

Together in practice

Ambitious for change

Research into NMC
processes and people's
protected characteristics

Full report

Published on 20 October 2020



Contents

Executive summary	3
Next Steps	6
Introduction	7
Background	8
This report	10
Section 1: Our approach	11
Data analysis	11
Section 2: What do we know already?	14
Wider inequalities between people with different protected characteristics	15
Differences in nursing and midwifery education and training	16
Differences in working as a nurse, midwife or nursing associate	18
The types of jobs and settings worked in	18
Progression and pay	19
Experiences of discrimination	20
Evidence on professional regulatory processes	22
Revalidation	22
Fitness to practise	23
Section 3: What does our data show?	26
Overseas Registration	26
Our overseas process	26
Our previous overseas process	27
The people who applied through our previous overseas process	28
Factors that influence registration in our previous overseas process	40

Contents

Revalidation	44
The people who revalidated	44
Factors that influence revalidation	53
Fitness to Practise: Referrals	55
The people who were referred to us	59
Factors that influence being referred to fitness to practise	67
Fitness to Practise: Case progression	79
The people in our fitness to practise process	80
Factors that influence fitness to practise case progression	89
Section 4: Conclusion	91
Annexe 1: External Advisory Group Members (as at August 2020)	93
Annexe 2: NMC Allegation Coding Framework	96
Annexe 3: References	110

Executive summary

- 1.** Our vision is safe, effective and kind nursing and midwifery that improves everyone's health and wellbeing. As the professional regulator of more than 700,000 nursing and midwifery professionals, we have an important role to play in making this a reality.
- 2.** Our core role is to regulate. First, we promote high professional standards for nurses and midwives across the UK, and nursing associates in England. Second, we maintain the register of professionals eligible to practise. Third, we investigate concerns about nurses, midwives and nursing associates – something that affects less than one percent of professionals each year. We believe in giving professionals the chance to address concerns, but we'll always take action when needed.
- 3.** To regulate well, we support our professions and the public. We create resources and guidance that are useful throughout people's careers, helping them to deliver our standards in practice and address new challenges. We also support people involved in our investigations, and we're increasing our visibility so people feel engaged and empowered to shape our work.
- 4.** Regulating and supporting our professions allows us to influence health and social care. We share intelligence from our regulatory activities and work with our partners to support workforce planning and sector-wide decision making. We use our voice to speak up for a healthy and inclusive working environment for our professions.
- 5.** Fairness is at the heart of our role as a trusted, transparent regulator and employer. We're working to end discrimination, create equal opportunities, and collaborate with our partners to tackle prejudice and promote understanding. This includes addressing any disadvantages that people experience because of their protected characteristics.
- 6.** In August 2019, we started an ambitious programme of work to assess the impact our regulatory processes have on different groups of nurses, midwives and nursing associates. We want to understand whether professionals with different protected characteristics¹ have different outcomes from our processes. We want to know why these differences happen and take action to stop any unfairness.

Summary

7. We know this is a huge piece of work. To be successful we need help and guidance from our stakeholders. We hope that by sharing these initial findings and our next steps, our stakeholders will feel empowered to support and challenge us. We want to hear from our partners in health and social care about what they understand from these findings and what they think we should do next.

8. This report is the first step. It presents our analysis of our own information and data, and wider research and evidence. We've looked at the numbers of nurses, midwives and nursing associates who receive different outcomes, and used statistical analysis to determine which factors really influence the outcomes people get. We've also calculated the precise percentage point difference between groups.

9. Much of what we've found echoes insights from previous research. We know that people with certain protected characteristics experience significant inequalities across many areas of their lives. These inequalities start from a young age with lower educational attainment and poorer physical and mental health for certain groups. The professionals on our register are no different to people in the wider population. They may experience inequalities in education, health, criminal justice and housing.

10. While evidence about these disparities has been around for a long time, the Black Lives Matter movement and the disproportionate impact of coronavirus on people with different protected characteristics, has brought differences into sharp focus.

11. As health and social care workers, the people on our register may experience further inequalities based on their protected characteristics. Black, Asian and disabled health and social care workers experience lower progression and pay but higher discrimination and more mental health conditions. Many of the issues that we've found – different educational experiences, lower revalidation rates and higher rates of referrals to fitness to practise processes – affect other health and social care professionals including doctors, dentists and social workers.

12. For nurses, midwives and nursing associates, disparities include:

12.1 Lower acceptance rates onto NMC-approved nursing and midwifery courses for Black and Asian students.

12.2 Lower chances of registering through our overseas process for applicants who are: Black; disabled; bisexual; over 41; Muslim; or whose gender, gender identity and training country we don't know (or who preferred not to say).

Summary

12.3 Lower chances of revalidating for nurses and midwives who are: male, over 60, disabled, White or those whose ethnicity we don't know (or they prefer not to say); those living outside the UK and the European Union (EU) or European Economic Area (EEA); or trained in Australia. Much of this aligns with the findings from Ipsos Mori's [independent evaluation of revalidation](#).

12.4 Higher referrals of particular groups of nurses and midwives – many of them reflected in the University of Greenwich's [research into disproportionate impacts in our fitness to practise process](#).

Looking at a person's protected characteristics alongside where they trained, live and work shows that professionals who are: male, trans, bisexual, Black, living in certain parts of the UK or places such as the Channel Islands, trained in Northern Ireland, working in settings such as the cosmetic or aesthetic sector, or being someone whose disability we don't know (or they prefer not to say) are more likely to be referred to us compared to others.

12.5 Like Greenwich we found that employers still refer higher proportions of minority ethnic nurses and midwives. Members of the public and people who use services still refer higher proportions of White nurses and midwives. These cases are more likely to be closed at screening compared to those referred by employers, which are more likely to progress to the adjudication stage.

12.6 With the exception of professionals whose ethnicity we didn't know (or who preferred not to say), Greenwich found that ethnicity didn't influence how far a person's case progressed in our fitness to practise process once source of referral was taken into account. However, this was based on ethnicity being known for only 41 percent of cases.

12.7 With more complete data we've found that ethnicity does influence case progression. Cases involving Black nurses and midwives are more likely to progress to the adjudication stage compared to White professionals. However, Black professionals aren't any more likely to be removed from our register than White nurses and midwives.

12.8 Like Greenwich we also found different outcomes for other groups. This includes men, disabled nurses and midwives and those who work in settings which we don't know compared to women, non-disabled and those working in any other type of setting.

13. Having this information is important but we don't yet know why this is happening. We don't know how much it is down to our having more complete data, or how much it is due to our own processes, or how much it is because of factors outside our control. We'll look at all of this in our next steps.

14. In developing our next steps we need to consider what has happened since we analysed the data in this report. The coronavirus global pandemic has changed work and life for the nurses, midwives and nursing associates on our register. It has also impacted on the thousands of people who have joined our emergency Covid-19 temporary register to help support the UK's response. It has meant working in unprecedented, and often challenging and difficult circumstances. And it has increased the risks of negative physical and mental health. This report gives a baseline to monitor Covid-19's impact on our nurses, midwives and nursing associates, and on our regulatory processes.

15. We've introduced many changes to the processes examined in this report. We made significant improvements to the overseas process that make it more efficient. We've made changes to revalidation in response to the independent evaluation. We've overhauled our approach to fitness to practise in response to the Greenwich findings, feedback about people's experiences, and a better understanding of the factors that influence individual professionals' behaviour. These changes make sure people are at the heart of the process. This means promoting a culture of openness and learning, working closer with employers to resolve issues locally where possible, and giving greater consideration to the context in which incidents happen. This report comes too early to take these changes into account, but it does give us a useful baseline that we can measure progress against.

Next Steps

16. We've already taken some steps that may help, such as improving the overseas process, developing a new resource for employers to support them to investigate concerns locally and being more systematic in how we consider context in fitness to practise cases. We need to give these changes time to have an impact. But we don't want to be complacent. We'll ensure that we revisit these issues and measure progress against the findings in this report.

17. There are further steps we can take now, like commissioning further work to understand people's experiences of revalidation, and why employers, members of the public and people who use services refer certain groups to us. We'll also continue to improve our data so that we can better understand the influence of where nurses, midwives and nursing associates train and work on their experiences of our processes.

18. But we know we need to do more, so we'll work with our stakeholders to plan further actions for the future as our understanding of the causes of these differences becomes clearer.

Introduction

19. In 2019, we published our [2020-2025 strategy](#) to support the delivery of excellent nursing and midwifery. We heard from over 10,000 people from across the UK, including the professionals on our register, our partners and stakeholders, people using health and care services, and our colleagues.

20. Our purpose is to promote and uphold the highest professional standards in nursing and midwifery to protect the public and inspire confidence in the professions. Three key roles support this purpose:

20.1 Our core role is to **regulate**. First, we promote high professional standards for nurses and midwives across the UK, and nursing associates in England. Second, we maintain the register of professionals eligible to practise. Third, we investigate concerns about nurses, midwives and nursing associates – something that affects less than one percent of professionals each year. We believe in giving professionals the chance to address concerns, but we'll always take action when needed.

20.2 To regulate well, we **support** our professions and the public. We create resources and guidance that are useful throughout people's careers, helping them to deliver our standards in practice and address new challenges. We also support people involved in our investigations, and we're increasing our visibility so people feel engaged and empowered to shape our work.

20.3 Regulating and supporting our professions allows us to **influence** health and social care. We share intelligence from our regulatory activities and work with our partners to support workforce planning and sector-wide decision making. We use our voice to speak up for a healthy and inclusive working environment for our professions.

21. Together, these three roles will help us deliver our vision of: "Safe, effective and kind nursing and midwifery practice, improving everyone's health and wellbeing"

Background

22. Our data shows differences in fitness to practise referrals and outcomes for professionals from different ethnic groups, genders, age groups and country of training.

23. In April 2017, we published [research into disproportionate outcomes for some nurses and midwives \(known as the Greenwich research\)](#). This report found differences in rates of referrals and fitness to practise outcomes for certain groups of nurses and midwives. For example, Black nurses and midwives and those whose ethnicity we don't know (or who preferred not to say) were referred to us in higher proportions compared to the numbers on our register as a whole. Employers were the largest source of referrals and these referrals were most likely to progress through to the later stages of the fitness to practise process.

24. We've used this knowledge to develop [new ways of working in our fitness to practise processes](#). We've also rolled out unconscious bias training for all our fitness to practise panellists and Case Examiners. We continue to advertise fitness to practise panellist recruitment campaigns widely to diverse groups. We believe that when nurses, midwives and (in England) 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. We know this is vital for safe and effective nursing and midwifery. Also, that having robust fair processes maintains the trust and confidence of the public.

25. We use previous research and the diversity data we hold on the register to inform our equality impact assessments of our policy and operational changes. For example, the Greenwich research informed the actions we took, in response to Covid-19, to ensure that changes to our fitness to practise processes did not exacerbate differences in referrals by ethnicity.

26. Our previous work in this area has been useful but it has focused on only one of our processes (fitness to practise) and it stopped at reporting the data trends. It didn't go further to ask why we were seeing such trends, or to try and understand what these meant for the different groups of people involved.

27. We want to be consistent and fair in our regulatory role and inclusive as an employer. We are subject to the Equality Act 2010² and the Human Rights Act 1998. Under the public sector equality duty (PSED), we must have due regard for eliminating discrimination, advancing equality of opportunity and fostering good relations. This means both in our own activities and wider where we have influence to tackle prejudice and promote understanding. Key to this is us evaluating the impact of our work on people with different protected characteristics and working with others to address inequalities.

28. In setting out to assess the impact of our regulatory processes on different groups of nurses, midwives and nursing associates, we have asked four questions:

28.1 Do nurses, midwives and nursing associates with different protected characteristics get different outcomes from our processes?

28.2 If so, why are these differences occurring?

28.2.1 How much of these differences are down to the professionals' protected characteristics rather than other factors such as profession and country of training?

28.2.2 How much of these differences can be attributed to us and our ways of working?

28.2.3 How far do these differences reflect patterns or trends in the wider health and care environment and in wider data and research?

28.3 What impacts do these differences have on the groups involved?

28.4 What can we do to address these differences on our own and in collaboration with others?

This report

29. This report is the first stage of our work to assess the impact of our regulatory processes on nurses, midwives and nursing associates with different protected characteristics.³

30. It presents our findings from an analysis of the data we hold and external data and research to identify which groups of professionals receive different outcomes from our processes. It also presents the factors that influence these outcomes.

31. It expands on the work we've done to date to look across all NMC regulatory functions and several protected characteristics.

32. We don't yet know why this is happening. So we cannot say whether this is because of things that are under our control (for example, the way that our processes are set up or our decision-making) or if it is due to factors that are outside of our control. This will be explored in the next stages of this project.

33. The report is divided into three sections:

33.1 Our approach including the questions we looked at and the methods we used to undertake the research.

33.2 What we know from existing data and research about differences in experiences and outcomes between nurses, midwives and nursing associates.

33.3 An analysis of our data about differences in outcomes for nurses, midwives and nursing associates with different protected characteristics in our overseas registration, revalidation and fitness to practise processes.

Section 1

Our approach

34. Our work has received expert advice and guidance from:

34.1 An external advisory group comprising representatives from across the UK and a broad range of people, organisations and interests ([see Annexe 1](#)).

34.2 Statistical advice, guidance and peer-review by an academic at the University of Essex.⁴

Data analysis

35. This report looks at three of our regulatory processes. It investigates whether there are differences between professionals with different protected characteristics in getting particular outcomes, and how far these differences can be attributed to certain protected characteristics or other factors such as country of training or place of work.

Table 1: Outcomes examined of NMC regulatory processes

Regulatory process	Outcomes examined in detailed analysis
Overseas registration	Which groups of professionals register successfully after applying and which do not?
Revalidation	Which groups of professionals revalidate successfully and which do not?
Fitness to Practise	Which groups of professionals get referred to fitness to practise and which do not?
	Cases involving which groups of professionals progress through our fitness to practise process and receive a more severe outcome and which do not?

36. Our approach largely mirrors what Greenwich did in the 2017 research, with some key differences:

36.1 We have looked at more protected characteristics (the seven characteristics for which we have data: age, disability, ethnicity, gender, gender identity, religion or belief, sexual orientation).

36.2 We have examined more than one of our regulatory processes (overseas registration, revalidation and fitness to practise).

Section 1

36.3 We have included more explanatory factors into our analysis.

36.4 We've gone further with our analysis to calculate the precise influence of each factor.

37. We have taken a two-stage approach to analysing the data we hold:

37.1 **Stage one: Descriptive analysis.** This stage focuses on identifying who is involved in our overseas registration, revalidation and fitness to practise processes. It analyses the numbers of nurses, midwives and nursing associates who get each outcome, broken down by protected characteristic (e.g. the percentage of men who revalidate compared to women).

37.2 This helps us to identify which factors (such as a person's age) might be affecting the outcome that people get (for example, whether they revalidate or not). It is only an indication and we need to do a more detailed type of analysis to be able to say, with confidence, whether those factors actually do influence the outcomes that people get in our processes.

37.3 **Stage two: Detailed analysis.** This stage goes a step further, enabling us to determine which factors are most influential on the outcomes people get, which factors can be ignored, and how these factors influence each other.

37.4 We've used the statistical technique regression to look at all of the factors we think are important in influencing the outcomes people receive from our processes (for example, protected characteristics plus place of training or work). We've then identified which of those factors really do influence the outcomes that a person gets from our processes. This includes finding out how much influence a person's protected characteristics has on the outcome they get. For example, does age affect a person's chance of registering through our overseas process or not? Using this type of analysis allows us to be more confident about the factors that are really influencing whether someone registers, revalidates, is referred or how far they progress through our fitness to practise process.

Section 1

37.5 Once we know which factors are important, we then look to see which characteristic is actually influencing the outcomes a person receives. So, if we find that age affects a person's chances of registering through the overseas process, is it that younger people are more or less likely to register or is it older groups? Once we know the specific characteristic that is influencing the outcome, we can then calculate the average marginal effect – that is, the specific percentage point difference in how much one characteristic influences an outcome compared to another. So how much being aged 21-30 influences your chances of registering through our overseas process compared to being over 41. The percentage point difference allows us to say that 21-30 year olds are 2.7 percentage points more likely to register compared to those aged 31-40 and 14.2 percentage points more likely compared to applicants aged 41 and over.

37.6 Relying only on the stage one results (for example, looking only at the percentages of people who go through each of our processes and then how many of them are successful or not) may lead us to draw the wrong conclusions about what affects someone's ability to register, revalidate, be referred or progress in fitness to practise. This type of inference would be purely speculative and not statistically driven. We use regression to better understand the true relationship and how it may change when controlling for other variables. We can also then determine which variables are of most interest and develop actions that focus on the characteristics that are most important in hindering registration, revalidation or experience of fitness to practise.

37.7 For example, taking fitness to practise referrals as example, our descriptive analysis shows that, compared to the proportions on our register, we received a higher proportion of referrals of 41-50-year-olds. Just looking at that alone with no other analysis might lead us to say that a person's age increases their chances of being referred to us. However when we look at the detailed analysis – which looks at a person's age alongside their other protected characteristics plus where they work, where they trained and where they live – we find that age is not significant and does not influence their likelihood of being referred.

Section 2

What do we know already?

38. This section outlines what we know about the experiences, progress and outcomes of nurses, midwives and nursing associates identifying with different protected characteristics. It draws upon three main sources:

38.1 previous work the NMC has done, including data we have published and research we have commissioned

38.2 an analysis of relevant external data and information

38.3 a summary of relevant international research that has been published since the University of Greenwich report.

39. As well as looking at work focusing specifically on the experiences of nurses, midwives and nursing associates, it is important to consider evidence about wider disparities between groups.

40. Our register is very diverse – 20 percent are from minority ethnic backgrounds, similar to the proportions of the UK population in England and Wales⁵ and more than those in Scotland⁶ and Northern Ireland⁷. Around two percent of our register identify as LGBT+, again similar to the proportions in the UK population⁸. Disabled nurses and midwives comprise four percent of our register compared to an estimated 19 percent of working age adults in the UK⁹. The professionals on our register may be subject to systemic and structural inequalities related to different protected characteristics.

41. These disparities have long been reported in various data, research and inquiries but have been brought into sharp focus as result of coronavirus and the Black Lives Matter movement.

42. Acknowledging these inequalities is important because they undoubtedly affect the day-to-day lived experiences and work of many of the professionals on our register. Studies have shown that experiences of discrimination can have a profound impact on those that experience it¹⁰. What's more, evidence shows that fair treatment of staff is linked to better patient care¹¹.

Section 2

43. This section is divided into four sub-sections:

- 43.1 evidence on wider inequalities between people identifying with different protected characteristics
- 43.2 differences in nursing and midwifery education and training
- 43.3 differences in working as a nurse, midwife or nursing associate
- 43.4 evidence on professional regulatory processes.

Wider inequalities between people with different protected characteristics

44. There is now strong international evidence to show that people with particular protected characteristics experience inequalities across many areas of their life. Inequalities most relevant to the people on our register include:

44.1 Education. Students who are male, whose first language is not English, who have special educational needs or are eligible for free school meals (as a proxy for economic disadvantage) have lower levels of educational attainment at ages 11 and 16 (end of primary and secondary education) compared to students who are female, who speak English as a first language, do not have special educational needs and are not eligible for free school meals. These differences start in the early years and increase at every stage of education¹². Differences are also apparent between students of different ethnicities. For example, in England at age 16, among low socio-economic status (SES) students, White British students do worse than students of other ethnicities, (with the exception of Black Caribbean boys who perform the same as White British boys). For those students of high SES, Indian students outperform White British students. A similar pattern is evident at ages 11–16, with White British low SES students and Black Caribbean boys (particularly the more able) making the least progress^{13,14}.

44.2 Health inequalities including physical and mental health that generally affect people from lower socioeconomic groups, those living in the most deprived areas, Black, Asian and minority ethnic groups, disabled people and people identifying as lesbian, gay, bisexual or trans (LGBT+). Such inequalities include lower life expectancies and worse health outcomes than other population groups¹⁵⁻⁵⁷.

44.3 Access to, and experiences of, health care and services. Evidence suggests that people who identify as LGBT+, Asian and have learning disabilities may delay seeking treatment and experience poor treatment and discrimination when accessing general health services^{19-21,58-66}.

Section 2

44.4 Access to housing and its quality. People from minority ethnic background are more likely to live in poorer quality housing⁶⁷. Black, Asian, minority ethnic and refugee communities are more likely to live in overcrowded, inadequate housing in deprived areas. They are also less likely to own their home, and more likely to be private renting than White households⁶⁷. For example, only two percent of White British households are overcrowded, compared with 30 percent of Bangladeshi households and 15 percent of Black African households⁶⁸. Homelessness disproportionately affects certain groups such as young people and those with mental health conditions⁶⁸.

44.5 Criminal justice including higher likelihoods for minority ethnic men of being stopped and searched, arrested, receiving prison sentences and being placed in high security prisons compared to White men^{69,70}. People with different protected characteristics have also been documented as experiencing an increase in hate crime and harassment on the basis of their race or ethnicity since 2013⁷¹⁻⁷³.

Differences in nursing and midwifery education and training

45. Evidence suggests that there are differences in the educational performance by gender, age and ethnicity. For example, male nursing and medical students may be at increased risk of poor academic outcomes⁷⁴⁻⁷⁸. One study found that older nursing students are more likely to complete their courses, while the opposite was true for those studying other subjects⁷⁹. White medical students tend to perform better on post-graduate medical examinations compared to students from minority ethnic groups^{80,81}. In addition, the exam performance of international medical graduates may be hindered by a lack of exposure in a UK context⁸².

46. Evidence also indicates poorer mental health and wellbeing while in education for certain groups. These include younger students; students with dyslexia;^{83,84} and Black or minority ethnic students^{85,86}. Students who are LGBT+, Black or minority ethnic, trans or non-binary report high levels of discrimination, such as derogatory comments and access to experience and placements in particular clinical areas⁸⁷⁻⁹¹.

Section 2

47. Gender, ethnicity and disability status markedly affects who decides to train as a nurse, midwife or nursing associate. These differences persist across application rates, acceptance levels and course completion. Once in education, research shows that experiences differ by protected characteristic. These differences include attainment, mental health issues and experiences of discrimination.

47.1 Applications and acceptances. Data from the Universities and Colleges Admissions Service (UCAS) show that the number of applications for pre-registration nursing and midwifery courses went down between 2017-18 and 2019-20 by 13 percent, from 173,555 to 151,530. There were almost no changes in the ethnicity or sex profiles of applicants over this period but there was an increase in applications from disabled students, those aged 18 years old and under, and those applying to UK institutions outside England.

47.2 Black and Asian students make up a lower proportion of acceptances onto NMC approved courses compared to the proportion that apply. This is largely driven by universities making less offers to Black applicants compared to applicants of other ethnicities. Asian applicants are also made less offers by universities (although the differences are not as large as those for Black applicants). Differences in application and acceptance rates for Asian students are driven by Asian applicants making a lower level of firm replies (confirming that the university is the applicant's first choice if they meet the necessary conditions, such as grades). Differences in application and acceptance rates are also apparent for those aged 18 compared to those aged 21 and over⁹².

47.3 Students enrolled on nursing and midwifery courses. About 1 in 11 of students enrolled onto NMC-approved nursing and midwifery courses in 2019-20 were male, just over a third were Asian, Black, Mixed, Other or people whose ethnicity was unknown (or who preferred not to say), about half were aged 21 or above and 1 in 9 were disabled⁹².

47.4 Course attrition. Data from the Higher Education Statistics Authority (HESA) indicates that there are some differences between the characteristics of students who complete their course successfully and those who drop out. Male students, those from Mixed ethnic backgrounds and disabled students were more likely to drop out between 2014-15 and 2016-17. However, male nursing students were slightly more likely to be disabled (18 percent compared to 14 percent of females), so it is unclear if gender, disability or both are driving a variation from the norm. This is the case for both nursing and midwifery pre-registration courses⁹³. Differences in course progression and completion is also highlighted in wider research⁹⁴⁻⁹⁸.

Section 2

47.5 Inclusive education. Other research has highlighted the lack of diversity in nursing and midwifery education. This includes the absence of nurses or midwives from different races in the curriculum and teaching resources and the likelihood that 94 percent of body parts used in simulation exercises are White^{99,100}. Research also highlights the fewer numbers of ethnic minority professors in nursing, midwifery and higher education compared to White^{101,102}.

Differences in working as a nurse, midwife or nursing associate

48. Differences between people identifying with particular protected characteristics when working as a nurse or midwife can be seen in three areas.

The types of jobs and settings worked in

49. Our [2019-2020 revalidation data](#) shows differences in the types of jobs and the settings worked in by gender, age, ethnicity and country of training. For example:

49.1 Gender. Men report a high proportion of jobs in mental health, learning disabilities and agencies. Men are also more likely to work in certain settings such as the military, prisons, ambulance service and trade unions or professional bodies. In contrast, women report a high proportion of jobs in midwifery, health visiting and school nursing and work in settings such as maternity units or birth centres, cosmetic or aesthetic sector and GPs or other primary care settings.

49.2 Age. Those working in agencies tend to be older. People aged 51 and over report a higher proportion of jobs in occupational health, quality assurance or inspection and education roles and in settings such as trade unions or professional bodies, inspectorate or regulators and the voluntary or charity sectors. In contrast, people aged 21-40 report a higher proportion of jobs in roles such as children's and neo-natal nursing, midwifery jobs and in settings such as maternity units or birth centres and the military.

49.3 Ethnicity. People employed via an agency are markedly more ethnically diverse than people employed directly. Black African nurses and midwives do over a third of agency jobs. People in the fields of adult general care nursing and mental health nursing are the most diverse in terms of ethnicity. Almost one third of jobs in adult and general care nursing are done by people who are not White British and mental health nursing has a high proportion of people of Black British African ethnicity. Work settings with the most ethnically diverse nursing and midwifery workforce include the care home sector, public health organisations, hospitals or other

Section 2

secondary care and prisons. In comparison, the least ethnically diverse work settings and scopes of practice include school nursing, quality assurance or inspection and education, and settings including the voluntary or charity sector, military and trade unions or professional bodies.

49.4 Country of training. Almost one quarter of jobs through an agency are done by people who trained outside of the EU/EEA, compared with one in ten jobs for those in direct employment. Jobs in adult and general care nursing have the highest proportion of jobs done by people trained outside of the EU/EEA as do settings such as care homes and hospital or other secondary care settings. In contrast, jobs in learning disabilities, school nursing and health visiting have the highest proportion of people trained in the UK as do settings including the military, community settings and the voluntary or charity sector¹⁰³.

50. Data from NHS Digital shows that there are higher proportions of Asian, Black and Chinese nurses in the NHS compared to the independent sector. There are also higher proportions of ethnic minority nurses compared to midwives in the NHS¹⁰⁴.

51. As well as job role and setting, research suggests there are also differences in the types of tasks that professionals with different protected characteristics do. This includes differences by age¹⁰⁵⁻¹⁰⁷, disability¹⁰⁸⁻¹¹¹, and gender¹¹². For example, older nurses may be less likely to work shifts and undertake tasks such as administering medication, interpreting test results and completing paperwork¹¹³. Those with disabilities may also experience structural challenges¹²⁴. A study of disabled healthcare workers in Turkey found that many were in roles which were below their skill level¹¹⁴. Male nurses may be seen more in terms of physical strength rather than competence and therefore assigned duties such as moving patients, cleaning trolleys and caring for violent patients^{115,116}.

52. Research with nurses from overseas suggests that nurses recruited from overseas experience loss of status and de-skilling, although this is likely to vary between people from different ethnic minorities and the region where people work¹¹⁷⁻¹¹⁹.

Progression and pay

53. Data from NHS Digital shows differences in nurses and midwives with different protected characteristics across pay bands five to nine between 2017 and 2019 in England. There are higher proportions of professionals who are male, White, non-disabled, Christian or aged 45-64 at more senior levels (Band 8a and above). There are also higher proportions of gay and lesbian nurses and midwives in the most senior (8a and above) grades¹²⁰.

Section 2

54. The gender pay gap in the NHS in the UK is 23 percent^{121,122}. Although the pay gap reduces when hours of work are accounted for, it still exists^{123,124}. One paper looking at the NHS in England in December 2017, found that the pay gap varies by age, gender and ethnicity¹²³.

55. Data from the Workforce Race Equality Standard (WRES) in England shows that in 2019 White applicants were 1.46 times more likely to be appointed from shortlisting compared to Black ethnic minority applicants; a similar figure to that reported in 2018, and an improvement on the 1.60 times gap in 2017 and 2016¹²⁵. Data from the Workforce Disability Equality Standard (WDES) in England shows that non-disabled applicants were 1.23 times more likely to be appointed from shortlisting compared to disabled applicants¹²⁶.

Experiences of discrimination

56. Data from the 2019 NHS staff survey in England shows that nurses and midwives who are female, White, non-disabled or heterosexual are more positive about their experiences while those who are Black, Muslim or male are less positive¹²⁷.

57. Nearly a third (29 percent) of ethnic minority NHS staff in England report that they have experienced bullying, harassment or abuse from other staff in the past 12 months, compared with 24.2 percent White staff; 15.3 per cent of ethnic minority staff report experiencing discrimination at work from a manager, team leader or other colleague – more than double the proportion of White staff reporting discrimination (6.4 percent); 69.9 percent of ethnic minority staff report that they believe their trust (employer) provides equal opportunities for career progression or promotion, compared with 86.3 percent of White staff. This data also shows that Black and minority ethnic staff are 1.22 times more likely to enter the formal disciplinary process compared to White staff¹²⁵.

