EQIA of the NMC's response to Covid-19

Version 6, covering 1 April 2021 – 30 September 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 almost 745,000 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 (FtP), registration and registration appeals processes, revalidation, communications and intelligence.

We regularly update this EqIA – this sixth version covers the period between 1 April 2021 and 30 September 2021. Previous versions of this document were published in July 2020, September 2020, January 2021 and June 2021.[1]

It should be noted that this version of the EqIA reflects the situation as at 30 September 2021. Subsequent changes (for example, in relation to mandatory vaccinations discussed on P.30 or the impact of the Omicron variant) will be covered in our next update.

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).

[1] Although there are six versions of this EqIA, only five of these versions have been published, starting in July 2020. The first version of this EqIA, completed in April 2020, was for internal purposes only.

Key activity since the publication of the previous version

This latest version of our EqIA brings us up to eighteen months since we introduced temporary registration in March 2020 and began monitoring the equality impacts of our Covid-19 response work.

While our analysis hasn't identified or received concerns about potential discrimination in our amended processes during this period, 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 services. 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 1 April to 30 September 2021, during which time many of the professionals on our register continued to work in challenging circumstances. Over the last six months we have taken several opportunities to recognise the nurses, midwives and nursing associates who have continued to dedicate themselves to the pandemic response, including those who have tragically lost their lives. In July, we shared our annual report for the previous year, which reflected on our ongoing temporary register, and emergency and recovery standards, in response to the Covid-19 pandemic. We rounded off this period by acknowledging the significance of the last 18 months on the nursing and midwifery professions in our celebrations of 100 years since the official opening of the register.

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

- We responded to the PSA's 'Learning from Covid-19' report and highlighted the improvements we have been able to make to key areas of our regulatory work as a result of adapting to the emergency conditions, which should benefit professionals in the long term, including our ability to hold virtual hearings and to grant limited extensions to revalidation application dates in exceptional circumstances.

- We conducted a further analysis of those with Covid-19 temporary registration which found that people with temporary registration were significantly more likely to be aged over 60, significantly more likely to be White British, slightly less likely to be disabled, slightly more likely to be female, and slightly more likely to be Christian, that those with permanent registration.

- We repeated our survey of the professionals who have been deployed since gaining temporary registration, in August 2021, following our earlier findings in September 2020. 57 percent of people with temporary registration who responded to the survey have told us that they have been deployed.

- As one of our revalidation support measures, we continued to offer hardship funding, although the numbers accessing this remain too low to undertake an equality analysis. We have also now moved to offering revalidation extensions of eight weeks for anyone who can provide sufficient reasoning, rather than having a standalone process for extensions relating to Covid-19. We capture data on whether Covid-19 is cited as a reason for requiring this extension.

- We continued to record reports of people on our register who have lost their lives as a result of Covid-19. The last time we analysed the available data on the diversity characteristics of the professionals on our register who lost their lives as a result of Covid-19, we found that 57 percent of people 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 percent). 42 percent were men, compared to 11 percent of those on the register as a whole. We haven't provided updated analysis in the latest version of this EqIA as we have received very few reports of professionals having lost their lives within the latest reporting period.

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.

We continue to uphold our commitment 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 previously 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. New reports have been published by UK REACH which include the data we provided:

- 'Access to personal protective equipment in healthcare workers during the COVID-19 pandemic in the United Kingdom: results from a nationwide cohort study', published September 2021

- '"*The vaccination is positive; I don't think it's a panacea*": A qualitative study on COVID-19 vaccine attitudes among ethnically diverse healthcare workers in the United Kingdom', published September 2021

- 'Ethnic differences in SARS-CoV-2 vaccine hesitancy in United Kingdom healthcare workers: Results from the UK-REACH prospective nationwide cohort study', published October 2021

We have highlighted EDI issues at various stages of the pandemic. In July 2021, we publicly called on everybody touched by nursing and midwifery (in our view, all of us at different points in our lives) to "consider their personal choices carefully and play their part in protecting vulnerable people." Also in July, we commented on the changes to self-isolation rules for health and care professionals in England, highlighting the need for employers to consider the enhanced risk Covid-19 carries for particular groups, and reaffirming to the people on our register that we will take relevant context into account when considering any referrals made against them.

In August 2021, in line with the Joint Committee on Vaccination and Immunisation's advice and in recognition of the new evidence of the significant impact of the virus on pregnant women and people, we encouraged those who were pregnant, and their families to receive a Covid-19 vaccination if they had not already done so.

We also continue to share our evidence and insight in response to reports and policy consultations in order to influence the ongoing response to the pandemic. Over the

period 1 April to 30 September 2021, we have provided the following consultation responses to government, other regulators and our partners (where our response has not been published externally, we have provided a brief summary of the headlines of our response):

- We responded to the DHSC consultation on mandatory vaccinations for care home staff in England and have committed to working with the Government, employers and the wider health and care sector to understand and address the reasons for vaccine hesitancy.

- We responded to the General Optical Council (GOC) consultation on their Remote hearings protocol for 2021, to share our own learning from our approach to virtual hearings in our Fitness to Practise (FtP) processes.

- We submitted our response to the Scottish Government on the development of a suggested approach to establishing an inquiry into the handling of the response to the Covid-19 pandemic in Scotland. In our response, we stated that we supported the principles outlined for the inquiry, particularly the person-centred approach and the importance of the 'four harms' involved in the pandemic. We asked for sight of the terms of reference, and noted connections with the work of some existing inquiries. We have committed to assisting the inquiry however we can.

- We responded to the Welsh Government's consultation on their 'Race Equality Action Plan: An Anti-racist Wales', citing the impact of the Covid-19 pandemic and the health inequalities experienced by people who are Black or from a minority ethnic background.

- We cited the impacts of the Covid-19 pandemic (both those we are currently aware of and those which might manifest in the future), and our own reflections on the work we need to do to understand and tackle health inequalities, in our submission to the Health Education England (HEE) call for evidence on their long-term strategic workforce review.

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 Unison survey which was reported on by the Nursing Times. The survey found that 68 percent of care workers felt their mental health had declined since the start of the pandemic, with 85 percent of those citing work as a reason for this. Other findings from the survey included that 11 percent said they felt unable to cope at times, 13 percent felt depressed or sad and 22 percent were experiencing anxiety, while 3 percent described experiencing post-traumatic stress disorder. The reasons cited by respondents which contributed to their worsening mental health and wellbeing included workload (63 percent), fear of catching or spreading Covid-19 (74 percent), seeing people in their care sick or dying (37 percent), financial worries (39 percent) and the strain of dealing with their employer about sick pay (18 percent).

In the face of this, we remain committed to ensuring that our processes are clear, proportionate and fair, and to minimising 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 the independent and confidential Careline we established for professionals going through the Fitness to Practise process. In May 2021 we signed a memorandum of understanding with the Scottish National Wellbeing Hub and the Scottish Workforce Specialist Service, a confidential self-referral wellbeing service for people on our register based in Scotland, allowing us to share our learning with the scheme and to also learn from its work in order to influence our own work.

Areas we will continue to monitor and report on

We have updated and shared multiple versions of this document as our understanding and evidence of the impact of Covid-19 has developed. Through the continual development of our action plan we have identified several areas we will need to continue to monitor in order to identify and mitigate for inequitable outcomes in our processes.

The areas we intend to continue to monitor as part of our business-as-usual work, are as follows:

- The full set of diversity data on people with temporary registration, compared to those with permanent registration (Action A7).
- Referrals, cases and temporary registration removals for issues which relate to discrimination, and temporary registration removals which explicitly reference discrimination, mental health and other EDI elements in the contextual factors (Actions B4, B5 and B14).
- Complaints we receive about our temporary registration process, or any of our other processes as they relate to Covid-19, which relate to discrimination (Actions B11 and B12).
- That our approach to virtual hearings remains inclusive and accessible, and compliant with the Human Rights Act 1998, including through monitoring and reviewing the relevant EqIA (Actions B17 and B25).
- Contacts made to our Careline in relation to Covid-19, including the numbers of contacts, thematic analysis of issues raised, and the diversity of those contacting the Careline (Action B27).
- Whether added conditions of practice to those with temporary registration who approach three years since practicing, had any negative impact on any groups (Action B32).
- Any intelligence we gather about Covid-19-related issues with EDI themes and links, specifically including mortality rates among professionals related to Covid-19 (Action C3).
- FtP referrals about professionals related to Covid-19 by protected characteristic, and any patterns in source of referral, allegation, and outcome, including analysis of whether referrals appear to be disproportionate for any group, or whether context forms indicate possible inequalities or potential discrimination (Actions C4 and C5).
- The diversity characteristics of people who apply for revalidation extension, those for whom that is granted, and those for whom this is not granted, and if and how this has any relation to the Covid-19 pandemic (Action D14).
- Student feedback, via our quality assurance and complaints processes, on the support available, and the implementation of this support from AEIs and devolved administrations, for any students who may have needed to defer their programmes (Actions E5 and E6).

As we move into a phase of the pandemic which requires us to embed the new ways of working and our learning into our everyday work, we will adopt a refreshed process for reviewing and reporting on the ongoing impact of Covid-19. We expect to next take stock of our learning after March 2022 to review the first two years of Covid-19, and we will ensure future analysis and insight remains accessible to those who have found this work valuable.

Engagement with this EqIA

We want to continue to hear from people to help us assess the impact of Covid-19. 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?
- Have you found these EqIA updates useful? If so, how have you used them?
- Would you like to receive future updates from us about our equality work?

Please respond with your answers to these 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.

