

LEARNING FROM COVID-19

A case-study review of the initial crisis response of 10 UK health and social care professional regulators in 2020

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About the Professional Standards Authority for Health and Social Care

We promote the health, safety and wellbeing of patients, service users and the public by raising standards of regulation and voluntary registration of people working in health and social care. We are an independent body, accountable to the UK Parliament.

We oversee the work of 10 statutory bodies that regulate health professionals in the UK and social workers in England. We review the regulators' performance and audit and scrutinise their decisions about whether people on their registers are fit to practise.

We also set standards for organisations holding voluntary registers for people in unregulated health and social care occupations and accredit those organisations that meet our standards.

To encourage improvement we share good practice and knowledge, conduct research and introduce new ideas including our concept of right-touch regulation. We monitor policy developments in the UK and internationally and provide advice to governments and others on matters relating to people working in health and social care. We also undertake some international commissions to extend our understanding of regulation and to promote safety in the mobility of the health and social care workforce.

Our organisational values are: integrity, transparency, respect, fairness and teamwork. We strive to ensure that our values are at the core of our work. More information about our work and the approach we take is available at www.professionalstandards.org.uk.

The regulators we oversee are: General Chiropractic Council (GCC), General Dental Council (GDC), General Medical Council (GMC), General Optical Council (GOC), General Osteopathic Council (GOsC), General Pharmaceutical Council (GPhC), Health and Care Professions Council (HCPC), Nursing and Midwifery Council (NMC), Pharmaceutical Society of Northern Ireland (PSNI) and Social Work England (SWE).

You can find out more about our work with the regulators and the professions they regulate [on our website](#).

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Acknowledgements

We are grateful to the 10 regulators of health and social care professionals overseen by the Authority who contributed to this work. They continued to engage with us in progressing this work even as the second wave of the pandemic worsened in late 2020 and early 2021. In particular we thank those who acted as the main point of contact for the project, and those who contributed to the case studies. We also thank those stakeholders who were able to find the time even in these difficult circumstances to send their views to us.

Chair's foreword

When the Covid-19 pandemic struck the UK in early 2020, the 10 regulators we oversee had two main tasks: to contribute to the pandemic emergency response and to continue to protect the public through their work regulating health and social care professionals.

This report provides some early insights into how the regulators responded in that first emergency period, and what we can learn from the actions they took. It looks at how they guided their registrants through this unprecedented time, supported the increase in the workforce, and enabled students either to help or to continue their studies. By switching to paperless technologies and remote working they also contributed to controlling the spread of infection. Their response demonstrated the strength of the collaborative relationships in the sector, and the depth of its commitment to public protection.

When we began this work, in autumn 2020, like many we had anticipated that we would be moving into a recovery phase. Instead, the pandemic continued. We hope this report will help all of us in the regulatory system consider what changes are worth keeping, just as we also begin to contemplate the reforms being consulted on by the Department for Health and Social Care and the recently announced Health Bill.

We also need to reflect on the weaknesses that the pandemic has revealed. What does the pandemic tell us about systemic inequalities and their impact on BAME people? How, in the future, will we ensure that the patient voice is secured throughout our response to crisis situations? Reflecting on both the strengths and weaknesses will inform the response to future emergencies, and the planning that will be necessary to ensure the preparedness of the health and care system and its regulators.

We suggest some areas for further work, at such time as that is possible, recognising that much further discussion with our stakeholders will be needed to evaluate, to prioritise and to plan. Our recommendations should be seen as an outline, not a to-do list.

We are grateful to the regulators for their contributions to this report and for the agility and skill with which they and their staff continued their work to protect the public. I must also express my deep admiration for the courage and commitment of health and social care professionals, who continue to provide care during this difficult time. We will not forget the difficulties they have faced or the risks they have taken and will work with the regulators to ensure they continue to be supported and any regulatory action taken is necessary, proportionate and fair.

Caroline Corby
Chair
Professional Standards Authority

Introduction

The first seven months of 2020 were a time of enormous upheaval across the public sector, and in particular in the delivery of health and social care, as systems struggled to respond to the enormous pressures placed on them by the pandemic of Covid-19 infection. The pressures were both direct, the need to care for the sick, dying, and vulnerable in our communities; and indirect, dealing with the consequences for the economy and daily working life of the restrictions that were placed on travel and social contact.

The 10 professional regulators whose work is overseen by the Authority play an important part in the architecture of care, through the delivery of their statutory responsibilities to set and uphold professional standards; to maintain an up to date register of those who may practise in the professions regulated; to quality assure education courses that lead to registration; and to investigate and act on allegations that registrants are not fit to practise.

....collaborations were arranged, and work was progressed and completed with energy and focus..

All regulators are bound by an overarching objective to protect the public through the three 'limbs': protecting the public from harm, maintaining public confidence in the profession; and declaring and upholding professional standards, which guide the delivery of those statutory functions. With the emergence of the pandemic and the imposition of lockdown, there emerged many new risks, and new challenges to regulators in fulfilling those functions and objectives. In this report we set out the actions taken in response to the pandemic in order that the regulators were able to continue to do so.

This report focuses on the action taken by regulators up to and including July 2020. During that first phase of the pandemic, in responding to these challenges, collaborations were arranged, and work was progressed and completed with energy and focus. Adaptations which involved the implementation of technology were adopted quickly, for example, in paperless communication and in the use of virtual hearings and meetings. Temporary registration was set up at pace, together with new supporting policies. Websites were adapted and developed to provide direct registrants and other stakeholders to sources of advice and guidance tailored to the demands of this crisis.

Much was achieved through joint working, both by established groups and those convened for the purposes of the moment. Innovations were achieved despite the regulators' existing legislation and despite the often-heard need for reform to support agility and flexibility to respond to new demands. Clearly then there is much to review and learn from what it was possible to achieve during this period, and whether and how these innovations can be taken forward and adopted as normal practice in future.

The Authority also heard some notes of caution during the period. Some felt that the patient voice had been lost in the rush to implement emergency response measures

and guidance quickly. Online working, while welcomed by many parties, saw some people struggle to engage. We were keen to understand more about the impact of guidance from different sources which were available to registrants.

The Authority recognises that whereas many frontline professionals were facing unparalleled clinical challenges in the face of the rapidly unfolding public health crisis, there were professionals for whom the national lockdown meant an immediate cessation or severe limitation of being able to provide care. The decision-making undertaken by regulators, and our reflections in this report, must be understood in these differing contexts.

In this report the Authority has given regulators the opportunity to describe in their own words the actions that they took in that first phase of the pandemic through illustrative case studies focussing on different areas of their pandemic response. We felt that this was the most effective way to set out the thinking about risks, benefits, opportunities, and other factors that lay behind the decisions that were made. The Authority has gone about this work in a spirit of collaboration and we hope that the regulators have valued the opportunity to create a record of the actions they took in his extraordinary period. Their contributions to this work, and those of stakeholder respondents to a call for views, have informed a number of recommendations from the Authority.

When the project was first conceived, the Authority had anticipated that by later in 2020 and into 2021 we would be further into a phase of recovery, which could itself be the subject of further review. We did not of course know that vaccines would be approved, and a vaccination programme would be in progress. Nor did we know that in parallel the crisis of infections and deaths would worsen, caused in part at least by new variants of the virus, nor of the continuing enormous strain on health and social care services. The Authority is grateful to the regulators and other stakeholders for continuing to engage with us in bringing this review to a conclusion in these difficult circumstances. We look forward to continuing to work with them and our wider our stakeholders as we all continue to learn from both the initial emergency response and the continuing situation.

It is important to note that the qualitative methodology that the Authority has followed does not provide the evidence which would allow us to substantively evaluate the impact or effectiveness of the regulators' responses and actions. Nor have we sought through this process to duplicate the Authority's ongoing process of performance review of the regulators. Rather, we have gone through this process in order to help us rapidly identify learning for the future about responding to crisis situations – be they Covid-related or not – and to capture the thinking of the moment in how decisions were reached during the first crisis period. We hope that this report will be a helpful contribution to future, more evaluative review and to shaping the way forward in relation to learning from this extraordinary time. Until such time as the situation stabilises and more complete evaluative review can take place, our findings should be considered to be to some extent provisional.

Examples of regulatory practice changes during the pandemic			
Enhanced collaboration with stakeholders	Adopting new technology	Supporting course adaptations	Increased time in clinical placements to support care
Virtual fitness to practise hearings	Covid specific guidance	Supporting information sharing	Paper based monitoring
Exploring new ways to communicate	Online investigating committee meetings	Deferral of revalidation/continuing fitness to practise requirements	Postponing and rescheduling some exams and assessments
Moving assessments online	Temporary registration	Moving to home working	Acceleration of full registration
Covid hubs on websites	Increasing capacity to handle queries	Virtual quality assurance visits	Provisional registration
Reducing in-person meetings	Extension of deadlines for fee payment	Producing guidance for decision makers	Electronic communication of formal documents

Summary of Authority findings

The Authority's view is that out of the regulators' emergency response actions many positive and constructive achievements emerged, including:

- ▶ **Improvements in collaborative inter-regulatory relationships** – working together as a sector to agree priorities and share information
- ▶ **Improvements in relationships between regulators and other stakeholders** in collaborating to assure safe care – achieving joint positions and shared guidance through re-energised relationships
- ▶ **Improvement in mutual understanding between regulators and their stakeholders** as to roles, powers, responsibilities and limitations
- ▶ **Rapid adoption of technology** – developed of course to keep regulation going when people could not travel and to uphold social distancing, but yielding many wider benefits including greater efficiency and potential cost reductions
- ▶ **Rapid development and implementation of other innovations**, often in collaborative arrangements – which we have been told frequently would have taken years to achieve otherwise
- ▶ **The importance of trust** has arisen as an issue on many occasions – the process having demonstrated the importance of trust between people and organisations, pre-existing trust having been a necessary antecedent of what was achieved collaboratively
- ▶ **The importance of corporate strategy** and the role of regulators' councils¹ in ensuring that strategy and governance enable an emergency response, supported by business continuity planning, when needed.

¹ Social Work England is an arm's length body with a unitary board, rather than a council.

However, in parallel a number of potential risk areas emerged which will need further exploration before new arrangements are embedded as business as usual, once the wider situation stabilises, and risks around decision-making become less volatile. These include:

- ▶ **Diminished involvement of patients, service users and the public** – in the rapid development of guidance and positions, some have reflected that the patient and public voice was not given sufficient influence
- ▶ **As yet incomplete assessment of the impact of innovations** – necessarily, as determined by the speed of necessary changes, but with potential negative impacts such as on the trust of the public in regulation
- ▶ **Blurring of boundaries** – has seemed an ever-present risk in the examples of regulators working with other organisations, with a resultant potential for confusion about where responsibilities lie
- ▶ **Limitations of technology** – some regulatory processes being a poor fit for online working, particularly where the supporting information or documentation is complex, and where too comprehensive adoption risks excluding some people
- ▶ **Losses from not being able to meet in person** – the exact nature of which is not easy to quantify, but which requires further consideration before online working becomes enshrined as a new normal
- ▶ **The operational impacts in some areas** – such as the build-up of fitness to practise cases which it has not been possible to progress – will need to be addressed.

Recommendations

The Authority's recommendations that follow fall into two broad groups: **maximising the longer-term value from pandemic response actions; and preparedness for future crisis, and future business as usual.**

The speed at which innovations were adopted belies the view that regulation is inherently a barrier to change.

In seeking to support these recommendations being taken forward the Authority will look to play a full part. As the current situation evolves, we will work collaboratively with others within

our powers and resources, discussing with regulators and other stakeholders the best way to proceed and how to prioritise the recommendations that follow in the light of emerging evidence. There will be much further shared learning to be derived through collaborations and ongoing dialogue with stakeholders. **Until such time as the situation stabilises and more complete and evaluative review can take place, our findings should be considered to be to some extent provisional.** The recommendations are discussed in more detail at chapter 6.

Maximising the longer-term value from pandemic response actions

The speed at which innovations were adopted belies the view that regulation is inherently a barrier to change. These innovations should be subject to review and evaluation in due course, to assess their impact and to ensure that any risks are properly and sustainably managed and that the interests of stakeholder groups have been properly reflected in their design and operation, work which the Authority will support.

- ▶ There would be benefit in reviewing the value to the pandemic response of the establishment of temporary and provisional registration set against the risks and costs, and whether value would have been added to the pandemic response by any other regulators having had these powers which did not. Such review should include the experiences of those temporarily registered, and wider impacts including on public confidence
- ▶ The Authority supports the continuing transfer to digital, electronic and virtual working in the interests of speed and efficiency, subject to further work to ensure that particular groups of stakeholders (in particular patients, service users and the public, registrants and potential registrants) are not excluded from engagement with regulators as a result. Further implementation should also be subject to assurance that public trust in regulatory decision-making is not compromised
- ▶ The Authority proposes there will be value in due course of a thorough review of the effects of the pandemic on collaborative working – what was achieved, what risks were taken, how these risks were managed, and how did any unintended consequences arise. This should include how roles and responsibilities remain clear in collaborative working, including looking at the risks where they do not. We propose that a review would include how effectively professional regulation collaborated with other regulatory sectors during the pandemic, and whether value would have been added by any different or more formally co-ordinated approaches, with a focus on future crisis
- ▶ The Authority supports further evaluation and assessment of the experience of patients, service users and members of the public, registrants, panellists and legal advisers in virtual hearings
- ▶ The way in which context will be taken into account at each stage of the fitness to practise process will also require careful further consideration and explanation, taking careful account of the views of patients, service users and their families so as to ensure fairness and continued wider public confidence in the fitness to practise process
- ▶ In fitness to practise, it would also be useful to understand in due course what impact the variations in approaches taken by the regulators had on employers and on the progress of individual cases – whether the changes reduced employers' burden or led to serious cases being missed or delayed. Whilst we can see that each regulator took burden into account, we are uncertain whether the different approaches or indeed just changing the requirements, involved more work for them rather than less and whether this had any impact on public protection
- ▶ The crisis has reinforced the urgent need for regulatory reform, to make regulation more agile and enhances its ability to put patient protection at its centre. The Authority will continue to work to explore, discuss and explain its view on how that should best be achieved. While the Authority is strongly committed to regulatory reform, it is concerned to ensure that greater flexibilities are balanced with appropriate oversight, including to minimise the risks arising from unjustifiable disparity of regulatory approaches, processes or practices; that the quality of decision-making is upheld; and that EDI impacts are fully considered

- ▶ We heard concerns that an unduly prolonged process of reform (that is, a staggered process with regulators being reformed over a long period of time) would create the risk of an inconsistent response to further crisis should it occur before the reforms were complete. The Authority will be concerned to ensure that design of a future reform programme will mitigate this risk
- ▶ To inform future reform work the Authority is keen to continue to explore the issue of consistency, including to understand the public's view of where it is most important. The Authority has commissioned research to explore this which will be published in Spring 2021.

Further learning for preparedness for future crisis, and future business as usual

The demands of responding to the pandemic have highlighted other areas for further work, reflection, discussion and research to enhance professional regulation's contribution to public protection and patient safety:

- ▶ Our discussions suggest that trust between organisations has been a vital component of successful collaborations. The Authority proposes that trust needs to be better understood, including to predict those situations where it may be inadvertently lost
- ▶ The Authority recommends that in due course, there are refreshed efforts in the sector to consider how to best to communicate the role, responsibilities and powers of regulators to best support collaborative working
- ▶ The Authority proposes work with stakeholders to review the impact and effectiveness of the combination of guidance, data, advice, management direction and other influences on professional practice and conduct that they encountered. A review should include looking at how regulators and their stakeholders addressed any perceived gaps in guidance and its interpretation, and the learning for future crisis and business as usual
- ▶ We will be interested to explore the question of the design of regulators' standards function, to identify whether there might be approaches to the development and promotion of standards that would better support both fast-moving, high-risk situations and that would better fulfil the long-held ambitions of the sector to be more influential in preventing harm. This to include reviewing the potential of a single, multi-professional code of conduct
- ▶ A review of ethical dilemmas encountered by health and social care professionals during the pandemic has been commissioned by the Authority and will be published in Spring 2021. The report will support onward discussions of how regulators can best support registrants in navigating difficult ethical terrain at times of crisis
- ▶ More generally, work will need to be done to assess the impact of Covid on practice and how this should be taken into account in the regulators' processes and decisions
- ▶ We will support continuing work to ensure that the public and patient voice is present in regulatory decision-making, even when expedience demands rapid action
- ▶ We believe that it would be timely to review the role of regulators in providing support for registrants and how this fits with the role of professional representation bodies, in light of the events of the past year. A review would examine the contribution of registrant health and wellbeing to patient safety, and

consequently recommend how the activities of regulators and those charged with representing the interests of the workforce (in particular professional bodies) might optimally work together for the benefit of the public, while retaining their distinct roles and responsibilities

- ▶ We think the experience of the pandemic suggests it would be worth evaluating whether the balance, structure and length of training is right for all professions. The regulatory system developed around single professions and single disciplines, and education followed suit, but modern service delivery requires multi-skilled teams
- ▶ The pandemic has had an unequal impact both on the public at large and on the health and social care workforce. The Authority will support future work to better understand the reasons for inequality and its longer-term consequences, and to enhance the role of regulation in addressing these issues
- ▶ Once the extraordinary circumstances of the pandemic are in the past regulators will need a period of recovery, review and consolidation. The Authority will look to support the regulators in the process of putting things back onto a more stable footing.

Purpose of this review

In taking forward this review the Authority wanted to understand better how the 10 regulators we oversee had responded to the initial crisis, including how decisions had been made and why particular actions and measures were implemented, and how regulators were able to respond with agility to changing circumstances. We have considered how the regulators contributed to the emergency response, whether by enabling the temporary increase of the number of registrants to work in services or providing guidance and support to them.

The Authority has sought to identify where innovations and adaptations catalysed by the pandemic have the potential to be adopted as normal practice, across the regulatory functions. The pandemic ignited greater inter-regulatory and wider collaborative working, so we have also been keen to understand whether this has any implications for the future role or position of regulation within the health and care system. We have attempted to identify the main learning points for further waves of the virus, other future, crisis, and future business as usual.

In the Authority's view, the actions taken by regulators contributed to a number of objectives, as well as the need to ensure that normal regulatory activities carried on:

- ▶ To minimise the spread of infection generally and in regulatory work
- ▶ To support students and trainees to continue to progress in their studies safely and maximise their contribution to patient care in the pandemic
- ▶ To support registrants to continue to practise safely, where possible to do so in these unprecedented circumstances and
- ▶ To support the health and social care workforce to meet the increased demand placed on it by the pandemic.

We have called these the 'Covid-response objectives' and have commented throughout the report on how different actions contributed to them. Our purpose in doing so is to demonstrate how the different regulatory functions each required a

different response, and made a different contribution, given the different stakeholders, contexts, processes and impacts of each.²

Who is this report for?

We hope this report will be of interest to anyone with a current or future interest in how the 10 regulators responded to the initial crisis. This might include:

- ▶ Those taking forward future reviews and inquiries into how different parts of the health and social care sector responded to the crisis
- ▶ Stakeholders, including registrants and those representing the interests of patients and the public, wishing to understand better why the regulators made the changes and decisions that they did
- ▶ Regulators in other sectors and other countries, with an interest in comparing different approaches
- ▶ Those conducting academic research on aspects of the pandemic
- ▶ The 10 regulators themselves, to support their own ongoing reviews of how they responded to the crisis and how they plan to implement longer term adaptations in their ways of working.

How is the report structured?

Section One

Section One has six chapters. In the first four we take one area of regulatory work at a time (registration and continuing fitness to practise; fitness to practise; standards, guidance and communication; and quality assurance of education). Each chapter first explains what that area of work involves. It summarises what needed to change in order for work to continue given the specific impacts of the pandemic in that area. Each chapter then sets out further information about what regulators did and provides discussion from the Authority specific to that area. We incorporate some key points and issues that were identified by those stakeholders who responded to our call for views.

The fifth chapter contains further information on overarching themes applying across all functions – strategy, collaboration and governance. Again, case studies from the regulators are discussed. We provide some discussion from the Authority and key points from the responses to the call for views. Within the first five chapters are links to the relevant case studies in Section Two.

The sixth chapter presents the Authority's overarching discussion and recommendations.

Section Two

Section Two contains the 28 illustrative case studies that have been provided by the regulators.

² Please note that these are objectives that we have inferred retrospectively from the actions taken by regulators

In some cases, the case study was initially drafted by the Authority after a discussion with the regulator. The regulator then amended or edited the draft as necessary. Each case study summarises the regulator's actions in a particular area of its response to the initial crisis.

The case studies are ordered according to chapters and discussion in Section One. After each set of case studies a more detailed account is provided of views that were expressed to the Authority by those stakeholders who responded to our call for views. For more information on our approach to responses to our call for views, see below.

A note on responses to the call for views from stakeholders

Responses and perspectives from stakeholders are provided throughout the report. Given the worsening crisis as it developed through December, the Authority was very pleased to receive 34 responses, and was grateful for the time and thoughtfulness of those stakeholders who responded.

This was not a formal consultation. The relatively low volume of responses received, due no doubt to the timeframe allowed and the challenges of the ongoing situation, may not represent the views of the full range of stakeholders of the sector. Nevertheless, the views articulated are insightful and valuable, and offer many pointers for further discussion, thinking and exploration. All comments made to the Authority, whether directly referenced in the report or not, have been considered in making recommendations.

In order to be clear that the Authority is not presenting a consolidated view of the numerous stakeholders of professional regulation in health and social care and avoid any misunderstanding we refer for example to 'respondents to our call for views' when reporting or summarising comments that were made to us, or making generalised observations.

The Authority is grateful to those respondents who have shared with us information on the actions that they themselves took in response to the initial emergency, in particular the accredited registers and regulators outside the oversight of the Authority. We regret that we have not been able to describe, compare or comment on them directly within the scope of this report. They have however, informed the way that we have shaped our discussion and recommendations and we will look forward in due course to convening stakeholders to continue to share experiences and learning from the pandemic.

The Authority also notes that a number of the responses identified particular difficulties, policies, decisions and approaches in the delivery of aspects of health and social care during the period, which we regret we have not been able to research or explore within the scope of this project.

A note on the Authority's Performance Review process

In recognition of the effect the pandemic would have on regulators' resources, the Authority introduced a set of principles to underpin our approach to performance reviews during the pandemic. The purpose of this was to ensure that we were able to continue with our oversight in line with our public protection duty, while seeking to

mitigate the burden that engaging with our process would have on the regulators. We sought to ensure that our requests took account of the difficulties regulators faced, while also ensuring that we addressed any concerns about public protection. We made it clear that we would not criticise regulators for decisions made in good faith in response to the pandemic or for delays to regulatory processes that were out of their control.

The Authority's approach has meant that, while we did not use some of our more intensive performance review tools, such as auditing, we have been able to continue to assess the performance of the regulators. We have also kept in close touch and engaged with them on the emergency measures that they undertook. Positive engagement from the regulators has helped to ensure this has been successful and that we can be confident in our oversight of them during this period.

A note on accredited registers

The Authority assesses organisations that register health and social care practitioners who are not regulated by law under our Accredited Registers (AR) programme. To become an AR, organisations need to meet the high standards we set for core processes such as governance, complaints and registration. There are over sixty different occupations covered by the AR programme currently, including complementary therapies, psychotherapy and health science.

The range of services provided by the ARs, and the broad definition of health and care that fall within the programme's scope, presented a challenge in recognising this ARs as a single group within Government Covid-19 guidance. We know this was particularly difficult for some ARs at the beginning of the pandemic, with some reporting that their members were both unable to work, or to access financial support. The ARs issued advice to their members, based on Government guidance, and specific to the occupations registered. We highlighted concerns to Government, and in subsequent versions of the guidance, specific advice for ARs on interpretation were provided. As the pandemic developed and guidance evolved, there was more specific references to some areas in the guidance itself, such as mental health. However, the differing approaches across the four UK countries in respect of the occupations covered by the programme continued to cause frustration for some ARs, particularly where they felt that their registrants could make a greater contribution to the pandemic.

The pandemic highlighted the lack of recognition that ARs can feel within the wider system. Our public consultation on the future of the programme, which ran from December 2020 to February 2021, sought views on how to achieve greater awareness and embedding of the programme within the wider system. In early 2021 we also sought views from current ARs of their experience during Covid-19, and how they think the occupations they register will be changed. The Authority will publish these findings as part of our report on the public consultation in Spring 2021.

SECTION 1

Chapter 1 Registration and continuing fitness to practise: supporting the workforce to respond to the emergency

The registration function and continuing fitness to practise

The scale of the pandemic placed great strain on the health and social care workforce who were themselves vulnerable to the infection. There were already workforce shortages even before the pandemic emerged. When it struck, many normal services were suspended or reduced, and many in the workforce were diverted to the emergency response or redeployed to unfamiliar areas of practice. However, there were still concerns that the workforce may become depleted and insufficient to provide care for patients and service users. There was an urgent need to increase the number of qualified professionals available to work. The solution was for regulators to rapidly re-register people who had left their registers including those who had retired and to speed up processes to allow students, where appropriate, to support the workforce.

Regulators maintain and publish registers of those who meet their requirements, including any restrictions on practice. They require registrants to comply with arrangements to demonstrate their continuing fitness to practise, for example through a revalidation process. This is usually a high-volume, busy area of work and it is important to keep the register up to date. The register allows registrants to demonstrate that they are eligible to work; it allows employers, patients, service users and the public to check someone is qualified and if there any restrictions on a registrant's practice.

Numbers of temporary registrants³	
General Medical Council	25,568
General Pharmaceutical Council	6,443 of whom 3,459 pharmacists and 2,984 pharmacy technicians
Health and Care Professions Council	21,518 of whom 20 students
Nursing and Midwifery Council	16,077
Pharmaceutical Society of Northern Ireland	261
Social Work England	14,004

Contribution to the 'Covid-response objectives'

Through the actions taken in this area of work, the regulators contributed to supporting the health and social care workforce to meet the increased demand

³ These figures are given for information and are as at the time of final drafting of this report ie late March 2021, not during the period to July 2020. They are the figures most recently available to the Authority from regulators and their websites.

placed on it by the pandemic; and to supporting registrants to continue to practise safely.

What needed to change as a result of the pandemic?

For those regulators with the powers to do so, the challenge was to establish systems of temporary registration to enable previously registered health and social care professionals to re-enter the workforce and contribute to the emergency response. This included defining criteria for access and for removal. Regulators needed to avoid, so far as possible, reinstating anyone who was not fit to practise.

Meanwhile all regulators were required to continue to maintain 'business as usual' and continue to publish an up to date register, despite the particular difficulties in a high-volume transaction area of work and adapting their operations so that where possible staff could work from home. As in other functions, a central challenge was to create and direct the capacity to deliver all of this, as well as responding to an increased volume of enquiries.

Once registered, registrants are required to show their regulator that they are keeping up to date and continue to be fit to practise. The challenge for regulators was to determine how to adapt this requirement when registrants and services were so busy and likely to find it hard to participate in activities that would usually contribute toward registrants being able to satisfy regulators that they remained fit to practise.

What did the regulators do?

