Nursing & Midwifery Council

Annual equality, diversity and inclusion report 2018–2019

Foreword

I am very pleased to introduce our annual Equality Diversity and Inclusion (EDI) report which presents a wealth of valuable data and is an opportunity to showcase the great work we are doing on EDI in the NMC, of which I am very proud.

The NMC is the independent professional regulator for nurses and midwives across the UK, and nursing associates in England. We are bound by equality legislation, but we want to go further by embedding EDI in all our work to promote better and safer care. We value the diversity of the nurses, midwives and nursing associates on our register, our colleagues and the wider community we serve.

The data in this report shows the diversity of our nurses, midwives and nursing associates. We must remain mindful of this in our approach to regulation, both now and in the future. I'm passionate about promoting inclusive healthcare regulation, and I'm inspired by what we have achieved over the last year. Some highlights for me have been welcoming the new profession of nursing associates and how we considered their diversity in our policy development; and our overseas review, which has given us the opportunity to hear from people with different experiences of our overseas processes – and make positive changes to the processes that impact them directly to make them more inclusive.

It's important to be transparent, and we know we have further to go on our journey. This year we have been able to increase the range of data we are able to share and going forward we plan to continue to broaden and deepen the analysis we provide. EDI is not an add-on, we want EDI to be at the core of all we do at the NMC and EDI will be at the heart of our new Strategy 2020-25. At the start of 2019 we welcomed Andrea Sutcliffe as our new CEO; her enthusiasm and commitment to EDI is evident and I know that with her leadership we will continue to move forward to greater inclusion.

Emma Broadbent
Director of Registration and Revalidation, and Senior Sponsor for EDI

Contents

Foreword 0

Executive Summary 3

Key activities and achievements 3

Highlights from the data 3

Why does EDI matter to the NMC? 5

About us 5

How we embed EDI in the NMC's work 6

How this report is structured 6

Section 1: Key activities and achievements 8

Ensuring we have strong foundations 8

Supporting our regulatory activity 9

Fitness to practise 10

Our workforce 11

Working with stakeholders 12

Improving our understanding of people's diverse needs and identities 13

What's next? 14

Preparing for the NMC Strategy 2020–2025 15

Section 2: Our data 16

Council, committee and board members 16

Fitness to practise panellists 16

Nurses, midwives and nursing associates 18

What do our data tell us about those on the register? 18

What do our data tell us about fitness to practise outcomes? 26

Executive Summary

Our annual EDI report 2018–2019 is a comprehensive review of how we, as the regulator of nurses, midwives and nursing associates, have progressed equality, diversity and inclusion across all our regulatory and workforce functions. It provides a picture of how we have used our EDI strategic framework and our People Strategy to achieve our EDI priorities for 2018-19.

Key activities and achievements

Some of the key activities and achievements for 2018-19 include:

- The creation of the Public Support Service (PSS), which will support people to have equal access to our services
- The development of the Future Nurse standards of education, including requirements and guidance with a much stronger EDI focus
- The review of our Health and Character guidance, which has significantly modernised our guidance and approach for people on our register and their employers in relation to appropriate disclosure of disability related conditions
- EDI being included in our new approach to Fitness to Practice, with one of the two regulatory outcomes stating EDI as an element of professionalism and regular reviews of the equality impact assessments
- The review of the overseas processes, where we have engaged with nurses, midwives and organisations that represent the views of diverse people and incorporated their input into our new processes and guidance
- Work to improve our processes for those disabled people and trans people that interact with us
- Developing our understanding of how race impacts on individuals that work for us, with us and the people on our register. For example through further analysis of our revalidation data and completing the BITC race benchmark
- Improving the suite of EDI training available to NMC colleagues and panellists
- Completing external benchmarks such as the Stonewall Workplace Equality Index (WEI), and moving from 357 in the index in 2018 to 215 in 2019
- Developing our staff networks: LGBT+, Cultural Network and a new Workaround network (for disabled employees).

Highlights from the data

We see our diversity data as an important source of intelligence. Understanding differences across our regulatory functions that relate to different protected characteristics will help us to decide our future priorities and ensure fairness. We cannot deliver on our aim to support better, safer care without understanding the diversity of the nursing and midwifery professions. We also know our data is a useful source of information for those working across the healthcare sector to support wider work to ensure inclusion. In this report we are starting to undertake more trend analysis and will build on this as our data develops over time.

The proportions of men and women on the register have remained the same since 2013, with men particularly under-represented in midwifery and dual registration (people who are registered as both a nurse and a midwife) compared to the UK

population. This year 99.7 percent of midwives are women compared with 88.6 percent of nurses, 99.1 percent of people with dual registration and 89 percent of nursing associates. This could begin changing as there has been a nine percent increase in men applying to study nursing and midwifery since summer 2018, linked to the 'We are the NHS' recruitment campaign.

There are 4,457 people on our register whose gender identity does not match the sex they were registered with at birth. This is 668 more people than last year. 3.7 percent of people on the register have told us they are disabled, compared to 3.9percent last year. These differences may be down to the continued increased completion rates of our diversity data.

The first cohort of nursing associates joined our register in January 2019. As we might expect with such a new role, this is a relatively young group with nearly 65 percent of nursing associates aged under 40 years.

There remain differences in the outcomes for registrants going through our fitness to practise processes on the basis of gender, age and ethnicity. Last year we highlighted substantial differences between white and black African registrants in fitness to practise outcomes. For new concerns raised we continue to see these differences between groups, but for hearing outcomes the differences between these groups are not the same as last year, with similar proportions for both the black African and white British groups.

People who selected 'prefer not to say/unknown' ethnicity have the highest proportion of the most serious outcomes at the case examiner and hearing stages of fitness to practise, as was the case last year. This is possibly because people who have not engaged in the fitness to practise process (and are therefore less likely to have recorded diversity information) are more likely to be referred to the adjudication stage. Although only 11 percent of people on our register are men, 23 percent of new fitness to practise concerns relate to this group.

This year we have some additional information about the people on our register who have revalidated. More detailed analysis of the work and practice settings by protected characteristics of the people on our register can be found in our annual revalidation report. Some interesting findings include that those working in agencies tend to be slightly older than those who are employed directly, which may be indicative of the flexibility and pay offered by agency work; and some settings rely strongly on a primarily white British workforce, including school nursing, quality assurance, policy, the voluntary sector, police, military, government and leadership roles.

Why does EDI matter to the NMC?

Equality, diversity and inclusion are principles the NMC actively seeks to embed in all our work to reflect the fact that effective healthcare regulation has people, in all our diversity, at its heart.

Everyone has a right to safe and effective care from nurses, nursing associates and midwives – and most of us will need to interact with the professionals on our register at some point in our lives, if not regularly.

It's vital that we understand the different health and care experiences people have in order to know that we are doing our job well as the regulator of nurses, midwives and nursing associates. We must be aware of the needs of all people and groups, and listen where things go wrong, particularly with more vulnerable people.

An unavoidable reality is that health inequalities across communities in the UK still persist today. We are committed to being an organisation that listens to the challenges facing different communities, and that champions the right we all have to access healthcare without fear of discrimination, harassment and victimisation.

About us

We are the professional regulator of nurses, midwifes and nursing associates. We work with these dedicated practitioners to ensure they have the knowledge and skills to deliver consistent, quality care that keep people safe.

We set the education standards that nurses, midwives and, in England, nursing associates, must achieve to practise. When they have shown both clinical excellence and a commitment to kindness, compassion and respect, we welcome them onto our register of nearly 700,000 professionals.

Once registered, professionals must uphold day in, day out the standards and behaviour set out in our code so that people can have confidence that they will consistently receive quality, safe care wherever they're treated.

We operate a revalidation process that encourages nurses, midwives and nursing associates to promote lifelong learning. It's a journey that asks professionals to reflect on their practice and how the code applies to their day-to-day work.

Professional regulation enables better care and keeps people safe. But on the rare occasions when care goes wrong or falls short of people's expectations, we step in to investigate and take action when needed.

We promote a culture that encourages professionals to be open and learn from mistakes, gives the public an equal voice, and where everyone involved is treated with kindness and understanding.

How we embed EDI in the NMC's work

Our equality, diversity and inclusion (EDI) work is evidence-based, meaning that our work is more than a collection of good ideas. It is underpinned by data, research and engagement, and informed by people and their experiences.

Our EDI strategic framework outlines our approach. It emphasises the need for leadership and vision, and sets out our commitment to use our diverse workforce, accessible and effective communication, and evidence about people's experiences to drive forward improvements.

Our EDI team ensures colleagues understand our legal responsibilities under the Equality Act 2010,[1] and empowers the people in our workforce to reflect on and improve the inclusivity of our work.

We are clear that it must be everyone's responsibility to promote equality, celebrate diversity and actively practise inclusion, if we are to achieve progress against our strategic objectives.

For 2018–2019 our Executive Board agreed the following EDI priorities:

- 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.

This enabled us to focus our resources on the areas that would have the greatest impact, based on evidence of need. This report shows how we have progressed against these priorities and our wider work to achieve EDI excellence.

How this report is structured

This is our seventh EDI annual report. We publish this report because a core part of delivering our EDI work is sharing our findings, reflecting on our progress, and being transparent about our challenges.

First, we outline some key activities and achievements that took place between April 2018 and the end of March 2019. Later in the report we share some highlights and trends in the diversity data about the nurses, midwives and nursing associates on our register.

[1] 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.

Nursing associates joined our register in January 2019, so this is the first time we have been able to share insights about the diversity of this new profession.

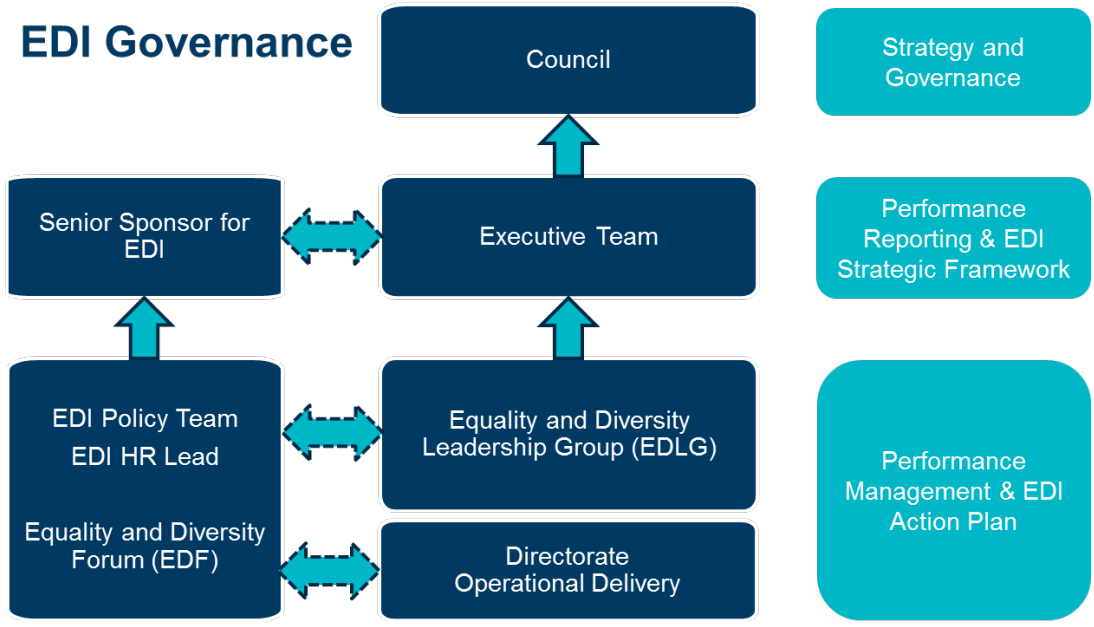
The diversity data of our Council members and fitness to practise panellists are also included in this report, as well as analysis of the different fitness to practise outcomes by protected characteristic.

