Witness Name: Andrea Sutcliffe
Statement No.:
Exhibits: 37
Dated: 2 October 2023

UK COVID-19 INQUIRY

WITNESS STATEMENT OF Andrea Sutcliffe

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 7 June 2023. I have been authorised by The Nursing and Midwifery Council ('the NMC') of 23 Portland Place, London, W1B 1PZ to provide this witness statement.

I, Andrea Sutcliffe of the NMC will say as follows:

Introduction

1. I am the Chief Executive and Registrar of The Nursing and Midwifery Council ('the NMC') and I have held this role since 14 January 2019.

2. I make this witness statement in response to the Rule 9 notice from the UK Covid-19 Inquiry solicitors, dated 7 June 2023.

3. I welcome the opportunity to provide a statement to the Inquiry. I am incredibly proud of the hard work and professionalism that the nurses, midwives and nursing associates on our register as well as student nurses, midwives and trainee nursing associates demonstrated throughout the pandemic. They worked tirelessly to provide the best treatment, care, and support possible under unrelenting pressure, complex clinical situations and ever-changing circumstances.

4. The first section of my statement outlines our role. The second section of my statement sets out how we adapted our regulatory approach to ensure we

contributed to safely expanding the nursing and midwifery workforce and reducing burdens on our professions through:

a. introducing temporary registration
b. taking a flexible approach to our registration requirements
c. adapting our education and training standards
d. refocusing our fitness to practise approach.

5. In the third section I will outline the support and guidance we provided to our professionals who were working during unprecedented and extremely challenging times.

6. The fourth section focuses on how our decisions were co-produced and informed by the context on the ground in each of the four countries, and how we ensured that our communications were clear and effective. The final section outlines our learning and reflections from the pandemic.

7. Throughout each of the sections I have also set out the steps we took to explore any potential and identified equality impacts of the changes we either considered or made to our regulatory processes in response to the pandemic.

8. The facts and matters set out in this statement are within my own knowledge unless otherwise stated, and I believe them to be true. Where I refer to information supplied by others, the facts and matters derived from other sources are true to the best of my knowledge and belief.

Section one: Our role

9. The NMC is the regulatory body for nursing and midwifery professionals in the UK, with a permanent register of 793,402[1] nurses and midwives in the UK and nursing associates in England. Our vision is safe, effective, and kind nursing and midwifery practice that improves everyone's health and wellbeing. Our core role is to regulate. First, we promote high professional standards for nurses and midwives across the United Kingdom (UK), and nursing associates in England. Second, we

[1] Data correct on 30 June 2023

maintain the register of professionals eligible to practise. Third, we investigate concerns about nurses, midwives and nursing associates.

10. Our statutory obligations and powers are set out within our governing legislation, which includes the Nursing and Midwifery Order 2001 ('the Order'). Rules made under the Order regulate the performance of our statutory functions.

11. Our overarching objective is the protection of the public.[2] It is central to everything that we do and we want to make sure every nurse, midwife and nursing associate can provide good and safe care.

12. To regulate well, we support our professions and the public. We create resources and guidance that are useful throughout the career of our professionals, helping them to apply our standards in their day-to-day practice and use their professional judgement and decision making when addressing new challenges. We also support people involved in our investigations, and we are increasing our visibility so people are engaged and empowered to shape our work.

13. Regulating well and supporting people who use services and our professions allow us to influence health and social care. We share intelligence from our regulatory activities and work with our partners to support workforce planning and sector-wide decision making. We use our voice to speak up for a healthy and inclusive working environment for our professions.

14. On 1 March 2020 we had 714,145 professionals with permanent registration on our register. The total numbers for each group of registrants were: 667,509 nurses, 37,887 midwives, 7,165 dual registered nurses and midwives, and 1,584 nursing associates. We hold the domiciliary address details for all those on our register and this is the data we use to provide the figures for each nation. The totals across each of the four nations on that date were:
    a. England: 523,394 nurses, 31,188 midwives, 5,802 nurse/midwives and 1,571 nursing associates.

[2] Article 3(1)(4) of the Order.

b. Wales: 34,546 nurses, 1,660 midwives, 438 nurse/midwives, four nursing associates.
c. Scotland: 66,144 nurses, 3,366 midwives, 411 nurse/midwives and one nursing associate.
d. Northern Ireland: 23,936 nurses, 1,212 midwives and 298 nurse/midwives.

15. The remaining 20,174 of those with permanent registration had registered addresses that were not in the UK.

16. Every three years we ask registrants to provide details of their work setting, scope of practice and employer as part of their revalidation[3] application. However, as this information is made by self-declaration and is only a snapshot of their practice at the point of revalidating, we only publish it in aggregate form, and therefore cannot provide data about where our registrants were working through the pandemic.

Section two: Adapting our regulatory approach

17. Throughout the Covid-19 pandemic we took an innovative, proportionate and agile regulatory approach to ensure we were responding at pace to the ever-changing demands placed on our professionals and the varied needs of people who receive care.

18. To support our regulatory functions during the Covid-19 emergency the Nursing and Midwifery Council (Emergency Procedures) (Amendment) Rules 2020 Order of Council 2020 came into force on 31 March 2020. These made a number of amendments to the following Rules:
    a. the Nursing and Midwifery Council (Fitness to Practise) Rules 2004
    b. the Nursing and Midwifery Council (Education, Registration and Registration Appeals) Rules 2004

[3] Revalidation is the process that all nurses and midwives in the UK and nursing associates in England need to follow to maintain their registration with us. It requires registrants to demonstrate their continued ability to practise safely and effectively and in line with our standards. Registrants are required to revalidate every three years.

c. the Nursing and Midwifery Council (Practice Committees) (Constitution) Rules 2008.

19. The key changes to our Rules from these amendments, and to our standards, were:
    a. To introduce emergency standards to allow more flexibility to be applied to the delivery of nursing and midwifery programmes.
    b. To allow extensions for longer than three months for individuals to revalidate.
    c. To allow for virtual hearings to take place, as well as more use of electronic forms of communication for service of documents and notice in our fitness to practise process.
    d. To allow for fitness to practise panels of two people to sit where necessary due to possible pressures in finding sufficient panellists.

Temporary registration

20. Before the start of the pandemic, our legislation meant that we did not have the ability to temporarily register nursing and midwifery professionals. In March 2020 we worked closely with the government to draft amendments to the Nursing and Midwifery Order 2001 which would provide us with new legal powers to allow for temporary registration. These amendments were implemented by the Coronavirus Act 2020 when it came into force on 25 March 2020.

21. This meant that, once we had been advised by the Secretary of State of an emergency, we could:
    a. Register a person, if I, as Registrar, consider that the person is a fit, proper, and suitably experienced person to be registered as a nurse, midwife or nursing associate with regard to the emergency.
    b. Register a group of people if I, as Registrar, consider that the group is comprised of persons who are of a type who may reasonably be considered fit, proper and suitably experienced persons to be registered as nurses, midwives or nursing associates, with regard to the emergency.

c. Apply conditions to the registration of a person registered under these provisions and vary or revoke these conditions or add new ones.
d. Remove someone registered in an emergency once we had been advised the emergency had ended, or for any other reason, including where we suspect that the person's fitness to practise may be impaired.

22. The Secretary of State for Health and Social Care formally advised me as Registrar of the Covid-19 emergency on 26 March 2020, meaning we could use our temporary registration powers from this date. These powers enabled us to temporarily add individuals to the register and we refer to this as being 'added to the temporary register'. These powers meant we could expand the nursing and midwifery workforce and support those responsible in each of the four nations for workforce deployment in response to the anticipated demands on health and social care caused by the pandemic.

23. The powers enabling temporary registration came into force on 27 March 2020. Temporary registration was voluntary. Provided applicants wishing to join the register met the eligibility requirements and submitted the right information, we were able to grant them temporary registration on the same day allowing them to start working immediately in roles requiring NMC registration. We had started to contact potential applicants in advance so that as many eligible people were aware of the requirements for temporary registration and able to join as quickly as possible after the powers came into effect. This meant that on 27 March over 7,000 former nurses and midwives were verified and granted temporary registration.

