EQIA of the NMC's response to Covid-19

Version 5, covering 31 October 2020 – 31 March 2021

Introduction

Covid-19 has exposed and exacerbated unacceptable and deep-seated inequalities experienced by people from various backgrounds, including ethnic minorities, disabled people, and older people.

Our vision is safe, effective and kind nursing and midwifery that improves everyone's health and wellbeing. As the professional regulator of more than 700,000 nursing and midwifery professionals, we have an important role to play in making this a reality. The work we do to ensure our processes are fair and inclusive and to be vigilant about discrimination and health inequalities in the sector underpins our vision.

We use equality impact assessments (EqIAs) as a tool to demonstrate our work complies with equalities legislation and to explore our data and insight on equality issues. It helps us to understand the impact of our activities on different groups of people and any action we need to take as a result. This EqIA reflects our work responding to Covid-19 across all our regulatory functions, including temporary registration, emergency standards, fitness to practise, registration and registration appeals processes, revalidation, communications and intelligence.

We regularly update this EqIA – this fifth version covers the period between 31 October 2020 and 31 March 2021. Previous versions of this document were published in July 2020, September 2020 and January 2021.

The purpose of this document

This EqIA enables us to:

- Monitor and report on the diversity of those with temporary registration, now and to inform future research and evidence
- Ensure our emergency education programme standards do not exacerbate inequalities
- Ensure our use of the emergency rules relating to our fitness to practise and registration appeals processes are fair, free from bias and do not disadvantage anyone involved
- Review our provision of clear guidance about inequality issues for people who use health and care services and how the Code can support the practice of professionals when working in emergency situations
- Highlight key equality issues and communicate support for the professionals on our register (for example, on matters such as access to personal protective equipment (PPE) and the need for mental health support).

Key activity since the publication of the previous version

This latest version of our EqIA marks over a year since we introduced temporary registration in March 2020 and began monitoring the equality impact of our Covid-19 response work. While we haven't identified or received concerns about potential discrimination in our amended processes during this time, we remain mindful and concerned about the long-term impact of the pandemic and the potential for widening disparities across the sector for both professionals and those accessing care. We monitor feedback carefully, and we have not identified any concerns which have been raised about people with temporary registration relating to discrimination.

This EqIA covers 31 October and 31 March 2021, during which time many of the professionals on our register were working in challenging circumstances amid a significant second wave of infections. In response our temporary register was extended and expanded to support the winter pressures and vaccine rollout, emergency education standards were reintroduced to enable final year nursing students to opt-in to extended clinical placements, and a new recovery standard was introduced to extend the time students can learn in simulated environments where conventional clinical practice isn't possible.

Noteworthy activity undertaken in this period to meet our equality commitments includes:

- a further analysis of those with Covid-19 temporary registration, which found that people with temporary registration were significantly more likely to be older, slightly less likely to be an ethnic minority, slightly more likely to be disabled and slightly more likely to have a religion than those with permanent registration

- a review of the diversity of the professionals accessing our revalidation support measures, which were slightly more likely to be used by people who were older and/or disabled

- ongoing work to review the use of emergency powers, including a diversity analysis of people responding to our public consultation (more on page 12) and proposals for taking these forward in a fair way while mitigating any negative impact

- a further review of our data on mortality rates relating to the professionals on our register who have sadly lost their lives in service. Although small numbers, our latest data shows of the individuals where data was available, 57 per cent identified as Black, Asian or another ethnic minority – almost three times as high as the percentage of those on the register as a whole (22 per cent), while 42 per cent were men, compared to 11 per cent of those on the register as a whole

- an analysis of the professionals with temporary registration who have been deployed - a higher proportion of people who are over 60, women, not disabled, Christian, of a White British ethnicity, whose gender identity matches their sex assigned at birth or with no caring responsibilities have been deployed

- the publication of Managing Concerns, a new resource to support employers to take effective action when concerns are raised about someone's practise including ensuring decisions are fair, proportionate and unbiased

- sharing resources on how the Code supports equality in practice, for example our Caring with Confidence animations, covering topics such as encouraging professionals to feel confident challenging discrimination and providing person-centred care

- reiterating our support in a joint letter with all four UK Chief Nursing Officers for professionals working in difficult and potentially new environments, drawing attention to the profound and potentially prolonged impact on those professionals

- highlighting the experiences of diverse professionals working in the pandemic though our Reflections on a traumatic year case studies online, including Dr Gloria Rowland's work capturing the challenges of professionals working in maternity services from a Black, Asian or ethnic minority background.

Sharing vital learning

We use our own data as well as external evidence to develop this EqIA and action plan, including information gained from engaging with employers, education institutions, unions, professionals on our register and the public.

Over the last year we have committed to sharing our data and insight with partners in order to collectively examine the impact on different groups, including sharing anonymised diversity data with Public Health England. We have also shared data with UK REACH, a national research study investigating if, how, and why ethnicity affects Covid-19 clinical outcomes for people working in health and social care. In December 2020 we wrote to a sample of half a million nurses and midwives to invite them to take part in the study, which aims to help protect professionals during the pandemic.

In December we also responded to the Scottish Parliament Equalities and Human Rights Committee's inquiry into the impact of the pandemic on equalities and human rights, where we shared our data and insight into the experiences of professionals working in Scotland. This included the stark overrepresentation of Black, Asian and mixed ethnicity professionals in roles with the highest risk of exposure to Covid-19, such as agency and care home roles.

We have highlighted EDI issues at various stages of the pandemic, including publically calling for better access to PPE and better risk assessments for nursing and midwifery professionals. We also welcomed and contributed to the relevant reports and research on why Covid-19 has had a disproportionately negative impact on some communities, including those from an ethnic minority background.

In this period we have responded to key reports and concerns being raised from partners across the sector, for example the Royal College of Midwives' calls for greater support to be given to women with severe and multiple disadvantage during pregnancy, and the Care Quality Commission's report on DNACPR decisions during Covid-19. In addition we raised stakeholders' concerns about issues facing patients seeking care from gender identity services during the pandemic in our response to the Women and Equalities inquiry into reform of the Gender Recognition Act in November.

We are particularly mindful of the ongoing mental health impact on the professionals working during the pandemic. Several reports and studies have raised worrying concerns, including a recent Nursing Times survey which found almost two-thirds of nurses feel their mental health has deteriorated since last Spring, and 44 per cent of nurses described their mental health and wellbeing as 'bad' or 'very bad'. We are committed to ensuring that our processes are clear, proportionate and fair, to minimise any further negative impact on the wellbeing of those on our register. Throughout the pandemic we have signposted professionals to mental health support services, including our Careline for professionals going through the fitness to practise process.

We want to continue to hear from people to help us develop future versions of this EqIA. We invite comment on the work we have done so far with the aim of improving our own processes and adding value in the wider health and care environment. We would like to know your views on these questions:

- Have we missed anything that is in our role to act on or use to influence across the sector?

- Going forwards, are there any particular topics of concern or opportunities that we should focus on?

Please respond with your answers to these two questions, or any other feedback you have, with 'COVID EQIA' in the subject line to Equality@nmc-uk.org, which is monitored by our Equality, Diversity and Inclusion team.

Equality impact assessment for the response to the Covid-19 emergency

We'll update this equality impact assessment (EqIA) in light of the fast-changing context and as we receive more information of the changing healthcare environment.

Version and date completed	Version 5 31 March 2021
Interdependencies	NMC Covid-19 communications hub NMC guidance during the Covid-19 emergency period Covid-19 emergency temporary registration policy Covid-19 temporary registration removal guidance Emergency and recovery standards for nursing and midwifery education
Name and title of person completing this assessment	Emma Lawrence Regulatory Equality, Diversity and Inclusion Manager
Senior sponsor	Francesca Okosi, Executive Director of People and Organisational Effectiveness
Review date	31 September 2021 (to update to version 6 and inform the senior sponsor of any significant changes to the actions)

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Section 1: Background

1 Better and safer care for people is at the heart of what we do, supporting the health and social care professionals on our register to deliver the highest standards of care. Any action we take in an emergency will seek to balance the need to support the health and social care workforce with the importance of minimising risks to the public.

2 We are subject to the Equality Act 2010 and the Human Rights Act 1998.[1] The public sector equality duty (PSED), which is outlined in Section 149(1) of the Equality Act, states that we must have due regard for eliminating discrimination, advancing equality of opportunity and fostering good relations. This applies to both our own activities and wider where we have influence to tackle prejudice and promote understanding (Ref 1 in action plan).

3 The aim of our actions has been:

3.1 to support the national effort to increase the size of the health and social care workforce available to tackle Covid-19 by:

3.1.1 identifying groups of fit, proper and suitably experienced people who can be granted temporary registration as nursing and midwifery professionals during the period of the Covid-19 emergency

3.1.2 developing emergency and recovery programme standards that give approved education institutions (AEIs) the flexibility to support students to continue their learning and support the workforce by ensuring clear learning pathways and practice placements

3.1.3 encouraging those with permanent registration not in clinical placements to take up a role in a clinical setting during the emergency

3.1.4 adapting our operational processes to be compliant with government guidelines, for example suspending objective structured clinical examinations (OSCEs) when required and holding fitness to practise (FtP) and registration appeals hearings virtually

3.1.5 monitoring possible disadvantage professionals may be facing and ensuring our processes don't exacerbate unnecessary barriers or inequality

3.2 to support efforts to better understand the impact of Covid-19 on certain groups of people, linked to their protected characteristics, by:

[1] The Equality Act 2010 and similar legislation in Northern Ireland. Our work also engages some articles of the European Convention of Human Rights e.g. Right to life (Article 2) with Freedom from discrimination (Article 14).

3.2.1 understanding the diversity of the professionals with temporary registration

3.2.2 sharing any intelligence/data we hold about all our registrants with appropriate partners across the health and care system.

4 Our purpose as an organisation is to promote and uphold the highest professional standards in nursing and midwifery to protect the public and inspire confidence in the professions. There are three key roles that support this purpose: regulate, support and influence. This EqIA and the actions identified as a result are key tools to enable us to carry out all three of these roles.

5 We know already that Covid-19 has a disproportionate impact on certain groups of people linked to their protected characteristics, and that healthcare workers are particularly vulnerable, in particular ethnic minority healthcare workers, both due to their ethnicity and the disproportionately higher risk of their deployment on the frontline.

6 This EqIA enables us to regulate effectively by ensuring that our processes are fair and in so doing complies with equalities and human rights legislation. We are able to support by providing information and assurance, and we continue to influence by reviewing and sharing what our data is telling us about the experiences and outcomes of different people and groups.

7 The NMC's response to the Covid-19 emergency has included action in the following areas:

7.1 temporary registration

7.2 emergency and recovery standards for nursing and midwifery education

7.3 communications and support

7.4 registration and registration appeals

7.5 retention

7.6 revalidation

7.7 fitness to practise

7.8 overseas registration

Covid-19 temporary registration

8 The temporary registration policy outlines our emergency registration powers and sets out our approach to identifying persons or specified groups of persons who are, or may reasonably be considered to be, suitable to be temporarily registered during this Covid-19 emergency. We publish the names of individuals with temporary registration and we have also published an analysis of the diversity of the professionals with temporary registration. As of 31 March 2021, we held diversity data for 53 per cent of people with temporary registration.