Section 1: Key activities and achievements

Ensuring we have strong foundations

Our EDI Framework is in year three of implementation. In this reporting year we recognised the importance in investing in our small team of EDI professionals to ensure we become a forward-looking organisation that can lead the way in inclusive healthcare regulation. They monitor our compliance with equality legislation and promote best practice. The EDI team now consists of an EDI Policy Manager and EDI Senior Policy Officer, alongside an EDI Lead for Organisational Development and Human Resources (OD&HR), who is responsible for EDI activity relating to our 800 colleagues. During the 2018–2019 reporting year we also recruited a new EDI Support Officer, in order to further expand our ability to provide support, advice and best practice in EDI across the organisation.

Our EDI governance structure is an integral part of measuring our progress. We continue to have an active Equality and Diversity Leadership Group (EDLG), with senior leaders from each directorate accountable for driving forward activity across their areas. Led by Emma Broadbent, Director of Registration and Revalidation and our Senior Sponsor for EDI, EDLG has enabled us to make better decisions with more scrutiny, and enabled a productive space for thought leadership on EDI matters.



We also have an Equality and Diversity Forum (EDF), made up of colleagues from across the organisation. This group serves the invaluable purpose of feeding organisational intelligence into the EDI team, as well as sharing knowledge and championing EDI in their own teams.
A growing number of employee networks, who work to celebrate and raise the profile of the experiences of diverse communities, complement our corporate groups.

With increased investment in the EDI team, and both corporate EDI governance structures and employee network activity making advances across the organisation, we have built stronger foundations from which to achieve EDI excellence.

We held EDI business planning workshops in January 2019 with our business planning leads and Equality and Diversity Forum (EDF) members. We have continued to engage with internal and external stakeholders about how to make our EDI priorities part of our everyday business.

Supporting our regulatory activity

It's been a busy year for us as an organisation in 2018–2019. We have reviewed many of our core regulatory activities, providing opportunities to analyse the equality impact of our work, ensuring that barriers to inclusion have been identified and reviewed early on, and allowing us to be satisfied that our core functions are as inclusive as possible.

Both the introduction of nursing associates in January 2019 and the development of our new Public Support Service (PSS) provided further opportunities to address barriers to inclusion. The **PSS strategy** was aligned to one of our EDI objectives, to ensure that our customers using our services will not have different outcomes because of their protected characteristics. For example, we have made more information publicly available on how we can make adjustments for disabled people.

In addition, the **Future Nurse standards of education** have been implemented with a suite of standards, requirements and guidance with a stronger EDI focus. For example, in Part 1: Standards framework for nursing and midwifery education, there is a requirement for approved education institutions and learning partners to 'ensure the learning culture is fair, impartial, transparent, and fosters good relations between individuals and diverse groups and is compliant with equalities and human rights legislation'.

We reviewed our health and character guidance from an equality perspective, being particularly keen to ensure our policy did not unnecessarily disadvantage disabled people. Our updated guidance takes a person-centred approach that makes it clear we only need to know about someone's disability or health condition where it is not being effectively managed by that person in a work context. It therefore empowers people on our register, encouraging them to reflect on their ability to manage the physical or mental health issue, rather than focusing on the disclosure of the condition, which is often unnecessary and can be distressing for the individual.

The **review of our overseas processes** continues into 2019–2020, but EDI was integral in the foundations of this review in 2018–2019. We held meetings with stakeholders, with a particular focus on the fairness and equalities compliance of our processes. The feedback from these expert groups informed our equality impact assessments and continues to influence our decisions as the programme of work progresses.

We have developed two cross-directorate EDI policy working groups – one on reasonable adjustments, and the other to explore the experiences of trans people as

they interact with our functions, whether they are a professional on our register or involved in another of our processes, such as a witness in a fitness to practise case.

Our **reasonable adjustments working group** has been working to identify any barriers disabled people face in accessing our services, and to ensure we are consistent in the way we anticipate and implement reasonable adjustments for our customers and employees.

Our **trans working group** is exploring the experiences that people who are gender minorities – whether they are trans, non-binary, intersex or identify in another way – have in their interactions with us. This activity will allow us to be confident we are compliant with relevant equality legislation, in particular when it comes to how we monitor, record and publish details of people on our register.

Another key improvement has been refining the categories we use for our **diversity data monitoring**. We have brought our categories up-to-date and in line with best practice guidance, ensuring that we do not create unnecessary barriers when it comes to asking people how they identify, and moving us forward in the collection of reliable, accurate data.

Fitness to practise

Work in this area includes the development of new ways of working in our fitness to practise processes. EDI was identified early as an integral part of this: 95 percent of respondents to our public consultation agreed that fitness to practise should support a professional culture that values equality, diversity and inclusion. This has given us a mandate to build inclusion into the very fabric of our new fitness to practise processes.

We believe that when nurses, midwives and nursing associates are treated fairly, regardless of their background or protected characteristics, they have the best possible chance to be open about their mistakes and to remediate effectively, which we know is vital for patient safety. Our new fitness to practise approach has provided us with an opportunity to remind all parties of their equality responsibilities, and to send a clear signal that bias has no place in making decisions about someone's fitness to practise. We also set an intention to use our influence to move towards a professional culture where we only receive the right referrals.

Part of this is ensuring our decision makers are representative, fair and unbiased. Our panel member recruitment campaign in 2018 was designed to attract a more diverse range of people and we saw increased interest from ethnic minority, younger and LGBT+ applicants. Around 23 percent of appointees from this campaign were ethnic minorities, increasing our total number of panel members who are ethnic minorities to 11 percent. Although there is still some way to go until the diversity of our panel members reflects the professions we regulate, we are pleased to have made demonstrable progress towards our aim.

All panel members received unconscious bias training and are required to complete our EDI e-learning. Our training programme for 2019–2020 focuses on the

importance of the people involved in our hearings and covers themes including identifying and supporting vulnerable parties, and making adjustments.

Our workforce

We want to be an employer of choice and attract the best candidates. We want our people to thrive and have the best employment experience while working with us. We know that for this to happen we need EDI to be at the heart of everything we do and embedded in our values.

EDI is a core strand within our People Strategy. We know that by excelling at EDI, embedding it into all elements of the employee lifecycle, we can have a positive impact on employee engagement. It is one of the ways that we can develop our employer brand, differentiating ourselves as an attractive employment proposition in an increasingly challenging, candidate-led market.

We are developing and implementing a three-year workforce EDI action plan that aims to address our inclusion issues with the following objectives:

1. Give people the tools to improve inclusion for all at the NMC (through training and support)
2. Develop a pool of resources (physical and virtual)
3. Increase the involvement of the people affected
4. Change policies and procedures to help us achieve better inclusion
5. Give support to people facing barriers
6. Gather and monitor more data to help us know our people better.

The plan mirrors the employee lifecycle (the journey of our colleagues from recruitment until they leave the organisation), in line with the key deliverables of our People Strategy. In 2018–2019 we focused on research to understand the issues, needs and find the best solutions. The time to implement and consolidate those solutions will be from 2019–2020 to 2020–2021, evaluating and reassessing as we go.

In 2018–2019 we made these improvements:

1. The number of people from ethnic minority backgrounds in management roles went up by 3.1 percentage points and this equated to 17 people
2. We climbed 140 places in this year's Stonewall Workplace Equality Index (WEI). The WEI is an annual audit of LGBT+ inclusion within organisations across the UK. It's used as benchmarking tool for employers to create a more inclusive workplace. In 2018, we were ranked 357 out of 434. This year, 445 organisations took part and we ranked 215
3. Our employee networks have grown and developed; the LGBT+ network (focusing on sexual orientation and gender identity) and the Cultural network (ethnic minorities) are valued partners and help us to review policies and procedures and give support to their members
4. More recently, the Workaround employee network was launched, challenging perceptions about disability.

We continue to monitor our measures of workforce engagement and training attendance. The completion rates for our basic EDI training courses were:

- 93 percent EDI e-learning completion rate (95 percent) in 2017/18)
- 77 percent EDI face-to-face attendance rate (85 percent) in 2017/18)

In addition we provide a range of learning and development opportunities, including but not limited to: discrimination law training for policy and legal teams, gender identity training for front-line teams, mental health awareness for fitness to practise teams and lunch-time talks (see below section on understanding people's diverse needs and identities).

Below are the scores from the EDI questions in our annual employee engagement survey. We highlight these scores (out of 10) as key measures for how our colleagues are engaging in the EDI framework. The survey shows a slight fall in our measures when compared year on year. The NMC is committed to being a great place to work and at the heart of that is treating people fairly and as inclusively as possible. We will continue to invest in EDI initiatives and will have a renewed focus in this area with agreement of a new internal EDI action plan in Q1 of 2019-20 which will demonstrate plans and commitment until 2021. This is the second year that these particular questions have been asked and we will continue to monitor the impact of our action plan against these questions in future years.

Employee engagement survey	2017	2018	+/-
I understand equality, diversity and inclusion and where it is relevant to my role	9.3	8.6	-0.7
I am aware of the NMC's valuing diversity policy	8.7	8.0	-0.7
People from all backgrounds are treated fairly at the NMC	7.4	7.2	-0.2
There is a real commitment at the NMC to continuing to improve performance on equality, diversity and inclusion.	7.2	7.6	+0.4
Overall EDI score	8.2	7.8	-0.4

Working with stakeholders

It's important to us that we are an outward-looking organisation that is committed to listening to people about their needs and experiences. We have continued to develop strong relationships with our diversity stakeholders, ensuring we are mutually informed of, and where possible involved in, each other's priorities and key developments.

We are members of several specialist EDI organisations, including the Business Disability Forum, Business in the Community's race campaign, the Employer's Network for Equality and Inclusion (ENEI) and Stonewall. In this reporting year we also became members of Mind and Inclusive Employers.

In October 2018 we presented findings from last year's EDI annual report to stakeholders from our membership bodies and other diversity contacts, inviting many of them to bring their own resources to share best practice information at the event. We also invited guests to help us shape our proposed 2019-20 EDI priorities at an early stage. This engagement and feedback was essential; for example, attendees encouraged us to focus on mental health and this feedback led to us including mental health in our external and workforce priorities for 2019–2020. We continued this conversation with our internal and external stakeholders with a survey in May 2019 about our 2019–2020 regulatory priorities and how to measure our progress.

In addition to other forms of engagement, over the past year we have organised several equality roundtables to inform our key policy work. These include one on our new approach to fitness to practise and one on our overseas review.

