Nursing & Midwifery Council

Annual equality, diversity and inclusion report

2017–2018

Foreword

I'm very pleased to introduce this report. We're passionate about diversity and inclusion and we're committed to putting equality, diversity and inclusion (EDI) at the heart of everything we do. Our commitment to EDI is reflected in our values of fairness, transparency and people.

2018 is an important year as we celebrate the 70th anniversary of the NHS. 1948 was also the year that the ship Empire Windrush docked in Tilbury, bringing nearly 500 Caribbean people to the UK, one of the first large groups of immigrants who became known as the Windrush generation. Over the last 70 years the NHS has relied on talent and workforce from around the world, including the Windrush generation, with ethnic minorities making up a fifth of its workers.

Today 202 nationalities are represented in the NHS workforce. We regulate nurses and midwives that work in all settings, but we acknowledge the significance of this particular milestone as so many of our nurses and midwives work in the NHS.

This annual report presents our actions and improvements across the year, our performance against our strategic aims and how we met our legal requirements. The report presents data about diversity to meet our legal requirements, and also supports our values by helping us be more transparent. The report focuses on the nurses and midwives we regulate.

I'm proud of what we have achieved over the past year and the fact that we are able to share more data and analysis in this report than we could in previous years. We'll continue to gather and share more data as we move forward. There are some challenges, but also many opportunities for improvement that we hope to progress.

It is clear from the data in this annual report that nurses and midwives are very diverse. How we regulate now and in the future, must be very mindful of this.

Emma Broadbent
Director of Registration and Revalidation

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Introduction

This is the sixth EDI annual report for the Nursing and Midwifery Council (NMC). It's divided into two sections. Section one is an overview of the achievements against the EDI strategic aims as taken from the *Strategy 2015–2020.* Section two presents a summary of the diversity data about the nurses and midwives on our register, including fitness to practise data.

About us

The NMC is the independent professional regulator for nurses and midwives across the United Kingdom. We exist to protect the public. Our regulatory responsibilities are to:

- maintain a register of all nurses and midwives who meet the requirements for registration in the UK
- set standards for education, training, conduct and performance so that nurses and midwives are able to deliver high-quality healthcare consistently throughout their careers
- take action to deal with individuals whose integrity or ability to provide safe care is questioned, so that the public can have confidence in the quality and standards of care provided by nurses and midwives.

Why do we produce this report?

We publish this report to promote best practice in EDI and to be transparent about how we are meeting our EDI aims and objectives. We want to put EDI at the heart of everything we do and are proud to demonstrate our achievements, while being open about the areas we find challenging. This report provides access to information about all the EDI work at the NMC, to assure our diverse stakeholders that we are actively considering their needs in our work.

We're bound by the Equality Act 2010. We're named in schedule 19 of the Act as being subject to the public-sector equality duty (PSED). The PSED states that we must, in the exercise of our functions, have due regard to the need to:

- eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act
- advance equality of opportunity between people who share a protected characteristic and those who do not
- foster good relations between people who share a protected characteristic and those who do not.

The PSED covers the nine protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

The Equality Act 2010 doesn't apply to Northern Ireland, where the equalities legislation is spread across several orders and regulations and has some differences to the rest of the UK. For example, Section 75 of the Northern Ireland Act 1998 also includes consideration of 'political opinion' as an equality category.

We believe that the best way to demonstrate our compliance with the Equality Act 2010 and other relevant legislation is by publishing our activities in this annual report.

What has happened in nursing and midwifery regulation?

After changes to our legislation, we're now the regulator in law for nursing associates – the new health and care role designed as a bridge between unregulated health care assistants and registered nurses. A driving force for this new role was to widen access to education to allow more people to potentially join the profession. We'll begin collecting diversity data in relation to this new profession from early 2019 when the first nursing associates begin to join our register.

In November 2017 we made changes to our registration processes, and expanded the types of evidence that we accept from overseas nurses and midwives in order to demonstrate their English language capability. This is part of our ongoing review of the overseas process with a clear aim of making that process more proportionate and flexible for candidates.

Earlier this year, Council also agreed the new nursing proficiencies, education and training standards, standards for supervision and assessment in practice, and prescribing standards, all of which were equality impact assessed, including wide stakeholder engagement, and targeted involvement of seldom heard groups.

The changing political landscape, in particular the potential implications of Brexit, may impact on the diversity of the register because five percent of nurses and midwives registered with us were first registered in an European Economic Area (EEA) country. We are monitoring the position with regard to EEA nurses and midwives closely and reporting separately on those numbers.

Section 1: Achievements against our aims

What is our EDI strategy?

We value the diversity of the nurses and midwives on our register, our employees and the wider community we serve. We want this diversity to be reflected in everything we do. Our Council approved the *Strategy 2015–2020: Dynamic regulation for a changing world* in June 2014, which contains our aims to:

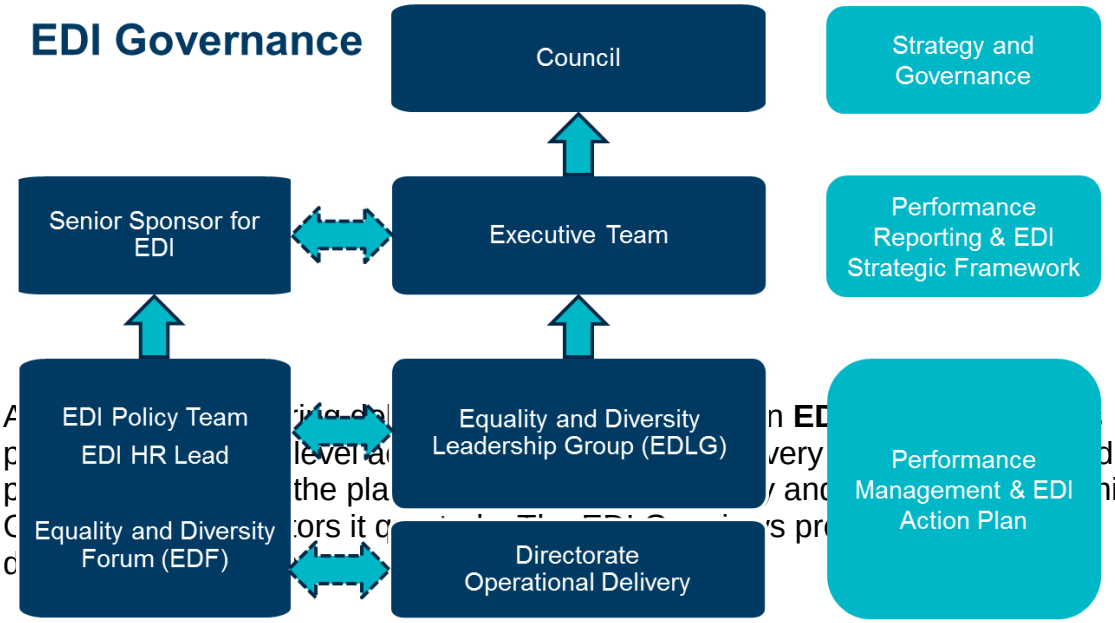
- Place promoting equality, diversity and inclusion at the heart of what we do.
- Comply with equality and human rights legislation by ensuring our regulatory processes are fair, consistent and non-discriminatory.
- Be a good employer – aspire to have a workforce that reflects the diversity of the communities in which we operate at all levels of our organisation.
- Use our influence to promote wider improvements in equality, diversity and inclusion practice.
- Build the trust and confidence of service users, nurses and midwives and others that share protected characteristics by showing understanding of their needs and preferences and challenging discrimination where evidence comes to our attention.
- Evaluate and, as needed, address equality issues raised by our work.
- Collect evidence that helps us know we are fair and consistent – working to enhance the quality and extent of EDI data about our registrants through their careers.
- Ensure that new entrants to the register are equipped to practise effectively in diverse and global environments.
- Set out our expectations that nurses and midwives challenge discrimination in their practice, are mindful of difference and show respect to all patients, service users and colleagues.
- Pursue diversity in those applying to become Council, committee and panel members.
- Be recognised as an organisation that upholds best practice in equality, diversity and inclusion, including meeting recognised sector standards.

How are we delivering the strategy?

Our EDI approach is the **NMC EDI strategic framework**, a delivery plan that was approved by the Executive Team in September 2016. The framework grouped delivery into five areas: leadership, policy, communication, evidence and people. The framework sets out how we will continue to pursue our strategic EDI aims, best practice approaches and how we will meet the PSED.

The framework includes a governance structure (Diagram 1). This is how we manage the performance of EDI in the organisation against our strategy.

Diagram 1



We also developed an overarching **strategic EDI action plan** that we presented to Council in November 2017. It's a high-level plan of the activities, outputs, measures and desired outcomes for each strategic aim. The table in *Annexe 1: Progress against the strategic EDI aims 2015-20*, shows how this plan has moved forward in the 2017–2018 reporting period.

The recruitment of a Senior Equality and Diversity Policy Officer will support the delivery of the EDI Strategic Action Plan. By March 2018 the NMC EDI team consisted of an Equality and Diversity Policy Manager, a Senior Equality and Diversity Policy Officer and an EDI Lead in the People and Organisational Development Directorate.

The Executive Team and the EDLG will continue to provide assurance by monitoring our EDI activities.

In addition, the quarterly Equality and Diversity Forum (EDF) is open to all employees for sharing EDI best practice, communicating across directorates and raising EDI concerns. A member of the EDF attends every EDLG meeting to report key updates.

Key EDI activities in 2017–2018

In this section we focus on some of the key achievements and challenges in this reporting year.

Our data

Our EDI aim 7 is to 'Collect evidence that helps us know we are fair and consistent - working to enhance the quality and extent of EDI data about our registrants through their careers'. This continues to be a priority.

As nurses and midwives update their information on NMC Online and through revalidation we're creating a richer picture. For example, some early analysis of new information about place of practice indicates that there are some differences in ethnicity and gender in certain areas of practice, including proportionately more men than women in mental health settings. We'll have a fuller picture in 2019 when everyone has revalidated.

In 2018 we published *The NMC register*, our first annual registration report. It reported on data by the protected characteristics of age and gender. The data in this report supplements *The NMC register*. We also published our annual Revalidation report in July 2018 which analyses the revalidation outcomes by protected characteristic.

Our fitness to practise panellists

Over the course of the reporting year we've collected diversity data from all current panel members. For the first time we can see the difference in representation between our register and the panel members appointed to the Fitness to Practise and Investigating Committees. The results show that there are significant differences in ethnicity, for example a higher percentage of panellists identifying as white compared to the proportion on the register (Table 01), as well as a higher proportion of older groups in our age profile (Table 02).

