Equality Impact Assessment Initial Screening - Relevance to Equality Duties

1. Name of the proposed new or changed legislation, policy, strategy, project or service being assessed.

Law Commissions, *Regulation of Health Care Professionals: Regulation of Social Care Professionals in England: Final Report* (2014)

2. Individual Officer(s) & unit responsible for completing the Equality Impact Assessment.

Tim Spencer-Lane, Law Commission, 1st Floor, Tower, 52 Queen Anne's Gate, London, SW1H 9AG

3. What is the main aim or purpose of the proposed new or changed legislation, policy, strategy, project or service and what are the intended outcomes?

Aims/objectives	**Outcomes**
(1) The simplification of the legal framework to allow the law to be more easily understood by the public and professionals;	(1) A simplified legal framework which allows the law to be more easily understood by the public and professionals;
(2) Consistency of powers between the regulatory bodies, which would allow the public and professionals to be clearer about what to expect from the regulatory scheme;	(2) A framework which provides consistency of powers between the regulatory bodies, thereby allowing the public and professionals to be clearer about what to expect from the regulatory scheme;
(3) Increased flexibility and autonomy for the regulators to keep pace with changes in health and social care;	(3) A more flexible and autonomous legal framework for the regulators, thereby allowing the regulators to keep pace with change;
(4) Clear accountability mechanisms for regulation; and	(4) A framework which provides clear accountability mechanisms for regulation; and
(5) Enabling cost efficiencies.	(5) A legal framework which enables cost efficiencies to be achieved.

4. What existing sources of information will you use to help you identify the likely equality impacts on different groups of people?

Our starting point is the statutory equality duty is contained within section 149 of the Equality Act 2010. Section 149(1) requires public authorities to have due regard to the need (1) to eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Act; (2) to advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; and (3) to foster good relations between persons who share a relevant protected characteristic and persons who do not share it. Section 149(3) requires public authorities to have due regard to the need to advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to (a)remove or minimise disadvantages

suffered by persons who share a relevant protected characteristic that are connected to that characteristic; (b) take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it; and (c)encourage persons who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low.

Section 149(5) requires public authorities to have due regard to the need to foster good relations between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to (a) tackle prejudice, and (b) promote understanding.

Section 149(7) identifies the following relevant protected characteristics: age; disability; gender reassignment; pregnancy and maternity; race; religion or belief; sex; and sexual orientation.

To identify the relevant equality impacts we considered the following:

(1) The numbers of health and social care professionals with protected characteristics.
(2) The recommendations within the final report that may have an impact on those with protected characteristics.

(1) The numbers of health and social care professionals with protected characteristics

The recommendations we make in our final report focus on how the health and social care professional regulators operate in relation to their regulatory functions. Given that these functions directly impact on the health and social care professional workforce, this is the stakeholder group that we primarily seek to identify.

(a) Age

The NHS Health and Social Care Workforce Census as at 30 September 2012 provides the following in relation to the age profile of medical and dental staff employed within hospital and community health services in England:

	All Ages	Under 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70 and over
All Staff	107,242	23,907	17,423	17,512	14,467	12,418	9,889	6,917	3,502	1,015	192
Consultant (including Director of Public Health)	40,394	2	762	5,992	9,296	9,044	7,120	5,081	2,400	604	93
Associate Specialist	3,540	1	5	96	370	714	905	731	525	164	29
Specialty Doctor	6,358	113	747	1,520	1,301	1,086	780	397	270	128	16
Staff Grade	623	13	36	72	106	132	115	78	45	16	10
Registrar Group	39,404	12,192	14,316	8,915	2,820	805	256	67	24	4	5
Senior House Officer	1,359	584	376	212	95	51	21	12	6	2	-
Foundation Year 2	6,200	5,286	589	216	68	29	7	3	2	-	-
House Officer and Foundation Year 1	6,275	5,638	410	147	51	20	9	-	-	-	-
Other Doctors in Training	130	-	11	17	22	31	23	18	7	1	-
Hospital Practitioner/	1,785	16	54	168	185	318	434	330	178	68	34

Clinical Assistant											
Other Staff	1,673	94	170	232	224	248	310	261	81	43	10

Not all the regulators publish information regarding the age of their registrants. However, the General Chiropractic Council ("the GCC") collects data in relation to age and states that it has data for all registrants across the UK. In its Annual Report and Accounts 2011 (at page 37 – www.gcc-uk.org), the GCC states that internal audits and decisions of the Investigating Committee and Professional Conduct Committee have not identified any evidence of discrimination on the grounds of age, although it is noted that numbers involved are too small to be statistically relevant.

