nmc Together in practice

Ambitious for change

Phase two report

2022

Foreword from the Chief Executive and Registrar

As the independent regulator of more than 758,000 nursing and midwifery professionals, we're committed to doing everything we can to eliminate discrimination, tackle inequality, celebrate diversity and promote inclusion.

In this report, you'll find the latest findings of our Ambitious for Change work which aims through qualitative research to find out why some professionals have different experiences of our processes based on who they are.

The findings highlight opportunities for us to improve our regulatory activities, to ensure our processes are fair for everyone. They also highlight where broader systemic issues of inequality are driving disparities in outcomes of our processes.

Recognising the problem

It's essential that we recognise people's experiences of discrimination – and the absolutely devastating impact this can have.

Most of the professionals we spoke to as part of this research felt one or more of their diversity characteristics, such as their ethnicity and/or gender, played a part in their referral from their employer and said an 'insider/outsider' culture left them feeling unsupported.

When we compared our fitness to practise referral rates with workforce diversity data, we found concerning results. For example, some employers refer more professionals who are Black and/or male to fitness to practise compared to the make-up of our register and their own workforce.

We also learned more about how the setting where someone works, and the type of work someone does, can influence a person's experience of revalidation or fitness to practise. Those working in care homes, GP practices or for providers which employ a lot of bank and agency staff are particularly affected. We know that certain groups, such as Black and overseas-trained professionals, are over-represented in these settings. This indicates longstanding, systemic inequalities across health and social care that perpetuate the disparities we're seeing.

We need to work together to create change

Much of what we found echoes the findings of others such as the Workforce Race Equality Survey and the General Medical Council.

When our data, evidence from professionals, and research from our partners all point to the same thing, this isn't a question of whether discrimination and inequality exist. They do. The urgent question is: what are the practical steps we can take to stop them from happening?

We've set out some areas for action for the NMC, which we'll take forward as part of our equality, diversity and inclusion plan so that improvements are embedded throughout our work. But our research tells us that's not enough. Systemic problems need system-wide solutions. We need to work with employers and our partners across the health and care sector – bringing to light what professionals have told us and helping to develop sustainable and effective solutions.

Together we must target these inequalities, which have no place in the working environment of our professionals or the care that people using services receive.

There's also more we need to do to gain insight about some groups who we heard less from in this research. For example, we know that disabled people are among the groups who are less likely to revalidate successfully and more likely to be referred. But we didn't hear about specific challenges disabled professionals face as part of this research, so we need to do more to understand these differences so we can take action to address any unfairness.

I'm very aware that there is a challenging road ahead of us. But that doesn't diminish our resolve, it makes it stronger. You have my commitment that we will keep pushing this work forward, and urge others to do the same.

Best wishes,

Andrea Sutcliffe
Chief Executive and Registrar

Executive Summary

Background

Our vision is safe, effective and kind nursing and midwifery that improves everyone's health and wellbeing. As the independent regulator of more than 758,000 nursing and midwifery professionals, we have an important role to play in making this a reality.

We value the diversity of people on our register and we're committed to ensuring our processes are fair and accessible to them all. In October 2020, we published Ambitious for Change: Research into NMC processes and people's protected characteristics. This examined the impact of our regulatory processes on professionals with different diversity characteristics. It found that sometimes people receive different outcomes from our processes based on who they are. This includes differences in our education, overseas registration, revalidation and fitness to practise processes.

We found that male or disabled professionals were more likely to receive disproportionate outcomes from all of the processes we looked at. Other groups, such as older, bisexual or Black professionals were found to have worse outcomes in some but not all of our processes. For example, people in these groups were less likely to register successfully through our overseas registration process but while older groups were also less likely to revalidate successfully, Black or bisexual professionals were more likely to be referred to us and progress through the stages of our fitness to practise process.

We're committed to becoming a fairer and more inclusive regulator and to supporting and promoting a professional culture that values equality, diversity and inclusion. To be able to take action to address any unfairness we need to understand why these differences are happening and the impact they have on people.

This report

Working with our external advisory group comprising representatives from across the UK with a background in equality and/or research, we launched a second phase of work to help us better understand the differences our data showed. This involved:

- speaking to professionals and employers and hearing their reflections on why they thought there were differences in revalidation rates and referrals to fitness to practise
- looking at the referrals we've received from employers involving male and/or Black professionals to identify any commonalties, themes or trends and to compare them to the size and diversity of each employers' workforce

- improving what we know about where professionals on our register train and work and their diversity characteristics to help us better understand the influence of job role and place of work on professionals' experiences of, and outcomes in, our processes
- monitoring the changes we made to our overseas registration and fitness to practise processes to look at the impact on professionals with different diversity characteristics and to measure progress against what we found in our phase one report
- commissioning an independent review of a sample of our registration appeal and fitness to practise cases to help us understand why cases involving certain groups of professionals progress further through our processes and/or receive more serious outcomes. The review will also help us to ensure that we're consistent in how we deal with such cases and identify improvements we can make to maximise fairness and consistency.

This report presents the findings from the first two pieces of work and reports our progress against the third and fourth pieces of work, which are ongoing.

We've experienced delays in commissioning the independent review of registration and fitness to practise cases because of difficulties identifying suppliers to undertake this work. We now plan to complete this work in 2022–23.

Our approach

We've received expert advice and guidance from an external advisory group throughout this work. The group comprises representatives from across the UK and a broad range of people, organisations and interests (see Annexe 1).

We took different approaches to the first and second phase of our work according to what we were trying to find out. More details about our approach are in Annexe 2.

The first phase focused on finding out whether professionals with different diversity characteristics received different outcomes from our processes and how much this was due to their diversity characteristics rather than other factors like where they trained or lived. We reviewed external data and research and analysed our own data to understand whether a person's diversity characteristics influence the outcomes they receive in our processes and if so, by how much. We were unable to include nursing associates in our analyses because, at that time, no nursing associates had applied to join our register through our overseas registration process, revalidated or been referred to our fitness to practise process.

The second phase focused on understanding why these differences were happening, what it meant for the professionals involved and what we and others could do to tackle any unfairness. We took a qualitative approach to this to allow us to explore professionals' and employers' perceptions, experiences and attitudes.

We also wanted to look more closely at the referrals we received from employers between April 2016 and March 2019. This involved more detailed analysis of our fitness to practise data and analysing this alongside data about the size and diversity of each employer's workforce.

Summary

There is now clear evidence to show that professionals with certain diversity characteristics revalidate in lower proportions, and are less likely to revalidate successfully, compared to other groups. We receive more referrals of some groups of professionals. Some of these, and others with different diversity characteristics, are more likely to be referred to us, with some more likely to progress further through the different stages in our fitness to practise process and receive more serious sanctions from it.

We heard professionals' and employers' views on why they think these differences are happening – much of which is consistent with research and data from across the sector.

We've got more clarity on how the type of job that a professional does, how they're employed and where they work shapes their experiences at work and their interactions with our regulatory processes.

Professionals working as agency or bank staff or in settings such as care homes or GP practices are adversely affected. Professionals with certain diversity characteristics are more likely to work in these types of roles and settings and are therefore disproportionately more likely to have negative experiences and outcomes in our processes. For example, Black African professionals make up 8 percent of our register but do 14 percent of jobs in care homes and 36 percent of agency jobs.

Professionals told us that a person's job role, employment type and work setting are the key drivers behind differences in revalidation rates, not necessarily a professional's diversity characteristics in isolation.

Professionals and employers differed on why they thought certain groups were more likely to be referred to us. Professionals feel that referrals of particular groups are often driven by perceptions of them as 'different' or an 'outsider'. People described feeling like an 'outsider' in many ways but key factors included being in minority groups when it came to ethnicity, gender, age, sexual orientation, gender identity, nationality or religion as well as a person's type of employment. Many Black and Asian professionals felt they were referred because of their ethnicity.

Most employers that we spoke to disagreed that a professional's diversity characteristics played any part in whether they made a referral to the NMC or not. However, they recognised some disparities for Black and minority ethnic professionals. For example, employers acknowledged that Black and minority ethnic professionals were more likely to be subject to disciplinary action and experience bias from members of the public and people who use services.