We also worked with stakeholders to provide learning opportunities for our staff. For example, we organised an event in collaboration with Mencap where people with learning disabilities shared their healthcare experiences with colleagues. This emotive and powerful event emphasised the need for us to slow down and listen more carefully, and the importance of empowering people to speak up about what they really need.

We continue to be active members of an inter-regulatory network of EDI professionals, allowing learning and best practice to be shared among all the key healthcare regulators. We also feed into the LGBT+ focused inter-regulatory group, meet with key influencers such as the LGBT+ lead in the Government Equalities Office, and our London offices were well-represented at the 2018 Pride parade.

Of key importance for us during this reporting year has been working with the Professional Standards Authority (PSA) in readiness for the approved new standard relating to EDI that we will pilot in the 2019–2020 period.

Improving our understanding of people's diverse needs and identities

When we say we recognise and respect the diverse needs and identities of people, we mean the people we regulate, the people we interact with, the people who work for and with us. We have taken steps to deepen our understanding of people's diverse identities and healthcare experiences – a crucial element in making sure we can be both an effective regulator which supports better and safer healthcare for everyone, and an employer of choice.

We completed more external benchmarks last year, to demonstrate transparency and receive appropriate external scrutiny of our EDI progress. For example, we submitted to Stonewall's Workplace Equality Index (WEI) for the second year running. We also took part in other benchmarks for the first time: the Business in the Community's race benchmark, socioeconomic mobility inclusion from the Social Mobility Foundation, and Mind's employee wellbeing index. At the beginning of 2019 we also started preparing our first submission to the Disability Standard benchmark by Business Disability Forum. Over the next few years we will be able to report on our progress.

To underpin our commitment to understanding and embracing diversity and tackling prejudice, we commissioned ENEI to deliver a programme of unconscious bias training. This mandatory course was initially designed for managers but has been rolled out across the organisation more widely. This additional training complements our existing mandatory e-learning and face-to-face EDI training course for all employees.

We have sought to improve our organisational empathy by arranging talks with diverse speakers. This has included a talk about life experiences as a non-binary person, a panel event on leadership and career progression for ethnic minority employees, a talk about the impact of living and working with mental health conditions, and the impact of race discrimination on people that are ethnic minorities in the healthcare context from Yvonne Coghill, Director of the Workforce Race Equality Standard (WRES) – a blog on this can be found on our website.

In particular, we have focused on deepening our awareness of the needs of gender minorities – including trans, non-binary and intersex people. We have produced factsheets and delivered in-depth training to frontline colleagues. We also responded to the Government Equality Office's 2018 consultation on proposals to update the 2004 Gender Recognition Act.

What's next?

We have made some tangible and positive progress in our EDI activities – but we aren't resting on our laurels. We're looking forward to sustained EDI improvements over the coming years.

In late 2018 we looked at evidence from data, research and complaints about what our 2019–2020 EDI priorities should be. As mentioned above, this included valuable insight gained from the 2018–2019 report launch event and subsequent survey. We felt that we should retain some of the 2018–2019 priorities as they will continue to provide an organisation-wide focus in the next year, for example our work on improving reasonable adjustments, while also adding new priorities areas.

The Executive Board agreed the following priorities for 2019–2020:

- Use our diversity data more to improve our decision-making.
- Use our reasonable adjustment policy when working with people with disabilities.
- Raise awareness of gender identity and how it affects our work.
- Work in partnership with others to encourage fair and non-biased referrals for all ethnic groups.
- Involve a more diverse range of stakeholders in our policy development.
- Share our understanding of health inequalities internally and externally.
- Improve our understanding of issues around mental health.

We will measure our progress against these priorities throughout 2019–2020.

Preparing for the NMC 2020–2025 strategy

A key EDI focus for 2019–2020 will be on the new **NMC 2020–2025 strategy**. We will work to embed EDI at the outset by listening to our diverse stakeholders and understanding where we can be effective in promoting EDI for our workforce, the nursing and midwifery professions and in all our interactions with the public. The development of the new strategy gives us an important opportunity to review and revise our EDI Framework so it's effective and relevant in the future healthcare environment for nurses, midwives, nursing associates, our employees, the public and anyone who interacts with us.

In support of developing our evidence base for the new strategy and in line with our 2019–2020 priorities we plan to make more use of our diversity data. In April 2017 we published research into disproportionate outcomes for some nurses and midwives (known as the Greenwich research). This report examined disproportionality in the progress and outcomes of black and minority ethnic (BME) nurses and midwives in relation to fitness to practise, from the point of referral to the point of case closure across the UK. We will be taking forward the commitment we made to repeat the analysis after the first cycle of revalidation was complete. We will also expand the research to look at more protected characteristics and all our regulatory functions so that we have a richer and more reliable picture.

Section 2: Our data

Key decision-makers

In this report we include information about the diversity of key decision-makers such as our Council members and fitness to practise panel members. We want to be transparent about how well people in these roles represent the professions we regulate and the wider community.

Council, committee and board 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, Investment Committee and an Appointments Board to support it in its role. Appointments Board members are not members of the Council. Diversity data is collected on appointment.

There were 17 members in office on 31 March 2019: 12 Council members and five members of the Appointments Board. Of the 17 members, 10 identify as women and seven as men. 16 members identify as heterosexual, with one preferring not to say. One member identifies as disabled. 16 members identify as white with one member from a BME background. In terms of age, all members are aged over 40. 10 members identify as Christian, five as having no religious beliefs and two preferring not to say.

Fitness to practise panellists

Fitness to practise (FtP) panellists are independent contractors engaged by the NMC to sit on our FtP panels.

Table 1: Fitness to practise panellists by gender

Gender	%	Register %	Population[2] %
Female	68.2	89.3	50.9
Male	27.7	10.7	49.1
Prefer not to say	4.2	-	-
Total	**100**	**100**	**100**

[2] Census - Office for National Statistics, Northern Ireland Statistics and Research Agency, National Records of Scotland

Table 2: Fitness to practise panellists by ethnic group

Ethnic group	%	Register %	Population[3] %
Black	3.9	8.3	3.4
Asian	4.4	8.5	7.5
Mixed	2.6	2.1	2.2
White	83.3	77.0	85.9
Other	1.3	0.9	1
Prefer not to say	3.9	1.9	-
Unknown	0.5	1.3	-
Total	**100**	**100**	**100**

Table 3: Fitness to practise panellists by sexual orientation

Sexual orientation	%	Register %	Population[4] %
Bisexual	0.8	0.6	0.8
Gay/Lesbian	4.4	1.7	1.2
Heterosexual	86.7	89.8	93.4
Other	-	-	0.5
Prefer not to say	8.1	6.6	4.1
Unknown	-	1.3	-
Total	**100**	**100**	**100**

Table 4: Fitness to practise panellists by age group

Age group	%	Register %	Population[5] %
18–30	0.8	14.2	17
31–40	6.0	22.1	13

[3] Ibid
[4] Sexual identity, UK; 2016; Office for National Statistics; https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/sexuality/bulletins/sexualidentityuk/2016 [accessed 23-05-19]
[5] ONS 2017 mid-year population estimates; https://data.london.gov.uk/dataset/ons-mid-year-population-estimates-custom-age-tables [accessed 06-06-19]

41–50	19.1	26.5	14
51–60	42.6	28.3	13
60+	28.5	8.8	22
Prefer not to say	3.1	-	-
Total	**100**	**100**	**80**[6]

Nurses, midwives and nursing associates

This section provides some of the diversity data that we hold about nurses, midwives and nursing associates 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 highlighted figures of particular interest.

In presenting 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 figures may add up to slightly over/under 100 percent.

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

What does our data tell us about those on the register?

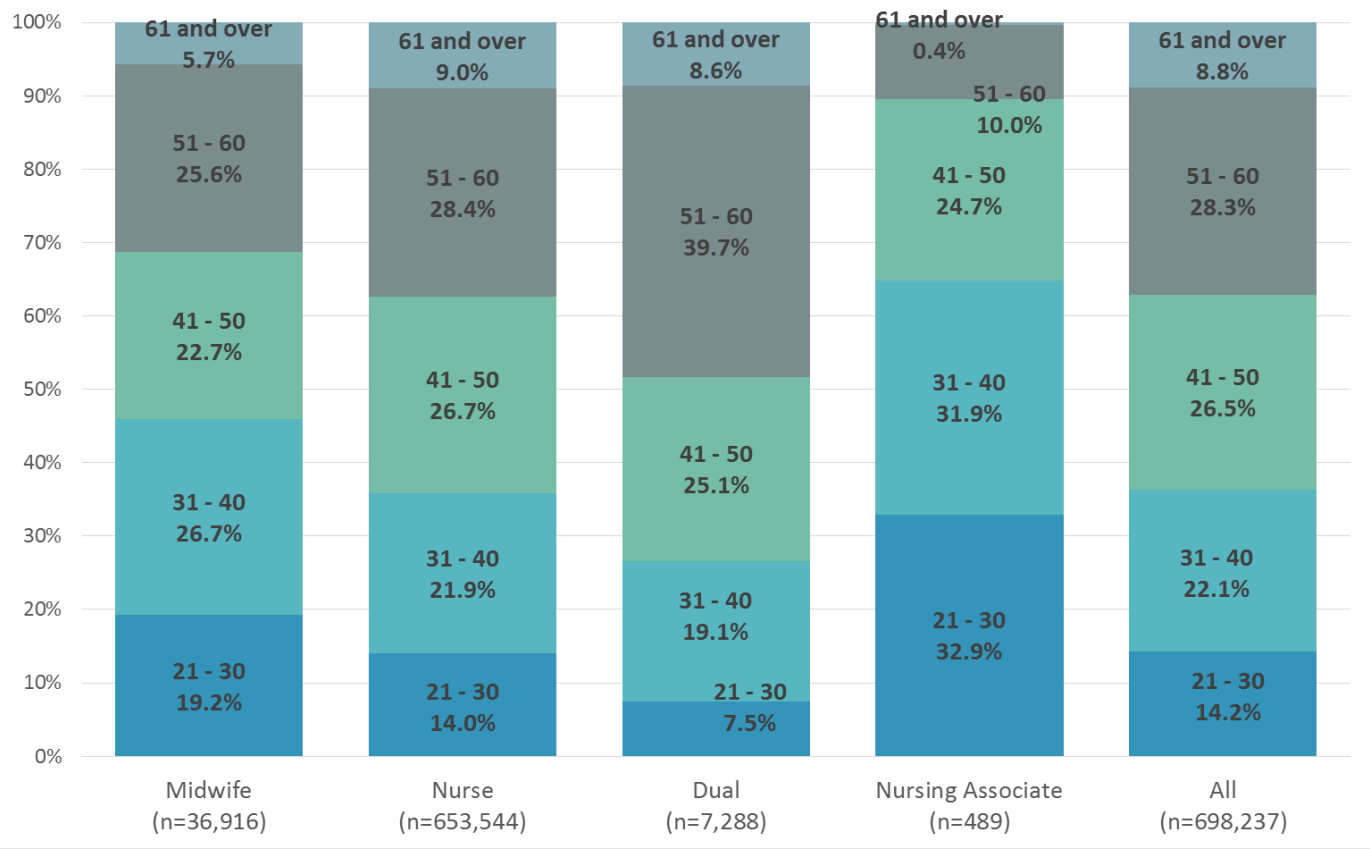
Most of the people on our register (around 94 percent) are nurses. This has remained unchanged since 2015. Since last year one notable change is the addition of a new profession and on 31 March 2019 there were 489 nursing associates on the register.