58. Disabled NHS staff in England were 7 percentage points more likely to experience harassment, bullying and abuse from patients or service users compared to non-disabled staff in 2019 (33.8 percent compared to 26.8 percent). Disabled staff were 6.8 percentage points more likely to experience it from managers in the previous 12 months compared to non-disabled staff (19.8 percent compared to 13.0 percent) and 8.7 percentage points more likely to receive it from colleagues compared to non-disabled staff (26.8 percent compared to 18.1 percent)¹²⁶.

Section 2

59. Research on experiences of discrimination by men and women is inconclusive^{28,128-133}. However, it is clearer for those of younger ages^{134,135}; disabled groups¹³⁶; ethnic minorities¹³⁷⁻¹⁴²; and LGBT and trans professionals^{143,144}. Fear of discrimination or bullying can make those professionals with less visible protected characteristics (such as professionals with learning difficulties) reluctant to disclose their identities, which can create feelings of discomfort, stress and anxiety^{144,145}.

60. One issue that impacts staff identifying with different religions is dress codes and uniform policies. Three aspects of dress code have been identified as problematic for Muslim staff; the prohibition of long sleeved clothing, niqab (face veil) and headscarf¹⁴⁶. One study assessed the experiences of female Muslim health professionals across the UK and found that while some were permitted to wear a headscarf in the operating theatre, either with or without a theatre cap, others were required to remove their headscarf completely¹⁴⁷. The latter experience created feelings that employers failed to meet religious requirements. Additionally, those who wished to wear a headscarf in theatre had experienced repeated questions, a lack of orthopaedic hoods and the inability to enter theatre. In cases where a headscarf was allowed, positive and negative experiences were reported. While some felt accepted and content, others felt embarrassed, anxious or bullied. The same study also explored experiences of the 'bare below the elbows' policy, which operates across many trusts and is designed to enhance infection control by prohibiting long sleeved clothing. Most participants covered their forearms outside of work as a matter of religious importance. However, trusts not allowing this and the impracticality of disposable sleeve alternatives, left some feeling that their religious requirement was not respected. Staff can have low awareness of their employer's policies on dress codes and religious beliefs¹⁴².

61. Research on the experiences of nurses recruited from overseas highlights challenges they face including cultural differences, communication issues, and unequal opportunities^{148,149}. The most common forms of harassment experienced by overseas nurses working in the UK include racism, denial of training and career development opportunities, and overrepresentation in disciplinary proceedings¹⁵⁰. These challenges have a negative impact on overseas nurses' emotions and career development. Formal support such as training, mentoring, adaptation or orientation programmes are thought to help alongside informal networks and social support¹¹⁹. There is also recognition that whilst much research treats overseas nurses as a single group, experiences may differ depending on race, ethnicity, nationality, and other factors¹⁵¹. For example, Shields and Wheatley Price (2002) report that Black African nurses were

Section 2

the most likely to have been racially harassed by work colleagues, suggesting that Black African nurses may face more discrimination than other overseas nurses¹⁵².

62. Evidence suggests that levels of bullying and discrimination may be higher in some work settings. For example, bullying and harassment for people with different protected characteristics has been reported in the NHS Ambulance Service¹⁵³⁻¹⁵⁶.

63. There is a notable difference in the number of complaints made by and against health professionals, across age groups and genders. Studies have found that younger professionals are more reluctant to raise concerns, with confidence and willingness to speak out increasing with age¹⁵⁷. This can be attributed to younger nurses having less experience and being lower down in workplace hierarchies¹¹¹. On the other hand, the proportion of complaints made against practitioners increases with age, with older professionals more likely to be subject to complaints⁵⁸, and involved in cases regarding their fitness to practise^{158,159}. Women are less likely to raise concerns than men. However, men are more likely to be complained about¹⁵⁸⁻¹⁶¹. One study looking at data from the 2010 NHS Adult Inpatient Survey alongside nurse and hospital administrator surveys suggests that the use of non-UK educated nurses in English NHS hospitals is associated with lower patient satisfaction¹⁶².

64. Evidence about the prevalence of mental health conditions among people of different genders, ages, ethnicity and religion is mixed¹⁶³⁻¹⁷³. For example, the menopause can have a significant impact on women^{174,175}. However, Banks (2019) highlights that few employers proactively address and manage menopause, with the NHS electronic staff records, which records absence, not recognising menopause¹⁷⁶.

Evidence on professional regulatory processes

Revalidation

65. Our independent evaluation of revalidation suggests that men, those aged over 65 years, Black and minority groups and disabled nurses and midwives may find it more difficult to complete the requirements. The evaluation also found that people working in certain settings, such as more isolated roles like working with vulnerable patients or in GP practices, could find it harder to collect enough practice-related feedback. They might also find it harder to identify an appropriate person with whom to have a reflective discussion or confirmation discussion¹⁷⁷.

66. Other studies suggest that revalidation may be a particular issue for older nurses. One study reports findings from a survey of 506 primary care nurses showing that a fifth of nurses considered retirement rather than revalidation¹⁷⁸. This is also reflected in studies of other professions such as doctors^{179,180}.

67. An evaluation of the General Medical Council revalidation process found higher deferral rates in some groups, including female doctors, younger doctors and those from Asian, Black, Mixed or Other ethnic backgrounds independent of where they obtained their primary medical qualification. The evaluation also found that people working in certain roles and settings, such as locums may find the process more difficult¹⁸¹.

68. Data from WRES shows that the relative likelihood of Black and minority staff accessing non-mandatory training and continuous professional development (CPD) compared to White staff was 1.15, an increase from 1.11 in 2016 and the same as last year¹²⁵.

Fitness to practise

69. Evidence indicates that being party to fitness to practise proceedings can be stressful for both complainants and health professionals¹⁸²⁻¹⁸⁵.

70. There is also evidence that people's experiences of fitness to practise may vary between different groups. For example, our annual equality, diversity and inclusion (EDI) data reports show disproportionate referrals of disabled professionals and those of certain age groups and ethnicities, compared to the proportions on our register¹⁸⁶. Research we commissioned from the University of Greenwich showed that we received higher proportions of referrals of nurses and midwives who were aged 40-60, male, Black or whose ethnicity we didn't know (or who preferred not to say), or who trained in Africa compared to the numbers on our register as a whole. Nurses and midwives who were Black, Asian or Other ethnicity, or those whose ethnicity we don't know, were referred in higher proportions by their employers. White professionals were referred in higher proportions by members of the public and people who use services¹⁸⁷.

71. Other professional regulators have found similar trends^{156,188,189}. Ethnic minority doctors are twice as likely as White doctors to be referred by their employer to the General Medical Council. Doctors who trained outside the UK are two and a half times as likely to be referred compared to those who trained in the UK¹⁹⁰. Other groups over-represented in the GMC fitness to practise procedures include older male doctors, some non-specialist doctors, certain specialties and locums¹⁹¹.

Section 2

72. Dentists who are male, in the first ten years of registration, Asian or Other ethnicity, or those that trained outside the UK are more likely to have been involved in fitness to practise cases with the General Dental Council¹⁹².

73. Between 2004 and 2011, social workers who were male, disabled, Black or from an minority ethnic background, or aged between 40-49 were over-represented in referrals to the former regulator of social workers the General Social Care Council (GSCC). Over a third of the referrals the GSCC received during this time were made by employers and these (together with referrals that were made by the police) were more likely to find that the social worker had committed misconduct at adjudication stage¹⁹³.

74. A recent study found that between 1 January 2018 and 1 January 2019, social workers were more likely to be referred to fitness to practise than doctors or nurses, with men also more likely to face fitness to practise proceedings than women across all three professions. While social workers in England (25 percent) were less likely than doctors (38 percent) or nurses (34 percent) to be suspended as a result of a hearing, they were more likely to be removed, with 32 percent of practitioners in England and 57 percent of those in Scotland, Northern Ireland and Wales being struck off, compared with 24 percent of doctors and 29 percent of nurses. The most common reason for social workers was the seriousness of the allegation, which was cited in 32 percent of cases to the Health and Care Professions Council (compared to 15 percent of cases to the General Medical Council and 17 percent to the Nursing and Midwifery Council). In comparison, the most common reason for doctors was the professional demonstrating remediation, insight or remorse (32 percent), whereas for nurses it was giving the professional time for remediation or insight¹⁹⁴.

75. Differences between health and care professionals with different protected characteristics exist across different professions. A 2019 study looking at fitness to practise cases across three health professional regulators found that men were more likely to be perpetrators in cases involving sexual harassment or abuse¹⁹⁵. In looking at why these differences occur, work has highlighted the importance of workplace culture and environment on individual behaviour, particularly professionals' experiences of bullying, harassment or abuse from colleagues, people who use services or managers¹⁹⁵. Research commissioned by the General Medical Council (GMC) also found that factors including a lack of effective feedback from managers who were reluctant to have difficult conversations with those from a different ethnic group;

Section 2

inadequate induction and/or ongoing support; a lack of development opportunities and support for those working in isolated or segregated roles or locations; and remote and inaccessible leadership teams are also important in explaining disproportionality in referrals to the GMC's fitness to practise processes¹⁹⁰.

76. Work has also looked at consistencies and differences between regulators in how they deal with concerns about professionals' fitness to practise. A 2019 scoping review commissioned by the Professional Standards Authority found limited evidence investigating consistency across regulators in health and social care. It found variability between regulators in terms of fitness to practise processes including differences in investigative process at the four stages, legal frameworks, categorisation of allegations and outcomes, and differences in the demographic details recorded¹⁹⁶.

77. The General Dental Council commissioned research. It found that a range of aggravating and mitigating factors determine the seriousness of each fitness to practise case. This is because each individual case is unique. While the review found a general consensus between regulators that cases involving sexual misconduct, dishonesty, or criminal convictions are likely to be treated as serious, it did not identify any shared definition of seriousness in relation to misconduct, due largely to the complexity, variety, and individualised nature of fitness to practise cases. A range of aggravating and mitigating factors are taken into account when determining seriousness. They include the registered professional's honesty or dishonesty, whether the alleged misconduct was repeated or extended, whether the professional has shown remorse or insight or has taken remediation, and the nature of the risk of harm to people using services¹⁹⁷. Two studies of fitness to practise processes for dentists and doctors also found a link between both risk of harm and dishonesty as aggravating factors for fitness to practise outcomes^{198,199}.

Section 3

What does our data show?

78. This section focuses on the results from our analysis of data the NMC holds. Only results that were found to be statistically significant (e.g. those findings that we can be confident are not due to chance) and with a one percentage point difference are reported. The rest of this section is divided into four sub-sections, each of which is focused on a particular process.

Overseas Registration

Our overseas process

79. People who trained outside the UK and the EU who wish to join our register apply through our overseas process. This process requires applicants to demonstrate that they:

79.1 hold an approved qualification

79.2 are capable of safe and effective practice, including meeting requirements for health and character

79.3 have an appropriate indemnity arrangement in place

79.4 have the necessary knowledge of English

79.5 have paid the evaluation and registration fees.

80. We updated this process in October 2019 to make a number of improvements to it. These changes included:

80.1 enabling applicants to be able to apply through an online system, rather than paper, providing them with a personal account to track their progress

80.2 streamlining requirements to confirm a candidate's competence. For example, instead of asking for training transcripts, we confirm that the applicants hold the qualification that would lead to registration in their home country

80.3 redesigning our online guidance to include easy read guidelines and a new pre-application checklist tool that can be shared with employers and recruiters.

Section 3

81. These changes follow improvements made in recent years, including reducing the cost of the computer-based test, an updated practical examination (OSCE) re-sit policy (allowing candidates to re-sit only the portion of the exam they failed), improved preparation materials (including a mock examination and marking criteria), updated English language requirements, and enabling overseas applicants to apply to work in the UK immediately after qualifying, rather than a 12-month waiting period.

82. The findings presented in this section are based on data that was collected before these changes came into effect (1 April 2016 to 31 March 2019). This process is different to that which current applicants go through.

Our previous overseas process

83. By way of explanation, the process that overseas applicants between 1 April 2016 to 31 March 2019 followed was:

83.1 Eligibility criteria. Applicants declared that they had the required qualifications and competence in English language but were not required to provide any evidence at this stage.

83.2 Test of competence. Overseas applicants that held an eligible qualification which was not automatically recognised were required to do a test of competence. This consisted of two parts:

83.2.1 Computer based theory examination ('Exam part 1: Computer-based test'). This usually happened first and took place after the eligibility stage.

83.2.2 Practical Objective Structured Clinical Examination (OSCE) that assessed the applicant in a number of situations and scenarios ('Exam part 2: OSCE'). This usually happened after the full application assessment stage.

83.3 Application fee and payment. Applicants were required to pay a fee to cover the cost of us assessing their eligibility (qualifications, English language competence).

83.4 Full application and assessment. This was the first point in which we made a decision on the application. Applicants were required to provide evidence of their qualifications and English language competence which we then assessed.

83.5 Identity check.

83.6 Registration fee payment and declaration.

Section 3

84. There were a number of issues with this process which impacted on how far people got through. The changes we have made are intended to address these issues. For example, many applicants started multiple applications without completing the eligibility form.

85. The previous system had no expiry period for incomplete applications. There was also no way of identifying where applicants had chosen to 'drop out' or not continue with their application. This skews the data we have about how far people progress through the process and therefore their likelihood of registering successfully.

The people who applied through our previous overseas process

86. This section presents the findings from our descriptive analysis and focuses on outlining the number and percentage of people with different protected characteristics who:

86.1 applied to join our register through the overseas process

86.2 successfully registered through this process

86.3 how this compares to the overall numbers of each group on our register.

87. The figures presented in this section are simply summarising and describing the people who applied to join our register through the overseas process. We cannot draw any conclusions from this section about why the figures are at particular levels or identify any trends.

88. The next section goes beyond this type of analysis to identify which factors influence a person's chances of registering successfully through our overseas process. Rather than looking at each factor individually as the descriptive figures in this section do, it allows us to consider several factors at once. This means we can look at the influence of a person's protected characteristics alongside where they trained, for example. In doing this, we can see not only whether a person's protected characteristics affect their chances of being able to register successfully, but also how much they influence it and which characteristics matter more than others. It will also enable us to know how certain we can be about the influence of these different factors and therefore determine those factors that affect a person's likelihood of registering successfully after starting an application with us confidently.

89. Between 1 April 2016 and 13 March 2019, 35,367 people started an application to join our register through the overseas route.

Section 3

90. Most (88 percent or 31,113 people) applicants made only one application to us. Around one in ten applicants (10.3 percent or 3,654 people) started two applications and 1.7 percent (600 people) started more than two applications. People may start multiple applications in error, because they have not completed the requirements within the necessary time period, or because they did not meet the requirements at a particular stage and so needed to start a new application.

91. As of 1 April 2019, just under a third of people who had started an application to join our register had been successful (30 percent or 10,614 people). Most (92.6 percent or 32,746 people) applied to be an adult nurse. Of the remaining 2,621 people, 4 percent (or 1,408 people) applied to be a midwife, 1.9 percent (or 660 people) applied to be a mental health nurse, 1.4 percent (or 508 people) applied to be a children's nurse and 0.1 percent (or 45 people) applied to be a learning disabilities nurse.

92. Over 84 percent (8,961 people) of successful applicants made only one application.

93. We can't tell from our data how many of the remaining people still had an ongoing application, how many had either chosen to exit or 'drop out' of the application process, how many had not met the required standard at each stage and therefore had been unable to progress any further (for example, did not pass the computer based test)²⁰⁰.

94. We do know that, as of 1 April 2019, the remaining two-thirds of people who had started an application but had not registered successfully:

94.1 Around a quarter (24.2 percent or 8,548 people) were at the eligibility criteria stage. This is the stage where applicants declared they had the required qualifications and competence in the English language but were not required to provide any evidence at this stage. Not progressing past this stage may mean that applicants did not declare having the required qualifications and/or competence in the English language; it may mean that an applicant started an application but did not complete an eligibility form so their progress stalled at this stage of the process; or it may mean that an applicant started an application but then decided not to continue with it.

94.2 Another quarter of people (26.1 percent or 9,224 people) were at the computer-based test (CBT) stage.

94.3 Less than 3 percent (2.8 percent or 991 people) were at the application fee payment stage.

Section 3

94.4 Just over 5 percent (5.7 percent or 2,016 people) were at the full application and assessment stage, where we assessed the evidence they had provided about qualifications and English language competence.

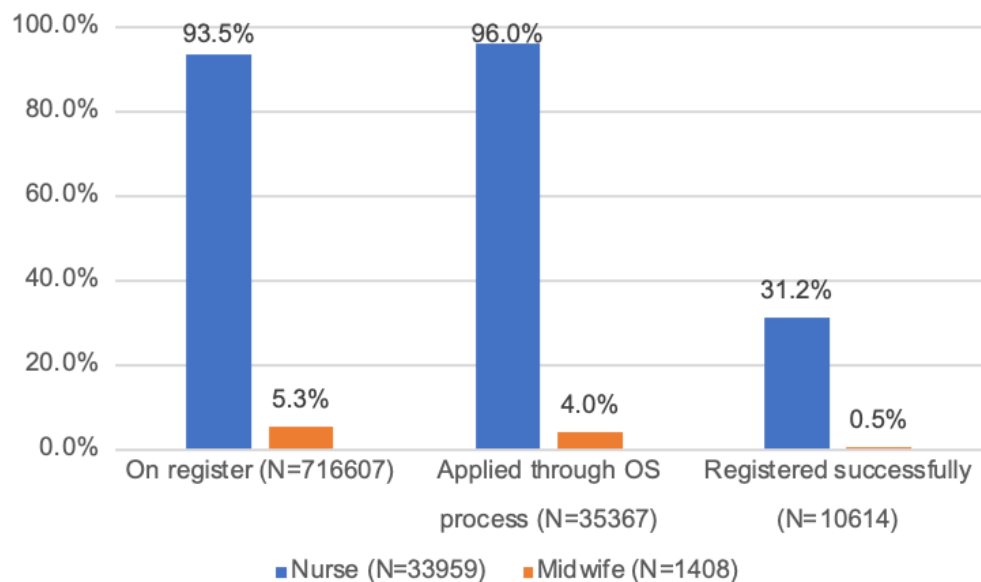
94.5 Two people were at the OSCE test of competence stage.

94.6 Just over a tenth (11.2 percent or 3,944 people) were at the ID check stage.

Profession

95. Only 0.5 percent of people applying to be a midwife (7 people) successfully registered, compared to 31.2 percent of those who applied to be a nurse (10,607 people).

Figure 1: Proportion of successful overseas applicants in comparison to all overseas applicants and people on NMC register by profession



Gender

96. Around two thirds of the people who applied through our overseas process were women (63.5 percent or 22,473 people). Under a fifth were men (16.7 percent or 5,920 people) and a fifth preferred not to say (19.7 percent or 6,974 people).

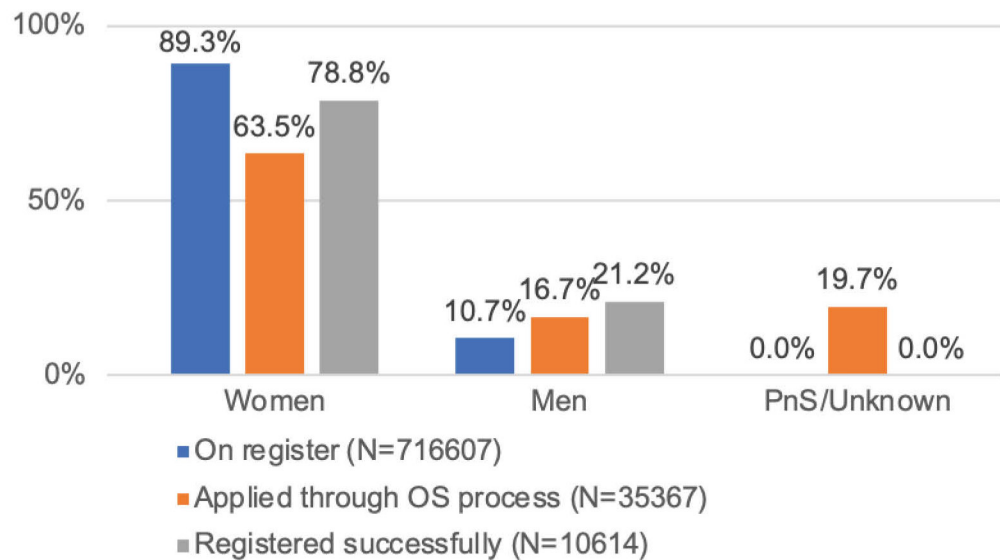
97. Compared to the people on our register as of 31 March 2020, there were a lower proportion of women who applied through our overseas process (89.3 percent of the people on our register are women compared to 63.5 percent who applied through the overseas process) and more men did (10.7 percent of the people on our

Section 3

register are men compared to 16.7 percent of overseas applicants). There were also a higher proportion of applicants whose gender we did not know, or who preferred not to say amongst overseas applicants compared to the numbers on our register as a whole (we don't know the gender of less than 1 percent of the people on our register, or they prefer not to say compared to 19.7 percent of overseas applicants).

98. Women make up a larger proportion of successful applicants than men (78.8 percent of successful applicants were women even though women only made up 63.5 percent of all applicants, compared to 21.2 percent of successful applicants were men even though they made up 16.7 percent of all applicants).

Figure 2: Proportion of successful overseas applicants in comparison to all overseas applicants and people on NMC register by gender



99. A similar proportion of women and men registered successfully as those who did not. For example, 37.2 percent (8,366 people) of women and 38 percent (2,248 people) of men who started an overseas application registered successfully. While 62.8 percent (14,107 people) of women and 62 percent (3,672 people) of men who started an overseas application did not register successfully.

100. However, these differences may be because none of the people whose gender we don't know (or who preferred not to say) are recorded beyond the computer-based test of the application process. It's unclear why this is the case. For example, whether it is because these applicants had decided not to continue with their application, their application had expired due to the time taken, the

Section 3

applicants didn't meet the required standard, or their applications were ongoing as of 1 April 2019. The changes we have made to the overseas process will address these issues.

Age

101. Over half of the people who applied through our overseas process were aged between 21-30 (55.1 percent or 19,503 people). A third were aged between 31-40 (35.6 percent or 12,577 people) with the rest aged over 41 (9.3 percent or 3,287 people).

102. Overseas applicants are a younger cohort than the people on our register. For example, only 16.2 percent of the people on our register are aged 21-30 compared to 55.1 percent of overseas applicants, while 61 percent (or 436,877 people) are aged over 41 years compared to the 9.3 percent of overseas applicants.

103. People aged 21-30 make up a bigger proportion of those who successfully registered compared to their numbers amongst all applicants (62.2 percent of people who successfully registered were aged 21-30 compared to 55.1 percent of applicants as a whole). The proportion of people aged 31-40 who successfully registered is similar to the proportion of all applicants. In contrast, those from older age groups (41 years and over) make up a lower percentage of those who were successful in registering compared to the proportions of all those who started an application.

104. Looking at the number of people in each group who successfully registered after starting an overseas application, 5.7 percent (4 people) of those aged over 61 and 7.1 percent (45 people) of ages 51-60 registered successfully compared to 33.8 percent (6,599 people) of ages 21-30 and 28.7 percent (3,604 people) aged 31-40.

Table 2: Proportion of successful overseas applicants in comparison to all overseas applicants and people on NMC register by age group

	On register (N=716607)	Applied through OS process (N=35367)	Registered successfully (N=10614)
21-30 years	16.2%	55.1%	62.2%
31-40 years	22.8%	35.6%	34.0%
41-50 years	25.9%	7.2%	3.4%
51-60 years	27.0%	1.8%	0.5%
61 and over	8.1%	0.2%	0.0%
Unknown/ Prefer not to say	0.0%	0.1%	0.0%

Section 3

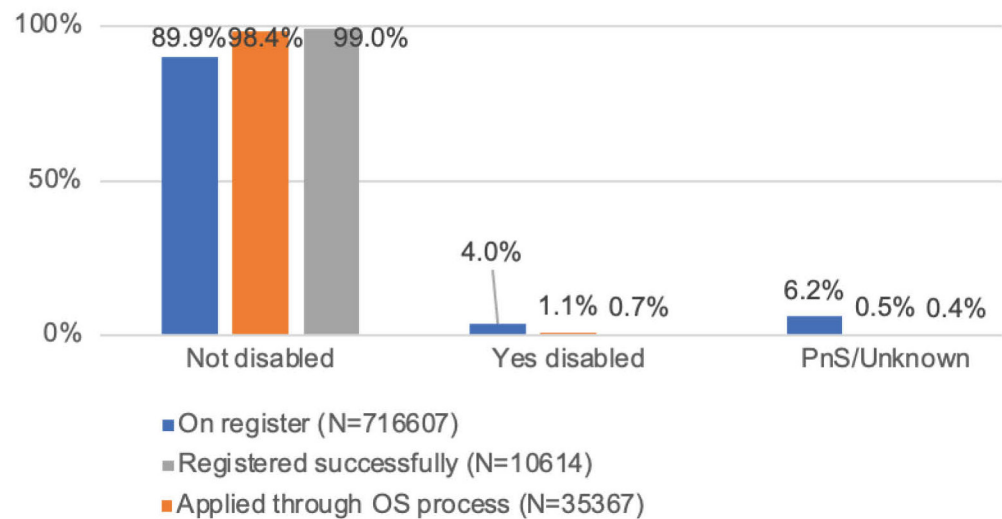
Disability

105. A lower proportion of disabled people applied to join our register through the overseas process compared to the proportion on our register; 4 percent (28,349 people) of people on our register are disabled compared to 1.1 percent of overseas applicants.

106. Disabled applicants make up a slightly lower proportion of those who registered successfully than applicants in general (0.7 percent of people who registered successfully are disabled compared to 1.1 percent of applicants).

107. Nearly a third of non-disabled applicants registered successfully (30.2 percent or 10,507 people) compared to 18.4 percent (69 people) of disabled applicants.

Figure 3: Proportion of successful overseas applicants in comparison to all overseas applicants and people on NMC register by disability



Section 3

Ethnicity

108. Nearly half of overseas applicants were Asian (46 percent or 16,269 people) and just under a third were Black (30.2 percent or 10,696 people). A tenth were of Mixed ethnicity (10.1 percent or 3,587 people), 7.5 percent (2,640 people) were White and 5.1 percent (1,819 people) were of Other ethnicity.

109. Around a quarter of applicants were of Asian Indian ethnicity (26.9 percent or 9,509 people) with another quarter identifying as Black African (25.5 percent or 9,013 people). Under a fifth of applicants identified as Asian – any other Asian background (17.9 percent or 6,344 people).

110. There are a higher number of people from minority ethnic backgrounds in our overseas process compared to our register as a whole. For example, people identifying as Asian Indian comprise 3.3 percent (23,498 people) of our register, people identifying as Black African make up 6.8 percent (48,990 people) of the register. In comparison, people of White British/English/Scottish/Welsh/Northern Irish ethnicity comprise 69 percent of our register as a whole compared to 7.5 percent (2,639 people) of overseas applicants.

111. People of Asian Indian ethnicity make up a bigger proportion of people who successfully registered than they do of applicants as a whole (32.8 percent of successful applicants were Asian Indian compared to 26.9 percent of applicants overall). This is also the case for people of other Asian backgrounds who comprise 27.1 percent of people who successfully registered compared to 17.9 percent of all applicants. Those identifying as Black African comprise a much lower proportion of people who successfully registered (9.7 percent of those who successfully registered were Black African compared to 25.5 percent of applicants overall).

112. Differences in registration are also apparent when you look at the numbers of people in each ethnic group that register successfully. For example, 11.4 percent (1,029 people) of Black African ethnicity who had started an application through the overseas process registered successfully compared to 45.3 percent (2,876 people) of Asian other ethnicity.

