EQIA of the NMC's response to Covid-19

Version 4, covering 31 August – 31 October 2020

Introduction

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

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

We use equality impact assessments (EqIAs) as an assessment tool to demonstrate our work complies with equalities legislation and to explore our data and insight on equality issues. It helps us to understand the impact of our activities on different groups of people and any action we need to take as a result.

This version of our EqIA reflects the further work we've done to respond to Covid-19 between 31 August and 31 October 2020. It covers all aspects of our response, including temporary registration, emergency standards, changes to fitness to practise, registration and registration appeals processes, revalidation, communications and intelligence.

We're committed to being transparent and open about our activity - previous versions of this document were published in July and September 2020. We have summarised the key activities we have undertaken since the previous version was published below.

The issues we cover

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

- We can monitor and report on the diversity of those with temporary registration, now and to inform future research and evidence
- 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)

Overview of key EDI activity in response to Covid-19

We spoke out about EDI issues in the early stages of the pandemic, including 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 disproportionately negative impact on some communities, including those from an ethnic minority background.

Earlier versions of this EqIA documented our work to publish the diversity data about the professionals with temporary registration, analyse the impact of virtual hearings, and consider inviting people with temporary registration to become permanently registered.

This latest version marks over six months since we introduced temporary registration in March 2020 and started to monitor the EDI impact of our Covid-19 response work. We are pleased to report that in this time we have not identified or had any feedback about any issues of bias or discrimination in our processes.

We monitor feedback carefully, and we have not received any concerns raised about people with temporary registration relating to discrimination. Similarly we haven't had any complaints about discrimination in our Covid-19 response processes, for example relating to decisions to remove a person's temporary registration.

Key activities since publication of the previous EqIA

Noteworthy activity undertaken between 31 August and 31 October includes:

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

- the publication of our Caring with Confidence: The Code in Action animation on supporting professionals to feel confident challenging discrimination wherever they see it

- ongoing work to anonymise applications for temporary registration, including removing names and gender markers to remove any opportunity for potential bias

- preparing a public consultation on future use of emergency powers given to the NMC, including on our use of virtual meetings and hearings. This is open for responses until 15 January 2021, and includes optional and anonymous diversity monitoring questions

- continued monitoring of the EDI information relating to those being referred to us

- reviewing what our data tells us about disparity in mortality rates relating to the professionals on our register who have sadly lost their lives in service. Of the individuals where data was available, 61% of those who died were from Black and minority ethnic (BME) backgrounds – three times as high as the percentage of those on the register as a whole (20 percent)

- reflecting our learning in our engagement with employers, with our Employer Link Service focusing on key areas of concern from BME nursing and midwifery professionals and sharing examples of good practice

- extending the delivery of our fitness to practise Careline, the pilot of which was due to finish in October 2020, meaning people will continue to be able to access this support. This may be particularly important for people from BME backgrounds, who we know are likely to be referred to us in disproportionate numbers

- the publication of our annual report on our Welsh language scheme, which covered how the needs of Welsh language speakers have been considered in our response to Covid-19.

In the same period we also shared the first report of Ambitious for change, our new research into our processes and people's protected characteristics. This work has been underway for some time and doesn't explore the impact of any new ways of working on the professionals on our register, but it does provide fresh insight into the experiences of different groups as they interact with our services, and creates a baseline from which we can monitor any changes.

Sharing vital learning

We used our own data as well as external evidence to develop this EqIA and action plan, including information gained from engaging with employers, education institutions, unions, professionals on our register and the public. We've also been able to share our anonymised diversity data with partners, such as Public Health England, to support our shared learning as we all navigate the pandemic and collectively examine the impact related activity has on different groups.

In particular we are grateful to equality and human rights organisations, whose evidence and insight have improved our awareness of wider issues in society. Our understanding of issues facing different people and communities has been broadened by recent insight including from Age UK's report into the impact of Covid-19 on older people's mental and physical health, National Autistic Society's Left Stranded report, Doreen Lawrence's 'An avoidable crisis' review, Runnymede Trust's research into ethnic disparities and University of Bristol's Learning Disabilities Mortality Review Programme, among others.

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

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

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

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

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

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

Version and date completed	Version 4 31 October 2020
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	Emma Lawrence Senior Equality and Diversity Policy Officer
Senior sponsor	Matthew McClelland, Executive Director of Strategy and Insight
Review date	31 January 2021 (to update to version 5 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 with permanent registration not in clinical placements to take up a role in a clinical setting during the emergency

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

3.1.5 ensuring that professionals with permanent registration do not inadvertently leave the register 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 with temporary registration

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

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

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

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

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

7.1 temporary registration

7.2 emergency standards for nursing and midwifery education

7.3 communications and support

7.4 registration and registration appeals

7.5 retention

7.6 revalidation

7.7 fitness to practise

7.8 overseas registration

Covid-19 temporary registration

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

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

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

9.2 demonstrate fairness in our processes and understand the identities of the people with temporary registration and how they are impacted by our work. Collecting this data enables us to 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 meet public interest in the diversity data of professionals involved in the Covid-19 crisis.