Table 01: Fitness to practise panellists by ethnic group

Ethnic group	Number	%	Register	Population[1]
Asian - Indian	5	1.6%	3.0%	2.8%
Asian - Pakistani	1	0.3%	0.5%	1.3%
Asian - Bangladeshi	1	0.3%	0.1%	0.5%
Asian - Chinese	2	0.6%	0.3%	0.6%
Asian - other background	2	0.6%	3.8%	1.5%
Black African	1	0.3%	6.1%	1.5%
Black Caribbean	7	2.2%	1.4%	1.1%
Black - other background	-	-	0.2%	0.4%
White and Asian	3	0.9%	0.3%	0.4%
White and black African	-	-	0.9%	0.2%
White and black Caribbean	-	-	0.4%	0.5%

[1] England and Wales working population- usual residents aged 16 to 74 in employment; 2011 Census

Mixed - other background	4	1.3%	0.3%	0.4%
White - English/Welsh/Scottish/ Northern Irish	264	83.5%	67.7%	81.4%
White - Irish	-	-	1.9%	1.0%
White - Gypsy or Irish Traveller	-	-	<0.1%	0.1%
White - other background	4	1.3%	4.5%	5.7%
Any other ethnic group	4	1.3%	0.9%	0.6%
Unknown/prefer not to say	18	5.7%	7.6%	-
Total	316	100%	100%	100%

Table 02: Fitness to practise panellists by age group

	Number	%	Register	Population[2]
20-29	2	0.6%	13.6%	19.5%
30-39	15	4.7%	21.5%	19.1%
40-49	48	15.2%	27.1%	19.6%
50-59	137	43.4%	29.0%	19.4%
Over 60	104	32.9%	8.7%	22.3%
Unknown/prefer not to say	10	3.2%	-	-
Total	316	100%	100%	100%

We launched a recruitment campaign focused on addressing the underrepresentation in these areas. The campaign had a strong emphasis on our organisational values of fairness, transparency and people, and used digital media to reach and appeal to a wider applicant base. We've been tracking the diversity data throughout process and there have been no indications of significant disadvantage for any particular group.

We've also given unconscious bias training to all panel members, case examiners, the Case Examiner Quality team and to employees who directly support panel members in our hearings. We did this to ensure proceedings are better supported and to give assurance that all our hearings are fair.

[2] Based on working age population 16-74; UK Population by age group 2016; Office of National Statistics; March 2018

Equality Impact Assessments (EQIAs)
One of our key areas of work is supporting employees to systematically review their work through an EDI lens using an Equality Impact Assessment (EQIA). EQIAs provide a detailed analysis of the impact of our work on protected and other vulnerable groups. To ensure consistency and encourage employees to embed EDI in their planning early on in their projects, we launched a new EQIA toolkit internally with in-depth guidance, advice on equality legislation, examples of barriers certain groups face, and templates.

Major programmes of work are conducting equality impact assessments and will be regularly updated as the programmes are delivered. For example, the Education programme, which delivered the new education standards, had a design principle for consultation that specified the standards must promote equality and diversity. The programme created a consultation assimilation team with the sole focus of EDI. It assessed whether this design principle had been met and how to integrate the EDI related consultation feedback into the standards. One example of how this approach lead to change was the action to include more information about reasonable adjustments in the supporting guidance.

Disproportionate outcomes on the basis of ethnicity
We published *The Progress and Outcomes of Black and Minority Ethnic (BME) Nurses and Midwives through the Nursing and Midwifery Council's Fitness to Practise Process* research into disproportionate outcomes for ethnic minority nurses and midwives in April 2017. The research showed that a disproportionate number of BME nurses and midwives go through the full fitness to practise process, mainly because they are more likely to be referred by employers, and that employer referrals are more likely to progress to a full hearing. We acknowledge that fairness, equality and patient safety are closely linked.

This research feeds into several of our projects. It has influenced our new approach to fitness to practise (it's one of the reasons EDI has been identified in a key regulatory outcome). The regulation advisers in the employee liaison service have shared themes from the research with directors of nursing and other employers.

In November 2017 we held a follow up meeting with the stakeholder group that advised the development of the research. We're committed to do further research into the experiences of ethnic minority nurses, midwives and nursing associates next year when we have more data. We also continue to meet with partners and stakeholders, such as NHS Improvement, to look at ways of addressing the issue.

Stakeholder engagement
We aim to reach diverse organisations so that their expertise and views can inform our work. In the reporting period our engagement included:

- the BME CNO Strategic Advisory Group (England)
- the Nigerian Nurses Association
- Mencap
- Challenging Behaviour Foundation
- Young Mothers.

It's important that we continue to build good relationships with a range of stakeholders who can engage with our work at an early stage. In 2018–2019 we will expand on our stakeholder engagement to reach a wider range of experiences and viewpoints.

Next steps 2018–2019

Our Corporate Plan for 2018-19 says that we will continue engaging with our stakeholders to make sure we understand patient and public perspectives and equality, diversity, and inclusion in our work. We also state that we will continue to fulfil our commitments to equality, diversity and inclusion as set out in our strategic framework.

Using our EDI Strategic Framework, we have identified the following EDI priorities for the organisation in 2018.

- Continue to improve the quality of the diversity data we hold.
- Implement our reasonable adjustments policy for customers.
- Raise awareness of gender identity and how it affects the service we provide.
- Reduce disproportionately negative outcomes for ethnic minority nurses, midwives and staff.
- Build the capability of employees to comply with equalities legislation.
- Embed equality impact assessments into our project and operational processes.

We will continue to embed the EDI framework – to ensure that EDI is at the heart of everything we do: communications, evidence, people, policy and leadership. This means EDI will be a key part in all our programmes of work and in our plan to develop our internal systems and processes. Using this evidence-based approach we'll seek to prioritise and measure how effective we are in achieving our EDI aims.

We're striving to actively manage EDI as part of our core business using evidence to prioritise our activities in this area. Examples of some activities we expect to deliver by March 2019 include:

- updating NMC online diversity monitoring categories in line with best practice.
- delivering trans awareness training for front line employees.
- updating our EDI intranet and internet pages.
- delivering unconscious bias training for all managers.
- agreeing high level measures for monitoring EDI progress.
- embedding equality impact assessment guidance and templates into all.
- project activities and process reviews.
- reviewing registration and FtP processes for trans nurses, midwives and nursing associates.
- delivering equality impact assessments of the Fitness to Practise strategy, nursing associate implementation and the overseas programme.
- launching an internal EDI strategy in line with the people strategy (see our workforce plan).

The Professional Standards Authority (PSA), which reports on our performance each year, is consulting on its Standards of Good Regulation. It is considering introducing a specific standard on EDI to ensure regulators understand the diversity of the people they regulate, and that their processes do not disadvantage people with protected characteristics. We support the PSA's intention to raise the profile of EDI and will work with them to support this goal and align any new reporting requirements into our EDI framework.

Section 2: Summary of the data

Council and committee members

Our Council is made up of twelve members: six lay people and six nurses and midwives, from England, Northern Ireland, Scotland and Wales, all appointed by the Privy Council. The Council has an Audit Committee; Remuneration Committee; and an Appointments Board to support it in its role. Appointments Board members are not members of the Council. Diversity data is collected when a member is appointed to the Council or the Appointments Board.

There were 17 members in office on 31 March 2018: 12 Council members and five members of the Appointments Board. Of the 17 members, 12 identify as female. All members identify as heterosexual. Two members identify as disabled, with one preferring not to say. Sixteen members identify as white with one member from a BME background. In terms of age, all members are in the age categories over 40. Nine members identify as Christian and eight as having no beliefs.

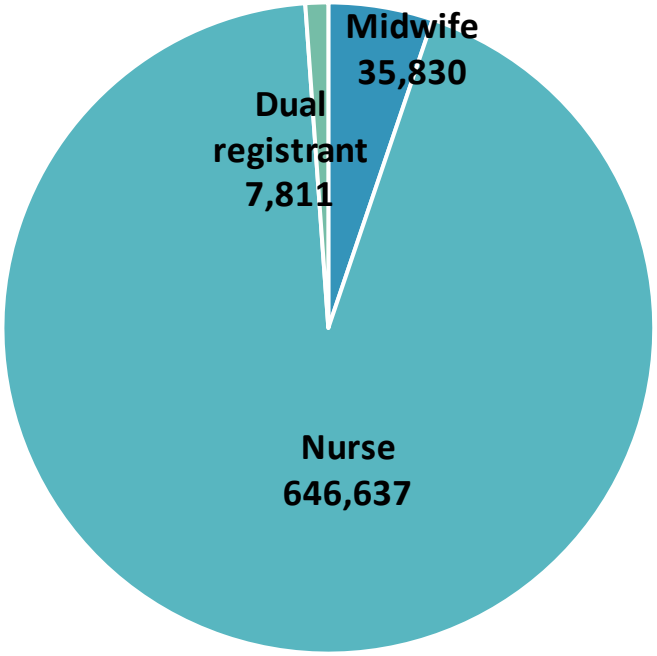
Nurses and midwives

This section provides a narrative summary of the diversity data that we hold about nurses and midwives on the register and in our fitness to practise processes. We hold and analyse data by age, disability, ethnicity, gender, gender identity, religion and belief and sexual orientation. In this year's report we have picked out the data that appears to be notable or of interest.

In presenting the data in this report we've rounded percentages up to the nearest whole number or one decimal place. In a small number of cases this means the data may add up to slightly over/under 100 percent.

In some instances our data presents small numbers for some groups that could lead to individuals being identified, or we have data that could be considered sensitive. In these cases that information has not been presented or smaller categories have been collapsed into bigger categories.

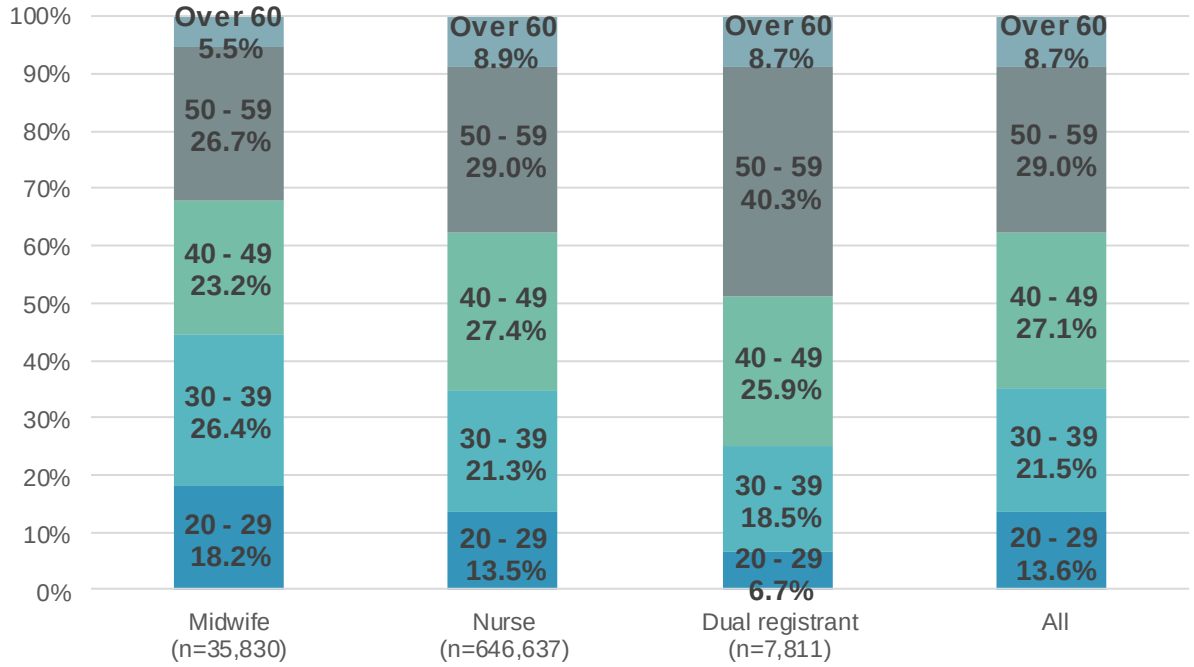
Chart 01: Breakdown of nurses, midwives and dual registrants on the register as at 31 March 2018



What does our data tell us about nurses and midwives on the register?