Section 3

Table 3: Proportion of successful overseas applicants in comparison to all overseas applicants and people on NMC register by ethnicity

	On register (N=716607)	Applied through OS process (N=35367)	Registered successfully (N=10614)
Asian - Any other Asian background	4.3%	17.9%	27.1%
Asian - Bangladeshi	0.2%	0.0%	0.0%
Asian - Chinese	0.3%	0.5%	0.4%
Asian - Indian	3.3%	26.9%	32.8%
Asian - Pakistani	0.5%	0.6%	0.2%
Black - African	6.8%	25.5%	9.7%
Black - Any other black background	0.2%	0.2%	0.1%
Black - Caribbean	1.5%	4.5%	3.2%
Mixed - Any other mixed/multiple ethnic background	0.4%	0.2%	0.2%
Mixed - White and Asian	0.3%	9.1%	12.9%
Mixed - White and black African	0.3%	0.7%	0.3%
Mixed - White and black Caribbean	1.1%	0.1%	0.1%
Other - Any other ethnic group	0.9%	5.1%	7.9%
White - Any other white background	4.6%	0.0%	0.0%
White - English/ Welsh/ Scottish/ Northern Irish/British	69.0%	7.5%	4.3%
Prefer Not to Say/ Unknown	4.5%	1.0%	0.9%

Section 3

Sexual orientation

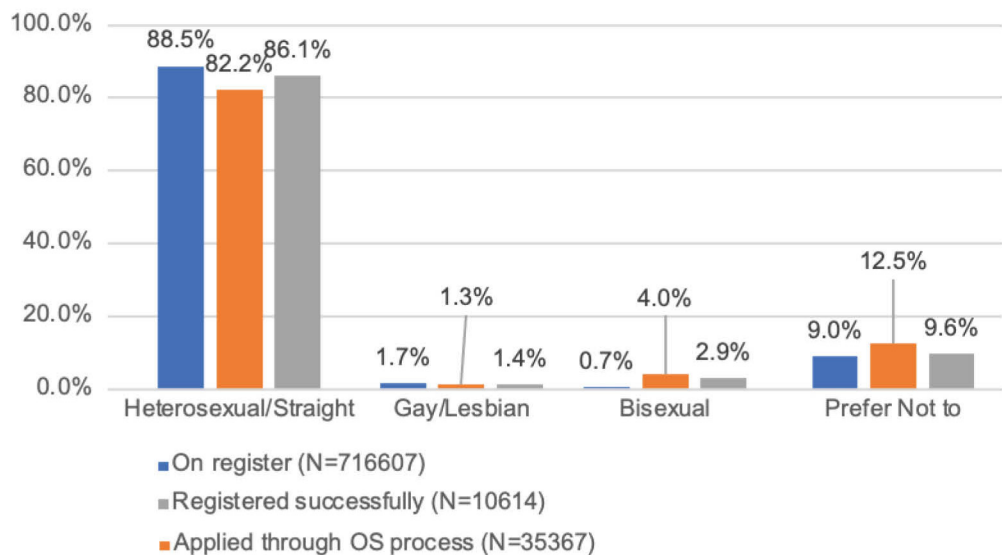
113. Most overseas applicants identified as heterosexual (82.2 percent or 29,065 people) with 4 percent identifying as bisexual (1,424 people), 1.3 percent as gay or lesbian (462 people) and 12.5 percent (4,416 people) preferring not to say.

114. Compared to our register as whole, there is a lower proportion of heterosexual overseas applicants and a higher proportion of bisexual people and those whose sexual orientation we don't know (or who prefer not to say). The percentage of people who applied through the overseas route and identify as bisexual is considerably higher than people who identify as bisexual on our register. For example, 88.5 percent of our register identify as heterosexual, 1.7 percent identify as gay or lesbian and 0.7 percent identify as bisexual. We didn't know the sexual orientation of under a tenth of people (9 percent or 64,801 people), or they preferred not to say, compared to the 12.5 percent of overseas applicants.

115. People identifying as heterosexual make up a bigger proportion of those who successfully register compared to all applicants (86.1 percent of people who successfully registered identified as heterosexual compared to 82.2 percent of all applicants). In comparison, only 2.9 percent of people who successfully registered identify as bisexual even though this group make up 4 percent of all overseas applicants.

116. A fifth of people identifying as bisexual who started an application registered successfully (21.3 percent, 304 people) compared to 31.2 percent (144 people) identifying as gay or lesbian and 31.5 percent (9,143 people) identifying as heterosexual.

Figure 4: Proportion of successful overseas applicants in comparison to all overseas applicants and people on NMC register by sexual orientation



Section 3

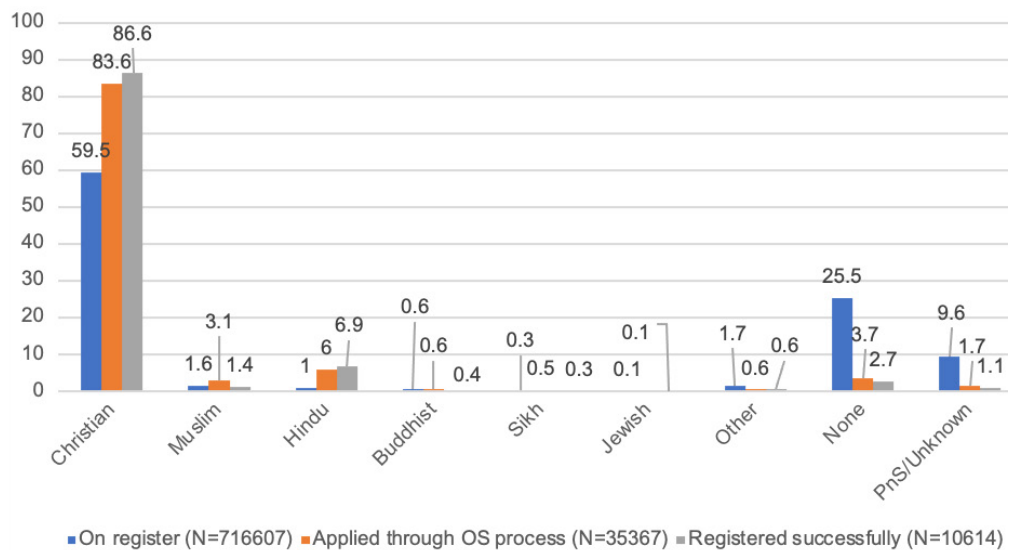
Religion or belief

117. Most overseas applicants identified as Christian (83.6 percent or 29,583) with the next biggest group being people identifying as Hindu who comprised 6 percent of applicants (2,130 people).

118. Overseas applicants are more religiously diverse than our register. There is a higher proportion of people identifying as Christian amongst the overseas applicants compared to on our register (83.6 percent of overseas applicants compared to 59.5 percent of our register), Hindu (6 percent of overseas applicants compared to 1 percent of our register), and Muslim (3.1 percent of overseas applicants compared to 1.6 percent of our register). In comparison, there are less people identifying as no religion (3.7 percent of overseas applicants compared to 25.5 percent of our register).

119. People identifying as Christian and Hindu make up a bigger proportion of the people who successfully register than they do applicants as a whole (86.6 percent and 6.9 percent of successful applicants identify as Christian and Hindu respectively compared to 83.6 percent and 6 percent of all applicants). In contrast, those identifying as no religion, Sikh, Buddhist and Muslim comprise a lower proportion of successful applicants than they do of all applicants (of successful applicants, 2.7 percent identify as no religion, 0.3 percent identify as Sikh, 0.4 percent as Buddhist and 1.4 percent as Muslim compared to 3.7 percent, 0.5 percent, 0.6 percent and 3.1 percent of all applicants respectively).

Figure 5: Proportion of successful overseas applicants in comparison to all overseas applicants and people on NMC register by religion or belief



Section 3

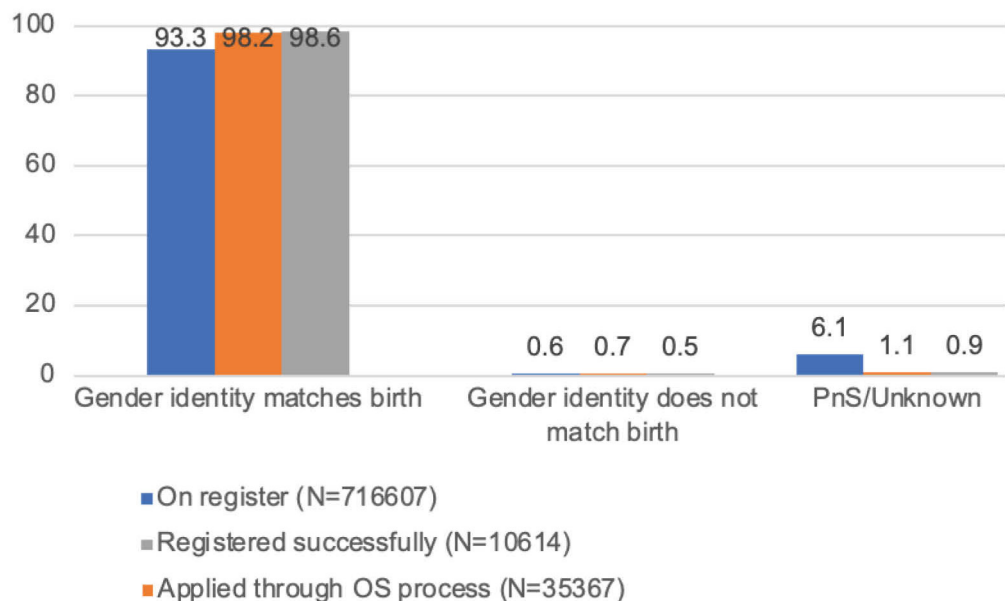
Gender identity

120. Nearly all overseas applicants said their gender matched the sex assigned to them at birth (or within six weeks) (98.2 percent or 34,739 people). In comparison, 0.7 percent (255 people) said that their gender did not match that assigned at birth.

121. There is a similar proportion of people whose gender identity does not match that assigned at birth (or within six weeks) on our register as a whole (0.6 percent) and a lower proportion of people whose gender matches that assigned at birth (93.3 percent). However, more people on our register prefer not to tell us their gender identity (or we don't know this) compared to overseas applicants (we don't know the gender identity of 6.1 percent of our register or they prefer not to say compared to 1.1 percent of overseas applicants).

122. There is a slightly lower proportion of people who say their gender identity does not match that at birth and those who prefer not to say among the people who successfully register compared to applicants in general (0.5 percent of people who successfully register said their gender identity does match that assigned at birth or within six weeks compared to 0.7 percent of all applicants, and 0.9 percent of people who successfully registered that we did not know their gender identity or they preferred not to tell us compared to 1.1 percent of all applicants).

Figure 6: Proportion of successful overseas applicants in comparison to all overseas applicants and people on NMC register by gender identity



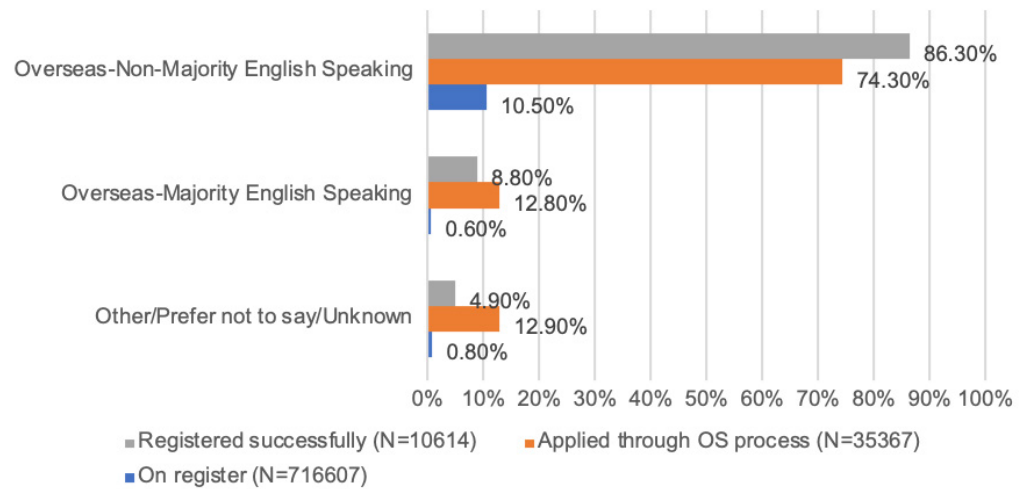
Section 3

Training country

123. Nearly two-thirds of overseas applicants had trained in a non-majority English speaking country outside of the UK and the EU (74.3 percent, 26,277 people). Just over a tenth of applicants trained in a majority English speaking country outside the UK and EU (12.8 percent, 4,533 people).

124. A higher proportion of applicants who had trained overseas in a non-majority English speaking country registered successfully compared to those who had trained in a majority English speaking country overseas, and those who had trained either in the UK or within the EU. For example, 34.8 percent (9,157 people) of applicants trained overseas in a non-majority English speaking country registered successfully compared to 20.6 percent (934 people) of people trained in a majority English speaking country overseas and 11.5 percent (523 people) trained elsewhere.

Figure 7: Proportion of successful overseas applicants in comparison to all OS applicants and people on NMC register by training country



Section 3

Factors that influence registration in our previous overseas process

125. This section is divided into two sub-sections.

125.1 Analysis of the proportion of applicants with different characteristics at different stages of our overseas process.

125.2 Detailed analysis to identify which factors influence a person's chances of registering successfully through our overseas process. This analysis will look at the influence of a person's protected characteristics alongside where they trained and will identify whether, and how much particular protected characteristics affect an applicant's chances of being able to register successfully.

The progress of different groups through our previous overseas process

126. Our data suggests that there are differences in how far people with different protected characteristics progress through our overseas process. As of 1 April 2019, the following groups were represented in bigger proportions in the earlier stages of our overseas process:

126.1 Trans applicants²⁰¹ - 31.4 percent of trans applicants were recorded at the eligibility criteria stage compared to 5.5 percent of women who identify with the gender assigned at birth and 5.6 percent of men who identify with the gender assigned at birth. Similar proportions of these groups are recorded at the computer-based test stage.

126.2 People aged 41 years and above - around a third of people aged 51-55 and over 56 years were recorded at the eligibility criteria stage compared to a quarter of 21-30 year olds and a fifth of those aged 31-40.

126.3 Disabled applicants - over a third (35.6 percent) of disabled applicants were recorded at the eligibility criteria compared to 24 percent of applicants without a disability. A similar proportion of these groups were recorded at the computer-based test stage of the process.

126.4 Black and White applicants - 31.4 percent and 34.1 percent of Black and White applicants were at the eligibility stage and 37.4 percent and 30.6 percent respectively were recorded at the computer-based test stage. This compares to 20.9 percent of Mixed and 19.2 percent of Asian applicants at the eligibility stage and 20.2 percent of each group at the computer-based test stage.

Section 3

126.5 Bisexual applicants – 31.2 percent of bisexual applicants were recorded at the eligibility stage compared to 22.9 percent of heterosexual, 27.5 percent of gay or lesbian, and 29.7 percent of applicants whose sexual orientation we didn't know (or they preferred not to say). Applicants identifying as bisexual or those whose sexual orientation we didn't know (or they preferred not to say) were also more likely to be showing at the computer-based test and ID check stages.

126.6 Muslim applicants and those with no religion – over a third of Muslim applicants (38.9 percent) and just under a third of applicants with no religion (30 percent) are recorded at the eligibility stage compared to 23.2 percent of Christian applicants.

127. This report looked at overseas applications between 1 April 2016 and 31 March 2019, a period in which applicants would have gone through our old overseas process (see points 79-85 above). The first stage of this process where we would have made a decision on a person's application would be the Full Application and Assessment stage.

128. There were issues with the old overseas process which mean we cannot identify which applicants have dropped out or decided not to continue with their application. We cannot identify which applications did not meet the required standard at each stage, or which were ongoing as of 1 April 2019. For example, many applicants started multiple applications without completing the eligibility form. This means that some applications may be showing at the eligibility when the applicant did not complete the eligibility form. The changes we have made to the overseas process address these issues. However, for this analysis it means that our findings on how far people progress through the process and therefore their likelihood of registering successfully should be interpreted with caution.

The influence of protected characteristics on likelihood of registering successfully

129. Our analysis looked at the influence of an applicant's protected characteristics on their likelihood of registering successfully through the overseas process. We included age, gender, gender identity, sexual orientation, religion, disability, ethnicity and where they trained.

130. We did not include profession as only a small number of people applied to join as a midwife, and no-one applied to join as a nursing associate.

Section 3

131. Our analysis suggests that of those who applied through the overseas process, the following groups are less likely to register successfully. These are the same groups that are recorded in higher proportions at earlier stages of our application process¹:

131.1 Applicants whose gender and/or gender identity we don't know or they prefer not to say. Overseas applicants whose gender and/or gender identity we don't know (or who prefer not to say) are the least likely to register successfully after starting an application compared to applicants identifying with other genders and gender identities. They are 34.8 percentage points*** less likely to register successfully compared to female applicants who identify with the gender they were assigned at birth [or within six weeks]; 34 percentage points*** less likely than male applicants who identify with the gender assigned to them at birth [or within six weeks]; and 21.8 percentage points*** less likely than applicants who identify as trans.

131.2 Applicants aged over 41. Overseas applicants over 41 years are the least likely to register successfully after starting an application compared to applicants of other ages. They are 14.2 percentage points*** less likely to register successfully than those aged 21-30; and 11.4 percentage points*** less likely than applicants aged 31-40 years.

131.3 Disabled applicants. Disabled applicants are the least likely to register successfully after starting an application and are 6.4 percentage points** less likely to register successfully compared to non-disabled applicants.

131.4 Black applicants. Black applicants are the least likely to register successfully after starting an application compared to applicants of other ethnicities. They are 21.8 percentage points*** less likely to register successfully than Asian applicants; 21.3 percentage points*** less likely than Mixed ethnicity applicants; 4.5 percentage points*** less likely than White applicants; 27.8 percentage points*** less likely than those identifying as Other ethnicity; and 16.5 percentage points*** less likely than applicants whose ethnicity we don't know or they prefer not to say.

131.5 Bisexual applicants. Bisexual applicants are the least likely to register successfully after starting an application compared to applicants identifying with other sexual orientations. They are 8.2 percentage points*** less likely to register successfully than heterosexual applicants; and 6.7 percentage points** less likely than gay or lesbian applicants.

¹Only those results that are statistically significant are presented and we have limited the results to those with a minimum of 1 percent percentage point difference. *** indicate that the result is significant to the 0.001 level ($P \leq 0.001$); ** indicates significance at the 0.01 level ($P \leq 0.01$) and * indicates significance at 0.05 level ($P \leq 0.05$).

Section 3

131.6 Muslim applicants. Applicants identifying as Muslim are the least likely to register successfully after starting an application compared to applicants of other religions or beliefs. They are 12.2 percentage points*** less likely to register successfully than Christian applicants; 9 percentage points*** less likely than Hindu applicants; and 8.7 percentage points*** less likely than applicants identifying as no religion.

131.7 Applicants whose training country we don't know. Applicants whose training country we don't know are the least likely to register successfully after starting an application compared to applicants that trained in other countries. They are 7.4 percentage points*** less likely to register successfully compared to those who trained overseas in a majority English speaking country; and 4.7 percentage points*** less likely than those who trained overseas in a non-majority English speaking country.

132. We looked to see whether there was any relationship between these characteristics and explore the intersectionality question about whether specific groups are impacted. We found no relationship between age, gender and gender identity. We did find a relationship between age and ethnicity. Our analysis shows that of all age groups, overseas applicants aged 21-30 are the most likely to register successfully and those aged over 41 are the least likely to register successfully. However, this does not hold when looking at the interaction between a person's age and their ethnicity. Our analysis suggests that Black nurses aged 31-40 are the most likely to register successfully, not those aged 21-30. Black nurses aged over 41 are still the least likely to register successfully compared to Black nurses of other ages.

133. Anecdotally, we know that the experience of applying to join our register may be easier for nurses and midwives who are supported by a recruitment agency. Research from organisations like the Royal College of Nursing suggest that the overseas application process is long and complex²⁰². It may be that those settings with higher proportions of staff who trained outside of the EU/EEA (as indicated by our revalidation data), such as care homes, mental health and prisons are less likely to use recruitment agencies.

Section 3

Revalidation

The people who revalidated

134. This section presents the findings from our descriptive analysis and focuses on outlining the number and percentage of people with different protected characteristics who:

134.1 were due to revalidate between 1 April 2016 and 31 March 2019

134.2 successfully revalidated.

135. The figures presented in this section simply summarise and describe the people who were due to, and either did or did not, revalidate. It does not explain why any groups did or did not revalidate or make any comment about whether certain factors are more important in determining whether someone revalidates successfully or not. This type of analysis is presented in the next section.

136. Between 1 April 2016 and 31 March 2019, 642,501 nurses and midwives were due to revalidate. Of these, 609,559 (94.9 percent) successfully completed the revalidation process, 17,031 (2.7 percent) started a revalidation application but did not successfully complete it. The revalidation status of the remaining 15,911 (2.5 percent) was still outstanding as of 1 April 2019.

137. Most people revalidating did so as a nurse, (or a Specialist Community Public Health Nurse (SCPHN) (93.8 percent or 602,873 people). During this period, 5 percent were revalidating as midwives (including midwife SCPHN) (32,353 people) and 1.1 percent (7,275 people) were revalidating as both a nurse and midwife (including nurse, midwife SCPHN).

138. People revalidating had been practising for between three to 36 years, with just over a third of people (35.6 percent or 229,023) practising between 23 and 25 years.

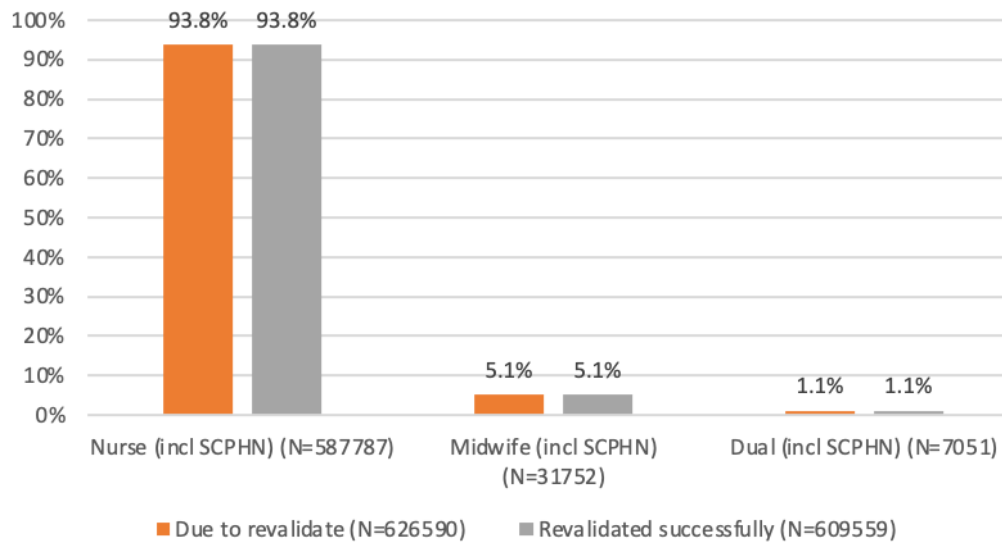
139. Most people who were revalidating during this period lived in the UK (1.6 percent or 10,800 people lived outside of the UK in the EU or more widely). More than a tenth (14.5 percent, 92,985 people) lived in South East England with the next largest group having an address in Scotland (10 percent or 64,523).

Section 3

Profession

140. There was no difference in the proportion of nurses and midwives that revalidated successfully compared to those who were due to revalidate.

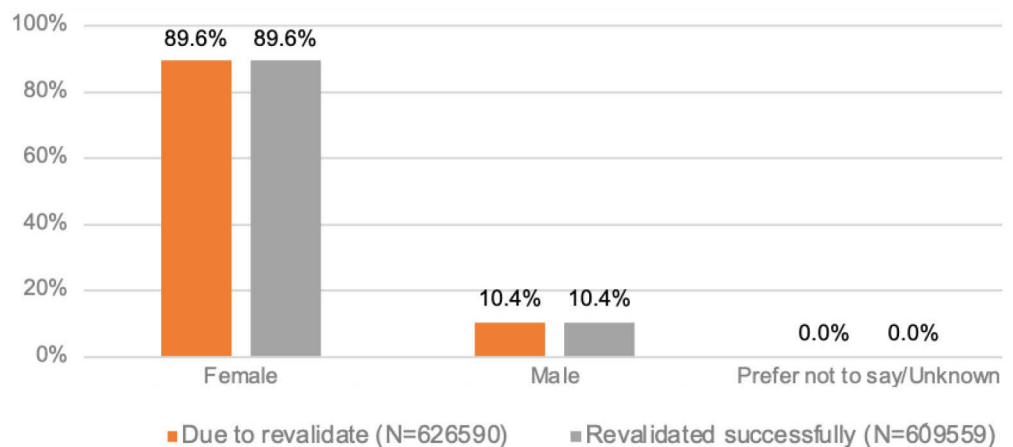
Figure 8: Proportions of nurses and midwives who revalidated successfully compared to those due to revalidate by profession



Gender

141. There was no difference in the proportion of men and women that revalidated successfully compared to those who were due to revalidate.

Figure 9: Proportions of nurses and midwives who revalidated successfully compared to those due to revalidate by gender

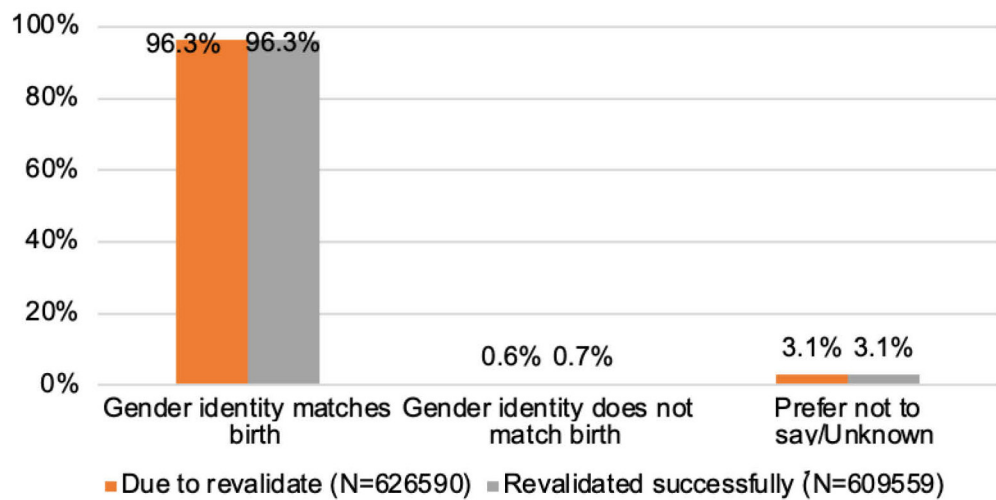


Section 3

Gender identity

142. There is no difference in the proportions of people who revalidated successfully compared to those who were due to revalidate for nurses and midwives who identify with the gender assigned to them at birth (or within six weeks) or those whose gender identity we don't know (or who preferred not to say). A slightly higher proportion of trans nurses and midwives revalidated successfully compared to the proportion that were due to revalidate.

Figure 10: Proportions of nurses and midwives who revalidated successfully compared to those due to revalidate by gender identity



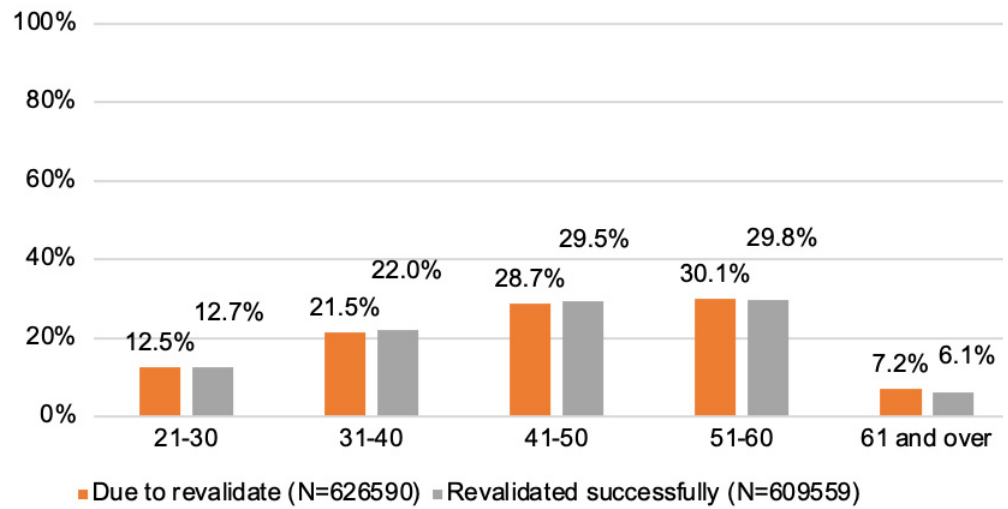
Age

143. People aged 50 and under make up a higher proportion of those who revalidated successfully compared to proportion that were due to revalidate.

144. A lower proportion of nurses and midwives aged 51 and above revalidated compared to the number that were due to. Some of these groups may have left our register without attempting to revalidate. Others may have chosen to retire rather than revalidate (as the existing evidence suggests). Of key concern to us is to determine how many of these people would have left our register or retired irrespective of having to revalidate.

Section 3

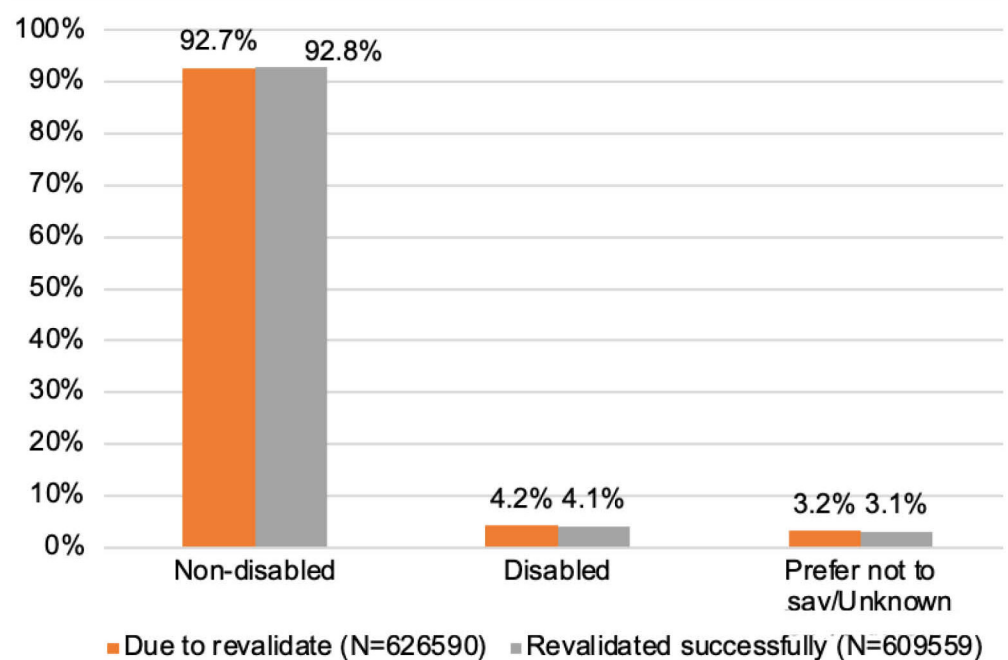
Figure 11: Proportions of nurses and midwives who revalidated successfully compared to those due to revalidate by age group



Disability

145. A higher proportion of non-disabled nurses and midwives revalidated successfully compared to those that were due to revalidate. A lower proportion of disabled nurses and midwives and those for whom we didn't know whether they were disabled or not (or they preferred not to say) revalidated successfully compared with those who were due to revalidate.