Looking at the registration data, some notable differences are that midwives are a younger group than nurses. People with dual registration (that is, people who are registered as both a nurse *and* a midwife) are the oldest group (40 percent of these are in the 51–60 age group) [Figure 1]. This is likely to be linked to the fact that before direct entry midwifery courses[7] started all midwives had to train as nurses first so many dual registrants will date from that time. The number of dual registrants has decreased by 7 percent since last year (from 7,811 to 7,288). This may be due to the fact that we are encouraging people to renew only the registration(s) in which they are practising when they revalidate.

The first cohort of nursing associates joined our register in January 2019. As we might expect with such a new role compared to the people that have been on the register with longer career lengths, this is a relatively young group with nearly 65 percent of nursing associates aged under 40 years.

[6] This total figure does not include people under the age of 18 in the UK population.
[7] Direct entry midwifery training has been available from different dates in each of the four countries.

Figure 1: Age groups of nurses, midwives, dual registrants and nursing associates

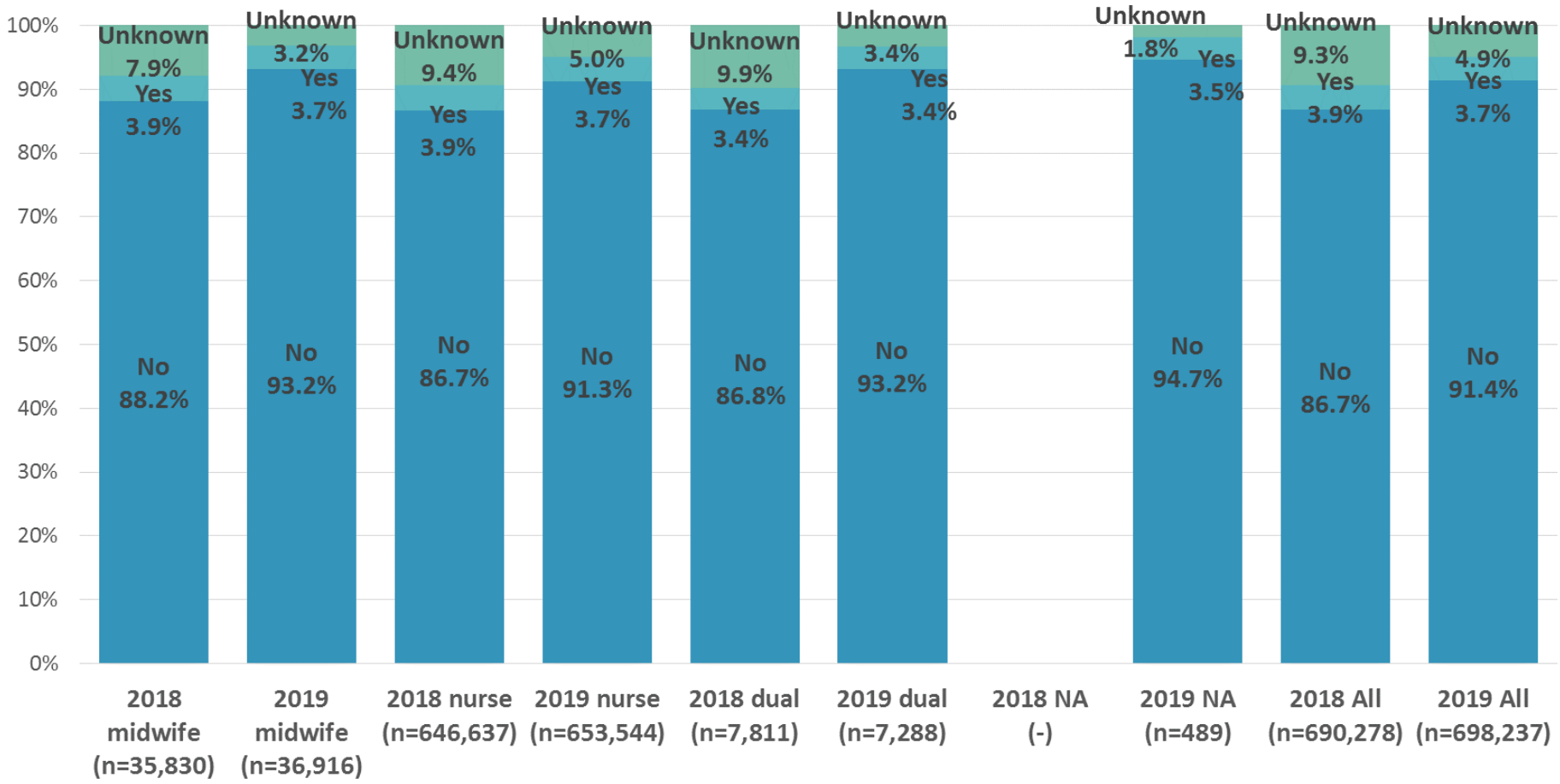


The completeness of the disability data has improved since last year's report. The number of people whose disability status is unknown has reduced from over 64,000 to around 34,000 in 2018–2019 [Table 5]. The number of people who identify as having a disability has decreased from 27,035 in 2017–2018 to 25,782 in 2018–2019– Figure 2 below shows that the proportion of people who identify as having a disability has reduced from 3.9 to 3.7 percent.

Table 5: Disability status of nurses, midwives, dual registrants and nursing associates

	No	Yes	Unknown	Total
2017 midwife	27,098	1,704	5,752	**34,554**
2018 midwife	31,599	1,394	2,837	**35,830**
2019 midwife	34,395	1,349	1,172	**36,916**
2017 nurse	497,601	33,345	116,659	**647,605**
2018 nurse	560,423	25,378	60,836	**646,637**
2019 nurse	596,612	24,167	32,765	**653,544**
2017 dual	6,602	334	1,678	**8,614**
2018 dual	6,777	263	771	**7,811**
2019 dual	6,792	249	247	**7,288**
2019 NA	463	17	9	**489**
2017 all	**531,301**	**35,383**	**124,089**	**690,773**
2018 all	**598,799**	**27,035**	**64,444**	**690,278**
2019 all	**638,262**	**25,782**	**34,193**	**698,237**

Figure 2: Disability of nurses, midwives and dual registrants



The data shows that nurses are more ethnically diverse than midwives, and dual registrants are the most ethnically diverse group of all [Table 6]. This was the same last year. Overall, 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 registrants who identify as white – English/Welsh/Scottish/Northern Irish/British increased in all registration types from 2017–2018 to 2018–2019: midwives from 80 percent to 84 percent, nurses from 67 percent to 70 percent, and dual registration from 60 percent to 64 percent.

Table 6: Ethnic groups on the register (numbers and percentages)

	Midwife	Nurse	Dual	NA	Total
Asian - Asian - Indian	217 (0.6%)	22,543 (3.4%)	62 (0.9%)	10 (2.0%)	**22,832 (3.3%)**
Asian - Asian - Pakistani	179 (0.5%)	3,388 (0.5%)	21 (0.3%)	3 (0.6%)	**3,591 (0.5%)**
Asian - Asian - Bangladeshi	55 (0.1%)	925 (0.1%)	5 (0.1%)	1 (0.2%)	**986 (0.1%)**
Asian - Asian - Chinese	101 (0.3%)	2,258 (0.3%)	37 (0.5%)	-	**2,396 (0.3%)**
Asian - other background	127 (0.3%)	29,175 (4.5%)	54 (0.7%)	23 (4.7%)	**29,379 (4.2%)**
Black African	772 (2.1%)	44,548 (6.8%)	1,091 (15.0%)	23 (4.7%)	**46,434 (6.7%)**
Black Caribbean	631 (1.7%)	9,491 (1.5%)	327 (4.5%)	13 (2.7%)	**10,462 (1.5%)**
Black - other	42 (0.1%)	1,209 (0.2%)	20 (0.3%)	-	**1,271 (0.2%)**

	Midwife	Nurse	Dual	NA	Total
background					
Mixed - white and Asian	133 (0.4%)	2,074 (0.3%)	28 (0.4%)	1 (0.2%)	**2,236 (0.3%)**
Mixed - white and black African	72 (0.2%)	1,982 (0.3%)	25 (0.3%)	3 (0.6%)	**2,082 (0.3%)**
Mixed - white and black Caribbean	459 (1.2%)	6,909 (1.1%)	77 (1.1%)	4 (0.8%)	**7,449 (1.1%)**
Mixed - other background	146 (0.4%)	2,550 (0.4%)	28 (0.4%)	2 (0.4%)	**2,726 (0.4%)**
White - English/Welsh/Scottish/Northern Irish	31,153 (84.4%)	454,836 (69.6%)	4,625 (63.5%)	376 (76.9%)	**490,990 (70.3%)**
White - Irish	658 (1.8%)	12,509 (1.9%)	239 (3.3%)	-	**13,406 (1.9%)**
White - Gypsy or Irish Traveller	11 (<0.1%)	274 (<0.1%)	5 (0.1%)	-	**290 (<0.1%)**
White - other background	1,531 (4.1%)	30,887 (4.7%)	454 (6.2%)	22 (4.5%)	**32,894 (4.7%)**
Any other ethnic group	153 (0.4%)	6,246 (1.0%)	36 (0.5%)	3 (0.6%)	**6,438 (0.9%)**
Prefer not to say	402 (1.1%)	13,066 (2.0%)	138 (1.9%)	5 (1.0%)	**13,611 (1.9%)**

	Midwife	Nurse	Dual	NA	Total
Unknown	74 (0.2%)	8,674 (1.3%)	16 (0.2%)	-	**8,764 (1.3%)**
Total	**36,916 (100%)**	**653,544 (100%)**	**7,288 (100%)**	**489 (100%)**	**698,237 (100%)**