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

Emergency 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 during 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).

13 We have been working with AEIs to ensure students have not been disadvantaged and that appropriate support has been put in place for all students. We are working with AEIs to seek assurances in relation to our emergency standards having been met.

Communications and support

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

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

Registration and registration appeals

16 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.

17 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

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

19 We have received concerns regarding professionals with temporary registration being required to pass the objective structured clinical examination (OSCE) in order to obtain permanent registration. Passing the OSCE is an important part of ensuring that those joining our permanent register meet our standards and can practise without the conditions or supervision that were necessary for temporary registration, and an important safeguard for those professionals themselves as

well as the public. Initial reports indicate that those who worked with temporary registration appeared to be better prepared for the test and achieved slightly better pass rates.

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

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

Retention payments

22 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.

23 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

24 We gave people who were due to revalidate between March to June 2020 a blanket extension of 12 weeks. From July onwards people were 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, but registrants are able to request a further extension of 12 weeks if their ability to revalidate is 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

25 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.

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

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

26.2 interim order applications

26.3 substantive order reviews

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

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

28 We have been working on a separate equality analysis on the topic of public access for virtual hearings to ensure that any decisions we make are compliant with equality legislation and best practice. We launched a public consultation on all our emergency powers, including public access for virtual hearings. The consultation is due to close on 15 January 2021, after which further decisions will be made by Council in March 2021.

29 As mentioned earlier, we have also extended the service of our fitness to practise Careline, the year-long pilot of which was due to finish in October 2020. The success of the pilot means the specialist counsellors will continue to be able to give emotional support and practical help and advice to all nurses, midwives and nursing associates during the fitness to practise process from 1 November 2020 onwards. This may be particularly important for people from BME backgrounds, who we know are likely to be referred to us in disproportionate numbers.

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. 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[3]. 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[4]. Runnymede Trust released 'Over-Exposed and Under-Protected', which found BME people face greater barriers in shielding from Covid-19 as a result of the types of employment they hold (i.e. key worker roles); having to use public transport more; living in overcrowded and multigenerational households; and not being given appropriate PPE at work. 50 percent of Bangladeshi, 42 percent of Pakistani and 41 percent of Black African key

[3] ONS; *Coronavirus and the social impacts of disabled people in Great Britain;* 20 August 2020
[4] ONS: *Coronavirus (COVID-19) related deaths by disability status, England and Wales: 2 March to 15 May 2020*; 19 June 2020

	worker respondents reported that they had not been given adequate PPE.[5] 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 percent 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).[6] Inclusion London's Abandoned, forgotten and ignored report found that disabled people, and people in high-risk groups have been unable to obtain PPE and had care packages cut and assessments delayed. Some disabled people had been asked to sign DNR notices, while many more feared they would be denied access to treatment if they contracted Covid-19.[7] EDI organisations have produced reports as summarised in *EDI Stakeholder responses to Covid-19*;; Emma Lawrence, Senior EDI Policy Officer. (Trim: 6828971)
Data	**Revalidation and retention** Our diversity data is taken from the register. Our Year four revalidation tables show that the revalidation rates of people on our register with permanent registration vary slightly between some people who share protected characteristics. Also that there are differences by protected characteristic in setting and scope of practice, for example people employed via an agency are more likely to be from ethnic minority backgrounds. **Temporary registration** EDI data about people with Covid-19 temporary registration is taken from different sources. This includes data we have collected from an EDI survey that is sent to everyone with temporary registration and where this is not available, data we have on our systems. A summary of the analysis of this data show us that: • people with temporary registration are older than those with permanent registration. Around two-thirds of those

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

	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. There are also has fewer people of black and mixed ethnicity, but more people identifying as Asian. Fewer people with temporary registration declare a disability and a higher proportion identify as bisexual. In comparison to our register as a whole, more people with temporary registration identify as Jewish and Hindu and fewer people identify 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 with temporary registration to ask them to complete a survey asking about their EDI characteristics. A link to the EDI survey is now included in all emails sent to confirm that someone has temporary registration, and we have contacted those people with temporary registration between 27 May and 1 July to ask them to complete the survey (Ref 1 in action plan). As of 18 November, 12,184 people had temporary registration, with 10,009 responses to the EDI survey. With the new virtual hearings we have an improvement survey that collects diversity data but the numbers responding have been very low.
Social media	Conversations on social media show there is public interest in the disproportionate numbers of ethnic minority health professionals working to combat Covid-19 dying from Covid-19. We are monitoring the social media communications as this is a form of intelligence and we acknowledge that disadvantaged groups may not be able to raise issues that concern them via mainstream communication channels.