Eligibility requirements

24. When using our temporary registration powers, our usual registration requirements did not apply. Instead, we had to assess whether individuals, or groups of individuals, could be considered to be, fit, proper and suitably experienced to be registered in the context of the Covid emergency. Individuals had to consider whether to apply for temporary registration keeping in mind their own health and personal situations. Employers were responsible for undertaking necessary checks through the Disclosure and Barring Service or Disclosure Scotland.

25. To provide clarity and ensure consistent decision making our Council approved the 'Covid-19 emergency temporary registration policy' on 25 March 2020 (AS/1 – INQ000232027) which set out our eligibility requirements.

26. We worked with our key stakeholders to develop our eligibility criteria and ensure those invited to apply to join the temporary register were fit, proper, and suitably experienced to be registered, with regard to the emergency. The stakeholders we engaged with were:
    a. the Department of Health and Social Care (DHSC) and the devolved administrations,
    b. Chief Nursing Officers (CNOs) of the four nations and their education leads,
    c. Lead Midwifery Officers (CMidOs) of the four nations and their education leads,
    d. Other health and care regulators,[4]
    e. Royal College of Nursing (RCN),
    f. Royal College of Midwives (RCM),
    g. Unison and Unite (trade unions),
    h. the Council of Deans of Health,
    i. NHS and social care providers, and
    j. education providers.

27. Access to temporary registration was initially granted in March 2020 for three eligible groups and the same eligibility criteria applied for both nurses and midwives (nursing associates could not take up temporary registration).
    a. **Group a**: those who left the register voluntarily up to three years previously.
        i. We set the time limit at three years as this was in line with our approach to revalidation. Every three years all our professionals must undertake continuing professional development and learning

[4] General Medical Council, General Pharmaceutical Council, Social Work England, General Optical Council, General Dental Council, Pharmaceutical Society of Northern Ireland, General Osteopathic Council, Health and Care Professions Council and General Chiropractic Council, Care Quality Commission, Care Inspectorate Wales, Care Inspectorate (Scotland), Regulation and Quality Improvement Authority, Social Care Wales, Scottish Social Services Council.

activity to demonstrate to maintain their registration with us. We felt it was appropriate to use the same time period for allowing registrants who had recently left permanent registration to take up temporary registration with no conditions on their practice.

b. **Group b**: nurses and midwives who were educated outside of the UK and were ready to sit their objective structured clinical examination (OSCE).[5]
    i. They had to have completed the requirements for permanent registration including meeting English language requirements and their application had to be supported by an employer who could verify that where were ready to take the OSCE.
c. **Group c**: those who left the register voluntarily four to five years previously.

28. Those in group b and group c were granted temporary registration 'with conditions' on their practice. Conditions were shown against their name on the temporary register and they were an additional safeguard for these groups who had either not yet been registered in the UK or had been off the register for longer than three years. The conditions were:
    a. The individual must work as a registered nurse or midwife in an employed capacity for a health or social care employer.
    b. The individual must always work under the direction of an NMC registered nurse, midwife or other registered healthcare professional who is not on the temporary register.

29. Any individuals who left the permanent register with outstanding concerns about their fitness to practise were not able to apply for temporary registration. With those educated outside of the UK and eligible to apply, before granting applicants temporary registration we asked employers to confirm:
    a. that they had no health conditions or disabilities that prevented them from providing safe care or, if they did have a condition or disability, that it was managed so they could practise in the emergency.

[5] Applicants educated outside of the UK and want to join our register have pass our Test of Competence (ToC). This is a two-stage process. The first is a computer-based test (CBT) which is usually done outside of the UK. Once an applicant has passed the CBT, they may move to the UK to prepare for the second stage which is a practical exam known as the objective structured clinical examination (OSCE).

b. that there were not aware of any concerns about their character that prevented them from practising in the emergency.

30. At the end of June 2020, we amended our eligibility criteria to provide clarity for applicants who were educated outside of the UK and to ensure the public remained protected. OSCE centres reopened in July which meant applicants were able to start progressing their applications again. The amendments were made in response to queries from applicants and employers. They ensured that employers fully understood the requirements for temporary registration which provided us with the continued confidence that only those considered as fit and proper to support the pandemic were temporarily registered. These changes were:
    a. Overseas applicants already on the temporary register who fail their OSCE up to twice would be able to remain on the temporary register.
    b. Where a first or second attempt resulted in a failure that led to the OSCE assessment team raising serious concerns about the applicant's clinical competence, their application would be considered under our process for revoking temporary registration, and their employers notified in line with that process.
    c. Those who fail a third OSCE should be considered under the formal process for revocation removal process and their employers notified in line with that process.
    d. To accept additional evidence of English language competence for people whose original evidence expired between 24 March 2020 and 20 January 2021.

31. In December 2020 we expanded the eligibility for the temporary register for those who left the permanent register more recently, between 1 March 2020 and 20 November 2020. We made this change to help with increased workforce demand that was anticipated in preparation for the second wave of infections. Between December 2020 and March 2022 (which was when we stopped adding people to the temporary register) 1,250 individuals were added to the temporary register who had left the permanent register between 1 March 2020 and 20 November 2020. 986 of those were added between December 2020 and March 2021.

32. The first cohort invited to apply for temporary registration included all eligible overseas educated professionals in the UK at the time. In late December 2020, as the travel ban was relaxed, we extended the invite to internationally educated nurses who had arrived more recently. We were not asked to expand temporary registration for midwives. We decided to expand the eligibility for two cohorts of overseas educated nurses who were already in the UK and ready to sit their OSCE and both groups were subject to the conditions of practice specified above. The groups were:
    a. Those whose applications had been assessed and had received a letter advising that they are ready to take their OSCE.
    b. Those who had submitted complete applications that had not yet been assessed.

Practising with temporary registration

33. Between 1 March 2020 and the last date that we accepted new applications in May 2022 we had granted temporary registration to 22,028 individuals, including 20,629 nurses, 1,160 midwives and 239 nurse/midwives.

34. All those with temporary registration had to comply with our Code[6] (AS/2 – INQ000232038). This included recognising and working within the limits of their competence and being open and honest about care activities and nursing procedures that they felt unable to do. They were also required to hold suitable indemnity arrangements which were, for most, provided by their employer and we had no concerns raised about this approach. We were not specifically aware of any concerns in relation to professional insurance for temporary registrants.

35. Where we received concerns about an individual with temporary registration I, as Registrar, had the power to revoke their temporary registration immediately, or to impose conditions on their temporary registration which might address any risks while allowing someone to continue practising. Between 27 March 2020 and 28 June 2022, we received concerns about 46 individuals with temporary registration.

[6] The Code (2018) is the professional standards of practice and behaviour for nurses, midwives and nursing associates.

We withdrew temporary registration from 24 individuals, took no further action with 20 individuals and applied conditions of practice to two individuals. For the 24 individuals where we withdrew temporary registration, one was removed for administrative reasons as they were already on the permanent register. Ten were removed as they should not have been temporarily registered due to the fact they had previously applied to join or rejoin the permanent register but their applications were refused. Of the remaining 13: seven were removed for concerns with their character which included not following Covid-19 guidance, inappropriate behaviour to colleagues, submitting fraudulent information, using status or patient information for personal benefit; four were removed for concerns relating to clinical practice, including being named in a larger investigation or poor clinical practice; one was removed for concerns with their health; and one for concerns with their English language proficiency. Within the same period, 357 individuals were struck off[7] the permanent register. This number was lower than non-pandemic years as we carried out fewer hearings than normal.

36. The total number of individuals who were granted temporary registration between 27 March 2020 and 31 March 2022 was 22,137 so the 24 individuals who had their temporary registration revoked represents 0.1 per cent of that total. By comparison, during the same period 811,215 had been on the permanent register so the number of removals accounted for 0.04 per cent of that total.

37. We were able to register individuals quickly and without significant challenges which meant there was a good supply of additional nursing and midwifery resource available to be deployed into roles in health and care settings. However, through our discussions with CNOs, DHSC and trade unions during April and May 2020 we knew the deployment of those temporary registrants across the health and care sector was inconsistent and meant that some of these individuals were not able to support the workforce as originally expected. We heard in those meetings that there were concerns about deploying older professionals who had joined the temporary register into frontline roles as they were at increased risk. There were difficulties deploying individuals into roles with private or independent providers

[7] At the final stage of our FtP process our panels are able to decide a number of outcomes. If the panel decides to strike the nurse, midwife, or nursing associate off the register, they are taken off the register and are no longer able to work as a registered professional.

and some individuals, although temporarily registered, changed their minds about wanting to work when faced with the reality of the situation.