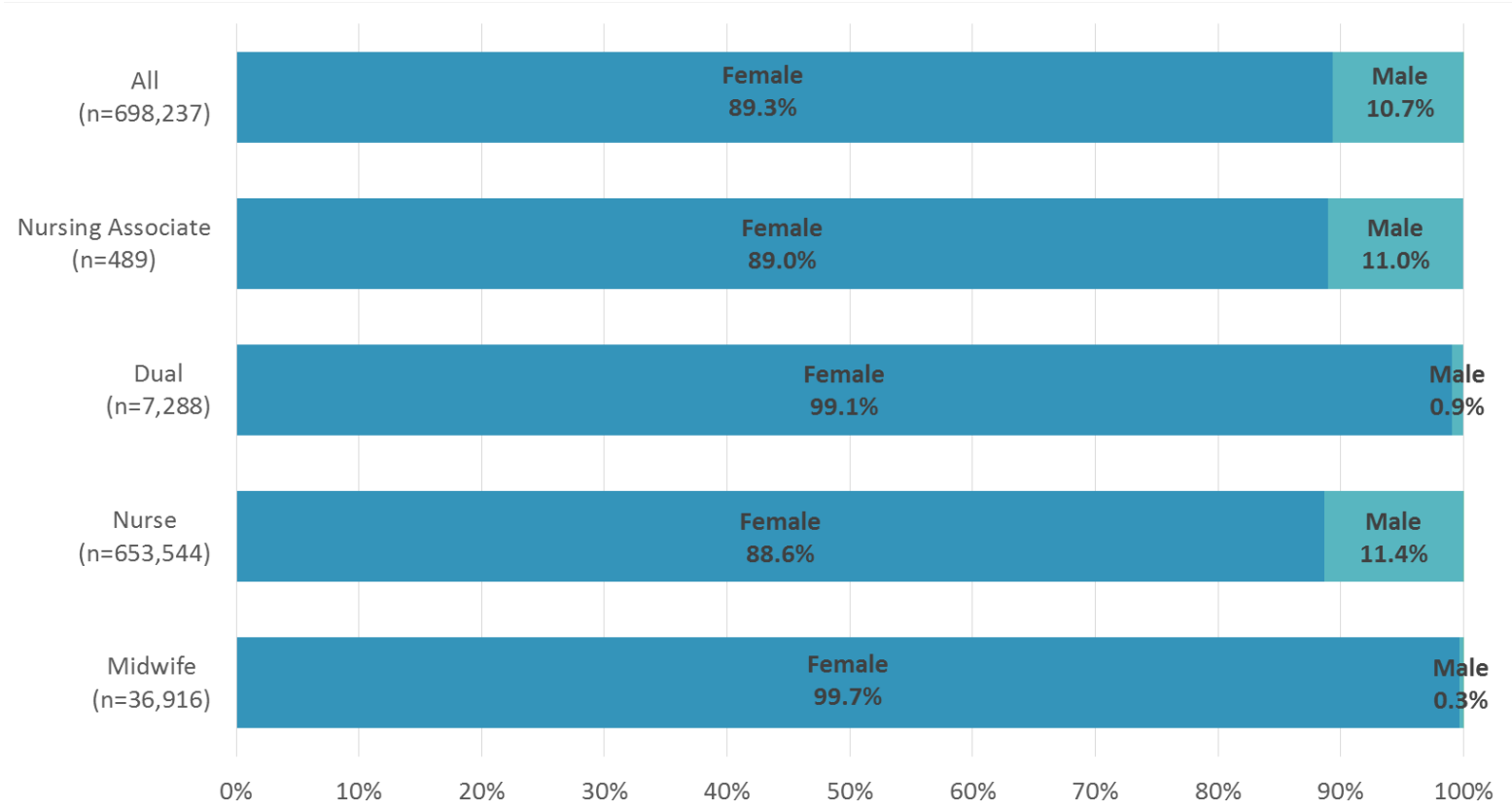
Most nurses and midwives who answered the question, 'does your gender identity completely match the sex you were registered with at birth?' confirmed that these matched. However, 4,457 (0.6 percent) said that they did not, which is a similar proportion to last year (but an increase of 668 because more people answered the question). There were a further 3.4 percent who preferred not to say, and 1.5 percent who were unknown.

Looking at religion or belief, notable differences include 34 percent of midwives who say they have no religion or belief compared with 24 percent of nurses and 18 percent of those with dual registration. In the small group of nursing associates on the register on 31 March 2019, 38 percent had no religion or belief. 56 percent of midwives identify as Christian compared with 62 percent of nurses and 72 percent of those with dual registration. In the nursing associate group, 54 percent identify as Christian.

Since the 2016–2017 report, the percentage of all registrant types saying they have no religion has increased steadily: midwives (26 percent in 2016–2017 to 34 percent in 2018–2019), nurses (19 percent in 2016–2017 to 24 percent 2018–2019), dual registrants (14 percent in 2016–2017 to 18 percent in 2018–2019). At the same time, the proportion of all registrants identifying as Christian is also increasing, with the biggest increase amongst dual registrants: midwives (51 percent in 2016–2017 to 56 percent in 2018–2019), nurses (54 percent in 2016–2017 to 62 percent in 2018-2019) and dual registrants (60 percent in 2016–2017 to 72 percent in 2018–2019). These increases are likely to be at least in part due to the number of people in the unknown category going down overall.

The Figure below shows that there are differences in the gender breakdown between the registration types. 99.7 percent of midwives are women compared with 89 percent of nurses, 99 percent of those with dual registration and 89 percent of nursing associates. The proportion of men and women has remained the same since 2013, with men underrepresented in midwifery and dual registration compared to the UK population.

Figure **3: Gender on the register**



0.7 percent of midwives identify as gay or lesbian compared with 1.8 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 (from 5.8 percent to 1.3 percent of all those on the register).

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 to reduce the chances of people being identified.

Some trends follow through all the sections. For example, we know that men 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.

Our historical data reflects the same trends. For example, men have made up a larger proportion of new concerns in fitness to practise than they do on the register as a whole since the 2013–2014 report (2013–2014: 24 percent, 2014–2015: 21 percent, 2015–2016: 23 percent, 2016–2017: 24 percent, 2017–2018: 23 percent, and 2018–2019: 23 percent). Men have been more likely to get interim suspension orders and women more likely to get interim conditions of practice orders since 2016 when we started reporting the data in this format. Similarly, men continue to be more likely to be struck off since we started reporting the figures in 2013.

We did some further analysis to compare this year's data with previous years, where the data allows us to[8] and where doing so illustrates continuing or divergent trends.

New concerns

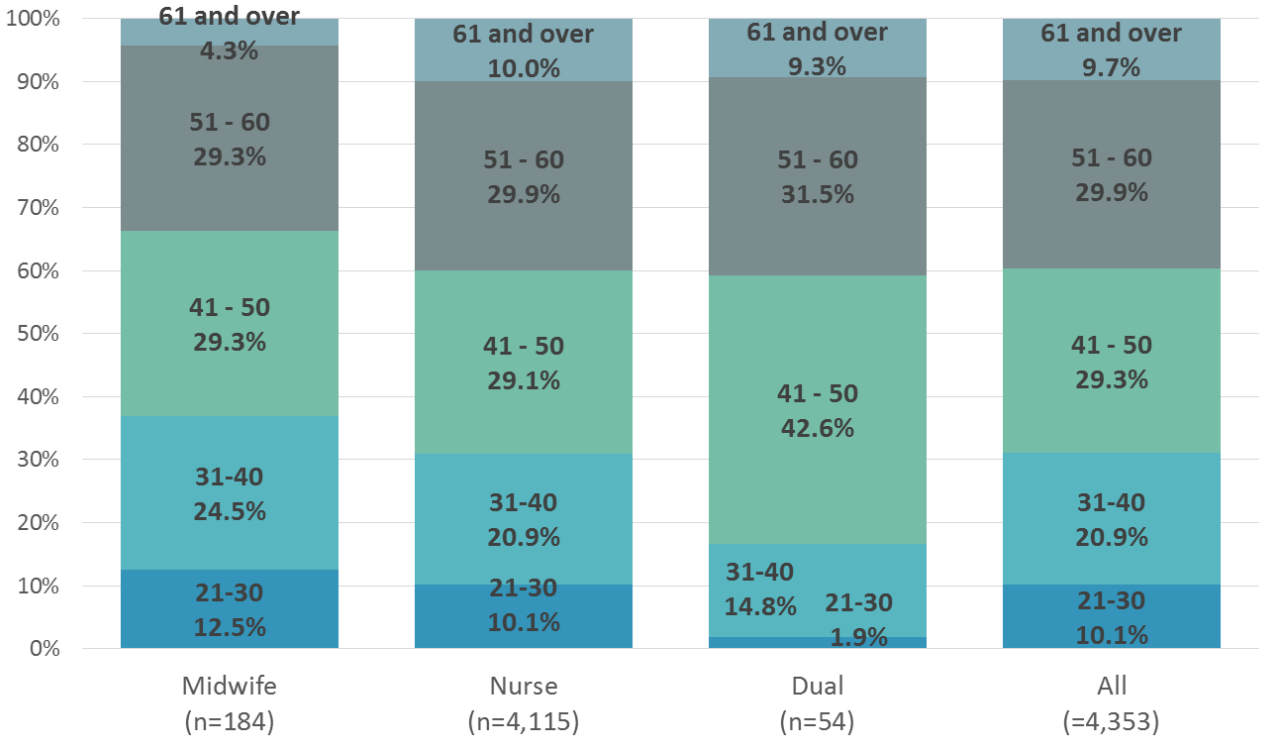
This section details the diversity data for the 4,353 new concerns where we opened a case between April 2018 and March 2019 and where the person referred was identified as being an NMC registrant.

We were not able to identify a registered nurse or midwife in 1,020 of the new cases raised with us. Some of those are cases we received at the end of the reporting period and would not have identified the nurse or midwife until after the reporting period. Others are cases where we do not have the authority to act because they do not relate to a registered nurse or midwife. The data in the charts below are for those individuals who had been identified as nurses or midwives by 31 March 2019.

The figures in this report are in line with the figures in our annual fitness to practise report 2018–2019 which reports on the 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.

[8] Most findings are compared back to 2016. Before this point, data and fitness to practise outcomes were collected and reported differently, preventing comparison.

Figure 4: New concerns by age group

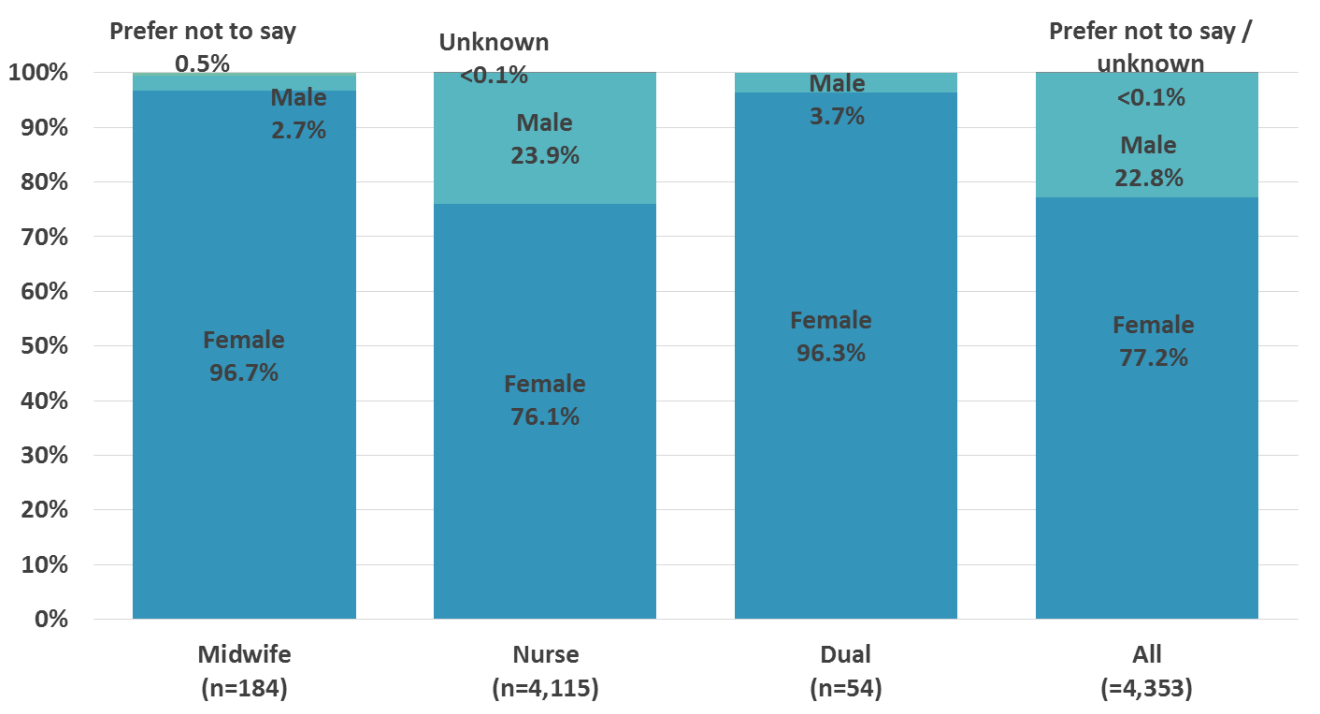


Comparing everyone on our register (Figure 4) to the data on new concerns for NMC registrants, we can see that nurses and midwives being referred are slightly more likely to come from older age groups.