Our data and wider external evidence suggests that some employers deal with concerns about male and/or Black professionals differently compared to other groups.

Black professionals report higher rates of harassment, bullying or abuse from managers and colleagues at work and are more likely to enter the formal disciplinary process compared to white staff[1]. Male and/or Black professionals are more likely to be referred compared to women and/or white staff. Employers' referrals of male and/or Black professionals are higher than both the proportions on our register and employers' own workforces. We close more of employers' cases that involve male and/or Black professionals in the early stages of our process compared to all cases referred by employers. This suggests that employers should be addressing more concerns locally rather than referring them to us.

The research also highlighted some issues within our own processes that may exacerbate difficulties for some groups. This includes a lack of clarity about some of our revalidation requirements, the length of time the fitness to practise process can take and communication in our fitness to practise process that can be infrequent and impersonal. Addressing these issues would help to improve all professionals' experience of our processes but on its own is unlikely to make an impact on differences in outcomes.

We invited a diverse pool of professionals to take part in this research. However we found it harder to gain as much insight about some groups compared to others. For example, our data showed that male or disabled professionals were less likely to revalidate successfully, more likely to be referred, more likely to have their case progress to adjudication and be struck off or suspended. However, neither diversity characteristic was mentioned by the professionals we spoke to about revalidation and disability was not brought up in relation to fitness to practise. Our data shows that men are overrepresented in some of the jobs and settings highlighted in our research as being less likely to revalidate successfully. For example, 11 percent of our register are men but they do 20 percent of agency jobs and 15 percent of nursing jobs in care homes. The higher concentrations of men in certain roles and settings may explain their lower revalidation rates.

We're not in a position to say why there are differences for disabled professionals. We heard from more disabled professionals compared to the proportions on our register. Seven of the 18 participants (39 percent) we spoke to about revalidation and five of the 60 (8 percent) people we spoke to about fitness to practise told us they were disabled compared to the 3 percent of our register that have declared that they are disabled. Yet, we didn't hear about the specific challenges faced by disabled professionals in the research itself. Given the number of regulatory processes that affect disabled professionals, we need to do more to build our understanding of the drivers of these differences.

From the evidence gathered as part of this research there appear to be three main drivers of the differences for professionals with different diversity characteristics:

Issues within our own processes that affect all professionals but may exacerbate differences for some groups. For example, professionals may not always be clear about what we expect of them, they're subject to unnecessary stress from delays and from changes in NMC personnel dealing with their fitness to practise case, and we don't always communicate with people as well as we should.

Issues with individual employers that mean professionals can be referred inappropriately, don't feel supported going through NMC processes, are not told about concerns that have been raised about them or are readily blamed when things go wrong. Our research suggests that these issues particularly affect those working in organisations such as care homes, GP practices or for providers which employ a lot of bank or agency staff.

Wider systemic issues in both nursing and midwifery and other health professions that perpetuate 'insider' and 'outsider' cultures - defined by an individual's characteristics leading to risk of discrimination, bias and stereotyping. Our research found that this particularly impacts professionals who are male, Black and/or those who trained outside of the UK.

Next steps

To address these root causes, we will take action at three different levels.

1. Improving how we regulate is within our gift and benefits everyone on our register. Actions we will take will include:

    - further training and development for our staff to ensure we provide consistent, clear, helpful advice and guidance to professionals contacting us

    - continue to prioritise reducing our fitness to practise caseload and improving our process as our top corporate priority to ensure that everyone impacted by a fitness to practise referral has a timely, person-centred, streamlined experience

    - work with disability organisations and networks to help us understand why there are differences in revalidation rates and referrals to fitness to practise for disabled professionals

    - commission the delayed review of registration appeal and fitness to practise cases to help us understand why cases involving professionals who are male, disabled or Black, or those who prefer not to tell us their sexual orientation (the groups for which we found disparities) progress further through our processes. The review will also ensure that we're consistent in how we deal with such cases, and help us to continue to improve our processes to maximise fairness and consistency.

2. We will work with individual employers in our fitness to practise process to provide them with more tailored information about the referrals they make to us, the outcomes of these referrals and any trends or patterns in terms of reasons for referral and how this compares to similar organisations.

3. Many of the factors contributing to different outcomes in our processes are the result of wider systemic or societal issues that span across and beyond health and social care. The nature of these issues means we need to work with partners and stakeholders to understand the issues, share insights about what has worked elsewhere, and co-develop new approaches to eliminate bias. Together we need to ensure all professionals are treated fairly and have an equal chance to practise safely and effectively.

We'll be taking this work forward as part of our equality, diversity and inclusion (EDI) plan that was approved by our Council at the end of May 2022 and will be published later this year.

Section 1

Revalidation

Revalidation is the process that all nurses and midwives in the UK and nursing associates in England need to follow to maintain their registration with the NMC.

To help the professionals on our register continue to develop in line with our Code and Standards of proficiency for nurses, midwives, and nursing associates and reflect on their practice, we ask them to revalidate every three years.

Nurses, midwives and nursing associates are required to submit an online form confirming that they have:

- practised for a minimum of 450 practice hours (900 hours for those with dual registration) over the three years prior to the renewal of their registration
- carried out 35 hours of continuing professional development (CPD), of which at least 20 hours must be participatory learning
- collected five pieces of practice-related feedback over the three years prior to the renewal of their registration
- completed five written reflective accounts on their CPD and/or practice-related feedback and/or an event or experience in their practice, and how this relates to the Code, over the three years prior to the renewal of their registration
- had a reflective discussion with another nurse, midwife or nursing associate
- received confirmation from an appropriate person that they have met all the requirements.

In addition, they must:

- provide a health and good character declaration
- declare that they have (or will have when they practise) an appropriate professional indemnity arrangement.

For more information on the revalidation requirements and the guidance and support available please visit our website.

The first phase of research

In the first phase of our research we looked at the numbers of professionals with different diversity characteristics who revalidated successfully compared to those that didn't (for example, the percentage of men who revalidated compared to women). We found that 95 percent of professionals who were due to revalidate, did so successfully.

We found differences in the proportion of people due to revalidate and those that did so successfully by gender identity, age, disability, ethnicity, sexual orientation, religion, country of address and training country. Professionals identifying as trans, over 51 years old, disabled or those who preferred not to say if they were disabled, White English/Welsh/Scottish/Northern Irish/British, White Irish or White Other, those whose sexual orientation we don't know (or who preferred not to say), Christian, Buddhist, those living outside the UK, or those who trained in Europe, revalidated in lower proportions compared to those that were due to do so.

Simply comparing the percentages of people who did revalidate with those that were due to does not tell us anything about which factors influence a person's chances of revalidating successfully. Therefore, we analysed how much a person's diversity characteristics affected their chances of revalidating when you took into account other factors like where they lived, trained and their profession.

We found lower chances of revalidating for nurses and midwives who are: male, over 60, disabled, White or those whose ethnicity we don't know (or they prefer not to say); those living outside the UK and the EU; or who trained in Australia.

The second phase of research

We commissioned qualitative research with a sample of professionals with experience of revalidation between April 2016 and March 2019 as part of the second phase. The purpose was to understand why they think certain groups are less likely to revalidate, the impact this has on them and what they think we can do to address these differences.

We wanted to hear from people living across the four UK countries who had revalidated successfully, those that hadn't revalidated by their due date as well as those who were given an extension. We contacted 1,412 professionals from across the four countries of the UK to invite them to take part. We selected people based on their diversity characteristics and to ensure we had representation of those groups that we found to be less likely to revalidate successfully in the first phase of our work.

In total, 35 professionals expressed an interest in taking part, of whom 18 then went on to participate. Annexe 2 gives a breakdown of the professionals that took part. We were particularly keen to hear from those people we found to be less likely to revalidate successfully.

We heard from a good proportion of White, disabled or professionals aged over 60 but no men, only one person who lived outside the UK and one person that had trained outside the UK and EU/EEA took part.