Looking at the registration data, some notable differences are that midwives are a younger group than the nurse group, while people with dual registration (that is, people who are registered as both a nurse *and* a midwife) are the oldest group (40.3 percent of these are in the 50-59 age group) [Chart 02]. The number of dual registrants has decreased by 9.3 percent since last year (from 8,614 to 7,811) which is a marked difference. This may be due to the fact that we are encouraging them only to renew the registration type(s) which they are currently using when they revalidate.

Chart 02: Age groups of nurses, midwives and dual registrants



The population of midwives is younger than the population of nurses and dual registrants with 18.2 percent in the 20-29 age group compared with 13.5 percent for nurses and 6.7 percent for dual registrant. Dual registrants have proportionately more people in the 50-59 age group at 40.3 percent. This is likely to be due to the longer time it takes be qualified as both a nurse and midwife.

Table 03: Disability of nurses, midwives and dual registrants

	2017 midwife	2018 midwife	2017 nurse	2018 nurse	2017 dual	2018 dual	2017 all	2018 all
No	27,098	31,599	497,601	560,423	6,602	6,777	**531,301**	**598,799**
Yes	1,704	1,394	33,345	25,378	334	263	**35,383**	**27,035**
Unknown	5,752	2,837	116,659	60,836	1,678	771	**124,089**	**64,444**
Total	**34,554**	**35,830**	**647,605**	**646,637**	**8,614**	**7,811**	**690,773**	**690,278**

Compared to last year's report there have been significant increases in the number of nurses and midwives that have completed the disability information, with the number of people in the unknown category reducing from 124,089 in 2017 to 64,444 in 2018 [table 03]. It appears that there were more people previously in the unknown category that were not disabled (the percentages and numbers of nurses and midwives that have identified as disabled have reduced in all registration types). The number of people that identify as having a disability has decreased considerably from 35,383 in the 2017 report to 27,035 in the 2018 report – Chart 03 below shows that the proportion of people that identify as having a disability has reduced from 5.1 to 3.9 percent.

Chart 03: Disability of nurses, midwives and dual registrants

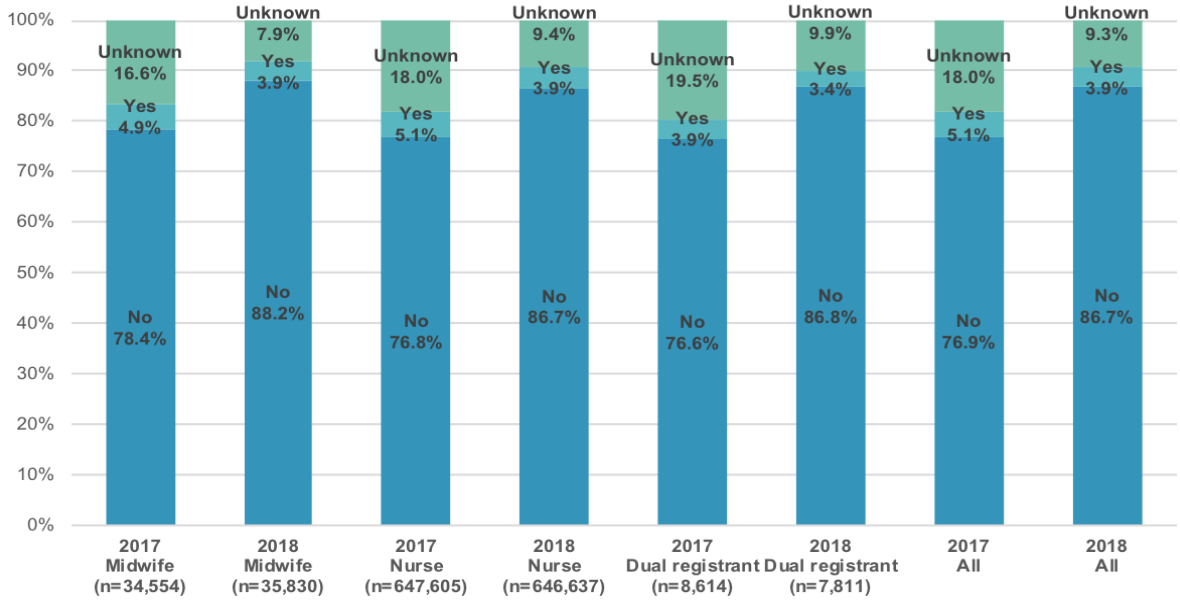


Table 04: Ethnic groups on the register (numbers)

	Midwife	Nurse	Dual	Total
Asian - Asian - Indian	197	20,676	66	20,939
Asian - Asian - Pakistani	150	3,030	22	3,202
Asian - Asian - Bangladeshi	45	794	5	844
Asian - Asian - Chinese	100	2,170	43	2,313
Asian - other background	112	25,993	48	26,153
Black African	679	40,433	1,050	42,162
Black Caribbean	583	8,841	308	9,732
Black - other background	40	1,506	22	1,568
Mixed - white and Asian	119	1,896	25	2,040
Mixed - white and black African	61	1,750	24	1,835
Mixed - white and black Caribbean	380	5,838	64	6,282
Mixed - other background	132	2,465	31	2,628
White - English/Welsh/Scottish/Northern Irish	28,778	433,622	4,718	467,118
White - Irish	655	12,454	268	13,377

White - Gypsy or Irish Traveller	11	269	6	286
White - other background	1,501	29,347	423	31,271
Any other ethnic group	143	5,704	35	5,882
Prefer not to say	358	12,416	132	12,906
Unknown	1,786	37,433	521	39,740
Total	35,830	646,637	7,811	690,278

Table 05: Ethnic groups on the register (percentages)

	Midwife	Nurse	Dual	Total
Asian - Asian - Indian	0.5%	3.2%	0.8%	3.0%
Asian - Asian - Pakistani	0.4%	0.5%	0.3%	0.5%
Asian - Asian - Bangladeshi	0.1%	0.1%	0.1%	0.1%
Asian - Asian - Chinese	0.3%	0.3%	0.6%	0.3%
Asian - other background	0.3%	4.0%	0.6%	3.8%
Black African	1.9%	6.3%	13.4%	6.1%
Black Caribbean	1.6%	1.4%	3.9%	1.4%
Black - other background	0.1%	0.2%	0.3%	0.2%
Mixed - white and Asian	0.3%	0.3%	0.3%	0.3%
Mixed - white and black African	0.2%	0.3%	0.3%	0.3%
Mixed - white and black Caribbean	1.1%	0.9%	0.8%	0.9%
Mixed - other background	0.4%	0.4%	0.4%	0.4%
White - English/Welsh/Scottish/Northern Irish	80.3%	67.1%	60.4%	67.7%
White - Irish	1.8%	1.9%	3.4%	1.9%
White - Gypsy or Irish Traveller	0.0%	0.0%	0.1%	0.0%
White - other background	4.2%	4.5%	5.4%	4.5%
Any other ethnic group	0.4%	0.9%	0.4%	0.9%

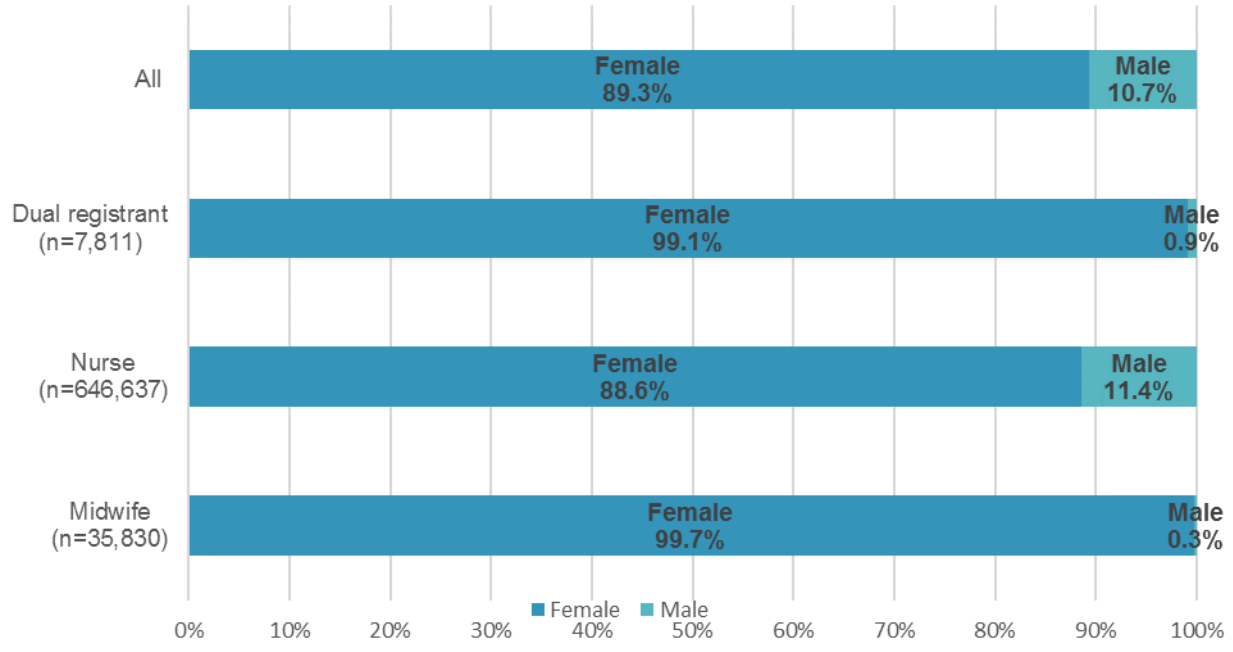
	Midwife	Nurse	Dual	Total
Prefer not to say	1.0%	1.9%	1.7%	1.9%
Unknown	5.0%	5.8%	6.7%	5.8%
Total	100%	100%	100%	100%

The data shows that nurses are more ethnically diverse than midwives, and those dual registrants are the most ethnically diverse group of all [tables 04 and 05]. Almost all ethnic groups have increased in both number and proportion in the last year as the number of 'unknowns' has decreased. For example the percentage of dual registrants that identify as 'white – English/Welsh/Scottish/Northern Irish/British' increased in all registration types from 2016/2017 to 2017/2018; midwives from 72.8 percent to 80.3 percent; nurses from 61.1 percent to 67.1 percent; and dual registration from 55.5 percent to 60.4 percent.

