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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

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EXECUTIVE SUMMARY

1. This study of the progress and outcomes of Black and Minority Ethnic (BME) nurses and midwives through the Fitness to Practise (FtP) process of the Nursing and Midwifery Council (NMC) has shown that ethnicity is related to the risk of referral to the NMC. Black nurses and midwives as well as those of Unknown ethnicity are disproportionately represented in the population of referrals to the NMC. Having qualified in Africa, as opposed to other continents, is also a risk factor for referral. It is important to note however, that ethnicity is known for only 60% of referrals. In the absence of more complete data on ethnicity, it cannot yet be concluded with certainty that some ethnic groups run a greater risk of referral.

2. Nurses and midwives referred to the NMC are older and more likely to be males compared to the whole population of registered nurses and midwives.

3. BME males are more likely to be referred to the NMC than are White male nurses and midwives who are under-represented in referrals.

4. There are many sources of referral to the NMC but the most common are employers and members of the public. BME nurses and midwives are disproportionately represented in referrals by employers, whereas White nurses and midwives are disproportionately represented in referrals by members of the public. Source of referral is extremely consequential in terms of progress and outcomes of the FtP process.

5. Ethnicity is also related to progression through the FtP process. Cases brought against nurses and midwives of White, Other or Unknown ethnicities are more likely to be closed at screening than are cases brought against Asian or Black nurses and midwives whose cases are more likely to be closed at the investigation stage.

6. Region of training is also related to progression through the FtP process. Having trained outside the UK increases the likelihood of the case going to investigation and having trained in Asia or Africa increases the risk of the case going to adjudication.

7. Different sources of referral are related to how far cases go through the FtP process with cases referred by members of the public, for example, being more likely to be closed at screening and cases referred by the police more likely to be closed at investigation.

8. Referrals by employers in which BME nurses and midwives are over-represented are unlikely to be closed at screening and most likely to be closed at investigation. A significant number of employer referrals go on to adjudication which contributes to the increased likelihood of BME nurses and midwives going all the way to the last stage of the FtP process.

9. The final stage of the FtP process results in a decision about whether or not the individual can continue to work as a nurse or midwife. All ethnicities, with the exception of those whose ethnicity is not known to the NMC, are likely to be allowed to continue to work.

White nurses and midwives are more likely to be barred from working than are Black or Asian nurses and midwives.

10. Logistic regression analyses of the whole dataset of referrals shows that the significant positive relationship between Black and Asian ethnicity and severity of outcome becomes insignificant when the source of referral is included in the model. Cases referred by employers have a more severe outcome than any other source of referral and employers are the main source of referrals of BME nurses and midwives.

11. Logistic regression analyses of a dataset restricted to cases at adjudication shows that those whose ethnicity it not known to the NMC are most at risk of receiving a severe penalty, followed by White, Black and Asian nurses and midwives, in that order. These findings are not affected by taking the source of the referral into account as was the case when studying the entire process from referral to final outcome described in (10) above.

12. There are few differences in referral and progression through the FtP process across the countries of the UK, however, at adjudication, cases originating in England are more likely to be allowed to continue to work than those from Scotland, Wales and Northern Ireland. The sample sizes for latter three countries are very small so these results must be interpreted with caution.

13. A systematic review of the literature found no previous investigations of the progress and outcomes of BME nurses and midwives through the NMC FtP process. However, we did find a body of research on the experiences of BME and internationally recruited nurses (IRNs) within the work setting, which we included in the review to provide context and background to the study. This showed that within the UK, BME healthcare professionals face a number of stressors at work. However, there is no evidence directly linking these challenges to overrepresentation of BME nurses and midwives in FtP enquiries.

14. Regulators of other health care professions that are overseen by the Professional Standards Authority have also conducted research on the progress and outcomes of BME members through FtP processes. For doctors and pharmacists, this research showed that "place of training" was significantly associated with more severe penalties. However, many of the studies advise caution as samples tend to be small.

15. Recommendations: These include the urgent need to gather accurate data on ethnicity, characteristics of the job, such as area of practice and level of seniority, type of allegation (which may change through the FtP process). Training for staff, managers and university students in areas such as unconscious bias is also recommended. Further research could also illuminate the relationship between the difficulties that BME and IRN nurses and midwives experience at work and referrals to the NMC.

Section 1: Introduction

In August 2016, the Prime Minister, Theresa May, announced that a "race audit" of public services would be conducted across the United Kingdom (UK) to investigate how ethnic minorities and White working class people are being treated by institutions such as the National Health Service (NHS), schools and the police and criminal justice system (accessed at http://www.bbc.co.uk/news/uk-politics-37194207). This initiative was prompted by a Race Report titled *Healing a Divided Britain* published by the Equality and Human Rights Commission (2016) that criticised the long-standing systemic unfairness and race inequality that has led to poorer outcomes for some ethnic and racial groups, in terms of pay, promotion and higher rates of unemployment in the UK. (accessed at https://www.equalityhumanrights.com/en/race-report-healing-divided-britain).

Concerns at the societal level about how Black and Minority Ethnic (BME) group members are treated also permeate debates about inter-group relationships in the NHS, where managers and staff have been accused of bias, discrimination and bullying of BME staff (NHS Staff Survey 2016). Media representations commonly suggest that BME staff are more likely to be referred to the regulator and to be given penalties that are more severe than White healthcare professionals. For example, the Nursing Standard recently surveyed Trusts to gather information about employment relations cases. They found that although BME nurses make up 19 per cent of the nursing workforce in England they make up 25 per cent of disciplinary cases and they were more likely than White nurses to be reported to the NMC (Spinks 2014). Reports such as these suggest that some groups might be experiencing discrimination and that further research is warranted to ensure that all groups have access to fair and unbiased disciplinary and regulatory processes.

Although media reports are important in highlighting issues of potential discrimination, their focus on individuals' experiences, rather than experiences of nurses and midwives in general can be limiting. The focus of enquiries into the experiences of BME groups has to date focused on disciplinary procedures within Trusts where the data are often missing and do not permit consideration of other factors, such as age, gender, seniority, or country of qualification that might play a significant role. To date, there have been no empirical studies that have compared the rates at which BME and white nurses are referred to the regulator, nor have there been any studies that have compared whether the progress and outcomes of nurses and midwives who are referred to the NMC differ according to ethnicity. Although some professions have already conducted research on the progress and outcomes of BME professionals, there is a gap in the literature on nursing and midwifery, which will be addressed in this study.

1.1 Aims of Study

1. "To establish whether the progress and outcomes of Black and minority ethnic (BME) nurses in relation to fitness to practice, from the point of referral to the point of case closure, is different from that of White nurses and midwives; and whether we can from the data account for any differences identified" (Call for research, NMC 2015).
2. To determine whether there are differences in the progress and outcomes of different groups depending on which of the four countries of the UK (England, Wales, Scotland, Northern Ireland) the case originated.
3. To describe the impact of the source of referral on the progress and outcomes of referrals.
4. To estimate whether or not other characteristics of the individual, such as age, gender, country of qualification and whether or not they were represented throughout the Fitness to Practise (FtP) process had an impact on progress and outcomes.

1.2 Outline of the report

The next section of the report, section 2, summarises a systematic review of the literature that was undertaken in order to understand the context and background for this study. The findings are in two parts: first, published, peer reviewed papers on the working experiences of BME nurses and midwives, and second, reports by other regulators, which examine the relationship between ethnicity and FtP processes. Section 3 briefly describes the datasets on which our analyses are based and the statistics used to describe the data and to identify relationships among the variables. The process of obtaining ethical approval for the study is also described in this section. The main results of the quantitative analyses are in section 4, which follows the stages of the FtP process, asking who gets referred to the NMC and how they compare to all registrants in terms of age, gender, and ethnicity. The analysis then focuses on progression through the FtP process, asking whether BME nurses and midwives are more likely than White nurses and midwives to have their cases closed at screening, investigation, or adjudication. The impact of the source of the referral (e.g., employer or member of the public), the country that was the origin of referral (England, Scotland, Wales or Northern Ireland), and whether or not the nurse or midwife referred has legal representation is also assessed. Sub-section 4.3 investigates how the outcome of adjudication, dichotomised into whether or not the nurse or midwife is allowed to continue to work or not, is related to a range of variables, including ethnicity and source of referral. Section 5 summarises all the findings and identifies the strengths and limitations of the study. Finally, in section 6, we set out for discussion some of the possible actions that could be taken based on the findings both of the literature review and the quantitative analyses, to ensure that ethnicity does not play a role in relation to referrals to the regulator, or to the outcomes of the FtP process.

Section 2: Previous research

2.1   Introduction

The nursing and midwifery professions constitute a significant proportion of the entire UK workforce. For decades, international recruitment of registered nurses has been a strategy used to alleviate shortages in the health care workforce (Tuttas, 2015). Britain has actively recruited BME nurses from former colonies, including the West Indies, Africa, Singapore, Malaysia and the Philippines (Alexis & Vydelingum, 2004); and in recent years from the European Union (Kings College London, 2014). Thus, today, the UK employs one of the highest proportion of foreign born nurses within its workforce (Magnusdottir, 2005). However, evidence suggests that BME staff in the NHS experience less favourable treatment, have a poorer experience of work life and fewer opportunities for development and career progression (Naqvi, Razaq, & Piper, 2016).

To date, no peer reviewed, published studies of BME nurses' and midwives' experiences of the FtP process have been found – although studies were found for other professional groups. This reflects Archibong, Baxter, Darr, Walton, and Jogi's (2013) assertion that while there is a growing body of research and anecdotal evidence indicating that BME doctors are more likely to be referred for FtP investigations, comparatively "less is known about the experiences of minority ethnic staff from other occupational groups within the NHS" (p. 6). This review aimed to elucidate the experiences of BME nurses and midwives in order to better understand the context for any overrepresentation of BME professionals in the FtP process; as well as understanding the experiences of other UK health profession regulators in relation to FtP enquiries of BME staff. A summary of the literature follows. To read the full literature review please refer to: West, E. & Nayar, S., (2016). *A review of the literature on the experiences of Black, minority and internationally recruited nurses and midwives in the UK healthcare system.* London, UK: University of Greenwich.

2.2   Methodology

A systematic search of the literature, using a selection of databases including Nursing Index; CINAHL; EBSCO; ERIC; Google Scholar; NHS Evidence; Nursing@OVID; Medline; Pubmed and Scopus, and covering the years 2000 to 2015, resulted in 36 full text, UK and international peer-reviewed and published articles. In addition, a search for reports by mainly UK health and social care regulatory bodies provided a further 22 documents for inclusion.

2.3   Working experiences of Black and Minority Ethnic Nurses and Midwives

"Performance concerns are a key issue for those who regulate health professionals around the world" (Schafheutle, Seston, & Hassell, 2011, p. 8). Understanding the key areas of performance in which BME nursing and midwifery health professionals encounter difficulties is necessary in providing a context for potential entry to the fitness to practise process. The literature revealed four main concerns surrounding BME and internationally recruited nurses' experiences. These include: 1) communication difficulties; 2) differences in cultural knowledge and practical skills; 3) issues of injustice – discrimination and racism; and 4) lack of workplace support.

2.3.1   Communication

Different styles of communication were noted by regulators as a potential issue (Archibong & Darr, 2010). Staff for whom English was not their first language may express themselves in ways that could easily be interpreted negatively by colleagues, managers and patients which, if left unchecked, could have serious consequences. Three dimensions associated with communication that proved to be challenging for BME staff were grammar associated with increased stress and embarrassment when corrected by their colleagues (Alexis & Vydelingum, 2004); having an accent, which provide a barrier both in regards to their own accent being understood and understanding the accent of their colleagues and patients (Matiti & Taylor, 2005); and technical terminology, which pertained to being trained in an American system (Daniel, Chamberlain & Gordon, 2001). Qualitative studies of ethnic minority nurses working in the US, Iceland and Sweden (Magnusdottir, 2005; Tavalli et al., 2014; Xu, Gutierrez, & Kim, 2008) all highlight communication, as well as different cultural knowledge and professional skills, as a challenge to working as an ethnic minority health care professional.