9 The actions we took to understand the diversity of the professionals with temporary registration enable us to:

9.1 comply with legislation, which is essential for our regulatory functions and makes us compliant with equalities and human rights legislation[2]

9.2 demonstrate fairness in our processes and understand the identities of the people with temporary registration and how they are impacted by our work. Collecting this data enables us to know whether we are being fair and not discriminating against any particular group, for example being able to analyse the protected characteristics of those referred and removed

9.3 meet public interest in the diversity data of professionals involved in the Covid-19 crisis

9.4 monitor actual or potential disproportionate outcomes of Covid-19 for people with certain protected characteristics, supporting the evidence base in the health and social care sector.

Emergency and Recovery standards for nursing and midwifery education

10 We have put in place additional systems to support students undertaking NMC-approved programmes. This included initially introducing emergency programme standards in 2020 that enabled second and final year students to support the workforce as part of their studies. They also allowed first year students to complete their first year in theoretical learning. These Emergency standards for nursing and midwifery were intended to be facilitative and not directive and these standards did not require AEIs or individual students to change their current programmes.

11 On 30 September 2020 these emergency standards were replaced with a set of recovery programme standards. These standards were designed to take account of individual student's needs, for example risk assessments that take account of the ethnicity of students as a potential risk factor.

12 In response to a request from the Secretary of State for Health and Social Care we subsequently introduced further emergency standards that enabled final year nursing students to undertake extended placements as part of their programmes, and again allows first year students to complete their year in theoretical learning. These standards were facilitative and wherever possible we expect our normal standards to be followed. The emergency standard enabling final year nursing students to undertake extended placements was removed on 19 May 2021, and the emergency standard allowing first year students to complete their first year in theoretical learning will be removed 30 September 2021.

[2] In the Equality Act 2010 and similar legislation in Northern Ireland. Our work also engages some articles of the European Convention of Human Rights for example, Right to life (Article 2) with Freedom from discrimination (Article 14).

13 As part of our arrangements we acknowledged that some students who are shielding or self-isolating may have to interrupt or extend their studies to complete their programmes. AEIs would need to follow their local policies, and as part of our quality assurance activity during the pandemic we continued to work with AEIs to ensure students were appropriately supported and not disadvantaged during their studies and that our standards continue to be met. To help support students we increased the amount of simulation that could be counted as part of their programmes by up to 300 hours. This was designed to help enable students to meet our standards through different modes of learning and complete their programme when expected.

Communications and support

14 We aim to provide information in accessible formats and support our registrants and stakeholders to maintain public protection without discrimination and in line with human rights principles. We have adapted our communications to include advice and information about our regulatory approach during the pandemic, including issuing joint statements with other regulators and nursing and midwifery leaders and creating a Covid-19 hub with targeted information for registrants, students, educators, employers and stakeholders.

15 In October we launched a new EDI web hub, so that people can find information and updates about our equality work easily. During the pandemic we have shared statements on personal protective equipment, do not attempt CPR forms and the disproportionate impact of Covid-19 on people from Black, Asian and minority ethnic backgrounds. We also published the latest in a series of our Caring with Confidence: The Code in Action animations, this time on the importance of inclusion and supporting professionals to feel confident challenging discrimination wherever they see it.

16 In January 2021 we included reflections on the impact of the pandemic and our updated processes on ethnic minority professionals in our statement on expanding the temporary register to overseas-trained nurses, reiterating that we expect to see partners using risk assessments where appropriate. It was also reiterated in our letters to employers. In March 2021 we highlighted the experiences of diverse professionals working in the pandemic though our Reflections on a traumatic year case studies online, including Dr Gloria Rowland's work capturing the challenges of professionals working in maternity services from a Black, Asian or ethnic minority background.

Registration and registration appeals

17 We continue to work as normal with UK applications to join and re-join the register. All registration colleagues are working from home, and any changes to our processes to accommodate the move to remote working have settled well.

18 Registration appeals, which were previously on hold, have restarted. We are holding appeals virtually under our emergency powers in response to the coronavirus guidance.

Overseas registration

19 The UK health and social care system relies on the care of professionals from other countries. We aim to do everything we can to support overseas candidates with their registration for UK practice. We continued to process applications from overseas applicants wishing to join our register. Due to advice from the UK Government, all OSCE tests were suspended from 23 March. All three OSCE test centres in the UK reopened on Monday 20 July 2020.

20 We have received concerns regarding professionals with temporary registration being required to pass the objective structured clinical examination (OSCE) in order to obtain permanent registration. Passing the OSCE is an important part of ensuring that those joining our permanent register meet our standards and can practise without the conditions or supervision that were necessary for temporary registration, and an important safeguard for those professionals themselves as well as the public. Initial reports indicate that those who worked with temporary registration appeared to be better prepared for the test and achieved slightly better pass rates.

21 We recognise that many of the candidates are from BAME backgrounds and how important it is that people feel safe and supported when taking their test. This has been a key consideration in all our decision-making, and our test centre partners have worked hard to carry out rigorous Covid-19 risk assessments and to ensure that testing has resumed in a safe, socially distanced way.

22 . Prior to the pandemic we were piloting running the computer based test (the CBT) online. This enables candidates to take the test at home rather than at a test centre. While we update our systems to move beyond the pilot we are allowing candidates to sit the online test if they're struggling to attend a test centre due to Covid-19 or local restrictions and lockdowns.

23 We previously published our analysis of those with Covid-19 temporary registration, which found that overseas qualified professionals included more people from Asian or Black ethnic groups and more people under 40, while returning professionals were older and mainly white, with more people declaring a disability.

Retention payments

24 We gave people who failed to pay their retention fee on time between March and May 2020 a blanket six-week extension. We considered any requests for further time for payment beyond six weeks were considered on an individual basis in line with our existing hardship processes. These changes were made to help support registrants during the emergency by offering them flexibility.

25 We have monitored the diversity of people applying for hardship support, but the numbers of professionals applying are so low that it is not appropriate or meaningful to share these data.

Revalidation

26 We gave people who were due to revalidate between March and June 2020 a blanket extension of 12 weeks, and from July to October 2020 people were able to opt in to a 12-week extension. In light of the worsening pandemic, we have once again applied a blanket 12-week extension to everyone due to revalidate from November 2020 to March 2021 (initially by way of 'opt in' for those due to revalidate from November to December 2020). These professionals may also be granted a second 12-week extension if their ability to revalidate continues to be affected by Covid-19, and if their request is supported by their confirmer. These extensions were designed to give our registrants enough time to meet the requirements and submit their applications.

27 We plan to allow people due to revalidate from April 2021 onwards an 8 week extension if they have a good reason for not being able to complete their application on time, but we will continue to review the support we offer those due to revalidate later in the year as the Covid-19 pandemic evolves.

28 We have monitored extension take-up by protected characteristic to ascertain if there was a disproportionate impact on any group. We found that the diversity of those who have been granted an extension since March 2020 is very similar to those who haven't had an extension; however, they tend to be slightly older and more likely to say they have a disability (5 per cent of those who have been granted an extension compared to 3 per cent who haven't). Slightly fewer were female – 87 per cent of those granted an extension were women, compared to 90 per cent without an extension.

Fitness to practise

29 We aim to maintain our fitness to practise processes for the purpose of public protection. We are mindful of the effect on referrers and registrants of extended delays to cases as well as the impact of our inquiries on individuals and employers – therefore we're working to minimise the impact and comply with equalities and human rights legislation. Further details about the current and proposed changes to our FtP processes can be read here, including holding virtual hearings. We have been working on a separate equality analysis on the topic of public access for virtual hearings to ensure that any decisions we make are compliant with equality legislation and best practice.

30 We launched a public consultation on the ongoing use of our emergency powers, including public access for virtual hearings. The consultation closed on 15 January 2021, with a number of respondents highlighting a number of benefits to the new rules, including saving time and costs by holding hearings virtually –qualitative research showed this was considered a benefit by some people with learning disabilities and autism, for example.

31 We commissioned an analysis of the responses to the consultation which did find differences in people's views. For example, 43 per cent of men thought there were reasons the NMC should not continue to hold hearings virtually once the emergency period ends compared to 19 per cent of women, and 38 per cent of disabled people thought there were reasons the NMC should not continue to hold

hearings virtually once the emergency period ends compared to 24 per cent of people who weren't disabled. While some carers welcomed virtual hearings, people from the Gypsy Roma Traveller communities felt access to the internet and literacy issues would mean virtual hearings could cause a disadvantage.

32 Some of those responding to the consultation said that there may be circumstances where we should not hold hearings virtually, however very few people appeared to hold the view that we should never hold hearings virtually. When deciding whether a hearing will be held virtually or with some or all parties attending a hearings centre, we will consider the non-exhaustive list of factors as set out in our guidance during the Covid-19 emergency period; this allows us flexibility in our approach depending on the needs of parties and the nature of the case.

33 We will ensure that a professional has access and is able to use technology before we will list a hearing virtually and that we will consider any barriers, such as a disability, which may prevent them from engaging effectively. Where there are barriers we will work with people to overcome these, but where we cannot overcome these we will list the hearing as a physical hearing. The view of the professional is one of the factors we will consider and, where they are unhappy with the decision that a hearing will be held virtually, the decision on how the hearing is held can go before a chair or the panel to decide. We will only hold a hearing virtually where it is fair and practical to do so and our processes allow us the flexibility to make sure that any potential negative impacts are dealt with and that barriers are removed so that no group is disadvantaged.

34 The legal review of our guidance during the Covid-19 emergency period raised no concerns regarding our approach and concluded that, as we can consider protected characteristics in deciding whether a hearing should be held virtually, it did not constitute a 'provision, criterion or practice' which puts any protected category of professionals or witnesses at a particular disadvantage compared with persons who do not share those protected characteristics. There are anticipated benefits to people with certain protected characteristics in hearings being held virtually. We want to be able to respond to this need and we feel our flexible approach allows for this whilst offering protection for those for whom a virtual hearing would not be appropriate.

35 Last year, as part of improving the way we handle concerns, we began taking steps to address an increase in our fitness to practise caseload. But the coronavirus pandemic meant that we had to pause some cases and prioritise others to allow professionals to focus on Covid-19. That meant that our caseload increased further. We're making changes to reduce the caseload quickly and fairly, creating long-lasting improvements to the way we regulate. As we address the backlog in our caseload we will continue to keep the fairness and effectiveness of our virtual hearings under review and we are committed to a full review of virtual hearings at the end of the emergency period. We consider the use of virtual hearings an important element of our recovery planning which can support the timely imposition of interim orders where there is a risk to the public. It is also a valuable option for panels making decisions at the end of the process.

36 Our caseload recovery efforts are aimed at resolving our backlog as quickly as possible. However, we know that individuals from different groups are disproportionately represented in the referrals we receive, and part of our recovery work includes ensuring that referrals which do not require regulatory intervention do not progress any further through the process than necessary. We will monitor the impact of our caseload recovery work and seek to mitigate any disproportionate impact on an ongoing basis.

37 We have extended the service of our fitness to practise Careline, the year-long pilot of which was due to finish in October 2020. The success of the pilot means the specialist counsellors will continue to be able to give emotional support and practical help and advice to all nurses, midwives and nursing associates during the fitness to practise process.

38 Between 1 March 2020 and 28 February 2021 the Careline received 446 contacts from professionals seeking support for various professional and personal issues. This included discussions about health, bereavement, sleep disruption and anxiety. We ask the people accessing this service for their diversity information however we receive low numbers in many categories, which makes analysing this data difficult. We have the highest number of complete data for gender – our data suggests that almost 79 per cent of the contacts were from women, compared to around 21 per cent of men.