In this report we are publishing for the first time the data from nurses and midwives who answered the question, 'does your gender identity completely match the sex you were registered with at birth?' Of all nurses and midwives, 3,789 answered no to this question, 0.5 percent. 13.2 percent are unknown.

Looking at religion or belief, notable differences include 30.1 percent of midwives that say they have no religion or belief compared with 22.1 percent of nurses and 15.3 percent of those with dual registration. Also, 54.8 percent of midwives identify as Christian compared with 59.8 percent of nurses and 67.8 percent of those with dual registration.

Chart 04: Gender on the register



The chart above shows that there are significant differences in the gender breakdown between the registration types. Midwives are 99.7 percent female compared with 88.6 percent of nurses and 99.1 percent of those with dual registration.

On sexual orientation the differences between the professions are that 0.6 percent of midwives identify as gay or lesbian as compared with 1.7 percent of nurses and 0.8 percent of those with dual registration. There are few differences from last year's report, except that as can be expected all groups have increased in numbers as the number of 'unknowns' decreases.

What does our data tell us about fitness to practise outcomes?

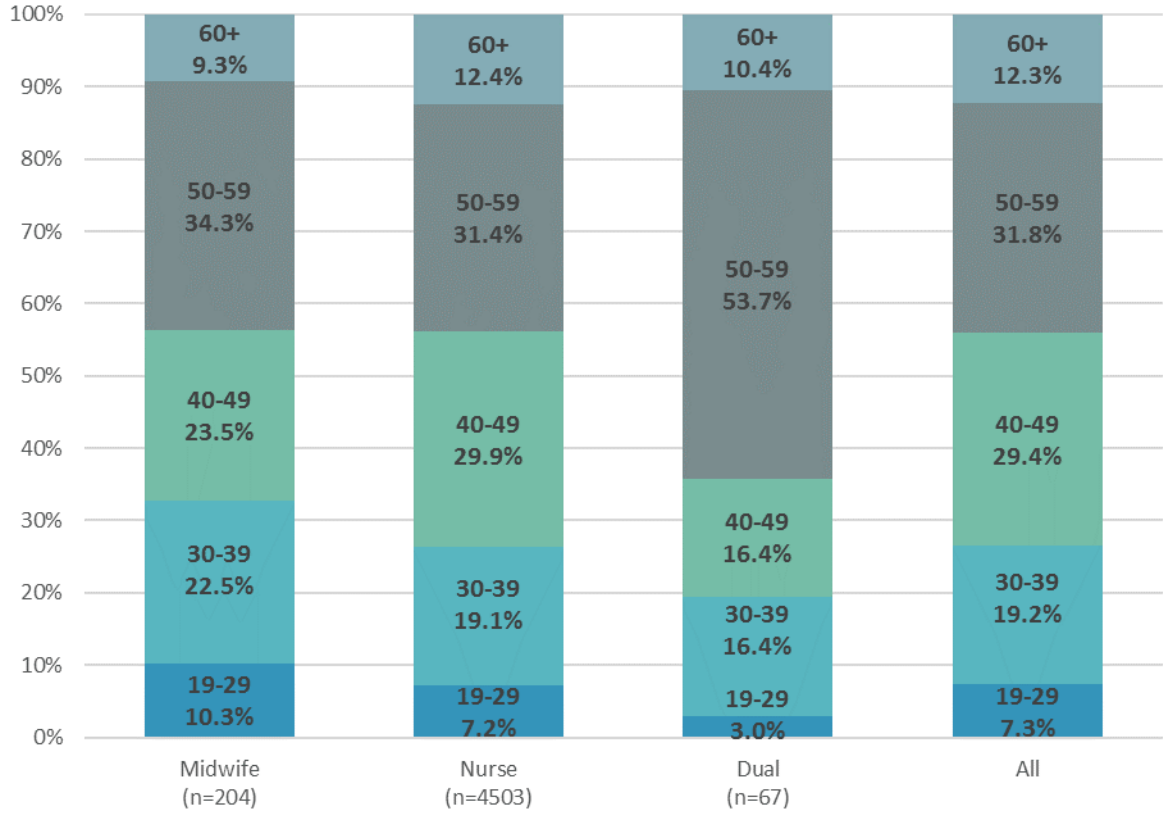
In this section we are only making comparisons with the register where there are relatively large groups. If the numbers by registration type are small we will not make a comparison.

Some trends follow through all the sections. For example, for gender we know from the 'new concerns' section that men make up a higher proportion of people who are referred to fitness to practise. They are more likely to be referred to fitness to practise than would be expected given their proportion on the register. At case examiner stage, they are more likely to get a 'case to answer' decision than women. They are more likely to get an interim suspension order than women and at hearing stage they are more likely to be struck off the register than women.

New concerns

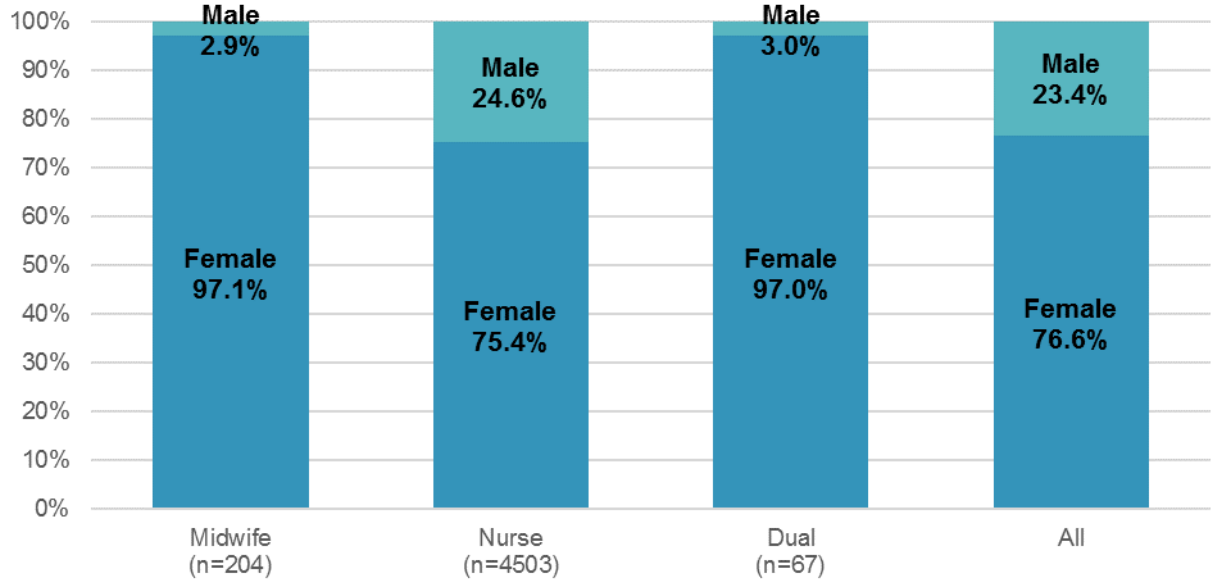
This section details the diversity data for the 4,778 new concerns where we opened a case between April 2017 and March 2018. In the same period four new concerns were raised about individuals that were not on our register at the time of the referral (but may have previously been on the register). These four concerns are not reported in the tables broken down by registration type. The figures in this report are in line with the figures in our annual fitness to practise report 2017–2018 which reports on number of referrals as a whole, not by individual. This means there may be more than one referral for an individual and that individual may present in the data more than once.

Chart 05: New concerns by age group



Comparing everyone on our register (Chart 02) to the data on new concerns we can see that nurses and midwives being referred are more likely to come from older age groups. For example, the 19-29 age group made up 10.3 percent of new concerns compared to being 18.2 percent of the register and nurses aged 19-29 made up of 7.2 percent of new concerns compared to being 13.5 percent of the register. Conversely 34.3 percent of new concerns raised about midwives were for the 50-59 age group compared with being only 26.7 percent of the register and 53.7 percent of dual registrants compared with being only 40.3 percent of the register.

Chart 06: New concerns by gender



Overall, 23.4 percent of new concerns were for men, compared with being 10.7 percent on the register. Across all registration types there are proportionately more men being referred than women.

Last year was the first year that we reported fitness to practise outcomes by ethnicity broken down into all 18+1[3] of the 2001 census categories. The proportion of 'unknown' ethnicity has decreased from 14.6 percent of new concerns in 2016–2017 to 7.8 percent of new concerns in 2017–2018, this has led to the numbers for other groups going up.

Table 06: New concerns by ethnic group

	Midwife	%	Nurse	%	Dual	%	All	%
Asian - Indian	1	0.5%	113	2.5%	1	1.5%	115	2.4%
Asian - Pakistani	2	1.0%	26	0.6%	1	1.5%	29	0.6%
Asian - Bangladeshi	-	-	9	0.2%	-	-	9	0.2%
Asian - Chinese	-	-	11	0.2%	2	3.0%	13	0.3%
Asian - other background	-	-	143	3.2%	-	-	143	3.0%
Black African	8	3.9%	574	12.7%	18	26.9%	600	12.6%
Black Caribbean	4	2.0%	79	1.8%	4	6.0%	87	1.8%
Black - other background	-	-	23	0.5%	-	-	23	0.5%
White and Asian	-	-	13	0.3%	-	-	13	0.3%
White and black African	1	0.5%	28	0.6%	1	1.5%	30	0.6%
White and black Caribbean	7	3.4%	53	1.2%	1	1.5%	61	1.3%
Mixed - other background	3	1.5%	21	0.5%	-	-	24	0.5%

[3] In the ONS census there are 5 broad categories (white, Asian, black, mixed, other), with a number of subcategories, making a total of 18 choices plus the one 'prefer not to say' option.

	Midwife	%	Nurse	%	Dual	%	All	%
White - English/ Welsh/ Scottish/ Northern Irish	151	74.0%	2,537	56.3%	26	38.8%	2,714	56.8%
White - Irish	0	-	51	1.1%	1	1.5%	52	1.1%
White - other background	5	2.5%	271	6.0%	2	3.0%	278	5.8%
Any other ethnic group	3	1.5%	66	1.5%	2	3.0%	71	1.5%
Prefer not to say	3	1.5%	135	3.0%	1	1.5%	139	2.9%
Unknown	16	7.8%	350	7.8%	7	10.4%	373	7.8%
Total	**204**	**100%**	**4,503**	**100%**	**67**	**100%**	**4,774**	**100%**

This year's data (Table 06) is echoing the findings in *The Progress and Outcomes of Black and Minority Ethnic (BME) Nurses and Midwives through the Nursing and Midwifery Council's Fitness to Practise Process* that people of white British ethnicity are proportionately less likely to be referred than expected given their proportions on the register (Table 02). People of black African ethnicity are more likely to be referred (than expected given their proportion on the register). The other ethnic groups are too small to make valid comparisons.

