EQIA for the NMC response to Covid-19

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

At the NMC, we use equality impact assessments (EqIAs) as an assessment tool to demonstrate our work complies with equalities legislation. It helps us to understand the effects of our activities on different groups of people and any actions we need to take as a result.

As of the end of August 2020, which this version of the EqIA reflects, we've already done a lot of work to respond to Covid-19. This is an update on the original document that was published in July 2020. To make it easier to note the changes since the last revision we have shaded the significant areas of change in grey. This EqIA covers all aspects of this response, including temporary registration, emergency standards, changes to fitness to practise, registration and registration appeals processes, revalidation, communications and intelligence.

This EqIA will be updated as long as we are taking on additional work to respond to Covid-19 and we invite feedback on it.

The issues we cover

In summary, the issues raised in this EqIA include ensuring that:

- We can monitor and report on the diversity of the temporary register, now and to inform future research and evidence. This recognises the disproportionate numbers of ethnic minority health professionals working to combat Covid-19.
- Our emergency education programme standards do not exacerbate inequalities.
- 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 in those processes.
- Professionals on our register have clear guidance about where equality, diversity and human rights in the Code are applicable to their practice when working in emergency situations (for example, when making decisions and communicating about 'do not attempt cardiopulmonary resuscitation' orders).
- We communicate support for professionals on our register (for example, when whistleblowing in relation to public safety and access to personal protective equipment (PPE) and signposting to mental health support services).

Action we took in the early stages of the pandemic included publically calling for better access to PPE and better risk assessments for nursing and midwifery staff. We also welcomed and contributed to the relevant reports and research on why Covid-19 has

had a worse impact on some communities, including those from an ethnic minority background (e.g. we provided data to PHE).

Since the publication of the last version of this document in July 2020, we have published data about the professionals on the temporary register with information about their diversity, rolled out virtual hearings with an improvement survey and made decisions about how the different cohorts of people who were invited to join the temporary register would become permanently registered. Some of the issues we envisaged as potentially discriminatory have not come into effect. For example, our original EqIA identified a potential issue of bias in our decisions about temporary registrants that have fitness to practise concerns raised about them – in actuality the numbers have been so small that we dealt with them with a high level of scrutiny and checks to reduce potential bias.

Developing this EqIA

We used our own data and external evidence to develop this EqIA and action plan. That includes our engagement activities with employers, education institutions, unions, professionals on our register and the public form part of this evidence. We want to continue to hear from people to help us develop the next iterations of this EqIA.

One intention in publishing our EqIA was to invite further comment on the work we have done so far with the aim of improving our own processes and add value in the wider health and care environment. Although we have had no specific feedback on the previous version, comments are still welcome.

We ask two questions:

- Have we missed anything that is in our role to do or influence?
- Looking to the future – are there any particular topics of concern or opportunities that we should focus on?

Please respond with your answers to these two questions, or any other feedback you have, with 'COVID EQIA' in the subject line to equality@nmc-uk.org

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	31 August 2020 Version 3
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 standards for nursing and midwifery education
Name and title of person completing this assessment	Aishnine Benjamin Equality and Diversity Policy Manager
Senior sponsor	Matthew McClelland, Executive Director of Strategy and Insight
Review date	31 October 2020 (to update to version 4 and inform the senior sponsor of any significant changes to the actions).

Contents

Section 1: Background

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

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

3 The aim of our actions has been:

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

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

3.1.2 developing emergency 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 on our permanent register 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) and holding fitness to practise (FtP) and registration appeals hearings virtually.

3.1.5 ensuring that those professionals with permanent registration do not inadvertently leave the register or because of a disadvantage caused by the emergency

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

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

3.2.1 understanding the diversity of the professionals on our temporary register

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

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

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

6 This EqIA enables us to regulate effectively by ensuring that our processes are fair and in so doing comply with equalities and human rights legislation. We are able to support by providing information and assurance and we are able to influence by monitoring reviewing and sharing what our data is telling us about how different groups are treated in the workplace.

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

7.1 temporary registration

7.2 emergency standards for nursing and midwifery education

7.3 communications and support

7.4 registration and registration appeals

7.5 retention

7.6 revalidation

7.7 fitness to practise

7.8 overseas registration

Covid-19 temporary registration

8 The temporary registration policy outlines our emergency registration powers and sets out our approach to identifying persons or specified groups of persons who are, or may reasonably be considered to be, suitable to be temporarily registered during this Covid-19 emergency. The names of individuals with temporary registration are published on our Covid-19 temporary register and we have also published a diversity breakdown of the professionals on the temporary register.

9 The actions we took to understand the diversity of the professionals on our temporary register are legitimate because we must:

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

9.2 demonstrate fairness in our processes and understand the identities of the people with temporary registration and how they are impacted by our work. Collecting this data enables us to do that. In order to know whether we are being fair and not discriminating against any particular group we need to know what those groups are and who falls into them. For example being able to analyse the protected characteristics of those referred and removed.

9.3 recognise that there is great public interest in the diversity data of professionals involved in the Covid-19 crisis.

9.4 we already know that there are disproportionate outcomes of Covid-19 for people with certain protected characteristics and our future analysis will support the evidence base in the health and social care sector.

Emergency standards for nursing and midwifery education

10 We have put in place systems to support students undertaking NMC-approved programmes. This includes introducing new emergency programme standards. These Emergency standards for nursing and midwifery are intended to be facilitative and not directive and these standards do not require AEIs or individual students to change their current programmes. They are temporary and will no longer apply after the emergency period. The potential outcomes of the emergency education standards are:

10.1 first year students for the emergency can move into full time theoretical learning rather than go on placement.

10.2 second year students can have up to 80 percent of their time during the emergency in clinical placement settings.

10.3 third year students can finish their final six months of their programmes in extended clinical placements.

10.4 all theoretical learning can be done online.

11 Our Emergency standards for nursing and midwifery education are designed to offer AEIs flexibility to support students to continue their learning, and support the workforce by ensuring clear learning pathways and practice placements.

12 We have now published recovery programme standards which will be retained as the emergency standards are phased out. These standards take account of individual student's needs, for example, risk assessments that take account of the ethnicity of students as a potential risk factor.

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

Communications and support

13 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. Our communications have adapted 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. We have also published statements in relation to public and registrant safety, including 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. Our wider communications include promotion of this EqIA and requesting feedback on our actions in response to Covid-19.

Registration and registration appeals

14 We are continuing as normal with UK applications to join and re-join the register. As all our registration staff are working from home, there may be some minor delays to our processing.

15 We stopped hearing registration appeals at the beginning of the emergency. We're keeping in close contact with all appellants who are affected and progressing some cases where we are not contesting the appeal to allow appellants to join the register. Emergency changes to our rules means we can hold registration appeals hearings remotely during the emergency period.

Overseas registration

16 The UK health and social care system relies on the care of professionals from other countries. We aim to do everything we can to support overseas candidates with their registration to UK practise.

