NIPEC
Northern Ireland Practice & Education Council

Central Nursing and Midwifery Advisory Committee (CNMAC):

Themed responses from NMC Independent Culture Review Report

July 2024

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1.0 Introduction

The Chief Nursing Officer (NI) has invited the Central Nursing and Midwifery Advisory Committee (CNMAC) to provide their views on the NMC Independent Culture Review[1] to her office to brief the Minister from a senior nursing and midwifery perspective across Northern Ireland.

CNMAC is a statutory advisory body established in 1974 under Article 24 of the Health and Personal Social Services (Northern Ireland) Order 1972. Its function is to provide relevant, timely and resolved advice to the Department through the Chief Nursing Officer (CNO) on matters concerning nursing and midwifery in Northern Ireland.

CNMAC members note that the NMC has also commissioned Ijeoma Omambala, KC, to lead two investigations which will report in the coming months – one into the way the nursing regulator has responded to the concerns raised and another into the Fitness to Practice cases highlighted within those concerns. The outcome of these should be used to more fully inform the way forward which is appropriate, timely and with the required urgency, in order to restore public and registrant confidence in the organisation. Members have indicated they may further consider the outcomes of these two investigations when they become available.

The responses contained within this report have been themed from the feedback received from members of CNMAC alongside notes captured during an extraordinary meeting between the CNO Office and Executive Directors of Nursing (EDoN's) on 9th July 2024.

[1] NMC (2024) *Independent Culture Review* available at www.nmc.org.uk/about-us/independent-reviews/

2.0 Background

The Nursing and Midwifery Council (NMC) exists to protect the public and has a vital role in building a safety culture that is open and fair.

Rise Associates and Nazir Afzal OBE were commissioned by the NMC to undertake an independent cultural review of the organisation in January 2024 following a series of disclosures by a whistle- blower in 2023, which claimed a “deep seated toxic culture” was leading to skewed and failed investigations. The remit was to review the workplace culture over the last five years

Over a period of five months, the review team gathered evidence from staff across the NMC, and from former employees, about what they experienced in the workplace and the wider culture. They also spoke with key stakeholders such as trade unions, staff networks and Chief Nursing and Midwifery Officers.

The review highlights this is not the first time the NMC has come under scrutiny regarding its culture. For well over a decade, the regulator has had claims of bullying, racism, incompetence and a dysfunctional workplace culture that fails patients and families and many of the challenges encountered by the team appear to predate the whistle-blower’s concerns that appeared in the media last year.

Given the frequency of reports and continual criticisms, the review team highlighted that, despite the fact that in the organisation there are directorates possessing healthy cultures that support the essential work of the regulator, questions must be asked as to whether this commitment is genuine, as unfortunately this review highlights similar concerns with evidence of a direct impact on public safety,

The review sets out a total of 36 recommendations relating to:

- A workplace where everyone is afforded dignity
- Regulation
- Whistleblowing and public trust
- Recruitment, retention, development and progression
- Equality, Diversity & Inclusion
- Improved line management, performance management, and Trade Union recognition
- Safeguarding
- The work of the NMC
- Transparency
- Supporting panel members

3.0 Summary of Responses

Although the Independent Culture Review report is shocking due to its difficult findings, it is important that we recognise that not only have the NMC commissioned this report they have also accepted the recommendations within it, therefore it's candour and detail are to be commended. There is transparency in revealing the reality for some NMC employees and registrants and it is only through acknowledging these issues can these be addressed collectively. It is also important to note that Northern Ireland has experienced significant benefits over the past 18 months with the appointment of the NMC NI adviser, who is an excellent expert resource and aid in NMC matters. She has assured us through her work that she is an exemplary professional who has clearly demonstrated the NMC values in her work with us and demonstrates a fair and just culture. We also wish to express our thanks to Sam Foster, NMC Professional Practice Executive Nurse Director and the 4 nations CNO's who have been raising concerns regarding NMC for some time.