People of black African ethnicity made up 3.9 percent of all referrals for midwives (they are 1.9 percent of the register). For nurses, there were a disproportionately higher percentage of referrals for the black African ethnic group at 12.7 percent compared to being 6.3 percent of the register. The black African ethnic group also made up a large percentage of dual registrant referrals at 26.9 percent (18 out of all 67 new concerns for dual registrants). On the register, 13.4 percent of dual registrants are black African. For the ethnic group of white - English/Welsh/Scottish/Northern Irish/ British, they were 74 percent of referrals of midwives compared with 80.3 percent on the register and for dual registrants they were 38.8 percent of referrals compared with 60.4 percent on the register.

Table 07: New concerns by sexual orientation

	Midwife	Nurse	Dual	All
Bisexual	0.5%	0.9%	-	0.9%
Gay or lesbian	1.0%	3.0%	1.5%	2.8%
Heterosexual or straight	84.8%	80.7%	83.6%	80.9%
Prefer not to say	5.9%	7.6%	4.5%	7.5%
Unknown	7.8%	7.8%	10.4%	7.8%
Total	**100%**	**100%**	**100%**	**100%**

For sexual orientation 80.7 percent of referrals were for nurses that are heterosexual/straight compared to 85.3 percent on the register. This difference may be related to the fact that there was a higher proportion of unknowns and prefer not to say for sexual orientation in the new concerns (15.3 percent) compared to the register (12.4 percent).

Interim orders

This section on interim orders (IOs) compare the differences between whether a nurse or midwife has received an interim conditions of practice order, interim suspension order or if it was decided that an IO was not necessary.

Table 08: Interim orders by age group

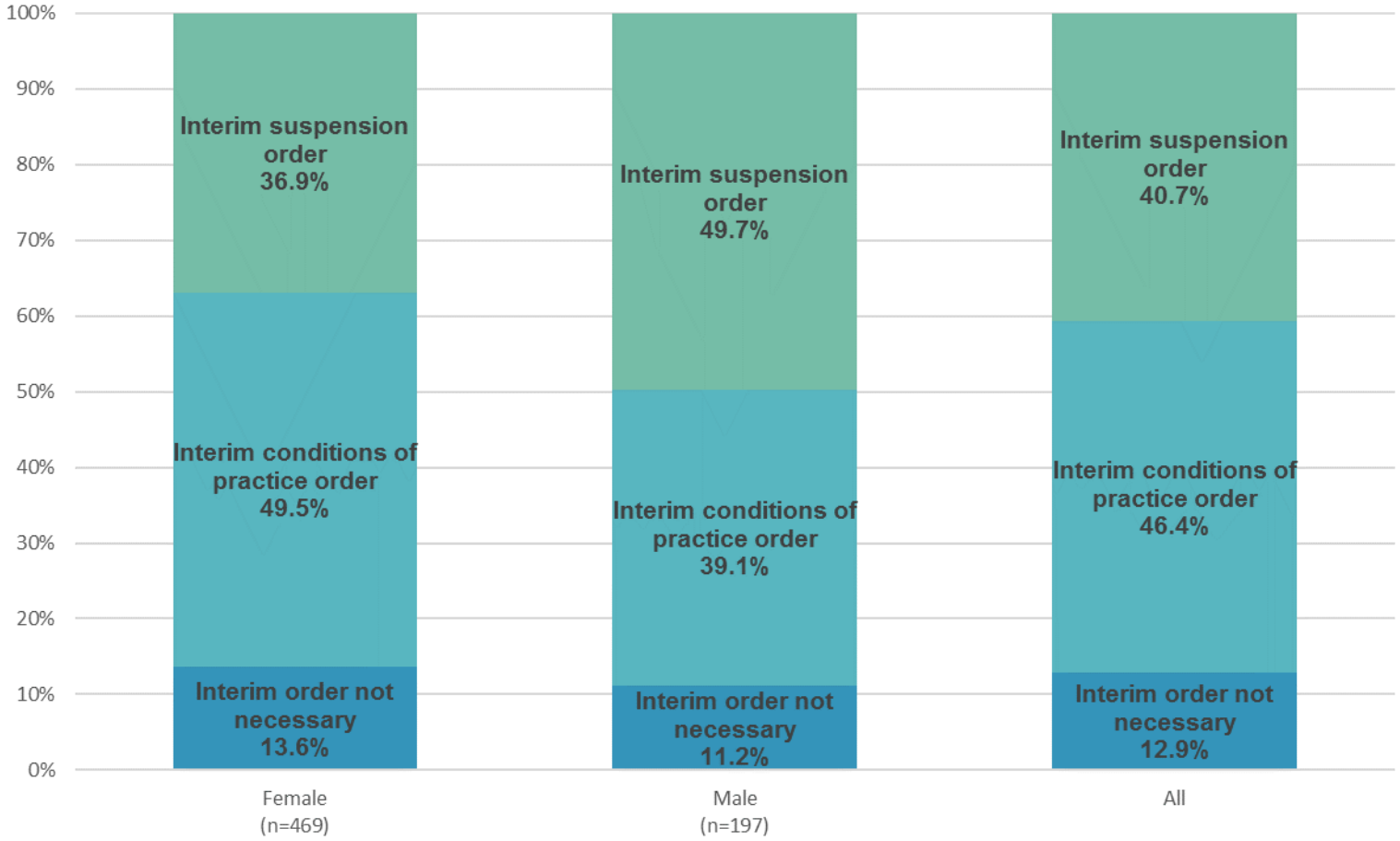
	19 - 29	%	30 - 39	%	40-49	%	50 - 59	%	Over 60	%	Total	%
Interim conditions of practice order	23	48.9%	56	47.5%	92	48.4%	95	43.6%	43	46.2%	309	**46.4%**
Interim order not necessary	3	6.4%	16	13.6%	26	13.7%	23	10.6%	18	19.4%	86	**12.9%**
Interim suspension order	21	44.7%	46	39.0%	72	37.9%	100	45.9%	32	34.4%	271	**40.7%**
Total	**47**	**100%**	**118**	**100%**	**190**	**100%**	**218**	**100%**	**93**	**100%**	**666**	**100%**

The table above shows there were a higher percentage of decisions that an IO was not necessary for people aged 60 and over compared with younger groups. The table below shows that this was also the case for those in the black and Asian ethnic groups compared with the other ethnic groups. This table shows the higher level ethnic categories as the numbers in the lower level categories are too small to report.

Table 09: Interim orders by ethnic group

	Asian	%	Black	%	Mixed	%	White	%	Other	%	Prefer not to say	%	Unknown	%	Total	%
Interim conditions of practice order	22	50.0%	50	48.1%	27	47.4%	153	46.9%	7	50.0%	10	58.8%	40	38.5%	**309**	**46.4%**
Interim order not necessary	7	15.9%	19	18.3%	8	14.0%	39	12.0%	2	14.3%	3	17.6%	8	7.7%	**86**	**12.9%**
Interim suspension order	15	34.1%	35	33.7%	22	38.6%	134	41.1%	5	35.7%	4	23.5%	56	53.8%	**271**	**40.7%**
Total	**44**	**100%**	**104**	**100%**	**57**	**100%**	**326**	**100%**	**14**	**100%**	**17**	**100%**	**104**	**100%**	**666**	**100%**

Chart 07: Interim orders by gender



The chart above shows that men are more likely to receive an interim suspension order, whereas women are more likely to receive an interim conditions of practice order. Of the 666 IO decisions being made 30 percent were for male nurses and midwives this is significantly higher than the 11 percent of men on the overall register of nurses and midwives.

Case examiner decisions

During a fitness to practise investigation, we gather evidence that is needed to make a full assessment of the allegations. At the end of the investigation, the case examiners review all the evidence and decide one of the following:

- No case to answer (NCTA)
- Case to answer (CTA) referred to a hearing
- Advice
- Warning
- Undertakings

The data in this section has not been separated into registration type to prevent individuals being identified by the small numbers. The percentages are column percentages – they show for each demographic group what percentage were NCTA, advice, warnings, undertakings and CTA.

Across the fitness to practise outcomes data, people with 'unknown' protected characteristics appear to have higher proportions of more severe outcomes and/or sanctions. This could be because people who do not engage with the fitness to practise process are both most likely to have more severe outcomes and be the least likely to complete their diversity data on NMC Online.

Table 10: Case examiner decisions by age group

Decisions	19-29	%	30-39	%	40-49	%	50-59	%	Over 60	%	Total	%
NCTA	57	50.9%	206	53.4%	344	55.7%	457	58.3%	206	61.7%	**1,270**	**56.8%**
Advice	1	0.9%	10	2.6%	5	0.8%	5	0.6%	3	0.9%	**24**	**1.1%**
Warning	5	4.5%	22	5.7%	25	4.0%	30	3.8%	11	3.3%	**93**	**4.2%**
Undertakings	1	0.9%	5	1.3%	6	1.0%	12	1.5%	4	1.2%	**28**	**1.3%**
CTA	48	42.9%	143	37.0%	238	38.5%	280	35.7%	110	32.9%	**819**	**36.7%**
Total	**112**	**100%**	**386**	**100%**	**618**	**100%**	**784**	**100%**	**334**	**100%**	**2,234**	**100%**

The older the age group, the smaller the proportion that have a CTA. Of all the decisions made about the 19-29 age group 42.9 percent of decisions led to CTA compared with 32.9 percent of all decisions about the over 60 age group.

Table 11: Case examiner decisions by disability

Decision	No	%	Yes	%	Prefer not to say	%	Unknown	%	Total	%
NCTA	1,043	61.0%	80	51.0%	63	54.8%	84	33.5%	**1,270**	**56.8%**
Advice	17	1.0%	3	1.9%	0	0.0%	4	1.6%	**24**	**1.1%**
Warning	78	4.6%	4	2.5%	4	3.5%	7	2.8%	**93**	**4.2%**
Undertakings	20	1.2%	2	1.3%	1	0.9%	5	2.0%	**28**	**1.3%**
CTA	553	32.3%	68	43.3%	47	40.9%	151	60.2%	**819**	**36.7%**
Total	**1,711**	**100%**	**157**	**100%**	**115**	**100.0%**	**251**	**100.%**	**2,234**	**100%**

The table above shows that disabled nurses and midwives have a higher proportion of CTA decisions than people without a disability (43.3 percent for people with a disability vs. 32.3 percent for people without a disability). Also, the proportion of people with ‘unknown’ disability status who have a CTA is high at 60.2 percent.