Nursing & Midwifery Council

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 6 30 September 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	Jack Kilker Senior Policy Officer (Equality, Diversity and Inclusion)
Senior sponsor	Francesca Okosi, Executive Director of People and Organisational Effectiveness
Review date	31 March 2022 (to undertake analysis of the previous two years of our EDI data and learning and set out our approach to monitoring the equality impact of the pandemic on a longer-term basis).

Nursing & Midwifery Council

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Nursing & Midwifery Council

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.[2] The public sector equality duty (PSED), which is outlined in Section 149(1) of the Equality Act, states that we must give due regard to the need to eliminate discrimination, and to advance equality of opportunity and foster good relations between people who share a protected characteristic and those who do not. 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:

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[2] 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 the professionals on our register 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. We are also mindful of the need to continue to review our own data and evidence, and external sources, to build as thorough an understanding as possible of the different inequalities which are caused and exacerbated by the pandemic.

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 registration and registration appeals

7.3 emergency and recovery standards for nursing and midwifery education

7.4 communications and support

7.5 overseas registration

7.6 retention

7.7 revalidation

7.8 fitness to practise

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 30 September 2021, we know

that we do not have a full set of diversity data for the people on our temporary register, although we have continued to ask for this data through our annual temporary registration survey (last completed August 2021). We published the findings of this survey on 9 December 2021. The survey received a 28.3 percent response rate (3,690) responses.

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[3]

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.

10 Throughout the pandemic, we have reviewed the process for obtaining temporary registration and sought to identify points where there is a risk of bias impacting on decision-making. Mitigating actions we have taken so far include removing identifying information (e.g. names, gender markers) from the documents which are submitted to decision-makers, in order to reduce the potential for bias at this point in the process. We have also built-in management checks at various points in the journey of an application to facilitate peer-review, scrutiny and challenge around the decisions being made. Action B9 in our EqIA action plan requires us to continue to review our temporary registration process for bias and to put in place any necessary mitigating actions.

11 We also continue to monitor our process to enable people with temporary registration to obtain permanent registration, and the rate at which this is happening. The process to move from temporary registration to permanent registration is the same as our process for readmission to the register for those who have lapsed their registration. We last conducted an EqIA on the readmissions process in September 2019, when we last made changes to the readmissions process.

12 Our latest registration data tells us that the number of people obtaining permanent registration following temporary registration has decreased considerably since the last reporting period: between April and September 2021, 1,361 people obtained permanent registration, while between October 2020 and March 2021, 1,895

[3] 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).

people did so. However, this reduction may be as a result of the reopening of our OSCE test centres as an alternative route to permanent registration, rather than professionals applying for temporary registration and then having to convert this to permanent registration.

Registration and registration appeals

13 We continue to work as normal with UK applicants to join and re-join the register. Any changes to our processes to accommodate the move to remote working have settled well, and all applications to join or re-join our register continue as normal. Engagement with our applicants remains at pre-pandemic levels, with telephone and email updates ensuring services remain in place.

14 Registration appeals, which were previously on hold, have restarted. We are holding appeals virtually under our emergency powers in response to the coronavirus guidance. Some of our registration appeal hearings are now also being held in-person, in line with the appropriate coronavirus health and safety guidance.

Emergency and Recovery standards for nursing and midwifery education

15 Throughout the pandemic, 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.

16 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.

17 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 was removed on 30 September 2021.

18 In February 2021, after engaging with our partners across the UK, we introduced an additional recovery standard to enable nursing students to practice and learn through simulated practice learning where conventional clinical practice isn't available or isn't possible up to a maximum of 300 hours. This was designed to help enable students to meet our standard through different modes of learning and

complete their programme when expected. We anticipate that this will have a positive impact on those students who needed to shield, and will work with Health Education England to monitor the impact of this.

19 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.

Communications and support

20 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.

21 In October 2020 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.

22 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.

23 Throughout the pandemic, we have continually reviewed and updated our overseas registration webpages and our Frequently Asked Questions (FAQs). Updates to our FAQs have been based on questions and concerns raised through our Contact Centre and other communications channels.

24 In June 2021, we shared an interview we conducted with the British Indian Nursing Association who are a voice and support network for nurses of Indian origin in the UK health and care system, and who created a helpline for peers in India facing severe effects from the Covid-19 pandemic. Also in June, we shared an interview with a Specialist Cultural Liaison Midwife about health inequalities in midwifery and how inequalities can specifically impact on people from ethnically diverse communities. In our June student newsletter we shared an interview we conducted

on a student’s experience of studying during the pandemic and their advice for other students.

Overseas registration

25 The UK health and social care system relies on the care of professionals who trained in other countries. We aim to do everything we can to support overseas candidates with their registration for UK practice. We continue to process applications from overseas applicants wishing to join our register. Due to advice from the UK Government, all objective structured clinical examination (OSCE) tests were suspended from 23 March 2020. All three OSCE test centres in the UK reopened on Monday 20 July 2020 and remain open, operating in line with government advice around Covid-19 safety measures (which we continually monitor). All of our current OSCE test centres also have fully up-to-date risk assessments in place which are reviewed regularly.

26 We have previously received concerns regarding professionals with temporary registration being required to pass the 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.

27 We recognise that many of the candidates are from Black and other minority ethnic (BME) 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.

28 Prior to the pandemic we were piloting running the computer based test (the CBT) online. This enables candidates to take the test at home or their place of work, rather than at a test centre. We have now completed the pilot which was considered a success, and are taking steps to permanently offer candidates the choice on how they sit the CBT. This change will require system development work for both the test supplier and the NMC, which is currently being scoped out. Whilst we update our systems to move beyond the pilot we are allowing those candidates that are eligible to complete the legacy CBT to sit the online test if they’re struggling to attend a test centre due to Covid-19 or local restrictions and lockdowns.

29 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. More recently, we published our EDI data tables 2020-2021 which include data about the people with temporary registration.

30 We recently published a mid-year report on those with permanent registration and temporary registration, covering the period 1 April 2021 to 30 September 2021. We have also recently published our analysis of the responses we received to our annual temporary registration survey. The survey ran between 24 August and 6

September 2021 and received responses from 3,690 of the 13,043 people on the temporary register at the time (a 28.3 percent response rate). We are also closely monitoring complaints and test appeals and developing a separate EqIA on our overseas registration processes.

Retention payments

31 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 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.

32 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 this data.

Revalidation

33 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. Over the winter, and in light of the worsening pandemic, we 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). This included an opportunity for professionals to be granted a second 12-week extension if their ability to revalidate continued to be affected by Covid-19, and if their request was supported by their confirmer.

34 As of 30 September 2021, we have reviewed and updated our approach to extensions so that revalidation extensions are available to anyone who is able to provide sufficient reasoning as to why they have not been able to meet the original deadline, whereas previously during the pandemic, this needed to be because of a specific issue relating to Covid-19. This is now embedded as part of our business-as-usual in our revalidation processes, although we will continue to monitor the impact of Covid-19 and whether this may need to be reviewed in the future.

35 We have previously 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 were granted an extension between March 2020 and March 2021 was very similar to those who hadn’t had an extension; however, they tended to be slightly older and more likely to say they have a disability (5 percent of those who have been granted an extension compared to 3 percent who haven’t). Slightly fewer were female – 87 percent of those granted an extension were women, compared to 90 percent without an extension. We are not currently monitoring the diversity data of those requesting and being granted an extension due to the change in the process, although we will ensure that we are able to do so moving forwards. We do know, however, that the number of extension requests which are rejected would be too low to be able to conduct an analysis of the diversity characteristics of the people making these rejected requests.

Fitness to practise

36 We aim to maintain our fitness to practise processes for the purpose of public protection. We are mindful of the effect on referrers and professionals of extended delays to cases as well as the impact of our enquiries 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.

37 In January 2021 we opened a public consultation on the ongoing use of our emergency powers, including public access for virtual hearings. In February 2021 we published an analysis of the responses to this consultation. We found that there were differences in people's views, for example, 43 percent of men and 38 percent of disabled people thought there were reasons the NMC should not continue to hold hearings virtually once the emergency period ends, compared to 19 percent of women and 24 percent of people who weren't disabled. Some carers welcomed virtual hearings, while people from the Gypsy Roma Traveller communities felt access to the internet and literacy issues would mean virtual hearings could cause a disadvantage.

38 As well as our own research, we are also mindful of the findings and recommendations of the Professional Standards Authority (PSA) in their April 2021 publication, 'Learning from Covid-19 – a case study review of the initial crisis response of 10 UK health and social care professional regulators in 2020'. In the report, the PSA noted the following; "We think that there are some clear advantages in moving hearings online: it makes them less London or England centric… and virtual hearings are more accessible for people wherever they live."[4] The PSA also noted that "regulators should formally evaluate [virtual hearings] and ensure they deliver appropriate protection to the public. In particular, it will be important to consider the experience of participants and panel members and identify their impact on efficiency and quality."[5]

39 We now include virtual hearings as a standard option in our processes, regardless of the Covid-19 emergency. We ensure that a professional has access to, and is able to use, our technology before we list a hearing virtually. We also assure professionals 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

[4] The Professional Standards Authority. *Learning from Covid-19 – a case study review of the initial crisis response of 10 UK health and social care professional regulators in 2020.* 15 April 2021. [accessed 8 November 2021].
[5] The Professional Standards Authority. *Learning from Covid-19*.

negative impacts are dealt with and that barriers are removed so that no group is disadvantaged.

40 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.