In April 2021 we analysed the diversity of the professionals who had been referred to our fitness to practise function relating to Covid-19. These referrals made up 12 per cent of the overall referrals received by us in the last year. The numbers of individuals are low and we are cautious about drawing conclusions from this data, however our current figures indicate some differences, for example higher numbers of Black professionals and male professionals being referred compared to their proportion on the overall register.

Section 2: Evidence

Research and reports	See references, links and footnotes in the document. *Covid-19 Insights from external research and data*; updated 15 April 2020; Caroline Kenny, Head of Research and Evidence (Trim: 6828329) Public Health England's Disparities in the risk and outcomes of COVID-19, published 2 June 2020. The report confirms that the impact of Covid-19 has replicated existing health inequalities and, in some cases, has increased them. The Race Disparity Unit commissioned an additional analysis, which further confirmed that specific ethnic minority groups (Asian and Black) had poorer survival following diagnosis with COVID-19 even when accounting for age, sex, deprivation, region, testing pillar, time since start of the epidemic and pre-existing health conditions[3]. Public Health England's Beyond the data: Understanding the impact of COVID-19 on BAME groups, published 16 June 2020. Coronavirus and the social impacts of disabled people in Great Britain**:** The ONS has published findings based on indicators from the Opinions and Lifestyle Survey, in addition to insight from qualitative research commissioned by the Cabinet Office Disability Unit, including that 25 per cent of disabled people who were receiving medical care before Covid-19 currently receiving treatment for only some of their conditions[4]. New data released by the ONS shows disabled women under 65 are over 11 times more likely to die than non-disabled women, while disabled men aged under 65 with limiting disabilities are 6.5 times more likely to die, and a third of all lives lost to Coronavirus in the UK have been those of disabled people[5]. Runnymede Trust released 'Over-Exposed and Under-

[3] Public Health England and Race Disparity Unit; COVID-19: pre-existing health conditions and ethnicity; 18 December 2020.
[4] ONS; *Coronavirus and the social impacts of disabled people in Great Britain;* 20 August 2020
[5] ONS: *Coronavirus (COVID-19) related deaths by disability status, England and Wales: 2 March to 15 May 2020*; 19 June 2020

	Protected', which found BME people face greater barriers in shielding from Covid-19 as a result of the types of employment they hold (i.e. key worker roles); having to use public transport more; living in overcrowded and multigenerational households; and not being given appropriate PPE at work. 50 per cent of Bangladeshi, 42 per cent of Pakistani and 41 per cent of Black African key worker respondents reported that they had not been given adequate PPE.[6] Mind's survey of adults in England and Wales revealed existing inequalities in housing, employment, finances and other issues have had a greater impact on the mental health of people from BAME groups than white people during the pandemic. For example, employment worries have negatively affected the mental health of 61 per cent of people from BAME backgrounds, compared to 51 per cent of white people. Other issues saw a similar pattern, including getting support for a physical health problem (39 per cent vs 29 per cent) and being a carer (30 per cent vs 23 percent).[7] Inclusion London's Abandoned, forgotten and ignored report found that disabled people, and people in high-risk groups have been unable to obtain PPE and had care packages cut and assessments delayed. Some disabled people had been asked to sign DNR notices, while many more feared they would be denied access to treatment if they contracted Covid-19.[8] EDI organisations have produced reports as summarised in *EDI Stakeholder responses to Covid-19*. (Trim: 6828971)
Data	**Revalidation and retention** Our diversity data is taken from the register. Our Year four revalidation tables show that the revalidation rates of people on our register with permanent registration vary slightly between some people who share protected characteristics. Also that there are differences by protected characteristic in setting and scope of practice, for example people employed via an agency are more likely to be from ethnic minority backgrounds. **Temporary registration** EDI data about people with Covid-19 temporary registration is taken from different sources. This includes data we have

[6] Runnymede Trust; *Over-exposed and under-protected: The Devastating Impact of COVID-19 on Black and Minority Ethnic Communities in Great Britain*; August 2020
[7] Mind; *Online survey of mental health*; July 2020
[8] Inclusion London; *Abandoned, forgotten and ignored; the impact of the coronavirus on disabled people*; June 2020

	collected from an EDI survey that is sent to everyone with temporary registration and where this is not available, data we have on our systems. A summary of the analysis of this data show us that: • There were fewer people from overseas with temporary registration on 31 March 2021 (5.6 per cent) compared to in July 2020 (18.2 per cent). This has had an impact on the demographic breakdowns of the temporary register, particularly around age and ethnicity, as described below. • Compared to those with permanent registration, overall we have less complete diversity data for people with temporary registration. Even when supplementing the survey data with the information we hold on our systems, there are around 25 per cent of overseas applicants for whom we do not know their diversity characteristics. • People with temporary registration are older than those with permanent registration. As of 31 March 2021, over three quarters of people with temporary registration were aged 50 and over, compared to just over a third of people with permanent registration being aged 51 and over. • Compared to people with permanent registration, there is a lower proportion of women with temporary registration. There is also a slightly lower proportion of men with temporary registration. These differences are due at least in part to the higher proportion of people with temporary registration whose gender is unknown. • Compared to July 2020, the people with temporary registration on 31 March 2021 were less ethnically diverse. They were also less ethnically diverse than those with permanent registration on the same date. Over three quarters of those with temporary registration (78 per cent) are White British, compared to around two thirds (67.7 per cent) of people with permanent registration. Only 1.8 per cent of people with temporary registration are Black African, compared to 7.3 per cent with permanent registration. The proportions of Asian Filipino, Asian Indian and White other people with temporary registration are also smaller than those with permanent registration. There is a slightly higher proportion of people with temporary registration (4.9 per cent) who are disabled compared to those with permanent registration (3.6 per cent). • There is a slightly higher proportion of Christians among people with temporary registration compared to those with

	permanent registration, and a lower proportion of Muslims and people who say that they have no religion. • Only 6.2 per cent (952 people) of the people with temporary registration have told us that they have been deployed. Most of these are those that used to have permanent registration (99.4 per cent), aged over 60 (56.1 per cent), women (85.9 per cent), not disabled (95.8 per cent), White British (90.4 per cent), heterosexual (92.8 per cent), their gender identity matches that assigned at birth (or within six weeks) (98.9 per cent), Christian (66.5 per cent) and have no caring responsibilities (63.9 per cent). • Not everyone with temporary registration has been asked whether they have been deployed. Questions about deployment have been asked mainly to those who left our register more than three years ago since July 2020 and therefore these figures may reflect this cohort rather than those who have been deployed generally. **Data gaps** On 27 May we emailed the 13,796 people with temporary registration to ask them to complete a survey asking about their EDI characteristics. A link to the EDI survey is now included in all emails sent to confirm that someone has temporary registration, and we have contacted those people with temporary registration between 27 May and 1 July to ask them to complete the survey (Ref 1 in action plan). As of 31 March 2021, 15,457 people had temporary registration, with nearly 11,000 responses to the EDI survey. With the new virtual hearings we have an improvement survey that collects diversity data but the numbers responding have been very low.
Social media	Conversations on social media show there is public interest in the disproportionate numbers of ethnic minority health professionals working to combat Covid-19 dying from Covid-19. We are monitoring the social media communications as this is a form of intelligence and we acknowledge that disadvantaged groups may not be able to raise issues that concern them via mainstream communication channels.
Corporate complaints and compliments	Since 31 October 2020 we have received a total of 82 Covid-19 related complaints – none of these have specified any particular equality, diversity or inclusion issues. The recent trends have been in relation to the below: • Delays in joining the temporary register;

	• Waiving our annual registration fee; • Queries relating to the Covid-19 vaccine and how registrants can get involved in the vaccination programme; • Partially effective registrants wanting to be dual registered on both registers; and, • Registrants being unhappy with the proposed NHS pay increase.

Section 3: Mapping the impact

All protected characteristics	**Our registrants engaging with the public** During this emergency period there may be health professionals who have been out of practice for a long period of time and may discriminate against people (inadvertently) due to them not being fully up to date with the most recent requirements, for example, the requirement to monitor sexual orientation. In a time of emergency the checks and balances to ensure there is no discrimination or bias may not be enforced, for example, mandatory EDI training. In addition there is evidence that some groups face discrimination from health care workers on the basis of protected characteristics. This is particularly notable for people who are disabled, lesbian, gay, bisexual, intersex, ethnic minorities and trans. For example, health professionals may lack understanding of wider requirements when interacting with trans people (Ref 2 and 10 in action plan). Nurses, midwives and nursing associates are still required to comply with the Code that states professionals on the register must be aware of and take steps to address health inequalities. If they are out of practice for a long period of time some health professionals taking up temporary registration may not know that certain groups experience more/particular health inequalities than others and this this is likely to make them more or less susceptible to Covid-19 or other impacts (including mental health impacts). These health professionals may be unaware of the steps that have to be taken to reduce negative health outcomes due to protected characteristics (Ref 2 and 10 in action plan). This issue did not occur as a result of the people taking up temporary registration. However, we are strengthening communication about the relevant parts of the Code including equality and human rights (Ref 2 in action plan). **Professionals with temporary or permanent registration** A study conducted in the UK found evidence of a rise in the anxiety levels of healthcare professionals during the pandemic (when compared to pre-pandemic levels). The main reasons for the increased anxiety was related to exposing themselves

and family to Covid-19 and lack of PPE[9]. Furthermore, when looking specifically at mental health nurses the risk of getting infected and infecting family were among the top concerns mentioned[10].

Those fears are validated when looking into the analysis ONS has published on deaths involving Covid-19 by occupation, according to which nurses have statistically significant higher death rates when compared with those of the same age and sex in the population[11].

An IPPR/YouGov poll conducted in 2021 found that 29 per cent of nurses and midwives state that they are more likely to leave the sector than they were a year ago[12].

Covid-19 vaccination

A survey conducted by the Royal College of Nursing shows that in February 2021 85 per cent of nursing staff had received at least one vaccine dose[13]. As the UK continues the rollout of vaccines and follows a roadmap out of the pandemic, the conversation shifts towards the appropriateness of mandatory vaccinations.

Under the Public Health Act 1984, the UK government cannot require a person to undergo mandatory medical treatment (including vaccination). However, at the time of writing it has been reported that the Health Secretary is considering making vaccination a legal requirement for care workers (24/03/21).

In April 2021 we responded to the UK-REACH study on health and care workers' Covid-19 vaccine hesitancy, which showed there were specific groups who were more likely to be hesitant, including those from ethnic minority backgrounds. The study recommended working with communities and designing inclusive communications on the vaccination programme.