Figure 12: Proportion of nurses and midwives who revalidated successfully compared to those due to revalidate by disability



Section 3

Ethnicity

146. A higher proportion of nurses and midwives who are Asian Pakistani and Black African revalidated successfully compared to the proportion that were due to revalidate. In comparison, a lower proportion of professionals who are White English/Welsh/Scottish/Northern Irish/British, White Irish or White Other revalidated successfully compared to the number that were due to revalidate.

Table 4: Proportion of nurses and midwives who revalidated successfully compared to those due to revalidate by ethnicity

	Due to revalidate (N=626590)	Revalidated successfully (N=609559)
Asian - Any other Asian background	4.1%	4.1%
Asian - Bangladeshi	0.1%	0.1%
Asian - Chinese	0.4%	0.4%
Asian - Indian	3.4%	3.4%
Asian - Pakistani	0.4%	0.5%
Black - African	6.3%	6.4%
Black - Any other black background	0.2%	0.2%
Black - Caribbean	1.5%	1.5%
Mixed - Any other mixed/multiple ethnic background	0.4%	0.4%
Mixed - White and Asian	0.3%	0.3%
Mixed - White and Black African	0.3%	0.3%
Mixed - White and Black Caribbean	1.1%	1.1%
Other - Any other ethnic group	0.9%	0.9%
Prefer not to say/Unknown	1.3%	1.3%

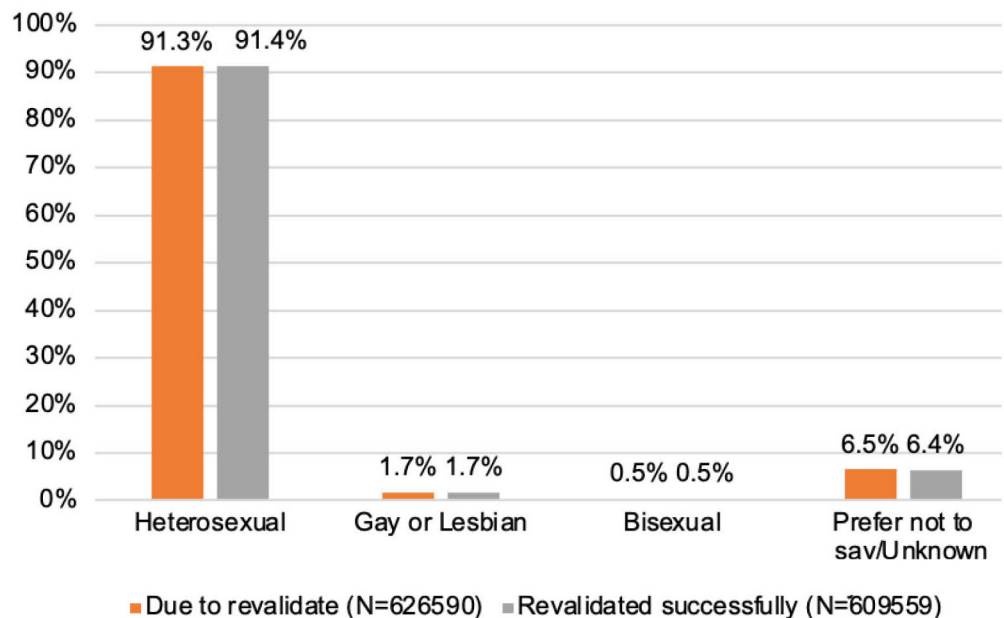
Section 3

	Due to revalidate (N=626590)	Revalidated successfully (N=609559)
White - Any other white background	4.7%	4.6%
White - English/Welsh/Scottish/ Northern Irish/British	72.7%	72.6%
White - Gypsy or Irish Traveller	0.0%	0.0%
White - Irish	2.0%	1.9%

Sexual orientation

147. A slightly higher proportion of heterosexual nurses and midwives revalidated successfully compared to the proportions that were due to revalidate. A slightly lower proportion of nurses and midwives whose sexual orientation we don't know (or who preferred not to say) revalidated compared to the proportion that was due to.

Figure 13: Proportion of nurses and midwives who revalidated successfully compared to those due to revalidate by sexual orientation



Section 3

Religion or belief

148. A lower proportion of Christian and Buddhist nurses and midwives revalidated successfully compared to the proportions that were due to revalidate. A higher proportion of nurses and midwives with no religion revalidated successfully in comparison to the proportion that were due to revalidate.

Table 5: Proportion of nurses and midwives who revalidated successfully compared to those due to revalidate by religion or belief

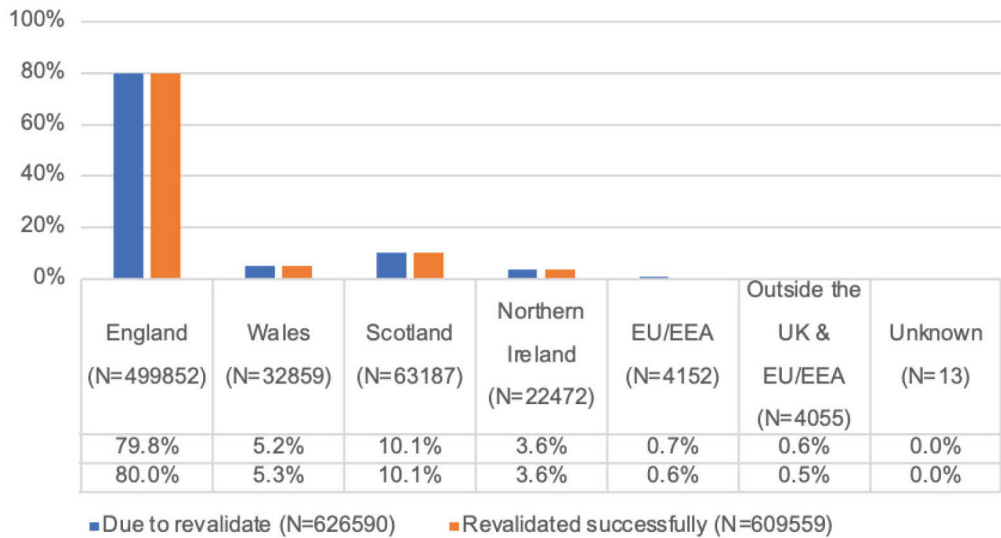
	Due to revalidate (N=626590)	Revalidated successfully (N=609559)
Christian	64.1%	64.0%
Muslim	1.3%	1.3%
Hindu	1.0%	1.0%
Buddhist	0.7%	0.6%
Sikh	0.3%	0.3%
Jewish	0.1%	0.1%
Others	1.7%	1.7%
None	23.8%	23.9%
Prefer not to say/Unknown	7.0%	7.0%

Section 3

Address country

149. A slightly higher proportion of nurses and midwives living in England and Wales revalidated compared to those that were due to revalidate. In contrast, a slightly lower proportion of professionals living outside the UK in either the EU/EEA, or outside of it, revalidated successfully compared to the numbers that were due to.

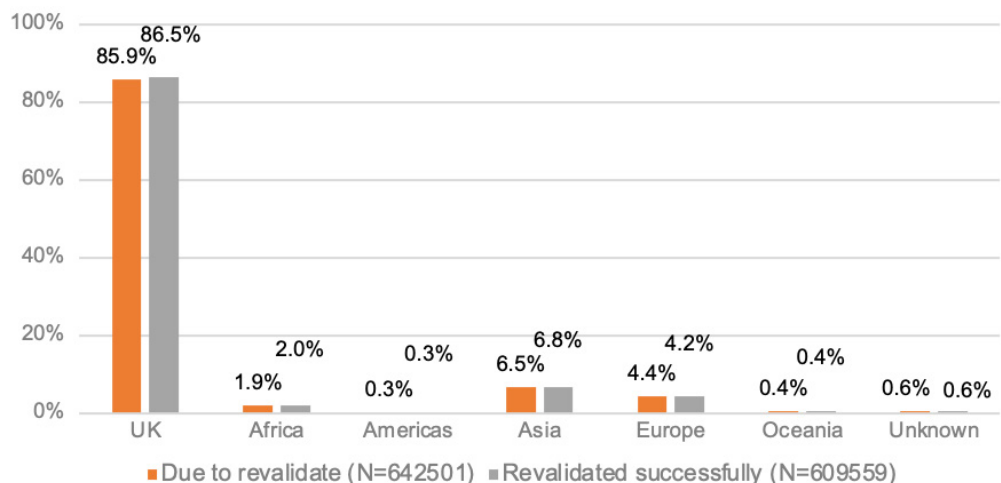
Figure 14: Proportion of nurses and midwives who revalidated successfully compared to those due to revalidate by country of address



Training country

150. Most of the people who were due to revalidate had trained in the UK (85.9 percent, 551,629). A higher proportion of nurses and midwives who had trained in the UK, Africa and Asia revalidated successfully compared to the proportions that were due to revalidate.

Figure 15: Proportion of nurses and midwives who revalidated successfully compared to those due to revalidate by where trained



Section 3

Work setting

151. We know that nurses and midwives can do more than one type of job. At revalidation, we ask people to declare all of the types of jobs that they do to meet the 450 practice hours' requirement. This means that someone who is self-employed and who does additional voluntary work could record both employment types at revalidation.

152. Between April 2016 and March 2019, nearly two-thirds of people were working in a hospital setting and a quarter said they were working in primary care (including GP practices and community settings). Just under a tenth were working in 'Other' settings, which includes the cosmetic or aesthetic sector, police and the military as well as non-direct clinical care such as consultancy, governing bodies, inspectorates and policy settings²⁰³. These proportions are broadly in line with the proportion of people who said they were working in these settings when they revalidated in 2019-2020.

153. Our [2019-2020 revalidation data](#) suggests that some settings are likely to have higher proportions of particular groups working in them. For example, women, people aged under 50 years, people who are not of White British ethnicity and people who trained outside the EU and EEA declared a higher proportion of jobs in hospital settings compared to other groups; women, people of White British ethnicity and people who trained in the UK reported a higher proportion of jobs in primary care settings compared to other groups and men, people who are not of White British ethnicity and people who trained outside the EU/EEA declared a higher number of jobs in social care settings compared to other groups.

Table 6: Proportion of nurses and midwives who revalidated successfully compared to those who revalidated successfully in 2019-20 by work setting

	Revalidated Apr 19–Mar 20 (N=212339)	Due to revalidate (N=626590)	Revalidated successfully (N=602531) ²
Hospital	59.3%	56.2%	59.0%
Primary care	23.5%	22.6%	23.8%
Social care	7.5%	7.4%	7.8%
Other	9.7%	9.0%	9.5%
Unknown	0%	6.0%	6.6%

²The total number of people who revalidated successfully between 1 April 2016 and 31 March 2019 was 609559. However, the number of people who revalidated with information about work setting was 602531.

Section 3

Factors that influence revalidation

The influence of protected characteristics on likelihood of revalidating successfully

154. This section presents the findings from our detailed analysis to identify which factors influence a person's chances of revalidating successfully. It analyses whether, and to what extent, a person's protected characteristics affect their chances of revalidating successfully alongside where they trained. It will also show how much they influence it and which characteristics matter more than others.

155. In looking at the influence of a person's protected characteristics on the likelihood of them revalidating, we included the following factors in our analysis: age, gender and gender identity, sexual orientation, disability, religion, ethnicity, where people lived, where they trained, and profession. No nursing associates were due to revalidate between April 2016 and March 2019 and so they are not included in our analysis.

156. When taking into account all of the factors above, our analysis suggests that of the nurses and midwives that were due to revalidate, the following groups are less likely to revalidate successfully³:

156.1 Nurses and midwives aged over 60. Nurses and midwives aged over 60 are the least likely to revalidate compared to other age groups. Professionals aged over 60 are 11.6*** percentage points less likely to revalidate than those aged 21-30, 11.4*** percentage points less likely than those aged 31-40 years; 11.4*** percentage points less likely than professionals aged 41-50; 10.3*** percentage points less likely than professionals aged 51-55; and 6.8*** percentage points less likely than those aged 56-60 years.

156.2 Male nurses and midwives who identify with the gender assigned to them at birth. Men identifying with the gender assigned to them at birth are the least likely to revalidate successfully compared to professionals identifying with other genders and gender identities. They are 1*** percentage point less likely to revalidate than women whose gender identity we don't know (or they prefer not to say) and 1.1*** percentage point less likely than people who do not identify with the gender assigned to them at birth.

³Only those results that are statistically significant are presented and we have limited the results to those with a minimum of 1 percent percentage point difference. *** indicate that the result is significant to the 0.001 level ($P \leq 0.001$); ** indicates significance at the 0.01 level ($P \leq 0.01$) and * indicates significance at 0.05 level ($P \leq 0.05$).

Section 3

156.3 Disabled nurses and midwives. Disabled nurses and midwives are the least likely to revalidate successfully compared to non-disabled professionals and those whose disability we don't know (or who prefer not to say). Disabled professionals on our register are 3.1*** percentage points less likely to revalidate compared to those without a disability and 1.4*** percentage points less likely to revalidate compared to those who we don't know whether they are disabled or not (or they prefer not to say). Nurses and midwives who we don't know if they are disabled (or they prefer not to say) are 1.7*** percentage points less likely to revalidate compared to those without a disability.

156.4 White nurses and midwives and those whose ethnicity we don't know (or they prefer not to say). White nurses and midwives and those whose ethnicity we don't know (or who prefer not to say) are the least likely to revalidate compared to other ethnicities. White nurses and midwives are 1.2*** percentage points less likely to revalidate than Asian professionals; 1.6*** percentage points less likely than Black professionals. Nurses and midwives whose ethnicity we don't know (or who prefer not to say) are 1***percentage point less likely to revalidate compared to Asian professionals; 1.4*** percentage points less likely compared to Black professionals.

156.5 Nurses and midwives living outside the UK and EU. People living overseas (outside the UK or EU) are the least likely to revalidate compared to people living elsewhere. Professionals who live overseas are at least 25 percentage points less likely to revalidate than those living in any area of England or the devolved countries; and 12.4 percentage points less likely than those living in EU.

156.6 Nurses and midwives who trained in Australia. Nurses and midwives who trained in Australia are the least likely to revalidate successfully compared to professionals who trained outside Australia. Compared to people trained in the UK, professionals who trained in Australia are: 2.9*** percentage points less likely to revalidate than those trained in a devolved country; 3.3*** percentage points less likely than those trained in the Midlands; 3.4*** percentage points less likely than those trained in the North; 2.3*** percentage points less likely than those trained in the UK before 2013; 3.1*** percentage points less likely than those trained in the south; and 2.5*** percentage points less likely than those trained in the UK after 2013 but whose educational institution we didn't know. Compared to those trained outside the UK, professionals who trained in Australia are: 1.5* percentage points less likely to revalidate than those trained in Americas; 3.5*** percentage points less likely than those trained in India; 3.5*** percentage points less likely than Philippines; 2.4*** percentage points less likely than Poland; 3.6*** percentage points less likely

Section 3

than those trained in the rest of Africa; 2.1*** percentage points less likely than those trained in the rest of Asia; 1.9** percentage points less likely than the rest of Oceania (a region in the Central and South Pacific Ocean that includes Australia, New Zealand, Papua New Guinea, Melanesia, Micronesia, and Polynesia (including the U.S. state of Hawaii)) 2.7*** percentage points less likely than Romania; 3.6*** percentage points less likely than South Africa.

157. These findings largely reflect what we know from our data and the independent evaluation of revalidation. That is, professionals who are aged over 60, who are male, disabled or living outside the UK have lower revalidation rates compared to others. Research suggests that older professionals in particular may find revalidation difficult with some choosing to retire rather than revalidate.

158. We were unable to look at the influence of work setting in our analysis. Yet we know from this research that people working in smaller organisations or more isolated settings such as GP practices and care homes, reported having less support from their employers to revalidate. They find it more difficult to meet some of the requirements, such as practice-related feedback. It may be that some of the differences we identify are due to place of work rather than characteristic. For example, we know that men, older nurses and midwives, and those who trained outside the EU/EEA, are represented in higher proportions among agency staff. Men are represented in higher numbers in settings such as mental health, prisons and care homes compared to their overall numbers on our register.

Fitness to Practise: Referrals

159. We launched a new [fitness to practise strategy in September 2017](#). This was a direct response to evidence we had about higher rates of employer referrals of certain groups, feedback about people's experiences of our fitness to practise processes and a better understanding about the factors that influence individual professionals' behaviour.

160. One aim of the strategy is to support employers to manage concerns appropriately at a local level. We know from the research we commissioned from the University of Greenwich that we receive disproportionate referrals of Black professionals and those whose ethnicity we don't know (or who prefer not to say). To help address this we've worked with a number of employers to develop a guide to support them to investigate concerns locally about someone's practice. The new resource helps employers think about all of the factors that may have contributed to a person's actions, inactions or behaviours.

Section 3

161. We're committed to promoting a 'just culture' that balances fairness, learning and accountability. By using tools and processes that promote a just culture, employers can ensure they look at concerns in a way that avoids fear and blame and helps everyone feel confident that they can speak up, knowing that they will be supported and treated fairly.

162. This new resource is about helping employers to have a better understanding of the challenges in the workplace that can affect a person's performance but has nothing to do with their capability to do the role. We investigate on the rare occasions when nursing or midwifery care goes wrong – something that affects less than one percent of the people on our register each year. We believe in giving professionals the chance to address concerns, but we'll always take action when needed.

163. We have also introduced new forms for professionals going through our fitness to practise process to help facilitate our approach to taking account of context in a more systematic, methodical and consistent way. The forms cover culture, discrimination and health.

164. The data in this report draws on our fitness to practise data between 1 April 2016 and 31 March 2019. As such, it is unlikely to capture any changes arising from our new strategy but will give us a useful baseline with which to measure progress against.

165. This section presents the findings from our descriptive analysis and focuses on outlining the number and percentage of people with different protected characteristics who:

165.1 were referred to us between 1 April 2016 and 31 March 2019

165.2 how this compares to the overall numbers of each group on our register.

166. The figures presented in this section are simply summarising and describing the people who were referred to us during this period. We cannot draw any conclusions about why the figures are at particular levels or identify any trends.

167. The next section identifies those factors that influence whether a person is referred to us or not. It considers protected characteristics alongside factors such as country of training and work setting. This allows us to identify how much influence a person's protected characteristics has on their chances of being referred, and which characteristics matter more than others.

Section 3

168. Between 1 April 2016 and 31 March 2019, 13,805 cases were referred to our fitness to practise process. These cases involved 12,077 professionals on our register (1,728 people were referred to us more than once over this period).

169. Nearly all cases involved a nurse (95 percent or 11,478 people) with less than 5 percent (4.8 percent or 577 people) involving a midwife.

170. We didn't receive any referrals relating to nursing associates²⁰⁴. As such, the section below focus only on nurses and midwives.

171. Most cases were referred by employers (43.7 percent or 6,027 cases), with just over a fifth referred by a member of the public or a person who uses services (22.9 percent or 3,163 cases).

Table 7: Referrals by source

Source	Number	Percentage
Employer	6027	43.7%
Patient/Public	3163	22.9%
Self-referral	1539	11.1%
Other registrant	626	4.5%
Police	295	2.1%
Other regulator	57	0.4%
Other	2021	14.6%
NA	77	0.6%
Total	13805	100.0%

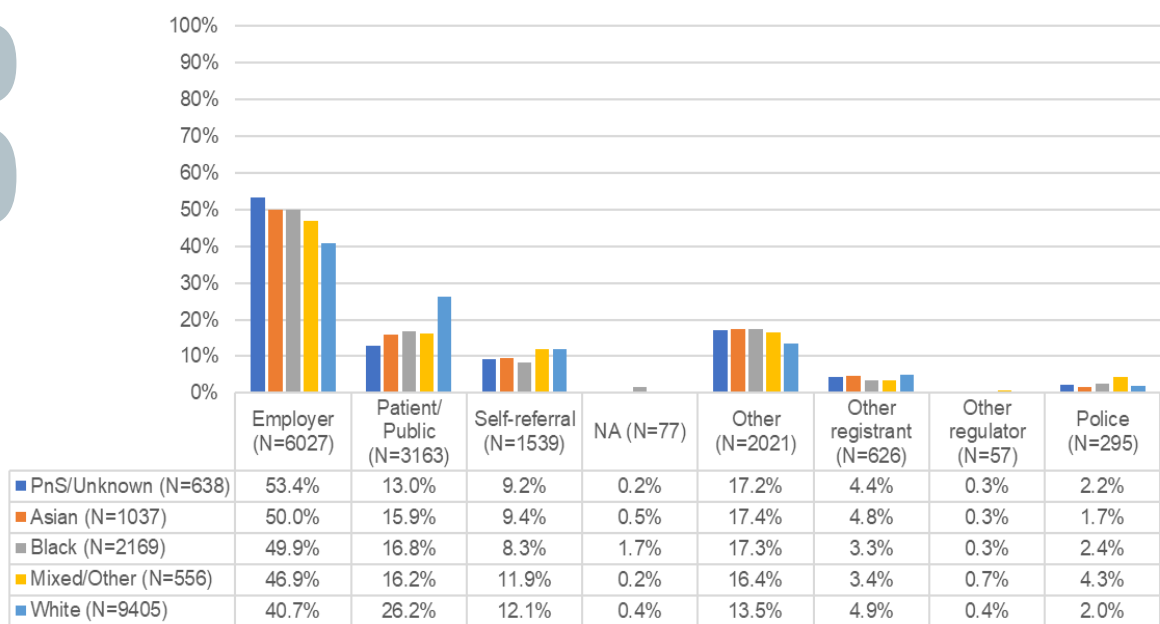
172. Employers were the biggest source of referral for all ethnic groups. Over half of referrals of people whose ethnicity we didn't know (or who preferred not to say) came from employers (53.4 percent, 341). Employers made around half of referrals of Asian (50 percent, 519) and Black professionals (49.9 percent, 1082). In comparison, employers made 40.7 percent (3,824) of referrals of White professionals.

Section 3

173. Members of the public and people who use services referred a higher proportion of White professionals compared to other ethnic groups. The public or people using services made just over a quarter (26.2 percent) of referrals of White nurses and midwives and these professionals made up 77.8 percent (2,460) of all referrals made by this group.

174. Nearly half of all cases involved a nurse, midwife or nursing associate who had trained in England (45.4 percent or 5,481 people). Around a third of cases involved a professional whose training country we didn't know (27.1 percent or 3,278 people).

Figure 16: Proportions of referrals by ethnic group and source of referral



Section 3

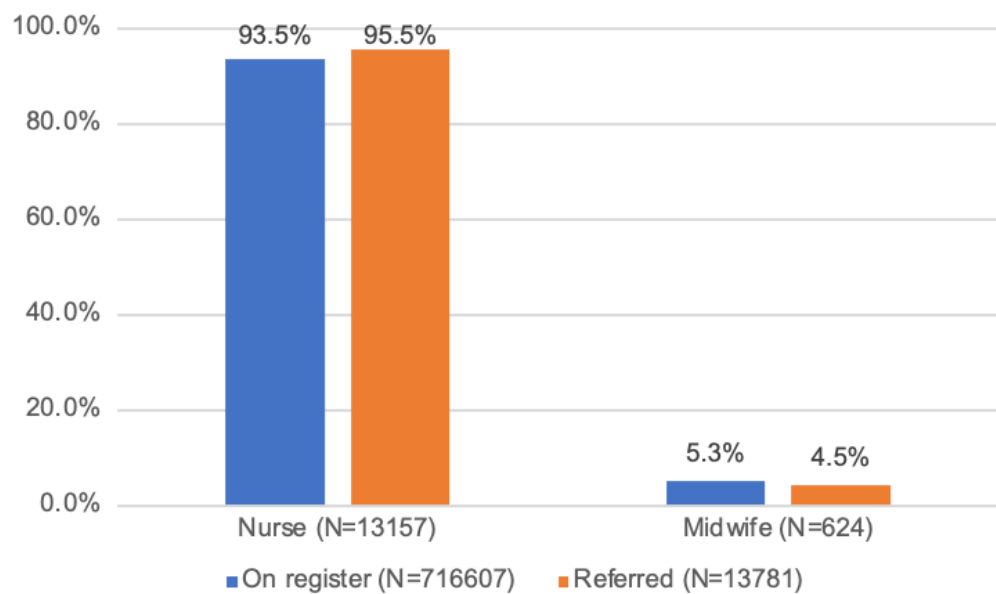
The people who were referred to us

175. This section presents the proportions of people with different characteristics who were referred to us between 1 April 2016 and 31 March 2019, alongside the proportions on register as of 31 March 2020.

Profession

176. Nurses made up a higher proportion of the people who were referred to us during this period compared to the overall proportions on our register (nurses made up 95.5 percent of the referrals we received during this time compared to comprising 93.5 percent of the people on our register). In contrast, midwives made up a lower proportion of referrals compared to the proportions on our register (4.5 percent of referrals compared to 5.3 percent of the register).

Figure 17: Proportions on register and referred by profession⁴



⁴The profession of the registrant was not available for 24 cases during this period.

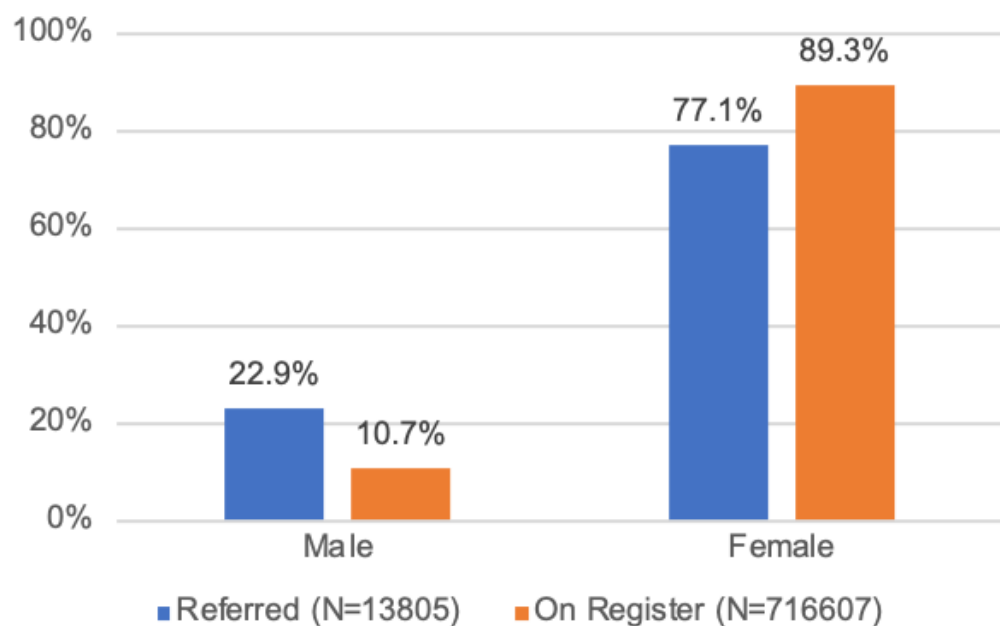
Section 3

Gender

177. More than two-thirds of the cases referred during this period involved a female nurse or midwife (77.1 percent or 9,431 people). Around a fifth involved a male professional (22.9 percent or 2,645 people).

178. We received a higher proportion of referrals about male nurses and midwives compared to the proportions of men on our register. In contrast, we received a lower proportion of referrals about female nurses and midwives compared to the proportions on our register.