Temporary registration

The Coronavirus Act 2020 gave or triggered powers for the GMC, NMC, HCPC, GPhC, PSNI and SWE to establish temporary registration, which they did quickly. As in other areas of their response to the pandemic, they did so through close working with stakeholders, and demonstrated agility and responsiveness.

Planning for and implementation of temporary registration involved the balancing of a series of risks, benefits, costs and other factors. Risks included the potential for entry to the register of those unfit to practise and thus presenting a risk to patient protection; risk of resources being wasted if the professionals made available for work did not align with the needs of the service and those requiring health and social care treatment; and the risks of specific different approaches to the task. **Case studies 1-3** from the GMC, NMC and PSNI show how the regulators of different professions did so, and the safeguards that were put in place including through the potential employers of those who were ultimately deployed. The regulators adopted different approaches, including whether eligible professionals could opt out or opt in; and how they assessed their fitness to practise.

Typically, for those regulators who established temporary registration, previous registrants were admitted to temporary registration in phases. For example, in the GMC case study below, there were four cohorts between 26 March and 2 April 2020,

with groups being determined through discussion with the four UK Chief Medical Officers.

Provisional registration

Case study 4 from the GPhC describes how the regulator went about planning for and implementing provisional registration for those trainees who could not take their registration assessment exam in March 2020 – the lockdown necessitating that it be postponed. The case study describes the risks and benefits that were balanced and the safeguards that were put in place to enable several thousand pharmacists to work during the emergency period who would otherwise not have been able to.

Registration ‘business as usual’

We were particularly interested to explore more about ‘business as usual’ in registration and how this was maintained, as a high-volume transaction area of regulatory work, and at a time when most of the regulatory workforce necessarily became home-based. **Case study 5** from the HCPC sets out how the regulator moved its operations to largely digital working, while retaining the option for hard copy and post. The case study describes the safeguards put in place, and the measures taken to adapt fee collection to the pressures being faced by those working on the front line of the pandemic. **Case study 6** that follows from SWE goes into further depth about the risks and benefits that were balanced in its decision to delay taking the final fee instalment from the registration year from its registrants.

Continuing fitness to practise

Regulators took a range of actions to adapt their continuing fitness to practise requirements to minimise the demands placed on registrants, including through deferral of deadlines. **Case study 7** from PSNI below provides more detail of one such approach.

Discussion

In terms of swelling the potential workforce the temporary registration initiative was remarkably successful. Despite the personal risk registrants faced a large number joined the registers. Over 30,000 doctors were automatically opted in and two thirds chose to remain. The GMC had speculated that the opt out approach would deliver the highest volume of returnees and this appears to have been borne out. The findings of the GMC’s survey could suggest that a little over half were deployed. Some rejoined later to help with the roll out of vaccines.

The NMC, which let registrants opt in, registered 15,000 additional nurses out of a potential pool of 100,000. Although the percentage who returned to the workforce was smaller, their approach does appear to have been successful in ensuring they were fit to practise; out of 12 concerns six were upheld.

PSNI, who also used the opt-out approach, shared responsibility for checking fitness to practise with employers. It checked that registrants who left the register had been in good standing, and employers were asked in addition to their usual checks to assess their competence and identify any information that might affect their fitness to practise.

It is not clear to us at this time whether the numbers who were reinstated and not deployed were excess to requirement or if they were under-utilised by the services. It does suggest there needs to be closer liaison in future between those responsible for emergency planning, service providers and regulators to ensure effort and resource is not wasted. Using this workforce more fully might have helped to alleviate the burnout and exhaustion being reported by the workforce as the pandemic continues. It may also have provided an opportunity to reinstate some normal services for patients and service users earlier.

The Authority notes that a number of the respondents to our review thought well of the temporary registration arrangements, were keen for the transition to convert temporary to permanent registration to be simple, and thought that priority should be given to those on the temporary register for reinstatement. We caution however that little is known at this stage about their deployment, their competence during practice and without wishing to cast any shadow on their contribution, that it can take time for concerns to work their way through complaints systems. A thorough evaluation is needed before these arrangements are cemented in place, including of the impact on public confidence.

Chapter 2 Fitness to Practise: continuing essential regulation to protect the public

The fitness to practise function

The fitness to practise process enables health and social care regulators to investigate concerns about registered professionals and, for the GPhC and GOC, registered businesses and if necessary, impose restrictions on their ability to practise. It plays a central role in the regulatory framework established to deliver public protection.

When the pandemic hit, regulators had to quickly decide what they would do about cases they were handling. Progressing these cases requires input from others, including health and social care providers and registrants, who were clearly busy dealing with the consequences of the pandemic. However, they also had to ensure that the public were protected, which meant work on the more serious cases needed to continue.

Nine of the 10 statutory regulators⁴ over which the Authority has oversight are subject to the same overarching objective of public protection:

- a. to protect, promote and maintain the health, safety and well-being of the public
- b. to promote, and maintain public confidence in the relevant profession and
- c. to promote and maintain proper professional standards and conduct for members of the relevant profession.

⁴ All except PSNI

Despite the common objective, they operate under different statutory frameworks providing a range of powers to investigate fitness to practise concerns. Broadly, each fitness to practise framework involves a triage, investigatory, and adjudication stage, which may result in the imposition of substantive or interim restriction on a professional's registration status.

Although there was a divergence of approach, in responding to the pandemic the regulators collaborated, shared knowledge and innovation. They sought to deliver a strong message that they were prioritising patient care and seeking to reassure professionals that the challenging context in which they were exercising their professional judgement would be fully recognised.

Contribution to Covid-response objectives

By moving to remote working, virtual hearings and online service of documents the regulators reduced the need for meetings in person and other contact. This contributed to the objective to minimise the spread of infection in pursuit of regulatory work. By seeking to take a risk-based and proportionate approach to cases they helped to support registrants to continue to practise safely, where possible to do so; and to support the health and social care workforce to meet the increased demand placed on it by the pandemic.

What needed to change?

Of the core statutory functions, fitness to practise was possibly at the greatest risk of being derailed by the pandemic and national lockdown because it relies upon concerns being referred to it by employers and the public who were busy dealing with the pandemic. It also relies on live evidence being provided in physical hearings before panels, usually with the registrant, witnesses, advocates and legal advisers present. The legislation is prescriptive about the steps of the process and much of it pre-dates recent technological developments.

The regulators were required to implement, at pace, extensive change in order to sustain their operations at each stage of the fitness to practise function. They had to balance four things:

- ▶ Whether there were any immediate changes they could make to relieve pressures on the workforce, for example, by pausing action on cases so as not to distract registrants from their work or tie up employers' time in providing evidence
- ▶ Whether there was sufficient flex in their regulatory framework to allow them to conduct their business differently
- ▶ In making changes, how to balance the interests and needs of registrants, complainants, witnesses, representatives, panel members and the wider public
- ▶ The regulator's own risk appetite.

As will be seen from the summary of actions taken by each of the regulators and case studies covering new referrals, case progression, and virtual hearings, a range of approaches were adopted by way of immediate response. As for the other regulatory functions, alongside the need to pivot to remote working at short notice,

many complex and wide-ranging matters had to be quickly addressed in relation to fitness to practise.

Matters they considered included what guidance, external or operational or other support was needed to enable their processes to continue; reviewing threshold criteria and the approach to new referrals to manage their own workload with staff working from home; and finding the right balance between not over-burdening employers on whose evidence many regulators rely, whilst minimising avoidable delays.

They had to decide which concerns were to be given priority, how they would be identified and any risks managed; how to adapt when physical meetings were not possible; and the approach to be taken to matters listed for imminent hearing, adjourned matters and orders (interim or substantive) that were about to lapse. They also had to consider how to allow public access, which the Authority considered was important.

Each change at each stage of the fitness to practise process involved complex considerations and demanded careful management. The impact was hard to anticipate. Nevertheless, the regulators rose to the challenge. They collaborated, adopted technology, sought to innovate and to adopt a risk-based, proportionate approach. Their efforts in seeking to be as consultative as the pace of change permitted allowed this core regulatory function to adapt and continue to deliver public protection in the unprecedented circumstances.

What did the regulators do?

All regulators continued to accept and risk-assess new referrals, seeking to prioritise the most serious concerns likely to require an interim order. Social Work England asked employers to only refer high risk matters so as to retain their focus on frontline efforts. Their approach to new FtP referrals is discussed in more detail at **Case Study 8**. The GPhC by contrast, amended its processes, doing an initial risk assessment at triage to identify and classify concerns that would ordinarily have been passed to the inspectorate for management. These were classified as intelligence and closed at triage, with inspectors undertaking a risk assessment and any follow up systems-related action if needed.

The approach to existing investigations varied; some regulators chose to pause all live early-stage investigations. The GMC decided to pause new investigations where no interim order was required and paused requests for information from organisations and health care providers (unless it was needed for an Interim Order Tribunal) in order for responsible officers to be able to focus on frontline service delivery. The GMC progressed other cases but were more flexible with timescales. The NMC reprioritised its existing caseload to focus on the most serious cases and risk assessed new information received. The PSNI decided only to actively advance cases where the threshold for an interim order was met. The HCPC introduced a limited case progression process to deprioritise matters which were less serious but keeping them under periodic review. The HCPC sets out more detail about its case progression plan at **Case Study 9**.

Regulators who were able to progress their existing investigations recognised the limitations they faced and modified their approaches to case progression, by keeping their requests for information from healthcare providers to a minimum, extending their timeframes for the receipt of information and undertaking enquiries by email only.

Where the approach taken was to pause existing investigations, the risk of further delay both to existing cases and new referrals was recognised. However, the intention was to reduce the burden on health and social care services at the height of the pandemic.

The need to prioritise high risk concerns was reflected by all regulators continuing to risk assess new referrals and new information received on existing cases and refer high risk-matters for interim orders, which were prioritised for virtual hearings alongside interim order reviews, substantive order reviews and High Court extensions of interim orders.

Regulators whose fitness to practise rules permitted the use of Case Examiners were accustomed to this stage of the process being undertaken without a physical meeting whereas investigating committee panels and case management meetings had to move to online working and decision-making.

The announcement of the national lockdown brought about the need for most regulators to postpone listed substantive hearings although a few regulators were able to progress uncontested straightforward matters on the papers where the parties consented. Again, it was recognised that this would create a backlog of cases awaiting hearing and increase the overall stress on all participants, but under the circumstances this was unavoidable.

For many regulators, the need to move rapidly to remote hearings raised the problem of the rigidity of their respective regulatory frameworks which did not allow for remote hearings or the services of notices by email or allow them to respond to the need for flexibility in the composition of panels and therefore rule changes were required by emergency legislation. This required, for some, approval by the Privy Council.

Once the rule changes were in place, the process of shifting to virtual hearings was well supported by the regulators with many developing guidance, virtual hearings protocols and training for panelists and guidance for registrants, witnesses, and professional bodies. Two regulators describe their approach to establishing virtual hearings: the GDC at **Case Study 10** and the GOC at **Case Study 11**.

Regulators worked with defence organisations and other representative bodies to enable IT and logistical matters to be resolved. Virtual platforms allowed the sharing of documents, recording of proceedings to enable transcripts to be created if necessary, private rooms to allow in-camera discussions between panelists and were able to support the full range of interim order, substantive and review hearings which largely recommenced in June/July 2020. Some regulators with the power to do so created internal guidance around early reviews of substantive orders in respect of

public interest only impairment findings or where concerns had been remediated to enable registrants to return to practice and rejoin the workforce.

The Authority recognises that many defence organisations were uneasy about these arrangements, with a number of concerns having been brought to the Authority's attention. In providing overarching guidance on virtual hearings (see below), one of the Authority's objectives was to assess and address their legitimate concerns.

Discussion

This was an area of unexpected and remarkable transformation by the regulators, given what is widely regarded as their outdated and inflexible legislation. It goes to show, as the Authority suggested in *Regulation rethought*, that much can be achieved through 'collaboration, innovation, imagination and determination', although the Authority remains convinced that reform is needed. The regulators moved swiftly to take action; they appropriately prioritised and continued with the cases, flexing their rules where necessary in order to do so. Take up of virtual hearings happened at different paces, but regulators addressed the technical and other issues and found it helpful to have the Authority's guidance.

The Authority noted the concerns of some respondents about the shift to virtual hearings. Our Virtual Hearings Guidance set out the matters we think regulators and panels should consider when assessing if a virtual hearing is appropriate in a particular case and we will be reviewing this guidance in light of further experience. We think that there are some clear advantages in moving hearings online: it makes them less London or England centric, which is important because the professional regulators operate across the UK and virtual hearings are more accessible for people wherever they live. Anecdotally, registrants are more likely to engage with a hearing. Online hearings have the potential to be more accessible for the public and whilst we heed some of the concerns expressed about this believe it is in the public interest for hearings to be held in public. Finally, as some respondents commented, they help to reduce the impact on the environment.

The Authority thinks that some of the respondents have raised valid points about virtual hearings and regulators should formally evaluate them and ensure they deliver appropriate protection of the public. In particular, it will be important to consider the experience of participants and panel members and identify their impact on efficiency and quality. We were critical of some of the restrictions placed on public access during this period. Thought needs to be given to witness support and IT accessibility for registrants and others. We would expect virtual hearings to continue to play a significant role and, while they will not be suitable for every case, they appear to have substantial advantages for registrants and witnesses.

It would also be useful to understand in due course what impact the variations in approaches taken by the regulators had on employers and on the progress of individual cases – whether the changes reduced employers' burden or led to serious cases being missed or delayed. Whilst we can see that each regulator took burden into account, we are uncertain whether the different approaches or indeed just

changing the requirements, involved more work for them rather than less and whether this had any impact on public protection.

Finally, and by no means wishing to detract from the regulators' positive performance, we note that some regulators will continue to face a significant backlog of cases. The pandemic has affected the timescales of regulators in different ways, as might be expected from the different environments in which their registrants work. Some initially saw a decrease in the number of referrals, others an increase. Most found that, for a period of three months, they were unable to hold substantive hearings which may well have affected their case load.

As we have discussed, others have found it more difficult to obtain information from employers or deliberately reduced or delayed inquiries. It is likely that some cases will prove impossible to resolve, because the delay means that evidence becomes less accessible, memories fade and witnesses may disengage. It is too early to say overall how this will have affected the backlog of cases or how regulators are able to address this. The Authority will monitor how regulators prioritise serious cases and address these challenges.

Chapter 3 Standards, guidance and communication: guiding safe care through crisis

The standards and guidance function

The 10 health and social care regulators maintain and promote up-to-date standards for registrants which are kept under review and prioritise patient and service user centred care and safety. They provide guidance to help registrants apply the standards and work to ensure that this guidance is up to date, addresses emerging areas of risk, and prioritises patient and service user centred care and safety.

There was no blueprint to follow

Communications is included in this section of the report, because communicating guidance and standards to registrants during this time was a particular challenge. It also included communicating to patients, service users and the public, trainees, employers and other stakeholders. Regulators had to tell people about the impacts of the pandemic on other regulatory functions, such as advising students and trainees on the impacts for them of arrangements for proceeding to registration.

During the pandemic many registrants were faced with unfamiliar territory. Covid-19 was new, its transmission uncertain and in the early days they treated patients drawing on their knowledge, experience and instinct. There was no blueprint to follow, no clinical guideline until, sharing knowledge across countries, clinicians began to work out the best ways of caring for patients with the virus. Health professionals are trained in infection control, and they are used to taking a

precautionary approach to dealing with sick patients in case of infectious diseases. But they can generally be confident that the measures they take will protect them.

This virus was different; despite PPE and other measures many got sick and several died. Social workers too were faced with the risk of infection. Many registrants were redeployed in unfamiliar clinical or service areas and had to brush up former skills, learn new ones and prioritise resources, making difficult choices about who to treat or attend, who first and in what order.

Contribution to the Covid-response objectives

Adaptations to regulators' standards and guidance for registrants supported the reduction of the spread of infection in the delivery of health and care services and helped to support the workforce in responding to the increased demands being placed on it.

What needed to change as a result of the pandemic?

The standards regulators set, for example the GMC's *Good medical practice*⁵ or the HCPC's *Standards of conduct, performance and ethics*⁶ are necessarily at a high level, as a series of principles which registrants should apply to practice. It therefore requires some interpretation by the registrant to apply it to the issue they are dealing with. Regulators provide some further guidance to help them interpret it in certain circumstances. However, regulators cannot and do not anticipate every situation they will face during their career.

During this extraordinary phase regulators had to produce guidance at speed, without being able to go through all of the usual procedures for consulting stakeholders including patients and the public (See **Case Study 24** on reintegrating the patient voice in regulation). They had to navigate the pandemic together with their registrants working out how the standards and guidance applied. Registrants were understandably anxious to know, for example, what they should do if asked to work when they felt their safety was compromised. Regulators had to consider their position in relation to emerging evidence of death rates amongst BAME registrants. This is discussed in **Case Study 21** later in the report.

The traditional boundaries between employers, professional bodies, and professional regulators became less clear. The Authority itself had to work out its own role in the pandemic, and how it might most helpfully optimise its position within the architecture of care and regulation for the benefit of patients in the crisis. We set up a Covid risk log, tracking new risks as they emerged to help us identify whether we or the regulators we oversee might need to take action to stem them. As a result of our monitoring, we consulted, and then produced, guidance on virtual hearings for regulators on holding hearings remotely, which we issued to help them achieve a

⁵ General Medical Council, 2013. *Good medical practice*. Available at www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical-practice [Accessed 20 March 2021]

⁶ Health and Care Professions Council, 2016. *Standards of conduct, performance and ethics*. Available at www.hcpc-uk.org/resources/standards/standards-of-conduct-performance-and-ethics/ [Accessed 20 March 2021]

consistent approach⁷. We tracked the issues surrounding personal protective equipment (PPE) and the impact of Covid on BAME staff, noting that regulators gave clear guidance to employers to undertake risk assessments to ensure their employees were protected – and we continue to monitor it.

The Authority tracked reports of the blanket imposition of Do Not Attempt Resuscitation (DNAR) Orders on people in care homes and with learning disabilities. Regulators responded promptly, putting out guidance to their registrants not to do so, but we were unclear whether any that had been imposed had been lifted. We subsequently wrote to the Department for Health and Social Care. We are pleased to see that recently the Care Quality Commission has followed up and reported on this matter.⁸

In addition, as suggested above, the Authority sought to make sure that our work did not delay or impede regulators' need to take urgent action.

What did the regulators do?

The challenge to regulators in responding to the pandemic in this area of its work was manifold. They had to rapidly gain an understanding of the new risks that arose from the pandemic and the consequences for the provision of care by registrants. Then they had to set out how existing standards applied to the circumstances of the pandemic, recognising that in a crisis it may not be possible to follow normal procedures. They had to decide, sometimes at speed, whether new or specific guidance was required and if they should produce the guidance, direct registrants to guidance, information or advice from another organisation or source, or to collaborate with another organisation to produce the guidance.

There are four case studies relating to this area of work, three of which address the actions taken to provide Covid-specific guidance. These first three encapsulate the different challenges that arose from the pandemic because of different kinds of practice in different settings, and in both the NHS and the private sector. They are from the GDC (**Case Study 12**), the GMC (**Case Study 13**) and the GOsC (**Case Study 14**). The fourth case study in this chapter, from the HCPC, describes in more detail the way the HCPC (**Case Study 15**) responded to the communications and engagement challenges presented by the pandemic.

The regulators quickly produced and continued to review, refine and develop a range of guidance material for registrants across a wide range of subjects, including joint guidance with other organisations – both with each other, and with other stakeholders. The group of Chief Executives (CEORB) issued two over-arching statements during the pandemic providing acknowledgement that the normal rules of engagement would need to change on account of the pandemic. The first of these is

⁷ Professional Standards Authority, 2020. *Guidance for regulators on fitness to practise hearings*. Available at [https://www.professionalstandards.org.uk/docs/default-source/publications/policy-advice/authority-guidance-for-regulators-on-fitness-to-practise-hearings-during-the-covid-19-pandemic-\(september-2020\).pdf?sfvrsn=78d67620_4](https://www.professionalstandards.org.uk/docs/default-source/publications/policy-advice/authority-guidance-for-regulators-on-fitness-to-practise-hearings-during-the-covid-19-pandemic-(september-2020).pdf?sfvrsn=78d67620_4) [Accessed 20 March 2021]

⁸ Care Quality Commission, 2021. *Protect, respect, connect – decisions about living and dying well with COVID 19*. Available at <https://www.cqc.org.uk/publications/themed-work/protect-respect-connect-%E2%80%93-decisions-about-living-dying-well-during-covid-19> [Accessed 20 March 2021]

reproduced below. The CEORB also discussed learning from Covid-19 in real time with various sub-groups sharing their own experiences to help one another respond in quick time. This included frequent meetings of the fitness to practise sub-group during this period.

Many regulators substantially adapted their websites to promote this work, including the creation of Covid hubs, also using these to direct registrants and other stakeholders to other sources of guidance, information and advice as necessary. They used multiple channels and formats including Questions and Answers and case studies.

The specific collection of issues of concern differed by regulator, according to many factors including working environments, scope of practice of registrants, and the presence and activities of other stakeholders, among others. However, the subjects of guidance to registrants included:

- ▶ Remote consulting
- ▶ Exercise of professional judgement
- ▶ PPE
- ▶ Track and trace
- ▶ Infection control
- ▶ Remote prescribing
- ▶ Working in different settings
- ▶ Redeployment
- ▶ Use of technology
- ▶ Advertising
- ▶ Health and wellbeing.

The regulators also produced guidance specific to the impacts on their own functions such as on arrangements for students and trainees, on specific points of the fitness to practise process, and on arrangements for renewal of registration and temporary registration, where applicable.

Joint statement from Chief Executives of statutory regulators of health and care professionals (3 March 2020)

We hold the registers of health and care professionals in the UK. We support those professionals to deliver better, safer care by setting the standards they need to meet, to act in the best interests of patients and people who use health and social care services at all times.

As registered professionals, the first concern of the individuals on our registers will be the care of their patients and people who use health and social care services. We encourage health and care professionals, working in partnership with each other and people using services, to use their professional judgement to assess risk to deliver safe care informed by any relevant guidance and the values and principles set out in their professional standards.

We recognise that in highly challenging circumstances, professionals may need to depart from established procedures in order to care for patients and people using

health and social care services. Our regulatory standards are designed to be flexible and to provide a framework for decision-making in a wide range of situations. They support professionals by highlighting the key principles which should be followed, including the need to work cooperatively with colleagues to keep people safe, to practise in line with the best available evidence, to recognise and work within the limits of their competence, and to have appropriate indemnity arrangements relevant to their practice.

We recognise that the individuals on our registers may feel anxious about how context is taken into account when concerns are raised about their decisions and actions in very challenging circumstances. Where a concern is raised about a registered professional, it will always be considered on the specific facts of the case, taking into account the factors relevant to the environment in which the professional is working. We would also take account of any relevant information about resource, guidelines or protocols in place at the time.

We may issue profession specific guidance to registrants to provide additional support where that is needed.

The statutory health and care regulators that have agreed to this statement are:

General Chiropractic Council
General Dental Council
General Medical Council
General Optical Council
General Osteopathic Council
General Pharmaceutical Council
Health and Care Professions Council
Nursing and Midwifery Council
Pharmaceutical Society of Northern Ireland
Scottish Social Services Council
Social Work England

Discussion

The Authority has written before about the dangers of creating confusion and cognitive overload by overburdening registrants with guidance, especially if it is contradictory or duplicates other sources. Regulators took this risk into account and closely monitored the developing situation to respond quickly to changes, including through feedback, discussion and engagement with stakeholders. Finally, as with other functions they had to create the capacity to achieve this, and to respond to increased volume of enquiries from registrants and other stakeholders.

Respondents to the Authority's call for views generally welcomed the advice provided by regulators and appreciated that they had to be produced at pace. Respondents were in favour of regulators collaborating and taking a multi-disciplinary approach. They also appreciated the expressions of support from regulators throughout the pandemic.

Some felt they could have done more to guide them when they faced difficult ethical challenges. The Authority recognises this concern and the difficulties for regulators in responding and have commissioned research to explore the ethical dilemmas registrants faced during this time to help us consider the regulators' role in such situations in future.

Chapter 4 Quality assurance of education: enabling flexible education and training during the pandemic

The quality assurance of education function

As many students, parents and educators know, the pandemic profoundly disrupted education and training. Lockdowns meant many institutions were closed to students and education shifted to online tuition. For healthcare and social work, it presented real difficulties for continuing the practical elements of their training and workplace placements. Staff who would otherwise have supervised and taught them during their placements were providing front-line care. Workforce shortages meant that regulators had to consider whether to accelerate their learning so that they could support the workforce delivering care sooner. They also had to consider the likely impact on students' future fitness to practise, their readiness for graduation and registration and their confidence when they enter the workforce if there have been gaps in their education and training. Regulators could no longer visit institutions to check on the quality of education and training.

The regulators' role in quality assurance of education is focussed on maintaining up-to-date standards for education and training which prioritise patient and service user care and safety. It is also concerned with ensuring that the educational providers and programmes they oversee are delivering students and trainees who meet the requirements for registration, taking action where assurance activities identify concerns either about training or wider patient safety matters.

Contribution to the Covid-response objectives

The ways in which regulators adapted their quality assurance of education courses can be seen to have contributed to the Covid-responses objectives in a number of ways. These include minimising the spread of infection through reducing contact between those involved in regulatory decision-making and their stakeholders, and through the implementation of online working. They can also be seen to have contributed to the progress of students in their courses despite the challenges faced, and to maximising students' safe contribution to patient care. In doing so, the regulators acted to support the health and social care workforce meet the increased demand placed on it by the pandemic.

What needed to change as a result of the pandemic?

The challenge to regulators in this area of its work included gaining a rapid understanding of the impact of the pandemic on the organisations involved in the provision of education courses, including higher education institutions and organisations delivering health and social care, and others; and then assessing what that meant for how their education and training standards would be achieved.

They had to implement arrangements for approving adaptations to courses to enable students to continue to progress and to contribute safely to patient care and needed to do so in such a way as to minimise the spread of infection, and the demands on the workforce and organisations delivering health and social care services. This meant minimising face to face meetings involved in course monitoring and approval.

Regulators had to closely monitor the developing situation to respond quickly to the changing situation, including through discussion and engagement with stakeholders. Finally, as with other functions, they had to create the capacity to achieve the above, and to respond to increased volume of enquiries from students, registrants, and other stakeholders.

What did the regulators do?

The regulators worked quickly to address the new risks that arose in this area of their work. This involved, as in all other functions, an enhanced level of engagement with stakeholders and collaborative working, and efforts to communicate the adapted arrangements by multiple channels including websites and other means.

The regulators moved to online working as the norm for meetings in which decisions were made about course monitoring and accreditation. In some cases, the number of people involved in decision-making was reduced to enable work to proceed in challenging circumstances. Regulators established processes and supporting documentation to let education providers seek approval for course adaptations by which they would demonstrate continued compliance with the regulators' education and training standards.

