action	Owner	Due date	Progress	Status
26 March 2025					
NMC/25/23 (26 March 2025) And **NMC/25/56 (2 July 2025)**	**Safeguarding update** **Action:** Provide a report setting out the approach to Council member champion and lead roles. **NMC/25/56 Summary of actions** **Action:** At the meeting on 2 July 2025, it was agreed that Council members would have an opportunity to input to the report, before it was submitted to Open Council in September 2025.	Secretary to the Council	27 January 2027	**16.11.2026** – Not yet due. Council member role descriptions are being reviewed as part of the Independent panel reviewing members remuneration, expenses and time commitment.	**IN PROGRESS**
2 July 2025					
NMC/25/60	**Draft Annual Fitness to Practise Report 2024-2025** **Action:** Arrange a Council Seminar to present the different processes and	Secretary to the Council/Executive Director, Professional Regulation	23 February 2027	**16.11.2026** - Not yet due. A Council Seminar session on the different processes and stages of FtP and the support	**IN PROGRESS**

Minute Ref	Minute Ref and Action	Owner	Due date	Progress	Status
	stages of the FtP and the support mechanisms available.			mechanisms available is on the forward plan for the Council Seminar February 2027	
23 July 2025					
NMC/25/74 And **NMC/25/86**	**Quarterly corporate performance report** **Action:** Following the Health Foundations review, consider whether to review the factors relating to the increase in the number of internationally educated professionals providing supporting information from employers as part of their application to join the register for the first time.	Executive Director, Strategy and Insight	24 March 2027	**16.11.2026** – not yet due We have commissioned a light-touch evaluation of Supporting Information for Employers (SIFE). Scoping is underway and external engagement is due to **commence in October 2026.** We continue to monitor our FtP referrals but do not have any evidence at the moment to suggest that the use of SIFE (Supporting Information from Employers) is having a negative impact on public protection.	**IN PROGRESS**
24 September 2025					
NMC/25/90 *Linked to action*	**Quarterly corporate performance report** **Action:** Present updates about log and learn rates of engagement and trends to	Interim Executive Director, Transformation and Technology Services	21 October 2026	**16.11.2026** –. Item on the agenda for Confidential Council 21 October 2026. Action Completed	**COMPLETED**

Minute Ref	Minute Ref and Action	Owner	Due date	Progress	Status
NMC/25/112 (a)	both Confidential Council and the Audit and Risk Committee from the end of Q3 2025-2026.				
NMC/25/90 Linked to NMC/25/116 **NMC/25/116**	**Quarterly corporate performance report** **Action:** Relating to the EDI learning suite, involve the Council and incorporate EDI into its learning and development plan, as well as to consider ways the Council could promote and role model this work. **EDI Workshop plan for Council** **Action:** Review the aims and proposals for previous Council EDI development sessions in April/July 2025, as well as the comments raised at the meeting, to inform the further development of the next Council EDI workshop.	Secretary to the Council	September/ October 2026	**16.11.2026** - a Council EDI development session took place on 20 October 2026. Further sessions are planned for 2027 and invites have been issued. Action Completed	**COMPLETED**

Minute Ref	Minute Ref and Action	Owner	Due date	Progress	Status
26 November 2025					
NMC/25/111 (b)	**Executive Report** **Action:** Provide the Council with an update regarding the regulation of Nursing Associates in Wales in the new year	Executive Director, Strategy and Insight	Dec 2026	**16.11.2026 – there is no** update on the timetable from the Department of Health and Social Care (DHSC) as yet.	**IN PROGRESS**
NMC/25/112 (a)	**Quarterly corporate performance report** **Action:** A paper with the first findings from the new Log and Learn system would be presented to the Council in early 2026. *Linked to action NMC/25/90.*	Chief of Staff	23 February 2026	**16.11.2026** - Not yet due. Update for the Confidential Council meeting 23 February 2026	**IN PROGRESS**
NMC/25/112 (c)	**Action:** Present work relating to the review of the quality framework for the FtP process to the Council in May 2026.	Executive Director, Professional Regulation	21 October 2026	**16.11.2026 –** this was an agenda item at the Council Seminar on 21 October 2026. Action completed.	**COMPLETED**
25 March 2026					
NMC/26/143	**Executive Report** **Action**: Consideration to be given to how a system of payment for support could work for the Diaspora	Executive Director, People and Culture	23 September 2026	**16.11.2026 –** A verbal update was provided at the Open Council meeting. Action completed.	**COMPLETED**

Minute Ref	Minute Ref and Action	Owner	Due date	Progress	Status
	Registrant Association Forum (DRAF).				
NMC/26/147	**Quarterly Safeguarding update (Q3) and Safeguarding Policy** **Action:** Further information on KPIs regarding outcomes and impact to be provided in future reports	Executive Director, Professional Practice	25 November 2026	**16.11.2026 –** Item on the agenda.	**IN PROGRESS**
01 July 2026					
NMC/26/188	**Draft Fitness to Practise Annual report 2025-2026** **Action:** Provide further detail for the 'any other informant' category in the autumn Insight report	Executive Director, Strategy and Insight	January 2027	**16.11.2026** – not yet due. Next Insights report due end of Q3 (December 2026)	**IN PROGRESS**
23 September 2026					
NMC/26/219	**Midwifery update and strategy launch** **Action:** Provide updates on the Registrant workplan to the Council	Executive Director, Professional Practice	27 January 2027	**16.11.2026 –** not yet due.	**IN PROGRESS**

Minute Ref	Minute Ref and Action	Owner	Due date	Progress	Status
	NMC/26/221 **Historical Reviews update** **Action:** Review and amend action 24 to clarify the difference between Council Raising Concerns leads and Council Empowered to Speak Up (ETSU) leads	Chief of Staff	25 November 2026	**16.11.2026** – action completed.	**COMPLETED**

Key	
	Actions categorised as completed.
	Actions in progress.
	Actions in progress, with unplanned delay to the work (i.e. completion date rescheduled).

Report to:	Open Council	Meeting Date:	25 November 2026

Quarterly Performance Report - Q2 2026/27

Publication Status	Open
Presenting the Report	Ben Wesson, Chief of Staff
Executive Director	Ben Wesson, Chief of Staff
Report Author	Rebecca Desmond, Head of Corporate Planning, Performance and Risk

PURPOSE OF REPORT AND REASON FOR RECOMMENDATIONS:

The purpose of this report is to present the Quarter 2 2026/27 (July to September 2026) quarterly performance report to the Council, outlining performance against our Business Plan 2026-2027.

Our performance data informs recommendations on how we can build on success, improve performance, and effectively manage risks to achieve our strategic priorities.

At this mid-year point, we also reflect on our progress towards the priority outcomes set out in our 2025-2027 strategy, where data is available.

Annexes:

- **Annexe 1**: Business Plan progress report
- **Annexe 2**: Corporate KPIs
- **Annexe 3:** Fitness to Practise performance dashboard September 2026
- **Annexe 4:** Fitness to Practise caseload breakdown (by country and profession)

RECOMMENDATION(S):

The Council is asked to:

- **Note** the report; and
- **Discuss** the performance and progress against the Business Plan 2026-2027, consider the areas of strategic challenge highlighted within the report, and provide feedback and direction to the Executive Board.

REPORT APPROVAL	
Executive Director:	**Approved** Date 16 November 2026
Director of Finance:	10 November 2026
General Counsel:	10 November 2026
Chief Executive and Registrar (CER):	10 November 2026
Secretary to the Council:	**Approved** 10 November 2026

External Engagement (undertaken to date)

Committee / Group	Date	Outcome
N/A		

Consideration at Committee/Group

Committee / Group	Date	Outcome
Executive Board	10 November 2026	Review and discuss the report.
Planning and Performance Committee	12 November 2026	Review and discuss the report. Recommendations for Council.

Quarterly Performance Report - Q2 2026/27

1. SITUATION / BACKGROUND

1.1. The purpose of this report is to present the Quarter 2 2026/27 (July to September 2026) quarterly performance report, outlining performance against our Business Plan 2026-2027.

1.2. Our performance data informs recommendations on how we can build on success, improve performance, and effectively manage risks to achieve our strategic priorities.

1.3. At this mid-year point, we also reflect on our progress towards the priority outcomes set out in our 2025-2027 strategy, where data is available. The report considers whether delivery of key initiatives is on track and whether intended outcomes are likely to be achieved.

1.4. It also highlights key barriers to delivery, along with actions to ensure delivery remains on track or gets back on track, and that any risks are mitigated.

1.5. Deliverables are assessed by the progress made against targets and due dates to give a confidence assessment (see key in ***Annexe 1***).

1.6. In ***Annexe 2***, we include both contextual measures (such as caseload volumes) to monitor trends and KPIs we measure against clear targets. This is to provide a more robust picture of our performance against any external factors that may influence it.

1.7. ***Annexes 3 and 4*** provide greater detail on our work within Fitness to Practise (FtP).

1.7.1. As part of our mid-year review, a light-touch assessment of progress against our strategy and our priority outcomes has been included, so that we can reflect on both our achievements in terms of delivery and the impact that activity has had thus far. A strategy measurement framework was agreed with the Executive Board in October 2026, blending performance and insight data to provide a rounded assessment against the outcomes we set out to achieve. Data was not available for all the measures within the framework at this mid-year point, so those measures could not be included. Where possible, we have highlighted where progress against our priority outcomes can be evidenced. A full end-of-strategy evaluation will be carried out after March 2027, using additional data such as the latest annual performance review report on the NMC's compliance with the Standards of Good Regulation from the Professional Standards Authority (PSA), the Your Voice staff survey results and a range of external perceptions data looking at FtP user experience, public trust and the sentiment of our professions.

1.8. The Planning and Performance Committee reviewed this report ahead of Council. The Committee endorsed the report, making the following observations:

1.8.1. The volume of deliverables rated as 'on track' is very encouraging; however, there is a clear disparity between delivery and the impact we

hope to see, as our performance against KPIs is 'off track'. It was discussed that such performance concerns would usually trigger a review of whether the deliverables are appropriate or effective, having not yet made the impact they aimed to; but it was accepted that it was not an issue of 'what' we need to do, but rather 'when' we will see positive change. The nature of the transformation programme means that there is significant change that needs to be embedded before any benefits will be realised. It is therefore important not to adjust the plan too early but to allow time for these changes to take hold. Greater work is being done within our operational teams to realistically map when improvements will be seen in our performance data. The Committee recommended that more regular formal reviews of performance are carried out by the Chief Executive and Registrar (CER) to ensure that any decision to refocus our resources is timely. Also, on the topic of KPIs, the Committee welcomed the annual review of our performance measures and KPIs, which will evolve as part of the business planning process and identification of new deliverables and objectives.

2. Quarterly Performance Report - Q2 2026/27 (July – September 2026)

2.1. Our overall Q2 performance assessment provides **reasonable assurance that delivery of the 2026–2027 Business Plan is on track**.

2.2. At Q2, the delivery of the 2026/2027 Business Plan is progressing, but delays and operational pressures mean that the overall position is mixed. Of the 90 deliverables, 20 are complete and 40 are on track. 13 of the 29 deliverables due by the end of Q2 were completed. Five deliverables are marked as 'not started' and 25 deliverables are of moderate concern due to delays. These exceptions have been highlighted in the priority narratives below.

2.3. Across the five strategic priorities there are focused plans in place to address the major performance concerns (i.e. the Culture Transformation Plan (CTP) and the FtP Improvement Plan). Improvement work is progressing, but has yet to deliver sustained improvements in key areas of service performance, particularly in FtP.

2.4. Reviewing the strategy alongside the business plan at the mid-point helps identify areas where progress may be off track and assess whether corrective action or additional resources are needed. Key challenges include:

2.4.1. **Education Quality Assurance (EdQA) (priority 1: Ensuring Trust in Professionals)**: The NMC has launched a comprehensive improvement plan to overhaul and modernise its EdQA framework. This overhaul moves the regulator away from a historical overreliance on institution self-reporting to a much more proactive, interventionist approach to monitoring nursing, midwifery, and nursing associate training across the UK. This shift directly addresses major criticisms from the PSA, which flagged EdQA as a high-risk area following failures at individual providers (such as Southampton Solent and Canterbury Christ Church University).

2.4.2. **FtP (priority 2: Improving FtP)**: The data shows the scale of work needed to get to an efficient, consistent, fair service at scale, in the face of historically high caseloads. Work is in hand to reduce inappropriate referrals, especially Equality, Diversity and Inclusion (EDI) disproportionate referrals, and to implement new ways of working to boost efficiency**.**

2.4.3. We have taken positive steps over the reporting period:

2.4.3.1. Proactive monitoring started in August, including visits to institutions and thematic monitoring of concerns. Our initial focus is on identifying themes related to EDI.

2.4.3.2. A dedicated concerns function has also been established, developing the risk-based approach tested on live cases. Recruitment to the new roles is under way.

2.4.3.3. A new risk model for concerns is due in draft by December 2026, with refreshed policy and processes.

2.4.3.4. The PSA has since recognised we have taken significant steps across the NMC to improve and respond to their concerns.

2.4.4. **Being a learning organisation (priority 5: Modernising the NMC)**: We are committed to strengthening how we share knowledge, learning and improvements across the NMC. This requires a cultural shift towards continuous improvement. With the executive-chaired Learning Actions Board (LAB) established, and the Log and Learn process and supporting tools and policies in place, our focus can now turn to embedding learning in everyday practice. This will help reduce recurring issues and build the capabilities needed to become a high-performing organisation.

2.4.5. Based on the strategy measurement framework, which collates data across performance KPIs and the status of deliverables within the business plan, **partial assurance can be taken regarding the successful delivery of our strategy** at this interim point. This reflects the current PSA report findings, long-standing challenges in FtP and around EDI, and limited data to support changes in perceptions amongst colleagues, professionals and the public (who are the focus of the priority outcomes). Performance data highlights the ongoing challenges within our core regulatory functions, which ultimately determine the experiences of those within our processes or those who receive care from our professionals. The better we deliver as a regulator, the better the outcomes for those we serve.

2.4.6. The evidence currently available provides greater assurance about activity under way than about achievement of strategic outcomes. Our ability to comprehensively assess our strategy's impact will be strengthened for the end-of-strategy evaluation, when a greater amount and variety of data is available.

2.4.7. The priority for the remainder of the year is to continue to deliver improvement activity and embed changes, so that we will start to see demonstrable improvements across our services in terms of timeliness, quality and people's experiences from 2027-28 onwards.

2.4.8. The Executive Board will consider this mid-year review to inform any strategic changes required over the remainder of this year, to drive performance and move closer to our desired outcomes by year end. The review will consider whether current recovery plans, resources and expected benefits are sufficient, recognising that some benefits will arise after March 2027. This will also inform the activity that will be carried forward into the 2027-28 Business Plan.

3. Priority 1 – Ensuring trust in professionals

3.1.1. **Q2 overview:** Overall delivery against this priority is strong, with the majority of activities being on track or completed. Those that are off track, such as our consultations and registration hearings, are justified below and pose low concern. The PSA has previously criticised our work in EdQA, so it is positive that delivery of improvement work regarding our regulatory approach and operations is progressing well. The outcomes sought in this priority are difficult to quantify at this point, so delivery can be considered as a proxy metric. Delivering initiatives that will enhance the experience and competence of our professionals during their career lifespan should ultimately improve the experience for the public and build trust. Delivery of our Professional Practice roadmap (including Advanced Practice, Practice Learning, Code and Revalidation reviews) drives that positive outcome. With activity progressing largely as planned, some confidence can be taken that the desired outcome will be achieved as a result.

3.1.2. The Strategy 2025-2027 runs until 31 March 2027. Thereafter, the Strategy and Insight directorate will issue a public perception and trust survey to better evaluate and evidence sentiment for this priority outcome.

3.2. Specific deliverables by exception

3.2.1. Completion of UK Registrations cases with concerns: This has recovered since Q1, now at 88 percent (target 90 percent). Similarly, the percentage of applications closed/Assistant Registrar decided within 90 days is also climbing toward the statutory time limit target, now at 94 percent.

3.2.2. Computer-based testing (CBT) registration appeals: The volume has increased significantly from 28 to 41 cases, also resulting in the median age rising from 96 to 104 weeks. This is due to poor quality, repeat applications. Appellants are reminded to only resubmit appeals once all information is included that could change our decision.

3.2.3. Incorrect and fraudulent entry (IE/FE) cases: The team is targeting both aged casework (received in 2024 and earlier) and more recent casework (received in 2025 and 2026) to ensure that any risks to the integrity of the

register are managed. This has included screening reviews of cases to close off any where no regulatory action is required. 23 of the aged caseload (2024 or earlier), and 56 of the more recent caseload (2025-2026), have been resolved this year so far. This reflects effective risk management and demonstrates the impact of the improvements which are being made in Registrations and Revalidation to reduce aged casework and improve management of new cases.

3.2.4. Safeguarding mailbox and hub enquiries actioned within five working days: The percentage has decreased over the past three months, now at 80 percent (target 100 percent). The team anticipated reduced performance as their capacity has been affected by long-term sickness, leaving them unable to keep pace with the volume of referrals. High-risk cases were still responded to as a priority, despite reduced capacity. The team plan to submit a business case to recruit an additional Safeguarding Advisor to address this.

3.2.5. Develop standards for Advanced Practice for public consultation: In Q2, the timeline for developing the standards was changed so that we are now working toward an October 2027 delivery of the standards, instead of in 2028. We had a moderate concern in Q2 while we scoped a new timeline for this. However, recent progress has been made based on the new timeline.

3.2.6. Deliver a registrant survey to inform standards development: It was agreed in September that we would not do a survey at this time but would engage with the sector through other means. This was also in part to ensure we are aligned to wider NMC strategic objectives and the need for pragmatic, targeted stakeholder engagement. This activity has therefore been marked as ‘not started’ as it is no longer required.

3.2.7. Refresh of the Code and review of our revalidation process: The separation of these reviews was to enable the Revalidation review to take account of any relevant recommendations from the Thirlwall inquiry and additional stakeholder feedback before consulting. Scheduling the Code consultation launch for the end of November has also enabled strategic stakeholders to engage in greater depth with the draft Code and consultation materials; this opportunity to engage has been well received.

3.2.8. International Registration Policy: The discovery work did not support a wide-ranging review of the policy and process, but we did identify some improvement actions which will be taken forward as a result of this work. The activity is marked as ‘not started’ to reflect that this will not be continuing.

3.2.9. Midwifery: The NMC recently launched its Midwifery Regulation Strategy 2026-2030, which sets out how the NMC will strengthen midwifery regulation – with a focus on learning from national maternity reviews, supporting midwifery education to ensure newly registered professionals are equipped with the right knowledge and skills, identifying risks to

people's safety earlier, and listening to women and families. The NMC is committed to making midwifery regulation safer, more equitable, anti-racist and trusted, guided by five strategic priorities. The strategy has been praised for prioritising earlier action and responding to racial disparities in maternity services.

4. Priority 2 - Improving Fitness to Practise

4.1. Performance metrics are detailed within the FtP performance dashboard presented at ***Annexe 3*** and the FtP caseload breakdown (by profession and country) presented at ***Annexe 4***.

4.2. **Q2 overview:** The FtP case backlog remains a significant challenge. Considerable work is underway to improve delivery, although sustained high levels of referrals continue to affect our ability to progress cases. Our mid-point strategy assessment draws on performance against PSA standards 3 (EDI) and 15 (timeliness), alongside our FtP operational data. We did not meet these standards, reflecting the age of our caseload and disparities in our processes, although the PSA acknowledged progress. Performance data (see ***Annexe 2***) illustrates the scale and complexity of the challenges we are working to address within the FtP process:

4.2.1. **FtP caseload** continues to rise, up an additional 565 cases compared to Q1, with cases increasing across all stages of the process.

4.2.2. The **percentage of cases closed within 15 months** (rolling average) fell across the last three quarters (now at 72 percent, target 80 percent), but the **number of decisions/progressions** is up across all stages apart from Adjudications (which fell slightly).

4.2.3. **FtP median age of caseload** has risen across all stages.

4.2.4. **Interim orders imposed within 28 days** continue to fall, now at 60 percent (target 80 percent).

4.3. Demand remains higher than the available operational capacity. This means that challenges continue in processing concerns throughout the FtP casework pipeline, and that queues and backlogs continue across FtP. In September 2026, we saw the volume of decisions increase compared to previous months and expect this trend to continue as recruited decision makers at Screening and Case Examiners begin to have a positive impact. We saw the average number of referrals increase again, and expect this trend to continue. We expect to exceed a caseload of 8,500 cases by year end.

4.4. The Executive Board considered the workforce modelling (the baseline model and the model overlaid with transformation benefits) at their meeting in October 2026. The next steps are to confirm the expected budget profiling for 2027-2028 and beyond to balance both corporate affordability and FtP recovery expectations.

4.5. Five significant benefit areas were recommended as priority efficiency improvement areas. These were reducing the length of hearings, more meetings and fewer full hearings, consistency in closures at Case Examiners, Compass (new case management system), and implementation of Legally Qualified Chairs. Realising benefits from the FtP transformation initiatives remains our targeted response to improve capacity.

4.6. Delivery of the FtP Improvement Programme continues to make good progress in responding to the challenges. As set out in Annexe 1, the programme has delivered against a substantial portfolio of improvements during the year, with delivery performance remaining strong overall, and delivery of projects continuing into 2027-28 is well-planned. Whilst some initiatives have encountered challenges or required adjustment to timescales as learning has emerged, overall programme delivery remains positive and aligned to needs. We would not expect to see immediate impacts on caseload volume or age, as many improvements require time to embed within business processes before their benefits can be fully realised, measured and evidenced.

4.7. **Specific deliverables by exception**

4.7.1. New ways of working (NWOW) and progression of 350 cases: This risk has now reduced due to successful mitigation activities, including extending the delivery partner contract by two weeks, with enhanced management information on progress forecasts vs actuals. Progress will continue to be monitored, alongside business readiness for change, aiming to return the project to GREEN status shortly. The design element of the NWOW project continues to progress well, with casework pathway designs progressing through final governance approval.

4.7.2. Quality assurance framework: Tactical projects are underway to implement quality thresholds and checklists, while moving towards the goal of a Quality Management System (QMS). The revised threshold will ensure that we receive appropriate and better-quality referrals and process these through Screening more effectively and promptly. This was marked off track as rollout was delayed to enable additional engagement and piloting. The final design for the Quality Thresholds Process has been agreed, with representative bodies engaged on the revised approach. We are aiming for completion of the full rollout and embedding of the quality checklist in January 2027.

4.7.3. Customer contact process: A Customer Contact Standard Operating Procedure (SOP) has been rolled out across teams on cases that are actively being managed. The revised SOP and supporting case-weighting tool will support consistent communication with case parties and monitor process compliance. The new approach includes a minimum three-monthly update requirement for active cases, improving transparency and customer experience. Separate work will focus on developing a practical and proportionate approach to customer contact and continuous risk assessment for aged and unallocated cases. This seeks to balance regulatory

responsibilities and customer expectations, with operational capacity and deliverability. Discussions are underway with Heads in FtP on how best to address this.

4.7.4. Case management system upgrade: Stage 1 user acceptance testing was undertaken in October 2026, focused on the design and usability of the new system, with work expected to be completed by the end of 2026. While the original high-level plan anticipated completion of both development and testing by this date, the complexity of the build and the later delivery of some features have resulted in testing being extended to 2027. Work to finalise the rollout approach is ongoing and, subject to successful testing outcomes, the programme is expected to be ready for implementation in April/May 2027. This revised timeline reflects a focus on ensuring the solution is fully tested and operationally ready before deployment. When implemented in 2027, we expect improved casework workflow, reduced hand-offs, and improved quality. Rollout is on track from Q1 2027/2028.

4.7.5. Leadership development: We will be procuring a partner to coach FtP teams on 'Operational Excellence' to drive consistency and performance management techniques. Our aim is to get maximum value for money by aligning the rollout of Operational Excellence coaching with the second phase of the rollout of our new Case Management System, Compass, to a wider range of FtP colleagues, to support adoption of new ways of working. The exact timing of the rollout is to be confirmed, but we are aiming to be in a position to procure a partner by mid-2027.

5. Priority 3 - Culture transformation

5.1. **Q2 overview:** Sustained and embedded culture change is complex and takes time, but from the information assessed we are moving in the right direction. The strategy mid-point assessment is based on the Culture Maturity Model (CMM) assessment and feedback from the Independent Oversight Group (IOG).

5.2. The Culture Transformation Plan continues to roll out across the NMC as our driving force for positive change. Progress is assessed against the CMM assessment at directorate level, which found all directorates to still be graded at the 'initiating' stage, as in Q1.

5.3. **Specific deliverables by exception**

5.3.1. Culture Maturity Model (CMM): A substantial number of initiatives have been undertaken to improve our internal culture and environment for colleagues. Our current self-assessment suggests that we will not reach the target level of 'leading' by the end of this financial year, but by the end of the CTP in 2028. It was an ambitious target, considering our baseline and the significant volume of change the organisation is implementing. We are confident our approach to improving our culture is enabling us to make steady progress through the stages of the maturity model.

5.3.2. Fairness at work policy: The Fairness at Work policy has evolved to become the “Dignity at Work” policy, and covers all bullying, harassment and discrimination related to the nine protected characteristics under the Equality Act 2010. An update is in draft, which includes steps the NMC will take to prevent harassment. The draft is currently under review by EDI colleagues and will then be shared with UNISON for comment.

6. Priority 4 - Strengthening leadership

6.1. **Q2 overview:** The strategy mid-point assessment is based on overall PSA commentary on being an effective and trusted regulator and HR data on representation and pay gaps. The NMC met 9 out of 18 Standards of Good Regulation in the PSA performance review. The PSA acknowledged that 2025 was a very challenging year for the NMC, as it continued to address the significant concerns identified in the Independent Culture Review (ICR), published in July 2024.

6.2. The PSA made recommendations in areas where the NMC has made progress over the past year – but still has work to do to assure the PSA of sustained improvement, meaning that the NMC met only nine of the PSA’s 18 Standards of Good Regulation for 2025. The NMC is committed to implementing the recommendations in the report.

6.3. During the PSA reporting period, the regulator transitioned to new leadership – Ron Barclay-Smith took up his role as Chair in April 2025, and Paul Rees MBE became the substantive CER in July 2025, having previously been the interim CER. A virtually new executive team was also appointed during 2025.

6.4. Under new leadership last year, the NMC rolled out a three-year transformation plan, designed to ensure that improvements in the regulator’s culture and operational performance progress at pace. This sat alongside the FtP Plan, which is steadily working towards a faster, fairer process.

6.5. As part of the transformation plan, the NMC launched a new set of values – Integrity, Fairness, Respect, Equity and Effectiveness – as well as a new set of behaviours. Under the new value of Integrity, and the speak-up culture being embedded at the NMC, a staff member came forward to raise concerns about a historical failure of the regulator’s registration process.

6.6. Since the PSA’s 2024-25 performance review report was published in May, we have engaged with colleagues across the NMC to develop a PSA Improvement Plan, which tracks the progress of actions targeted at improving our performance. This plan has been approved by Council and is considered on an ongoing basis by the Planning and Performance Committee. We have also engaged closely with the PSA to build a collaborative relationship and develop a better understanding of our processes. For example, we have hosted in-person walkthroughs dedicated to the Standards we failed, which has allowed operational colleagues to explain their work and improvement initiatives to the PSA.

6.7. Leadership development and capability: Our initiatives to diversify the broader leadership group have successfully brought Grade 6 ethnic minority representation in line with our targets**.** In contrast, we remain significantly below target regarding pay gaps - a metric heavily influenced by external labour market factors outside our direct control. Moving forward, we will continue to monitor these trends while refining our recruitment and retention strategies to drive progress wherever possible.

6.8. **Leadership appointments:**

6.8.1. The recruitment process to appoint a substantive Executive Director of Finance is underway with interviews taking place by the middle of November 2026; we have partnered with executive recruitment agency "Green Park" to recruit to the role, and the process is being chaired by the Chair of Council. With the departure of Lesley Maslen, the Executive Director Professional Regulation post has been filled on an interim basis by Richard Cartland and Jen Taylor has taken up the Executive Director, Transformation and Technology Services post on an interim basis. We expect permanent recruitment for both posts to launch in January 2027.

6.8.2. The recruitment exercise for four new Council members began in September 2026. We are seeking to appoint two registrant members and two lay members. The Panel has undertaken longlisting and shortlisting, supported by search consultants Hunter Healthcare. The final interviews are scheduled to take place on 7-9 December 2026.

7. Priority 5 – Modernising the NMC

7.1. **Q2 overview:** Our mid-point strategy assessment considers the timely delivery of Business Plan commitments within budget, the PSA's assessment of our processes and delivery, financial performance, contract management and how we embed learning. The PSA recognised progress and a positive direction of travel; however, it concluded that further work was needed to meet its standards. It highlighted delays and weaknesses in transparency and risk management in the delivery of improvement programmes, alongside the need for stronger governance. The PSA also recognised the establishment of the Policy and Standards Board as a positive step towards becoming a learning organisation. However, it found insufficient evidence that learning from issues in one area was consistently applied to improve performance elsewhere. The Operational Change, Quality and Improvement team is working to address this through the new Log and Learn system and by fostering a culture of evaluation.

7.2. **Specific deliverables by exception**

7.2.1. Log and Learn: The number of events logged increased by approximately 200 percent. Colleagues believe this reflects the introduction of a more accessible, easier-to-use system and a more open, psychologically safe

culture that supports learning and improvement, rather than an increase in events occurring.

7.2.2. Redaction software: The NMC has faced significant administrative backlogs, particularly within its FtP directorate, largely due to a reliance on manual processing and delays in modernising its technology infrastructure. A major bottleneck in progressing cases involves the laborious task of manually removing sensitive, confidential, or personal data from case files before they can be disclosed or published. To address this, the NMC initiated the Modernising the Fitness to Practise Systems programme, which explicitly includes procurement for a dedicated automated or semi-automated document redaction software solution. The rollout of this software has been a multi-stage process integrated into a wider overhaul of its case management environment. Specifically, extended trials, market research and vendor engagement in late 2025 led to remote supplier trials and technical evaluations between December 2025 and February 2026. The programme is currently moving through public sector procurement protocols. The official tender process and licensing reviews are still ongoing to ensure strict alignment with data protection, confidentiality, and information governance standards. In the interim, the NMC has implemented an alternative plan to test options in a controlled short-term pilot, which will provide immediate feedback on user preferences.

8. Developing our 2027-2028 Business Plan

8.1. We are planning the process and structure for the Business Plan 2027-2028 with the Executive Board. The business planning team are working with individual Executive Directors to identify key initiatives and deliverables for inclusion in the draft plan.

8.2. A new structure and five new strategic priorities were agreed for the Business Plan in 2026, and it is proposed that the structural framework is maintained for 2027-2028 to ensure consistency and data comparability across fiscal years. The Executive Board will undertake business planning processes to ensure that the plan is evidence-led and will provide an update to the Planning and Performance Committee on 18 January 2027, ahead of a briefing to the full Council at the Council Seminar on 23 February 2027. The Business Plan for 2027-2028 will be presented to the Open Council meeting for approval on 24 March 2027.

8.3. The business plan acts as a practical vehicle to execute and fund operations, in tandem with the strategy document which provides the overarching mission, goals, and strategic intent. The Business Plan and the new Strategy will be in alignment, and the new strategy will be presented to the Open Council for approval on 27 January 2027. The strategy builds on our Culture Transformation and FtP Plans, through which we have already made major strides.

8.4. To support newly appointed Council members joining in the new year, we will offer briefings on the current and new plans as part of their induction.

9. FINANCIAL / GOVERNANCE IMPLICATIONS

9.1 Financial implications associated with delivery of activities within the Business Plan are covered in the Financial Report presented separately at this meeting.

10. RECOMMENDATION

10.1 The Council is asked to:

a) **Note** the report; and

b) **Discuss** the performance and progress against the Business Plan 2026-2027, consider the areas of strategic challenge highlighted within the report, and provide feedback and direction to the Executive Board.

11. ASSESSMENT

Impact Assessment	Question / Consideration	Response
Equality, Diversity and Inclusion	Has an Equality Impact Screening been undertaken (including Welsh Language)?	This report demonstrates that the NMC is monitoring EDI improvements and tracking whether the NMC's cultural and inclusion goals are translating into tangible business outcomes.
Safeguarding considerations	Are there any safeguarding implications?	Yes, within Priorities 1 and 2.
Four country factors and considerations	Are there any four country factors?	No specific country factors to note.
Resource (incl People) implications	Are there any people implications?	Yes, within Annexe 2 and Priorities 1, 2 and 5.
Risk implications associated with the work and the controls proposed/ in place.	What are the key risks and how are they mitigated?	Risks associated with delivery of the plan are detailed in the paper. Associated strategic risks are also reported in detail in the quarterly risk exposure report and strategic risk register, a separate item at the meeting.

Legal considerations, incl Regulatory Reform	Are there any legal or regulatory reform implications?	The Nursing and Midwifery Order requires the NMC to produce and lay in Parliament “a strategic plan for the Council”; this is essentially the Business Plan, which provides a summary of performance against our strategy. This report demonstrates how the Council monitors performance against the plan.
Midwives and/or Nursing Associates	Any specific implications for midwives and/or nursing associates?	Alongside all professions impacted by work within Priorities 1, 2 and 5.

Item 6 Annexe 1: Business Plan progress report

5 Strategic Priorities - 90 deliverables

Completed | On track/Minor Concern | Moderate Concern | Significant Concern | Not Started

Strategic Priority 1: Ensuring Trust in Professionals

Initiative	Deliverable	Due date	Status Q1	Q2	Q3	Q4
Review of practice learning requirements	Complete the public consultation on practice learning requirements	By 31 July 2026				
	Develop revised practice learning standards and assess financial implications	By 30 September 2026				
	Seek Council approval for proposed changes	By 30 September 2026	Not started	Not started		
	Begin transition to new standards, with a minimum two-year implementation period	From January 2027	Not started	Not started		
Advanced practice	Complete horizon scanning and engagement with early adopters to inform draft standards	By 31 March 2027				
	Develop standards for advanced practice for public consultation	2027-2028				
	Deliver a registrant survey to inform standards development	By 30 June 2026		Not started		
Education standards and education quality assurance (EdQA)	Deliver the EdQA Development Plan to meet PSA Standards of Good Regulation	By 31 March 2027				
	Upgrade EdQA case management and quality tracking systems	By 31 March 2027				
	Improve EdQA processes using D365 automation and workflow	By 31 March 2027				
	Strengthen EdQA capacity and capability through new and additional roles	By 31 March 2027				
	Assess technology options for proactive monitoring of AEI performance	By 31 March 2027				
	Strengthen partnership working with the current quality assurance provider	By 31 March 2027				
	Reduce disproportionate outcomes in nursing and midwifery education and training	By 31 March 2027	Not started			
Review of the Code and Revalidation	Refresh the Code > public consultation (Sep - Nov 2026) > analysis (Dec 2026 - Mar 2027)	By March 2027				
	Update the revalidation process > public consultation (Sep - Nov 2026) > analysis (Dec 2026 - Mar 2027)	By March 2027				
	Confirm requirements for advanced practitioners	By 31 March 2027				
	Ensure the Code reflects key issues raised by stakeholders, including EDI, AI, professional behaviour outside work and delegation	By 31 March 2027				
Midwifery Action Plan	Publish FAQs on the Principles for supporting women's choices in maternity care	By 31 March 2027				
	Publish anti-racism principles for nursing and midwifery education and practice	By 31 May 2026				
	Support implementation of anti-racism principles across education and practice	By 30 September 2026				
	Enable system regulators to apply the principles through inspection activity	By 31 March 2027				
Integrity of our register	Ensure policies, processes and procedures are followed, undertaking stronger quality assurance checks	By 31 March 2027				
	Strengthen the integrity of the register by improving the consistency, fairness and proportionality of registration decisions	By 31 March 2027				
	Strengthen fraud controls and review international registration policy and processes where required	By 31 March 2027				
International registrations	Complete Computer-Based Training hearings (Fraudulent and Incorrect Entry only) and capture learning	By 30 September 2026				
	Launch the Patient Safety Intelligence Forum to assess international education risk	By 30 June 2026				
	Complete a discovery phase on international registration policy and process	By 30 September 2026		Not started		
	Agree the scope of a Test of Competence review	By 31 January 2027				
Registrations	Complete quality assurance checks on registration decisions	By 30 June 2026				
	Review health and character assessment processes	By 30 June 2026				
Policy and partnership working	Strengthen international and European partnerships to detect and prevent registration fraud	By 31 March 2027				
	Support improved information-sharing arrangements across Northern Ireland and the Republic of Ireland	By 30 September 2026				
	Clarify registration requirements for specific international applicant cohorts, including those linked to Ukraine	By 31 March 2027				

34 deliverables | Completed: 9 On Track: 16 Moderate Concerns: 5 Significant Concerns: 0 Not Started: 4

Strategic Priority 2: Improving Fitness to Practise (FtP)

Reduce delays	Deliver the Right Referral, Right Place programme to reduce unnecessary referrals and improve referral quality	By March 2027				
	Embed stronger disclosure practices with third parties to reduce avoidable delays	By 30 June 2026				
	Introduce legally qualified chairs and new case management powers, subject to rule changes >Council appointments in January and inductions in March 2027	By March 2027				
	Implement a new Investigations operating model and progress 350 cases to Case Examiner decisions	By 31 December 2026				
	Strengthen operational performance management through targeted coaching and training	1 October 2026 - 31 March 2027				
Strengthen equity and fairness	Introduce proactive debiasing measures across Fitness to Practise processes: Agreement of a delivery plan	By 30 June 2026				
	Embed priority bias-mitigation actions for early decision-makers using data and insight	By 30 June 2026				
	Implement and review bias-mitigation interventions for early decision-makers	By 31 December 2026				
	Deliver targeted training on discrimination in regulatory contexts, including anti-Jewish and anti-Muslim hate	By 30 September 2026				
	Deliver EDI training for Fitness to Practise decision-makers to recognise and mitigate bias	By 31 March 2027				
	Deliver enhanced anti-racism training for Panel Members	By 31 December 2026				
	Continue EDI case clinics for complex cases and share learning across teams	By 31 March 2027				
	Deliver a consistent quality assurance framework through the Fitness to Practise Improvement Plan, with EDI embedded	By 30 September 2026				
Improve decision-making quality and use of clinical advice	Improve the clinical advice process and increase its use across Fitness to Practise casework	Timing subject to approval. ETA by 31 Dec 2026				
	Introduce targeted investigation pathways, including testing a Dedicated Clinical Pathway Hub with early clinical input	By 31 December 2026				
	Strengthen quality gateways in Investigations and CPP to reduce rework and improve consistency	By 31 December 2026				
	Embed updated removal and warnings guidance across decision-making	By 30 September 2026				
Improve communication, engagement and safeguarding	Embed the reset customer contact process and track performance quarterly	By 30 June 2026				
	Deliver trauma-informed training so colleagues apply trauma-informed approaches consistently	By 31 March 2027				
	Improve communications with people involved in our processes	By 30 September 2026				
	Deliver the next Safeguarding Plan to strengthen engagement, wellbeing and operational assurance	By 31 December 2026				
	Evaluate the health pilot and agree next steps	By 30 September 2026				
	Introduce new rules to strengthen support for witnesses in hearings	Timing subject to approval. ETA by 31 Dec 2026				
	Embed safeguarding consistently through targeted training and assurance	By 30 September 2026				
Manage incoming concerns proportionately	Implement new investigations ways of working to improve efficiency and progress an additional 350 cases	By 31 December 2026				
	Deploy the new case management system to improve efficiency and case progression	By 31 March 2027				
	Improve hearing facilities and transcription to enhance timeliness and user experience	By 30 June 2026				
	Implement the legal services review to support timely and proportionate case progression	By 30 June 2026				
	Strengthen operational management capability and cross-department working	1 October 2026 - 31 March 2027				
	Establish a dedicated FtP service quality and improvement function	By 31 March 2027				