CNMAC members have first-hand experience of many of the issues outlined in the review including protracted delays in the progress of referrals through the NMC processes, a lack of clinical understanding and communication from those tasked with taking witness statements and recollections/evidence and a lack of support for registrants involved in Fitness to Practice (FtP) processes. In response to the review, CNMAC members have made several observations and highlighted the following 6 key themes:

3.1 Theme 1: Emotional Response

As members of the world's most trusted profession it is very concerning to read this independent review regarding the NMC, the regulator of nursing and midwifery professions. Initial reactions from CNMAC members are that of shock, damage to the reputation of the professions and huge concern for the future of Nursing and Midwifery regulation in the UK. What makes this more alarming is that it seems that much of what has been reported appears to have been ongoing for many years. The NMC have indicated that they do not believe there are any concerns with its ability to discharge its responsibilities for public protection but there are significant safeguarding issues that need to be addressed to restore public confidence and the confidence of the nursing and midwifery professions. The NMC Code (2018) requires nurses and midwives to receive feedback and reflect on learning from their practice. Following review of this report it is clear that they did not adopt those principles with respect to their operations and staff engagement. Furthermore, it is clear that they did not embody the values expected from their registrants which is very disappointing for CNMAC members.

3.2 Theme 2: Impact on Registrants

The NMC Code of Practice is part of the identity of the nursing and midwifery professions who uphold and work within the principles of the Code from the NMC so to read this damning report about the regulator which enforces the code is a difficult message for registrants. The report indicates that 17% of respondents had witnessed discrimination, victimisation or harassment whilst acting as a panel member. This is particularly disturbing in a setting when registrants are at their most vulnerable. This report has the potential to add additional stress and distress to all registrants and families. Referral of a registrant to the NMC is a significant career and life event yet the regulator does not appear to listen to or ask for the lived experience of these registrants or learned from previous experiences. Decision to make referrals to the NMC are not undertaken lightly and there is considerable professional discussion and consideration prior to any referral being submitted.

There is key concern regarding the psychological support provided to registrants who have been through or are currently part of the FtP process. The report highlighted that within the past year 6 people have died by suicide or suspected suicide while under, or having concluded, FtP investigations. In addition, since 2016 a total of 27 registrants have taken their own lives prior to the conclusion of their case. The distressing report of staff taking their own lives whilst awaiting outcomes is extremely sad and we must ask questions as to why this was allowed to happen. One death was one too many.

Importantly, there are currently close to 6000 outstanding FtP cases. A significant number of registrants may wait up to 10 years for decisions to be taken. In light of this a number of concerns have been raised by CNMAC members, as below:

- Registrants who have been subject to NMC actions may seek review of the decision requiring cases to be reopened
- Registrants currently in FtP process may not have confidence in the process resulting in a number of challenges and as a consequence delays in decision making and subsequent outcomes.
- Cases screened out by NMC may be potentially unsafe decisions- as a consequence this may result in public and professional lack of confidence in the FtP of staff still practising.
- Future impact on Muckamore Abbey Hospital (MAH) Inquiry and public confidence
- For our International staff there may be heightened concern about any cases previously or currently referred to the NMC from a discrimination, racism or bullying perspective which was identified within the NMC which could impact upon the NMC's ability to function effectively and make fair decisions
- The impact of the backlog on staff and families cannot be underestimated from a psychological point of view

- It is anticipated there will be considerate public interest on past and current cases and decisions taken.

3.3 Theme 3: Safeguarding

Members recognise that safeguarding registrants and the public is a key priority and that current processes for referral should continue to be used along with availing of the excellent advice from the NI NMC Advisory Representative. Timeliness of referrals by employers will remain a key priority in order to protect the public. This will be within the context of a considerable backlog of cases, and clearly stretched NMC workforce, whilst at the same time the NMC concurrently address and takes forward the far-reaching recommendations of the review.

Safeguarding should be the highest priority within the NMC which has demonstrably failed to fulfil its responsibilities in this area. The review also leaves doubt regarding previous cases and questions the need for a 'look back' exercise in order to provide assurance. It is of notable concern that safeguarding concerns, both internally within the NMC and in regard to cases of Fitness to practice were, in a number of cases, not appropriately managed (unsafe decisions) which resulted in risk of further harm to the public and to registrants.

3.4 Theme 4: Authentic leadership

The report accused the NMC's leadership of failing to take concerns seriously or to tackle problems it had been aware of for the past 15 years and highlights clearly the discriminating culture of the organisation. The review found that previous reports had identified a long history of "toxic culture" dating back to at least 2005, but the concern now is that the issues are widespread with unacceptable behaviours including bullying, nepotism and racism. Whilst the NMC has conveyed regret and undertaken to implement the recommendations, the question must be asked as to whether this is a sufficiently robust expression of accountability. In simple terms, is the position of the current NMC Senior Team and Council tenable? CNMAC members are generally concerned about the ineffective leadership identified in the report that points to failures in senior leadership to address challenges and foster a positive culture.