41 We will continue to keep the fairness and effectiveness of our virtual hearings under review. We consider the use of virtual hearings an important element of our recovery planning from the Covid-19 pandemic, 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, and will enable us to hold hearings whilst there remains a concern from participants about travelling to our hearing centres, and in future, where participants might otherwise experience barriers in travelling to or accessing our hearing centres.

42 Early in 2020, as part of improving the way we handle concerns, we began taking steps to address an increase in our FtP caseload. However, the Covid-19 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, creating long-lasting improvements to the way we regulate, including through our Change Board and our Fitness to Practise Improvement Programme.

43 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. The steps we have taken to simplify our guidance and enable professionals to provide us with information about how they've strengthened their practice have led to an increased number of cases being resolved without the need for a lengthy investigation. We will monitor the impact of our caseload recovery work and seek to mitigate any disproportionate impact on an ongoing basis.

44 Last year we 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. The contract for the Careline has been extended for a further year from October 2021.

45 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. Between 1 April 2021 and 30 September 2021, the Careline received 267 contacts from professionals seeking support for various professional and personal issues. This included discussions about health, family, performance and employment termination.

46 We ask the people accessing this service for their diversity information however we receive low numbers in many categories, which makes analysing this data for some protected characteristics difficult. We have the highest number of complete data for gender, which we have been able to analyse as follows; our data for this period suggests that 86 percent of the contacts were from women and 14 percent from men, which is a change compared to the previous period where 78 percent of the contacts were from women, compared to around 21 percent from men. The data for other characteristics are still too small for us to meaningfully analyse or share, but we will work with the provider to enhance our data collection in this area.

47 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 percent of the overall referrals received by us in the last year (since March 2020). The numbers of individuals were low and we were cautious about drawing conclusions from this data, however the figures did indicate some differences, for example higher numbers of Black professionals and male professionals being referred compared to their proportion on the overall register.

48 We have analysed the diversity of the professionals who had been referred to our fitness to practise function relating to Covid-19 again, this time for the period 1 April 2021 to 30 September 2021. The EDI dataset available on the referrals received was again too small to draw robust conclusions, however we have been able to identify some points of interest in our analysis.

49 During the reporting period of 1 April 2021 to 30 September 2021, there were 2,731 referrals received by the NMC; 133 (5 percent) of these related to Covid-19, considerably lower than the 12 percent of referrals received between March 2020 and April 2021. 27 percent of the referrals related to Covid-19 involved allegations relating to the theme of ‘breach of lockdown rules’, 19 percent related to ‘inappropriate Covid-19 related social media posts’, and 15 percent related to ‘social distancing’.

50 Our analysis of the diversity characteristics of the people on our register whom the referrals were made about showed that white people, females and people aged between 41 and 50, were slightly overrepresented compared to their proportions on our register, which is a direct contrast to our findings for the previous period from March 2020 to April 2021. However, as the numbers are still relatively small and the current reporting period is only six months compared to our previous report covering a period of 12 months, we are not yet able to draw robust conclusions regarding this data. We intend to review the full dataset across a two year period from April 2022 in order to build a more robust understanding of the representation of data across the fuller two-year reporting period.

51 In the six months leading up to 30 September 2021, 77 percent of the Covid-19 related concerns had been concluded and 23 percent remained open. All of the concluded referrals had decisions not to investigate, while 9 percent of the open

cases had passed the NMC referral threshold and are currently being investigated, and the remaining 14 percent of referrals are still in the screening stage. By contrast, our April 2021 analysis of referrals from the previous 12 months showed that 64 percent of Covid-19 related referrals during that period had not progressed for further investigation.

Section 2: Evidence

Research and reports	See references, links and footnotes in the document. *Covid-19 Insights from external research and data*; updated 29 October 2021; Caroline Kenny, Head of Research and Evidence (Trim: 6828329) Four new reports have been published as part of the UK REACH project looking at the disproportionate impact of Covid-19 on health and care workers from a Black or minority ethnic background. This includes research into access to personal protective equipment, finding professionals from Asian backgrounds, and those based in London, have experienced a relative lack of access to appropriate PPE[6]; a qualitative study exploring attitudes to vaccines among healthcare workers which identifies greater hesitancy among those of Black and minority ethnic backgrounds[7]; and differences in the rate of vaccine hesitancy among healthcare workers, reported to be greater among younger, women, pregnant and Black professionals[8]. **Further research published since the previous update of this EQIA includes:** A report published in the BMJ discussing the 'equal but inequitable' nature of specialist palliative care services for ethnic minority groups with Covid-19[9];

[6] Martin, A., C., Pan, D., Nazareth, J., Aujayeb, A., Bryant, L., Carr, S., Gray, L. J., Gregary, B., Gupta, A., Guyatt, A., Gopal, A., Hine, T., John, C., McManus, C., Melbourne, C., Nellums, L. B., Reza, R., Simpson, S., Tobin, M., Woolf, K., Zingwe, S., Khunti, K., Pareek, M. *Access to personal protective equipment in healthcare workers during the COVID-19 pandemic in the United Kingdom: results from a nationwide cohort study (UK-REACH)*, 21 September 2021 [accessed 21 October 2021].

[7] Gogoi, M., Wobi, F., Qureshi, I., Al-Oraibi, A., Hassan, O., Nellums, L., Pareek, M. *"The vaccination is positive; I don't think it's the panacea": A qualitative study on COVID-19 vaccine attitudes among ethnically diverse healthcare workers in the United Kingdom,* 28 September 2021 [accessed 22 October 2021].

[8] Woolf, K., McManus, I., Martin, C. A., Nellums, L. B., Guyatt, A. L., Melbourne, C., Bryant, L., Gogoi, M., Wobi, F., Al-Oraibi, A., Hassan, O., Gupta, A., John, C., Tobin ,M., Carr, S., Simpson, S., Gregary, B., Aujayeb, A., Pareek, M. Ethnic differences in SARS-CoV-2 vaccine hesitancy in United Kingdom healthcare workers; Results from the UK-REACH prospective nationwide cohort study, October 2021 [accessed 22 October 2021].

[9] Bajwah, S., Koffman, J., Hussain, J., Bradshaw, A., Hocaoglu, M. B., Fraser, L. K., Oluyase, A., Allwin, C., Dunleavy, L., Preston, N., Cripps, R., Maddocks, M., Sleeman, K. E., Higginson, I. J., Walshe, C., Murtagh (CovPall study team), *Specialist palliative care services response to ethnic minority groups with COVID-19: equal but inequitable – an observational study*. 12 September 2021. [accessed 22 October 2021].

	Two papers exploring the disproportionate impact of Covid-19 on minority ethnic groups, one from the BMJ[10] and one published in the Journal of Infection[11]; Further research on ethnic minority healthcare worker attitudes to vaccination published in Ethnicity and Health[12]; Work from Cambridge University Press concerning the impact of the pandemic on the health and well-being of healthcare workers in the UK[13]; The Royal College of Nursing (RCN) 'Second Covid-19 Vaccine Survey Report', published in April 2021[14]; A study accepted by The Lancet on 23 September 2021, titled 'Long Covid risk – a signal to address sex hormones and women's health.'[15]
	Previously noted research includes: *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

[10] Katikireddi, S. V., Lal, S., Carrol, E. D., Niedzwiedz, C. L., Khunti, K., Dundas, R., Diderichsen, F., Barr, B. *Unequal impact of the COVID-19 crisis on minority ethnic groups: a framework for understanding and addressing inequalities.* 21 April 2021. [accessed 22 October 2021].

[11] Martyn, M. E., Whitaker, H., Gil, E., Ighomereho, P., Lambe, G., Conley, R., Saldiray, J., Ladhani, S. N., Mirfenderesky, M. *Disproportionate impact of SARS-CoV-2 on ethnic minority and frontline healthcare workers: A cross-sectional seroprevalence survey at a North London hospital*. June 2021. [accessed 22 October 2021].

[12] Woodhead, C., Onwumere, J., Rhead, R., Bora-White, M., Chui, Z., Clifford, N., Connor, L., Gunasinghe, C., Harwood, H., Meriez, P., Mir, G., Nielson, J. J., Raffery, A-M., Stanley ,N., Peprah, D., Hatch, S., L. *Race, ethnicity and COVID-19 vaccination: a qualitative study of UK healthcare staff,* 6 June 2021 [accessed 22 October 2021].

[13] Gilleen, J., Santaolalla, A., Valdearenas, L., Salice, C., Fuste, M, *Impact of the COVID-19 pandemic on the mental health and well-being of UK healthcare workers.* 29 April 2021. [accessed 22 October 2021],

[14] The Royal College of Nursing (RCN). *Second RCN COVID-19 Vaccine Survey Report.* 13 April 2021. [accessed 8 November 2021].