30 deliverables | **Completed:** 7 **On Track:** 12 **Moderate Concerns:** 11 **Significant Concerns:** 0 **Not Started:** 0

Strategic Priority 3: Culture Transformation

Culture maturity	Operate at a 'Leading' level, against the Culture Maturity Model	By 31 March 2027				
Reconnecting colleagues to purpose and fairness	Strengthen colleagues' connection to regulatory purpose and fairness through improved induction and role-specific learning, including patient and registrant perspectives > learning scaled by 31 December 2026 > Targeted follow-up by March 2027	By 31 March 2027				
Strengthening management capability and consistency	Deliver a structured Management Development programme so managers can set expectations, manage performance and wellbeing, and intervene earlier > launched by 30 June 2026 > expanded by 31 December 2026 > embedded by 31 March 2027	By 31 March 2027				
Embedding equity, inclusion and psychological safety	Embed equity, inclusion and psychological safety so colleagues feel safe to speak up and experience fairness consistently > core activity delivered by 30 September 2026 > targeted action up to 31 March 2027	By 31 March 2027				
	Maintain a zero-tolerance approach to bullying, harassment and discrimination, and review the Fairness at Work policy to ensure it remains clear and trusted	By 30 September 2026				
Regulatory fairness	Embed equity, inclusion and anti-bias objectives across regulatory functions, with a focus on fitness to practise decision-making	By 31 December 2026				
	Improve communications with registrants, witnesses and others, informed by the Ambitious for Change review and stakeholder feedback	By 31 December 2026				
Delivering Independent Culture Review recommendations	Deliver the agreed PCC governed Independent Culture Review recommendations, with clear governance and oversight, and demonstrate sustained progress against agreed milestones	By 31 March 2027				

8 deliverables | **Completed:** 0 **On Track:** 4 **Moderate Concerns:** 4 **Significant Concerns:** 0 **Not Started:** 0

Strategic Priority 4: Strengthening Leadership

Clear leadership expectations	Embed clear leadership expectations in objectives, recruitment, appraisal and development, reinforced by coaching and feedback > objectives by 30 June 2026 > people processes aligned by 30 September 2026 > reinforcement through 31 March 2027	By 31 March 2027				
Leadership governance and alignment	Strengthen leadership governance and decision-making through a single leadership spine (SLG and LG), supported by consistent performance, culture and risk reporting > arrangements 30 June 2026 > reporting by 30 September 2026 > alignment and barrier removal through 31 March 2027	By 31 March 2027				
Leadership development and capability	Build leadership capability at all levels through mandatory development, coaching, feedback and talent and succession planning > programme launched by 30 Jun 2026 > coaching by 30 September 2026 > succession planning introduced by 31 December 2026 > learning consolidated by 31 March 2027	By March 2027				
Improve performance against the PSA Standards of Good Regulation	Develop and agree a delivery plan to increase the number of Standards assessed as 'met'	By 30 June 2026				

4 deliverables | **Completed:** 1 **On Track:** 3 **Moderate Concerns:** 0 **Significant Concerns:** 0 **Not Started:** 0

Strategic Priority 5: Modernising the NMC

War on waste	Deliver £500,000 of non-pay savings	By 31 March 2027				
Technology and data	Deploy transcription software for FtP hearings	By 30 June 2026				
	Deploy redaction software to improve document handling	By 30 September 2026				
	Deploy reporting automation to improve management information	By 31 December 2026				
	Deliver a common data model and publish priority datasets > from 1 July 2026 > further releases from 1 January 2027	By 31 March 2027				
	Replace spreadsheet-based processes with D365 automation	By 31 March 2027				
	Replace the legacy FtP case management system	By 31 March 2027				
Prepare for reform of the NMC's governing legislation	Amend the NMC's Fitness to Practise and Fees rules, subject to Council's decisions	By 30 June 2026				
	Commence regulation of nursing associates in Wales, once confirmed by Department of Health and Social Care (DHSC)	Subject to DHSC confirmation				
	Develop the new NMC Order by undertaking policy and legal work, in readiness to deliver the public consultation on the new NMC Order > policy and legal work by 31 December 2026 > prepare for public consultation by 31 March 2027	By 31 March 2027		Not started		
External relationships	Deliver a coordinated programme of strategic stakeholder engagement with clear ownership	By 31 March 2027				
	Coordinate consultations centrally with early stakeholder input	By 31 March 2027				
	Strengthen UK-wide professional fora to support two-way engagement	By 31 March 2027				
	Use system intelligence to identify and respond to emerging risks and opportunities	By 31 March 2027				

14 deliverables | **Completed:** 3 **On Track:** 5 **Moderate Concerns:** 5 **Significant Concerns:** 0 **Not Started:** 1

Delivery Confidence Assessment- RAG Descriptions

Key	Description
R	**Significant Concern:** **Time:** There is a significant risk/issue to the programme/project/Standard schedule that could affect delivering its objective (output/outcome). **Costs:** The budget is or could be overspent by more than 10% (including its contingency) outside approved tolerance. **Risk:** An aggregated risk factor of a collection of moderate risks occurring or a single risk event that would be catastrophic to the delivery of the project/programme. **Resources:** Significant resourcing events are or could affect capacity or capability which put the delivery of the initiative schedule in jeopardy. **Benefits**: Significant risk/issue to realising the benefits
A	**Moderate Concern:** **Time**: There is a moderate risk/issue to the programme/project/Standard schedule that could affect delivering its objective to the time agreed (output/outcome). **Costs**: The current financial forecasts put the project/programme budget over the approved budget but within its contingency or there is uncertainty on meeting the financial budget due to unforeseen circumstances which are currently being assessed. **Risks**: There are several moderate level risks to the programme/project delivery which are being actively managed. Or waiting to assess the effectiveness of management actions to see if the risk score is reduced. **Resources**: Moderate resourcing events are or could affect capacity or capability which will put the delivery of the initiative schedule at risk. **Benefits**: Moderate risk/issue to realising the benefits
G	**Minor Concern/On Track** **Time:** The programme/project/Standard schedule is on track to be delivered on time with any changes to thedeliverables absorbed in the float. **Costs**: The budget spend forecast is on track to meet the costs approved in the BC or at completion is anticipated to not exceed the approved budget. **Risks**: A low risk factor with all the risks identified and mitigatedaccordingly. **Resources**: The required resources have been scheduled and allocated accordingly with no anticipated challenges to capacity or capability that would affect delivery of the project and programme. **Benefits**: The benefits and benefits realisation plan is on track to bedelivered.

Item 6: Annexe 2

Sep-26 **Core Business Scorecard**

Registrations	Target	Mar-26	Jun-26	Sep-26	Trend	Current Month RAG Status
UK Registrations						
% UK initial registration applications with no concerns, completed in one day	97%	100%	100%	100%	▬	●
% UK initial registration applications with concerns, completed within 60 days	90%	89%	58%	88%	▲	●
Overseas Registrations						
% Overseas registration applications assessed within 30 days	95%	99%	100%	100%	▬	●
% Readmission applications completed within 21 days	95%	98%	95%	98%	▲	●
% of applications closed/AR decided within 90 days (statutory time limit)	100%	N/A	82%	94%	▲	●
CBT (Fraudulent Entry)						
Volume of the overall caseload		N/A	7	6	▼	
Median age of caseload (weeks)		N/A	N/A	178		
No. of decisions made		N/A	0	0	▬	
CBT (Registration Appeals)						
Volume of the overall caseload		N/A	28	41	▲	
Median age of caseload (weeks)		N/A	N/A	52		
No. of New Appeals per Month (month actual)		N/A	N/A	4		
No. of decisions made		N/A	1	2	▲	
Median age of decisions (weeks)		N/A	96	104	▲	
IE/FE (Incorrect/Fraudulent Entry)						
Volume of the overall caseload		N/A	272	265	▼	
% sent to AR for decision (health/character/conviction)		N/A	0.4%	0.8%	▲	
Median age of caseload (weeks)		N/A	48	51	▲	
Oldest case (weeks)		N/A	305	319	▲	
Cases inside stage timeliness target (%)- overall		N/A	N/A	52%		
No. of decisions made		N/A	5	14	▲	
Median age of decisions (weeks)		N/A	30	42	▲	
Protection of Title						
Volume of the overall caseload		N/A	95	108	▲	
No. of New Cases		N/A	11	4	▼	
Median age of caseload (weeks)		N/A	46	44	▼	
Oldest case (weeks)		N/A	162	223	▲	
No. of decisions made		N/A	0	10	▲	
Restorations						
Volume of the overall caseload		N/A	22	24	▲	
No. of New Cases		N/A	3	3	▬	
Median age of caseload (weeks)		N/A	46	45	▼	
Oldest case (weeks)		N/A	250	264	▲	
No. of decisions made		N/A	1	2	▲	
Registration Appeals						
Volume of the overall caseload		N/A	24	20	▼	
No. of New Appeals per Month (month actual)		N/A	2	1	▼	
Median age of caseload (weeks)		N/A	33	26	▼	
Oldest case (weeks)		N/A	49	55	▲	
No. of decisions made		N/A	0	2	▲	

Annexe 2

Sep-26

Core Business Scorecard

Education Quality Assurance	Target	Mar-26	Jun-26	Sep-26	Trend	Current Month RAG Status
Context						
Volume of the overall caseload	-	N/A	303	291	▼	
Volume of total new concerns	-	N/A	34	22	▼	
Timeliness						
No. of cases closed	-	N/A	21	30	▲	
Quality						
Proportion of critical concerns with QA Board ratified action plans	-	1/1	1/1	1/1		●

Safeguarding	Target	Mar-26	Jun-26	Sep-26	Trend	Current Month RAG Status
Context						
Volume of cases being referred for safeguarding concerns	-	264	269	246	▼	
Timeliness						
% safeguarding mailbox and hub enquiries actioned within 5 working days	100%	N/A	97%	80%	▼	●
% of emergency high-risk scenarios receiving a response on the same day they are received	100%	N/A	100%	100%	▬	●
% of high-risk safeguarding concerns (with no immediate threat to life) receiving a response within 2 working days	100%	N/A	100%	100%	▬	●
% of emergency helpline calls received during business hours that are answered	100%	N/A	100%	100%	▬	●
Quality						
% organisational compliance with Safeguarding Level 1 e-learning.	90%	N/A	96%	96%	▬	●

People and Culture	Target	Mar-26	Jun-26	Sep-26	Trend	Current Month RAG Status
ICR						
ICR recommendations Implemented	37	24	30	30	▬	●
Embedding EDI						
Unison anti-racist organisation charter - No. of actions completed or substantially delivered and our delivery confidence assessment	20	N/A	10	10	▬	●
Regulatory EDI Targets						
Eliminate disproportionate outcomes, based on ethnicity, in nursing and midwifery education and training by 2035		N/A			▬	●
Eliminate disparities based on ethnicity and gender in the NMCs FtP processes by 2030		N/A			▬	●
Eliminate the disproportionate pattern of FtP complaints received from employers in relation to ethnicity by 2030		N/A			▬	●
Workforce EDI Targets						
Eliminate disparities in the representation of Black, Asian and ethnic minority NMC colleagues in the upper two pay quartiles		N/A			▬	●
% of Black and Minority ethnic colleagues represented in grades 6 and above	30%	29%	29%	30%	▲	●
% Median Pay Gaps- Gender	0%	14.5%	11.9%	12.2%	▲	
% Median Pay Gaps- Ethnicity	0%	32.3%	31.5%	30.4%	▼	
% Median Pay Gaps- Health Condition	0%	-13.3%	-15.8%	-11.7%	▲	

Enquiries and Complaints	Target	Mar-26	Jun-26	Sep-26	Trend	Current Month RAG Status
Timeliness						
Complaints handled within 20 working days (%)	90%	93%	96%	95%	▼	●
Enquiries responded to in 20 working days (%)	90%	100%	93%	95%	▲	●
MP enquiries responded to in 20 working days (%)	90%	100%	100%	100%	▬	●
MP Enquiries responded outside 20 days within agreed extension period with customer (%)	100%	100%	100%	N/A		
Information requests within statutory timeframes (%)	90%	90%	95%	91%	▼	●
Person-centred						
FTP related complaints received (from public/registrants regarding their experience)		39	61	41	▼	

Annexe 2

Sep-26

Core Business Scorecard

Fitness to Practise	Target	Mar-26	Jun-26	Sep-26	Trend	Current Month RAG Status
Context						
Referrals in - 12 month rolling trend	-	N/A	597	605	▲	
Volume of the overall fitness to practise caseload	-	6725	7284	7849	▲	
Volume of Closing Caseload- Screening	-	2103	2597	3110	▲	
Volume of Closing Caseload- Investigations	-	2661	2538	2456	▼	
Volume of Closing Caseload- Case Examiners	-	840	986	1031	▲	
Volume of Closing Caseload- Adjudications	-	1121	1163	1252	▲	
Timeliness and Efficiency						
% of Cases concluded within 15 months?	80%	80%	74%	70%	▼	🔴
% Cases concluded within 15 months of opening (12-month rolling average)	80%	74%	74%	72%	▼	🟡
No. of cases closed per month		857	463	496	▲	
No. of decisions made per month (both progressions and closures)		N/A	852	893	▲	
No. of decisions made- Screening	600	564	504	525	▲	🔴
No. of progressions made- Investigations	118	173	188	196	▲	🟢
No. of decisions made- Case Examiners	144	83	109	126	▲	🔴
No. of decisions made- Adjudications	47	37	51	46	▼	🟡
% Proportion of alternative disposals compared to all Adjudications outcomes	-	N/A	46%	42%	▼	
Volume of alternative disposals (meetings, CPDs, agreed removals, warnings)	-	N/A	23	19	▼	
Median age of decision - Screening (weeks)		N/A	4	7	▲	
Median age of decision - Investigations (weeks)		N/A	76	75	▼	
Median age of decision -Case Examiners (weeks)		N/A	109	94	▼	
Median age of decision - Adjudications (weeks)		N/A	156	143	▼	
Median age of caseload - Screening (weeks)	8	15	17	18	▲	🔴
Median age of caseload - Investigations (weeks)	24	52	53	56	▲	🔴
Median age of caseload - Case Examiners (weeks)	6	89	95	98	▲	🔴
Median age of caseload - Adjudications (weeks)	24	138	141	149	▲	🔴
Safety and Experience						
% IOs Imposed Within 28 Days (Under review)	80%	67%	69%	60%	▼	🔴
% IOs Imposed Within 28 Days (12-month rolling average) (Under Review)	80%	69%	70%	68%	▼	🔴
Health of the pipeline						
Unallocated cases- Screening	-	N/A	256	417	▲	
Unallocated cases -Investigations	-	N/A	839	713	▼	
Unallocated cases - Case Examiners	-	N/A	663	680	▲	
Unallocated legal reviews - CPP	-	N/A	377	474	▲	

Annexe 2
Sep-26
Core Business Scorecard

Key	
Key Label	**Key Description**
Trend Icon	The icon shows whether the trend is tracking up, down or stable, the icon color indicates whether the change is positive, negative or neutral.
RAG Status	The RAG ratings are based on the current month's values vs target. For KPIs RAG ratings are based on KPI RAG rating Table; and programme delivery is RAG rated against our Delivery Confidence Assessment

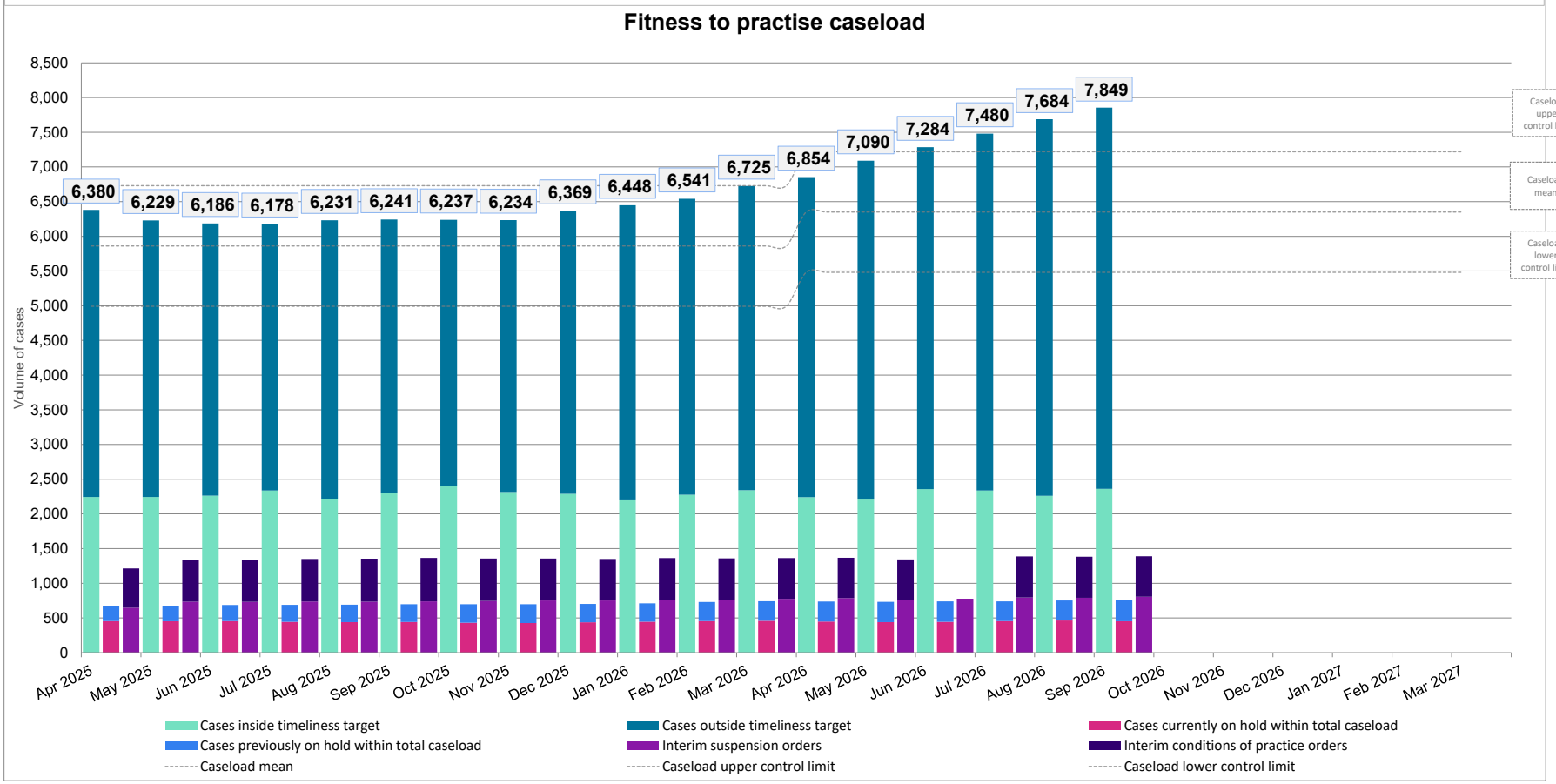
Delivery Confidence Assessment - RAG Descriptions	
RAG Label	**RAG Description**
R	Significant Concern: Time: There is a significant risk/issue to the programme/project/Standard schedule that could affect delivering its objective (output/outcome). Costs: The budget is or could be overspent by more than 10% (including its contingency) outside approved tolerance. Risk: An aggregated risk factor of a collection of moderate risks occurring or a single risk event that would be catastrophic to the delivery of the project/programme. Resources: Significant resourcing events are or could affect capacity or capability which put the delivery of the initiative schedule in jeopardy. Benefits: Significant risk/issue to realising the benefits
A	Moderate Concern: Time: There is a moderate risk/issue to the programme/project/Standard schedule that could affect delivering its objective to the time agreed (output/outcome). Costs: The current financial forecasts put the project/programme budget over the approved budget but within its contingency or there is uncertainty on meeting the financial budget due to unforeseen circumstances which are currently being assessed. Risks: There are several moderate level risks to the programme/project delivery which are being actively managed. Or waiting to assess the effectiveness of management actions to see if the risk score is reduced. Resources: Moderate resourcing events are or could affect capacity or capability which will put the delivery of the initiative schedule at risk. Benefits: Moderate risk/issue to realising the benefits
G	Minor Concern/On Track/Complete: Time: The programme/project/Standard schedule is on track to be delivered on time with any changes to the deliverables absorbed in the float. Costs: The budget spend forecast is on track to meet the costs approved in the BC or at completion is anticipated to not exceed the approved budget. Risks: A low risk factor with all the risks identified and mitigated accordingly. Resources: The required resources have been scheduled and allocated accordingly with no anticipated challenges to capacity or capability that would affect delivery of the project and programme. Benefits: The benefits and benefits realisation plan is on track to be delivered.

KPI RAG Rating Table		
KPI RAG	**KPIRAG Label**	**KPI RAG Description**
R	Significant Risks	Significant below target More than 8% below target
A	Off Target	Off target Between 0 and 8% below target
G	Within Range	Within range On or above target

Annexe 3 Fitness to Practise Council performance dashboard September 2026

The chart below shows the total fitness to practise caseload broken down into the cases that are within and outside our timeliness targets. The chart also shows within that caseload the cases that are currently on hold for a third party investigation and those that have previously been on hold but are now active. It also shows the number of interim suspension orders and interim conditions of practise orders for the cases that are still open without a final outcome.

A1

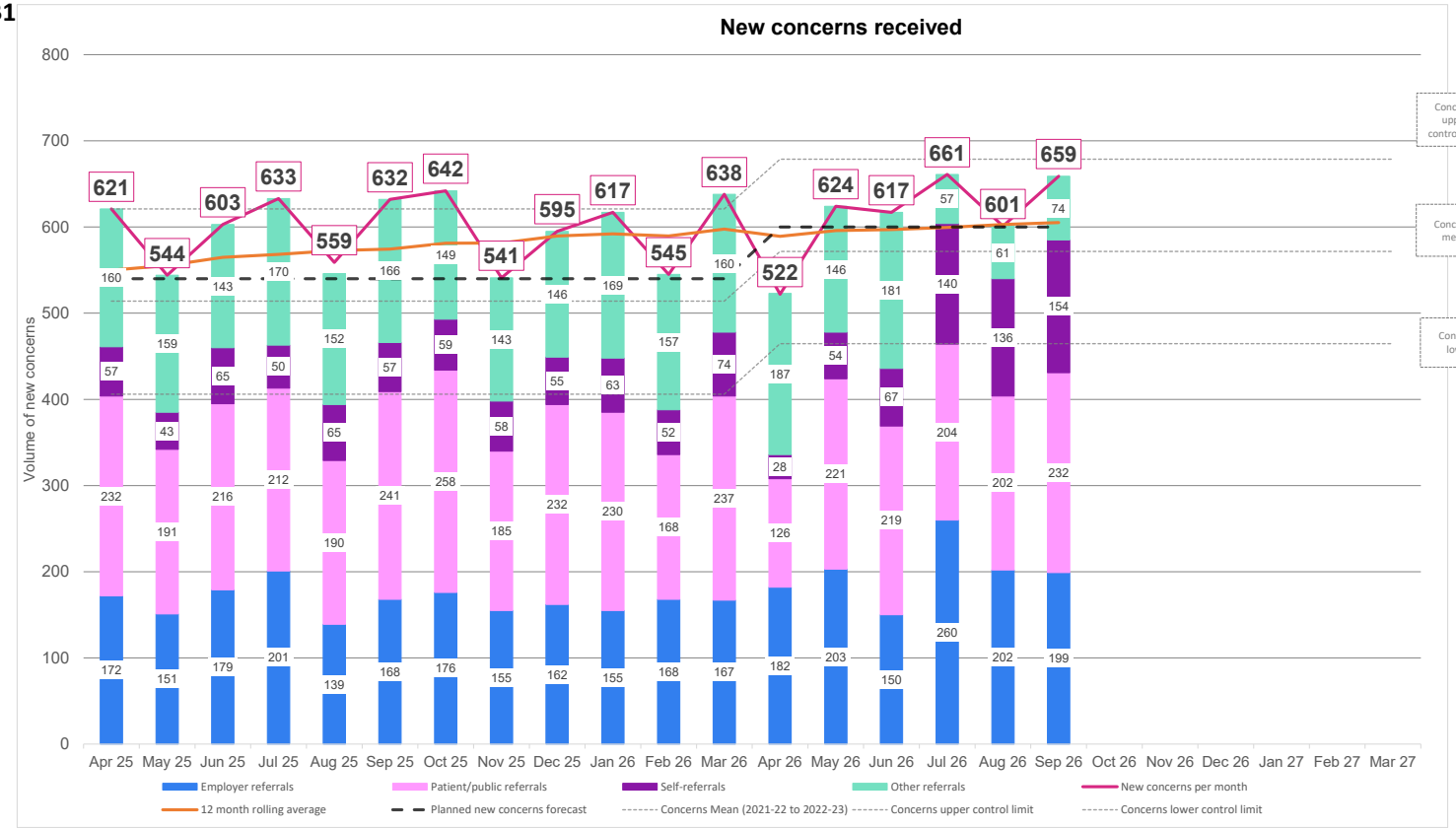


Commentary
[TBC]

Fitness to Practise Council performance dashboard September 2026

The chart below shows the total number of new concerns we have received into fitness to practise on a monthly basis, and also our rolling 12 month average for the concerns we have received. The chart also includes our planned forecast for referrals for the financial year. We have provided a breakdown of the new concerns by referrer type: employer; patient/public; self-referrals and other. The other cohort includes the following: colleagues (nursing or midwifery), other health professionals, police, anonymous referrers, local authorities, educational institutes, the NMC and unknown referrers.

B1



Commentary

[TBC]

C1 Monitoring and Compliance

Substantive order review caseload:	375
Undertakings caseload:	186

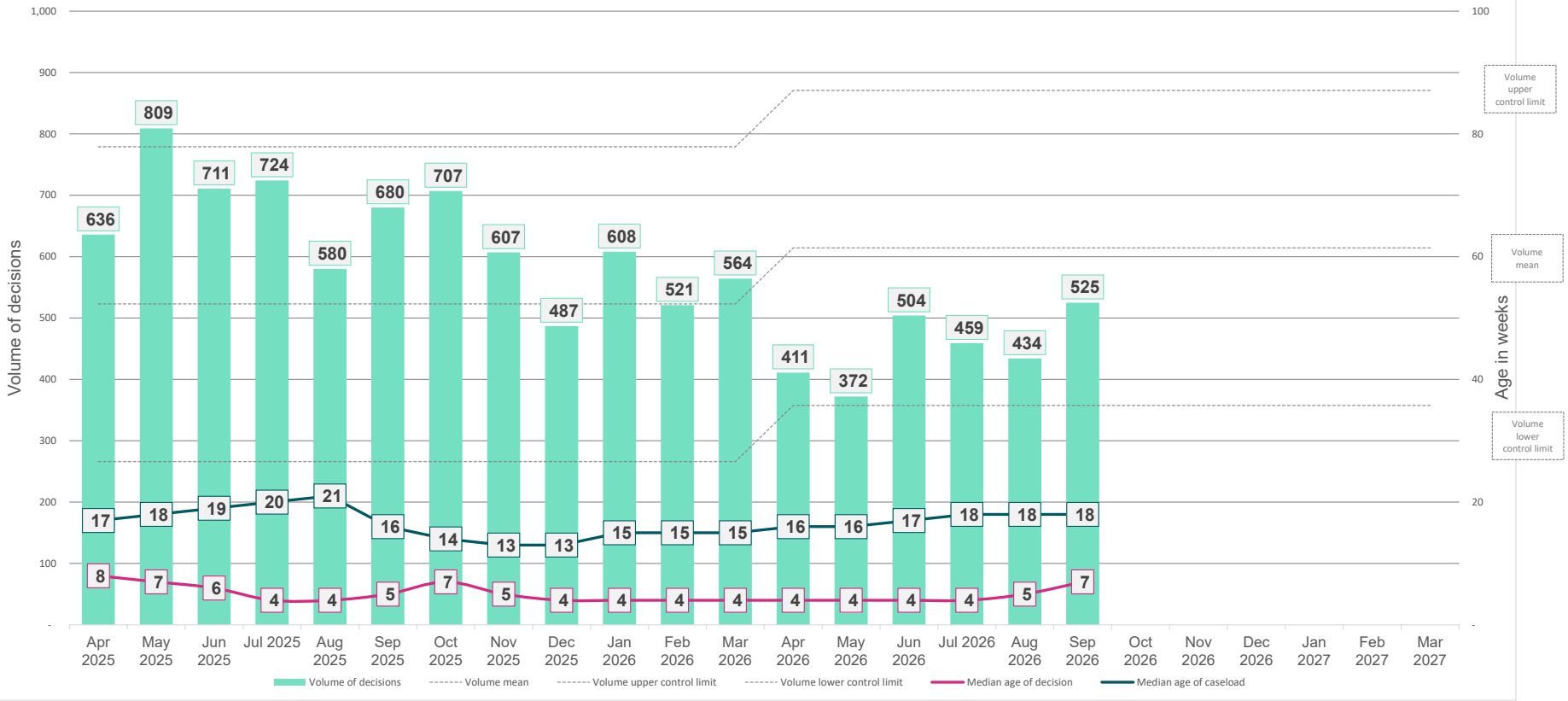
The figures above shows the total number of substantive orders that are subject to review following a decision by a Fitness to Practise Committee Panel at a hearing or meeting. It also shows the total number of undertakings offered by Case Examiners that were accepted, were still active and being reviewed.

Fitness to Practise Council performance dashboard September 2026

The charts below provide a performance summary for the Screening stage of our fitness to practise process. The bar charts provide the total number of decisions or completed cases within the month, and the line charts show both the median age of decisions/completed cases in weeks and the other shows the median age of the open caseload at that stage.

D1

Screening

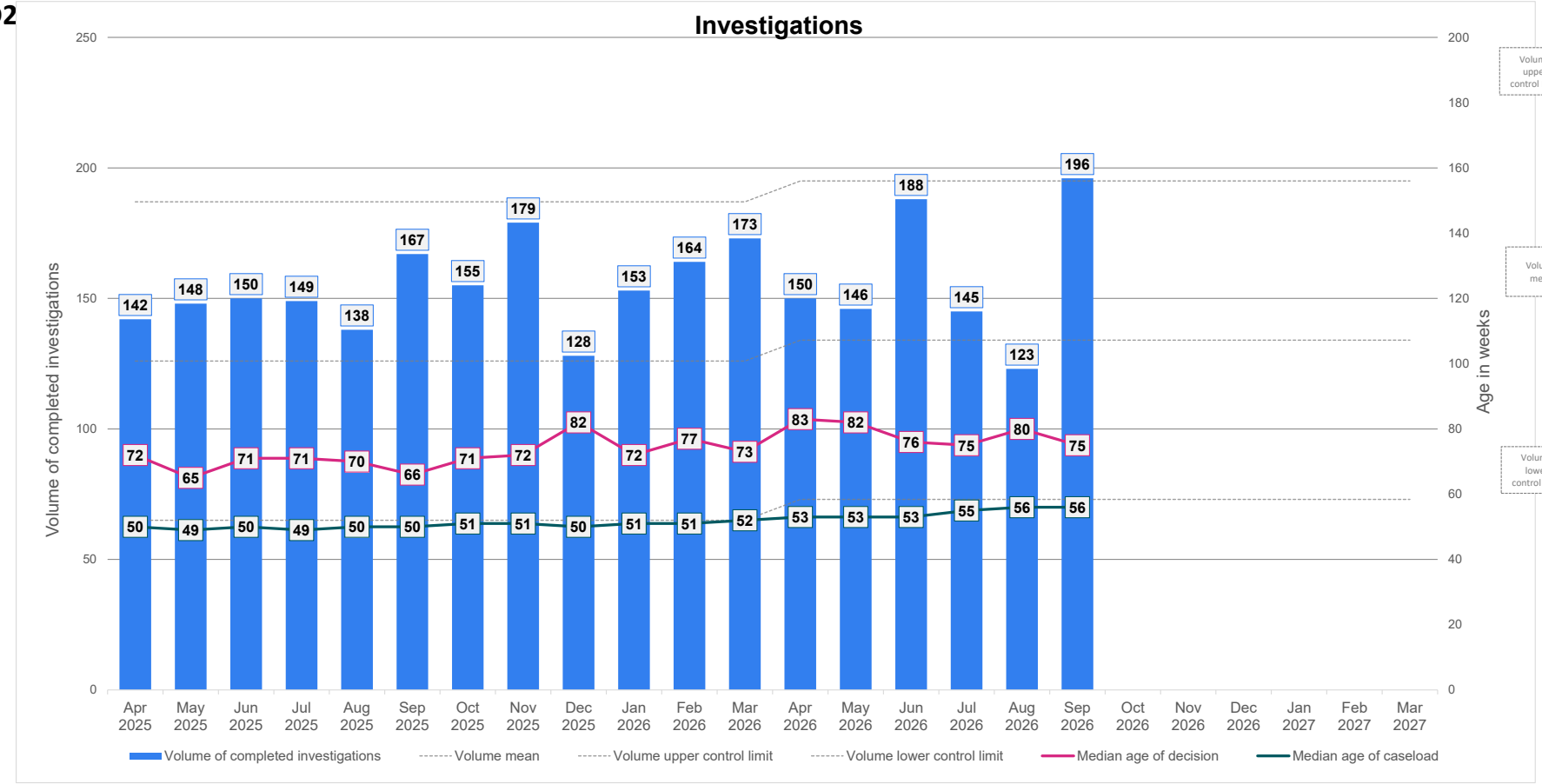


Commentary
TBC

Fitness to Practise Council performance dashboard September 2026

The charts below provide a performance summary for the Investigations stage of our fitness to practise process. The bar charts provide the total number of decisions or completed cases within the month, and the line charts show both the median age of decisions/completed cases in weeks and the other shows the median age of the open caseload at that stage.

D2



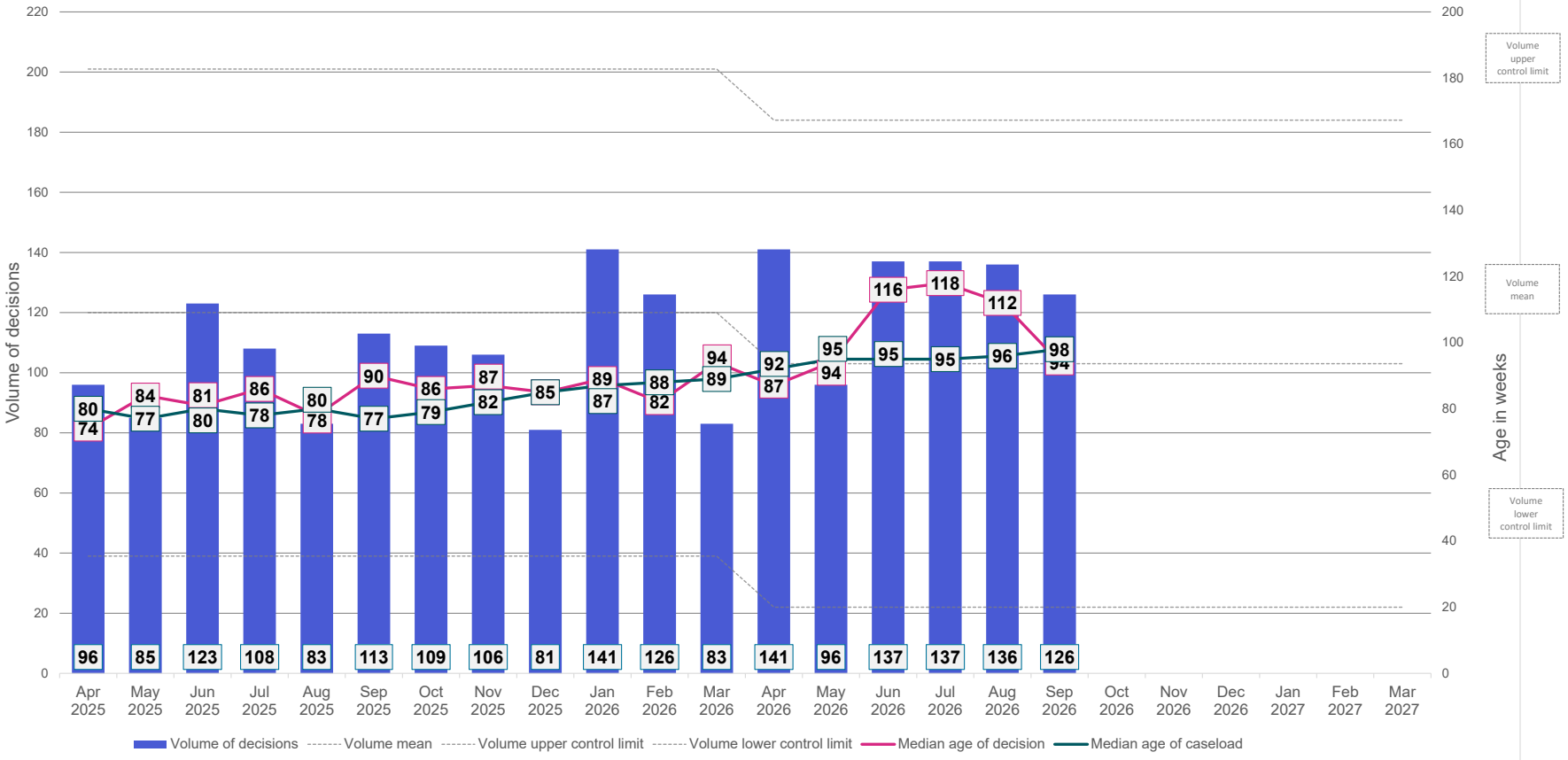
Commentary
TBC

Fitness to Practise Council performance dashboard September 2026

The charts below provide a performance summary for the Case Examiner stage of our fitness to practise process. The bar charts provide the total number of decisions or completed cases within the month, and the line charts show both the median age of decisions/completed cases in weeks and the other shows the median age of the open caseload at that stage.