The Nursing and Midwifery Council also provide a breakdown of data on registrants across the protected characteristics by age, etc as at July 2011. Based on data received from 286,190 out of 665,545 registrants [43%] the following obtains:

Table: NMC Registrants decade of birth, 2011

Region	**Decade of birth**				
	1940s	1950s	1960s	1970s	1980s
Overall	5%	23%	33%	23%	14%
England	6%	23%	33%	24%	14%
Northern Ireland	4%	23%	34%	23%	15%
Scotland	4%	23%	37%	22%	14%
Wales	5%	25%	35%	23%	12%
Non-UK	6%	22%	29%	23%	20%
Midwives	4%	23%	36%	21%	15%
Nurses	5%	23%	33%	24%	14%
SCPHNs	8%	36%	39%	14%	3%

Source: http://www.nmc-uk.org/About-us/Equality-and-diversity/Analysis-of-diversity-data-2011/

(b) Disability

We have only been able to identify information regarding the disability profile of those working as doctors between 2005 – 2007. This data is contained in the BMA Equal Opportunities Committee report *Disability equality in the medical profession* (July 2007).

	Dec-05	Jan-06	Feb-06	Mar-06	Apr-06	May-06	Jun-06	Jul-06
Total surveyed	6,090	4,392	4,601	9,337	14,747	20,469	13,636	10,034
Disabled	16	22	36	59	71	128	109	112
Not disabled	6,058	4,367	4,560	9,266	14,647	20,317	13,515	9,905
Undisclosed	16	3	5	12	29	24	12	17
Total disclosed	6,074	4,389	4,596	9,325	14,718	20,445	13,624	10,017
% Disabled	0.26%	0.50%	0.78%	0.63%	0.48%	0.63%	0.80%	1.12%
% Not Disabled	99.47%	99.43%	99.11%	99.24%	99.32%	99.26%	99.11%	98.71%
% Undisclosed	0.26%	0.07%	0.11%	0.13%	0.20%	0.12%	0.09%	0.17%

	Aug-06	Sep-06	Oct-06	Nov-06	Dec-06	Jan-07	Feb-07
Total surveyed	6,329	12,220	20,406	16,582	13,125	12,311	4,958
Disabled	53	77	135	93	64	111	28
Not disabled	6,261	12,122	20,259	16,474	12,988	12,121	4,837
Undisclosed	15	21	12	17	73	79	95
Total disclosed	6,314	12,199	20,394	16,567	13,052	12,232	4,865
% Disabled	0.84%	0.63%	0.66%	0.56%	0.49%	0.90%	0.56%
% Not Disabled	98.93%	99.20%	99.28%	99.35%	98.96%	98.46%	97.56%
% Undisclosed	0.24%	0.17%	0.06%	0.10%	0.56%	0.64%	1.92%

However, information has been made available regarding the disability profile of healthcare professions working in Northern Ireland. The following table, obtained from the Belfast Health and Social Care Trust in January 2012, provides a breakdown of disability amongst health care professionals employed in that Trust:

Profession	**Disability – no**	**Disability – yes**	**Not disclosed**	**Total**
Doctor	1195	12	547	1754
Nurse	4373	86	1983	6442
Occupational Therapist	180	2	154	236
Optometrist	26	-	3	29
Pharmacist	93	-	3	29
Physiotherapist	264	4	68	336
Podiatrist	42	-	23	65
Radiographer	234	3	81	318
Speech and Language Therapist	100	1	28	129

The Northern Trust also provided information in relation to its workforce as at January 2012:

Profession	Disability - no	Disability - yes	Not Known	Total
Medical and Dental	66.5%	0.3%	33.2%	100%
Nursing and Midwifery	86%	1.3%	12.7%	100%
Occupational Therapist	88%	1%	11%	100%
Orthoptist	100%	0%	0%	100%
Pharmacist	89.4%	1.1%	9.6%	100.1%
Physiotherapist	82.1%	3.2%	14.7%	100%
Podiatrist	95.3%	0%	4.7%	100%
Radiographer	90.4%	2.4%	7.2%	100%
Speech and Language Therapist	88%	0.9%	11.1%	100%

Not all regulators publish data in relation to disability amongst their registrants. However, the General Chiropractic Council ("the GCC") collects data in relation to the disability and states that it has data for just over 76% of its registrants across the UK [See page 104 of Council papers, 8th August 2013]. In its Annual Report and Accounts 2011 (at page 40 – www.gcc-uk.org), the GCC states that internal audits and decisions of the Investigating Committee and Professional Conduct Committee have not identified any evidence of discrimination on the grounds of disability, although it is noted that numbers involved are too small to be statistically relevant.