Table 12: Case examiner decisions by ethnicity

Decision	Asian	%	Black	%	Mixed	%	White	%	Any other ethnic group	%	Prefer not to say / unknown	%	Total	%
NCTA	129	65.2%	240	64.7%	31	52.5%	732	58.1%	18	62.1%	120	37.7%	**1,270**	**56.8%**
Advice	0	0.0%	2	0.5%	0	0.0%	18	1.4%	0	0.0%	4	1.3%	**24**	**1.1%**
Warning	6	3.0%	13	3.5%	6	10.2%	57	4.5%	2	6.9%	9	2.8%	**93**	**4.2%**
Undertakings	3	1.5%	5	1.3%	1	1.7%	14	1.1%	0	0.0%	5	1.6%	**28**	**1.3%**
CTA	60	30.3%	111	29.9%	21	35.6%	438	34.8%	9	31.0%	180	56.6%	**819**	**36.7%**
Total	**198**	**100%**	**371**	**100%**	**59**	**100%**	**1,259**	**100%**	**29**	**100%**	**318**	**100%**	**2,234**	**100%**

Nurses and midwives in the black (29.9 percent) and Asian (30.3 percent) group categories had a lower proportion of CTA decisions than those in the mixed (35.6 percent) and white (34.8 percent) ethnic groups. It is important to note that the groups have very different sizes, for example there are only 59 in the mixed ethnic group, compared to 1,259 in the white ethnic group.

The case examiner decisions for the ethnic groups with the largest numbers of cases from the lower level 18+1[4] ethnic group categories are presented in the table below. The ethnic groups that seem to have proportionately more NCTA decisions are Asian Indian (69.2 percent of all decisions about the Asian Indian ethnic group) and black African (64.7 percent of all decisions made about black African ethnic group). Of the nurses and midwives that we do not know their ethnic group (the unknowns) 33.6 percent of decisions were NCTA compared with the relatively high 60 percent CTA decisions.

[4] In the ONS census there are 5 broad categories (white, Asian, black, mixed, other), with a number of subcategories, making a total of 18 choices plus the one 'prefer not to say' option.

Table 13: Case examiner decisions for the ethnic group categories with more than 50 cases

Decision	Asian - Indian	%	Asian - other	%	Black African	%	White - English/ Welsh/ Scottish/ Northern Irish	%	White - other	%	Prefer not to say	%	Unknown	%	Total	%
NCTA	63	69.2%	45	57.7%	211	64.7%	655	58.8%	70	55.6%	36	52.9%	84	33.6%	**1270**	**56.8%**
Advice	0	0.0%	0	0.0%	1	0.3%	16	1.4%	1	0.8%	0	0.0%	4	1.6%	**24**	**1.1%**
Warning	3	3.3%	3	3.8%	11	3.4%	53	4.8%	2	1.6%	2	2.9%	7	2.8%	**93**	**4.2%**
Undertakings	0	0.0%	3	3.8%	2	0.6%	12	1.1%	2	1.6%	0	0.0%	5	2.0%	**28**	**1.3%**
CTA	25	27.5%	27	34.6%	101	31.0%	377	33.9%	51	40.5%	30	44.1%	150	60.0%	**819**	**36.7%**
Total	**91**	**100%**	**78**	**100%**	**326**	**100%**	**1113**	**100%**	**126**	**100%**	**68**	**100%**	**250**	**100%**	**2234**	**100%**

Chart 08: Case examiner decisions by gender

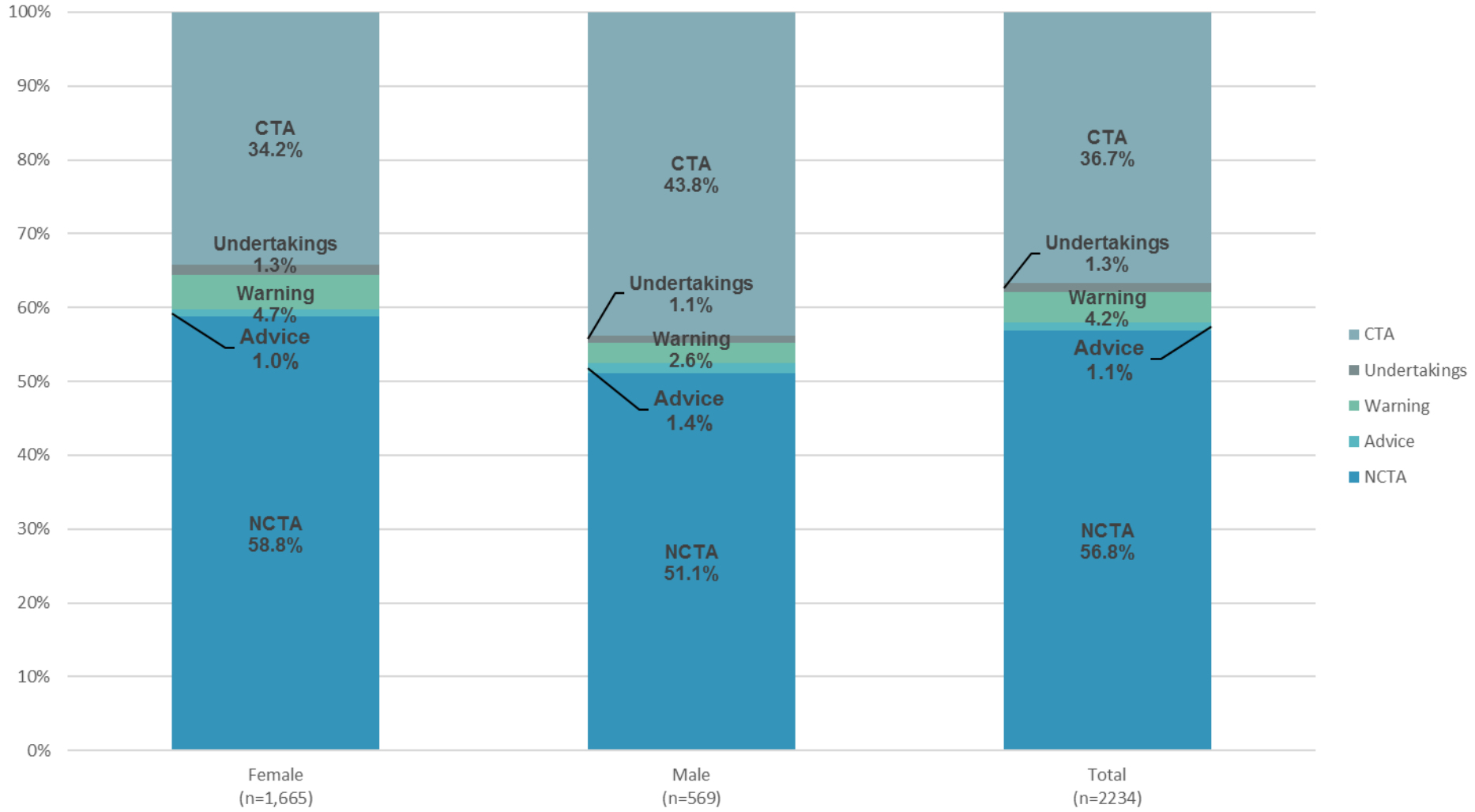


Chart 08 above shows that women have a smaller proportion of CTAs than men (34.2 percent of decisions for women vs. 43.8 percent of decisions for men).

Hearings

Some of the diversity data that we hold about nurses and midwives that go to hearings is sensitive data and cannot be published in this report. For the same reason the data in this section is not divided into nurse, midwife and dual registration. The sanctions that the panels determine are listed below. Go to the Sanctions we can impose pages on our website for more information.

Sanctions	Abbreviation
Facts not proved	FNP
Fitness to practise not impaired	FTPNI
Caution order	CO
Conditions of practice order	CPO
Suspension order	SO
Striking off order	SOO

Table 14: Hearing outcome by age group

Outcome	19-29	%	30-39	%	40-49	%	50-59	%	Over 60	%	Total	Total
FNP	0	-	0	-	1	0.3%	3	0.7%	2	1.2%	**6**	**0.4%**
FTPNI	5	10.0%	43	21.6%	74	22.5%	104	22.7%	52	30.6%	**278**	**23.1%**
CO	6	12.0%	19	9.5%	33	10.0%	57	12.4%	14	8.2%	**129**	**10.7%**
CPO	11	22.0%	32	16.1%	43	13.1%	58	12.6%	21	12.4%	**165**	**13.7%**
SO	18	36.0%	67	33.7%	102	31.0%	137	29.8%	48	28.2%	**372**	**30.8%**
SOO	10	20.0%	38	19.1%	76	23.1%	100	21.8%	33	19.4%	**257**	**21.3%**
Total	**50**	**100%**	**199**	**100%**	**329**	**100%**	**459**	**100%**	**170**	**100.0%**	**1,207**	**100.0%**

People aged 60 and over were more likely to be found to **not** have their fitness to practise impaired (30.6 percent of outcomes for this age group vs. 10.0 percent of outcomes for the 19-29 age group.) They were also less likely to have caution orders, conditions of practice orders or suspension orders than the younger age groups.

Table 15: Hearing outcome by disability

	No	%	Yes	%	Prefer not to say	%	Unknown	%	Total	Total
FNP	3	0.4%	0	0.0%	1	1.9%	1	0.4%	**5**	**0.4%**
FTPNI	221	27.4%	19	16.5%	19	35.8%	20	8.7%	**279**	**23.1%**
CO	105	13.0%	7	6.1%	6	11.3%	11	4.8%	**129**	**10.7%**
CPO	105	13.0%	24	20.9%	5	9.4%	31	13.4%	**165**	**13.7%**
SO	231	28.6%	44	38.3%	9	17.0%	88	38.1%	**372**	**30.8%**
SOO	143	17.7%	21	18.3%	13	24.5%	80	34.6%	**257**	**21.3%**
Total	**808**	**100%**	**115**	**100%**	**53**	**100%**	**231**	**100%**	**1,207**	**100%**

Table 15 shows that disabled nurses and midwives were more likely to have a conditions of practice (20.9 percent compared to 13 percent for non-disabled people) and suspension order (38.3 percent compared with 28.6 percent for non-disabled people) and non-disabled people had proportionately more decisions that their fitness was not impaired (27.4 percent compared with 16.5 percent for disabled people) and given caution orders (13 percent compared with 6.1 percent for non-disabled people).