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 registration. 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 registration policy. Their communications teams have directed doctors to their ethical guidance on their website.
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

	Individual/organisation	Date	Feedback
			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 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[8] 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)

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

	Individual/organisation	Date	Feedback
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 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

	Individual/organisation	Date	Feedback
			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 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 a 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 take up temporary registration. We responded that people over 70 had not been invited to take up temporary registration 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.
3	A nurse	17 July 2020	A concern that the support for BME professionals from the NMC is too late. We responded confirming we understand the concerns. We have welcomed the relevant reports and research on why Covid-19 has had a worse impact on some communities, including those from an ethnic minority background. We have committed to championing the values of equality, diversity and inclusion and will continue to work to address this in our new five year strategy We have also publically called for better access to PPE and better risk assessments for nursing and midwifery staff.
4	Two nurses	20 July 2020	A concern that the NMC have offered more support for Black Lives Matter than for professionals on the register. We responded to the comments by recognising that this is an incredibly difficult time and confirming our commitment to equality and diversity

			rightly extends to everyone on our register. We felt it was important to acknowledge the huge impact that the movement has had on dialogue about racial inequality across the world. We have committed to championing the values of equality, diversity and inclusion in our new five year strategy, and we also recognised our role in supporting our professions to address health inequalities.

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. If they are out of practice for a long period of time some health professionals taking up temporary registration may not know that certain groups experience more/particular health inequalities than others and this this is likely to make them more or less susceptible to Covid-19 or other impacts (including mental health impacts). These health professionals may be unaware of the steps that have to be taken to reduce negative health outcomes due to protected characteristics (Ref 2 and 10 in action plan).

	This issue did not occur as a result of the people taking up temporary registration. However, we are strengthening communication about the relevant parts of the Code including equality and human rights (Ref 2 in action plan).
Age	**Our registrants engaging with the public** The effects of Covid-19 are more serious for people older than 60.[9] The patients being treated for Covid-19 are more likely to be above 60 years of age. Some groups may be more susceptible to being discriminated against in a healthcare setting on the basis of their protected characteristic. And if there are limited resources, health professionals may have to make decisions about which individuals can access those resources. This could raise issues of fairness, human rights and ethics if for those decisions are based on bias. For example, if decisions are based on age. In their report into the impact of Covid-19 on older people's mental and physical health, Age UK highlighted issues for older people including loss of mobility and balance from moving around less, pain from untreated medical treatment, reduced ability to receive appropriate nutrition, cognitive decline, stress and isolation. 43 percent of people with a long-term health condition are now unable to walk as far as before, while the proportion of over 70s experiencing depression has doubled since the start of the pandemic. **Professionals with temporary registration** Nurses, midwives and nursing associates that are above 60 may be less likely to apply for temporary registration due to the government guidance about greater risk of Covid-19 for older people. Our analysis of the data 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 those with temporary registration 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 take up temporary registration because we felt it wouldn't be responsible to do so given the government guidance (updated 1 May 2020) that people over

[9] 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]

	the age of 70 are clinically vulnerable. See Section 4: Analysis and outcome (Ref 3 in action plan). People over the age of 70 are able to take up temporary registration. Anyone can apply through the open route available on our website. The information on our website states: 'If you are aged over 70: Because of the government's advice that people aged 70 or over should take extra care during the Covid-19 emergency, we decided not to proactively invite those aged 70data gaps or over to join the temporary register. However, you can still apply to join our temporary register if you want to.' As of 28 October, there were 179 professionals aged 70 or over with temporary registration. Initially our website provided some conflicting information about this, and we've confirmed that people age 70 or over will be able to join if they apply and would not be refused on the grounds of age alone. We updated the information on the website to reflect this position (Ref 4 in the action plan). **Adapting our operational processes** The separate EqIA into virtual hearings identifies that older people may have difficulties in accessing the hearings in its new virtual format (Ref 8 in the action plan). We are currently assessing the data received through the improvement survey and will consider the findings of the public consultation on our emergency powers in future decisions relating to access to virtual hearings. We also have a Specialist Case Lead in FtP whose work ensures we understand the requirements of people with different needs, including people who are vulnerable or who have disabilities.
Disability	**Our registrants engaging with the public** The effects of Covid-19 are more serious for people with underlying conditions such as hypertension, diabetes, cardiovascular disease, chronic respiratory disease and cancer.[10] 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

[10] Ibid.

	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.[11] The National Autistic Society's Left Stranded report found that nine out of ten autistic people worried about their mental health during lockdown and were six times more likely to have low life satisfaction compared to the general public. There is evidence people with certain disabilities are more likely to have health inequalities in normal health settings. Nurses, midwives and nursing associates are still required to comply with the Code that states professionals on the register must be aware of and take steps to address health inequalities. When there are limited resources health professionals may have to make decisions about which individuals can access those resources. This could raise issues of fairness, human rights and ethics if for those decisions are based on bias. For example, if decisions are based on complex disabilities or health conditions. Findings from the Learning Disabilities Mortality Review Programme suggests the key symptoms of Covid-19 in the general population may not be as apparent in people with learning disabilities, and found that 1 in 5 of deaths which were reviewed involved a person who has been discharged from hospital to be readmitted soon again afterwards. Careful attention must be paid to prejudicial attitudes towards care and judgements about ceilings of care. Recent guidance from NICE has been amended following criticism from patient groups and representatives who state that using the Clinical Frailty Scale (CFS) to determine hospital admissions would lead to detrimental outcomes for those with learning disabilities or long-term disabilities such as cerebral palsy.[12] 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 with temporary registration** Nurses, midwives and nursing associates who have underlying

