



## No more excuses – tackling inequalities in health and care professional regulation

••  
'All the skeletons of inequalities came out of proverbial cupboards' ••

**British Association for Physicians of Indian Origin (BAPIO) report on differential attainment in the medical profession during Covid-19, 2021**

In this chapter we look at how inequalities are arising in professional regulation and affecting users of health and care services as well as professionals; and propose some ways of helping to address them.

## Alongside many others, the health and social care sectors are going through a period of self-reflection around equality, diversity and inclusion (EDI).

The NHS Race and Health Observatory (NHSRHO) recently reported stark racial inequalities in access to and experience of health and care. Their findings reveal disparities in maternal and neonatal healthcare, mental health services, digital inclusion and access to health services, genetic testing and genomic medicine studies, as well as within the NHS workforce. Their report focuses specifically on actions for the health service in England but much of the research referenced is UK-wide.

Where they exist, the statistics on healthcare outcomes are shocking – for example, black women are four times more likely than white women to die in childbirth in the UK.<sup>11</sup> Such inequalities are also present in outcomes within social care although data is scarcer.<sup>12,13</sup>

The UK Government has announced plans to address health inequalities as part of its broader levelling up agenda, launching separate independent reviews into ethnic inequalities around medical devices and tobacco control.<sup>14</sup> It has also created the Office for Health Improvement and Disparities to take on some of the functions of Public Health England, with an explicit focus on tackling health inequalities.<sup>15</sup> The Scottish Government has highlighted the potential benefits of improving equality of access to social care services across Scotland for different groups.<sup>16</sup>

These are just some first steps. Governments and public health and care services across the UK, the independent sector, and all bodies involved in the safety and quality of health and social care still have much to do. The work will need to be done in partnership with patient and service user groups and explore the diversity of views and experiences across protected and socio-economic characteristics.

Awareness of the impact discrimination and inequality have on health professionals is growing; particularly as workforce pressures and challenges around recruitment and retention are increasing in both health and social care. Two thirds of healthcare workers who died from Covid-19 were from an ethnic minority background.<sup>17</sup>

The impact of harms caused by major medical failures on particular groups is also becoming clearer. In 2020, we saw reports published for four major patient safety scandals primarily affecting women.<sup>18</sup> This included the Ockenden Inquiry's report into failings at Shrewsbury and Telford Hospital NHS Trust, published in March 2022, revealed avoidable harm to mothers and babies on a major scale.

As mentioned above, the aspects of inequality we cover here fall into two main categories:

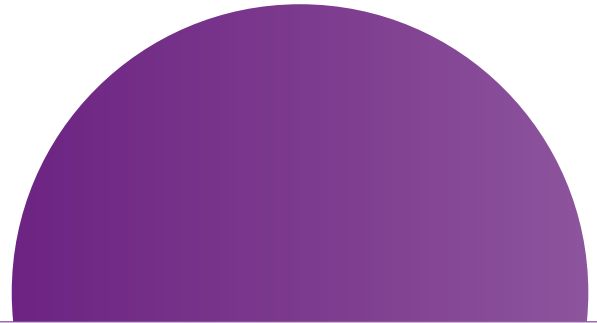
- inequality affecting registrants
- inequality affecting patients and service users.

We acknowledge that this is a vast subject, focusing on race discrimination alone could make up this entire report. Much of this chapter does just that, partly because much of the research carried out in this area focuses on race. However, we recognise that other inequalities are just as important and may have an impact on large sections of the population. The most recent ONS (Office for National Statistics) data reports that over 20% of the population of Great Britain are disabled as defined by the Equality Act.<sup>\*19</sup>

\* We note that Northern Ireland is not covered by the Equalities Act and is subject to separate equalities legislation: <https://www.equalityni.org/Legislation>

As well as inequalities relating to protected characteristics as defined in law we are becoming more aware of those around socio-economic status — particularly with the rising cost of living. The Health Foundation's 2020 report, marking 10 years since the influential Marmot Review, found that people in more deprived areas can expect to spend more of their lives in poor health. Improvements to life expectancy have stalled, and declined for the poorest 10% of women, the health gap has grown between wealthy and deprived areas and there are growing geographical disparities across the UK for health outcomes and life expectancy.<sup>20</sup>

Time and capacity constraints have left us unable to cover all types of inequalities in the same level of detail in this report, but we have done so where we can. We recognise that there is more work to do in uncovering the detailed issues arising for different groups.