The report points out that most of the senior team at the NMC are not registrants and therefore have little or no understanding of the professions they are charged with regulating. It is of great concern that because there are too few clinical voices generally within the NMC at every level, including the investigation process. this erodes the confidence in the professions who are accountable to this regulatory body.

3.5 Theme 5: Disconnected Learning

It is evident that this review is not the first report in which the NMC has been clearly failing in the discharge of its responsibilities, including the need for change in organisational culture. This recurrent theme over a period of years impacts the confidence in the NMCs ability to take forward these recent recommendations within the context of this history. Regrettably both the NMC Executive Team and Council have provided responses of a reassuring nature, however this is in the absence of providing assurance that there is a robust plan for stepped improvement. It is also important to note that whilst the NMC notified noncompliance with Standard 15 to the Public Standards Authority, who escalated this to the Secretary of State, it is not clear if there was any corresponding action taken.

It is important that other regulators learn from this review.

3.6 Theme 6: Culture and Behaviours

Staff wellbeing should be taken extremely seriously but this is not reflective of the culture within the NMC whereby staff reported high levels of burnout, emotional drain and mental health issues due to the organisational culture. Issues of bullying, harassment, sexism, racism and unacceptable behaviour are cited in the report. This is reported as impacting on how decisions are made, which affect 'public protection and patient safety' (P55). This must be urgently addressed and whilst it will be a challenge it is considered that the recommendations outlined in the report are not ambitious enough to support the resultant change that is required.

Furthermore, within the NMC the lack of trust and fear to speak up is characterised by suspicion, fear, blame and resistance to change hindering transparency and improvement within the organisation. The issues raised in this report highlight the need for all organisations to establish and have in place assurance mechanisms regarding culture so that lessons from this cultural review of the NMC are used as key learning, thus preventing such difficulties from pervading other organisations, including those in Northern Ireland.

There are also significant concerns that both staff and the public may perceive that because the NMC is one of the regulatory bodies that nurses and midwives within other organisations follow the same practices therefore it would be important to differentiate in particular the separate identities of the NMC, HSC organisations and other employers of nurses and midwives.

There are also indications in the review that pressures within the work environment were a factor in creating the culture. It is clear that the NMC failed to address issues around the increasing backlog of FtP cases and despite continued investment in this area since 2016 the problem has become much worse. This area is ripe for structured improvement work with a focus on systems and processes.

4.0 Potential Impact for the Professions

CNMAC members have highlighted a number of additional potential issues that may need to be considered to inform further actions. These include:

- Potential for negative impact on morale within the nursing and midwifery professions
- Potential for increase in hostility toward nurses/ midwives
- Impact on the views of nurses and midwives held by other professions.
- Potential for increase in complaints/ FOI requests
- Media coverage and need for consistent messaging
- Financial and resource implications, for associated legal challenges
- Loss of respect and frustration among registrants that the regulator did not uphold or reflect it's own standards
- Potential for an increase in staff leaving the professions
- Impact on high profile investigations such as Muckamore Abbey Hospital – loss of credibility

5.0 Conclusion and Recommendations

It is now nearly 30 years since the review that led to the creation of the NMC and the organisation has proven, time and time again, that it does not effectively discharge its responsibilities as a regulator. This report does not stand in isolation and should be read alongside the serious criticisms made of the NMC in a range of other high-profile reports over many years.

This report has the potential to damage public confidence in the nursing and midwifery professions. The NMC to this point has been held in high esteem along with respect for their role as the regulatory body. This review may undermine the high esteem in which the public holds the professions and result in a loss of confidence and respect.

It is time for a new beginning and the review reinforces the need for all organisations to prioritise the development of healthful cultures.

CNMAC members have made the following recommendations for consideration:

1. The role of the PSA in this regard has been limited therefore a UK oversight group reporting directly to Ministers should be set up to agree terms of reference within which the NMC will work and be monitored regarding progress.

2. The Minister of Health in NI, along with his counterparts in the other 3 countries of the UK, should consider the need for a fundamental review of the

structure, functions and workings of the UK nursing and midwifery regulatory body

3. Ensure clear pathways are in place across all health and care organisations for staff reporting concerns to managers and safeguarding leads.

4. Work in partnership to support colleagues in the NMC to take forward the changes that are required.

5. Implementation of the report recommendations may have an impact on employers of nurses and midwives and their capacity to respond to the resultant changes. This should be identified and supported.

6. Undertake a review of FtP referrals from NI to ascetrain if there are distinct issues that need to be addressed regionally.