[15] Stewart, S., Newson, L., Briggs, T. A., Grammatopoulos, D., Young, L., Gill, P. *Long COVID risk – a signal to address sex hormones and women's health*. 2 November 2021. [accessed 8 November 2021].

	age, sex, deprivation, region, testing pillar, time since start of the epidemic and pre-existing health conditions[16]. 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 percent of disabled people who were receiving medical care before Covid-19 currently receiving treatment for only some of their conditions[17]. 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[18]. Runnymede Trust released 'Over-Exposed and Under-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 percent of Bangladeshi, 42 percent of Pakistani and 41 percent of Black African key worker respondents reported that they had not been given adequate PPE.[19] 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 BME groups than white people during the pandemic. For example, employment worries have negatively affected the mental health of 61 percent of people from BME backgrounds, compared to 51 percent of white people. Other issues saw a similar pattern, including

[16] Public Health England and Race Disparity Unit; COVID-19: pre-existing health conditions and ethnicity; 18 December 2020.
[17] ONS; *Coronavirus and the social impacts of disabled people in Great Britain*; 20 August 2020
[18] ONS: *Coronavirus (COVID-19) related deaths by disability status, England and Wales: 2 March to 15 May 2020*; 19 June 2020
[19] Runnymede Trust; *Over-exposed and under-protected: The Devastating Impact of COVID-19 on Black and Minority Ethnic Communities in Great Britain*; August 2020

	getting support for a physical health problem (39 percent vs 29 percent) and being a carer (30 percent vs 23 percent).[20] 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.[21] 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 previous Year four revalidation tables showed that the revalidation rates of people on our register with permanent registration varied 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. Our Year five revalidation tables again show that the revalidation rates of people on our register with permanent registration vary slightly between some people with different protected characteristics. For example, people on our register from an Asian/British Asian Indian background were the most likely to revalidate (87.7 percent), while people from 'any other mixed background' were the least likely (58.0 percent). Also, people whose gender identity did not match the sex assigned at birth (or within six weeks) were slightly more likely to revalidate (84.4 percent) than those whose gender identity did match the sex assigned at birth (or within six weeks) (80.7 percent). **Temporary registration** EDI data about people with Covid-19 temporary registration is taken from different sources. This includes data we have 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. For clarity, the following summary has been broken down into time periods. Data as of March 2021 (including comparisons to July 2020):

[20] Mind; *Online survey of mental health*; July 2020
[21] Inclusion London; *Abandoned, forgotten and ignored; the impact of the coronavirus on disabled people*; June 2020

	• There were fewer people who trained overseas with temporary registration on 31 March 2021 (5.6 percent) compared to in July 2020 (18.2 percent). 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 percent 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 percent) are White British, compared to around two thirds (67.7 percent) of people with permanent registration. Only 1.8 percent of people with temporary registration are Black African, compared to 7.3 percent 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 percent) who are disabled compared to those with permanent registration (3.6 percent). • 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.

- Between July 2020 and March 2021 there was a reduction in the proportion of overseas applicants for temporary registration across each of the four UK nations, and this differed considerably for each nation. In England the proportion of overseas applicants fell from 20.7 percent in July 2020 to 5.7 percent in March 2021; in Scotland the proportion of overseas applicants fell from 1.8 percent in July 2020 to 0.6 percent in March 2021; in Wales the proportion of overseas applicants fell from 10.9 percent in July 2020 to 0.8 percent in March 2021; and in Northern Ireland the proportion of overseas applicants fell from 14.3 percent in July 2020 to 6.6 percent in March 2021.

- In July 2020, 2,645 professionals (28.3 percent) with temporary registration had started practising, 1,053 (11.3 percent) had received an offer but not yet started, and 5,190 (55 percent) had not yet received an offer of employment or started practising. The remaining professionals either selected 'prefer not to say' or 'other' in response to the question on deployment.

Data as of September 2021:

- Of the 3,690 people with temporary registration who responded to our most recent survey (August – September 2021), 57.5 percent (2,120) told us that they had been deployed. Most of these are those that used to have permanent registration (98.8 percent), are aged over 60 (62.5 percent), are women (91.8 percent), are not disabled (95.1 percent), are White British (92.7 percent), are heterosexual (93.5 percent), their gender identity matches that assigned at birth (or within six weeks) (99.2 percent), and are Christian (64.8 percent).

- Not everyone with temporary registration has been asked about their deployment. Deployment questions were only asked of those that were sent the Annual Temporary Registration Survey in June 2020 and August 2021. This includes people who had left the register less than three years ago, between three and five years ago and overseas applicants.

	Data completeness On 27 May 2020 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 contacted those people with temporary registration between 27 May and 1 July 2020 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. We have contacted the people with temporary registration to ask them to complete their diversity information as follows: • Sending a one-off email on 27 May 2020 to 13,796 people with temporary registration asking them to complete their diversity information. • Adding a link to our diversity monitoring form to all confirmation emails sent to new joiners with temporary registration from 1 July 2020. • A one-off email to those people who gained temporary registration between 27 May and 1 July 2020 asking them to complete their diversity information. • A further email to 13,043 people with temporary registration on 24 August 2021 which also included a request to complete diversity information. With the new virtual hearings we have an improvement survey that collects diversity data, but the numbers responding have been very low. This was last completed in August and September 2021. • As of 27 October 2021, there are 14,660 professionals with temporary registration. However, due to EDI questions being optional in the surveys we have sent out, we do not have EDI data for all of these professionals. • We are currently missing gender data from 854 professionals and ethnicity data from 851 professionals (5.8 percent). • We do not know the deployment status of 6,325 professionals with temporary registration (43.1 percent). Deployment questions were only included

	in the Annual Temporary Register Surveys, rather than in the additional EDI data requests. We granted a blanket 12-week extension period for all of the professionals on our register who were due to revalidate from March 2020 until during the summer of 2020, and again from November 2020 to March 2021. As a result of this, we are not able to analyse data on who has been granted an extension throughout the pandemic and whether or not this has related to Covid-19, as our blanket 12-week extension period meant there was no need for professionals to request an extension or to provide their reasoning.
Social media	Between 1 April and 30 September 2021, conversations on social media have reflected the nursing and midwifery workforce's on-going concerns around the impact Covid-19 is having on staffing, morale and retention. As the summer progressed calls increased for more to be done to address the upcoming winter and its inevitable pressures on the health and social care sector as a whole. In addition, many students expressed their concerns that the disruption of their studies caused by Covid-19 means they are struggling to meet practice placement hours and get valuable experience. There was an increasing interest in what the NMC is doing to tackle referrals where there may have been an element of racial discrimination. Many of these conversations were a positive reaction to our Managing Concerns resource; however, there was frustration expressed at the speed at which these referrals are closed.
Corporate complaints and compliments	Since 1 April 2021 we have received a total of 41 Covid-19 related complaints. This compared to 82 complaints received relating to Covid-19 during the period 30 September 2020 to 31 March 2021, double that received in the current reporting period. We haven't received any Covid-19 complaints highlighting equality, diversity or inclusion issues since before March 2021. The recent trends have been in relation to the below: • Waiving our annual registration fee; • Proposed legislation to make Covid-19 vaccinations mandatory for care home staff; • Registered nurses being required to administer vaccines despite them not having been through the usual rigorous testing procedures; • Possible rollout of the vaccines to under 18s;

	• Pregnant women and people, and those nursing taking the Covid-19 vaccine; and, • Non-medical individuals administering the Covid-19 vaccine.

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. We have limited the length of time that can have lapsed since a professional was last on our register; our website states “the Covid-19 temporary register is currently only open to people who left our permanent register between 1 March 2015 and 31 December 2021.” 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). We have not found evidence that this issue occurred 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 The ONS have published analysis 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[22]. An IPPR/YouGov poll conducted in 2021 found that 29 percent of nurses and midwives state that they are more likely to leave the sector than they were a year ago[23]. **Covid-19 vaccination** A survey conducted by the Royal College of Nursing shows that in February 2021, 85 percent of nursing staff had received at least one vaccine dose[24]. As the UK continues the rollout of vaccines and follows a roadmap out of the pandemic, the conversation shifted towards the appropriateness of mandatory vaccinations. The Royal College of Nursing repeated this survey in April 2021, and reported that, of those who responded to their survey, 98 percent of respondents had been offered a Covid-19 vaccine and 94 percent had received at least their first dose.[25] Under the Public Health Act 1984, the UK government cannot require a person to undergo mandatory medical treatment (including vaccination). However, it was announced that all frontline health and care workers, including volunteers, in England will be required to demonstrate that they have been fully vaccinated against Covid-19 in order to be deployed, with the deadline for those working or volunteering in adult care home settings set for Thursday 11 November. This was due to expand to other settings from April 2022. The Department of Health and Social Care have outlined their rationale in response to the consultation on mandatory vaccinations, which the NMC provided our response to in May 2021. 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 say they would be hesitant to take up the vaccine, including those from ethnic minority backgrounds. The study recommended working

[22] 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
[23] Patel, P. & Thomas, C. (2021) *Recover, Reward, Renew: A post-pandemic plan for the healthcare workforce*, Institute for Public Policy Research
[24] Royal College of Nursing, *RCN COVID-19 Vaccine Survey Report*, 09-02-21,
[25] Royal College of Nursing, *Second RCN Covid-19 Vaccine Survey Report*. 13 April 2021.

	with communities and designing inclusive communications on the vaccination programme. The report, *A qualitative study on COVID-19 vaccine attitudes among ethnically diverse healthcare workers in the United Kingdom* was published in September 2021 as a result of the study. **People shielding** In England, over two million of people have been identified as clinically extremely vulnerable (CEV) to severe impact from Covid-19 and have been advised to shield from others. The Office of National Statistics (ONS) 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 percent said they were not at all comfortable to work outside their home.[26] A similar study by the ONS for the period 11-16 October, found that 22 percent of CEV people were continuing to shield and 68 percent were no longer shielding but still taking extra precautions.[27] 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[28]. 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[29]. 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[30] and others having an increased levels of wellbeing[31]. In January 2021 we received an email from a disabled nurse who was on the clinically extremely vulnerable register. They

[26] 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 19-11-21]
[27] Office of national Statistics; *Coronavirus and shielding of clinically extremely vulnerable people in England: 11 October to 16 October 2021*; 02-11-2021 [last accessed 19-11-21]
[28] 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]
[29] 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]
[30] 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
[31] Sloan, M. et al. (2021) COVID-19 and shielding: experiences of UK patients with lupus and related diseases, *Rheumatology Advances in Practice,* 5:1