## Addressing inequalities within professional regulation and registration

- 'There is no doubt that the generation of overseas doctors who came to the UK at the invitation of the UK Government, [were] full of optimism and ambition... there was little support to underpin challenges round arriving in a different culture, speaking English but not necessarily with an understanding of local idiom or accent, and facing significant amount of racism not just from patients but from others in the system.' ●●



### UK trained BAME GP, Fair to refer?<sup>21</sup>

Professional regulators have long been aware that their processes may have a disproportionate impact on certain groups of registrants. The extent of these concerns is now becoming more apparent and regulators, and the Authority along with them, need to address these problems more directly and urgently. At a minimum we should ensure that regulation does not reinforce or perpetuate wider system inequalities within health and care.

There are a number of points at which inequalities can affect a professional's career as a direct or indirect result of regulation. Evidence shows different levels of academic and career

attainment amongst certain groups of students, particularly women and those from ethnic minority backgrounds. As BAPIO highlight, despite making up almost 40% of the medical workforce, international medical graduates are more likely to experience these differentials. This includes in entry to training, assessment, research and academia, career progression and leadership.<sup>22</sup>

According to the the Royal College of General Practitioners' (RCGP) annual report from 2017/18, the pass rate of the Applied Knowledge Test (AKT) for white doctors was 86.8% and 60.7% for all minority ethnic doctors.

For the Clinical Skills Assessment (CSA), 93.8% of white graduates passed, compared with 83.4% of UK-educated minority ethnic graduates and 39% of internationally-educated minority ethnic graduates.<sup>23</sup>

The NMC has examined variations in revalidation rates amongst nurses and midwives. Their independent evaluation suggests that men, people over 65, black and minority groups, and disabled nurses and midwives may find it more difficult to fulfil what the process asks of them.<sup>24</sup>

In England, amongst NHS staff as a whole (all staff groups taken together), Black and minoritised ethnic (BAME) staff are more likely to enter local disciplinary processes. In 70% of NHS Trusts, the likelihood of BAME staff entering the local disciplinary process is more than for white staff. In over a quarter of NHS Trusts, the likelihood of BAME staff entering the disciplinary process is more than twice as high as for white staff (Equality and Diversity Council, 2019).<sup>25</sup>

GMC commissioned research into the fitness to practise process shows that black and minority ethnic (BAME) registrants are twice as likely to be referred to the GMC by employers compared to white doctors; and that international medical graduates (IMGs) are more likely to be subject to more serious sanctions through the fitness to practise process.<sup>26</sup> This is echoed in the findings of other regulators which indicate that BAME professionals are overrepresented at all stages of the fitness to practise process.<sup>27</sup>

Data is key in identifying and tackling EDI issues. Although it is not the only way regulators can understand the diversity of their registrants, it is an important element of recognising the impact of their own processes. Whilst regulators have improved in this area, not all of them hold adequate data, as historically they have not asked registrants to provide this information at the point of registration or renewal. This means that comprehensive data is lacking across the regulators we oversee.

If they want to fill this gap, it is important that regulators communicate clearly with registrants and build trust in why they need their data and what they intend to do with it. Social Work England is having to find ways to overcome the challenges it has experienced as a new regulator gathering this data – just 4% of social workers had submitted diversity data as of February 2022.<sup>28</sup> Other regulators have been more successful for example the GOC has been able to gather data on almost 100% of registrants, although over a longer period.<sup>29</sup>

Those who managed to secure this information have begun to look at where the impacts arise within their processes in more detail, and how they will address them. Specific actions taken by regulators in relation to the fitness to practise process include providing further guidance for employers on criteria for referral,<sup>30,31</sup> and improved training, including on unconscious bias, for those involved in fitness to practise decision-making.

It is positive to see regulators setting themselves targets, for example the GMC's ambition to eliminate disproportionate referral of BAME registrants into the fitness to practise process by 2026 and differential attainment by 2031.<sup>32</sup> They continue to report their progress towards these targets and we will continue to monitor it in our reviews of their performance.

The regulators acknowledge inequality issues and are all committed to addressing them. It can be difficult for them to pinpoint the causes and, even when they can, dealing with them may not be fully within their control in a structurally unequal society.

Fitness to practise referrals from employers may be the result of the culture within their organisations. However, the reasons behind over-referral of BAME registrants into the fitness to practise process may be complex. For example, it may also be the case that referral rates for white registrants are too low. This may be because employers are less likely to refer cases involving white registrants (for reasons we do not fully understand), or because employers

and colleagues give them more support to resolve their concerns earlier in the process.

This ultimately shows us the structural disadvantages that exist for certain groups of professionals skewing their experience within the regulatory process.

