General Medical Council – Gender Equality Scheme

Introduction

1. By section 76A of the Sex Discrimination Act 1975 (as amended), the General Medical Council is required, in carrying out its functions, to have due regard to the need:
   
   a. To eliminate unlawful discrimination and harassment;

   b. To promote equality of opportunity between men and women. This requirement is referred to in this Scheme as ‘the general duty’.

2. The Sex Discrimination Act 1975 (Public Authorities) (Statutory Duties) Order 2006 requires the GMC to prepare and publish a Gender Equality Scheme, that is, a scheme showing how it intends to fulfil the general duty and its duties under the Order (‘the specific duties’). This Scheme is published in response to that requirement.

3. This Scheme sets out the overall gender equality objectives which the GMC has identified as being necessary for it to perform the general and specific duties.

4. This Scheme also sets out the actions which the GMC has taken, or intends to take:

   a. To gather information on the effect of its policies and practices on men and women and in particular:

      i. The extent to which they promote equality between its male and female staff; and

      ii. The extent to which the GMC’s services and functions take account of the needs of men and women.

   b. To make use of such information (and any other relevant information) to assist in the GMC’s performance of the general and specific duties and in particular its regular review of:

      i. The effectiveness of the actions identified to achieve its overall gender equality objectives;

      ii. Its arrangements for the preparation of subsequent Schemes.

   c. To assess the impact of its policies and practices, or the likely impact of its proposed policies and practices, on equality between women and men;

   d. To consult relevant employees, service users and others and
e. To achieve the fulfilment of the GMC’s overall gender equality objectives.

The General Medical Council

5. The General Medical Council is the independent national regulator for doctors in the UK. Our job is to ensure that patients can have confidence in doctors. Our statutory powers and duties are to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine. We do that by controlling entry to the medical register and setting the educational standards for medical schools. We also determine the principles and values that underpin good medical practice and we take firm but fair action where those standards have not been met.

6. In carrying out our functions we must:
   a. Put patient safety first.
   b. Support and develop the good medical practice of doctors.
   c. Be independent of Government as the dominant healthcare provider and employer of doctors, and independent of dominance by any single interest.
   d. Work to command the confidence and support of those with whom we deal.
   e. Promote fairness and equality and value diversity.

7. As an organisation, our key aims for the year ahead are:
   a. To operate an independent, accountable and integrated system of medical regulation that commands the confidence and support of our four key interest groups;
   b. To deliver effective and responsive regulation by engaging fully with those receiving and providing healthcare across the four countries of the UK;
   c. To enhance the role of the Medical Register as the single authoritative source of information on doctors; and as a national resource for patients, employers and the profession;
   d. To support the delivery of high quality care to patients by setting rigorous standards for doctors and co-ordinating all stages of medical education;
e. To enhance patient safety by improving further the procedures for dealing with doctors whose fitness to practise may be impaired;

f. To enhance the economy, efficiency and effectiveness of the GMC.

The GMC and Diversity

8. The GMC promotes equality and values diversity. Whilst all doctors must meet the minimum competency standards, we want a profession that is able to accommodate people with a range of ambitions, different faiths and backgrounds, those from different racial groups, and those with a disability, not least because varied perspectives will make valuable contributions to the profession and the population it serves.

9. Our guiding principle in meeting the general duty is to place the elimination of unlawful sex discrimination and harassment, and the promotion of equality of opportunity, at the heart of our policy-making and decision-making – to consider it in the mainstream of decision-making rather than as an ‘add-on’. In this way we hope to ensure that we value diversity in doctors and patients as well as in our own staff; and that our services work for everyone. This Scheme contains practical examples of ways we have already tried to achieve this, as well as an Action Plan for the future.

10. This Scheme seeks to address gender equality across all functions of the GMC including partnership and procurement. Our plans to review all these functions are set out in our Action Plan at Annex A.

11. To demonstrate our leadership commitment to meeting the general duty, we have appointed a Director as our ‘champion’ for diversity including gender equality. Paul Buckley, our Director of Strategy and Planning, will ensure that diversity, including gender equality, is integral to our work and is embedded in policy development and service provision across the organisation. He will ensure that diversity issues are considered by Directors and Council as part of every relevant decision making process.

12. The lead staff responsible for this Scheme are Sarah Bedwell, our Head of Governance and Elaine Bromberg, our Governance Policy Manager – Diversity and Engagement.

13. We have prepared our gender equality scheme and action plan as part of our business planning process so that items included in the action plan are also monitored as part of our business planning processes. We have also ensured that Directors consider the diversity implications of all objectives and activities when preparing their Directorate Plans to ensure that we identify any gender equality (or other diversity) impact at an early stage.