Both the GCC and the HCPC moved to making virtual visits, assessing documentation and discussing it with the providers by telephone, in conference with other members of the visit team. The GCC introduced video-conferencing software which it plans to continue using and intends to use a hybrid approach in future, visiting in person only when needed for example with new institutions. The regulator describes its approach to virtual course monitoring visits at **Case Study 16**.

The HCPC concluded virtual hearings were efficient and that amongst other advantages reduced travelling was also beneficial to the environment. They considered that 'nothing was lost' and have decided to continue virtual visits. The HCPC gives further insight into its virtual course monitoring and other flexibilities at **Case Study 17**. The HCPC found that its approach to compliance, not its standards, needed to change. It told providers they could make temporary, one-off changes to adapt their programmes during the pandemic. For example, moving teaching online,

using simulation alongside face-to-face training, adapting assessment methods, flexing the number of practice-based learning hours to be achieved and rearranging academic and placement blocks across the curriculum.

Case Study 18, from the GOC, describes how the regulator overcame the obstacles to practical training for optical students in the private sector. Optical education combines higher or further education and work-based learning and experience, which is most frequently gained in the private sector in high-street optical practices, unlike other regulators whose registrants mainly work in the NHS. With opticians closed, they were faced with a cohort of students unable to progress and to qualify. Doing nothing and waiting out the pandemic was not an option, so they collaborated within their sector to develop a combination of online training and simulation.

In one case, the regulator (NMC) introduced emergency education and training standards which let final year students complete their last six months at work; and second year students carry out the majority of their training in clinical placements to support the workforce. This is the focus of **Case Study 19**.

Measures to support the delivery of health and social care included both reducing and increasing the percentage of time students spent in clinical placement depending on the stage of training reached, to decrease the burden on health and social care organisations and increase contribution to patient care, respectively. Some regulators also deferred planned development work and policy changes to a later date, or extended deadlines for other work, to reduce the burden on higher education institutions and other stakeholders.

SWE authorised the innovative inclusion of an element of simulated practice but concluded that ‘an entire placement without the involvement to real life service user engagement was unlikely to provide the student with the skills and experience of social work that would meet the professional standards required of a social worker’. This is discussed more fully as part of **Case Study 20** from SWE on collaborating with education providers – placement planning with the West Midland Teaching Partnership.

Discussion

The pandemic has offered up some new approaches and shown that online learning, virtual simulation and immersive technologies can play a useful role for teaching – especially when they can again be combined with face to face teaching and placements. It has also shown that that new technologies can reduce the impact of regulators on the education institutions.

Education providers and regulators have clearly taken an innovative and creative approach to ensure that students could progress to the next year of study or complete their programme and seek registration. The impact of this will of course need to be monitored to assess its effect on students’ learning outcomes. Regulators will also need to consider, along with health and social care providers, whether new registrants whose studies were interrupted need additional support.

The Authority thinks the experience of the pandemic suggests it would be worth evaluating whether the balance, structure and length of training is right for all professions. For example, we were struck by the comment of one respondent, that the pandemic suggested all registrants needed to retain core skills to respond in emergency situations. We think this is worth considering, alongside whether there needs to be greater cross-disciplinary and inter-professional learning, and the role of patient involvement.

In suggesting this the Authority notes the calls for mental health staff to improve their skills in physical health assessment; for learning disability staff to have both nursing and social work skills and that some advanced practitioners and other health professionals work across disciplines. The regulatory system developed around single professions and single disciplines, and education followed suit, but modern service delivery requires multi-skilled teams.

The Authority is also mindful of the principles that the Authority proposed for the future development of the quality assurance of education function in our publication *Right-touch reform*.⁹ These principles were that a successful approach:

- ▶ Is underpinned by a legislative framework which is based on the duty to protect the public and is sufficiently flexible to allow a risk-based approach to assuring different professional groups and to meet future challenges
- ▶ Builds on other quality assurance activities and seeks to actively review and, where appropriate, withdraw activity where other agencies can provide sufficient assurance
- ▶ Promotes the benefits of interprofessional education and supports the development of shared values across professional groups to ensure a consistent approach to patient safety
- ▶ Actively involves and seeks perspectives of students, patients and other members of the public in quality assurance processes and the development of training courses
- ▶ Ensures processes, criteria and procedures are consistently applied and, along with outcomes and rationale, are publicly available and clearly explained
- ▶ Actively encourages the sharing and use of data to ensure that education and training programmes are fit for purpose
- ▶ Supports flexibility in training and allows development of new roles where required to address wider workforce challenges.

In the Authority's view these principles remain a useful guide for the future development, improvement and reform of this area of regulation – in particular, in their emphasis on interprofessional learning and education, and patient involvement.

⁹ Professional Standards Authority, 2017. *Right-touch reform; a new framework for assurance of professions*. Available at https://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/right-touch-reform-2017.pdf?sfvrsn=2e517320_7 [Accessed 20 March 2021]

Chapter 5 Strategy, collaboration and governance: sustaining effective regulation through the first wave

Each of the 10 regulators has its own Council¹⁰ and separate legislation. The pandemic did not impact them all in the same way. The registrants of the GMC, NMC, GPhC, PSNI, HCPC and SWE were at the forefront of the pandemic response; doctors, nurses, pharmacists, paramedics and social workers continued to work directly with patients and service users throughout. The regulators had to work fast, to enable an increased workforce and provide guidance and support to their registrants working in unfamiliar circumstances.

Other regulators' registrants also volunteered or were transferred into clinical roles, working to support their colleagues. The GDC, GOC, GOsC and GCC's registrants continued to provide some services to their patients but many in the private sector were heavily impacted by lockdowns. Trying to provide remote care and support to their patients and service users, where even possible, was a challenge. Dentists faced challenges for example in arranging emergency care. Vulnerable children kept at home, away from schools were out of sight of social workers and the oversight of the usual systems of protection and assurance.

Where do boundaries lie in a time of crisis?

In this section the Authority looks at a range of issues that arose for regulators during the pandemic and how it impacted their strategy and governance which shape their regulatory functions. We also consider collaboration. We present instances where regulators have in some way worked outside their normal remits or jurisdictions and begin to discuss the implications of this for future regulatory business. The question in short is: where do boundaries lie in times of crisis?

We also present the regulators' case studies on some general corporate issues: the role of corporate strategy in responding to crisis; public and patient involvement in times of crisis; and the move to paperless working that was catalysed by the pandemic. As we can see from their studies, the larger regulators generally assembled small teams with authority to lead the response. Smaller regulators, like the GCC, commented that being so helped them make fast decisions and be agile. Respondents to our call for information appreciated the regulators' agility and partnership approach. They commented that it had however revealed that many business as usual processes were cumbersome and considered that reform is needed. They suggested the pandemic had revealed disparities in approach between regulators across the UK and that regulation needed to be designed around 'on the ground' service delivery.

¹⁰ Social Work England is an arm's length body with a unitary board, rather than a council.

The measures discussed in this section contribute to all of the overarching objectives:

- ▶ Supporting the health and social care workforce to meet the increased demand placed on it by the pandemic
- ▶ Supporting registrants to continue to practise safely, including through Covid-specific guidance
- ▶ Minimising the spread of infection in carrying out the regulatory functions, protecting the regulators' own workforces and those interacting with them and
- ▶ Enabling students and trainees to continue to progress in their studies safely, maximising their contribution to patient care where possible.

Responding to the prevalence of infection in Black and Minority Ethnic people

The pandemic has had a disproportionate impact on Black and Minority Ethnic people (BAME) people. While it became apparent during the early stages that this was the case, it has only been later that the different contributory factors to this terrible outcome have been more fully analysed.

What then is the position of a regulator in responding to such a complex question of epidemiology, equality and social justice? What is the right approach within its

.... **With their knowledge of the professions they regulate they are in a strong position to contribute to a deeper understanding of the problems and the development of long-term solutions to complex**

statutory responsibilities and the duties to which it is subject – in particular of course the Public Sector Equality Duty? It is important to recognise the limitations given that a regulator does not have direct levers to affect workforce deployment, resourcing of care, use of PPE or treatment. It may be that in general terms, a regulator's role is to remind those of its registrants who are in a position to have an impact about their duties – and, to take the different factors

into account in assessing any fitness to practise allegations afterwards. However, regulators are also able to use their resources and their position within the architecture of care to access and analyse data, support research and collaborate with stakeholders. With their knowledge of the professions they regulate they are in a strong position to contribute to a deeper understanding of the problems and the development of long-term solutions to complex questions of inequality.

The way that one regulator responded, the GMC, is explored in **Case Study 21**.

Corporate strategy

In the initial submission made to this review from the NMC we were struck by its comments that its corporate strategy had had a positive supporting and enabling impact on its response to the pandemic. The Authority was keen to learn more about this relationship and asked the NMC to provide a case study to unpack this in more

detail, which is presented as **Case Study 22**. We include a further study from the GMC, **Case Study 23**, on the experience of the March lockdown falling while a review of its corporate strategy was in progress, and how the GMC applied learning from the pandemic into that ongoing development of a new strategy.

Patient and public involvement

The issue of patient and public involvement in the regulators' pandemic response arose earlier in relation to guidance and standards. It is of course a much wider issue in the development of regulatory policy and approaches that would usually be the subject of public consultation and engagement. At **Case Study 24** the General Osteopathic Council presents its thinking on the experience of the pandemic and how the patient voice can be secured even when regulators are having to respond in crisis.

Collaborative working

Collaborative working has been prevalent throughout the regulators' pandemic response including information and intelligence sharing and joint statements and guidance. This has been within the regulatory sector and with other stakeholders.

For example, on behalf of the group of chief executives (CEORB), a shared record of actions taken by the regulators was produced, and was distributed regularly to its members for discussion at monthly meetings for the whole of the pandemic period. CEORB issued two over-arching statements during the pandemic providing acknowledgement that the normal rules of engagement would need to change on account of the pandemic. The group of Chief Executives also discussed learning from Covid-19 in real time with various sub-groups sharing their own experiences to help one another respond in quick time. This includes frequent meetings of the fitness to practise sub-group during this period.

While recognising this, the Authority would be interested to review how effectively professional regulation collaborated with other regulatory sectors during the pandemic, and whether value would have been added by any different or more formally co-ordinated approaches. A review would focus on learning for future crisis and might include who should be involved in future emergency response planning and how to ensure it is coordinated.

We include three case studies on collaborative working, two from the General Pharmaceutical Council and one from Social Work England. The first of the case studies from the GPhC, **Case Study 25**, describes its work with Hestia to support the development of community pharmacies as 'safe spaces' for victims of domestic abuse, the prevalence of which rose markedly from the outset of the pandemic. The second case study from the GPhC, **Case Study 26**, describes its work with the Competition and Markets Authority on pricing, in response to anti-competitive and unprofessional behaviour by a small number of pharmacies. The case study from SWE, **Case Study 27**, describes its work with the Department for Education, the Department of Health and Social Care and the Local Government Association on the deployment of social workers, Social Work Together.

Paperless working

The move to online working that has been widely adopted in the course of the pandemic has had many benefits, including environmental and cost benefits achieved through the significant decrease in the use of paper and the reduction in travelling. In **Case Study 28** the GCC reflects on what has been achieved and the barriers that have been overcome in different areas of its work.

Chapter 6 The way forward

The pandemic has been a national crisis and a personal tragedy for many. Few lives have been left untouched by it; all have lived under conditions of unprecedented risk and constraint. Within our working lives in the public sector generally, and in the regulatory sector specifically, it is extraordinary how much has been done with willingness, technology, energy and supportive legislation. That the UK health and social care professional regulators reacted quickly, kept the show on the road, and have done so since, is a testament to the commitment to public protection of all involved.

...it is extraordinary how much has been done with willingness, technology, energy and supportive legislation.

With the crisis having continued and worsened in late 2020 and into 2021, we questioned at points whether it was appropriate to continue with this work. On balance, we felt that it was important to persist despite the difficulty of doing so, to capture learning for future crisis while memories of the first emergency period remained fresh. In this section we suggest a way forward to build on what has been learned.

The crisis instigated by the pandemic profoundly disrupted the risk profile and risk factors central to many regulatory decisions, and what might be considered proportionate actions. However, out of the regulators' response actions many helpful, positive and constructive achievements emerged, including:

- ▶ **Improvements in inter-regulatory relationships** – working together as a sector to agree priorities and share information
- ▶ **Improvements in relationships between regulators and other stakeholders** in the delivery and safety of health and social care – achieving joint positions and shared guidance through re-energised relationships
- ▶ **Improvement in mutual understanding between regulators and their stakeholders** as to roles, powers, responsibilities and limitations
- ▶ **Rapid adoption of technology** – developed of course to keep regulation going when people could not travel and to uphold social distancing, but yielding many wider benefits including greater efficiency and potential cost reductions
- ▶ **Rapid development and implementation of other innovations**, often in collaborative arrangements – which we have been told frequently would have taken years to achieve otherwise

- ▶ **The importance of trust** has arisen as an issue on many occasions – the process having demonstrated the importance of trust between people and organisations, pre-existing trust having been a necessary antecedent of what was achieved collaboratively
- ▶ **The importance of corporate strategy** and the role of regulators' councils¹¹ in ensuring that strategy and governance enable an emergency response, supported by business continuity planning, when needed.

However, in parallel a number of potential risk areas emerged which will need further exploration before new the arrangements are embedded as business as usual, once the wider situation stabilises, and risks around decision-making become less volatile. These include:

- ▶ **Diminished involvement of patients, service users and the public** – in the rapid development of guidance and positions, some have reflected that the patient and public voice was not given sufficient influence
- ▶ **As yet incomplete assessment of the impact of innovations** – necessarily, as determined by the speed of necessary changes, but with potential negative impacts such as on the trust of the public in regulation
- ▶ **Blurring of boundaries** – has seemed an ever-present risk in the examples of regulators working with other organisations, with a resultant potential for confusion about where responsibilities lie
- ▶ **Limitations of technology** – some regulatory processes being a poor fit for online working, particularly where the supporting information or documentation is complex, and where too comprehensive adoption risks excluding some people
- ▶ **Losses from not being able to meet in person** – the exact nature of which is not easy to quantify, but which requires further consideration before not-in-person working becomes enshrined as the new normal
- ▶ **The operational impacts in some areas** – such as the build-up of fitness to practise cases which it has not been possible to progress – will need to be addressed.

Recognising the safeguards that regulators put in place, the Authority proposes that the future central challenge to the sector will be to secure the gains that have come through the crisis, while attending to benefits that have been lost, concerns necessarily put to one side, or risks tolerated in their achievement. Below we expand on this with recommendations for the future. In seeking to support these recommendations being taken forward the Authority will look to play a full part. As the current situation evolves, we will work collaboratively with others within our powers and resources, discussing with regulators and other stakeholders the best way to proceed and how to prioritise the recommendations that follow in the light of emerging evidence. There will be much further shared learning to be derived through collaborations and ongoing dialogue with stakeholders. **Until such time as the situation stabilises and more complete and evaluative review can take place, our findings should be considered to be to some extent provisional.**

¹¹ Social Work England is an arm's length body with a unitary board, rather than a council.

New ways of working

Innovations were implemented much more quickly than usual particularly electronic working, online working and tuition, virtual hearings, virtual visits which appear to have benefits worth keeping. Expanding the use of online means to engage with stakeholders also appears to have resulted in a broader reach than was being achieved before.

The speed at which innovations were adopted belies the view that regulation is inherently a barrier to change. These innovations should of course be subject to review and evaluation in due course, to assess their impact, ensure that any risks are properly and sustainably managed and that the interests of stakeholder groups have been properly reflected in their design and operation.

There would be benefit in reviewing the value to the temporary and provisional registration (as applicable) set against the risks and costs. The effects of the pandemic will continue to be felt for some time and many services were already suffering staff shortages. It is not currently part of UK regulators' remit, unlike some regulators in other countries, to have any duty for workforce supply. A review should also include the experiences of temporary registrants, and whether value would have been added to the pandemic response by any other regulators having had powers of temporary registration which did not, and what were the wider impacts including on public confidence.

The Authority supports the continuing transfer to digital, electronic and virtual working in the interests of speed and efficiency, subject to further work to ensure that particular groups of stakeholders (in particular patients, service users and the public, registrants and potential registrants) are not excluded from engagement with regulators as a result. Further implementation should also be subject to assurance that public trust in regulatory decision-making is not compromised.

The Authority supports further evaluation and assessment of the experience of patients, service users and members of the public, registrants, panellists and legal advisers in virtual hearings.

In fitness to practise, it would also be useful to understand in due course what impact the variations in approaches taken by the regulators had on employers and on the progress of individual cases – whether the changes reduced employers' burden or led to serious cases being missed or delayed. Whilst the Authority can see that each regulator took burden into account, we are uncertain whether the different approaches or indeed just changing the requirements, involved more work for them rather than less and whether this had any impact on public protection.

Finally, and again in the area of fitness to practise, the way in which context will be taken into account at each stage of the fitness to practise process will also require careful further consideration and explanation, taking careful account of the views of patients, service users and their families so as to ensure fairness and continued wider public confidence in the fitness to practise process.

Flexibility, oversight and reform

This crisis has reinforced the urgent need for regulatory reform

It was often expressed to us that the flexibility and agility that responding to the pandemic required starkly demonstrated the need for regulatory and legislative reform to allow regulators to be flexible, through for example the ability to change their own rules quickly, not least so that they would be empowered to react more quickly in future situations demanding a rapid response.

The crisis has reinforced the urgent need for regulatory reform to make regulation more agile and enhance its ability to put patient protection at its centre. The Authority will continue to work to explore, discuss and explain its view on how that should best be achieved. While the Authority is strongly committed to regulatory reform, it is concerned to ensure that greater flexibilities are balanced with appropriate oversight, including to minimise the risks that might arise from unjustifiable disparity of regulatory approaches, processes or practices; that the quality of decision-making is upheld; and that EDI impacts are fully considered.

The Authority heard concerns that an unduly prolonged process of reform (that is, a staggered process with regulators being reformed over a long period of time) would create the risk of an inconsistent response to further crisis should it occur before the reforms were complete. The Authority will be concerned to ensure that design of a future reform programme will mitigate this risk.

Consistency

The issue of consistency between regulators is perennial, complex and very difficult to quantify. For example, the Authority has previously worked with researchers to understand the factors that contribute to consistency (or otherwise) of fitness to practise outcomes, which demonstrated the immense complexity brought about by a multitude of factors. Issues of consistency are not of course limited to fitness to practise and could include many (at least seemingly) similar decisions being made by regulators across the full scope of the functions.

Consistency arose as a theme during the review and was generally welcomed when it was recognised in the regulators' joint and individual response actions. To inform future reform work the Authority is keen to continue to explore the issue of consistency, including to understand the public's view of where it is most important. The Authority has commissioned research to explore this. The research is due to be published in Spring 2021.

Collectivity and clarity

A theme throughout the project has been the balance between working with other organisations to achieve shared objectives, and on the other hand 'staying in lane'. On the one hand crisis situations compel working quickly and flexibly. On the other, involvement in work outside the core remit risks causing confusion, the blurring of responsibilities, conflicts of interest and resource difficulties. It is clear that the

imperative to respond in a collaborative way across so many fronts has re-energised relationships. We have seen examples of regulators stepping outside their usual boundaries in creative and innovative ways. We have also seen situations where regulators have arguably gone beyond their statutory remit to contribute to addressing risks which they would not usually be concerned with, but which in the pandemic they were well placed to.

The Authority proposes that there will be value in due course of a thorough review of the effects of the pandemic on collaborative working – what was achieved, what risks were taken, how these risks were managed, and how did any unintended consequences arise.

We would want to include how roles and responsibilities remain clear in collaborative working, including looking at the risks where they do not. Specifically, we would want to review how effectively professional regulation collaborated with other regulatory sectors during the pandemic, and whether value would have been added by any different or more formally co-ordinated approaches, with a focus on learning for future crisis.

Trust and caution

The importance of trust has been repeatedly emphasised; trust between organisations has been a vital component of successful collaborations. Trust needs to be better understood including to predict those situations where it may be inadvertently lost. As previously commented, we think it essential that the effect of pandemic innovations on trust between the public and regulator is explored.

Clarity of the role of the regulator

On occasion we heard that confusion about the role of the regulator impeded progress from being made as quickly or effectively as it might have been otherwise. This arose in two areas in particular – collaborations with other organisations, and in standards and guidance. In the former, confusion as to the role and powers of regulators may have led to joint initiatives getting off to a slower start. In the latter, regulators were faced with pressure from a number of fronts to provide clarity, assurance and guidance in areas over which they had limited or no jurisdiction.

In crisis, when speed is of the essence, a clear shared understanding of what other stakeholders can and cannot do is crucial to a rapid response. We recommend that in due course, there are refreshed efforts in the sector to consider how to best to communicate the role, responsibilities and powers of regulators.

Standards

The Authority proposes that an action for the future will be to work with stakeholders, to review the combination of guidance, data, advice, management direction and the multitude of other influences on professional practice and conduct that they encountered. This would include:

- ▶ What was most helpful with decision-making, where was there duplication, where was there inconsistency, and where were there gaps?
- ▶ How did regulators and their stakeholders address any perceived gaps in guidance and its interpretation?
- ▶ Which approaches were most effective in guiding registrants to manage risks as they arose and to what extent did they turn to their regulator for guidance?
- ▶ What are the limits of regulation to guide registrants through complex decisions and issues where roles and responsibilities are unclear?
- ▶ How should regulators and other sources of advice and guidance most effectively complement each other's roles and powers, particularly in difficult and disputed areas?
- ▶ Would a single multi-professional code of conduct have added value?

The Authority will also be interested to explore the question of the design of regulators' standards function, to identify whether there might be approaches to the development and promotion of standards that would better support both fast-moving, high-risk situations and that would better fulfil the long-held ambitions of the sector to be more influential in preventing harm. This to include reviewing the potential of a single, multi-professional code of conduct.

More specifically, a review of ethical dilemmas encountered by health and social care professionals during the pandemic has been commissioned by the Authority and is being conducted by Professor Deborah Bowman, St George's University of London, and will be published in Spring 2021. The report will support onward discussions of how regulators can best support registrants in navigating difficult ethical terrain at times of crisis. More generally, work will need to be done to assess the impact of Covid on practice and how this should be taken into account in the regulators' processes and decisions.

Education

The pandemic has caused profound disruption throughout courses of education at every level, and in every discipline both inside health and social care and without. It is particularly difficult to attempt to anticipate the full consequences for regulation in a situation that remains so uncertain for the future completion of studies and the delivery of health and social care. These will undoubtedly need to be discussed and analysed for the foreseeable future, and the impacts on students' education and by extension their preparedness for practice will need to be assessed. The Authority will monitor developments in this area closely.

The Authority thinks it would be worth evaluating whether the balance, structure and length of training is right for all professions, in the light of the pandemic. For example, we were struck by the comment of one respondent, that the pandemic suggested all registrants needed to retain core skills to respond in emergency situations. We think this is worth considering, alongside whether there needs to be greater cross-disciplinary and inter-professional learning. In suggesting this we note the calls for mental health staff to improve their skills in physical health assessment; for learning disability staff to have both nursing and social work skills and that some advanced practitioners and other health professionals work across disciplines. The

regulatory system developed around single professions and single disciplines, and education followed suit, but modern service delivery requires multi-skilled teams.

Regulation and the wellbeing of registrants

For some time regulatory policy has separated professional regulation from professional representation. With this boundary in place, matters affecting the welfare of staff are the responsibility of employers or their professional bodies, who represent their interests. The regulator's role is not to represent their registrants, who are not members; their relationship with registrants is different.

Registrant wellbeing and its contribution to the quality and safety of care has been thrown into stark relief.

The pandemic challenged that boundary. Registrant wellbeing and its contribution to the quality and safety of care has been thrown into a stark relief. At the time of writing serious warning notes are being sounded about well-being of health and social care professionals as the pandemic continues into 2021. There are

increasing and disturbing reports about the impact of the pandemic on the wellbeing of the health and social care workforce after such a period of sustained intense working, the emotional demands of caring for the sick, dying and vulnerable, and those close to them, and the potential for burnout and trauma.

If registrants are expected to place their lives at risk in a time of national emergency there needs to be an infrastructure around them to shield them and allow them to decompress. Regulators will have a role in working with employers and others to enable this. Comparisons need to be made with other emergency services including armed forces. Registrants suffered avoidable stress and harm because protections had to catch up.

In summary the Authority believes that it would be timely to review the role of regulators in providing support for registrants and how this fits with that of professional representation bodies, in light of the events of the past year. A review would examine the contribution of registrant health and wellbeing to patient safety, and consequently recommend how the activities of regulators and those charged with representing the interests of the workforce (in particular professional bodies) might optimally work together for the benefit of the public, while retaining their distinct roles and responsibilities.

Public and patient engagement

A number of stakeholders and regulators raised with the Authority the issue of public and patient involvement being to some extent lost in the rapid development of guidance and policies in response to the pandemic. We support the work being taken forward by regulators to continue to improve their engagement with the public, such as that described by the GOsC at Case Study 24. We will support continuing work to ensure that the public and patient voice is present in regulatory decision-making, even when expedience demands rapid action.

Equality and diversity

The pandemic has had an unequal impact both on the public at large and on the health and social care workforce. The Authority will support future work to better understand the reasons for this inequality and its longer-term consequences, and to enhance the role of regulation in addressing these.

The regulatory workforce

As in many other sectors the regulatory workforce has rapidly adapted, responding quickly to changing and working with dedication and flexibility. In assessing the longer-term adoption of innovations achieved during the pandemic sustainability will be a key concern. It is clear that the regulatory workforce has demonstrated great resilience over a sustained period, with many staff making extraordinary and prolonged efforts to make things work. Once the extraordinary circumstances of the pandemic are in the past, regulators will need a period of recovery, review and consolidation. The Authority will look to support the regulators in the process of putting things back onto a more stable footing.

Concluding remarks

A regulator's primary aim is to ensure that its registrants are competent to protect the public and that the public can have trust in them. In doing so, it obviously has to take account of the conditions facing registrants and the context in which they work. A regulator should not interfere in the work of employers and organisations who have the primary responsibility for providing care and supporting clinical decisions and should not step into the territory of representative bodies, particularly where those bodies are powerful and well able to represent their members' views.

....the public and the patient voice needs to run through everything regulators do.

However, regulators need to look closely at the changing context of the environment in which their registrants work and satisfy themselves that their existing rules and processes are appropriate and fair given the changing conditions and that their guidance is still apt to achieve public protection. Regulators are also likely to need to work collaboratively with others in the system to ensure that their processes achieve the best possible public protection in the circumstances and that providers of care, the regulators of systems, and other regulators are alert to the risks they identify. In short, the public and patient voice needs to run through everything regulators do.

States of emergency are sometimes held to be states of emergence. It is indisputable that during the initial phase of the pandemic the regulators overseen by the Authority realised great achievements in adapting their work, to continue to deliver their core statutory functions in order to protect the public. The Authority recognises the commitment to public protection manifest in this response, and will look forward to working with the sector and its stakeholders to ensure that the innovations that have been achieved can proceed to undergo the fuller assessment

and evaluation necessary for longer-term implementation. The Authority again thanks those who have worked with us in this early collaborative step of creating this report, for which we are immensely grateful.