2.3.2   Differences in cultural knowledge and professional skills

Literature revealed that both the ethnic culture and 'nursing' culture that IRNs brought with them, shaped their adaptation and practice processes in the host country (Daniel et al., 2001; Matiti & Taylor, 2005; Withers & Snowball, 2003) and that induction programmes did not adequately prepare them to deliver care reflective of their new cultural environment (Alexis & Vydelingum, 2004). Differences in cultural knowledge and professional skills can lead to feelings of being devalued and deskilled (Taylor, 2005). Winkelmann-Gleed and Seeley (2005) have related this to the fact that the average age of the IRN is around 34, meaning many of these nurses have practised for many years but are recruited at a lower level in the host country. Taylor (2005) recommended encouraging a climate of inclusion within nursing teams, and allowing overseas nurses to receive professional practice training as part of their adaptation programme.

2.3.3   Discrimination and racism

It was generally noted that across the literature there is agreement that most foreign nurses have a negative experience of working in the UK, and that central to this is the perception of having been bullied or on the receiving end of workplace racism (Alexis, Vydelingum & Robbins, 2007; Shields & Wheatley Price, 2002; Tuttas, 2015). Experiences of racism do vary among BME staff. Likupe (2006) argued that while some African nurses had positive experiences of working in the NHS, equally, some encountered racism within the work setting and discrimination in pay and conditions of

service. Indeed, a later study revealed that African nurses were more likely to perceive that they were discriminated against than nurses from India and Pakistan (Alexis, 2015).

The adverse influence of institutional racism on the daily working relationship between BME health professionals and their colleagues has been noted by Allan, Larsen, Bryan and Smith (2003). They described racism as an attitude that, when expressed covertly, could hinder BME workers' place in nursing hierarchies and their career progression. Indeed, follow-up research has confirmed these feelings of discrimination (and sometimes overt or covert racism) expressed by overseas trained nurses (Larsen, 2007) and the perceived difficulty in career progression (Henry, 2007). Issues of racism and discrimination also arise in Australian and American studies (Mapedzahama, Rudge, West & Perron, 2012; Xu et al., 2008) regarding the experiences of BME staff.

2.3.4   Workplace support

Lack of perceived appreciation and feelings of inadequacy, experienced as diminished workplace support was the final area in which BME staff experienced workplace challenges. Allan (2010) has argued that there are barriers to effective and non-discriminatory practice when mentoring overseas nurses within the NHS and the care home sector. These include a lack of awareness about how cultural differences affect mentoring and learning for overseas nurses during their period of supervised practice prior to registration with the UK NMC. The need for appropriate mentoring, taking into account cultural practices was highlighted by Smith et al. (2006).

This review of the literature reveals that BME nurses and midwives employed within the UK healthcare system encounter both positive and challenging experiences in their daily practice. Although the challenges are more prominent, two positive experiences that came through in the literature were exposure to a new culture (Alexis et al., 2007) and workplace support (Alexis, 2015). Thus, while it is heartening to know that not all experiences are negative; nevertheless, serious issues do exist.

2.4   Fitness to Practise—Reports from other professional regulators

In light of the growing empirical and anecdotal evidence indicating that health professionals with a BME background are overrepresented in disciplinary procedures (Carter, 2000; Royal College of Midwives, 2013), there is an urgent need to address this issue for the benefit of staff members and ultimately, patient care. In this section available peer-reviewed and published reports related to the FtP process amongst selected regulatory authorities in the UK were reviewed.

The pathway through a FtP enquiry is generally standard across regulatory bodies (Chamberlain, 2011; General Osteopathic Council, 2016; Singh, Mizrahi, & Korb, 2009); although there is a degree of subjectivity, for example around what is and what is not defined as serious professional misconduct, and potential for the process to be subject to bias (though this was not substantiated for the GMC—de Bere et al., 2014).

The evidence supports the proposition that BME staff are overrepresented in disciplinary hearings (Archibong & Darr, 2010) and are more likely to receive more severe penalties. Data from the Royal College of Midwives (2012) indicated that 60.2% of the midwives who were subject to disciplinary proceedings in London were Black/Black British however only 32.0% of midwives in London were Black/Black British. They were also more likely to receive higher impact decisions (dismissal and suspension) and less likely to have no further action taken.

Factors contributing to overrepresentation of BME professionals in FtP procedures involving doctors and pharmacists include the place where qualification has been obtained (Allen, 2000; Campbell et al., 2011; General Medical Council, 2015; Humphrey, Hickman & Gulliford, 2011), as well as the

particular area of practice (Schafheutle, 2011; Tullett et al., 2003). However, much of the literature reviewed advises caution in interpreting the results due to small sample size. Additionally, obtaining an accurate picture of the outcomes for BME healthcare professionals who undergo a FtP process is hampered by the fact that some regulatory bodies are not collecting ethnicity related data.

2.5   Summary of literature review findings
Given the dearth of information directly relating to the progression of BME nurses and midwives through the FtP process, this literature review sought to shed light on potential reasons for the overrepresentation of BME nurses and midwives in disciplinary procedures. Literature addressing the experiences of BME and IRNs within the work setting, as well as literature related to health and social care regulatory bodies within the UK reveal that BME healthcare professionals face a number of stressors and pressures within the NHS and health care settings. However, there is no evidence directly linking these challenges to overrepresentation of BME nurses and midwives in FtP enquiries. Further research is required to better understand these challenges, the relation to regulatory processes, and the provision of support for BME nurses and midwives within the UK healthcare sector.

Section 3:   Data and methods

3.1   Dataset of all registrants
The Workforce Imaging System for Effective Regulation (WISER) has socio-demographic information about all registrants up to December 2014. The total number of nurses and midwives in the WISER dataset is 681,258.

3.2   Dataset of referrals
The Case Management System (CMS) has information about cases referred to the NMC from April 2012 to December 2014. There were structural changes to the way data was collected in CMS before April 2012. Dec 2014 was chosen as it provided data that was relatively up-to-date at the time this project was commissioned. Only cases that had been opened and subsequently closed in this date range were included in the dataset. The total number of nurses and midwives in CMS is 5,851.

3.3   Descriptive statistics
We show the data graphically using line graphs and bar charts. We also report cross-tabulation analyses that examine the relationships between categorical variables, such as ethnicity and source of referral, and test whether or not these cross-tabulations depart from the pattern that would be expected if the two variables are independent using the Chi-squared statistic.

3.4   Inferential statistics
Although describing the data is very important at the outset of the analysis, inferential statistics can be used to allow for inferences to be made to the wider population, beyond the sample under study. We want to be able to estimate, for example, the likelihood of BME or White nurses or midwives cases being closed at screening, investigation or adjudication, controlling for other sources that might account for different outcomes. It may be that some groups are, for example, younger than others, in which case we would want to include "age" as a control variable. Similarly, the source of the referral or the referral type might be important control variables in models that seek to obtain accurate estimates of the impact of BME status on the outcomes of the FtP process. The main statistical test that we intend to use in this study is logistic regression. This is used when the dependent variable is dichotomous, which would apply if the dependent variable were, for example, whether or not an interim order was imposed. If the outcome variables can be treated as stages in

an ordered progression, such as closed at screening, closed at investigation or closed at adjudication then ordinal logistic regression is the appropriate method of analysis.

3.5   Ethical approval

Ethical review of the proposal was sought from the University Research Ethics Committee (UREC) of the University of Greenwich. Although this is an analysis of secondary data which does not normally require ethical review, the data on which these analyses are based contain both personal data and sensitive data. Personal data is information that can identify individuals either singly, such as a name or in combinations, such as date of birth and country of qualification. Sensitive data include race and ethnicity, commission or alleged commission of an offence and proceedings for any offence or alleged offence or sentence of a court. The datasets provided for this study do not include the nurse of midwife's name or Personal Identification Number, but the data cannot be fully anonymised as conceivably a number of variables could be used in combination to identify a specific individual or case.

Once ethical approval was granted by UREC, the NMC used a secure method of transferring the data (EGRESS) to the research team. The data were then stored in a restricted area of the University shared drive. Only members of the research team had access to this restricted area and, in addition, the datasets were password protected. Only aggregate level statistics are included in reports, presentations and papers.

Section 4: Results

4.1   Referrals to the NMC

A key question is whether there are any differences between the nurses and midwives referred to the NMC and the wider population of all registrants. Variables of interest are age, gender, ethnicity and source of referral. We also investigated whether there is a relationship between gender and ethnicity and between ethnicity and sources of referral using cross-tabulation analyses.

4.1.1 Age: comparing referred to all registered nurses and midwives
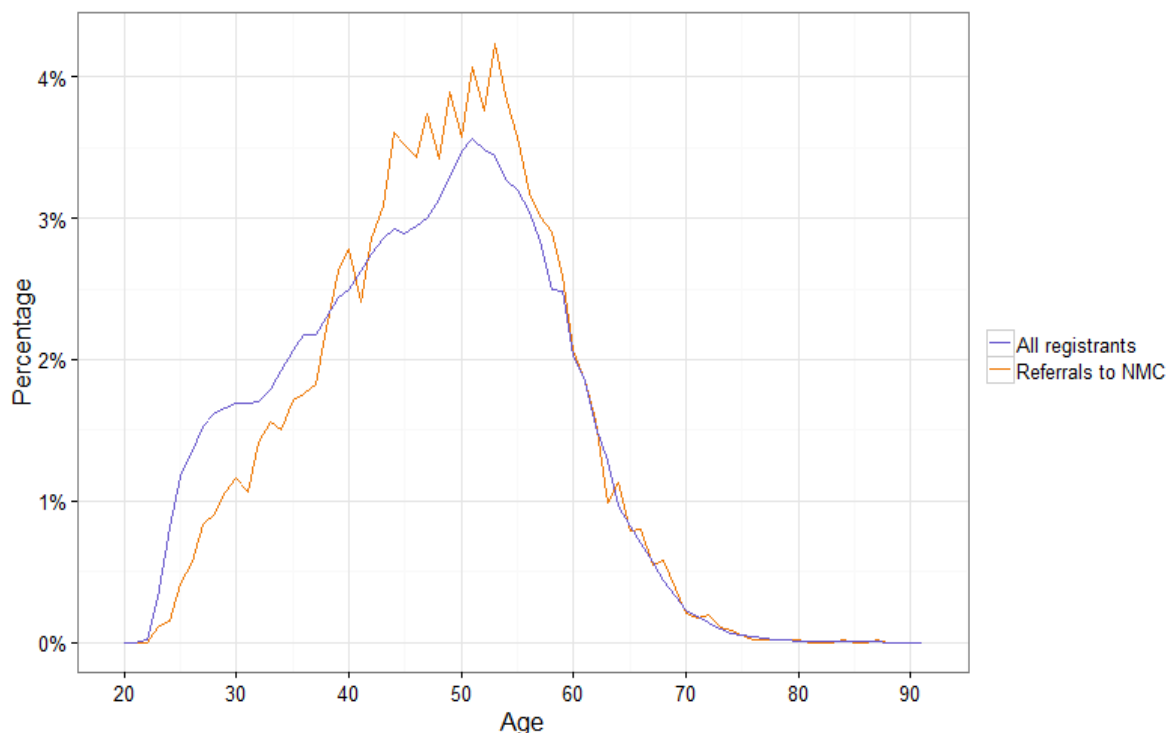
This chart shows that there is a difference in the age distributions between all registrants and those referred to the NMC. There are fewer referrals in the younger age groups and more in the "middle aged" (40 to 60 years old) categories. Stated simply, referrals to the NMC are older on average, than the population of registered nurses and midwives. This may be partly due to the length of time since they were trained which may mean that their knowledge has declined and they may not be up-to-date with the changing norms of nursing and midwifery practice. Alternatively, older nurses may have, over the years, become "burnt out" which is a syndrome characterised by emotional exhaustion, depersonalisation and a reduced sense of personal efficacy that is known to affect members of caring professions (Maslach & Jackson 1982). Finally, it might be that older nurses are subject to discrimination which leads to their over-representation as referrals to the NMC. Each of these ideas—decline in knowledge, emotional burnout and discrimination could be tested empirically in further research.