For example, although 19 percent of midwives are in the 21–30 age group, only 13 percent of new concerns for midwives were about people in this age group. Similarly, 10 percent of new concerns about nurses were about people aged 21–30, although 14 percent of nurses are in this age group.

Conversely, 29 percent of new concerns raised about midwives relate to people in the 51–60 age group, while only 26 percent of the midwives are in this age group.

Figure 5: New concerns by gender



Overall, 24 percent of new concerns were for men, compared with being 11

percent on the register. Across all registration types more men are referred than we would expect, given their proportion on the register.

Since 2017 we have reported fitness to practise outcomes by ethnicity broken down into all 18+1[9] of the 2001 census categories. The proportion of unknown ethnicity has decreased from 8 percent of new concerns in 2017–2018 to 3 percent of new concerns in 2018–2019.

Table 7: New concerns by ethnic group

	Midwife	Nurse	Dual	All	Register
Asian - Asian - Indian	1 (0.5%)	127 (3.1%)	1 (1.9%)	**129 (3.0%)**	**22,832 (3.3%)**
Asian - Asian - Pakistani	3 (1.6%)	41 (1.0%)	-	**44 (1.0%)**	**3,591 (0.5%)**
Asian - Asian - Bangladeshi	-	10 (0.2%)	-	**10 (0.2%)**	**986 (0.1%)**

[9] In the ONS census there are five 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	Register
Asian - Asian - Chinese	-	14 (0.3%)	-	**14 (0.3%)**	**2,396 (0.3%)**
Asian - other background	1 (0.5%)	138 (3.4%)	-	**139 (3.2%)**	**29,379 (4.2%)**
Black African	7 (3.8%)	521 (12.7%)	12 (22.2%)	**540 (12.4%)**	**46,434 (6.7%)**
Black Caribbean	6 (3.3%)	72 (1.7%)	4 (7.4%)	**82 (1.9%)**	**10,462 (1.5%)**
Black - other background	-	13 (0.3%)	-	**13 (0.3%)**	**1,271 (0.2%)**
Mixed - white and Asian	1 (0.5%)	17 (0.4%)	-	**18 (0.4%)**	**2,236 (0.3%)**
Mixed - white and black African	-	24 (0.6%)	1 (1.9%)	**25 (0.6%)**	**2,082 (0.3%)**
Mixed - white and black Caribbean	4 (2.2%)	53 (1.3%)	2 (3.7%)	**59 (1.4%)**	**7,449 (1.1%)**
Mixed - other background	3 (1.6%)	24 (0.6%)	-	**27 (0.6%)**	**2,726 (0.4%)**
White - English/Welsh/Scottish/Northern Irish	134 (72.8%)	2,496 (60.7%)	27 (50.0%)	**2,657 (61.0%)**	**490,990 (70.3%)**
White - Irish	4 (2.2%)	64 (1.6%)	2 (3.7%)	**70 (1.6%)**	**13,406 (1.9%)**
White - Gypsy or Irish Traveller	-	-	1 (1.9%)	**1 (<0.1%)**	**290 (<0.1%)**
White - other background	10 (5.4%)	211 (5.1%)	2 (3.7%)	**223 (5.1%)**	**32,894 (4.7%)**

	Midwife	Nurse	Dual	All	Register
Any other ethnic group	3 (1.6%)	60 (1.5%)	-	**63 (1.4%)**	**6,438 (0.9%)**
Prefer not to say	6 (3.3%)	116 (2.8%)	2 (3.7%)	**124 (2.8%)**	**13,611 (1.9%)**
Unknown	1 (0.5%)	114 (2.8%)	-	**115 (2.6%)**	**8,764 (1.3%)**
Total	**184 (100%)**	**4,115 (100%)**	**54 (100%)**	**4,353 (100%)**	**698,237 (100%)**

We have only made comparisons where the numbers are large enough to make valid comparisons.

This year's data (Table 7) continues to echo 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*. It shows that people of white British ethnicity are less likely to be referred than expected given their proportion on the register (61 percent of referrals compared to 70 percent on the register in Table 6). People of black African ethnicity are more likely to be referred (12 percent of referrals) than expected given their proportion on the register (7 percent of people on the register). This mirrors the findings since the 2016–2017 report.

Table 8: New concerns by sexual orientation
Due to small numbers, this table presents only the percentages to ensure individuals can't be identified.

	Midwife %	Nurse %	Dual %	All %
Bisexual	1.1	1.1	-	**1.1**
Gay or lesbian	1.6	3.2	-	**3.1**
Heterosexual or straight	91.3	85.5	96.3	**85.9**
Prefer not to say	5.4	7.4	3.7	**7.3**
Unknown	0.5	2.8	-	**2.7**
Total	**100**	**100**	**100**	**100**

The number of people that we had new concerns for with unknown and prefer not to say sexual orientation has continued to reduce from 15 percent last year to 10 percent this year. This is slightly higher than the proportion on the register (7.9 percent).

Interim orders

This section on interim orders (IOs) analyses 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 broken down by protected characteristics. The number of cases considered for an IO has dropped considerably from 666 in 2017–2018 to 575 in 2018–2019, which is a 14 percent decrease, but the percentage breakdown of outcomes is similar to last year.

Table 9: Interim orders by age group

	21 - 30	31 - 40	41 - 50	51 - 60	61 and over	Total
Interim order not necessary	2 (3.8%)	17 (13.4%)	20 (13.8%)	20 (11.2%)	10 (13.9%)	**69 (12.0%)**
Interim conditions of practice order	25 (47.2%)	54 (42.5%)	62 (42.8%)	93 (52.2%)	34 (47.2%)	**268 (46.6%)**
Interim suspension order	26 (49.1%)	56 (44.1%)	63 (43.4%)	65 (36.5%)	28 (38.9%)	**238 (41.4%)**
Total	**53 (100.0%)**	**127 (100.0%)**	**145 (100.0%)**	**178 (100.0%)**	**72 (100.0%)**	**575 (100.0%)**

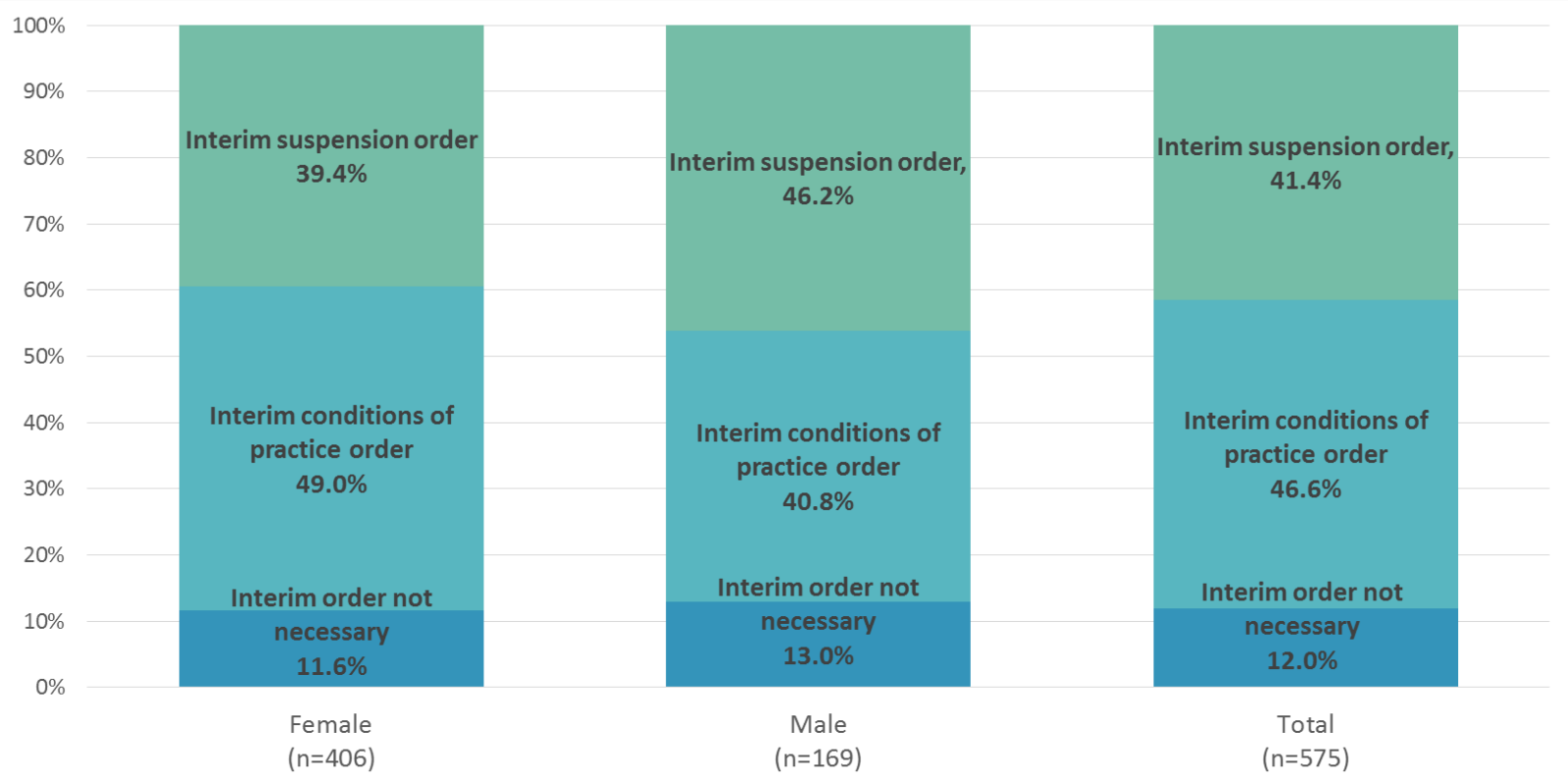
Note the different sizes of the age groups. The table shows that those in the 21–30 age group had the lowest proportion of cases considered for an IO where it was considered that an IO was not necessary. Conversely, the 21–30 age group have the highest proportion of interim suspension orders. The 51–60 group have the highest proportion of interim conditions of practice orders and the lowest proportion of interim suspension orders.