38. We also knew deployment was an issue from our temporary register surveys. We surveyed temporary registrants in July 2020 and August 2021, including on their employment since taking up temporary registration. In July 2020 we found that over half (56 percent) of the temporary registrants who responded (response rate 66 percent) had not started practising or received an offer of employment at the point they filled out the survey. Over one quarter of respondents (28 percent) had started practising as a nurse or midwife, and a further tenth (11 percent) had received an offer of employment but not yet started. Around seven in ten of those who had not yet started practising said it was because they had not been contacted by potential employers.

39. In August 2021 over half of survey respondents (response rate 28 percent) had practised since taking up temporary registration, with two fifths still practising at the time of response. Almost one third had not yet received an offer of employment or started practising, and a small percentage had received an offer but not started practising. About one third of respondents who had stopped practising said it was because they were no longer needed by their employer. However, around one quarter cited stress, lack of support or poor culture as a reason. Over three quarters of those who had yet to start working reported not being contacted by potential employers as a reason.

Extension of temporary registration

40. The Government's plan for living with Covid-19, published on 21 February 2022, announced that the provisions within the Coronavirus Act 2020 which allowed temporary registration would expire at midnight on 24 March 2022. This meant we could not accept new applicants for temporary registration after 24 March 2022, although those already on the register would remain registered until their temporary registration was revoked.

41. We issued a statement on 22 February 2022 to explain the implications for the thousands of temporary registered nurses and midwives and outlined our plans for the closure of temporary registration (AS/3 – INQ000232049).

42. We also emailed all temporary registered nurses and midwives confirming that temporary registration would end on 30 September 2022. This date was based on the indications government gave us of when the emergency would be formally declared as over and therefore temporary registration would automatically end. We had committed to warning individuals and employers about this date to enable effective workforce planning. We strongly encouraged those with temporary registration to move across to the permanent register and were clear on the impacts of not doing so.

43. On 22 September 2022 the Secretary of State for Health and Social Care Therese Coffey MP announced in 'Our plan for patients' that temporary emergency registration will remain until 2024. Although we were not directly consulted on these plans, we were aware that this was being considered. Our understanding of the rationale for this decision was as set out in the plan, to enable the most experienced staff to practise for longer and support the health and social care system to deal with the consequences of the pandemic.

44. On 28 September 2022 the then Minister of State for Health Robert Jenrick MP wrote to us and other relevant professional health regulators asking them to retain temporary registration for a further two years.

45. On 6 October 2022 our Executive Board agreed to keep the temporary emergency register open, in line with the government's request, although as already noted we no longer had the power to temporarily register new professionals, only retain those already registered. We wrote to Minister Jenrick on 17 October 2022 to confirm this. In that letter we outlined that we would need to carefully consider the risks of keeping the register open and take steps to mitigate against any risks identified (AS/4 – INQ000232056).

46. On 25 January 2023, we wrote to the then Minister of State for Health, Will Quince MP, making him aware that from March 2023, we would be implementing changes to the way we maintained the temporary register to ensure we operated it safely and continued to protect the public (AS/5 – INQ000232057). These changes were:
    a. Retaining those who left the permanent register less than three years ago but applying conditions once it had been more than three years since they left the permanent register.
    b. Retaining those who left the permanent register more than three years ago and were practising but applying conditions of practice.
    c. Retaining overseas educated temporary registrants who were completing the final stages of their application for permanent registration.
    d. Removing those who left the permanent register more than three years ago and were not practising.
    e. Removing overseas educated temporary registrants who were not actively progressing their application for permanent registration.

47. In addition, to ensure that those with temporary registration were keeping their knowledge and skills up to date we applied the following condition of practice to everyone on the temporary register. We call this the continuing professional development (CPD) condition of practice:
    a. They must undertake appropriate training and continuing professional development to practise safely and effectively in their role during the emergency.

48. In March 2023 we surveyed everyone with temporary registration who had left the permanent register more than three years ago to ask if they were practising. If they replied to say that they were, we applied conditions of practice to their registration. If they indicated that they were not practising or did not respond at all then we revoked their temporary registration. We also contacted all internationally educated individuals who had been granted temporary registration but did not have an active application open to seek permanent registration advising them that we would revoke their temporary registration.

49. On 21 March 2023 we revoked temporary registration from 10,379 individuals which reduced the number of individuals with temporary registration from 12,411 to 2,030. Of these:
    a. 10,340 had left the permanent register more than three years ago and were either not practising or did not respond.
    b. 39 were internationally educated individuals who did not have an active application open to join the permanent register.

50. For the 2,030 individuals who retained their temporary registration:
    a. 816 had confirmed they were working but had left the permanent register more than three years ago so they had conditions of practice applied.
    b. 33 individuals who had been internationally educated and were actively progressing their application for permanent registration had conditions of practice applied.
    c. 1,181 who had left the permanent register less than three years ago had the CPD condition of practice applied.

51. On 11 September 2023 we were notified by Will Quince MP that the period of the Covid-19 emergency in relation to our temporary registration powers will conclude at the end of March 2024. In our response we outlined that we would continue to support those who wish to continue practising after March 2024 to join our permanent register (AS/6 - INQ000280063). As of 13 September 2023, there are 1,446 nursing and midwifery professionals with temporary registration.

52. Between 27 March 2020 and 28 June 2022 6,308 individuals who were granted temporary registration successfully applied for permanent registration. We continue to survey those who meet the threshold of being off the permanent register for more than three years every month and take the actions outlined above depending on their answers.

Equalities impact

53. It was important for us to explore the potential risks and identify equality impacts of changes to our regulatory processes in response to the pandemic. In April 2020

we produced the first version of our equalities impact assessment (EqIA). We produced a further five versions of our Covid-19 Regulatory EqIA and the final version was published on 29 October 2021 (AS/7 – INQ000232058).

54. We found that regularly reviewing and updating these EqIAs was a useful tool that influenced the decisions we took as a regulator responding during an emergency. It kept internal colleagues and external stakeholders informed about our understanding of the impacts of the regulatory changes we were making. Our EqIA action plan enabled us to plan actions to mitigate any risks of potential unlawful discrimination.

55. Based on our own data and external evidence, including our own Ambitious for Change research into NMC processes and people's diversity characteristics, we identified that there could be potential risks of unlawful discrimination by protected characteristic in our actions on temporary registration. Below we set out how we acted to mitigate these risks.

56. The risks we identified were:
    a. Potential bias in the decisions being made about who could be on or would be removed from the temporary register based on a protected characteristic.
    b. Potentially exacerbating existing biases in the concerns raised about professionals being disproportionately referred through our fitness to practise process.
    c. People with temporary registration behaving in a way that was contrary to the Code, by discriminating against colleagues or people using services based on their protected characteristic.
    d. The criteria to determine who was given temporary registration being biased towards certain groups (for example, age).
    e. The criteria for removal from the temporary register not taking account of the context of the practice of professionals in an emergency.

57. When promoting temporary registration, we sent out invitations to people we had determined would be eligible. However, we did not directly invite some groups to

join the register based on age, in line with UK Government guidance at that time on vulnerable groups and groups required to shield. Our aim was to ensure that we did not encourage people in vulnerable circumstances to put themselves at risk, or to act contrary to government guidance in place to protect vulnerable groups. However, we allowed members of these groups to join the register if they directly contacted us so we did not risk discriminating against them on the basis of age.

58. On reflection, we feel that this approach was proportionate and the right approach in the circumstances. We have not received any complaints relating to our approach and have not identified any issues in our data which would suggest we should take a different approach if faced with another emergency in the future.