D3

Case Examiners

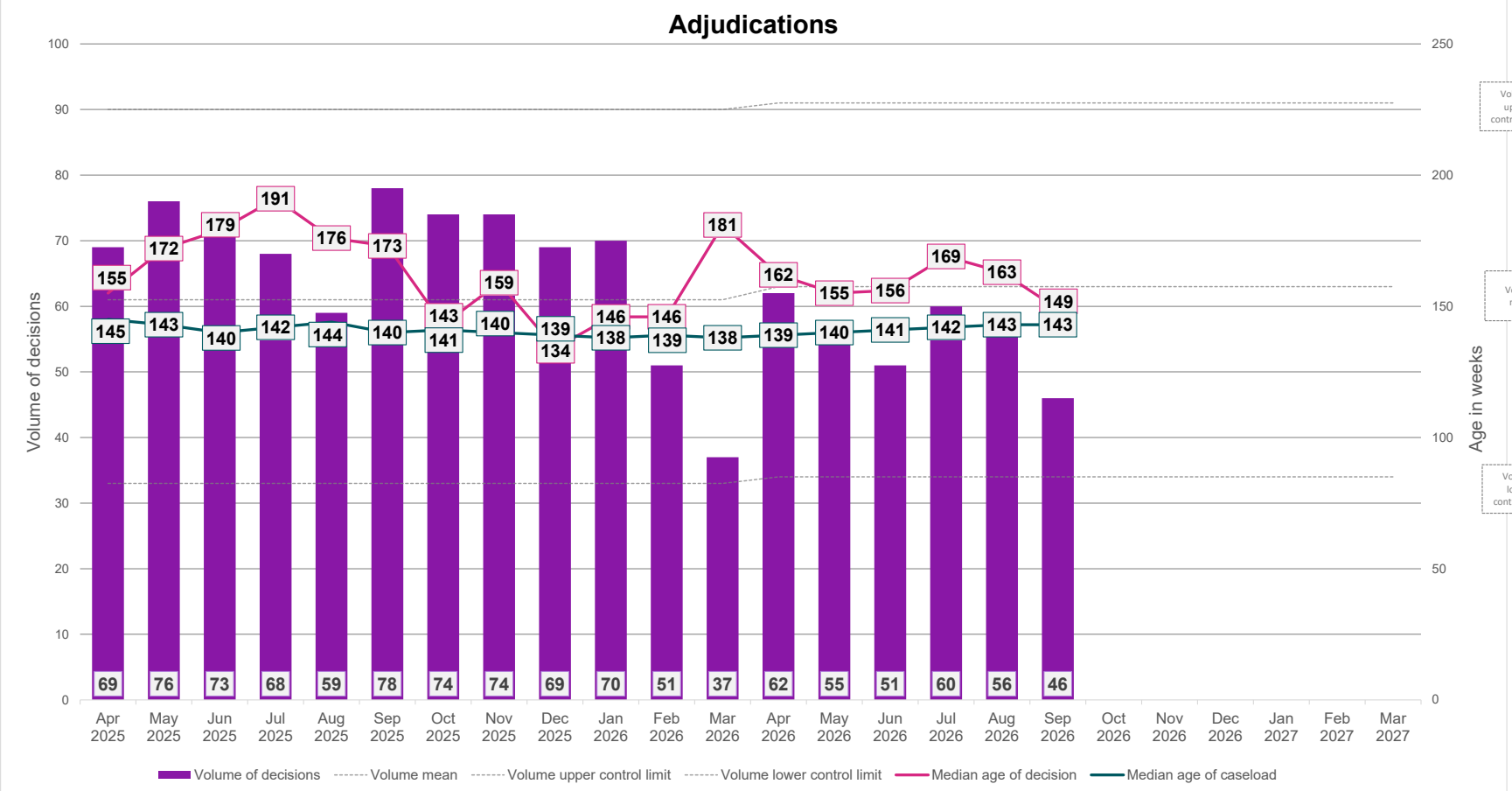


Commentary
TBC

Fitness to Practise Council performance dashboard September 2026

The charts below provide a performance summary for the Adjudication stage of our fitness to practise process. The bar charts provide the total number of decisions or completed cases within the month, and the line charts show both the median age of decisions/completed cases in weeks and the other shows the median age of the open caseload at that stage.

D4



Commentary
TBC

Annexe 4: 2026-2027 Quarter two – September 2026

Fitness to Practise caseload by country of registered address

Fitness to practise caseload by country of registered address broken down into our stages, as of September 2026 caseload	Screening stage	Investigations stage	Case Examiners stage	Adjudication stage	Total caseload	% of registrants from each country who are in the FtP process
England	1,992	1,973	840	1,009	**5,814**	0.8%
Scotland	245	213	75	100	**633**	0.8%
Wales	143	100	55	64	**362**	0.9%
Northern Ireland	71	107	35	46	**259**	0.9%
Overseas	52	63	26	33	**174**	0.5%
No Registrant PIN linked to case	607				**607**	-
Grand Total	**3,110**	**2,456**	**1,031**	**1,252**	**7,849**	**0.9%**

Fitness to practise caseload by country of registered address broken down into our stages, as of September 2026 caseload	Screening stage	Investigations stage	Case Examiners stage	Adjudication stage	Total caseload
England	64.1%	80.3%	81.5%	80.6%	**74.1%**
Scotland	7.9%	8.7%	7.3%	8.0%	**8.1%**
Wales	4.6%	4.1%	5.3%	5.1%	**4.6%**
Northern Ireland	2.3%	4.4%	3.4%	3.7%	**3.3%**
Overseas	1.7%	2.6%	2.5%	2.6%	**2.2%**
No Registrant PIN linked to case	19.5%				**7.7%**
Grand Total	**100%**	**100%**	**100%**	**100%**	**100%**

Fitness to Practise caseload by registration type

Fitness to practise caseload by registration type broken down into our stages, as of September 2026 caseload	Screening stage	Investigations stage	Case Examiners stage	Adjudication stage	Total caseload
Nurse	2,288	2,311	971	1,175	**6,745**
Midwife	176	104	54	66	**400**
Nurse & Midwife (Dual)	8	2		1	**11**
Nursing Associate	31	39	6	10	**86**
No Registrant PIN linked to case	607				**607**
Grand Total	**3,110**	**2,456**	**1,031**	**1,252**	**7,849**

Fitness to practise caseload by registration type broken down into our stages, as of September 2026 caseload	Screening stage	Investigations stage	Case Examiners stage	Adjudication stage	Total caseload
Nurse	73.6%	94.1%	94.2%	93.8%	**85.9%**
Midwife	5.7%	4.2%	5.2%	5.3%	**5.1%**
Nurse & Midwife (Dual)	0.3%	0.1%		0.1%	**0.1%**
Nursing Associate	1.0%	1.6%	0.6%	0.8%	**1.1%**
No Registrant PIN linked to case	19.5%				**7.7%**
Grand Total	**100%**	**100%**	**100%**	**100%**	**100%**

Item 7
NMC/26/235
25 November 2026

Report to	Open Council	Meeting Date:	25 November 2026

Quarterly Risk Exposure Report November 2026	
Publication Status	Open
Presenting the Report	Ben Wesson, Chief of Staff
Executive Director	Ben Wesson, Chief of Staff
Report Author	Karen Sellick, Corporate Planning, Performance and Risk Manager Rebecca Desmond, Head of Corporate Planning Performance and Risk

PURPOSE OF REPORT AND REASON FOR RECOMMENDATIONS:

The purpose of this report is to provide our quarterly strategic risk report to Council. It is compiled with input from colleagues across the NMC to provide an overview of our risk landscape. The Council is asked to note the changes and decide whether the risks are being managed appropriately, so that any recommendations can be considered and implemented to strengthen our risk management approach and controls.

RECOMMENDATION(S):

1. The Council is asked to:
   a) **Discuss** whether we are managing strategic risks appropriately and whether there are any exceptions to address.
   b) **Note** the changes that have been made to the strategic risks since our last report to Council in July.

ANNEXES:

Annexe 1: Strategic risk register 2026-2027

Annexe 1.1: Risk appetites by category
Annexe 2: Strategic Issues Log
Annexe 3: Strategic risk threshold chart
Annexe 4: Strategic risk heat map
Annexe 5: Corporate Risk Framework 2026-2028

REPORT APPROVAL	
Executive Director:	Approved 10 November 2026
Director of Finance:	Considered at Executive Board
General Counsel:	Considered at Executive Board
Chief Executive and Registrar (CER):	Considered at Executive Board
Secretary to the Council:	Considered at Executive Board

External Engagement (undertaken to date)		
Committee / Group	**Date**	**Outcome**
N/A		

Consideration at Committee/Group		
Committee / Group	**Date**	**Outcome**
Audit and Risk Committee	9 November 2026	Reviewed and discussed the strategic risk register
Executive Board	10 November 2026	Reviewed and discussed the strategic risk register
Finance and Resources Committee	11 November 2026	Reviewed and discussed Finance, Cyber and Technology risks
Planning and Performance Committee	12 November 2026	Reviewed and discussed Regulatory Processes,

		Regulatory Reform, High Performing Organisation and Strategy risks

Quarterly Risk Exposure Report November 2026

1. SITUATION / BACKGROUND:

1.1. The purpose of this report is to provide our quarterly strategic risk report to Council. It is compiled with input from colleagues across the NMC to provide an overview of our risk landscape. We ask Council to note the changes and decide whether the risks are being managed appropriately, so that any recommendations can be considered and implemented to strengthen our risk management approach and controls.

1.2. The paper includes key themes from risk discussions with our risk network, which includes risk owners, Senior and Executive Business Managers (S/EBMs) from all directorates, stakeholders from our operational and people teams, portfolio management office and those that manage key priorities.

2. SPECIFIC MATTERS FOR CONSIDERATION

Strategic risk register updates since Council meeting on 21 July 2026

2.1. The strategic risk register is summarised at **annexe 1**.

2.2. The Corporate Risk Team held a **mid-year risk appetite review** session on 8 September with the Executive Board (EB). The session aimed to confirm whether our appetites were still appropriate and consider any amendments to the risks and their scores. As a result, the cyber element of the technology risk category moved from 'cautious' to 'minimalist', which means that **TECH26B** cyber risk now exceeds appetite. Whilst the risk is above threshold, EB accepted this in the short term because new controls will be in place shortly and KPMG will be carrying out an internal audit to identify the controls needed to reduce this risk.

2.3. Updated risk appetites and the threshold chart are shared in **annexes 1.1 and 3**, respectively. There are four strategic risks outside appetite: **REG26** – regulatory processes, **GOV26A** – regulatory reform, **FIN26** – financial stability and **TECH26B** – cyber. Each Executive Director (ED) risk owner is comfortable with their risk currently being outside appetite because work is underway that should bring it back within appetite, including:

2.3.1. REG26 Regulatory processes – Regulatory health checks are underway and will result in further recommendations to help mitigate this risk.

2.3.2. GOV26A Regulatory Reform – There are still unknowns that we cannot mitigate, but the team is laying the foundations to ensure business readiness for Regulatory Reform when we are asked to start work by DHSC.

2.3.3. FIN26 Financial stability – Multiple actions have been taken to bring our finances back under control, with the organisation concentrating on NMC-wide cost-saving efforts. Whilst we have made considerable progress in stabilising our financial position, the issue is yet to be fully resolved.

2.3.4. TECH26B Cyber – Due to the nature of this risk, updates on controls will be shared with Council in confidential meetings.

2.4. It has been agreed that risk appetites will be reviewed quarterly at EB, rather than twice yearly, to align with the recommendation in the Treasury's Orange Book.

2.5. We have completed our regular eight-weekly **ED risk owner updates**. Our discussions focus on overall assurance, reviewing descriptions and scores, as well as the evidence available to demonstrate that strategic risks are being well managed. Each planned action and risk measure is RAG-rated to show where things may be on or off track. This latest review confirmed that the majority of planned actions are on track and that there are no risk triggers (i.e. evidence suggesting poor performance of controls) to cause concern.

2.5.1. While new controls and planned actions are being introduced, many of our higher-rated risk scores have not yet decreased. This reflects the long-term nature and complexity of these risks (for example, FtP), as well as the need to await the outcomes of evaluations such as the regulatory health checks, which will determine effective controls for regulatory processes. Delivery of our existing improvement plans and the actions arising from these evaluations will drive further improvement in performance against our risks.

2.6. As a result of these discussions and EB meetings, specific updates were made to the following risks:

2.6.1. At EB on 17 November 2026, the likelihood score for **TECH26B: Cyber** risk was increased, raising the overall risk score from AMBER 15 to RED 20. This reassessment was due to recent high-profile cyberattacks and advice from our internal auditors regarding the increased volume of AI-generated attacks. Recent Committee discussions also supported an increase in the score.

2.6.2. Data is being split out from **TECH26A: Fit for purpose technology**, as there is distinct work in place to manage data and technology concerns separately. The data risk will be presented to Council within the strategic risk register once its profile has been completed. The date for achieving the target risk score for TECH26A has been deferred to align with anticipated rollout milestones for Compass, the replacement case management system.

2.6.3. The date for achieving our target risk score for **GOV26B: High performing organisation** has also been deferred to reflect the volume and complexity of work required to build the foundations of a quality management system, operationalise it and embed it fully.

2.6.4. **PEO26B: Culture:** EB agreed at its meeting on 27 October 2026 to reduce the overall risk score from AMBER 12 to GREEN 8. This decrease reflects the work, controls and initiatives put in place to mitigate the risk and reduce its likelihood. These include our new values, development-

focused check-ins for all staff, the Management Development Programme and the Culture Coaching programme.

2.6.5. EB also agreed that a **business continuity and disaster recovery** risk should be added to the strategic risk register to reflect the current external landscape. Work is underway to update and escalate an existing operational risk that considers our minimum viable operations.

2.7. During these discussions, Executive Directors also provided details to support the next risk prioritisation exercise, which we will carry out with EB on 26 November. This exercise shifts the focus from standard likelihood and impact scores to analysing a risk's current impact on the Business Plan and the effectiveness of its existing controls. This discussion will highlight where we need to strengthen controls and mobilise resources to address the most urgent risks. The outcome of this exercise will be shared with the Audit and Risk Committee (ARC).

Corporate risk framework

2.8. The Corporate Risk Framework has been updated as part of its regular two-yearly review. ARC approved the framework at its meeting on 7 September (see **annexe 5**). The main changes include:

2.8.1. Additions to the glossary, including comprehensive assurance reviews (CARs), risk deep dives, operational risks and family trees, risk prioritisation exercises, risk tolerance, assurance and contingency. These terms and tools cover how we now manage risk;

2.8.2. How the framework supports our new values;

2.8.3. New risk appetites for 2026-2027; and

2.8.4. New Committees and their roles.

2.9. The updated framework will be shared with colleagues via our intranet.

Materialised risks (issues)

2.10. For live issues currently being managed and progressed, see **annexe 2**, our new Strategic Issues Log.

Risk exposures

2.11. **Staffing and recruitment:** Total NMC headcount started the year below establishment due to efficiencies work and recruitment controls. Headcount has seen a gradual controlled increase towards the agreed establishment primarily driven by pressures in FTP.

Risk deep dives and comprehensive assurance reviews (CARs):

2.12. Three of our committees convened ahead of Council to review the strategic risks they have specific oversight of, providing constructive challenge on our controls and the level of assurance that can be taken:

2.12.1. The **Planning and Performance Committee** focused on **REG26** (regulatory processes) and **GOV26A** (regulatory reform), both of which

are currently scored outside appetite at RED 20, the highest score on the register. REG26 is within our control, and we know its score will only decrease once the health checks are complete and the action plan starts to take effect. GOV26A is largely outside our control. The Committee asked whether the level of control should be reflected in the scores. We might hope that the likelihood would be lower for REG26, as we are proactively looking for weaknesses in our processes. However, this cannot be quantified until the health checks are complete and we understand the resulting level of risk. The ED risk owner will therefore review the score when those results are available, by February 2027.

2.12.2. The **Finance and Resource Committee** has oversight of the remaining two risks that are outside appetite. To gain clarity on how the controls will affect **FIN26** (financial stability) over time, it requested a visualisation of the risk trajectory. Due to the current uncertainty around the timing of initiatives and their impact, this recommendation will be revisited once further detail from the business planning and budgeting cycle has been collated. This will include a greater understanding of when key benefits, such as FtP efficiencies, will be realised. The Committee also queried whether there were specific efficiency targets for each directorate to help mitigate the risk of costs growing again, noting that non-PAYE savings alone may not have sufficient impact. The ED risk owner provided assurance about the organisation-wide War on Waste programme, as well as the targeted financial planning within each directorate as part of business planning. We are seeking to strengthen internal leadership and expertise in cybersecurity. Alongside this, an internal audit by KPMG will fully assess our controls and provide greater assurance for **TECH26B**. Until the findings are reported and actions implemented, we are unlikely to see this risk decrease by the next quarterly report.

2.12.3. The **Audit and Risk Committee** has oversight of the whole strategic risk register. **TECH26B** (cyber) was also a key concern in this discussion, and the Committee welcomed a future deep dive with the team to scrutinise the risk in detail. The Committee also supported separating **TECH26A** (fit for purpose technology), **TECH26B** (cyber) and data to allow more focus on each component and its controls, and more accurate risk scoring. The positive impact of the committees and the updated scheme of delegation was noted as an additional mitigation for **GOV26B** (High performing organisation), demonstrating the strengthening of our governance. The overall positive shift in risk culture at the NMC was also acknowledged, following a mid-year update on the action plan from the Annual Review of Risk Effectiveness 2025/26. The main theme from that review was improving our ability to proactively identify and effectively assess risk, rather than primarily responding to an issue or crisis. The health checks, planning for Regulatory Reform and cyber internal audit are all positive examples that demonstrate this shift in our approach.

The deep dive focused on our wellbeing risk **REG26/03** (operational risk for 2026-2027) has been deferred from the November Audit and Risk Committee (ARC) meeting to February 2027. This is because additional work is required to provide full assurance.

A CAR to review the impact of **Log and Learn** in its first year of implementation will also be presented at ARC in February 2027.

2.13. Further deep dives may be requested as a result of the risk prioritisation exercise at EB on 26 November. These may be hosted by the relevant oversight Committees to give them the required focus and expertise.

3. FINANCIAL / GOVERNANCE IMPLICATIONS:

3.1. None as a result of this paper.

4. RECOMMENDATIONS

The Council is asked to:

4.1. **Discuss** whether we are managing strategic risks appropriately and whether there are any exceptions to address.

4.2. **Note** the changes that have been made to the strategic risks since our last report to Council in July.

5. ASSESSMENT

Impact Assessment	Question / Consideration	Response
Equality, Diversity and Inclusion	Has an Equality Impact Screening been undertaken (including Welsh Language)?	Not applicable.
Safeguarding considerations	Are there any safeguarding implications?	Considered within operational risk REG24/01.
Four country factors and considerations	Are there any four country factors?	Factors are considered within risks where applicable.
Resource (incl People) implications	Are there any people implications?	Considered within strategic risks PEO26A and FIN26.
Risk implications associated with the work and the controls proposed/ in place.	What are the key risks and how are they mitigated?	This is the focus of this paper.
Legal considerations, incl Regulatory Reform	Are there any legal or regulatory implications?	Factors are considered within risks where applicable.

Midwives and/or Nursing Associates	Any specific implications for midwives and/or nursing associates?	Within REG26 and all operational risks associated with education, standards, registration and fitness to practise.

Annexe 1 - Strategic Risk Register 2026-2027

Risk ref	Strategic risk description	Risk owner	Current score			Current mitigations	Planned mitigations	Inherent score							Ultimate target score			Committee oversight
			L	I	Lxl			L	I	Lxl	Q4	Q1	Q2	Q3	L	I	Lxl	
REG26 Processes	**Regulatory objectives, targets, tools and processes are not robust or complied with**	ED T&TS	**5**	**4**	**20**	Executive & Council level (including Planning & Performance Committee) oversight of regulatory performance and strategic risk	R&R Improvement plan, FtP Improvement programme, EdQA Development Plan and MoTS covering people, systems and processes	**5**	**5**	**25**	**N/A**	**20**	**20**	**20**	3	3	**9** Mar 28	Planning and Performance Committee
						Governance of FtP Improvement Programme and wider transformation portfolio	Regulatory reform and incoming FtP Rules change											
						Operational QA and safeguarding arrangements (to come Operational delivery board - see planned actions)	Strategic workforce, capacity and demand modelling - specialised contractor to provide resource/scenario options to manage FtP caseload - inc demand through the system and reduction of backlogs to inform resourcing for caseload recovery and deliver sustainable regulatory performance											
						Workforce planning and recruitment governance through local and corporate RCPs. Financial forecasts prepared in partnership between the business and Finance Business Partners and subject of bi-monthly challenge sessions between relevant Exec Director and Director of Finance (Cross-ref with risk FIN26.) Recovery plan for FtP includes returning to headcount on key operational and decision making roles	Code review											
						Policy governance boards and forums inc. Patient Safety Intelligence Forum to share intelligence	Health checks across all regulatory operations to identify missing, inaccurate or inefficient processes, surface issues and allow corrective action to be determined and prioritised alongside other business priorities; ultimately leading to creation of a Quality Management System to work in partnership with all regulatory functions to ensure consisteny application of policies and procedures.											
						Internal team to review regulatory decisions with external referral mechanisms to PSA.	Manage incoming concerns proportionately through MoTS, Right Referral, Right Place											
						Partner support to deliver new ways of working (PWC - new ways or working).	regulatory reform programme to develop tight transition framework											
						Ongoing programme of training to target discrimination in regulatory context	EDQA programme											
						Regulatory reform programme to develop tight transition framework	Embed education improvement programme											
							Operational delivery board											
GOV26A Reg Reform	**We fail to capitalise on the opportunity of Regulatory Reform**	ED S&I	**4**	**5**	**20**	Can't control but maintain close policy and influencing engagement with DHSC	initial restacking in Q3, ongoing assessment thereafter	**5**	**5**	**25**	**N/A**	**20**	**20**	**20**	**3**	**5**	**15** TBC	Planning and Performance Committee
						Clarity about what we want to safeguard and full involvement in the drafting of the GMC Order	Continued full engagement in pan-regulatory work on the GMC draft Order											
						early identification of likely demand	Activity mapping based on the GMC draft Order											
						early attention to the technical/system demands of RR, as far as they can be predicted	Keep prog board membership under review as we move through phases of work now with representation from the tech and operational parts of the business. Periodic reviews of programme resources.											
						EB and Council attach the right priority to RR and begin at the right time to 'clear the runway' - giving clarity internally and externally about asks that will have to wait until after RR	learning sessions with Council and Executive to ensure decision makers have a good understanding of the opportunities and risks of RR. Policy visibility at programme board with issues to be escalated to EB											
						Programme manager recruitment Q2	onboarding project support at the right time											
						Planning of resources and implementation teams structure to be in place as soon as possible and regular re-evaluation of resource needs	early identification of process/system/tech changes associated with each change so that prioritisation is informed by readiness assessments											

						Ensuring a cross-organisational approach to planning and ongoing engagement with the EB.	working with the Chair of the new PPC to establish its sphere of interest in RR													
						Clear understanding and articulation of when technical IT and process design instructions are needed	comprehensive handover notes from key leavers													
						Sound oversight from Portfolio Board about interplay between RR implementation and other changes in flight														
						close working between TTS' work on improving current regulatory processes and RR work on future regulatory approach														
TECH26B Cyber	**We are compromised by a cyber security attack**	ED T&Ts	**4**	**5**	**20**	Detailed controls to be shared with Council in confidential meeting to maintain security	Recruitment of Head of Cyber	**5**	**5**	**25**	**N/A**	**15**	**15**	**20**	**2**	**5**	**10** 27/28	Finance and Resources Committee
						Cyber security workplan	Recruitment of Head of Busines Continuity													
						Mandatory information security training for all staff	Set-up of the Workplace Incident Response Group													
FIN26 Financial stability	**We do not have sufficient funds to operate**	ED Finance	**4**	**4**	**16**	Planning and budget controls including on-going prioritisation by Portfolio and Exec Board	FtP Development in train (RAG and due date will depend on outcomes) Resource planning; New ways of working; Case management; Process improvements	**5**	**5**	**25**	**20**	**16**	**16**	**16**	**2**	**4**	**8** Mar 27	Finance and Resources Committee
						periodic monthly/quarterly/annual business plan and budget reviews.	Further fee increase proposal being modelled-paper to EB with options Oct 26													
						Environment monitoring including economic outlook, registrant applications and numbers	Continued recruitment controls. Recruitment Control Panel continues to meet.													
						c. Insurance policies (e.g. for property damage, public/employee liability, cyber attack)	Longer term financial strategy													
						Centralised change function grips change planning & benefits capture including efficiency gains.	Identifying/implementing further income/savings options													
						Report Procurement pipelines to departments, contract management reporting farmwork, procurement system (atamis, ebis) and Procurement department plan	Reorganisation and centralisation of our Procurement and Contract Management teams including recruiting to vacant roles to ensure better oversight and the ability to track value for money and savings													
						Competitive procurement to ensure value for money. Review of STAs by Audit & Risk Committee 6-monthly.	Develop a detailed Procurement team strategy, implement more robust reporting which included pipelines, reporting and good practice and improved use of systems													
						DB pension trustees locked in most recent triennial review surplus. Buy-in options under review.	agree a revised reserves policy range to provide greater resilience													
						recruitment controls through the recruitment control panel														
						Finance and Resources Committee in place to bring greater focus to finance and delivery														
						reserves policy amended March 2025 to allow greater access to financial reserves to support activity.														
						Implementation of approved fee increase 2026														
						Roll out of "War on waste" project														
GOV26B High performing org	**We do not operate as a high-performing organisation**	ED T&Ts Chief of Staff	**4**	**4**	**16**	Standing Orders and Scheme of Delegation.	Reviews of Standing Orders and Scheme of Delegation	**4**	**5**	**20**	**N/A**	**16**	**16**	**16**	**3**	**3**	**9** Mar 29	Planning and Performance Committee
						Council member recruitment and succession planning	Review of composition of Council including skills matrix and succession planning													
						Corporate Plan and annual Business Plan with progress reviewed regularly by EB and Council	Qtly business plan performance reviews with EB, P&PC and Council													
						Executive and management coaching, leadership development initiatives and management development programmes.	Mid year business plan review, ahead of developing next annual plan/2027-30 Strategy													
						Turnaround and improvement activity has introduced additional skills, expertise and capacity.	Portfolio Board business case and overall portfolio reviews													

						Directorate restructures are undertaken to ensure leadership capacity, capabilities and accountabilities remain aligned to the NMC's strategic priorities, operating model and financial strategy	Review of Financial Strategy including investments and reserves policy												
						Right Referral, Right Time, Right Place programme supports more effective management of FtP	Income Generation working group convened to consider opportunities for additional income streams												
						Regular dialogue with the DHSC and government officials across the four countries regarding capacity constraints and external demand pressures.	Reconfiguration of Portfolio Board to ensure it has appropriate membership, skills and capacity												
						Strengthened performance management through the ambitious appraisal framework.	War on Waste to identify inefficiencies, duplication and opportunities for non-pay savings												
						Corporate KPIs and performance dashboards													
						Culture Transformation Plan inc values and behaviours coaching, alongside wider culture and leadership initiatives,													
						New Transformation and Technology Services Directorate for major change initiatives across the NMC.													
						Documented strategies and plans for our finances, investments and accommodation inc a suite of internal policy documents, Portfolio Board overview of programmes and projects, and Recruitment Control Panel.													
						Cross-directorate governance forums													
TECH26A Technology	**Our technology is not fit for purpose**	ED T&Ts	**4**	**4**	**16**	Automated fail over monitoring and testing	Review of business impact assessments as part of wider business continuity review	**5**	**5**	**25**	**N/A**	**16**	**16**	**16**	**2**	**3**	**6** Q3 2027 2028	Finance and Resources Committee
						Business Continuity plans (owned by Directorates)	Disaster recovery scenario planning												
						IT governance: planning, Technical Design Authority, Architecture, Design Board and AI governance	Review of cloud recovery options												
						IT roadmap prioritises new systems and system dev to meet business need	BC test scenario session - disaster activity (IT)												
						Out of hours support introduced	BC test scenario session - disaster activity (wider business impact)												
							Purview - microsoft product (to look at shared documents and how we share - applies rules - recognises legal docs etc)												
							Back recovery software introduced												
PEO26A Skills	**We do not have the right people, in the right roles, with the right skills**	ED P&C	**3**	**4**	**12**	Recruitment and onboarding processes in place.	Implement refreshed workforce plan by Q2 2026	**5**	**5**	**25**	**N/A**	**12**	**12**	**12**	**2**	**4**	**8** Apr 27	People and Culture Committee
						Learning and development offer, including mandatory and role-specific training	Expand leadership and development offers to build resilience												
						Performance and development reviews - AA identify capability and development needs. AA refinement means we now have 2/4 check ins dedicated to career conversations, skills and experience needed to progress and develop.	Improve workforce analytics to predict and respond to gaps												
						Leadership team are held to account, objectives are published, shared with wider SLG and cascaded down, and also refined each year to align to Corporate priorities. E.g. 2026/27 now includes a financial objective for ED's.	Work with S&I on RR requirements												
						Performance against project plans and outcomes is regularly monitored and action is taken where progress is slow or outcomes are not being achieved	Skills gap analysis to be carried out												

						Recruitment Control Panel, regular establishment and vacancy monitoring through workforce reporting. Regular review of organisational structure and role design	As part of our 2026 People and Culture Plan, we have a number of actions planned to support colleagues' career development: this includes implementing a 70/20/10 learning so that colleagues own their own development, and careers. We are developing a storytelling series to showcase colleagues' real career journeys at the NMC											
						Management and Leadership Development Programme	Legal profession, registrant profession, operational delivery profession (incl trauma aware work) given frameworks for recruitment, professional identity, a community and continued development											
						Agency and interim resource used where appropriate and necessary to maintain critical services	Manager development programme (4 levels in Oct/Nov - on track)											
						Established regular Leadership Group and Senior Leadership Group meetings	Year 2 Coaching programme refined and retendered based on organisational need and Year 1 analysis. EDI in delivery, Values and Enjoyment at work in preperation for next phase, Leadership planned for April+.											
						Targeted recruitment strategy for PR												
						Apprenticeships Programme												
						Review points are now automated to managers from HR Self Serve for colleagues with a reasonable adjustment/ flexible working arrangment												
STR26 Strategy	**We fail to deliver against our strategy**	ED S&I	**3**	**3**	**9**	robust strategy development process between Council and Executive, with proportionate internal and external engagement	Ongoing process for Strategy development	**4**	**3**	**12**	**N/A**	**9**	**9**	**9**	**2**	**3**	**6** Q3 26/27	Planning and Performance Committee
						we have a dynamic strategy and assess emerging imperatives carefully against planned actions, and either (a) increase resoruces/capacity (b) amend timelines, or (c) be transparent about what we cannot do	Careful assessment of unplanned work, at EB and PSB - with the option of rephasing or rescheduling other work to redeploy capacity											
						produce the skeleton of the strategy in time to inform business planning, and assess plan proposals rigorously against the strategy	A rigorous gateway for business plan content											
						assess and report on the extent to which our resoruces are supporting our strategic objectives	Portfolio benefits (monitored against FIN26)											
PEO26B Culture	**We do not create a positive, empowering and inclusive culture**	ED P&C	**2**	**4**	**8**	Management Development Programme that brings to life our policies and guidance. Embeds having challenging conversations, empowers and supports managers	Management Development Programme- levels - 21> current delivery, 3-4 planned on schedle to deliver	**5**	**5**	**25**	**N/A**	**12**	**12**	**8** ⇩	**1**	**3**	**3** Apr 27	People and Culture Committee
						Year 2 Coaching programme refined and retendered based on organisational need and Year 1 analysis. EDI in delivery, Values and Enjoyment at work in preperation for next phase, Leadership planned for April	Year 2 Coaching programme refined and retendered based on organisational need and Year 1 analysis. EDI in delivery, Values and Enjoyment at work in preperation for next phase, Leadership planned for April+.											
						A programme of 6 x 1-1 sessions with an external specialist partner for each permanent Executive Director to ensure a consistent and united Senior Leadership approach	Consolidated EVP offer, promotion of existing resources											
						Ambitious Appraisals that are consistent and ensure performance is monitored consistently and regularly. AA calibration and moderation	CMM feedback workshops, consistent approach to communication and engagement from top down- authors presenting at Board and Committee, all colleagues included and having at voice at team meetings											
						Regular communication and engagement from CER and SLT as a unified unit	Promotion of development opportunities at AA and in other forums, promotion of colleagues experiences of e.g. Rising Together											
						Corporate staff awards, local staff recognition shceme and other mechanisms ie. recognition of work at team meetings	Trauma informed and wellbeing frameworks developed alongside a professionalisation of all operational delivery											
						Regular 360 feedback that is acted upon	Mandatory Learning Review											
						ETSU ambassadors, ETSU Guardian	Regular structured meetings with UNISON to resolve pay/reward issues,											
						Employee engagement survey, staff suggestions at Executive Board, exit interview, and new starter feedback. Staff Networks	Close the loop with exit interview data, new starters, probation feedback.											

| | | |

Annexe 2 – Strategic Issues Log

Issue ID	Strategic Risk / Area	Issue Description & Evolution	Status & Current Trajectory
ISS-01	**REG26 (regulatory objectives, targets, tools and processes).** **Area:** Education QA	**Southampton Solent University (SSU) Deficiencies:** • ***Initial:*** Mental Health (MH) and Adult Nurse programmes deemed critical concern; Adult Nursing resolved. • ***Mid-point:*** Proposal drafted for past graduates; MH de-escalation recommended. • ***Current:*** MH programme officially de-escalated from critical concern; remains under Enhanced Scrutiny. Registrant Assurance Plan submitted for 107 past graduates. The plan concerns the registrants that are already on the register but completed a programme that was not in line with our standards. The plan sets out the remedial action that needs to be taken in order that we are assured that these registrants can remain on the register.	**In Progress (Enhanced Scrutiny)** • University under enhanced monitoring during 'teach-out' of old curriculum and launch of the new programme in Sept 2026 has been closely monitored. • The Registrant Assurance Plan is making progress, but slower than anticipated. Comms have planned for letters to registrants and stakeholders. This is now being reviewed by GCT prior to distribution.
ISS-02	**REG26** **Area:** Education QA	**University of Sunderland Nursing Hours Discrepancy:** • ***Initial:*** Non-compliant with multiple NMC standards; placed on critical concern monitoring. • ***Mid-point:*** Evidence review meetings held according to SOP; QA Board confirmed positive co-operation, no additional concerns emerging. • ***Current:*** Critical concern has been deescalated from critical concern status to minor concern.	**Closed (Critical Concern)** • 05 October 2026 – QA Board close the critical concern. • Affected programme is in 'teach-out' to allow currently enrolled students to finish.
ISS-03	**REG26** **Area:** Fitness to Practise	**FtP Performance and Capacity:** • ***Initial:*** Caseload has hit record highs from March due to a trending increase in referrals, complex and aged cases, delays and backlogs within process pipeline and lowest headcount in 2 years. • ***Current:*** Caseload reached an all-time record high of 7,849 in September including 659 new referrals. • Process remains bottlenecked in some areas due to linear dependencies. • The caseload at Screening, Adjudications and Case Examiner stage has increased this month. Investigation cases have decreased by 67 cases – as a result of cases being held up at the Screening stage. **Issues could result in:** • Registrant wellbeing and professional uncertainty • Public protection as concerns remain unresolved	**In Progress** • Accelerating recruitment across all FtP roles • Screening decision makers at full capacity but not yet up to speed (expected October) with further action to increase Screening Decision Makers • Long-term: Workforce modelling underway (3–6-month lag time expected for capacity recovery).

		• Likelihood of complaints about delays Costs increasing due to the need for additional staff	
ISS-04	**REG26** **Area:** Registrations & Revalidation	**Registration Investigation Team (RIT) Control Failures**: • ***Initial*:** Checks in RIT proved existing regulatory controls are ineffective; REG26 risk elevated to RED 20. **Current: As of Wednesday 12th November 2026:** • 81 percent of the Phase 2 caseload has been processed and completed (327/403 cases). • 223 cases have been considered by an AR through the weekly review meeting, all of which were accepted to remain on the register. • 99 cases have been closed without an AR decision being required. • 76 cases are open, and investigations are on-going. • *Going forwards, it is worth noting that we often receive declarations multiple times where registrants and applicants are being cautious. Whilst this is largely a matter of education and guidance, it is something that will continue to present, as individuals continue to be overzealous in providing us with information. Work is planned that should help to minimise declarations that are not required.*	**In Progress** • The Registration Review caseload has reached 81% completion rate.
ISS-05	**GOV26B (High performing organisation)** **Area:** Governance & Portfolio	**Corporate Portfolio Progress to Delivery:** • Currently 9 projects/programmes are 'Green' which demonstrates that issue and risk management is being well managed and that their current trajectory is positive for reaching their delivery objectives. • The remaining 3 projects are expected to return to 'Green' status after their expected Change Requests are submitted in November.	**In progress** • Work is continuing to drive an improvement in benefits management which will see benefits tracked into BAU and reported on through Benefit Owners.
ISS-06	**REG26** **Area: Education QA**	**Mental Health programme management concerns:** • *Initial:* Newly escalated concern self-reported by an AEI in early May.	**Open (Critical Concern)** • AEI have been notified of their critical concerns status and the

		• *Mid-point:* QAA Extraordinary Review Assessment conducted 18–26 June. Evidence submitted; QAA considering outcome. Paper of recommended actions prepared for the Executive Board and taken forward with the institution. • *Current:* escalated to critical concern for education status by extraordinary QA Board 29 September. Programme placed into critical concern. Action plan has been accepted as appropriate to address the concerns. Report not approved and will be returned to the QAA for points of clarification.	appropriate management process will now be followed • AEI are now reporting data on student fitness to practice on a fortnightly basis and this has seen nine final year students removed from their programme to date.