4.1.2   Gender: comparing referred to all registered nurses and midwives
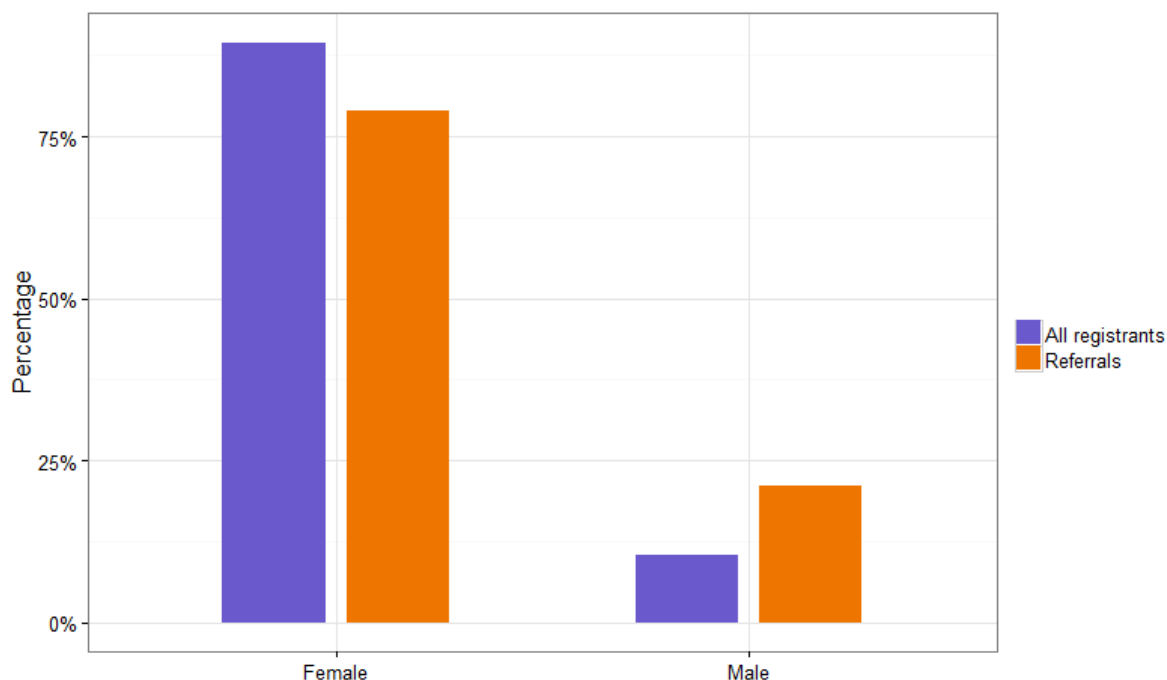
This bar chart shows that nearly 90 per cent of all registrants are female (N=609,985 or 89.5%) whereas only about three quarters of referrals are female (N=4616 or 78.9%). The chart also shows that just ten per cent of registrants are male (N=71,262 or 10.5%) whereas more than 20 per cent of referrals are male (N=1,235 or 21.1%). That is, the number of male referrals is about twice the number that would be expected given the number of men registered with the NMC. This may reflect the differential distribution of men and women across different specialisations within nursing and midwifery, that is, men may be working in specialties or jobs that, for some reason, carry a greater risk of being referred to the NMC. However, the data currently available do not enable us to link whether or not the nurse or midwife is working in a particular job or specialist area to the risk of referral to the NMC. Men are clearly in the minority in nursing and midwifery and the difficult situation that minorities occupy in work settings has been described in the literature, often, however, in terms of the minority status that women occupy at the top of large corporations (Kanter 1977).

4.1.3   Ethnicity: comparing referred to all registered nurses and midwives
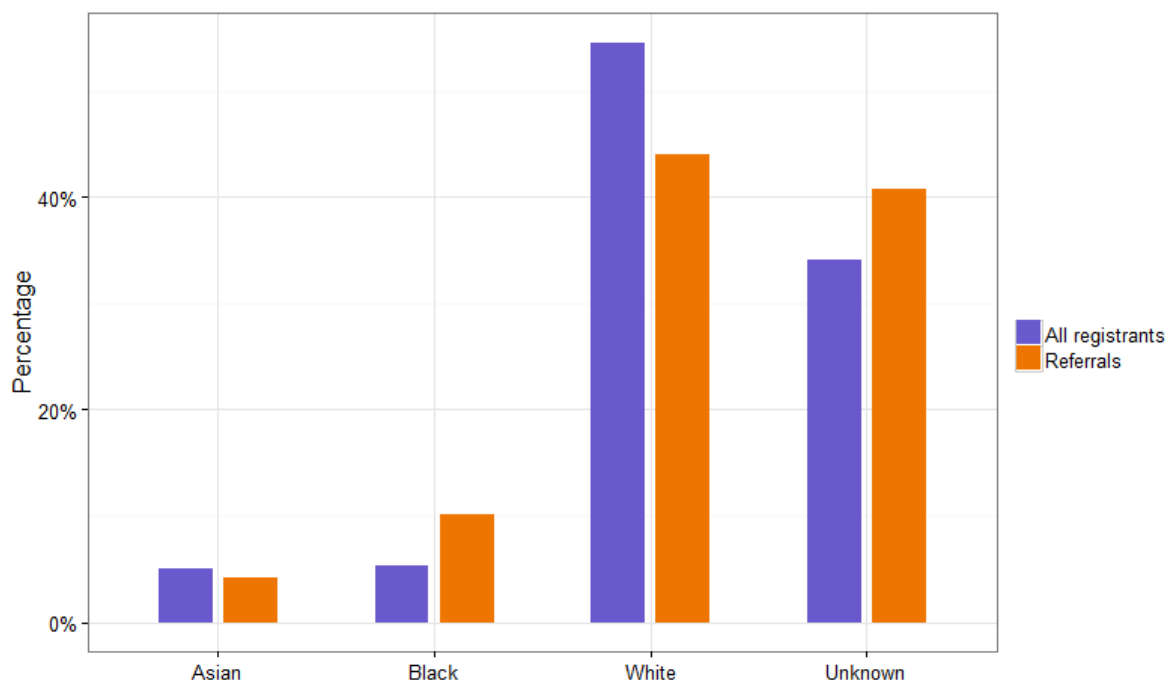
This chart shows the distribution of registrants and referrals across ethnic groups. One category—"Other"—is not shown because the numbers are so small. The chart shows that in two categories (White and Asian) the number of referrals are less than would be expected given the number of registrants. This difference is quite marked for White nurses and midwives who could be described as under-represented in referrals. Conversely, individuals in the Black and Unknown categories are referred with greater frequency than would be expected given their numbers in the population of registrants. The category of Unknown ethnicity refers to nurses and midwives who have chosen not to disclose their ethnic status to the NMC, either by choosing the "prefer not to say" option or by not sending back their Equality and Diversity Forms. However, the fact that the Unknown ethnicity category is so large (about 40% of cases are of unknown ethnicity) makes it difficult to clearly assess the relationship between ethnicity and the risk of referral.

4.1.4   Ethnicity and Gender: Cross-tabulation

|		Female	Male	**Total**
White	Observed N	2103	475	**2578**
	Expected N	2033	544	
	Chi-square contribution	2.35	8.79	
	N / Row Total	81.57%	18.43%	
Asian	Observed N	182	66	**248**
	Expected N	195	52	
	Chi-square contribution	0.95	3.56	
	N / Row Total	73.39%	26.61%	
Black	Observed N	451	144	**595**
	Expected N	469	125	
	Chi-square contribution	0.72	2.7	
	N / Row Total	75.8%	24.2%	
Other	Observed N	34	14	**48**
	Expected N	37	10	
	Chi-square contribution	0.4	1.48	
	N / Row Total	70.83%	29.17%	
Unknown	Observed N	1846	536	**2382**
	Expected N	1879	502	
	Chi-square contribution	0.59	2.19	
	N / Row Total	77.5%	22.5%	
Total		**4616**	**1235**	**5851**

Chi-square = 23.7, df = 4, $p < 0.05$

Cross-tabulations are often used to test a hypothesis about the relationship between two variables, in this case, ethnicity and gender. To do this we calculate the number we would expect to see in each cell of the table if the two variables were, in fact, unrelated. These expected numbers are then compared with the actually observed number. For example, if there is no relationship between ethnicity and gender, the number in the cell counting White males will simply reflect the proportion of nurses that are White and the proportion of nurses that are male in the table. In this example, those numbers are (2578/5851) and (1235/5851), which we can multiply together to get the expected proportion in the cell. We then multiply that by the total number in the table to get the expected count, which in this case is 544.15, rounded to 544 in the table. This forms the basis of the calculation of the chi-square statistic, which can be used to test the null hypothesis that the two variables are independent.

This cross-tabulation then shows that there is a significant relationship between gender and ethnicity. Specifically, fewer White male nurses and midwives are referred to the NMC than would be expected, while the opposite is true for those who are Asian, Black or of Unknown ethnicity.

The relationship between ethnicity and gender could be at least partially explained if men from different ethnic groups occupy different positions in the health system. It may be, for example, that White men disproportionately occupy managerial positions which carry a lower risk of referral to the NMC. Alternatively, male nurses from a BME background may be doubly disadvantaged as they are a minority in society by virtue of their ethnicity and a minority in the profession by virtue of their gender.

4.1.5 Sources of referral to the NMC (major categories)
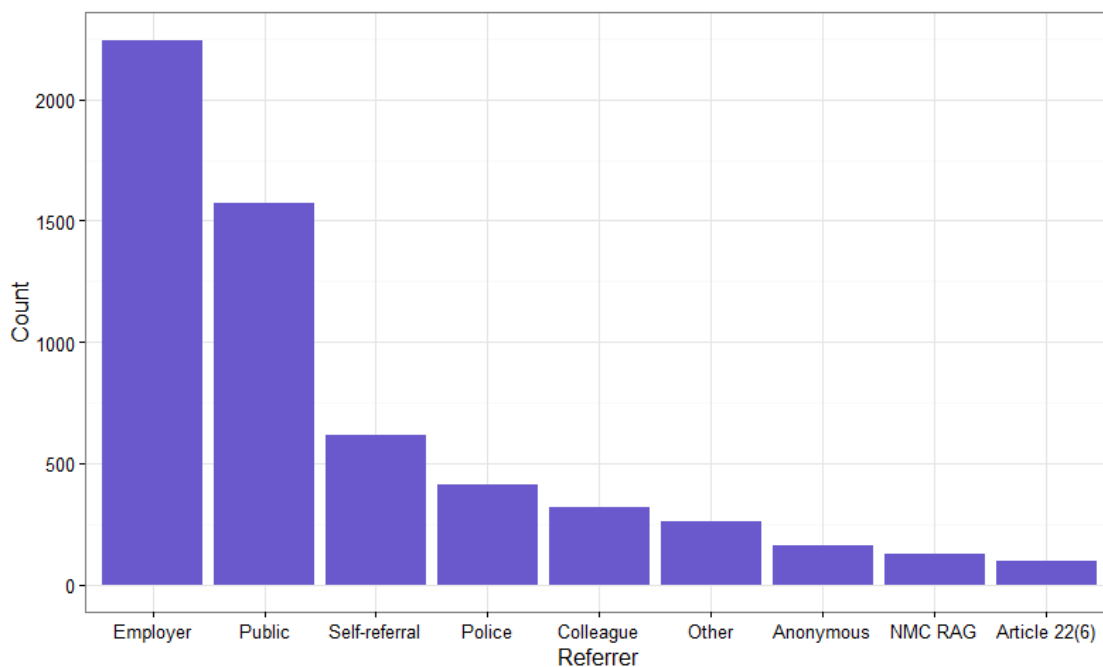
This bar chart shows that the most common source of referrals to the NMC is employers, followed by members of the public. The other named sources are much less significant in terms of the number of cases they refer to the NMC.