	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. On 1 April 2021 the government paused the shielding programme as part of the roadmap out of the pandemic. On 15 September the government advised that the CEV population will not be advised to shield again, as the government agreed to end the requirement for centralised guidance for CEV groups, following expert clinical advice. **Mental health** 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[32]. Furthermore, when looking specifically at mental health nurses the risk of getting infected and infecting family were among the top concerns mentioned.[33] A paper published by Cambridge University Press has highlighted the significant mental health and wellbeing impact of the pandemic on healthcare workers in the UK, with nearly a third reporting moderate to severe levels of anxiety and depression, and the number reporting 'very high' symptoms being more than four times what it was 'pre-COVID-19'. Those who reported severe symptoms were reported as being more likely to be female; working on the 'front line'; having previous psychiatric diagnoses; having experienced traumatic events and being an allied healthcare worker or manager.[34] A recent Unison survey, reported on by the Nursing Times in September 2021, also found that 68 percent of care workers felt their mental health had declined since the beginning of the pandemic, with 74 percent of respondents to the survey identifying fear of catching or spreading Covid-19 as a reason

[32] 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.
[33] 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.
[34] Gilleen et al.

	for this, and 37 percent citing seeing people in their care sick or dying.[35]
Age	**Our registrants engaging with the public** The effects of Covid-19 are more serious for people older than 60.[36] The patients being treated for Covid-19 are more likely to be above 60 years of age. 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 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 percent 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 in March 2021 showed that people with temporary registration are older than those with permanent registration. Around three quarters of those with temporary registration (78 percent) are aged 50 and over, compared to around a third (35.1 percent) with permanent registration being aged 51 and over.[37] 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

[35] Ford, M., Unison, The Nursing Times. *Fresh concerns over mental health and wellbeing of care workforce.* 15 September 2021. [accessed 8 November 2021].
[36] 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]
[37] 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.

	applicants (who tend to be younger) as many overseas temporary registrants have now obtained permanent registration and a higher proportion who had previously left the permanent register (who tend to be older). The findings of our annual temporary registration survey (September 2021) showed that people aged 61 and over are more likely to consider applying for permanent registration than people aged 20-60 with temporary registration. We also know that 62.5 percent of those with temporary registration who have told us that they have been deployed are aged over 60. 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). 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 previously stated: '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 70 or over to join the temporary register. However, you can still apply to join our temporary register if you want to.' As of 31 March 2021, there were 207 professionals aged 71 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). A report on access to personal protective equipment (PPE) published in September 2021, suggested that older healthcare workers were more likely to report having access to appropriate PPE 'at all times'.[38] **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). The PSA have also recently stated the following in their *Learning from Covid-*

[38] Martin et al, *Access to personal protective equipment*, (UK REACH)

	19 report; “the Authority supports the continuing transfer to digital, electronic and virtual working in the interests of speed and efficiency, subject to further work to ensure that particular groups of stakeholders (in particular patients, service users and the public, registrants and potential registrants) are not excluded from engagement with regulators as a result.”[39] We 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. We continue to monitor the types of adjustments which are required and steps we can take to make sure that our hearings are accessible, whether virtual or physical. **Vaccination** Research by the UK REACH project identified ‘younger age’ as one of the independent predictors of Covid-19 vaccine hesitancy for healthcare workers in the UK. Younger professionals as such may be at greater risk of complications from Covid-19, as well as spreading infection when engaging with members of the public and colleagues.[40]
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.[41] 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 percent for non-disabled people. This research also indicates that around a quarter of disabled people were currently receiving treatment for only some of their conditions in comparison to before the coronavirus pandemic.[42]

[39] The Professional Standards Authority. *Learning from Covid-19*.
[40] Woolf et al. (UK REACH).
[41] Ibid.
[42] Office for National Statistics (2020) Coronavirus and the social impacts on disabled people in Great Britain: July 2020

	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 experience health inequalities in health settings. Nurses, midwives and nursing associates are 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 suggest 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 had 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. 2020 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.[43] 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 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.

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

	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 showed that there was 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). Of the people with temporary registration who have told us whether or not they have been deployed, 4.9 percent have told us that they are disabled. 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,[44] particularly among those with severe symptoms. Women are more likely to be diagnosed with a common mental illness[45] but men are more likely to take their own lives. The professionals on our register are more likely be experiencing stress and working in stressful conditions, and their mental health concerns may be higher than for the general population.

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

	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. 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. We have implemented a range of reasonable adjustments to support professionals engaging with our regulatory processes, which have included holding a hearing physically or virtually depending on the needs of those involved; facilitating mixed/hybrid hearings where some participants were able to attend virtually; allowing people with poor connectivity and digital access to attend one of our sites and access our Wi-Fi in order to participate virtually; allowing additional time in virtual hearings to account for connectivity issues; use of speech-to-text simultaneous transcribers to facilitate participation for someone who is deaf; screening a virtual hearing at one of our sites for observers to watch, where they do not have the digital access or satisfactory connectivity to be able to do this themselves from home. The National Voices report, 'Unlocking the Digital Front Door: Keys to inclusive healthcare', notes the following; "we understand that people might be digitally excluded for a range of reasons. There is sometimes an assumption that equipment and skills will solve the virtual health access problem, but it is much more complex than this… often people have more than one reason why they might be at a disadvantage. People might face barriers to digital health if they are disabled, blind or partially sighted, deaf, have dementia, learning difficulties or mental health issues."[46] **Supporting students** For students with health conditions who were shielding either personally, or by association with a family member, they may have had to suspend their studies and complete later than they normally would (Ref 17 in the action plan).

[46] National Voices. *Unlocking the Digital Front Door: Keys to inclusive healthcare.* May 2021. [accessed 10 November 2021].

	Vaccination In light of the government announcement that all staff and volunteers working in adult care homes in England will be required to evidence that they have been fully vaccinated against Covid-19 as a condition of deployment, this could have unintended impacts on disabled people in the adult care workforce. The government's equality impact assessment on this policy decision noted that "the policy could force staff to disclose their disabilities to management, with the risk of less favourable treatment by their employer or colleagues."[47] We replied to the government consultation on this decision in May 2021. An Understanding Society UK study from April 2021 found that disparities in uptake of the Covid-19 vaccine were linked to pre-pandemic diagnoses relating to both mental and physical health. The study also found that individuals who had been prioritised for Covid-19 vaccinations due to their physical medical conditions were more likely to have accepted the vaccine.
Gender	**Our registrants engaging with the public** Data has suggested that the effects of Covid-19 are more serious for men, however,[48] the government guidance about vulnerable groups does not specify that men should be taking different steps. An article published in The Lancet in September 2021, 'Long COVID risk – a signal to address sex hormones and women's health' described factors contributing to the disproportionate impact of Long Covid-19 on women, stating "despite the already vulnerable socioeconomic positions of women during the pandemic, their ability to return to work is further impeded by the chronicity of symptoms of Long COVID. This situation is likely far more challenging for perimenopausal and menopausal women who already experience significant additional inequality in the workplace."[49] The article goes on to describe how "many symptoms of Long COVID (fatigue, muscle aches, palpitations, cognitive impairment, sleep disturbance) have a significant overlap with perimenopause and menopause, both which can affect women of all ages. Such overlap may create diagnostic uncertainty

[47] DHSC, Equality Impact Assessment.
[48] 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.
[49] Stuart, S., et al. September 2021.

	and requires clinicians to assess for this additional diagnosis… it could lead to women with symptoms of the perimenopause and menopause being misdiagnosed with Long COVID."[50] **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.[51] Our latest annual registration data report shows that as of 31 March 2021, 89 percent of the people on our register were female.[52] 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 percent) with temporary registration, compared to those with permanent registration (89.2 percent). There is also a slightly lower proportion of men amongst those with temporary registration (9.8 percent) compared to those with permanent registration (10.8 percent). 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 percent of professionals with temporary registration did not provide their gender, compared to less than 0.1 percent of professionals with permanent registration who did the same. A large proportion of the overseas cohort (24.4 percent) are missing information on gender. As of September 2021, we know that, of the people with temporary registration who have told us whether or not they have been deployed, 91.8 percent of those who have been deployed are women, which is slightly higher than the proportion of women with temporary registration overall. 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, between March 2020 and March 2021, 42 percent of those who lost their lives were male – more than four times higher their number on the register as a whole (11 percent). The numbers of people being reported to us as having lost their lives have been too small for us to repeat this analysis.