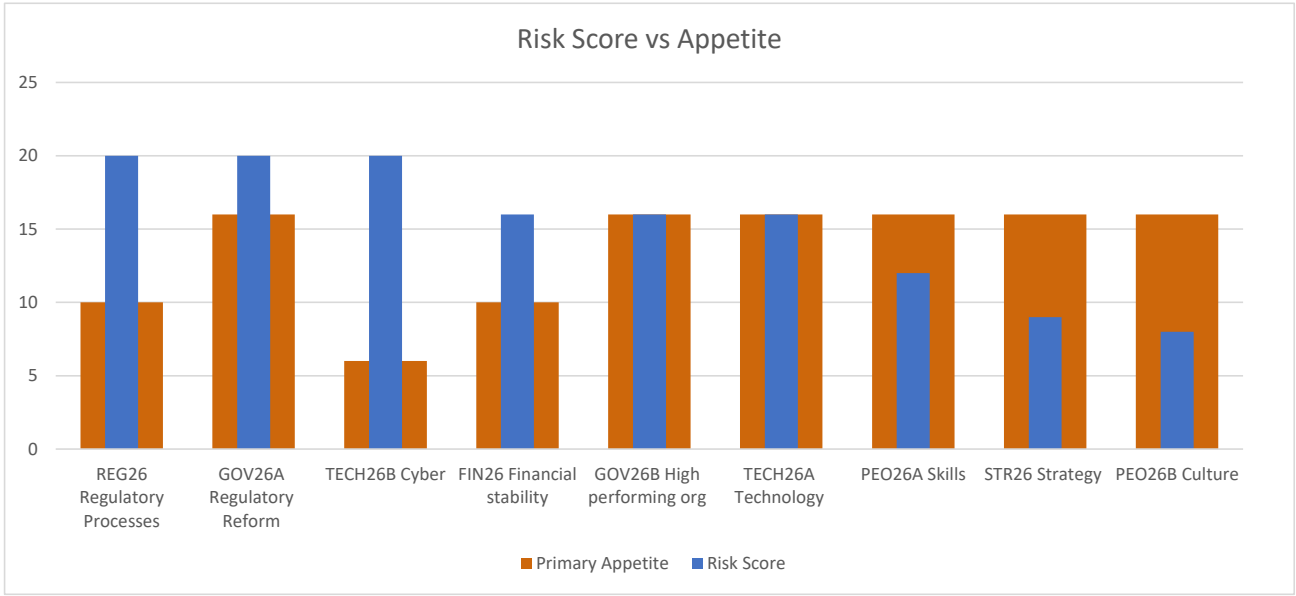
Annexe 3: Strategic risk threshold chart

	Risk Score	Primary Appetite	
REG26 Regulatory Processes	20	10	Cautious
GOV26A Regulatory Reform	20	16	Open
TECH26B Cyber	20	6	Minimalist
FIN26 Financial stability	16	10	Cautious
GOV26B High performing org	16	16	Open
TECH26A Technology	16	16	Open
PEO26A Skills	12	16	Open
STR26 Strategy	9	16	Open
PEO26B Culture	8	16	Open

Risk tolerance scoring chart

Appetite level	Risk Approach	Tolerance Boundary (Scores 1-25)
Averse	Avoid risks at all costs	1-3 Within tolerance 4-25 Out of tolerance
Minimalist	Accept risks only when unavoidable	1-6 Within tolerance 7-25 Out of tolerance
Cautious	Prefer safe options with low risk	1-10 Within tolerance 11-25 Out of tolerance
Open	Willing to take calculated risks	1-16 Within tolerance 17 -25 Out of tolerance
Eager	Innovate and take high risk for rewards	1-25 Always within tolerance

This model aligns with HM Treasury's Risk Appetite Guidance



Annexe 4 - Strategic risk heatmap

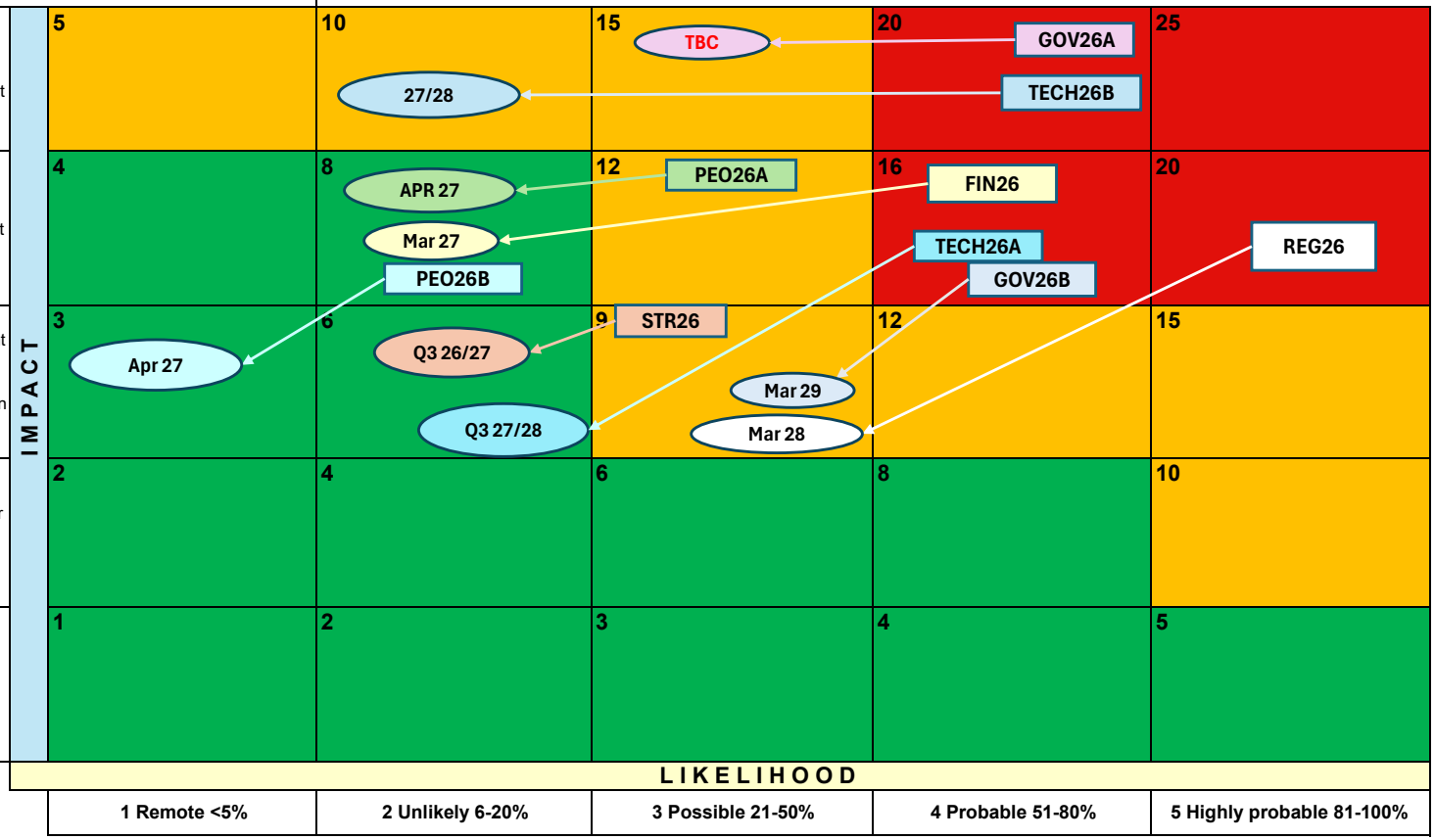
5 Critical
Significant impact on regulation or objectives cross cutting and difficult to recover from in the long term.

4 Major
Major impact on regulation or our objectives. Affects a significant part of the business. Difficult to recover from medium to long term.

3 Moderate Significant waste of time and resources, impact on efficiency quality or outputs. Not easy to recover from in the medium term.

2 Minor
Minor loss, delay, inconvenience or interruption. Objectives not compromised. Easy to recover from.

1 Insignificant
Minimal loss or delay, very easy to recover from.



Annexe 5: Corporate Risk Management Framework

Version date	August 2026
Release date	
Review date	August 2028
Linked documents	To support you in applying the Framework, there are "how to" guidance documents being updated and developed. These include: • Risk roles and responsibilities • Risk appetite guide • How to run a risk identification workshop • How to complete your risk register • How to score your risks • How to escalate a risk • How to prioritise your risks
Owner	Corporate Planning, Performance and Risk team
Author(s)	Karen Sellick Corporate Planning, Performance and Risk Manager Rebecca Calver Head of Corporate Planning, Performance and Risk

Glossary

Assurance	Risk assurance is an independent evaluation process that gives company leaders and boards confidence that their risk management systems and internal controls actually work in practice, rather than just on paper.
Comprehensive assurance reviews (CARs)	Risks owners present their risks to one of the Council sub-committees to talk about how the risk is managed, reason for the scores and what actions are planned for the risk to be reduced to its target score. The purpose is to provide overall assurance that the risk is being managed effectively and supplements our annual internal audit timetable.
Compound (aggregate) risk	When two or more risks interact, or happen simultaneously, the potential collective effect or impact on the organisation can be greatly increased (cumulative effect).
Contingency plans	What you may need to put into place if your existing controls fail (i.e., a plan B)
Controls	Risk controls are proactive steps that aim to prevent a risk from happening.
Current risk score	The risk score that you are experiencing at present, with the current mitigations or controls and they are in place and working.
Heat map	A risk heat map is a graphical representation of risk scores, where the values are contained in a matrix and are represented as colours – Red, Amber and Green (RAG) depending on how highly they score.
Incident reporting	A method where we capture issues that have occurred across the organisation (see **Log and learn**).
Inherent risk score	The risk score that you allocate before you have added mitigations or controls.
Issues (known and unknown)	Issues are materialised risks; they are events that have already happened and require us to take immediate action. Some issues are risks that we identified that have now happened (known issues) – in this case, we are likely to have contingency plans that we can use to reduce the impact and recover quickly. Some issues are a surprise to us because we have not anticipated or planned for them (unknown issues) - in this case, they tend to be more disruptive, more costly, take more time to recover from and have lasting consequences.
Log and learn	A database used to record incidents and issues that have arisen from any process across the organisation. Incidents are then reviewed to capture learning and identify opportunities to improve (see **Incident reporting**).
Mitigations	Risk mitigations are proactive strategies and actions used to lower the chance of a negative event happening or to reduce the severity of its impact. The goal is not to wipe out all threats completely, but to bring risks down to a safe, manageable level
Operational risks	Operational risks are collated in 'family trees' that sit underneath their linked strategic risk(s) to show the full risk landscape for that risk type. These risks will stem from inadequate or failed internal procedures, employee errors, or external events such as climate change. These would be managed, monitored and reviewed at directorate level to ensure effective controls and oversight are in place. They would be escalated to the Executive if the impact on delivery threatens our strategic aims.
Risks	Risks are uncertainties, which, if they happen, could negatively affect how we carry out our role as a regulator, service provider and an employer; and affect our ability to achieve planned strategic or operational objectives. Uncertainty can also be positive. Risk can also present opportunities to change our role or how we deliver an activity for the better.
Risk appetite	The amount of risk that an organisation is willing to take to meet their strategic objectives. Risk appetite at the NMC is set by Council (see also **risk tolerance**).
Risk deep dive	When a risk needs further scrutiny, either as a result of an incident or the **risk prioritisation exercise**. The risk owner will present the risk to a wider group (usually the Executive). The group will challenge the risk scores, controls, planned actions and overall risk management to gain assurance that enough is being done

	to manage and reduce the risk. The exercise may result in further management actions.
Risk family tree	A consolidation of all related risks (strategic and operational) within a risk appetite category to build a comprehensive risk landscape.
Risk management framework	A set of guidelines, standards and processes that seek to manage risk without impacting an organisation's ability to grow; striking a good balance between taking risks and reducing them.
Risk management process	Steps that are taken in order to manage the lifecycle of a risk including controls, mitigations, reporting and improvement.
Risk prioritisation exercise	Risk prioritisation exercises are carried out to help focus our attention and resources on those risks that need immediate management. The risk owner will score the risk on how confident they are that the controls in place are effective and the impact the risk may have on the business plan. This gives a different perspective to scoring on likelihood and impact alone. Risks that are deemed to be high priority (i.e., those where we lack confidence in controls) will be selected for a **risk deep dive** discussion to determine next steps.
Risk register	A risk register is a central document or database used to describe, assess, track, and manage risks. This a key governance document.
Risk tolerance	Risk tolerance is used to measure how far you will allow each risk to progress in the context of your overall risk appetite (see also **risk appetite**). There is a strategic risk chart that sits alongside the strategic risk register with a metric set for each risk showing if they are within or outside of tolerance. The risks have clear thresholds set to signal when a risk has exceeded the tolerance and needs to be escalated or requires a **risk deep dive**.
Risk trajectory	The direction of travel of a risk using inherent, current and planned risk scores and the target date showing when you expect the risk to either close or reduce.
Strategic risks	Strategic risks threaten an organisation's ability to deliver expected outcomes, which can harm the organisation's ability to grow and prosper. Such risks can arise from things such as technological change, an evolving external landscape, poor management, or changes in customer/stakeholder demands. These would be monitored and reviewed at Executive Board and Council level to ensure effective controls and oversight are in place.
Target risk score	The risk score that you expect the risk to reduce to once all of your mitigations, controls and planned actions are in place and making an impact.
Three lines of defence	A risk governance framework that splits responsibility for risk management across three functions: first line – operational, second line – compliance, and third line – audit (see **figure 1**).

1. Who does this framework apply to?

1.1. Our **risk management framework** covers all areas of our delivery to regulate, support and influence our relationships with the public, nurses, midwives and nursing associates, people who use our services, partners, and our colleagues.

1.2. All colleagues have responsibility for being risk aware and escalating any concerns appropriately, so it is important that they familiarise themselves with this framework and how to apply it within their roles.

1.3. The framework also supports our values:

- **Integrity:** Managing risks with integrity means aligning your risk choices with honest, ethical behaviour. It's about, facing problems openly, and accept responsibility when things go wrong.

- **Fairness**: Our framework helps us to be fair because it encourages regular reviews of evidence and context to understand the amount of risk that we may face. The way that we manage risk brings in views from across the NMC, at all levels, meaning that perspectives and accountability are shared. This way of working helps us to make good transparent decisions, have rounded discussions, balances the responsibilities of everyone involved, and helps us to do the right thing.
- **Respect:** We build open, supportive relationships where everyone feels valued and respected within their role to effectively manage risk. We act as one organisation when dealing with risk, collaborating and sharing information and expertise. We build strong networks across the organisation, bringing people together to share knowledge for greater awareness of the risks and issues that we may be facing.
- **Equity:** By involving others to think about risk, we work together to identify possible threats, opportunities, and mitigations, ensuring that we consider other people's views and perspectives.
- **Effectiveness:** Risk management underpins our strategy and business plan. To achieve our ambitions and to be an effective regulator, we need to take some planned **risks** so that we can innovate and take opportunities when appropriate. We are open to exploring new ways of thinking to make us more efficient and effective in dealing with risks.

2. Introduction

2.1. We work within an ever-changing regulatory context, where we need to make sure that the risks we take are intentional, well planned, and support the achievement of our business plan.

2.2. Risk is inherent in everything we do, whether we are delivering our regulatory duties, piloting new ways of working, or making significant changes to our infrastructure.

2.3. The amount of risk we experience at any one time is dependent on a number of internal and external factors. It is important that we understand our operating environment so that we can make informed decisions and take action to ensure that the level of risk is acceptable.

2.4. When risks are not understood and managed, they can negatively affect performance levels, efficiency, and the confidence and trust that the public, professionals on our register, and stakeholders have in us as a regulator.

2.5. The purpose of the **risk management framework** is not only to evaluate known risks, but to identify potential challenges or opportunities before they happen to prevent a risk from becoming an

issue.

2.6. We should not view risk management as a barrier to delivery, but as a tool for success, which enables us to make good decisions and appropriately allocate and prioritise resources.

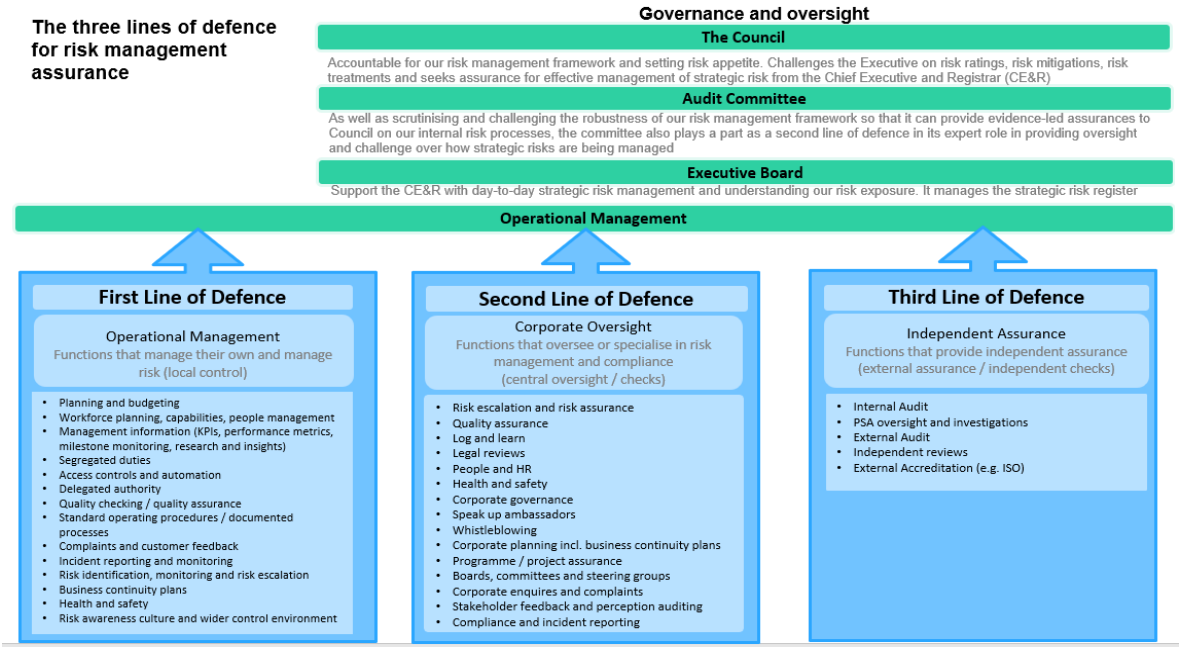
2.7. Our annual business plan and budget are developed with a focus on addressing the most significant risks facing the organisation. The activities that are listed within the business plan are prioritised due to the level of impact they will have on mitigating those risks. We are always driven to deliver activity which will tackle the largest areas of risk and provide the greatest benefit for us and the people we interact with. Activity is assessed and adjusted on an ongoing basis, as risks change and emerge.

2.8. On occasion, there will be external events that happen that we did not expect and are beyond our control. In this instance, we rely on robust risk and recovery **mitigations** within our framework and operations to manage the consequences of the risk i.e., using our three lines of defence model.

2.9. **Figure 1** outlines our **three lines of defence**. This model provides assurance that we have appropriate **controls** in place to help prevent risks materialising. The three lines mirror our governance structure so that these mitigations are proportionate to the level of risk. The aim is that the majority of risks will be effectively managed by controls at an operational level within the first line of defence.

2.10. Audit Committee appears in the overall governance of risk (see top of **Figure 1**) but also plays a part as a second line of defence in its expert role in providing oversight and challenge over how strategic risks are being managed (see **section 7.4.** for more detail on roles and responsibilities).

Figure 1: *The three lines of defence for risk management assurance*



3. Risk management

3.1. We use risk management to help us understand, assess, and take proactive action on risks to reduce the likelihood of an incident.

3.2. Risk management happens at every level of our organisation, across teams and directorates, within projects and programmes, and within our corporate governance structure.

3.3. Risk management is an integral part of day-to-day working, such as following standard operating procedures (SOPs), so that we can prevent and be alerted to risks continually.

3.4. It works best as part of an integrated approach with other corporate processes, such as business planning, performance management, change management, external and internal audit, **incident reporting (Log and Learn)** and quality assurance. Adopting a standard approach, outlined within the framework, helps us to be consistent in how we articulate, assess, control, and monitor risks.

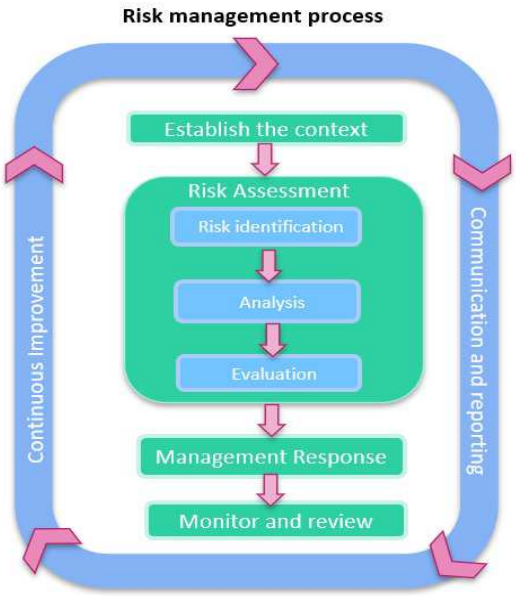
3.5. The benefits of an effective risk management framework are:

- To help us to be better prepared to identify potential problems or opportunities before they happen. This enables us to make informed, timely decisions on mitigations and plans and appropriately plan resources.
- It tells us how much risk we are willing to take.
- It allows us to take calculated risks/opportunities which are planned and controlled in order to deliver our strategy.
- Risk discussions are timely, structured, and targeted so we can act, learn, and continuously improve.
- Increased accountability through defined ownership and managing registers.

4. Our risk management process

4.1. Our **risk management process** provides a simple approach to consider risk. Our roles and responsibilities are the corner stone of this process. We have modelled our process on ISO 31000 risk management guidance from the International Organisation for Standardisation.

Figure 2: *Risk management process*



4.2. **Figure 2** outlines the risk management process, which can be broken down into stages:

4.3. **Stage 1: Establish the context:** before you begin risk assessing, understand the context you are working within by confirming your objectives and clarifying key internal and external drivers, which may affect your work.

4.4. **Stage 2: Undertake a risk assessment***:* once you are clear about the context, consider whether there are potential risks or opportunities, which could affect successful delivery of your objectives. Stages of risk assessment are:

- **Identification**: identify and describe the risk that might happen.
- **Analysis**: determine the severity of the risk or opportunity by analysing the likelihood together with the potential impact. Consider contributing factors and causations, potential consequences, and potential controls and their effectiveness. If the risk has materialised in the past, remember to use intelligence held within our **log and learn** system, as this will give you indicators as to how the risk was previously managed and the type of measures and controls that were put in place. This information may indicate that more stringent mitigating actions are needed, or that new preventative measures should be trialled to avoid a repeat incident.
- **Evaluation:** decide whether the risk or opportunity is within our **appetite** and **tolerance** by referring to our risk

appetite and tolerance guidance (section 6). If the risk falls outside of our appetite, seek guidance from the Corporate Risk Team.

4.5. **Stage 3: Management response:** once you have identified and evaluated the potential risks and opportunities, decide what action you will take. Will you treat, tolerate, or transfer (share) the risk or opportunity, or terminate the activity to avoid the risk altogether? Record this on your **risk register**.

4.6. **Stage 4: Monitor and review**: establish ongoing monitoring and periodic reviews of your risks. This ensures that your risk assessment and risk treatments (**mitigations**, **controls**, and **contingency plans**) remain up to date and appropriate. If there are any changes, you should return to the first stage of the process to check your assumptions.

4.7. You should also consider how you will regularly check that your risk management and controls are working effectively. This stage will inform your **risk trajectory** and target date and will indicate if the risk remains within **tolerance**. Your three risk scores will show the direction that your risk is moving in and if your controls are working. Your first score will show the level before you have added any controls, we call this the **inherent risk score**. Your **current risk score** will show the level of risk once you have added some mitigations. Your planned actions will inform your **target risk score** and is linked to a target date, this is when you expect your risk to either reduce or close as a result of your risk management controls (for more detail, see the *How to score your risks* guide).

4.8. **Stage 5: A continuous cycle of communication, reporting and improvement:**

4.8.1. Our risk management process is a key part of planning and monitoring. We should consider risk management within our annual business planning, when planning our change and transformation initiatives, when improving processes, and within day-to-day management. The information and learning we gather throughout the year feeds into the planning for the next.

4.8.2. **Communication and reporting:** You should document the outcomes of risk discussions and report these as part of regular governance processes. Keep the Corporate Risk Team updated on any changes to your risks or live issues – this will help the flow of information through the escalation process (as required) to ensure we respond to changes in a timely way.

4.8.3. Communicate with your stakeholders to keep them up to date about major threats, opportunities, key controls, and any actions that need to put in place. This is particularly important where risks are owned in one area of the business, but is managed, or the impact is felt, elsewhere.

4.8.4. Regular reporting of risks and issues is provided to Executive Board monthly, and Council quarterly (see **section 8**).

4.8.5. **Continuous improvement:** We should learn from risk events so that we can continually improve our processes, risk management approach and controls. You should revisit your risk descriptions, scores, and planned actions on a regular basis - we recommend every 8 weeks. This is to see if your descriptions reflect your current context and any changes to the risk; and that the controls and actions are reducing the risk as you would have expected, or if they need amending. If things have changed you should go back to the start of the risk management process to ensure that your risk still has the right focus. You may need to amend your risk description and mitigating actions or raise a new risk depending on your findings. Any learning that has been gained from reported incidents (i.e., **Log and Learn**) should be captured on your risk registers. You would need to report this to the Corporate Risk Team to ensure registers and reports are up to date.

4.8.6. Use your risk assessment to inform your decisions. Management information, **incident reporting** and monitoring, and localised risk

reviews (within teams or directorates) will provide key data about whether a risk is improving, stable or getting worse. This assessment should trigger an appropriate response to reduce, maintain or enhance existing controls.

4.8.7. The **log and learn** system is designed to capture learning and will help us to identify opportunities to improve. Thematic reporting of the types of incidents we experience will help us to assess if the prevalence of risks/issues is improving or getting worse by the number of incidents being reported. This will help target our review of controls and the resources required to reduce those types of incidents.

4.8.8. The annual review of risk effectiveness and control, carried out by the Corporate Risk Team, checks that our risks are being managed in line with our risk appetite and provides assurance that the controls that we are using are effective and proportionate. This annual stocktake gives us an opportunity to reflect and improve.

5. Risk maturity and culture

5.1. Our risk culture reflects our values and context. The regulatory environment which we operate within, our strategy and business plan, and our values and behaviours set the context for how much risk we are willing to take.

5.2. Linking our risk culture to our strategy allows us to be flexible and responsive within our plans, and to prepare for any potential risk events or opportunities which could occur.

5.3. Accepting some risk is necessary to ensure we are responsive and meet our objectives, especially as we move into new areas of work. The Council and Executive Board are committed to having a ‘risk aware’ culture rather than a ‘risk averse’ culture. This means that we are willing to accept some risk in pursuit of delivering our strategic objectives but are not willing to take risks that threaten our ability to regulate effectively or threaten patient safety.

5.4. Any risks we do take will be intentional and based on evidence to understand the potential opportunity, costs, and consequences or benefits for the public, people on our register, people who use our services, partners, and colleagues.

5.5. Effective risk management should support decision making to drive a ‘no surprises’ culture.

6. Risk appetite

6.1. **Risk appetite** is the amount of risk that we are willing to accept to achieve our objectives. Risk appetite helps us to understand our **tolerance** for risk taking.

6.2. The risk appetite classifications we use are based on those set by HM Treasury. There are five levels: adverse, minimalist, cautious, open, and eager.

6.3. The Council sets our risk appetite against six categories of risk using these classifications. The categories are people, technology, governance, regulatory/operational, strategy/expectations and financial (see **Figure 3**).

6.4. Risk appetites, whether strategic or operational, must not exceed the appetite set by the Council without their agreement. In some cases, we have an appetite range agreed to allow flexibility in applying our approach, considering the context or specific activities within the category or work. Some examples are provided in **Figure 3**.

Figure 3: *Risk appetites agreed by Council for 2026-2027. Ranges are set to a maximum of two appetites to allow for limited flexibility.*

Strategic risk appetites 2026 -27	Averse	Minimalist	Cautious	Open	Eager
Appetite description 1 = primary classification 2 = secondary classification applied on a case by case basis approved by EB	Avoidance of risk and uncertainty is a key organisational objective	Preference for ultra-safe business delivery options that have a low degree of inherent risk and a potential for limited reward.	Preference for safe delivery options that have a low degree of inherent risk which may only have limited potential for reward.	Willing to consider all potential delivery options and choose the one that is most likely to result in successful delivery while providing an acceptable level of reward (and value for money).	Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).
Categories of risk					
Regulatory/Operational (Risk associated with discharging our day to day regulatory duties)	**2** Defensive approach to operational delivery - aim to maintain/protect, rather than create/innovate. Priority for close management controls and oversight with limited devolved authority.		**1** Tendency to stick to the status quo, innovation avoided unless necessary. Decision making generally held by senior management. Management through leading indicators. **(Governance and OKR framework)**		
Governance (Risks associated with aligning the organisations business goals)			**2** Willing to consider actions where benefits outweigh risks. Processes, and oversight/monitoring arrangements enable cautious risk taking **(Fulfilling statutory requirements)**	**1** Receptive to taking difficult decisions when benefits outweigh risks. Processes and oversight or monitoring arrangements enable considered risk taking. **(New governance structure and agile decision making)**	
Strategy/Expectations (Risks associated with the pursuit of our strategic aims)				**1** Guiding principles in place receptive to considered risk taking. Strategy refreshed every 2-3 years. Appetite to take decisions with potential to expose organisation to additional scrutiny only where steps are taken to minimise exposure **(Adapt plans through ongoing prioritisation)**	**2** Guiding principles/rules in place welcome considered risk taking in actions and pursuit of priorities. Strategy refreshed every 1-2 years. Appetite to take decisions which are likely to bring scrutiny only where potential benefits outweigh risks. **(Risk-based assessment of activity)**
Financial (Risk associated with financial control, investments, fraud, supplier management)	**2** Avoidance of any financial impact or loss, is a key objective.		**1** Seek safe delivery options with little residual financial loss only if it could yield upside opportunities. **(Maintaining stability)**		
Technology (Risks arising from technology not delivering the expected services)		**2** Only essential systems and technology developments to protect current operations. **(Cyber, info sec and AI experimentation)**		**1** Systems / technology developments considered to enable improved delivery. Agile principles may be followed. **(Automation and innovation of systems)**	
People (Risks associated with organisational culture impacting our people)				**1** Prepared to invest in our people to create an innovative mix of skills environment. Responsibility for noncritical decisions may be devolved. **(To make change, as long as sustainable)**	**2** Innovation pursued – desire to ‘break the mold’ And challenge current practices. High levels of devolved authority – management by trust rather than close control. **(Developing people and addressing performance issues)**

Figure 4: Risk tolerance scores and descriptions: *aligns to our risk appetite using a simple scoring matrix:*

Appetite level	Risk Approach	Tolerance Boundary (Scores 1-25)
Averse	Avoid risks at all costs	1-3 Within tolerance 4-25 Out of tolerance
Minimalist	Accept risks only when unavoidable	1-6 Within tolerance 7-25 Out of tolerance
Cautious	Prefer safe options with low risk	1-10 Within tolerance 11-25 Out of tolerance
Open	Willing to take calculated risks	1-16 Within tolerance 17 -25 Out of tolerance
Eager	Innovate and take high risk for rewards	1-25 Always within tolerance

This model aligns with HM Treasury's Risk Appetite Guidance

Applying risk appetite

6.5. Risk appetite influences our behaviour when managing risks. We approach our risks with an understanding that our controls and responses need to be proportionate and in line with the agreed appetite. For example:

- If a risk category has an **adverse/minimalist** appetite we would expect a more cautious approach to risk taking, potentially higher investment in risk management resources, and substantial controls and mitigations in place to prevent **issues**.
- If a risk category has an adverse/minimalist appetite, but has a red risk score, this would indicate that the mitigations and controls are either not sufficient or not working effectively. Additional management actions would need to be applied and the risk would be escalated to the next level of governance for review to ensure the risk score is reduced back to a tolerable level for that appetite.
- If the risk category has an **open/eage**r appetite we would expect to see a greater willingness to test and try new processes, invest in projects, and direct resources towards taking opportunities, accept that there will be challenges and persevere through them.

- If we have a more open appetite for a risk, but several teams are implementing controls and processes to mitigate the risk, this may indicate that a disproportionate number of resources (e.g., staff time or funds) are being used to mitigate that risk. By reviewing risk management against the selected appetite, we can assess if our approach is proportionate and could allow us to free up resource for redeployment elsewhere.

7. Roles and responsibilities

7.1. Effective risk management requires clear responsibilities as people are at the heart of ensuring that our risk management is working well.

7.2. **Managers and leaders** are responsible for identifying, assessing, and treating risks and taking opportunities within their area of responsibility. They appropriately resource risk controls and contingency plans, and make sure that suppliers and partners work within our risk culture, appetite, and values.

7.3. **Everyone has a role to play** in spotting potential risks or opportunities and conducting their work with due care and control to avoid unnecessary risk. If you spot something that is of concern, speak to your line manager.

7.4. Corporate roles include:

- The **Council** is accountable for approving our **risk management framework** and setting risk **appetite**. They review our strategic risk exposure report quarterly and our strategic risk register annually. They challenge the Executive Board on risk ratings, risk mitigations, risk treatments and seek assurance for effective management of strategic risk from the Chief Executive and Registrar (CE&R). Council will recommend new risks if they identify gaps in our register or will suggest additional content if they feel that existing risk causations or treatments are not reflecting the current exposure. The Council review our annual review of risk effectiveness and controls and will highlight areas where they are not assured that risk is being managed well.

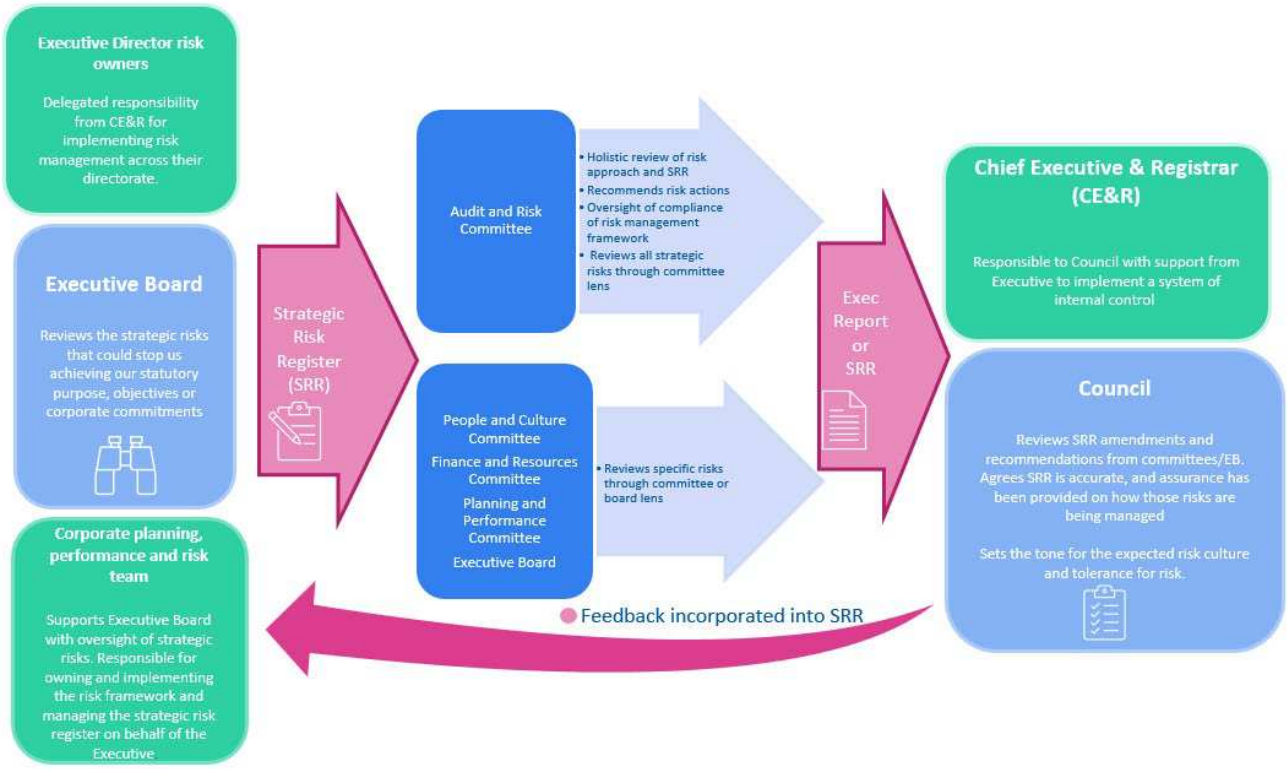
- **Audit and Risk Committee** scrutinises and challenges the robustness of our risk management framework so that it can provide **assurance** to Council on our internal risk

processes and provide oversight and challenge over how strategic risks are being managed. To enable this, the Committee reviews all strategic risks at each meeting, carries out deep-dive **comprehensive assurance reviews** on specific areas of risk and reviews our annual review of risk effectiveness and controls. The Committee will make recommendations where it thinks our risk management processes or management of specific risks should be amended.

- **People and Culture Committee, Finance and Resources Committee and Planning and Performance Committee** provide oversight for relevant **strategic risks** and some **operational risks**, through their committee lens, reporting any findings to the Council. This is to ensure that those committees with the relevant expertise and focus can help shape our risks to make sure they fairly reflect the context for that category of risk.
- Additional information on the roles of our committees and boards, including their involvement in risk management can be found in more detail on our website: Committees of Council - The Nursing and Midwifery Council (nmc.org.uk)
- The **CE&R** oversees the risk management framework agreed by the Council. They ensure that risks are identified and evaluated, that appropriate controls are put in place to mitigate risk and that progress is monitored and reported.
- **Executive Board** support the CE&R with day-to-day **strategic risk** management and understanding our risk exposure. It manages the strategic risk register; collectively agreeing risk ratings, risk mitigation and contingency plans, and reviewing risks that teams have escalated to them. They make sure that we implement our risk management framework.
- Executive directors are also **risk owners** for **strategic risks**. As a risk owner, they are responsible for proposing risk assessment scores, making sure that the risk is controlled and mitigated appropriately, monitored regularly and that Executive Board understand the risk.

- The **Corporate Risk Team** is responsible for embedding the risk management framework, developing risk management maturity and culture, and providing risk scrutiny. The team provides the Executive Board (EB), Council and committees with hands on support and oversight of strategic and operational risk registers. The team also has a role in risk identification and escalation for Executive Board's attention. They support the Governance team to structure EB agendas according to risk priorities so that risk is discussed at a strategic level, and recommendations cascaded to managers.

Figure 5: *Corporate roles for strategic risk management*



Directorate roles include:

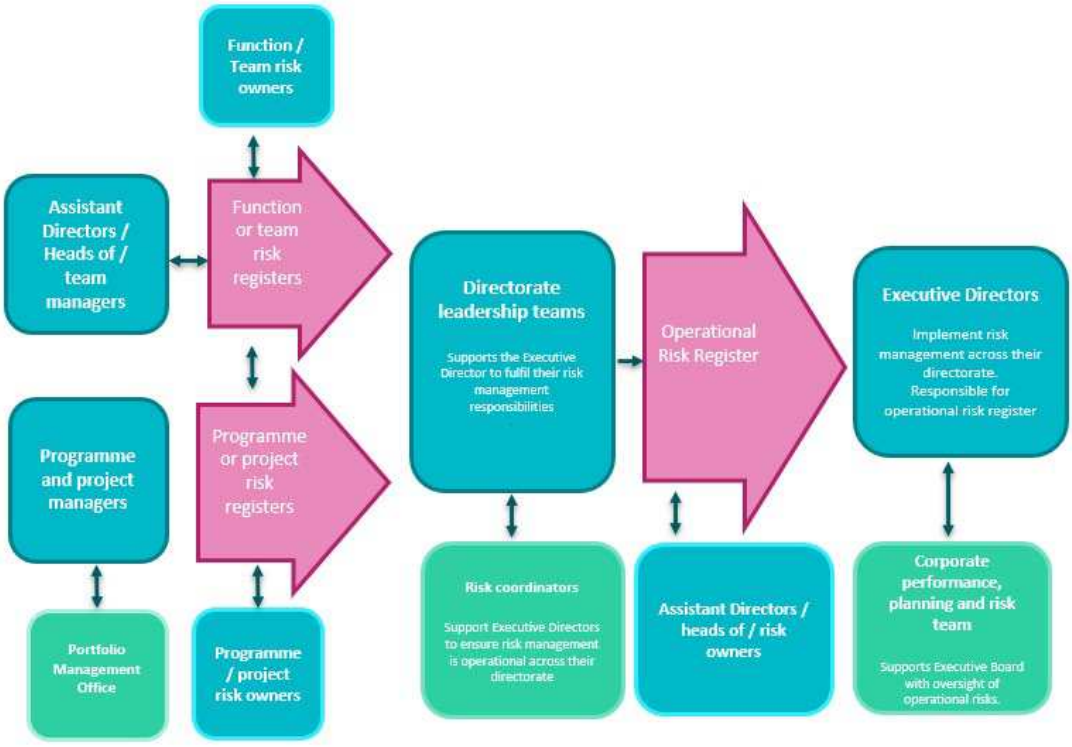
- **Executive Directors** have delegated authority from CE&R for implementing risk management across their directorate. They make sure that risk management and internal control procedures are in place and effective. Executive Directors are also senior responsible owners (SRO) for major programmes and projects within their directorate. They are responsible for making sure that the programme or project manages key risks.