59. We implemented several actions through our EqIA action plan, to mitigate against these risks of unlawful discrimination. These included:
    a. Using our data and evidence to assess the make-up of those on our temporary register compared to our permanent register through publishing data reports. The most recent one was published in March 2023 (AS/8 – INQ000232059).
    b. Introducing conditions of practice for those joining the temporary register who had left the register four to five years ago (see paragraph 28) and were less likely to have revalidated. This was to minimise the risk of temporary registrants behaving in a way that was contrary to the Code by discriminating against colleagues or patients with protected characteristics.
    c. Monitoring concerns raised about people on the temporary register, removals of people from the temporary register, and complaints about our temporary registration process for potential risks of bias in decision making. As a result of this monitoring, we removed identifying information (names, gender markers) from the documents submitted to decision-makers, and we built peer-review checkpoints into the decision-making process on who is added to or removed from the temporary register.

60. Analysis of the diversity characteristics of people with temporary registration compared to people with permanent registration in July 2020 found smaller

proportions of people identifying as white, Black and mixed ethnicity, but larger proportions identifying as Asian and people whose ethnicity is unknown. By cohort a much larger proportion of people in the overseas group were Asian Indian or Asian Other ethnicity compared with those who left in the last three years and those who left three to five years ago.

61. We have not recorded any concerns raised about professionals on our temporary register about discrimination, or which we have been able to determine related to discrimination, bias or inequality.

Registration requirements

62. We were acutely aware of the impact the pandemic had on our registrants and we made changes to our continued registration requirements to help reduce burdens on frontline staff.

63. At the start of the pandemic, we introduced emergency measures to allow registrants an additional 12 weeks to meet their revalidation requirement and submit their applications. However, registrants were able to request a further extension of 12 weeks if their ability to revalidate had been affected by Covid-19. We felt that this approach struck the right balance between reducing the impact of the Covid-19 emergency on registrants with the need to ensure public protection.

64. Our registrants are required to pay an annual fee of £120 to remain registered with us. This can be paid quarterly, or annually. Through gathering research conducted by others to inform our EqIA we recognised that Covid-19 was more likely to impact financially on women and ethnic minority groups, and that paying an annual fee might have had a disproportionate impact on women, minority groups and those from lower socio-economic groups (see AS/7 - INQ000232058 pages 22, 54 and 56).

65. However, as we explained on our website charging a fee is a statutory requirement, part of the legal framework that sets out what we do and how we do it. Changing that requires the approval of parliament. A key reason the fee is

important to the NMC is that it is our only source of income and we do not rely on government funding for our regular activities. This keeps us independent so we can protect the public by supporting our professionals, in normal times and during the emergency. I published a blog on 27 April 2020 which outlined the support we were providing to our professions as well as the reasons for not being able to reduce the fee (AS/9 - INQ000232060).

66. To reduce the burden on professionals and help mitigate against risks of unlawful discrimination we decided to give all registrants who were not able to pay their annual fee an additional six weeks to pay. We considered any requests for further time on an individual basis in line with our existing hardship processes. This change was made to help support registrants and offer flexibility. We are not aware of any financial or other support the Government provided to registrants.

International registration

67. The computer-based test (CBT) is the first part of our process for assessing the competence of people who have been educated outside of the UK. Prior to the pandemic we were piloting running the CBT online, which allowed candidates to take the test at home rather than at a test centre. After the pilot concluded, and while we updated our systems to allow continued online testing for all, we continued to allow candidates to sit the online test at home if they faced barriers to attending a test centre due to Covid-19, local restrictions, and lockdowns.

68. Following government guidance on social distancing, all our OSCE test centres closed on 24 March 2020. This meant we could no longer conduct the practical clinical test for trained applicants. We encouraged and supported those waiting to take an OSCE to apply for temporary registration.

69. As soon as government guidelines allowed in July 2020, we supported our OSCE test centres to reopen safely and we supported international applicants to progress their application to join the permanent register. All the centres conducted risk assessments to ensure that staff and those attending the centres were safe and adequately protected.

Education and training

70. In March 2020 to enable students to support the workforce while being appropriately supervised as part of their programme, we issued a set of emergency education standards. These changes enabled students to safely continue their programmes and support the workforce during the most intense period of the pandemic.

71. The standards were facilitative rather than directive. They did not require Approved Education Institutions (AEIs) or individual students to change their current approved programmes. They offered AEIs flexibility to support students to continue their learning safely whilst also supporting the workforce by ensuring clear learning pathways and practice placements.

72. The emergency standards for nursing and midwifery education published on 25 March 2020 (AS/10 – INQ000232061) enabled:
    a. First year students to move into full time theoretical learning rather than go on practice placement during their first year of study.
    b. Second year students to have up to 80 percent of their time during the emergency in practice placement settings.
    c. Third year students to finish their final six months of their programmes in extended practice placement settings.
    d. All theoretical learning to be done online.

73. We identified that people who were required to shield from Covid-19 may have been at risk of experiencing potential unlawful discrimination resulting from our emergency education standards. For example, students who were required to shield may not have been able to attend a practice placement if this were a requirement for their year group. This might have disproportionately affected students who were pregnant, carers or living with a long-term condition that made them clinically extremely vulnerable.

74. We implemented several actions through our EqIA action plan, to help mitigate against these risks of unlawful discrimination, including:

a. Requiring AEIs to put appropriate adjustments in place for individual students to enable them to meet their study requirements and follow the relevant shielding guidance.
b. Communicating regularly with students about the options available to them.
c. Reviewing AEIs exceptional reporting forms to monitor for evidence of disadvantage and tracking student feedback on their experiences.

75. We have not recorded any issues raised to us by AEIs, or directly from students, in relation to examples of students being disproportionately negatively impacted by any of our emergency or recovery standards during the pandemic.

76. As the pandemic developed, in July 2020 Council approved the phasing out of the emergency standards and replacing them with recovery standards from 30 September (AS/11 – INQ000232028).

77. Following consultation and engagement with stakeholders and in acknowledgement of the pressures in placement settings, the recovery standards included the increased use of simulation for practice to help support students who had been affected by the pandemic to join the register as close to when expected as possible. They also enabled AEIs to manage placement risks as we know that simulation learning is effective in helping students enhance their practice learning, gain confidence, and engage with their peer group.

78. We made some amendments to existing standards for student supervision and assessment to provide flexibility in ensuring appropriate supervision and support for students in each year of their programme. This included exceptionally allowing a student's practice supervisor to also fulfil the role of practice assessor. Within normal circumstances these would be different individuals. This provided flexibility to help remove additional burden on the workforce at this time while still ensuring appropriate support and assessment for students.

79. We also suspended our previous Standards for support, learning and assessment in practice ensuring that all programmes immediately implemented our new Standards for Student Supervision and Assessment (SSSA). The SSSA standards

allow for greater flexibility, by allowing any registered health or social care professional to supervise students. In a period where the workforce was under extreme pressure this helped ensure students had the appropriate supervision and support.

80. We also allowed more flexibility in the methods for student support, supervision, learning and assessment in all programmes we set standards for during the emergency including through blended learning approaches.

81. We consulted with the four CNOs, CMidOs, education commissioning bodies, the Council of Deans of Health, RCN, RCM and trade unions before making these changes.

Fitness to practise (FtP)

82. When a concern is raised about a registrant's behaviour, health, or skills and knowledge we investigate through our FtP process. We take action where needed to protect people who use health and social care services and to ensure public trust and confidence in the professions is maintained. Our FtP process can be a cause of stress both for those who have raised concerns and for the professionals involved.

Casework

83. In March 2020 we decided to prioritise our FtP casework to maintain public protection and minimise the impact on those providing frontline health and care services. We focused on four priority areas that we had to maintain as they were essential for protecting the public. These were:
    a. logging and risk assessing any new referrals and risk assessing new information on existing cases
    b. interim order applications and review hearings
    c. substantive order review hearings
    d. High Court or Court of Sessions interim order extension applications.

84. We also committed to only contacting individuals and employers where we felt we needed the information to enable us to assess whether there was an immediate risk to the public and manage that risk effectively. Other casework was paused.

85. We decided to resume our FtP casework in July 2020. We engaged with stakeholders on the best approach for resuming casework. We took a phased approach applying prioritisation and risk assessment criteria to both initial referrals and our caseload.

Virtual hearings

86. On 24 March 2020, in line with government guidance, we made the decision to postpone all scheduled substantive hearings and not to schedule any new substantive hearings until further notice. We recognised that this would result in the risk of significant backlog forming in our caseload but agreed it was the right decision to make following the government's advice to contain the spread of the virus.