[50] Stuart, S., et al. September 2021.
[51] 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
[52] House of Commons Library (2020) Mental Health Awareness Week: The impact of coronavirus on health and social care workers. UK Parliament

	Vaccination Research by the UK REACH project identified 'female sex' as one of the independent predictors of Covid-19 vaccine hesitancy for healthcare workers in the UK. Given the large majority of nursing and midwifery staff are women, they may be at greater risk of complications from Covid-19, as well as spreading infection when engaging with members of the public and colleagues.[53] Conversely, the Department of Health and Social Care equality impact assessment on '[making vaccination a condition of deployment in care homes for working age adults]' (June 2021) notes that "although women are more likely to admit to vaccine hesitancy, they are also more likely to have been vaccinated. NHS England data on vaccination uptake as of 10 June [2021] shows that in every age group and in every region of England, more women than men had received both doses of the vaccine."[54] **Mental health** The paper from Cambridge University Press cites being a female healthcare worker as increasing the risk of experiencing a negative impact on their mental health and wellbeing, specifically severe symptoms of anxiety and depression, as a result of the pandemic.[55]
Gender reassignment[56]	**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 percent of the population might identify as trans, including people who identify as non-binary,[57] 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 experience health inequalities in health settings.[58] In addition there is evidence that some groups of patients face discrimination from health care workers, while trans health professionals face discrimination from other

[53] Woolf et al. (UK REACH).
[54] DHSC, Equality Impact Assessment.
[55] Gilleen et al.
[56] Including trans and non-binary
[57] 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]
[58] *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 percent 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 percent of people who are ‘prefer not to say’ or unknown for gender identity. As of September 2021, we know that 0.8 percent of the people with temporary registration who have told us that they have been deployed, have said that their gender identity does not match the sex they were assigned at birth (or within six weeks), which is higher than the proportion of those with temporary registration to identify in this way overall. There is evidence[59] that gender identity clinics were closed for at least six months and the employees were redeployed. As of September 2021, we believe clinics have now re-opened, although understand that they may be offering only a reduced service. This period of closure, and the subsequent backlog of appointments, could have had, and may continue to have, a detrimental impact on people on our register 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 currently 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** Our understanding of the impacts on and outcomes of pregnant women and people with Covid-19, compared to those

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

	who are not pregnant, continues to evolve as further research is conducted and the pandemic progresses. The NHS's guidance on pregnancy states that "if you're pregnant your chance of getting COVID-19 is not higher than anyone else and it's very unlikely you'll get seriously ill with it. Pregnant women are in the moderate risk (clinically vulnerable) group as a precaution. This is because you can sometimes be more at risk from viruses like flu if you're pregnant. It's not clear if this happens with COVID-19." The guidance goes on to say that "although it's very rare for pregnant women to become seriously ill if they get COVID-19, it may be more likely later in pregnancy… It may be possible for you to pass COVID-19 to your baby before they're born. But when this has happened, the babies have got better. There's no evidence COVID-19 causes miscarriage or affects how your baby develops in pregnancy." This guidance was most recently updated on 11 November 2021. However, the National Perinatal Epidemiology Unit at Oxford University, have reported that new data shows a rise in hospital admissions for unvaccinated pregnant women (July 2021). This report states that "COVID-19 poses significant risks to both mother and baby. Pregnant women are particularly vulnerable to becoming severely ill from COVID-19, and around one in ten pregnant women admitted to hospital with symptoms of COVID-19 require intensive care. One in five pregnant women admitted to hospital with symptoms of COVID-19 gives birth prematurely." This report also discusses how data from the UK Obstetric Surveillance System, shows that Covid-19 vaccinations offer effective protection from these risks: "Vaccination data has been collected since 1 February 2021. Of 742 women admitted since that date, only four have received a single dose of vaccine and none have received both doses." 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 index (BMI) and whether they have any underlying health conditions.[60]

[60] 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)

	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. We do not currently have data on the proportion of those with temporary registration who are pregnant and have been deployed. **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 women and people, or those on maternity or other forms of parental leave, 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). **Vaccination** Research by the UK REACH project identified 'pregnancy' as one of the independent predictors of Covid-19 vaccine

	hesitancy for healthcare workers in the UK. Pregnant professionals as such may be at greater risk of complications from Covid-19, as well as spreading infection when engaging with members of the public and colleagues.[61] The Department of Health and Social Care equality impact assessment on 'making vaccination a condition of deployment in care homes for working age adults' (June 2021) notes that the advice on vaccination during pregnancy was updated in April 2021 and that "the advice recommends that those who are breastfeeding are informed about the lack of data on the safety of the vaccine while breastfeeding."[62] In August 2021, we issued a statement on new vaccination advice for pregnant women, in which we stated "we encourage all pregnant women and their families to receive a Covid-19 vaccination if they have not already done so in order to provide the best protection against Covid-19." This advice was in line with advice from the Joint Committee on Vaccination and Immunisation.
Race	**Professionals with temporary registration** Data from NHS England shows that ethnic minority professionals are more likely to be employed in lower bands.[63] 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 our data about people with temporary registration. Our analysis showed that disproportionately high numbers of people who trained overseas and/or were from an ethnic minority background made up those with temporary registration. Our analysis of those with temporary registration

[61] Woolf et al. (UK REACH).
[62] DHSC, Equality Impact Assessment.
[63] NHS (2020) WRES

	on 31 March 2021, shows that as a group, people with temporary registration are less ethnically diverse than in July 2020. Over three quarters of those with temporary registration in March 2021 (78 percent) were White British, compared to 67.7 percent of people with permanent registration. There is a lower proportion of people who are Black African (1.8 percent) amongst those with temporary registration compared with those with permanent registration (7.3 percent). The proportion of people with temporary registration who are Asian Filipino (1.1 percent) is lower than amongst those with permanent registration (4.3 percent). The proportion of Asian Indian people is also lower amongst those with temporary registration (2.6 percent) compared with those with permanent registration (3.9 percent). The proportion of people who are Any other White ethnicity is also lower amongst those with temporary registration (2.2 percent) compared with permanent registration (4.5 percent). We also know that 92.7 percent of the people with temporary registration who have told us (as of September 2021) whether or not they have been deployed, are White British. This shows a significant overrepresentation of the White British group compared to their overall representation amongst those who hold temporary registration. However, this is only from a small sample of the overall group who hold temporary registration, as our August – September 2021 survey received a 28.3 percent response rate, and so these data are not necessarily conclusive. Further to this, research published in the Journal of Infection found that professionals of all ethnicities were more likely to test positive for Covid-19 compared with White British and Irish staff, with Black African staff at the greatest risk, followed by mixed ethnicity, Black Caribbean and Asian Chinese and Other Asian.[64] **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 at increased risk of infection. In 2018, nurses and health visitors from black, Asian and minority ethnic groups comprised 18.8 percent of this workforce in all care settings in England.[65]

[64] Martyn et al.
[65] 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.

	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.[66] In April 2020 a HSJ report showed that 71 percent 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.[67] A Public Health England Report in June 2020 clarified that individuals from ethnic minority groups are more likely to work in occupations with a higher risk of Covid-19 exposure.[68] 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, between March 2020 and March 2021, 57 percent 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 percent). The numbers of people being reported to us as having lost their lives have been too small for us to repeat this analysis. Our data shows us that people employed via an agency are more likely to be from ethnic minority backgrounds than people employed directly.[69] Over 72 percent of jobs done through direct employment are by people of white British ethnicity, with 5 percent by people of Black/Black British African ethnicity. In comparison, 36 percent of jobs done via an agency are by people of Black African ethnicity, and 33 percent are by people of white British ethnicity. In the earlier stages of the pandemic our intelligence and stakeholder engagement indicated that some agency employed professionals felt they were 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 higher levels of infections amongst residents in care homes in England.[70]

[66] Tweets accessed 08-04-20 https://twitter.com/jsbamrah/status/1247633745278111747
[67] Cook T, Kursumovic E, Lennane S; *Exclusive: deaths of NHS staff from Covid-19 analysed*; HSJ; 22 April 2020 [accessed 28-04-20]
[68] *Beyond the data: Understanding the impact of Covid-19 on BAME groups*; Public Health England; June 2020
[69] NMC (2019) Revalidation: Annual data report. Year 3: April 2018 to March 2019.
[70] Office for National Statistics (2020) Impact of coronavirus in care homes in England: 26 May to 19 June 2020

	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.[71] As of 11 November 2021, all health and care staff working in adult care home settings in England will be required to evidence that they are fully vaccinated against Covid-19 as a condition of deployment. 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. The findings of this study have since been published in September and October 2021 and are referenced in the 'Evidence' section of this EqIA (section 2). **Adapting our fitness to practise and removals processes** We know that Black and other minority ethnic professionals are more likely to be referred to us, compared to their overall proportion on the register. These referrals are most often from employers. We also know that cases referred to us by employers are more likely to progress to the adjudication stage than cases referred to us by members of the public. Cases involving Black nurses and midwives are therefore more likely to progress to the adjudication stage compared to White professionals. However, Black professionals aren't any more likely to be removed from our register than White nurses and midwives.[72] 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

[71] 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
[72] Nursing and Midwifery Council. *'Ambitious for Change: Research into NMC processes and people's protected characteristics.'* October 2020.

	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 hearings in virtual format (Ref 8 in the action plan). We do not currently have evidence this is actually the case, but we will monitor complaints and feedback carefully. **Our registrants engaging with the public** There is evidence that people from certain ethnic groups are more likely to experience health inequalities in health settings. As explored in the 'all protected characteristics' section, health professionals may not be up to date about how to prevent these inequalities, as required by the Code (Ref 13 in the action plan). We know that people from an ethnic minority background in the UK are at greater risk of being affected by Covid-19. 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 shows 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[73] (Ref 13 in the action plan). People from Gypsy, Roma and Traveller (GRT) communities are often 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

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

	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-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). **Vaccination** Further research published in the Ethnicity and Health journal notes 'vaccine mistrust' among Black African, Black Caribbean and other Black groups reflecting mistrust in government and pharmaceutical companies[74]. Participants in the study cited concern that Black and minority ethnic staff were feeling 'pressured' to get vaccinated, and that this may further increase suspicion of the vaccine.[75] There is evidence from a UK REACH study that vaccine hesitancy continues to be greater among healthcare workers of ethnic minority backgrounds. Specifically cited were issues around historical mistrust around how vaccines have been trialled among Black and minority ethnic people, with several participants discussing a drug trial carried out by Pfizer on Nigerian children in 1996 without proper ethical clearance. The report suggests this scepticism is consolidated by a broader lack of trust in institutions of authority among Black and minority ethnic healthcare workers, which has been eroded over years of experiencing discrimination.[76] This UK REACH paper also cited scepticism as to why ethnic minority staff were not prioritised for vaccination early on (given