17 We continued to process applications from overseas applicants wishing to join our register. Due to advice from the UK Government, all OSCE tests were suspended from 23 March. All three OSCE test centres in the UK reopened on Monday 20 July 2020. They have put measures in place to make sure candidates and staff are safe which are kept under constant review. During that time many of the employees in the OSCE centres were furloughed and have been fully risk assessed to determine how they return to work.

Retention payments

18 We gave people who failed to pay their retention fee on time between March and May 2020 a blanket six-week extension. Any requests for further time for payment beyond six weeks were considered on an individual basis in line with our existing hardship processes.

19 These changes were made to help support registrants during the emergency by offering them flexibility. The numbers that had extensions are being monitored by

protected characteristic to ascertain if there was a disproportionate impact on a particular group.

Revalidation

20 We have given people who were due to revalidate between March to June 2020 a blanket extension of 12 weeks. From July onwards people will be able to opt in to an extension of 12 weeks. We hope that this 12 week extension will give our registrants enough time to meet the requirements and submit their applications. However, registrants are able to request a further extension of 12 weeks if their ability to revalidate has been affected by Covid-19 and their request is supported by their confirmer. We'll continue to review the need to offer 12 week extensions to those due to revalidate later in the year as the Covid-19 pandemic evolves. Any further requests have been somewhat determined by changes to our technical system at the time.

Fitness to practise

21 We aim to maintain our fitness to practise processes for the purpose of public protection. We are mindful of the effect on referrers and registrants of extended delays to cases as well as the impact of our inquiries on individuals and employers – therefore we're working to minimise the impact and comply with equalities and human rights legislation.

22 We have identified and maintained our four fitness to practise (FtP) services essential for the purpose of public protection:

22.1 new referrals and initial risk assessments (and risk assessing new information on existing cases)

22.2 interim order applications

22.3 substantive order reviews

22.4 High Court/Court of Sessions interim order extension applications.

23 Further details about the current and proposed changes to our FtP processes can be read here, including holding virtual hearings.

Section 2: Evidence

Research and reports	See references, links and footnotes in the document. *Covid-19 Insights from external research and data*; updated 15 April 2020; Caroline Kenny, Head of Research and Evidence (Trim: 6828329) Public Health England's Disparities in the risk and outcomes of COVID-19, published 2 June 2020. The report confirms that the impact of Covid-19 has replicated existing health inequalities and, in some cases, has increased them. Public Health England's Beyond the data: Understanding the impact of COVID-19 on BAME groups, published 16 June 2020. EDI organisations have produced reports as summarised in *EDI Stakeholder responses to Covid-19*; updated 7 June 2020; Emma Lawrence, Senior EDI Policy Officer. (Trim: 6828971) After 1 May 2020 a separate document monitors *Covid-19 EDI media commentary and inquiries* (Trim:689391)
Data	**Revalidation and retention** Our diversity data is taken from the register. Our Year four revalidation tables show that the revalidation rates of people on our register with full registration vary slightly between some people who share protected characteristics. Also that there are differences by protected characteristic in setting and scope of practice, for example people employed via an agency are more likely to be from ethnic minority backgrounds. **Temporary registration** EDI data about people with Covid-19 temporary registration is taken from different sources. This includes data we have collected from an EDI survey that is sent to everyone on the temporary register and where this is not available, data we have on our systems. A summary of the analysis of this data show us that: • people with temporary registration are older than those with permanent registration. Around two-thirds of those with temporary registration are aged over 50 compared to just over a third with permanent registration.

	• compared to our register as a whole, there are fewer females and fewer people identifying as white. The temporary register also has fewer people of black and mixed ethnicity, but more people identifying as Asian. Fewer people on the temporary register declare a disability and a higher proportion identify as bisexual. In comparison to our register as a whole, the temporary register has more people identifying as Jewish and Hindu and fewer people identifying as Muslim and who prefer not to say. Overall, we have less complete data for people in the overseas cohort. Even when supplementing the survey data with the information we hold on our systems, there are around 30 percent of overseas applicants for whom we do not know their diversity characteristics. **Data gaps** On 27 May we emailed the 13,796 people on the temporary register 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 is on the temporary register, and we have contacted those people that were confirmed on the temporary register between 27 May and 1 July to ask them to complete the survey (Ref 1 in action plan). The survey has now been completed by 9,433 people. With the new virtual hearings we have an improvement survey that collects diversity data but the numbers responding have been very low.
Media:	Social economic factors play part in high proportion of Covid-19 ethnic minority patients, GP says (ITV News, 15 April 2020) Inquiry announced into disproportionate impact of coronavirus on BAME communities (The Guardian, 16 April 2020) Q&A – Why don't we know how many BAME people are dying? (The Guardian, 16 April 2020) Racism is the root cause of ethnic inequities in Covid19 (Discover Society,17 April 2020) Failure to record ethnicity of Covid-19 victims a 'scandal', says BMA chief (The Guardian, 18 April 2020) Coronavirus cases to be tracked by ethnicity (BBC News, 18 April 2020) Are ethnic minority coronavirus patients more likely to die? (Channel 4 News, 21 April 2020) Black coronavirus patients are dying at double the rate of white in hospitals (The Times, 24 April 2020) Doctors urge: We must find out why so many black and Asian Britons are dying from coronavirus (The Daily Mail, 25 April 2020) The toll of coronavirus on NHS staff isn't just physical – it's

	psychological, too (The Guardian, 27 April 2020) Transgender people 'extremely vulnerable' during lockdown (The BBC, 29 April 2020) PPE 'designed for women' needed on frontline (The BBC, 29 April 2020) Disproportionate impact of Covid-19 on ethnicity minority and nurses from the Philippines (Newsnight BBC2, 30 April 2020) After 1 May 2020 a separate document monitors *Covid-19 EDI media commentary and inquiries* (Trim:689391)
Healthcare media	**Nursing times** Checked on 17 April 2020 *Exclusive: Are we whitewashing coronavirus?* 12 April 2020 by Jo Stephenson Interview with Yvonne Coghill, Director of the Workforce Race Equality Standard WRES at NHS England. Raising concerns about the disproportionate impact of Covid-19 on ethnic minority healthcare workers and a perceived lack of recognition of their essential role. *Exclusive: BME nurses 'feel targeted' to work on Covid-19 wards* 17 April, 2020 by Megan Ford. This article brings attention to the disproportionate impact of Covid-19 on healthcare workers and anecdotal evidence of ethnic minority nurses feeling they are targeted to work on Covid-19 wards. Checked 29 April 2020 *Exclusive: Survey reveals negative impact of Covid-19 on nurse mental health* 29 April 2020 by Steve Ford Highlighting that all nursing staff are feeling more stressed and anxious during the Covid-19 crisis. Linked to the Nursing Times 'Are you OK?' campaign to support nurses through the crisis. Checked 5 May 2020 *Suicides among health workforce rising, warns shadow minister* 04 May, 2020 By Gemma Mitchell Checked 19 May 2020 NHS launches trauma helpline for Filipino health and care staff 18 May 2020 by Gemma Mitchell Checked 27 May 2020 Visa fears mean Filipino nurses 'feel unable to say no' during crisis 25 May 2020 by Rebecca Gilroy **The King's Fund** Checked on 30 April 2020