4.1.6 Ethnicity and sources of referral: Cross-tabulation

		Employer	Public	Self-referral	Police	Colleague	Article 22(6)	Anon.	NMC RAG	Other	Total
White	Observed N	865	801	303	150	162	46	79	46	106	2558
	Expected N	988	692	269	180	141	43	70	56	114	
	Chi-square	15.37	16.87	4.07	5.28	3.03	0.13	1.04	1.9	0.62	
	N / Row Total	33.82%	31.31%	11.85%	5.86%	6.33%	1.8%	3.09%	1.8%	4.14%	
Asian	Observed N	113	54	19	17	12	9	7	7	10	248
	Expected N	95	67	26	17	13	4	6	5	11	
	Chi-square	3.08	2.58	1.96	0.02	0.21	5.38	0	0.43	0.11	
	N / Row Total	45.56%	21.77%	7.66%	6.85%	4.84%	3.63%	2.82%	2.8%	4.03%	
Black	Observed N	262	111	71	47	16	8	15	20	41	591
	Expected N	228.32	160	62	41	32	10	16	13	26	
	Chi-square	4.97	15.05	1.2	0.65	8.49	0.43	0.1	3.74	8.02	
	N / Row Total	44.33%	18.78%	12.01%	7.95%	2.71%	1.35%	2.54%	3.4%	6.94%	
Other	Observed N	26	8	4	3	2	0	1	2	1	47
	Expected N	18	12	4	3	2	0	1	1	2	
	Chi-square	3.38	1.76	0.19	0.03	0.14	0.8	0.07	0.89	0.58	
	N / Row Total	55.32%	17.02%	8.51%	6.38%	4.26%	0%	2.13%	4.3%	2.13%	
Unknown	Observed N	979	600	216	194	129	36	58	53	102	2367
	Expected N	914	641	249	167	130	40	65	52	105	
	Chi-square	4.56	2.64	4.55	4.22	0.02	0.46	0.79	0.01	0.14	
	N / Row Total	41.36%	25.35%	9.13%	8.2%	5.45%	1.52%	2.45%	2.2%	4.31%	
Total		2245	1574	613	411	321	99	160	128	260	5811

Chi-squared = 130.0, df = 32, $p < 0.05$

The table shows that fewer White nurses and midwives are referred by their employer than would be expected, while more people from all other ethnic groups are referred by their employer than would be expected. The situation is reversed, however, in the column showing referrals by members of the public. Here, White nurses are over-represented and the chi-squared contribution

of this cell is 16.87 which suggests that it makes a significant contribution to the overall significance of the table. Members of the public are less likely than expected to refer any of the other ethnic groups.

White nurses and midwives are more likely to be self-referrals than would be expected, with the reverse being true of all other ethnicities.

Police referrals are comparatively rare; there are too few among Asian or Black nurses or midwives to be able to draw any conclusions. However, fewer White nurses and midwives are referred by the police than would be expected, while more people of unknown ethnicity are referred by this source.

As regards people who are referred by a colleague, more referrals of White nurses and midwives come from this source than would be expected, with the opposite pattern being seen among Black nurses and midwives. Differences for other groups are not significant.

4.1.7   Region of qualification and referral
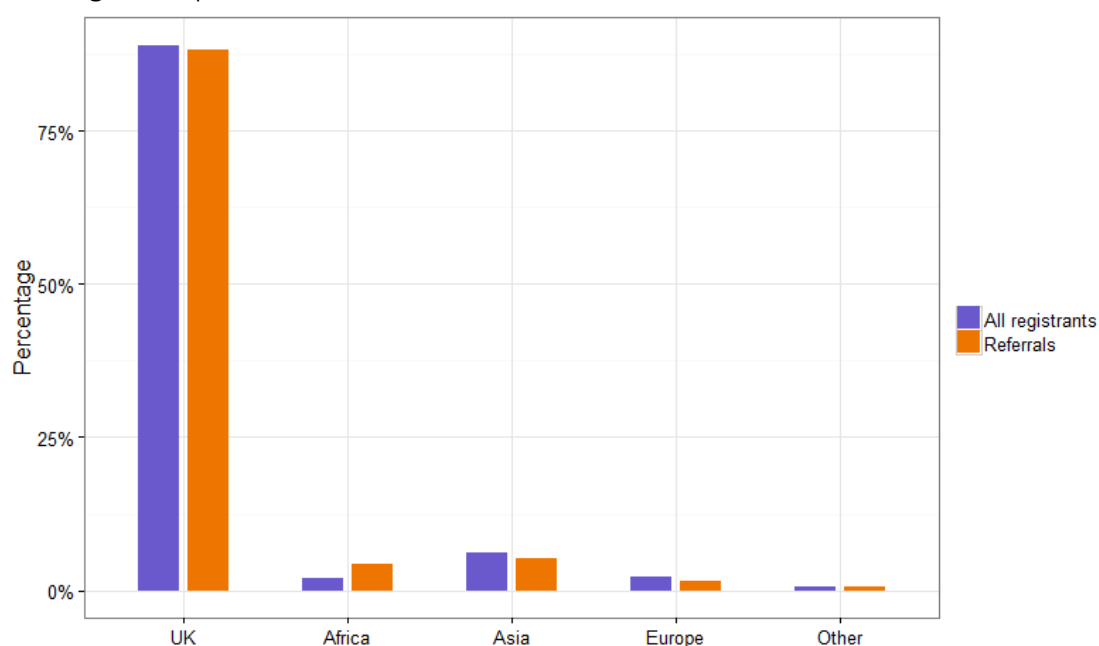
This chart shows that the vast majority of all registrants (N=594,363 or 89%) and referrals to the NMC (N=4964 or 89.3%) were trained in the UK. The number of referrals is close to being in proportion to the number on the register. Nurses and midwives who trained in Asia constitute a significant proportion of the registrants (N=41,402 or 6.2%) and they are less likely to be referred than their numbers would predict (N=289 or 5.1%). Nurses trained in Europe who constitute a smaller proportion of registrants (N=15,427 or 2.3%) are also under-represented (N=59 or 1.6%). However, the pattern is reversed for nurses and midwives who trained in Africa. They constitute less than two percent of all registrants (N=12,695 or 1.9%), but more than four percent of referrals (N=245 or 4.4%). This may be a reflection of the quality of training that they received before they came to the UK, or could be related to some interaction between their place of training and their experiences in the UK. Alternatively, there may be cultural differences or communication difficulties that raise the risk of being referred to the regulator for nurses and midwives who trained in Africa.

4.1.8 Summary of findings on referrals to the NMC

Referrals to the NMC are more likely than all NMC registrants to be middle aged, male, and of Black or Unknown ethnicity. Having trained in Africa is also a risk factor for referral. Employers and members of the public are the most frequent sources of referrals but they differ markedly in the ethnic groups that they are most likely to refer. Employers refer BME nurses and midwives and members of the public refer White nurses and midwives. These differences are interesting and consequential for the FtP process as later analyses will show. Cross tabulation analyses also show that there is a relationship between ethnicity and gender; BME males are over-represented in referrals to the NMC and White males are under-represented.

4.2 Progression through the Fitness to Practise Process

4.2.1 Stages of the Fitness to Practise Process

The NMC website gives the following definition: "Being fit to practise requires a nurse or midwife to have the skills, knowledge, good health and good character to do their job safely and effectively." (https://www.nmc.org.uk/concerns-nurses-midwives/what-we-do/what-is-fitness-to-practise/). After referral, cases go through a process of screening, investigation and adjudication. These stages form a sequence through which each case must pass but cases can be closed and no further action taken at each of the three stages. The final stage, adjudication, can have several outcomes but the most meaningful distinction for nurses and midwives must be whether or not they are allowed to continue practising. For the purposes of this analysis we have aggregated outcomes into two mutually exclusive categories: outcomes where the registrant can continue to work and outcomes where the registrant is prohibited from working as a nurse or midwife. Interim orders, which suspend or restrict the nurse or midwife's registration can be applied as the case progresses from screening to investigation.

The following bar charts show the percentages within each of the ethnic groups shown on the horizontal axis that have their cases dealt with at each of the three stages. The total number in each group is shown next to the group label. It is important to bear in mind that some groups are small, in which case even large differences in percentages have to be interpreted with caution.

4.2.2   Ethnicity and progression through the FtP process
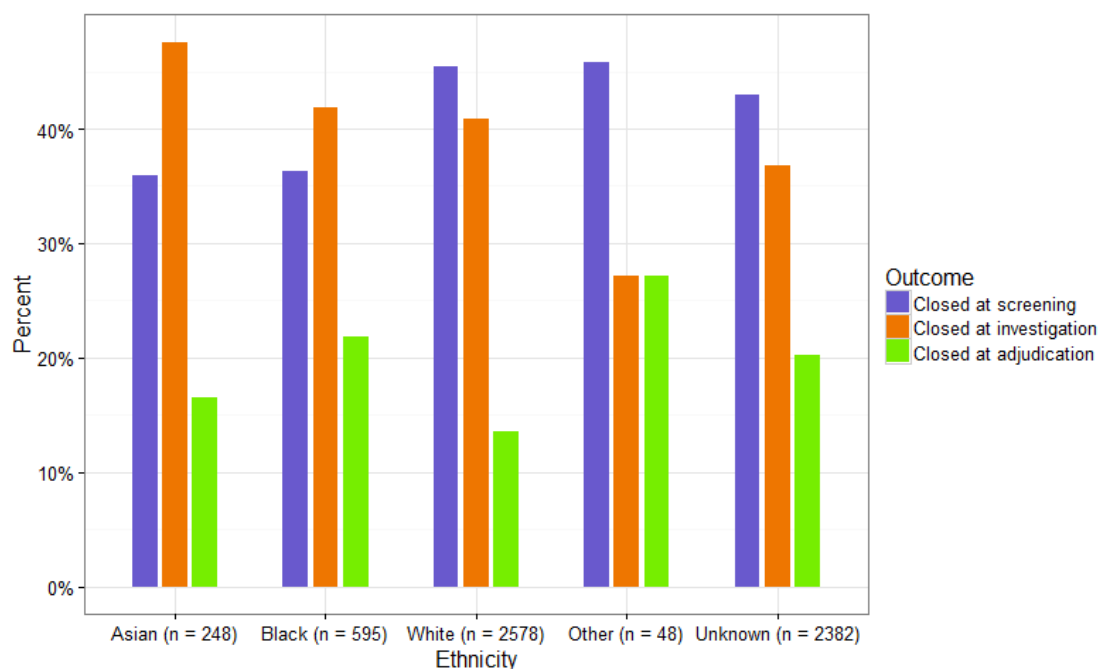
This chart shows that cases involving nurses or midwives who are White, Other, or of Unknown ethnicity are most likely to be closed at screening, whereas those brought against Asian or Black nurses or midwives are most likely to be closed at investigation.