People shielding

In England, over two million of people have been identified as

[9] Siddiqui, I., Aurelio, M., Gupta, A. Blythe, J. and Khanjo, M.Y (2021) COVID-19: Causes of anxiety and wellbeing support needs of healthcare professionals in the UK: A cross-sectional survey, *Clinical Medical Journal*, 21:2, pp.66-72.
[10] Foye, U. et al. (2021) How has Covid-19 affected mental health nurses and the delivery of mental health nursing care in the UK? Results of a mixed methods study, *Journal of Psychiatric and Mental Health Nursing*, 28:2, pp.126-137.
[11] Office for National Statistics; Coronavirus (COVID-19) related deaths by occupation, England and Wales:deaths registered between 9 March an 28 December 2020; 25-01-2021
[12] Patel, P. & Thomas, C. (2021) *Recover, Reward, Renew: A post-pandemic plan for the healthcare workforce*, Institute for Public Policy Research
[13] Royal College of Nursing, *RCN COVID-19 Vaccine Survey Report*, 09-02-21,

	clinically extremely vulnerable (CEV) to severe impact from Covid-19 and have been advised to shield from others. The Office of National Statistics has produced a series of analysis on CEV people's behaviours and mental and physical well-being. During a July 2020 iteration of the analysis ONS found that among those who usually work, 32 per cent said they were not at all comfortable to work outside their home[14]. The Health Foundation's Networked Data Lab further analysed the shielding population and found regional differences in the way people were identified, as well as differences in personal characteristics and underlying medical conditions[15]. The Networked Data Lab was also able to identify a substantial fall in secondary care use by the CEV population and to point out the possible unmet health needs CEV people might have[16]. Research in relation to the impact of shielding from COVID-19 has provided variable outcomes, with some groups being negatively affected both physically and mentally[17] and others having an increased levels of wellbeing[18]. In January 2021 we received an email from a disabled nurse who was on the clinically extremely vulnerable register. They highlighted the negative impact on their mental health of shielding, working from home in a different nursing role and feeling guilty about not being on the frontline. We recognise professionals with disabilities have had additional issues and worries to consider, and may be concerned about the long term impact of shielding on their health and employment.
Age	**Our registrants engaging with the public** The effects of Covid-19 are more serious for people older than 60.[19] The patients being treated for Covid-19 are more likely to be above 60 years of age.

[14] Office of national Statistics; *Coronavirus and shielding of clinically extremely vulnerable people in England: 9 July to 16 July 2020*; 05-08-2020 [last accessed 07-04-21]
[15] The Health Foundation: Networked Data Lab; *Understanding the needs of those most clinically vulnerable to COVID-19*; [last accessed 06-04-21] & The Health Foundation: Networked Data Lab; *Who was advised to shield from COVID -19?*; 27-01-21 [last accessed on 06-04-21]
[16] The Health Foundation: Networked Data Lab; *How has hospital use among those clinically extremely vulnerable to COVID-19 been impacted by the pandemic?*; 24-03-21 [last accessed on 06-04-21]
[17] Pulmonary Hypertension Association (2020) *Shielded Voices: Lived experiences during the early stages of the COVID-19 pandemic, [last accessed 07/04/21];* Cleaton, N. et al. (2021*)* The impact of COVID-19 on rheumatology patients in the UK centre using an innovative data collection technique: prevalence and effect of social shielding, *Rheumatology International,* 41, pp. 707-714
[18] Sloan, M. et al. (2021) COVID-19 and shielding: experiences of UK patients with lupus and related diseases, *Rheumatology Advances in Practice,* 5:1
[19] Novel coronavirus disease 2019 (COVID-19) pandemic: increased transmission in the EU/EEA and the UK – sixth update; European Centre for Disease Prevention and Control; 12-03-2020 [accessed 27-30-2020]

	Some groups may be more susceptible to being discriminated against in a healthcare setting on the basis of their protected characteristic. And if there are limited resources, health professionals may have to make decisions about which individuals can access those resources. This could raise issues of fairness, human rights and ethics if for those decisions are based on bias. For example, if decisions are based on age. In their report into the impact of Covid-19 on older people's mental and physical health, Age UK highlighted issues for older people including loss of mobility and balance from moving around less, pain from untreated medical treatment, reduced ability to receive appropriate nutrition, cognitive decline, stress and isolation. 43 per cent of people with a long-term health condition are now unable to walk as far as before, while the proportion of over 70s experiencing depression has doubled since the start of the pandemic. **Professionals with temporary registration** Nurses, midwives and nursing associates that are above 60 may be less likely to apply for temporary registration due to the government guidance about greater risk of Covid-19 for older people. Our analysis of the data shows that people with temporary registration are older than those with permanent registration. Around three quarters of those with temporary registration (78 per cent) are aged 50 and over, compared to around a third (35.1 per cent) with permanent registration being aged 51 and over.[20]The age profile of those with temporary registration has therefore got older than in July 2020, when around two thirds of people were aged 50 and over. This is likely because there is a now a lower proportion of people with temporary registration who are overseas applicants (who tend to be younger) as many overseas temporary registrants have now joined the permanent register and a higher proportion who had left the permanent register (who tend to be older). We do not have a policy to exclude people aged 70 or over, although we have treated this group differently by not actively inviting this group by email to take up temporary registration because we felt it wouldn't be responsible to do so given the government guidance (updated 1 May 2020) that people over the age of 70 are clinically vulnerable. See Section 4: Analysis and outcome (Ref 3 in action plan).

[20] The 10 year age bands available for the permanent register group people from 21-30, 31-40 etc., so do not exactly match those for the temporary register.

	People over the age of 70 are able to take up temporary registration. Anyone can apply through the open route available on our website. The information on our website states: 'If you are aged over 70: Because of the government's advice that people aged 70 or over should take extra care during the Covid-19 emergency, we decided not to proactively invite those aged 70data gaps or over to join the temporary register. However, you can still apply to join our temporary register if you want to.' As of 28 October, there were 179 professionals aged 70 or over with temporary registration. Initially our website provided some conflicting information about this, and we've confirmed that people age 70 or over will be able to join if they apply and would not be refused on the grounds of age alone. We updated the information on the website to reflect this position (Ref 4 in the action plan). **Adapting our operational processes** The separate EqIA into virtual hearings identifies that older people may have difficulties in accessing the hearings in its new virtual format (Ref 8 in the action plan). We are currently assessing the data received through the improvement survey and will consider the findings of the public consultation on our emergency powers in future decisions relating to access to virtual hearings. We also have a Specialist Case Lead in FtP whose work ensures we understand the requirements of people with different needs, including people who are vulnerable or who have disabilities.
Disability	**Our registrants engaging with the public** The effects of Covid-19 are more serious for people with underlying conditions such as hypertension, diabetes, cardiovascular disease, chronic respiratory disease and cancer.[21] The patients being treated for Covid-19 are more likely to have underlying conditions and have complex health needs. Evidence suggests that the Covid-19 pandemic has significant impacts on disabled people. Research commissioned by the Cabinet Office Disability Unit shows that in July 2020, around three-quarters of disabled people (75 percent) reported they were 'very worried' or 'somewhat worried' about the effect Covid-19 was having on their life compared to 66 per cent for non-disabled people. This research also indicates that around a quarter of disabled people were currently receiving treatment

[21] Ibid.

	for only some of their conditions in comparison to before the coronavirus pandemic.[22] The National Autistic Society's Left Stranded report found that nine out of ten autistic people worried about their mental health during lockdown and were six times more likely to have low life satisfaction compared to the general public. There is evidence people with certain disabilities are more likely to have health inequalities in normal health settings. Nurses, midwives and nursing associates are still required to comply with the Code that states professionals on the register must be aware of and take steps to address health inequalities. When there are limited resources health professionals may have to make decisions about which individuals can access those resources. This could raise issues of fairness, human rights and ethics if for those decisions are based on bias. For example, if decisions are based on complex disabilities or health conditions. Findings from the Learning Disabilities Mortality Review Programme suggests the key symptoms of Covid-19 in the general population may not be as apparent in people with learning disabilities, and found that 1 in 5 of deaths which were reviewed involved a person who has been discharged from hospital to be readmitted soon again afterwards. Careful attention must be paid to prejudicial attitudes towards care and judgements about ceilings of care. Recent guidance from NICE has been amended following criticism from patient groups and representatives who state that using the Clinical Frailty Scale (CFS) to determine hospital admissions would lead to detrimental outcomes for those with learning disabilities or long-term disabilities such as cerebral palsy.[23] This guidance has been amended but professionals making day to day decisions in emergency situations may perpetuate these inequalities (Ref 10 and 13 in the action plan). In December 2020 we commented on the Care Quality Commission's interim report on DNACPR decisions during Covid-19, making it clear they should not be applied to anyone without their involvement, consent and their individual needs being taken into account. We will take the appropriate

[22] Office for National Statistics (2020) Coronavirus and the social impacts on disabled people in Great Britain: July 2020

[23] NICE (2020) NICE updated rapid COVID-19 guideline on critical care. [accessed 25-03-2020]

	regulatory action where there is evidence that professionals on the register aren't following the principles of person-centred and individualised care in a way that protects people's safety and rights. While not directly related to care during the pandemic, in December 2020 we asked a Learning Disability Nurse to share a blog on improving care for people with learning disabilities using maternity services. **Professionals with temporary or permanent registration** Nurses, midwives and nursing associates who have underlying conditions are less likely to be in a position to apply for temporary registration. Our analysis shows that there is a slightly higher proportion of people with temporary registration as of 31 March 2021 who are disabled (4.9 percent), compared to people with permanent registration (3.6 percent). The temporary registration policy states that 'In line with the latest government health advice, we have not contacted former registrants…with known health conditions'. This was an active decision we made to not proactively invite people who we know have health conditions to take up temporary registration in line with government guidance to mitigate against the potentially negative impact of our actions on disabled people (Ref 3 in the action plan). The temporary registration policy states that 'we will not be applying our normal health, character or language requirements' and that 'potential registrants will be asked to assess their own suitability for temporary registration based on their own health conditions and personal situations' in light of the latest Government guidance. Therefore in taking up temporary registration we ask people to think of the same issues as when making the registration health and character declaration (Ref 3 and 4 in the action plan). **Adapting our operational processes** The prevalence of mental health concerns in the UK is increasing,[24] particularly among those with severe symptoms. Women are more likely to be diagnosed with a common mental illness[25] but men are more likely to take their own lives. The professionals on our register are more likely be experiencing

[24] Fundamental facts about mental health; 2016; Mental health Foundation; accessed 30-03-20
[25] NHS Digital, Mental Health & Wellbeing in England, Adult Psychiatric Morbidity Survey 2014

	stress and working in stressful conditions, and their mental health concerns may be higher than for the general population. This could have an impact on their behaviour and could raise situations where their conduct could impact their fitness to practise. We set up a Careline to provide extra support for professionals going through the fitness to practise process. A study of 1,257 health care workers in 34 hospitals in China showed that a considerable proportion of health care workers reported experiencing symptoms of depression, anxiety, insomnia, and distress, especially women, nurses, those in Wuhan, and front-line health care workers directly engaged in diagnosing, treating, or providing nursing care to patients with suspected or confirmed Covid-19[26] (Ref 5, 6, 11, 14 and 15 in the action plan). The separate EqIA into virtual hearings identifies that disabled people may have difficulties in accessing the hearings in its new virtual format (Ref 8 in the action plan). Access to virtual hearings may impact individuals with different disabilities both positively or negatively. We seek to provide opportunities for hearing participants, particularly registrants, witnesses and members of the public, to indicate if they require a reasonable adjustment or additional support. **Supporting students** For students with health conditions who are shielding either personally, or by association with a family member, they may have to suspend their studies and complete later than they normally would (Ref 17 in the action plan).
Gender	**Our registrants engaging with the public** The effects of Covid-19 are more serious for men.[27] The government guidance about vulnerable groups does not specify that men should be taking different steps. **Professionals with temporary registration** Covid-19 has increased inequalities in mental health in the UK, particularly for women who already had lower levels of mental health before Covid-19.[28] Our latest registration data report