	Ethnic minority deaths and Covid-19: what are we to do? 30 April 2020, Michael West and Suzie Bailey A blog that suggests the inequalities in the impact of Covid-19 for the public and healthcare workers is an opportunity to make changes in the long term that will disrupt structural and systemic inequalities on the basis of race. Checked on 26 May 2020 Deaths from Covid-19 (coronavirus): how are they counted and what do they show? 13 May 2020 by Veena Raleigh
Social media	Conversations on social media show there is public interest in the disproportionate numbers of ethnic minority health professionals working to combat Covid-19 dying from Covid-19. We are monitoring the social media communications as this is a form of intelligence and we acknowledge that disadvantaged groups may not be able to raise issues that concern them via mainstream communication channels.

After 1 June 2020 we continued to monitor the media via a separate document. See separate document *Covid:19 EDI Media Commentary and Enquiries* (Trim: 6895391).

In addition some of the notable reports from other organisations since publication of version 2 on 24 July include:

- **Report: Disparities in the impact of Covid-19 in Black and Minority Ethnic populations**
  Independent SAGE's review of the evidence indicates the reasons why some BME groups are at greater risk of dying with Covid-19 are complex with interplay between socio-economic disadvantage, high prevalence of chronic diseases and the impact of long-standing racial inequalities. Their recommendations include better protection arrangements for frontline workers, culturally appropriate testing programmes, and mandatory ethnicity data collection in health and social care[3].
- **Research: 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[4].
- **Data: new data released by the ONS** shows disabled women under 65 are over 11 times more likely to die than non-disabled women, while disabled men aged under 65 with limiting disabilities are 6.5 times more likely to die, and a third of all lives lost to Coronavirus in the UK have been those of disabled people[5].
- **Report:** Runnymede Trust released '**Over-Exposed and Under-Protected**', which found BME people face greater barriers in shielding from Covid-19 as a

[3] Independent SAGE; *Disparities in the impact of Covid-19 in Black and Minority Ethnic populations*; 03 July 2020
[4] ONS; *Coronavirus and the social impacts of disabled people in Great Britain;* 20 August 2020
[5] ONS: *Coronavirus (COVID-19) related deaths by disability status, England and Wales: 2 March to 15 May 2020*; 19 June 2020

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[6].

- **Survey: Mind's survey** of adults in England and Wales revealed existing inequalities in housing, employment, finances and other issues have had a greater impact on the mental health of people from BAME groups than white people during the pandemic. For example, employment worries have negatively affected the mental health of 61 percent of people from BAME backgrounds, compared to 51 per cent of white people. Other issues saw a similar pattern, including getting support for a physical health problem (39 percent vs 29 percent) and being a carer (30 percent vs 23 percent)[7].
- **Report: *Abandoned, forgotten and ignored***
  Disabled people, and people in high-risk groups have been unable to obtain PPE and had care packages cut and assessments delayed. Some disabled people had been asked to sign DNR notices, while many more feared they would be denied access to treatment if they contracted Covid-19[8].

Stakeholder engagement log

After 8 April 2020 the EDI stakeholder responses are monitored in a separate document Equality *Stakeholder Responses to the Covid-19 Pandemic* (Trim: 6895243) and accompanying blog.

	Individual/organisation	Date	Feedback
1	General Medical Council (GMC) EDI team	27 March 2020	Discussed the GMC approach to EqIA for their temporary register. They have sent a copy of the EHRC letter to the government and to their EDI champions to remind them that 'Human rights provide a clear and practical framework to help our leaders determine what are reasonable restrictions and what are not, ensuring they can navigate the delicate balance between protecting our health and safeguarding our vital freedoms and individual needs' (Ref 7 in the action plan). They will be doing an equality analysis of their Covid-19 temporary register policy. Their communications teams have directed doctors to their ethical guidance on their website.

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

	Individual/organisation	Date	Feedback
2	Joint statement from the health professional bodies on supporting nurses and midwives across the UK and nursing associates (England only)	12 March 2020	The statement identifies the difficulties in the times of an emergency that may cross over with EDI and human rights considerations. 'We need to stick to the core principles of nursing and midwifery practice. As registered professionals you are expected to practice in line with the NMC code and use judgement in applying the principles to situations that you may face. However, these also take account of the realities of a very abnormal emergency situation. We want nursing and midwifery professionals in partnership with patients and those individuals that we care for, to use their professional judgement to assess risk and to make sure people receive safe care, informed by the values and principles set out in their professional standards. A rational approach to varying practice in an emergency is part of that professional response. It is the responsibility of the organisations in which you work to ensure that you are supported to do this. They must bear in mind that clinicians may need to depart, possibly significantly, from established procedures in order to care for patients in the unique and highly challenging but time-bound circumstances of the peak of an epidemic.'
3	Care Quality Commission (CQC) EDI team	7 April 2020	The CQC has published its EQIA into the COVID-19 crisis. The parts relevant to the NMC are: General comment 12: Mitigation of potentially negative impact - Consider how we monitor how providers ensure that clinicians make ethical decisions that impact on human rights, including the right to life, when resources to address COVID 19 healthcare needs become limited, as it relates to regulation 12 and 17. Use provider engagement methods and work with system partners to flag good practice and expectations around equality issues in clinical decision-making Action 2: Produce other communications that give support to the health and adult social sector to promote equality and human rights within existing COVID 19 limitations, as required, for example in relation to

	Individual/organisation	Date	Feedback
			ethical decision making.
4	British Association of Physicians of Indian Origin	7 April 2020	Issued and published a letter to the Chief Medical Officer England, NHS England, Public Health England raising concerns about the number of ethnic minority healthcare workers dying from Covid-19 and asking that the numbers are monitored by ethnicity and profession. twitter.com/jsbamrah/status/1247633745278111747
5	Business in the Community (BITC)	14 April 2020	Ethnicity and the Economic Impact of COVID-19[9] factsheet makes recommendations for the Cabinet Office's Race Disparity Unit that are relevant to the NMC: • Ensure the cases of those who sadly pass away because of COVID-19 are monitored by ethnicity. • Ensure the NHS and social care employees who contract COVID-19 are monitored by ethnicity group, and, those who sadly pass away. (Ref 1 in action plan)
6	Yvonne Coghill	30 March 2020	*Communities, Colour and the Corona Virus* 30 March 2020 by Yvonne Coghill • The blog notes the disproportionate impact of the Coronavirus on ethnic minorities and links to the WRES data that shows ethnic minority healthcare workers are more likely to be in frontline roles.
7	Roger Kline	17 April 2020	*NHS Covid 19 and health care worker deaths: questions that need asking* 17 April 2020 by Roger Kline. This blog notes the substantial numbers of key workers are being infected by Coronavirus and that a substantial proportion of those dying from it are from black and Minority Ethnic (BME) backgrounds.
8	Chief Nursing Officer (CNO) (England) BME Strategic Advisory Group		23 April 2020 The disproportionate impact of the Covid-19 on our nurses, midwives, nursing associates from ethnic minority backgrounds was discussed in a meeting of CNOs BME Strategic Advisory Group. More than