The Nursing and Midwifery Council also publish data on disability as at July 2011. Based on data received from 286,190 out of 665,545 registrants [43%] the following obtains:

Table: NMC Registrants with/out a Disability,2011

	Yes	No
Overall	6%	94%
England	6%	94%
Northern Ireland	4%	96%
Scotland	5%	95%
Wales	6%	94%
Non-UK	12%	88%
Midwives	6%	94%
Nurses	6%	94%
SCPHNs	5%	95%

Source: http://www.nmc-uk.org/About-us/Equality-and-diversity/Analysis-of-diversity-data-2011/

(c) Gender reassignment

We have been unable to locate any direct statistical information on the numbers of health and social care professionals who have undergone or are in the process of undergoing gender reassignment. The Equality and Human Rights Commission in its report *A Review of Access to NHS Gender Reassignment Services (England only)* (2011) states that "there are no reliable figures available on the size of the trans population in the UK or in England. Nor is there any central data on how many people request or receive gender reassignment services in England."

An indicative figure of the number of individuals in the UK who have undergone or who are in the process of undergoing gender reassignment is suggested by research from the Gender Identity

Research and Education Society (GIRES). Their research states that 'Employers should expect about 1% of the workforce to experience and/or express their gender in ways that do not conform to the typical binary man/woman model….., 25 per 100,000 in the general population have already sought medical treatment'.[Legal protection and good practice for gender variant, transsexual and transgender people in the workplace. Guidelines for employers. July 2011 – http://www.gires.org.uk/TransitionAtWork.pdf]

We assume that this figure could be applied to health and social care professionals. On this basis the estimated number of registrants with this protected characteristic is about 1% of 1.45 million registrants, ie. 14,500 persons.

(d) Pregnancy and maternity

We have been unable to locate any direct statistical information on the number of pregnant health and social care professionals there are on an annual basis. However, Hospital Episode Statistics (www.hesonline.nhs.uk) provides maternity data. Using the figures for the year 2012 -13, there were 722,254 reported pregnancies in England alone. We can calculate the proportion of pregnancies in relation to the overall UK population of 63.7 million in mid-2012, as estimated by the ONS (0.0113).

(e) Race

The NHS Health and Social Care Workforce Census as at 30 September 2012 provides the following in relation to the race profiles of medical and dental staff employed in England within hospital and community health services:

	Ethnic Group Categories							
	White	**Black or Black British**	**Asian or Asian British**	**Mixed**	**Chinese**	**Any Other Ethnic Group**	**Not Stated**	**All Groups**
All Staff	59,324	3,663	28,294	2,528	2,350	3,857	7,226	107,242
Consultant (including Director of Public Health)	25,708	1,104	8,910	649	663	1,273	2,087	40,394
Associate Specialist	1,459	181	1,327	80	21	274	198	3,540
Specialty Doctor	2,325	325	2,647	158	51	390	462	6,358
Staff Grade	239	36	232	11	7	46	52	623
Registrar Group	19,532	1,507	11,555	1,122	1,103	1,418	3,167	39,404
Senior House Officer	530	91	519	39	25	59	96	1,359
Foundation Year 2	3,570	195	1,353	192	191	176	523	6,200
House Officer and Foundation Year 1	3,702	170	1,300	245	263	175	420	6,275
Other Doctors in Training	89	4	17	-	3	1	16	130
Hospital Practitioner/ Clinical Assistant	1,291	23	274	17	9	34	137	1,785
Other Staff	1,167	35	283	24	21	28	115	1,673

In addition, the Northern Ireland Health and Social Care Trusts collect information regarding the ethnic profile of their staff. The following table, obtained from the Belfast Health and Social Care Trust in

January 2012, provides a breakdown of the racial group to which health care professionals employed in that Trust belong:

Profession	White	Black African	Filipino	Indian	Other	Unknown	Total
Doctor	1246	13	-	68	92	335	1754
Nurse	5091	12	199	189	61	890	6442
Occupational Therapist	207	-	-	-	-	29	236
Optometrist	28	-	-	-	-	1	29
Pharmacist	122	-	-	-	2	5	129
Physiotherapist	299	-	-	-	4	33	336
Podiatrist	46	-	-	-	-	19	65
Radiographer	304	-	-	-	1	13	318
Speech and Language Therapist	111	-	-	-	-	18	129

Not all the regulators publish information in relation to the ethnicity of their registrants. However some information is available.