87. Changes to our Rules[8] which came into effect on 31 March 2020 enabled hearings and meetings to take place by videoconferencing, audio-link and telephone and enabled us to serve notices of hearing by email.

88. The changes meant urgent hearings and meetings like interim orders and substantive order reviews could continue to take place. We also applied these Rules to substantive hearings when we needed to.

Handling misinformation

89. Where concerns were raised with us about registrants spreading misinformation about Covid-19 and the response to the pandemic, we managed these through our FtP process. We also managed concerns raised about professionals breaching Covid-19 restrictions or spreading misinformation through our FtP process. Where a concern is raised, we first consider whether there is evidence of a serious

[8] The Nursing and Midwifery Council (Emergency Procedures) (Amendment) Rules 2020 Order of Council 2020 (Part 2)

concern that could require us to take regulatory action. We then consider whether the concern would fall into any of our categories that determine seriousness[9].

90. Serious cases are more likely to be referred to our FtP Committee for decision rather than being resolved at an earlier stage in the FtP process. We also consider whether the allegations pose immediate risks to patients and require a referral for consideration to impose an interim order.

91. During the relevant period we received 356 concerns about Covid-19 relating to breaching lockdown rules, inappropriate Covid-19 social media posts or vaccine misinformation. 325 of those cases were closed at the initial stage of our FtP process as they did not satisfy the relevant tests at that stage[10]. For the remaining cases:
    a. 16 have been referred for a decision through a meeting or hearing of an independent panel at the final stage of our FtP process.
    b. Six of those cases relate to inappropriate Covid-19 related social media posts.
    c. Three of those six cases have concluded and resulted in strike off orders for three individuals for inappropriate Covid-19 related social media posts.

92. It is important to note that FtP cases can have more than one allegation. This means that there can be other non-Covid-19 related allegations which may have an impact on the outcome of a case.

Equalities impact

93. We identified that there were some risks in our FtP activities which could have been exacerbated by the Covid-19 pandemic. In addition, we were conscious there was a risk that the actions we took to adapt our processes in response to Covid-

[9] These categories are (a) serious concerns which are more difficult to put right, (b) serious concerns which could result in harm to patients if not put right, (c) serious concerns based on the need to promote public confidence in nurses, midwives and nursing associates.
[10] Our screening process has three stages. We have to consider (a) whether we have a written concern about an individual on our register (b) whether there is evidence of a serious concern that could require us to take regulatory action to protect the public and (c) whether there is clear evidence to show that the individual is currently fit to practise.

19 may particularly disadvantage individuals, or groups of people, with protected characteristics. These activities included:

a. holding essential hearing activity virtually
b. deciding not to contact employers on cases unless there was an immediate risk
c. cancelling non-essential hearings; and
d. changes we made to the process.

94. We assessed these risks and implemented several actions through our EqIA action plan, to try and mitigate against any disadvantage or risks of unlawful discrimination and to ensure the actions we took were proportionate measures, necessary to fulfil our public protection function whilst minimising the risk of public harm from Covid-19. The actions we feel addressed these risks most effectively included:

a. Monitoring feedback about access to remote hearings for issues for particular groups.
b. Creating 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.
c. The Public Support Service team providing ongoing specialist support to our fitness to practise teams in removing barriers to access for those that required this including making reasonable adjustments for disabled people and those with long term health conditions. The team also provided support for people involved in virtual hearings.
d. 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.
e. Conducting a separate EqIA for public access to virtual hearings.
f. Monitoring anonymised diversity data relating to professionals contacting our Careline and the concerns they had.
g. Monitoring and analysing FtP referrals which related to Covid-19 by protected characteristic and patterns in source, allegation, and outcome.

h. Monitoring whether FtP referrals appeared to be disproportionate for any group, and whether context forms indicate possible inequality or discrimination factors.

95. When we analysed the FtP referral data against diversity data, the number of referrals were low so whilst we were cautious about drawing conclusions from the data there were some interesting insights. Our analysis of referrals from March 2020 to April 2021 showed higher numbers of Black professionals and male professionals being referred compared to their proportion on the overall register. Our analysis of referrals between 1 April 2021 and 30 September 2021 showed that white people, females and people aged between 41 and 50 were slightly overrepresented compared to their proportions on the register which was in direct contrast to the previous reporting period. Our EDI plan includes a specific action to continue to monitor the impact of any changes to our regulatory processes from any new ways of working arising from the pandemic and their impact on the experiences and outcomes of our customers. We are also committed to better understand the reasons for why some groups are disproportionately referred to FtP.

96. In order to help us improve our understanding of the impact of changes to our processes on different groups, we also conducted a public consultation on the emergency powers granted to us by the DHSC in response to the Covid-19 pandemic. This consultation ran from 4 November 2020 until 15 January 2021.

97. There were 160 responses to the online consultation and we also had 25 participants from representative groups take part in focus groups. The analysis of the consultation responses (AS/12 - INQ000232029) showed some trends in the way particular groups responded to the consultation. For example, 43 per cent of men thought there were reasons the NMC should not continue to hold hearings virtually once the emergency period ended, compared to 19 per cent of women, and 38 per cent of disabled people thought there were reasons the NMC should not continue to hold hearing virtually once the emergency period ended, compared to 24 per cent of people who were not disabled.

98. While some carers welcomed virtual hearings, and some people with learning disabilities and/or autism felt the reduced need to travel was a benefit of virtual hearings, people from other communities, such as those identifying as Gypsy Roma Traveller, felt access to the internet and literacy issues could mean virtual hearings may lead to disadvantage.

99. Our separate EqIA on public access to virtual hearings, which has been regularly updated throughout the pandemic, identified people with hearing loss or deafness and/or those with a learning disability as the groups most likely to be negatively impacted by the available options for participating in hearings.

100. In addition to using our Reasonable Adjustments Policy to meet people's needs and minimise any negative impact, we have also committed to undertaking research and working with partners to understand sustainable solutions to the barriers that might exist. We also anticipate that our programmes to improve our IT infrastructure will result in a greater range of accessibility tools being available to support participants in our hearings.

101. Our current guidance on determining whether a hearing should take place virtually considers the accessibility of the hearing to all of those involved.

Section three: Support and guidance for our professions

102. An important part of our role is providing clear and consistent guidance to our professions. Our Code and standards set out the professional values, knowledge, skills, and behaviours required for all nurses, midwives working in the UK and nursing associates working in England.

103. Covid-19 brought unique challenges for all those working in health and care settings and in the early stages we received queries about emerging ethical issues and dilemmas facing our professions. Our professions were worried about the consequences of using their professional judgement in these unique situations.

104. In the early stages of the pandemic concerns were raised with us about:

a. provision of personal protective equipment (PPE) in the workplace
b. deployment and placements
c. arrangements for verification of death
d. prescribing and administering medicines remotely and vaccines (but not specifically for the clinically vulnerable)
e. Do not attempt cardiopulmonary resuscitation (DNACPR)
f. eligibility requirements for temporary registration.

Key messages

105. Throughout the pandemic we made clear that our standards were there to provide a framework for professional judgement and decision making. We acknowledged that during such challenging times, professionals may need to depart from established procedures to care for patients and people using health and social care services. We provided reassurance that we would take that context into account if concerns were raised with us and we also acknowledged the hard work and commitment shown by our professionals. We did this through issuing:

a. A joint statement with the other health and care regulators on 3 March 2020 which we reissued on 8 December 2021 (AS/13 – INQ000232030).
b. A joint letter with the CNOs, the RCN, RCM and Council of Deans of Health sent to nurses and midwives on 12 March 2020 (AS/14 – **INQ000283205**
c. A joint statement on 19 March 2020 with CNOs from each of the four nations, DHSC, the Council of Deans of Health, RCN, RCM, and trade unions (AS/15 – INQ000232032).
d. A joint statement on 25 March 2020 on developing immediate critical care nursing capacity with CNOs, RCN. RCM, trade unions, British Association of Critical Care Nurses, UK Critical Care Nursing Alliance, Intensive Care Society and Critical Care Network Directors' Group (AS/16 – **INQ000227427**
e. A second joint letter on 19 November 2020 to support our registrants providing care through the second wave of the pandemic (AS/17 – INQ000232034).