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

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

	conditions are less likely to be in a position to apply for temporary registration. The temporary registration policy states that 'In line with the latest government health advice, we have not contacted former registrants…with known health conditions'. This was an active decision we made to not proactively invite people who we know have health conditions to take up temporary registration in line with government guidance to mitigate against the potentially negative impact of our actions on disabled people (Ref 3 in the action plan). The temporary registration policy states that 'we will not be applying our normal health, character or language requirements' and that 'potential registrants will be asked to assess their own suitability for temporary registration based on their own health conditions and personal situations' in light of the latest Government guidance. Therefore in taking up temporary registration we ask people to think of the same issues as when making the registration health and character declaration (Ref 3 and 4 in the action plan). **Adapting our operational processes** The prevalence of mental health concerns in the UK is increasing,[13] particularly among those with severe symptoms. Women are more likely to be diagnosed with a common mental illness[14] but men are more likely to take their own lives. The professionals on our register are more likely be experiencing stress and working in stressful conditions, and their mental health concerns may be higher than for the general population. 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 Wuhan, and front-line health care workers directly engaged in diagnosing, treating, or providing nursing care to patients with suspected or confirmed Covid-19[15] (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

[13] Fundamental facts about mental health; 2016; Mental health Foundation; accessed 30-03-20
[14] NHS Digital, Mental Health & Wellbeing in England, Adult Psychiatric Morbidity Survey 2014
[15] 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.

	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.[16] The government guidance about vulnerable groups does not specify that men should be taking different steps. **Professionals with temporary registration** Covid-19 has increased inequalities in mental health in the UK, particularly for women who already had lower levels of mental health before Covid-19.[17] 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.[18] The identification of the groups to be invited to take up temporary registration did not consider gender. Our analysis shows that compared to the numbers with permanent registration, there is a lower proportion of women with temporary registration (78.9 percent with temporary registration, compared to 89.3 percent with permanent registration) but a similar proportion of men (10.9 percent and 10.7 percent respectively). The lower proportion of women is most likely due, at least in part, to the higher proportion of people temporary registration for which this information is unknown (10.2 percent with temporary registration, compared to <0.1 percent with permanent registration). 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).

[16] 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.
[17] 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
[18] House of Commons Library (2020) Mental Health Awareness Week: The impact of coronavirus on health and social care workers. UK Parliament

Gender reassignment[19]	**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,[20] which would equate to about 600,000 trans and non-binary people in the UK. There is evidence that people who are trans or non-binary are more likely to have health inequalities in normal health settings.[21] In addition there is evidence that some groups of patients face discrimination from health care workers, while 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 vulnerable to being discriminated against in a healthcare setting on the basis of their protected characteristic. **Professionals with temporary registration** People who have left our register and identify as other than male or female did not have the options on our registration systems to reflect them. 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 having temporary registration (Ref 1 in the action plan). Our analysis of gender identity shows that compared those with permanent registration, a lower proportion of people with temporary registration say their gender identity matches the sex assigned at birth (88.1% compared to 93.3% with permanent registration). Again, this is likely due to the higher proportion of people for whom this information is unknown. There is evidence[22] 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

[19] Include trans and non-binary
[20] 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]
[21] *LGBT Action Plan 2018: Improving the lives of Lesbian, Gay, Bisexual and Transgender people*; Government Equalities Office; 2018.
[22] Links to information about closures of the Leeds and Charing Cross clinics.

	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.[23] **Professionals with temporary registration** Our invitations to join the register ask that individuals should consider their personal circumstances in line with latest government guidance. We neither encourage nor discourage particular groups within the cohort (Ref 3 in the action plan). Nurses, midwives and nursing associates who are pregnant or on maternity leave are less likely to apply to take up temporary registration. **Adapting our operational processes** People who are pregnant may be impacted by the OSCE centres closing due to the timelines available that they would complete their assessments. We considered factors related pregnancy and maternity in how we re-introduced the OSCE tests (Ref 9 in the action plan). Pregnant people or those on maternity, may benefit from the roll out of virtual hearings as this can minimise their travel, time and other stressors with physical hearings. We have now re-opened physical hearings, and processes are in place for us to engage with parties in advance of the hearing