The General Chiropractic Council provides data on its 2,901 registrants as at July 2013 as follows:

Ethnicity Group	Asian	Black	Chinese	Mixed	Not Known	Other	White	Total
All registrants - number	73	23	7	31	698	31	2038	2901
All registrants - percentage	2.52%	0.79%	0.24%	1.07%	24.06	1.07%	70.25%	100.00%

The Nursing and Midwifery Council provide data in relation to the race profiles of registrants as at the end of July 2011. Based on data received from 286,190 out of 665,545 registrants [43%] the following obtains:

Table: NMC Registrants ethnicity profile, 2011

	White British	Other White	Asian	Black African	Black Caribbean	Other/Mixed
Overall	73%	11%	7%	5%	2%	2%
England	72%	9%	8%	7%	2%	2%
Northern Ireland	55%	39%	5%	0.40%	few	0.60%
Scotland	89%	6%	2%	1%	few	0.40%
Wales	84%	9%	5%	1%	0.30%	0.90%
Non-UK	36%	46%	9%	4%	2%	1%
Midwives	79%	11%	2%	4%	2%	1%
Nurses	72%	11%	8%	6%	2%	2%
SCPHNs	83%	9%	2%	3%	2%	0.70%

Source: http://www.nmc-uk.org/About-us/Equality-and-diversity/Analysis-of-diversity-data-2011/

Research has been commissioned by the General Medical Council to examine whether doctors who have qualified outside of the UK are more likely to experience onerous outcomes or high impact

decisions as a result of fitness to practise procedures. This research found that decisions reached at fitness to practise proceedings about doctors who qualified outside the UK are more likely to result in harsher sanctions than decisions reached about their UK-qualified counterparts. However, the research determined that it was not possible to reach a conclusion regarding the cause of the difference as there was insufficient evidence to determine whether real differences exist in fitness to practise between groups of doctors or whether the process tends to discriminate against certain groups of doctors. Further studies were carried out to investigate the meaning and significance of the findings. This further research identified challenges in four key areas: medical education and professional practice; the circumstances of doctors' working lives; their personal circumstances outside work; and the attitudes and behaviour of other people towards them. However, there was no direct evidence about whether or how such challenges might influence performance or fitness to practise. It has been considered by the General Medical Council that the lack of research directly investigating the relationship between ethnicity or place of qualification and possible performance problems means that there is no good basis as yet for drawing firm conclusions. (See General Medical Council "Fitness to Practise Factsheet 2010 "Ethnicity"" and www.gmc-uk.org).

The General Chiropractic Council collects data in relation to ethnicity providing data for just over 76% of its registrants across the UK. Council papers for 2013-2015 identify. In its Annual Report and Accounts 2011 (at page 37 – www.gcc-uk.org), the Council states that internal audits and decisions of the Investigating Committee and Professional Conduct Committee have not identified any evidence of discrimination on the grounds of ethnicity, although it is noted that numbers involved are too small to be statistically relevant.

(f) Religion or belief

The Nursing and Midwifery Council are one of the few regulators providing information on the numbers of health and social care professionals who identify themselves as [not]/having a religious faith. Based on data received from 286,190 out of 665,545 registrants [43%] as at July 2011 the following obtains:

Table: NMC Registrants religious belief, 2011

	Buddhist	Christian	Hindu	Jewish	Muslim	None	Other	Sikh
Overall	0.80%	75%	1.10%	0.20%	1.10%	18%	4%	0.30%
England	0.90%	75%	1.30%	0.20%	1.30%	5%	4%	0.30%
Northern Ireland	few	89%	few	few	few	5%	6%	few
Scotland	0.50%	70%	0.20%	few	0.30%	26%	3%	few
Wales	0.50%	74%	0.50%	few	0.30%	20%	4%	few
Non-UK	1.60%	77%	1.00%	few	1.30%	14%	4%	few
Midwives	0.80%	75%	0.50%	0.20%	1.10%	19%	3%	0.20%
Nurses	0.80%	75%	1.20%	0.20%	1.20%	18%	4%	0.30%
SCPHNs	0.70%	81%	0.30%	0.30%	0.50%	15%	3%	0.30%