[26] Lai J; Ma S; Wang Y (2020) Factors associated with mental health outcomes among health care workers exposed to Coronavirus Disease 2019. Jama Network Open. 3(3):e203976.
[27] Novel coronavirus disease 2019 (COVID-19) pandemic: increased transmission in the EU/EEA and the UK – sixth update; European Centre for Disease Prevention and Control; 12-03-2020 [accessed 27-30-2020.
[28] Banks J & Xu X (2020) The mental health effects of the first two months of lockdown and social distancing during the Covid-19 pandemic in the UK. Institute for Fiscal Studies

	shows that as of 31 March 2020, 89 per cent of the people on our register were female and so at increased risk of experiencing poorer mental health as a result of Covid-19.[29] The identification of the groups to be invited to take up temporary registration did not consider gender. Our analysis shows that there is a lower proportion of women (82.8 per cent) with temporary registration, compared to those with permanent registration (89.2 per cent). There is also a slightly lower proportion of men amongst those with temporary registration (9.8 per cent) compared to those with permanent registration (10.8 per cent). However, the lower proportions of both groups are most likely due, at least in part, to the higher proportion of people with temporary registration for which this information is unknown (7.3 per cent of those with temporary registration, compared to <0.1 per cent of those with permanent registration). In particular, as noted above a large proportion of the overseas cohort (24.4 per cent) are missing information on gender. Reviewing our data relating to disparities in mortality rates of the professionals on our register who have sadly lost their lives in service has shown that, of the individuals where data was available, 42 per cent of those who lost their lives were male – more than four times higher their number on the register as a whole (11 per cent).
Gender reassignment[30]	**Our registrants engaging with the public** In the UK there are increasing numbers of people who are openly identifying as trans, non-binary and other gender identities. The best estimate at the moment is that around 1 per cent of the population might identify as trans, including people who identify as non-binary,[31] which would equate to about 600,000 trans and non-binary people in the UK. There is evidence that people who are trans or non-binary are more likely to have health inequalities in normal health settings.[32] In addition there is evidence that some groups of patients face discrimination from health care workers, while trans health professionals face discrimination from other

[29] House of Commons Library (2020) Mental Health Awareness Week: The impact of coronavirus on health and social care workers. UK Parliament
[30] Include trans and non-binary
[31] The truth about trans: a Q&A for people who are hungry for real info; Stonewall; 2019; https://www.stonewall.org.uk/truth-about-trans#trans-people-britain [accessed 23-05-19]
[32] *LGBT Action Plan 2018: Improving the lives of Lesbian, Gay, Bisexual and Transgender people*; Government Equalities Office; 2018.

	healthcare professionals. In a time of emergency the checks and balances to ensure there is no discrimination or bias may not be enforced. Some groups may be more vulnerable to being discriminated against in a healthcare setting on the basis of their protected characteristic. **Professionals with temporary registration** People who have left our register and identify as other than male or female did not have the options on our registration systems to reflect them. We have information on the gender identity of over 90 per cent of those with temporary registration. Our analysis shows that a lower proportion of people with temporary registration (0.2 percent) say that their gender does not match that at birth (or within six weeks) compared to those with permanent registration (0.7 percent). The proportion of people with temporary registration with a gender identity (7.5 percent) of 'prefer not to say/unknown' is slightly higher than those with permanent registration, which has 4.3% of people who are 'prefer not to say' or unknown for gender identity. There is evidence[33] that gender identity clinics were closed for at least six months and the employees being redeployed. This could have a detrimental impact on people on our register who might be trying to access treatment or health care services (and consequently the care they can provide) (Ref 3 in the action plan).
Marriage and civil partnership	There is no evidence that people will be affected differently on the basis of being in a marriage or civil partnership, or not.
Pregnancy/maternity	**Our registrants engaging with the public** Pregnant people appear to experience similar clinical manifestations as non-pregnant adult patients with Covid-19. However, the government policy is to treat pregnant people as a vulnerable group in light of the lack of information about the long term impact of Covid-19. A study has shown that pregnant Black and minority ethnicity women are significantly more likely to be admitted to hospital with Covid-19 which cannot easily be explained by factors such as where they live, how old they are, their body mass

[33] Links to information about closures of the Leeds and Charing Cross clinics.

	index (BMI) and whether they have any underlying health conditions.[34] In November 2020 we responded to the Royal College of Midwives' calls for greater support to be given to women with severe and multiple disadvantage during pregnancy, sharing how our midwifery standards can help ensure no one is left behind in the care they receive. **Professionals with temporary registration** Our invitations to join the register ask that individuals should consider their personal circumstances in line with latest government guidance. We neither encourage nor discourage particular groups within the cohort (Ref 3 in the action plan). Nurses, midwives and nursing associates who are pregnant or on maternity leave are less likely to apply to take up temporary registration. **Adapting our operational processes** People who are pregnant may be impacted by the OSCE centres closing due to the timelines available that they would complete their assessments. We considered factors related pregnancy and maternity in how we re-introduced the OSCE tests (Ref 9 in the action plan). Pregnant people or those on maternity, may benefit from the roll out of virtual hearings as this can minimise their travel, time and other stressors with physical hearings. We have now re-opened physical hearings, and processes are in place for us to engage with parties in advance of the hearing to make appropriate arrangements for people with this protected characteristic. Pregnancy and maternity is a factor which would influence the decision taken on which type of hearing is most appropriate. **Supporting students** As there is potentially increased vulnerability for students who are pregnant, we encouraged AEIs and practice learning partners consider the particular needs of this group (Ref 17 in the action plan).
Race	**Professionals with temporary registration**

[34] The UK Obstetric Surveillance System SARS-CoV-2 Infection in Pregnancy Collaborative Group (2020) Characteristics and outcomes of pregnant women hospitalised with confirmed SARS-CoV-2 infection in the UK: a national cohort study using the UK Obstetric Surveillance System (UKOSS)

	Data from NHS England shows that ethnic minority staff are more likely to be in lower bands.[35] The nurses, midwives and nursing associates who are dealing directly with patients are more likely to be in frontline and potentially lower bands. Therefore this may be a factor leading to ethnic minority professionals being more likely to be exposed to Covid-19 (Ref 3 in the action plan). We have invited some overseas qualified nurses and midwives to take up temporary registration to increase the numbers of health professionals available to fight the Covid-19 pandemic. Overseas nurses are more likely to be from ethnic minority backgrounds. In January 2021, when we extended applications to the temporary register to additional cohorts of overseas-trained nurses, we made it clear that partners across the system need to take full responsibility for protecting professionals from additional risks, including using workforce risk assessments. We monitored the ethnicity of the people with temporary registration to see if it has disproportionately high numbers of overseas and ethnic minorities that are more likely to be at risk of being at the front line of the pandemic. Our analysis of those with temporary registration on 31 March 2021, shows that as a group they are less ethnically diverse than in July 2020. Over three quarters of those with temporary registration in March 2021 (78 per cent) are White British, compared to 67.7 per cent of people with permanent registration. There is a lower proportion of people who are Black African (1.8 per cent) amongst those with temporary registration compared with those with permanent registration (7.3 per cent). The proportion of people with temporary registration who are Asian Filipino (1.1 per cent) is lower than amongst those with permanent registration (4.3 per cent). The proportion of Asian Indian people is also lower amongst those with temporary registration (2.6 per cent) compared with those with permanent registration (3.9 per cent). The proportion of people who are Any other White ethnicity is also lower amongst those with temporary registration (2.2 per cent) compared with permanent registration (4.5 per cent). **Influencing and supporting professionals on our register (with temporary and permanent registration)** Black and other minority ethnic individuals make up a large share of jobs considered essential in tackling the virus and so

[35] NHS (2020) WRES

	at increased risk of infection. In 2018, nurses and health visitors from black, Asian and minority ethnic groups comprised 18.8 per cent of this workforce in all care settings in England.[36] We are monitoring conversations in the media and social media and from ethnic minority professional representative bodies about the health professionals (and wider population) who are dying from Covid-19 being more likely to be ethnic minorities.[37] In April a HSJ report shows that 71 per cent of the 35 nurses and midwives who had died were from ethnic minority backgrounds and a minimum of 56 (53 percent) of healthcare workers who had died were not born in this country. The researchers call for the government's inquiry into the deaths of ethnic minority healthcare workers and staff who had migrated to the UK.[38] Since then the evidence of the disproportionate impact on ethnic minorities has grown, a Public Health England Report in June clarifying that individuals from ethnic minority groups are more likely to work in occupations with a higher risk of Covid-19 exposure.[39] Reviewing our data relating to disparities in mortality rates of the professionals on our register who have sadly lost their lives in service has shown that, of the individuals where data was available, 57 per cent identified as Black, Asian or another ethnic minority – almost three times as high as the percentage of those on the register as a whole (20 per cent). Our data shows us that people employed via an agency are more likely to be from ethnic minority backgrounds than people employed directly.[40] 72 per cent of jobs done through direct employment are by people of white British ethnicity, with 5 per cent by people of black/black British African ethnicity. In comparison, 35 per cent of jobs done via an agency are by people of black African ethnicity, and 34 per cent are by people of white British ethnicity. The information we have gleaned through our intelligence and stakeholder engagement suggests that some agency employed professionals feel they are more likely to be deployed to care for Covid-19 patients without adequate PPE (Ref 12 in the action plan). The frequent use of bank or agency nurses or carers has been associated with

[36] NHS Digital (2019) NHS Hospital and Community Health Services (HCHS): Nurses & health visitors by care setting and ethnic group, in NHS Trusts and CCGs in England, as at 30 November 2018, headcount. 8 March 2019.
[37] Tweets accessed 08-04-20 https://twitter.com/jsbamrah/status/1247633745278111747
[38] Cook T, Kursumovic E, Lennane S; *Exclusive: deaths of NHS staff from Covid-19 analysed*; HSJ; 22 April 2020 [accessed 28-04-20]
[39] *Beyond the data: Understanding the impact of Covid-19 on BAME groups*; Public Health England; June 2020
[40] NMC (2019) Revalidation: Annual data report. Year 3: April 2018 to March 2019.

	higher levels of infections amongst residents in care homes in England.[41] Our latest revalidation data shows that a significant proportion of Black African nurses and midwives work in care homes. A recent study of care homes in Scotland has shown an association between larger care homes and outbreaks of Covid-19.[42] Our Employer Link Service has been reflecting our intelligence and learning in their routine engagement with employers, with a targeted focus on key areas of concern for Black and minority ethnic registrants, as well as sharing examples of good practice. We have shared anonymous diversity data with UK REACH, a national research study investigating if, how, and why ethnicity affects Covid-19 clinical outcomes for people working in health and social care. In December 2020 we wrote to a sample of half a million nurses and midwives to invite them to take part in the study, which aims to help protect professionals during the pandemic. **Adapting our fitness to practise and removals processes** We know that black and ethnic minority registrants are more likely to be referred to us for matters that do not, after investigation, require a regulatory sanction.[43] Ethnic minority registrants are more likely to be referred to us by employers and more likely to end up with a serious outcome. Our decisions to adapt our processes, for example decisions about which cases to progress with limited resources, may inadvertently increase the likelihood of ethnic minority people have their temporary registration removed and those with permanent registration going through fitness to practise processes (Ref 4 in the action plan). **Adapting our operational processes** The separate EqIA into virtual hearings identifies that people with English as a second language may have difficulties in accessing the hearings in its new virtual format (Ref 8 in the

[41] Office for National Statistics (2020) Impact of coronavirus in care homes in England: 26 May to 19 June 2020