Although we haven't identified any disparities for professionals aged 21–30 years, those who live in Northern Ireland, or anyone who trained in Wales or Northern Ireland, we also didn't hear from these groups. The validity of qualitative research is partly based on the range of voices heard and so the absence of these groups is disappointing. However, we're reassured that our findings reflect themes in the wider literature – another aspect on which qualitative research is assessed[2].

What we heard from professionals

We heard similar perceptions of revalidation across all professionals – much of which echoes the findings from the three-year evaluation of revalidation we commissioned in 2016[3]. This included recognition of the value of revalidation but a sense that the first time was stressful and overwhelming.

Professionals felt some of the requirements were unclear and open to interpretation. We also heard some conflicting feedback. Some professionals told us that the process took a long time in a context where most were already under a lot of pressure. Others felt the revalidation process could be strengthened to tighten loopholes and/or ensure a more thorough sign-off process.

> **I think revalidation is a good idea. At the beginning it wasn't quite explained properly, so it was quite daunting to a lot of nurses, a lot of people were quite worried. I think eventually we've got over the hurdle, so, I think it's a good thing.**

Nurse, England

> **The organisation I work for now would not allow me to do that [training courses] in work time... I would have to do that separately and pay for it separately.**

Nurse, Wales

The research also highlighted some differences amongst professionals:

Most professionals noted the inconsistent support provided by employers, but this was a particular issue for those working in smaller organisations such as care homes, GP practices or in the voluntary sector; those in isolated environments where they may be the first or only professional to go through the process; and those working via agencies or as bank staff who may lack a strong support network. Professionals working in these settings were also more likely to report difficulties in completing certain requirements of revalidation compared to those who worked elsewhere.

Black and Asian professionals reported difficulties in meeting revalidation requirements. This aligns with other qualitative research we've commissioned[3] but differs from what we found when we analysed our data. Our data indicates that White professionals revalidate in lower proportions compared to those that were due to and that they are less likely to revalidate successfully compared to other ethnicities.

Professionals on, or who had recently been on, maternity or long-term sickness leave said they can face difficulties meeting the required practice hours on return to work, with only a limited extension available.

Older professionals felt they were often overlooked for training opportunities and faced challenges meeting the number of practice hours required due to caring responsibilities.

The practice hours requirement was also highlighted as difficult to meet by professionals with family abroad who may need to spend extended periods of time out of the country.

Professionals suggested improvements we could make to our processes, such as:

- greater clarity on revalidation requirements including what constitutes learning versus participatory learning, as well as advice on how much evidence is required and how to find an appropriate confirmer (for example whether the line manager is the most appropriate in all circumstances)
- better and more regular communication with professionals throughout the three-year revalidation period to prompt a continuous learning and development experience, perhaps using prompts or reminders at yearly intervals
- more guidance for employers to better enable them to allow their staff to complete revalidation requirements at work. For example, encouraging them to allocate time where possible and tips on how to support their employees through the revalidation process by encouraging the use of appraisals
- sharing information about professionals who can act as confirmers for those that may struggle to find one to support them through revalidation.

We asked professionals why they thought some groups were less likely to revalidate successfully compared to others.

No men chose to take part in this aspect of the research which may have impacted on what we heard. The professionals we spoke to felt that differences stem from the type of job that a professional does, where they work or how they're employed and not because of their diversity characteristics. As certain groups of professionals are more likely to work in particular roles and settings (as indicated in the data we publish annually about revalidation), they are disproportionately impacted.

Data from our revalidation process suggests that men are overrepresented in some job roles and work settings compared to women. Only 11 percent of our register are men but they do 20 percent of agency jobs, 15 percent of jobs in care homes and 22 percent of jobs in prisons. There's also evidence to suggest that men may be asked to do different types of tasks compared to women. For example, male nurses can be asked to do more physical tasks such as moving people, cleaning trolleys and caring for people who show violent behaviour[4,5]. This may suggest that differences by gender are being driven by job role and work setting.

We also didn't hear anything about the challenges faced by disabled professionals despite us having found them to be less likely to revalidate successfully in the first phase of our work. Seven of the 18 participants identified as disabled but we didn't hear anything about the challenges faced by this group in the research itself.

We don't currently look at differences in job role and work setting by disability in our annual revalidation data. However, wider research suggests that there are misconceptions about the ability of disabled professionals to perform necessary job tasks and low acceptance by members of the public, people who use services and colleagues of disabled nurses. [6,7,8,9,10,11] Based on the evidence we have currently, we cannot say why there are differences for disabled professionals.

Section 2

Fitness to practise

One of the ways we regulate is by investigating concerns about nurses, midwives and nursing associates – something that affects a tiny minority of professionals each year.

Our standards are set out in our Standards of proficiency for nurses, midwives, and nursing associates and in The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates. Professionals must make sure that their skills, knowledge, education and behaviour don't fall below these standards which are needed to deliver safe, effective and kind care. If they meet these standards, this is what we call being fit to practise.

If someone raises a concern about a nurse, midwife or nursing associate's skills, behaviour and their right to be on our register, this will go through what we call the fitness to practise process. We refer to concerns raised with us as 'referrals'. Our process allows us to understand as quickly as possible whether a registered professional presents a risk to the public. If they do, we can take steps to promote learning and prevent issues arising again. As a regulator, our role isn't to punish people for things that have happened, but to make sure that nurses, midwives and nursing associates meet the standards they need to practise safely.

Once we receive a referral about a professional on our register, we proceed through three main stages of our fitness to practise process. We can close a case against a professional on our register at any of these stages:

Screening. At screening stage, we decide whether an allegation needs a full investigation. This involves considering: whether the concern relates to a professional on our register; whether there is evidence of a serious concern that could require us to take regulatory action to protect the public; and whether there is clear evidence to show that the nurse, midwife or nursing associate is currently fit to practise.

Investigation. If a case proceeds past screening stage, we investigate serious concerns about a nurse, midwife or nursing associate's fitness to practise. These are concerns which could place people using services at risk, or undermine professional standards or public confidence. We also investigate concerns about whether the entry of an individual professional on our register may be incorrect, or may have been made as a result of fraud. Our aim in investigating these concerns is to allow our decision makers to make the right decision at the earliest opportunity. Once our investigations team has completed their investigation into the concerns about a nurse, midwife or nursing associate, our case examiners decide whether or not there is a case to answer. They also decide what happens to the case. For example, if they decide the nurse, midwife or nursing associate has no case to answer, case examiners can still issue a warning, or give advice. They can recommend that we need to do further investigation before they can decide whether or not there is a case to answer.

Adjudication. If case examiners decide there is a case to answer, they can decide to send the case to the Fitness to Practise Committee, which is known as the adjudication stage. Fitness to Practise Committees can apply a number of sanctions to a case including: taking no further action; a caution order of between one and five years; a conditions of practice order of up to three years; a suspension order of up to twelve months; or a striking-off order.

The first phase of research

We looked at the numbers of professionals with different diversity characteristics who had each of the following fitness to practise experiences:

- They were referred to us
- They had their case closed at screening stage
- They had their case closed at investigation stage
- They were permitted to continue to practise at adjudication stage
- They were removed from our register at adjudication stage

We found differences across all diversity characteristics and associated with where professionals live, train and work.

Most of the referrals we received between April 2016 and March 2019 came from employers rather than other sources such as members of the public or people who use services. Employers refer higher proportions of professionals who are male, Black, or both male and Black compared to the proportions of these groups on our register. This aligns with what we found in the 2017 research we commissioned from the University of Greenwich[12].

Compared to the proportions on our register, we received higher referrals of professionals who are: male; Black; trans; aged 41–50 years; disabled (or preferred not to tell us if they were disabled); gay or lesbian; Christian, Muslim, Hindu, Buddhist, other (including Jewish) religion or who prefer not to tell us their religion; or who had trained in Africa or Europe; or who lived in England and Wales.

For case progression, cases involving women, those aged 21–30, who are not disabled, who identify with the gender assigned to them at birth, who are bisexual, White, have no religion, who trained in the UK, who work in primary care or who live outside of the UK and the EU have the highest proportion of cases closed at screening.