[99] BITC; Ethnicity and the Economic Impact of COVID-19; 2020

	Individual/organisation	Date	Feedback
			600 registrants dialled into the meeting, giving their experiences of working on the front-line and the discrimination they feel they are experiencing. A note of this meeting was shared via internal communications. 4 April 2020 Education and Standards team attended a meeting hosted by the CNO BME SAG to discuss Covid-19 and its impact on final year BME students deployed as staff, final year BME students opting for theory and BME students at other stages of their programme.
9	NHS England	29 April 2020	*Letter from the Chief Executive Sir Simon Stevens & Chief Operating Officer Amanda Pritchard to all NHS trusts and providers of community health services. (Trim: 6847208)* "Emerging UK and international data suggest that people from Black, Asian and Minority Ethnic (BAME) backgrounds are also being disproportionately affected by Covid19. Public Health England have been asked by DHSC to investigate this. In advance of their report and guidance, on a precautionary basis we recommend employers should risk-assess staff at potentially greater risk and make appropriate arrangements accordingly."
10	Nigerian Nurses Association in the UK	1 May 2020	Hosted a webinar discussing the greater risk of Covid-19 on ethnic minority nurses and midwives. Speakers included Gill Watson, CEO of Royal Collage of Midwives and Dame Donna Kinnair, CEO of Royal Collage of Nursing. The discussion pointed towards the responsibility to provide adequate protection for all staff.
11	Workplace Race Equality Standard Team (WRES) (NHS England)	12 May 2020	Hosted a webinar Covid-19 BAME: A conversation with the experts featuring presentations from: Prerana Issa, NHS Chief People Officer, NHS England and NHS Improvement; Dr David Williams, Harvard University; Yvonne Coghill, Director – WRES Implementation, NHS England and NHS Improvement; Professor James Nazroo, The University of Manchester and Dr Omar Khan, Director of The Runnymede Trust. The importance of this discussion was emphasised

	Individual/organisation	Date	Feedback
			by data that ethnic minority staff make up 20 percent of NHS workforce, 40 percent doctors and 20 percent nurses, midwives and nursing associates but of the 203 deaths to date 60 percent are from ethnic minority backgrounds.
12	Nigerian Nurse Association in the UK	03 July 2020	Our Chief Executive, Andrea Sutcliffe was on a panel of speakers at a webinar with the topic of, the role of the regulators and unions during the pandemic. Andrea spoke about our EDI commitments and responded to questions about where EDI features in the curriculum of the nursing and midwifery professions.
13	Chief Nursing Officer (CNO) (England) BME Strategic Advisory Group	23 July 2020	EDI Policy Manager, Aishnine Benjamin spoke at webinar for agency nurses and midwives. To give assurance about the role of the regulator and listen to the discussion about issues for agency nurses and midwives e.g. lack of access to training for PPE.

Corporate complaints and compliments log

Ref	Name/organisation	Date	Feedback
1	A member of Parliament (MP) query.	27 March 2020	A constituent raised an issue that they were 70 years old and had not been invited to join the temporary register. We responded that people over 70 had not been invited to join the temporary register in accordance with government policy about the people that were in high risk categories, but people over the age of 70 could still apply if they chose to and would not be refused on the grounds of age alone.
2	A nurse	18 May 2020	A complaint regarding news coverage, which was interpreted as suggesting that nurses from ethnic minority backgrounds were being put at risk more so than professionals from white backgrounds. We responded stating our concern for the professionals on our register that may not have adequate protection, where they could raise these concerns and with

			information about how to make a complaint to the media company.

Section 3: Mapping the impact

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

	The effects of Covid-19 are more serious for people older than 60.[10] The patients being treated for Covid-19 are more likely to be above 60 years of age. Some groups may be more open to being discriminated against in a healthcare setting on the basis of their protected characteristic. And if there are limited resources, health professionals may have to make decisions about which individuals can access those resources. This could raise issues of fairness, human rights and ethics if for those decisions are based on bias. For example, if decisions are based on age. **Professionals on our temporary register** Nurses, midwives and nursing associates that are above 60 may be less likely to apply to join the temporary register due to the government guidance about greater risk of Covid-19 for older people. Our analysis of the data shows that people with temporary registration are older than those with permanent registration. Around two-thirds of those with temporary registration are aged over 50 compared to just over a third with permanent registration. The diversity data on the make-up of the temporary register is now published here. 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 join the temporary register 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 join the register. Anyone can apply through the open route available on our website. The information on our website states: 'If you are aged over 70: Because of the government's advice that people aged 70 or over should take extra care during the Covid-19 emergency, we decided not to proactively invite those aged 70 or over to join the temporary register. However, you can still apply to join our temporary register if you want to.' At 7 April 2020 there were 27 people that are over 70 who have applied. Initially our website provided some conflicting information about this, and we've confirmed that people age 70 or over will

[10] 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]

	be able to join if they apply and would not be refused on the grounds of age alone. We updated the information on the website to reflect this position (Ref 4 in the action plan). **Adapting our operational processes** The separate EqIA into virtual hearings identifies that older people may have difficulties in accessing the hearings in its new virtual format (Ref 8 in the action plan).
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.[11] 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.[12] There is evidence people with certain disabilities are more likely to have health inequalities in normal health settings. Nurses, midwives and nursing associates are still required to comply with the Code that states professionals on the register must be aware of and take steps to address health inequalities. When there are limited resources health professionals may have to make decisions about which individuals can access those resources. This could raise issues of fairness, human rights and ethics if for those decisions are based on bias. For example, if decisions are based on complex disabilities or health conditions. Recent guidance from NICE has been amended following criticism from patient groups and representatives who state that using the Clinical Frailty Scale (CFS) to determine hospital admissions would lead to

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

	detrimental outcomes for those with learning disabilities or long-term disabilities such as cerebral palsy.[13] 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). **Professionals on our temporary register** Nurses, midwives and nursing associates who have underlying conditions are less likely to be in a position to apply to join the temporary register. The temporary register 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 join the temporary register 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 register 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 joining the temporary register 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[14], particularly among those with severe symptoms. Women are more likely to be diagnosed with a common mental illness[15], but men are more likely to take their own lives. The professionals on our register are more likely be under stress and their mental health concerns may be higher than for the general population. This could have an impact on their behaviours and could raise situations where their conduct is not compatible with their fitness to practise. A study of 1,257 health care workers in 34 hospitals in China showed that a considerable proportion of health care workers reported experiencing symptoms of depression, anxiety, insomnia, and distress, especially women, nurses, those in