[42] Burton J, Bayne G, Evans C, Garbe F, Gorman D, Honhold N, McCormick D, Othieno R, Stevenson J, Swietlik S, Templeton K, Tranter M, Willocks L & Guthrie B (2020) Evolution and impact of COVID-19 outbreaks in care homes: population analysis in 189 care homes in one geographic region. Medrxiv. doi: https://doi.org/10.1101/2020.07.09.20149583

[43] West, Nayar, Taskila and Al-Haboubi. (2017). The Progress and Outcomes of BME Nurses and Midwives through the NMCs FtP process. University of Greenwich and London School of Hygiene and Tropical Medicine.

	action plan). We have insufficient evidence of whether this is actually the case, but we will monitor complaints and feedback to ascertain if there is a particular barrier. **Our registrants engaging with the public** There is evidence that people from certain ethnic groups are more likely to have health inequalities in normal health settings. As explained in the 'all protected characteristics' at the start of this section health professionals may not be up to date about how to prevent these inequalities, as they are required to by the Code (Ref 13 in the action plan). We know that ethnic minorities in the UK are at greater risk of being affected by Covid-19. Ethnic inequalities are likely to manifest from the Covid-19 crisis in two main ways: through exposure to infection and health risks, including mortality, and through exposure to loss of income. A report by the Institute of Fiscal Studies show that per-capita, Covid-19 hospital deaths are highest among the black Caribbean population and three times those of the white British majority. Some minority groups – including Pakistanis and black Africans – have seen similar numbers of hospital deaths per capita to the population average, while Bangladeshi fatalities are lower[44] (Ref 13 in the action plan). People from Gypsy, Roma and Traveller (GRT) communities will be less likely to have access to healthcare and could be more likely to be discriminated against due to a lack of understanding of their needs (Ref 13 in the action plan). Research from The Runnymede Trust and the Institute for Public Policy Research (IPPR) suggests co-morbid diseases, like diabetes, do not fully explain the difference in risk of death from Covid-19 between ethnic groups. Higher deprivation levels explain the disparities to a greater extent, but the majority of the additional risk of death from Covid-19 experienced by minority ethnic communities is unexplained, in part because of difficulties with data. They suggest differential access to healthcare and structural racism play a significant part in the disproportionality. Doreen Lawrence's 'An avoidable crisis' review points to healthcare barriers including a lack of cultural and language-appropriate communication, lack of clinical training on the presentation of different illnesses across communities, and Black Asian and minority ethnic people being under-

[44] Platt, L and Warwick, R; May 2020; Are some ethnic groups more vulnerable to COVID-19 than others? Institute of Fiscal Studies

	represented in the senior leadership of the NHS. **Supporting students** The data and research shows that people from ethnic minority backgrounds have been impacted more by Covid-19 infection and mortality rates. This has led to recommendations for NHS trusts to risk assess their ethnic minority employees before deployment to care for Covid-19 patients. This indicates that there is a potential for increased vulnerability for students who are from ethnic minority backgrounds in placements. AEIs and practice learning partners will need to consider the particular need of this group (Ref 17 in the action plan).
Religion/belief	**Adapting our fitness to practise processes and supporting professionals** Nurses, midwives and nursing associates may have religious beliefs and practices that may become more prevalent or relevant in an emergency situation. For example: • religious dress that may not comply with temporary emergency measures • beliefs that dictate praying for those in distress or critically ill Our consideration of contextual factors may need to take these issues into account. **Professionals with temporary registration** The group of people with temporary registration has a slightly higher proportion of Christians (61.2 per cent compared to 58 per cent of people with permanent registration). Those with temporary registration have a lower proportion of people who say they have no religion (22.4 per cent) compared to those with permanent registration (28.9 per cent). There is a smaller proportion of Muslims (0.6 per cent) with temporary registration compared to those with permanent registration (1.8 per cent). Again, some of these differences may be accounted for by the fact that there is a higher proportion of people with unknown religion who have temporary registration (12.4 per cent) than those with permanent registration (7.6 per cent). **Our registrants engaging with the public** Patients also have beliefs that may be contrary to measures that are deemed to be best practice in this emergency situation. For example when the Coronavirus Act states that

	disposal of bodies must be consistent with the person's religion or beliefs. For some groups[45] the practices in relation to death and bereavement are very important and the healthcare professionals on our register must endeavour to respect these, in line with the Code. There could also be geographical hotspots that link to religious and cultural beliefs. For example London and the Midlands were noted to have higher numbers of cases and deaths from Covid-19 possibly linked to religious/cultural practices and beliefs.[46] **Adapting our operational processes** The separate EqIA into virtual hearings identifies that people from certain religious groups may have difficulties in accessing the hearings in its new virtual format. For example, if the person's religion requires them to use a holy book to take the oath and we are unable to accommodate that virtually, this could pose a barrier (Ref 8 in the action plan). This will be dealt with on a case by case basis with adaptations.
Sexual orientation	**Professionals with temporary registration** There are more people with temporary registration overall whose sexual orientation is prefer not to say or unknown (13 per cent) compared to those with permanent registration (7.8 per cent). This is likely to account for at least some of the differences between groups. Amongst those with temporary registration, a lower proportion are heterosexual (84.5 per cent compared to 89.1 per cent on the permanent register); and slightly lower proportions are gay or lesbian (1.5 per cent compared to 1.9 per cent on the permanent register); and bisexual (1.0 per cent compared to 1.2 per cent). **Our registrants engaging with the public** There is evidence that lesbian, gay and bisexual groups find it harder to access care, and receive poorer care[47][48] in normal health settings. In addition there is evidence that some groups of patients face discrimination from health care workers, also that lesbian, gay and bisexual health professionals can face discrimination on the basis of their sexual orientation from

[45] Muslim Council of Britain statement burial measures in COVID-19 emergency legislation; 21-03-20
[46] Parveen N (2020) Officials investigate coronavirus hotspot in West Midlands. Guardian. Friday 20 March 2020
[47] Health4LGBTI EU funded project - TASK 1: State-of-the-art study focusing on the health inequalities faced by LGBTI people D1.1 State-of-the-Art Synthesis Report (SSR)
[48] Public Health England (2018) Improving the health and wellbeing of lesbian and bisexual women and other women who have sex with women.

	other healthcare professionals. In a time of emergency the checks and balances to ensure there is no discrimination or bias may not be enforced. Some groups may be more open to being discriminated against in a healthcare setting on the basis of their protected characteristic. The LGBT Foundation have produced a briefing that sets out the direct and indirect impact on people who identify as LGBT. Issues relevant to our Covid-19 response include exacerbation of already poor health outcomes, reduced access to medication and increased fear of discrimination from healthcare providers.[49] A study of LGBTQ people's experience during the pandemic, by University College London (UCL) and Sussex University, found 69 per cent of respondents suffered depressive symptoms, rising to about 90 per cent of those who had experienced homophobia or transphobia. Around a sixth of the respondents said they had faced discrimination during the pandemic because of their sexuality. The rate rose to more than a third among those living in homes where they were not open about their identity. Almost 10% of people reported they felt unsafe in their homes.
Other groups[50]	**Caring responsibilities** Women over 50 are more likely to be carers.[51] Our register is made up of 89 per cent people who identify as women and older women are a greater proportion of the register. In this emergency situation there will be more pressure on carers, in particular carers of people who are in the vulnerable groups identified. Professionals with families/children may be less likely to apply to take up temporary registration. In addition students who are carers in a household with someone who is shielding, may have to suspend their studies and complete later than they normally would (Ref 3, 5 and 6 in the action plan). Those with caring responsibilities were potentially impacted by the OSCE centres closing and revalidation requirements due to shielding or restricted times they can engage or practice (Ref 9 in the action plan). For some people with caring responsibilities virtual hearings will be more suitable, whilst for others Covid-19-secure physical hearings may be preferred. We will make adjustments and decisions on a case by case basis.

[49] LGBT Foundation; April 2020; *The Essential Briefing on the Impact of COVID-19 on LGBT Communities in the UK;* [accessed 27-04-20]
[50] Examples include carers and people from different socio-economic groups
[51] Carers UK; 10 facts about women and caring; [accessed 30-03-20]

	Covid-19 has also had an impact by creating additional childcare and housework which has fallen more on mothers than fathers, especially among working parents. One report argues that this may inhibit work and career progression for mothers (Blundell R, Joyce R, Costa Dias M & Xu X (2020) Covid-19: the impacts of the pandemic on inequality, Institute for Fiscal Studies). **Socio-economic status** Those living in the most deprived areas of the UK have poorer health outcomes. People living in the most deprived areas have seen their healthy life expectancy decline over the last 10 years.[52] Those in deprived areas have higher exposure to Covid-19 and face worse health outcomes from emergency.[53] Some of the professionals on our register may fit into this group and be at greater risk or work with people at greater risk. Socio-economic status may be a relevant factor when looking at the impact of Covid-19 on healthcare professionals. We do not monitor socio-economic status of the professionals on our register and will be unable to inform wider calls for evidence that may require this data. The separate EqIA into virtual hearings identifies that people from deprived areas with less access to technology may have difficulties in accessing the hearings in its new virtual format. Similarly if the assessments for overseas nurses are changed to be held online (Ref 8 and 9 in the action plan). If an individual indicates they have a difficulty accessing the technology to participate in our virtual hearings, we would make adjustments on a case by case basis, for example inviting them to a hearing centre to participate from there. The financial impact of Covid-19 is more likely to impact on those people from lower socio-economic backgrounds and the intersection of women[54] and ethnic minority groups.[55] These groups may have less access to income during the emergency and unable to pay annual fees at this moment in time. We will adapt our processes to reduce disproportionate impacts on these groups (Ref 16 in the action plan).

[52] Marmot et al (2020) *Health Equity in England: The Marmot Review 10 Years On, Health Foundation* https://www.health.org.uk/funding-and-partnerships/our-partnerships/health-equity-in-england-the-marmotreview-10-years-on

[53] Bibby, J. Everest, G. Abbs, I; 07-05-20; *Will Covid-19 be a Watershed Moment for Health Inequalities?;* The Health Foundation

[54] UK Women's Budget Group; 19-03-20; *Covid-19: Gender and other Equality Issues*; Women's Budget Group

[55] Khan, Omar (2020); The colour of money: How racial inequalities obstruct a fair and resilient economy; Runnymede Trust

	Our latest data indicates that there are very low numbers of professionals applying for hardship support. The figures are too low for us to analyse this by protected characteristic.

Section 4: Analysis and outcome

The actions taken in response to Covid-19 are unprecedented and in the context of extreme circumstances and we think they are proportionate **in these circumstances**.

This section provides an analysis of where there may be potential unlawful discrimination in the action we have taken in response to the emergency. The action plan in section 5 details how we will mitigate against these areas and where we will take further action to advance equality of opportunity and foster good relations as required by the public sector equality duty.

Temporary registration

Decisions to include groups with temporary registration were risk-based and taken by the Registrar in line with the temporary registration policy approved by the Council on 25 March 2020. The basis for the decisions was an assessment as to whether the group – not the individuals within the group – were considered to be 'fit, proper and suitably experienced'. Information considered in this decision included length of time away from the register, the information assessed as part of the overseas registration process and stage of training. None of these considerations favoured or disadvantaged any individual or group over another in relation to any protected characteristic.