In contrast, cases involving men, disabled people, Hindus, people who have chosen not to tell us their sexual orientation, ethnicity, where they work, or if they identify with the gender assigned to them at birth, who trained in Europe or who live in the EU/EEA have higher proportions of adjudication decisions that prevent them from practising.

We looked at all of these factors together to identify which influence a person's chances of being referred to us and having their case closed at different stages of our process.

We found that certain groups of professionals were more likely to be referred to us compared to others. This includes professionals who are: male, trans, bisexual, Black, living in certain parts of the UK or places such as the Channel Islands; those who trained in Northern Ireland, work in settings such as the cosmetic or aesthetic sector, or professionals who don't disclose their disability status.

Nurses and midwives who are male, disabled or work in undisclosed settings, are more likely to have their case progress to adjudication stage and be struck off or suspended compared to professionals who are female, not disabled or work in primary, social care, hospital or other types of settings (including the cosmetic or aesthetic sector or the ambulance service).

Nurses and midwives who are Black or whose sexual orientation we don't know (or they preferred not to say) are more likely to have their case progress to adjudication stage but, at this stage, they are not any more likely to have a decision that prevents them from continuing to practice compared to professionals who are White or heterosexual.

Nurses and midwives who are White, live outside the UK or have been referred by a member of the public or people who use services, are most likely to have their case closed at screening compared to professionals who are Black, live in the UK or were referred by any other source.

The second phase of research

We undertook two pieces of work as part of the second phase:

We commissioned qualitative research with a sample of 60 professionals and 11 employers with experience of fitness to practise between April 2016 and March 2019. We wanted to understand why they think certain groups are more likely to be referred to us and the impact this has on those professionals. We also wanted to ask them what they think we can do to address these differences.

We analysed the referrals we received from employers that involved professionals who are male and/or Black, to look at any trends in these referrals and how the number of referrals compare to the overall size and diversity breakdown of employers' workforces.

To help us understand differences in case progression and outcomes, we are commissioning an independent review of a sample of fitness to practise case files. This work will also ensure that we're consistent in how we deal with such cases, and help us to continue to improve our processes to maximise fairness and consistency. Due to difficulties securing a supplier to undertake this work, this project has yet to start. We now plan to undertake the work in 2022-23.

For the qualitative research, we wanted to hear from professionals who had been referred by either their employer, a member of the public or person who used services between April 2016 and March 2019. We contacted 2,819 professionals who had been referred to invite them to take part. As with revalidation, we selected people to ensure representation across the four countries of the UK and to ensure representation of those groups that we found to be more likely to be referred to us.

In total, 130 professionals expressed an interest in taking part and 60 went on to participate. Annexe 2 gives a breakdown of the professionals that took part.

We heard from a good proportion of male, disabled or Black professionals but smaller numbers of professionals who are bisexual, trans, those who lived outside the UK, or those who had trained in Northern Ireland. We also didn't hear from others including anyone aged 21–30 years or anyone who had trained in Wales – although we haven't identified disparities for these groups.

We also wanted to hear from employers that had made a referral to us. We contacted all employers that had referred a male and/or Black professional between April 2016 and March 2019 for which we could find contact details. We invited 574 employers to take part. We also reached out through our Employer Link Service and networks in each of the four UK countries.

In total, 19 employers expressed an interest and 11 participated. Annexe 2 gives a breakdown of the employers that took part.

We heard from employers in a range of settings and with diverse workforces in terms of male and/or Black professionals and those that used bank staff. We heard from smaller numbers of independent sector employers and those that use agency staff. Most of the organisations we heard from were based in England although some had a UK-wide remit. We didn't hear from any employers based in Scotland, Wales or Northern Ireland.

The validity of qualitative research is partly based on the range of voices heard and so the absence of these groups is disappointing. For professionals, we're reassured that our findings reflect themes in the wider literature – another aspect on which qualitative research is assessed[2]. However, the low take up by employers is concerning. Undoubtedly, this is partly due to the pressures they're under but it does raise broader questions about how we can best engage and work with employers on this topic.

What we heard from professionals and employers

A lot of what we heard from professionals and employers about their experiences of our fitness to practise process echoes what we know from other work.

Professionals in all groups expressed a fear of the fitness to practise process and its impact on them professionally and personally. Both professionals and employers spoke about the perceived disparity in the length of time it took for us to progress cases and the little time they were given to respond to queries from us or provide further information. Both also said that changes in NMC personnel dealing with cases, as well as issues with how we communicated (tone, content and frequency), caused them additional stress. Many professionals and employers were unaware of the guidance available to them from the NMC and even those that did use the NMC website found the guidance difficult to find.

> **If you are a manager and you notice one of your nurses is not competent or whatever, you do a supervision. You identify if there are any mistakes that you can correct, maybe by training or anything, I was never called in the office to say I am not performing and doing a supervision or offered training.**

Nurse, Northern Ireland

> **It makes you anxious - fearful. I was the main wage earner and could have lost my livelihood. I had three young children to support and look after, would not have been able to get a job outside nursing at the same income level**

Nurse, Wales

Some experiences were specific to certain groups:

Bank and agency staff or those working in care settings felt they were less likely to have prior warning of their referral, particularly where they had left employment before any internal investigation and/or referral. This group also said they were unlikely to have a strong support system of colleagues that could help them during a case.

While professionals in all groups reported financial impacts, those who work as bank staff or via an agency were more likely to report that their shifts were denied due to disclosing a previous referral.

The majority of professionals we heard from had their case closed prior to the hearing stage, therefore feedback on hearings was limited. The few that had experienced a hearing said they found attending hearings difficult, due to having to travel and stay overnight. Many professionals, particularly those from Black and Asian backgrounds, felt unable to speak up and defend themselves in hearings and that when they did, felt it counted against them in the hearing. Professionals who had experienced the adjudication process told us they were advised by their legal representatives not to speak to the NMC except where required.

During the hearings, professionals said they were made to feel as though they were guilty and did not feel respected. They also found the hearing incredibly emotional and overwhelming.

The participants highlighted improvements we could make to our processes:

- Offer professionals the choice of attending a fitness to practise hearing virtually rather than face-to-face to address some of the barriers that those with caring responsibilities or with financial constraints face.
- Reduce our fitness to practise caseload and continue to improve our process to ensure that everyone impacted by a fitness to practise referral has a timely, person-centred, streamlined experience.
- Continue to improve the tone, content and frequency of NMC communications and give professionals and employers more reasonable timeframes for responding to queries.
- Raise awareness of available guidance and signpost professionals and employers to support.

> **Well, if it's going to be three or four months long, then even if you just had a monthly phone call to say, 'I'm sorry we haven't managed to gather all the information we need'. I think you are just a little bit in the dark.**

Nurse, Scotland

We asked professionals and employers why they thought some groups are more likely to be referred to us.

White, Black and Asian professionals said some groups are seen as outsiders and this is why they're more likely to be referred. Ethnicity and nationality were described as examples of reasons for this perception.

Many Black and Asian professionals felt their ethnicity was a reason for their referral and felt they were held to different standards compared to white staff.

Different communication styles were highlighted by White, Black and Asian professionals. Participants linked differences in communication style to a range of diversity characteristics such as country of training and whether you speak English as a second language.

Most employers that we spoke to didn't feel diversity characteristics played any part in their own decisions to refer professionals to the NMC. However, they acknowledged that Black and minority ethnic professionals were more likely to be subject to disciplinary action and be referred.

When talking about differences in referral rates for Black and minority ethnic professionals, several employers talked about bias from members of the public and people who use services. This contrasts with what we found in the first phase of our work which was that members of the public and people who use services referred higher proportions of White professionals compared to other groups. One employer suggested that their organisation had a racial bias in the referrals they made as none of the referrals they had made of Black and Asian professionals had been upheld by the NMC.