SECTION TWO

In this section we present 28 short illustrative cases studies describing the approaches taken by the 10 regulators overseen by the Authority, during the first phase of the Covid-19 pandemic in the UK. The case studies were either (i) written by the regulators themselves, or (ii) in some cases were produced jointly, with the Authority writing a first draft based on a discussion with the regulator and the regulator then editing or redrafting as necessary. The case studies are grouped according to the chapter of the report to which they relate. We drew on these case studies and feedback when writing our narrative in Section One.

Following each set of case studies, we provide a summary of the feedback we received from stakeholders who responded to our call for views relating to this area. As we noted earlier in the report, the responses received, due no doubt to the timeframe allowed and the challenges of the ongoing situation, may not represent the views of the full range of stakeholders of the sector. Nevertheless, the views articulated are insightful and valuable, and offer many pointers for further discussion, thinking and exploration. All comments made to us, whether directly referenced in the report or not, have been considered in making the Authority's recommendation as set out in Section One.¹²

Registration and continuing fitness to practise

Case studies 1-7 and responses to our call for views



Case study 1

GMC: TEMPORARY EMERGENCY REGISTRATION IMPLEMENTATION

The Secretary of State wrote on 25 March to inform us that our emergency powers had been triggered under section 18A of the Medical Act 1983. This made the decision for us to implement our existing plan to increase the number of registered medical practitioners available to the UK health services by up to 10%.

Our approach was based on the need to increase the number of available doctors, as quickly as possible, so the health service could start to draw on them to support the pandemic response. In doing so, we sought to minimise any risks to patients. We focussed on those who had most recently stopped practising and for whom returning to practise would be easier and we only considered doctors we understood to be in the UK so that they would be available to the health service. We were mindful of the risks to the doctors we registered. We considered the equality and fairness impacts of our approach and the administrative impacts on them of being temporarily emergency registered.

Our approach

Two primary options were considered. An individual opt-in model where non-registrants apply to be temporarily registered or an opt-out bulk approach. We adopted the bulk opt-out model because our legislative framework enabled this

¹² Further information: Section One, *A note on responses to our call for views from stakeholders*.

approach. We had also considered these options previously as part of pandemic planning in relation to swine flu and identified clear benefits of delivering significant volumes of potential doctors in rapid time.

All temporary registrants have the choice to opt-out through a very simply process. If not opting out – they still decide whether and how they want to contribute to the pandemic response (including through non-front-line roles such as NHS 111). This ensures each temporary registrant is able to make the best decision to reflect their characteristics and circumstances and practice within their competency.

Our approach reduced the burden placed on registrants - doctors were granted registration or a licence to practise under temporary emergency registration arrangements without an application or fee for registration. They are not required to revalidate. At the end of the emergency period their temporary emergency registration will automatically be withdrawn, and doctors will not have to take any action.

For both the GMC and partners in the health service bulk-processing provided efficiencies of scale. We provided lists and contact details of temporary emergency registrants relevant to each health service across the 4 UK countries as a resource for them to draw upon to help manage the crisis. We shared this data through our secure online information sharing portal.

This approach also gave us the option to add additional cohorts of doctors to temporary emergency registration as the size and scale of the pandemic and the impact on the NHS became clearer.

- Cohort 1 - On 26 March, 11,894 doctors were granted temporary emergency registration. These were doctors who left the register or relinquished their licence to practise in the last three years and were in good standing at that time.
- Cohort 2 - On 29 March, 3,023 doctors were granted temporary registration. This group were doctors excluded from the first cohort so that we could review their registration history in more detail and update the information we held for them before granting temporary emergency registration. This group included: Doctors who had voluntarily erased their registration in the run up to their revalidation date; Doctors who were erased for not paying their fees; Doctors who did not have an email address on their record – but subsequently contacted us to confirm this; Doctors who had a non-UK address on their record but had since contacted us to confirm that they are based in the UK.
- Cohort 3 - On 31 March, 12,190 doctors not in cohorts 1 or 2 who were *registered without a licence to practise* - had their licence to practise restored under temporary emergency registration.
- Cohort 4 - On 2 April we granted temporary emergency registration to 8,333 doctors with a registered UK address and email address who left the register up to six years ago.

To protect patients, a range of exclusions were applied. Doctors were not granted temporary emergency registration if they had an open fitness to practise investigation or sanction at the time they left the register or relinquished their licence to practice; if they had failed our revalidation assessment; had their licence removed

due to fraud; had a health, vulnerability or *stop comms* flag in our systems; a non-UK registered address; or did not have an email address on their GMC account.

How decisions were made

Following the advice from the Secretary of State our Director of Registration and Revalidation was nominated as the single GMC-lead to deliver temporary emergency registration. She was supported by a daily meeting of key leads across the GMC and was accountable for the process in close consultation with the Chief Executive. Council and the broader Senior Management Team were updated.

We consulted the 4 UK CMOs to agree which groups of doctors should be registered.

We completed an equality impact assessment on our approach to using our emergency powers to support in the response to the COVID-19 coronavirus pandemic. Consideration of the ED&I dimensions informed our decision making.

Summary

While our approach rapidly identified a high number of doctors with potential to support the pandemic response, we are aware that there were challenges in deployment of temporary emergency registrants within the service and there are learnings for the broader service if the full value of the temporary emergency registration is to be realised.

We are also mindful that the pandemic response and recovery will take a protracted toll on the health service and that additional capacity and support will be needed to enable longer-term workforce sustainability. In October 2020 we had found that around 1/3 of temporarily emergency registered doctors had opted out of registration. In this context we sought to better understand how temporary emergency registrants had been deployed and whether they would consider returning to routine registration through a survey. Of c.8000 respondents:

- Around 3000 indicated a willingness to return to practice to support the pandemic but had not secured any offer or employment
- Around 1800 expressed an interest in remaining in practice after the pandemic and transition to routine full registration.

Following the vaccination announcements in November 2020, we started to see a growing cohort of doctors asking to have temporary emergency registration reinstated so they can support the vaccination rollout programme. A further cohort of doctors who left the register since April 2020 have also requested temporary emergency registration so they can return to practise to support the pandemic response.

Ensuring that we retain as many current doctors as possible and transition those that want to return to the workforce needs to be a key priority across the health service. This is reflected in our other case studies on ED&I and our Corporate Strategy development.



Case study 2

NMC: DEVELOPING AND IMPLEMENTING THE NMC'S TEMPORARY REGISTER

Introduction

1. Before the Covid-19 pandemic, the NMC didn't have the necessary emergency powers to enable us to establish temporary registration. The Coronavirus Act 2020 that gave the NMC our emergency powers was laid on 25 March 2020. The day after the Secretary of State for Health and Social Care declared under that Act that there was an emergency situation and that we could begin to temporarily register professionals to support the unprecedented emergency.
2. While the emergency legislation was being drafted we prepared for the opening of the temporary register. We identified some 100,000 registrants who'd voluntarily left the permanent register within the five years to the end of February 2020. We wrote to these former nurses and midwives on 20 March telling them that we would be opening the temporary register once the legislation was in place and when the Secretary of State tells us that we are in an emergency situation, inviting them to tell us if they would be willing to join. Within one hour over 1,200 had responded and by the Monday morning almost 6,700 professionals responded to this call to arms.
3. We knew that we had a number of overseas-trained applicants in the UK ready to take the second part of the test of competence to complete their registration with us. The test sites closed at the end of March under the first national lockdown and these valuable professionals were unable to progress their applications. In April therefore we worked with the test centres and employers to identify and invite overseas-trained applicants who met our criteria to join the temporary register.
4. Over 15,000 professionals joined our temporary register including 2,600 overseas applicants. Our test centres reopened in July and by the end of November almost 95% of the overseas applicants on the temporary register had gained permanent registration.
5. Allowing professionals to join the temporary register has given us a complete and accurate reflection of those who were ready to join the workforce. Had we simply added all those we'd identified as eligible to the temporary register the information shared with those responsible for deploying the workforce would not have been useable.

Assurance over temporary registrants' fitness to practise

6. The emergency legislation allows the Registrar to identify groups of people as being fit to support the emergency. We set criteria for both the former nurses and midwives who were invited to join the temporary register and the overseas-trained applicants.

7. Nurses and midwives who'd been away from the permanent register for more than three years had conditions of practice attached to their temporary registration. This was to recognise they may need additional supervision given the time they'd been away. Similarly, overseas-trained applicants who joined the temporary register had conditions of practice applied to recognise that they'd not completed the permanent registration process.

8. The emergency legislation allows the Registrar to remove temporary registrants where there are any concerns or to apply conditions of practice. We assessed referrals through our Registrar review process rather than through fitness to practice. From April to the end of November 2020 we removed four temporary registrants and applied conditions of practice to a further two. Six referrals resulted in the nurses being able to continue their temporary registration.

Decision making and governance

9. At the start of the emergency we quickly established a two-tier decision-making structure to identify, manage and respond to the rapidly changing landscape. Both met daily to escalate issues and to implement key decisions that were ratified by our Executive Board and where necessary, Council.

10. This structure enabled the NMC to be agile in its risk management and decision making while maintaining appropriate oversight and governance. An early example of the effectiveness of the governance was the decision not to include students on the temporary register.

11. There was a wide-spread assumption and from some quarters, a drive, for us to register students. The senior decision-making team consulted quickly with senior stakeholders, identified and assessed alternatives. They considered the risks and benefits of the options, weighing these against the benefits to the workforce and the operational effort required to implement. It was quickly decided that temporary registration was not an effective way to support the pandemic and that developing emergency standards was the most appropriate option.

12. The emergency standards allowed educators and healthcare providers to adopt innovative ways to provide practice placements during the emergency. We understand that in the region of 25,000 were able to support the workforce.

Benefits

13. Establishing the temporary register has been a truly collaborative endeavour, both within the NMC and with external stakeholders. This provides a strong basis for future developments.

14. We have developed processes and systems at pace in a controlled way. Using best practice we have put in place mechanisms that allow us to respond to the changing situation with confidence and with speed. As an example, in response to the rapidly established vaccination programme we were able to update our eligibility criteria and begin to receive applications in four weeks.

Summary

15. The NMC, like the rest of the world, faced an unprecedented challenge during the most difficult of times. All our teams have been personally affected by Covid-19, whether it be moving to a fully working from home basis to their own mental or physical ill-health and loss.

16. However we pulled together to deliver our support to the workforce who are making the real sacrifices and we've been proud to do so.



Case study 3

PSNI: TEMPORARY REGISTER IMPLEMENTATION

Under the Coronavirus Act, the Registrar was given powers to temporarily register certain individuals or groups in the circumstances of an emergency, under certain conditions. The Act received royal assent on 25 March 2020.

The creation of such a register generated a requirement to balance the needs of service provision, with the protection of the public. To help mitigate this Council was asked to agree a framework within which the Registrar would exercise the powers including any removal powers. Options were explored and developed in extensive engagement between the Department of Health NI and the Council, CEO and SMT of the Pharmaceutical Society NI.

It was considered that there could not be any significant administrative, cost or regulatory barriers to joining the temporary register, otherwise its core objective of providing support to tackle the healthcare emergency, would not be met. It was further considered that to meet these requirements mitigations would have to be put in place to manage risk to public safety.

The following proposal for Phase 1 of a temporary register was subsequently developed to meet the potential demands of the public health emergency:

- Those individuals that left the professional register in good standing in the last three years would be written to at their registered address at the time of leaving, and also emailed if their email was available, informing them that they will be automatically placed on the temporary register, unless they inform us that they would like to opt out. Our data suggested that this would amount to around 340 people. This would be subject to obligations upon the regulator to provide information to employers.
- To avoid unhelpful barriers, no fee would be charged for joining the temporary register, and individuals on the register would not have to provide evidence that they had carried out CPD.

The following obligations were imposed by Council to mitigate against potential regulatory/public safety risks associated with such an approach:

- Any annotations that individuals previously held when on the professional register would not be transferred on the temporary register.
- All individuals placed on the temporary register were written to outlining the professional obligations, standards and fitness to practise procedures they would be subject to whilst on the temporary register.
- All employers would be written to requesting that, as well as carrying out their usual checks, upon engaging any individual from the temporary register, they should also check the following: the individual's Covid-19 Temporary Registration number; a form of identification and proof of address; the area of pharmacy in which they practised; their assessment of their level of competency; and any information relating to any health or conduct issues that might affect their fitness to practise;
- A dedicated temporary register link would be created on our website to allow employers to easily identify individuals, and that this register would further remind employers of the additional checks they should be carrying out.

The Council of the Pharmaceutical Society NI had previously developed new pandemic protocols to approve decisions relating to the pandemic remotely, outside of formal meetings. This option was utilised for approving the requirements for the temporary register, with an E-paper being presented to Council outlining the proposal and options available to them. Council approved the initiation of the temporary register in March 2020.

Phase 1 of the Temporary Register became operational on 04 April 2020, resulting in some 260 individuals being placed on the temporary register. Phase 2 of the temporary register limited eligibility for those applying to be added to the temporary register, to being registered on or, in the last three years having voluntarily left, in good standing, the GPhC, the Pharmaceutical Society of Ireland or another EEA pharmacy register and by completing a detailed application process . Phase 2 was initiated in May 2020.

As outlined above the purpose of the temporary register was to assist in unprecedented pressures on the health service experienced during the different waves of the pandemic. Our analysis shows that individuals have been engaged from the temporary register during the ongoing emergency and that the majority of those on the temporary register who have not been engaged are still prepared to work, if necessary. This should be considered in the context of recent correspondence from the Chief Pharmaceutical Officer for Northern Ireland, which requests further assistance to meeting increasing demand during the third wave of this pandemic



Case study 4

GPhC: ESTABLISHMENT OF PROVISIONAL REGISTRATION

Pharmacy graduates work for one year as a pre-registration trainee and then must pass a registration assessment before being able to register with the GPhC. The registration assessment was previously held twice a year at a number of regional centres across Great Britain.

It became clear in late February and early March 2020 that the impending lockdown would put the assessment sittings at risk, that the pre-registration trainees were under significant pressure which would affect their ability to prepare for the assessment and that more pharmacists would be needed to help respond to the pandemic and deliver care for patients.

We confirmed on 26 March that the assessment would be postponed and that we would consider a form of provisional registration for the interim period.

A policy for provisional registration was drafted and discussed with over 50 stakeholders on 21 April, then further developed in the light of their feedback. Council was kept informed throughout and approved the policy at its meeting on 21 May 2020.

The approach was based on the following principles:

- To maintain standards for entry to the register to protect patient safety and the quality of care given to patients and the public both now and over the long term
- To support the NHS and community pharmacy by strengthening the workforce at this critical time
- To minimise blockages or gaps in the pipeline for qualified new registrants to join the profession in 2020 and in coming years too
- To safeguard the welfare of students and trainees whilst also ensuring that their hard work, and that of their tutors, over many years is given suitable recognition at this key stage in their professional lives
- To enhance the transition from trainee to pharmacist by strengthening the framework of support in their initial period of work

The policy includes clear eligibility criteria, including having been awarded a GPhC-accredited MPharm degree or Overseas Pharmacists' Assessment Programme, having entered pre-registration training no earlier than July 2019 and having successfully completed 52 weeks of pre-registration training. There are also self-declarations and declarations from tutors required. All provisionally registered pharmacists must practise under the guidance and direction of a senior pharmacist and the employers must conduct a risk assessment.

We published guidance for the trainees, for those employing them and for the tutors completing their declarations and kept these under review. We have conducted surveys with the provisional registrants, partly to ensure that they have the appropriate risk assessments in place and are receiving clinical support. In the very small minority of cases where provisional registrants have reported problems, we have contacted the employer concerned to discuss these. We have also commissioned research with this unique cohort, those who are supervising them and those who chose not to provisionally register to understand their experiences and look at the impact of provisional registration.

As of 15 January 2021, 2,599 pharmacists were provisionally registered to support the provision of pharmacy services during the pandemic.

The main risk factors considered in the development of provisional registration were patient and public safety, the risks to pharmacy services if these qualified professionals could not join the workforce and the risks to the trainees themselves caused by having their careers interrupted and by uncertainty about their registration assessment. We sought a position which balanced the risks of registering individuals who had not completed the assessment which completes their initial education and training with the risks of leaving hospitals and community pharmacies short of up to 3,000 pharmacists when services are under significant pressure.

The establishment and administration of provisional registration has been achieved within existing resources. As it became clearer that it will not be possible to re-schedule the registration assessments in their previous format in the near future, we have undertaken additional work to move to an online assessment. This necessitated bringing forward work which we had planned to do over the next couple of years.

We have kept the policy under review as the healthcare environment has changed during the pandemic. The Council recently took the decision that provisionally-registered pharmacists cannot operate as Responsible Pharmacists with responsibility for COVID-19 vaccination services as this would involve considerable legal, regulatory and professional responsibilities and could put unacceptable pressure on provisional registrants. (They can, however, operate as RPs where COVID-19 vaccination services are not offered and can also work within a vaccination service as vaccinators or in other appropriate roles).

Our ability to establish this novel form of provisional registration in response to the pandemic is testament to the advantages of having a flexible outcomes-focused set of powers relating to registration. We did not need to use the emergency registration powers which we used to register former registrants on the temporary register – that was a quite separate exercise.



Case study 5

HCPC: REGISTRATION MAINTAINING 'BUSINESS AS USUAL'

One of the key challenges for the HCPC was the need to create the temporary Register at speed whilst also maintaining business as usual. The maintenance of business as usual required a number of adaptations to the ordinary course of doing things as the system was largely paper based which needed to be converted to a digital system at speed. Consequently, one of the key questions the HCPC asked itself is – what can we do to streamline our existing processes?

The HCPC considered that their existing legislation gave them scope to adapt to a digital system. For example, there was no bar on accepting digital signatures on new applications to join the Register. The HCPC therefore adapted the existing process to accept digital signatures and a safeguard was built in by way of a declaration, which provided that the regulator reserved the right to conduct further checks in the future.

The requirement to provide paper based certified documents was also replaced with a process to allow applicants to digitally sign a declaration and email it in. Again, a declaration was used to allow the HCPC the option to conduct further checks if necessary. In the case of applications to join the register for the first time following the successful completion of a HCPC approved education programme, the HCPC verified the information provided against the education provider pass list.

Having been a predominantly paper-based system, with the exception of registration renewals, this posed logistical challenges. The HCPC developed a separate process for handling applications received by post, deploying a small team to attend the office to open and scan documents. Once the documents were digitised, this allowed the rest of the team working remotely to process the applications. The benefits of this approach were flexibility and continuity of service. Process guides were amended in tandem to ensure that the new processes were adequately communicated and embedded.

Whilst transitioning to a digital system, the HCPC further ensured continuity of service by retaining the option to submit renewals by post, thus not closing off this avenue for registrants who may not be able to submit online.

A further area of uncertainty was the fact that many registrants were in the middle of their renewal period at the peak time of the first wave yet were also delivering essential front-line services. To ensure that such services could be continued, the HCPC decided to extend the renewal periods to create additional flexibility to allow registrants to continue in their vital roles. This was communicated on the COVID-19 hub section of the HCPC website, along with proactive communications to individual Registrants.

Registration appeals were temporarily suspended in March, however by the end of summer appeals were taking place virtually. The HCPC also deployed a new virtual telephone service in 2020 which enabled queries to be dealt with remotely by phone.

The HCPC report that one of the key benefits to the changes introduced has been improved flexibility and customer service, with prospective registrants being able to send applications for admission and readmission directly by email and decisions being communicated quickly by email. Overall, the HCPC note that the experience has emphasised the need to move more to digital systems, which has been largely achieved at pace.



Case study 6

SOCIAL WORK ENGLAND: FEE INSTALMENT DELAY

The final fee instalment for approximately 70,000 registered social workers who choose to pay their registration fee by Direct Debit was due to be collected on 1 April 2020.

The Registration year for registered social workers in England runs from 1 December to 30 November.

The annual registration fee is £90.00, and we have continued the provision that the Health and Care Professions Council allowed for the fee to be split and paid on 1 October (to cover the period 1 December-31 May) and 1 April (to cover the period 1 June-30 November). The Direct Debit is collected two months earlier to give time to those people whose payments fail for them to pay in another way without having an immediate impact on their registration status and ability to practise.

In early March 2020, the entire country started to respond to the significant impact being caused by the coronavirus emergency, and we were also considering our response to powers that might be granted under the Coronavirus Bill. This gave us an indication that we needed to consider whether to delay taking the final fee instalment for the registration year.

In recognition that the country was responding to changing information and guidance, and that registered social workers as designated key workers were among the group likely to be disrupted, we questioned whether it was the most appropriate time for us to take the final fee instalment.

Although this was the final fee instalment for the registration period, it would have been the first time we had taken payments (apart from application payments) since becoming the specialist regulator for social workers in England on 2 December 2019, and we were still in the process of getting registered social workers familiar with the guidance and procedures on our website.

We started to receive enquiries about whether the payment could be delayed in order to allow registered social workers time to respond to the immediate needs of the pandemic.

We considered if we went ahead with taking the fee on 1 April 2020 whether there would be a higher risk of Direct Debits failing, whether registered social workers who were responding to the changing guidance and demands relating to coronavirus would miss important communications about payments.

We considered if we delayed taking the payment until the 4 May 2020, whether this would create risk because people would only have one month to pay their fees in the event of Direct Debits failing, and that some people might be confused because they were used to and expecting a payment to be taken on 1 April.

There were no substantial costs to us postponing taking the fee, due to the nature of financial arrangements and funding at the time. The benefits we identified were that it would give us more time to communicate our processes and procedures to registered social workers, it would demonstrate that we understood that it was a difficult time for people and that we as the regulator wanted registered professionals to spend time absorbing guidance and responding to changes that would protect the public rather than being distracted by a payment needing to be made.

The decision was made by the Chief Executive, and Executive Director of Registration, Quality Assurance and Legal.

We used the extra month to send out weekly communications to registered social workers, to ensure that they understood that we had taken the decision to delay the payment, and so that they could be prepared and ready for the payment to be taken on 4 May 2020.



Case study 7

PSNI: DECISION TO DELAY CPD SUBMISSION DATE

Pharmacy services in Northern Ireland would be a key part of the pandemic response, and in discussion with the Department of Health, it was recognised that the regulatory burden placed upon pharmacists during this period should be proportionate to the circumstances, whilst maintaining regulatory objectives.

A risk assessment around the benefits of requiring submission of evidence in a proscribed form of CPD, against what proportionate steps might be taken to appropriately ease the regulatory burden on pharmacists, whilst, maintaining patient safety and meeting our regulatory objectives, was undertaken. It was considered that whilst it was important that pharmacists maintain their skills and knowledge, the administrative burden of writing-up and submitting their CPD portfolio may place a disproportionate burden upon pharmacists, during a period of extreme pressure and potential staff shortages. Analysis also suggested that postponing the submission of CPD portfolios was unlikely to create immediate public safety risks, diminution of standards or impact upon public confidence in the profession, particularly as the assessment process is designed around remediation over a period of time.

In early March 2020, Council was therefore asked to consider approving a temporary adjustment to the CPD Framework for 2019/2020, which would postpone the 2019/20 CPD submission date of 1st June 2020. Such a postponement, it was judged would have two immediate benefits. Firstly, it would reduce the administrative burden on pharmacists where there were recognised shortages and increased workload and secondly it would remove the immediate requirement to divert a separate cohort of healthcare professionals to carry out the assessment of CPD portfolios, against our standards. The CPO for NI endorsed this approach, noting it would assist with planning for the pandemic.

In proposing this postponement, the purpose of the CPD Framework was carefully considered, in that it is designed to ensure that pharmacists keep their practice up to date and relevant to their area of practice, which subsequently helps maintain patient safety and wider regulatory objectives – communications emphasised the need to maintain knowledge and skills waiving only the need to report and submit evidence. It was decided that there would be no reduction in the amount of CPD evidence required in 2019/20, nor would there be any increase in recognition of the longer CPD period.

This proposal required Council to consider several consequential outcomes. As the pathway of the pandemic was extremely unclear at this stage, setting a definitive new submission date was not considered appropriate. Rather Council was asked to agree to provide 2-months' notice to pharmacists of a new submission date later in

2020. It was also considered necessary to reset the requirements for CPD year 2020/2021, which would be a shorter year, and to delay some changes in that year, which had been consulted upon and approved previously.

Council had developed new pandemic protocols to approve decisions relating to the pandemic remotely, outside of formal meetings. This option was utilised for approving the requirements for the postponement of CPD submissions, with an E-paper being presented to Council outlining the proposal and options available to them.

Pharmacists and interested stakeholders were informed of the decision on 19 March 2020. Pharmacists were also informed that 2-months' notice would be given of a new submission date, with a preliminary new submission date of 31st August 2020 being stated.

On 9 July 2020, it was announced that the June Council meeting had affirmed its decision to end the 2019/2020 registration and CPD year on the 31 August 2020, with portfolio submissions due on that date. In coming to its decision, Council was cognisant of the current level of pandemic response and the three key objectives for healthcare regulators: ensuring patient safety; setting and upholding standards; and maintaining public confidence in the profession.

On 14 September 2020, it was announced that a submission rate of 98.4% had been achieved by the end of August 2020, consistent with previous years, including some of the largest and most comprehensive portfolios in recent years. Subsequent assessment of portfolios (all registrants are required to make an annual assessment and 10% are sampled for assessment) revealed a pass rate which was consistent with previous years, suggesting no change in performance arising from the delay.

It was also announced that in order to return to a CPD submission date of 31 May 2021, minor amendments had been made to CPD Year 2020/21, as follows:

- CPD Year 2020/21 will run for 9 months from 01 September 2020 – 31 May 2021.
- The time requirement for portfolio submissions will proportionately reduce as follows:
 - Full portfolio: reduced to 22.5 hours including 3.75 hours documentation time.
 - Partial portfolio: reduced to 11.25 hours including 2 hours documentation time.

Council is committed to continue to risk assess CPD submission dates and requirements as the pandemic continues, balancing the need for maintenance of skills and knowledge, confidence in the profession, and the burden placed upon registrants with unusual pressures and demands in the service.

Responses to our call for views: registration and continuing fitness to practise

Temporary registration

The feedback we received was supportive of the emergency and existing powers that were used to provide temporary registration for some professions. There was acknowledgement that the temporary registers increased the workforce to help ease the pressure on healthcare services and it was held that their implementation was quick and effective. We heard views that risks were managed well, despite the temporary registers being established quickly. The feedback about temporary registration for both those who had recently retired and early registration for students was also generally positive.

A number of respondents commented that the transition from the temporary to permanent registration should be made as simple as possible, and that those on the temporary register should be prioritised for permanent registration.

Challenges for temporary registrants

We heard some feedback about what happened to people who had become temporarily registered. Some faced challenges such as limited supervision when they were deployed, reduced course content for students registered early and limited opportunities to make a meaningful contribution. We heard about the pressure some professionals felt to join the temporary register, and concern about the implications for future employment if they chose not to. In some cases, there was concern amongst students on the temporary register about the possibility of removal from the register due to fitness to practise concerns impacting their ability to register permanently.