Figure 18: Proportions on register and referred by gender



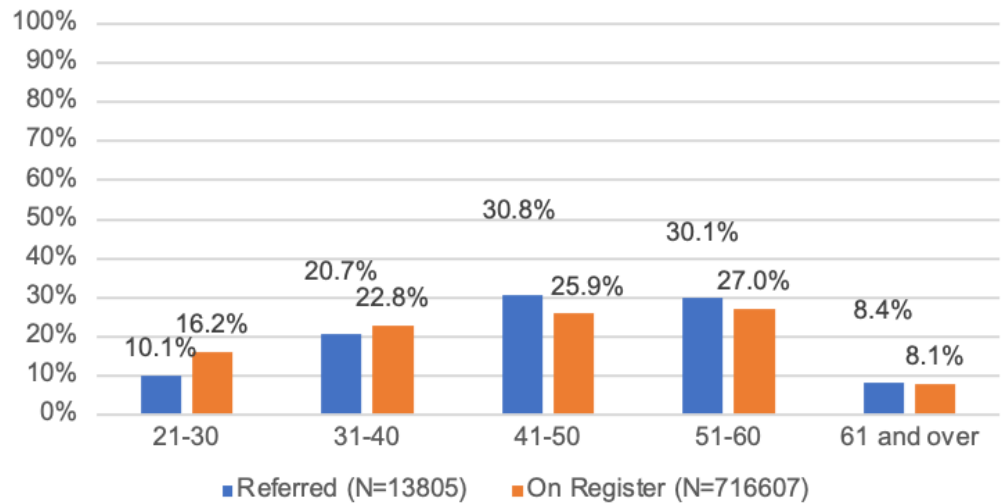
Age

179. Nearly a third of cases referred involved a professional aged between 41-50 (30.2 percent or 3,652 people) or 51-60 (30.1 percent or 3,634 people). A fifth involved a professional aged 31-40 (20.6 percent or 2,490 people).

180. A higher proportion of people aged 41-50 were referred to us compared to the number on our register as a whole. In comparison, fewer people aged 21-30 were referred to us than make up our register.

Section 3

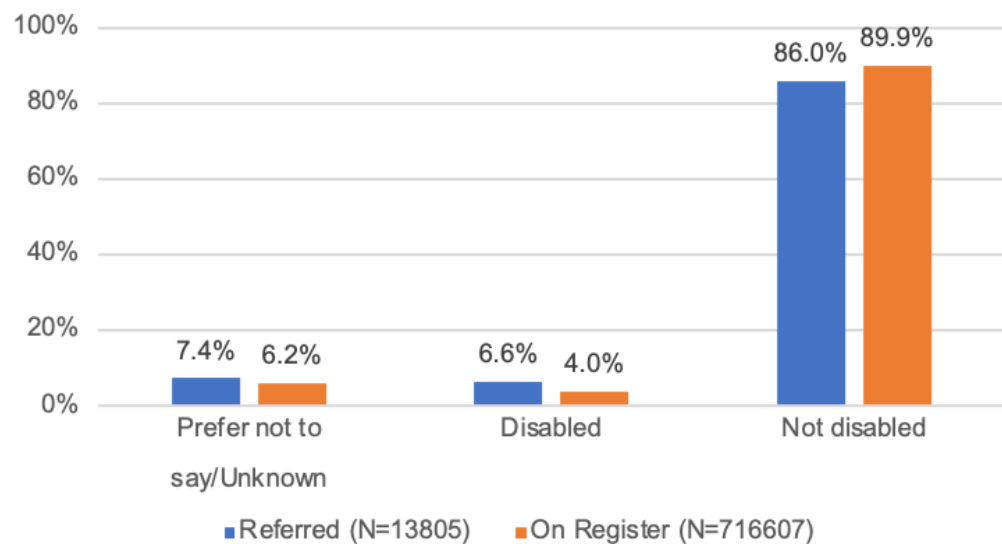
Figure 19: Proportions on register and referred by age group



Disability

181. Most referrals involved a nurse or midwife who was not disabled (86.4 percent or 10,439 people). There were a broadly similar proportion of cases that involved a disabled nurse or midwife or a professional whose disability we did not know (or who preferred not to tell us).

Figure 20: Proportions on register and referred by disability



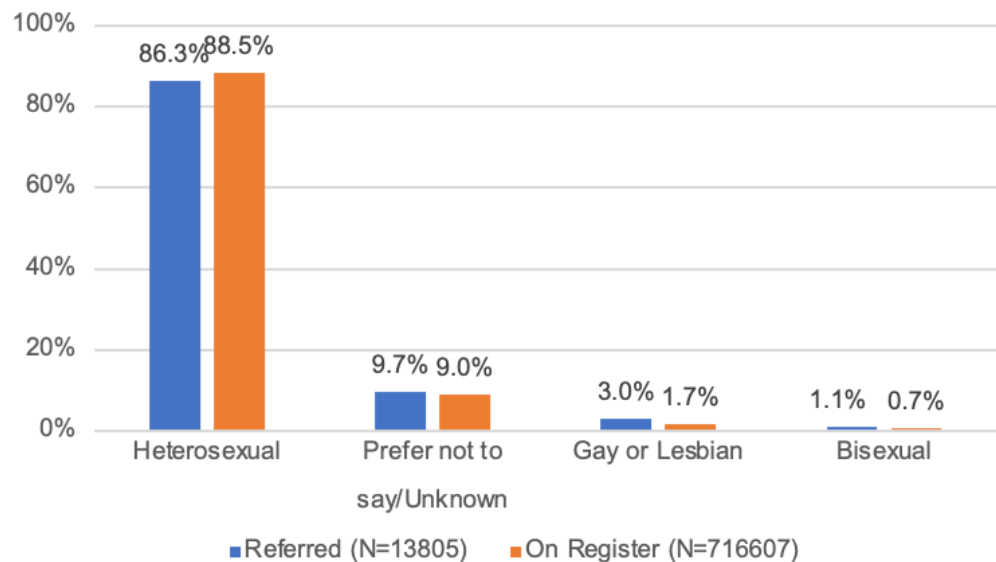
Section 3

Sexual orientation

182. Most cases involved a heterosexual nurse or midwife (86.3 percent or 11,910 people). Around a tenth of cases referred involved a professional whose sexual orientation we don't know or they had chosen not to declare this (9.7 percent or 1,337 people).

183. More people identifying as gay or lesbian were referred to us compared to the proportions on the register (1.7 percent on the register and 3.0 percent of referrals involved a professional identifying as gay or lesbian). There were also fewer referrals of people identifying as heterosexual compared to the proportions on the register (88.5 percent on the register and 86.3 of referrals).

Figure 21: Proportions on register and referred by sexual orientation



Ethnicity

184. Over two thirds of the cases referred to us involved a White nurse or midwife (68.3 percent or 9,425 people). Black professionals were involved in 15.7 percent of cases (2,169 people) and those from an Asian background were involved in 7.4 percent of cases (1,026 people).

185. In terms of specific ethnicities, most cases involving a White professional referred to someone who identified as White English/Welsh/Scottish/Northern Irish/British (60.8 percent or 8,389 people). Most cases that involved a Black professional referred to someone who identified as Black African (13.1 percent or 1,852 people).

Section 3

186. Compared to our register, more people identifying as Black (whether Black African, Caribbean or other) were referred compared to their numbers on the register. We saw fewer referrals of those identifying as White British and White Irish compared to their proportions on the register.

Table 8: Proportions on register and referred by ethnicity

	Referred (N=13805)	On Register (N=716607)
Asian - Any other Asian background	3.2%	4.3%
Asian - Bangladeshi	0.2%	0.2%
Asian - Chinese	0.3%	0.3%
Asian - Indian	2.9%	3.3%
Asian - Pakistani	0.8%	0.5%
Black - African	13.4%	6.8%
Black - Any other black background	0.4%	0.2%
Black - Caribbean	1.9%	1.5%
Mixed - Any other mixed/multiple ethnic background	0.5%	0.4%
Mixed - White and Asian	0.4%	0.3%
Mixed - White and Black African	0.5%	0.3%
Mixed - White and Black Caribbean	1.2%	1.1%
Other - Any other ethnic group	1.3%	0.9%
Prefer not to say/Unknown	4.7%	4.5%
White - Any other white background	6.1%	4.6%
White - English/Welsh/Scottish/Northern Irish/British	60.8%	69.0%
White - Gypsy or Irish Traveller	0.0%	0.0%
White - Irish	1.4%	1.9%

Section 3

Religion or belief

187. Around two thirds of cases referred to us involved a nurse, midwife or nursing associate who identified as Christian (62.7 percent or 8,6857 people). Around a fifth of cases involved a professional identifying with no religion (20.9 percent or 2,886 people).

188. We received more referrals involving professionals identifying as Christian, Muslim, Hindu, Buddhist, other (including Jewish) religion and those whose religion we don't know (or who preferred not to say) compared to the numbers on our register as a whole.

Table 9: Proportions on register and referred by religion

	Referred (N=13805)	On Register (N=716607)
Christian	62.7%	59.5%
None	20.9%	25.5%
Prefer not to say/ Unknown	9.7%	9.6%
Other (including Jewish)	2.5%	1.8%
Muslim	1.9%	1.6%
Hindu	1.1%	1.0%
Buddhist	0.8%	0.6%
Sikh	0.3%	0.3%

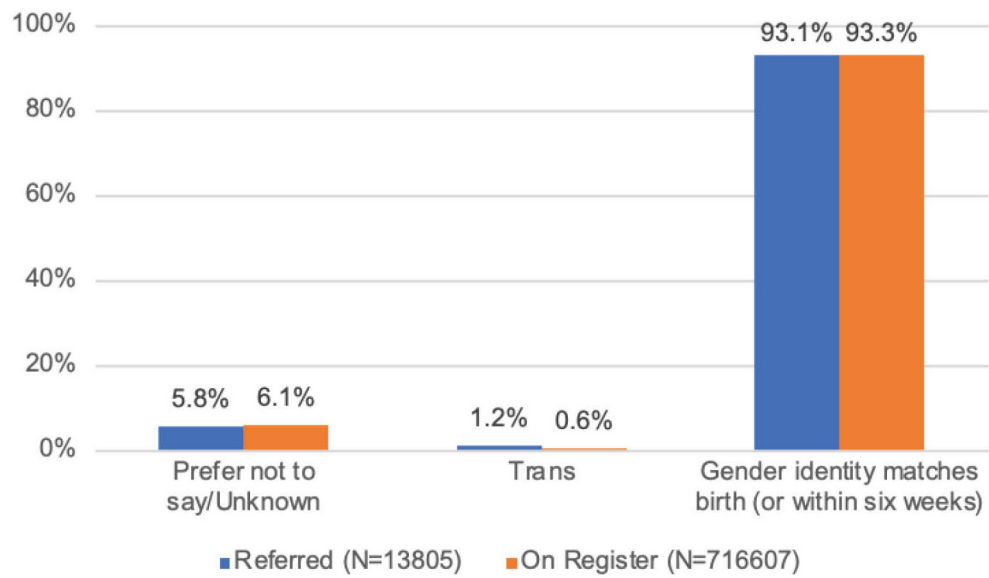
Gender identity

189. Most cases that were referred during this period involved a nurse, midwife or nursing associate who identified with the gender assigned to them at birth (93.1 percent or 12,848 people). Professionals who do not identify with the gender assigned to them at birth were involved in 1.2 percent of cases (161 people).

190. Compared to the numbers on the register in general, we received a higher number of referrals about professionals who do not identify with the gender assigned at birth and a lower proportion of those whose gender identity we didn't know (or who preferred not to say).

Section 3

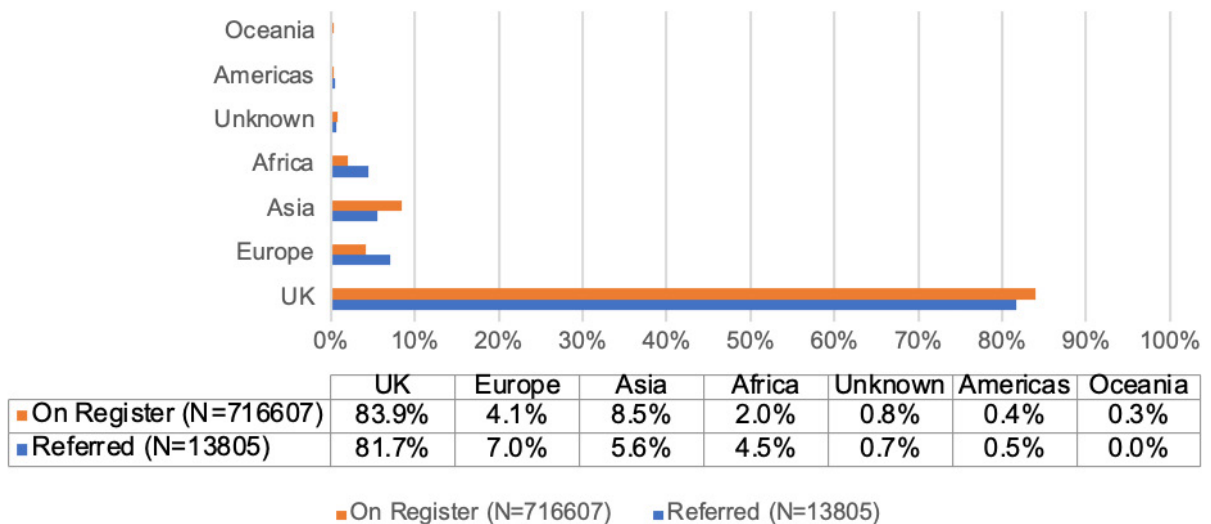
Figure 22: Proportions on register and referred by gender identity



Training continent

191. More than 80 percent of the people referred to us trained within the UK (81.7 percent or 11,277 people). Between 1 April 2016 and 31 March 2019, we received a disproportionate number of referrals of nurses and midwives who had trained in Africa in comparison to their proportions on the register. For example, 4.5 percent or 769 cases referred related to a nurse or midwife who had trained in Africa compared to 2 percent of professionals on our register who trained in Africa. We also received a disproportionate number of referrals related to professionals who had trained in Europe (professionals who had trained in Europe made up 7 percent of referrals but only represent 4.1 percent of the register).

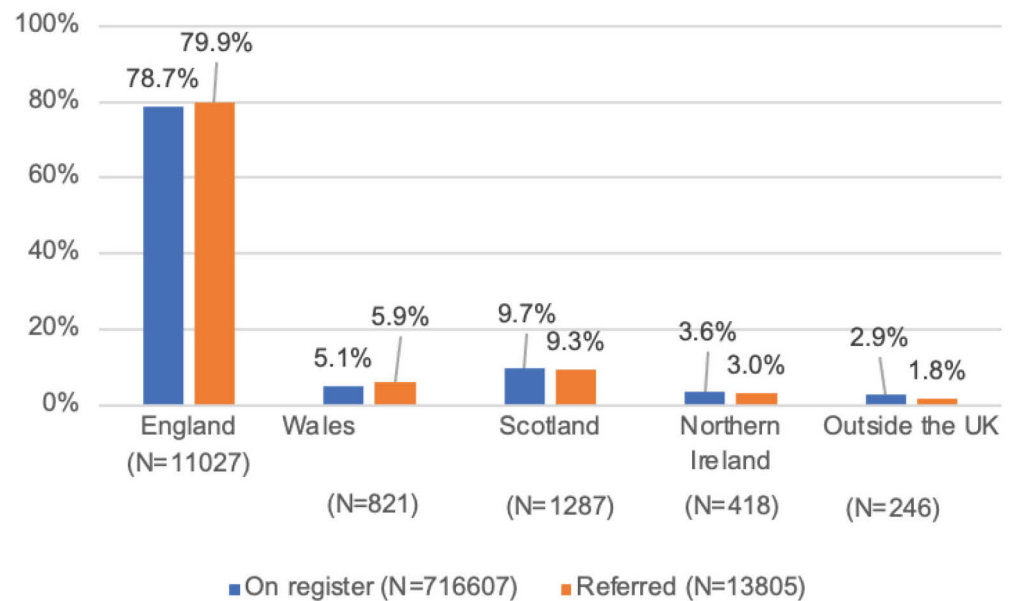
Figure 23: Proportions on register and referred by training continent



Address country

192. We received a higher proportion of referrals of nurses or midwives who live in England and Wales compared to the proportions on our register. In comparison, we received fewer referrals of professionals living in Scotland, Northern Ireland and outside of the UK compared to the numbers on our register as a whole.

Figure 24: Proportions of nurses and midwives who were referred compared to all professionals by address country⁵

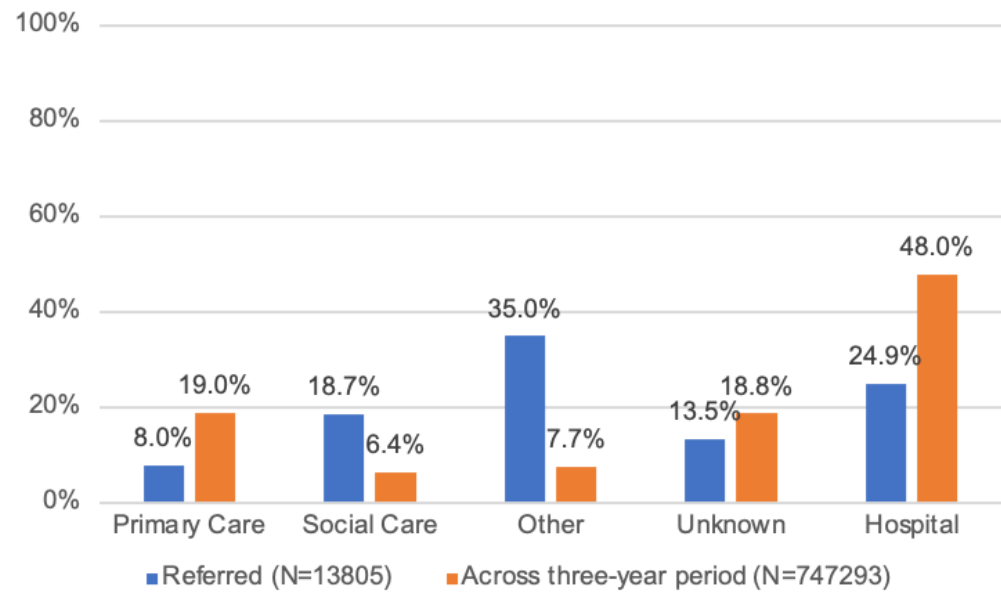


Work setting

193. We received a greater proportion of referrals of those working in social care and 'other' settings compared to the proportions of people who told us they were working in these settings between 1 April 2016 and 31 March 2019. In comparison, we received a lower proportion of referrals of people working in hospital or primary care settings²⁰³.

⁵This does not include the six cases for which the address country was unknown.

Figure 25: Proportions of nurses and midwives who were referred compared to all professionals by work setting



Factors that influence being referred to fitness to practise

The allegations for which people are referred

194. We wanted to explore whether there were differences in the type of allegations for which people with different protected characteristics were referred. The nature of the allegations is likely to influence how far the case progresses through our fitness to practise process and the outcome it receives.

195. Previous work indicates that cases involving sexual misconduct, dishonesty, or criminal convictions are likely to be treated as serious by professional regulators in health and social care. It also found that many factors are taken into account when determining seriousness (and therefore the decision whether to progress the case and what outcome it receives). These include the registered professional's honesty or dishonesty, whether the alleged misconduct was repeated or extended, whether they showed remorse or insight, or took remediation, and the nature of the risk of harm to patients¹⁷⁹.

Section 3

196. We looked at the allegation types that were associated with cases referred between 1 April 2016 and 31 March 2019. Several allegations can be associated with each case so the number of allegations will add up to more than the total number of cases referred during this period. We have multiple levels of allegation coding ([see Annexe 2](#)); level one is the headline allegation category and level two provides more detail about the allegation type. The information below is based on the level one allegation. The number and type of allegations associated with a case can change during the course of a fitness to practise investigation. So, the same case can have different allegations associated with it at different stages of our process. Therefore, the numbers below are likely to be different to the proportion of cases associated with each allegation at our case examiner, adjudication and interim order stages.

197. Allegations about patient care make up a large proportion of all referrals, although there are some differences in the percentages between groups.

198. Profession. Compared to midwives, referrals about nurses were associated with a higher percentage of allegations about violent behaviour; criminal proceedings; and prescribing/medicines management. In contrast, referrals about midwives were associated with a higher percentage of allegations about: communications issues; dishonesty; and registrants' health compared to referrals made about nurses.

Table 10: Proportion of referrals associated with different types of allegations by profession

	Referrals involving nurses	Referrals involving midwives
Patient care	2,602 (30.1%)	172 (50.6%)
Violent behaviour	938 (11.0%)	24 (7.1%)
Criminal proceedings	1,028 (12.1%)	34 (10%)
Prescribing/medicines management	1,759 (20.7%)	24 (7.1%)
Communications issues	682 (8%)	57 (16.8%)
Dishonesty	1,041 (12.3%)	49 (14.4%)
Registrant's health	865 (10.2%)	40 (11.8%)

Section 3

199. Gender. Compared to referrals made about male nurses or midwives, referrals involving female professionals were associated with a higher proportion of allegations about dishonesty; registrants' health; and prescribing/medicines management. Compared to referrals made about female nurses or midwives referrals about male professionals were associated with a higher proportion of allegations about violent behaviour; criminal proceedings; professional boundaries; and sexual offences.

Table 11: Proportion of referrals associated with different types of allegations by gender

	Referrals involving female professionals	Referrals involving male professionals
Patient care	2,222 (33.3%)	499 (25.5%)
Violent behaviour	636 (9.5%)	309 (15.8%)
Criminal proceedings	710 (10.6%)	337 (17.2%)
Prescribing/medicines management	1,403 (21.0%)	333 (17.0%)
Professional boundaries	134 (2.0%)	139 (7.1%)
Dishonesty	870 (13.0%)	198 (10.1%)
Registrant's health	705 (10.6%)	168 (8.6%)
Sexual offences	14 (0.2%)	109 (5.6%)

Section 3

200. Disability. Compared to non-disabled professionals, referrals involving disabled nurses and midwives were associated with a higher proportion of allegations about record keeping; registrants' health; and prescribing/medicines management. Compared to referrals about disabled professionals, referrals involving non-disabled nurses and midwives were associated with a higher proportion of allegations about violent behaviour; management issues; and professional boundaries. Referrals involving nurses and midwives whose disability we didn't know (or who preferred not to say) were associated with a higher proportion of allegations about professional boundaries to referrals about disabled and non-disabled professionals.

Table 12: Proportion of referrals associated with different types of allegations by disability

	Referrals involving disabled professionals	Referrals involving non-disabled professionals	Referrals involving professionals whose disability we don't know/prefer not to say
Patient care	159 (27.9%)	2,434 (32.3%)	129 (25.3%)
Violent behaviour	56 (9.8%)	832 (11%)	57 (11.2%)
Management issues	13 (2.3%)	345 (4.6%)	25 (4.9%)
Prescribing/medicines management	140 (24.6%)	1,495 (19.9%)	101 (19.8%)
Professional boundaries	13 (2.3%)	231 (3.1%)	29 (5.7%)
Registrant's health	122 (21.4%)	661 (8.8%)	90 (17.7%)
Record keeping	88 (15.4%)	1,016 (13.5%)	59 (11.6%)

Section 3

201. Sexual orientation. Compared to referrals about gay/lesbian or bisexual nurses or midwives, referrals involving heterosexual professionals were associated with a higher proportion of allegations about dishonesty; and record keeping. Compared to referrals about heterosexual and gay/lesbian nurses or midwives, referrals involving bisexual professionals were associated with a higher proportion of allegations about patient care, registrants' health; and prescribing/medicines management.

Table 13: Proportion of referrals associated with different types of allegations by sexual orientation

	Referrals involving heterosexual professionals	Referrals involving gay/ lesbian professionals	Referrals involving bisexual professionals	Referrals involving professionals whose sexual orientation we don't know/ prefer not to say
Patient care	2,435 (32.0%)	59 (22.1%)	28 (34.2%)	254 (28%)
Record keeping	1,041 (13.7%)	26 (9.8%)	9 (11%)	115 (12.7%)
Prescribing/ medicines management	1,513 (19.9%)	57 (21.4%)	24 (29.3%)	189 (20.8%)
Dishonesty	950 (12.5%)	26 (9.8%)	8 (9.8%)	107 (11.8%)
Registrant's health	748 (9.8%)	40 (15%)	13 (15.9%)	109 (12%)

Section 3

202. Gender identity. Compared to referrals about nurses or midwives who identify with the gender assigned to them at birth (or within six weeks) and those whose gender identity we didn't know (or who prefer not to say), referrals involving trans professionals were associated with a higher proportion of allegations about communication issues; criminal proceedings; dishonesty; record keeping; professional boundaries. It is worth noting the small number of cases involving trans professionals associated with these allegations. Those whose gender identity we didn't know (or who prefer not to say) have a higher number of referrals associated with allegations about prescribing/medicines management compared to referrals made about professionals who identify with the gender assigned at birth and trans professionals.

Table 14: Proportion of referrals associated with different types of allegations by gender identity

	Referrals involving professionals identifying with gender assigned at birth (or within six weeks)	Referrals involving professionals who do not identify with gender assigned at birth (or within six weeks)	Referrals involving professionals whose gender identity we don't know/ prefer not to say
Patient care	2,587 (31.7%)	27 (27.3%)	162 (26.7%)
Criminal proceedings	977 (12%)	16 (16.2%)	78 (12.9%)
Record keeping	1,097 (13.5%)	16 (16.2%)	78 (12.9%)
Professional boundaries	253 (3.1%)	7 (7.1%)	21 (3.5%)
Prescribing/ medicines management	1,635 (20.1%)	14 (14%)	134 (22.1%)
Dishonesty	1,011 (12.4%)	17 (17.2%)	63 (10.4%)
Communications issues	669 (8.3%)	11 (11.1%)	59 (9.7%)

Section 3

203. Ethnicity. Compared to referrals about White, Asian and Mixed/Other professionals, referrals involving Black nurses or midwives are associated with a higher proportion of allegations about dishonesty; and professional boundaries. White and Mixed/Other professionals have a higher proportion of cases associated with allegations about their health compared to Black or Asian nurses or midwives. White, Asian and Black professionals have a similar proportion of referrals associated with record keeping and this is higher than the number of referrals involving professionals from Mixed/Other ethnic groups.

Table 15: Proportion of referrals associated

	Referrals involving Black professionals	Referrals involving Asian professionals	Referrals involving White professionals	Referrals involving Mixed/Other ethnicity professionals
Patient care	530 (38.9%)	230 (36.1%)	1,777 (29.7%)	110 (30.8%)
Record keeping	178 (13.1%)	88 (13.8%)	832 (13.9%)	32 (8.9%)
Registrant's health	39 (2.9%)	28 (4.4%)	747 (12.5%)	40 (11.2)
Prescribing/medicines management	280 (20.5%)	130 (20.4%)	1,195 (20%)	73 (20.4%)
Dishonesty	186 (13.7%)	76 (12%)	735 (12.3%)	39 (10.9%)
Professional boundaries	54 (4%)	12 (1.9%)	192 (3.2%)	10 (2.8%)

Section 3

204. Work setting. Professionals working in hospital settings have a higher proportion of cases associated with allegations about registrants' health compared to cases involving professionals working in other settings. Professionals working in hospital and other settings have a higher proportion of referrals associated with allegations about dishonesty compared to those working in other settings. Nurses and midwives working in primary care have a higher proportion of referrals associated with violent behaviour compared to those in other work settings. Professionals whose work setting we didn't know have a higher proportion of referrals associated with criminal proceedings compared to those in other settings. Nurses and midwives in social care have a higher proportion of cases associated with allegations about record keeping, prescribing/ medicines management and management issues compared to professionals working in other settings.

Table 16: Proportion of referrals associated with different types of allegations by work setting

	Referrals involving professionals working in hospital settings	Referrals involving professionals working in other settings	Referrals involving professionals working in primary care settings	Referrals involving professionals working in social care settings	Referrals involving professionals working in unknown settings
Patient care	234 (27.6%)	890 (33.7%)	61 (26.8%)	231 (37.6%)	1,360 (30%)
Violent behaviour	120 (14.1%)	278 (10.5%)	43 (18.9%)	68 (11.1%)	454 (10%)
Criminal proceedings	83 (9.8%)	227 (8.6%)	17 (7.5%)	16 (2.6%)	728 (16.1%)
Record keeping	63 (7.4%)	428 (16.2%)	30 (13.2%)	124 (20.2%)	546 (12.1%)
Registrant's health	125 (14.7%)	276 (10.5%)	29 (12.7%)	37 (6%)	443 (9.8%)
Prescribing/ medicines management	153 (18%)	546 (20.7%)	31 (13.6%)	195 (31.7%)	858 (18.9%)
Dishonesty	116 (13.7%)	351 (13.3%)	22 (9.7%)	61 (9.9%)	541 (11.9%)
Management issues	21 (2.5%)	98 (3.7%)	13 (5.7%)	55 (8.9%)	204 (4.5%)

Section 3

205. Source of referral. Referrals made by employers are associated with a higher proportion of allegations about record keeping, prescribing/medicines management and (together with cases referred by patients or the public) dishonesty compared to cases referred by other sources. Referrals made by the police or the registrant themselves are associated with a higher proportion of allegations involving criminal proceedings compared to cases referred by other sources. Referrals made by people using services or members of the public are associated with a higher number of allegations about communications issues compared to cases referred by other sources. Cases referred by other professionals are associated with a higher proportion of allegations about violent behaviour compared to cases referred by other sources.