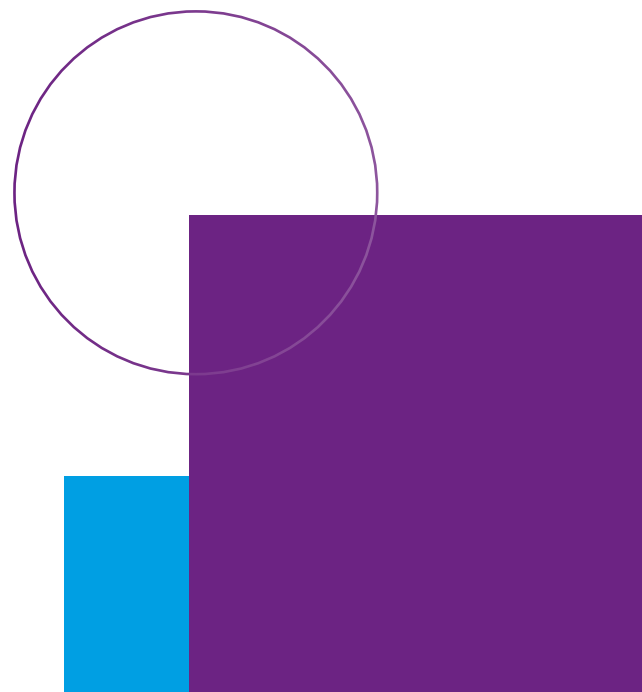
As we will see in the following section, there is little information available about the characteristics of complainants. This too could be a factor in the over-representation of particular groups with protected characteristics in the fitness to practise process. As well as unconscious bias training, it may also mean equipping investigators with the tools to interrogate the information included within a referral, to consider wider factors and avoid progressing cases that are not well-founded. It will be important for regulators to continue working to understand the causes of all these problems so that they can address them effectively.

It is clear that there are still significant disparities in the experience of different groups within the regulatory process and it is the regulators' responsibility to address this.<sup>33</sup>

As well as tackling disproportionate referrals this includes acknowledging the impact of systemic racism and ensuring that the regulatory process mitigates, as far as possible, the structural advantages/disadvantages that this gives to different groups of professionals. Another area needing further work is the diversity of senior leadership. There is an increasing body of evidence that having more diverse leadership can accelerate change and help to crystallise priorities for organisations. A number of regulators have taken some action in this area, for example, by taking steps to improve the diversity of candidates for recruitment to non-executive positions, or by introducing the role of 'Associate' Council members. However, progress has been slow. The GMC Chair, Dame Clare Marx, was the first female Chair since the organisation was formed in 1858 and although this was welcome, it was also long overdue.<sup>34</sup>

An area that may lend itself to joint-working between regulators is improving the diversity of the pool of available decision-makers, particularly in fitness to practise. We examined the issue of fitness to practise Panel member diversity in our 2019 report on how public confidence is taken into account when fitness to practise decisions are made, carried out following the Williams Review into the Bawa-Garba case. We concluded that currently regulators are drawing panellists from the same pool, which leads to people with similar backgrounds and experience being overrepresented on fitness to practise Panels. We recommended that: 'Regulators should ensure that Panels have access to a wide range of public views and seek to ensure that Panel members are drawn from a sufficiently diverse pool.'<sup>35</sup>

We think that regulators and registers should work collaboratively to improve the diversity of fitness to practise panels, other decision-makers and senior leadership to ensure they more closely reflect the diversity of the community. Within the Authority we will also be considering our own role in encouraging action through our review of the relevant performance review standard (Standard 3). Further details on the areas we intend include in this review are given in the final section of this chapter.



## Inequalities felt by patients and service users

- ‘They will say to you “email me” but older people don’t have a computer... I don’t want to use a computer.’ ●●

### ‘Focus group participant, *Breaking down the barriers - Older people and complaints about health care* <sup>36</sup>

#### The demographics of complainants

Despite an increasingly clear picture of the disparities in access to and experience of care, surprisingly little is known about those who make complaints and the barriers facing particular groups in complaining about poor care or misconduct by health and care professionals.

We have previously described the complex patient safety landscape and the challenges for all patients in navigating the system and understanding where and with whom to raise concerns.<sup>37</sup> It would not be surprising if this complexity had a differential impact on different groups of patients or service users.

During the pandemic, access to technology became an issue for certain groups of both registrants and complainants, as regulators began holding remote hearings and sharing papers and evidence for fitness to practise proceedings by email. The issue of digital exclusion, which spans different groups, may also be a barrier to patients complaining about their care in the first place, despite the benefits of improved access technology can bring to others.