4.2.3   Source of referral and progression
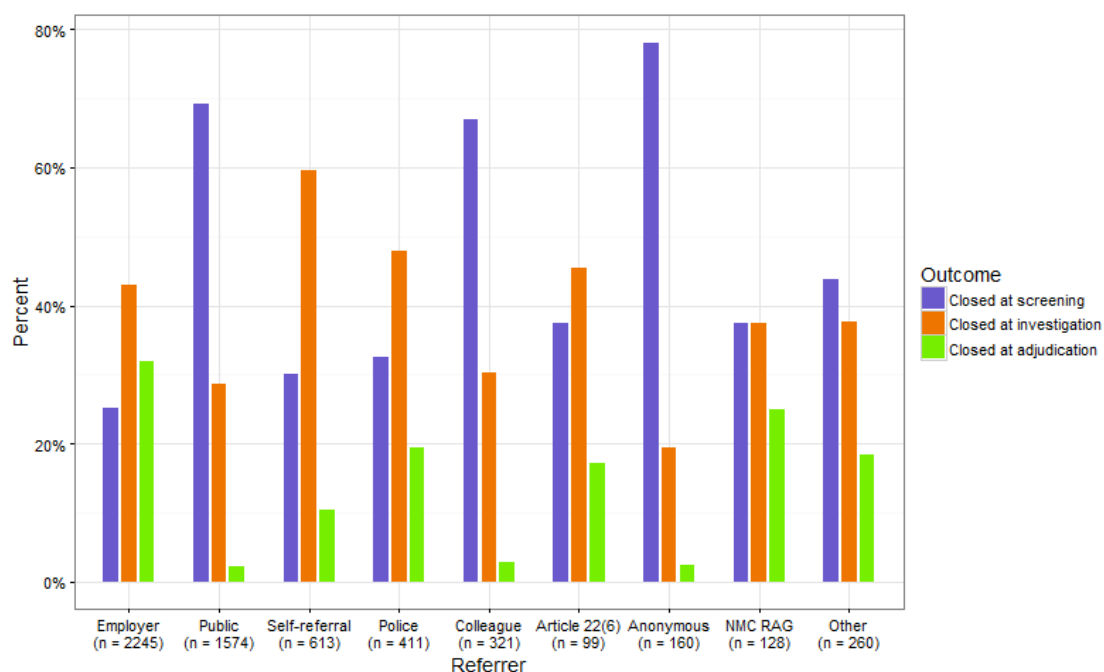
Most of the sources of referral on this chart are self-explanatory but there are two sources that require explanation. First, the NMC Registrar's Advisory Group (NMC RAG) deals with applications to join the register where there is a question about the applicant's health or character. Second, in current regulatory legislation, Article 22(6) allows the NMC to initiate its own investigation without

referral from another source.   The above chart shows that referrals from some sources, particularly members of the public, colleagues and from anonymous sources, are likely to be closed at screening. Referrals from the miscellaneous category of other referrals are slightly more likely to be closed at screening than at the other two decision points. Referrals from the NMC RAG are equally likely to be closed at screening or investigation. Referrals from employers, police, Article 22(6), and self-referrals are most likely to be closed at investigation. A significant percentage of cases brought by employers go to adjudication as do, to a lesser extent, referrals from the police, Article 22(6), NMC RAG and Other sources. Cases referred by members of the public, colleagues or where the source remains anonymous are unlikely to go to adjudication.

4.2.4   Region of qualification and progression
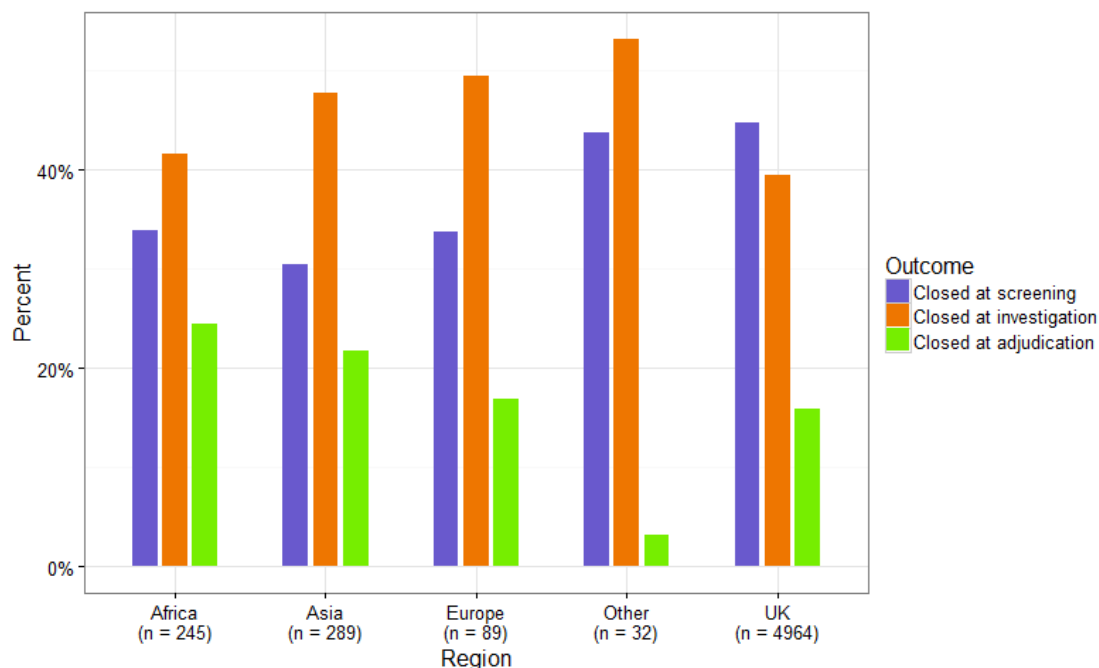
Cases involving nurses and midwives who trained outside the UK are more likely to be closed at the investigation stage than at any other decision point; whereas cases brought against UK trained nurses and midwives are most likely to be closed at screening. The chart suggests that having trained in Africa or Asia increases the risk of the case going to adjudication. However, the numbers of referrals who trained overseas is relatively small which suggests that some caution should be exercised in interpreting the findings.

4.2.5   Country of referral and progression
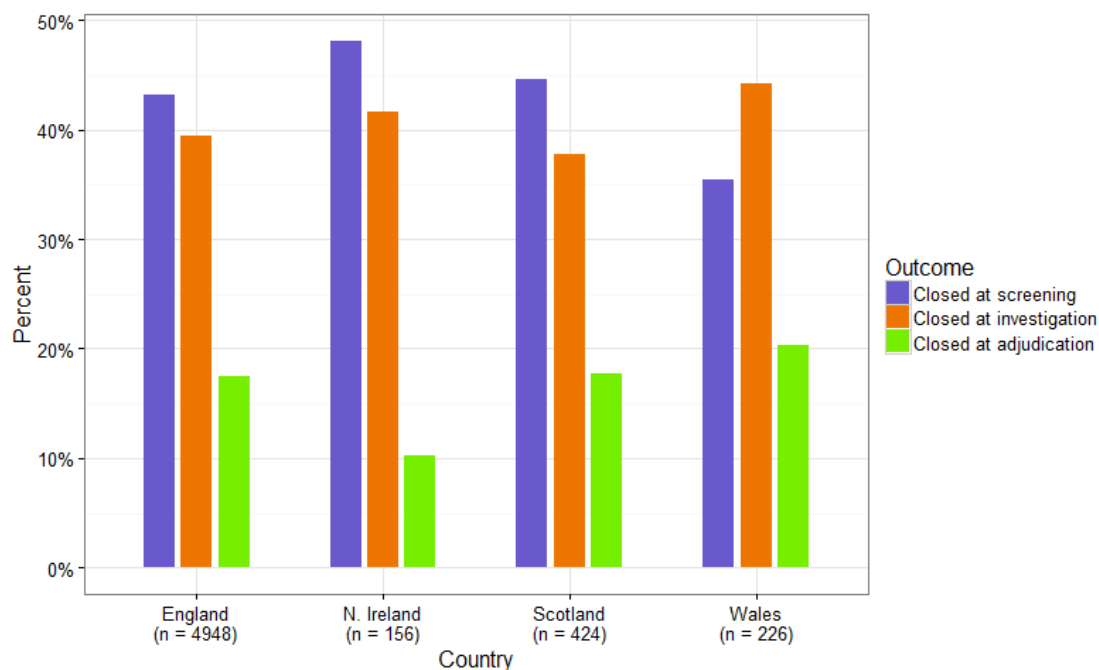
The pattern of progression is fairly similar across the UK, except for some differences in Wales where cases are less likely to be closed at screening and more likely to go on to the investigation and adjudication stages.

4.2.6   Imposition of interim orders by ethnicity
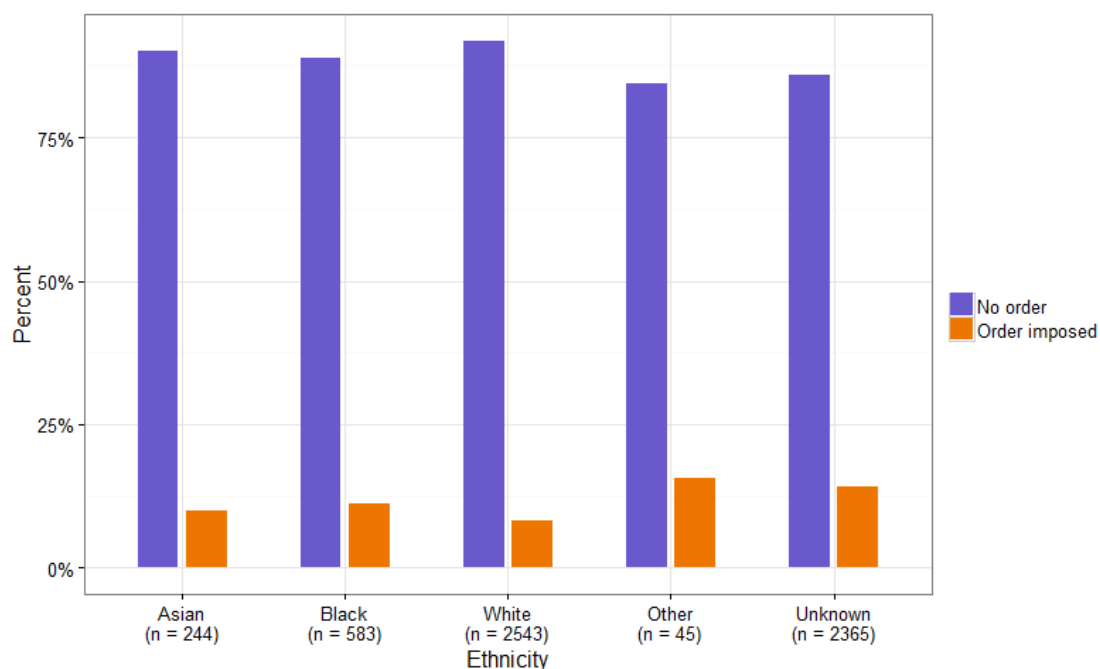
This chart shows that in the vast majority of cases, nurses or midwifes referred to the NMC are allowed to continue to work while the case is going through the FtP process, that is, no interim order is imposed. There are some differences among the groups with those in the "Other" and "Unknown" categories more likely than the other ethnic groups to have an interim order imposed, but they are still in the minority.

4.2.7   Legal representation and progression through the FtP process

In these data, legal representation (n=2,037) was less common than cases that had no legal representation (n=3,814). The majority of unrepresented cases were closed at screening (63%); just over a quarter were closed at investigation (27%) and only 10% went to adjudication without representation.   The opposite pattern of results is shown for cases that had representation with closure at screening (7%), investigation (60%) and adjudication (33%).   So the presence of a representative may be a reflection of the individual's assessment of the seriousness of the case against them rather than any effect that legal representation might have on the outcome of the case.

4.2.8   Summary of findings on progression through the Fitness to Practise process

Cases involving nurses and midwives of White, Other, or Unknown ethnicities are most likely to be closed at screening. Cases brought against Asian or Black nurses are most likely to be closed at investigation.

Cases involving nurses and midwives who trained outside the UK are more likely to be closed at the investigation stage than at any other decision point whereas cases brought against UK trained nurses and midwives are most likely to be closed at screening. Having trained in Africa or Asia increases the risk of the case against a nurse or midwife going to adjudication. The imposition of interim orders which would affect the nurse or midwife's ability to work is fairly evenly distributed across the different ethnic groups.

The source of referral to the NMC is important in relation to whether the case is closed at screening, investigation or adjudication. Different sources of referral are related in an important way to how far along the FtP process a case is likely to go.

There are similar outcomes across the four nations of the UK with some slight differences in the pattern shown for Wales. However, the small numbers in the sample must be taken into account in assessing the significance of this finding.