- **Directorate leadership teams** support the Executive Director to fulfil their risk management responsibilities on behalf of the directorate. They support the Executive Director to identify, evaluate and treat potential risks, and to communicate major risks across the directorate. They also consider risks escalated to them or make recommendations for risk escalations.
- **Assistant Directors and Heads of departments** are responsible for implementing operational risk management procedures across their function and escalating risk to the directorate leadership team as appropriate. They may be risk owners for operational or project/programme risks. An Assistant Director may also be the SRO for a major programme or project and are responsible for making sure that key risks are being managed.
- **Programme and project managers** are responsible for identifying, monitoring, and reporting on programme or project risks. They will escalate major risks to the SRO and liaise with risk owners.
- **Risk owners** are responsible for proposing risk assessment scores, making sure that the risk assigned to them is controlled, mitigated appropriately, and monitored regularly. They liaise with key stakeholders to ensure that they understand key risk issues.
- **Risk coordinators** who are usually Executive Business Managers (EBMs) or Senior Executive Business Managers (SEBMs), support the Executive Director and directorate leadership team to coordinate the directorate's risk management activities. They champion risk management, maintain the operational risk register and periodically review team risk registers.
- The **corporate change and portfolio management teams** are responsible for ensuring that they implement risk management across the change portfolio and for setting risk procedures for programmes and projects, which aligns with the corporate risk framework. They support programme and project managers to manage risk throughout the lifecycle of the programme or project. They also identify and evaluate **compound (aggregate) risks**, which could potentially affect the portfolio. They escalate significant portfolio risks to the Executive Board, informing the corporate risk and performance team who maintain the strategic risk register.
- The **Corporate Risk Team** is responsible for supporting Executive Directors and leadership teams to implement risk management at strategic and operational levels. They provide advice, training, support, and tailored workshops so that teams'

functions can set-up risk processes. The team are also responsible for reviewing risks across the organisation quarterly to produce a compound or aggregate risk statement for the Executive and the Council. They highlight common risks across the organisation for the Executive and Council to consider whether more controls need to be in place or to confirm if they are content that sufficient mitigations are already in place.

- **All colleagues** have a responsibility for being risk aware and escalating any concerns they have to their line managers.

Figure 6: *Directorate roles for operational risk management*



8. Risk governance and monitoring

8.1. Risk reporting and monitoring highlights information about the most pressing risks at that moment. Typically, it will address

risks where consequences for us could be critical; as well as emerging risks that could cause us trouble in the future.

Corporate requirements

8.2. We consider risk implications within all governance reports and it is standing item within the report template.

8.3. Regular reporting includes:

- annual approval of the strategic risk register for the following financial year usually in April or May
- annual review of risk effectiveness and internal controls
- annual governance statement as part of our statutory annual report and accounts
- quarterly risk exposure reporting to Council, including the **strategic risk register, appetites, heat map** and **trajectories**
- quarterly risk report to the Audit and Risk Committee (all risks) and Finance and Resources Committee, Planning and Performance Committee and People and Culture Committee relating to only the risks that each committee oversees
- monthly risk exposure reporting to Executive Board, including the **strategic risk register, appetites, heat map** and **trajectories.** This is also an opportunity for risk owners to propose changes to scores and discuss controls.

Directorate and operational requirements

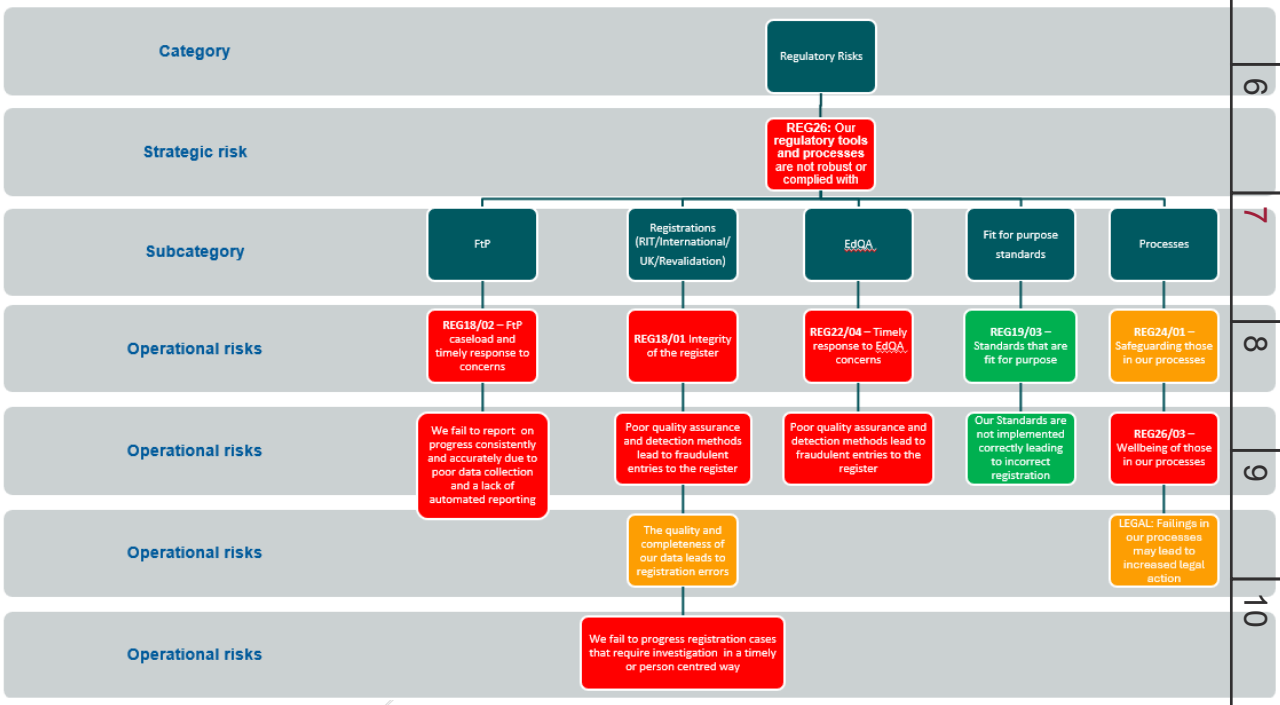
8.4. Each directorate maintains an **operational risk register** and **heat map.**

8.5. These consist of the generic operational risks for the organisation, but detail how they are specifically managed in that area. For example, the operational risk may be concerning colleagues' capabilities to fulfil their roles, so each directorate may identify specific training to mitigate that concern for their teams.

8.6. Operational risks will sit within a **risk family tree** with relationships determined by the overall strategic risk category. The tree consolidates all related risks (strategic and operational) into a comprehensive risk landscape to provide a

holistic view in inter-related risks. This supports how we assess the level of risk in a particular area and whether we are managing it effectively. They are reviewed at EB and relevant committees to support assessing our level of risk within each category.

Figure 7: *Example of a risk family tree for Regulatory risks. In this example many of the operational risks are RED, which supports the overarching strategic risk also being appropriately rated as RED.*



8.7. The directorate leadership team reviews the risks at least every eight weeks. The Corporate Risk Team scrutinise and provide peer review.

Programmes and projects

8.8. Each programme and project maintain a **programme or project risk register** which the teams review. Our programme and project boards discuss risks at each meeting.

8.9. The Portfolio Management Office (PMO) holds a **portfolio risk register**, which is reviewed quarterly by the Portfolio Board.

8.10. Programme and project risks are escalated to the senior responsible owner (SRO), who may escalate to Executive Board when they are strategically significant or to ask for resource to boost controls.

9. Risk escalation.

9.1. We escalate significant or urgent risks to the next level of authority for consideration, evaluation, or risk treatment (including allocating resources) when the risk level increases.

9.2. Escalation is an important process to support risk owners with managing risks that may be getting worse. A risk owner will send a risk to the next level of authority so that they can make decisions about risk treatment.

9.3. A risk may need to be **escalated** when:

- The risk becomes too difficult to manage at that level and additional mitigations are needed to control the risk.
- The risk could impact the delivery of a programme or project or is a barrier to benefit realisation.
- The risk will have cross-directorate or functional impact and therefore requires input from multiple risk owners.
- The risk exceeds the associated risk appetite, so the level of risk cannot be tolerated.

9.3. A risk can also be moved to a lower level **(delegated)** if:

- The risk can be adequately controlled or managed at an operational level.
- The risk rating decreases significantly.
- The risk has been stable for a long period of time without near-misses or major risk events.
- If the risk materialised, its impact would be limited.

9.4. The risk owner is responsible for escalating a risk. They should seek advice and guidance from the Corporate Risk Team or the lead of the relevant programme or project.

9.5. Someone who is not the risk owner may highlight that there is a need to escalate a risk. In this case, a recommendation will be made to the risk owner, or the SRO and they should take responsibility for the escalation process.

9.6. In practice, the Corporate Risk Team will highlight in the risk exposure report to EB, Committees and/or Council, any risks that need attention or have proposed changes.

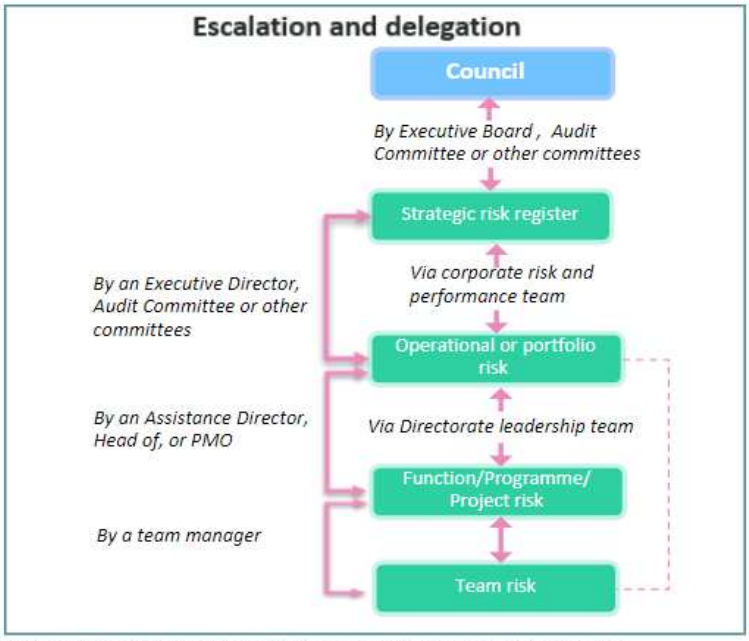
9.7. If you are proposing an increase or decrease to a **risk score** that already appears on the strategic risk register, the Corporate Risk Team will include this in their monthly risk exposure report for the Executive to consider. Please provide the score proposal with your rationale and the Corporate Risk Team will log the request for you.

9.8. Risk owners may need to escalate an operational risk to the strategic risk register, if they believe that the risk has significant strategic relevance. When escalating a risk, the Corporate Risk Team can provide a form to capture your escalations. If you are not the risk owner, you will speak to them first to see if they agree that the risk should be escalated. Once agreed you will detail what the contributing factors are, the impact that the risk would have if it materialised, the rationale for escalation and any recommended actions for consideration. The Corporate Risk Team will add the narrative to their risk exposure report for EB to consider. They may

- accept the escalation, and the risk will be included on the strategic risk register and will be assigned committee oversight as appropriate.
- decide that the risk is more appropriate to remain on its existing risk register for local management, but provide guidance as to what else can be done.
- ask you for further information to be able to decide appropriate next steps.

9.9. In cases where the Executive is unable to agree on the outcome of a risk escalation, the proposal will be shared by the Corporate Risk Team with Council for a final decision, see **Figure 8.**

Figure 8: *Risk escalation and delegation process*



*Risk escalation/delegation should be documented for assurance purposes
** Dashed line is the route if there is no function risk register in place (e.g. for small teams)

Please contact the Corporate Risk Team within Office of the Chair and Chief Executive directorate for support, advice and templates.

Item 8
NMC/26/236
25 November 2026

Report to:	Council	Meeting Date:	25 November 2026

Financial Performance Report Quarter 2, 2026-2027

Publication Status	Open
Presenting the Report	Christopher Kinsella, Executive Director of Finance
Executive Director	Christopher Kinsella, Executive Director of Finance
Report Author	Richard Wilkinson, Assistant Director, Finance and Audit Sevinj Essien, Head of Financial Planning and Analysis

PURPOSE OF REPORT AND REASON FOR RECOMMENDATIONS:

The purpose of this report is to provide an overview of our financial performance for the first six months of financial year 2026-27, to 30 September 2026. It summarises income and shows expenditure compared to budget across directorates and provides an updated forecast to the year-end.

RECOMMENDATION:

The Council is asked to:

- **Note** the attached financial report at **annexe 1** and discussed in the body of this paper.

ANNEXES

The following annexe is attached to this paper:

Annexe 1 Financial outturn report for the six months to 30 September 2026

REPORT APPROVAL	
Executive Director: Christopher Kinsella	12 November 2026
Director of Finance: Christopher Kinsella	12 November 2026
General Counsel:	Not required – regular reporting
Chief Executive and Registrar (CER):	Not required – regular reporting
Secretary to the Council:	**Approved** 17 November 2026

External Engagement (undertaken to date)		
Committee / Group	**Date**	**Outcome**
None	Not applicable	Not applicable

Consideration at Committee/Group		
Committee / Group	**Date**	**Outcome**
Executive Board	27 October 2026	A more detailed version of this report was presented to Executive Board to note and discuss. The Board also reviews a detailed report each month.

Financial Performance Report Quarter 2, 2026-2027

1. SITUATION / BACKGROUND

1.1. The report provides an overview of our financial performance for the first six months of financial year 2026-27, to 30 September 2026. It summarises income and shows expenditure compared to budget across directorates and provides an updated forecast to the year-end. Details are shown at **annexe 1**.

1.2. The forecast reflects the increase in the registrant fee from 1 October 2026.

1.3. At time of producing this report, draft management accounts showing outturn for the seven months to 31 October have been prepared although they have not yet been discussed by the Executive Board. The overall position and forecast indicated by those draft accounts is not materially different to the position set out below.

2. SPECIFIC MATTERS FOR CONSIDERATION

Overview of Financial Performance and Forecast

2.1 At the end of September our reserves, as measured by cash and investments, stood at £42.5 million. This is above budget, reflecting a lower-than-budgeted accounting deficit driven by underspending and slippage in spend to date and additional one-off income (a settlement received in July from a supplier). It also reflects brought forward reserves from the previous financial year being higher than assumed in the budget. These favourable variances were partly offset by lower-than-expected income from overseas applications. As highlighted in our report to 21 July Council **NMC/26/199** the positive variance also reflects a significant provision driven by an expected tribunal case no longer being required.

2.2 Looking ahead, our current forecast shows expected reserves at 31 March 2027 of about £28 million compared to the budgeted £16 million. The forecast assumes a significant acceleration in spend in some areas in the second half of the year. Most significantly, that our Professional Regulation Directorate, which manages our Fitness to Practise (FtP) work, spends an additional £4 million (14%) in the second half of the year compared to the first. This reflects our drive to recruit to vacant posts as well as some additional posts to help address increased workload.

2.3 Otherwise, key drivers of the forecast improvement in reserves compared to budget are additional income of £7 million expected from the registrant fee rise from 1 October, the one-off supplier settlement, offset by a reduction in income from overseas applications. In addition, anticipated costs and payments of over £4 million due to the tribunal case are no longer required.

2.4 There are also some other forecast variances as set out in **annexe 1**. For core directorates it should be noted that we have an assumed 6% vacancy rate on staff posts deducted from their budgets. This is not intended to deter vacancy-filling but is a budgeting tool that reflects the typical level of vacancies across the organisation in recent years. As a result, directorates that have a lower than 6%

vacancy rate are likely to overspend. We are considering holding the vacancy assumption centrally for the next financial year.

2.5 Although forecast reserves at 31 March 2027 have improved compared to budget, they will remain significantly below the £50 million held at the start of the year. This reflects our forecast deficit of about £22 million for 2026-27, alongside continued capital investment.

2.6 Whilst our budgeting process for next year is still underway, our initial projections for 2027-28 continue to indicate a deficit. This is to be expected even in the context of the October fee rise since it will not generate its full annual income benefit of £21 million until 2028-29. This full benefit compares to the expected deficit of £22 million in this financial year and the context of higher than anticipated CPI inflation. We are also facing significant workload pressures, in particular with FtP referrals continuing to rise, having already risen 40 percent in the past three years from 5,068 in 2022-23 to 7,152 in 2025-26.

2.7 Against these pressures we continue to work, through a range of programmes, to bring significant improvements to our efficiency on top of those already made.

Income

2.8 Total income is in line with budget, however overseas applications continue dropping significantly (by 30%) compared to budget. Actual overseas applications and registration fees for the year to date amounted to £0.9 million against a budgeted £1.4 million. Our income forecast is adjusted to reflect this ongoing drop, and we are now projecting £1 million less income from overseas applications this year compared to a budgeted £2.7 million. It also reflects the increase in fees for the professionals on our register.

Core business costs – key variances

2.9 **Professional Regulation** is £1.1 million (4%) underspent at the end of September, primarily driven by staff vacancies and lower-than-planned hearing costs resulting from reduced activity levels. These savings have helped offset cost pressures within Investigations and Case Preparation and Presentation teams, where increased case volumes, greater use of external case presenters, and the financial impact of a significant appeal case have led to higher expenditure.

2.10 The overall position remains significantly impacted by vacancies, although these are reducing. Staff numbers at end September were 46 FTE (7%) below budget. This compares to 63 FTE (10%) below budget at the end of August and 84 FTE (13%) below budget at the end of June. With a strong recruitment drive across key operational areas, the current underspend is expected to be offset, with an overspend of up to £1 million forecast for the full year.

2.11 **Transformation & Technology Services** is near budget to date but forecasting a year-end overspend of £1.0 million (6%), primarily driven by a lower than budgeted vacancy rate and increased IT hosting costs, previously approved by Council.

2.12 **Office of the Chair and Chief Executive (OCCE)** is £0.7 million (20%) over budget year to date, reflecting a combination of staff cost pressures and higher external legal costs. The year-end overspend is forecast be £0.8 million (11%), due to a low vacancy rate and recently approved additional resources including for operational teams that provide support to FtP panellists and regulatory assurance.

2.13 **Professional Practice** is underspent on budget by £1.1 million (12%) largely due to the number of vacancies across Casework Support, International Registration, Registration Investigations and Education Quality Assurance (EdQA) teams. Lower than budgeted spend on our external EdQA and slippage along the Professional Practice Roadmap activities are also contributing to the underspend. Recruitment for roles are now underway with plans to have most roles filled by January. The full year forecast of £1.2 million (7%) reflects the same factors.

Corporate spend

2.14 **Contingency:** currently we are showing no allocation against the contingency £1.4 million forecast for the year. Significant unbudgeted pressures include 'Exceptional items' (see below) totalling at least £1.3 million for the year as well as the income shortfall for overseas applications (forecast as £1 million at this stage). To the extent that the contingency is used to offset these identified pressures (and no further pressures arise), then the current total forecast spend will be reduced.

2.15 **Depreciation:** This is a non-cash item and does not affect our reserves although it does impact on our reported surplus/deficit. Although cost to date is in line with profile, the forecast for the year is for depreciation to be higher than budgeted by £1 million. This reflects capitalisation in March of some IT intangible (software) assets as part of preparation of the year end accounts and which were, as a result, omitted from the budget estimate of depreciation prepared earlier.

2.16 **Other:** The prime item and change within this £4.1 million corporate budget is the withdrawal of a tribunal claim, releasing some £4 million of expected costs and payments. This mirrors the approach taken in our annual accounts for 2025-26 with the agreement of our external auditors. This change in approach reflected events after the year end and so after the budget was agreed.

2.17 **War on Waste:** also included in 'other' is the £0.5 million savings forecast for the War on Waste project, which is progressing at pace. As part of this, Waste Watch was launched to all colleagues asking for suggestions along with a questionnaire to gauge their understanding of value for money and how they influence it in their role. So far there is a potential of £1.19 million of cashable actions, with £0.181 million delivered. Confidence remains high in meeting the targeted £0.5 million target for the year. There are also a range of suggestions which will support non-cashable actions to make improvements including to performance reporting and processes which may lead to further savings in the future.

Programmes and Projects

2.18 Expenditure shows a net underspend on budget of £3.5 million (42%) which reflects revised delivery timelines and the rephasing of expenditure rather than reductions in overall programme cost. This is also reflected in the forecast where some costs will be taken into 2027-28.

Exceptional Items

2.19 **Health Check** – work to review and assess regulatory processes has incurred costs of £0.25 million to date. The estimated total expenditure on this initiative is forecast at £0.5 million although, given the benefits identified from this, options to extend it are being considered.

2.20 **Incident Support** – actual spend year to date is £0.6 million. This is an unbudgeted initiative that was approved after the 2026-27 budgets were set. Total external expenditure is forecast to be around £0.7 million this financial year, bringing the total project cost (before internal staff) to just under £1.1 million.

Other areas to note

Investments

2.21 Our portfolio of externally managed investments, totaling £40 million at the end of September, continues to consist of liquid short-term funds designed to optimize income while minimising risk.

Staff numbers

2.22 **Annexe 1** also shows Full Time Equivalent (FTE) actual compared to budget. As reflected in the commentary above, there are significant levels of vacancies: 9% overall with higher levels in frontline regulatory functions. This compares to the assumed 6% vacancy rate at the time budgets were set. This is impacting delivery and has an impact on FTE (and hence financial) forecasts.

2.23 The year end forecast reflects both some increases in staffing approved by the Executive Board and our Recruitment Control Panel and a strong current drive to boost recruitment to support regulatory delivery. Assumptions on actual net recruitment performance are probably at the upper end of what is likely to be achieved.

3 FINANCIAL/GOVERNANCE IMPLICATIONS

3.1 These are addressed in the body of the report. This paper has been cleared with the Executive Director of Finance.

4 RECOMMENDATION

4.1 Council is asked to:

- **Note** the attached financial report at **annexe 1** and discussed in the body of this paper.

5 ASSESSMENT

Impact Assessment	Question / Consideration	Response
Equality, Diversity and Inclusion	Has an Equality Impact Screening been undertaken (including Welsh Language)?	Not applicable.
Safeguarding considerations	Are there any safeguarding implications?	No.
Four country factors and considerations	Are there any four country factors?	No.
Resource (incl People) implications	Are there any people implications?	Financial resource implications are addressed in the body of the report. No direct people implications.
Risk implications associated with the work and the controls proposed/ in place.	What are the key risks and how are they mitigated?	This report helps address the strategic risk FIN21/02 which deals addresses the risk of not achieving a sustainable budget.
Legal considerations, incl Regulatory Reform	Are there any legal or regulatory implications?	No
Midwives and/or Nursing Associates	Any specific implications for midwives and/or nursing associates?	No

Item 8:Annexe 1
NMC/26/236
25 November 2026

Nursing and Midwifery Council Financial Monitoring Report

£'m	September 2026 Year-to-Date				Full Year			
Income	**Actual**	**Budget**	**Var.**	**Var. (%)**	**#Forecast**	**Budget**	**Var.**	**Var. (%)**
Registration fees ^	52.1	52.2	(0.1)	(0.2%)	111.7	105.2	6.5	6%
Other ^^	3.1	2.0	1.1	53%	4.4	4.1	0.3	8%
Total Income	**55.2**	**54.2**	**1.0**	**1.8%**	**116.1**	**109.3**	**6.8**	**6.2%**
Expenditure								
Core Business								
Professional Regulation	26.7	27.8	1.1	4%	57.2	56.2	(1.0)	(2%)
Transformation & Technology Services	8.0	7.9	(0.1)	(2%)	16.8	15.8	(1.0)	(6%)
Finance	5.4	5.1	(0.3)	(6%)	11.1	10.9	(0.2)	(2%)
People & Culture	2.4	2.2	(0.2)	(9%)	4.8	4.4	(0.4)	(8%)
Office of the Chair & Chief Executive	4.2	3.5	(0.7)	(20%)	8.2	7.4	(0.8)	(11%)
Professional Practice	7.6	8.7	1.1	12%	15.5	16.7	1.2	7%
Strategy & Insight	1.8	2.0	0.2	9%	4.3	4.2	(0.1)	(2%)
Communications & Engagement	1.5	1.6	0.1	6%	3.4	3.2	(0.2)	(6%)
Directorate - Core Business	57.5	58.8	1.3	2%	121.2	118.8	(2.4)	(2%)
Corporate								
Depreciation	2.4	2.4	-	-	4.8	3.8	(1.0)	(27%)
PSA Fee	1.2	1.2	-	-	2.5	2.5	-	-
Apprenticeship Levy*	0.2	0.2	-	-	0.3	0.3	-	-
Contingency	-	0.6	0.6	100%	1.4	1.4	-	-
Other**	0.1	4.1	4.0	100%	(0.7)	4.1	3.4	83%
Total Corporate	3.9	8.5	4.6	54%	8.3	12.0	3.8	0.3
Total Core Business	**61.4**	**67.3**	**5.9**	**9%**	**129.5**	**130.8**	**1.3**	**1%**
Surplus/(Deficit) excluding Programmes	**(6.2)**	**(13.0)**	**6.8**	**52%**	**(13.4)**	**(21.5)**	**(8.2)**	**38%**
Programmes & Projects								
Accommodation Project	0.1	0.1	-	-	0.2	0.2	-	-
Modernisation of Technology Services	1.5	1.7	0.2	12%	2.3	2.0	(0.3)	(16%)
Technology Improvements	-	0.2	0.2	100%	0.4	0.4	-	-
Legislative Change	0.2	0.4	0.2	56%	1.0	1.0	-	-
Functional master & data project	-	-	-	-	0.2	0.1	(0.1)	(100%)
Legally Qualified Chairs	0.1	0.1	-	-	0.3	0.3	-	-
Regulatory Reform Project	-	0.5	0.5	100%	0.7	1.1	0.4	35%
FTP Improvement/Transformation	2.7	4.3	1.6	38%	5.2	5.6	0.4	7%
Fee Increase Implementation	-	-	-	-	0.2	0.2	-	-
Finance System Upgrade	-	-	-	-	0.1	0.1	-	-
ED QA IT & Data Project	0.05	0.02	(0.03)	(>100%)	0.1	0.1	-	-
Corporate Capital Programme Fund	-	1.0	1.0	100%	-	1.9	1.9	100%
Total Programmes/Projects	**4.7**	**8.2**	**3.5**	**42%**	**10.7**	**13.0**	**2.3**	**18%**
Exceptional Item: Health Check	0.3	-	(0.3)	(>100%)	0.5	-	(0.5)	(>100%)
Exceptional Item: RIT Incident Support	0.6	-	(0.6)	(>100%)	0.8	-	(0.8)	(>100%)
Total Expenditure including Capex and Exceptional Items	**67.0**	**75.5**	**8.5**	**11%**	**141.5**	**143.8**	**2.3**	**1.6%**
***less* Capital Expenditure**	1.6	3.1	1.5	49%	3.2	5.0	1.8	36%
Total expenditure excluding Capex	**65.4**	**72.4**	**7.0**	**10%**	**138.3**	**138.8**	**0.5**	**0.4%**
Net Surplus/(Deficit) including Capex	**(11.8)**	**(21.2)**	**9.4**	**44%**	**(25.4)**	**(34.6)**	**9.2**	**27%**
Net Surplus/(Deficit) excluding Capex	**(10.1)**	**(18.2)**	**8.1**	**45%**	**(22.2)**	**(29.6)**	**7.4**	**25%**
Reserves (Cash and Investments)	**42.5**	**25.4**	**17.1**	**67.4%**	**27.8**	**15.9**	**11.9**	**74.8%**

NB: *figures are subject to rounding*

* Apprenticeship Levy is tax paid to HMRC

**War-On-Waste, extra non-pay inflation pressure, employment tribunal provision

Forecast is as at 09 October 2026 (high level)

^ Registration Income Forecast includes additional income due to19.2% fee increase from 1 October 2026

^^ Includes overseas applications fee, bank interest

Balance Sheet (£'m)	Mar-26	Sep-26	Change	Change %
Fixed Assets				
Tangible and Intangible Fixed Assets	43.4	42.6	(0.8)	(1.7%)
Total Fixed Assets	**43.4**	**42.6**	**(0.8)**	**(1.7%)**
Current Assets				
Debtors	4.9	4.9	-	-
Fixed notice bank deposits and liquid investments	44.0	40.2	(3.9)	(9%)
Cash	5.6	2.4	(3.2)	(58%)
Total Current Assets	**54.5**	**47.4**	**(7.1)**	**(13%)**
Total Assets	**97.9**	**90.0**	**(7.9)**	**(8%)**
Liabilities				
Creditors	(16.0)	(16.8)	(0.8)	(5%)
Deferred Income	(41.4)	(43.5)	(2.1)	(5%)
Provisions and lease premium	(1.6)	(1.0)	0.6	37%
Total Liabilities	**(59.0)**	**(61.3)**	**(2.3)**	**(4%)**
Net Assets	**38.9**	**28.7**	**(10.1)**	**(17%)**
Reserves (Cash & Investments)	**49.6**	**42.5**	**(7.1)**	**(14%)**

Statement of Cash Flows (£'m)	Sep-25	Sep-26
Cashflow from operating activities		
Net Surplus/(Deficit) excluding Capex	(11.2)	(10.1)
Adjustment for Depreciation (Non-cash)	1.9	2.4
(Gains)/Losses on Investments	(0.9)	-
Investment/Dividend income	(0.6)	-
(Increase)/Decrease in current assets	(0.4)	(0.1)
Increase/(Decrease) in liabilities	(10.3)	2.3
Net Cash inflow/(outflow) from operating activities	**(21.5)**	**(5.5)**
Cashflow from investing activities		
Capital Expenditure (YTD)	(3.5)	(1.6)
Net Cash inflow/(outflow) from investing activities	**(3.5)**	**(1.6)**
Cashflow from financing activities		
Short and medium term investments moved from long term	-	-
Cumulative net increase/(decrease) in cash and cash equivalent at month end	**(25.0)**	**(7.1)**
Cash & Cash Equivalent at the beginning of the year	84.2	49.6
Cash & Cash Equivalent at the end of the month	**59.2**	**42.5**

Staff Full Time Equivalent (FTE)	September 2026				Full Year 2026-27 (as at end March)			
	Actual	Budget	Var.	Var.(%)	Forecast	Budget	Var.	Var.(%)
Core Activities								
Professional Regulation	602.0	648.1	46.1	7%	674.8	648.1	(26.7)	(4%)
Professional Practice	195.0	228.8	33.8	15%	227.8	227.8	-	-
Transformation & Technology Services	121.3	133.8	12.5	9%	136.3	134.3	(2.0)	(1%)
Office of the Chair and Chief Executive	77.8	81.8	4.0	5%	82.7	81.7	(1.0)	(1%)
Finance	55.9	58.0	2.1	4%	59.0	58.0	(1.0)	(2%)
Strategy & Insight	46.5	50.0	3.5	7%	53.0	51.0	(2.0)	(4%)
People & Culture	46.3	42.7	(3.6)	(9%)	42.3	40.7	(1.6)	(4%)
Communications & Engagement	35.6	35.0	(0.6)	(2%)	37.0	35.0	(2.0)	(6%)
Core Activites Total	**1,180.4**	**1,278.3**	**97.9**	**8%**	**1,312.9**	**1,276.6**	**(36.3)**	**(2.8%)**
Programmes/Projects								
Modernisation of Technology Services (MOTS)	6.0	8.0	2.0	25%	6.0	8.0	2.0	25%
FTP Improvement/Transformation	14.7	20.7	6.0	29%	5.0	4.0	(1.0)	(25%)
Functional master & data project	2.0	2.0	0.0	0%	1.0	1.0	-	-
Regulatory Reform Project	-	8.0	8.0	100%	8.0	8.0	-	-
Legislative Change	4.8	6.0	1.2	20%	6.0	6.0	-	-
Legally Qualified Chairs	-	-	-	-	1.0	1.0	-	-
Programmes/Projects Total	**27.5**	**44.7**	**17.2**	**38%**	**27.0**	**28.0**	**1.0**	**4%**
STAFF FTE TOTAL	**1,207.9**	**1,323.0**	**115.1**	**9%**	**1,339.9**	**1,304.6**	**(35.3)**	**(2.7%)**

Item 9
NMC/26/237
25 November 2026

Report to:	Council	Meeting Date:	November 2026

Quarterly Safeguarding Report Q2 (2026/2027)	
Publication Status	Open
Presenting the Report	Nicky Burns-Muir, Assistant Director for Safeguarding
Executive Director	Chris Dzikiti, Executive Director for Professional Practice
Report Author	Nicky Burns-Muir, Assistant Director for Safeguarding

PURPOSE OF REPORT AND REASON FOR RECOMMENDATIONS:

The purpose of this report is to provide the Council with oversight of safeguarding matters across the organisation and forms part of the NMC's established governance and assurance framework.

The report relates to strategic risk REG24/01, which is currently rated at 12.

RECOMMENDATION(S):

1. The Council is asked to:

- **Note** the safeguarding activity delivered to mitigate and reduce safeguarding risks at the NMC.

ANNEXES:

None

REPORT APPROVAL	
Executive Director: Chris Dzikiti Executive Director Professional Practice	**Approved** (30/10/26)
Director of Finance:	**N/A**
General Counsel:	**N/A**
Chief Executive and Registrar (CER):	**N/A**
Secretary to the Council:	**Approved** 17 November 2026

External Engagement (undertaken to date)		
Committee / Group	**Date**	**Outcome**

Consideration at Committee/Group		
Committee / Group	**Date**	**Outcome**

Safeguarding Board Quarterly Report Q2 (2026/2027)

1. SITUATION / BACKGROUND

1.1. The purpose of this report is to provide the Council with oversight of safeguarding matters across the organisation and forms part of the NMC's established governance and assurance framework.

1.2. The report relates to strategic risk REG24/01, which is currently rated at 12.

2. SPECIFIC MATTERS FOR CONSIDERATION

2.1. **Governance and Risk –** The safeguarding strategic risk is reviewed and updated at each Safeguarding Board meeting to reflect the current level of risk and ensure that planned actions are robust and reduce risk as far as possible.

2.2. Strategic risk REG24/01: *We fail to meet our statutory safeguarding responsibilities to protect people who come into contact with the NMC through our work from abuse and mistreatment.*

2.3. The current rating is within the organisation's agreed risk tolerance. It indicates that the risk is being managed with proportionate controls, supported by ongoing monitoring of compliance and escalation of concerns in line with the safeguarding policy.

2.4. Safeguarding Action Plan – Progress was made against the safeguarding action plan in Q2. The plan remains rated amber on the corporate performance dashboard.

2.5. Significant staff sickness in the safeguarding team has reduced operational capacity and delayed some work plan actions. To mitigate the impact, available resources have been prioritised to meet operational demands and respond to high-risk safeguarding and wellbeing concerns.

2.6. A waiting list tracker has been introduced for amber-rated safeguarding concerns and lower-risk wellbeing cases in response to ongoing capacity pressures. High-risk concerns remain the priority. The waiting list is reviewed weekly, and advice is provided as capacity allows to maintain oversight and manage risk.

2.7. A business case will be submitted for an additional Senior Safeguarding Adviser to strengthen team resilience and address increased demand. Safeguarding advice requests have risen by 46% following the introduction of the Fitness to Practise (FtP) Safeguarding Standard Operating Procedure (SOP) in October 2025.

2.8. Safeguarding Data **–** In Q2, 336 safeguarding cases were discussed at the Safeguarding Hub, and a further 436 referrals for advice were received through the safeguarding mailbox outside the Hub. A significant proportion of Hub cases involved sexual misconduct, child abuse and failures to safeguard. These cases illustrate the serious and complex concerns being managed, including behaviour

outside professional practice that may pose transferable risks to patients and the wider public.

2.9. Established safeguarding processes have been followed in line with the Charity Commission's safeguarding expectations. These include appropriate risk assessments, timely information sharing and referrals to relevant statutory agencies where required, to support the management and mitigation of safeguarding risks.

2.10. **Education and Training**

2.11. Mandatory Safeguarding Level 1 training – Compliance with mandatory Level 1 safeguarding e-learning is 95.2%, exceeding the organisation's compliance requirement of over 90%.

2.12. Safeguarding Essentials – Level 2 Safeguarding Essentials training compliance is currently 87%. Additional sessions were arranged to meet the organisation's compliance requirement but were cancelled because staff sickness reduced team capacity and operational duties took priority. The sessions are planned to resume in Q3.

2.13. At Risk of Self-Harm and Suicide Protocol – The protocol has been updated to strengthen the identification, assessment and management of self-harm and suicide risks. A supporting training package, including a video module, has been developed to guide colleagues in using the risk assessment tool, recognising risk indicators and managing sensitive conversations.

2.14. Implementation has been delayed by competing Learning and Development priorities; a revised launch date is yet to be confirmed. After implementation, tailored face-to-face training will be delivered to case teams. Practical scenarios will help colleagues assess risk, manage difficult conversations and respond to safeguarding and wellbeing concerns with greater confidence and consistency.

2.15. Following implementation of the At Risk of Self-Harm and Suicide Protocol training, a further programme will be developed to help colleagues manage complex and challenging situations throughout the regulatory process.

2.16. The programme will strengthen colleagues' confidence, knowledge and practical skills in managing sensitive conversations, applying professional curiosity, recognising escalating risks and responding to challenging behaviours. It will also cover effective communication, de-escalation, professional boundaries and person-centred, trauma-informed practice.

2.17. Practical case scenarios tailored to different regulatory teams will support consistent handling of complex interactions and help colleagues recognise when safeguarding advice, additional support or escalation is needed.

3. FINANCIAL / GOVERNANCE IMPLICATIONS

3.1. A business case will be developed for an additional Senior Safeguarding Adviser to meet current and future service demands arising from increased referral activity. The proposed resource would support delivery of safeguarding advice and guidance within agreed performance standards and strengthen the service's long-term resilience.

4. RECOMMENDATION

4.1. The Council is asked to:

- **Note** the safeguarding activity delivered to mitigate and reduce safeguarding risks at the NMC.

5. ASSESSMENT

Impact Assessment	Question / Consideration	Response
Equality, Diversity and Inclusion	Has an Equality Impact Assessment been undertaken?	No – this is an overarching report on safeguarding activity.
Safeguarding considerations	Are there any safeguarding implications?	Safeguarding implications are addressed throughout the report.
Four country factors and considerations	Are there any four country factors, including Welsh Language?	Yes – the safeguarding data covers all four countries.
Resource (incl People) implications	Are there any people implications?	Reduced team capacity and the proposed additional Senior Safeguarding Adviser are addressed in the report.
Risk implications associated with the work and the controls proposed/ in place.	What are the key risks and how are they mitigated?	Key risks and mitigating controls are set out in the report.
Legal considerations, incl Regulatory Reform	Are there any legal or regulatory implications?	No

Does this item require any procurement services	Have you spoken to the procurement team about requirements?	No
Midwives	Any specific implications for midwives?	No
Nursing Associates	Any specific implications for nursing associates?	No

Item 10
NMC/26/238
25 November 2026

Report to:	Council	Meeting Date:	25 November 2026

Annual Health and Safety Report 2025-2026	
Publication Status	Open
Presenting the Report	David Power, Head of Estates
Executive Director	Christopher Kinsella, Executive Director of Finance
Report Author	David Power, Head of Estates

PURPOSE OF REPORT AND REASON FOR RECOMMENDATIONS:

The purpose of this annual report is to inform the Council on how we ensure compliance with health and safety requirements, our security arrangements and the assurance available to the Council.