[23] 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)

	to make appropriate arrangements for people with this protected characteristic. Pregnancy and maternity is a factor which would influence the decision taken on which type of hearing is most appropriate. **Supporting students** As there is potentially increased vulnerability for students who are pregnant, we encouraged AEIs and practice learning partners consider the particular needs of this group (Ref 17 in the action plan).
Race	**Professionals with temporary registration** Data from NHS England shows that ethnic minority staff are more likely to be in lower bands.[24] 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 take up temporary registration to increase the numbers of health professionals available to fight the Covid-19 pandemic. Overseas nurses are more likely to be from ethnic minority backgrounds. 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, a lower proportion of people of white ethnicity (71.3% compared to 75.5% with permanent registration), a lower proportion of Black ethnicity (3.7% compared to 8.5% with permanent registration), and a lower proportion of Mixed ethnicity people (1% compared to 2.1% with permanent registration) have temporary registration. However, a higher proportion of people with temporary registration are of Asian ethnicity (11.4% compared to 8.6%). There is 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 share of jobs considered essential in tackling the virus and so

[24] NHS (2020) WRES

	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.[25] 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.[26] 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.[27] 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.[28] Reviewing our data relating to disparities in mortality rates of the professionals on our register who have sadly lost their lives in service has shown that, of the individuals where data was available, 61% of those who died were from Black and ethnic minority backgrounds – three times as high as the percentage of those on the register as a whole (20 percent). Our data shows us that people employed via an agency are more likely to be from ethnic minority backgrounds than people employed directly.[29] 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

[25] 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.
[26] Tweets accessed 08-04-20 https://twitter.com/jsbamrah/status/1247633745278111747
[27] Cook T, Kursumovic E, Lennane S; *Exclusive: deaths of NHS staff from Covid-19 analysed*; HSJ; 22 April 2020 [accessed 28-04-20]
[28] *Beyond the data: Understanding the impact of Covid-19 on BAME groups*; Public Health England; June 2020
[29] NMC (2019) Revalidation: Annual data report. Year 3: April 2018 to March 2019.

	higher levels of infections amongst residents in care homes in England.[30] Our latest revalidation data shows that a significant proportion of Black African nurses and midwives work in care homes. A recent study of care homes in Scotland has shown an association between larger care homes and outbreaks of Covid-19.[31] Our Employer Link Service has been reflecting our intelligence and learning in their routine engagement with employers, with a targeted focus on key areas of concern for Black and minority ethnic registrants, as well as sharing examples of good practice. **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.[32] 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, but we will monitor complaints and feedback to ascertain if there is a particular barrier. **Our registrants engaging with the public** There is evidence that people from certain ethnic groups are more likely to have health inequalities in normal health

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

[31] 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

[32] 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.

	settings. As explained in the 'all protected characteristics' at the start of this section health professionals may not be up to date about how to prevent these inequalities, as they are required to by the Code (Ref 13 in the action plan). We know that ethnic minorities in the UK are at greater risk of being affected by Covid-19. Ethnic inequalities are likely to manifest from the Covid-19 crisis in two main ways: through exposure to infection and health risks, including mortality, and through exposure to loss of income. A report by the Institute of Fiscal Studies show that per-capita, Covid-19 hospital deaths are highest among the black Caribbean population and three times those of the white British majority. Some minority groups – including Pakistanis and black Africans – have seen similar numbers of hospital deaths per capita to the population average, while Bangladeshi fatalities are lower[33] (Ref 13 in the action plan). People from Gypsy, Roma and Traveller (GRT) communities will be less likely to have access to healthcare and could be more likely to be discriminated against due to a lack of understanding of their needs (Ref 13 in the action plan). Research from The Runnymede Trust and the Institute for Public Policy Research (IPPR) suggests co-morbid diseases, like diabetes, do not fully explain the difference in risk of death from Covid-19 between ethnic groups. Higher deprivation levels explain the disparities to a greater extent, but the majority of the additional risk of death from Covid-19 experienced by minority ethnic communities is unexplained, in part because of difficulties with data. They suggest differential access to healthcare and structural racism play a significant part in the disproportionality. Doreen Lawrence's 'An avoidable crisis' review points to healthcare barriers including a lack of cultural and language-appropriate communication, lack of clinical training on the presentation of different illnesses across communities, and Black Asian and minority ethnic people being under-represented in the senior leadership of the NHS. **Supporting students** The data and research shows that people from ethnic minority backgrounds have been impacted more by Covid-19 infection and mortality rates. This has led to recommendations for NHS trusts to risk assess their ethnic minority employees before

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

	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[34] the practices in relation to death and bereavement are very important and the healthcare professionals on our register must endeavour to respect these, in line with the Code. There could also be geographical hotspots that link to religious and cultural beliefs. For example London and the Midlands were noted to have higher numbers of cases and deaths from Covid-19 possibly linked to religious/cultural practices and beliefs.[35] **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.