[13] NICE (2020) NICE updated rapid COVID-19 guideline on critical care. [accessed 25-03-2020]
[14] Fundamental facts about mental health; 2016; Mental health Foundation; accessed 30-03-20
[15] NHS Digital, Mental Health & Wellbeing in England, Adult Psychiatric Morbidity Survey 2014

	Wuhan, and front-line health care workers directly engaged in diagnosing, treating, or providing nursing care to patients with suspected or confirmed Covid-19[16] (Ref 5, 6, 11, 14 and 15 in the action plan). The separate EqIA into virtual hearings identifies that disabled people may have difficulties in accessing the hearings in its new virtual format (Ref 8 in the action plan). Access to virtual hearings may impact individuals with different disabilities both positively or negatively. We seek to provide opportunities for hearing participants, particularly registrants, witnesses and members of the public, to indicate if they require a reasonable adjustment or additional support. **Supporting students** For students with health conditions who are shielding either personally, or by association with a family member, they may have to suspend their studies and complete later than they normally would (Ref 17 in the action plan).
Gender	**Our registrants engaging with the public** The effects of Covid-19 are more serious for men[17]. The government guidance about vulnerable groups does not specify that men should be taking different steps. **Professionals on our temporary register** 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.[18] Our latest registration data report shows that as of 31 March 2020, 89 percent of the people on our register were female and so at increased risk of experiencing poorer mental health as a result of Covid-19.[19] The identification of the groups to be invited to join the temporary register did not consider gender. Our analysis shows that compared to the numbers on our permanent register, there is a lower proportion of women on the temporary register (78.9 percent on the temporary register, compared to 89.3 percent on the permanent register) but a similar proportion of men (10.9 percent and 10.7 percent

[16] Lai J; Ma S; Wang Y (2020) Factors associated with mental health outcomes among health care workers exposed to Coronavirus Disease 2019. Jama Network Open. 3(3):e203976.
[17] 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.
[18] 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
[19] House of Commons Library (2020) Mental Health Awareness Week: The impact of coronavirus on health and social care workers. UK Parliament

	respectively). The lower proportion of women is most likely due, at least in part, to the higher proportion of people on the temporary register for which this information is unknown (10.2 percent on the temporary register, compared to <0.1 percent on the permanent register). In particular, a large proportion of the overseas cohort (730 people or 28 percent) are missing information on gender. (Ref 4 in the action plan).
Gender reassignment[20]	**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[21], which would equate to about 600,000 trans and non-binary people in the UK. There is evidence that people who are gender diverse are more likely to have health inequalities in normal health settings[22]. In addition there is evidence that some groups of patients face discrimination from health care workers, also that trans health professionals face discrimination 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 open 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. The diversity data we hold about these people does not record non-binary people. The information we collect via the optional survey may not provide a significant percentage of data to analyse. However, we have received a 66.2 percent response rate to date and links to the survey will now be sent out at the point in which people are confirmed as on the temporary register (Ref 1 in the action plan). Our analysis of gender identity shows that compared to the permanent register, the temporary register has a lower proportion of people who say their gender identity matches the sex assigned at birth (88.1% compared to 93.3% on the permanent register). Again, this is likely due to the higher

[20] Include trans and non-binary
[21] 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]
[22] *LGBT Action Plan 2018: Improving the lives of Lesbian, Gay, Bisexual and Transgender people*; Government Equalities Office; 2018.

	proportion of people for whom this information is unknown. There is evidence[23] that gender identity clinics were closed for at least six months and the employees being redeployed. This could have a detrimental impact on people on our register who might be trying to access treatment or health care services (and consequently the care they can provide) (Ref 3 in the action plan).
Marriage and civil partnership	There is no evidence that people will be affected differently on the basis of being in a marriage or civil partnership, or not.
Pregnancy/maternity	**Our registrants engaging with the public** There is limited scientific evidence on the severity of illness among pregnant people with Covid-19. Pregnant people appear to experience similar clinical manifestations as non-pregnant adult patients with Covid-19. However- the government policy is to treat pregnant people as a vulnerable group in light of the lack of information about the long term impact of Covid-19. A recent 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.[24] **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 join the temporary register. **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 will considered factors related pregnancy and maternity in how we re-introduced the OSCE

[23] Links to information about closures of the Leeds and Charing Cross clinics.
[24] The UK Obstretric 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 Obstretric Surveillance System (UKOSS)

	tests (Ref 9 in the action plan). Pregnant people or those on maternity, may benefit from the roll out of virtual hearings as this can minimise their travel, time and other stressors with physical hearings. **Supporting students** As there is potentially increased vulnerability for students who are pregnant, we encouraged AEIs and practice learning partners consider the particular needs of this group (Ref 17 in the action plan).
Race	**Professionals with temporary registration** Data from NHS England shows that ethnic minority staff are more likely to be in lower bands[25]. 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 invited some overseas qualified nurses and midwives to join the temporary register 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. We monitored the ethnicity of the people with temporary registration to see if it has disproportionately high numbers of overseas and ethnic minorities that are more likely to be at risk of being at the front line of the pandemic. Our analysis shows that compared to the numbers on the register in general, the temporary register has a lower proportion of people of white ethnicity (71.3% compared to 75.5% on the permanent register), a lower proportion of Black ethnicity (3.7% compared to 8.5% on the permanent register), and a lower proportion of Mixed ethnicity people (1% compared to 2.1% on the permanent register). However, it has a higher proportion of people of Asian ethnicity (11.4% compared to 8.6%). There are also a higher proportion of people whose ethnicity is unknown (9.8% compared to 2.5%), which again may account for at least some of the differences noted. **Influencing and supporting professionals on our register (with temporary and permanent registration)** Black and other minority ethnic individuals make up a large

[25] NHS (2020) WRES

	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.[26] 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.[27] In April In April a HSJ report shows 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.[28] Since then the evidence of the disproportionate impact on ethnic minorities has grown, a Public Health England Report in June clarifying that individuals from ethnic minority groups are more likely to work in occupations with a higher risk of Covid-19 exposure[29]. Our data shows us that people employed via an agency are more likely to be from ethnic minority backgrounds than people employed directly.[30] 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, 35 percent of jobs done via an agency are by people of black African ethnicity, and 34 percent are by people of white British ethnicity. The information we have gleaned through our intelligence and stakeholder engagement suggests that some agency employed professionals feel they are more likely to be deployed to care for Covid-19 patients without adequate PPE (Ref 12 in the action plan). The frequent use of bank or agency nurses or carers has been associated with higher levels of infections amongst residents in care homes in England.[31] 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