Source: http://www.nmc-uk.org/About-us/Equality-and-diversity/Analysis-of-diversity-data-2011/

Data available from the Office for National Statistics provides the following table in the "Full story: What does the census tell us about religion in 2011? (2013):

Table: Largest religious ethnic groups, England and Wales, 2011

			('000 persons)
1	Christian	White British	28,739
2	No Religion	White British	12,624
3	Christian	Other White	1,618
4	Muslim	Pakistani	1,028
5	Christian	African	691
6	Hindu	Indian	622
7	No Religion	Other White	465
8	Christian	Caribbean	442
9	Christian	Irish	426
10	Muslim	Bangledeshi	402

It is not possible to extrapolate the above to estimate numbers in the health and social service profession because of considerable variation by religion in economic activity/inactivity.

Information has been made available regarding the religious beliefs of healthcare professionals working in Northern Ireland. The Health and Social Care Trusts collect information regarding the section 75 profile of their staff. The following table, obtained from the Belfast Health and Social Care Trust in January 2012, provides a breakdown of the religious affiliation of health care professionals employed in that Trust:

Profession	**Protestant**	**Catholic**	**Other or Not Known**	**Total**
Doctor	761	631	362	1754
Nurse	2843	3194	405	6442
Occupational Therapist	127	104	5	236
Optometrist	21	8	-	29
Pharmacist	45	80	4	129
Physiotherapist	193	131	12	336
Podiatrist	28	34	3	65
Radiographer	152	158	8	318
Speech and Language Therapist	60	62	7	129

The Northern Trust also provided statistics in relation to the religion of staff employed in that Trust area as of January 2012:

Profession	**Protestant**	**Catholic**	**Other or Not Known**	**Total**
Medical and dental	42%	30.6%	27.4%	100%
Nursing and Midwifery	48.8%	43.8%	7.4%	100%

Occupational Therapist	51.2%	44.5%	4.3%	100%
Orthoptist	50%	12.5%	37.5%	100%
Pharmacist	58.5%	34%	7.5%	100%
Physiotherapist	65.8%	25.8%	8.4%	100%
Podiatrist	60.9%	31.3%	7.8%	100%
Radiographer	64%	31.2%	4.8%	100%
Speech and Language Therapist	56.4%	37.6%	6%	100%

In the Southern Health and Social Care Trust, within the Medical and Dental, Nursing and Midwifery and Allied Health Professions, 1,659 staff are Protestant, 2,469 are Catholic and the religious belief of 332 staff is unknown.

(g) Sex

The NHS Health and Social Care Workforce Census of 30 September 2012 provides the following in relation to the gender profiles of medical and dental staff employed within hospital and community health services in England:

	All Staff	
	No.	**%**
Male Staff	59,542	56
Female Staff	47,700	44
All Staff	107,242	100

The Northern Ireland Health and Social Care Workforce Census of 31 March 2011 provides the following information in relation to the gender profile of the health care professions workforce in Northern Ireland:

Profession	**Male**	**Female**
Medical and Dental	2039	1877
Qualified Nursing and Midwifery	1064	14948
Dietician	-	228
Occupational Therapist	-	800
Orthoptist	-	34
Dietetic/Orthoptic/Speech and Language Therapist	11	-
Physiotherapist	126	875
Podiatrist	57	203
Radiographer	63	671
Speech and Language Therapist	-	421
Pharmacist	85	337
Clinical Psychologist	73	108
Dental and Dental Support	-	53
Optometrist	-	25

It appears that the regulators do not all publish data in relation to the gender profile of the registrants who face fitness to practise processes.

The General Medical Council does publish such data, although it is collected on a UK-wide basis. For example, in 2011, the General Medical Council Fitness to Practise Fact Sheet 2011 "Gender" provides a breakdown by gender of fitness outcomes. In relation to case examiner outcomes, 32.1% of decisions about female doctors resulted in no further action, about 42% resulted in closure with advice, 7.1% resulted in a warning and 10.5% in undertakings. The remaining 8.2% resulted in a referral to a Fitness to Practise Panel Hearing. This represents 0.04% of all female doctors currently registered. In relation to male doctors, 32.6% of case examiner decisions resulted in no further action, 37.3% resulted in closure with advice, 11.4% resulted in a warning and 6.9% in undertakings. The remaining 11.9% resulted in a referral to a Fitness to Practise Panel Hearing. This represents 0.12% of all male doctors currently registered. Fitness to Practise Panel Hearings in 2011 resulted in 70.3% of referred female doctors being found to be impaired and 77.6% of male doctors. Six female doctors and 59 male doctors were erased from the register in 2011. This represents 0.01% of all female doctors with current registration in that year and 0.04% of all male doctors.