As identified in the evidence section above there were differences on the basis of age and disability of the people who were invited to have temporary registration. Under s.13(2) Equality Act 2010, it is not discriminatory to treat someone differently on the grounds of a protected characteristic if the treatment is a proportionate way of achieving a legitimate aim. In this case the aim being not to encourage people to act in breach of government guidance in place to protect more vulnerable groups, but allowing them to join if they contacted us.

We identified that there could be potential unlawful discrimination by protected characteristic in our actions. These include:

1 Bias in the decisions being made about who can or will have temporary registration removed on the basis of protected characteristic.

2 Potentially exacerbating current biases in the referral processes, for example, referrals from employers being more likely to refer people from certain ethnic groups because of discrimination and bias in their own processes.

3 People with temporary registration behaving in a way that is contrary to the Code by discriminating against colleagues or people using services on the basis of their protected characteristic – particularly if they have been out of practice for a time period where they were unable to update their continuing professional development or had not revalidated.

4 The criteria to determine who is given temporary registration being biased towards certain groups (for example, age).

5 The criteria for removal of temporary registration not taking account of the context of the practise of registrants in an emergency situation (for example, the mental health of nurses, midwives and nursing associates).

We ensured that we could monitor and report on removals of temporary registration and complaints raised against those with temporary registration from an EDI perspective.

Emergency standards for nursing and midwifery education

Some students will be at a disadvantage if their study and assessment needs are unable to be met due to shielding from Covid-19. People who are pregnant, carers or have disability or health issues may not be able to meet their study requirements. Where this occurs AEIs were expected to assess if the requirements are competence standards or whether adjustments can be made.

Revalidation and retention

The financial impact of Covid-19 is more likely to impact on women and ethnic minority groups. Inflexibility of our processes could have had a disproportionate impact on women, minority groups and those from lower socio-economic groups.

Communications and support

In addition we should take action to advance equality of opportunity and foster good relations. For example using our influence through our external communications channels. Developing guidance for our stakeholders on changes to our processes and working with partners to provide clarity on the importance of maintaining EDI and human rights principles during the emergency.

Fitness to practise

We identified that there is some risk in our activities that could be exacerbated by the Covid-19 emergency, for example not taking account of context of how the professionals are practising in an emergency situation. In addition there could be potential unlawful discrimination in the actions we have taken to adapt our processes in response to Covid-19. These include:

1 The decision to hold essential hearings activity virtually, which could have an adverse impact on people with a range of protected characteristics, such as people with health conditions who may not be able to participate as effectively in a fully virtual hearing. Reasonable adjustments will be considered on an individual basis.

2 The decision not to contact employers on cases unless there is an immediate risk. Delays could have an adverse impact on people with protected characteristics, such as registrants and members of the public with health conditions. Since the last version of the EqIA case work has now recommenced so this is much less of a risk.

3 The decision to cancel non-essential hearings. The delay could have an adverse impact on people with protected characteristics, such as registrants and members

of the public with health conditions. Since the last version of the EqIA non-essential hearings are being relisted so this is much less of a risk.

4 Changes to the way we hold hearings leading to inaccessibility of the complaints process (ref. the Article 6 of the Human Rights Act on the right to a fair trial) for registrants and referrers. Since the last version of the EqIA the accessibility of the channels to raise concerns have been constantly reviewed via a new referrals working group.

We will be analysing views on the use of our emergency powers on an ongoing basis. This includes views on public access to hearings, covered in our public consultation which closed in January 2021. We have monitored responses by protected characteristic, as described earlier in the document.

Section 5: Welsh language assessment

Does the activity relate to 'our public business in Wales'?	Yes
How could Welsh language speakers in Wales be impacted by the activity?	Welsh language speaking patients may need to be communicated to in Welsh (Ref 14 in the action plan).
Have Welsh language speakers been consulted?	Not directly in relation to this policy.
How have/will communications and publications be translated to Welsh?	The emergency education standards have been translated into Welsh. This was published on 31 March 2020. The 'How to revalidate during C-19' guidance was published in Welsh. The Covid-19 emergency rules public consultation has a Welsh language option.
Does the activity comply with our Welsh language scheme?	Yes
How will the activity be altered to ensure equal treatment of English and Welsh languages for Welsh speakers in Wales?	The Welsh Language Commissioner wrote a letter to the NMC Registrar and Chief Executive, Andrea Sutcliffe (dated 17 March 2020) to set out the legal duties under the Welsh standards and schemes during the Covid-19 emergency. 'Welsh language standards and schemes continue to apply, as do my regulatory functions under the Welsh Language Measure. Standards and schemes create important rights for Welsh speakers, and I am keen to see opportunities to use the Welsh language maintained. I accept that normal processes may not always be followed and that there will be significant time and resource constraints. I ask organisations to do their best to continue to use the Welsh language when dealing with the public as far as possible, including with patients in the health sector. But I recognise that many practitioners will work under intense pressure, and I do not want anyone to feel any stress arising from this aspiration while demands are significant. Sharing general information and advice with

	the public and customers will be important, and will sometimes have to happen quickly. It will be up to you to make decisions about using the Welsh language when sharing emergency information, taking into account the circumstances and the nature of the situation. I encourage you to put in place adequate translation arrangements as part of your preparations, considering the importance of using the Welsh language when communicating with the public'

Section 6: Action Plan

The actions have been separated into five themes under our three key roles of regulate, influence and support.

A. Regulate - diversity data
B. Regulate - managing the register (including those with temporary and permanent registration)
C. Influence - providing insight
D. Support - professionals on our register
E. Support – students in placements.

Issue/opportunity	**Implications/groups impacted and plans to address the issues raised**	**Action**
A Regulate – diversity data		
We must be able to have diversity data about the people on our register involved in the Covid-19 emergency by protected characteristic to inform our understanding of the equality and human rights implications (Ref 1).	All groups Clarify reasons for collecting the data and put in place systems to do so where possible and proportionate.	A1. Define legitimate reasons (regulatory and legal) for collecting diversity data. COMPLETED A2. Update DPIA with the reasons above in COMPLETED A3. Use the data from the EDI research to review the demographic characteristics of leavers and overseas cohort to have a picture of the wider group of registrants who may have been invited to take up temporary registration. COMPLETED

Issue/opportunity	Implications/groups impacted and plans to address the issues raised	Action
		A4. Review diversity data of the people with temporary registration based on data we already hold. COMPLETED A5. Determine if we will report with temporary registration data. There will be very high level report (not the diversity data) of those with temporary registration as at the 31 March. COMPLETED A6. Decide if we need to retrospectively ask people with temporary registration for their diversity data dependent on the completeness of the data we already have. COMPLETED A7. Continue to analyse the full set of diversity data of the people with temporary registration and compare it to those with permanent registration. COMPLETED A8. Look into what our diversity data on deployment tells us. ONGOING A9. Explore and share diversity data by four UK nations, ensuring our analysis includes insight into national differences wherever possible. ONGOING
B Regulate – managing the register (including those with temporary and permanent registration)		

Issue/opportunity	Implications/groups impacted and plans to address the issues raised	Action
People who are granted temporary registration behaving in a way that is contrary to the Code by discriminating against colleagues or patients on the basis of their protected characteristic – particularly if they have been out of practice for a time period where they were unable to update their CPD or had not revalidated (Ref 2)	People using healthcare services who are: • Lesbian, gay, bisexual • Trans and non-binary • Religious groups • Older people • Disabled people	B1. Identify the parts of the Code relevant to ethics, human rights and equality to be communicated internally and externally. COMPLETED B2. Include EDI and human rights messages in policies, processes, FAQs and external communications where appropriate. ONGOING B3. Create conditions to mitigate against negative impact of time out of practice for example, the 4-5 year group who are less likely to have done CPD or revalidation are subject to COP to mitigate risk of less recent practice. COMPLETED B4. Monitor complaints raised about temporary registrants on issues that relate to discrimination. ONGOING B5. Monitor temporary registration removals decisions made by Assistant Registrars for issues related to discrimination. ONGOING
The criteria for those who 1) are eligible to join and 2) have been actively invited	Age – older or younger people Disabled people People from some ethnic minority backgrounds	B6. One mitigating action to reduce the impact on disabled people is stated in the policy that ‘In line with the latest government health

Issue/opportunity	Implications/groups impacted and plans to address the issues raised	Action
to take up temporary registration being biased towards certain groups (like age) (Ref 3).	Pregnant people People with caring responsibilities Gender reassignment The criteria can currently be justified and do not place a disproportionate barrier in any individual's way but will need to be reviewed regularly to ensure they are fair and legitimate. There should be no barriers that can't be objectively justified.	advice, we have not contacted former registrants…with known health conditions'. All those invited to join are expressly asked to consider their own health and directed to latest guidance including possible increased risk to ethnic minority groups. COMPLETED B7. Keep the criteria for taking up temporary registration under regular review as government advice is updated. COMPLETED B8. Continue to monitor government guidance for risk factors for the professionals who may be exposed to Covid-19 and raise awareness of the risks related to protected characteristics to the professionals with temporary and permanent registration. ONGOING
Potential bias in the decisions being made about the people whose temporary registration is removed on the basis of protected characteristic (Ref 4).	Some ethnic minorities Disabled people Men People over 70 We are keen to ensure that we can monitor and report on removals from the temporary register and complaints raised against those with temporary registration from an EDI perspective.	B9. Identify the points in the temporary registration process where bias could occur and put in place mitigating actions. ONGOING B10. Brief individuals and teams involved in decision-making about the potential EDI and human rights issues of bias that could arise in this emergency situation. COMPLETED B11. Collect diversity data at the point of opt-in for those who are eligible to take up temporary registration. In line with data protection

Issue/opportunity	Implications/groups impacted and plans to address the issues raised	Action
		requirements. COMPLETED B12. Monitor complaints relating to any of our processes relating to Covid-19, particularly if it relates to potential discrimination. ONGOING
The criteria for removing temporary registration not taking account of the context of the practice of registrants in an emergency situation (for example the mental health of nurses, midwives and nursing associates) (Ref 5).	Disabled people (potentially all working professionals) will have increased mental health concerns Carers	As B8. B13. Review criteria to determine if it is fair and legitimate. There should be no barriers that can't be objectively justified. COMPLETED B14. Monitor removals of temporary registration that cite context relating to mental health and other EDI factors as a contextual factor. ONGOING
The risk of FtP investigations not taking account of the context of the practice of registrants (for example the mental health of nurses, midwives and nursing associates) may be exacerbated by the emergency situation (Ref 6).	Disabled people (potentially all working professionals) will have increased mental health concerns Carers	As B8. B15. Explore the possibility of monitoring FtP referrals linked to Covid-19 that cite context relating to mental health and other EDI factors as part of wider programme of work on a contextual factors. ONGOING
When we stop temporary registration – having regard	Unknown which groups are affected.	We don't have a standard operating procedure for stopping temporary registration yet and this