Table 16: Hearing outcome by ethnicity

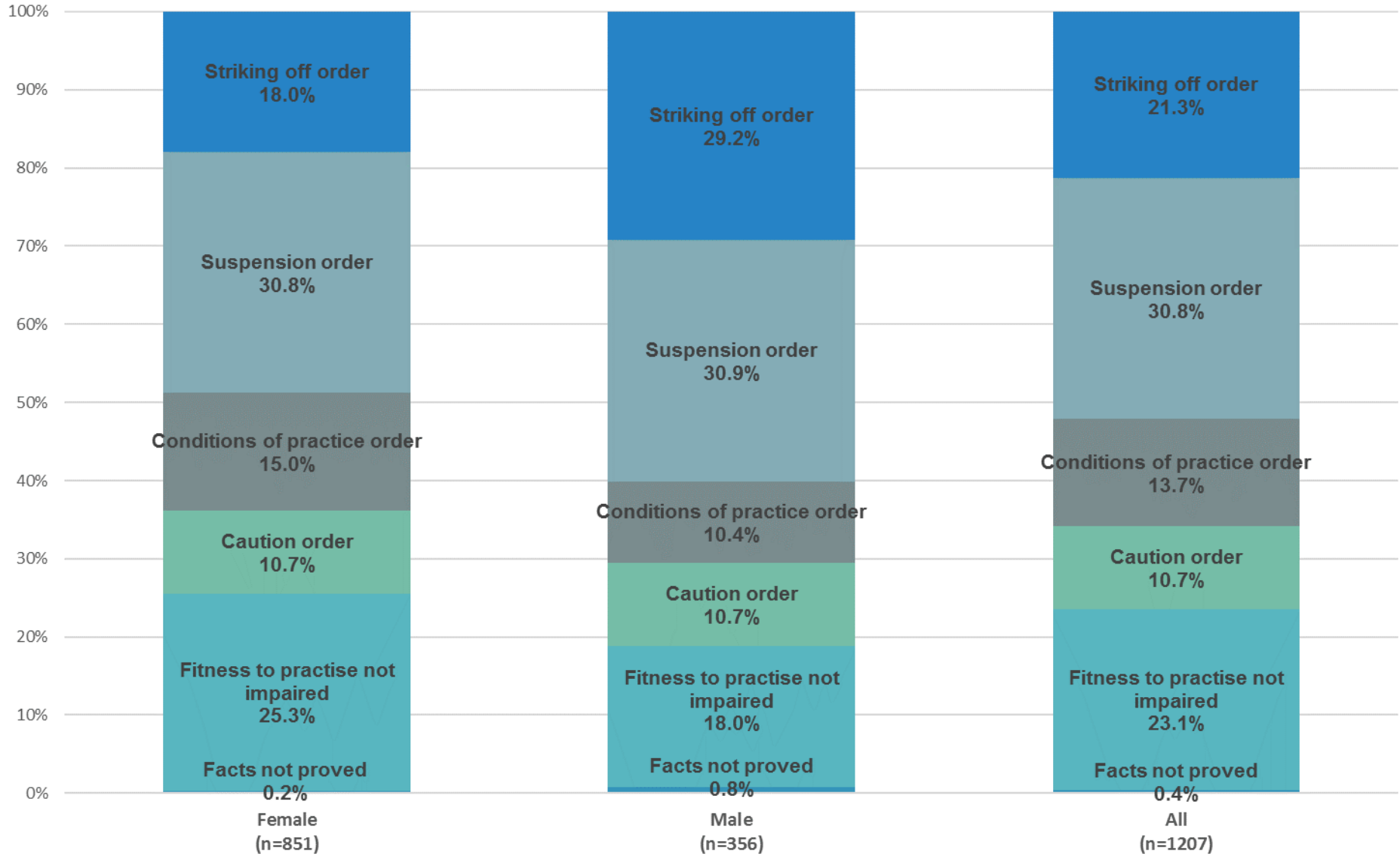
This chart shows the four ethnic groups that had more than 50 cases going through the hearings stage of FtP. These are from the lower level 18+1 ethnic group categories.

	Black African	%	White - English/ Welsh/ Scottish/ Northern Irish/ British	%	White - other background	%	Unknown	%	All	%
FNP	1	0.6%	1	0.2%	0	0.0%	1	0.4%	**5**	**0.4%**
FTPNI	60	35.1%	136	24.4%	14	19.7%	20	8.7%	**279**	**23.1%**
CO	20	11.7%	71	12.7%	9	12.7%	11	4.8%	**129**	**10.7%**
CPO	19	11.1%	78	14.0%	6	8.5%	31	13.5%	**165**	**13.7%**
SO	44	25.7%	167	29.9%	28	39.4%	87	38.0%	**372**	**30.8%**
SOO	27	15.8%	105	18.8%	14	19.7%	79	34.5%	**257**	**21.3%**
Total	**171**	**100%**	**558**	**100%**	**71**	**100%**	**229**	**100%**	**1207**	**100%**

People of black African ethnicity have a higher proportion of ‘fitness to practise not impaired’ outcomes than people who are white British or white other. They have correspondingly fewer suspension orders. 35.1 percent (60 out of 171) of decisions for black African registrants were ‘fitness to practise not impaired’. 24.4 percent (136 out of 558) decisions for white British registrants were ‘fitness to practise not impaired’ (Table 16).

There were a disproportionately higher number of cases where male nurses and midwives received striking off orders. 29.2 percent of men have a striking off order compared to 18.0 percent of women (Chart 09). At the same time, we know from the ‘new concerns’ section that men make up a higher proportion of people who are referred to FtP.

Chart 09: Hearing outcome by gender



Annexe 1: Progress against the strategic EDI aims 2015–2020

The EDI progress of the NMC is reported below against the strategic aims that are part of the Strategy 2015–2020. This table provides a status update against the plan that was presented to Council in November 2017.

	EDI Strategic Aims	Objectives	Measures	Current status
1	Place promoting equality, diversity and inclusion at the heart of what we do.	To embed EDI into governance, business planning and performance monitoring systems.	• Business plans contain relevant EDI activities. • EDI exceptions reported to the Executive Team. EDI action plan updated quarterly by EDLG.	The EDI Framework was agreed by the Executive Team in September 2016. We continue to communicate the EDI Framework across the organisation through regular face to face briefings with leaders and teams. The EDLG have quarterly meetings to monitor the status of the annual EDI annual action plan. We recruited a Senior E&D Policy Officer to support the implementation of the EDI Framework. We continue to produce this annual EDI report and the Welsh language report to demonstrate our progress.
2	Comply with equality and human rights legislation by ensuring our regulatory processes are fair, consistent and non-discriminatory.	a) To revise systems, information and guidance for employees to ensure compliance with discrimination law, and relevant equalities legislation.	• EDI and EQIAs are discussed in meeting minutes of NMC boards. • Surveys show employee awareness of EQIAs and EDI increased. • EQIAs are developed and monitored for NMC policies and projects. • Non-mandatory EDI training courses are well attended.	We revised the equality impact assessment (EQIA) guidance and templates. We held EQIA workshops for key programmes of work including the Education Programme, Nursing Associate and FtP Strategy. EQIA guidance, templates and training includes Welsh language compliance. Completion of equality and diversity training (e-learning and face to face) is mandatory for all new starters and all employees must repeat the e-learning every two years. Welsh language awareness is included in EDI mandatory training.

	EDI Strategic Aims	Objectives	Measures	Current status
		b) Compliance with the Welsh Language Scheme to be integrated into activities about equality impact assessment (EQIA) and EDI best practice.		EDI mandatory training attendance from 1st April 2017 – 31 March 2018: • Face to face training. 215 eligible employees joined the organisation and 183 attended face to face EDI training. 85 percent attended. • E-learning completions were 95 percent. In addition, we have inserted an EDI section in our face-to-face induction training to make employees aware of our EDI commitments and expectations from the start of their employment with us.
3	Be a good employer. Aspire to have a workforce that reflects the diversity of the communities in which we operate at all levels of our organisation.	a) To take actions as part of workforce planning to achieve a workforce that is meaningfully diverse (as expected when compared with appropriate comparator populations and related to job role). b) To review EDI training provision for employees to be role	• a) The workforce is more proportionate by protected characteristic at each pay grade (as expected). • a/b) Employees survey results (broken down by directorate) show: equal perceptions of fairness when analysed by protected characteristic; an increased number of employees know the EDI objectives; and an increased number of employees that know where to go for EDI support. • b) EDI training is mapped and monitored	We published the gender pay gap report and conducted analysis of pay grades in one directorate by ethnicity. In addition to mandatory training the EDI team run face-to-face EDI briefings for senior managers and teams. For example, equality impact assessment workshops, trans awareness, the history of black history month and briefings about Reasonable Adjustment compliance for disabled customers for the Fitness to Practise Senior Management Team. We commissioned unconscious bias training for all managers to roll out in 2018–19. In our 2017 employee survey, of the employees that responded: • 88 percent said their manager treats them fairly (up from 83 percent last year). • 93 percent said they understood EDI and where it is relevant to their role. • 87 percent were aware of the Valuing Diversity Policy (down from 92 percent last year).

	EDI Strategic Aims	Objectives	Measures	Current status
		specific. To deliver tailored training for all employees, panellists and Council members.	by role.	• 74 percent said the NMC is an inclusive place to work and 18 percent were unsure. • 72 percent agreed that there is a real commitment at the NMC to continue to improve performance on EDI. In addition to the employee survey results above, we conducted further analysis of workforce data to understand better what factors have led to disproportionate representation of certain groups by protected characteristic in grades/teams. A new employee LGBT+ network was launched in 2017 and a new employee Cultural Network was launched in January 2018. We recruited a new post of EDI Lead in HR to take forward our EDI activities as an employer as part of the People Strategy. This is in addition to the work that the EDI Policy Team do to support regulatory EDI compliance.
4	Use our influence to promote wider improvements in equality, diversity and inclusion practice.	a) To identify within our regulatory role where we can make improvements to EDI externally. b) To publish data about differences in outcomes for different groups going	• Research commissioned and engagement monitoring with diverse stakeholders. • Data reports are produced and published in time, broken down by protected characteristic. • Education QA reports contain information about EDI practice in AEIs and other institutions.	In April 2017 we published research that looked at the differences by ethnicity, gender and country in new concerns raised and fitness to practice outcomes. The findings of the research were communicated widely to employers and a further meeting was held in November 2017 with the advisory group who informed the design of the research. The agreed next steps of that meeting were: • for all bodies to continue to share research, findings and best practice; • for the NMC to continue to involve and communicate with the advisory group members in relation to relevant developments such as the FtP Strategy; • to explore the possibility of expanding future research to analyse outcomes for nurses and midwives on the basis of

	EDI Strategic Aims	Objectives	Measures	Current status
		through our regulatory processes e.g. revalidation and FtP data. c) To ensure EDI compliance considered by bodies which we regulate and procure contracts to (e.g. AEIs)	• Contracts contain EDI compliance and best practice requirements. • Evaluations of contracts monitor if EDI requirements have been met.	additional protected characteristics such as age; • to repeat this analysis in 2019 when we have richer data about nurses and midwives, e.g. where they are practising, as well as a greater percentage of diversity data to continue to communicate the findings of the research to external stakeholders and • use the research internally to discuss the impact on our regulatory role e.g. in our FtP Strategy consultation. Our procurement tender processes and contracts specify that businesses we have contracts with must comply with equalities legislation. We consulted with our Test of Competence suppliers about how to standardise the EDI considerations of each test site. We held a workshop with the provider sites to explore potential areas of concern and improvements. This was followed by a questionnaire completed by all sites to determine further support the NMC can provide to the test sites on EDI best practice.
5	Build the trust and confidence of service users, registrants and others that share protected characteristics. By showing understanding of their needs	a) To create systems to effectively engage with diverse stakeholders. b) NMC publications, meetings, correspondence and consultations	• Our engagement lists have an increased number of diverse stakeholders. • Feedback from engagement events shows diverse representatives feel engaged. • Increased number of meetings with external groups/individuals that	We have been working to improve EDI within external affairs in line with a new EDI external affairs strategy for inclusive communications and engagement. We produced guidance for employees running events and engaging with diverse stakeholders. We have been building relationships with the organisations who represent a diverse range of groups. For example, for our work to develop new standards of education for midwives, we have been engaging with charities representing young women, people who have experienced domestic violence, refugees and asylum

<table>
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<tr><td></td><td>and preferences and challenging discrimination where evidence comes to our attention.</td><td>are accessible and available in alternative formats when requested and reasonable.
c) The internal and external communications are updated to include relevant EDI information. E.g. social media engagement with diverse nurses and midwives.</td><td>represent diverse views.
• Our website and external communications contain up to date EDI information and are accessible by external benchmark standards.</td><td>seekers, LGBT+ people, people living with HIV, and Gypsies, Roma and Travellers.