The General Chiropractic Council collects data in relation to gender and states that it has data for all registrants across the UK. In its Annual Report and Accounts 2010 (at page 22 – www.gcc-uk.org), the Council states that internal audits and decisions of the Investigating Committee and Professional Conduct Committee have not identified any evidence of discrimination on the grounds of gender, although it is noted that numbers involved are too small to be statistically relevant.

The Nursing and Midwifery Council states in its Annual Fitness to Practise Report 2012-2013(see page 14 – www.nmc-uk.org) that the collection of data in relation to age, gender, religion, ethnicity, sexual orientation and disability was commenced in 2009. In 2012-2013, across the UK, 2,565 females were referred to the Nursing and Midwifery Council (77% of referrals) and 745 males (23% of referrals). Out of a total of 865 interim orders made in 2012-2013, 71% were in relation to females and 29% in relation to males. Out of a total of 165 cautions, conditions of practice or suspensions imposed, about 73% were made in relation to females and 27% in relation to males. Of the 585 registrants removed or struck off the register, about 67% were female and 33% were male.

The General Dental Council states in its Annual Report and Accounts 2012 that 22,271 male and 17,623 female dentists are registered across the UK (see page 16 – www.gdc-uk.org). Where dental care professionals are concerned, 6,009 males and 55,691 females are registered across the UK.

(h) Sexual orientation

We have been unable to locate any direct statistical information on the sexual orientation of health and social care professionals. We are aware that the Office for National Statistics collected information as part of its Integrated Household Survey in 2010. It found that more than 480,000 people consider themselves to be gay or lesbian and a further 245,000 people say that they are bisexual. However, the overall sample size was small.

The Nursing and Midwifery Council are one of the few regulators providing information on the sexual orientation of health and social care professionals. Based on data received from 286,190 out of 665,545 registrants [43%] as at July 2011 the following obtains:

Table: NMC Registrants sexual orientation, 2011

	Bisexual	Gay / lesbian	Heterosexual
Overall	1.50%	1.50%	97%
England	1.50%	1.50%	97%
Northern Ireland	1.90%	0.50%	98%
Scotland	1.10%	1.40%	98%
Wales	1.50%	1.20%	97%
Non-UK	1.70%	1.90%	96%
Midwives	0.80%	0.60%	99%
Nurses	1.60%	1.60%	97%
SCPHNs	0.50%	0.80%	99%

Source: http://www.nmc-uk.org/About-us/Equality-and-diversity/Analysis-of-diversity-data-2011/

In respect of Northern Ireland, the following table, obtained from the Belfast Health and Social Care Trust in January 2012, provides a breakdown of the sexual orientation of health care professionals employed in that Trust:

	Heterosexual	**Lesbian, gay, bisexual and transgender**	**Not disclosed**	**Total**
Doctor	780	16	958	1754
Nurse	2235	61	4146	6442
Occupational Therapist	101	2	133	236
Optometrist	17	-	12	29
Pharmacist	47	1	81	129
Physiotherapist	149	6	181	336
Podiatrist	20	-	45	65
Radiographer	125	3	190	318
Speech and Language Therapist	72	1	56	129

In the Southern Health and Social Care Trust, within the Medical and Dental, Nursing and Midwifery and Allied Health Professions, 1,580 staff are attracted to the opposite gender, 23 to the same gender, 1 is attracted to both genders and the sexual orientation of 2,856 staff is unknown.

(2) The Recommendations that may have an impact on those registrants with protected characteristics.

To identify the recommendations within the final report that may have an impact on those with protected characteristics we considered our recommendations *generally* and *specifically*.

In general terms, the overriding theme of the final report is that we are making recommendations to change the *structure* of the legal framework for the regulation of health and social care professionals. In the main, we are not recommending that certain decisions must be made by the regulators. This would continue to be a matter for the regulators to decide taking into account their individual circumstances and resources. Rather, we are seeking to reform the existing legal position in order to achieve our law reform objectives of simplicity, consistency, flexibility, accountability and efficiency. However, we accept that our recommendations will give the regulators additional powers and discretion to make regulatory

decisions, and that therefore the potential for decisions to be made which affect those with protected characteristics will increase.