Table 17: Proportion of referrals associated with different types of allegations by source of referrals

	Employer referrals	Other registrant referrals	Self-referrals	Police referrals	Patients/ Public referrals	Other referrals
Patient care	1,403 (34.3%)	90 (21.3%)	24 (2.2%)	11 (6%)	844 (46.6%)	401 (32%)
Violent behaviour	415 (10.1%)	124 (29.3%)	95 (8.8%)	23 (12.6%)	203 (11.2%)	101 (8.1%)
Communication issues	313 (7.7%)	42 (9.9%)	7 (0.7%)	<5	296 (16.4%)	80 (6.4%)
Record keeping	790 (19.3%)	25 (5.9%)	14 (1.3%)	<5	209 (11.6%)	151 (12%)
Criminal proceedings	185 (4.5%)	6 (1.4%)	659 (60.7%)	112 (61.5%)	39 (2.2%)	67 (5.3%)
Prescribing/ medicines management	1,295 (31.7%)	62 (14.7%)	50 (4.6%)	20 (11%)	160 (8.8%)	194 (15.5%)
Dishonesty	575 (14.1%)	58 (13.7%)	30 (2.8%)	<5	270 (14.9%)	152 (12.1%)

Section 3

206. Cases involving professionals who are male, Black, trans, work in 'other' work settings and are referred by employers have a higher proportion of cases associated with allegations about professional boundaries, dishonesty or criminal proceedings which are more likely to be treated more seriously by regulators¹⁹⁷.

The influence of protected characteristics on likelihood of being referred

207. This section presents the findings from our detailed analysis to identify which factors influence a person's chances of being referred to our fitness to practise process. It analyses whether, and to what extent, a person's protected characteristics affect their chances of being referred, alongside where they trained, where they live and the setting in which they work. It will also show how much these factors influence the likelihood of being referred and which ones matter more than others.

208. We took the following factors into account when looking at the influence of a person's protected characteristics on their likelihood of being referred: age, ethnicity, disability, gender, gender identity, sexual orientation, religion, where they trained, where they live and the setting in which they work. No nursing associates were referred to us during the period, so they are not included in our analysis.

209. Taking all the factors listed above into consideration, our analysis suggests that the following groups are more likely to be referred to fitness to practise⁶:

209.1 Male nurses and midwives. Male professionals are 1.5*** percentage points more likely to be referred to fitness to practise compared to female professionals.

209.2 Trans nurses and midwives. Nurses and midwives who do not identify with the gender assigned to them at birth (or within six weeks) are more likely to be referred compared to those that identify with the birth assigned to them at birth (or within six weeks). They are 1.2*** percentage points more likely to be referred to fitness to practise compared to those who do identify with the gender assigned to them at birth (or within 6 weeks) and those whose gender identity we didn't know (or who preferred not to say).

⁶Only those results that are statistically significant are presented and we have limited the results to those with a minimum of 1 percent percentage point difference. *** indicate that the result is significant to the 0.001 level ($P \leq 0.001$); ** indicates significance at the 0.01 level ($P \leq 0.01$) and * indicates significance at 0.05 level ($P \leq 0.05$).

Section 3

209.3 Bisexual nurses and midwives. Bisexual nurses and midwives are the most likely to be referred compared to those of other sexual orientations. They are 1*** percentage point more likely to be referred than those who identify as heterosexual and those whose sexual orientation we didn't know (or who preferred not to say).

209.4 Nurses and midwives who we don't know whether they are disabled or not (or they have chosen not to tell us). Professionals whose disability we don't know (or who prefer not to say) are the most likely to be referred compared to non-disabled professionals. They are 1.1*** percentage point more likely to be referred than those who are not disabled.

209.5 Black nurses and midwives. Black nurses and midwives are the most likely to be referred compared to other ethnicities. Black professionals are 1.2*** percentage points more likely to be referred than Asian nurses and midwives; 1.2*** percentage points more likely than Mixed-Other professionals; 1.3*** percentage points more likely to be referred than Mixed - White and Asian professionals; 1*** percentage points more likely to be referred than Mixed White and Black professionals; 1.2*** percentage points more likely than other ethnicity professionals; and 1.9*** percentage points more likely to be referred than White professionals.

209.6 Nurses and midwives living in the Channel Islands, Isle of Man and other parts of the UK. People living in certain parts of the UK, the Channel Islands and the Isle of Man are the most likely to be referred compared to people living elsewhere. Professionals living in these areas are: at least 5*** percentage points more likely to be referred than professionals living in other areas of the UK, the EU and outside of it.

209.7 Nurses and midwives who trained in Northern Ireland. Professionals who did their pre-registration training in Northern Ireland are the most likely to be referred compared to those who trained elsewhere. They are 2-6** percentage points more likely to be referred than professionals who trained in all areas (except those who trained in the UK where the university was unknown).

209.8 People working in certain work settings. People working in settings¹⁸⁵ including the ambulance service and cosmetic or aesthetic sector as well as non-direct clinical care settings such as trade unions or professional bodies are the most likely to be referred compared to people working in other types of settings. Professionals working in these settings are: 6.9*** percentage points more likely to be referred than those in hospital or other secondary care settings; 7.0*** percentage points more likely

Section 3

than those in primary care settings; 3.4*** more likely than those in social care; and 6.3*** more likely than those in unknown work settings.

210. It is difficult to draw any conclusions from the work setting finding above. Outside our fitness to practise process, our data about where people work is based on what people tell us at revalidation. Here, people declare the jobs they have done over the previous three years to meet the 450 practice hours' revalidation requirement. Some of the jobs that people tell us about may be their current employment, and some may be jobs they have done during the previous three years. The jobs that people tell us about may cover the entire three-year period or may only cover a fraction of that time, as long as it meets the 450 hours requirement.

211. People can report jobs in 25 different work settings at revalidation. This means that there can be very small numbers of people in particular settings. In order for us to analyse this, we grouped the 25 different work settings into four broader categories: Hospital (including jobs in hospitals or other secondary care and maternity units or birth centres); Primary care (including jobs in community settings, including district nursing and community psychiatric nursing and GP practices or other primary care); Social care (including jobs in care homes); Other (including jobs in the following settings: ambulance service; consultancy; cosmetic or aesthetic sector; governing body or other leadership; inspectorate or regulator; insurance or legal; military; occupational health; police; policy organisation; prison; private domestic setting; public health organisation; school; specialist or other tertiary care including hospice; telephone or e-health advice; trade union or professional body; university or other research facility; voluntary or charity sector; other).

212. We found that people working in 'other' work settings are more likely to be referred to us. This category contains several different settings, each of which has a different profile of people. For example, a higher proportion of men report working in the ambulance service, while more women report working in the cosmetic and aesthetic sector. Older groups make up a higher proportion of jobs in inspectorate or regulator settings while younger groups make up a higher proportion of jobs in the military.

213. The different profile of nurses, midwives and nursing associates in each of these settings may indicate higher or lower levels of discrimination or bullying. At the same time, people in some settings may be more likely to experience discrimination compared to other settings. For example, men are more likely to be complained about and more likely to work in settings that report higher levels of bullying and harassment, such as the ambulance service.

Section 3

Fitness to Practise: Case progression

214. To look at progress through the fitness to practise process as a whole, we examined the factors that influence the likelihood of a person's case being closed at different stages of our process. These stages were (in ascending order of "severity" of outcome): closed at screening, closed at investigation, adjudication finding allows person to continue to practise, and adjudication finding prevents continued practise.

214.1 Screening. At screening stage we decide whether a case needs a full investigation. This involves considering: whether the concerns are serious enough to suggest that the nurse, midwife or nursing associate may not be fit to practise; whether the case meets our formal requirements; whether we will be able to obtain credible evidence about the concerns; and any remediation undertaken by the nurse, midwife or nursing associate and whether this addresses any risk to patients, public trust or professional standards. We may not need to go through all the stages in every case.

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

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

Section 3

The people in our fitness to practise process

215. This section presents the findings from our descriptive analysis and focuses on outlining the number and percentage of people with different protected characteristics who:

215.1 had their case closed at screening stage

215.2 had their case closed at investigation stage

215.3 were permitted to continue to practise at adjudication stage

215.4 were removed from our register at adjudication stage

216. The figures presented in this section simply summarise the people who were involved in our fitness to practise process during this period. We cannot draw any conclusions from this section about why the figures are at particular levels or identify any trends.

217. The next section goes beyond this type of analysis to identify which factors influence a person's chances of having their case closed at screening or investigation stage, or being suspended or struck off at adjudication stage. It considers how much a person's protected characteristics affect their chances of getting these outcomes from our fitness to practise process when you take into consideration other factors such as where they trained and where they work.

218. Between 1 April 2016 and 31 March 2019, 13,781 people received an outcome from our fitness to practise process.

218.1 Screening. 7,466 were closed at screening.

218.2 Investigation. 3,551 were closed at investigation stage.

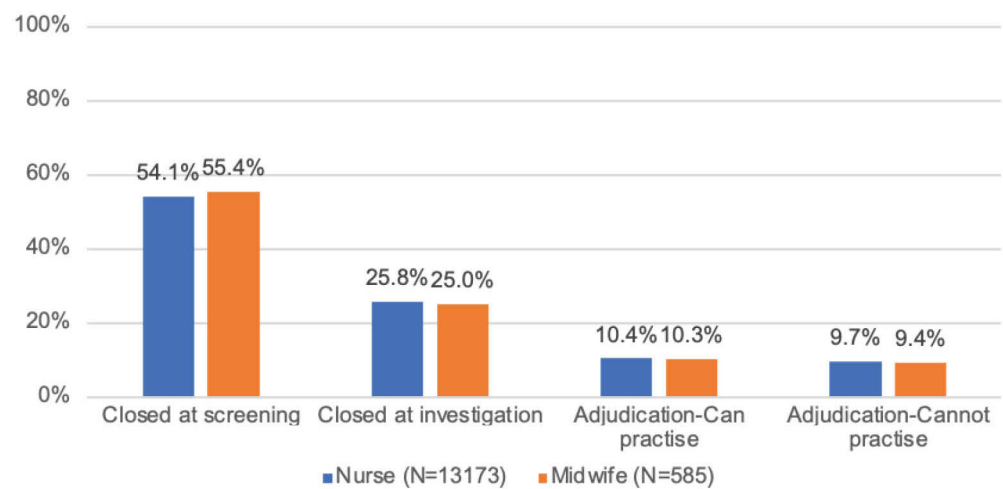
218.3 Adjudication. 2,765 received an outcome at adjudication stage: 1,433 that enabled the nurse or midwife to continue to practise (including with conditions of practise) and 1,332 decisions that prohibited the professional from continuing to practise (involving striking off or suspending the professional, or the professional voluntarily removing themselves from the register).

219. There were no nursing associates involved in our fitness to practise processes during 1 April 2016 and 31 March 2019 and so the next sections focus only on nurses and midwives.

Profession

220. A slightly higher proportion of cases involving midwives were closed at screening compared to those involving nurses (54.1 percent of cases involving a nurse and 55.4 percent of cases involving midwives). In comparison, a slightly higher proportion of cases involving nurses were closed at investigation stage and a higher proportion of nurses received more decisions preventing them from continuing to practise at adjudication stage.

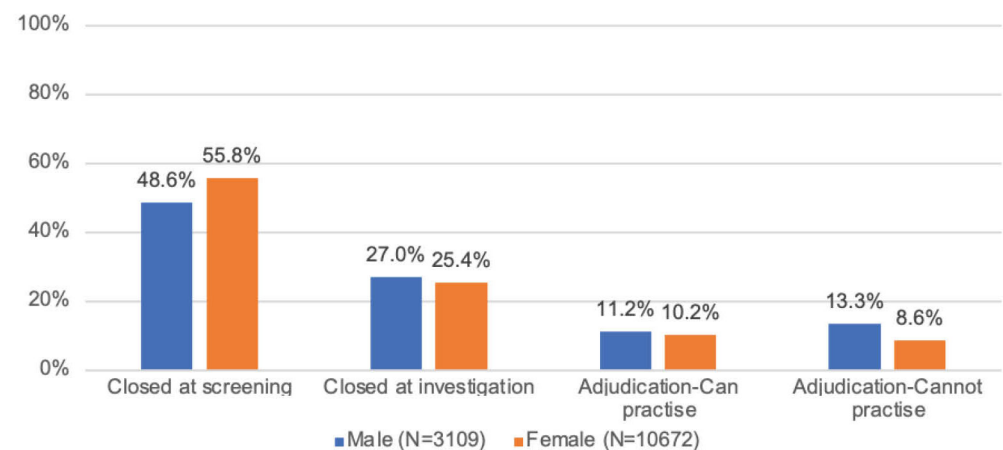
Figure 26: Profession and progression through the fitness to practise process



Gender

221. A higher proportion of cases involving female nurses and midwives are closed at screening compared to men. Men also receive a higher proportion of decisions preventing them from continuing to practise at adjudication stage.

Figure 27: Gender and progression through the fitness to practise process⁷



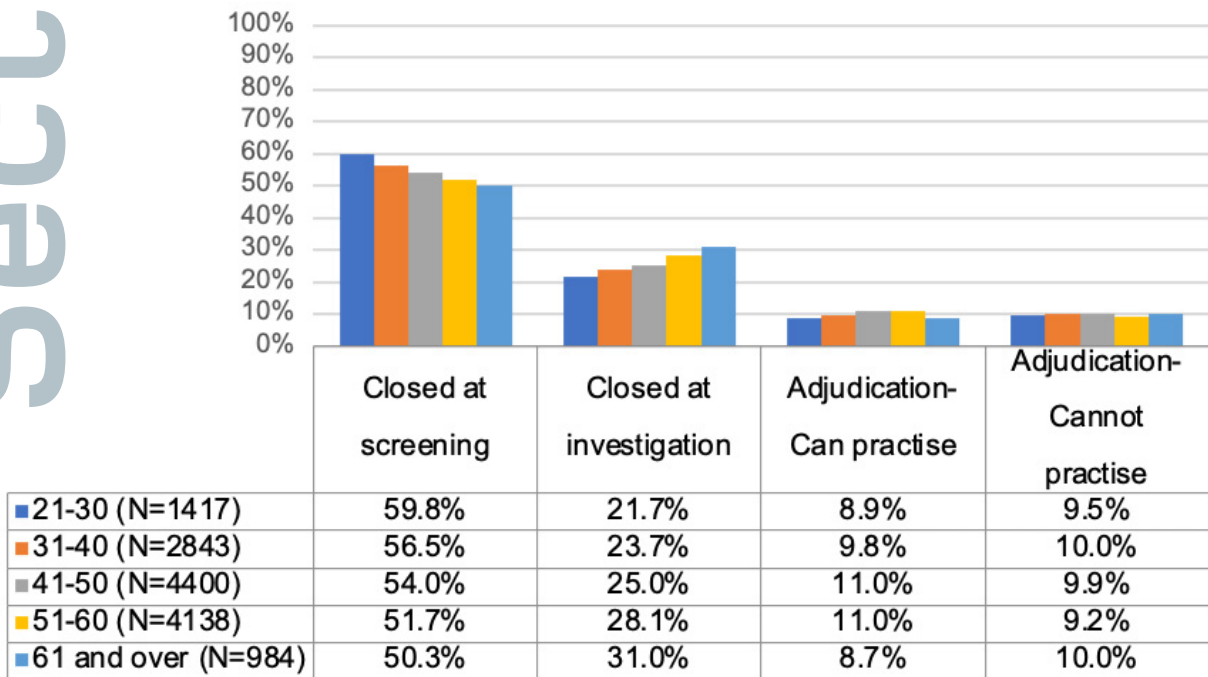
⁷This chart does not include the one person whose gender we do not know or who preferred not to tell us.

Section 3

Age

222. Those in younger age groups (21-30) have the highest proportion of cases closed at screening. There is little difference in the proportion of different age groups that receive a decision at adjudication stage that stops them from practising as a nurse or midwife.

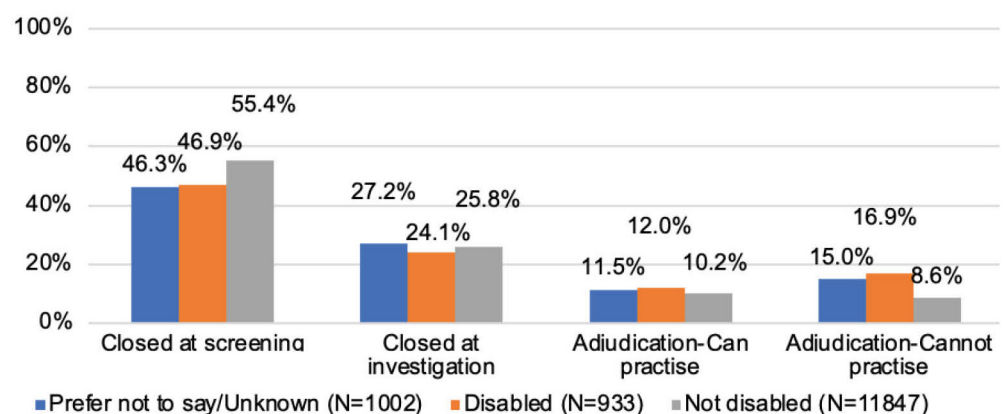
Figure 28: Age and progression through the fitness to practise process



Disability

223. Nurses and midwives whose disability we don't know (or who prefer not to say) have the lowest proportion of cases closed at screening. Disabled nurses and midwives have the highest proportion of adjudication decisions preventing them from practise.

Figure 29: Disability and progression through the fitness to practise process

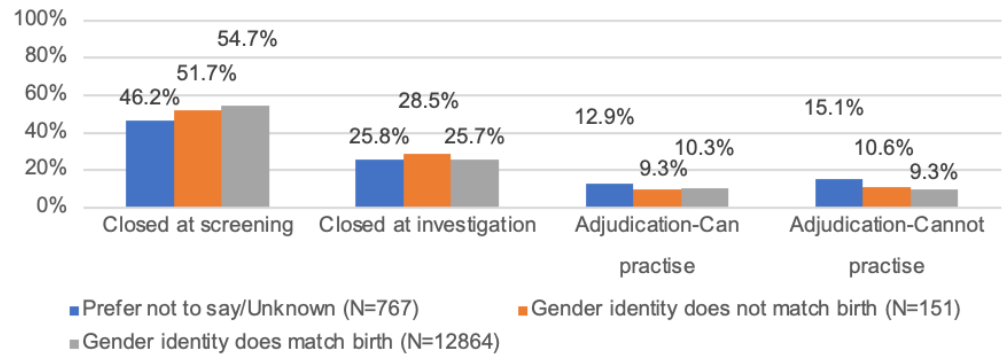


Section 3

Gender identity

224. Nurses and midwives whose gender identity matches that assigned at birth (or within six weeks) have the highest proportion of cases closed at screening. People whose gender identity we didn't know (or who preferred not to say) have the highest proportion of adjudication decisions that prevent them from practising.

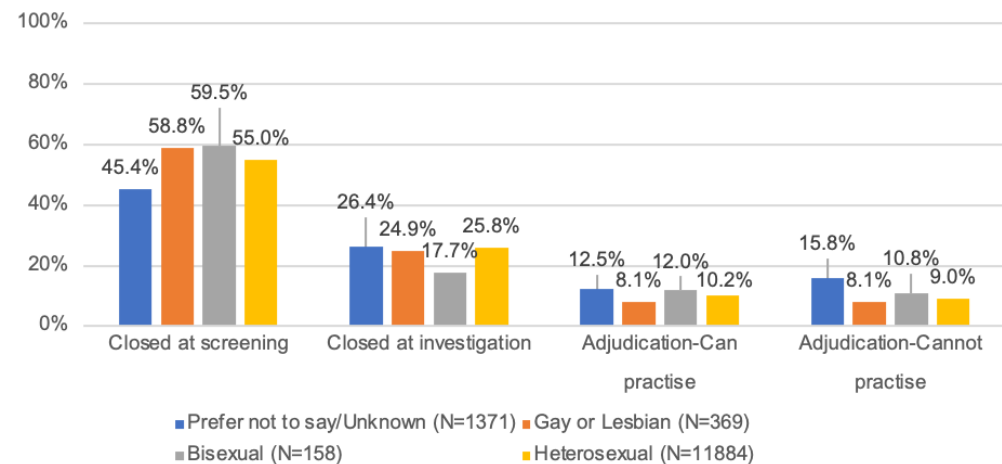
Figure 30: Gender identity and progression through the fitness to practise process



Sexual orientation

225. A higher proportion of cases involving bisexual nurses and midwives are closed at screening. Nurses and midwives whose sexual orientation we didn't know (or who preferred not to say) have the highest proportion of decisions that result in them being struck off or suspended at adjudication stage.

Figure 31: Sexual orientation and progression through the fitness to practise process

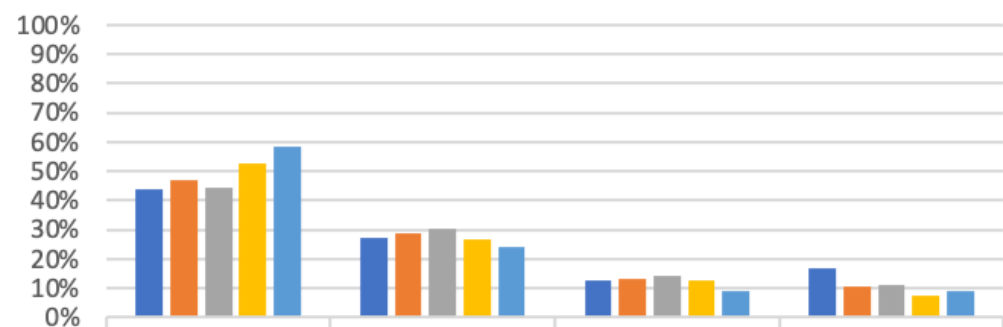


Section 3

Ethnicity

226. White nurses and midwives have the highest proportion of cases closed at screening while those whose ethnicity we didn't know (or who preferred not to say) have the lowest proportion of cases closed at screening. In contrast those whose ethnicity we don't know (or who preferred not to say) have the highest proportion of adjudication decisions that prevents them from practising while nurses and midwives of Mixed or Other ethnicity received the lowest proportion of decisions that resulted in them being struck off or suspended.

Figure 32: Ethnicity and progression through the fitness to practise process



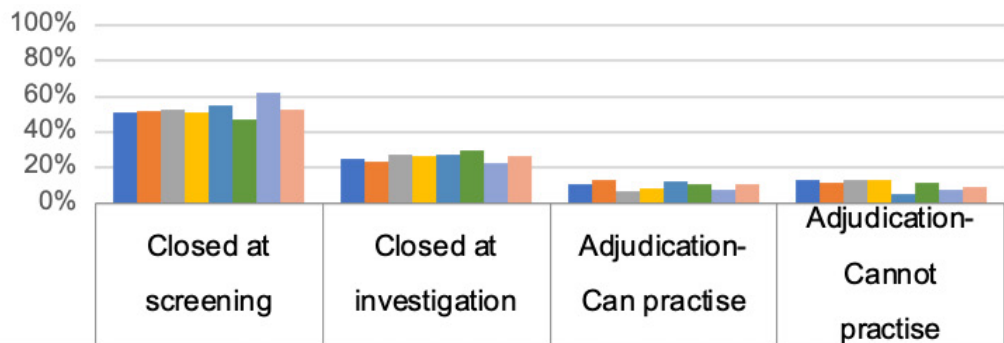
	Closed at screening	Closed at investigation	Adjudication-Can practise	Adjudication-Cannot practise
■ Prefer not to say/Unknown (N=646)	43.7%	27.1%	12.7%	16.6%
■ Asian (N=1088)	47.2%	29.0%	13.1%	10.8%
■ Black (N=2224)	44.2%	30.4%	14.2%	11.2%
■ Mixed/Other (N=527)	52.8%	26.9%	12.9%	7.4%
■ White (N=9297)	58.2%	24.1%	8.9%	8.8%

Section 3

Religion or belief

227. Nurses and midwives with no religion have the highest proportion of cases closed at screening. Hindu professionals have the highest proportions of adjudication decisions that prevents them from practising.

Figure 33: Religion and progression through the fitness to practise process



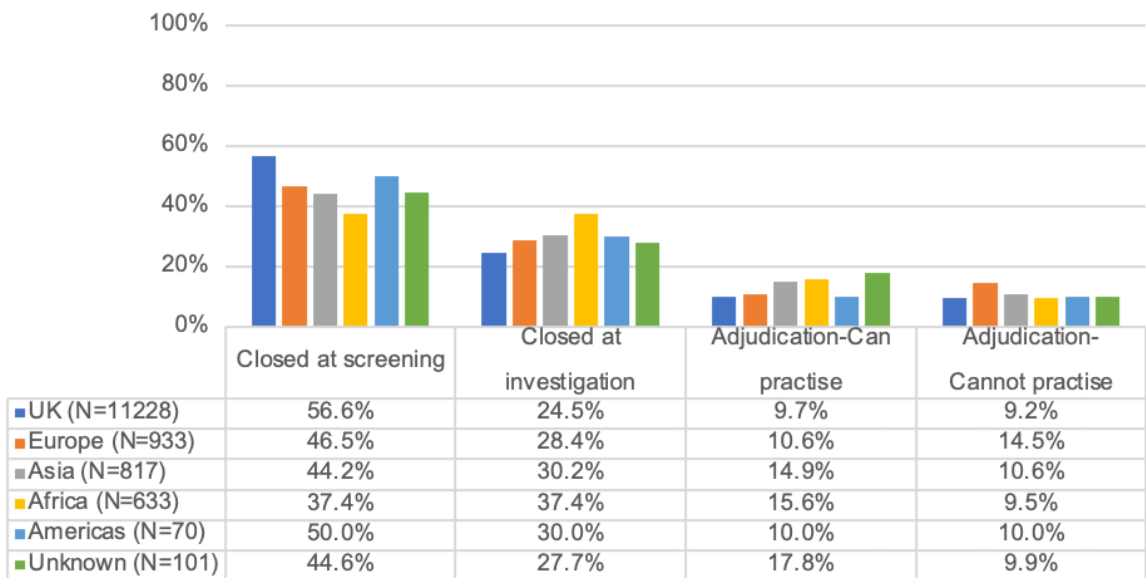
	Closed at screening	Closed at investigation	Adjudication-Can practise	Adjudication-Cannot practise
■ Prefer not to say/Unknown (N=1320)	50.9%	25.1%	10.8%	13.3%
■ Muslim (N=272)	52.2%	23.2%	13.2%	11.4%
■ Hindu (N=170)	52.4%	27.1%	7.1%	13.5%
■ Buddhist (N=115)	51.3%	27.0%	8.7%	13.0%
■ Sikh (N=40)	55.0%	27.5%	12.5%	5.0%
■ Other (including Jewish) (N=356)	47.2%	30.1%	11.2%	11.5%
■ None (N=2822)	61.7%	22.9%	8.0%	7.5%
■ Christian (N=8687)	52.7%	26.7%	11.1%	9.6%

Section 3

Where people trained

228. Nurses and midwives who trained in the UK have the highest proportion of cases closed at screening while those who trained in Africa have the lowest. People who trained in Europe have the highest proportion of adjudication decisions that prevents them from practising.

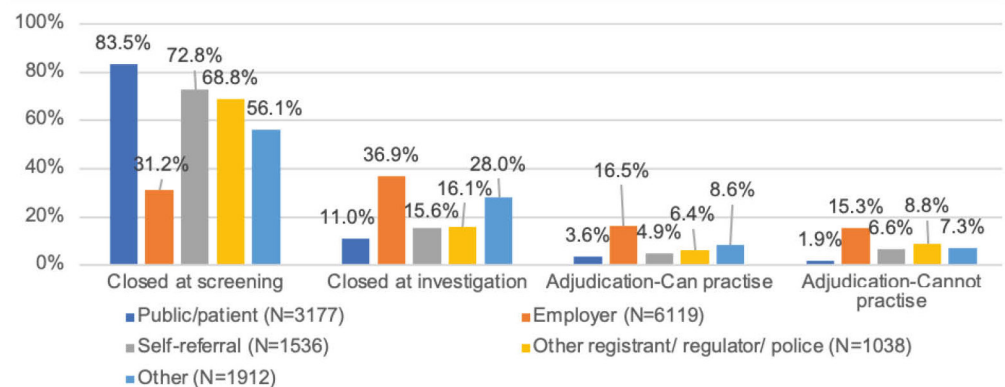
Figure 34: Continent of training and progression through the fitness to practise process



Source of referral

229. More cases referred by people who use services or the public are closed at screening compared to cases referred by other sources. A higher proportion of cases referred by other registrants, regulators or the police result in the professional being struck off or suspended at adjudication stage compared to cases referred by other sources.

Figure 35: Source of referral and progression through the fitness to practise process

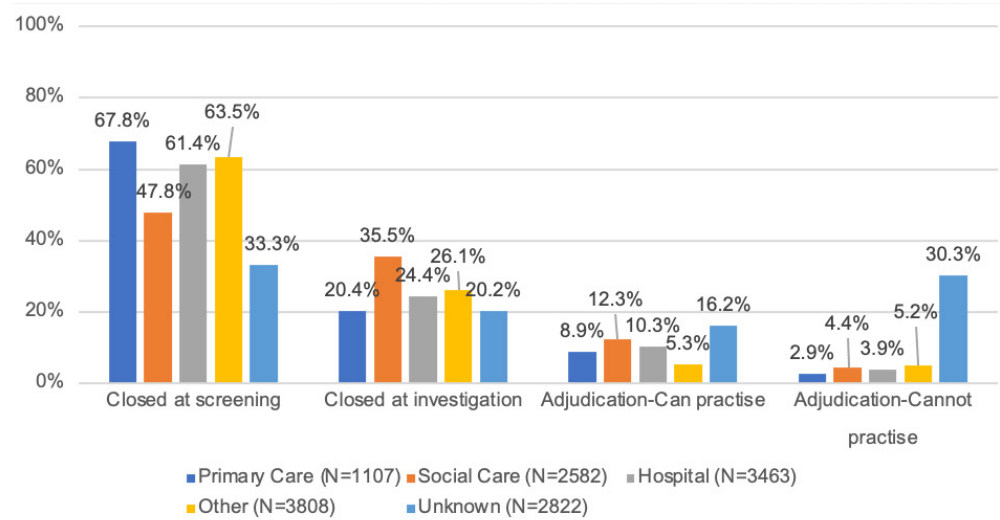


Section 3

Where people work

230. Cases involving a nurse or midwife working in a primary care setting have the highest proportion of closures at screening, while cases where the work setting is unknown have the highest levels of adjudication decisions prohibiting the professional from continuing to practise.