> **"The system will still discriminate against people who don't fall into the category of 'normal'. I am an ethnic minority, Asian male, but even if I came from the Black community, African, Jamaican [it would be the same]. Whereas if I were from the white community, things would have possibly been looked at differently... and that is the country we are living in.**
>
> Nurse, England

A few employers highlighted other diversity characteristics they thought might put professionals at a higher risk of being referred. This included being male, due to unconscious bias in health and care and perceptions about male professionals' attitudes and behaviours.

Both professionals and employers highlighted what they saw as cultural factors or language barriers that may explain the over-referral of particular groups. For example, not looking a patient or person who uses services in the eye can signal lack of respect in some cultures while in others, it is a sign of respect. Lifting a hand up in the air can seem aggressive in some cultures, in others it is a sign to thank God. Employers also mentioned language barriers during the fitness to practise referral process with some believing this impacted on case progression.

Professionals and employers also felt that employment type, role and setting influenced referrals. Professionals working as bank staff or via an agency were highlighted by the people we spoke to as being particularly at risk, as were those working in certain settings, such as mental health or the police. Employers felt that factors such as staffing levels, level of support available from employers and workload were likely to play a part in this.

Employers also told us about inconsistent processes between settings. For example, while most employers said they investigate concerns fully internally before escalating to the NMC, one employer said that until recently they automatically referred agency workers when a concern had been raised and believed that other organisations still continue to do this to mitigate risk. Others highlighted inconsistencies in how complaints are raised and dealt with within their organisation as well as the type and level of support available to professionals.

> **"There is a disproportionate number of agency staff from a Black ethnic background [being referred]. My predecessor [12 months ago] would have automatically referred agency workers, not on gender, not on ethnicity but because they are an agency member of staff. So automatically because we have a higher proportion of agency staff that are male and from a Black ethnic background, you are more likely to be referred if you are male or from a Black ethnic background because you are an agency member of staff and the threshold is lower.**
>
> Employer, UK-wide, Independent

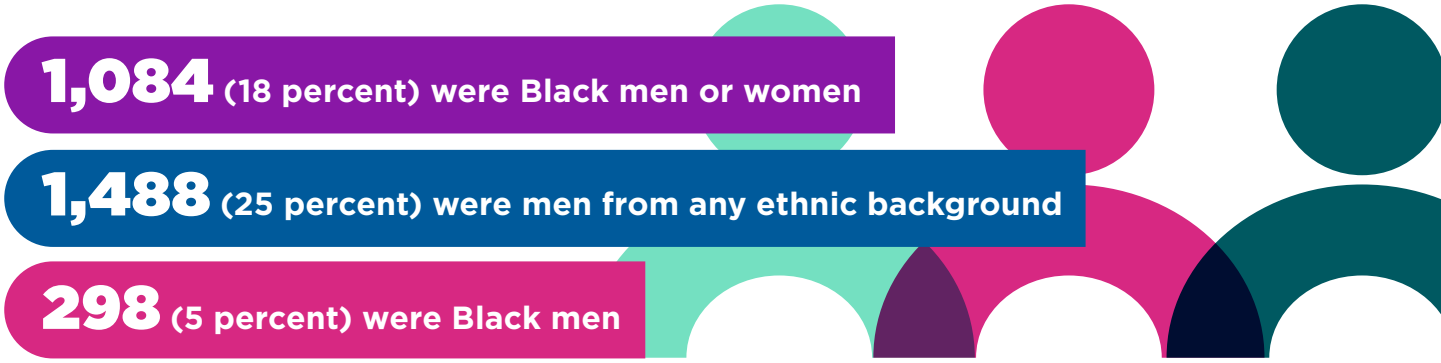
We didn't hear anything about the challenges faced by disabled professionals even though the first phase of our work showed that they may be more likely to be referred to us (our data indicates that those whose disability we don't know, or they prefer not to say, are more likely to be referred to us compared to disabled and non-disabled professionals).

Five of the 60 professionals we spoke to (eight percent) identified as disabled - a higher proportion than our register. We also know that around a quarter of disabled professionals working in the NHS in England have experienced harassment, bullying or abuse from colleagues each year since 2016. This increases to around a third who have experienced harassment, bullying or abuse from patients, service users or the public each year since 2016[13].

External research suggests that colleagues and people receiving care from disabled professionals may have misconceptions about the ability of disabled professionals to perform necessary job tasks[6,7,8,9,10,11]. But we need to do more work to better understand what these challenges are and how they influence the experience and outcomes that disabled professionals receive in our processes.

What we learned about employer referrals

Between 1 April 2016 and 31 March 2019, we received 13,805 referrals to our fitness to practise process. Cases referred by an employer amounted to 6,027 (or 43.7 percent). These referrals involved 5,731 professionals because some professionals were referred more than once. Nearly half of the professionals referred by an employer (2,870 or 47.6 percent) were either Black, male, or both Black and male:



In 2021–22, 11 percent of professionals on the NMC register were men and 10 percent were Black.

These referrals were made by 942 employers. We were able to identify workforce information for 602 (63.9 percent) of these employers. Not all had nursing and midwifery specific workforce information available. We were able to find data on the ethnicity breakdown for 220 NHS trusts in England from WRES data, which reports on the proportion of Black and minority ethnic staff at each organisation. We also had data on workforce size for 218 of these 220 NHS trusts.

Most of the referrals we received were from the largest employers in terms of size of workforce. With a few exceptions, the 100 employers that made the most referrals between April 2016 and March 2019 were those with more than 500 employees.

There were big differences in the number of referrals that some employers made involving male and/or Black professionals compared to the proportions of Black and minority ethnic staff at their organisation. Referrals of male and/or Black professionals varied from 10 percent to 99 percent more than the proportion of Black and minority ethnic staff that they employed.

It's worth noting that the number of referrals made by each organisation differed significantly. Some organisations made only one referral during the three-year period which involved a male and/or Black professional. Similarly, organisations differed in size and diversity breakdown. Our findings are skewed by the fact that information on workforce size and diversity composition is more readily available for NHS organisations, particularly in England.

We also looked further into the referrals to identify any trends or patterns.

Most professionals had been registered for a number of years rather than being newly qualified and most had trained in England.

A higher proportion of cases involving male and/or Black professionals are closed at earlier stages of our process compared to all of the referrals made by employers. Approximately 10 percent more cases involving male and/or Black professionals are closed at screening and investigation stage compared to all referrals from employers. For example, at screening stage, 44 percent of cases involving male and/or Black professionals were closed compared to 34 percent of the overall referrals from employers. At investigation stage, 54 percent of cases involving male and/or Black professionals were closed compared to 45 percent of all employer referrals.

In deciding whether to progress a case beyond our screening stage, we look at whether the concern relates to someone on our register, whether the concern is serious enough to require us to take regulatory action to protect the public and whether the evidence shows that the nurse, midwife or nursing associate is currently fit to practise. Many of the concerns we receive aren't serious enough for us to take regulatory action, but this doesn't mean these concerns shouldn't be looked at. We usually recommend raising these cases with employers to investigate and resolve. Most cases referred by an employer – including those that involved male and/or Black professionals - were closed because they were not sufficiently serious to suggest that the professional was not fit to practise.

The most common outcome of all cases referred by employers is a striking off order at adjudication. However, Black and/or male professionals referred by employers receive fewer striking off orders compared to others. A total of 36 percent of referrals involving men received a striking off order, although they only accounted for a quarter of all employer referrals.

There seems to be a difference in why employers refer professionals who are male and/or Black to us compared to the referrals they make to us overall. Most referrals from employers describe concerns about patient care, prescribing medicines and record keeping. In comparison, referrals involving professionals who are male and/or Black mainly relate to the inappropriate or delayed response to negative signs, deterioration or incidents, concerns with diagnosis, observations and assessments or concerns with patient and/or clinical records.

These findings suggest that employers deal with concerns about male and/or Black professionals differently compared to those involving other groups of professionals. Employers refer more male and/or Black professionals compared to the proportions of these groups on our register. Several referred more compared to the proportions of Black and minority ethnic professionals in their own workforces. We close more cases involving male and/or Black professionals in the early stages of our process compared to all cases referred by employers. This suggests that many of employers' concerns – particularly those involving male and/or Black professionals – shouldn't have been referred and would have been better managed locally.