Analysis of the demographics of complainants, and research looking at barriers to complaining appear to be relatively limited. A 2015 Parliamentary and Health Service Ombudsman report examined the barriers facing older people in making complaints about health and care and found that there were a number of factors affecting their willingness to complain about their care.<sup>38</sup> More recently, the Patients Association published a report from the Patient Coalition for AI, Data and Digital Tech in Health

which highlighted the impact of digital health inequalities alongside a growing movement to digitise service provision.<sup>39</sup>

Some regulators have actively sought the views of people raising concerns about professionals. More of this work would provide a basis for addressing any difficulties particular groups encounter in raising concerns about care. Its absence is likely to perpetuate the problems around access and experience.

Regulators should work with other health and care bodies to gain a better understanding of the demographic profile of complainants and reduce barriers to raising complaints for particular groups.

An underlying problem is that national, routine data on health and care service complaints is limited in scope across the different parts of the UK. NHS Digital publishes data on complaints made to the NHS in England but this only captures certain categories of information about the complainant including age and status (patient, parent, guardian, carer, other).<sup>40</sup> Healthwatch has previously raised this issue to encourage maximum learning from the information gleaned from complaints.<sup>41</sup> Demographic data about complainants to health services in Scotland, Wales and Northern Ireland is also limited.

Data on social care complainants appears to be even more limited, in part due to the structure of social care provision across the UK. The Local Government and Social Care Ombudsman publish data on complaints they receive about adult social care providers and local authorities in England, but this does not include any demographic information about complainants.<sup>42</sup>

Without this information, it is impossible to get a clear picture of the problems different groups of patients and service users encounter and address them effectively.

A further structural barrier is emerging in England. Currently national oversight of complaints made to Trusts is fulfilled by NHS England through NHS Digital. The Integrated Care System (ICS) framework formalised by the Health and Care Act has moved responsibility for commissioning primary care services from NHS England to local ICSs. As it stands, it is possible there will be no national oversight of complaints received as a matter of course. Healthwatch England has called on the Government to use the NHS mandate to instruct NHS England and ICS leaders to design a national system for learning from complaints which may provide an opportunity to use data to inform consistent action.<sup>43</sup> We support this but believe that demographic data captured needs to be broader in scope to allow meaningful lessons to be learned.

In the long term, demographic data on complaints made to the health and care services across the UK should be recorded and made available for all bodies to use. This data should be analysed at a cross-sector level to identify disproportionate impacts and risks to protected groups.

For England this would build on the recommendation by the NHS Race and Health Observatory that NHS Digital should produce national NHS statistics on service use by ethnic group, age and gender.<sup>44</sup>

## The role of the patient voice in improving the quality and safety of care

Ensuring that diverse patient voices are heard is crucial in improving the safety and quality of care. As highlighted in the previous section, this is more challenging without more detailed information on who is making complaints.

The response to Covid-19 brought agility and innovation to the fore at a time of crisis. However, as the Patients Association,<sup>45</sup> National Voices<sup>46</sup> and others have reported, the pandemic left many users of health and care services feeling isolated and unsupported as well as impacting on patient and public involvement in policy-making and service delivery.

For many, the patient voice has always been undervalued, and sometimes unheard, in health and care. This has often been the case with major failures of care where patients and families have been ignored or their concerns minimised. An area for consideration and potentially further research is the disproportionate impact of harm, particularly arising from major failures of care, on groups of patients and service users sharing protected characteristics. A superficial observation at this stage is that people affected by such incidents are likely to share either one or multiple protected characteristics. Both the Cumberlege Review<sup>47</sup> and Paterson Report<sup>48</sup> highlighted harm caused to predominantly female patients and the difficulties faced by those trying to raise the alarm. The Cumberlege Review described a 'denial' of women's concerns.<sup>49</sup>

Maternity failings – often involving harm to mothers – are the frequent subject of inquiries. The Care Quality Commission (CQC) has raised concerns about the variation in quality in maternity services across England and limited progress in implementing recommendations to improve outcomes for particular groups.<sup>50</sup> The recently published Ockenden Report highlights another shocking example of avoidable harm and death in maternity services with families

forced to campaign for years to have their concerns addressed. On the back of other, similar, findings the inquiry raises a question about whether the voices of patients, and particularly women, are listened to both in terms of the care they receive and when they are making complaints.