We have also attended meetings of the CNO (England) BME Strategic Advisory Group and invited their members to respond to our consultations on the Education Framework.

During our consultation on our new education standards, we worked with a learning disability charity to hold an event. Around 20 people with learning disabilities attended to share their views on the future of nursing education.

During our consultations on education, nursing associates and fitness to practise, we have contracted external companies to gather the views of underrepresented groups including people with learning disabilities, younger people and older people.

Our NMC consultations also monitor responses by protected characteristic, which has enabled us to do targeted engagement with underrepresented groups such as learning disabled and traveller groups. For example, we know that the nursing associate fees consultation had the following breakdown of respondents:

<table><tr><td>Gender</td><td>Number</td><td>Percentage</td></tr><tr><td>Female</td><td>446</td><td>54</td></tr><tr><td>Male</td><td>127</td><td>15</td></tr><tr><td>Non-binary</td><td>3</td><td><1</td></tr><tr><td>Not stated</td><td>256</td><td>31</td></tr></table>
Organisations that responded to the consultation that said they officially represents views of nurses/ midwives and/or public that</td></tr>
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<table>
<tr><th></th><th>EDI Strategic Aims</th><th>Objectives</th><th>Measures</th><th>Current status</th></tr>
<tr><td></td><td></td><td></td><td></td><td>share the following protected characteristics:
<table>
<tr><td></td><td>Number</td><td>Percentage</td></tr>
<tr><td>Older</td><td>13</td><td>42</td></tr>
<tr><td>Ethnic minorities</td><td>13</td><td>42</td></tr>
<tr><td>Younger</td><td>12</td><td>39</td></tr>
<tr><td>Gender</td><td>12</td><td>39</td></tr>
<tr><td>Disabled</td><td>11</td><td>35</td></tr>
<tr><td>Religion or belief</td><td>11</td><td>35</td></tr>
<tr><td>Lesbian, Gay and Bisexual</td><td>10</td><td>32</td></tr>
<tr><td>Transgender</td><td>9</td><td>29</td></tr>
<tr><td>Pregnancy/maternity</td><td>9</td><td>29</td></tr>
<tr><td>Not stated</td><td>15</td><td>48</td></tr>
</table>

By carrying out continuous equality assessments of our processes and systems, we were able to identify areas where we could improve our processes for certain groups. An EDI review of our registration and revalidation processes identified that we could make improvements to our communications for disabled and trans service users. This led to sensitivity training and awareness raising activities for front line employees.

We have also been working to improve our understanding of equality, diversity and inclusion issues by attending internal and external training and events. For example, in November 2017 we attended a workshop on reducing health inequalities amongst groups such as homeless people, sex workers and vulnerable migrants.</td></tr>
<tr><td>6</td><td>Evaluate and as needed address,</td><td>To improve our understanding of how our</td><td>• All external consultations have EQIA summaries</td><td>We published an EQIA summary with the Education Standards and nursing associate (NA) fees consultation. We held EQIA workshops with the employees that were involved with the</td></tr>
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	EDI Strategic Aims	Objectives	Measures	Current status
	equality issues raised by our work.	activities, functions and services impact on diverse groups and take action to eliminate unlawful discrimination.	published. • Monitoring of the number of EQIAs, workshops and meetings. • Evaluation reports and EDI review documents that show EDI considerations and recommendations for improvement.	development of both the Education Standards and the NA programme. Our registration and revalidation function had an EDI review to look at gaps in their EDI regulatory role. This is part of our ongoing equality impact reviews, based on prioritised areas of potential concern. This was translated into prioritised actions in their business plan, for example trans awareness training for customer facing employees. Formal evaluations for Revalidation and the test of competence for overseas nurses and midwives included looking at different outcomes for nurses and midwives by protected characteristics as well as perceptions of fairness. Through the evidence stream of our EDI Strategic Framework we identified the following EDI priorities for the organisation in 2018-19 to: • Continue to improve the quality of the diversity data we hold; • Implement our reasonable adjustments policy for customers; • Raise awareness of gender identity and how it affects the service we provide; • Reduce disproportionately negative outcomes for ethnic minority nurses, midwives and staff; • Build the capability of employees to be compliant with equalities legislation; • Embed equality impact assessments into our project and operational processes.
7	Collect	a) To collect,	• Reduce ‘unknown’	During the reporting period we commissioned research and

<table>
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<tr><td></td><td>evidence that helps us know we are fair and consistent. Working to enhance the quality and extent of E&D data about our registrants through their careers.</td><td>analyse and publish data about the diversity of nurses and midwives on our register.
b) We understand where our functions impact on different groups of nurses and midwives.</td><td>percentage of diversity data of nurses and midwives.
• Research and evaluation reports compare outcomes for different groups of nurses and midwives on the basis of protected characteristic.</td><td>evaluations that looked at our regulatory outcomes but also at differences between patients, public and registrants by protected characteristic.

The figures below show the improvements to the percentage of diversity data we hold about nurses and midwives on the register:

<table><tr><td>Protected characteristic</td><td>Mar-17</td><td>Mar-18</td></tr><tr><td>Age</td><td>100%</td><td>100%</td></tr><tr><td>Gender</td><td>100%</td><td>100%</td></tr><tr><td>Ethnicity</td><td>83%</td><td>94%</td></tr><tr><td>Disability</td><td>80%</td><td>90%</td></tr><tr><td>Religion or belief</td><td>64%</td><td>71%</td></tr><tr><td>Sexual orientation</td><td>83%</td><td>94%</td></tr><tr><td>Marital Status</td><td>83%</td><td>94%</td></tr><tr><td>Gender identity</td><td>70%</td><td>89%</td></tr></table>
This is the first year that we are publishing the gender identity of the nurses and midwives on the register. There are 3,789 nurses and midwives on the register that say their gender identity does not completely match the sex they were registered with at birth, equivalent to 0.5 percent of the register.</td></tr>
<tr><td>8</td><td>Ensure that new entrants to the register are equipped to practise effectively in diverse and global</td><td>a) Standards for nurses and midwives entering the register contain relevant information</td><td>• increased engagement events for those involved in the education/ assessment of nurses, midwives coming onto the register
• more communications and guidance about EDI</td><td>During our engagement for the revision of the education standards we recognised the need to improve information about supporting students with diverse needs, which led to clearer information on the expectations of education providers to support disabled students. Our newly published standards for pre-registration nursing programmes contain the following text: ‘Approved education institutions (AEIs) together with practice learning partners must take account of students’ individual needs and</td></tr>
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	EDI Strategic Aims	Objectives	Measures	Current status
	environments.	about the equality diversity and inclusion requirements. b) QA of education and assessment institutions look at compliance with PSED.	expectations. • QA reports show where bodies have considered EDI.	personal circumstances when allocating their practice learning including making reasonable adjustments for students with disabilities'. Our interaction with AEIs in Wales highlighted our need to be continuously aware of the needs of Welsh language speaking patients, nurses and midwives. We have planned for an EDI question in our QA feedback from AEIs in the next reporting year. We conducted an EDI questionnaire of all our Test of Competence providers to share their best practice of the EDI and ensure consistency in access to the sites and fair assessment processes.
9	Set out our expectations that nurses and midwives challenge discrimination in their practice, are mindful of difference and show respect to all patients, service users and colleagues.	Our standards, the Code and FtP guidance contain EDI requirements for how nurses and midwives should practise without discrimination against diverse service users and with an understanding of health inequalities.	• Standards and guidance documents contain relevant EDI requirements.	Our consultation questions for the revision of the Education Standards asked a specific question about EDI. The EQIA of the Education Programme included engagement with diverse groups. In our consultations and engagement, we received feedback that the language in the standards should be explicit in what is expected of nurses and midwives. Our new *Future nurse: Standards of proficiency for registered nurses* contain the following words 'at the point of registration, the registered nurse will be able to demonstrate an understanding of, and the ability to challenge, discriminatory behaviour'. FtP allegation codes were updated to include discrimination against service users and colleagues.
10	Pursue diversity in those applying	For our Council and committee	• The diversity data of applicants, shortlisted and appointments to	We held two recruitment campaigns for Council and committee members during 2017–2018. One was for a new Chair of Council who took office on 1 May 2018. The other was for a new Chair and

	EDI Strategic Aims	Objectives	Measures	Current status
	to become Council, committee and panel members.	members and panellists to reflect the diverse nurses and midwives on the register and the diverse patients and public.	Council and FtP panelist posts by protected characteristic is proportionate in comparison with a relevant pool of people e.g. FtP registrant panellists to have similar makeup to the makeup of the register.	two new members of the Appointments Board. Both recruitment exercises were equality impact assessed. Our search and advertising strategies were designed to encourage applications from candidates from underrepresented groups and we promoted the vacancies to key stakeholder groups. The diversity profile of the Council and committee members is available in section 2 of this report. During the reporting period the FtP Panel recruitment was commissioned to an external partner with the specific criteria of providing a diverse applicant pool by protected characteristic.
11	Be recognised as an organisation that upholds best practice in equality, diversity and inclusion, including through meeting recognised sector standards.	To promote NMC EDI activities externally.	• Completed external benchmarks and assessments. Improvements annually. • More feedback from employees and external stakeholders (in surveys and meetings) about perception of NMC.	We connect with the other healthcare regulators, such as the General Medical Council and General Pharmaceutical Council, and learn from each other's insights and research. The EDI leads from each regulator have a forum where we discuss best practice. We completed the Stonewall Workplace Equality Index (WEI) benchmark in 2018. Our overall score was 30.5 marks out of a possible 200. The sector average for health and social care is 60 marks. This gave us an immediate push to raise awareness of LGBT+ equality by hosting events and increasing communications about LGBT+ equality during LGBT History Month. For example, talks by Schools Out, the National Aids Trust and trans health and justice campaigner Christine Burns. We completed the Social Mobility Employer Index and will receive the result in the next reporting period. In the next reporting year, we will complete the Stonewall WEI, Social Mobility Employer Index and the Business in the Community (BITC) Race Index.