Section 3

Progress with other activities in the second phase

Improving our data about where people train and work and our diversity data

We've taken a number of steps over the last few years to improve the diversity information we have about the professionals on our register. We have diversity information for more than 90 percent of the professionals on our register across the seven diversity characteristics we currently capture data on (age, gender, gender identity, ethnicity, religion or belief, sexual orientation and disability).

We are reviewing the diversity information we ask our professionals about to ensure that it remains compliant with equalities legislation across the UK and is in line with best practice. We're also working closely with other health professional regulators to look at diversity data that is captured about different professions and to explore whether we can agree on what should be captured and how.

We're unable to test statistically whether job role or work setting influences the outcomes professionals receive in our processes because of the way we capture this information currently. In improving our information, we plan to make sure that it aligns with data captured by other organisations across health and social care so that it can also inform workforce planning. This will also help us to understand risk factors for poor practice by setting or geographical location and to prevent and respond appropriately.

Working with our partners in the four countries of the UK, we've developed a list of organisations in which our professionals may work and will be embedding these into our processes over the next 12 months. We will capture this information better (for example, by asking people to confirm information they've provided previously rather than asking them to input the same information multiple times) and more frequently. Once we have made the necessary system changes, we can begin collecting information from professionals and share this with our partners and stakeholders. We hope to be able to start sharing information in 2023–24.

Monitoring the impact of recent changes to our overseas and fitness to practise processes

We had introduced many changes to our overseas registration and fitness to practise processes around the time that we published the phase one Ambitious for Change report.

We weren't able to take these changes into account in our analyses so we said we would monitor the impact of them and measure progress against the findings from the first phase of our work.

We have put in place twice-a-year monitoring and reporting on the progress and outcomes of applicants with different diversity characteristics in our new overseas process.

We also monitor the performance of the new test of competence to ensure candidates have a fair and consistent experience.

Our test development partner and our Objective Structured Clinical Examination (OSCE) delivery partners collect a range of test and candidate data so that we can understand how our candidates are responding to different parts of the test of competence.

Our quality assurance partner and the assurance advisory group continue to provide us with the independent and expert oversight so we can demonstrate the test meets our standards and is demonstrably robust.

Our two new OSCE delivery partners, Leeds Teaching Hospital and Northumbria University went live earlier this year and are currently mobilising with support from our three established test sites. Test consistency and candidate pass rates continue to be monitored through our established governance and control mechanisms such as the clinical working group and our regular contract meetings with all our suppliers.

We're also monitoring the progress and impact of many aspects of the fitness to practise strategy on professionals with different diversity characteristics. We undertook initial evaluations relating to our work on encouraging the professionals on our register to strengthen their practice in response to regulatory concerns and taking account of context. Both focused on the screening stage of our process. We also undertook a more recent second evaluation of our work on context in December 2021.

As part of these evaluations, we gathered diversity data relating to cases which formed part of this work, and compared that data with the diversity data relating to our screening caseload.

By doing this, we were able to see if there were any variations among the different groups of diversity characteristics. As our sample sizes for the purposes of these evaluations were relatively small compared to the overall screening caseload, some small variations were expected.

Our work on encouraging strengthened practice requires our decision makers to identify cases where we think the concerns in the case can be addressed. Our initial analysis of this area of work showed no significant variations amongst the different groups of diversity characteristics.

Our work on taking account of context includes asking employers to provide us with any contextual factors relating to a case, which our decision makers can then take into account as part of their decision making. Our initial analysis into our work on taking account of context also showed no significant variations amongst professionals with different diversity characteristics. Our second analysis also generally showed no significant variations amongst the different groups – which included disabled, male and Black and minority ethnic professionals.

There were some minor variations: for example, the 41–50 year age group was slightly overrepresented in terms of receiving contextual information, and the 31–40 year age group slightly underrepresented.

As part of our work on taking account of context, we also gather information on whether an allegation relates to diversity characteristics – which includes discrimination, harassment or victimisation. From our initial audit sample, there were three cases involving allegations that a professional had said or done something discriminatory. For our second audit sample (which was a larger sample), there were 18 cases where the allegations related to discrimination, harassment and/or bullying.

Conclusion

Sometimes people receive different outcomes from our processes based on who they are. Male or disabled professionals are more likely to receive disproportionate outcomes in our education, overseas registration, revalidation and fitness to practise process. Other groups, such as older, bisexual or Black professionals have disproportionately adverse experiences of some but not all of our processes.

There are different views about why these differences are happening. For revalidation, professionals feel that a person's job role, employment type and work setting are the key drivers behind differences in revalidation rates. When it comes to referrals to fitness to practise however, professionals feel that these are often driven by perceptions of certain professionals as 'different' or an 'outsider'. The perception of being an outsider was described in many ways but key factors included being in minority groups when it came to ethnicity, gender, age, sexual orientation, gender identity, nationality or religion as well as a person's type of employment. Many Black and Asian professionals felt they were referred because of their ethnicity.

This view wasn't shared by the employers we spoke to and most disagreed that a professional's diversity characteristics played any part in their own decisions to refer professionals to the NMC. They acknowledged that Black and minority ethnic professionals were more likely to be subject to disciplinary action and the inconsistencies in how concerns are investigated within, and between, organisations.

Both professionals and employers also felt that employment type, role and setting influenced referrals. It's clear from the research that the type of job that a professional does, how they're employed and where they work shapes their experiences at work and their interactions with our regulatory processes. Agency and bank staff and those working in settings such as care homes, GP practices or the police are seen by professionals and employers to be particularly at risk of negative experiences and outcomes. Reasons highlighted include the size of these organisations which might mean that a professional is the only registered nurse, midwife or nursing associate working there or, for agency workers, the lack of a support network that comes from being more transient in the workforce.

Professionals with certain diversity characteristics are more likely to work in these types of roles and settings. They are therefore disproportionately more likely to have negative experiences and outcomes in our processes. For example, men make up 11 percent of our register but they do 20 percent of agency jobs and 15 percent of jobs in care homes. Black African professionals make up 8 percent of our register but do 14 percent of jobs in care homes and 36 percent of agency jobs.

The research also highlighted some issues within our own processes that may exacerbate difficulties for some groups. This includes a lack of clarity about some of our revalidation requirements, the length of time the fitness to practise process can take and communication in our fitness to practise process that can be infrequent and impersonal. Addressing these issues would help to improve all professionals' experience of our processes but on its own is unlikely to make an impact on the differences in outcomes.

We're committed to becoming a better regulator and to setting standards for a professional culture that values equality, diversity and inclusion. These findings suggest the need for action at three levels.

Actions we'll take in relation to our own processes

This is an area over which we have direct control and which we know has an impact on how professionals feel about our processes and their experiences of them.

We'll do the following work under this area.

- Developing a programme of updates and training for NMC colleagues who are in regular contact with our professionals and those who support them to ensure that they receive consistent, clear, helpful advice and guidance from us on our requirements.
- Continuing to improve our data and insights and use these to develop targeted communications providing more relevant, specific information to support the revalidation of different groups on an ongoing basis.
- Continuing to prioritise reducing our fitness to practise caseload and improving our process as our top corporate priority to ensure that everyone impacted by a fitness to practise referral has a timely, person-centred, streamlined experience.
- Commissioning the delayed review of registration appeal and fitness to practise cases to ensure that we're consistent in how we deal with cases involving professionals with different diversity characteristics, and continue to improve our processes and ways of working to maximise fairness and consistency. We'll focus on cases involving male, disabled or Black professionals, or those who prefer not to tell us their sexual orientation, as we found disparities for these groups in the first phase of our work in terms of how far they are likely to progress through our process and the sanctions they receive.
- Doing further work to help us understand why there are differences for disabled professionals. This will include further analysis of our data and qualitative research with professionals to ask them about the barriers they face. We'll work with disability organisations and networks to develop an inclusive and appropriate approach for this work as we recognise professionals' reluctance to declare their disability status to us (three percent of our register told us they were disabled as of 31 March 2022 compared to 20 percent of the working age population that reported they were disabled in October-December 2020) and to talk about their experiences in the research we've done so far.