We were told that there were limited opportunities for registrants to work in areas other than critical care or Covid wards, where many did not want to work. We also heard some frustration about the low levels of deployment of temporary registrants, but there was recognition that this was not within the remit of the regulators. There was a concern that temporary registrants may have struggled in unfamiliar areas of work and may not have been ready to practise with the freedom they were given. Concerns were expressed that this may have exposed both the public and temporary registrants themselves to risk of harm.

We also heard a view that the impact on public protection of temporary registrants engaging in private practice is unknown. A further issue raised by a respondent was whether the bar for temporary registration was set too high. The Authority recognises that many of these are issues outside the direct influence of the regulators. We discuss later a recommendation for future review of temporary registration looking at the experience of those temporarily registered, the costs involved, the benefits realised, and the wider impacts.

Continuing fitness to practise (CPD & continuing fitness to practise/revalidation) and appraisal

Flexibility around Continuing Professional Development (CPD), continuing fitness to practise activity including revalidation, and appraisal was widely welcomed by respondents; it was said to ease the pressure on health professionals and their supervisors and allowed them to support the response to the pandemic. Support was expressed by some respondents for a more flexible approach to continue after the pandemic.

Reform of professional registration requirements

Feedback we received supported a reform of professional registration requirements, following the flexibility demonstrated by the temporary registers and the removal of what were seen as lengthy and bureaucratic processes. A number of respondents suggested that there might be a role for temporary registration in the longer term to assist in the transition to full registration for a number of groups (students; international applicants) and for future areas of workforce or recruitment challenges.

Fitness to practise

Case studies 8-11 and responses to our call for views



Case study 8

SOCIAL WORK ENGLAND: NEW FITNESS TO PRACTISE REFERRALS

Social Work England's approach to new referrals remained largely unaltered during this period. Our ability to receive and progress new referrals through our initial assessment process (triage) continued without disruption. Between 20 March 2020 and 10 June 2020, we published guidance on our website to outline the adjustments that we had introduced in fitness to practise to support the social care sector to focus on their frontline response to the acute stage of the pandemic and to ensure that our resources could be focussed on progressing those concerns that gave rise to the most serious risks. We asked employers to only refer new concerns that related to higher risk situations and confirmed that we would continue to progress the highest risk investigations during this time, but would not actively seek to progress enquiries with employers that related to lower risk concerns.

In deciding to implement this approach Social Work England was mindful of the need to support social work employers to focus their efforts on responding to the unprecedented challenges of the acute phase of the pandemic response. Our primary concern at this stage was that there would be wider risks to the public if this focus on the frontline response was not supported by other agencies, including Social Work England. An additional consideration was the uncertainty of the impact of the initial stages of the pandemic on our own resources due to sickness, remote working and caring responsibilities. At that stage, we determined that the risk to the public would be best addressed by ensuring that our efforts, and those of employers, were focussed on progressing higher risk concerns. We adjusted our template letters

to ensure that social workers and complainants were informed of the changes we had made and what this meant for them.

We collaborated with the sector to continually assess our response and to gauge the appropriate time to resume normal activity. Throughout the period our Regional Engagement Leads were fully briefed on the guidance issued to employers and asked a series of targeted questions to employers within their regions to help us to understand local pressures. They worked with the sector to raise awareness and to respond to any queries. This included engaging with over 4,500 social workers across the country in the period February to June 2020 and holding four fitness to practise workshops with employers in the north east and south west in early July, in which we provided updated information on Social Work England's response to the pandemic. Through this activity in June 2020, we determined that it was appropriate to return to a more normal service in fitness to practise.

Throughout this period, we also attended frequent meetings with fellow regulators across the UK and we formed a steering group with key members of the representative bodies for social workers to share ideas about suitable regulatory action and ensure, where appropriate, that responses were consistent. The strategy we implemented aligned with the case prioritisation strategy that we had already implemented to support the progression of the transition caseload that was received from the Health and Care Professions Council in December 2019. By March 2020 we had reviewed, and risk assessed, the transition caseload. This ensured that that we had a complete and up-to-date risk profile for the entire transition caseload which enabled us to quickly identify those higher risk investigations that continued to be a priority to progress, those cases that could be progressed to closure or the case examiners, and those cases that were unlikely to progress significantly during this period.

We anticipated that the pandemic could result in significant volatility in new referral rates and in our ability to progress investigations. Since March 2020 we have experienced delayed responses from a wide range of agencies as a result of the pandemic. This has inevitably resulted in delays in our investigations. We have worked closely with our Regional Engagement Leads to remove barriers to accessing information at a local level wherever possible. We have built extra capacity at all levels, streamlined our processes and introduced new service targets in both our triage and investigations teams. This will enable us to respond more effectively to fluctuations in new referral rates, to target the progression of lower risk investigations and to deliver a managed reduction in caseloads to a sustainable level as we move into 2021.



Case study 9 HCPC: CASE PROGRESSION PLAN

The HCPC determined at the early stages of the pandemic that it was necessary to continue to receive, log and investigate fitness to practise concerns. However it was recognised that the lockdown was likely to have a significant impact on the progression of early stage fitness to practise investigations in that investigations

tended to rely heavily on information from third-parties, many of which were NHS bodies under intense operational pressure,.

The HCPC put a case progression plan in place offering guidance for the management of pre-ICP cases where it was anticipated, due to the pandemic, that progression would be limited. The guidance was developed with its quality and compliance team and designed to enable case managers to ensure oversight, effective monitoring and risk assessment of investigations.

The guidance sought to encompass a range of approaches including ensuring that there was a comprehensive understanding of the cases that had been placed on hold, that these cases were risk assessed and what was required to progress the investigation was clearly identified.

A pragmatic approach was taken as to how much information and evidence was necessary to enable an informed decision to be taken by the Investigating Committee Panel and where, appropriate, the threshold for the extent of information to be obtained was adjusted; if information could be obtained from alternative sources, case managers were encouraged to pursue such lines of inquiry. For example, the closure of the Court Service made it difficult to obtain certificates of conviction and therefore where there were other verifiable sources of information such as from solicitors, it was accepted that cases should be progressed on that basis.

High risk early stage investigations continued to be progressed and cases in which an interim order was considered necessary, were subjected to more frequent and more robust scrutiny.

A similar approach was adopted with post ICP investigations progressed by the HCPC's external legal providers by which cases put on hold were subject to regular review at monthly contract meetings.

It was recognised that the pandemic represented a potential additional source of stress for registrants and therefore a more flexible approach was adopted as to deadlines for the receipt of responses. The general approach being adopted was set out on the HCPC's website and received positive feedback from registrants and their representatives.

For cases scheduled for hearing, it was discovered that moving at short notice to virtual hearings required a slightly different approach in engagement with witnesses in preparation for remote hearings. This included supporting those unfamiliar with technology, talking them through what a remote hearing would be like so as to maximise their engagement.

Overall, remote hearings have worked well and encouraged greater degrees of registrant participation, the process being less costly (avoiding the need for travel and accommodation) and less intimidating and stressful. The sudden move to the use of remote hearings has allowed the HCPC to consider how it recruits and trains panel chairs and members to as to ensure that they are well supported in undertaking their adjudication roles in either settings.

Looking forward

Although many of the measures and initiatives adopted have been developed at short notice and without any gauge as to when normal activities would be able to be resumed, the experience during the pandemic has operated as something of a pilot project and an impetus for accelerated change.

The lockdown and move toward remote working meant that the way in which investigations were planned was substantially reviewed: the use of evidence matrices to enable the necessary information to be identified at the outset of the case and thus promoting streamlined lines of enquiry have been a positive development as have the use of corrective case plans where investigations have become stuck. These measures will be developed into a permanent feature of the HCPC'S investigative approach going forward.

The pandemic has brought about a move very quickly away from paper-based operations and the use of technology and electronic communication; stakeholders have been willing to embrace change and it is anticipated that this will be sustained in the future.

The HCPC is keen to retain some of the benefits of utilizing virtual hearings; ICPs (which have always met in private) will continue to be undertaken remotely. Going forward, it is anticipated that physical hearings will be the most appropriate option in the vast majority of final substantive hearings. However, the HCPC is reviewing how virtual hearings can continue to be utilised in other scenarios, for example preliminary and review hearings, as well as for final hearings identified as being appropriate for virtual hearings (such as those in which live evidence is not required) and where the registrant does not object.



Case study 10

GDC: THE GDC'S DEVELOPMENT OF VIRTUAL HEARINGS

We had been reviewing the situation since February and on 16 March, we decided that we would not hold any hearings at our hearings centre after that week, because COVID-19 risks were advancing significantly. However, by lunchtime that day, we became aware that two people in the building had been linked to contacts who had tested positive and so the decision was taken that all hearings activity should be suspended.

Our immediate concern and focus was to resume interim order and substantive review hearings, to ensure we managed the most pressing risks to the public. Initially, most hearings were held “on the papers”, with attendance by Skype facilitated in some circumstances. At that time, Skype was the only mechanism available by which we could facilitate remote hearings, although we did move to Microsoft Teams in June after evaluating different options, assessing technical capability and data protection.

Things moved quickly, and by the end of March, guidance was in place for hearings staff on how to conduct remote hearings. However, we were less sure that this approach would work for substantive hearings and, as we had little prospect of

quickly returning to Wimpole Street, we cancelled all substantive hearings until the end of June, focusing on interim order and review hearings. We relisted most of the substantive cases within 2020.

By April, the hearings and in-house presentation teams had developed a proposal to hear some substantive cases remotely, as we were concerned that otherwise, we would accumulate a significant backlog. We balanced the requirement to ensure that registrants had a fair hearing – in particular, the right of an individual to cross-examine witnesses – with the GDC’s need to ensure we fulfilled our statutory obligations and held hearings in a reasonable timescale. As part of our testing, we held a mock hearing with support from Counsel to identify issues and refine guidance. The Registrar agreed a programme of cases to be heard remotely – starting with cases involving criminal conduct or a non-engaging registrant and escalating to cases with three or fewer witnesses.

We consulted with defence representatives and ensured that they were fully sighted on our plans. We have received excellent support from the defence organisations and have managed to resolve issues in a pragmatic way to ensure most cases have proceeded.

In July we started to prepare for a return to in-person hearings from the beginning of September. Although the level of the virus had declined our expectation was there would be a second wave, but we considered important to try to use the facilities whilst we could. Following a risk assessment, we decided to start with one in-person hearing per week and increase when appropriate. The building was configured for social distancing and we installed Perspex screens in our largest hearing room.

From September, until the third lockdown in December, we were able to complete many of our hearings in “hybrid” – attending in-person for only the necessary parts of a hearing with other parts being heard remotely - to reduce travel and the risk of infection for all parties. Fortunately, we have not had to cancel any hearings because of illness and have been able to successfully accommodate the press in one remote hearing.

Initially, the in-person hearings were agreed by the Case Management team and the parties, usually for cases where a party considered there to be benefit in a committee seeing the witness give evidence. However, given the increasing demand for in-person hearings, the Registrar agreed the default position that hearings would be heard remotely, and that applications for in-person hearings would be considered in a preliminary hearing. The number of in-person hearings has remained at one per week, as we are mindful that increased attendance at our hearing centre increases the risk of illnesses among staff and witnesses, which could severely impact on many future hearings. We will keep this under review. Despite some technical issues, most remote hearings have finished successfully. We have found that they often take longer than they would in-person, requiring more support for test calls, and are tiring for all parties. We are also considering using two Committee Secretaries for more complex hearings.

We have also recently completed a planned panel recruitment exercise and adapted our induction and training programmes to account for the new hearings’

environment. We have scheduled additional training to compensate for the lack of support they will receive in their first hearings.

While performance was initially impacted by the cancellations, the number of cases waiting to be heard is now falling, which suggests this approach is working. Maintaining a schedule of interim order and review hearings, and resuming substantive hearings, has meant we have continued to ensure the public are protected appropriately. We have also minimised the delays for most registrants, which is important given how stressful this process can be. We are still evaluating the relative costs and potential savings of this change.



Case study 11

GOC: VIRTUAL HEARINGS AT GOC

Following the announcement of a national lockdown, the GOC undertook rapid IT testing of Skype for Business and Microsoft Teams and managed to successfully hold its first non-substantive remote virtual hearing within 24 hours of the closure of its offices on 18 March 2020.

In planning for the implementation of virtual hearings and other alternatives to in-person hearings, the GOC actively engaged with stakeholders, including representatives, committee members, legal advisers to test systems planned for use to enable technical issues arising to be resolved and thus enabled smooth running of, and enhanced confidence in, virtual hearings.

The hearing facility at 10 Old Bailey, London has been reconfigured to ensure compliance with social distancing guidelines and therefore it has been possible to arrange physical and virtual hearings; it is anticipated that blended hearings will be in place by April 2021. In recognition of both the efficiency benefits and the need to support registrants and witnesses, the GOC plans to resume in-person hearings although it is also intended that the option of remote hearings be used where appropriate.

Challenges encountered in taking hearings online included connectivity and security of the links, although suitable contingencies were in place to enable proceedings to be moved to alternative platforms in the event of difficulty. In order to manage on-going concerns regarding potential unauthorised recording of proceedings, observers were required to confirm adherence to a set of rules prior to gaining approval to observe and panel Chairs issue regular reminders to all participants. The need to review electronic documents on the same screen as watching the hearing was recognised to be a challenge and therefore in more complex cases (involving large numbers of allegations and/or witness, large bundles and patient records) hard copy documents were provided.

The GOC decided against adopting a rigid approach as to the types of cases appropriate for virtual hearing; it took the view that subject to consideration on a case by case basis of relevant risk factors, no cases were, by definition, unsuitable. Relevant to its assessment were whether there was any identified risk to the integrity or fairness of the hearing, access to and ability to make use of technology, concerns

regarding potential breaches of or lack of privacy affecting participation, the impact of disabilities and/or vulnerabilities, the public interest in the prompt disposal and any other matters that may affect the smooth running of the hearing.

In preparing for the use of remote hearings, the GOC sought to adopt a collaborative approach, holding stakeholder group meetings to consider processes and agree next steps at an early stage. Preliminary discussions with defence bodies, panel firms and the Professional Standards Authority led to the publication of Council-approved guidance to panels on remote hearings and a further targeted consultation exercise with stakeholders including panel firms, representative bodies and legal advisers in July 2020 resulted in the publication of a hearings protocol and witness guide for remote hearings.

There are plans to hold virtual hearings in the longer term and the GOC will look to support this by providing hard-copy bundles where required, notwithstanding limited access to the building, exploring improved systems for handling of virtual bundles (including, for example, the ability to annotate and highlight) and will adopt measures to ensure that the formality and security critical to hearings is upheld, for example, in the use of standardised backgrounds.

Overall, the GOC is satisfied that the quality of decision-making has been maintained. There have not been concerns regarding the quality of presentation, respondent or witness participation although this will be subject to independent review and audit in 2021.

Example

We served our case on the registrant in October 2019 and a procedural hearing was held on 10 January 2020. The allegations, which were a combination of clinical and conduct matters and anticipated to attract public/sector interest, involved evidence from nine live witnesses and two clinical experts. The substantive hearing was scheduled to start in July 2020 and last five weeks and leading counsel (QCs) had been instructed by both the GOC and the Registrant.

After the UK entered lockdown in March 2020, we considered whether it was possible to proceed with a physical hearing: we explored the option of holding the hearing local to the participants in order to minimise the need to travel to London and secured a conference-venue in the Midlands to enable the family's attendance. We also considered whether the hearing should be postponed but noted that due to the availability of key participants, the likelihood was that the matter would need to be moved to November 2020 at the earliest, or February 2021. All participants recognised the need for expeditious disposal given the high-profile and serious nature of the allegations and agreed that a postponement was the very last resort. Eventually, it was agreed that the best option was to proceed with a virtual hearing.

Internal decision making regarding the risks and benefits of the various options involved senior leaders and the Chief Executive. Procedural and case management decisions not reached by agreement were determined by way of case management directions from the preliminary hearing prior to the pandemic with the involvement of the Committee Chair.

The technology was subject to thorough testing and confirmed to be fit for purpose and capable of supporting public access through a dedicated hearing link. However, there were a number of additional competing interrelated factors to navigate: the wellbeing of attendees and participants could be ensured by shorter hearing days, identified breaks and formal support mechanisms, and the maintenance of the formality of the hearing could be supported by prior training and prompt feedback being given when proceedings strayed into informality. Electronic bundles were sent well in advance and panel members were also provided with paper bundles to ensure that the quality of decision making was not impeded. Anticipated issues regarding connectivity and the security of the link were managed by restricting access to confirmed parties, back-ups and the requirement that observers agree to abide by a set of rules established to support the virtual proceedings. Although the case eventually went part-heard due to an unforeseen no-case to answer application, additional time had been factored into the planned timetable for decision making.

The case going part-heard necessarily involved increased costs and additional costs were incurred due to the need for a live transcriber rather than the use of digital recording facilities available in the hearing centre.

Balanced against this however were reduced panel member expenses. Additional benefits, some of which have now become a regular feature of proceedings have included bundles, witness statements and written statements of facts at each stage for the smooth progression of the hearing, and where there is a public presence the reading of decisions into the record for transparency.

A positive consequence of virtual hearings has been the increase in public participation: family members and other interest parties for whom attendance may have been problematic were able to participate remotely.

Overall, virtual hearings have brought about significant benefits and we have successfully mitigated the risks around the potential challenges to effectiveness. The pandemic has assisted with the implementation of a new way of working and we have accelerated measures such as witness guidance and improved arrangements for bundles. Increased confidence in the remote hearing process and arrangements have allowed us to deliver 95% of our overall hearings and 83% of substantive hearings; 50% substantive matters initially adjourned have since been completed remotely.

Respondents recognised the challenges presented by the pandemic and the urgent need to look at alternative modes of delivery to fulfill their primary aim of public protection in this area, as for other functions. They recognised that the regulators had sought to be flexible and consultative in their approach. Efforts made to listen to and work alongside stakeholders were widely felt to be a positive outcome.

Remote hearings and electronic service

Remote hearings were generally recognised by respondents to have brought about numerous benefits. Many expressed the view that the move towards remote

hearings had allowed matters to be concluded more quickly, and had served to alleviate stress for registrants who would otherwise be waiting for extended periods for in-person hearings. They had minimised the impact on those participating to continue to contribute to frontline patient and service user care. Delay was widely recognised as being detrimental to all parties and therefore it was considered that virtual hearings may have been the most appropriate option for some cases (particularly for interim orders and uncontested health matters) and may have helped to address the inevitable backlog of cases caused by the pandemic.

Some respondents observed the shift towards remote hearings and video based gathering of evidence had resulted in a greater degree of registrant engagement, greater equality and had reduced physical barriers to participation for those living outside London, Manchester or Sheffield. In their view virtual hearings did away with the need for registrants to be away from their home setting, at times for a number of weeks and the significant anxiety involved as well as travel and accommodation expenditure. For this reason, defence body respondents in particular welcomed the opportunity for their members to participate in proceedings in a far less stressful and imposing environment and with the benefit of family support networks while proceedings were on-going.

Some defence body respondents however, pointed to the negative impact on the mental wellbeing of members who did not have the advantage of being with their legal representative at hearings and receiving the same degree of support as they would at a physical hearing. Other respondents mentioned the difficulty of reading and interpreting body language online.

Although a number of defence body respondents reported that they had worked closely and constructively with regulators in developing the approach to be taken regarding virtual hearings and resolving logistical and technical issues, concerns were expressed that some regulators had demonstrated a determination to move forward with a remote hearing in specific cases despite objections being raised, with the onus appearing to be on registrants to prove why a remote hearing was not suitable.

A number of respondents sounded a note of caution to regulators that remote hearings were not universally suitable and maintained that notwithstanding the emergency situation, registrants should not be compelled to have their cases dealt with by way of virtual hearing. Defence body respondents were keen to work closely with regulators to develop joint guidelines regarding the thresholds and criteria for matters classed as appropriate for virtual hearings incorporating factors such as the complexity of the case, the extent of documentation necessary and the complexities of witness evidence needed.

Furthermore, although there were clear benefits to conducting hearings remotely, respondents identified a number of serious, yet still unresolved, issues including security and data ownership, and risk said to arise from public access. The possibility of members of the public and the media having online access were said to raise the risk of screen shots being taken, recording proceedings being made and the potential for witness coaching given the limitations in ensuring that other parties were not present. For registrants, it was said by respondents that there were

concerns to be resolved regarding unreliable access including WiFi access: there was a reported incident in which rather than seek an adjournment of the proceedings a registrant had sought WiFi access in a public library or church.

A number of defence organisation respondents also expressed the view that public access should be restricted to supervised viewing galleries, a hearings centre or members of the public being provided with only virtual audio access rather than visual access. Of these, some considered public access should be prohibited and that until regulators are able to open their offices safely, transcripts should be provided to members of the public to meet the need for transparency, noting that unlike criminal proceedings, in which contempt of court process acted as a deterrent to abuse, there was no meaningful sanction available to regulators.

The Authority was aware of all of these concerns and recognised that the virtual hearings raised difficult and new issues. It issued guidance which attempted to set out the considerations that regulators and panels should consider in assessing whether a virtual hearing was suitable for a particular matter. We will be reviewing this guidance in the light of experience.

Electronic service of documents

There were mixed views from respondents regarding the electronic service of documents: some considered that as well as reducing the carbon footprint of proceedings, it was a positive step for registrants to receive documents by email which should continue beyond the emergency period. Some respondents however articulated concerns that regulators could wrongly presume that all parties have access to the right technology and might not take full account of disabilities. Bundles could often be voluminous or complex and therefore alternative hard-copy delivery of papers needed to be available on request in the interests of ensuring appropriate access to documentation so as to avoid reported situations such as registrants attempting to access hearings on a mobile phone and having to access documents on the same device.

Steps taken by some regulators to implement safeguards around the service of documents were noted and welcomed by some respondents: for example, one regulator had required registrants to require acknowledgment of receipt within 24 hours failing which the notice would be sent by post.

There were some concerns expressed by respondents that measures brought in by way of emergency legislation to enable electronic service of documents without a 'sunset clause' could result in emergency measures becoming the new normal by default and without adequate impact assessment.

In summary, respondents considered that as there was as yet still limited experience of virtual hearings, and little data in particular on longer or contested hearings, more work was needed. Some respondents recommended that an equality impact assessment to identify any unintended consequences and hear more from focus groups including complainants and members of the public to obtain a clearer and more comprehensive understanding of their experiences of the measures that came into effect at the time. Defence body respondents called for further independent

research to be commissioned to look at the process and the quality of the experience of participants, particularly the effects on the mental wellbeing of registrants.

The flexibility of the fitness to practise process

Some defence organisations expressed the view that whilst putting cases on hold and focusing on high risk matters was initially the correct approach, many cases had been put on hold for too long and as a result, there were large numbers of cases stuck at the early investigation stage. Delays resolving fitness to practise concerns were noted to create distress for registrants involved and a potential impact on workforce capacity.

Regulators were encouraged by respondents to build capacity in their system by undertaking assessments quickly and resolving cases at the lower end of the scale of seriousness early on in the process. It was further recommended by respondents that regulators should take account of the delays arising as a result of the decision to pause investigation in looking at the appropriate sanction for a registrant.

Some representative bodies observed that the pandemic had shown that flexibility and pragmatism in response to reasonable requests for extensions of time at early stages of the process had proved to be beneficial to the fitness to practise process as a whole.

Registrants' representatives considered that the extent to which the pandemic impacted the ability of registrants to comply with conditions or undertakings was yet to be understood and that regulators will need to take account of the effect the pandemic when assessing compliance.

Where the power existed, the regulators' power to schedule early reviews of restrictions on registration (such as registrants subject to low level conditions or undertakings that were shortly to expire) were considered to provide flexibility in response to the workforce needs arising.

Context

Many respondents welcomed the joint statement by the regulators at the early stage of the pandemic assuring them that context would be taken into account in the event of action being taken against clinicians, although some expressed the view that the strength of support could have been greater. It was considered that issues such as staff working in unfamiliar settings, the limited availability of PPE and the difficulties in wearing it, the disproportionate impact of the disease on frontline BAME health professionals and the challenges of working with changing and at times, conflicting guidance was relevant to the overall context of an incident or concern.

Regulators were encouraged by some respondents to produce detailed guidance on the approach to be taken to complaints arising during the Covid-19 period and, whilst broad commitment to take context into account was welcomed, some respondents would welcome detailed guidance on how contextual factors would be considered as part of the investigative process and decision-making. It was also recommended that regulators seek to take account of national and local guidance issued by NHS

bodies, Trusts' practices and others during the pandemic in order to be sure of the measures and guidelines in place at the time of an alleged incident. There was a specific proposal to build a 'library' of local Covid-19 guidelines and protocols as soon as possible in anticipation of future complaints.

The Authority recognises that it is very likely that regulators and panels will legitimately take into account the challenges caused by the pandemic in taken decisions in respect of fitness to practise and we think that it would be appropriate for them to consider, at least in general, how those might be taken fairly and consistently, while recognising that it is far too early to assess all the different scenarios that may apply.

Standards, guidance and communication

Case studies 12-15 and responses to our call for views



Case study 12

GDC: APPROACH TO PROVIDING COVID-SPECIFIC GUIDANCE

We began planning how best to communicate Covid-specific information long before the first national lockdown came into effect on 16 March 2020. The potential impacts were publicly discussed as a future challenge at the GDC Moving Upstream Conference on 12 February 2020 and we were in regular conversation with stakeholders, both from across the sector and the UK, as developments came to light. We also reviewed guidance from the CDO's, departments of health and government bodies, as it became available to ensure that we were up to date with the issues and could plan how best to address them.

We communicated a joint statement with ten other healthcare regulators on 3 March 2020, urging healthcare professionals to follow national public health advice and guidance. The statement also helped emphasise that we would continue to regulate during the pandemic and confirmed that, where a concern is raised, we would always take into account the factors relevant to the environment in which the professional was working, as well as any relevant information about resource, guidelines or protocols in place at the time. We have continued to reinforce this message throughout the pandemic.

As more guidance and information became available from a range of sources, we concluded that dental professionals might struggle to identify the information that was relevant to them. We were also regularly being asked to provide clarity on topics such as clinical guidance, which lies outside of our remit.

The GDC is the only UK health professional regulator which regulates all the professions in its sector, from nurses to technicians to dental surgeons. We built a Covid-19 information hub, divided by nation and stakeholder, to signpost to the range of guidance and information that was available from across the sector. Alongside this, we monitored social media, press coverage and correspondence, logging issues that were arising, which we reviewed regularly to decide what

information needed to be highlighted or updated, where clarification was necessary and how best to communicate any new information.

In addition to our web content, we produced four 'Responding to COVID' articles to address more specific topics and answer some of the questions we were receiving about what dental professionals should do in response to the spread of Covid-19 and how best to protect their patients and themselves in unprecedented circumstances. We signposted to these articles alongside other relevant information in our update emails, to ensure that dental professionals and stakeholders had a range of means to access the information.