Looking more widely at other failures of care and examples of abuse and neglect across the UK such as Winterbourne View, Muckamore Abbey and Brithdir Nursing Home, there is a clear theme of those with protected characteristics, including older people and those with disabilities, being amongst those regularly affected by serious care failure. Research indicates that: 'ethnic minority consumers may experience inequity in the safety of care and be at higher risk of patient safety events'.<sup>51</sup>

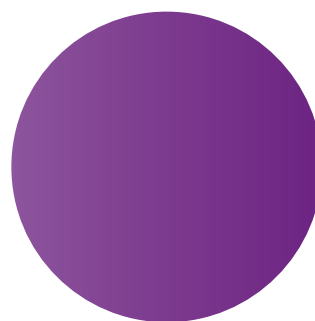
This is a complex area but, for regulators, it reinforces the need to understand who is affected by failures of care and what more can be done to mitigate the risks for particular groups. It also highlights that the patient and service user voice needs to be strengthened and amplified; and that proper partnership with patients and service users must be built into health and care provision and regulation. The CQC's 2021-25 Equality Objectives support its aim of 'amplifying the voices of people most likely to have a poorer experience of care or have difficulty accessing care'.<sup>52</sup> This needs to be reflected in reality across health and care.

The déjà-vu experienced by many reading the Ockenden Report exposes a key problem relating to public inquiries: the lack of any mechanism to identify themes and learnings, and to ensure that recommendations acted upon in a coherent way.<sup>53</sup> This problem is exacerbated by the variation in how particularly, non-statutory inquiries and reviews are set up and managed. Typically, governments deal with individual inquiry reports separately, and the recent responses to Paterson, Cumberlege and others bear this out.

This is an observation rather than a criticism, and we recognise that governments are generally under pressure to be seen to respond to each individual occurrence quickly. However, this structural issue in the way that inquiry responses are managed has often failed to address issues and themes which may cut across multiple inquiries, including:

patterns in the demographic profile of those affected

- the challenges faced by complainants in getting their voices heard
- problems caused by the complexity of the system and gaps between organisations
- specific problems arising from care provided within the independent sector and/or from commercial or financial interests. [This finding supports the recommendation for the Health and Social Care Safety Commissioners.]





## Coming together to address inequalities and discrimination

- 'We found that the very inequalities we were trying to tackle were being hampered by the culture which sustains such inequalities.' ●●

**Dr Charlotte Woodhead, King's Institute of Psychiatry, Psychology & Neuroscience**<sup>54</sup>

### Poor culture, poor care?

There is clear evidence to demonstrate that poor cultures, where discrimination and inequality are allowed to persist, are bad for both professionals, and patients and service users. They may also have an impact on public confidence, quality of care and patient safety as well as on the wellbeing of staff. Tackling this will require a collaborative, coordinated effort from all bodies involved in the provision and regulation of health and care. We know that some of this work is already underway.

The impact of discrimination and inequality on staff morale, wellbeing and retention is well documented.<sup>55</sup> NHS Providers recently reported Trust Boards in England's views that there is still much to do to embed race equality as a core part of their business. Respondents acknowledged the need for more support for staff facing discrimination and more work to improve retention.<sup>56</sup> As set out in our chapter on workforce, the magnitude of the workforce pressures faced by the health and care service makes this even more urgent.

However, discrimination and poor culture also have a significant impact on patients. This may include both discriminatory behaviours between staff, from staff to patients, and from patients to staff.

Perceptions of discrimination from staff may have an impact on the willingness of patients to access care.<sup>57</sup> Research suggests that implicit

bias by healthcare professionals can have an impact on 'patient-provider interactions, treatment decisions, treatment adherence, and patient health outcomes'.<sup>58</sup>

It also seems likely that a discriminatory or unequal workplace culture more generally is likely to have a negative impact on patient experience, patient outcomes and patient safety.\* The NHS Race and Health Observatory highlights research showing that, 'the greater the proportion of ethnic minority NHS staff who report experiencing discrimination at work, the lower the levels of patient satisfaction'.<sup>59</sup>

While patient experience and satisfaction have not always been seen as a helpful measure of safety and effectiveness of care, evidence suggests that there is likely to be a relationship between patient experience, patient safety and clinical effectiveness.<sup>60</sup>

What the direct impact might be on patient safety (i.e. the prevention of errors and adverse effects) is less well understood. However, as we know from the inquiry into events at Mid-Staffordshire and other public inquiries, cultures where staff feel bullied or isolated may mean that major failures of care go unreported and unresolved to the detriment of patient safety. It seems logical that, where staff feel bullied or discriminated against, or where patients feel unable to raise concerns, the risks for patients will increase.