Actions we'll take in relation to employers

We have the opportunity to target specific employers for support through our Employer Link Service (ELS).

We will take the following actions.

- Continuing to help employers to understand our fitness to practise process and to provide them with advice and guidance before making a referral to us through our Employer Advice Line. We will also continue to promote our resource for employers to support them to take effective action when concerns arise in relation to someone's practice, including agency staff.
- Delivering a new approach to our outreach work and expand the team so that we reach more health and care providers and other stakeholders. In particular, we aim to strengthen relationships with smaller employers as well as those in the independent sector.
- Developing bespoke support for employers to provide them with up to date information about the referrals they have made and the progress and outcomes of these referrals. This will include highlighting potential patterns of referrals that involve particular groups of professionals, are closed at our screening stage or are inconsistent with organisations with similar characteristics.
- Encouraging employers to address such patterns of referrals. Where there are persistent patterns of unequal outcomes we may consider whether formal action by us or another regulator is required.

Actions we'll take in relation to systemic issues

Creating the long-lasting change that will tackle discrimination and inequality isn't easy and systemic issues are not something we can fix alone. This doesn't just affect nursing and midwifery – the same trends are reported in other health and care professions including medicine. We will work with partners and stakeholders in the wider health and social care sector to influence change.

We will take the following actions in this area.

- Working with those responsible for international recruitment across the four UK countries to encourage them to include revalidation as part of their induction and ongoing support for their international recruits. This will ensure that overseas-trained professionals who join our register fully understand the value of revalidation, the requirements they need to meet and the process they need to follow.
- Bringing together organisations from different sectors and settings to share learning and best practice about supporting international recruits into UK practice, and eliminating bias from local investigative approaches and referrals to fitness to practise. This will help to ensure that all professionals are treated fairly and given an equal chance to practise safely and effectively.

Our equality, diversity and inclusion (EDI) plan that covers our work as both a regulator and employer will take this work forward. We'll publish this plan later this year.

Annexe 1: **Ambitious for Change External Advisory Group**

Name	Organisation
Dr Gail Adams OBE	Unison
Obi Amadi	Unite
Professor Udy Archibong MBE	University of Bradford
Dr Doyin Atewologun	Delta Alpha Psi and University of Oxford
Beccy Baird	King's Fund
Michelle Bateman	Chief Nursing Officer Black Minority Ethnic Strategic Advisory Group
Rhiannon Beaumont-Wood	Public Health Wales
Neomi Bennett BEM RGN	Equality 4 Black Nurses
Dr Michael Brady	NHS England and NHS Improvement
Jabeer Butt OBE	Race Equality Foundation
Lesley Chan	Manchester University NHS Foundation Trust
Cavita Chapman	NHS England
Sarah Coleman	Mencap
Juliet Cosgrove	NHS Professionals
David Darton	General Medical Council
Janine Davey	University of the West of England
Paul Deemer	NHS Employers
Richard Desir	Welsh Government
Dr Alys Einion	University of Swansea
Anton Emmanuel	NHS England/NHS Improvement WRES team
Tosca Fairchild	NHS England and NHS Improvement – East of England

Clenton Farquharson MBE	Coalition for Collaborative Care
Elsie Gayle	HAPIA: Healthwatch and Patient Involvement Association
Dawn Hodgkins	Independent Healthcare Providers Network
Roz Hooper	Royal College of Nursing
Wendy Irwin	Royal College of Nursing
Jenny Jean-Jacques	NHS England
Mohammed Jogi	NHS Employers
Val Johnston	Unison
Liz Jones	National Care Forum
Roger Kline OBE	Middlesex University Business School
Felicia Kwaku OBE	Chief Nursing Officer Black Minority Ethnic Strategic Advisory Group
Paulette Lewis MBE	Chief Nursing Officer Black Minority Ethnic Strategic Advisory Group
Claire Light	General Medical Council
Connie Mitchell	Aughnacloy House Lurgan
Stuart Moore	NHS England
Sally Nyinza	Kenyan Nurses and Midwives Association-UK (KENMA-UK)
Professor Donna O'Boyle	Chief Nursing Officer's Directorate, Scottish Government
Wendy Olayiwola BEM, FRCM, FRSA RN, RM	National Maternity Lead for Equality at NHS England/NHS Improvement
Cherith Rogers RN QN	Healthcare Ireland
Professor Laura Serrant OBE	Chief Nursing Officer Black Minority Ethnic Strategic Advisory Group/Sheffield Hallam University
Alice Sorby	Royal College of Midwives
Elizabeth Streeter	NHS England and NHS Improvement
Karen Toohey	Public Health Wales
Suzanne Tyler	Royal College of Midwives

Margaret Verghese	NHS Professionals
Helen Whyley	Royal College of Nursing Wales
Lucy Wilkinson	Care Quality Commission

Annexe 2: **Our approach**

Phase One

This phase was focused on finding out whether professionals with different diversity characteristics received different outcomes from our processes and the factors that influenced these outcomes. We looked at our education, overseas registration, revalidation and fitness to practise regulatory processes.

We took two approaches. First, we reviewed external data and research to understand more about the experiences, progress and outcomes of nurses, midwives and nursing associates with different diversity characteristics. Second, we analysed the data we hold to understand what drives differences in regulatory outcomes. We weren't able to look at nursing associates or our education process. No nursing associates had applied to join our register through our overseas registration process, revalidated or been referred to our fitness to practise process at the time we did our analysis. We don't hold information about the students on our courses and so instead, we analysed external data from the Higher Education Statistics Authority.

Our approach involved two stages:

Stage one: Descriptive analysis. Here we analysed the numbers of nurses and midwives that received different outcomes in our overseas registration, revalidation and fitness to practise processes by diversity characteristic.

Stage two: Detailed analysis. We then went further to determine which factors influence the outcomes people receive. We used a statistical technique called regression to better understand the relationship between different factors and how it may change when controlling for other variables. We then calculated the average marginal effect – that is, the specific percentage point difference in how much one characteristic influences an outcome compared to another.

Dr Cara Booker at the University of Essex provided statistical advice, guidance and peer-review.

Phase Two

We agreed with our external advisory group to focus on differences in revalidation and referrals to fitness to practise in the second phase. We did two pieces of research:

Speaking to professionals and employers about their experiences and hearing their reflections on why they thought there were differences and what we and others could do to tackle any unfairness.

Analysing the referrals we received from employers involving professionals who are male and/or Black to identify any commonalties, themes or trends and to compare them to the size and diversity of each employers' workforce.

Qualitative research

To help us understand why there were differences in revalidation rates and referrals to fitness to practise, we commissioned qualitative research with a sample of professionals and employers with experience of revalidation or fitness to practise between April 2016 and March 2019.

We took a qualitative approach because we wanted to understand people's perceptions, experiences and attitudes. As with all qualitative research, we weren't aiming to speak to a statistically representative sample of professionals or employers. Rather, we wanted to speak to a range of different people to ensure we captured the breadth of views and opinions.

Tables 1 and **2** shows the characteristics of the people that took part. We wanted to hear from people living across the four UK countries. For revalidation, we wanted to hear from people who had revalidated successfully, those that hadn't revalidated by their due date as well as those who were given an extension. We contacted 1,412 professionals to invite them to take part. We selected people based on their diversity characteristics to ensure we included those groups that we found to be less likely to revalidate successfully in the first phase of our work.

For fitness to practise, we wanted to hear from professionals and employers. We were interested in professionals who had been referred by either their employer, a member of the public or person who uses services between April 2016 and March 2019. We contacted 2,819 professionals to invite them to take part. As with revalidation, we selected people to include those groups that we found to be more likely to be referred to us.

We wanted to speak to employers that had referred a male and/or Black professional between April 2016 and March 2019. Rather than select a sample, we contacted all employers that met this criteria, and for which we could find contact details. We invited 574 employers to take part and also reached out through our Employer Link Service.