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

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[3637] 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.[38] A study of LGBTQ people's experience during the pandemic, by University College London (UCL) and Sussex University, found 69 percent of respondents suffered depressive symptoms, rising to about 90 percent of those who had experienced homophobia or transphobia. Around a sixth of the respondents said they had faced discrimination during the pandemic because of their sexuality. The rate rose to more than a third among those living in homes where they were not open about their identity. Almost 10% of people reported they felt unsafe in their homes.
Other groups[39]	**Caring responsibilities** Women over 50 are more likely to be carers.[40] Our register is made up of 89 percent people who identify as women and older women are a greater proportion of the register. In this emergency situation there will be more pressure on carers, in particular carers of people who are in the vulnerable groups identified. Professionals with families/children may be less likely to apply to take up temporary registration. In addition students who are carers in a household with someone who is shielding, may have to suspend their studies and complete

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

	later than they normally would (Ref 3, 5 and 6 in the action plan). Those with caring responsibilities were potentially impacted by the OSCE centres closing and revalidation requirements due to shielding or restricted times they can engage or practice (Ref 9 in the action plan). For some people with caring responsibilities virtual hearings will be more suitable, whilst for others Covid-19-secure physical hearings may be preferred. We will make adjustments and decisions on a case by case basis. Covid-19 has also had an impact by creating additional childcare and housework which has fallen more on 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.[41] Those in deprived areas have higher exposure to Covid-19 and face worse health outcomes from emergency.[42] Some of the professionals on our register may fit into this group and be at greater risk or work with people at greater risk. Socio-economic status may be a relevant factor when looking at the impact of Covid-19 on healthcare professionals. We do not monitor socio-economic status of the professionals on our register and will be unable to inform wider calls for evidence that may require this data. The separate EqIA into virtual hearings identifies that people from deprived areas with less access to technology may have difficulties in accessing the hearings in its new virtual format. Similarly if the assessments for overseas nurses are changed to be held online (Ref 8 and 9 in the action plan). If an individual indicates they have a difficulty accessing the technology to participate in our virtual hearings, we would make adjustments on a case by case basis, for example inviting them to a hearing centre to participate from there.

[41] 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

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

	The financial impact of Covid-19 is more likely to impact on those people from lower socio-economic backgrounds and the intersection of women[43] and ethnic minority groups.[44] 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:

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

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

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

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

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

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

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

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

Emergency standards for nursing and midwifery education

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

Revalidation and retention

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

Communications and support

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

Fitness to practise

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

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

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

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

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

We will be analysing views on the use of our emergency powers, including public access to hearings in the current public consultation which closes in January 2021. We are monitoring responses by protected characteristic.

Section 5: Welsh language assessment

Does the activity relate to 'our public business in Wales'?	Yes
How could Welsh language speakers in Wales be impacted by the activity?	Welsh language speaking patients may need to be communicated to in Welsh (Ref 14 in the action plan).
Have Welsh language speakers been consulted?	Not directly in relation to this policy.
How have/will communications and publications be translated to Welsh?	The emergency education standards have been translated into Welsh. This was published on 31 March 2020. The 'How to revalidate during C-19' guidance was published in Welsh. The Covid-19 emergency rules public consultation has a Welsh language option.
Does the activity comply with our Welsh language scheme?	Yes
How will the activity be altered to	The Welsh Language Commissioner wrote a

ensure equal treatment of English and Welsh languages for Welsh speakers in Wales?	letter to the NMC Registrar and Chief Executive, Andrea Sutcliffe (dated 17 March 2020) to set out the legal duties under the Welsh standards and schemes during the Covid-19 emergency. ‘Welsh language standards and schemes continue to apply, as do my regulatory functions under the Welsh Language Measure. Standards and schemes create important rights for Welsh speakers, and I am keen to see opportunities to use the Welsh language maintained. I accept that normal processes may not always be followed and that there will be significant time and resource constraints. I ask organisations to do their best to continue to use the Welsh language when dealing with the public as far as possible, including with patients in the health sector. But I recognise that many practitioners will work under intense pressure, and I do not want anyone to feel any stress arising from this aspiration while demands are significant. Sharing general information and advice with the public and customers will be important, and will sometimes have to happen quickly. It will be up to you to make decisions about using the Welsh language when sharing emergency information, taking into account the circumstances and the nature of the situation. I encourage you to put in place adequate translation arrangements as part of your preparations, considering the importance of using the Welsh language when communicating with the public’

Section 6: Action Plan

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

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

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

Issue/opportunity	Implications/groups impacted and plans to address the issues raised	Action
		A4. Review diversity data of the people with temporary registration based on data we already hold. COMPLETED A5. Determine if we will report with temporary registration data. There will be very high level report (not the diversity data) of those with temporary registration as at the 31 March. COMPLETED A6. Decide if we need to retrospectively ask people with temporary registration for their diversity data dependent on the completeness of the data we already have. COMPLETED A7. Continue to analyse the full set of diversity data of the people with temporary registration and compare it to those with permanent registration. COMPLETED
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	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