Legal representation tends to increase from screening to adjudication and may be sought by the individual as they realise that the case is serious and likely to progress through the FtP process.

4.3   Outcome at Adjudication

4.3.1   Definition of Outcome

For the purposes of this analysis we have constructed an outcome variable which has two mutually exclusive categories: Outcomes where the registrant can continue to work and outcomes where the registrant is prohibited from working as a registered nurse or midwife. The latter includes the outcome "Struck Off" which is often used in media reports of these processes.

4.3.2 Ethnicity and outcome
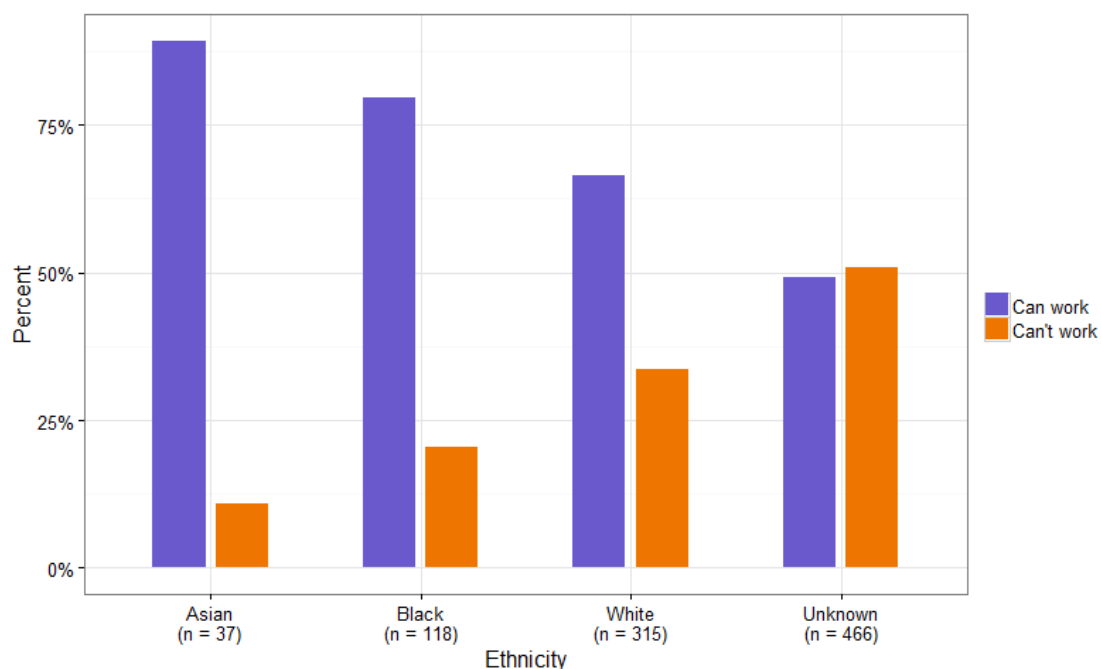
The chart shows that for most groups, the outcome of adjudication is most likely to allow them to continue to work as a nurse or midwife. This is not true for the Unknown ethnicity group where the outcome is slightly more likely to be one that prohibits them from working in jobs that require registration. The likelihood of a decision that prohibits work is by far the highest for the Unknown ethnicity group, but interestingly, given all the adverse publicity about the severity of penalties meted out to BME groups, it is the White group that is next highest, followed by Black and then Asian. However, this pattern might be quite different if we were able to redistribute those in the Unknown category into the known categories.

4.3.3 Source of referral and outcome
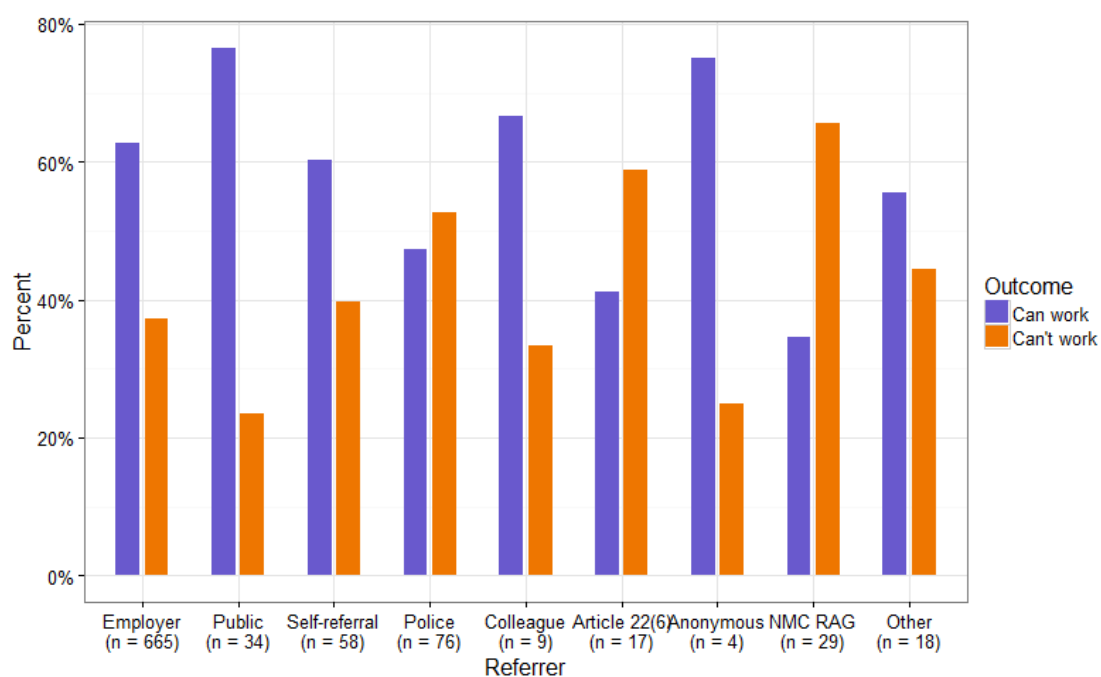
This chart shows that cases that went through the FtP process to the adjudication stage were most likely to be referred by the following sources: Employers (N=665), followed by the Police (N=76), Self-referrals (N=58), Members of the Public (N=34), NMC RAG (N=29), Article 22(6) (N=17), Colleagues (N=9) and Anonymous (N=4). The final category, Other (N=18), collects the remaining smaller sources into one group.

In most cases, the final decision allows the nurse or midwife to continue to work, but cases referred by the police are most likely to result in a decision that prohibits further practice as a nurse or midwife. Similarly, cases investigated by the NMC using powers granted by the Nursing and Midwifery Order (2001) Article 22(6) and cases referred by the NMC RAG which makes decisions about applications to join or rejoin the register that declare pending charges, cautions or convictions, or where there are questions about the applicant's health or character, are more likely to lead to a decision that does not allow the nurse or midwife to continue to practise.

4.3.4 Country of referral and outcome
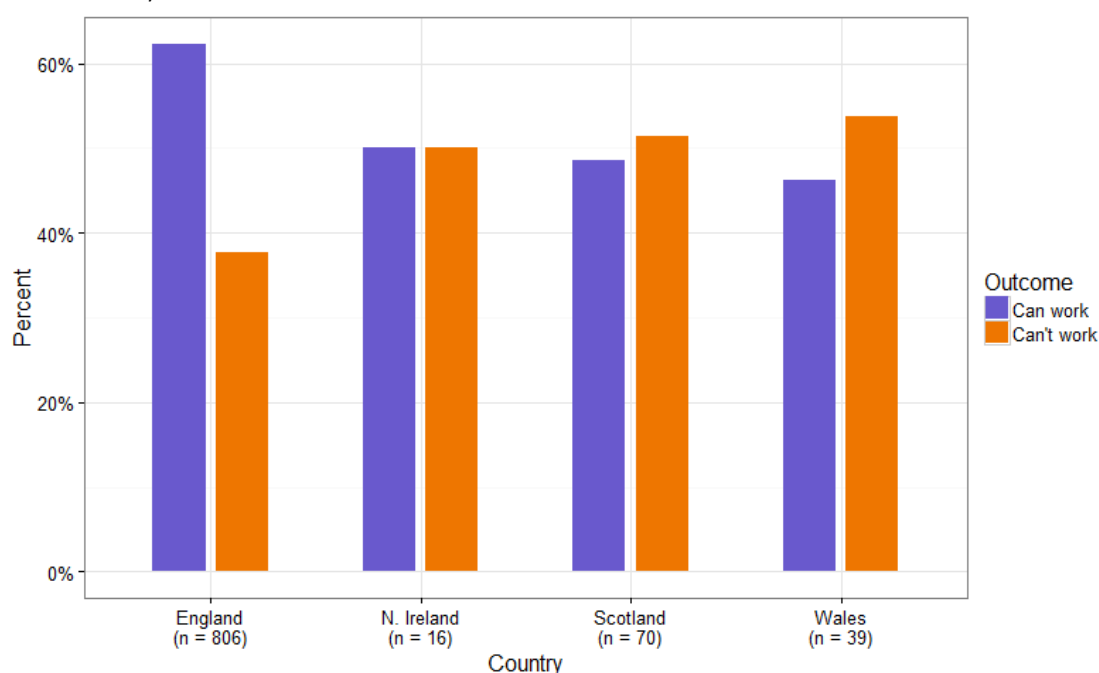
This chart shows that in cases that originate in Northern Ireland the outcome of adjudication is approximately 50:50. In Scotland and Wales more cases result in nurses and midwives not being able to continue to practise whereas the situation is reversed in England where more than 60% of cases conclude with a decision that allows the nurse or midwife to continue practising. It is important to note that the numbers of cases for countries other than England is quite small so these differences must be interpreted with caution.

4.3.5 Ordinal logistic regression of the CMS data

Table 1 shows the results of three sets of ordinal logistic regressions. The outcome variable has four categories: closed at screening, closed at investigation, adjudication finding allows person to continue to practise, and adjudication finding prevents continued practise, in ascending order of "severity" of outcome. A positive parameter estimate in the table implies that the chances of a more severe outcome are higher.

In all three models we can see that male nurses and midwives are more likely to receive a more severe outcome than their female counterparts. Gender is significant even in models that control

for ethnicity and source of referral. On the other hand, estimates of the effect of age are small and not statistically significant.

Table 1. Ordinal logistic regression results, with categories 'Closed at screening', 'Closed at investigation', 'Closed at adjudication: Can work', 'Closed at adjudication: Cannot work'. Standard errors are shown in parentheses.

	(1)	(2)	(3)
Age	0.003	0.002	0.002
	(0.002)	(0.003)	(0.003)
Male	0.485***	0.464***	0.279***
	(0.060)	(0.061)	(0.063)
Asian		0.270**	0.089
		(0.122)	(0.128)
Black		0.359***	0.115
		(0.085)	(0.089)
Other		0.044	-0.288
		(0.294)	(0.307)
Unknown		0.226***	0.145**
		(0.055)	(0.058)
Referrers:			
Member of public			-2.019***
			(0.071)
Self-referral			-0.620***
			(0.086)
Police			-0.502***
			(0.103)
Colleague			-1.920***
			(0.126)
Article 22(6)			-0.634***
			(0.197)
Anonymous			-2.466***
			(0.196)
NMC RAG			-0.515***
			(0.183)
Other			-0.891***
			(0.129)
Observations	5780	5780	5742
Log Likelihood	-6524	-6510	-5912

*** means significant at the .001 level; ** means significant at the .01 level; * means significant at the .05 level

Model 2 introduces ethnicity into the regression; as always when categorical variables are used in regression analysis, one category serves as the reference category; in this case it is White nurses and midwives. The estimates for the other ethnic groups are, therefore, relative to Whites. The positive estimates for all other groups implies that they have a higher probability of a more severe outcome than their White counterparts, although the estimate for the 'Other' ethnicity group is not statistically significant.