\* Patient outcomes and patient safety are closely interrelated, but in this context we use outcomes to refer to 'measurable changes in health, function or quality of life that result from... care' (see: Great Ormond Street Hospital for Children NHS Foundation Trust, 2020, Clinical Outcomes. Available at: [https://www.euro.who.int/en/health-topics/Health-systems/patient-safety](https://www.gosh.nhs.uk/conditions-and-treatments/clinical-outcomes/#:-:text=Clinical%20outcomes%20are%20measurable%20changes,that%20result%20from%20our%20care); by patient safety we mean: 'the prevention of errors and adverse effects to patients associated with health care' (see: World Health Organisation: <a href=))

Our research looking at the impact of breaches of sexual boundaries between colleagues bears this out. It found that workplace cultures where staff feel uncomfortable or bullied by colleagues are likely to pose risks for patients.<sup>61</sup> Research into sexual misconduct and dishonesty has also shown that poor workplace culture can embed and exacerbate negative behaviour amongst staff.<sup>62</sup>

Unfortunately, the most recent NHS England Staff Survey demonstrates that such experiences remain widespread and, in some cases, are increasing.<sup>63,64</sup> The Equality and Human Rights Commission reports that lower-paid ethnic minority workers in health and social care feel they are treated differently compared to their white counterparts, particularly during the Covid-19 pandemic. They also fear raising concerns, and even reported not having access to mechanisms for doing so.<sup>65</sup> The 2020 NHS Wales Staff Survey found that 16% of staff had been bullied or harassed by a colleague and 10% by a manager.<sup>66</sup> The 2019 survey for the health service in Northern Ireland revealed a slight increase in staff experiencing discrimination at work.<sup>67</sup> Although the most recent NHS Scotland Staff Experience Report paints a broadly positive picture, the Scottish Pulse Survey National Report of health and care staff in 2020 reports instances of bullying and harassment; cases reported in the media suggest that this remains an issue to a greater or lesser degree across the UK.<sup>68</sup>

All of this demands that system and professional regulators, as well as healthcare providers, should come together to tackle discriminatory and offensive behaviour from and towards staff.

Employers, system regulators and inspectorates across the UK have an important and influential position in reinforcing the right kind of culture within provider organisations. In England, the CQC has created a more ambitious role for itself in its equality objectives for 2021-25. This includes using data to assess the culture and leadership of health and care services.<sup>69</sup> Healthcare Inspectorate Wales's latest Strategic

Plan contains their commitment to creating an equality strategy to ensure that it meets the needs of minority groups adequately in its work.<sup>70</sup>

In England, the NHS Workforce Race Equality Standard has resulted in a series of positive actions.<sup>71</sup> The recent introduction of a Workforce Race Equality Standard for social care is likely to focus this sector on making improvements too.<sup>72</sup>

We recognise that it is not the professional regulators' gift to address some of these problems directly and that they will need to prioritise actions and work collaboratively with other UK bodies to bring about change.

However, there are things that employers and regulators can do to support action to tackle discrimination, improve workplace culture and ultimately improve outcomes for patients which include:

- Developing clear and consistent standards and guidance (particularly for registrants in leadership and management positions) and disseminating them effectively.
- Adopting a firm and consistent approach in enforcing expected standards of behaviour in employment settings and via the fitness to practise process.
- Training and educating current and future professionals in the significance of equality and fair and open cultures in health and care, and of tackling workplace discrimination.
- Supporting professionals to tackle workplace discrimination and manage difficult situations and signposting them to the mechanisms and resources available.

In overseeing the regulators and scrutinising their final fitness to practise decisions we have observed a variable approach to how they deal with racist behaviour, both within their sanctions guidance and in practice. This is not to suggest that regulators do not take such behaviour seriously – we know they do. However, although we have not carried out a systematic review of decisions in this area, examples such as the

Hayes case demonstrate that, sometimes panels are uncertain about what kind of sanction to impose.<sup>73</sup>

It is also important to note that cases ending up within the fitness to practise process are likely to represent the more obvious cases of racist behaviour, as opposed to more subtle or insidious behaviours and micro-aggressions that can also be very damaging.

Regulators and registers should review how their fitness to practise processes, including their indicative sanctions guidance and other fitness to practise guidance, address allegations of racist and discriminatory behaviour.

Guidance should be clear that racism and other discrimination are a serious breach and may result in removal from the register. However, we also think that we need research to improve understanding of the impact that such behaviours may have on both public safety and confidence. We know that regulators recognise that we need a consistent approach which can be more powerful than individual actions. The Authority is ideally placed to support collaboration in this area. We will work with our regulatory colleagues to explore how we can use our oversight and policy and research function to make it happen effectively.