Furthermore, we have proposed to give the regulators autonomy to create their own rules and to remove their dependence on the Privy Council (and through it the Department of Health). We have not made recommendations in relation to the content of these rules which would be a matter for the regulators to decide. However, arguably the scrutiny process currently undertaken by the Department of Health may help to ensure that the regulators are compliant with the Equality Act 2010. If this is correct, then the regulators will need to take additional care to ensure that they ensure compliance. Such further work might include further research and policy work in order to determine the numbers of registrants who have one or more of the protected characteristics, whether such people are affected disproportionately by the decisions taken by the regulator and the development of policies to promote equality of opportunity.

In addition, there are some specific recommendations that may have a direct impact on those with protected characteristics. We have identified the following:

(1) We have recommended the removal of the general requirement of "good health" in order for a practitioner to be registered. In our view, this requirement suggests some general state of health that is required for registration and obscures the primary issue for the regulators of whether these matters affect a professional's fitness to practise. Moreover, the Disability Rights Commission in its 2007 report *Maintaining Standards: Promoting Equality* (2007) provided evidence that such requirements can impact negatively on disabled people, often leading to unwillingness to disclose a disability which in turn reduces the availability of reasonable adjustments in law and individual support.

(2) The introduction of a single definition of a "vulnerable witness" across the regulators modelled on the Youth Justice and Criminal Evidence Act 1999. Where a person is classified as being a "vulnerable witness", special measures can be introduced to assist the giving of evidence. Most regulators' rules define who is a vulnerable witness by reference to whether the person has a mental disorder, impaired intelligence or physical disabilities, the allegations are of a sexual nature or the witness has been intimidated. Some regulators are required to treat any witness under 18 as being a vulnerable witness, whilst for others the age is under 17. At the General Chiropractic Council and General Osteopathic Council there are no express provisions for vulnerable witnesses. In our view, the statute should establish a central definition of a vulnerable witness. It is not acceptable that some regulators do not have any express provision for vulnerable witnesses. Furthermore some of the definitions we have reviewed are outdated and potentially discriminatory; for example some establish that all disabled people are automatically *vulnerable* and will require special arrangements. Our proposed definition would ensure that disabled people would receive support and assistance if the quality of their evidence is likely to be diminished without it.

(3) The regulators would have powers to specify in rules which qualifications would entitle EEA applicants to be registered and powers to determine the registration requirements for applicants beyond the EEA. At present, the provisions for overseas applicants are highly detailed and vary considerably between the regulators. We believe that these provisions should be provided at a level where such detail is more appropriate, such as in rules or regulations made by the regulators. Indeed, it is highly unlikely that the new statute could consolidate all these provisions effectively, whilst at the same time recognising the different aspects that apply to the various regulated professions. These recommendations represent changes in the structure of how applicants are registered, rather than setting any different substantive requirements. Accordingly, whilst we acknowledge the relevance of the protected characteristic of race, we do not envisage any impact.

5. Are there gaps in information that make it difficult or impossible to form an opinion on how your

and when do you plan to collect additional information?

Note this information will help you to identify potential equality stakeholders and specific issues that affect them - essential information if you are planning to consult as you can raise specific issues with particular groups as part of the consultation process. EIAs often pause at this stage while additional information is obtained.

As indicated above, there are gaps in the information available to us in relation to the numbers of people within the protected characteristics of gender reassignment, pregnancy and maternity, and sexual orientation. In relation to the protected characteristics of age, disability, race, religion or belief and sex we only have partial information.

However, we do not consider that these gaps make it impossible to form an opinion on the equality impacts of our recommendations. As we conclude at the end of this screening assessment, it is our view that our recommendations do not suggest any adverse equality impact.

6. Having analysed the initial and additional sources of information including feedback from consultation, is there any evidence that the proposed changes will have a <u>positive impact</u> on any of these different groups of people and/or promote equality of opportunity?

Please provide details of who benefits from the positive impacts and the evidence and analysis used to identify them.

In our view, two of our recommendations will have a positive impact on groups with a protected characteristic.

(1) The removal of the requirement that "good health" is a pre-requisite to registration would we believe have a positive impact on disability equality. As noted above, this requirement suggests some general state of health that is required for registration and obscures the primary issue for the regulators of whether these matters affect a professional's fitness to practise. Moreover, the Disability Rights Commission in its 2007 report *Maintaining Standards: Promoting Equality* (2007) provided evidence that such requirements can impact negatively on disabled people, often leading to unwillingness to disclose a disability which in turn reduces the availability of reasonable adjustments in law and individual support.