Issue/opportunity	Implications/groups impacted and plans to address the issues raised	Action
characteristic – particularly if they have been out of practice for a time period where they were unable to update their CPD or had not revalidated (Ref 2)		communications where appropriate. ONGOING B3. Create conditions to mitigate against negative impact of time out of practice for example, the 4-5 year group who are less likely to have done CPD or revalidation are subject to COP to mitigate risk of less recent practice. COMPLETED B4. Monitor complaints raised about temporary registrants on issues that relate to discrimination. ONGOING B5. Monitor temporary registration removals decisions made by Assistant Registrars for issues related to discrimination. ONGOING
The criteria for those who 1) are eligible to join and 2) have been actively invited to take up temporary registration being biased towards certain groups (like age) (Ref 3).	Age – older or younger people Disabled people People from some ethnic minority backgrounds Pregnant 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	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

Issue/opportunity	Implications/groups impacted and plans to address the issues raised	Action
	regularly to ensure they are fair and legitimate. There should be no barriers that can't be objectively justified.	B7. Keep the criteria for taking up temporary registration under regular review as government advice is updated. COMPLETED B8. Continue to monitor government guidance for risk factors for the professionals who may be exposed to Covid-19 and raise awareness of the risks related to protected characteristics to the professionals with temporary and permanent registration. ONGOING
Potential bias in the decisions being made about the people whose temporary registration is removed on the basis of protected characteristic (Ref 4).	Some ethnic minorities Disabled people Men People over 70 We are keen to ensure that we can monitor and report on removals from the temporary register and complaints raised against those with temporary registration from an EDI perspective.	B9. Identify the points in the temporary registration process where bias could occur and put in place mitigating actions. ONGOING B10. Brief individuals and teams involved in decision-making about the potential EDI and human rights issues of bias that could arise in this emergency situation. COMPLETED B11. Collect diversity data at the point of opt-in for those who are eligible to take up temporary registration. In line with data protection requirements. COMPLETED B12. Monitor complaints about discrimination or bias in the temporary registration processes. ONGOING
The criteria for removing	Disabled people (potentially all working	As B8.

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

Issue/opportunity	Implications/groups impacted and plans to address the issues raised	Action
		during implementation. ONGOING
Our actions in response to Covid-19 breaching equalities or human rights legislation due to acting at speed and missing checks and balances (Ref 7).	All groups. Raise awareness for internal decision-makers about the responsibilities under equalities and human rights legislation.	As B8. B17. Ensure any changes to access to remote hearings for the public are compliant with the Human Rights Act 1998. ONGOING
The adaptions to our FtP and registration appeals processes due to the emergency having a negative impact on people who share protected characteristics. For example requiring everyone to attend virtual hearings and delays causing mental distress (Ref 8).	Disabled people Carers Older people Socio-economic status People with communication barriers e.g. needing interpreters Some religious groups Identify where our temporary actions may have a negative impact on certain groups and put in place mitigating actions. Complete more detailed equality impact 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.

Issue/opportunity	Implications/groups impacted and plans to address the issues raised	Action
		COMPLETED B22. Taking action to progress cases where possible, including reviewing caseloads, communicating potential delays to parties for cases involving frontline workers and holding hearings in Covid-19 secure hearing centres. COMPLETED B23. We have had a care line in place for registrants with active FtP cases since October 2019. We will expand the service to other registrants to assist them whilst dealing with this crisis. COMPLETED B24. Put together a working group to look at expanding our FtP and Registration appeals hearings activity and take forward the actions from the EqIA for virtual hearings. COMPLETED B25. Conduct a separate EqIA for public access to virtual hearings (also related to physical hearings). COMPLETED
The adaptations to our overseas registration processes due to the due to the emergency having a negative impact on people	Ethnic minority groups and non-UK nationals Disabled people Carers People who are pregnant	As B17. B26. Clear communications with overseas candidates. For example by providing information on our Covid-19 hub on the

Issue/opportunity	Implications/groups impacted and plans to address the issues raised	Action
who share protected characteristics. For example closing OCSE centres (Ref 9).	Identify where our temporary actions may have a negative impact on certain groups and put in place mitigating actions. Complete more detailed equality impact assessments for longer term changes.	website. COMPLETED B27. All overseas nurses and midwives who met the eligibility criteria were offered to become temporarily registered. COMPLETED B28. Working closely with our OSCE delivery partners and development partner on reopening OSCE centres safely and accessibility. COMPLETED B29. We are piloting online computer based tests which, if successful, will allow candidates to take the test at home rather than travelling. ONGOING
C Influence – providing insight		
Health inequalities and discrimination already exist in the wider healthcare environment. These should not be exacerbated in this crisis. We have a responsibility under the PSED to use our influence to tackle prejudice and promote understanding (Ref 10)	All groups We will act to eliminate discrimination and promote equality, diversity and inclusion. Cognisant of how the NMC can add value to the insights in the wider healthcare environment.	C1. Monitoring external publications on the topic of health inequalities and impacts on the basis of protected characteristic to inform our decisions. ONGOING C2. Monitor the intelligence we gather about Covid-19 related issues for EDI themes. ONGOING C3. Review external research and work with other bodies to ensure there is a sufficiently detailed picture of the impact of the emergency