In total, we spoke to 78 professionals and 11 employers. More professionals chose to take part in the research about fitness to practise than revalidation. We were particularly keen to hear from those people we found to be less likely to revalidate successfully and more likely to be referred.

For revalidation, we heard from a good proportion of White, disabled or professionals aged over 60 but no men, only one person who lived outside the UK and EU/EEA and one person that had trained outside the UK and EU/EEA took part. Although we haven't identified any disparities for professionals aged 21–30 years, those who live in Northern Ireland, or anyone who trained in Wales or Northern Ireland, we also didn't hear from these groups.

For fitness to practise, we heard from a good proportion of male, disabled or Black professionals but only one professional identifying as either bisexual or trans. One participant preferred not to declare their gender identity. We also only heard from one professional who lived outside the UK and EU/EEA and one who trained in Northern Ireland.

We also didn't hear from others including anyone aged 21–30 years or anyone who had trained in Wales – although we haven't identified disparities for these groups.

We heard from employers in a range of settings and with diverse workforces in terms of male and/or Black professionals and those that used bank staff. We heard from smaller numbers of independent sector employers and those that use agency staff. Most of the organisations we heard from were based in England although some had a UK-wide remit. We also didn't hear from any employers based in Scotland, Wales or Northern Ireland. Table 3 shows the characteristics of the employers that took part.

The validity of qualitative research is partly based on the range of voices heard and so the absence of these groups is disappointing. However, we're reassured that our findings reflect themes in the wider literature – another aspect on which qualitative research is assessed.[2]

Table 1: Profile of professionals who took part in the qualitative research about revalidation

Number of participants: 18

Role	
Nurse (inc. nurse with SCPHN)	15
Midwife (inc. midwife with SCPHN)	2
Dual registration	1

Where they live	
England	14
Scotland	2
Wales	1
Outside the UK	1

Currently practising as a nurse, midwife or nursing associate	
Yes	15
No	3

Sector*+	
NHS	10
Independent	3
Voluntary	0
Other	2

Type of Employment*+	
Employed directly as a permanent member of staff	11
Employed directly on a temporary contract	2
Agency worker	2
A bank worker	2

*only asked of those who are still practising. +respondents can give more than one answer.

Age	
31–40	1
41–50	6
51–55	4
56–60	1
61–65	3
66–70	3

Caring responsibilities	
Yes	8
No	10

Sexual orientation	
Heterosexual or straight	18

Gender identity	
Matches sex registered at birth (or within six weeks)	18

Religion or belief	
Christian	13
Muslim	1
Other religion	2
No religion	2

Gender	
Female	18
Male	0

Where trained	
England	16
Scotland	1
Outside the UK and EU/EEA	1

Setting*+	
Community setting	3
Hospital or other secondary care	7
University/other research facility	2
Voluntary or charity sector	1

English as first language	
Yes	17
No	1

Disability	
Yes	7
No	10
Prefer not to say	1

Type of disability+	
Deaf or hearing loss	1
Mobility	4
Manual dexterity	2
Mental health concern	1
Other	3

*only asked of those who are still practising. +respondents can give more than one answer.

Seniority*	
Band 5	6
Band 6	5
Band 7	2
Band 8a and above	1
Prefer not to say	1

Ethnicity	
White British, English, Northern Irish, Scottish or Welsh	11
Black African	2
Black Caribbean	2
Asian Indian	1
Other White background	2

Table 2: Profile of professionals who took part in the qualitative research about fitness to practise referrals

Number of participants: 60

Role	
Nurse (inc. nurse with SCPHN)	53
Midwife (inc. midwife with SCPHN)	4
Dual registration	3

Currently practising	
Yes	56
No	4

*only asked of those who are still practising.

Where they live	
England	45
Scotland	10
Northern Ireland	3
Wales	1
Outside the UK and EU/EEA	1

Sector*+	
NHS	34
Independent	23
Voluntary	3
Other	4

Gender	
Female	45
Male	15

Type of Employment*+	
Employed directly as a permanent member of staff	42
Employed directly on a temporary contract	1
Agency worker	2
A bank worker	15

Age	
31–40	5
41–50	16
51–55	21
56–60	9
61–65	5
66–70	4

*only asked of those who are still practising. +respondents can give more than one answer.

Religion or belief	
Christian	37
Hindu	3
Sikh	1
No religion	14
Other	3
Prefer not to say	2

Caring responsibilities	
Yes	27
No	29
Prefer not to say	4

Sexual orientation	
Heterosexual or straight	56
Gay or lesbian	2
Bisexual	1
Prefer not to say	1

Where trained	
England	43
Scotland	7
Northern Ireland	1
European Union/EEA	1
Outside the UK and EU/EEA	7
Prefer not to say	1

Setting*+	
Ambulance service	1
Care home	14
Community setting	7
GP practice/other primary care	7
Hospital or other secondary care	18
Cosmetic	1
Military	2
Police	1
Inspectorate	1
Maternity unit	4
Prison	1
University/other research facility	1
Voluntary or charity sector	2
Other	2

English as first language	
Yes	49
No	11

Disability	
Yes	5
No	54
Prefer not to say	1

Type of disability+	
Deaf or hearing loss	1
Mobility	1
Other	3

*only asked of those who are still practising. +respondents can give more than one answer.

Seniority*	
Band 4	1
Band 5	17
Band 6	19
Band 7	9
Band 8a and above	7
Prefer not to say	3

Gender identity	
Matches sex assigned at birth (or within six weeks)	58
Does not match sex assigned at birth (or within six weeks)	1
Prefer not to say	1

Ethnicity	
White British, English, Northern Irish, Scottish or Welsh	42
Black African	11
Asian Filipina/Filipino	1
Asian Indian	3
Other White background	2
Other Asian background	1

Table 3: Profile of employers who took part in the qualitative research about fitness to practise referrals

Number of respondents: 11

Remit	
UK-wide	4
England	7

*only asked of those who are still practising.

Sector	
NHS	8
Independent	3

Professions employed	
Nurse (including Nurse with SCPHN)	7
Midwife (including Midwife with SCPHN)	3
Nurse and midwife (including Nurse and Midwife with SCPHN)	3
Nursing associate	7
NA*	4

Type of setting+	
Urgent and emergency care including ambulance service	3
Care home setting	2
Community setting, inc. district nursing & community psychiatric nursing	4
Education	1
Hospital or other secondary care	8
Learning disabilities	2
Maternity unit or birth centre	3
Mental health	3
Military	1
Prison or custody	1
Social care including domiciliary care	1
Specialist or other tertiary care including hospice	3
Other	1

*not answered: not all employers answered all questions in the recruitment survey. +respondents can give more than one answer.

Percentage of vacant shifts filled by bank nurses, midwives and/or nursing associates	
None	5
1–5%	1
6–10%	2
11–15%	2
16–20%	3
21–40%	1
More than 80%	3
NA*	16

Where organisation is based	
England	10
UK-wide	1

Proportion of full-time equivalent nursing and midwifery workforce that are male**	
None	4
1–5%	5
6–10%	1
11–15%	2
16–20%	1
21–40%	4
NA*	16

*not answered: not all employers answered all questions in the recruitment survey.
** Employers could tell us the percentage of their workforce by profession (so for nurses, midwives and/or nursing associates). As such, the numbers shown exceed the number of employers that participated. +respondents can give more than one answer.

Proportion of full-time equivalent nursing and midwifery workforce that are Black**	
None	**3**
1–5%	**4**
6–10%	**1**
11–15%	**3**
16–20%	**2**
21–40%	**3**
41–60%	**1**
NA*	**16**

Percentage of vacant shifts filled by agency nurses, midwives and/or nursing associates	
None	**6**
1–5%	**5**
6–10%	**4**
11–15%	**1**
16–20%	**1**
NA*	**16**

*not answered: not all employers answered all questions in the recruitment survey.
** Employers could tell us the percentage of their workforce by profession (so for nurses, midwives and/or nursing associates). As such, the numbers shown exceed the number of employers that participated.
+respondents can give more than one answer.

Endnotes

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