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

	association between larger care homes and outbreaks of Covid-19.[32] **Adapting our fitness to practise and removals processes** We know that black and ethnic minority registrants are more likely to be referred to us for matters that do not, after investigation, require a regulatory sanction.[33] Ethnic minority registrants are more likely to be referred to us by employers and more likely to end up with a serious outcome. Our decisions to adapt our processes, for example decisions about which cases to progress with limited resources, may inadvertently increase the likelihood of ethnic minority people have their temporary registration removed and those with permanent registration going through fitness to practise processes (Ref 4 in the action plan). **Adapting our operational processes** The separate EqIA into virtual hearings identifies that people with English as a second language may have difficulties in accessing the hearings in its new virtual format (Ref 8 in the action plan). We have insufficient evidence of whether this is actually the case, we will monitor complaints and feedback to ascertain if there is a particular barrier. **Our registrants engaging with the public** There is evidence that people from certain ethnic groups are more likely to have health inequalities in normal health settings. As explained in the 'all protected characteristics' at the start of this section health professionals may not be up to date about how to prevent these inequalities, as they are required to by the Code (Ref 13 in the action plan). We know that ethnic minorities in the UK are at greater risk of being affected by Covid-19. Ethnic inequalities are likely to manifest from the Covid-19 crisis in two main ways: through exposure to infection and health risks, including mortality, and through exposure to loss of income. A report by the Institute of Fiscal Studies show that per-capita, Covid-19 hospital deaths are highest among the black Caribbean population and three times those of the white British majority. Some minority groups

[32] 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

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

	– including Pakistanis and black Africans – have seen similar numbers of hospital deaths per capita to the population average, while Bangladeshi fatalities are lower[34] (Ref 13 in the action plan). People from Gypsy, Roma and Traveller (GRT) communities will be less likely to have access to healthcare and could be more likely to be discriminated against due to a lack of understanding of their needs (Ref 13 in the action plan). **Supporting students** The data and research shows that people from ethnic minority backgrounds have been impacted more by Covid-19 infection and mortality rates. This has led to recommendations for NHS trusts to risk assess their ethnic minority employees before deployment to care for Covid-19 patients. This indicates that there is a potential for increased vulnerability for students who are from ethnic minority backgrounds in placements. AEIs and practice learning partners will need to consider the particular need of this group (Ref 17 in the action plan).
Religion/belief	**Adapting our fitness to practise processes and supporting professionals** Nurses, midwives and nursing associates may have religious beliefs and practices that may become more prevalent or relevant in an emergency situation. For example: • religious dress that may not comply with temporary emergency measures • beliefs that dictate praying for those in distress or critically ill Our consideration of contextual factors may need to take these issues into account. **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[35] 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.

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

[35] Muslim Council of Britain statement burial measures in COVID-19 emergency legislation; 21-03-20

	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.[36] **Adapting our operational processes** The separate EqIA into virtual hearings identifies that people from certain religious groups may have difficulties in accessing the hearings in its new virtual format. For example, if the person's religion requires them to use a holy book to take the oath and we are unable to accommodate that virtually, this could pose a barrier. (Ref 8 in the action plan). This will be dealt with on a case by case basis with adaptations.
Sexual orientation	**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[37][38] in normal health settings. In addition there is evidence that some groups of patients face discrimination from health care workers, also that lesbian, gay and bisexual health professionals can face discrimination on the basis of their sexual orientation from other healthcare professionals. In a time of emergency the checks and balances to ensure there is no discrimination or bias may not be enforced. Some groups may be more open to being discriminated against in a healthcare setting on the basis of their protected characteristic. The LGBT Foundation have produced a briefing that sets out the direct and indirect impact on people who identify as LGBT. Issues relevant to our Covid-19 response include exacerbation of already poor health outcomes, reduced access to medication and increased fear of discrimination from healthcare providers.[39]
Other groups[40]	**Caring responsibilities** Women over 50 are more likely to be carers.[41] Our register is made up of 89 percent people who identify as women and

[36] Parveen N (2020) Officials investigate coronavirus hotspot in West Midlands. Guardian. Friday 20 March 2020
[37] 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)
[38] Public Health England (2018) Improving the health and wellbeing of lesbian and bisexual women and other women who have sex with women.
[39] LGBT Foundation; April 2020; *The Essential Briefing on the Impact of COVID-19 on LGBT Communities in the UK;* [accessed 27-04-20]
[40] Examples include carers and people from different socio-economic groups
[41] Carers UK; 10 facts about women and caring; [accessed 30-03-20]

	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 join the temporary register. In addition students who are carers in a household with someone who is shielding, may have to suspend their studies and complete later than they normally would (Ref 3, 5 and 6 in the action plan). Those with caring responsibilities were potentially impacted by the OSCE centres closing and revalidation requirements due to shielding or restricted times they can engage or practice (Ref 9 in the action plan). Covid-19 has also had an impact by creating additional childcare and housework which has fallen more on mothers than fathers, especially among working parents. One report argues that this may inhibit work and career progression for mothers (Blundell R, Joyce R, Costa Dias M & Xu X (2020) Covid-19: the impacts of the pandemic on inequality. Institute for Fiscal Studies. **Socio-economic status** Those living in the most deprived areas of the UK have poorer health outcomes. People living in the most deprived areas have seen their healthy life expectancy decline over the last 10 years.[42] Those in deprived areas have higher exposure to Covid-19 and face worse health outcomes from emergency.[43] Some of the professionals on our register may fit into this group and be at greater risk or work with people at greater risk. Socio-economic status may be a relevant factor when looking at the impact of Covid-19 on healthcare professionals. We do not monitor socio-economic status of the professionals on our register and will be unable to inform wider calls for evidence that may require this data. The separate EqIA into virtual hearings identifies that people from deprived areas with less access to technology may have difficulties in accessing the hearings in its new virtual format. Similarly if the assessments for overseas nurses are changed to be held online (Ref 8 and 9 in the action plan). If an individual indicates they have a difficulty accessing the technology to participate in our virtual hearings, we would

[42] 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

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

	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[44] and ethnic minority groups[45]. These groups may have less access to income during the emergency and unable to pay annual fees at this moment in time. We will adapt our processes to reduce disproportionate impacts on these groups (Ref 16 in the action plan).

Section 4: Analysis and outcome

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

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

Temporary registration

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

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

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

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

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

1 Bias in the decisions being made about who can be on or will be removed from the temporary register 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 and from individuals.

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 been revalidated.

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

5 The criteria for removal from the temporary register 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 from the temporary register and complaints raised against those with temporary registration from an EDI perspective.

Emergency standards for nursing and midwifery education

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

Revalidation and retention

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

Communications and support

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

Fitness to practise

We identified that there is some risk in our activities that could be exacerbated by the Covid-19 emergency, for example not taking account of context of how the

professionals are practicing 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.

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

3 The decision to cancel non-essential hearings. The delay could have an adverse impact on people with protected characteristics, such as registrants and members of the public with health conditions. Since the last version of the EqIA non-essential hearings are being relisted so this is much less of a risk.