Table 10: Interim orders by ethnic group

	Asian	Black	Mixed	White	Any other ethnic group	Prefer not to say / unknown	Total
Interim order not necessary	5 (13.5%)	18 (18.2%)	2 (12.5%)	36 (9.8%)	3 (25.0%)	5 (11.9%)	**69 (12.0%)**
Interim conditions of practice order	20 (54.1%)	47 (47.5%)	7 (43.8%)	176 (47.7%)	5 (41.7%)	13 (31.0%)	**268 (46.6%)**
Interim suspension order	12 (32.4%)	34 (34.3%)	7 (43.8%)	157 (42.5%)	4 (33.3%)	24 (57.1%)	**238 (41.4%)**
Total	**37 (100.0%)**	**99 (100.0%)**	**16 (100.0%)**	**369 (100.0%)**	**12 (100.0%)**	**42 (100.0%)**	**575 (100.0%)**

Although we have amalgamated the ethnic categories to these higher level groups there are still few cases for many groups so we will only make comparisons between groups with larger numbers. Black people have a higher proportion of 'interim order not necessary' decisions than white people. Conversely, black people have a lower proportion of interim suspension orders. People whose ethnic group is unknown or prefer not to say, are most likely to have the most serious outcome – 'interim suspension order', which is in line with the findings for case examiner decisions and hearing outcomes. This could be because people who don't 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.

Figure 6: Interim orders by gender



The Figure 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. This is similar to the breakdowns by gender from last year.

Of the 575 IO decisions made, 29 percent were for male nurses and midwives. This is substantially 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 outcomes:

- No case to answer (NCTA) – separated into facts not proved and no further action
- No case to answer – advice issued
- No case to answer – warning issued
- Case to answer – undertakings
- Case to answer (CTA) referred to a hearing

The data in this section have 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. When looking at the figures in this section please note that there are considerably fewer cases going to case examiner stage than last year – a reduction from 2,234 to 1,638 (a decrease of 27 percent). The proportions who are receiving a warning or an undertaking have gone up since last year because advice, warnings and undertakings only started in July 2017.

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 11: Case examiner decisions by age group

Decisions	21-30	31-40	41-50	51-60	61 and over	Total
NCTA – Facts not proved	24 (20.0%)	44 (15.9%)	87 (18.4%)	102 (18.6%)	40 (18.1%)	**297 (18.1%)**
NCTA – No further action	45 (37.5%)	125 (45.3%)	177 (37.3%)	223 (40.8%)	96 (43.4%)	**666 (40.7%)**
NCTA – Advice issued	-	2 (0.7%)	2 (0.4%)	7 (1.3%)	1 (0.5%)	**12 (0.7%)**
NCTA – Warning issued	8 (6.7%)	19 (6.9%)	35 (7.4%)	33 (6.0%)	7 (3.2%)	**102 (6.2%)**

Decisions	21-30	31-40	41-50	51-60	61 and over	Total
CTA – Recommend Undertakings	3 (2.5%)	9 (3.3%)	11 (2.3%)	14 (2.6%)	4 (1.8%)	**41 (2.5%)**
CTA – Refer to FtP committee	40 (33.3%)	77 (27.9%)	162 (34.2%)	168 (30.7%)	73 (33.0%)	**520 (31.7%)**
Total	**120 (100.0%)**	**276 (100.0%)**	**474 (100.0%)**	**547 (100.0%)**	**221 (100.0%)**	**1,638 (100.0%)**

The differences by age group that were apparent last year (a smaller proportion of older age groups had a CTA) have not been replicated this year.

Table 12: Case examiner decisions by disability

Decision	No	Yes	Prefer not to say	Unknown	Total
NCTA – Facts not proved	242 (18.0%)	25 (20.7%)	16 (17.2%)	14 (17.1%)	**297 (18.1%)**
NCTA – No further action	568 (42.3%)	39 (32.2%)	46 (49.5%)	13 (15.9%)	**666 (40.7%)**
NCTA – Advice issued	12 (0.9%)	-	-	-	**12 (0.7%)**
NCTA – Warning issued	89 (6.6%)	6 (5.0%)	4 (4.3%)	3 (3.7%)	**102 (6.2%)**
CTA – Recommend Undertakings	31 (2.3%)	7 (5.8%)	2 (2.2%)	1 (1.2%)	**41 (2.5%)**

Decision	No	Yes	Prefer not to say	Unknown	Total
CTA – Refer to FtP committee	400 (29.8%)	44 (36.4%)	25 (26.9%)	51 (62.2%)	**520 (31.7%)**
Total	**1,342 (100.0%)**	**121 (100.0%)**	**93 (100.0%)**	**82 (100.0%)**	**1,638 (100.0%)**

The table above shows that disabled nurses and midwives have a higher proportion of CTA – Refer to fitness to practise committee decisions (36 percent) than people without a disability (30 percent). Also, the proportion of people with unknown disability status who have a CTA – Refer to fitness to practise committee decision is high at 62 percent. This is similar to last year where 60 percent of people with unknown disability status had CTA – Refer to fitness to practise committee decision.

Table 13: Case examiner decisions by ethnicity

Decision	Asian	Black	Mixed	White	Any other ethnic group	Prefer not to say / unknown	Total
NCTA – Facts not proved	19 (16.7%)	48 (16.6%)	6 (11.5%)	195 (19.0%)	5 (17.9%)	24 (18.6%)	**297 (18.1%)**
NCTA – No further action	54 (47.4%)	132 (45.5%)	25 (48.1%)	414 (40.4%)	11 (39.3%)	30 (23.3%)	**666 (40.7%)**
NCTA – Advice issued	2 (1.8%)	1 (0.3%)	1 (1.9%)	8 (0.8%)	-	-	**12 (0.7%)**
NCTA – Warning issued	5 (4.4%)	22 (7.6%)	4 (7.7%)	60 (5.9%)	2 (7.1%)	9 (7.0%)	**102 (6.2%)**
CTA – Recommend Undertakings	1 (0.9%)	9 (3.1%)	1 (1.9%)	29 (2.8%)	-	1 (0.8%)	**41 (2.5%)**

Decision	Asian	Black	Mixed	White	Any other ethnic group	Prefer not to say / unknown	Total
CTA – Refer to FtP committee	33 (28.9%)	78 (26.9%)	15 (28.8%)	319 (31.1%)	10 (35.7%)	65 (50.4%)	**520 (31.7%)**
Total	**114 (100%)**	**290 (100%)**	**52 (100%)**	**1,025 (100%)**	**28 (100%)**	**129 (100%)**	**1,638 (100%)**

We have looked at the ethnicity figures using the broader groupings of: white, Asian, black, mixed and other. It is important to note that the ethnic groups here have very different sizes, for example there are only 52 in the mixed ethnic group, compared with 1,025 in the white ethnic group.

The differences between groups here are small. White people have a slightly lower proportion of NCTA – No further action outcomes than groups such as Asian people, black people and people of mixed ethnicity, which is a similar picture to last year.

Similar to the hearings section, people who have prefer not to say/unknown ethnicity have the highest proportion of the most serious outcome, CTA – Refer to fitness to practise committee, as was the case last year. As noted previously about people in the unknown category, this could be because people who don't 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.

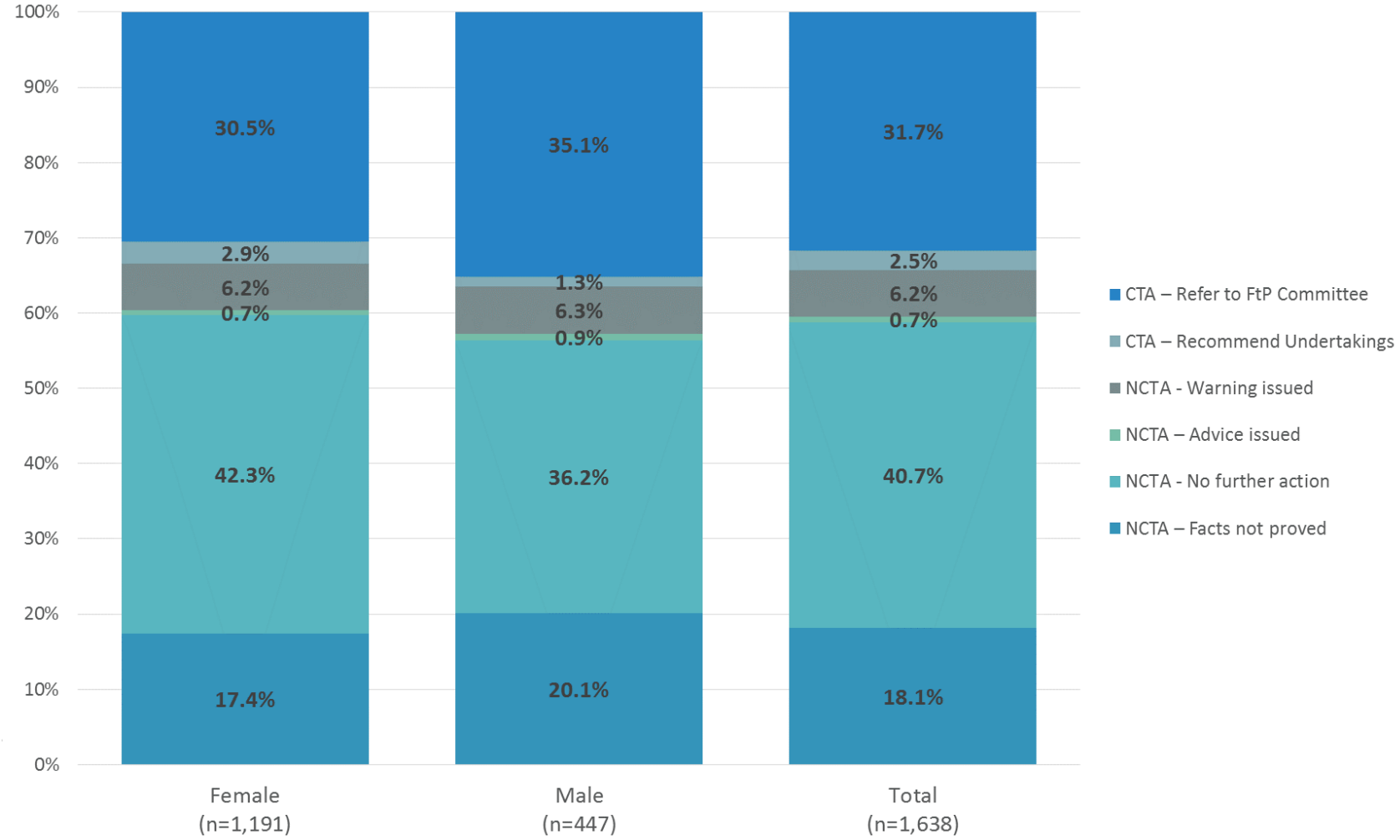
The case examiner decisions for the ethnic groups with the largest numbers of cases from the lower level 18+1[10] ethnic group categories are presented in the table below. The ethnic groups that have proportionately more NCTA (facts not proved and no further action taken) decisions are Asian Indian (66 percent) and black African (63 percent). Of the nurses and midwives with unknown ethnicity 33 percent of decisions were NCTA – Facts not proved and no further action taken compared with the relatively high 63 percent CTA – Recommend undertakings and refer to a fitness to practise committee decisions.