During the pandemic, we commissioned public and patient and stakeholder research, including round table discussions with stakeholders online to better understand the impact of Covid-19 on dental services. This has enabled us to further develop our web content and to highlight our findings on the impact the pandemic has had on the public and dental professionals. We developed a dedicated online Covid-research hub, which has allowed us to provide an holistic view of stakeholder and patient feedback from the initial Covid-research findings. We communicated our overall findings in a webinar in February, with the video then being made available on our website to ensure that those unable to attend could still consider the key points. These developments have made the content more accessible and show our continued aim to keep the professions informed.



Case study 13

GMC: APPROACH TO COVID-SPECIFIC GUIDANCE

In the early stages of the pandemic there were many unknowns, overwhelming amounts of information in the health service, and tremendous stress on doctors and patients and their families. We wanted to ensure that we could provide the right ethical advice, as quick as we could, to support the profession in navigating the crisis – in a way that reinforced our proven existing approach to developing and issuing ethical guidance.

Our approach

As part of business continuity planning, we had previously considered how we would regulate in the event of a pandemic. In Autumn 2019 our Council had agreed that in a pandemic we:

- should not develop a 'separate' set of standards for use in time of national emergency. Instead we should support doctors to understand how the existing principles of our ethical guidance apply in the circumstances of a pandemic. By providing advice on the areas of greatest concern, mapped to the domains of Good medical practice (GMP), we could rely on the thorough consultation and engagement that underlies GMP, and apply the same principles in rapidly emerging circumstances.
- should continue to work in a joined-up way with our regulatory and wider healthcare partners with the aim of ensuring that that responses are aligned as much as possible.

- prepare and present our advice online in an accessible and user centred manner.

We identified subjects to develop advice on based on the key themes in the incoming ethical queries. These were received directly from the profession, public and other stakeholders. We considered this together with intelligence gained through our outreach teams and national offices. In addition, we used our Data, Research and Insight Hub (DRIH) team to produce 'rapid scans' of the external environment so we understood as best we could – what other guidance was being issued, and what doctors were saying via trade press, articles and social media. What we learnt was a sense of 'information overload' and that conflicting messages were causing confusion and frustration among the profession.

In response to this, where several voices needed to be aligned, we worked with other organisations to produce joint statements. Jointly badged statements can give a statement extra power and can also remove potential differences in approach or understanding across the multidisciplinary team. Where there was already an authoritative voice on the topic we tried to link and signpost to their resource in order to make it easier for doctors to find the information they needed

When developing advice, we stress-tested the content with clinicians and critical friends (e.g. defence bodies and BMA). The stress testing was to ensure that the content would work for the intended audience and that it was clear and would not be misinterpreted.

We already have a space on our website, the ethical hub, where we pull together different pieces of guidance to address a specific topic for doctors. We were able to use this channel to create a dedicated COVID ethical hub on our website where we aggregated all relevant advice in one place to help users access material.

We also gave a focus on reassuring doctors that they wouldn't be unfairly held to account for decisions made in very challenging circumstances or for circumstances beyond their control. This is in line with the approach other professional regulators take, and with the joint statement prepared by the Chief Executives in 2016. We also felt that our approach of relying on the principles of our existing guidance provided, as much as was reasonable, clarity of expectations and standards of good practice for the profession to try to uphold during these challenging times.

As we received COVID-19 enquiries we prioritised and responded to them within three days, rather than our usual agreed service level for ethical queries of 15 working days. Key areas of concern included: concerns over supplies of personal protective equipment (PPE); how risks to doctors' own health should be managed; guidance on conducting remote consultations; and questions about working outside of normal fields of practice. Many of the pandemic related enquiries were from black and minority ethnic (BME) doctors raising concerns about personal safety and PPE, risk assessments and redeployment to other roles, and managing increased risk to their family members while continuing to work. We redeployed staff from across teams to supplement capacity in responding to ethical enquiries.

How decisions were made

Decisions on our approach were made through our existing governance – namely the Medical Director and Director, Education and Standards, Chief Executive, broader Senior Management Team, and Chair of Council, as necessary.

Summary

Our response to the ongoing pandemic continues. The COVID-19 Q&A pages will remain online for as long as they are needed and we have continued to listen to intelligence and update the pages, for example in early December 2020 we added FAQs on vaccines. We are also in the process of updating the patient pages. Although the COVID-19 hub will not remain online indefinitely, the pandemic has confirmed our ability to make rapid changes to the ethical support so we can support doctors in applying our guidance in different contexts.

We also think this experience highlights the value of thorough policy development and consultation to underpin the core principles set out in our ethical guidance. Our confidence in these high-level principles meant we could respond quickly to give advice on their practical application during the pandemic.



Case study 14

GOsC: APPROACH TO PRODUCING CORONAVIRUS-SPECIFIC GUIDANCE

General approach to producing guidance

The GOsC's approach to producing coronavirus-specific guidance was initially and necessarily a reactive response to the information it was continuously receiving on a daily basis. However, over time, the approach became more planned in dialogue with others.

Information came from daily Covid-19 briefings across the organisation involving all teams, feedback from queries it received (which increased significantly) including through social media, osteopathic stakeholders (including the higher education sector). Information also came from other regulators about their approach and role as a health professional regulator during the pandemic, and regular reviews of all the legislation and guidance that was being produced across the UK both by the Health and Safety Executives, Public Health and the four country governments. The England, Scotland, Wales and Northern Ireland government approaches have diverged over the course of the pandemic with implications for practitioners across the UK.

Guidance on continuing osteopathic practice during Lockdown

Osteopathy is an allied health profession in England but not in the other countries of the UK and it is also not part of traditional primary care group structures, although

often a first point of contact for patients. Osteopaths predominantly (although not exclusively) work in the independent sector.

The GOsC identified that for practitioners working predominantly outside the NHS structure there was a gap in interpreting and applying government and public health guidance, for example how it applied to someone working in their own home.

There were also questions around who would signpost practitioners to relevant guidance (and in particular public health guidance) and support. With practitioners who operate outside NHS practice, it was difficult to navigate. The GOsC worked closely with the professional membership body, the Institute of Osteopathy, who in turn worked with other allied health professional bodies with significant numbers of health professionals who also work in the independent sector as well as in the NHS, such as the physiotherapists and the podiatrists, to ensure osteopaths were signposted to the correct guidance.

It was a rapid learning curve for the GOsC and included issuing guidance on infection control (signposting public health and government guidance for osteopaths to apply) and issuing a statement on osteopathic practice. The GOsC received high levels of emotive correspondence; from some saying that osteopaths should not be practising, and from others saying patients desperately needed to see an osteopath as they were in pain, including from a doctor who worked in intensive care and was eager to see an osteopath in order to get back to work.

Government did not prohibit osteopathic practice. On the contrary it was listed, along with dentists, as specifically being allowed to open. Therefore, the GOsC's position was that osteopaths should use their professional judgement about whether to continue practising, taking into account their health and safety and risk assessments and the guidance published by Government and Public Health Bodies.

The GOsC found that individuals wanted a definite answer as to whether osteopathic practice could continue, but it came down to clinical judgement and responsibility. The GOsC was aware that this is a difficult message to deliver when osteopaths were deciding whether to keep a practice open; the decision to remain open or to close was one which would directly impact on an osteopath's ability to earn an income, balanced against the public health risk. The GOsC had to check and challenge itself that the guidance it was issuing was the right thing to do taking into account the views of all stakeholders.

The guidance produced was prioritised based on data and feedback the GOsC received from osteopaths, patients and others and it sought advice from other regulators to ensure they were broadly in alignment. This required rapid analysis and rapid response. The GOsC was the first regulator to issue infection control guidance and guidance continued to be updated as the situation evolved, such as on the introduction of the second lockdown. Subsequently, other regulators also strengthened their statements in this area to signpost relevant guidance for their professions who may also work in the independent sector.

Hearings guidance

The GOsC produced guidance for a new hearings protocol which was particularly important to ensure that core statutory responsibilities continued to be met. There was no prior experience of the new ways of working, so the GOsC did not know what the consequences of this approach would be. Guidance issued to support the continuation of our fitness to practise activity was informed by patient feedback obtained through focus group meetings. Please see the GOsC case study on patient engagement and involvement for further information.

Other reflections

The GOsC considers that regulation should not be a barrier to responding to a crisis, and consequently not protecting patients. For example, regulators should have flexibility in their powers and outcomes-focused guidance. There was perhaps a misunderstanding between the role of the regulator and patients and there is a gap between the public and private sectors that risks patient safety if we do not work together and recognise that patients access healthcare in different ways and they should be entitled to the same level of care and consideration in the context of the changes necessary to practise during the pandemic.

The GOsC has seen the challenges in trying to translate guidance that is designed for one context to another, and the health professional regulator's role in that. The GOsC is still interpreting and signposting the guidance for osteopaths but unlike the independent sector, the NHS has a governance structure and system to implement the guidance. It is not just about regulation, but more about how the whole system

An important legacy of this will be increased and strengthened relationships with external stakeholders including the devolved administrations and the different organisational structures within them.



Case study 15

HCPC: COMMUNICATIONS AND ENGAGEMENT

One of the early key considerations for the HCPC was how to communicate essential advice to registrants as the priority was to keep them informed and supported. Initially much of this information was government guidance and advice, yet this developed as time went on to include support on health and wellbeing, and advice on how to apply the HCPC standards during the pandemic.

The HCPC considered that this later guidance was important in order to signpost and support registrants in how to continue to meet the standards in the unprecedented circumstances.

In developing the guidance, one of the challenges was how to support registrants through the difficult times, whilst also ensuring standards were met and the public were adequately protected. This included advice on infection prevention control, communicating effectively and both adapting and scope of practice with many registrants being asked to work in new roles.

The HCPC concluded that one of the key ways to achieve this was to demonstrate what professionalism looks like in the time of a pandemic from the regulators point of view. It was considered that one of the best ways to ensure public protection was to arm registrants with the tools they needed in order to demonstrate professionalism.

One of the key mechanisms deployed by the HCPC to communicate with registrants and the public was the COVID-19 Hub created for the HCPC website. Alternative options were considered, such as listing information on already established pages, however the hub model was chosen as it could provide a central place in which users could access information, including non-registrants such as students, student providers and employers who may also have questions. The hub ensured that a large amount of information across a range of topics could be accessed in one place without changing the composition of the existing website. Access to the hub was possible from the home page and given a prominent position on the website.

The HCPC were also very conscious to communicate with registrants directly and increased the frequency of the 'In Focus' registrant newsletter throughout March and April. The HCPC report that engagement with the newsletter was higher than usual and was well received. The content of the newsletter focused on guidance for registrants which was also promoted on social media channels, to which the HCPC reported a high levels of engagement.

Engagement with stakeholder groups continued, primarily by email and regular collaboration took place with the policy team and regulatory functions. Internally communication took place by way of regular management 'huddles', which improved communication across teams and encouraged collaborative working, for example with regards to the updating of policies and guidance.

A particular piece of communications work which received very positive feedback was the 'My COVID Stories' involving interviews with registrants on the front line. The HCPC considered that telling the stories of their registrants was a powerful communication tool, assisting in promoting the advice on meeting the standards. This received good feedback and will continue.

The HCPC also developed video content involving their Council members, Chief Executive and Chair, which were well received on social media channels and provided a further tool in which to engage with registrants and the public.

Some of the benefits of the approaches taken include enhanced collaborative working and increased engagement. For example, the use of Council members had never been done before and this opened up an avenue for engagement, with the public, registrants and stakeholders. The development of 'My COVID Stories' also created an opportunity for the HCPC to better relate to and engage with its registrants, which the HCPC report has aided their understanding of the experiences of those on the front line.

Responses to our call for views: standards, guidance and communication

General

A theme within the feedback received from respondents was welcome for the regulators' communication with the professions and the guidance they provided to registrants at the outset and throughout the pandemic. The use of social media, blogs and Covid-19 hubs on regulators' websites to communicate with the professions was noted and welcomed, as well as releasing regular and, on occasions, joint statements of support and reassurance. There was an acknowledgement that guidance had to be produced or amended at pace.

There was appreciation for the regulators' support and reassurances to the professions about the challenges they faced, for example, requirements to work outside their usual area of expertise, reassurance that the context of the pandemic would be taken into account in fitness to practise investigations and supporting professions to practise remotely.

It was recognised by respondents that communication from the regulators was not limited to that aimed at registrants. For example, we received positive feedback about the promotion of guidance encouraging pregnant women to continue attending appointments. The feedback we received was supportive of guidance that was produced jointly between regulators and identified benefits to some guidance being multi-professional, for example, on the duty of candour and confidentiality.

Regulatory gaps

We received feedback from respondents that in some cases, regulators could have provided more regular updates to registrants and that differences in the devolved nations were not always fully accounted for.

We heard views from some respondents that regulators' standards are not designed for the unprecedented circumstances in which health and social care professionals found themselves practising. This was said to have resulted in registrants faced with difficult decisions having on occasion been unsure of whether they were in acting compliance with regulators' standards. Regulators therefore may wish to consider whether there is evidence of significant areas which were not covered by their standards, recognising that standards are not intended to provide instructions on how to act in detailed or unusual factual situation

One respondent expressed concerns about the threat of future risks to compliance with regulators' standards resulting from longer term consequences of the pandemic. These included the risk of moral disengagement from a workforce exhausted by frequent adaptations to change; disruption to supervision and management; and financial pressures compounded by the perception that others outside the sector have profited from the pandemic. These, it was suggested, pointed to the need for regulators and employers to find ways to audit disengagement to help predict where problems might occur.

Learning

Many responses made clear that in their view communication, clear guidance and advice are vital from the regulators for both future crisis and business as usual. The stakeholders told us that in their view the guidance must be detailed and consistent

amongst regulators, as well as open, honest and supportive of registrants. We heard that regulators working collaboratively with their stakeholders in the development of guidance is likely to make guidance stronger and more effective and enhance public protection.

Education and training

Case studies 16-20 and responses to our call for views



Case study 16

GCC: VIRTUAL COURSE MONITORING VISITS

The pandemic and associated national lockdown of March 2020 meant that the GCC could not conduct its usual in-person course monitoring visits. In deciding how to adapt its approach, the GCC sought to identify what it could do in order to continue operating as well as possible in the circumstances. It found that stakeholders were keen to assist them in achieving that goal and had a positive and supportive attitude towards being flexible. The GCC also recognised the hard work of their staff, who were incredibly flexible, tolerant and patient in dealing with the challenges presented by the pandemic.

The first remote visit took place by telephone on the day the GCC's offices closed. Conducting the visit by telephone was not ideal but it meant that education visitors at opposite ends of the country were able to participate and it was completed successfully, as were the ensuing processes for submitting the recommendations to Committee and the Privy Council.

The approach taken by the GCC enabled the visit to progress rather than be cancelled or deferred. It also provided an opportunity for the GCC to identify how subsequent remote visits could be improved through the use of software which enabled participants to see each other as well as hear each other.

The arrangements for this first remote visit were made without knowing what was to come. No formal risk assessment was conducted but the existing relationship between the GCC and the provider lent itself to a collaborative, proactive and constructive approach towards getting the visit completed.

After the visit, the GCC sought feedback from those who had been directly involved and took the opportunity to assess the adapted process it had used with the benefit of that feedback and hindsight. It was satisfied that they were able to conduct a thorough visit and its remote nature did not reduce the level of scrutiny given to the programme. The GCC's ability to complete a thorough visit was aided by the existing relationship between the GCC and the provider.

The feedback received by the GCC highlighted the practical impacts of conducting visits by telephone, such as the challenges of chairing a remote meeting. It also highlighted a view that visits provide 'essential reassurance' as well as a perception that the loss of in-person interactions, and associated inability to observe body language, may be detrimental to the process. The success of the approach used

during the pandemic led the GCC to challenge these perceptions and to consider how important these aspects of the approval visit are.

Going forward, the GCC does not intend to revert to its previous approach. It plans to use a hybrid model, recognising that it will be beneficial to attend in person for certain types of visits. The GCC is yet to approve a new programme at a provider that is not already known to it but it anticipates this type of visit would benefit from in-person attendance. A visit attended by one or two people to meet the new provider and see the programme's facilities will provide a more rounded picture on which future monitoring decisions can be based.

The pandemic led to planned changes being introduced more quickly. Without the same time pressures that were present in March 2020, the GCC is now able to take a more considered and deliberate approach to deciding which aspects of the monitoring visits are necessary and which can be adapted.

The use of videoconferencing software is likely to continue as the process was improved when participants were able to see each other. The GCC will be giving further consideration to the types of circumstances where meeting in-person is preferable or necessary.

The GCC continues to be flexible and continues to be met with flexibility from its stakeholders. The pandemic demonstrated that the GCC can and did adapt quickly and the GCC credits its small size for enabling this. It was also clear that it was beneficial having an existing relationship with the provider as this facilitated flexibility. The GCC will be giving this aspect of its learning further consideration as it continues with planned work that may require ongoing nimbleness and flexibility.

Learning for the future

While it is difficult to plan and prepare for future crisis, the GCC considers it is possible to design an over-arching approach which would aid the response to, and management of, future events of this nature. From its experience of this pandemic, the GCC's view is that the approach should be inclusive and consultative and it should also be less risk-averse than the approach regulators would usually adopt.



Case study 17

HCPC: VIRTUAL COURSE MONITORING VISITS AND OTHER FLEXIBILITIES

Virtual programme approvals

Managing the risk

In late January and early February 2020, the HCPC received enquiries from education providers about whether it would continue to conduct quality assurance visits in light of the emerging pandemic. The HCPC worked to establish what moving to virtual visits might look like, the risks involved and what changes might need to be made.

The HCPC identified that the main risk was not seeing people face to face. However, it thought pragmatically, and considered whether perceived barriers meant it could not make a judgement about approval. It decided to test virtual visits in early March with one or two providers.

The key point from an education provider's perspective was whether it felt it had a fair and consistent hearing on the proposals it submitted. From the visitors' perspective the consideration was whether they felt their professional judgement was hampered. The visitors felt they could make the same judgement on the programme documentation and that they could make good judgements against the standards following virtual discussions. Providers felt they were provided with a good opportunity to engage effectively with the visitors through virtual meetings. The outcomes from visits also remained consistent, with important issues still being identified and explored virtually.

The HCPC rolled out virtual visits across all other providers and apart from one or two (who decided to push back their programmes in light of the pandemic), all virtual visits went ahead. It will continue with this approach during the pandemic period as it enables new programmes to continue to be assessed for approval.

Benefits

The feedback from providers was positive; holding virtual meetings meant they were not restricted to a specific window of people attending, instead, meetings could be held at different times virtually which made scheduling a lot easier. This also resulted in more availability of visitors; people can fit the visits into their day, rather than conducting an on-site visit that entails travelling and spending days away.

The feedback the HCPC received and its own analysis indicated that nothing has been lost, so going forward it has taken the decision to communicate to the sector that it is a model it will adopt for the foreseeable future, and has committed to it for the 2021-22 academic year.

Learning from virtual visits has also fed into the criteria for a new quality assurance approach which removes the requirement for site visits as standard. However, there will still be an option to conduct a site visit if necessary, and if this is the case, the HCPC will advise the provider.

Other flexibilities

As lockdown was introduced, the education sector was not fully prepared for the implications on face to face training and onsite placements. All education programmes depended on those things functioning well.

The HCPC received some enquiries in March 2020 about what was possible; such as what would happen if students could not progress from one year to the next, creating a backlog in the system. Students who could not progress could not achieve registration and then continue into the workforce.

Significant changes would normally go through a change process but the HCPC and providers did not have the benefit of time to do that, so took the decision to be

pragmatic. It decided that nothing about the standards needed to change (these are already flexible and output focused), but rather the approach to compliance needed to change. It therefore told providers they could make temporary, one-off changes to adapt their programmes during the pandemic. For example, moving teaching online, using simulation alongside face to face training, adapting assessment methods, flexing the number of practice-based learning hours to be achieved and rearranging academic and placement blocks across the curriculum.

The HCPC did not require the education providers to engage with it in order to approve the changes and acknowledged that providers might need to trial adaptations and then make further changes to find the right solutions. The HCPC did however make it clear that education providers would need to maintain standards and that they would need to use their professional judgement to ensure learners continue to achieve learning outcomes and meet their proficiency standards. With this flexibility, providers were also required to ensure they could explain and evidence any decisions they took, should the HCPC ask for this in future.

It was identified that the risk of the proposed approach was that providers would potentially make changes which do not meet regulatory standards. This could impact on learner and service user experiences and the quality of education provided. It noted, however that there was no evidence to suggest that that was the case presently.

The HCPC engaged with national bodies (e.g. Health Education England, Chief Allied Health Professions and Scientific Officers, Council of Deans, professional bodies) to address student progression challenges and it communicated the policy of regulatory flexibility to the sector as part of this. The HCPC acknowledges that the student experience was not the same as it was prior to the pandemic, and it will look to understand this more in relation to the standards they set as time goes on. The HCPC will use future monitoring cycles to do a thematic exploration of education provider's responses to the pandemic.

Benefits

By changing the approach to compliance checking, the HCPC created a space for providers to be agile and to innovate in response to the challenges they were facing. For example, by providing guidance to education providers about using technology-enabled care placement (TECS), using simulation and digitally led learning methods more when face to face training became difficult and being flexible with the number of hours in placements to determine competency, placing more emphasis on the outcomes to be achieved.

The HCPC also asked itself whether it could replicate this new approach. The HCPC was already in the process of piloting a new approach to quality assurance which no longer requires education providers to inform it every time they change their approach. The new approach to quality assurance focuses regulatory engagement on providers that are considered riskier, and the HCPC will take a more hands-off approach with those with a proven track record.

This new thought process enabled the HCPC to feel more confident leading into the pandemic, as it felt it is repeatable because it is something it was already testing.

Historically, there has been a divide in opinions about the use of digitally led technology to support pre-registration training (e.g. simulation versus face to face training, technology-enabled care services, online learning). The pandemic showed that there can be a good in-between and it has provided an opportunity for all stakeholders to consider and invest in different learning approaches, and to be more innovative.

Engagement

Overall, the engagement the HCPC had with education providers was positive. The HCPC did a lot of 'myth-busting' regarding their requirements and it was helpful to be able to outline the regulatory framework in place to maintain quality, but to also allow flexibility. The HCPC found that there is a lot that can be done if it, and stakeholders, are willing to embrace it.

Response from education providers.

The HCPC found that generally, education providers were happy to follow the guidance it provided. The HCPC received some further questions from some providers to check what they can and cannot do. Generally, providers viewed this as a pragmatic and mature approach and it felt as a regulator, it was supporting them.



Case study 18

GOC: APPROACH TO APPROVAL OF CHANGES/COURSE ADAPTATIONS

Our core role during the pandemic, consistent with our statutory purpose, is public safety. In ordinary times, we maintain public safety through setting standards and approving qualifications for entry to the profession.

At the outset of the pandemic we recognised its potential two-fold impact. First, on providers of GOC-approved qualifications (a mixture of higher education institutions, further education colleges and private member organisations) and their continuing ability to comply with our requirements for qualification approval, and second, its impact on us, as a regulator, in our ability to deliver our education quality assurance and approval functions to maintain public confidence.

All healthcare regulators were similarly affected, and we worked closely with our colleagues within statutory regulation to ensure our response to the impact of the pandemic remained proportionate and targeted to areas of highest risk. We were also fortunate to have a close and collaborative working relationship within optics with our broader stakeholder community, evident in weekly sector-level meetings where we were able to quickly take the pulse of the profession as the pandemic unfolded. Of prime concern was the effect of the pandemic upon future workforce supply in meeting patient and public eye care needs and to maximise the opportunities for direct patient contact for students, given the restrictions on optical practice.

It's important to note that Optical education is a combination of higher or further education and work-based learning and experience, which is most frequently gained in the private sector in high-street optical practices. In the first lockdown in March/April 2020, with the closure of many optical practices (apart from those

offering urgent or emergency eye-care) and furloughing of optical professionals, opportunity for students' direct patient contact, which forms a critical component of our requirements for qualification approval, was increasingly limited. Our interface with private sector employers as a supplier of clinical experience is a key difference between the optical sector and our colleagues in other regulated professions, who are primarily employed within the NHS. With reductions in placement capacity we were faced with a cohort of students unable to progress and to qualify. There was simply no option to 'do nothing', to wait out the pandemic.

We immediately conducted a rapid and comprehensive risk analysis of the impact of COVID-19 on our requirements for qualification approval, which includes detailed numerical requirements for patient episodes in different categories (such as paediatric patients or contact lens fittings). To substantiate our analysis, we worked closely with our education providers to understand their risks, concerns and needs, and potential solutions, alongside considering the impact of COVID-19 upon the education sector as a whole. Together, we identified the following key areas of risk:

- Course structure, mode of delivery and assessments – it was clear that both theoretical and practical assessments involving face-to-face contact would need to be conducted in alternative ways, and the suitability and equivalency of the alternative methodologies would need to be considered by the GOC to maintain the validity of assessments.
- Clinical experience and progression – Due to the initial closure of many private optical practices and furloughing of some optical professionals, and the limits placed on student placements within hospital eye services, there was a risk that the required volume of clinical experience to support progression would be significantly reduced, or not available at all.

Our approach to mitigating these risks was to work collaboratively with the sector to develop, consult upon and propose solutions. Together we identified what adaptations to qualification delivery providers might make that would enable them to continue to meet our requirements for qualification approval. We managed this notification of temporary changes through a desk-based review of providers' submissions to us, noting changes to qualification delivery and their management of risk. These were predominantly notification of temporary arrangements, for example, to move teaching and assessment online, replace direct patient contact with online or simulated experiences, reorganise modules and use alternative methods of assessment for both the theoretical and practical components. We checked that there was sufficient information within these written notifications to provide assurance of the suitability and comparability of the temporary arrangements proposed – including that alternative methods of assessment were appropriate for our required learning outcomes or core competencies, noting the new arrangements and requesting an update as appropriate.

Despite this management of temporary changes, the impact of the pandemic on the availability of direct patient contact for optical students at the volume required for progression necessitated consideration of further adaptations. First, for the cohort of optometry students preparing to graduate and progress into their pre-registration year in practice (for the academic year 2019/2020), and the cohort of students close

to completing their pre-registration year. Many of these pre-reg students had already successfully achieved their undergraduate degree, the majority of their mandatory stage one patient episodes and core competencies, and were expecting to complete their final qualifying examinations and enter the register by mid-summer 2020.

Working closely with the Optometry Schools Council and The College of Optometrists, together we designed a proposal which enabled undergraduate optometry students to 'trail' their required stage one (undergraduate) patient episodes and experience into The College of Optometrists' pre-registration Scheme for Registration (and equivalent), thereby securing student progression and workforce supply, putting in place appropriate safeguards for its safe governance, supervision and assessment. Satisfied that such arrangements would be safe and appropriate, and after a short (four week) consultation, Council gave its approval, thereby enabling optometry students to graduate and be supported safely into their pre-registration year on their journey to full registration.