However, we have to be careful to control for other possible factors that we have already seen may be associated with outcome. Model 3 adds the source of referral as an explanatory variable; the excluded category being employers. All of the estimated regression parameters are negative, implying that all other sources of referral are less likely to lead to a severe penalty relative to cases referred by employers. In this model, the size of the estimates associated with two of the ethnic categories, Black and Asian, are much smaller than in model 2, so much so that they are no longer statistically significant. The implication of this is that an apparent difference in outcomes across ethnic groups is actually due to differences in outcomes that depend on the source of referral. People referred by their employer are more likely to get a more serious outcome, and as a larger proportion of BME nurses and midwives are referred by their employer than is true of White nurses and midwives, this results in an apparent association between ethnicity and outcome of the FtP process.

One important caveat is that, while the estimated size of the parameter associated with people of Unknown ethnicity goes down in model 3 compared to model 2, it remains large enough for the disadvantage relative to White nurses and midwives to remain statistically significant.

4.3.6   Logistic regression of cases closed at adjudication

Table 2 shows the results of binary logistic regression estimates. These regressions are carried out on the sub-set of people whose cases go to adjudication. The outcome variable is whether the outcome resulted in the nurse or midwife being able to continue with their professional practice or not. A positive parameter estimate implies a greater probability of *not* being able to continue in professional practise. It is important to note that the number of cases is, of course, much smaller than for the regressions reported in the previous section.

Model 2 shows that, consistent with the chart shown in section 4.3.2, nurses and midwives who are Asian or Black have a lower risk of not being able to continue in professional practice, while the opposite is true for nurses and midwives whose ethnicity is unknown. Model 3 shows that these results are not affected by the inclusion of the source of referral, in contrast to the results shown in table 1.

Source of referral does matter, however, as can be seen by the statistically significant estimates for referrals from the public (lower probability of not being allowed to continue to practise), the police, Article 22(6), and NMC RAG (all higher probability)

Table 2. Binary logistic regression results, showing effects on the probability of being unable to work following an adjudication. Standard errors are shown in parentheses.

	(1)	(2)	(3)
Age	0.013*	0.011	0.016**
	(0.007)	(0.007)	(0.008)
Male	0.173	0.181	0.120
	(0.146)	(0.151)	(0.157)
Asian		-1.417***	-1.492***
		(0.543)	(0.552)
Black		-0.685***	-0.718***
		(0.259)	(0.265)
Other		-0.713	-1.098
		(0.801)	(0.842)
Unknown		0.708***	0.722***
		(0.152)	(0.156)
Referrers:			
Member of public			-0.753*
			(0.422)
Self-referral			0.273
			(0.295)
Police			0.679***
			(0.259)
Colleague			-0.341
			(0.726)
Article 22(6)			1.060**
			(0.532)
Anonymous			-0.580
			(1.197)
NMC RAG			1.463***
			(0.429)
Other			0.345
			(0.344)
Constant	-1.145***	-1.276***	-1.617***
	(0.368)	(0.392)	(0.417)
Observations	946	946	934
Log Likelihood	-632.1	-599.7	-579.3

*** means significant at the .001 level; ** means significant at the .01 level; *** means significant at the .05 level

4.3.7   Summary of findings on outcomes at adjudication

Individual members of all ethnic groups, except those of Unknown ethnicity, are more likely than not to emerge from adjudication with a decision that allows them to continue to work as a nurse or midwife. Individuals in the Unknown ethnicity category are more likely to have a decision that prohibits them from working as a nurse or midwife. White nurses and midwives are next in terms of how likely it is that they are prohibited from working, followed by Black and then Asian. However, it is important to remember that this pattern might be quite different if we were able to redistribute those in the Unknown category across the other ethnic categories.

Referrals from most sources, such as employers or members of the public, are likely to get a decision that allows them to continue working; but referrals from the police, Article 22(6) and NMC RAG are more likely to end in a decision that prohibits further work as a nurse or midwife.

Across the UK, there is a difference in outcome depending on whether or not the case originated in England where the decision at adjudication is most likely to allow work. In the other three countries the decision is more likely to prohibit work but these numbers are small and should be interpreted with caution.

The logistic regression analysis conducted on the whole dataset of cases showed that the relationship between ethnicity and severity of outcome is actually due to differences in outcomes that depend on the source of referral. People referred by their employer are more likely to get a more serious outcome, and as a larger proportion of BME nurses and midwives are referred by their employer than is true of White nurses and midwives, this results in an apparent association between ethnicity and outcome of the FtP process.

The binary logistic regression on the dataset of referrals that get to the adjudication stage tells the same story as the descriptive statistics shown above (table 4.3.1). Black and Asian nurses and midwives are less likely to receive a severe penalty than Whites, but those of Unknown Ethnicity are more likely, even than Whites to get a penalty that prohibits them from continuing to work as a nurse or midwife.

Section 5: SUMMARY AND CONCLUSIONS

5.1 Summary of findings and relationship to previous literature

The focus of this study is on the progress and outcomes of BME nurses and midwives through the FtP process. Examining the ethnicity of referrals shows that being Black or of Unknown ethnicity is a risk factor for referral. Two groups (White and Asian) are a smaller proportion of referrals given their representation in the population of all registrants. This difference is quite marked for White nurses and midwives who could be described as under-represented in referrals. Conversely, individuals in the Black and Unknown categories are referred with greater frequency than would be expected given their numbers in the population of registered nurses and midwives. The fact that the Unknown ethnicity category is so large (about 40% of cases are of unknown ethnicity) makes it difficult to clearly assess the relationship between ethnicity and the risk of referral. Data on the regions of the world where nurses and midwives received their training suggests that having trained in Africa is also a risk factor for referral to the NMC.

Comparing referrals to the whole population of registrants in terms of their age and gender, shows that they are older, more often "middle aged" (40 to 60 years old), and more often male. Males are referred to the NMC at approximately twice the rate than would be expected given the number of male nurses and midwives registered with the NMC. This may reflect the differential distribution of men and women across different specialisations within nursing and midwifery, that is, men may be working in specialties or jobs that, for some reason, carry a greater risk of being referred to the NMC. However, the data currently available do not enable us to link whether or not the nurse or midwife is working in a particular job or specialist area to the risk of referral. Men are in the minority in nursing and midwifery and minority groups may have difficult experiences in the workplace.

There is a significant relationship between ethnicity and gender with more BME male nurses and midwives being referred to the NMC than would be expected. Male nurses and midwives may experience a double disadvantage in that they are a minority in society by virtue of their ethnicity and a minority in the profession by virtue of their gender. The observed number of females referred to the NMC is less than the expected number for each ethnic group.

The most common source of referrals to the NMC is employers and cross-tabulation analyses showed that they are much more likely to refer BME than White nurses and midwives. This difference is highly significant. Members of the public, the second most common source of referrals to the NMC, are significantly more likely to refer White nurses and midwives rather than any other ethnicities.

In summary, referrals to the NMC are older, more often male, and disproportionately Black or of Unknown ethnicity, compared all NMC registrants. Having trained in Africa is a risk factor for referral. Employers and members of the public are the most frequent sources of referrals and they differ in the ethnic groups that they are most likely to refer with employers focusing on BME nurses and midwives and members of the public tending to report White nurses and midwives. These differences are interesting and consequential for the FtP process.

In investigating progress through the FtP process we found that cases brought against White, Other, or Unknown ethnicities are most likely to be closed at screening whereas cases brought against Asian or Black nurses are most likely to be closed at investigation. Having trained outside the UK is also associated with cases going to investigation and having trained in Africa or Asia increases the risk of the case going to adjudication. The imposition of interim orders which would affect the nurse or midwife's ability to work is fairly evenly distributed across the different ethnic groups.

The source of referral to the NMC is important in relation to whether the case is closed at screening, investigation or adjudication. Different sources of referral are related in an important way to how far along the process the case is likely to go.

There are few differences in progression through the FtP process across the four countries in the UK with the exception of Wales where fewer cases are closed at screening. However, the number of observations for countries other than England is small so caution is advising in interpreting the differences among the countries of the UK.

The investigation of the outcomes of adjudication showed that all groups except those of Unknown ethnicity are more likely to emerge from adjudication with a decision that allows them to continue to work as a nurse or midwife. White nurses and midwives are more likely to receive a judgement prohibiting them from working than are Black or Asian nurses and midwives. However, this pattern might be quite different if we were able to redistribute those in the unknown category into the known categories.

Referrals from most sources, such as employers or members of the public, are likely to get a decision that allows them to continue working, but referrals from the police, Article 22(6) and NMC RAG are more likely to end in a decision that prohibits further work as a nurse or midwife.

Across the UK, there is a difference in outcome depending on whether or not the case originated in England where the decision at adjudication is most likely to allow work. In the other three countries the decision is more likely to prohibit work.

The logistic regression analysis conducted on the whole dataset of cases showed that the relationship between ethnicity and severity of outcome is actually due to differences in outcomes that depend on the source of referral. People referred by their employer are more likely to progress through the FtP stages and to receive a more serious outcome. As a larger proportion of BME nurses and midwives are referred by their employer than is true of white nurses and midwives, this results in an apparent association between ethnicity and outcome of the FtP process.

The binary logistic regression on the dataset of referrals that get to the adjudication stage tells the same story as the descriptive statistics. Black and Asian nurses and midwives are less likely to receive a severe penalty than are Whites, but those of Unknown ethnicity are more likely, even than Whites, to get a penalty that prohibits them from continuing to work as a nurse.

In conclusion, there are concerns in the UK about how ethnic minorities are treated by the institutions of the state, such as the NHS, schools and the police and criminal justice system. These concerns are reflected within the NHS where the disproportionate representation of BME staff in employers' disciplinary hearings has been covered in the media. Several professions have investigated whether BME staff are more likely to be referred to the regulator and whether they are more likely to receive a severe penalty as a result of the FtP process. This study was designed to address these questions with regard to the nursing and midwifery professions.

The study was informed by a systematic review which found some evidence of discrimination by employers but less evidence of discrimination by professional regulators, although caution should be exercised because the numbers of referrals are far smaller than the number of disciplinary procedures that are conducted across the NHS. The review also showed a consistent problem with the accuracy of data on ethnicity across the professions.

There is evidence that ethnicity plays a role in referrals to the NMC and it is important to note that the NMC has no control over referrals. The regulator must deal with all referrals that are made to it. Our analysis does show that cases against BME nurses and midwives are more likely to progress through the FtP process, but this difference is not statistically significant once the source of the referral is taken into account. Employers refer BME nurses and midwives and referrals to the NMC that come from employers are more likely to progress to the final stage. However, at adjudication, BME nurses are the least likely to receive a penalty that prohibits them from working. This suggests that the FtP process does not discriminate against BME nurses but that there is some evidence of discrimination in terms of the disproportionate number of referrals by employers.

5.2   Strengths and limitations of the study

This study was preceded by a systematic review which identified a gap in the literature on the regulation of nurses and midwives and informed the design of the study. The main strength of the study was the access to the register of all nurses and midwives in the UK which is more than 600,000 individuals as well as access to administrative data on referrals to the NMC which numbered nearly 6,000. These large datasets allowed us to compare characteristics of referrals to the whole population of nurses.

However, there are weaknesses in these data. For example, the dataset of all nurses and midwives (WISER) does not tell whether or not the individual is currently working. If they are not, this means they are less exposed to the risk of referral. The most serious problem though in relation to this analysis is that 40% of cases are of Unknown ethnicity. This means that our findings must remain tentative until more complete data are available. Another limitation is that there are no data available on the job that the nurse or midwife is currently occupying or indeed in many cases

whether they are working as nurse or a midwife. Many are dual qualified. The significance of the job occupied is important because some jobs in some areas may be fundamentally more risky than others and that should perhaps be taken into account in future analyses. Finally, we found some variables that were of interest, such as the referral type, impossible to recode for analyses. There are well known problems with using administrative datasets for research purposes and a case can be made for further data collection specifically to address some of the deficiencies identified here.