Figure 36: Work setting and progression through the fitness to practise process



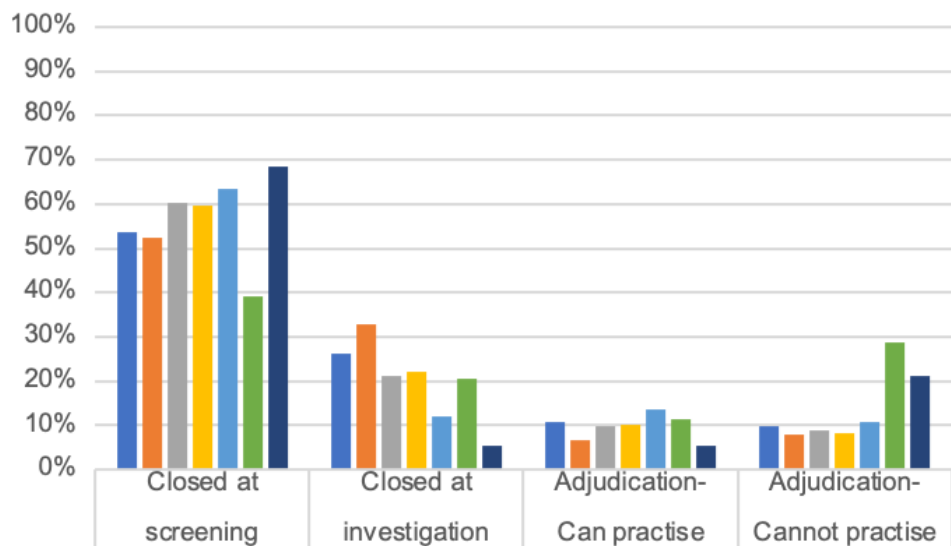
Section 3

Where people live

231. People living outside of the UK and the EU have the highest proportion of cases closed at screening however it is worth noting the small numbers of cases in this category. Nurses and midwives living outside the UK but in the EU have the highest proportion of adjudication decisions preventing them from continuing to practice. However, again there are small numbers of people here.

232. Within the UK, a higher proportion of cases involving nurses or midwives who live in Scotland are closed at screening compared to the other four countries. In contrast, a higher proportion of cases involving professionals who live in England are struck off or suspended at adjudication stage compared to those living in Scotland, Wales and Northern Ireland.

Figure 37: Address country/region and progression through the fitness to practise process



	Closed at screening	Closed at investigation	Adjudication-Can practise	Adjudication-Cannot practise
■ England (N=11099)	53.5%	26.1%	10.7%	9.7%
■ Wales (N=811)	52.5%	32.9%	6.8%	7.8%
■ Scotland (N=1255)	60.3%	21.1%	9.7%	8.8%
■ Northern Ireland (N=371)	59.6%	22.1%	10.0%	8.4%
■ Crown dependencies (N=74)	63.5%	12.2%	13.5%	10.8%
■ EU/EEA (N=150)	39.3%	20.7%	11.3%	28.7%
■ Outside the UK & EU/EEA (N=19)	68.4%	5.3%	5.3%	21.1%

Section 3

Factors that influence fitness to practise case progression

The influence of protected characteristics on likelihood of progressing through fitness to practise and receiving a serious outcome at adjudication stage

233. This section presents the findings from our detailed analysis to identify which factors influence a person's chances of having their case closed at screening or investigation stage. It also looks at their chances of being struck off or suspended if they get to the adjudication stage. It analyses whether, and to what extent, a person's protected characteristics affect their chances alongside where they trained, where they live, the setting in which they work and the source of their referral.

234. Our detailed analysis included the following explanatory factors: ethnicity, age, disability, religion, gender, gender identity, sexual orientation, source of referral, work setting, training country, and where they live. Between April 2016 and March 2019, there were no nursing associates in our fitness to practise process, so they are not included in our analysis.

235. Taking all of the factors listed above into consideration, our analysis shows that⁸:

235.1 Groups that are most likely to progress to adjudication stage and be struck off or suspended. Nurses and midwives who are male,** disabled* or work in settings which we don't know*** are more likely to have their case progress to adjudication stage and be struck off or suspended compared to nurses and midwives who are female, non-disabled or work in primary, social care, hospital or other types of settings (including the cosmetic or aesthetic sector or the ambulance service).

235.2 Groups which are most likely to progress to adjudication stage but not any more likely to be struck off or suspended. Nurses and midwives who are Black** or whose sexual orientation we don't know (or they preferred not to say)** are more likely to have their case progress to adjudication stage but, at this stage, they are not any more likely to have a decision that prevents them from continuing to practice compared to nurses and midwives who are White or heterosexual. Cases referred by employers are more likely to get to adjudication stage compared to those referred by

⁸Only those results that are statistically significant are presented and we have limited the results to those with a minimum of 1 percent percentage point difference. *** indicate that the result is significant to the 0.001 level ($P \leq 0.001$); ** indicates significance at the 0.01 level ($P \leq 0.01$) and * indicates significance at 0.05 level ($P \leq 0.05$).

Section 3

members of the public or people who use services, but at this stage, cases referred by other registrants, other regulators or the police are more likely to result in the nurse or midwife being struck off or suspended compared to those referred by employers.

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

Section 4

Conclusion

236. This report is the first step in our ambitious project to assess the impact our regulatory processes have on different groups of nurses, midwives and nursing associates. We want to understand whether professionals with different protected characteristics have different outcomes from our processes. We want to understand why there are these differences and, where unfairness arises, take action to stop it.

237. We've now completed the first part of this work – analysing the data we hold as well as external data and research. We've found that certain protected characteristics influence the outcomes that people get in our education, overseas registration, revalidation and fitness to practise processes.

238. We don't yet know why this is happening. We don't know how much it's due to issues under our control, or factors outside our control. We do know that many inequalities start from a young age. For example, lower educational attainment at ages 11 and 16 for boys, students whose first language is not English, who have special educational needs or are eligible for free school meals. We also know that the people we regulate may experience further inequalities from being a health and care worker, rather than anything specific to nursing or midwifery. These issues cut across professional boundaries and many of the issues we've identified (different educational experiences, lower revalidation rates and higher rates of referrals to fitness to practise processes for certain groups) are also reported for doctors, dentists and social workers.

239. We also know though that certain groups of nurses, midwives and nursing associates face disparities. This includes lower acceptance rates on NMC-approved courses and less chance of registering through our overseas process or revalidating. It also means more chance of being referred to us, or going further through our fitness to practise process and getting a more severe outcome.

Section 4

240. We're committed to equality, diversity and inclusion in health and social care. While we can point to wider inequalities, we don't yet know whether there are specific issues in nursing and midwifery driving these disparities. We don't know what effect these differences have on the professionals involved, or what we can do, with others, to address these differences. We'll explore this in the next stages of this project. We can't successfully tackle these trends without fully understanding what causes them.

241. We know that this isn't going to be easy and there are no quick fixes. We want our stakeholders and partners in health and social care to feel empowered to support and challenge us on this journey. We want to hear from others in health and social care about what they understand from these findings and what they think we should do next.

Annexe 1

External Advisory Group Members (as at August 2020)

Name	Organisation
Paulette Lewis	Chief Nursing Officer's Black Minority Ethnic Strategic Advisory Group
Professor Donna O'Boyle	Chief Nursing Officer's Directorate, Scottish Government
Felicia Kwaku	Chief Nursing Officer's Black Minority Ethnic Strategic Advisory Group
Professor Laura Serrant	Chief Nursing Officer's Black Minority Ethnic Strategic Advisory Group/Sheffield Hallam University
Dr Michael Brady	NHS England and NHS Improvement
Elizabeth Streeter	NHS England and NHS Improvement
Clenton Farquharson	Coalition for Collaborative Care
Lucy Wilkinson	Care Quality Commission
Dr. Doyin Atewologun	Cranfield School of Management
Claire Light	General Medical Council
David Darton	General Medical Council
Cavita Chapman	NHS England

Annexe 1

Stuart Moore	NHS England
David Furness	Independent Healthcare Providers Network
Marion Thorpe	Independent Healthcare Providers Network
Beccy Baird	King's Fund
Lesley Chan	Manchester University NHS Foundation Trust
Sarah Coleman	Mencap
Roger Kline	Middlesex University Business School
Liz Jones	National Care Forum
Mohammed Jogi	NHS Employers
Paul Deemer	NHS Employers
Jenny Jean-Jacques	NHS England
Owen Chinembiri	NHS England
Dr Aideen Naughton	NHS Safeguarding Network
Wendy Olayiwola	Nigerian Nurses Charitable Association UK
Elsie Gayle	Patients First
Karen Toohey	Public Health Wales
Rhiannon Beaumont-Wood	Public Health Wales
Jabeer Butt	Race Equality Foundation

Annexe 1

Alice Sorby	Royal College of Midwives
Suzanne Tyler	Royal College of Midwives
Charlotte Rogers	Royal College of Nurses
Roz Hooper	Royal College of Nurses
Wendy Irwin	Royal College of Nurses
Helen Whyley	Royal College of Nurses Wales
Richard Desir	Senior Workforce Transformation Nurse/Clinical Futures Programme, Aneurin Bevan University Health Board
Aiden Greenall	Stonewall
Gail Adams	Unison
Val Johnston	Unison
Obi Amadi	Unite
Yana Richens	University College London Hospital
Professor Udy Archibong MBE	University of Bradford
Professor James Nazroo	University of Manchester
Dr Alys Einion	University of Swansea
Janine Davey	University of the West of England
Jane Dale	Health Inspectorate Wales

NMC Allegation Coding Framework

1. In January 2017 we introduced a coding framework for allegations which allows us to understand the type of cases we hold.

2. NMC allegation codes are arranged into three different levels of hierarchy, reflecting different levels of details about the allegation:

2.1 Level 1: There are 20 groups of allegation types at level 1. An allegation usually involves more details, which is captured in level 2.

2.2 Level 2: this is the largest group of codes. They are the most common and reflect the range of specific types of allegation. Most allegations are detailed enough to be specified within level 2.

2.3 Level 3: This level adds further, very specific details, such as how exactly the professional was alleged to have done something wrong. Not all level 2 codes have this extra level of detail.

Level 1 Allegation Code: Behaviour or violence

Level 2 Allegation Codes	Level 3 Allegation Codes
Bullying, intimidation or harassment	<ul style="list-style-type: none"> • Bullying, intimidation, or harassment of colleagues • Bullying, intimidation, or harassment of patients or families • Bullying, intimidation, or harassment out of work • Other

Annexe 2

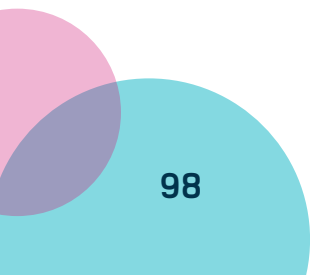
Discrimination	<ul style="list-style-type: none"> • Race discrimination • Age discrimination • Disability discrimination • Gender reassignment based discrimination • Marriage and Civil Partnership based discrimination • Pregnancy and maternity based discrimination • Religion or belief based discrimination • Sex discrimination • Sexual orientation discrimination • Other
Verbal abuse	<ul style="list-style-type: none"> • Verbal abuse of colleagues • Verbal abuse of patients • Verbal abuse out of work • Other
Violence or violent behaviour	<ul style="list-style-type: none"> • Violence or violent behaviour out of work • Violence or violent behaviour towards colleagues • Violence or violent behaviour towards patients • Violence in work not person specific • Other
Other behaviour or violence	<ul style="list-style-type: none"> • Other

Level 1 Allegation Code: Communication issues

Level 2 Allegation Codes	Level 3 Allegation Codes
Ineffective communication	<ul style="list-style-type: none"> Ineffective communication with colleagues Ineffective communication with patients Other
Language problems	
Not abiding by duty of candour	
Not contacting patients or family about issue	
Not giving full or right information to patients and their families	
Swearing and inappropriate language	
Unfriendly, uncaring or rude manner	<ul style="list-style-type: none"> Unfriendly, uncaring or rude manner to colleagues Unfriendly, uncaring or rude manner to patients or families Other
Other communication issues	<ul style="list-style-type: none"> Other

Level 1 Allegation code: Dishonesty

Level 2 Allegation Codes	Level 3 Allegation Codes
Employment-related dishonesty	
Non-work-related dishonesty	
Patient care-related dishonesty	
Other dishonesty	<ul style="list-style-type: none"> Other



Level 1 Allegation code: Employment and contractual issues

Level 2 Allegation Codes	Level 3 Allegation Codes
Collusion to cover up information	
Concealing or misrepresenting training or employment record	
Missing on duty	
Not completing training or abiding by remedial measures	<ul style="list-style-type: none"> • Not abiding by local remedial measures • Not completing capability programme successfully • Not completing other training or unspecified training • Not completing preceptorship or probation successfully • Midwife not completing supervised practice programme successfully • Only able to work in supernumerate capacity • Other
Not notifying employers of criminal proceedings	
Sleeping on duty	
Working elsewhere in breach of contract	
Other employment and contract issues	<ul style="list-style-type: none"> • Other

Level 1 Allegation code: Information access

Level 2 Allegation Codes	Level 3 Allegation Codes
Breach of patient confidentiality	

Inappropriate access of medical records	<ul style="list-style-type: none"> • Inappropriate access of medical records of colleague • Inappropriate access of medical records of other people • Inappropriate access of medical records of patient • Inappropriate access of medical records of registrant • Other
Other information access	<ul style="list-style-type: none"> • Other

Level 1 Allegation code: Investigations by other bodies

Level 2 Allegation Codes	Level 3 Allegation Codes
Barring	
Determination by another body	
Not cooperating with fitness to practise investigations by other healthcare regulators	
Not cooperating with other formal investigations	
Not cooperating with other investigations by healthcare regulators	
Not cooperating with police investigations	
Other investigations by other bodies	<ul style="list-style-type: none"> • Other

Level 1 Allegation code: Issues in non-nursing or midwifery roles

Level 2 Allegation Codes	Level 3 Allegation Codes
Beauty treatments	

Annexe 2

Dentistry	
Other issues in non-nursing or midwifery roles	<ul style="list-style-type: none"> • Other

Level 1 Allegation code: Management issues

Level 2 Allegation Codes	Level 3 Allegation Codes
Allocation of staff time and resources	
Line and staff management issues	
Not ensuring adequate patient care	<ul style="list-style-type: none"> • Inadequate systems and procedures • Medication ordering, management, and administration • Other
Not managing health and safety issues appropriately	
Not reporting incidents and complaints	
Not acting appropriately on an incident or complaint	
Provision of training	
Supervision	
Other management issues	<ul style="list-style-type: none"> • Other

Level 1 Allegation code: Motor vehicle related

Level 2 Allegation Codes	Level 3 Allegation Codes
Drink driving	
Speeding	
Other motor vehicle related issues	<ul style="list-style-type: none"> • Other

Level 1 Allegation code: NMC registration and proceedings

Level 2 Allegation Codes	Level 3 Allegation Codes
Fraudulent or incorrect entry to NMC register	<ul style="list-style-type: none"> • Fraudulent entry to NMC register • Incorrect entry to NMC register • Other
Not cooperating with NMC investigation	<ul style="list-style-type: none"> • Referral subject not cooperating with NMC investigation • Witness not cooperating with NMC investigation • Other
Not disclosing NMC investigation to employer	
Not notifying NMC of criminal proceedings	
Practising in breach of NMC Order	
Practising without NMC registration	
Other NMC registration and proceedings	<ul style="list-style-type: none"> • Other

Level 1 Allegation code: Not maintaining professional boundaries

Level 2 Allegation Codes	Level 3 Allegation Codes
Not maintaining professional boundaries, sexually	<ul style="list-style-type: none"> • Not maintaining professional boundaries with colleagues, sexual • Not maintaining professional boundaries, with patients or families, sexual • Other

Annexe 2

Not maintaining professional boundaries, non-sexually	<ul style="list-style-type: none"> • Not maintaining other professional boundaries with colleagues • Not maintaining other professional boundaries with patients or families • Other
Other not maintaining professional boundaries	<ul style="list-style-type: none"> • Other

Level 1 Allegation code: Other crimes and offences

Level 2 Allegation Codes	Level 3 Allegation Codes
Benefit fraud	
Drug crimes	
Female Genital Mutilation	<ul style="list-style-type: none"> • Not reporting FGM • Performing FGM • Other
Financial abuse of patients	
Murder or manslaughter	
Theft	<ul style="list-style-type: none"> • Theft from colleagues • Theft from employer • Theft from patients • Theft out of work • Other
Wilful neglect or ill treatment	<ul style="list-style-type: none"> • Wilful neglect or ill treatment of child in registrant's personal care • Wilful neglect or ill treatment of patient • Wilful neglect or ill treatment of vulnerable adult in registrant's personal care • Other

Annexe 2

Other crime or offence	<ul style="list-style-type: none"> • Other
Other fraud or false representation	<ul style="list-style-type: none"> • Other

Level 1 Allegation code: Patient care

Level 2 Allegation Codes	Level 3 Allegation Codes
Badly prepared discharge	
Diagnosis, observation, assessment	<ul style="list-style-type: none"> • Carrying out observation or assessment incorrectly or inadequately • Disability or fitness to work or occupational health assessments • Not conducting patient observations, assessment or follow up • Not monitoring condition of mother and baby during labour • Not recognising signs and symptoms or missed diagnosis • Other
Handling patients	<ul style="list-style-type: none"> • Inappropriate confinement of patients • Inappropriate use of restraint • Not ensuring appropriate turning • Rough handling • Other
Hydration and nutrition	
Hygiene and infection control	
Inappropriate delegation of patient care	

Annexe 2

Inappropriate or delayed response to negative signs, deterioration, or incidents	<ul style="list-style-type: none"> • CPR and resuscitation • Escalating or communicating issues to colleagues, clinicians, or emergency services • Other
Leaving patients unattended	
Not abiding by safeguarding requirements	
Not acting on or following care plan	
Not assisting colleagues or responding to instructions	
Not obtaining patient consent	
Not responding to patient preferences or requests	
Pain management	
Patient handover	
Practising outside of scope of practice	
Provision and use of equipment	
Other patient care issues	<ul style="list-style-type: none"> • Other

Level 1 Allegation code: Prescribing and medicines management

Level 2 Allegation Codes	Level 3 Allegation Codes
Administered at the incorrect time	
Administered incorrect dosage	
Administered incorrect drug	

Annexe 2

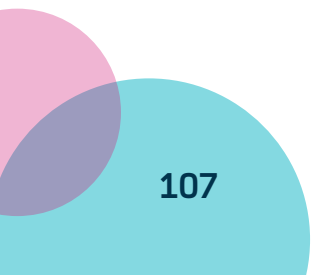
Administered to incorrect patient, mix up of drugs between patients	
Breach of controlled drugs procedures	
Breach of other local drugs policies or procedures	
Inappropriate or incorrect delivery of medication	
Inappropriate storage, transportation, preparation, disposal	
Not administering or refusing to administer medication	
Not completing checks before administering medication	
Not notifying or escalating a drug administration error	
Prescribing	<ul style="list-style-type: none"> • Administered drug without prescription or clinical review • Prescribed incorrect drug • Prescribing when not a qualified prescriber • Other
Theft or misappropriation of drugs from workplace	
Other drugs administration or medicines management errors	<ul style="list-style-type: none"> • Other

Level 1 Allegation code: Record keeping

Level 2 Allegation Codes	Level 3 Allegation Codes
Care plan	<ul style="list-style-type: none"> • Inappropriate or incorrect entry to care plan • Not creating or maintaining adequate care plan • Other
Drugs or medication records	<ul style="list-style-type: none"> • Inappropriate or incorrect entry to record • Not recording drug administration or related issues • Other
Patient or clinical records	<ul style="list-style-type: none"> • Inappropriate or incorrect entry to record • Not ensuring records in place e.g. risk assessment • Not recording observation, care given, incident • Other
Other record keeping issues	<ul style="list-style-type: none"> • Other

Level 1 Allegation code: Registrant's health

Level 2 Allegation Codes	Level 3 Allegation Codes
Alcohol misuse or dependency	
Drugs misuse or dependency	
Mental health	
Physical health	
Other health issues not further specified	<ul style="list-style-type: none"> • Other



Level 1 Allegation code: Sexual offences

Level 2 Allegation Codes	Level 3 Allegation Codes
Adult sexual assault	<ul style="list-style-type: none"> • Colleague sexual assault • Adult out of work sexual assault • Adult patient sexual assault • Other
Child sexual abuse	<ul style="list-style-type: none"> • Out of work child sexual abuse • Child patient sexual abuse • Other
Possessing child pornography	
Other sexual offences	<ul style="list-style-type: none"> • Other

Level 1 Allegation code: Social media

Level 2 Allegation Codes	Level 3 Allegation Codes
Posting inappropriate material	<ul style="list-style-type: none"> • Posting inappropriate material about colleagues • Posting inappropriate material about employer or NHS • Posting inappropriate material about general issues • Posting inappropriate material about other specific individuals outside work • Posting inappropriate material about patients • Posting inappropriate material about the nature of their work • Posting inappropriate material about themselves • Other
Other social media activity	<ul style="list-style-type: none"> • Other

Annexe 2

Level 1 Allegation Code: Criminal proceedings

Level 2 Allegation Codes	Level 3 Allegation Codes
Arrest	
Caution	
Charge	
Conditional discharge	
Conviction	
Fine	
Fixed Penalty Notice	
Investigation	
Other criminal proceeding	

Level 1 Allegation Code: Other allegations

Level 2 Allegation Codes	Level 3 Allegation Codes
Other types of allegations	<ul style="list-style-type: none">• Other

References

1. In the Equality Act 2010 the protected characteristics are; age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.
2. 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.
3. In the Equality Act 2010 the protected characteristics are; age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.
4. We would like to thank Dr Cara Booker for her excellent advice and guidance from the start and throughout this project.
5. UK Government (2019) [Population of England and Wales](#). Ethnicity facts and figures
6. Scottish Government (2018) [Ethnicity in Scotland, 2019](#). Equality Evidence Finder
7. Central Statistics Office and Northern Ireland Statistics and Research Agency (2014) [Census 2011: Ireland and Northern Ireland](#).
8. Office for National Statistics, Sexual Orientation, 2017. [Experimental statistics on sexual orientation in the UK in 2017 by region, sex, age, marital status, ethnicity and socio-economic classification](#)
9. Department for Work and Pensions (2020) [Family Resources Survey 2018/19](#)
10. Ross S, Jabbal J, Chauhan K, Maguire D, Randhawa M & Dahir S (2020) [Workforce race inequalities and inclusion in NHS providers](#), The King's Fund
11. West M, Dawson J, Admasachew L & Topakas A (2011) NHS Staff Management and Health Service Quality. Results from the [NHS Staff Survey and Related Data](#).
12. Education Endowment Foundation (2017) [The Attainment Gap](#). London, EEF

Annexe 3

13. Strand, S. (2014). Ethnicity, gender, social class and achievement gaps at age 16: Intersectionality and 'getting it' for the white working class. *Research Papers in Education*, 29. 118–171
14. Strand, S. (2015) Ethnicity, deprivation and educational achievement at age 16 in England: Trends over time. Report to the Department for Education.
15. Equality and Human Rights Commission (2018) *Is Britain fairer? The state of equality and human rights 2018*
16. Institute of Health Equity (2020). *Health Equity in England: The Marmot Review 10 years on.*
17. Memon A et al. (2016) Perceived barriers to accessing mental health services among black and minority ethnic (BME) communities: a qualitative study in South East England. *BMJ Open*.
18. Watson, H. et al. (2019). A systematic review of ethnic minority women's experiences of perinatal mental health conditions and services in Europe. *PLoS ONE*. 14(1).
19. Mooney, R., Trivedi, D. and Sharma, S. (2016). How do people of South Asian origin understand and experience depression? A protocol for a systematic review of qualitative literature. *BMJ Open*.
20. Halvorsrud, K. et al. (2019). Ethnic inequalities in the incidence of diagnosis of severe mental illness in England: a systematic review and new meta-analyses for non-affective and affective psychoses. *Social Psychiatry and Psychiatric Epidemiology*.
21. Gov UK (2017). *Ethnicity facts and figures: self-harm and suicidal thoughts and attempts.*
22. Gov UK (2020). *Ethnicity facts and figures: happiness*
23. Gov UK (2019). *Ethnicity facts and figures: anxiety*
24. Race Disparity Unit (2020). *Chinese ethnic group: facts and figures.*
25. Hanif, W. and Susaria, R. (2018). Diabetes and cardiovascular risks in UK South Asians: an overview. *The British Journal of Cardiology*.
26. Darlington-Pollock, F. and Norman, P. (2017). Examining ethnic inequalities in health and tenure in England: a repeated cross-sectional analysis. *Health and Place*. 46: 82-90.

27. Wohland, P. (2015). Inequalities in healthy life expectancy between ethnic groups in England and Wales in 2001. *Ethnicity and Health*. 20(4).
28. Darlington, F. et al. (2015). Exploring ethnic inequalities in health: evidence from the Health Survey for England, 1998-2011. *Diversity and Equality in Health and Care*. 12(2): 54-65
29. George, J. et al (2017). Ethnicity and the first diagnosis of a wide range of cardiovascular diseases: Associations in a linked electronic health record cohort of 1 million patients. *PLoS ONE*. 12(6)
30. Public Health England (2017). Public Health Outcomes Framework: Health Equity Report. Focus on ethnicity.
31. Cumella, A. and Haque, A. (2018). On the edge: How inequality affects people with Asthma
32. Gruer, L. (2016). Life expectancy of different ethnic groups using death records linked to population census data for 4.62 million people in Scotland. *Journal of Epidemiology and Community Health*. 70(12): 1251-1254
33. Allik, M. et al. (2019). Differences in ill health and in socioeconomic inequalities in health by ethnic groups: a cross-sectional study using 2011 Scottish census. *Ethnicity and Health*.
34. Montacute, R. and Bunn, S. (2016) Infant mortality and stillbirth in the UK. *POSTnote* 527
35. Li, Y. et al. (2018). The contribution of gestational age, area deprivation and mother's country of birth to ethnic variations in infant mortality in England and Wales: A national cohort study using routinely collected data. *PLoS ONE*. 13(4).
36. Gov UK (2019). Ethnicity facts and figures: physical inactivity.
37. Gov UK (2019). Ethnicity facts and figures: cigarette smoking among adults.
38. Semlyen J, King M, Varney J, Hagger-Johnson G. Sexual Orientation and Symptoms of Common Mental Disorder or Low Wellbeing: Combined Meta-Analysis of 12 UK Population Health Surveys. *BMC Psychiatry*. 2016; 16:67
39. Exploring sexual orientation and patient experience. NHS England and NHS Improvement. Slide presentation for internal use by Dr Michael Brady, National Advisor for LGBT Health

40. Health4LGBTI: Reducing health inequalities experienced by LGBTI people. Information on this project can be found at: <https://www.ilga-europe.org/what-we-do/our-advocacy-ork/health/health4lgbti>
41. Shabab L, Brown J, Hagger-Johnson G, Michie S, Semlyen J, West R, Meads C. Sexual orientation identity and tobacco and hazardous alcohol use: findings from a cross-sectional English population survey. UCL. Manuscript 2016.
42. Hagger-Johnson G, Taibjee R, Semlyen J, Fitchie I, Fish J, Meads C, Varney J. (2013) Sexual orientation identity in relation to smoking history and alcohol use at age 18/19: Cross-sectional associations from the Longitudinal Study of Young People in England (LSYPE). *BMJ Open* 3(8): 1-7.
43. Public Health England (2018) Improving the health and wellbeing of lesbian and bisexual women and other women who have sex with women. This publication has extensive references on research into the health of LBWSW.
44. Hodson K, Meads C, Bewley S. (2017) Lesbian and bisexual women's likelihood of becoming pregnant: a systematic review and meta-analysis. *Bjog*. 124(3):393-402. doi:10.1111/1471-0528.14449.
45. Parliamentary Office of Science and Technology (2018) LGBT+ Health Inequalities event, July. Accessed at: <https://www.parliament.uk/documents/post/LGBT-Health-Inequalities.pdf>
46. Einfeld, S., Ellis, L. & Emerson, E. (2011) Comorbidity of intellectual disability and mental disorder: A systematic review, *Journal of Intellectual & Developmental Disability*, 36, pp.137-143
47. Emerson E. & Hatton C. (2007) *Health Inequalities and People with Intellectual Disabilities*, Cambridge University Press, Cambridge.
48. Cooper, S., Smiley, E., Morrison, J., Williamson, A., & Allan, L. (2007) Mental Ill-Health in Adults With Intellectual Disabilities: Prevalence and Associated Factors, *British Journal of Psychiatry*, 190, pp.27-35
49. Hatton, C., Emerson, E., Robertson, J., & Baines, S. (2017) The mental health of British adults with intellectual impairments in general households, *Journal of Applied Research in Intellectual Disabilities*, 30:1, pp.188-197.
50. Emerson, E., Baines, S., Allerton, L., & Welch, V. (2012) *Health Inequalities and people with learning disabilities in the UK: 2012. Improving Health and Lives: Learning Disability Observatory.*

51. Hatton, C., Emerson, E., Robertson, J., & Baines, S. (2017) The mental health of British adults with intellectual impairments in general households, *Journal of Applied Research in Intellectual Disabilities*, 30:1 pp.188-197
52. National Institute for Health and Care Excellence (NICE) (2016) *Mental health problems in people with learning disabilities: prevention, assessment and management*.
53. Bond, L., Carroll, R., Mulryan, N., O'Dwyer, M., O'Connell, J., Monaghan, R., Sheerin, F., McCallion, P., & McCarron, M. (2019) The association of life events and mental ill health in older adults with intellectual disability: results of the wave 3 Intellectual Disability Supplement to The Irish Longitudinal Study on Ageing, *Journal of Intellectual Disability Research*, 63:5, pp.454-465
54. Austin, K. L., Hunter, M., Gallagher, E., & Campbell, L. E. (2018) Depression and anxiety symptoms during the transition to early adulthood for people with intellectual disabilities, *Journal of Intellectual Disability Research*, 62:5, pp.407-421.
55. Ali, A., King, M., Strydom, A., & Hassiotis, A. (2015) Self-reported stigma and symptoms of anxiety and depression in people with intellectual disabilities: Findings from a cross sectional study in England, *Journal of Affective Disorders*, 187, pp.224-231.
56. Heslop P, Blair P, Fleming P, Hoghton M, Marriott A and Russ L. (2013) *Confidential Inquiry into premature deaths of people with learning disabilities (CIPOLD): Final report*. Bristol
57. Norah Fry Research Centre, University of Bristol; University of Bristol Norah Fry Centre for Disability Studies (2019) *The Learning Disabilities Mortality Review (LeDeR) Programme: Annual Report 2018*. London: Healthcare Improvement Quality Partnership (last accessed 11/06/2020).
58. Ellis, S. J., Bailey, L., & McNeil, J. (2015). Trans people's experiences of mental health and gender identity services: A UK study. *Journal of Gay & Lesbian Mental Health*, 19(1), 4-20.
59. [Health4LGBTI](#) EU funded project - [TASK 1: State-of-the-art study focusing on the health inequalities faced by LGBTI people](#) D1.1 State-of-the-Art Synthesis Report (SSR)
60. Hulbert-Williams, N. J., Plumpton, C. O., Flowers, P., McHugh, R., Neal, R. D., Semlyen, J., & Storey, L. (2017). The cancer care [experiences of gay, lesbian and bisexual patients](#): A secondary analysis of data from the UK Cancer Patient Experience Survey. *European journal of cancer care*, 26(4), e12670.