106. With a workforce under such severe pressure, we wanted to make finding that information as easy as possible so we created a Covid-19 hub on our website. We published advice and guidance as well as the most up-to-date information on how we were continuing to regulate and support.

107. We used a range of media articles, blogs, social media, and webinars to ensure we reached as wide an audience as possible. We created a dedicated section of our hub to support our registrants where we signposted them to resources to help manage their mental wellbeing. Professionals were able to contact our call centre for advice and support. We also held internal webinars for registrants to share their experience and insights including working in critical care and managing long Covid, to help NMC employees to better understand the lived experiences of people on our register.

Guidance

108. We initially published a short PDF document called 'Maintaining professionalism and trust during the Covid-19 emergency' in April 2020 (AS/18 – INQ000232035). This outlined the ethical considerations for professional practice in line with the Code and was intended to support registrants. As other ethical materials were continually being published by other organisations, we decided to withdraw this document to develop different resources that were easily accessible and easily digestible for professionals who were time pressured. We developed a series of short animations to support our Code. These animations are called 'Caring with confidence: the Code in action' and remain on our website.

109. These animations form a series of nine that focus on key aspects of our professionals' practice. The topics include accountability, professional judgement, delegation, speaking up, inclusivity and challenging discrimination, social media, person-centred care, end of life care, and professionalism. Although these animations are not situated in a Covid specific context they were developed during the pandemic to support our professions. The topics were selected from the common themes from enquiries we received during the first year of the pandemic.

We launched the first animation in September 2020 and published a new animation every three to four weeks for the remainder of 2020.

Personal Protective Equipment (PPE)

110. We were aware of the issues surrounding availability and suitability of PPE from media reports and regular discussions we were having with our stakeholders in meetings about the pandemic. The RCN issued a press release on 23 March 2020 which urged the Prime Minister to intervene to ensure that all nursing staff treating patients had access to sufficient PPE. On 23 March 2020 we issued a statement in response and support (AS/19 – INQ000232036). Although we did not have our own robust evidence base it was clear that this was an issue for our professions. We used the best available evidence at the time to develop our statement and provide reassurance, support and clarity to our professions during an extremely challenging time. We were not aware that this was an issue specifically impacting the ability of nurses and midwives to join the temporary register.

111. During meetings with the CNOs for each of the four nations in early April 2020 we continued to discuss the availability and suitability of PPE and we decided to issue a statement to support our system partners and the professions we regulate. On 14 April 2020 we issued a second statement on PPE which signposted registrants to the national guidance and to our Code (AS/20 – INQ000232037). We met with other regulators and other sector bodies including Medicines and Healthcare Products Regulatory Agency, NHS England/ NHS Improvement to discuss concerns around PPE over the initial period of the pandemic.

Do not attempt cardiopulmonary resuscitation (DNACPR)

112. We issued a joint 'Statement on advance care planning during the Covid-19 pandemic, including do not attempt cardiopulmonary resuscitation (DNACPR)' with the General Medical Council (GMC) on 15 April 2020 (AS/21 – INQ000232039). This was in response to information we and the GMC received from people who use services, patients, registrants, and media reports that there

had been instances where advance care plans, including those with or without DNACPR forms had been applied to groups of people in response to the pandemic. We were reacting to emerging concerns in collaboration with our stakeholders and are not able to quantify how prevalent the issue was. The statement clarified that it is fundamental for complying with our standards that professionals on both our registers ensure that people, their families and carers are involved in decision making, and always consider people's individual wishes and preferences. The CQC raised similar concerns, leading to their joint statement on advanced care planning in the same month (AS/22 – **INQ000235489**).

113. We provided support to the Department of Health (Northern Ireland) to develop a national cardiopulmonary resuscitation policy. We were able to draw on our own guidance and previous work with relevant stakeholders in England, Scotland, and Wales, to provide expert advice.

114. When DHSC asked the Care Quality Commission (CQC) to review how DNACPR decisions were used during the pandemic in October 2020 we were a member of the stakeholder advisory group. We issued a response to the CQC's interim report on DNACPR decisions on 3 December 2020 where we reiterated the importance of the professionals on our register acting in line with our Code to provide person centred and individualised care (AS/23 – INQ000232041).

Use of PPE during CPR

115. In April 2020 we received several queries from our registrants that the Resuscitation Council UK (RCUK) guidance differed from the Public Health England (PHE) guidance which was causing confusion. At that time, PHE advice was that chest compressions should not be treated as an aerosol generating procedure which affects the level of PPE people should wear.

116. The RCUK guidance stated that chest compressions should be treated as an aerosol generating procedure and required stricter PPE rules. Although we do not give clinical advice in our role as a professional regulator we wrote to RCUK to ask for clarification and were advised at that time that their position remained the

same. The PHE guidance was subsequently updated along with the RCUK's guidance following further evidence in line with the RCUK's processes.

Midwifery

117. We supported the Joint Committee on Vaccination and Immunisation's (JCVI) advice on vaccinations for pregnant women. When the CMidO in England issued a statement encouraging pregnant women to take up the vaccine, we issued a supporting statement in August 2021 (AS/24 – INQ000232042). In December 2021 in support of national efforts to increase vaccine take-up, we emailed midwives on the register reiterating the advice of the JCVI for pregnant women.

118. In January 2022 in our newsletter to midwives we encouraged midwives to support pregnant women and people to receive the vaccine. In February 2022 we reiterated our message to encourage vaccinations and the benefits it brings to those receiving care, individuals, families communities and the wider health and social care system (AS/25 – INQ000232043).

119. We do not hold information or data about the impact on the delivery of ante-natal, neonatal or maternity services, the reduction or delay in pregnant women seeking this care or concerns around contracting Covid-19 during the relevant period. The NMC is not aware of any specific concerns about the delivery of this care.

Other guidance

120. We considered whether to use our powers[11] to add temporary annotations for prescribing to allow nurses and midwives to temporarily prescribe medicines during the pandemic without having a prescribing qualification. We discussed this with our partners and were not assured that the need outweighed the risks and we published a statement in May 2020 that made our position clear (AS/26 – INQ000232044).

[11] The Nursing and Midwifery (Amendment) Order 2008 (SI 2008/1485)

121. We worked with the RCN on their guidance on certification for adult deaths as nurses were being asked to undertake this task in the care sector. The RCN's guidance was on the members' only section of their website but they moved it to the public section of their site to enable all professionals to benefit from the advice.

122. Our Standards set out the required skills and competencies for people on our register, and our Code specifies the standards of behaviour we expect in practice. Beyond that, we did not issue specific guidance to nurses, midwives or nursing associates, including for those who were clinically vulnerable. In line with our Code, professionals on both the permanent and temporary registers are expected to take steps to manage their health conditions and risks to ensure they are working safely which would include those at higher risk of severe Covid-19. We do not keep formal records or hold information on the number of registrants with either temporary or permanent registration who died of, or became infected with, Covid-19 during the relevant period.

Section four: Collaboration and influence

Collaboration

123. We prioritised working collaboratively with our partners to navigate our response to Covid-19 and ensure that we took a range of perspectives into account when making decisions, including the unique nature of each of the four countries. This helped to ensure a joined-up approach to issues affecting our professions during the emergency.

124. Our approach throughout the pandemic was to prioritise regular stakeholder engagement with UK Government, the devolved administrations, the CNOs, CMidOs and national leads for midwifery to ensure alignment on our actions and communications.

125. We had regular meetings with the RCN, RCM and trade unions to discuss the changes we made in all aspects of our work, including education, registration and FtP. We worked collaboratively to hold meetings with student leaders, from

their various networks and committees, to engage with them on the emergency and recovery education standards, and to seek their help in sharing the news about changes with students in their networks.

126. In addition, throughout the decision-making process there was senior and operational stakeholder engagement with NHSE, NHS Scotland, NHS Wales, Health and Social Care in Northern Ireland (HSCNI). This engagement took place predominantly through the regular meetings we had with the UK CNOs and CMidOs and representatives of the devolved administrations. In addition, the lead executive directors for each of the devolved nations had regular contact with senior officials to share intelligence and I occasionally met with the Chief Executive of NHSE.