In tandem with temporarily adapting our requirements for undergraduate education and progression into the pre-registration year for optometry students, we also devised, consulted upon and introduced changes to our requirements to what we call 'stage two' qualifications, broadly, the qualification optometry students take after their undergraduate degree which leads to entry to the register. We welcomed the opportunity to work in close consultation with the sector to consider which of our requirements for stage two qualifications approval required amendment given the sudden contraction in placement opportunities and more limited direct patient contact for students approaching their final qualifying examinations with the expectation of entering the register from summer 2020 onwards. Following a short consultation we:

- made our patient experience requirements more flexible, to ensure an appropriate breadth of experience, rather than strict numerical values, and permitted observation with formal reflection to be counted as patient experience. This approach enabled clinical experience to be delivered in a safe and practical way and contribute to preparing students for the new world of practice brought about by the pandemic; and
- expanded our rules on supervision, allowing non-GOC fully qualified statutorily registered healthcare professionals to supervise students, as long as they met our supervision criteria.

These changes were particularly well received by providers and students, who now report a greater level of confidence in meeting our temporary requirements, despite the disruption in the optical sector caused by the pandemic, to protect patients, students and the public, maintain the quality of clinical experience, and enable new and innovative approaches to the pre-registration year.

Learning

We successfully navigated the pandemic because we worked closely with stakeholders in the optical sector, including our education providers, professional bodies, Education Visitor Panel, statutory advisory committees, Council and the Executive. Equally critical to our collective success has been the speed at which these changes have been delivered. As we go on through the next stages of the

pandemic, we will continue to work collaboratively with our sector to create the best solutions possible, maintaining public safety at the heart of all we do.



Case study 19

NMC: DEVELOPING AND IMPLEMENTING THE NMC'S EMERGENCY AND RECOVERY STANDARDS

Introduction

1. In March 2020 and with the significant pressures on the health and care workforce it became clear that nursing and midwifery education could not continue as normal.
2. Working closely with the four Chief Nursing Officers, Chief Midwifery Officers, Council of Deans of Health, Royal Colleges and representative bodies a set of emergency standards were identified. These standards enabled:
 - Students in the final six months of their final year to complete their programmes in clinical placements
 - Students in their second year or first six months of their final year to spend up to 80 percent of that period in clinical placements
 - First year students to complete their first year through theoretical learning.
3. These standards also removed the requirement for supernumerary status of students, and the governments of each of the four countries agreed to remunerate these students who opted to undertake these placements. As a result, by September over 35,000 students had spent some time in clinical practice under these arrangements across the four countries.
4. On 30 September 2020 these emergency standards were removed and replaced with a set of recovery standards designed to try and normalise student education.

Assurance over our standards being met

5. Our emergency and recovery standards were optional for Approved Education Institutions (AEIs) to implement locally as appropriate.
6. Where AEIs and their practice learning partners adopted the emergency standards they were required to submit a dedicated Covid-19 exceptional reporting form outlining how they had adopted the standards.
7. Mott MacDonald our quality assurance service delivery partner then reviewed these reports to provide assurance that our standards continued to be met. Where any potential concerns were identified these were then followed up.
8. AEIs are currently submitting their Annual Self Reports and will need to provide an update as part of that process on if and how they have adopted the recovery standards.



Case study 20

SOCIAL WORK ENGLAND: COLLABORATING WITH EDUCATION PROVIDERS – PLACEMENT PLANNING WITH THE WEST MIDLANDS TEACHING PARTNERSHIP

In March 2020, during the initial stages of the pandemic and lockdown, we paused planned inspection activity whilst developing our remote inspection process. We increased dedicated pandemic response engagement with course providers. At this time, course providers had the opportunity to have a direct link with a single point of contact with the Education Quality Assurance (EQA) Team for their locality to assist with planning opportunities, implementing the guidance and to assist where course providers had questions or proposals that needed insight from officers who could benchmark across the rest of emergency provision in England.

Within the West Midlands, we attended weekly virtual planning meetings with individual course providers and came together within the Teaching Partnership and HEI reference groups to specifically address risks to student's placement completion and to assist in conversations that sought to mitigate reactionary actions put in place during the country wide and local lockdowns that were identified as raising risks later within the student's course, or to wider placement capacity within the local area. The intelligence gained within these meetings provided vital strategic oversight into concerns within the social work education sector and allowed us to quickly adapt with developing guidance and positioning within the regulatory body.

In assessing adjustments that could be made to adapt to local restrictions within placements, a course provider within the West Midlands Teaching Partnership produced a proposal to adapt placements for students unable to attend any face-to-face interaction with people receiving social services. The proposal contained innovative thinking about how placements could be adapted in emergency situations to allow students that were identified as having risk levels at this time that would prevent them from completing a placement to carry out their placement within a simulated environment. The proposal addressed problems with placement capacity caused by providers suspending placements, third sector placement activity that was no longer taking place, or where a reduced number of days could only be completed to allow for placement opportunities to be shared with the capacity required within the local area. Initial planning meetings had been made with local authority placement providers, organisations that would both provide the simulated environments and people with lived experience who would work with students in the placement.

The initial proposal was reviewed following a collaborative working arrangement with EQA and the course provider. EQA also consulted with members of the Social Work England Education and Training Forum to seek independent viewpoint on the range of actions identified within the proposal. Advice was provided to the course provider that the presence of simulated activity within a placement was an acceptable and welcomed adjustment during these times, but an entire placement without the

involvement to real life service user engagement was unlikely to provide the student with the skills and experience of social work that would meet the professional standards required of a social worker. In assessing the risks relating to the approval of an alternative delivery of placement activity, we considered the ability to demonstrate the learning outcomes of a placement experience, confidence that the student would experience the unpredictable and realistic experience of social work using pre-prepared case studies and considered public expectations of social workers qualifying with an approved social work course during this time. In balancing the risks that students may not be able to complete their social work qualifications and reduce the number of social workers joining the register and work force, as well as disrupting capacity planning later in the next academic years, the impact on public safety of social workers who were not exposed to the reality of social work in a placement environment was determined to be principle that was not one that could be adjusted even in the exceptional circumstances of pandemic.

We worked closely with the course provider to identify areas within the proposal that could be explored and implemented, as well as further encouraging partnership working within the Teaching Partnership to develop the proposal in conjunction with the other course providers within the area.

The West Midlands Teaching Partnership has now developed a Placement Planning Contingency process and supporting guidance that outlines 14 adjustment activities using nine delivery methods that can be adapted for placement planning for all students that have disruption to scheduled placement activity. It has been developed with both a short-term assessment of a second, and possible third UK lockdown, and as a longer term range of opportunities to inform placement planning within the area for the next few years. Joint working on placement planning contingency has been at no financial cost of Social Work England but is expected to provide a range of options, with limited or minimal financial impact to the course providers.

Feedback from this course provider in our Annual Monitoring detailed:

'In March 2020 when adjustments were being made to placements, we worked closely with our Regional Engagement [Lead] and our Education Quality Assurance Officer to gain feedback on planning and to share adjustments and adaptations. This was on an individual basis and as part of the HEI reference group in the West Midlands Teaching Partnership. This support was invaluable. Work that we completed as part of the HEI reference group is now being used to inform a regional approach to potential placement adjustments for January 2021.'

Responses to our call for views: education and training

Increased flexibility in the delivery of education and training

A number of respondents commented positively on the regulators' approach to adaptations made to the delivery of education and training in response to the pandemic, and said that they would welcome the heightened responsiveness of the regulators in this area continuing in the longer term.

They felt that regulators were quick to recognise the significant impact that the pandemic would have on the delivery of education and training and to respond to the challenges involved. Some respondents commented on the regulators' close cooperation with partners in education to assess what changes would be required.

There was appreciation for the pragmatic and proportionate approach taken by the regulators to proposed adaptations to courses, and their support for trainees to continue to progress to registration. One stakeholder commented on the degree of trust placed in education providers to use professional judgement to assess risks in relation to aspects of pre-registration training and assessment.

A number of stakeholders commented that online delivery of education and training had worked well and could be used to a greater extent in the future. It was noted that online teaching and assessment could reduce travel costs and the environmental impact of holding events in person, as well as increasing the accessibility of courses for a wider range of students.

Greater use of simulation and online practice were suggested as a means to mitigate the disruption to learning caused by the pandemic (in particular in clinical placements) and to support students to progress, complete, and join the professional register in a timely way. It was proposed that continuing flexibility would be needed to enable students to progress.

One respondent noted that immersive technologies had enabled the development of simulated practice placements, which can develop skills and behaviours without the need for face-to-face interaction. It was noted that online patient consultations were a useful way for clinically vulnerable students to access practice settings without endangering their health. However, it was stressed by others that face-to-face teaching remained invaluable for patient-facing health professions and that simulated patient experience could not safely replace the experience gained by dealing with real patients and the variation and unpredictability of their responses to the conditions they have.

The negative impact of changes to education and training during the pandemic

Stakeholders described some negative consequences of changes to the way in which education and training have been delivered during the pandemic. These included concerns around the quality of students' learning experiences and the impact on their mental health.

We received feedback that paid deployment of students in the final year of their training caused confusion for some around their status and level of access to support from their education providers. One stakeholder expressed the view that supernumerary student status must be maintained across the full programme duration in future, arguing that its removal will not support student progression and could compromise patient safety.

We also heard that some employers had found it a challenge to provide sufficient placement opportunities to those students in their first and second year of training who missed out on them in the 2019/20 academic year.

Areas where further work may be needed

A number of respondents highlighted the need for further work to understand the full impact of measures taken in education and training during the pandemic. They said that while education providers had taken an innovative and creative approach to ensure that students could progress to the next year of study or complete their programme and seek registration, there remained a need to monitor the impact of the changes made on learning outcomes.

One respondent stressed the importance of employers paying close attention to the experiences of newly qualified professionals and recognising that some new graduates may need more support in light of their interrupted studies. The respondent was of the view that the regulators should be proactive in promoting this.

One respondent noted that regulators, in partnership with educators and other relevant bodies, should undertake work to understand how technological developments can be integrated into theory and practice education as this would be the norm in future both in training and indeed in the delivery of care. It was argued that there is a need for updated definitions and guidance for new technologies in the context of regulated education and that increased flexibility in this area could reduce pressure on practice placements.

Comments on learning for future crisis

One respondent told us that the pandemic had demonstrated the importance of maintaining basic general medical skills (e.g. the management of the breathless, septic or hypoxic patient) in a larger part of the medical workforce in order to embed the flexibility needed to deal with future pandemics or other crisis. Another stressed the need to ensure that all students and new registrants have access to learning resources and support around bereavement care, and other training such that even in highly challenging situations professionals could continue to offer personalised, compassionate care.

Strategy, collaboration and governance

Case studies 21-28 and responses to our call for views



Case study 21

GMC: HOW THE REGULATOR RESPONDED TO EMERGING EVIDENCE OF HIGHER PREVALANCE OF COVID-19 INFECTION IN BAME PEOPLE

In the immediate response, new policies we developed complied with the Equality Duty including considering the impact on people with protected characteristics. The emerging evidence of higher prevalence of Covid-19 infection in BME people was considered as part of all our operational responses (also highlighted in our other case studies in this report). Our approach to temporary emergency registration was supported by an equality analysis, our case study on ethical guidance highlighted the predominance of enquiries from BME registrants, and our new [corporate strategy](#) states our ambition to be an effective, relevant and compassionate regulator and to foster a culture of equality, diversity and inclusion.

During 2020 our [State of Medical Education and Practice in the UK](#) report explored and highlighted the experience of the profession through the pandemic and particularly the different experiences of doctors from different backgrounds. This report helps us to raise broader understanding of the issues across stakeholders. We also added an additional question in the National Training Survey to help us understand more about the inclusivity of training environments for doctors. To further help build the evidence base, we supported jointly funded research by UK Research and Innovation and the National Institute for Health Research on the relationship between Covid-19 and ethnicity among UK healthcare workers.

Looking to the medium and longer-term, our Chair and Chief Executive asked for a review of the available evidence and the call for action. This review was led by our Equality, Diversity and Inclusion team and informed by consultation with our ED&I Steering Group and champions, staff networks, staff forum, benchmarking, operational teams, and a wide-ranging body of research, including recent work such as [Fair to refer?](#), [Caring for doctors, caring for patients](#), and past work on understanding [differential attainment](#) in education and training.

Our response

The evidence is compelling that further action is required to improve the wellbeing and sustainability of the workforce and with it improve patient experience and care. In 2020 38% of all licensed doctors in the UK were BME. This proportion is growing. 61% of new doctors joining the register in 2020 are BME, up from 42% in 2017. As the number of BME doctors in the UK workforce grows, the evidence is clear that they continue to experience disadvantage and differential treatment – in particular, BME students/ trainees experience an attainment gap in medical education and training, and employers are significantly more likely to refer BME doctors to the GMC for fitness to practise concerns, than their white peers. Both issues have been long-standing concerns for the GMC. Our research and analysis on [fairness in referrals \(published June 2019\)](#) and on [differential attainment \(published annually\)](#) has demonstrated the sustained nature of these issues and provided insights to their causes and impacts.

Despite the complexity of the issues, we know that more inclusive and supportive working environments have a proven impact on promoting fairer outcomes and positive patient outcomes within NHS organisations, such as providing improved patient satisfaction, quality of patient care and (in the acute sector) reduced patient mortality.¹³ Research shows that a large part of disadvantage stems from being part of the ‘out group’. The reality is that those in the ‘out group’ enjoy lesser protective factors than the ‘in group’. This manifests in reduced quality and frequency of feedback and limited informal mentoring and sponsorship. Inclusive and supportive environments are shown by research evidence to be a critical factor in reducing these disparities, as well as benefitting all staff¹⁴. Caring working environments for

¹³ [Caring for Doctors, Caring for Patients](#) - Longitudinal analyses of data from the NHS Staff Survey in England, have consistently shown associations between staff reports of stressful and unsupportive work Environments.

¹⁴ https://journals.lww.com/academicmedicine/Fulltext/2020/05000/Belonging,_Respectful_Inclusion,_and_Diversity_in.1.aspx

doctors also improves the quality of care, patient safety and the sustainability of our health services.

In September our Council agreed to a step-change in ambition to bring into sharper focus the need to target and reduce these race-related differentials. In doing so, we aim to drive improvements in the inclusivity of working environments for doctors and the quality of care patients receive. Our Council will soon be considering proposals to establish measures and targets around FtP referrals and differential attainment to focus energy and highlight system-wide progress on improving these outcomes more clearly. With this heightened focus we will work closely, and collaboratively, with stakeholders across the system to coordinate efforts for improving local environments, to support fairer and better outcomes for doctors and patients.

Summary

We have considered and accepted that the causal factors for these issues are complex and most of our levers are arm's length. We know that making meaningful change requires others to commit their resources to addressing the underlying issues and that this work will risk being perceived as a burden on a pandemic exhausted system and profession. But we also think that the evidence and workforce sustainability dimension cannot be ignored, and that the pandemic has highlighted more than ever that a professionals individual health and well-being is central to their ability to deliver good care, and we must focus our attention on supporting the right environments to enable doctors to do so.



Case study 22 **NMC: THE NMC'S STRATEGY FOR 2020-2025**

1. The NMC launched its five year strategy at the start of the first Covid lockdown, and during the months that have followed we have continually returned to these critical questions:

- Do the objectives and the values we set out remain relevant and right in these most testing of times?
- What impact will Covid have on our delivery of our strategy and how should we respond?

2. We were heartened with how well our Covid response work reflected our values:

- Fair – assuring registrants that they would not be called to account in circumstances where Covid meant they had no choice but to offer less than optimal care
- Kind – extending revalidation deadlines so that our registrants could focus on their important work
- Ambitious – helping the government to legislate for temporary registration in a matter of weeks
- Collaborative – working with educators and employers to give final year students the option of completing programmes in practice so they could play a part in fighting Covid.

3. Covid 19 has required us to find new ways of delivering our strategic aims. For example, we want to provide proactive support for our professions and be more visible and informed. In 2020 we couldn't do this via a physical presence in health and care settings. So we adapted our advice line for senior registrants so that any concerns that might lead to referrals could be discussed remotely with a regulation adviser in advance. This meant senior nurses felt supported and the NMC did not attract inappropriate referrals, saving time and cost, and avoiding distress.

4. Once the first spike was past, we needed to take stock of the impact of Covid on our work and our future plans. Pausing physical fitness to practise hearings during the first wave was a necessary step, because no-one wanted registrants' time and energy spent on NMC processes. However, the consequence is that we have a backlog of cases to process. We recognise, as we set out in the strategy, that doing our core regulatory functions well is how we protect the public and maintain the trust and confidence of our stakeholders, and so we know that some of the things we planned to do on 2021-22 and beyond will need to be paused or re-profiled in order that we can prioritise fitness to practise recovery. For example, we had planned to extend and evolve our outreach capability, but now is not the time to change a function which has helped us to make sure we only receive referrals that require regulatory action.

5. Throughout this time we have had to reflect rapidly on our decisions and learn from our reflections. For example, we reviewed the risks and benefits of the decision we made in the first wave to pause physical hearings, and we decided that we would continue to hold physical hearings through the second lockdown, having tested our ability to do so safely and understood the views of our stakeholders.

6. As we undertake business planning and budget-setting for 2021-22 we are working through which of our strategic goals can be pursued without diverting energy or resources from fitness to practise recovery, and more generally, which of our plans will need to be fulfilled over a longer horizon because we cannot invest in them yet. We are also taking account of the planned work that is subject to external timelines such as Brexit preparation or regulatory reform.

7. One of our considerations is to think about how the pandemic has affected our work with different stakeholder groups. We acknowledge that our partnership working with other national bodies has thrived but Covid pressures have reduced our focus on public engagement in 2020. We have used this time to plan a future public engagement approach, and while in theory that is a project that could be pushed back, we currently envisage proceeding with it in 2021-22 in order to redress the balance somewhat.



Case study 23

GMC: THE IMPACT OF THE PANDEMIC ON THE REGULATOR'S CORPORATE STRATEGY; THE IMPACT OF THE STRATEGY ON THE REGULATOR'S RESPONSE

We had been developing our new corporate strategy for 2021-2025 since summer 2019. Our Council agreed four core themes of the strategy in early March 2020 before we went into lockdown:

- Enabling professionals to provide safe care
- Developing a sustainable medical workforce
- Making every interaction matter
- Investing in our people to deliver our ambitions

The pandemic's demands on the profession and our organisation challenged us to consider if what we'd identified as our key strategic priorities for the forward five years remained fit for purpose. We had also paused the bulk of our non-essential activity from March through to June and we wanted to ensure that as and when we restarted paused activity, we did so aligned with our strategy, but also in a way that was fit for purpose for the pandemic, and post-pandemic world.

Our approach

Our strategy, regulation policy and data teams worked together, drawing widely on published articles and research from other organisations such as the BMJ, the Health Foundation, Nesta and the NHS Confederation around the impacts of the pandemic. We considered three scenarios (best case, medium case, worst case) across several timeframes (6, 12 and 24 months) and explored what we thought the impact would be against the following hypotheses:

- Clinical practice - The pandemic highlights potential barriers and enablers to efficient and effective delivery of care by professionals that we and others should address.
- UK workforce - The pandemic highlights shortcomings in the composition of the UK's clinical workforce – both mix of skills and total numbers.
- Societal - Society's attitudes to a host of topics are changed by the pandemic resulting in a need to recalibrate some fundamental assumptions about how we regulate and providing opportunities to regulate differently.
- GMC operations - The GMC's response to the pandemic has changed how the organisation operates and this highlights opportunities to continue these ways of working, as well as some challenges in reverting back to previous operations.
- Key risks identified concerned: patient safety, the resilience and capacity of the workforce, the impact of new ways of working such as remote consultation, and the impact of the pandemic on BME professionals and patients. The work highlighted opportunities to improve the way we work and support the profession and the healthcare system, for example:
- Greater focus on wellbeing for our people and registrants, building on the more human, empathetic tone we have adopted
- Increasing flexibility to provide a better service and to increase our own and system resilience

- Joining up with others in the system to form a 'single view' where practical, and actively considering when to lead and when to support

The outputs were used by our Recovery and Renewal Taskforce to ensure that how we resumed paused activity was done so with a view to the longer-term future. Certain areas of our pre-pandemic Strategy were reinforced or refined in order to reflect the changed environment. Changes included:

- A stronger emphasis on equality, diversity and inclusion in response to concerns about the disproportionate impact of the pandemic on BME professionals and patients
- Greater focus on mental health, wellbeing and workforce support
- Improved understanding of and support for the workforce
- More emphasis on collaboration with other regulators and partners to build resilience and capacity
- Greater focus on public and patient involvement (PPI) in order to better understand the patient experience
- Greater flexibility in education and training to optimise skills and capabilities around generalism, specialisation, professionalism and multi-disciplinary teamwork
- A greater focus in our Making every interaction matter theme on proportionality, efficiency and respect

Our new Corporate Strategy 2021-2025 was published in November 2020. Our new 3-year plan which supports the strategy can be found here. We continue to assess our priorities in the light of developments in the pandemic and the healthcare landscape, prioritising some initiatives and pausing others as appropriate to the needs of the system.



Case study 24

GOsC: RE-INTEGRATING THE PATIENT VOICE IN REGULATION

Summary

The GOsC took steps to enhance patient engagement and dialogue to inform its regulatory processes since the onset of the coronavirus pandemic.

This has manifested in a patient centred approach to the development of key standards and fitness to practise guidance. Further work is now ongoing to develop a patient partnership and co-production model and further detail can be found in our February 2021 Council papers¹⁵.

Involving patients in a more meaningful way

One of the key things the GOsC noticed early in the pandemic was the loss of the patient voice. This was also emphasised through work by organisations such as the Patients Association and National Voices. For example, during the first lockdown

¹⁵ <https://www.osteopathy.org.uk/news-and-resources/document-library/about-the-gosc/council-february-2021-public-item-10-patient-engagement-final/?preview=true>

there was discussion about what was 'essential' medical care in a range of areas and this was defined by the practitioners, not the patients, without seeking the views of patients. Also, some professional bodies had produced guidance to suggest that shielding patients should not be treated, which effectively erased the voice of those shielding patients and their rights to consent to a degree of risk like other patients.

The GOsC had been challenged prior to the coronavirus pandemic recruiting high numbers of osteopathic patients to get involved in osteopathic regulation beyond the usual surveys and focus groups. This was despite employing a range of innovative mechanisms including: flyers in the community and engaging with local community patient groups online via Healthwatch and other similar organisations.

The lockdown has highlighted the need for better, more meaningful and personal communication and GOsC has applied this to its thinking and work with patients and involvement in regulation. GOsC has recently been creating safe spaces to allow patients to share experiences on a one to one level as well as through traditional mechanisms such as focus groups to inform its approach. The GOsC recognises that 'people respond to people, not just adverts' and is working towards building its relationships with patients to improve understanding of osteopathy, regulation and how patients can work in partnership in this process.

This more person-based approach has resulted in a greater number of patients being involved and also more meaningful feedback.

Discussions with patients in both one to one and focus group settings revealed that some patients wanted the certainty of treatment being declared safe, including the safety of entering and exiting a building for an appointment and there being sufficient personal protective equipment. The GOsC wanted to ensure that patients' expectations would be met before being in the treatment room. It was important to consider the wider journey as well as what happens when receiving treatment.

The GOsC also identified that themes and messages from patients were that decisions should be made with them not for them: they should be involved in the discussion. This fitted with recent work published by the GOsC¹⁶¹⁷ and but takes it further and applies this thinking to its whole regulatory approach not just practitioners working with patients.

So, a regulatory 'co-production' meaning that an organisation should not assume they know what is best for the patient. Some would say, in the current climate, they would prefer to stay in pain, others said they would trust their osteopath to follow guidelines, for example with infection control: that degree of balancing risk is a patient's decision in conjunction with the clinician.

In its immediate response, GOsC identified that its infection control guidance needed to be enhanced in the context of coronavirus. The aim of this enhanced guidance was to highlight and signpost relevant public health and health and safety guidance and other government guidance relevant to osteopathic practice in the context of the

¹⁶ <https://onlinelibrary.wiley.com/doi/full/10.1111/jep.13279>

¹⁷ https://link.springer.com/chapter/10.1007/978-3-030-47852-0_45

pandemic emphasising professional judgement and dialogue with the patient in applying the guidance and supporting informed decision making.

Fitness to practise review

Patients also fed into the development of guidance about fitness to practise hearings in the context of the pandemic. Patients were involved in the fitness to practise review process and shone fresh light on it, so that it is accessible to a person on the street.

The GOsC also conducted a literature review of civil and criminal court procedures, and an Equality Impact Assessment of a breadth of work which resulted in it using terms for hearings like 'remote' instead of 'virtual' and 'blended' instead of 'hybrid'. Patients told GOsC that they are put off by looking at their face on a screen when giving evidence. Guidance has been amended to reflect this sensitivity and has been further shared with other tribunals such as the Solicitors' disciplinary tribunals.

The GOsC will move on to review experiences of the implementation of remote hearings. It is currently doing some pre-consultation work, including patients.

Conclusions

The GOsC took steps to enhance and integrate the patient voice more meaningfully into its thinking, approach and work. It realised that regulators do not always put the patient at the heart of things when thinking about different 'functions'; regulation is thought of registration, education, fitness to practise and so on. The GOsC thinks this is increasingly an issue as we move forward, they are here for the patient so that should be the starting point. This has informed the GOsC's strategy and approach for 2021-22 which is based on a much more structured and safe approach to patient engagement both operationally and strategically. (See our Council paper above for further information about this).



Case study 25

GPhC: WORK WITH HESTIA ON DOMESTIC ABUSE – SAFE SPACES IN PHARMACIES

The GPhC is part of the Employers' Initiative on Domestic Abuse and through that we were aware of the the Safe Spaces initiative operated by the UK Says No More campaign – a national campaign aiming to raise awareness to end domestic abuse and sexual violence across the UK.

The first pandemic lockdown saw a dramatic rise in domestic abuse as victims were forced to isolate with their abusers. It was estimated that one in four women and one in six men were suffering. The National Domestic Violence Helpline was reporting a 25% increase in calls and the charity Hestia saw a 47% rise in victims reaching out for information and support.

We were already working with Hestia on the possibility of pharmacies becoming 'safe spaces' but this was escalated in the context of the pandemic. We identified an

opportunity to protect vulnerable people by using our influence with the sector. We engaged with a number of our stakeholder organisations, raising the issue with them, explaining how safe spaces could be provided and the benefits they could bring. In May 2020, with significant stakeholder support, we asked pharmacies which have consulting rooms to make those rooms available as safe spaces where victims of domestic abuse can contact specialist domestic abuse services for support and advice.

Pharmacies in the community both remained open during the pandemic and are a place where a victim of abuse may be able to go, even if subject to coercive control. We therefore hoped that making pharmacy consultation rooms a safe space, people would be able to find the support they needed when other options might be temporarily unavailable.

In the consultation rooms, people have access to:

- 24-hour National Domestic Abuse Helpline: 0808 2000 247
- Men's Advice Line: 0808 801 0327
- Scotland - Domestic Abuse & Forced Marriage Helpline (freephone 24/7): 0800 027 1234
- Wales - Live Fear Free Helpline (freephone 24/7): 0808 801 0800
- Northern Ireland - 24 Hour Domestic & Sexual Abuse: 0808 802 1414
- Signposting to download free mobile app Bright Sky, which provides support and information to anyone who may be in an abusive relationship or those concerned about someone they know.