[74] Wood head et al. *Race, ethnicity and COVID-19 vaccination.*
[75] *Ibid.*
[76] Gogoi et al *"The vaccination is positive"*. (UK REACH)

	there was already awareness around the greater impact of Covid-19 on Black and minority ethnic healthcare workers).[77] Further research from UK REACH has found that healthcare workers from Black Caribbean (54.2 percent), Mixed White and Black Caribbean (38.1 percent), Black African (34.9 percent), Chinese (33.1 percent), Pakistani (30.4 percent) and Other White (28.7 percent) ethnic groups were significantly more likely to be hesitant to getting vaccinated compared to White British health care workers (21.3 percent).[78] This research also identified through qualitative data that a belief that there was a lack of ethnic diversity in vaccine studies was a contributor in vaccine hesitancy.[79] Participants in this research from ethnic minority backgrounds reported that inclusive communication, including healthcare workers involved in vaccine rollout and promoting vaccination through trusted networks, would help improve uptake.
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 percent compared to 58 percent of people with permanent registration). Those with temporary registration have a lower proportion of people who say they have no religion (22.4 percent) compared to those with permanent registration (28.9 percent). There is a smaller proportion of Muslims (0.6 percent) with temporary registration compared to those with permanent registration (1.8 percent). Again, some of these differences may be accounted for by the fact that there is a higher proportion of people with unknown

[77] Gogoi et al.
[78] Woolf et al. *Ethnic differences in vaccine hesitancy*. (UK REACH)
[79] *Ibid.*

	religion who have temporary registration (12.4 percent) than those with permanent registration (7.6 percent). Christians account for the most highly represented group amongst those who hold temporary registration who have been deployed (as of September 2021) at 64.8 percent of those who told us they had been deployed. **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[80] 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.[81] **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 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. **Vaccination** The UK Parliament published a report on vaccine uptake, 'COVID-19 vaccination coverage and targeted interventions to improve vaccination uptake' (July 2021), which noted that "people of Muslim religion or those who identified as having an 'Other' religion had lower vaccination rates (71.8 percent and 79.9 percent respectively) compared to those with Christian and Jewish religion (92.1 percent and 91.0 percent

[80] Muslim Council of Britain statement burial measures in COVID-19 emergency legislation; 21-03-20
[81] Parveen N (2020) Officials investigate coronavirus hotspot in West Midlands. Guardian. Friday 20 March 2020

	respectively). Those with no religion displayed a vaccination rate of 87.3 percent."[82] An Office for National Statistics (ONS) study, 'Coronavirus and vaccination rates in people aged 70 years and over by socio-demographic characteristic, England (8 December 2020 – 9 May 2021)' (published 7 June 2021), noted that "among those who received a first dose, only 84.7 percent of those identifying as Muslim received a second dose."[83]
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 percent) compared to those with permanent registration (7.8 percent). 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 percent compared to 89.1 percent on the permanent register); and slightly lower proportions are gay or lesbian (1.5 percent compared to 1.9 percent on the permanent register); and bisexual (1.0 percent compared to 1.2 percent). 93.5 percent of those with temporary registration who told us in September 2021 that they had been deployed, were heterosexual, which accounts for a significantly greater proportion of the population compared to those with both temporary and permanent registration. **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[84][85] in 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 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 susceptible to being discriminated against in a healthcare setting on the basis of their protected characteristic.

[82] UK Parliament. COVID-19 vaccination coverage and targeted interventions to improve vaccination uptake. 2 July 2021. [accessed 8 October 2021].
[83] ONS. Coronavirus and vaccination rates in people aged 70 years and over by socio-demographic characteristic, England (8 December 2020 – 9 May 2021). 7 June 2021. [accessed 8 October 2021].
[84] 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)
[85] Public Health England (2018) Improving the health and wellbeing of lesbian and bisexual women and other women who have sex with women.

	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.[86] A study of LGBTQ people's experience during the pandemic, by University College London (UCL) and Sussex University, found 69 percent of respondents suffered symptoms of depression, rising to about 90 percent 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 sexual orientation. The rate rose to more than a third among those living in homes where they were not open about their identity. Almost 10 percent of people reported they felt unsafe in their homes.
Other groups[87]	**Caring responsibilities** Women over 50 are more likely to be carers.[88] Our register is made up of 89 percent of 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 were carers in a household with someone who was shielding, may have had 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. Covid-19 has also had an impact by creating additional childcare and housework which has fallen more on women than men, 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)

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

	Covid-19: the impacts of the pandemic on inequality, Institute for Fiscal Studies). Research published in the BMJ suggests that families of patients from ethnic minority groups have been particularly affected by restrictions on visiting during the pandemic. As such, those with caring responsibilities for an elderly relative, who are from an ethnic minority background, may have experienced significant distress at their inability to complete these responsibilities while restrictions were in place. This was cited as being particularly the case for those from Muslim backgrounds where having high numbers of people visiting at time of death is traditionally valued.[89] Other issues in palliative care identified by the research (which have disproportionally impacted those from minority ethnic backgrounds) include: • Communication challenges (especially where English is not the first language); exacerbated by the wearing of PPE; • End-of life religious and faith needs not met as family visits were restricted, difficulties were experienced accessing support from faith leaders, and needs for burial within 24 hours for Muslim and Jewish families were more difficult to fulfil; • Mistrust in advance care planning discussions, particularly among certain groups e.g. Orthodox Jewish community. The report also highlights a lack of consideration for how applying restriction policies in and around end of life and death to those from minority ethnic and religious backgrounds may adversely impact these groups, and the absence of palliative care that is not 'culturally congruent'. In its discussion, the report concludes that 'Our data demonstrated no evidence of systematic assessment of the impact of these policies.'[90] **Socio-economic status** Those living in the most deprived areas of the UK have poorer health outcomes and have seen their healthy life expectancy decline over the last 10 years.[91] Those in deprived areas have higher exposure to Covid-19 and face worse health outcomes

[89] Bajwah et al.
[90] *Ibid.*
[91] 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

	from emergency.[92] 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 backgrounds with less access to technology may have difficulties in accessing the hearings in virtual format. Similarly if the assessments for overseas professionals 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[93] and ethnic minority groups.[94] These groups may have less access to income during the emergency and find themselves 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). 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. **Nation/Region of the UK** Research has suggested that access to appropriate PPE is not consistent across the UK, and is reported as better in the South East and North East of England, and worse in London.[95] The Journal of Infection paper on the prevalence of Covid-19 infection among ethnic minorities also found that higher rates of positive testing correlated with those living in the most deprived local wards, further suggesting geography and deprivation level as factors in the disproportionate impact of the virus.

[92] Bibby, J. Everest, G. Abbs, I; 07-05-20; *Will Covid-19 be a Watershed Moment for Health Inequalities?;* The Health Foundation
[93] UK Women's Budget Group; 19-03-20; *Covid-19: Gender and other Equality Issues*; Women's Budget Group
[94] Khan, Omar (2020); The colour of money: How racial inequalities obstruct a fair and resilient economy; Runnymede Trust
[95] Martin et al.

	In July 2021 Carers Trust Scotland released their report 'Covid-19 in Scotland: The Impact on Unpaid Carers and Carer Service Support Workers'. This report found that the mental and physical health of carers in Scotland had worsened throughout the pandemic: 34 percent of respondents said their mental health was much worse than before the pandemic and 50 percent said it was worse than before the pandemic; 23 percent said their physical health was much worse than before the pandemic and 45 percent said it was worse than before the pandemic. Respondents also said that since the beginning of the pandemic, they were much more stressed (52 percent), tired (55 percent), lonely or isolated (50 percent), and anxious or worried (52 percent), than usual. 82 percent said that since the lockdown began in March 2020, they had not been able to access any respite or breaks from caring.[96] While 92 percent of those who responded to the consultation identified as White Scottish/White British, the next mostly highly represented ethnic group was Pakistani/Pakistani Scottish/Pakistani British at 4 percent.

[96] Carers Trust Scotland. *Covid-19 in Scotland: The Impact on Unpaid Carers and Carer Service Support Workers.* 14 July 2021. [accessed 22 November 2021].

Section 4: Analysis and outcome

The actions we have taken in response to the Covid-19 pandemic have been unprecedented. However, we think that our actions have been appropriate and proportionate in the context of the extreme circumstances we have found ourselves in.

This section provides an overview of the activities which we feel have been the most at risk of leading to potential discrimination or differential outcomes between particular groups. We have not currently identified any unlawful discrimination which has taken place, but will continue to monitor our activities to ensure that this does not take place. The action plan in section 5 details how we will mitigate against the risk of unlawful discrimination in 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. We also continually review our processes to identify activities within these processes where there is a risk of bias having an impact, and ensure that we take appropriate actions to mitigate for this risk.

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 a 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. Case work has now recommenced so this is much less of a risk although we are mindful of the impact of the backlog of cases.

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. Non-essential hearings are now 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. The accessibility of the channels to raise concerns are being reviewed via a new referrals working group.

We have analysed the responses received to our consultation on the use of our emergency powers on an ongoing basis, including our views on public access to hearings, which closed in January 2021. We have monitored responses by protected characteristic, and published our analysis in February 2021.