In terms of health, safety and security, the NMC is a relatively low-risk environment. However, it is still important and part of its statutory duties that the Council monitors the extent to which we have formal policies, guidance and procedures in place, assuring the health, safety, welfare and security of our employees, contractors and visitors.

The Council is asked to review and approve this report and the assurances and actions that have taken place over the period to support the above.

This report covers the 12-month period from 1 April 2025 to 31 March 2026.

RECOMMENDATION(S):

The Council is asked to:

- **approve** the Annual Health and Safety Report, as well as the new health, safety and security priorities recommended for 2026-2027.

ANNEXES:

The following annexe is attached to this paper:

- **Annexe 1**: Annual Health and Safety Report 2025-2026 v2.2

REPORT APPROVAL [mandatory for all Council/Committee Reports]	
Executive Director: Christopher Kinsella	**Approved** 30 October 2026
Director of Finance: Christopher Kinsella	**Approved** 30 October 2026
General Counsel:	**N/A**
Chief Executive and Registrar (CER):	**N/A**
Secretary to the Council:	**Approved** 17 November 2026

External Engagement (undertaken to date)		
Committee / Group	**Date**	**Outcome**
N/A		

Consideration at Committee/Group		
Committee / Group	**Date**	**Outcome**
Executive Board	27 October 2026	Endorsed the Annual Health and Safety Report to be presented to Council

Annual Health and Safety Report 2025-2026

1. SITUATION / BACKGROUND

1.1. The purpose of this annual report is to inform the Council on how we ensure compliance with health and safety requirements, our security arrangements and the assurance available to the Council.

1.2. In terms of health, safety and security, the NMC is a relatively low-risk environment. However, it is still important and part of their statutory duties that the Council monitors the extent to which we have formal policies, guidance and procedures in place, assuring the health, safety, welfare and security of our employees, contractors and visitors.

1.3. The Council is asked to review and approve this report and the assurances and actions that have taken place over the period to support the above.

1.4. This report covers the 12-month period from 1 April 2025 to 31 March 2026.

1.5. Professional Regulation (PR) publish their own annual report which includes the measures they undertake to support the health, wellbeing and safeguarding of nurses, midwives and nursing associates and other people who come into contact with the NMC in connection with Fitness to Practise (FtP), as well as PR colleagues.

2. SPECIFIC MATTERS FOR CONSIDERATION

2.1. The Council is asked to review and approve this report (**annexe 1**) and the assurances and actions that have taken place over the period.

2.2. As well as our regulatory health and safety responsibilities, the provision of a safe environment in which people can work promotes a ‘fit for future’ organisation.

3. FINANCIAL / GOVERNANCE IMPLICATIONS

3.1. Health and safety is part of the Estates budget with the People and Culture budget covering health and wellbeing items and initiatives for colleagues.

3.2. The sources of assurance listed in **annexe 1** and the overall report inform the Executive Board and Council of the arrangements and measures in place for health, safety and security.

4. RECOMMENDATION

4.1. The Council is asked to:

- **approve** the Annual health and safety report, as well as the new health, safety and security priorities recommended for 2026-2027.

ASSESSMENT

Impact Assessment	Question / Consideration	Response
Equality, Diversity and Inclusion	Has an Equality Impact Screening been undertaken?	EQIA assessments are undertaken, as required.
Safeguarding considerations	Are there any safeguarding implications?	Safeguarding is reviewed as part of the arrangement or process involved, for example lone or remote working, as necessary.
Four country factors and considerations	Are there any four country factors, including Welsh Language)	This report covers all four countries, with any individual country legislation considered, as necessary.
Resource (incl People) implications	Are there any people implications?	Heath, safety and security requirements and support are built into the yearly Estate's budget. People and Culture have their own budget in connection with colleague health and well-being. Both teams are directly involved in the provision of the above. For example, dealing with more complex DSE workstation assessments and associated reasonable adjustments, the provision of debrief and reflective practice sessions etc.
Support Risk implications associated with the work and the controls proposed/ in place.	What are the key risks and how are they mitigated?	This report provides assurance that we have the measures and arrangements in place to address health, safety and security risks.
Legal considerations, incl Regulatory Reform	Are there any legal or regulatory implications?	The NMC has an overall duty of care under the Health and Safety at Work etc Act 1974 and subsequent associated regulations and guidelines.
Midwives	Any specific implications for midwives?	Not applicable.
Nursing Associates	Any specific implications for nursing associates?	Not applicable.

Annual Health and Safety Report 2025-2026

Introduction

This annual report to Council reports on how we ensure compliance with health and safety requirements, our security arrangements and the assurance available to the Council.

In terms of health, safety and security, the NMC is a relatively low-risk environment. However, it is still important and part of their statutory duties that the Council monitors the extent to which we have formal policies, guidance and procedures in place, assuring the health, safety, welfare and security of our employees, contractors and visitors.

This report covers the 12-month period from 1 April 2025 to 31 March 2026.

Sources of assurance

1. The following arrangements are in place and provide assurance that we have measures in place to address health, safety and security risks:

1.1 A Health and Safety Steering Group (HSSG), chaired by the Head of Estates under the Executive Director of Finance, with membership drawn from across the organisation. During the reporting period the HSSG has met on four occasions, reporting to the Executive Board;

1.2 A Reasonable Adjustments Working Group (RAWG), co-chaired by the Head of People Services and the Private Secretary supporting the return to the office and hybrid working;

1.3 Health and safety is a standing agenda item at Executive Board meetings;

1.4 Mandatory e-learning on health and safety for all colleagues;

1.5 Training for compliance with statutory responsibilities and further training for specific roles, as necessary;

1.6 The health and safety policy statement signed by the Chief Executive and Registrar is displayed on our health & safety notice boards at each of our office premises;

1.7 A NMC Health and Safety guide for colleagues;

1.8 Sufficient trained first aiders and fire marshals at all sites, including refresher courses as necessary;

1.9 The provision of Mental Health First Aiders (MHFAs);

1.10 Personal Emergency Evacuation Plans (PEEPs) for colleagues with reasonable adjustments or disabilities, as necessary;

1.11 Fire Risks Assessments (FRAs) in place for all NMC buildings;

1.12 Fire alarm testing and evacuation drills at our buildings;

1.13 Security measures including CCTV and access control systems in place at all our properties; security guards on duty at our hearings venues;

1.14 A programme of planned preventative maintenance and compliance work to the mechanical and electrical plant and associated infrastructure, fire alarm, CCTV and access control systems;

1.15 Policies and guidance notes are reviewed and updated for compliance with any new legislation or best practice;

1.16 Health and safety includes consideration of colleagues' health and wellbeing which is also part of the NMC's People Plan owned by colleagues in People and Culture (P&C) – formerly People and Organisational Effectiveness;

1.17 Under the P&C remit, we continue to offer different channels of support to all colleagues including: the employee assistance programme, promotion of Thrive app, occupational health, Perkbox wellness hub, guidelines, risk assessments, group discussions and 1-2-1 meetings, as necessary. Further detail and activity can be found in the 'progress against priorities' section, paragraphs 12 and 13.

Reviews during the year

2. The Display Screen Equipment (DSE) Workstation assessment undertaken by colleagues was updated in April 2025. This revised and clarified the process of obtaining additional equipment for the work and home environment to support reasonable adjustments.

3. The Personal Emergency Evacuation Plan (PEEP) for colleagues with mobility issues during the time of an evacuation, was reviewed and updated in April 2025. The question asking if a PEEP may be required is also now included in the DSE Workstation assessment and the Ambitious Appraisal quarterly 'check-in.'

4. The Fire Evacuation Plans for all of our buildings were reviewed and updated in May 2025. As well as being publicised on Pulse, our internal messaging portal, the new Plans were also publicised at an All Staff Briefing.

5. A review of the NMC Health and Safety Guide for all staff was undertaken which included engagement with P&C, the Employee Forum and UNISON, our recognised union.

5.1 *Post Annual Report ending March 2026*

A new Guide was published and promoted to all staff in August 2026. This included a presentation at an All Staff Briefing and further promotion on Pulse.

6. The Reasonable Adjustments Policy was updated in November 2025 alongside the new process for requesting and managing reasonable adjustments through a single form, and to outline the approach to facilitating reduced or nil office attendance as a reasonable adjustment.

7. Following the efficiencies and restructuring of the NMC during the year, the Health and Safety Steering Group (HSSG) was reconstituted and the Terms of Reference reviewed. This has led to a greater and wider participation from all areas of the organisation, with regular reporting to the Executive Board.

Training

8. Following a number of unplanned fire evacuations at our buildings (false alarms/no fire) and recognising that with hybrid working not everyone is in the office on all days, we publicised training for new first aiders and fire marshals and refresher training for existing ones. We took this action to increase the numbers of first aiders and fire marshals. This was supported by the Executive Board, who introduced an incentive payment for those who undertook the training and qualified.

8.1. *Post Annual Report ending March 2026*
As from October 2026, we now have 48 first aiders and 55 fire marshals across our sites. This represents an increase of 20 new first aiders and 40 new fire marshals since January 2026.

9. Colleagues' e-learning training for health and safety is between 86-96 percent completion across all directorates, with an organisational completion of 89 percent. This is an improvement on last year, where the organisational completion was 83 percent. The scores include new colleagues as well as those colleagues who are asked to repeat the training course every two years. We have focused on those directorates with the lowest completion rates to help to improve the overall completion scoring.

10. P&C introduced an ongoing monthly learning programme in 2025 for our Mental Health First Aiders (MHFAs) to ensure their skills are kept up to date.

Incidents and general health and safety

11. During the year 1 April 2025 to 31 March 2026, there were 14 reported health and safety incidents which were actioned and recorded in our log. 12 of the incidents involved NMC colleagues and two of the incidents involved third party contractors. Of the 14 incidents:

- two were slips, trips or falls
- three were cuts/blister to a finger
- one was a burn to a finger from hot water

11.1. None of the above required hospital treatment beyond an on-site first aider.

11.2. With regards to rest of the incidents, they were not directly work related with six people feeling unwell – three of which had existing medical conditions, who attended hospital and were discharged; one person sneezed and hurt their back; and a colleague with a nut allergy suffered an allergic reaction at a building of an off-site training event (catering was not provided for the training event).

11.3. Reviews of the above incidents included consideration of the associated equipment and workplace, the provision of first aiders and the inclusion of a 'nut allergy' check as well as 'food allergy' check for the booking of training events, even those that are off site.

11.4. One of the priorities for this year was to increase the awareness of health and safety across the organisation, which includes the reporting of accidents and near misses. It is a positive sign that 14 incidents were reported, much improved compared to last year where only one incident was recorded, even if a number of the incidents were not directly work related.

11.5. We did not have any RIDDOR incidents (Reporting of Injuries, Diseases, and Dangerous Occurrences Regulations 2013) that would require reporting to the Health and Safety Executive (HSE).

Progress against priorities for this report period

12. In addition to regular monitoring of incidents and accidents, and maintaining oversight of any changes to legislative requirements, priorities for health and safety over the covering period were:

12.1. To promote and increase awareness to all colleagues for health, safety and security including fire evacuation procedures and other associated training - to support hybrid working and the return to the office across all our sites.

12.1.1. *Outcome:* A lot of work has gone into this priority, with reviews, updates and promotion across a wide range of areas, as illustrated in this report. We have all new fire evacuation plans for all of our sites; increased the number of trained first aiders and fire marshals; published a new NMC Health and Safety Guide promoted to all staff; updates to the Display Screen Equipment (DSE) process; revision to the Personal Emergency Evacuation Plan (PEEP) plan and process; and the reconstitution of the Health and Safety Steering Group. All of which help our colleagues to undertake their work, as well as support their health and safety.

12.2. To keep security under review for all our buildings/venues.

12.2.1. *Outcome:* The NMC chairs and contributes to the local West End Police Ward Panel meetings. These meetings include the police, local residents and organisations, for example: the BBC, the Langham Hotel, Fitzrovia Partnership BID and the Marylebone Residents Association. The NMC also liaises with the police at our other buildings through the respective building management companies. An additional video intercom link has been installed at our main office entrance area in 10 George Street, Edinburgh. In liaison

with the building manager at One Westfield Avenue, additional CCTV cameras have been installed on the floor of our lift lobby/entrance areas.

12.3. For colleagues with more complex reasonable adjustments, engage and support work to review our existing procedures and documentation to help improve collaboration and timeliness in responding to these requests and support our hybrid return to the office.

12.3.1. *Outcome:* As well as those items indicated in this report and actions undertaken by P&C to support well-being, 'reasonable adjustments' is now included as a separate question to be answered within the quarterly Ambitious Appraisal (AA) process undertaken by all staff to support this priority. The RAWG was stood down at the end of March 2026 (para 13.1), with the policy updated, actions undertaken and continued monitoring through the AA process.

12.4. To continue working with the P&C team to promote health and wellbeing.

12.4.1. *Outcome:* P&C has updated its offering to provide a more accessible range of tools and learning; promote and health and wellbeing through Pulse and Learning Pool, and posters in the office. The Thrive app and therapy service offers a modern, easy to access 24/7 support to colleagues in relation to their mental health and wellbeing. Thrive delivers a wide range of psycho-education webinars and workshops, an unlimited 24/7 therapy service, and activities and tools designed to support colleagues to be proactive in managing their mental health and wellbeing.

12.4.2. *Outcome:* Over the period April 2025 to March 2026, we had 83 new users on Thrive, 80 of those actively checking in regularly; 86 callers to the Employee Assistance Programme (EAP) with 37 of those referred for counselling and five people referred to occupational health services.

Further activity led by P&C colleagues:

13. A wellbeing check-in is included in our quarterly appraisals, which includes questions about general health and wellbeing, workload, and reasonable adjustments. The check-in also includes signposting to health and wellbeing resources as well as policies and guidance.

13.1. Following the initial return to the office period, the Reasonable Adjustment Working Group (RAWG) was stood down at the end of March 2026. This was in parallel with the introduction of the new reasonable adjustments request process launched in November 2025 and owned by P&C. A learning and insights meeting took place in September 2026 to review the impact of the new process and further identify opportunities for improvement.

13.2. The new process requires one form, that includes the DSE Workstation checklist, which colleagues use to request a reasonable adjustment or workplace equipment. The requests are logged on a case tracker and assigned to HR Business Partners, Advisors and HR services team as

appropriate. There have been 94 requests through the new process since launch, with the average time taken from submission to completion at 14 days.

13.3. People and Culture continue to offer different channels of support to all colleagues including: the promotion of the above mentioned Thrive app, the employee assistance programme, occupational health, Perkbox wellness hub, guidelines, risk assessments, group discussions and 1-2-1 meetings, as necessary.

13.4. We maintained and extended the decompression service to April 2026 (when overall Thrive contract was due for renewal), to ensure all colleagues, not just those in Professional Regulation could access the service if needed. We have used Thrive to deliver individualised decompression support sessions. These decompression support sessions are held with an assigned professional over the course of a 12-month period. We have renewed the Thrive contract and reduced the number of spaces on the decompression service and can flex based on need.

13.5. We continue to provide regular debriefing and reflective practice sessions facilitated by our in-house trained cohort. Their training was delivered by an Organisational Psychologist from Thrive to ensure participants had a good foundation of understanding before hosting debriefing, reflective practice and safe space discussions with NMC colleagues. We have regular sessions for our Empowered to Speak up (ETSU) ambassadors and network chairs and launched open sessions for all NMC colleagues to join when they need or want to.

13.6. The contract for our Occupational Health and EAP providers ended in April 2026. Prior to this we went out to tender and have procured new providers, Health Partners and Health Hero.

Forward looking activity led by P&C colleagues:

13.7. Scheduled to progress in Q3/4 2026-27, the NMC will become a trauma-informed organisation in which colleagues are appropriately prepared, supported and developed to undertake complex regulatory work.

13.8. This means creating an environment where trauma-informed practice is not regarded solely as a wellbeing intervention but as an essential element of professional capability, safeguarding effectiveness and sound regulatory judgement.

13.9. Success will be demonstrated when colleagues feel psychologically safe, leaders consistently support their teams, safeguarding responsibilities are applied effectively, exposure risks are actively managed, and trauma-informed principles are embedded within organisational systems, processes, culture and decision-making.

13.10. What this means in practice is that we will be implementing a framework that supports giving colleagues support and help when they need it in relation to the work they do. This will be a tiered approach set out below:

13.10.1. Capability and Professional Standards Plan
A tiered capability framework will be introduced, aligned to the wider Operational Delivery Profession (mainly Fitness to Practise and PR).

13.10.2. Foundation Level
Every colleague will have a basic understanding of trauma-informed practice, safeguarding responsibilities and available support mechanisms. They will understand how trauma can affect individuals, colleagues and workplace interactions and will contribute to psychologically safe environments.

13.10.3. Practitioner Level
Colleagues who regularly engage with sensitive material will build their capability in trauma-informed communication, reflective practice, safeguarding application, emotional resilience and escalation processes.

13.10.4. Specialist Level
Specialists working in high-exposure environments will develop advanced skills in trauma-informed interviewing, management of sensitive evidence, safeguarding leadership and support of colleagues across the organisation.

13.10.5. Leadership Level
Managers and leaders will receive dedicated development to help them identify emerging wellbeing concerns, manage exposure risks, conduct effective wellbeing conversations, facilitate debriefing and create healthy team cultures.

New priorities for the period April 2026 to March 2027

14. The proposed priorities for the period 2026 to 2027 are:

14.1. In conjunction with P&C, undertake a complete review of the mandatory e-learning health and safety modules to make them more meaningful, proportionate, engaging and accessible.

14.2. Following publication, continued promotion of the new NMC Health and Safety Guide for all staff, with health and safety items promoted through All Staff Briefings and other channels.

14.3. To keep security under review for all our buildings/venues.

14.4. To continue working with the P&C team to promote colleague health and wellbeing.

Item 11
NMC/26/239
25 November 2026

Report from Committee to Council

Name of committee	Audit and Risk Committee
Date of meeting	9 November 2026
Committee chair / report author	Committee Chair: Eileen McEneaney (deputising for Lindsay Foyster) Report author: Alexa Halabi
Date of report	12 November 2026

This report has been prepared to provide Council members with a summary of the key issues considered by the Audit and Risk Committee at its meeting on 9 November 2026. The Terms of Reference for the Committee can be found here.

Key decisions made:

- **Internal Audit Progress Update:** following an item at the Executive Board and a members' ARC meeting during October, the Committee discussed and agreed a revision to the Head of Internal Audit reporting format for the end of year opinion. This will now be an annual conclusion covering the four domains of Risk, Finance, Data, and Governance and will be provided in alignment with the Global Internal Audit standards.

  The Committee **approved:** the expansion of the 2026-2027 Internal Audit programme to include a review of the FtP Transformation Programme; the closure of two actions from previous audits; and the adoption of the proposed annual conclusion approach and the associated update to the Internal Audit Charter.

- **Review of Accounting Policies:** this is an annual review of our accounting policies. The Committee noted and **approved** the draft accounting policies statement. We are now operating with a new Charities Statement of Recommended Practice (SORP 2026) which impacts the NMC's 2026-2027 accounts and a new accounting policy for leases, as a result of adopting the new SORP. These changes will not make a material difference to our cash position, however, the Finance team will review their capacity around the changes required to how leases are accounted for.

Key discussions:

- **Health Check Interim Update:** following an item at Council Seminar on 21 October 2026, the Committee had a further discussion and oversight on this work, including the concern around operational flags. There was a discussion to how this work related to the establishment of an overarching design function, which would be supported by a new role of Assistant Director of Transformation Design. The organisational position regarding artificial intelligence was scrutinised with

risks surrounding unmonitored shadow usage highlighted. This topic will come back to the Committee at a later date.

- **Timeline for the Annual Report and Accounts 2026-2027 and the FtP Annual Report 2026-2027:** the Committee provided a steer for the Annual Report narrative, alongside the NAO's External Audit Initial High-Level Plan which was also on the agenda. The Committee recommended a balanced report that should include honest reflection of progress, comparative and accurate data, and details on stakeholder engagement and highlighted the need for cohesion between the Annual Report and Accounts and the FtP Annual Report.
- **Six-month Assurance Report on Single Tender Actions (STA):** this is a standing paper but included a change to the target for exceptional STAs. This was approved by the Executive Board and has been set at 10% of all procurement activity for 2027-2028, reducing to 5% from 2028-2029 onwards. The accountability mechanisms and enforcement for avoidable non-compliance were queried, and it was explained that leverage was being provided through stricter reporting and proactive challenge. Forward-looking reporting on strategic contracts had been developed for the Finance and Resource Committee.
- **Risk Register:** a mid-year review of risk appetites had been conducted by the Executive Board, wherein the technology and cyber categories were separated. The Committee wanted to see more on the Cyber risk following the appointment of the Head of Cyber. The need for the approval of the new Terms of Reference for committees, following the establishment of the Performance and Planning Committee was noted and the impact that was having on the risk discussions. This work is in progress.
- **Reflections of the meeting:** the Committee commended the papers for this meeting. Members wanted to revisit attendance of the Executive and the CEO as Accounting Officer, with a particular focus to ensure that relevant risk owners and Internal Audit report owners were present. The Chair of the Committee will work with the Governance team on this.

Item 12.1
NMC/26/240
25 November 2026

Report from Committee to Council

Name of committee	Planning and Performance Committee
Date of meeting	8 October 2026
Presented by	Jacqueline Maunder, Secretary to the Council
Committee chair	Anna Walker CB
Report author	Alex Urquhart, Senior Governance Manager
Date of report	9 November 2026

The report has been prepared to provide Council members with a summary of the key issues considered by the Planning and Performance Committee at its meeting on 8 October 2026.

1. Terms of Reference

1.1. The Committee received the updated Terms of Reference and noted some refinements following feedback from the previous meeting. Members welcomed the increased clarity regarding the Committee's oversight responsibilities.

1.2. The Committee considered and supported an oversight framework designed to strengthen assurance across the NMC's regulatory functions.

1.3. The Committee agreed that a comprehensive performance and impact framework should be developed to support effective oversight across all regulatory functions.

2. Integrity of the Register

2.1. The Committee received assurance regarding actions being taken to strengthen and protect the integrity of the Register. Members recognised the central importance of the Register to public protection and confidence in Professional Regulation.

2.2. Members noted:

a. ongoing improvement activity following the registration incident reported in May 2026,

b. work underway to address concerns raised by the Professional Standards Authority (PSA) regarding Standards 10 and 11 of the Standards of Good Regulation,

c. the introduction of new performance indicators and monthly reporting arrangements across registration workstreams

d. further work remained to develop measures relating to equality, diversity and inclusion (EDI) and registrant experience.

2.3. Members sought additional assurance regarding contractual oversight of English Language Test providers.

2.4. The Committee endorsed the current approach and the associated risk management arrangements.

3. Conduct and Performance Standards

3.1. The Committee received an update on key programmes within the Professional Practice roadmap, including the Code Review, Revalidation Review and Advanced Practice programme.

3.2. Members noted:

a. the decision to separate consultations on the Code Review and Revalidation Review following publication of the Thirlwall Inquiry report,

b. an extension to the Revalidation Review timetable to allow full consideration of the Inquiry's recommendations,

c. plans to accelerate development of Advanced Practice standards and proficiencies, bringing implementation forward to October 2027; and

d. the importance of ensuring sufficient resources were in place to support delivery.

3.3. The Committee supported the revised programme timelines and requested future consideration of the NMC's end-to-end consultation processes to strengthen organisational learning and consistency.

4. Safeguarding Performance

4.1. The Committee received assurance regarding the effectiveness and maturity of safeguarding arrangements across the organisation.

4.2. The Committee welcomed the actions being taken to manage current pressures of increased referrals and staff absence, and improve compliance with PSA standards. Members also requested that future reports include EDI data and registrant outcomes to support a fuller assessment of impact and effectiveness.

5. Education Quality Assurance (EdQA)

5.1. The Committee reviewed progress against the EdQA Improvement Plan and received assurance regarding actions being taken to strengthen the function.

5.2. Members noted:

a. significant progress in stabilising the function and establishing foundations for improvement,

b. ongoing work to address concerns relating to PSA Standard 9 over the next three years,

c. enhanced approaches to public protection through proactive monitoring and strengthened concerns management arrangements; and

d. the need to develop a more mature suite of KPIs to enable effective performance oversight.

5.3. The Committee endorsed the continued implementation of the EdQA Improvement Plan and requested a future update setting out proposed KPIs and measurement arrangements.

6. Strategic Risk Register

6.1. The Committee reviewed the strategic risks assigned to its oversight and discussed the current risk profile.

6.2. Members noted:

a. both the Regulatory Processes risk and Regulatory Reform risk remained outside the agreed appetite pending further assurance work,

b. concerns regarding the removal of the High-Performing Organisation risk from the strategic risk register,

c. the need for clearer articulation of risk statements, ensuring they focus on the consequences of failing to deliver strategic objectives rather than describing the failure event itself; and

d. plans for an annual review of risk appetite with Council during the next business planning cycle.

6.3. The Committee requested further refinement of the Strategic Risk Register and agreed that concerns regarding the removal of the High-Performing Organisation risk should be raised through the Committee Chairs' governance arrangements.

7. Overall assurance

7.1. The Committee received assurance that improvements are progressing across key regulatory functions, including registration, professional practice, safeguarding and education quality assurance.

7.2. The Committee's discussions highlighted the importance of strengthening performance frameworks, impact measurement and risk articulation.

Note – the Chair of the Planning and Performance Committee has not yet reviewed this report and the content remains subject to amendment.

Item 12.2
NMC/26/240
25 November 2026

Report from Committee to Council

Name of committee	Planning and Performance Committee
Date of meeting	12 November 2026
Presented by	Jacqueline Maunder, Secretary to the Council
Committee chair	Anna Walker CB
Report author	Alex Urquhart, Senior Governance Manager
Date of report	13 November 2026

The report has been prepared to provide Council members with a summary of the key issues considered by the Planning and Performance Committee at its meeting on 12 November 2026.

1. Fitness to Practise (FtP)

1.1. The Committee noted two reports on FtP performance and the FtP Improvement Portfolio.

1.2. The Committee received a paper on the FtP Workforce modelling work for noting, the committee shared some feedback on the modelling and welcomed the work.

1.3. The Committee agreed to receive an updated paper on the modelling following Executive Board approval.

2. Strategy measurement development

2.1. The Committee received two papers on strategy measurement and development. The Committee was assured the measurement framework was proportionate for measuring performance.

2.2. The Committee noted the draft strategy for 2027-30 and approved it for Council at a later date. The Committee endorsed the ambitions in the strategy and encouraged the strategy to focus on the regulatory functions of the NMC.

3. Quarterly Performance Report - Q2 2026-27

3.1. The Committee received the Quarterly Performance Report for 2026-27 Q2 which set out how performance data informs recommendations on how the NMC can build on success, improve performance, and effectively manage risks to achieve our strategic priorities for assurance.

3.2. The Committee discussed the report and asked that there is a clear distinction would be drawn between delivery activity, operational outcomes, strategic measurement, and the planned scorecard overhaul – this would help assure the Committee that progress was considered against outcomes in addition to actions.

4. **PSA Improvement Plan**

4.1. The Committee received assurance that delivery of the PSA Improvement Plan was progressing positively. Members noted successful walkthroughs in Registration and Education Quality Assurance, positive feedback from the PSA regarding the NMC's collaborative approach, and a Significant Assurance rating from KPMG's Phase One internal audit review.

4.2. The Committee requested sight of the streamlined 36-action improvement plan and supporting audit findings before confirming approval by correspondence. An action was agreed for the Chief of Staff to circulate the revised plan and KPMG findings to support approval outside the meeting.

5. Regulatory Reform Update

5.1. The Committee received an update on the regulatory reform programme and noted that engagement on the proposed Nursing and Midwifery Order was expected to commence in spring 2027, with formal consultation anticipated in autumn 2027.

5.2. Members discussed the risks arising from uncertainty in Department of Health and Social Care timelines, the long-term nature of implementation, and opportunities to explore earlier adoption of Fitness to Practise flexibilities.

5.3. The Committee also considered the governance implications of a future unitary board model. An action was agreed to schedule a future discussion on regulatory reform through the Committee's forward plan.

6. Midwifery Regulation Strategy Programme

6.1. The Committee reviewed progress on the Midwifery Regulation Strategy Programme and received assurance that programme funding, governance arrangements and delivery resources were in place.

6.2. Members discussed programme timescales, alignment with wider regulatory reform activity, and the importance of maintaining a multidisciplinary focus across maternity services.

7. Planning and Performance Committee Risk Register

7.1. The Committee reviewed the strategic risks within its remit and noted that two of the four risks remained outside the organisation's risk appetite.

7.2. Members discussed the oversight and prioritisation of these risks, including one risk driven by external dependencies associated with regulatory reform. Due to time constraints, the Committee agreed that detailed consideration of the Risk Register would be deferred to the next meeting to allow fuller scrutiny and discussion.

Note – the Chair of the Planning and Performance Committee has not yet reviewed this report and the content remains subject to amendment.

Item 13
NMC/26/241
25 November 2026

Report from Committee to Council

Name of committee	Finance and Resource Committee
Date of meeting	11 November 2026
Committee chair / report author	Committee Chair: Julia Mundy Author: Renée Melton Klein and Alexa Halabi
Date of report	12 November 2026

This report has been prepared to provide Council members with a summary of the key issues considered by the Finance and Resource Committee (FRC) at its meeting on 11 November 2026. The Terms of Reference for the Committee (ToR) can be found here.

Key discussions

Overall, the Committee felt that oversight arrangements are strengthening, with progress across the improvement agenda and substantial work still ahead. The FRC is applying additional scrutiny across finance, risk, procurement, project portfolio, Fitness to Practise (FtP) improvement, and estates, combining constructive challenge with support for delivery. The shared responsibility for financial health was acknowledged and is part of the organisational-wide culture owned by Executive Board, directorates and all staff, with Council and its committees supporting the right level of grip and accountability.

Financial grip and control

1 Financial Performance Report: The Committee received assurance on finance business partnering, regular forecast reviews, recruitment controls and strengthened contract oversight as it considered the mid-year position, reserves forecast and initial approach to the 2027–28 budget. Constructive discussion explored directorate variances, vacancy assumptions and opportunities for sustained efficiencies across pay and non-pay. Members supported the finance team in taking this discussion forward with Executive Board and Council, reinforcing shared responsibility for financial stewardship across the organisation. Clearer summary reporting will help distinguish financial oversight from delivery by the business.

2 FtP Improvement and wider project portfolio: Several projects have moved to green, with early New Ways of Working results indicating potential improvements. Overall delivery confidence for FtP improvement remains amber, reflecting the scale of the remaining work. Further evidence on scalability, baseline measures, milestones and realised benefits will inform delivery. Analysis of unit costs, distinguishing unit cost from volume, and exploration of a lower future FtP share of the cost base will help inform longer-term transformation. The FRC will focus on financial implications and financial benefits realisation on FtP and wider change, complementing scrutiny through the Planning and Performance Committee.

Assurance

3 Risk Register: Risk profiles and risks against appetite provided a basis for discussion. Members requested clearer risk trajectories, milestones and evidence of control effectiveness, alongside separate mitigations for savings, fee-related income and other income. These will support understanding of how financial stability and other out-of-appetite risks are being managed. Work is underway to strengthen cyber and business continuity arrangements, with further assurance sought on scoring and resilience through a proposed confidential deep dive, coordinated with the Audit and Risk Committee. A consistent risk methodology will support trend analysis while accommodating emerging risks.

4 Procurement and Commercial Update: Progress includes bringing procurement and contract management together, improving reporting and developing business partnering with directorates. The War on Waste had secured £181,000 against the £500,000 annual target. Members supported the direction of travel. Future reporting on the maturity assessment, improvement priorities, travel controls and changes in contract performance will help demonstrate progress in savings, commercial oversight and organisational behaviours.

Item 14
NMC/26/242
25 November 2026

Report to:	Council	Meeting Date:	25 November 2026

Thirlwall Inquiry	
Publication Status	Open
Presenting the Report	Emma Westcott, Executive Director of Strategy and Insight
Executive Director	Emma Westcott, Executive Director of Strategy and Insight
Report Author	Grace Costain, Policy Manager

PURPOSE OF REPORT AND REASON FOR RECOMMENDATIONS:

The Thirlwall Inquiry was established on 19 October 2023 to examine events at the Countess of Chester Hospital (CoCH) and their wider implications following the convictions of Lucy Letby (LL). Its final report was published on 15 September 2026.

The purpose of this paper is to update Council on implications of the report arising for the NMC. It highlights the action we have already taken, provides a proposed approach to responding to outstanding issues, and commits to next steps in response to the findings. This work supports our strategic priorities to strengthen trust in the professions, improve fitness to practise and maintain effective core regulatory functions.

RECOMMENDATION(S):

1. The Council is asked to:
   - **Note** the report; and
   - **Endorse** the proposed next steps.

ANNEXES:

The following annexe is attached to this paper:

- Annexe 1: Summary of key issues and activity to date

REPORT APPROVAL	
Executive Director: Emma Westcott	**Approved** (09 November 2026)
Director of Finance:	**N/A**
Secretary to the Council:	**Approved** 17 November 2026

Consideration at Committee/Group		
Committee / Group	**Date**	**Outcome**
Executive Board	05 November 2026	The paper provided a proposed approach for responding to the Inquiry's final report and for updating Council. Next steps were approved.

Thirlwall Inquiry

1. SITUATION / BACKGROUND

1.1. The purpose of this paper is to update Council on implications of the report arising for the NMC. It highlights the action we have already taken, provides a proposed approach to responding to outstanding issues, and commits to next steps in response to the findings. This work supports our strategic priorities to strengthen trust in the professions, improve Fitness to Practise (FtP) and maintain effective core regulatory functions.

1.2. The Inquiry was established in October 2023 to examine events at CoCH following the convictions of LL for the murder and attempted murder of babies at the hospital.

1.3. The NMC was a Core Participant to the Inquiry which conferred additional participatory rights. Over the course of the Inquiry, we submitted six witness statements and provided opening and closing submissions. Three individual staff members also provided witness statements and evidence.

1.4. Our engagement with the Inquiry provided early insight into potential improvement areas or criticisms and enabled us to take early action in advance of the final report (see **Annexe 1**).

1.5. The final report was published on Tuesday 15 September 2026 and makes 17 recommendations in total. Although none are directed at the NMC, there is a specific chapter about the NMC which we view as containing *de facto* recommendations for us (Chapter 18).

2. SPECIFIC MATTERS FOR CONSIDERATION

Key issues

2.1. The chapter about the NMC rehearses some of the themes and criticisms that have featured throughout the Inquiry. These fall broadly into the following areas (see **Annexe 1** for more detail):

2.1.1. Professional curiosity, deliberate harm and safeguarding

2.1.2. Regulatory decision-making, escalation and peer review

2.1.3. Information sharing, external engagement and local oversight

2.1.4. Assurance and organisational accountability

2.1.5. Revalidation and health and character

Response and assurance

2.2. We have critically reflected on our regulatory practices from the outset of the Inquiry, to identify learning and drive improvements. This pre-publication scrutiny identified learning broadly consistent with the Inquiry's findings, and learning areas were largely expected.

2.3. We have already taken considerable action to address areas of concern, strengthen our regulatory frameworks, and embed improvements for the benefit of public protection. This means that action is either complete or planned in many of the areas identified in the final report, as demonstrated in **Annexe 1**.

2.4. The Inquiry's findings relate to public protection and public confidence in the regulatory process; where we have already made relevant changes, we will undertake additional assurance checks to test whether existing work is sufficient and delivering its intended impact. Proposals will be taken to the NMC's internal Learning and Actions Board and a further update to Council in due course.

Develop a checklist of questions to guide referral conversations and advice

2.5. The Chair concludes that we did not sufficiently probe or challenge the information provided by CoCH and recommends supporting materials, including a checklist of concise, relevant questions, to guide Regulation Advisers' (RAs) conversations with employers.

2.6. We have existing tools to help guide conversations with employers, including our Advice Line Template. Our Culture of curiosity guidance has also helped embed greater critical scrutiny across our regulatory processes and teams.

2.7. In response to the Chair's recommendation, we will revisit existing processes and develop new guidance and tools to support the provision of fair and appropriate referral advice, and to support colleagues to critically probe and challenge information provided. Improvements will be underpinned by training to ensure successful implementation.

Develop training and resources on deliberate harm

2.8. The information provided by CoCH should have prompted us to consider the possibility of deliberate harm. In response, the Chair calls for the potential for deliberate harm to be more firmly embedded in RA training and checklists.

2.9. These findings have organisation-wide implications beyond Employer Link Service (ELS). We have already taken steps to strengthen our FtP guidance so that the potential for deliberate harm is understood and considered.

2.10. In response to this recommendation, we will review where we can strengthen guidance and understanding of deliberate harm across all functions, including via our mandatory safeguarding training for all staff. New ELS guidance and tools (paragraph 2.7) will also address these findings.

Interim Order (IO) guidance improvements

2.11. An IO application should have been made sooner, at the point of arrest rather than charge.

2.12. We are now clear that when we are dealing with the most serious of allegations, the evidential threshold for IO imposition needs to be different in order to protect the public. Our updated IO guidance now clarifies that an application can be made before a person has been charged, and that the

seriousness of concerns must be considered. In March 2026 we also launched our new IO applications framework to help guide decision making.

2.13. Whilst improvements to our IO approach are acknowledged, the Chair criticises a sentence which states that a charge may be sufficient '*if we are satisfied that the decision to charge and prosecute the person was made following a robust consideration of the evidence'*, and questions how we would assess such a decision. The Chair also recommends that our IO Framework include a direction to establish what, precisely, is being referred to an IO panel and why. We will make these two further changes.

The NMC's revalidation model

2.14. The Inquiry raises fundamental questions about our revalidation model and the assurance it provides. Our use of the term 'revalidation' is criticised and the confirmer role considered 'purely administrative'. There is a strong inference that our model should more closely align the GMCs', though the Chair does acknowledge that the GMC model is 'detailed, onerous and expensive'.

2.15. We were preparing to consult on strengthening revalidation and some of our proposals speak to the Chair's concerns. This includes reducing the circumstances in which a confirmer can be someone who is not a line manager and strengthening the registrant and the confirmer's accountability for revalidation via a statement of truth.

2.16. We expected recommendations in this area and paused our revalidation review in August 2026 to take account of the Chair's final report before consulting. The Chair makes positive comments about the rigour of the GMC's model of revalidation though the NMC's approach is more in line with that of other healthcare regulators. The responsible officer model is enshrined legislation relating to providers and it has not been replicated for the new professions that have recently joined the GMC register. Notwithstanding, our review will consider the Chair's comments and will include further consideration of the GMC's model and some targeted discussion with stakeholders, building on the wide engagement already completed. We are mindful of the changes to our statute imminent via regulatory reform.

Broaden the types of character declarations required

2.17. At revalidation, professionals must make character declarations as set out in our Health and Character Guidance and Code. LL met our requirements and revalidated in 2017. At that point she had not worked on a ward for over a year, was on restricted duties, and was subject to a police investigation.