Our inspectors – who have switched to a role supporting the pharmacies in their area during the pandemic – have made over 4000 support calls to pharmacies and every inspector has encouraged the pharmacies they work with to join the scheme. By October, over 25% of pharmacies had signed up to provide safe spaces and it was estimated that those spaces had been used over 3,700 times – demonstrating that there was a real need for this provision.

We have been adding examples of good practice in regard to safeguarding to our Knowledge Hub, as well as publishing articles about the scheme to encourage more pharmacies to join.

In January 2021, 2,300 Boots pharmacies and 255 independent pharmacies also began offering the government-backed 'Ask for ANI' codeword scheme which allows those suffering or at risk from abuse to signal to need help. If someone 'asks for ANI', a trained pharmacy worker will offer them immediate assistance, providing them with a private space and finding out what the victim needs – whether that be to speak to the police, to access national helplines or local services.

There can be no better way to convey the impact of this scheme than to quote from someone who has used it. A person who was shielding due to complex medical needs realised during lockdown that they were experiencing coercive control in their relationship, and had been doing for some time. During lockdown the abuse escalated to aggression and then to violence and the person realised that they needed help but did not know how to find it. Ordering medication online, the person

saw information about safe spaces and was delighted to see that their local pharmacy was listed.

“I could now make a plan and on the first day that ... us shielders could have outdoor exercise time, after 10 weeks indoors, I raced to the pharmacy and asked to use their Safe Space.

The consultation room became a second, safe and sound part of my lockdown from hell. I called the local domestic abuse and violence partnership who immediately worked out the best plans to keep me safe in the first instance. I phoned my mum and sister for the first time in months (everything I did at home was monitored), I phoned a good friend and a solicitor. Over the weeks I used the Safe Space, I developed a plan to get the abuser out of my home.

Last week I got him out of my home, had the locks changed, and boxed all his things. I am beginning to feel safe in my home again, but without the Safe Space, things could have been very different and far, far worse.”

Information about the safe spaces initiative, including the pharmacies involved and the resources available to pharmacies to support them, can be found on the UK Says No More website at www.uksaysnomore.org/safespaces



Case study 26

GPhC: WORK WITH THE COMPETITION AND MARKETS AUTHORITY

Early in the first wave of the COVID-19 pandemic we began to receive concerns about unprofessional and anti-competitive behaviour by a small number of pharmacies. These included reports linked to the pandemic about unjustified or excessive price inflation and attempts to drive up locum rates. The price inflation was on products related to the pandemic including hand sanitiser, face masks and paracetamol and we were receiving significantly more concerns about these issues than others related to the pandemic.

As a healthcare regulator, we see community pharmacy first and foremost as a healthcare environment and do not usually take action on matters which are purely commercial, unless there are broader issues which could impact on public confidence in pharmacy. However, the sale of non-medicinal products is part of the service which many pharmacies offer and so retail prices can impact on public confidence if it appears that there may be profiteering. There could even be patient safety issues, especially if certain medicines become unaffordable.

We therefore took the decision that it was appropriate to act to ensure that the public was able to access pharmacy products and services safely and in a manner which maintains public confidence.

On 19 March 2020 we issued a statement on profiteering praising the way that the majority of the profession was acting during the pandemic but pointing out that “the actions of a small minority are raising concerns and anger within the profession itself and more widely. Profiteering to take selfish advantage of the current challenging

situation, whether with prices of shortage products or locum rates, risks bringing the profession into disrepute at a time when public confidence generally is so fragile, and so important.”

We wrote to a number of registered pharmacies about which we had received concerns, reminding them of the need to continue to meet our standards and in some cases asked them to review the price they were charging for a particular item.

Concerns continued to come in and we needed to review how we managed them, in line with our regulatory powers and in a way that was consistent and proportionate. We therefore initiated contact with the CMA to explore our respective roles and responsibilities, including sharing information in a way appropriate to our respective roles and powers. The CMA is the UK’s competition and consumer authority and works to ensure that businesses operate within the law and that consumers get a fair deal when buying goods and services. It has recourse to a range of competition and consumer powers and can take enforcement action if it has evidence that competition or consumer protection law has been broken.

In addition to potentially breaching competition and consumer law, pricing or locum rate fixing which seeks to profit from the pandemic may call into question the professionalism of any registered pharmacy professional or owner, as it may indicate placing financial gain over the safety and care of members of the public and harm the reputation of the practice of pharmacy. Such behaviour has the potential to breach certain standards for pharmacy professionals: namely providing person-centred care; using professional judgement; and behaving in a professional manner.

Pharmacy owners and Superintendent Pharmacists have a responsibility to ensure the safety and effectiveness of the pharmacy services provided. A pharmacy may not be acting safely if it has priced important medicinal products so as to make them unaffordable to those who need them. Any breach of consumer or competition law has the potential to undermine public trust and confidence in pharmacy as a whole.

We held a number of meetings with the CMA and shared high-level information about what we were seeing during the pandemic. We wrote jointly to all pharmacies setting out the ways in which price increases during the pandemic could be harmful to public health and damage the perception of pharmacy. In our joint letter we took particular care not to conflate the roles and responsibilities of the GPhC and the CMA; to the contrary, we highlighted the relevant limitations on the GPhC’s remit and interest in the topic. We also produced guidance for our caseworkers setting out which concerns relating to pricing and rate fixing we would potentially investigate and which should be signposted to the CMA.

If we had taken action alone on these matters, such action could have been open to challenge because we are not a markets or commercial practices regulator. However, the risks of taking no action (lack of access for patients to affordable medicines; an undermining of trust and confidence in pharmacy through perceived profiteering during the pandemic) were considerable, and so we felt that acting jointly with the CMA was the appropriate and proportionate course of action.

The benefits of the collaboration were that it allowed us to have mutual signposting, managing expectations about what we could achieve for those raising concerns; to deal with matters proportionately; to reinforce clear messages about our expectations to the profession; and to draw on the CMA's expertise when considering the levels of price rises.



Case study 27

SOCIAL WORK ENGLAND: WORKING IN PARTNERSHIP TO DELIVER SOCIAL WORK TOGETHER

As part of the national response to the COVID-19 pandemic, on 25 March 2020 we were given emergency powers under the Coronavirus Act 2020 to allow former social workers and those currently not actively practising, to return to social work. Anyone who had left the register since 18 March 2018 was automatically returned so that they did not need to formally apply to return to practice and support the social work profession during an exceptional time.

Anyone who had been removed from the register for fitness to practise reasons was not included in the automatic registration. Since introducing emergency powers, 9,213 social workers have been added to the register with temporary registration. Social workers working under temporary registration could apply to have their registration fully reinstated, in accordance with our usual process for restoration.

Alongside establishing temporary registration status, a campaign 'Social Work Together' was developed in partnership with the Department for Education (DfE), Department of Health and Social Care (DHSC) and the Local Government Association (LGA). These organisations formed a partnership in recognition that while healthcare recruitment rightly geared up at pace to address a potential shortfall in volunteers and professionals to deliver immediate care, it would be harder to quantify longer-term implications of covid-19 for social work. A commitment was made with positive ministerial endorsement to develop a contingency measure that would encourage those falling within the below categories support the national effort:

- A registered social worker but currently not working in frontline practise
- Social workers out of practice for less than two years who have been automatically re-registered by Social Work England.
- Registered social workers working in another sector or not currently in employment.

The aim of Social Work Together was to create a pool of interested candidates for local areas to draw upon as and when need arose. The partnership was mindful from the outset that this incentive would need to compliment local recruitment activity, rather than compete with it and keep regional insight from professional networks and cross government groups firmly in sight to gather intelligence on emerging supply and demand issues. This strategic approach used the LGA to drive efficiencies, utilising their existing regional contacts, applicant systems and a pre-existing

recruitment website to connect those offering their expertise to local employers. This approach was important given that the settings in which social workers operate are not 'one size fits all' and span across both health and social care, children and adult services.

Social Work England's role in this partnership was to support the deployment of social workers back into practice as quickly as possible, without compromising standards or safety for the benefit of vulnerable people. Social Work Together was a way to bolster the efforts of local social work employers through the LGA offer of a bespoke matching service to bring in the right candidate to meet a specific local need.

Social Work Together resulted in 1,000 social workers expressing their interest to support their local community if required in response to the pandemic. The partnership has communicated the offer widely to local authorities and matched approximately 3% of social workers who expressed interest in/availability for work which is comparable to a similar service provided for nursing, midwifery and the police.



Case study 28 GCC: MOVING TO PAPERLESS WORKING

FTP

Before the pandemic, the regulators were each at differing levels of being paperless. The GCC was already communicating with stakeholders by email and had the ability to send documents securely with no restrictions on file size as it was using secure email software. However, hearings predominantly relied on paper bundles and documents. With the pandemic, that approach stopped immediately and the team had to adapt to new internal processes for sending documents electronically and securely.

The Coronavirus Act 2020 provided necessary legislative changes which enabled the GCC to serve documents electronically.

The GCC recognised there may have been issues around learning how to use the secure email software and accessibility would have been dependent on the recipient's technical equipment and literacy. It offered training on how to use the system to its Professional Conduct Committee members.

The switch to sending documents electronically carried risks relating to data loss but the risk is arguably reduced by using a secure online system, which provides more control over the data than sending something by post.

The GCC had been taking steps towards paperless working prior to the pandemic but had been met with some reluctance and a general fear of change. The pandemic compelled and enabled the acceleration of the GCC's existing plans to go paperless and Committee members have adapted to this new way of working, learning new skills in the process and becoming more comfortable working in a paperless way. It

is apparent that going paperless has worked and there have been benefits, including cost and time savings, although the GCC recognises that some parties will choose to continue printing documents.

There were parties to fitness to practise proceedings who found the technology more challenging and struggled with the paperless approach. In these cases, the GCC worked with their solicitors to provide paper documentation. While necessary, this meant that the process took longer for these cases.

Going forward, the GCC has decided it will not be reverting to using paper for Investigating Committee meetings and will continue to operate them on a remote, paperless basis. In addition to the cost savings, holding meetings remotely has enabled a better work/life balance as members no longer have to allow for travel time to the GCC's London offices.

Council activity

It was not possible to hold Council meetings in person, as was the norm before the pandemic. Council members had to transition to attending meetings via videoconference and to working in a paperless way. Members had differing levels of technical experience and some continued to print papers, however they adapted, and continue to adapt, to using the software available and the full functionality it provides, such as page links and electronic bookmarks.

In order to inform its approach going forward, the GCC sought feedback on the remote meetings that had taken place and on members' preferences for future meetings. It received mixed feedback with some members welcoming the opportunity to meet in person and some expressing a preference for a blended approach due to a sense that something is lost when meetings are purely held remotely. The GCC intends to continue using electronic papers, even where meetings are held in person.

Education and Test of Competence (TOC)

The TOC is in effect a panel interview for applicants who qualified outside the EU. Previously, the GCC's standard approach was to provide both electronic and paper copies of documents for TOCs. In light of the pandemic, the GCC stopped providing paper copies. This was a change that had been suggested by the GCC before the pandemic but had been met with resistance.

The absence of paper documents added to the challenges arising from having to manage a panel interview remotely whilst cross-referencing paperwork that is wide-ranging and complex. TOC panel members, who have differing levels of experience, also had to adapt to meeting remotely for pre-interview planning sessions when this process would usually be done in person.

The paperwork for TOCs differs to the paperwork for FTP hearings in its complexity and in the way in which it is presented with FTP bundles being tabulated and presented in a chronological way that facilitates their use. The GCC recognised that

there may be learning that can be shared across the functions which could address some of the challenges experienced in holding remote TOCs.

The GCC is considering how best to manage TOCs going forward and one option it may introduce is a hybrid approach where the applicant attends remotely while the panel convene together in the same room. This could benefit applicants who are not in the UK at the time of their TOC.

Learning for the future

There is a perception that the health and social care regulators are slow to adapt and respond to changing circumstances but the pandemic has demonstrated that this is not the case and has proven that they can respond in a flexible and agile way. The GCC has benefited from being a small regulator, which enabled it to make quick decisions.

The GCC also noticed an improvement in the joint working between the regulators, with an increased willingness amongst them to share learning and information and to work collaboratively. The GCC viewed this as positive and wants it to continue.

When change is being implemented, the GCC's Council plays an important leadership role and can facilitate the roll-out of changes by encouraging and embracing new ways of working, such as new technology and going paperless.

The GCC's experience during the pandemic has also highlighted that it would benefit from proactively, rather than reactively, staying informed and up-to-date on different software or technological advances available so that it is in a position to adapt more readily in future.

Responses to our call for views: strategy, collaboration and governance

Enabling role of corporate strategy

The fast response times to proposed changes, including not having to wait for Council meetings, allowed changes to be implemented quickly and was welcomed by a number of respondents. While the pandemic has demonstrated that agile decision-making is possible, respondents noted that this must be balanced with risk assessment and a focus on patient safety.

Patient and public involvement

We heard concerns from some respondents that the demand to make decisions and produce guidance quickly excluded the patient, public and service user voice, and that this must be addressed in taking forward as normal practice any measures implemented during the pandemic. Concern about patient involvement in decision-making was not restricted to regulators' decision-making but also about decisions regarding patient care including end of life care.

Collaborative working

The feedback we received from respondents highlighted the collaborative work of the regulators, such as sharing approaches and experiences, was particularly valuable. We received notable positive feedback about the benefits and value of stakeholder engagement in the pandemic response. This included recognition that strong stakeholder relationships had enabled a rapid and pragmatic response and that in a number of areas relationships between regulators and stakeholder organisations had improved as a result of the close working that had been required. Professional bodies welcomed the increased communication and additional updates from regulators, which we heard led to better decision-making in areas such as policy work and case work. We also heard that such increased communication would be a beneficial approach going forwards.

One particular recommendation from a respondent, with potentially wider significance, was that the regulator with whom they had most interaction should consider a future major programme of work until such time as the situation had stabilised and stakeholders who would be involved with implementation had the capacity to proceed, balanced of course with other considerations.

Paperless working

Measures such as the move to remote working, the electronic service of documents and adopting other digital practices were noted as some of the most effective factors in responding to the pandemic. This advancement was noted by some to have been not only within the ten regulators but also in other sectors and stakeholder organisations. It was acknowledged felt by some respondents that years' worth of innovation was achieved in a matter of months.

We heard from respondents that increased agility was key in responding effectively to the pandemic, although the digital infrastructure would need to be in place to ensure effective adoption of technological innovation in the longer term.

Other – regulatory reform

While increased flexibility and agility were noted and welcomed by respondents, we heard the view at more permanent changes cannot be made until there is an enabling regulatory framework. We heard views that the pandemic has highlighted that existing processes are slow and outdated, and that there is a need for a more streamlining. We also heard that the pandemic has highlighted unhelpful disparities across the regulators, and that in the view of some respondents there is a need for greater uniformity and joint working. Some respondents noted that the differences in processes and proceedings between regulators can lead to different outcomes and experiences, in particular in fitness to practise processes. Some respondents commented that the direction of reform should be towards more shared approaches across regulators. This included shared standards, elements of professional education and CPD.

Another respondent commented that the pandemic had highlighted that review was needed of which professions were and were not statutorily regulated, pointing to apparent inconsistencies of approach across the UK. We also heard that the improved relationships between regulators and their stakeholders that had resulted

from collaborative working during the pandemic was conducive to the development of more agile regulation in future of a more flexible workforce, with an appropriate balance of specialist and general skills . Some respondents commented that regulation needed to be better aligned in future to ‘on the ground’ service delivery.

Other – registrant well-being

We heard from respondents that while the full impact of the pandemic is unknown, the negative impact on professionals is already taking a severe toll. We heard that professionals have reported increased stress and have struggled to provide the best care when working outside their usual roles. Respondents told of risks that some professionals were exposed to and the need for improved support and safety for professionals. We heard from some respondents that there should be a better understanding of registrants’ experiences throughout the pandemic, particularly about the factors that impacted on their ability to work safely.

Other – Business Continuity Planning

Some respondents told us of communication difficulties with the regulator with whom they worked, as methods of communication become more email-based, resulting in some errors, fluctuations in capacity and enquiries being directed at other organisations; and that for future crisis it would be helpful if business continuity plans could seek to mitigate such outcomes.

Appendix 1

Those individuals and organisations who responded to our call for views

	Organisation
1	Association of British Dispensing Opticians
2	Dr Abi Masterson, Abi Masterson Consulting Ltd
3	Association of Anaesthetists
4	BLM Law
5	British Acupuncture Council
6	British Association for Counselling and Psychotherapy
7	British Dietetic Association
8	Chartered Society of Physiotherapy
9	College of Paramedics
10	Community Pharmacy Northern Ireland
11	Community Pharmacy Wales
12	Complementary and Natural Healthcare Council
13	Council of Deans of Health
14	Department for Education
15	Federation of Dispensing Opticians
16	Health Education England
17	Medical Defence Union
18	NHS Employers
19	Optical Consumer Complaints Service
20	Opticians Academic Schools Council
21	Play Therapy UK
22	Public Health Wales
23	Professor Rosalind Searle, Adam Smith Business School, University of Glasgow
24	Richard Edwards, Optomise Consulting
25	Royal College of Nursing
26	Royal College of Physicians
27	SANDS, the stillbirth and neonatal death charity
28	Security Industry Authority
29	Social Care Wales
30	Society of Homeopaths
31	Susanne Roff, Health Professions Education Consultant
32	UK Council for Psychotherapy
33	UNISON
34	Unite the Union

Appendix 2

Method and limitations of this review

The Authority wrote to chief executives of the 10 regulators we oversee on 15 September 2020. In that letter we set out our intent that a review would seek to learn from actions taken by the 10 regulators in the emergency response to the first phase of the pandemic, i.e. to the end of July 2020. Each organisation was asked to nominate a point of contact for the project and was invited to make a preliminary submission to us of no more than 1,500 words by 16 October setting out:

- Which measures, new policies, new approaches or key decisions do you assess to have been most effective in responding to the pandemic, and why?
- Where do you think measures, new policies, new approaches, or key decisions have had particular impact – positive or negative?
- Have there been any unintended consequences of measures, new policies, new approaches, or key decisions
- Are there areas where the full impact of measures taken is not yet fully understood?
- Do you think that any regulatory gaps have been disclosed by the pandemic?
- What are the main learning points for further waves of the virus, other future crisis, and future business as usual?

In the letter, we also informed regulators that we intended to commission research from an academic on the challenging situations that are being encountered by health and social care professionals during the pandemic relating to the ethics of care. We intended to do so such that a report would be delivered by the end of March 2021. We invited comments on that proposal. The Authority has now appointed a researcher to conduct this work to that timescale.

During that period we were also working to identify the actions taken by the regulators during the period from four main sources:

- The spreadsheet summarising actions that was shared with us during the period, that has been produced on behalf of the Chief Executives of Regulatory Bodies (CEORB)
- Our own corporate knowledge through the Authority's performance review process
- The content of the regulators' submissions in response to the September letter as above
- The regulators' websites
- Our own records and monitoring of the pandemic.

We reviewed and discussed the regulators' submissions to the September letter and considered the best way forward. We wanted to proceed in the most collaborative way possible, and in a way which would do best justice to the richness of the responses received. Therefore, we felt that the best way forward would be to work with the regulators to generate a series of case studies, looking in more depth at

specific response to the pandemic and the actions taken. We identified a list of possible case study areas.

On 12 November we wrote to the point of contact for the project in each regulator, proposing 2-4 case study areas. After some discussion an agreed list of 28 case study areas was arrived at with a number allocated to each regulator. We envisaged short illustrative cases studies of 500-750 words each but were flexible if the regulator felt that that word limit was too restrictive. In order to minimise the workload on the regulators, we offered to meet with them to discuss the areas agreed that they would look at and draft the case study.

In November we also wrote to over 300 stakeholders inviting a contribution. The list included a wide range of organisations in health, different areas of regulation, registers accredited by the Authority's scheme, law firms, researchers, professional bodies, and Government officials amongst others. In this email we asked stakeholders for their views on the following points:

- Which measures, new policies, new approaches or key decisions implemented by regulators during the period do you assess to have been most effective in responding to the pandemic, and why?
- Should any measures implemented by regulators during the first phase of the crisis become the new normal?
- Are there areas where further work is needed before innovations become adopted in the longer term?
- Are there areas where you feel regulatory innovations or actions during this period have been particularly impactful?
- Have there been any unintended consequences of measures, new policies, new approaches, or key decisions?
- Are there areas where the full impact of measures taken is not yet fully understood?
- Do you think that any regulatory gaps have been disclosed by the pandemic?
- What are the main learning points for further waves of the virus, other future crisis, and future business as usual?

We asked for responses by 21 December and agreed a small number of extensions. By mid-January we had received 34 responses.

During January we compiled a first draft of the report bringing together these different elements of the work that had been done to date. While originally we had planned to structure the report into four parts (activity summaries; case studies; stakeholder views; discussion from the Authority) on further reflection we decided that a better and more readable and accessible structure would be to follow regulatory functions, together with a section on corporate and strategic issues. Following internal quality assurance, the regulators were invited to comment on a draft in February, and it was signed off by the Board of the Authority in March.

It is important to recognise that the methodology that we have followed does not provide the evidence which would allow us to formally evaluate the impact or effectiveness of the regulators' responses and actions. Nor have we sought through this process to duplicate the Authority's ongoing process of performance review of

the regulators. Rather, we have gone through this process in order to help us identify learning for the future about responding to crisis situations – be they Covid-related or not – and to capture the thinking of the moment in how decisions were reached during the first crisis period. We hope that this report will be a helpful contribution to future, more evaluative review and to shaping the way forward in relation to learning from this extraordinary time. Until such time as the situation stabilises and more complete evaluative review can take place, our findings such be considered to be to some extent provisional.

Appendix 3

Emergency legislation: the Coronavirus Act 2020

The Coronavirus Act 2020 ('the Act') received Royal Assent on 25 March 2020 with the aim and purpose of enabling the Government to respond and manage the effects of the COVID-19 pandemic. One of the key objectives of the Act was to increase the available health and social care workforce, primarily achieved with the introduction of new registration powers for the NMC, HCPC and SWE.

The new registration powers were contingent on the Secretary of State advising the Registrars of the NMC and HCPC that an emergency (involving loss of human life and human illness) was occurring, had occurred or was about to occur¹⁸. The powers granted to the NMC and the HCPC were almost identical and enabled both regulators to temporarily register fit, proper and suitably experienced persons with regard to an emergency as regulated healthcare professionals¹⁹. The provisions permitted Registrars to:

- Register individuals and groups of people considered fit, proper and suitably experienced persons to be registered as nurses, midwives, nursing associates and those professionals regulated by the HCPC.²⁰
- Include an annotation to the register indicating that the person was on the temporary register ²¹
- Impose, vary and revoke conditions on registration.²²

The Act also allowed Registrars to revoke temporary registration²³ and prevented a fee being charged for temporary registration.²⁴ The NMC used the provisions in the Act to create a temporary 'opt in' temporary register, whilst the HCPC opted for an 'opt out' system.

Amendments to the relevant legislation in Scotland, Wales and Northern Ireland were also made to allow for the fast deployment of temporarily registered healthcare workers in the NHS.

¹⁸ See for example, Coronavirus Act 2020, Schedule 1, paragraph 2, 9A (1) with regards to amendments to the Health Professions Order 2001

¹⁹ Explanatory notes to the Coronavirus Act 2020 at page 8

²⁰ Coronavirus Act 2020, Schedule 1, paragraph 2, 9A (2) and Schedule 1, paragraph 1, 9A (2)

²¹ Ibid at Schedule 1, paragraph 2, 9A (4) and Schedule 1, paragraph 1, 9A (4)

²² Ibid at Schedule 1, paragraph 2, 9A (5) and Schedule 1, paragraph 1, 9A (5)

²³ Ibid at Schedule 1, paragraph 2, 9A (7) and Schedule 1, paragraph 1, 9A (7)

²⁴ Ibid at Schedule 1, paragraph 2, 9A (9) and Schedule 1, paragraph 1, 9A (9)

With respect to pharmacists in Northern Ireland, amendment was also made to the Pharmacy (Northern Ireland) Order 1976 to ²⁵allow the Registrar of PSNI to temporarily register individual pharmacists or groups of pharmacists, such as those who had recently retired and pre-registration pharmacists, in the event of an emergency, similar to the powers afforded to the HCPC and NMC. Provision was also made to allow the Registrar to annotate the register of those temporarily registered to extend the power to prescribe certain drugs, medicines and appliances where they would not ordinarily be authorised under the 1976 Order²⁶. The Act also introduced greater flexibility to allow for additional pharmacists to assist with the prescribing and supply of medicines in an emergency.²⁷

Additional registration powers were not granted to the GMC and GPhC as existing legislative provisions already existed (on which the powers under the Act were modelled) which permitted for the temporary registration of doctors and pharmacists in an emergency. No provisions were made for the temporary registration of other healthcare professionals, such as dentists.

In relation to social care, the Act also introduced emergency registration powers for the Registrar of SWE and Social Care Wales ²⁸which largely reflected the powers given to the NMC and HCPC. Amendments were also made to secondary legislation in Scotland to allow newly employed social workers up to twelve months (from six) to complete their registration.²⁹ Provisions were also introduced to temporarily register retired social workers in Scotland.³⁰

Finally, the Act also made provision for the use of video and audio technology for courts and tribunals though no provisions were made specifically for professional discipline tribunals.

²⁵ Ibid at Schedule 4, paragraph 3

²⁶ Ibid at Schedule 4, paragraph 6

²⁷ Ibid

²⁸ Coronavirus Act 2020, Schedule 5

²⁹ Coronavirus Act 2020, Schedule 6, paragraph 2

³⁰ Ibid at paragraph 1

Appendix 4

Statutory regulators overseen by the Authority

Regulator	Regulated
General Chiropractic Council	Chiropractors
General Dental Council	Dentists, clinical dental technicians, dental hygienists, dental nurses, dental technicians, dental therapists, orthodontic therapists
General Medical Council	Doctors
General Optical Council	Optometrists, dispensing opticians, student opticians and optical businesses
General Osteopathic Council	Osteopaths
General Pharmaceutical Council	Pharmacists, pharmacy technicians and pharmacy premises
Health and Care Professions Council	Arts therapists, biomedical scientists, chiropodists/podiatrists, clinical scientists, dieticians, occupational therapists, hearing aid dispensers, operating department practitioners, orthoptists, paramedics, physiotherapists, practitioner psychologists, prosthetists/orthotists, radiographers, speech and language therapists.
Nursing and Midwifery Council	Nurses, midwives and nursing associates
Pharmaceutical Society of Northern Ireland	Pharmacists and registered pharmacies
Social Work England	Social workers

Appendix 5

Statutory functions of regulators

- Set standards of competence and conduct that health and social care professionals must meet in order to be registered and practise
- Check the quality of education and training courses to make sure they give students the skills and knowledge to practise safely and competently
- Maintain a register that everyone can search
- Investigate complaints about people on their register and decide if they should be allowed to continue to practise or should be struck off the register - either because of problems with their conduct or their competence.

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