Issue/opportunity	Implications/groups impacted and plans to address the issues raised	Action
to equitable opportunities for people who wish to apply to for permanent registration or readmission.	Consider EDI issues arising in horizon scanning work.	is not likely to be needed for some time. B16. Consider EDI and bias in determining the mechanisms for individuals to move from temporary to permanent registration including if there is an issue with the different health and character requirements. To be monitored during implementation. ONGOING
Our actions in response to Covid-19 breaching equalities or human rights legislation due to acting at speed and missing checks and balances (Ref 7).	All groups. Raise awareness for internal decision-makers about the responsibilities under equalities and human rights legislation.	As B8. B17. Ensure any changes to access to remote hearings for the public are compliant with the Human Rights Act 1998, monitoring any feedback which may suggest any issues for particular groups. ONGOING
The adaptions to our FtP and registration appeals processes due to the emergency having a negative impact on people who share protected characteristics. For example requiring everyone to attend virtual hearings and delays causing mental distress (Ref 8).	Disabled people Carers Older people Socio-economic status People with communication barriers e.g. needing interpreters Some religious groups Identify where our temporary actions may have a negative impact on certain groups and put in place mitigating actions. Complete more detailed equality impact	B18. Case teams are corresponding with case parties electronically/over the telephone where possible due to the office being closed. COMPLETED B19. We have created guides for parties to assist them with responding electronically, and pdf documents that can only be amended in the sections that we require a response. COMPLETED B20. The Public Support Service team is providing ongoing specialist support to

Issue/opportunity	Implications/groups impacted and plans to address the issues raised	Action
	assessments for longer term changes.	screening teams in making reasonable adjustments for disabled customers. COMPLETED B21. Facilities colleagues are coming into the office weekly to pick up and scan post that is still coming in to ensure that we are still receiving correspondence that is being sent in. COMPLETED B22. Taking action to progress cases where possible, including reviewing caseloads, communicating potential delays to parties for cases involving frontline workers and holding hearings in Covid-19 secure hearing centres. COMPLETED B23. We have had a care line in place for registrants with active FtP cases since October 2019. We will expand the service to other registrants to assist them whilst dealing with this crisis. COMPLETED B24. Put together a working group to look at expanding our FtP and Registration appeals hearings activity and take forward the actions from the EqIA for virtual hearings. COMPLETED B25. Conduct a separate EqIA for public

Issue/opportunity	Implications/groups impacted and plans to address the issues raised	Action
		access to virtual hearings (also related to physical hearings). COMPLETED
The adaptations to our overseas registration processes due to the due to the emergency having a negative impact on people who share protected characteristics. For example closing OCSE centres (Ref 9).	Ethnic minority groups and non-UK nationals Disabled people Carers People who are pregnant Identify where our temporary actions may have a negative impact on certain groups and put in place mitigating actions. Complete more detailed equality impact assessments for longer term changes.	As B17. B26. Clear communications with overseas candidates. For example by providing information on our Covid-19 hub on the website. COMPLETED B27. All overseas nurses and midwives who met the eligibility criteria were offered to become temporarily registered. COMPLETED B28. Working closely with our OSCE delivery partners and development partner on reopening OSCE centres safely and accessibility. COMPLETED B29. We are piloting online computer based tests which, if successful, will allow candidates to take the test at home rather than travelling. ONGOING B30. Explore whether added conditions of practice to those with temporary registration who approach three years since practicing has any negative impact on any groups. ONGOING B31. Analysis of diversity data for those going

Issue/opportunity	Implications/groups impacted and plans to address the issues raised	Action
		through updated overseas processes. ONGOING
C Influence – providing insight		
Health inequalities and discrimination already exist in the wider healthcare environment. These should not be exacerbated in this crisis. We have a responsibility under the PSED to use our influence to tackle prejudice and promote understanding (Ref 10)	All groups We will act to eliminate discrimination and promote equality, diversity and inclusion. Cognisant of how the NMC can add value to the insights in the wider healthcare environment.	C1. Monitoring external publications on the topic of health inequalities and impacts on the basis of protected characteristic to inform our decisions. ONGOING C2. Monitor the intelligence we gather about Covid-19 related issues for EDI themes and share data with partners wherever relevant, including disparities in mortality rates among professionals. ONGOING C3. Review external research and work with other bodies to ensure there is a sufficiently detailed picture of the impact of the emergency on professionals on our registers by protected characteristic. ONGOING
Potentially exacerbating current biases in the FtP referral processes for professionals with temporary or permanent registration (for example referrals from employers being more likely to refer	Some ethnic minorities Disabled people Men Monitor referrals by protected characteristic to identify patterns and bias. Communicate with employers if concerns are	C4. Monitor and analyse FtP referrals about professionals on the registers related to Covid-19 by protected characteristic and patterns in source, allegation and outcome. ONGOING C5. Monitor whether FtP referrals appear to be disproportionate for any group, and whether context forms indicate possible inequality or

Issue/opportunity	Implications/groups impacted and plans to address the issues raised	Action
people from certain ethnic groups because of discrimination and bias in their own processes and from individuals) (Ref 11)	raised that appear to be based on bias.	discrimination factors. ONGOING C6. Look for evidence and patterns in our data/ intelligence which could indicate bias or discriminatory factors are impacting on employer decision-making when considering making a referral and/or managing FtP concerns locally. ONGOING Use learning from this information as a basis for engaging and educating employers in considering how to improve local FtP processes so discrimination and bias are reduced. ONGOING
Conversations in social media have shown that there is public interest in the disproportionate numbers of ethnic minority health professionals working to combat Covid-19 dying from Covid-19. We expect there will be calls for inquiries and data on these numbers after the pandemic has finished (Ref 12)	Ethnic minorities (professionals and the public) We will provide accurate EDI and workplace data about our registrants to other public health organisations in each UK country in order to allow them to verify the numbers of professionals on the our register (with temporary and permanent registration) who are infected, hospitalised or die from Covid-19 by protected characteristic.	C7. Ensure the systems are in place to monitor ethnicity (and other relevant protected characteristics) on both registers. COMPLETED C8. We will keep under review the call for evidence from the Women and Equalities Unit and future calls for evidence (where we may inform wider discussion to understand how people with protected characteristics are disproportionately affected by Covid-19). ONGOING C9. Provide accurate diversity data to support our partners looking into the numbers of

Issue/opportunity	Implications/groups impacted and plans to address the issues raised	Action
		professionals on our registers who have died as a result of Covid-19. ONGOING C10. Where suitable sensitively communicate EDI messages re the data externally. ONGOING C11. Monitor issues relating to professionals 'refusing' Covid-19 vaccination, seek to understand the EDI issues and monitor any referrals on this basis for EDI information. ONGOING
D Support – professionals on our register		
Professionals on our register working in an emergency situation are more likely to be under pressure to make decisions that could breach equalities legislation, ethics and engage the Human Rights Act (Ref 13)	All groups – but particularly vulnerable disabled groups and those who already have health inequalities including ethnic minorities, disabled and LGBT people Monitor and address issues as they arise. Attend external forums and monitor concerns with stakeholders.	D1. Attend Moral and Ethical Guidance Committee – monitor issues that arise and work that arises from this group. COMPLETED D2. Publish PPE guidance and guidance on DNACPR action completed. Regularly review issues as they emerge tied into ethical guidance and case studies. COMPLETED. D3. Review contract with the supplier delivering more training to staff making screening decisions on identifying context factors – to include heightened issues about ethics and discrimination in crisis situations. ONGOING

Issue/opportunity	Implications/groups impacted and plans to address the issues raised	Action
Use our influence to support healthcare workers and people using services that will be facing more difficulties during this emergency because of their protected characteristics (Ref 14)	Disabled health professionals – mental health People with disabilities – including learning difficulties, autism and those with long-term health conditions. Pregnant people Carers Welsh speaking professionals and people using services Use external communications channels to promote mental health and other considerations for example, ethics in decision-making. Sign post to our Careline which offers support to professionals going through the fitness to practise process.	D4. Ensure communications are translated into Welsh in line with our Welsh Language Scheme. COMPLETED D5. External communications and collaboration with other stakeholders – signposting to resources on mental health. COMPLETED
It may be difficult for people to meet the revalidation requirements when they are working in different ways during the emergency. This could have a disproportionate impact on different people, in different ways and at different times. We know that revalidation rates differ between different groups who share	Carers (more likely to be women and 89 people of the register are women) Disabled people That our actions mitigate any disproportionate revalidation rates by protected characteristics and the process is flexible to take account of different circumstances.	D6. Make revalidation extensions available to all people on the register. COMPLETED D7. Produce ‘How to revalidate during C-19’ guidance. To include information about updating diversity information and to be translated into Welsh. COMPLETED D8. Monitor the diversity data of those who apply for, are accepted, and those who are not accepted for support measures. ONGOING

Issue/opportunity	Implications/groups impacted and plans to address the issues raised	Action
protected characteristics (Ref 15)		
Our retention requirements such as payment of fees may be difficult for certain groups of people to meet during the emergency (Ref 16)	Socio-economic status may indicate less financial flexibility	D9. People who fail to pay fees are given six week extensions and those who need support after this are referred to the hardship criteria. COMPLETED D10. Use criteria to determine hardship cases for additional support with payments. COMPLETED D11. Explore the possibility of monitoring the diversity characteristics of those who apply for and are accepted for hardship support. ONGOING D12. Identify any work being done to assess the impact of our processes and emergency powers on professionals with disabilities. ONGOING D13 Ensure our communications with professionals, including joint statements, consider and reflect EDI implications ONGOING
E Support – students in placements		
Use our influence to	Disabled students	E1. Work with key stakeholders to create joint

Issue/opportunity	Implications/groups impacted and plans to address the issues raised	Action
support students who will be facing more difficulties during this emergency because of their protected characteristics (Ref 17)	Carers Ethnic minorities We will work with key stakeholders to ensure students remain supported and supervised during this period. Where students who may have to suspend/defer their studies during this period they will be supported to continue their studies after the emergency	statements which outline the options for students, and that students will not be negatively impacted because of their personal situation. COMPLETED E2. Create a table outlining to students their options and that they will not be negatively impacted because of their personal situation. COMPLETED E3. Publish our emergency programme standards outlining that students should continue to be appropriately supported and supervised. COMPLETED E4. Review AEIs' exceptional reporting forms to ensure that students have not been disadvantaged and that appropriate support has been put in place for all students during this period. ONGOING

Section 7: Review

Date of next review	Ongoing updates in action monitoring log. Full review of this EqIA on 31 September 2021.
Name of business/operational lead	The EDI Team are coordinating the monitoring of the actions.
How will operational impact be monitored?	Meetings to review the actions with action leads.
What are the success indicators to monitor the impact of the activity?	1 Professionals on our register feel that the NMC is supportive and non-biased because of the information we communicate on Covid-19. 2 The adaptions we make to our registration and fitness to practise functions for the Covid-19 emergency do not lead to unlawful discrimination. 3 There is no bias in the criteria for or in the decisions that are made about temporary registration (access to and removal from the register). 4 Complaints about discrimination or bias on the basis of protected characteristic in how professionals access or are removed from Covid-19 temporary registration are not upheld. 5 We are assured that the professionals on our register are practising in line with the EDI and human rights requirements in the Code despite the emergency situation and take action if we have evidence that they are not. 6 The NMC can report on the diversity of professionals with temporary registration.
How often will the impact be reviewed?	First meeting on 14 April 2020. Review meeting on 2 June 2020. Ongoing meetings and communications with action leads.

Section 8: Sponsor/director sign-off

Declaration: I have read this EqIA and I am assured that all the available evidence has been analysed to determine any potential for unlawful discrimination, advancing equality of opportunity, promoting best practice and fostering good relations. The mitigations where appropriate have been identified and the action plan will be implemented. I am assured that the activity will be compliant with the NMC Welsh language scheme. The equality impacts of this work will continue to be monitored.	
Name/role:	Francesca Okosi, Executive Director of People and Organisational Effectiveness
Date:	31 March 2021