The other serious gap in the data related to the reason for the referral. In the data provided to us, there were 1,359 different reasons for referral, which is far too many to be useful. Neither do we have any way of measuring the 'severity' of the cases; presumably there are a range of cases from very clear cut (for example, a nurse who has been convicted of a serious criminal offence) to very marginal, but we have no way of accounting for such differences. In an ideal world, the outcome of the FtP process should primarily be related to the seriousness of the offence committed not to characteristics of the individual, including BME status.

Section 6:   RECOMMENDATIONS

6.1   Policy

Ascertain how the regulation of nursing and midwifery in other countries compares to regulation in the UK. Quality of care and patient safety, in part, depend on regulatory processes. In 2009 the UK General Medical Council commissioned a study to provide an evidence base on the systems of medical regulation in place in the countries of origin (n=10) of doctors seeking to enter the UK and obtain registration to practise (de Vries et al., 2009) to ascertain whether any differences could potentially affect quality of care and patient safety. Understanding these differences might assist in developing specific policies to facilitate the smooth transition of non-UK trained professionals into the UK healthcare system.

6.2   Practice Settings

Implement and evaluate formal induction programmes. The literature across all professions has highlighted the need for more comprehensive induction programmes for new BME staff, especially IRNs. Induction programmes need to be mandatory and include sessions that address communication needs (e.g. use of British medical terminology) and practice skills pertinent to the work setting, as well as information on cultural norms, customs and practices in the UK.

6.3   NHS Management

Implement and evaluate NHS management training sessions. The literature evidenced that issues of racism and discrimination are prevalent throughout the NHS. Addressing discrimination requires a change in workplace culture and this can only be effective if led by management. It may be that managers are unsure of how best to support BME staff or what processes to follow if an employee raises a complaint against a BME colleague. Thus training to help staff understand the difference between performance management and disciplinary issues is necessary. The quantitative analysis described in this report has shown that employers are the most common source of referrals to the NMC and that ethnicity seems to be a factor in the referral process. Further work remains to be done in collaboration with employers to understand how they are making decisions about who to refer and why.

6.4   NHS Staff

Implement and evaluate NHS staff training sessions. There is a need to sensitise new nurses to the problems experienced by BME and IRNs. Equally, for experienced nurses changing jobs, it may be helpful to revisit these issues in the new context. There is an identified need for regular equality and diversity training sessions, including the concept of unconscious bias, for staff members as a way to remind those making decisions of their responsibilities in relation to the requirement of race relations legislation.

6.5   Educational Institutions

Implement and evaluate the integration of issues experienced by BME nurses and IRNs into curricula. Tackling issues of discrimination, patience in communication and understanding difference in cultural values, knowledge and skills, needs to happen as people embark on their career in nursing or midwifery. Leaving these matters for discussion until graduates actually enter the workforce is leaving it too late. It is imperative that nursing and midwifery educators, at both undergraduate and postgraduate level, undertake to raise awareness of how staff can support one another and the process and implications of raising an enquiry into FtP.

Section 7:   REFERENCES

Alexis, O. (2015). Internationally recruited nurses' experiences in England: A survey approach. *Nursing Outlook, 63*(3), 238-244. http://dx.doi.org/10.1016/j.outlook.2014.10.005.

Alexis, O., & Vydelingum, V. (2004). The lived experiences of overseas black and minority ethnic nurses in the NHS in the south of England. *Diversity in Health and Social Care, 1*(1), 13–20.

Alexis, O., Vydelingum, V., & Robbins, I. (2007) Engaging with a new reality: Experiences of overseas minority ethnic nurses in the NHS. *Journal of Clinical Nursing, 16*, 2221-2228.

Allan, H, Larsen, J. A., Bryan, K., & Smith, P. A. (2003). The social reproduction of institutional racism: Internationally recruited nurses' experiences of the British health services. *Diversity in Health and Social Care, 1*, 117–125.

Allen, I. (2000). The handling of complaints by the GMC: A study of decision making and outcomes. London, UK: Policy Studies Institute.

Archibong, U., Baxter, C. E., Darr, A., Walton, S., & Jogi, M. (2013). Disciplinary and fitness-to-practice data, policies, and practices in the NHS trusts and health professional bodies in the UK. *Journal of Psychological Issues in Organizational Culture, 4*(3), 6-25. doi: 10.1002/jpoc021117

Archibong, U., & Darr, A. (2010). *The involvement of Black and minority ethnic staff in NHS disciplinary proceedings*. University of Bradford, UK. ISBN 99781851432646.

BBC news *Theresa May Launches a Race Audit of Public Services*. http://www.bbc.co.uk/news/uk-politics-37194207

Campbell, J. L., Roberts, M., Wright, C., Hill, J., Greco, M., Taylor, M., & Richards, S. (2011). Factors associated with variability in the assessment of UK doctors' professionalism: Analysis of survey results. *British Medical Journal, 343*:d6212. doi: 10.1136/bmj.d6212

Carter, J. (2000). New public management and equal opportunities in NHS. *Critical Social Policy, 20,* 61-83.

Chamberlain, J. M. (2011). The hearing of fitness to practice cases by the General Medical Council: Current trends and future research agendas. *Health, Risk & Society, 13*(6), 561/575. doi: 10.1080/13698575.2011.613984

de Bere, S. R., Bryce, M., Archer, J., Lynn, N., Nunn, S., & Roberts, M. (2014). *Review of the decision-making in the General Medical Council's fitness to practise procedures.* London, UK: Camera with Plymouth University.

Daniel, P., Chamberlain, A., & Gordon, F. (2001). Expectations and experiences of newly recruited Filipino nurses. *British Journal of Nursing, 10*(4), 258–265.

Equality and Human Rights Commission (2016) *Healing a Divided Britain.* Accessed at: https://www.equalityhumanrights.com/en/race-report-healing-divided-britain

General Medical Council. (Ed.). (2015). Complaints about doctors. In *The state of medical education and practice in the UK 2015* (pp. 58-83). London, UK: Author. Retrieved from http://www.gmc-uk.org/SOMEP_2015.pdf_63501874.pdf

General Osteopathic Council. (2016). *Fitness to practise report 2014-15.* London, UK. Retrieved from http://www.osteopathy.org.uk/news-and-resources/document-library/fitness-to-practise/fitness-to-practise-annual-report-2014-15/

Henry, L. (2007) Institutionalized disadvantage: Older Ghanaian nurses' and midwives' reflections on career progression and stagnation in the NHS. *Journal of Clinical Nursing, 16*(12), 2196-203. doi: 10.1111/j.1365-2702.2007.02094.x

Humphrey, C., Hickman, S., & Gulliford, M. (2011). Place of medical qualification and outcome of UK General Medical Council "fitness to practice" process: Cohort study. *British Medical Journal,* 340:d1817. doi:10.1136/bmj.d1817

Kings College London. (2014). Nurse migration from the EU: What are the challenges? *Policy Plus Evidence, issues and opinions in Healthcare, 42/* Retrieved from http://www.kcl.ac.uk/nursing/research/nnru/policy/by-issue-number/policy--issue-42.pdf

Kanter R. (1977) *Men and Women of the Corporation.* New York: Basic Books.

Likupe, G. (2006). Experiences of African nurses in the UK National Health Service: a literature review. *Issues in Clinical Nursing, 15,* 1213-1220. doi: 10.1111/j.1365-2702.2006.01380.x

Magnusdottir, H. (2005). Overcoming strangeness and communication barriers: A phenomenological study of becoming a foreign nurse. *International Nursing Review, 52*, 263–269.

Mapedzahama, V., Rudge, T., West, S., & Perron, A. (2012). Black nurse in white space? Rethinking the in/visibility of race within the Australian nursing workplace. *Nursing Inquiry, 19*(2), 153-164. doi: 10.1111/j.1440-1800.2011.00556.x

Matiti, M. R., & Taylor, D. (2005). The cultural lived experience of internationally recruited nurses: A phenomenological study. *Diversity in Health & Social Care*, *2*(1), 7-15.

Maslach C, Jackson S. Burnout in health professions: A social psychological analysis. In: Sanders G, Suls J, editors. Social psychology of health and illness. Hillsdale, NJ: Lawrence Erlbaum; 1982. pp. 79–103.

Naqvi, H., Razaq, S. A., & Piper, J. (2016). *NHS workforce race equality standard 2015 data analysis report for NHS trusts.* Publication Gateway Reference Number: 05062. Retrieved from https://www.england.nhs.uk/wp-content/uploads/2014/10/WRES-Data-Analysis-Report.pdf

NHS Staff Survey 2016. http://www.nhsstaffsurveys.com/Page/1006/Latest-Results/2015-Results/

Schafheutle, E. I., Seston, E. M., & Hassell, K. (2011). Factors influencing pharmacist performance: A review of the peer-reviewed literature. Health Policy, 102, 178-19. doi: 10.1016/j.healthpol.2011.06.004

Shields, M., & Wheatley Price, S. (2002). Racial harassment, job satisfaction and intentions to quit: Evidence from the British nursing profession. *Economica*, *69*, 295-326.

Singh, P. Mizrahi, E., & Korb, S. (2009). A five-year review of cases appearing before the General Dental Council's Professional Conduct Committee. *British Dental Journal, 206*, 217-223.

Smith, P., Allan, H., Henry, L., Larsen, J., & Mackintosh, M. (2006). *Valuing and recognising the talents of a diverse healthcare workforce. Report from the REOH Study: Researching equal opportunities for overseas-trained nurses and other healthcare professionals*. Guildford. Retrieved from http://www.covwarkpt.nhs.uk/aboutus/equality-and-diversity/Documents/Valuing%20and%20Recognising%20Talents.pdf

Spinks J. (2014) Survey shows BME nurses are more likely to face disciplinary hearings. *Nursing Standard* 28(22), 14-15.

Tavalli, A. G., Kabir, Z. N., & Jirwe, M. (2014). Ethnic Swedish parents' experiences of minority ethnic nurses' cultural competence in Swedish paediatric care. *Scandinavian Journal of Caring Science, 28*, 255-263. doi: 10.1111/scs.12051

Taylor, B. (2005). The experiences of overseas nurses working in the NHS: Results of a qualitative study. *Diversity in Health and Social Care 2*(1), 17-27.

The Royal College of Midwives. (2012). *Freedom of information request: Midwives and disciplinary proceedings in London*. London, UK: The Royal College of Midwives. Retrieved from https://www.rcm.org.uk/sites/default/files/RCM%20Research%20Report%20Freedom%20of%20Information%20Request%20-%20BME%20Midwives%20and%20Disciplinary%20Proceedings.pdf

The Royal College of Midwives. (2016). *BME midwives, disciplinary proceedings and the workplace race equality standard.* Equality and Diversity Publication. Retrieved from https://www.rcm.org.uk/sites/default/files/Equality%20and%20Diversity%20Publication%20-%20BME%20Midwives%20and%20Race%20Equality%20Standard%20A5%2028pp_Spread.pdf

Tuttas, C. (2015). Perceived racial and ethnic prejudice and discrimination experiences of minority migrant nurses: A literature review. *Journal of Transcultural Nursing, 26*(5) 514-520. doi: 10.1177/1043659614526757

Tullett, J., Rutter, P., & Brown, D. (2003). A longitudinal study of United Kingdom pharmacists' misdemeanours trials, tribulations and trends. *Pharmacy World and Science, 25,* 43-51.

Winklemann-Gleed, A., & Seeley, J. (2005). Strangers in a British world? Integration of international nurses. *British Journal of Nursing, 14*(17), 899-906. doi: 10.12968/bjon.2005.14.18.19880

Withers, J., & Snowball, J. (2003). Adapting to a new culture: A study of the expectations and experiences of Filipino nurses in the Oxford Radcliffe Hospitals NHS trust. *Nursing Times Research, 8*(4), 278-290.

Xu, Y., Gutierrez, A., & Kim, S. H. (2008). Adaptation and transformation through (un)learning. Lived experiences of immigrant Chinese nurses in US healthcare environment. *Advances in Nursing Science, 31*(2), E33–E47.