professional standards authority

LEARNING FROM COVID-19

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

Section 2: CASE STUDIES ONLY

April 2021

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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.

Contents

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%.

*O*ur 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

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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 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 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 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-pared 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 staff[14]. 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 then 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 papers[15].

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 GOsC[16][17] 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 meangingfully 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

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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-exiting

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 occur[18]. 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 professionals[19]. 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 registration[23] 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 [25]allow 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 Order[26]. 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 [28]which 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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