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?	Activity prior to 1 April 2021: • 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. Activity between 1 April and 30 September 2021: • The 'Annual registration report April 2020-March 2021' Wales breakdown. • The 'Current recovery programme standards'.
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. CLOSED A2. Update DPIA with the reasons above in CLOSED 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. CLOSED

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. CLOSED 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. CLOSED 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. CLOSED A7. Continue to analyse the full set of diversity data of the people with temporary registration and compare it to those with permanent registration. MONITOR 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

Issue/opportunity	Implications/groups impacted and plans to address the issues raised	Action
B Regulate – managing the register (including those with temporary and permanent registration)		
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. ONGOING 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. CLOSED B4. Monitor referrals and cases raised about temporary registrants on issues that relate to discrimination. MONITOR B5. Monitor temporary registration removals decisions made by Assistant Registrars for issues related to discrimination. MONITOR

Issue/opportunity	Implications/groups impacted and plans to address the issues raised	Action
The criteria for those who 1) are eligible to join and 2) have been actively invited to take up temporary registration being biased towards certain groups (like age) (Ref 3).	Age – older or younger people Disabled people People from some ethnic minority backgrounds Pregnant women and 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.	B6. One mitigating action to reduce the impact on disabled people is stated in the policy that 'In line with the latest government health 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. CLOSED B7. Keep the criteria for taking up temporary registration under regular review as government advice is updated. ONGOING 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	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. CLOSED

Issue/opportunity	Implications/groups impacted and plans to address the issues raised	Action
	with temporary registration from an EDI perspective.	B11. Monitor complaints about discrimination or bias in the temporary registration processes. MONITOR B12. Monitor complaints relating to any of our processes relating to Covid-19, particularly if it relates to potential discrimination. MONITOR
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 for removing temporary registration to determine if it is fair and legitimate. There should be no barriers that can't be objectively justified. CLOSED B14. Monitor removals of temporary registration that cite context relating to mental health and other EDI factors as a contextual factor. MONITOR
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 contextual factors. ONGOING

Issue/opportunity	Implications/groups impacted and plans to address the issues raised	Action
When we stop temporary registration – having regard to equitable opportunities for people who wish to apply to for permanent registration or readmission.	Unknown which groups are affected. Consider EDI issues arising in horizon scanning work.	We continue to actively monitor the temporary registration situation. When a closure decision is taken we will determine the appropriate process to safely close the temporary register, including using EqIAs to assess the likely and potential equality impacts of our approach. We don't have a formal standard operating procedure for stopping temporary registration, we will however ensure our chosen process will be in line with our agreed policy for closing the temporary register. 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. CLOSED/MONITOR
The adaptions to our FtP and registration appeals processes due to the	Disabled people Carers Older people	B18. Case teams are corresponding with case parties electronically/over the telephone where

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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).	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 assessments for longer term changes.	possible due to the office being closed. CLOSED 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. CLOSED B20. The Public Support Service team is providing ongoing specialist support to screening teams in making reasonable adjustments for disabled customers. CLOSED 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. CLOSED 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. CLOSED 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

Issue/opportunity	Implications/groups impacted and plans to address the issues raised	Action
		registrants to assist them whilst dealing with this crisis. CLOSED 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. ONGOING B25. Conduct a separate EqIA for public access to virtual hearings (also related to physical hearings). ONGOING/MONITOR B26. Monitor the interaction between our emergency and recovery work in response to the Covid-19 pandemic in management of our FtP cases, and the impact of our work to reduce our FtP caseload. ONGOING B27. Monitor contacts to our Careline relating to Covid-19, in terms of the numbers of contacts, the themes which are raised as concerns, and the diversity of those contacting the Careline. MONITOR
The adaptations to our overseas registration processes due to the due to the emergency having a negative impact on people who share protected	Ethnic minority groups and non-UK nationals Disabled people Carers People who are pregnant	As B17. B28. Clear communications with overseas candidates. For example by providing information on our Covid-19 hub on the website. ONGOING

Issue/opportunity	Implications/groups impacted and plans to address the issues raised	Action
characteristics. For example closing OCSE centres (Ref 9).	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.	B29. All overseas nurses and midwives who met the eligibility criteria were offered to become temporarily registered. CLOSED B30. Working closely with our OSCE delivery partners and development partner on reopening OSCE centres safely and accessibility. ONGOING B31. We are piloting online computer based tests which, if successful, will allow candidates to take the test at home rather than travelling. ONGOING B32. Explore whether added conditions of practice to those with temporary registration who approach three years since practicing has any negative impact on any groups. MONITOR B33. Analysis of diversity data for those going through updated overseas processes. ONGOING
C Influence – providing insight		
Health inequalities and discrimination already exist in the wider healthcare environment. These should	All groups We will act to eliminate discrimination and promote equality, diversity and inclusion.	C1. Monitoring external publications on the topic of health inequalities and impacts on the basis of protected characteristic to inform our decisions. ONGOING

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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)	Cognisant of how the NMC can add value to the insights in the wider healthcare environment.	C2. 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 C3. 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/MONITOR
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 people from certain ethnic groups because of discrimination and bias in their own processes and from individuals) (Ref 11)	Some ethnic minorities Disabled people Men Monitor referrals by protected characteristic to identify patterns and bias. Communicate with employers if concerns are raised that appear to be based on bias.	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. MONITOR C5. Monitor whether FtP referrals appear to be disproportionate for any group, and whether context forms indicate possible inequality or discrimination factors. MONITOR C6. Communicate with employers if concerns are raised that appear to be based on bias or discriminatory factors – with intelligence from RIU. ONGOING

Issue/opportunity	**Implications/groups impacted and plans to address the issues raised**	**Action**
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. CLOSED C8. 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. 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 C9. 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 C10. Provide accurate diversity data to support our partners looking into the numbers of professionals on our registers who have died as a result of Covid-19. ONGOING

Issue/opportunity	Implications/groups impacted and plans to address the issues raised	Action
		C11. Where suitable sensitively communicate EDI messages re the data externally. ONGOING C12. 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
The Covid-19 pandemic is going to continue to have a significant impact and influence on public policy for the foreseeable future. We should be using our internal knowledge and insight to respond to public consultations and influence the health and care sector in order to address inequalities and support the good practise of the people on our register.	Professionals on our permanent and temporary registers with a range of protected characteristics, including: Age Disability Ethnicity Gender Pregnancy/maternity	C13. Continue to respond to consultations and inquiries relating to the pandemic, and monitor those which have an EDI element, and the stance we are taking in our responses. ONGOING C14. Monitor the public statements and announcements we continue to make, relating to Covid-19, and which have an EDI element, as well as EDI factors to consider within our work on preparing for future inquiries. ONGOING
D Support – professionals on our register		
Professionals on our register working in an emergency situation are	All groups – but particularly vulnerable disabled groups and those who already have health	D1. Attend Moral and Ethical Guidance Committee – monitor issues that arise and work that arises from this group. ONGOING

Issue/opportunity	Implications/groups impacted and plans to address the issues raised	Action
more likely to be under pressure to make decisions that could breach equalities legislation, ethics and engage the Human Rights Act (Ref 13)	inequalities including ethnic minorities, disabled and LGBT people Monitor and address issues as they arise. Attend external forums and monitor concerns with stakeholders.	D2. Publish PPE guidance and guidance on DNACPR action completed. Regularly review issues as they emerge tied into ethical guidance and case studies. CLOSED. 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
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 women and 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. ONGOING D5. External communications and collaboration with other stakeholders – signposting to resources on mental health. ONGOING

Issue/opportunity	Implications/groups impacted and plans to address the issues raised	Action
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 protected characteristics (Ref 15)	Carers (more likely to be women and 89 percent 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. CLOSED D7. Produce 'How to revalidate during C-19' guidance. To include information about updating diversity information and to be translated into Welsh. CLOSED D8. Monitor the diversity data of those who apply for, are accepted, and those who are not accepted for support measures. CLOSED
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. CLOSED D10. Use criteria to determine hardship cases for additional support with payments. CLOSED 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

Issue/opportunity	Implications/groups impacted and plans to address the issues raised	Action
		powers on professionals with disabilities. ONGOING D13. Ensure our communications with professionals, including joint statements, consider and reflect EDI implications ONGOING D14. Monitor and report internally on the diversity characteristics of people who apply for a revalidation extension, those for whom this is granted, and those for whom this is not granted. MONITOR D15. Continue to review our offer around revalidation extension periods and alter this as required based on evidence and feedback relating to the Covid-19 pandemic. ONGOING
E Support – students in placements		
Use our influence to support students who will be facing more difficulties during this emergency because of their protected characteristics (Ref 17)	Disabled students 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	E1. Work with key stakeholders to create joint statements which outline the options for students, and that students will not be negatively impacted because of their personal situation. CLOSED E2. Create a table outlining to students their options and that they will not be negatively

Issue/opportunity	Implications/groups impacted and plans to address the issues raised	Action
	period they will be supported to continue their studies after the emergency	impacted because of their personal situation. CLOSED E3. Publish our emergency programme standards outlining that students should continue to be appropriately supported and supervised. CLOSED 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. CLOSED E5. Monitor the impact and student feedback, via our quality assurance and complaints processes, on the implementation of support (e.g. funding) from AEIs and devolved administrations, for students who may have needed to defer their programmes. ONGOING/MONITOR E6. Monitor student feedback and complaints relating to communication from individual AEIs and the devolved administrations, on the options and support available to students. ONGOING/MONITOR

Section 7: Review

Date of next review	Ongoing updates in action monitoring log. Review of this EqIA on 31 March 2022, with a view to undertaking the proposed ‘two years in’ analysis from April 2022 onwards, as part of wider work on understanding the changes we made in response to Covid-19 and their impact.
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?	Meetings and consultation with action leads have taken place throughout the duration of the pandemic. Ongoing consultation will be needed to enable the completion of the 'two years in' analysis from April 2022 onwards.

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:	29 October 2021