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

Section 5: Welsh language assessment

Does the activity relate to 'our public business in Wales'?	Yes
How could Welsh language speakers in Wales be impacted by the activity?	Welsh language speaking patients may need to be communicated to in Welsh (Ref 14 in the action plan).
Have Welsh language speakers been consulted?	Not directly in relation to this policy.
How have/will communications and publications be translated to Welsh?	The emergency education standards have been translated into Welsh. This was published on 31 March 2020. The 'How to revalidate during C-19' guidance was published in Welsh.
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	The Welsh Language Commissioner wrote a letter to the NMC Registrar and Chief Executive, Andrea Sutcliffe (dated 17 March

speakers in Wales?	2020) to set out the legal duties under the Welsh standards and schemes during the Covid-19 emergency. ‘Welsh language standards and schemes continue to apply, as do my regulatory functions under the Welsh Language Measure. Standards and schemes create important rights for Welsh speakers, and I am keen to see opportunities to use the Welsh language maintained. I accept that normal processes may not always be followed and that there will be significant time and resource constraints. I ask organisations to do their best to continue to use the Welsh language when dealing with the public as far as possible, including with patients in the health sector. But I recognise that many practitioners will work under intense pressure, and I do not want anyone to feel any stress arising from this aspiration while demands are significant. Sharing general information and advice with the public and customers will be important, and will sometimes have to happen quickly. It will be up to you to make decisions about using the Welsh language when sharing emergency information, taking into account the circumstances and the nature of the situation. I encourage you to put in place adequate translation arrangements as part of your preparations, considering the importance of using the Welsh language when communicating with the public’

Section 6: Action Plan

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

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

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

Issue/opportunity	Implications/groups impacted and plans to address the issues raised	Action
		A4. Review diversity data of the people with temporary registration based on data we already hold. COMPLETED A5. Determine if we will report with temporary registration data. There will be very high level report (not the diversity data) of the temporary register as at the 31 March. COMPLETED A6. Decide if we need to retrospectively ask people with temporary registration for their diversity data dependent on the completeness of the data we already have. COMPLETED A7. Continue to analyse the full set of diversity data of the people with temporary registration and compare it to those with full registration.
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	People using healthcare services who are: • Lesbian, gay bisexual • Trans and non-binary • Religious groups • Older people • Disabled people	B1. Identify the parts of the Code relevant to ethics, human rights and equality to be communicated internally and externally. COMPLETED B2. Include EDI and human rights messages in policies, processes, FAQs and external communications where appropriate.

Issue/opportunity	Implications/groups impacted and plans to address the issues raised	Action
practice for a time period where they were unable to update their CPD or had not been revalidated (Ref 2)		B3. Create conditions to mitigate against negative impact of time out of practice for example, the 4-5 year group who are less likely to have done CPD or revalidation are subject to COP to mitigate risk of less recent practice. COMPLETED B4. Monitor complaints raised about temporary registrants on issues that relate to discrimination. B5. Monitor temporary registration removals decisions made by Assistant Registrars for issues related to discrimination.
The criteria for those who are 1 eligible to join, and those who 2 have been actively invited to join the temporary register being biased towards certain groups (like age) (Ref 3).	Age – older or younger people Disabled people People from some ethnic minority backgrounds Pregnant people People with caring responsibilities Gender reassignment The criteria can currently be justified and do not place a disproportionate barrier in any individual's way but will need to be reviewed regularly to ensure they are fair and legitimate. There should be no barriers that can't be objectively justified.	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. COMPLETED B7. Keep the criteria for joining the temporary register under regular review as government advice is updated. COMPLETED B8. Continue to monitor government guidance

Issue/opportunity	Implications/groups impacted and plans to address the issues raised	Action
		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.
Potential bias in the decisions being made about the people who are removed from the temporary register on the basis of protected characteristic (Ref 4).	Some ethnic minorities Disabled people Men People over 70 We are keen to ensure that we can monitor and report on removals from the temporary register and complaints raised against those with temporary registration from an EDI perspective.	B9. Identify the points in the temporary registration process where bias could occur and put in place mitigating actions. B10. Brief individuals and teams involved in decision-making about the potential EDI and human rights issues of bias that could arise in this emergency situation. COMPLETED B11. Collect diversity data at the point of opt-in for those who are eligible to join the temporary register. In line with data protection requirements. COMPLETED B12. Monitor complaints about discrimination or bias in the temporary registration processes.
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,	Disabled people (potentially all working professionals) will have increased mental health concerns Carers	As B8. B13. Review criteria to determine if it is fair and legitimate. There should be no barriers that can't be objectively justified. COMPLETED B14. Monitor removals from the temporary

Issue/opportunity	Implications/groups impacted and plans to address the issues raised	Action
midwives and nursing associates)(Ref 5).		register that cite context relating to mental health and other EDI factors as a contextual factor.
The risk of FtP investigations not taking account of the context of the practice of registrants (for example the mental health of nurses, midwives and nursing associates) may be exacerbated by the emergency situation. (Ref 6)	Disabled people (potentially all working professionals) will have increased mental health concerns Carers	As B8. B15. Explore the possibility of monitoring FtP referrals linked to Covid-19 that cite context relating to mental health and other EDI factors as part of wider programme of work on a contextual factors.
When we close the temporary register – having regard to equitable opportunities for people who wish to apply to for full registration or readmission.	Unknown which groups are affected. Consider EDI issues arising in horizon scanning work.	We don't have a standard operating procedure for closing the temporary register yet and this is not likely to be needed for some time. B16. Consider EDI and bias in determining the mechanisms for individuals to move from temporary to permanent registration including if there is an issue with the different health and character requirements. To be monitored during implementation.
Our actions in response to Covid-19 breaching equalities or human rights legislation due to acting at	All groups. Raise awareness for internal decision-makers about the responsibilities under equalities and	As B8. B17. Ensure any changes to access to remote hearings for the public are compliant with the

Issue/opportunity	Implications/groups impacted and plans to address the issues raised	Action
speed and missing checks and balances (Ref 7).	human rights legislation.	Human Rights Act 1998.
The adaptions to our FtP and registration appeals processes due to the emergency having a negative impact on people who share protected characteristics. For example requiring everyone to attend virtual hearings and delays causing mental distress (Ref 8).	Disabled people Carers Older people Socio-economic status People with communication barriers e.g. needing interpreters Some religious groups Identify where our temporary actions may have a negative impact on certain groups and put in place mitigating actions. Complete more detailed equality impact assessments for longer term changes.	B18. Case teams are corresponding with case parties electronically/over the telephone where possible due to the office being closed. COMPLETED B19. We have created guides for parties to assist them with responding electronically, and pdf documents that can only be amended in the sections that we require a response. COMPLETED B20. The Public Support Service team is providing ongoing specialist support to screening teams in making reasonable adjustments for disabled customers. COMPLETED B21. Facilities colleagues are coming into the office weekly to pick up and scan post that is still coming in to ensure that we are still receiving correspondence that is being sent in. COMPLETED B22. Taking action to progress cases where possible, including reviewing caseloads, communicating potential delays to parties for cases involving frontline workers and listing