Influencing change

127. We shared data about our temporary register to help support wider workforce and pandemic response planning. This data was shared on a weekly basis initially, moving to monthly as the temporary register became more established and the data changed less. The circulation list for these updates included the DHSC, the Cabinet Office, the Scottish Government, the Welsh Government, the Department of Health Northern Ireland, the CNOs and CMidOs across each nation, NHS England, health and care regulators and education and training bodies of all four countries.

128. I held regular meetings with then Minister of State for Care Helen Whately MP to brief her on our work in response to the Covid-19 pandemic, and we met with the Secretary of State Matt Hancock. We kept key parliamentarians updated on our work through stakeholder information packs which were updated fortnightly in 2020. Our Chair and I also held discussions with the then Chair of the Health and Social Care Committee Jeremy Hunt MP.

129. We continued to work closely with the DHSC and the devolved administrations throughout the pandemic. This engagement enabled us to respond with speed to the changing environment whilst also giving the necessary

assurances that our decisions were appropriate and fair in the circumstances. This included providing them with regular updates on our work.

130. We submitted responses to several inquiries throughout the relevant period. For each of these responses, we outlined our views and advised on what next steps were needed:

a. In June 2020, we responded to the House of Commons' Health and Social Care Select Committee inquiry into the management of the coronavirus outbreak (AS/27 – INQ000232045).

b. In July 2020, we responded to the Welsh Parliament's Health, Social Care and Sport Committee inquiry into the impact of Covid-19 (AS/28 – INQ000232046).

c. In July 2020, we responded to the House of Commons' Health and Social Care Select Committee inquiry into delivering core NHS and care services during the pandemic and beyond (AS/29 - INQ000232047).

d. In November 2020, we responded to the joint inquiry from the House of Commons Health and Social Care Select Committee and the Science and Technology Committee on lessons learned from coronavirus (AS/30 – INQ000232048).

e. In December 2020, we responded to the Scottish Parliament Equalities and Human Right's Committee's inquiry into the impact of the Covid-19 pandemic on equalities and human rights in Scotland (AS/31 – INQ000232050).

131. Throughout the relevant period we acknowledged the disproportionate impact of Covid -19 on professionals with protected characteristics. We expressed our concerns at the disproportionate impact and recognised how this exacerbated deep seated health inequalities affecting Black, Asian and Minority Ethnic Groups. These included:

a. In April 2020, issued a statement recognising this disproportionate impact and welcomed the Government's planned review (AS/32 – INQ000232051).

b. Responded to the PHE report 'Beyond the data: Understanding the impact of Covid-19 on BAME groups' in June 2020 (AS/33– INQ000232052).

c. Responded to the RCN's survey that BAME nursing staff experienced the greatest PPE shortages in May 2020 (AS/34 – INQ000232053).

132. We shared pseudonymised diversity data with Public Health England, and with the UK REACH study (UK Research study into Ethnicity and Covid-19 outcomes in healthcare workers). In December 2020, we wrote to a sample of half a million nursing and midwifery professionals to invite them to participate in the study.

133. In March 2021 as part of our 'Reflections on a traumatic year' we published case studies on the experiences of diverse professionals working in the pandemic on our website. One of these focused on the work of Dr Gloria Rowland in capturing the challenges of professionals from Black and minority ethnic backgrounds working in maternity services (AS/35 – INQ000257991).

Vaccinations

134. We raised concerns with the DHSC's consultation 'Making vaccination a condition of deployment in older adult care homes' on 21 May 2021 (AS/36 – INQ000232054). We also responded to the DHSC's consultation on 'Making vaccination a condition or deployment in the health and wider social care sector' on 19 October 2021 (AS/37 – INQ000232055).

135. In both of those responses, we talked about the disproportionate impact we felt the decision to make vaccination a condition of deployment would have on people with protected characteristics, specifically people from particular ethnic groups (Black, Pakistani, Bangladeshi, and other non-UK White/Irish groups), disabled people, people who are pregnant, have certain beliefs or who are from particular socio-economic backgrounds. Although the Government's initial decision was to follow through with these proposals, we were pleased when the mandate was rescinded.

136. We participated in DHSC's Moral and Ethical Advisory Group (MEAG), which considered a wide range of emerging ethical concerns across health and social care.

Section five: Learning lessons

137. In June 2022, we took the opportunity to reflect on the pandemic. We reviewed what we did, how prepared we were for dealing with the pandemic and assessed how well we responded and adapted to an ever-changing landscape. We also sought to understand the impact of the changes we made and learn lessons where we could for the future.

138. This review was considered by our Executive Board in June 2022 and by our Council at a workshop in July 2022. I outline the lessons we identified that specifically relate to the scope of Module three below.

Regulation and legislative reform

139. The changes we made were delivered at incredible pace during an unprecedented time. We worked with others to implement our emergency legislative powers within days which ensured we were able to support the workforce and reduce burdens on professions but also ensure we were able to continue regulating effectively.

140. Much of our process is set out prescriptively in legislation, either in our Order or in our (Privy Council-approved) rules. We were only able to make the necessary changes to our legislation so quickly at the beginning of the pandemic by working closely with DHSC. The pandemic has highlighted the importance of us having the power to change our own rules without having to go through lengthy and complex legislative processes. Our current legislation is overly prescriptive and difficult to amend.

141. We would like our legislation to focus on what we need to do, with the procedures and processes outlining how we would achieve this set out in rules, which we are able to adapt more proportionately to respond to developments. We continue to work with DHSC on progressing regulatory reform to remove the current barriers that limit the improvements we can make to the way we regulate and recently submitted our response to their consultation on legislative reform.

142. When our legislation changes, FtP will keep the public safe by enabling us to make the right decision on cases as early as we can. Our work to address our high caseload is laying important groundwork in helping us make more decisions earlier on in our processes and promoting engagement and learning. But to make more impact, our legislation needs to change.

Workforce and deployment

143. We have reflected on whether we could have done more to ensure that more temporary registrants were deployed. We liaised with the devolved administrations and employers and shared details of people with temporary registration with them. We feel that as the regulatory body we did all that we could to facilitate deployment, and it would not have been appropriate for us to move beyond our role of facilitating temporary registration. We continue to encourage those on with temporary registration to move to permanent registration and we share relevant workforce data where we can with our partners.

144. The data from our temporary register surveys showed that deployment was most successful where those on the temporary register were known to employers. In the later stages of the pandemic, deployment was also most successful with supporting the vaccination programme. There are lessons for the system around engaging with employers and taking a decentralised approach to deployment which we can support.

145. We have initiated a programme of work to review the data we capture to help improve our insight into issues such as workforce. We have also committed in our corporate plan to producing an annual insight report to influence positive change for the benefit of our professionals and the public.

Collaborative working

146. We would not have been able to make the changes we did without collaborating with others. Collaboration with our partners was critical to making the changes we made and supporting our professions.

147. The relationships we had have been strengthened by this experience and we are continuing to work closely with our partners for the benefit of patients and people who use services.

148. We had regular meetings with key leads in each of the nations to ensure our decision making considered the context across the different nations. We worked with them to co-produce statements and letters for the professions we regulate to ensure the messaging was directly relevant to their own context.

149. It was difficult to reach consensus between stakeholders on some key issues affecting our professions. This led to an inconsistent approach in some areas which meant that our professions were not always given clear and consistent messages. In future, a joined-up approach to issuing guidance and advice would be preferable.

Equalities impacts

150. Our corporate EqIA allowed us to keep our Executive, internal colleagues and external stakeholders informed about our understanding of the impacts of the regulatory changes we were making. Our EqIA action plan enabled us to drive forward actions to mitigate for any risks of potential unlawful discrimination identified and to communicate our actions to stakeholders.

151. In our EqIA we assessed external research and evidence on the equality impacts of the Covid-19 pandemic. We also reviewed our own internal data and insights related to the changes we made in response to the pandemic. We are aware there may be gaps in our intelligence but we have not been able to identify evidence that suggests actions we took led to unlawful discrimination against any

protected groups, or were not proportionate and reasonable given the emergency circumstances we were in.

152. Our ongoing analysis allowed us to identify groups at greater risk of being negatively impacted by our regulatory changes, and this supported our decisions to put mitigating actions in place to eliminate, reduce, and/or monitor any negative impacts.

153. Our regular review of research, reports and stakeholder concerns raised during the last two years has given us insight into long-term and wide-ranging equality implications of the pandemic within the UK and global healthcare landscape.