2.18. The Chair does not believe LL should have revalidated in these circumstances and her view is that registrants revalidating should be required to declare any complaints, warnings or restrictions or gaps in practice so that they are considered when renewing registration.

2.19. Our IO imposition changes mean that if a case like this happened today and a person was arrested for a similar serious offence, their revalidation would be

paused because they would be subject to an IO. This speaks to Chair's concerns and provides an important safeguard.

2.20. Notwithstanding, we will consider whether to require additional declarations in our forthcoming review of our Health and Character Guidance in the new year.

Strengthening links between Revalidation and Fitness to Practise

2.21. The Chair is critical that information held by our ELS and FtP teams about LL was not shared with our Registrations Team and calls for information to be easily shared electronically across teams. At the material time this is because the information held at that stage would not have affected LL's ability to revalidate.

2.22. This recommendation will be considered as part of our Revalidation review, and Health and Character Guidance review.

Wider learning

2.23. Beyond Chapter 18, the Inquiry identifies significant failings across the health and care system, including failings in safeguarding, leadership and governance, professional accountability, escalation, candour, and organisational culture.

2.24. We are assessing wider findings including the Inquiry's formal recommendations to identify potential implications and next steps.

Next steps

2.25. Council is invited to ask any questions or make comments about the actions we have taken (**Annexe 1**) and that we propose, to help guide next steps and assurance activity.

2.26. Once Executive Board (EB) and Council are clear on our commitments we will work with the Learning and Actions Board on implementation planning and to scope wider assurance activity. Periodic reports to Council on progress will be provided.

2.27. Once agreed, our Inquiries actions will be published on our website to support transparency and accountability.

3. FINANCIAL / GOVERNANCE IMPLICATIONS

3.1. No financial or governance implications identified at this stage, though this will depend on the actions we agree to take in response to the final report.

3.2. Recommendation 17 proposes that the National Audit Office assumes responsibility for auditing the implementation statutory inquiry recommendations. This could impact our own auditing and reporting arrangements. Developments will be carefully monitored.

4. RECOMMENDATION

4.1. The Council is asked to:

- **Note** the report; and
- **Endorse** the proposed next steps.

5. ASSESSMENT

Impact Assessment	Question / Consideration	Response
Equality, Diversity and Inclusion	Has an Equality Impact Assessment been undertaken?	No. EDI implications will depend on the actions we agree to take in response the final report. EQIA assessments will be undertaken.
Safeguarding considerations	Are there any safeguarding implications?	Safeguarding failures are a key focus of the Inquiry, including learning for the NMC.
Four country factors and considerations	Are there any four country factors, including Welsh Language?	Though the Inquiry is England focused, learning will apply across all the four nations as we are a four-country regulator. There are no Welsh language implications.
Resource (incl People) implications	Are there any people implications?	There are no immediate resource implications, though this will depend on the actions we agree to take in response.
Risk implications associated with the work and the controls proposed/ in place.	What are the key risks and how are they mitigated?	The Inquiry's findings raise significant public protection and confidence risks. We have already taken considerable action to respond to the key areas and can demonstrate impact. We are carefully considering the final report to identify additional action required to mitigate outstanding issues and risks, and the proposals in this paper form a key part of that.

Legal considerations, incl Regulatory Reform	Are there any legal or regulatory implications?	Any legal implications arising from the final report will be carefully considered, and our General Counsel team is closely engaged. There is one related FtP investigation ongoing. We are also supporting the police with their criminal investigation for gross negligence manslaughter.
Does this item require any procurement services	Have you spoken to the procurement team about requirements?	No
Midwives	Any specific implications for midwives?	No
Nursing Associates	Any specific implications for nursing associates?	No

Annexe 1: Summary of key issues and activity to date

Issue	Detail	Action(s)	Status
Professional curiosity and critical scrutiny	We should have probed the information provided and subjected it to greater critical scrutiny. This includes asking questions about why LL had moved from clinical duties, asking about the nature of the clinicians' concerns and whether the nurse was currently working on the unit.	1. **Culture of curiosity guidance**: In 2024 we published our new culture of curiosity guidance which encourages greater examination of information before determining the appropriate course of action. We have taken steps to embed this guidance via bespoke training and internal communications. We evaluated this guidance in March 2026 with updates expected in early 2027.	**Completed**
		2. Strengthened partnerships: We have stronger interagency partnerships and developed more robust mechanisms for seeking, testing and triangulating what we are told. We are a member of the Executive Quality Board – part 2 (formerly the National Joint Strategic Oversight Group (NJSOG)) and the National Perinatal Safety and Surveillance Group (NPSSCG), both of which are convened by NHS England. Our ELS attends Regional Quality Groups in England and equivalent groups in the other countries of the UK. We are also a signatory of the cross regulatory Emerging Concerns Protocol for England and have been since its inception in 2018.	**Completed**
		3. Strengthened quality assurance: We have stronger internal processes, and ELS advice is subject to strengthened quality assurance measures, including peer review and benchmarking with Clinical Advisors, Safeguarding and Screening input.	**Completed**
		4. ELS capacity: ELS was in its infancy at the time when LL was first brought to the attention of our regulation advisers. It has expanded as a team and enhanced its processes over the last ten years and benefits from greater experience to guide employer discussion and referral advice.	**Completed**
		5. Assurance checks: Ongoing health checks are reviewing some key ELS processes, and they will be subject to the new corporate quality assurance approach.	**Ongoing**
		6. Strengthening ELS resources: We will revisit existing ELS processes and develop new guidance and tools to support the provision of fair and appropriate referral advice, and to support colleagues to critically probe and challenge information provided.	**Ongoing**

Annexe 1: Summary of key issues and activity to date

Consideration of deliberate harm	The information provided by the Countess of Chester Hospital (CoCH) should have prompted us to consider the possibility of deliberate harm and respond with greater urgency. There is a clear message that we failed to take account of wider patient safety risks.	1. **Strengthened FtP guidance**: a. Our Screening Guidance includes a section dedicated to 'Matters requiring full investigation by the NMC', which explicitly references concerns of deliberate harm. b. Our guidance 'Factors to consider before deciding on sanctions' lists conduct which puts people receiving care at risk of harm as a possible aggravating feature and makes clear conduct or failings will be more serious if they deliberately chose to take an unreasonable risk with the safety of people in their care. c. In July 2025 we conducted a review of our FtP guidance library to identify additional areas for improvement and greater clarity about cases of deliberate harm. This prompted changes to our Sanctions guidance so that it, too, now references deliberate harm, confirming that it will always be a significant aggravating factor and that it will normally result in a striking-off order. d. In August 2024 we published our new culture of curiosity guidance which emphasises the need to always approach concerns with an open mind, without making assumptions, and we expect colleagues remain alert to the possibility of deliberate harm as part of this.	**Completed**
		2. Ways of working: In December 2024 we became signatories to the Memorandum of Understanding (MoU) for investigating healthcare incidents where criminal activity may have contributed to death or serious harm. This means we can openly and effectively share information with other signatories investigating in parallel. We have embedded this agreement into our processes through bespoke training with key colleagues in our FtP and ELS teams, and through wider internal communications and newsletters. The Department of Health is reviewing this MoU with changes expected soon. Internal processes will be evaluated following any MoU revisions.	**Completed**
		3. Training and guidance on deliberate harm: We will review where we can strengthen guidance and understanding of deliberate harm across all functions, including via our mandatory safeguarding training for all staff.	**Ongoing**
Peer review and benchmarking	Our referral advice should have been escalated earlier for senior oversight,	**1. ELS QA and escalation:** In January 2024 we updated our ELS peer review and benchmarking SOP to provide clearer routes for escalating serious concerns, including extraordinary meetings where needed. Our monthly peer review meetings now also	**Completed**

Annexe 1: Summary of key issues and activity to date

	and our review processes should have been more effective.	include representatives from our Clinical Adviser and Safeguarding teams to enable more effective evaluation and scrutiny.	
		2. **Internal oversight:** we have new internal mechanisms such as the Intelligence Sharing Hub and Patient Safety Intelligence Forum to support earlier sharing, triage and senior oversight of emerging risks and planned actions.	**Completed**
		3. **Interagency working:** Inter-agency forums and the Emerging Concerns Protocol help triangulate intelligence and coordinate responses.	**Completed**
Oversight of local investigations	The Chair criticises us for advising CoCH to continue to manage the concern locally without understanding the quality or scope of the local investigation. Whilst it is not our responsibility to assure the quality of local investigations, we should have done more to satisfy ourselves that the concerns were being investigated fully and appropriately at local level.	1. **ELS advice line template:** We have updated our advice line template to include a preamble which makes clear that whatever advice we give, if additional information comes to light that would change the advice we initially provided, employers must let us know.	**Completed**
		2. **Guidance for employers:** We publish a resource for employers on managing concerns and how to conduct local investigations effectively. We last updated this guidance in 2024. As part of our 'Right Referrals, Right Place' change of behaviour campaign, we are currently developing new guidance and online resources for employers which will include new separate sections about how to manage concerns locally and when and how to make a referral to us. This guidance is supported by our 'Approach to Fitness to Practise' learning sessions that we deliver to senior staff within employers.	**Completed** **Ongoing**
		3. **Strengthened interagency working** We now have much closer working relationships with the Care Quality Commission (CQC). We have a new MoU and participate in regional meetings that focus on emerging risks. There is also now the Emerging Concerns Protocol in place to work more closely with CQC.	**Completed**
Information sharing and interactions with the police	We should have engaged directly with the police and	1. **Strengthened partnerships with the police:** We are currently developing a MoU with the National Police Chief's Council (NPCC) to facilitate better working relationships and more timely sharing of information.	**Ongoing**

Annexe 1: Summary of key issues and activity to date

	sought regular updates on their investigation.	We also now have MoUs or information sharing agreements (ISAs) with individual police forces to encourage information sharing on a local scale.	**Complete**
		2. Article 25 Guidance and training: Article 25(1) of the NMC Order 2001 empowers the NMC to require any person who is able to supply information or produce any document relevant to the discharge of any function to supply that information or documents. We have developed new guidance to support colleagues in knowing when to invoke our Article 25 power to help ensure the timely disclosure of information needed, as well as training to help embed the process and understanding.	**Complete**
Interim Order Decision making	An application for an Interim Order should have been made earlier, at the point of arrest rather than charge.	**1. Interim Order Guidance:** Our IO actions were in keeping with the policy at the time, but we have reflected on our learning from this case and changed our guidance in the context of the most serious allegations. In March 2024 we updated our IO guidance so that it now makes clear that there will be circumstances in which we will not need to wait until a person has been charged before applying for an IO, and that the seriousness of concerns and the importance of maintaining public confidence must be considered. We have moved the emphasis of the guidance away from a "prima facie evidence" test to focus more on cogency of evidence and given more flexibility to our decision-makers to act on the basis of a known risk, where there is evidence that the risk is being seriously considered by other agencies such as the police.	**Completed**
		2. Case conferences: We have instigated a new practice of holding case conferences in complex or sensitive cases to ensure that the right expertise informs our risk assessment.	**Completed**
		3. IO decision making framework: We now have an IO applications framework that enables us to seek legal advice earlier and to improve the quality and accountability of IO decision making.	**Completed**
		4. IO guidance improvements: We will review our IO guidance and framework and respond to the Chair's recommended changes.	**Ongoing**

Annexe 1: Summary of key issues and activity to date

Inquiry Management	The language used in our submissions did not demonstrate sufficient accountability for our failures and mistakes. The Chair also highlights divergent views across internal teams regarding the impact of the changes implemented. These differences led to a team submitting separate correspondence to the Inquiry and, ultimately, to changes in language between our opening and closing submissions.	1. **Clarifications:** Our commitment to Inquiries is to be clear, candid and reflective, in order to assist Inquiries in their deliberations. The Chair commented on variation in our language during the Inquiry's closing hearings. In response, we immediately wrote to the Inquiry to clarify our position, acknowledging that we *should* have done things differently, and to apologise for the ambiguity and perceived lack of accountability and responsibility for mistakes made.	**Completed**
		2. **Process improvements:** We will update our Inquiries management Standard Operating Procedure to be clear about steps to be taken if there is not internal unanimity about the organisation's proposed submissions to an Inquiry.	**Ongoing**
Safeguarding	Whilst it is not our role to consider whether Trusts have complied with their safeguarding obligations, or whether adequate safeguarding processes were in place, we should have done more to understand the safeguarding measures being taken by CoCH and to prompt it to consider its safeguarding responsibilities.	1. **Specialist capabilities:** In October 2022 we appointed a new Strategic Safeguarding Lead and in March 2024 we appointed a safeguarding consultant to review and strengthen the organisational safeguarding function. Following a review in May 2024 we expanded the safeguarding service with an additional four Safeguarding Advisors, a Safeguarding Educator, and Safeguarding Co-ordinator and Analyst.	**Completed**
		2. **Strengthened internal processes:** In September 2024 we established a Safeguarding Board which reports directly to the Executive Board and Council and produces a quarterly report on safeguarding activity and risk. This provides organisational oversight and assurance on all safeguarding concerns. We also established a multi-professional safeguarding hub which provides safeguarding expertise and guidance on all new referrals received. We are currently developing new Advice Line Guidance for ELS. This will include more details about safeguarding concerns and internal escalation steps.	**Completed** **Ongoing**

Annexe 1: Summary of key issues and activity to date

		3. **Training:** We have strengthened the training available for colleagues, including the introduction of new mandatory safeguarding training for all NMC colleagues. We have also updated our Safeguarding and Protecting People Policy which governs how we identify, manage and escalate safeguarding concerns across the organisation. We have developed and delivered Level 2 Safeguarding Fundamentals to all colleagues in FtP which embeds enhanced safeguarding knowledge from the co-produced Safeguarding SOP.	**Completed**
		4. **ELS QA:** Representatives of our Safeguarding Team now attend monthly ELS peer review meetings, which form a key part of our quality assurance activity.	**Completed**
		5. **Employer engagement:** We have updated our Advice Line template so that it now includes an additional question to help ensure that safeguarding concerns are considered from the outset during all pre-referral conversations with employers. We are also reviewing the employer referral form, and the safeguarding team will be engaged to help identify possible improvements in this area.	**Completed**
The NMC's revalidation model and information sharing between team	Our revalidation model should provide greater assurance of professionals' competence and FtP. Our revalidation model should be supported by stronger links between our FtP and registration functions.	1. **Revalidation review:** We were preparing to consult on strengthening revalidation on some respects that speak to Lady Justice Thirlwall's concerns, including strengthening the registrant and the confirmer's accountability for revalidation via a statement of truth. We have paused in order to take stock of whether there are further ways in which we can address the Chair's comments on revalidation.	**Ongoing**
		2. **Regulatory reform:** Future legislation is expected to provide broader powers to assess professionals periodically against standards and require information where needed.	**Ongoing**
Health and character declarations	We should revisit the requirements for professionals to notify us of character concerns.	1. **Self-referral and health and character declarations:** We will shortly review our Health and Character guidance (and related references in the Code) to consider	**Ongoing**

Annexe 1: Summary of key issues and activity to date

		whether there are further character concerns that we should require registrants to self-declare.	

Item 15
NMC/26/243
25 November 2026

Report to:	Council	Meeting Date:	25 November 2026

Practice Learning Review: Consultation Findings & Next Steps

Publication Status	Public [Council Paper]
Presenting the Report	Chris Dzikiti, Executive Director, Professional Practice
Executive Director	Chris Dzikiti, Executive Director, Professional Practice
Report Author	Julie Bliss, Senior Nursing Education Adviser & Jacqui Williams, Senior Midwifery Advisor (Education)

PURPOSE OF REPORT AND REASON FOR RECOMMENDATIONS:
The purpose of this paper is to outline the findings of the Practice Learning Review (PLR) and to gain approval of recommended changes to relevant standards following public consultation as well as gain approval for future work to improve the quality of practice learning.

The Practice Learning Review forms part of the Professional Practice Roadmap 2025-2027. It enables us to deliver a key workstream within the NMC Strategy 2025-2027 (*Supporting trusted, safe and effective nursing and midwifery professions).*

RECOMMENDATION(S):

1. The Council is asked to:
   a. **Note** the report; and
   b. **Approve** changes to education standards following the recent Practice Learning Review consultation as well as further work to improve quality in practice learning.

ANNEXES:
The following annexes attached to this paper:

Annexe 1: Thinks Consultation Report

Annexe 2: Synthesis Report

Annexe 3: Proposed changes to practice learning education standards

Annexe 4: Equality Impact Assessment Summary

REPORT APPROVAL [mandatory for all Council/Committee Reports]	
Executive Director: Chris Dzikiti	**Approved** 9 November 2026
Director of Finance:	**N/A**
General Counsel:	**Approved/N/A** (add date)
Chief Executive and Registrar (CER):	**Approved/N/A** (add date)
Secretary to the Council:	**Approved** 17 November 2026

External Engagement (undertaken to date)		
Committee / Group	**Date**	**Outcome**
Public Consultation	30 April-23 July 2026	Support for the proposals we recommend taking forward.
Qualitative Research: Stakeholder Engagement	30 April-23 July 2026	Support for the proposals we recommend taking forward.

Consideration at Committee/Group		
Committee / Group	**Date**	**Outcome**
Midwifery Strategic Advisory Group	14 September 2026	Support for proposals we recommend taking forward.

Independent Steering Group	24 September 2026	Support for proposals we recommend taking forward.
Executive Board (EB)	30 September 2026	Support for proposals we recommend taking forward and presentation to Council Seminar.
Council Seminar	21 October 2026	Support for proposals we recommend taking forward and presentation to EB and Council.
Executive Board	5 November	Support to take this paper to Council.

PRACTICE LEARNING REVIEW: CONSULTATION FINDINGS & NEXT STEPS

1. SITUATION / BACKGROUND

1.1. The purpose of this paper is to outline the findings of the Practice Learning Review (PLR) and to gain approval of recommended changes to relevant standards following public consultation as well as gain approval for future work to improve the quality of practice learning.

1.2. The Practice Learning Review forms part of the Professional Practice Roadmap 2025-2027. It enables us to deliver a key workstream within the NMC Strategy 2025-2027 (*Supporting trusted, safe and effective nursing and midwifery professions).*

1.3. As part of nursing, midwifery and nursing associate education, students undertake practice learning which accounts for 50% of programmes. Alongside theoretical learning which accounts for the other 50%, this emphasises the equal importance of academic and practice learning.

1.4. Practice learning provides students with opportunities to develop the competency and confidence to think critically, apply their knowledge and skills in real-life settings, and provide evidence-based care while under supervision. It is seen as crucial for students to develop into safe and effective practitioners.

1.5. The evidence we gathered in the discovery phase of this work found that while many students benefit from positive practice learning placements, the quality of practice learning experiences can vary, including unwarranted variation in students' experiences with simulated practice learning, team cultures, and the amount and type of student support available. Previous studies have established a link between the quality of the practice learning environment for students and the quality of care they provide once they join the NMC Register.

1.6. Council approved a public consultation as part of the Practice Learning Review in November 2025 (NMC/25/114). The consultation ran from 30 April to 23 July 2026 and focused on strengthening several practice learning-focused education standards.

1.7. We received 6,577 responses to the main survey and 45 to the easy read survey. We also commissioned independent qualitative focus groups with nursing and midwifery professionals, students, educators, employers, practice learning partners (PLPs) and members of the public (see Annexe 1).

1.8. In addition, we held 26 stakeholder engagement events involving 1,043 participants across the four nations (see Annexe 2).

2. SPECIFIC MATTERS FOR CONSIDERATION

2.1. Addressing the issues we have identified in practice learning will require action from us and the support of our partners and stakeholders in health and care.

2.2. Our consultation focused on proposals that are within our remit as a professional regulator to address – and which we are statutorily required to consult on. However, we are aware that there are other actions that we can take, which do not require consultation, as well as areas where we need to work in coalition with our approved education institutions (AEIs), practice

learning partners (PLPs), and wider stakeholders including Chief Nursing Officers (CNOs) and Chief Midwifery Officers (CMidOs).

Consultation findings

2.3. Overall, there was support for most of the 14 proposals. Support was not given for two proposals which focused on reducing pre-registration nursing programme hours and extending the length of midwifery programmes.

2.4. Respondents asked for greater clarity on how the proposals would work in practice, how we would implement them, and how we could be more ambitious in driving up quality in practice learning. We want to explore options in partnership with our key partners and stakeholders to build a coalition for change to improve practice learning. Our implementation plans and next steps are set out below.

2.5. The consultation also surfaced issues outside of our regulatory remit, including student finances, newly qualified jobs and staffing shortages in practice learning. We will work with partners and stakeholders to try and influence change within health and care, where we have identified concerns outside of our regulatory role.

Proposals we recommend

2.6. We recommend taking forward the following proposals that were supported in the consultation to strengthen practice learning in the interests of public protection, student wellbeing and preparedness for practice. These proposals are also supported by consultation stakeholder engagement and the pre-consultation evidence.

Proposal	**Survey Response**	**Recommendation**
Standards framework for nursing and midwifery education		
Strengthen anti-racism, bias awareness and cultural curiosity, safety and respect in practice learning.	85% NET agree 4% NET disagree	To recommend this is accepted.
Strengthen partnership working in practice learning in relation to reasonable adjustments.	83% NET agree 4% NET disagree	To recommend this is accepted.
Standards for student supervision and assessment (SSSA)		
Allow midwives with a Specialist Community Public Health Nurse (SCPHN) qualification to act as practice assessors	70% NET agree 6% NET disagree	To recommend this is accepted.

Proposal	Survey Response	Recommendation
for pre-registration nursing students, who are in a public health practice learning setting.		
Standards for pre-registration nursing programmes		
Nursing students must have at least one community practice learning experience in health and care.	92% NET agree 4% NET disagree	To recommend this is accepted.
Standards for pre-registration midwifery programmes		
Strengthen our requirement around holistically assessing labour and birth.	83% NET agree 5% NET disagree	To recommend this is accepted.
Strengthen caring for women with additional needs, including across the whole continuum of maternity care.	Open Text Responses Only	To recommend this is accepted - proposals informed by consultation responses.
Require student midwives to undertake one practice learning placement during the final part of their pre-registration programme. This placement should be at least eight weeks.	81% NET agree 4% NET disagree	To recommend this is accepted.
Clarify that continuity of supervision for student midwives throughout the practice learning journey, should be provided wherever possible.	74% NET agree 13% NET disagree	To recommend this is accepted.
Simulated practice learning should contribute towards practice learning hours within pre-registration midwifery programmes.	65% NET agree 22% NET disagree	To recommend this is accepted.

Proposals not recommended for approval

2.7. We do not recommend taking forward the following proposals. These were not supported in the consultation or were dependent on proposals which were not supported.

Proposal	Survey Response	Recommendation
Standards for pre-registration nursing programmes		
Reduction of pre-registration Nursing programme hours from minimum of 4,600 to minimum of 3,600.	32% NET agree 62% NET disagree	To recommend this is not accepted - due to survey feedback and stakeholder concerns about potential impact on student preparedness.
Simulated practice learning should make up no more than 25% of pre-registration nursing programme's practice learning hours.	71% NET agree 21% NET disagree	To recommend this is not accepted – as only necessary if we accept reduction in nursing programme hours.
Standards for pre-registration nursing associate programmes		
Remove the requirement that a nursing associate programme is no less than 50% of a nursing programme.	42% NET agree 38% NET disagree	To recommend this is not accepted – as only necessary if we accept the reduction in nursing programme hours.
Standards for pre-registration midwifery programmes		
Increase the minimum length of midwifery programmes, including degree apprenticeships, from three years to four years.	49% NET agree 34% NET disagree	To recommend this is not accepted. Whilst many agreed with the proposal, there were concerns about the impact on student finances, programme viability and a fallow year in workforce planning.
Lengthen shortened midwifery programme to a minimum of two years.	60% NET agree 20% NET disagree	To recommend this is not accepted – as only necessary if we accept

Proposal	Survey Response	Recommendation
		elongation in midwifery programme hours.

2.8. **Nursing pre-registration hours.** We recommend that pre-registration nursing programme hours remain at 4,600 hours, with a 50:50 theory-practice split.

2.9. We therefore recommend that nursing associate programme hours remain no less than 50% of the minimum programme hours required of nursing degree programmes (2,300 hours). We further recommend that simulated practice learning within practice learning hours for pre-registration nursing programmes would continue to be a maximum of 600 hours where approved. These proposals were only necessary if the reduction in pre-registration nursing hours is accepted.

2.10. **Midwifery programme length:** We recommend that pre-registration midwifery programmes continue to have a minimum programme length of three academic years for full-time programmes. This means there are also no changes to requirements for shortened midwifery programmes resulting from this review.

2.11. The NMC Midwifery Regulation Strategy will continue to build upon the evidence gathered during the practice learning review, see 2.16.

Implementation

2.12. Annexe 3 sets out the proposed changes to existing practice learning-focused education standards.

2.13. Education quality assurance will be central to implementing, monitoring and evaluating agreed changes. Early adopters will be able to implement new standards by September 2027. Most AEIs will gain approval for updated programmes in the academic year 2027-28 with all programmes in alignment by September 2029. All programmes accepting new students from September 2028 will need to be aligned to these updated standards. This will provide adequate time for AEIs and PLPs to transition to the new requirements.

2.14. We believe most changes will be minor modifications to education programmes. However, we note that three concurrent minor modifications constitute a major modification.

2.15. Implementation will include:

2.15.1. Developing supporting information on new expectations for AEIs and PLPs, including information on supporting partnership working on reasonable adjustments, tackling racism in practice learning, clarifying expectations for community practice learning placements in nursing, clarifying requirements for holistic assessment in midwifery and clearly stating what we mean by rare and hard-to-achieve proficiencies. This may include breech birth, episiotomy and suturing. This does not include the 40 births requirement.

2.15.2. Identifying case studies showcasing best practice and innovation in practice learning.

2.15.3. Updating the NMC website to make supporting information more accessible.

2.16. **Midwifery Regulation Strategy:** The strategy includes education focused elements and undertakes, as Priority 1, "to learn from national reviews and strengthen standards, education and practice". The Strategy will spend its initial phase engaging with and listening to stakeholders and its approach will ensure that the NMC will remain open to any possibilities which support safer, more equitable, anti-racist and trusted midwifery regulation.

Further work we recommend undertaking

2.17. Our remit as a regulator sets parameters around the actions we can take. Some of these must be consulted on under our legislation. Others do not require consultation. There are also wider actions that, while not possible within our existing legislation, we can pursue as part of legislative change within regulatory reform. The success of many of these measures will depend on the cooperation and support of our partners and stakeholders, including AEIs and PLPs.

2.18. We propose exploring further actions - in coalition with our partners and stakeholders - as part of future work:

2.18.1. **Position statement for practice learning:** A clear statement on what high-quality practice learning placements should provide to drive up quality in practice learning, increase consistency, remove unwarranted variation and improve student wellbeing.

2.18.2. **Practice learning placement quality and action on poor-quality placements:** Identifying further actions that can strengthen the assessment and evaluation of practice learning, and actions to address poor placement quality.

2.18.3. **Recognise and reward excellence:** How best to recognise and value outstanding practice learning environments, to influence and encourage the sharing of best practice in practice supervision and practice assessment.

2.18.4. **Strengthen joint academic and clinical sign-off, registration readiness and practice readiness:** How the SSSA requirement for a tripartite discussion between the student, practice assessor and academic assessor at the end of the programme can be strengthened, including students identifying where they need support and development before starting a preceptorship.

2.18.5. **Improve visibility of student practice learning experience:** Identifying whether existing national surveys across the four countries can better incorporate perception questions on students' practice learning experiences.

2.18.6. **Quality in preceptorship:** There is need to strengthen the use of preceptorship to ensure students are continually supported when moving between education and professional practice. The NMC does not regulate organisations so we would expect this work to be led by Chief Nursing/Midwifery Officers of the four nations with the NMC taking an advisory/partnership role.

3. FINANCIAL / GOVERNANCE IMPLICATIONS

3.1. Education quality assurance will play a central role in implementing the agreed changes. The recommended proposals are aligned with education quality assurance improvement plans.

4. RECOMMENDATION

4.1. The Council is asked to:
a) **Note** the report; and
b) **Approve** changes to education standards following the recent Practice Learning Review consultation as well as further work to improve quality in practice learning.

5. ASSESSMENT

Impact Assessment	Question / Consideration	Response
Equality, Diversity and Inclusion	Has an Equality Impact Assessment been undertaken?	Yes. We have identified the risk as 3. The EqIA Summary is included as Annexe 4.
Safeguarding considerations	Are there any safeguarding implications?	Yes. Strengthening practice learning partnership working between AEIs and PLPs is intended to improve safeguarding of students.
Four country factors and considerations	Are there any four country factors, including Welsh Language?	Changes to NMC education standards will apply to all four UK nations. We have undertaken a Welsh Language Impact Assessment.
Resource (incl People) implications	Are there any people implications?	Education Quality Assurance will be central to the implementation, monitoring and evaluation of new standards. PP and C&E resources will be needed to develop supporting information and case studies.
Risk implications associated with the work and the controls proposed/ in place.	What are the key risks and how are they mitigated?	Updated standards are intended to strengthen the quality of practice learning and improve student preparedness for professional practice as well as strengthen midwifery education in line with recent maternity reviews.
Legal considerations, incl Regulatory Reform	Are there any legal or regulatory implications?	We have consulted on the standards we propose to change, in line with the Order.
Does this item require any procurement services	Have you spoken to the procurement team about requirements?	Procurement is not required.

Midwives	Any specific implications for midwives?	Yes. This paper includes a recommendation to approve specific changes to the Standards for pre-registration midwifery programmes in line with maternity inquiry requirements.
Nursing Associates	Any specific implications for nursing associates?	Changes to the Standards Framework for Nursing and Midwifery Education will apply to nursing associate students as well as nursing and midwifery students.

Nursing & Midwifery Council

Practice Learning Review: Annexe 1: Thinks Consultation Report

Please follow the link to the report: Thinks Consultation Report

Practice Learning Review: Annexe 2: Synthesis Report

Introduction

1. This synthesis report provides an overview of the evidence collected before the practice learning consultation, from stakeholder engagement that happened during the consultation and implications from wider work that was undertaken in parallel to the consultation.
2. Findings from the consultation itself – including the consultation surveys and the qualitative research undertaken independently by Thinks Insight and Strategy – is presented in Annexe 1.

Pre-consultation evidence

3. Our evidence base on practice learning that was gathered as part of other projects, including our review of education programme standards, following the UK's departure from the EU, includes the following:
    a. Independent evidence review of minimum education standards in nursing and midwifery.
    b. Independent benchmarking report of minimum education standards in nursing and midwifery.
    c. Independent qualitative research about education programme standards.
    d. NMC review of international nursing practice hours.
4. A further discovery phase of work was approved by Council in January 2023. This encompassed:
    a. Independent commissioned research by the Nuffield Trust and Florence Nightingale Foundation;
    b. An NMC evaluation of simulated practice learning (SPL) within pre-registration nursing programmes; and
    c. Outcomes from our education quality assurance mandatory exceptional reporting completed during the summer of 2024.
5. There is also extensive evidence showing inequalities in the health and care experiences and outcomes for people from different socio-economic backgrounds, Black, Asian and ethnic minority backgrounds, and disabled people. We have also identified several recurring themes in maternity care, including from inquiries, NMC and external research, and from reviews of our own Fitness to Practise data.

Evidence supporting the proposals

6. We consulted on 14 proposals to change our practice learning education standards. These proposals were based on the evidence we had gathered pre-consultation, including engagement we had carried out with different stakeholders. In addition, we also asked two further questions:

    a. Views about how to strengthen care for women with additional needs in maternity care; and

    b. Views on whether the length of 'shortened' midwifery programmes should be increased to a minimum of two years, if the length of direct entry pre-registration midwifery education programmes is increased.

Table 1: Underpinning evidence for proposals included in the practice learning consultation Proposal	Summary of evidence
1. Embed anti-racism, bias awareness and cultural curiosity, safety and respect in nursing, nursing associate and midwifery education and training.	The Nuffield Trust and Florence Nightingale Foundation independent research found that challenges around equity, diversity and inclusion impacted on students practice learning experiences. The 2020 NMC Ambitious for Change report and 2024 Spotlight on Nursing and Midwifery report found external evidence showing inequalities in experience and outcomes in health and care for people with certain protected characteristics.
2. Reduce programme hours that pre-registration nursing students complete from a minimum of 4,600 hours to a minimum of 3,600 hours.	The Nuffield Trust and Florence Nightingale Foundation independent research highlighted stakeholder concerns that the current emphasis on hours inadvertently promotes task-oriented care over meaningful learning. Research on the number of practice hours, including the international benchmarking report, found significant variation. Research with students and stakeholder engagement including the key lines of enquiry (KLOE) found evidence of negative impacts on student health and wellbeing. This was alongside feedback of system pressures. No evidence collated on theory hours or the ratio between theory and practice.
3. Remove the requirement that a nursing associate (NA) programme is no less than 50% of a nursing programme (if the minimum hours of nursing programmes are reduced).	The proposal was underpinned by a desire for the NA programme to stay aligned to foundation degree requirements.

4. Simulated practice learning (SPL) should make up no more than 25% of a nursing programme's practice learning hours (if we reduce the total minimum number of nursing programme hours from a minimum of 4,600 to a minimum of 3,600).	The NMC evaluation of SPL found that students valued authentic SPL which increased their confidence in practice learning. The proposal was based on a desire that SPL should remain proportionate.
5. Nursing students to have at least one community practice learning experience in health or care.	Four country policy directives continue to move care into local communities. Our stakeholder engagement found that some students benefit from practice learning experiences in the community, but this is not consistent. The Nuffield Trust and Florence Nightingale Foundation independent research identified the benefits of exposing students to a range of settings for practice learning. These benefits include achieving the required proficiencies and students' future career choices. It is therefore important that students gain practice learning experience in the community.
6. Strengthen our requirement around holistically assessing labour and birth.	Inquires and reviews into maternity care. Analysis of themes from our FtP data and a review of external evidence on inequalities in maternity care, published in the 2023 Spotlight on Nursing and Midwifery report.
7. Increase the minimum length of midwifery programmes, including degree apprenticeships, from three years to four years.	Stakeholder engagement identified several challenges including the need for more time to develop and consolidate proficiencies, as well as financial pressures such as the cost of living. Stakeholder concerns also included whether students have sufficient time to gain exposure to a wide range of practice scenarios – including caring for women and mothers from diverse backgrounds – and to consolidate their learning.

8. Require student midwives to undertake one of their practice learning placements during the final part of their pre-registration programme and that this placement should be at least eight weeks.	Stakeholder engagement highlighted students' concerns about gaining the confidence they need due to lack of chances to consolidate learning.
9. Continuity of supervision for student midwives throughout the practice learning journey, should be provided wherever possible.	During stakeholder engagement we heard about the importance of continuity in supervision rather than many practice supervisors during one practice learning experience.
10. Simulated practice learning to contribute towards practice learning hours within pre-registration midwifery programmes.	The independent evidence review undertaken as part of the programme standards review identified research evidence showing that students valued SPL and it increased their confidence in hard to achieve proficiencies.
11. Strengthen partnership and collaborative working on reasonable adjustments.	The Nuffield Trust and Florence Nightingale Foundation independent research with students and educators found evidence of inconsistency in approaches to reasonable adjustments. This research alongside our stakeholder engagement also found confusion amongst stakeholders on the difference between reasonable adjustments and flexible working requests. There was anecdotal evidence of students expecting flexible working requests to be supported.
12. Registered specialist community public health nurse (SCPHN) midwives to act as practice assessors for pre-registration nursing students.	Stakeholder engagement and enquiries to the Education and Standards team highlighted that midwives with a SCPHN qualification working in public health settings are unable to act as a practice assessor for a nursing student.

A summary of key themes from stakeholder engagement undertaken during the consultation

7. During the consultation we held 26 stakeholder engagement events involving 1,043 participants. This included nursing and midwifery registrants working in practice, AEIs and students, across the four nations.
8. The discussion was led by stakeholders following presentation of an overview of the proposals. Most of the discussion across all events was linked to the proposals to:
    a. Reduce nursing programme hours, for which there was mixed support;
    b. Mandate a community practice learning placement for nursing students, which was supported by most people we spoke to as part of our stakeholder engagement. With one suggestion that 50% of practice learning should take place in community settings;
    c. Extend the midwifery programme, for which there was mixed support;
    d. Include the potential use of simulated practice learning in midwifery which was supported by many people we spoke to as part of our stakeholder engagement; and
    e. strengthening partnership for reasonable adjustments. This was supported by most people we spoke to as part of our stakeholder engagement.
9. The remaining proposals were supported with brief discussion.
10. Some of the discussion illustrated a limited understanding of what is currently permitted within the standards - this was often clarified by other participants in the group and included sharing examples of best practice.
11. The importance of public protection and quality assurance was a thread throughout all stakeholder engagement events during the consultation.
12. Three main themes came out of these discussions:
    a. Implementation and sustainability
    b. Delivery and quality
    c. People, partnership and inclusion.

Implementation and sustainability

13. The proposals to reduce the minimum nursing programme hours and extend the midwifery programme were the focus of stakeholder engagement about implementation and sustainability of the proposals.
14. The importance of professional recognition and workforce mobility was highlighted, for example the close working relationship between the Republic of Ireland and Northern Ireland. Concerns were raised that taking the proposed changes to nursing and midwifery programmes forward would have a detrimental impact on workforce mobility.
15. The implications of future UK-EU policy changes for professional recognition and workforce mobility were also raised.
16. Stakeholders also noted that countries cited as having shorter programmes, with less practice learning, typically provide more structured support from dedicated clinical educators and have stronger support arrangements for newly qualified registrants.
17. Participants expressed concern that changes to programmes, such as reducing the programme hours with no other changes could increase the pressure on AEIs, PLPs and students to meet the requirements - at a time with increasing care

demands and less resources to support practice learning. Concerns were also raised about increased pressure on students to meet the proficiencies. This was linked to the time required for students to achieve competence with a suggestion that reviewing outcome measures and proficiencies alongside programme hours could be more effective than just changing programme hours.

18. Participants also raised that the requirement for programmes to be a 50:50 split between theory and practice. Meaning that a reduction in practice learning hours would also result in a reduction of theory hours for nursing programmes. Some stakeholders suggested that this requirement should be reviewed in the future.

Delivery and quality

19. Some stakeholders felt that greater flexibility would allow programmes to tailor learning experiences to individual student needs and local workforce requirements - noting that some students achieve competence well before reaching current hour requirements, while others may require additional support and time.
20. It was suggested there may be opportunities to create more flexibility for students and focus more explicitly on competence rather than fixed hour requirements, provided that the quality of practice learning is protected.
21. Some felt that retaining a number for nursing practice learning hours would continue a focus on quantity rather than quality. Some participants felt a need to improve the quality and structure of practice learning rather than retain a focus on practice learning hours.
22. The importance of ensuring consistency and quality of practice learning environments and learning experiences was also emphasised as important to reduce unwarranted variation in practice learning.
23. The preparation of practice supervisors and practice assessors was considered a key part of the quality of the practice learning experience for students. Some participants asked for stronger support and guidance, and a future review of supervision arrangements.
24. Some participants suggested that high-quality midwifery simulation practice learning experiences can be more valuable than some learning experiences available in practice.
25. There was support for a mandated community practice learning experience which recognises the value of community as an area of practice.
26. The challenge of defining what constitutes a ‘good’ community practice learning experience was noted with concern because overly prescriptive definitions risk becoming quickly outdated. However, some participants felt that too little clarity would risk continued variation in practice learning quality and experience.
27. A mandatory community practice learning experience provides an opportunity to understand how care is coordinated across systems and the journey of people who use services across health and care. Further enhancing students’ understanding of the complexity of population needs and inequalities, the role of non-clinical and third sector organisations, and the contribution of community assets and the value of social connectivity.
28. It was noted that there are ongoing challenges around community practice learning experience capacity and infrastructure, with AEIs and PLPs working to expand community practice learning opportunities.