Issue/opportunity	Implications/groups impacted and plans to address the issues raised	Action
		straightforward hearings. COMPLETED B23. We have had a care line in place for registrants with active FtP cases since October 2019. We will expand the service to other registrants to assist them whilst dealing with this crisis. COMPLETED B24. Put together a working group to look at expanding our FtP and Registration appeals hearings activity and take forward the actions from the EqIA for virtual hearings. COMPLETED B25. Conduct a separate EqIA for public access to virtual hearings (also related to physical hearings).
The adaptations to our overseas registration processes due to the due to the emergency having a negative impact on people who share protected characteristics. For example closing OCSE centres (Ref 9).	Ethnic minority groups and non-UK nationals Disabled people Carers People who are pregnant Identify where our temporary actions may have a negative impact on certain groups and put in place mitigating actions. Complete more detailed equality impact assessments for longer term changes.	As B17. B26. Clear communications with overseas candidates. For example by providing information on our Covid-19 hub on the website. COMPLETE B27. All overseas nurses and midwives who met the eligibility criteria were offered to become temporarily registered. COMPLETED B28. Working closely with our OSCE delivery

Issue/opportunity	Implications/groups impacted and plans to address the issues raised	Action
		partners and development partner on reopening OSCE centres safely and accessibility. COMPLETED B29. We are piloting online computer based tests which, if successful, will allow candidates to take the test at home rather than travelling.
C Influence – providing insight		
Health inequalities and discrimination already exist in the wider healthcare environment. These should not be exacerbated in this crisis. We have a responsibility under the PSED to use our influence to tackle prejudice and promote understanding (Ref 10)	All groups We will act to eliminate discrimination and promote equality, diversity and inclusion. Cognisant of how the NMC can add value to the insights in the wider healthcare environment.	C1. Monitoring external publications on the topic of health inequalities and impacts on the basis of protected characteristic to inform our decisions. C2. Monitor the intelligence we gather about Covid-19 related issues for EDI themes. C3. Review external research and work with other bodies to ensure there is a sufficiently detailed picture of the impact of the emergency on professionals on our registers by protected characteristic.
Potentially exacerbating current biases in the FtP referral processes for professionals with temporary or permanent	Some ethnic minorities Disabled people Men Monitor referrals by protected characteristic to	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.

Issue/opportunity	Implications/groups impacted and plans to address the issues raised	Action
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)	identify patterns and bias. Communicate with employers if concerns are raised that appear to be based on bias.	C5. Explore ways to monitor if FtP referrals are raised that appear to be based on bias or discriminatory factors. C6. Communicate with employers if it appears that referrals are being made that appear to be based on bias or discriminatory factors.
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 full registration) who are infected, hospitalised or die from Covid-19 by protected characteristic.	C7. Ensure the systems are in place to monitor ethnicity (and other relevant protected characteristics) on both registers. COMPLETED C8. We will keep under review the call for evidence from the Women and Equalities Unit and future calls for evidence (where we may inform wider discussion to understand how people with protected characteristics are disproportionately affected by Covid-19). C9. 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. C10. Where suitable sensitively communicate EDI messages re the data externally.
D Support – professionals on our register		

Issue/opportunity	Implications/groups impacted and plans to address the issues raised	Action
Professionals on our register working in an emergency situation are more likely to be under pressure to make decisions that could breach equalities legislation, ethics and engage the Human Rights Act (Ref 13)	All groups – but particularly vulnerable disabled groups and those who already have health inequalities including ethnic minorities, disabled and LGBT people Monitor and address issues as they arise. Attend external forums and monitor concerns with stakeholders.	D1. Attend Moral and Ethical Guidance Committee – monitor issues that arise and work that arises from this group. D2. Publish PPE guidance and guidance on DNACPR action completed. COMPLETED. Regularly review issues as they emerge tied into ethical guidance and case studies. 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.
Use our influence to support healthcare workers and people using services that will be facing more difficulties during this emergency because of their protected characteristics (Ref 14)	Disabled health professionals – mental health People with disabilities – including learning difficulties, autism and those with long-term health conditions. Pregnant people Carers Welsh speaking professionals and people using services Use external communications channels to promote mental health and other considerations for example, ethics in decision-making.	D4. Ensure communications are translated into Welsh in line with our Welsh Language Scheme. D5. External communications and collaboration with other stakeholders – signposting to resources on mental health. COMPLETED

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 people of the register are women) Disabled people That our actions mitigate any disproportionate revalidation rates by protected characteristics and the process is flexible to take account of different circumstances.	D6. Make revalidation extensions available to all people on the register. COMPLETED D7. Produce 'How to revalidate during C-19' guidance. To include information about updating diversity information and to be translated into Welsh. COMPLETED D8. Monitor the diversity data of those who apply for, are accepted, and those who are not accepted for support measures.
Our retention requirements such as payment of fees may be difficult for certain groups of people to meet during the emergency (Ref 16)	Socio-economic status may indicate less financial flexibility	D9. People who fail to pay fees are given six week extensions and those who need support after this are referred to the hardship criteria. COMPLETED D10. Use criteria to determine hardship cases for additional support with payments. COMPLETED D11. Explore the possibility of monitoring the diversity characteristics of those who apply for and are accepted for hardship support.
E Support – students in placements		

Issue/opportunity	Implications/groups impacted and plans to address the issues raised	Action
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 period they will be supported to continue their studies after the emergency	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. COMPLETED E2. Create a table outlining to students their options and that they will not be negatively impacted because of their personal situation. COMPLETED E3. Publish our emergency programme standards outlining that students should continue to be appropriately supported and supervised. COMPLETED E4. Review AEIs' exceptional reporting forms to ensure that students have not been disadvantaged and that appropriate support has been put in place for all students during this period.

Section 7: Review

Date of next review	Ongoing updates in action monitoring log. Full review of this EqIA on 31 October 2020.
Name of business/operational lead	The EDI Policy Team are coordinating the monitoring of the actions.
How will operational impact be monitored?	Meetings to review the actions with action leads. This EqIA will be updated bi-monthly.
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 the Covid-19 temporary register are not upheld. 5 We are assured that the professionals on our register are practicing in line with the EDI and human rights requirements in the Code despite the emergency situation and take action if we have evidence that they are not. 6 The NMC can report on the diversity of professionals with temporary registration.
How often will the impact be reviewed?	First meeting on 14 April 2020.

	Review meeting on 2 June 2020. Ongoing meetings and communications with action leads.

Section 8: Sponsor/director sign-off

Declaration: I have read this EqIA and I am assured that all the available evidence has been analysed to determine any potential for unlawful discrimination, advancing equality of opportunity, promoting best practice and fostering good relations. The mitigations where appropriate have been identified and the action plan will be implemented. I am assured that the activity will be compliant with the NMC Welsh language scheme. The equality impacts of this work will continue to be monitored.	
Name/role:	Matthew McClelland, Executive Director of Strategy and Insight
Date:	31 August 2020