154. We know through our research that inequality does not happen in isolation. So far, we have analysed the equality impacts of Covid-19 on a characteristic-by-characteristic basis. This may well mean that we have not fully understood the specific experiences of some particular groups who have experienced intersecting disadvantage because of the pandemic.

155. We developed our post registration standards during the pandemic and the importance on public health of addressing health inequalities was further emphasised in the standards that were published in 2022.

156. The impacts of Covid-19 will be felt for a long time. We will need to continue to review our intelligence and insight, and work with partners, to identify any longer-term inequalities experienced by professionals and the public.

157. We are exploring ways to understand people's experiences through the lens of multiple and intersecting disadvantage through our corporate equality, diversity, and inclusion action plan, as well as the different experiences between the professions on our register and the four nations of the UK.

Impact on professionals and students

158. When we started our internal review in Autumn 2021, we wanted to understand the impact of our changes so we conducted a rapid evidence review of both our internal evidence and data as well as publicly available evidence relating to our regulatory changes. We identified gaps in that data so we also commissioned a research agency to conduct some qualitative research to ensure we better understood the impact on students and professionals for our own learning. This was not a representative sample but provided useful insights on the impact of the pandemic.

159. The research highlighted professionals' concerns with increased workload, staffing shortages, changing responsibilities, challenges in care delivery, increased physical health risk and mental health challenges.

160. Our total FtP caseload increased from 4,500 in April 2020 to 6,464 at the end of June 2022. In April 2020 we had 1,700 cases at our Screening stage and this rose to 3,448 in June 2022. Whilst pausing our FtP casework and focusing on risk at the onset of the pandemic was the right thing to do at the time, the impact on our case progression is continuing to be felt by all those in the process. This led to our decision not to pause casework during the second and subsequent waves, because we could see the impact our earlier decisions were having.

161. The research showed us that nursing and midwifery students faced significant challenges including:

a. increased stress levels
b. frustration at missed opportunities
c. issues around professional identity
d. limited opportunities to learn
e. issues with digital literacy
f. general disruption to course progression
g. mental health impacts
h. advice being unclear and/or untimely.

162. Those on clinical placement had challenges around a lack of preparation and induction, little chance to meet with supervisors, issues around PPE and challenges in facing death at scale.

163. However, there was also evidence that showed students adapting well to the move to online teaching and (for some) taking additional clinical placements during the height of the pandemic. Positive experiences included:

a. being able to grow professionally under pressure
b. having had the opportunity to 'step up' at a time of national crisis
c. being able to undertake more advanced responsibilities
d. practising/refining coping and self-care strategies
e. financial remuneration for those on clinical placements
f. gratitude and support from colleagues, family and others.

164. We will continue to work collaboratively with our education partners to support students through the remainder of their studies and through to registration with us.

The public voice

165. Throughout our emergency response our ability to engage with the public in a way that informed the immediate policy decisions we were making was limited. We made a deliberate strategic decision that the best way to protect the public was to make changes that ensured the workforce had burdens removed or reduced. The speed at which we were moving and the lack of fully embedded arrangements for public involvement in our working practices also made this public engagement difficult.

166. We did engage with organisations that represent people who use health and care services on some of the key changes and developments over the relevant period which we believe was the best approach at the time.

167. We are developing and embedding a new approach to public involvement and engagement, building early engagement into projects and programmes to

support our commitment to co-produce standards and policies. We have also established our Public Voice forum, which brings together a group of people with lived experiences to shape and inform our work. This will ensure that in future the voice of the public shapes all our key initiatives. We are also sharing our learning from the Public Voice forum with partners and are supporting the GMC and Professional Standards Authority[12] (PSA) on their own public engagement approaches.

Closing remarks

168. The impact of the Covid-19 pandemic will be felt for many years by all of us. The impact on health and social care has been immense and I am in awe of the professionalism and dedication shown by our nurses, midwives, and nursing associates, student nurses and midwives and trainee nursing associates during such challenging times both in the front line, at universities and in leadership roles. I am also proud of what we achieved as an organisation during the pandemic to help expand the workforce, support our professionals, and ensure we continued to take a fair, kind and effective approach to regulation.

169. I am sure there will be learning for all of us arising from this Inquiry and I am grateful for the opportunity for the NMC to contribute to your important work.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: Personal Data

Dated: 2 October 2023

[12] This is the body that oversees the regulation and registration of healthcare professionals.

Exhibit number	Date	Description
AS/1 - INQ000232027	25 March 2020	Covid -19 temporary emergency registration policy
AS/2 - INQ000232038	31 March 2015[13]	The Code
AS/3 - INQ000232049	22 February 2022	End of temporary registration statement
AS/4 - INQ000232056	17 October 2022	Letter on temporary registration to Robert Jenrick MP
AS/5 - INQ000232057	25 January 2023	Email to Will Quince MP on temporary registration
AS/6 – INQ000280063	14 September 2023	Letter to Will Quince MP on temporary register
AS/7 - INQ000232058	29 October 2021	Covid EqIA version 6
AS/8 - INQ000232059	March 2023	Temporary register data tables
AS/9 - INQ000232060	27 April 2020	Blog – helping nurses, midwives and nursing associates through the Coronavirus pandemic
AS/10 - INQ000232061	25 March 2023	Emergency programme standards
AS/11 - INQ000232028	September 2020	Recovery programme standards
AS/12 - INQ000232029	February 2021	Continued use of new powers arising from the coronavirus pandemic consultation analysis
AS/13 - INQ000232030	03 March 2020	Joint statement from statutory regulators
AS/14 - **INQ000283205**	12 March 2023	Statement supporting nurses, midwives and nursing associates in the event of a Covid-19 epidemic
AS/15 - INQ000232032	19 March 2023	Joint statement on expanding nursing workforce in the Covid-19 outbreak
AS/16 - **INQ000227427**	25 March 2020	Joint statement on developing immediate critical care nursing capacity

[13] Effective from date

AS/17 - INQ000232034	19 November 2020	Joint letter on supporting nurses and midwives throughout the second wave of the pandemic
AS/18 - INQ000232035	April 2020	Maintaining professionalism in the Covid emergency
AS/19 - INQ000232036	23 March 2020	Response to concerns over the availability of PPE for nursing and midwifery professionals
AS/20 - INQ000232037	14 April 2020	Statement on PPE during the pandemic
AS/21 - INQ000232039	15 April 2020	Statement on advance care planning, including DNACPR
AS/22 - **INQ000235489**	03 April 2020	CQC joint statement on advanced care planning
AS/23 - INQ000232041	03 December 2020	Response to the CQC report on DNACPR
AS/24 - INQ000232042	03 August 2021	Statement on new vaccination advice for pregnant women
AS/25 - INQ000232043	09 February 2022	Statement on Covid-19 vaccinations
AS/26 - INQ000232044	11 May 2020	Temporary annotation of prescribing qualification in relation to Covid-19
AS/27 - INQ000232045	02 June 2020	Response to the management of the coronavirus outbreak inquiry
AS/28 - INQ000232046	13 July 2020	Submission to Senedd Cymru inquiry into the impact of Covid
AS/29 - INQ000232047	22 July 2020	Submission to Health and Social Care Committee Inquiry
AS/30 - INQ000232048	November 2020	Response to Health and Social Care Committee and Science and Technology Committee inquiry into coronavirus lessons learnt
AS/31 - INQ000232050	22 December 2020	Response to Scottish Parliament Equalities and Human Rights Committee inquiry on the impact of Covid 19

AS/32 - INQ000232051	April 2020	Statement on the disproportionate impact of Covid-19 on people from Black, Asian and minority ethnic backgrounds
AS/33 - INQ000232052	17 June 2020	Response to PHE report 'Beyond the data: Understanding the impact of Covid-19 on BAME groups'
AS/34 - INQ000232053	28 May 2020	Response to RCN survey that shows BAME nursing staff experience greatest PPE shortages
AS/35 – INQ000257991	March 2021	Reflections on a traumatic year
AS/36 - INQ000232054	21 May 2021	Response to DHSC consultation on mandatory vaccination in care homes
AS/37 - INQ000232055	19 October 2021	Response to DHSC consultation on mandatory vaccination in health and care sector in England