People and partnerships

29. Overall, there was support for further embedding and strengthening anti-racism, bias awareness and cultural curiosity, safety and respect into programmes. It was noted that environments which deliver anti-racist care also have a positive impact on staff and the student practice learning experience.
30. Participants identified that widening participation and consideration of neurodiverse students may impact on their practice learning experience. They noted the importance of student-centred practice learning experiences to meet these diverse needs.
31. The importance of tripartite working between AEIs, PLPs and students was identified as key to successfully implementing reasonable adjustments to support student practice learning.
32. Partnership working between AEIs, PLPs and students was also linked to programme development and delivery. The importance of tripartite working, and the link between partnership working and a positive practice learning experience was clearly articulated.
33. Student mental health and wellbeing were highlighted as contributing factors when assessing programme pressures and educational requirements.
34. Midwifery discussions highlighted the complexity of midwifery care and the opportunities to use SPL to achieve hard to achieve proficiencies. This was also linked to partnership working between AEIs, PLPs and people who use services for programme development and delivery.

Implications from wider work

Financial considerations

35. Health and care, education and student finance are outside the remit of the NMC. However, we note that regulation has costs. The proposals may have direct and indirect financial implications on health and care systems, education providers, employers and students.
36. Four country discussions focused on strategic funding implications considering students, AEIs, PLPs, employers and funders.
37. Financial implications are highly dependent on the delivery model, evidence of the benefits, timing of implementation, and four-country funding arrangements.
38. For example, extending the midwifery programme would increase programme fees. In England, students would bear the additional cost, while in the devolved nations it would fall to commissioners. It was suggested that the existing funding could be redistributed by reducing the number of commissioned places.
39. All key stakeholders identified the need to understand how the proposals would be delivered to fully test any strategic funding implications.
40. Whilst the proposal to introduce a mandatory community practice learning placement was welcomed by all four countries, concerns were flagged about funding to establish new community practice learning experiences. Other factors identified included capacity, premises and hiring dedicated education staff to support community practice learning.

Other considerations

41. Stakeholders flagged a concern about the proposal to extend the midwifery programme. This focused on the fact that four-year programmes without a year in industry are normally at master's level.

Findings from inquiries and reviews

42. Since 2022, there have been six inquiries and reviews that have made recommendations relevant to pre-registration nursing and midwifery education. Only two recommendations from two inquiries explicitly name the NMC, but several have indirect implications.
43. These recommendations are not limited to pre-registration practice learning. However, when considering what actions to take in relation to practice learning, we may want to consider whether any proposed changes in areas such as midwifery should be incorporated into a broader review of pre-registration education.
44. Recommendations that explicitly name us stem from the 2026 Nottingham Maternity Review and Amos National Maternity Investigation:

Inquiry	Immediate and essential action	Detail
Nottingham Maternity Review	• Embed Maternity Patient Safety Incident Reporting Framework (PSIRF) methodology into medical, nursing midwifery and NMC curricula.	• Embed Maternity Patient Safety Incident Reporting Framework (PSIRF) methodology into medical, nursing, midwifery and NMC curricula to address the lack of foundational patient-safety education, ensuring future clinicians deliver safer care for women and families, with improvement demonstrated through curriculum adoption and competency assessments.
Amos National Maternity Investigation	• Department of Health and Social Care (DHSC), NHS England (NHSE), Integrated Care Boards (ICBs), NHS trusts, the General Medical Council (GMC) and the NMC must treat racism, discrimination and inequality as a critical maternity safety issue within 12 months, with work starting immediately.	

45. In addition, the Chair of the Nottingham maternity review publicly stated that returning to an education system where midwives trained as nurses first should be considered, as mothers now have more complex needs and midwives do not have the same breadth of experience in high acuity settings.
46. The criticisms in the review also relate to the quality of education. The implications are that the quality of practice learning placements and education delivery may not be preparing students sufficiently. We need to consider different

approaches to assessing whether AEIs and their PLPs deliver the quality of education required to meet high standards.

47. Inquiries with indirect implications for nursing and midwifery education include:

Inquiry	Immediate and essential action	Detail
Nottingham Maternity Review	• All Trusts must support training for midwives in the use of speculum examination. • Enhanced maternal care. • There must be a national standard and documentation for maternity triage and record keeping in maternity care provision. • All Trusts must define criteria for the safe use of telephone postnatal follow up, indicating when telephone follow-up is acceptable or when face-to-face follow-up is mandatory.	• All Trusts must ensure that midwives are supported to achieve local training competencies to perform speculum examinations for women at any gestation of pregnancy, with clear escalation pathways for women in preterm labour or those requiring immediate ongoing care. • All staff caring for pregnant women must receive regular, structured multidisciplinary training to ensure timely recognition and effective management of the deteriorating woman. Training must equip midwives, obstetricians, anaesthetists, critical care teams, and outreach services with the skills, knowledge, and confidence to deliver safe, high-quality enhanced maternal care. Insights from simulation and team-based training should directly inform the development and refinement of clinical systems, processes, and pathways. Dedicated training time must be protected and recognised as part of mandatory training requirements, and trainers themselves must be appropriately trained. • Trusts must develop a robust method of training for midwives providing triage care. This must include minimum competency standards for telephone risk assessment, agreed pathways for mandatory attendance for review and a holistic review of

		physical, mental and social wellbeing assessment. • Trusts must develop lists of circumstances in which ALL postnatal follow-up should be face to face. Where a mother is advised to seek further medical review in relation to either maternal, or neonatal, care the responsibility for arranging appropriate follow-up lies with the healthcare professional providing that advice. Signposting alone is not sufficient. • While it is no longer stipulated in the midwives standards (Nursing and Midwifery Council) that mothers and babies remain under the care of maternity services up to 28 days postnatal, women and families must be able to contact their maternity provider during this time if they wish or need to.
Amos National Maternity Investigation	• DHSC, NHSE, ICBs and NHS Trusts must work with colleges, universities, post graduate educators and others to improve culture and teamworking and strengthen leadership at all levels of the system and across professions within 12 months.	
Kark review of Muckamore Abbey Hospital (2026)	• Education and training on the use of restrictive practices should be grounded in human rights principles.	

Ockenden review of Shrewsbury and Telford (2022)	• Commission an external, independent review of the standards following the publication of East Kent and Nottingham inquiry reports. • Review how we gain assurance in relation to midwifery programmes meeting our standards.	
Kirkup review of East Kent (2022)	• Those responsible for undergraduate, postgraduate and continuing clinical education to be commissioned to report on how compassionate care can best be embedded into practice and sustained through lifelong learning.	
Shanley review of Greater Manchester Mental Health NHS Foundation Trust (2024)	• The Trust must ensure that Edenfield provides compassionate, high-quality care and that all staff, permanent or temporary, have the skills, knowledge, and support to achieve this.	

Practice Learning Review: Annexe 3: Proposed changes to practice learning education standards

1. Following the recent Practice Learning Review public consultation, we intend to make the changes set out in this report to NMC education standards.

Standards Framework for Nursing and Midwifery Education

2. **Reasonable Adjustments (Standard 3.11):** We propose strengthening partnership working in practice education in regarding reasonable adjustments.

3. The new standard will read:

   '*Approved education institutions, together with practice learning partners, must ensure that all students: have their diverse needs planned for, respected and taken into account across all learning environments, with support, reasonable adjustments for students with disabilities, and other adjustments provided in line with equalities and human rights legislation and good practice*'.

4. As part of implementation, we plan to develop new supporting information on strengthening the partnership working and communications between approved education institutions (AEIs), practice learning partners (PLPs) and students in relation to reasonable adjustments and develop supporting information to clarify our expectations on what is a reasonable adjustment and what is a flexible working request.

5. **Anti-racism (Standard 3.12)**: We propose strengthening anti-racism, bias awareness and cultural curiosity, safety and respect to better support students in practice education.

6. The new standard will read:

   '*Approved education institutions, together with practice learning partners, must ensure that all students: are protected from discrimination, harassment and other behaviour that undermines their performance or confidence by embedding anti-racism, anti-discrimination, bias awareness and cultural curiosity, safety and respect in all aspects of their education and training*'.

7. We will also update the glossary in the Standards Framework to further strengthen the importance of cultural competence with a clear definition to include all forms of discrimination.

8. These changes sit alongside our wider equity, diversity and inclusion (EDI) work, including our Principles to support anti-racism in midwifery and nursing education and practice which set out our expectations across education and practice for nursing, midwifery and nursing associate professionals, as well as the Code review.

9. This work also contributes to our EDI target to eliminate disproportionate outcomes, based on ethnicity, in nursing and midwifery education by 2035.

10. As part of implementation, we plan to develop supporting information on new expectations for AEIs and PLPs. Monitoring of changes to standards in the Standards Framework will be undertaken via education quality assurance.

Standards for Student Supervision and Assessment (SSSA)

11. **SCPHN midwives (Standards 6.3 and 6.6):** We propose enabling midwives with a specialist community public health nursing (SCPHN) qualification to act as practice assessors for pre-registration nursing students and nursing associate students who are in a public health practice learning setting.

12. The new standards will read:

13. *6.3 'Approved education institutions, together with practice learning partners, must ensure that: nursing students are assigned to practice and academic assessors who are NMC registered nurses with appropriate equivalent experience for the student's intended field or fields of practice.*

    6.3.1 in addition, nursing students who are undertaking practice learning experiences in specialist community public health nursing (SCPHN) settings may be assigned to a practice assessor who is a midwife with a specialist community public health nursing registration, and who has appropriate equivalent experience for the student's intended field or fields of practice'.

    6.6 'Approved education institutions, together with practice learning partners, must ensure that: nursing associate students are assigned to practice and academic assessors who are either an NMC registered nursing associate or an NMC registered nurse.

    6.6.1 in addition, nursing associate students who are undertaking practice learning experiences in specialist community public health nursing (SCPHN) settings may be assigned to a practice assessor who is a midwife with a specialist community public health nursing registration, and who has appropriate equivalent experience'.

14. Amending these standards will help increase the pool of practice assessors to assess pre-registration nursing and nursing associate students studying in public health settings. As of March 2026, there were 2,419 midwives with SCPHN qualifications on the NMC Register.

15. As part of implementation, we will develop new supporting information for midwives with SCPHN qualifications acting as practice assessors for pre-registration nursing students in public health settings.

16. Relevant public health settings will be practice learning settings where nurses and midwives with SCPHN qualifications are working.

Standards for Pre-Registration Nursing Programmes

17. **Community placement (Standard 3.2):** We propose that pre-registration nursing programmes have at least one community practice learning experience in health and care**.**

18. Student nurses' experiences of practice learning vary between programmes. It is important that students gain a varied experience in different care settings, locations, models of care delivery, and with people from different backgrounds.

19. The new standard will read:

    '*ensure that students experience the variety of practice expected of registered nurses to meet the holistic needs of people of all ages. This must include at least one practice learning experience in a community-based practice setting*'.

20. As part of implementation, we will develop new supporting information to outline what we mean by a community practice setting, the appropriate length for a placement in a community setting, and the nursing standards of proficiency that may be best achieved in a community setting.

21. We envisage a broad definition of community settings. This could include care homes, day centres, nursing homes, schools, child health services, urgent community response teams and occupational workplace environments, and practice areas such as health visiting, district nursing, general practice, public health, health promotion and prevention. Opportunities for community practice learning placements will vary depending on factors such as location, including rural, coastal and inner-city settings.

Standards for Pre-Registration Midwifery Programmes

22. **Holistic assessment (Standard 3.5.2):** We recommend a new holistic assessment of competence and confidence in universal care of labour and conducting vaginal birth.

23. This assessment would be focused on competence and confidence and take place alongside the requirements to provide learning opportunities, across the whole continuum of care.

24. The new standard will read:

    '*support and care for women in labour and to conduct the birth.*

    To achieve this, they must: support and care for no less than 40 women in labour and conduct the birth over the course of the programme.

    They must also undergo a holistic assessment in respect of their proficiency and confidence to care for a woman in labour with universal needs, conduct the birth and provide early postnatal care to the woman and baby, ensuring proficiency across the continuum of care.

In situations where 40 births cannot be achieved owing to the lack of available women giving birth, this number may be reduced to a minimum of 30, provided that the student assists with caring for an additional 20 women giving birth.'

25. As part of implementation, we will clarify what the holistic assessment would include in relation to the Standards of Proficiency for Midwives, and its connection to the eight-week final placement experience period.

26. **Eight-week final placement experience (NEW Standard 3.12):** This would require student midwives to undertake practice placement experiences of at least eight weeks during the final part of their pre-registration programme.

27. The new standard will read:

    '*ensure students undertake practice learning experience(s) of at least 8 weeks duration during the final part of their pre-registration midwifery programme specifically for consolidating their practice learning, in preparation for joining the register*'.

28. **Strengthen caring for women with additional needs (Standards 3.4, 3.5, 3.5.1, 3.5.4, 3.5.5, 3.5.6, 3.5.7)** We recommend strengthening care for women with additional needs. Whilst we did not ask a yes/no question in the consultation on this proposal, there was strong support in open text responses for strengthening care.

29. This includes feedback that all midwifery students should gain exposure to caring for women in surgical, medical, critical care and perinatal mental health and gynaecology settings to recognise deterioration in women and where escalation to the multi-disciplinary/multi-agency team is required. AEIs and PLPs will be expected to develop clear learning outcomes for students to transfer their learning into the maternity setting - for example, in relation to observations and escalation.

30. The new standards will read:

    '3.4 provide students with learning opportunities to enable them to achieve the proficiencies related to continuity of midwifery care across the whole continuum of care for all women and newborn infants, working in partnership with the woman, listening to her views, decisions and needs. This must include experience of caring for women with universal care needs and women with additional care needs throughout the programme, working within multidisciplinary and multi-agency teams where referral/and/or escalation is required.

    3.5 provide learning opportunities, across the whole continuum of care, that enables students to gain experience to:

    3.5.1 support and care for women during pregnancy including in triage.

To achieve this, they must undertake no less than 100 antenatal examinations over the course of the programme.

3.5.4 support and care for women postnatally and healthy newborn infants.

To achieve this, they must support and care for no less than 100 women postnatally and 100 healthy newborn infants over the course of the programme.

3.5.5 develop the required knowledge, skills and behaviours needed to support and care for women and newborn infants who have additional care needs or develop complications, including recognition of deterioration and escalation.

To achieve this, they must support and care for no less than 40 women who have additional care needs or develop complications undertaking practice learning experiences in a range of settings including surgical, medical, critical care and perinatal mental health, with clear learning outcomes for transferability to the maternity setting.

3.5.6 care for newborn infants requiring additional care or who have complications.

To achieve this, students must have practice learning experience in transitional care and a neonatal unit with clear learning outcomes for transferability to the maternity setting; and

3.5.7 care for women across the life course with additional sexual and reproductive health needs.

To achieve this, students must undertake one practice learning experience of gynaecology with clear learning outcomes for transferability to the maternity setting.

31. As part of implementation, we will update our Pre-Registration Midwifery Programme Standards glossary:

    31.1. Additional needs: this is where a woman or newborn infant has a need or complication that requires substantive changes in care which could include referral and escalation to a range of multidisciplinary or multiagency professional coordination of care to provide the additional care required as well as universal midwifery care. A demographic, cultural, religious or social characteristic may not be considered additional needs for a woman's maternity care.

    31.2. Transitional care: Keeps women and their newborn infant together avoiding separation in a neonatal unit when their baby needs extra care. The woman is the primary caregiver and is supported by midwives and neonatal nurses. It can occur in a designated transitional care space, a transitional care cot, a side room or at the bedside on a postnatal ward.

31.3. [1]Continuity of carer or relational continuity of care: care provided by a midwife or small group of midwives who provide care for a woman and her newborn infant, partner and family throughout the continuum of her maternity journey.

31.4. Continuity of care or management continuity: continuity and consistency of management, including providing and sharing information and care planning, and any necessary co-ordination of care required.

31.5. Continuum of care: care across the whole childbearing period from pre pregnancy, pregnancy, labour, birth, the immediate postpartum, and the early days and weeks of life.

32. **Continuity of supervision (Standard 4.6):** We recommend strengthening the continuity of supervision within pre-registration midwifery programmes. As part of implementation, we will develop supporting information.

33. The new standard will read:

    Approved education institutions, together with practice learning partners, must: '*ensure appropriate continuity and consistency of supervision and assessment of students to promote learning and confirm progress and proficiency in preparation for professional practice as a midwife*'.

34. **Simulated practice learning (3.5.3).** We recommend enabling simulated practice hours to count as part of the 2,300 practice learning hours for rare and hard-to-achieve proficiencies in line with the SSSA.

35. Simulation can be useful to support students' theory learning within midwifery programmes and where it is difficult to gain experience in hard-to-achieve proficiencies such as breech birth, episiotomy and suturing.

36. We note that simulated practice learning can count towards 600 of the 2,300 practice learning hours within nursing where approved. However, qualitative and stakeholder engagement across the consultation period indicated that midwifery stakeholders wanted to permit simulated practice learning within midwifery practice learning hours only for rare and hard-to-achieve proficiencies. This does not include the 40 births requirement.

37. We therefore don't intend to set an hours requirement for the use of simulated practice hours within midwifery practice hours as it will only be used in limited circumstances. We will monitor this situation and bring forward a maximum hours requirement in the future if this becomes necessary.

38. The new standard will read:

    '*participate in the support and care of women in labour and the conduct of breech births.*

[1] Definitions for 31.3, 31.4 and 31.5 are taken from NMC Standards of Proficiency for Midwives (Nov 2019) standards-of-proficiency-for-midwives.pdf

Where there are no opportunities in practice to gain experience of breech births and other hard-to-achieve proficiencies or rare episodes of clinical care, proficiency may be gained by simulated practice learning and can be counted as practice learning hours if undertaken in line with the Standards of student supervision and assessment'.

39. As part of implementation, we will be clearly stating what we mean by rare and hard-to-achieve proficiencies. This may include breech birth, episiotomy and suturing. This does not include the 40 births requirement.

40. Across implementation of changes to midwifery standards, we will continue to collaborate with the Independent Steering Group, Midwifery Strategic Advisory Group and the Midwifery Critical Friends Group to ensure our supporting information is clear, helpful and reflects contemporary midwifery practice.

Summary of Equality Impact Assessment (EQIA) findings

This document is designed to act as a high-level overview for colleagues and stakeholders. It is not a replacement for completing a fuller EQIA – please review the EQIA policy or ask the EDI team if you are unclear on how to use this document.

Project details

Title of project: Practice Learning Review (PLR)
Name and title of person completing EQIA summary: Jools Dixon, Nursing Education Adviser
Name and title of person providing support from the EDI team: Mimi Rantala, Senior Policy Officer

Who / which groups did you find were most likely to be impacted by this work?

☑Age
☑Sex
☑Gender reassignment
☑Religion or belief ☑Northern Ireland only – religious belief and political opinion
☑Race and ethnicity
☑Sexual orientation
☑Disability, including mental health
☑Pregnancy and maternity
☑ Marriage and civil partnership
☑ Socioeconomic status
☑ Caring responsibilities

Summarise in as few bullet points as possible the key impacts you identified which decision-makers would need to know about – focus on the highest risk and specify which group(s) are affected

- Overall, the proposed changes have the potential to improve the quality, flexibility and inclusiveness of practice learning. The anticipated benefits will depend on effective implementation by AEIs and PLPs.
- Disabled students, including those with mental ill health or long-term health conditions, may benefit from strengthened expectations relating to reasonable adjustments, accessibility and partnership working. Inconsistent implementation could, however, perpetuate existing barriers.
- Students from Black, Asian and minority ethnic backgrounds may benefit from strengthened expectations relating to anti-discriminatory practice, bias awareness and culturally responsive learning environments. These changes are consistent with the NMC's anti-racist principles and respond to evidence of existing inequalities in educational experiences and outcomes.
- The proposed community practice learning requirement for nursing students may present challenges where placement availability, travel or associated costs create

barriers, particularly for disabled students, those with caring responsibilities and those experiencing financial constraints.
- The proposed final eight-week placement and other changes to midwifery programmes will require careful implementation to support equitable access, assessment and progression, particularly for students with disabilities, health conditions, pregnancy or maternity-related needs and caring responsibilities.
- SPL in midwifery may provide additional flexibility for achieving rare and hard-to-achieve proficiencies. Accessibility and inclusive design will be important where simulation is used. The proposals do not increase the existing permitted use of SPL in nursing programmes.
- Intersectional impacts may arise where protected characteristics and wider personal circumstances interact. Students experiencing multiple barriers may be disproportionately affected by inconsistent placement arrangements, accessibility or support.

Summarise the key mitigations and actions that you will put in place to avoid, and/or minimise the key impacts you identified, including the timeline for completion

- Support consistent and inclusive implementation of the revised standards across AEIs and PLPs, including accessible practice learning, reasonable adjustments and equitable assessment arrangements.
- Strengthen partnership working between AEIs and PLPs to support timely identification of individual needs and planning of reasonable adjustments.
- Promote anti-discriminatory practice, cultural responsiveness and inclusive practice learning environments, consistent with the NMC's anti-racist principles.
- Encourage equitable planning of community practice learning opportunities in nursing programmes, taking account of placement location, travel requirements and associated costs.
- Support inclusive implementation of the proposed midwifery requirements, including the final eight-week placement, holistic assessment and opportunities to care for women with additional needs.
- Promote accessibility and inclusive design where SPL is used, ensuring that learning opportunities support students with differing needs and circumstances.
- Recognise intersectional barriers and the importance of coordinated support for students whose protected characteristics and personal circumstances may interact.
- Consider emerging equality impacts through existing regulatory intelligence, EdQA activity, stakeholder feedback and available evidence, updating the EQIA where appropriate.
- Timeline: Actions will be taken forward during implementation and ongoing review, including post-implementation review.

Outline your proposal to decision-makers

☑ Approve on the basis that the EDI risk is low and/or actively being mitigated
☐ Consider the options set out in the accompanying paper as there is active EDI risk which cannot be fully mitigated

☐ Postpone project until further work is undertaken to manage and monitor EDI risk

Senior sponsor confirmation

I have reviewed the EQIA and agree that the above summary, actions and proposal is correct and in line with our values and goals on equality, diversity and inclusion.
Additional comments:
Name and title of senior sponsor:
Date:

END OF DOCUMENT

Item 16
NMC/26/244
25 November 2026

Report to:	Open Council	Meeting Date:	25 November 2026

Executive Report	
Publication Status	**Open**
Presenting the Report	Paul Rees MBE, Chief Executive and Registrar
Executive Director	Julia Corkey, Executive Director of Communications and Engagement
Report Author	Jess Gray, Executive Business Manager

PURPOSE OF REPORT AND REASON FOR RECOMMENDATIONS

The purpose of this paper is to provide information on key developments, updates and engagements since the previous Open Council meeting on 23 September 2026.

RECOMMENDATIONS:

Council is asked to:

- **Note** and **discuss** the Executive's report on key developments, updates and engagements up to 17 November 2026.

ANNEXES:

None

REPORT APPROVAL	
Executive Director: Julia Corkey	**Approved**
Director of Finance:	**N/A**

General Counsel:	**N/A**
Chief Executive and Registrar (CER):	**Approved 16 November 2026**
Secretary to the Council:	**Approved 16 November 2026**

External Engagement (undertaken to date)		
Committee / Group	**Date**	**Outcome**
N/A	N/A	N/A

Consideration at Committee/Group		
Committee / Group	**Date**	**Outcome**
N/A		

Executive Report

1. BACKGROUND

1.1. The purpose of this report is to update Council on key developments, updates and engagements since the previous Open Council meeting on 23 September 2026.

2. SPECIFIC MATTERS FOR CONSIDERATION

Key stakeholder engagement

2.1 Between 16 September and 18 November 2026, the NMC continued to deepen engagement with key partners. This engagement is helping shape our regulatory priorities across professional standards, practice learning, equity, diversity and inclusion (EDI), maternity and wider system improvement.

2.2 Paul Rees, Chief Executive and Registrar, Chris Dzikiti, Executive Director of Professional Practice, and Paula McLaren, Senior Advanced Practice Advisor, appeared on the Council of Deans of Health Podcast, presented by their Chief Executive Ed Hughes, to discuss the NMC's anti-racism principles.

2.3 On 7 October, Paul Rees, Chief Executive and Registrar addressed the Royal College of Nursing's Council meeting, presenting on our culture and operational transformation progress.

2.4 NMC's engagement continued with representative bodies and trade unions, including Paul Rees, Chief Executive and Registrar's regular touchpoints with UNISON – both with Gail Adams, Head of Professional Services, and separately with our staff representative. Lesley Maslen also hosted her final monthly Fitness to Practise (FtP) meeting with Royal College of Nursing, Royal College of Midwives, Unite the union, and UNISON.

2.5 Engagement also continued with the independent and social care sector, with Paul Rees and Chris Dzikiti attending the Independent Healthcare Providers Network (IHPN)'s Chief Nursing Officer and Clinical Director Roundtable.

2.6 On 28 October, Paul Rees, Chief Executive and Registrar chaired the first in a new series of strategic meetings convening all four Chief Nursing Officers and Chief Midwifery Officers. These will be bi-monthly going forward. These meetings complement the Bi-annual meetings of NMC Council and the four Chief Nursing Officer and Chief Midwifery Officers with the next meeting taking place on 24 November.

2.7 On 16 September Ron Barclay-Smith, Chair of Council and Paul Rees, Chief Executive and Registrar met Scotland's new Cabinet Secretary of Health and Care, Angela Constance MSP to discuss shared priorities including maternity safety in Scotland.

2.8 Chris Dzitiki, Executive Director of Professional Practice led a number of engagements around the Professional Practice Roadmap, including

representatives from all four UK Chief Nursing Officer teams, the Royal College of Nursing and the Royal College of Midwives.

2.9 The NMC supported a joint statement led by the Professional Standards Authority committing to develop shared principles on how the use of artificial intelligence (AI) by health and care professionals across the UK is regulated. This follows the National Commission into the Regulation of AI in Healthcare's recommendations, which set out how the UK's regulatory framework should evolve as AI develops.

2.10 On 30 September, Tracey McCormack, Assistant Director for Midwifery, Nursing and Standards, chaired a meeting of Diaspora Registrants Associations Forum. This meeting focused on discussing our work to include regulatory fairness, strengthening our approach to safeguarding, and Right Referrals, Right Place.

2.11 On 13 October, Paul Rees, Chief Executive and Registrar delivered the keynote address at the Council of Deans of Health Autumn Conference 2026, providing an update on our Practice Learning Review, which will improve the quality of students' practice learning experiences. Council will consider recommendations from the Practice Learning Review at item 9. This was also an opportunity to outline our work to embed anti-racism principles across health and care, which aim to strengthen anti-racism, bias awareness, cultural safety, curiosity and respect across education and professional practice.

2.12 On 22 October, the NMC continued delivering on our commitments to provide more consistent and transparent updates to interested parliamentarians via a letter.

Four Country Engagement

2.13 On 23 September, Council met in Belfast. As part of the meeting, Council heard from Maria McIlgorm, Chief Nursing Officer for Northern Ireland, about the opportunities and challenges facing nursing and midwifery in Northern Ireland, and about work under way on workforce planning, education and training, and quality and safety. Council members also visited health and care settings across Northern Ireland, including an emergency department, a care home, a university simulation centre, and maternity and neonatal units. These visits gave members the opportunity to hear directly from professionals about their experiences of delivering care in Northern Ireland.

2.14 The NMC thanks Maria McIlgorm, Chief Nursing Officer, Mary Frances McManus Deputy Chief Nursing Officer and Caroline Keown, Chief Midwifery Officer for Northern Ireland and their team for their engagement and invaluable support in planning this successful event. The NMC looks forward to working with Sue Tranka, Chief Nursing Officer for Wales and her team on its Council and Executive visit to Wales in September 2027.

2.15 On 6 November, Chris Dzitiki, Executive Director of Professional Practice, Emma Westcott, Executive Director of Strategy and Insight and Alexandra Birch, Deputy Director of Professional Practice, attended the Chief Nursing Officer for Wales's Executive Directors of Nursing Forum. The forum brings together senior nursing leaders from across NHS Wales. It provided an opportunity to update on key projects such as the Code consultation, anti-racism principles and Right Referrals, Right Place, as well as to strengthen engagement with nursing leadership in Wales.

2.16 On 11 November, Chris Dzitiki, Executive Director of Professional Practice and Alex Urquhart, Senior Governance Manager attended a reception hosted by Jackie Baillie MSP, Shadow Cabinet Secretary for Health and Care and Holyrood magazine at the Scottish Parliament. The reception and panel discussion focused on healthcare in Scotland and included a welcome from Jackie Baillie MSP, Shadow Cabinet Secretary for Health and Care. Attendance provided an opportunity to strengthen relationships with parliamentarians and key stakeholders in Scotland, and to reinforce engagement across all four countries of the UK.

Equity, diversity and inclusion (EDI) remain central to our work

2.17 On 13 October, Paul Rees MBE, Chief Executive and Registrar, was named one of the Health Service Journal's (HSJ) 75 most influential Black, Asian and minority ethnic leaders in health.

2.18 On 20 October, Council and the Executive Board held a joint EDI development day, the first in a series of three planned over the next 18 months. The day set out the respective EDI roles of Council, the Executive Board and individual members, and how those roles can be used to drive progress internally and with external stakeholders. A spotlight session on faith literacy was framed around Lord Mann's recommendations that leaders of the UK health and care system and professional regulators undertake training on antisemitism and anti-racism. The day concluded by aligning on current position, intended outcomes and measures of progress against PSA Standards and EDI targets.

2.19 The NMC continued to promote and embed its anti-racism principles across the system. This included a roundtable with system regulators, a webinar for employers on 5 November and social media promotion of the anti-racism case studies.

2.20 In October, the NMC marked Black History Month. Activity included a webinar with Felicia Kwaku OBE and reflections shared by Diaspora Registrants Associations (DRAF) Forum members. In November, the NMC is marking Islamophobia Awareness Month and the start of Disability History Month as well as celebrating the start of Diwali and Bandi Chhor Divas.

2.21 On 6 November Paul Rees, Chief Executive and Registrar spoke on a Senior Leadership Panel at the Malawian UK Nurses Association Conference in Reading. The subject of the panel was 'Leading with Purpose: Influence, Trust, Equity and Belonging'.

Update on our Professional Practice Roadmap

2.22 The NMC's work on the revised Code has involved professionals, members of the public, students, educators, employers and partners across the four countries of the UK. The NMC thanks its advisory groups and the Independent Steering Group, particularly its Chair, Professor Sharon Arkell MBE. Their experience and insight, alongside wider research, regulatory evidence and learning from reviews and public inquiries, have helped shape the draft Code on which the NMC will launch its consultation on 26 November.

Maternity

2.23 On 26 September, Paul Rees, Chief Executive and Registrar and senior leaders attended the second family day of Donna Ockenden's independent review of maternity and neonatal services in Leeds. The day provided an opportunity to listen directly to families' experiences, including how concerns about the fitness to practise of nurses, midwives and nursing associates can be raised. New guidance for families on what to expect when raising a concern was shared, together with a dedicated resource for fathers and partners. Individual surgeries are also being offered, where families can share their experiences and receive further support with raising concerns.

2.24 Engagement with Donna Ockenden and the Independent Review teams in Leeds and Sussex continues to be guided by a family-first approach, in line with the Midwifery Regulation Strategy 2026–2030. This means being accessible and visible, listening closely and making changes to our ways of working where appropriate. Regular meetings with the review teams provide a direct route for families' concerns to be raised and acted upon. Communications with families are trauma-informed, with care taken over timing to avoid significant dates and to reduce the likelihood of families receiving multiple communications at once. Learning from the Nottingham review continues to be applied, so that lessons translate into lasting improvements in how families are listened to and supported.

2.25 On 5 October, a dedicated maternity specialism went live within the Sensitive and Complex Casework Team and currently manages approximately one-third of the team's caseload. A review of all maternity cases currently held is under way, supported by data analysis, to identify further cases that would benefit from this consistent approach.

2.26 During Baby Loss Awareness Week, from 9 to 15 October, the Parents and Carers Staff Network led activity to mark the week internally and externally. This raised awareness of pregnancy and baby loss, signposted pathways to support, and contributed to a culture of care and fairness for everyone.

Midwifery Strategy

2.27 On 3 November, the NMC published its Midwifery Regulation Strategy 2026–2030. This was approved by Council on 23 September. The strategy draws on learning from national maternity and neonatal reviews and on feedback from midwives, women and families. It sets out clearly where direct action can be taken, where responsibility is shared with partners, and where regulatory influence can be used to drive change.

2.28 Five strategic priorities will guide this work over the next four years:

- learning from national reviews and strengthening standards, education and practice
- ensuring fair, informed and effective midwifery regulation
- listening, learning and advancing equity and anti-racism
- strengthening UK-wide midwifery regulatory leadership and accountability
- using intelligence to identify risks and drive regulatory action

2.29 The strategy provides a shared direction for decisions and action across NMC regulatory work. It connects learning from reviews and lived experience with improvements to standards, education, regulation and the approach to risk. It commits to strong standards and to evidence-led, transparent regulation. It also commits to recognising risks to women and babies earlier, and to fair, consistent and timely decision-making informed by relevant midwifery expertise.

2.30 Women, families, midwives, students and other professionals will be given meaningful and accessible ways to shape priorities and decisions. Intelligence from across the four countries of the UK will be drawn together to drive regulatory action. The ambition is that, by 2030, midwifery regulation will be safer, more equitable, anti-racist and trusted, with clear evidence of learning, accountability and improvement.

Improving NMC's regulatory processes

Health checks and quality assurance

2.31 The programme of regulatory health checks covers all regulatory areas, including education quality assurance, registration and revalidation and FtP. It provides a structured assessment of whether processes and controls are working effectively to manage risk. Fieldwork, which includes walkthroughs, case audits and data analysis to assess the effectiveness of controls is well under way.

2.32 A report and proposed action plan which will be agreed with business leads is expected at the end of the year, for discussion and decision on investment required by Executive Board in the new year. This will be followed by an

update to Council on the proposed approach, timeframes and anticipated outcomes. The programme is an important part of building consistent quality management and of providing assurance that regulatory processes are delivered effectively.

2.33 The New Ways of Working project, which aims to support more timely, consistent and proportionate decision-making in FtP proceedings, has progressed since the last report, with cases starting to progress to Case Examiners for a decision. The project has supported NMC experts to design and pilot case pathways which focus on risk and likely case outcome and a user-friendly quality and evidential framework. The pathways ensure that the right experts are involved early, evidential standards are applied consistently, and proportionate steps are taken to investigate cases. The project has helped reduce the backlog of cases at the investigation stage of the process. The model is still being tested and will be evaluated towards the end of the year. Initial data analysis indicates that the pathways have the potential to improve timeliness.

2.34 The project forms part of a wider package of investment in FtP. That package includes recruitment to vacant posts across the Professional Regulation directorate, refitting hearing rooms with modern technology and development of a new case management system. Work is also under way to identify cases that can appropriately be concluded earlier, reducing unnecessary delay while keeping public protection central to decision-making.

Legally Qualified Chairs

2.35 New FtP rules, approved by Council in April 2026, came into effect on 1 October. The rules enable the appointment of Legally Qualified Chairs to lead some FtP hearings. Legally Qualified Chairs are experienced solicitors, barristers or advocates who will combine the roles of Panel Chair and Legal Assessor, removing the need for a separate Legal Assessor.

2.36 A campaign to recruit 140 Legally Qualified Chairs closed on 5 October, and applications from people from backgrounds under-represented at senior levels were particularly encouraged. The change will reduce duplication, support more consistent chairing, and enable timely and proportionate hearings while maintaining fairness and robust decision-making. It brings the approach into line with that already used by other healthcare regulators

Education Quality Assurance Improvement

2.37 On 1 October 2026, the NMC announced a more proactive approach to education quality assurance delivered through two new monitoring methods: thematic monitoring, which will look at a specific theme across NMC-approved programmes, and Approved Education Institutions (AEI) monitoring, which will look at an institution's quality assurance arrangements for all NMC-approved programmes it delivers. The new methods are informed by feedback from students, educators and partners and are designed to be fair, consistent and

constructive. The first thematic monitoring will focus on how well EDI are embedded within programmes.

Culture transformation

2.38 Colleagues came together for in-person and virtual town halls. The second round of Living Out Our Values awards recognised colleagues who demonstrate the NMC values of Integrity, Fairness, Respect, Equity and Effectiveness. Paul Rees, Chief Executive and Registrar hosted the award winners for a celebration of their achievements. The third round of nominations concluded on 6 November.

2.39 Managers Central on Pulse, the organisation's intranet, launched on 22 October to support consistent leadership across the organisation. It is one central place where line managers can find clear, practical guidance, tools and resources to help them lead with confidence, manage consistently and support their teams effectively.

New Senior Leadership

2.40 Lesley Maslen, Executive Director of Professional Regulation, left the NMC at the beginning of November. The NMC acknowledges her significant contribution to the improvement of FtP and thanks her for her leadership during a period of considerable change. On 2 November, Richard Cartland took up the role of Acting Executive Director of Professional Regulation. Jen Taylor has been appointed Interim Executive Director of Technology and Transformation.

2.41 On 7 September, the NMC launched a recruitment process to appoint four new Council members – two registrants (with the aim of one being a midwife) and two lay people. To help ensure the Council reflects the diversity of the professionals the NMC regulates and the public the NMC serves, applications were open to candidates from across the UK, particularly encouraging applications from people with the right skills and expertise from Black, Asian and ethnic minority backgrounds.

2.42 As members of the governing body, the successful candidates will play a critical role in setting the organisation's strategic direction, providing oversight and ensuring effective governance as the NMC continues to become the stronger, more effective regulator everyone wants to see. The successful appointments will be announced in due course.

3. FINANCIAL/GOVERNANCE IMPLICATIONS

Not applicable.

4. RECOMMENDATION

4.1 The Council is asked to:

a) **Note and discuss** the report content including key developments, updates and engagements up to 17 November 2026.

5. ASSESSMENT

Impact Assessment	Question / Consideration	Response
Equality, Diversity and Inclusion	Has an Equality Impact Screening been undertaken?	Not applicable.
Safeguarding considerations	Are there any safeguarding implications?	No.
Four country factors and considerations	Are there any four country factors, including Welsh Language)	Stated throughout the paper.
Resource (incl. People) implications	Are there any people implications?	Not applicable.
Risk implications associated with the work and the controls proposed/ in place.	What are the key risks and how are they mitigated?	Not applicable.
Legal considerations, incl. Regulatory Reform	Are there any legal or regulatory implications?	Not applicable.
Midwives and/or Nursing Associates	Any specific implications for nursing associates?	Not Applicable.