### **A step-change in challenging inequality and discrimination**

It is essential that action taken by professional regulators is part of the wider push to address inequalities within health and care. With greater awareness of health inequalities comes the wider question of whether health professionals should have a more explicit role in ensuring they, themselves, are informed of issues affecting different groups, and supporting action to address these disparities. For example, there is evidence suggesting limited understanding by some healthcare professionals of issues affecting women going through the perimenopause and menopause due to insufficient focus on these topics in medical training.<sup>74</sup>

The approach also varies amongst accredited registers, with many giving their registrants information and guidance to support them in providing care to a diverse population. For example, the British Association for Counselling and Psychotherapy (BACP) has published research on counselling and female genital mutilation (FGM), and on LGBT issues.<sup>75</sup>

In New Zealand, the Medical Council has taken a proactive approach with its requirements for doctors around 'cultural safety', intended to address the well-documented poorer health outcomes for Maori patients. The requirements ask doctors to consider: 'Challenging the cultural bias of individual colleagues or systemic bias within health care services, which may contribute to poor health outcomes for patients of different cultures' in their practice.<sup>76</sup>

While all regulators address discrimination in their codes, the strength of the wording they use varies. Some require registrants to actively challenge discriminatory behaviour, other wording focuses on respecting and providing for diversity and difference.

We think that as part of wider thinking around how regulators and registers can work within the system to address inequalities, they should consider whether health professionals should have a more explicit duty to support work to tackle inequalities within health and care. This could also then be reinforced through training, guidance and continuing fitness to practise requirements. As mentioned at the start of this chapter, this is increasingly a focus for all Governments across the UK.

We recognise that some regulators are already looking at what more can be done within standards, for example the GMC say of their planned review of Good Medical Practice: 'We'll also review our guidance to see if we can do more to address the inequalities and systematic issues that exist in medicine. This will help to create more inclusive supportive environments for all.'<sup>77</sup>

This is unlikely to be a quick fix and some professionals may be concerned about what seems to be an increase in expectations, at a time when many are already feeling overworked and under pressure. Others may see it as already part of the role of a health or care professional. We will do what we can to create the space for such discussions about the role of professionals and professional regulation in this complex area.

Regulators have done a significant amount of work in this area to date, although progress varies. It is impossible to capture it all here, but the Authority reviews this work in detail as part of the annual performance review of each regulator against the Standards of Good Regulation introduced in 2019, under Standard 3: 'The regulator understands the diversity of its registrants and their patients and service users and of others who interact with the regulator and ensures that its processes do not impose inappropriate barriers or otherwise disadvantage people with protected characteristics.'<sup>78</sup>

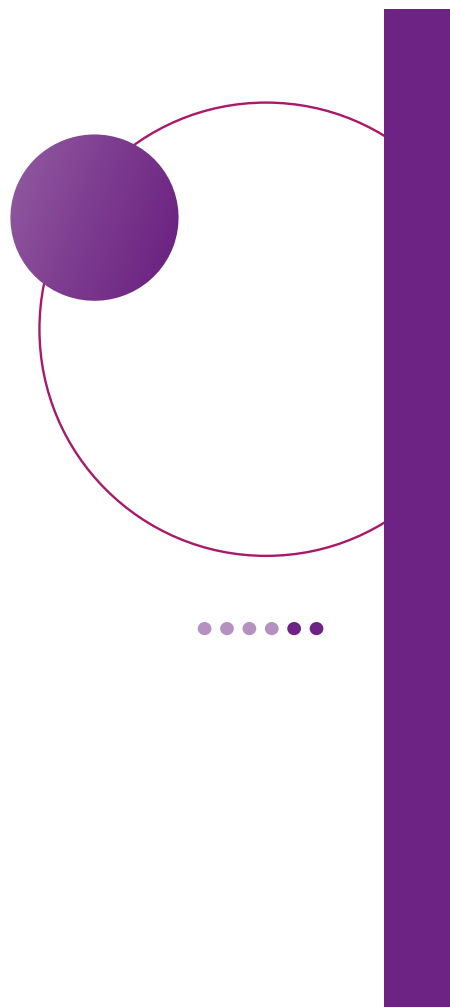
This Standard is recent, and the Authority is intending to review, in consultation with stakeholders, whether our expectations are sufficiently clear and ambitious for us to drive change. We have recently published our own EDI Action Plan and in the accompanying blog outlined some of the questions we intend to ask as part of this review including:

- What is the minimum information that regulators need in order to claim credibly that they have an understanding of the diversity of their registrants and the communities they serve?