Issue/opportunity	Implications/groups impacted and plans to address the issues raised	Action
		on professionals on our registers by protected characteristic. ONGOING
Potentially exacerbating current biases in the FtP referral processes for professionals with temporary or permanent registration (for example referrals from employers being more likely to refer people from certain ethnic groups because of discrimination and bias in their own processes and from individuals) (Ref 11)	Some ethnic minorities Disabled people Men Monitor referrals by protected characteristic to identify patterns and bias. Communicate with employers if concerns are raised that appear to be based on bias.	C4. Monitor and analyse FtP referrals about professionals on the registers related to Covid-19 by protected characteristic and patterns in source, allegation and outcome. ONGOING C5. Explore ways to monitor if FtP referrals are raised that appear to be based on bias or discriminatory factors. ONGOING C6. Communicate with employers if it appears that referrals are being made that appear to be based on bias or discriminatory factors. ONGOING
Conversations in social media have shown that there is public interest in the disproportionate numbers of ethnic minority health professionals working to combat Covid-19 dying from Covid-19. We expect there will be calls for inquiries and data on these numbers after the pandemic has finished (Ref 12)	Ethnic minorities (professionals and the public) We will provide accurate EDI and workplace data about our registrants to other public health organisations in each UK country in order to allow them to verify the numbers of professionals on the our register (with temporary and permanent registration) who are infected, hospitalised or die from Covid-19 by protected characteristic.	C7. Ensure the systems are in place to monitor ethnicity (and other relevant protected characteristics) on both registers. COMPLETED C8. We will keep under review the call for evidence from the Women and Equalities Unit and future calls for evidence (where we may inform wider discussion to understand how people with protected characteristics are disproportionately affected by Covid-19). ONGOING

Issue/opportunity	Implications/groups impacted and plans to address the issues raised	Action
		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. ONGOING C10. Where suitable sensitively communicate EDI messages re the data externally. ONGOING
D Support – professionals on our register		
Professionals on our register working in an emergency situation are more likely to be under pressure to make decisions that could breach equalities legislation, ethics and engage the Human Rights Act (Ref 13)	All groups – but particularly vulnerable disabled groups and those who already have health inequalities including ethnic minorities, disabled and LGBT people Monitor and address issues as they arise. Attend external forums and monitor concerns with stakeholders.	D1. Attend Moral and Ethical Guidance Committee – monitor issues that arise and work that arises from this group. COMPLETED D2. Publish PPE guidance and guidance on DNACPR action completed. Regularly review issues as they emerge tied into ethical guidance and case studies. COMPLETED. D3. Review contract with the supplier delivering more training to staff making screening decisions on identifying context factors – to include heightened issues about ethics and discrimination in crisis situations. ONGOING
Use our influence to support healthcare workers and people using services	Disabled health professionals – mental health People with disabilities – including learning	D4. Ensure communications are translated into Welsh in line with our Welsh Language Scheme. COMPLETED

Issue/opportunity	Implications/groups impacted and plans to address the issues raised	Action
that will be facing more difficulties during this emergency because of their protected characteristics (Ref 14)	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.	D5. External communications and collaboration with other stakeholders – signposting to resources on mental health. COMPLETED
It may be difficult for people to meet the revalidation requirements when they are working in different ways during the emergency. This could have a disproportionate impact on different people, in different ways and at different times. We know that revalidation rates differ between different groups who share 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. ONGOING
Our retention requirements such as payment of fees	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

Issue/opportunity	Implications/groups impacted and plans to address the issues raised	Action
may be difficult for certain groups of people to meet during the emergency (Ref 16)		after this are referred to the hardship criteria. COMPLETED D10. Use criteria to determine hardship cases for additional support with payments. COMPLETED D11. Explore the possibility of monitoring the diversity characteristics of those who apply for and are accepted for hardship support. ONGOING
E Support – students in placements		
Use our influence to support students who will be facing more difficulties during this emergency because of their protected characteristics (Ref 17)	Disabled students Carers Ethnic minorities We will work with key stakeholders to ensure students remain supported and supervised during this period. Where students who may have to suspend/defer their studies during this 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

Issue/opportunity	Implications/groups impacted and plans to address the issues raised	Action
		E4. Review AEIs' exceptional reporting forms to ensure that students have not been disadvantaged and that appropriate support has been put in place for all students during this period. ONGOING

Section 7: Review

Date of next review	Ongoing updates in action monitoring log. Full review of this EqIA on 31 January 2021.
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 Covid-19 temporary registration are not upheld. 5 We are assured that the professionals on our register are practising in line with the EDI and human rights requirements in the Code despite the emergency situation and take action if we have evidence that they are not. 6 The NMC can report on the diversity of professionals with temporary registration.
How often will the impact be reviewed?	First meeting on 14 April 2020. Review meeting on 2 June 2020. Ongoing meetings and communications with action leads.

Section 8: Sponsor/director sign-off

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