61. Semlyen J. et al (2018) Sexual orientation identity in relation to unhealthy Body Mass Index (BMI): Individual Participant Meta-Analysis of 93,429 individuals from 12 UK health surveys
62. Semlyen J, King M, Varney J, Hagger-Johnson G. (2016) [Sexual Orientation and Symptoms of Common Mental Disorder or Low Wellbeing](#): Combined Meta-Analysis of 12 UK Population Health Surveys. BMC Psychiatry; 16:67
63. Public Health England (2018) [Improving the health and wellbeing of lesbian and bisexual women and other women who have sex with women](#)
64. King, M., Semlyen, J., Tai, S. S., Killaspy, H., Osborn, D., Popelyuk, D., & Nazareth, I. (2008). [A systematic review of mental](#) disorder, suicide, and deliberate self harm in lesbian, gay and bisexual people. BMC psychiatry, 8(1), 70.
65. Public Health England (2018). [Local action on health inequalities. Understanding and reducing ethnic inequalities in health.](#)
66. [Declare Your Care: People with learning disabilities.](#) Care Quality Commission
67. McKee K, Pearce A & Leahy S (2020) [The unequal impact of Covid-19 on Black, Asian, Minority Ethnic and Refugee Communities.](#) UK Collaborative Centre for Housing Evidence, 6 May 2020
68. Marmot M, Allen J, Boyce T, Goldblatt P & Morrison J (2020) [Health equity in England: The Marmot Review 10 years on.](#) London: Institute of Health Equity
69. Lammy D (2017) [The Lammy Review.](#)
70. Equalities and Human Rights Commission (2016) [Healing a divided Britain: The need for a comprehensive race equality strategy.](#) London, EHRC
71. House of Commons Library (2019) [Hate crime statistics.](#) CBP 8537
72. Home Office (2018) [Hate crime, England and Wales 2017/18](#)
73. Nandi A, Luthra R, Saggar S & Benzeval M (2017) [The prevalence and persistence of ethnic and racial harassment and its impact on health: a longitudinal analysis.](#) Institute for Social and Economic Research, University of Essex
74. Abshire, D. (2018). Student support in accelerated nursing programmes: gender-based perspectives and impact on academic outcomes. Nursing Outlook. 66:84-93

- ⁷⁵. Kronsberg, S., Bouret, J. and Brett, A. (2018). Lived experiences of male nurses: dire consequences for the nursing profession. *Journal of Nursing Education and Practice*. 8(1): 46-53.
- ⁷⁶. Whitford, H. et al. (2018). Pre-registration nursing recruitment and retention – underrepresentation of men, influences and causes.
- ⁷⁷. Wakeford, R. et al. (2018). Fitness to practise sanctions in UK are predicted by poor performance at MRCGP and MCCP (UK) assessments: data linkage study.
- ⁷⁸. Unwin, E. et al. (2018). Passing MRCP (UK) PACES: a cross-sectional study examining the performance of doctors by sex and country. *BMC Medical Education*. 18:70.
- ⁷⁹. Wray, J. et al. (2017). Factors affecting the programme completion of pre-registration nursing students through a three year course: a retrospective cohort study. *Nurse Education in Practice*. 24: 14-20.
- ⁸⁰. Wakeford, R. et al. (2018). Fitness to practise sanctions in UK are predicted by poor performance at MRCGP and MCCP (UK) assessments: data linkage study.
- ⁸¹. Unwin, E. et al. (2018). Passing MRCP (UK) PACES: a cross-sectional study examining the performance of doctors by sex and country. *BMC Medical Education*. 18:70.
- ⁸². Pattinson, J. et al. (2019). Exploring reasons for differences in performance between UK and international medical graduates in the membership of the Royal College of General Practitioners Applied Knowledge Test: a cognitive interview study. *BMJ Open*. 9
- ⁸³. Shaw, S. and Anderson, J. (2017). Doctors with dyslexia: a world of stigma, stonewalling and silence, still? *MedEdPublish*
- ⁸⁴. Shaw, S. and Anderson, J. (2018). The experiences of medical students with dyslexia: an interpretive phenomenological study. *Dyslexia*. 24: 220-233.
- ⁸⁵. Morrison, N., Machado, M. and Blackburn, C. (2019). Student perspectives on barriers to performance for black and minority ethnic graduate-entry medical students: a qualitative study in a West Midlands medical school. *BMJ Open*.
- ⁸⁶. Scherer, M., Herrick, L. and Stamler, L. (2019). The learning experiences of immigrants who are graduates of an entry-level baccalaureate nursing programme: a hermeneutic phenomenological study. *Nurse Education in Practice*. 34: 185-191.

- ⁸⁷. Morrison, N., Machado, M. and Blackburn, C. (2019). Student perspectives on barriers to performance for black and minority ethnic graduate-entry medical students: a qualitative study in a West Midlands medical school. *BMJ Open*
- ⁸⁸. Dimant, O. et al. (2019). Experience of transgender and gender non-binary medical students and physicians. *Transgender Health*. 4(1): 209-216
- ⁸⁹. Broad, J. et al. (2018). Discrimination, harassment and non-reporting in UK medical education. *Medical Education*. 52: 414-426
- ⁹⁰. Budden, L., Birks, M. and Bagley, T. (2017). Australian nursing students' experiences of bullying and/or harassment during clinical placement. *Collegian*. 24: 125-133
- ⁹¹. Eliason, M., Streed, C. and Henne, M. (2018). Coping with stress as an LGBTQ+ healthcare professional. *Journal of Homosexuality*. 65(5): 561-578.
- ⁹². Universities and Colleges Admissions (2020) The Number of Applications, Number of Offers as-at 30 June, Number of Applicant Firm Replies as-at 30 June, Number of Applicant Insurance Replies as-at 30 June, Number of Applicant Declines as-at 30 June, Number of Acceptances split by User defined subject group, Provider Name 2019, Sex, Ethnic Group (Summary Level), Disability Indicator, Age Band (5 Levels) at End of Cycle for the 2016 - 2019 entry years. UCAS Exact Query Reference: EXACT_003621. The EXACT Data has been provided by the Universities and Colleges Admissions Service
- ⁹³. HESA Student Record 2015/16; HESA Student Record 2014/15; HESA Student Record 2013/14; HESA DLHE Record 2015/16; HESA DLHE Record 2014/15; HESA DLHE Record 2013/14; HESA Student Record 2016/17; HESA DLHE Record 2016/17; HESA Student Record 2017/18
- ⁹⁴. Wray, J. et al. (2017). Factors affecting the programme completion of pre-registration nursing students through a three year course: a retrospective cohort study. *Nurse Education in Practice*. 24: 14-20
- ⁹⁵. Kronsberg, S., Bouret, J. and Brett, A. (2018). Lived experiences of male nurses: dire consequences for the nursing profession. *Journal of Nursing Education and Practice*. 8(1): 46-53.
- ⁹⁶. Whitford, H. et al. (2018). Pre-registration nursing recruitment and retention – underrepresentation of men, influences and causes
- ⁹⁷. Whitford, H. et al. (2019). Men on pre-registration programmes of nursing in Scotland: an exploration of reasons for attrition and possible ways of improving retention.

- ⁹⁸. Tranter, S. et al. (2017). Initiatives aimed at retaining ethnically diverse student nurses in undergraduate programmes: an interactive review. *Journal of Clinical Nursing*. 27: 3,846-3,857.
- ⁹⁹. Foronda C, Baptiste D & Ockimey J (2017) As simple as black and white: The presence of racial diversity in simulation product advertisements. *Clinical Simulation in Nursing* 13, 24–27. DOI: <https://doi.org/10.1016/j.ecns.2016.10.007>
- ¹⁰⁰. Burnett A, Moorley C, Grant J, Kahin M, Sagoo R, Rivers E, Deravin L & Darbyshire P (2020) Dismantling racism in education: In 2020, the year of the nurse and midwife, “it’s time.” *Nurse Education Today* 93: 104532. doi: 10.1016/j.nedt.2020.104532
- ¹⁰¹. Burnett A, Moorley C, Grant J, Kahin M, Sagoo R, Rivers E, Deravin L & Darbyshire P (2020) Dismantling racism in education: In 2020, the year of the nurse and midwife, “it’s time”. *Nurse Education Today*. DOI: <https://doi.org/10.1016/j.nedt.2020.104532>
- ¹⁰². Cortisman L (2008). Experiences of African American students in a predominantly white, two-year nursing program. *Association of Black Nursing Faculty Journal*, 19(1),8-13
- ¹⁰³. NMC (2020) [Year 4 Revalidation Data Tables](#).
- ¹⁰⁴. NHS Digital (2020) Hospital and Community Health Services (HCHS) workforce statistics: Equality and Diversity in NHS Trusts and CCGs in England, March 2019.
- ¹⁰⁵. Lillis, S. and Milligan, E. (2017). Ageing doctors. *Australian Journal on Ageing*. 36(1): 14-18
- ¹⁰⁶. Ryan, C., Bergin, M. and Wells, J. (2017). Valuable yet vulnerable – a review of the challenges encountered by older nurses in the workplace. *International Journal of Nursing Studies*. 72: 42-54
- ¹⁰⁷. Kshetrimayum, N., Bennadi, D. and Siluvai, S. (2019). Stress among staff nurses: a hospital based study. *Journal of Nature and Science of Medicine*. 2: 95-100.
- ¹⁰⁸. Picakciefe, M., Akkaya, V. and Erbas, E. (2018). A sample to determine the conditions and problems faced by disabled healthcare professionals: a training and research hospital. *Occupational Environmental Medicine*. 75(2).
- ¹⁰⁹. Mogensen, K. and Hu, W. (2019). “A doctor who really knows ...”: a survey of community perspectives on medical students and practitioners with disability. *BMC Medical Education*. 19: 288.

110. Kinsella, M., Waduud, M. and Biddlestone, J. (2017). Dyslexic doctors, an observation on current United Kingdom practice. MedEdPublish.
111. Ikematsu, Y., Egawa, K. and Endo, M. (2019). Prevalence and retention status of new graduate nurses with special support needs in Japan. *Nurse Education in Practice*. 36: 28-33.
112. Younas, A. and Sundas, A. (2018). Experiences of and satisfaction with care provided by male nurses: a convergent mixed-method study of patients in medical surgical units. *Journal of Advanced Nursing*. 74: 2,640 – 2,653
113. Ryan, C., Bergin, M. and Wells, J. (2017). Valuable yet vulnerable – a review of the challenges encountered by older nurses in the workplace. *International Journal of Nursing Studies*. 72: 42-54
114. Picakciefe, M., Akkaya, V. and Erbas, E. (2018). A sample to determine the conditions and problems faced by disabled healthcare professionals: a training and research hospital. *Occupational Environmental Medicine*. 75(2).
115. Powers, K. et al. (2018). The lived experience of being a male nursing student: implications for student retention and success. *Journal of Professional Nursing*. 34: 475-482.
116. Ndou, N. and Moloko-Phiri, S. (2018). Four-year diploma male students' experiences in a profession traditionally perceived as a female domain at a selected public college of nursing in Limpopo, South Africa. *Curationis*. 41(1).
117. Alexis O & Vydelingum V (2009) Experiences in the UK National Health Service: The overseas nurses' workforce. *Health Policy*: 90(2-3): 320-328
118. Taylor B (2005) The experiences of overseas nurses working in the NHS: results of a qualitative study. *Diversity in Health and Social Care* 2: 17-27
119. Lin Y-Q, Ding Y & Li J-Y (2018) [A literature review of research exploring the experiences of overseas nurses in the United Kingdom \(2002-2017\)](https://doi.org/10.1515/fo-2018-0003). *Frontiers of Nursing* 5(1). DOI: <https://doi.org/10.1515/fo-2018-0003>
120. NHS Digital (2020) Hospital and Community Health Services (HCHS) workforce statistics: Equality and Diversity in NHS Trusts and CCGs in England, March 2019. Available from: [NHS workforce statistics](https://www.nhs.uk/healthcare-workforce-statistics/).

121. Punshon, G. et al. (2019). Nursing pay by gender distribution in the UK – does the glass escalator still exist? *International Journal of Nursing Studies*. 93: 21-29.
122. Department of Health and Social Care (2019). New data on gender pay gap in medicine. 29th March 2019.
123. Appleby, J. and Schlepper, L. (2019). The gender pay gap in the English NHS. Analysis of some of the underlying causes: briefing May 2019.
124. NHS (2020) [NHS Workforce Race Equality Standard](#)
125. NHS England (2020) [NHS Workforce Disability Equality Standard \(WDES\). Annual Report 2019](#)
126. NHS (2019) NHS Staff survey. 2019 results
127. Dehghan-Chaloshtari, S. and Ghodousi, A. (2020). Factors and characteristics of workplace violence against nurses: a study in Iran. *Journal of Interpersonal Violence*. 35(1): 496-509.
128. Burrowes, S. et al. (2017). Midwives' and patients' perspectives on disrespect and abuse during labor and delivery care in Ethiopia: a qualitative study. *BMC Pregnancy and Childbirth*. 17: 263
129. Royal College of Nursing (2019). RCN employment survey 2019.
130. Najafi, F. et al. (2017). Human dignity and professional reputation under threat: Iranian nurses' experiences of workplace violence. *Nursing and Health Sciences*. 19: 44-50.
131. UNISON (2019). It's never ok: a report on sexual harassment against healthcare staff.
132. British Medical Association (2017). Workplace bullying and harassment of doctors. A review of recent research
133. British Medical Association (2018). Caring, supportive and collaborative? Doctors' views on working in the NHS
134. Cheung, T., Lee, P. and Yip, P. (2018). The association between workplace violence and physicians' and nurses' job satisfaction in Macau. *PLoS one*. 13(2).
135. Stephenson, J. (2018). Nurses with disabilities face discrimination in the workplace. *Nursing Times*. 8th March 2018.
136. Cottingham, M., Johnson, A. and Erickson, R. (2018). "I can never be too comfortable": race, gender and emotion at the hospital bedside. *Qualitative Health Research*. 28(1): 145-158.

137. Munn, F. (2017). Reporting racism on the wards. *The BMJ*. 20th December 2017
138. Johnson, J. et al. (2017). An investigation into the relationship between bullying, discrimination, burnout and patient safety in nurses and midwives: is burnout a mediator? *Journal of Research in Nursing*. 24(8): 604-619.
139. Sharma, S. et al. (2019). Individual and organisation characteristics associated with workplace bullying on school nurses in Virginia. *The Journal of School Nursing*. 1-10.
140. Keshet, Y. and Popper-Giveon, A. (2018). Race-based experiences of ethnic minority health professionals: Arab physicians and nurses in Israeli public healthcare organisations. *Ethnicity and Health*. 23(4): 442-459.
141. Pendleton, J. (2017). The experience of black and minority ethnic nurses working in the UK. *British Journal of Nursing*. 26(1).
142. Eliason, M., Streed, C. and Henne, M. (2018). Coping with stress as an LGBTQ+ healthcare professional. *Journal of Homosexuality*. 65(5): 561-578
143. British Medical Association (2017). Workplace bullying and harassment of doctors. A review of recent research
144. Major, R. and Tetley, J. (2019). Effects of dyslexia on registered nurses in practice. *Nurse Education in Practice*. 35: 7-13.
145. Malik, A. et al. (2019). "I decided not to go into surgery due to dress code": a cross-sectional study within the UK investigating experiences of female Muslim health professionals on bare below the elbows (BBE) policy and wearing headscarves (hijabs) in theatre. *BMJ Open*.
146. Saidun, S. Akhemtova, E. and Rahman, A. (2018). Muslim female healthcare personnel dress code: a proposed guideline. *IJUM Medical Journal Malaysia*, 17(2).
147. Bond S, Merriman C & Walthall H (2020) The experiences of international nurses and midwives transitioning to work in the UK: A qualitative synthesis of the literature from 2010 to 2019. *International journal of Nursing Studies* 110 (103693). DOI: <https://doi.org/10.1016/j.ijnurstu.2020.103693>
148. Moyce S, Lash R & de Leon Siantz M (2015) Migration experiences of foreign educated nurses: A systematic review of the literature. *Journal of Transcultural Nursing* 27(2): 181-188

149. Likupe G & Archibong U (2013) Black African Nurses' Experiences of Equality, Racism, and Discrimination in the National Health Service. *Journal of Psychological Issues in Organizational Culture* 3(S1). DOI: 10.1002/jpoc.21071
150. Royal College of Nursing (2008). *The work-life experiences of black nurses in the UK*. London, England: Royal College of Nursing
151. Shields M & Wheatley Price S (2002) Racial harassment, job satisfaction and intentions to quit: Evidence from the British nursing profession. *Economica*, 69(274), 295–324.
152. Moore A (2020) Staff suspended after 'great distress' to BAME workers. *Health Services Journal* 4 September
153. NHS (2019) [Anti-Bullying Alliance](#)
154. The King's Fund (2015) [Making the difference: diversity and inclusion in the NHS](#). London, The King's Fund
155. Wankhade P (2018) [The crisis in NHS Ambulance Services in the UK: Let's deal with the 'elephants in the room'!!](#). *Ambulance Today* 15(1): 13-17
156. Fisher, M. and Kiernan, M. (2019). Student nurses' lived experience of patient safety and raising concerns. *Nurse Education Today*. 77: 1-5.
157. Zahara, D. et al. (2017). Analysis of fitness to practice case data for the General Dental Council.
158. Atewologun, D., Kline, R. and Ochieng, M. (2019). Fair to refer. Reducing disproportionality in fitness to practise concerns reported to the GMC.
159. Spittal, M., Bismark, M. and Studdert, D. (2019). Identification of practitioners at high risk of complaints to health profession regulators. *BMC Health Services Research*. 19:380.
160. General Medical Council (2018). *What our data tells us about general practitioners working for the NHS in England and Scotland*
161. Germack H, Griffiths P, Sloane Dm Rafferty A-M, Ball J, Aiken J (2015) Patient satisfaction and non-UK educated nurses: a cross-sectional observational study of English National health Service Hospitals. *BMJ Open* 5:e009483. DOI: 10.1136/bmjopen-2015-009483
162. Hunter, B. et al. (2019). Midwives in the United Kingdom: levels of burnout, depression, anxiety and stress and associated predictors. *Midwifery*. 79

163. Kim, H. and Yeom, H. (2018). The association between spiritual well-being and burnout in intensive care unit nurses: a descriptive study. *Intensive and Critical Care Nursing*. 46: 92-97
164. Kinman, G. and Teoh, J. (2018). What could make a difference to the mental health of UK doctors? A review of the research evidence.
165. Momani, M. (2017). Factors influencing public hospital nurses' intentions to leave their current employment in Jordan. *International Journal of Community Medicine and Public Health*. 4(6).
166. Kurjenluoma, K. et al. (2017). Workplace culture in psychiatric nursing described by nurses. *Scandinavian Journal of Caring Sciences*. 31(4).
167. Labrague, L. et al. (2018). Factors influencing turnover intention among registered nurses in Samar Philippines. *Applied Nursing Research*. 39: 200-206.
168. Pu, J. (2017). Gender differences in psychological morbidity, burnout, job stress and job satisfaction among Chinese neurologists: a national cross-sectional study. *Psychology, Health and Medicine*. 22(6).
169. Tsara, K. et al. (2017). Predicting factors of depression and anxiety in mental health nurses: a quantitative cross-sectional study. *Medical Archives*. 72(1): 62-67.
170. Halpin, Y. Terry, L. and Curzio, J. (2017). A longitudinal, mixed methods investigation of newly qualified nurses' workplace stressors and stress experiences during transition. *Journal of Advanced Nursing*. 73(11).
171. Cottingham, M., Johnson, A. and Erickson, R. (2018). "I can never be too comfortable": race, gender and emotion at the hospital bedside. *Qualitative Health Research*. 28(1): 145-158
172. Karami, F. et al. (2018). Relationship between religious attitude and anxiety in nursing and midwifery students. *Journal of Nursing and Midwifery Sciences*. 5(3): 103-108.
173. Converso, D. et al. (2019). The relationship between menopausal symptoms and burnout: a cross-sectional study among nurses. *BMC Women's Health*. 19(148).
174. NHS (2018). Overview: menopause.
175. Banks, S. (2019). Menopause and the NHS: caring for and retaining the older workforce. *British Journal of Nursing*. 28(16): 1,086-1,090.

176. Ipsos Mori (2019) [Evaluation of revalidation for nurses and midwives.](#)
177. Bhardway S (2017) Retirement or revalidation? Practice Management 26(3). DOI: <https://doi.org/10.12968/prma.2016.26.3.28>
178. Cleland J, Porteous T, Ejebu O-Z & Skåtun D (2019) 'Should I stay or should I go now?: A qualitative study of why UK doctors retire. Medical Education 1-11. DOI: <https://doi.org/10.1111/medu.14157>
179. Draper B (2017) Older doctors and retirement. Medical Journal of Australia 206(5): 202-203. DOI: [doi: 10.5694/mja16.01424](https://doi.org/10.5694/mja16.01424)
180. UK Medical Revalidation CoLLaboration (2018). Evaluating the regulatory impact of medical revalidation.
181. Watters, C., Assessing the health consequences of fitness to practise investigations. British Journal of Nursing, 2018. 27(11): p. 639-641.
182. Collin, V., et al., (2019) A survey of stress, burnout and well-being in UK dentists. BDJ, 226: p. 40.
183. Toon, M., et al. (2019) An analysis of stress and burnout in UK general dental practitioners: subdimensions and causes. BDJ. 226: p. 125.
184. Bourne, T., et al., The impact of complaints procedures on the welfare, health and clinical practise of 7926 doctors in the UK: a cross-sectional survey. BMJ Open, 2015. 5(1).
185. NMC (2020) [Annual equality, diversity and inclusion report 2019-2020](#)
186. West E, Nayar S & Taskila T (2017) [The progress and outcomes of Black and minority ethnic \(BME\) nurses and midwives through the Nursing and Midwifery Council's Fitness to Practise process.](#) Final report
187. General Medical Council (2015) [The state of medical education and practice in the UK 2015](#)
188. Singh P, Mizrahi E & Korn S (2009) A five-year review of cases appearing before the General Dental Council's Professional Conduct Committee. British Dental Journal 206(4): 217-223
189. Atewologun D & Kline R (2019) [Fair to refer? Reducing disproportionality in fitness to practice concerns reported to the GMC.](#)

190. GMC (2018) [The state of medical education and practice in the UK 2018](#).
191. Zahra D, Roberts M, Bryce M, O'Brien T, Archer J (2017) [Analysis of fitness to practise case data for the General Dental Council](#)
192. McLaughlin K, Leigh J & Worsley S (2016) The state of regulation in England: From the General Social Care Council to the Health and Care Professions Council. *British Journal of Social Work* 46(4): 825-838. doi: [10.1093/bjsw/bcv030](https://doi.org/10.1093/bjsw/bcv030)
193. Worsley A, Shorrocks S & McLaughlin K (2020) Protecting the public? An analysis of professional regulation – comparing outcomes in fitness to practise proceedings for social workers, nurses and doctors. *British Journal of Social Work* 0: 1-19. doi: [10.1093/bjsw/bcaa079](https://doi.org/10.1093/bjsw/bcaa079)
194. Searle R (2019) Sexual misconduct in health and social care: understanding types of abuse and perpetrators' moral mindsets. Report for Professional Standards Authority
195. Griffin A, Medisauskaite A, Sarker S-J, Viney R, Knight L & Tweedie J (2019) [Developing a methodology to assess the consistency of fitness to practise outcomes](#). Report for the Professional Standards Authority by the Research Department of Medical Education UCL Medical School
196. Bryce M, Archer J, Brennan N, Burns L, O'Brien T & Price T (2018) [Fitness to practise: Impairment and Serious Misconduct](#). General Dental Council
197. Gallagher C & De Souza A (2015) A retrospective analysis of the GDC's performance against its newly-approved fitness to practise guidance. *British Dental Journal*; 219(5): E5. Available from: <http://dx.doi.org/10.1038/sj.bdj.2015.686>
198. Bourne T, Vanderhaegen J, Vranken R, Wynants L, De Cock B, Peters M (2016) Doctors' experiences and their perception of the most stressful aspects of complaints processes in the UK: An analysis of qualitative survey data. *BMJ Open*; 6(7): 1-10.
199. We publish details of the numbers of people taking both the CBT and OSCE elements of the Test of Competence on our website four times per year (<https://www.nmc.org.uk/registration/joining-the-register/register-nurse-midwife/trained-outside-the-eueea/nursing-and-midwifery-test-of-competence/pass-rates-and-candidate-numbers/>). Between July and September 2019, 5,620 people took a CBT and 98 percent achieved a pass. For the OSCE, 2,727 people took this test between July and September 2019 and 93 percent achieved a pass.

Annexe 3

²⁰⁰. The numbers in some of these categories, particularly those related to trans and applicants whose gender/gender identity we didn't know (or who preferred not to say) are very small and should be interpreted with caution.

²⁰¹. Scott K (2019) 'Too many obstacles' Royal College of Nursing Bulletin 25 March 2019.

²⁰². Nurses, midwives and nursing associates are able to declare all of the types of jobs that they do to meet the 450 practice hours' requirement. For each job, people are asked to tell us the scope of practice and work setting. For each job, people can select from 16 different scopes of practice and 25 different work settings (including an 'other' option in each). To enable us to analyse these meaningfully, we grouped the 25 different work settings into four larger categories: Hospital (including jobs in hospitals or other secondary care and maternity units or birth centres); Primary care (including jobs in community settings, including district nursing and community psychiatric nursing and GP practices or other primary care); Social care (including jobs in care homes); Other (including jobs in the following settings: ambulance service; consultancy; cosmetic or aesthetic sector; governing body or other leadership; inspectorate or regulator; insurance or legal; military; occupational health; police; policy organisation; prison; private domestic setting; public health organisation; school; specialist or other tertiary care including hospice; telephone or e-health advice; trade union or professional body; university or other research facility; voluntary or charity sector; other).

²⁰³. Fitness to practise cases are recorded according to the type of professional involved in the case. Where the professional is registered as both a nurse and midwife, the case is categorised according to the particular job role being undertaken by the professional at the time of the incident. For example, if the dual registrant was working a nurse-role at the time of the incident, the case would be coded as involving a nurse. This is why there are no cases showing that involving people registered as both a nurse and midwife.

Together in practice



nmc.org.uk



[@nmcnews](https://twitter.com/nmcnews)



[@nmcuk](https://www.facebook.com/nmcuk)

Nursing and Midwifery Council
23 Portlanvvd Place, London W1B 1PZ

Registered charity in England and Wales
(1091434) and in Scotland (SC038362)