- Can a regulator that has a significant disproportion of minority registrants in its fitness to practise process be regarded as meeting our standards? Is it enough that they're doing work to address it?
- What do we expect regulators to do to ensure that their registrants are providing proper care to a diverse population?<sup>79</sup>

The inter-regulatory EDI Forum provides an important space for regulators to share best practice. We will work with this group on how to define new expectations under this standard.

The registers of non-statutorily regulated practitioners that we accredit have huge potential to help build a picture of the wider workforce, particularly those roles that have good coverage under the programme, such as counselling and psychotherapy. Although some are making strides in this area, not all currently collect data on EDI within their processes or have clear plans in place for doing so. The Authority will consult on a new EDI standard for the Accredited Register programme in 2022.



## No more excuses: our conclusions

Professional regulation and registration alone will not be able to solve the problem of inequalities. However, regulators and registers are in an influential position as they oversee professional or practitioner pathways, from training through to registration and practice. Furthermore, the evidence of differential experience of different groups within the regulatory process shows very clearly that it is something regulators should tackle.

As these issues cut across the whole health and care system it will be important that the action we take is broad enough to accommodate care delivered in different ways and by different groups of practitioners. Although the majority of the registers we accredit have significant progress to make in this area, their practitioners may have an increasingly important part to play.\*

We welcome the work carried out so far but accept the difficulties of addressing some of these issues, particularly if they are linked to wider societal attitudes or deep-rooted inequalities; for example those arising from sharp socio-economic divisions as described by the Marmott Review.<sup>80</sup> It has to be acknowledged, however, that efforts to date have failed to address many of the concerns. We have highlighted areas where collective activity by regulators, registers and/or other bodies would achieve more, or where action can have a disproportionately large positive impact. As the various bodies in health and care will need to work together, it will be important for regulators to communicate and collaborate, both between themselves, and with others in the sector, to ensure that they are using the levers at their disposal to tackle shared challenges.

\* For example, there is a growing move to make better use of social prescribing, a link role that often sits as part of the multi-disciplinary team in primary care networks, as a way of addressing inequalities and helping those from different groups to access the care they need. Dr Jagan John, Chair - North East London Clinical Commissioning Group and Clinical Director for Personalised Care in London. Social prescribing as a way of tackling health inequalities in all health settings. Available at: <https://www.england.nhs.uk/blog/social-prescribing-as-a-way-of-tackling-health-inequalities-in-all-health-settings/>

## Recommendations

We recommend that:

- Regulators and registers work collaboratively to improve the diversity of fitness to practise panels, other decision-makers and senior leadership to ensure they more closely reflect the diversity of the community.
- Regulators work with other health and care bodies to gain a better understanding of the demographic profile of complainants and reduce barriers to raising complaints for particular groups.
- Regulators and registers review how their fitness to practise processes, including their indicative sanctions guidance and other fitness to practise guidance address allegations of racist and other discriminatory behaviour.
- Demographic data on complaints made to the health and care services across the UK is recorded and made available for all bodies to use.

**Throughout this report, we build the case for a structural change in the world of health and care safety – a Commissioner role with oversight across both sectors, and a specific focus on identifying emerging risks to patients and service users and recommending action. Some of the gaps we identify would ideally be filled by this role, including the following recommendation:**

- Demographic data on complaints should be analysed at a cross-sector level to identify disproportionate impacts and risks to protected groups.

## ■ The Authority also needs to do more.

### We will:

- Ensure that the application of our standards for regulators is stretching and stimulates continuous improvement.
- Endeavour to bring consistency of approach across both regulated and unregulated practitioners through our Accredited Registers programme, where we will be introducing clearer EDI requirements for registers later this year.
- Examine our own processes to ensure that we are not reinforcing or exacerbating inequalities that arise in the regulatory system. Our Equality, Diversity and Inclusion Action Plan: 2022-23 which we published in April of this year outlines a range of commitments we have made both in relation to our internal processes and our external role.<sup>81</sup>
- Use our oversight role to encourage co-operation, collaboration, and coherence across the system, noting the inherent challenges in trying to address patient safety concerns when it is so fragmented. This is an issue we address further in the final chapter of this report and in our overarching recommendations.

Through all of this work, it will be essential to keep the focus on patients, service users and those seeking to raise concerns across all four countries of the UK, and the impact that addressing inequalities and discrimination can have in improving the safety and quality of health and care for all.