Our recommendations will have a positive impact for disabled people since registration could only lawfully be refused in cases where the applicant's fitness to practise is impaired, and not on the basis of a general requirement of good health.

(2) A consistent definition of a "vulnerable witness" modelled on the Youth Justice and Criminal Evidence Act 1999 would we believe have a positive impact on disability equality. As noted above, the current position is not acceptable, whereby some regulators do not have any express provision for vulnerable witnesses. Furthermore some of the definitions we have reviewed are outdated and potentially discriminatory; for example some establish that all disabled people are automatically assumed to be *vulnerable*. Our recommendation is that the statute should provide that a witness is eligible for assistance if under 17 at the time of the hearing or if the Fitness to Practise Panel considers that the quality of evidence given by the witness is likely to be diminished as a result of mental disorder, significant impairment of intelligence and social functioning, physical disability or physical disorder. We think that this reform will discourage an attitude that disabled people are less capable than anyone else in society of giving evidence, while also ensuring that assistance is provided where there is a need to provide it.

This recommendation will we believe have a positive impact on equality of opportunity for young people who will be eligible for assistance since it will offer young witnesses valuable protection whilst giving evidence before such a fitness to practise hearing.

7. Is there any feedback or evidence that additional work could be done to promote equality of opportunity?

If the answer is yes, please provide details of whether or not you plan to undertake this work. If not, please say why.

During the consultation process we worked with stakeholders – including the Department of Health and the devolved governments/executives – to identify if additional work is needed in order to promote equality of opportunity and if so what work is needed.

8. Is there any evidence that proposed changes will have an <u>adverse equality impact</u> on any of these different groups of people?

Please provide details of who the proposals affect, what the adverse impacts are and the evidence and analysis used to identify them.

As stated above, the majority of our recommendations sought to change the structure of professional regulation, rather than requiring a certain course of action by the regulators. However, we accept that our recommendations will give the regulators additional powers and discretion to make regulatory decisions, and that therefore the potential for decisions to be made which affect those with protected characteristics will increase.

Furthermore, there is a risk of an adverse equality impact because under our recommended scheme the regulators would be given greater powers to create their own rules without direct oversight and scrutiny from the Department of Health. This may lead to a greater risk that such rules are not created in compliance with section 149 of the Equality Act 2010. However, to some extent this risk may be offset by our proposed duty to consult when a regulator is considering making rule changes minimises such risk. Furthermore, all of the regulators have developed Equality and Diversity Schemes to guide their decision-making on equality issues. Accordingly, our provisional view is that the risk described is minimal.

9. Is there any evidence that the proposed changes have <u>no equality impacts</u>?

Please provide details of the evidence and analysis used to reach the conclusion that the proposed changes have no impact on any of these different groups of people.

We highlighted above one recommendation that has relevance to the protected characteristics as follows:

The regulators would have powers to specify in rules which qualifications would entitle applicants (including EEA applicants to be registered and powers to determine the registration requirements for applicants beyond the EEA. At present, the provisions for overseas applicants are highly detailed and vary considerably between the regulators.

This recommendation represents a change in the structure of how applicants are registered, rather than setting any different substantive requirements. Accordingly, whilst we acknowledge the relevance of the protected characteristic of race, we do not envisage any change in impact.

10. **Is a full Equality Impact Assessment Required?** Yes ☐ No ✓

If you answered 'No', please explain below why not?

We do not consider that a full Equality Impact Assessment was required. We have assessed the size and nature of the health and social care professions and we have assessed our recommendations in relation to them. We were able to identify two recommendations that might have positive equality benefits, and one recommendation that is likely to have no equality impact. As for the remaining recommendations, whilst most can be described as structural or technical, we acknowledge that the potential for decisions to be made

which affect individuals with a protected characteristic will increase.

We have engaged with relevant stakeholders and this informs our consideration of the equality impacts, or otherwise, of our recommendations. The Law Commission complies with the Government's Code of Practice on Consultation.

11. Even if a full EIA is not required, you are legally required to monitor and review the proposed changes after implementation to check they work as planned and to screen for unexpected equality impacts. Please provide details of how you will monitor evaluate or review your proposals and when the review will take place.

The Law Commission is not responsible for monitoring the effect of recommendations that are implemented as a result of the final report, which we intend to publish in 2014. This role is the responsibility of the implementing Department and the devolved governments/executives.

12. Name of Senior Manager and date approved

Name: Richard Percival
Department: Law Commission
Date: 2 April 2014