[10] In the ONS census there are five 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 14: 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 (n=1,638)
NCTA – Facts not proved	6 (15.8%)	10 (16.4%)	45 (17.7%)	162 (17.9%)	29 (27.1%)	10 (21.3%)	14 (17.1%)	**297 (18.1%)**
NCTA – No further action	19 (50.0%)	30 (49.2%)	115 (45.3%)	364 (40.3%)	44 (41.1%)	17 (36.2%)	13 (15.9%)	**666 (40.7%)**
NCTA – Advice issued	1 (2.6%)	1 (1.6%)	1 (0.4%)	8 (0.9%)	-	-	-	**12 (0.7%)**
NCTA – Warning issued	3 (7.9%)	2 (3.3%)	15 (5.9%)	56 (6.2%)	3 (2.8%)	6 (12.8%)	3 (3.7%)	**102 (6.2%)**
CTA – Recommend Undertakings	-	-	8 (3.1%)	25 (2.8%)	4 (3.7%)	-	1 (1.2%)	**41 (2.5%)**
CTA – Refer to FtP committee	9 (23.7%)	18 (29.5%)	70 (27.6%)	288 (31.9%)	27 (25.2%)	14 (29.8%)	51 (62.2%)	**520 (31.7%)**
Total	**38 (100%)**	**61 (100%)**	**254 (100%)**	**903 (100%)**	**107 (100%)**	**47 (100%)**	**82 (100%)**	**1,638 (100%)**

Figure 7: Case examiner decisions by gender



ionately more
ortions of CTA

Some of the diversity data that we hold about nurses and midwives that go to hearings is sensitive data and can't 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

There are fewer cases that are reaching the hearing stage overall (661 compared to 1,207 last year), and also lower proportions of fitness to practise not impaired outcomes (14 percent this year compared with 23 percent last year). A key part of our new approach to fitness to practise was to deal with less serious cases at an earlier stage (for example, with advice, warnings or undertakings) and this would have contributed to the lower proportion of serious cases getting to the hearings stage.

Table 15: Hearing outcome by age group

Outcome	21-30	(%) in 2017/18	31-40	(%) in 2017/18	41-50	(%) in 2017/18	51-60	(%) in 2017/18	61 and over	(%) in 2017/18	Total
FNP	-	-	3 (3%)	-	9 (4%)	(0.3%)	5 (2%)	(0.7%)	-	**(1.2%)**	**17 (3%)**
FTPNI	6 (12%)	(10%)	12 (10%)	(22%)	27 (13%)	(23%)	38 (18%)	(23%)	12 (16%)	**(31%)**	**95 (14%)**
CO	2 (4%)	(12%)	8 (7%)	(10%)	20 (10%)	(10%)	24 (11%)	(12%)	3 (4%)	**(8%)**	**57 (9%)**
CPO	11 (22%)	(22%)	12 (10%)	(16%)	33 (16%)	(13%)	36 (17%)	(13%)	7 (9%)	**(12%)**	**99 (15%)**
SO	21 (42%)	(36%)	39 (34%)	(34%)	72 (35%)	(31%)	72 (34%)	(30%)	27 (36%)	**(28%)**	**231 (35%)**
SOO	10 (20%)	(20%)	42 (36%)	(18%)	44 (22%)	(23%)	39 (18%)	(22%)	27 (36%)	**(19%)**	**162 (25%)**

Outcome	21-30	(%) in 2017/18	31-40	(%) in 2017/18	41-50	(%) in 2017/18	51-60	(%) in 2017/18	61 and over	(%) in 2017/18	Total
Total	**50 (100%)**	**(100%)**	**116 (100%)**	**(100%)**	**205 (100%)**	**-**	**214 (100%)**	**-**	**76 (100%)**		**661 (100%)**

Those aged 31–40 and the 61 and over have higher proportions of striking off orders, with over one-third of cases for these groups receiving this sanction.

Table 16: Hearing outcome by disability

	No	Yes	Prefer not to say	Unknown	Total
FNP	16 (3.4%)	1 (1.7%)	-	-	**17 (2.6%)**
FTPNI	84 (17.7%)	6 (10.3%)	2 (5.4%)	3 (3.3%)	**95 (14.4%)**
CO	48 (10.1%)	5 (8.6%)	4 (10.8%)	-	**57 (8.6%)**
CPO	63 (13.3%)	15 (25.9%)	7 (18.9%)	14 (15.2%)	**99 (15.0%)**
SO	157 (33.1%)	20 (34.5%)	14 (37.8%)	40 (43.5%)	**231 (34.9%)**
SOO	106 (22.4%)	11 (19.0%)	10 (27.0%)	35 (38.0%)	**162 (24.5%)**
Total	**474 (100%)**	**58 (100%)**	**37 (100%)**	**92 (100%)**	**661 (100%)**

Table 16 shows that disabled nurses and midwives were more likely to receive a conditions of practice order (26 percent of disabled people compared to 13 percent for non-disabled people). This is a higher proportion of disabled people than last year (21 percent of disabled people compared to 13 percent for non-disabled people). Non-disabled people had proportionately more decisions that their fitness was not impaired (18 percent of non-disabled people, down from 27 percent last year compared with 10 percent for disabled people, down from 17 percent last year). Therefore the same movement has happened for both disabled and non-disabled people since last year, decisions for conditions of practise going up and decisions of fitness to practise not impaired going down.

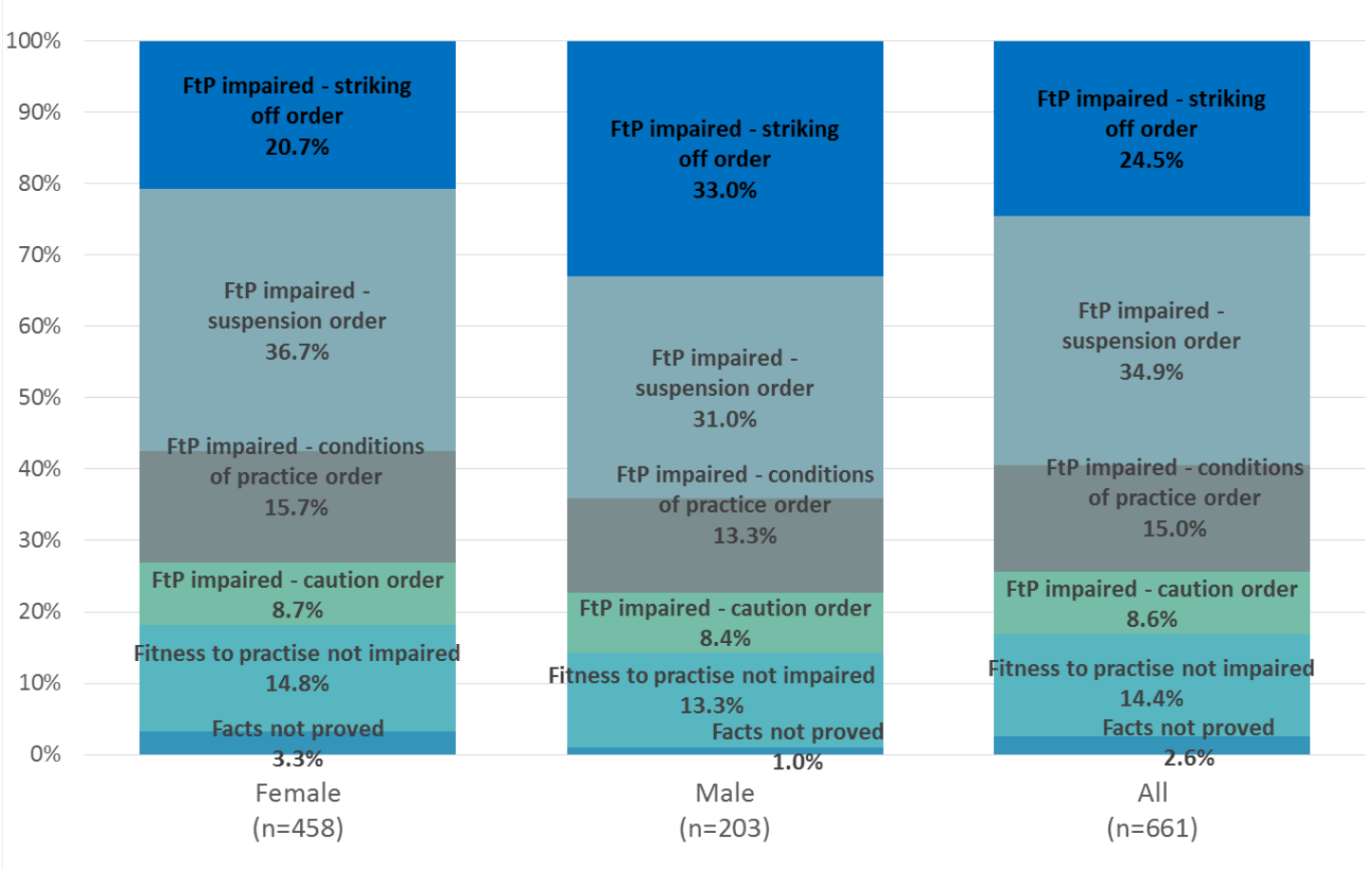
Table 17: Hearing outcome by ethnicity
This table shows the four ethnic groups that had more than 40 cases going through the hearings stage of fitness to practise. These are from the lower level 18+1 ethnic group categories.

	Black African	White - English/ Welsh/ Scottish/ Northern Irish/ British	White - other background	Unknown	All ethnic groups (n=661)
FNP	3 (3.4%)	9 (3.1%)	1 (2.4%)	-	**17 (2.6%)**
FTPNI	13 (14.6%)	51 (17.6%)	5 (11.9%)	3 (3.3%)	**95 (14.4%)**
CO	11 (12.4%)	24 (8.3%)	2 (4.8%)	-	**57 (8.6%)**
CPO	9 (10.1%)	43 (14.8%)	3 (7.1%)	14 (15.2%)	**99 (15.0%)**
SO	28 (31.5%)	96 (33.1%)	21 (50.0%)	40 (43.5%)	**231 (34.9%)**
SOO	25	67	10	35	**162**

	Black African	White - English/ Welsh/ Scottish/ Northern Irish/ British	White - other background	Unknown	All ethnic groups (n=661)
	(28.1%)	(23.1%)	(23.8%)	(38.0%)	**(24.5%)**
Total	**89 (100%)**	**290 (100%)**	**42 (100%)**	**92 (100%)**	**661 (100%)**

Last year people from the black African group had a higher proportion of fitness to practise not impaired (35 percent) than people in the white British (24 percent) or white other (20 percent) groups. This difference has not been replicated this year. People who have unknown ethnicity have the highest proportion of striking off orders, as they did last year. As stated previously in this report one reason for 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..

Figure 8: Hearing outcome by gender



Male nurses and midwives had a higher proportion of cases that received a striking off order (33 percent) compared with female nurses and midwives (21 percent of women). This is likely to be related to the fact that men make up a higher proportion of people who are referred to fitness to practise.