1 The GMC already reviews the diversity policies and procedures of recruitment agencies with whom we enter into contracts. Agencies are also required to provide monitoring data, including on gender.
Our Starting Points for Work on Gender Equality

14. Our starting points for work on gender equality includes the following:

a. 62.5% of the total workforce are women. There are 33% of women at Director level, 33% at Assistant Director level and 39% at Head of Section level. We aim to investigate ways of increasing the representation of women at senior management level.

b. 38 members of staff work part-time (8% of the workforce). 12 of the 38 are at Level 2, Head of Section. Many staff work at home on an informal basis, agreed locally with their line manager. The flexible working policy is open to all staff.

c. Our maternity and paternity schemes go beyond statutory requirements. Employees receive the equivalent of normal salary for the first 18 weeks, instead of 90% of pay. Our paternity leave payment is also enhanced as employees receive the equivalent of normal salary for the period as opposed to the statutory rate.

d. Of doctors subject to completed fitness practice hearings during January to November 2007, 174 have been male (83.3%) and 35 have been female (16.7%).

e. We allow doctors to claim a discount on the annual retention fee if they are in receipt of a lower income; this would include doctors who are on maternity leave or working part time.

f. In our fitness to practise function, in November 2004, we introduced major reforms to the way we handle complaints and concerns about doctors. Our aim was to ensure that our processes were fair, objective, transparent and free from discrimination. The reforms followed a comprehensive review of our processes and placed all decision-making within our procedures on a professional footing. Since 2003, we have run three recruitment rounds for Case Examiners (who are responsible for determining whether to refer a doctor to a Fitness to Practise panel for a full hearing). These examiners were appointed against objective competencies through a public appointments process with the assistance of the Office of the Commissioner for Public Appointments. That recruitment process was ‘equality proofed’ on our behalf by Third Vision Consultancy, who made a number of suggestions (which we took on board) to avoid unintentional discrimination in the recruitment process. The advertisements for Case Examiners encouraged applications from women, with the aim of ensuring that the composition of Examiners reflected the balance of the population as a whole. A total of 11 Examiners were appointed, of whom five are women, three are from ethnic minority groups, and one is registered disabled. We have also run three recruitment rounds for panellists (both medical and lay members sitting on Fitness to
Practise panels) since 2004. We took similar steps with the aim of ensuring diversity in these appointments – 66% of panellists are male, 34% female. All our panellists are required to undertake equality and diversity training on induction. They are also scheduled to attend refresher training by the end of 2007.

g. As regards employment, all our staff are required to attend mandatory diversity training (level 1). We have a target of 85% attendance on the programme by the end of 2007. From January 2008, this training will include a section on the general duty (see action 21, Annex A). In addition, we have offered e-learning courses for staff on equality (including gender equality) legislation. This is desk-top learning via computers and gives employees the opportunity to be flexible with their time when undertaking the modules. This is currently being reviewed and updated (see action 22, Annex A). We are also making specific arrangements to meet the role-specific training needs of the staff responsible for managing and delivering the gender equality scheme. A second programme (level 2) of more detailed modules will be launched in November 2007 and available from January 2008 for GMC employees with policy making, planning and key service delivery roles to provide a higher level of training on the general and specific duties. This training will be incorporated into a range of other programmes (for example chartered manager programme, recruitment training) where relevant. Human Resources staff are already required to attend update training on all aspects of employment law and on the general and specific duties in line with their professional requirements.

h. We seek to ensure that professional guidance we give is non-discriminatory and does not make unnecessary assumptions about doctors of either sex. For example, our guidance for doctors on inappropriate sexual and emotional relationships, *Maintaining Boundaries*, ensures that doctors of both sexes are aware of the desirability of offering a chaperone to a patient for an intimate examination, whether or not that patient is the same gender as the doctor.

i. We have made diversity, including gender, an integral part of our business planning process and routinely use Equality Impact Assessments as part of the policy development process.

j. Our staff intranet site includes material about the Equality Scheme, the Committee for Equality and Diversity (CDE), the Equality Impact Assessment procedure and the results of our recent Communications Accessibility Audit (see below) as well as our Valuing Diversity resource guides, developed to provide information and advice on diversity and equal opportunities for doctors and others such as healthcare managers.

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For example: training for policy and management staff on impact assessments, consultation and monitoring; training for communication staff on publishing and public access duties; training for HR staff on the employment duty.
The Gender Equality Scheme

Responsibility for the Scheme

15. The work in the Scheme, and its Action Plan, is core to the work of all parts of the GMC and is, therefore, built into the operational objectives of our directorates. Day-to-day responsibility for ensuring that targets in the Action Plan are achieved will therefore fall upon the member of staff having responsibility for the relevant work area. Initial monitoring of progress will be carried out by directors and senior managers as part of their normal work. Progress will be monitored more formally once a month at a meeting of the Chief Executive and Directors, who carry senior management responsibility for the Scheme. Our Diversity Champion, Paul Buckley, Director of Strategy and Planning will ensure that the monitoring is undertaken and that any necessary mitigating action is taken forward.

16. The Committee for Diversity and Equality will review all work in the Action Plan at its scheduled meetings by careful consideration of written reports and discussion with directors and senior managers.

17. Monitoring of employment issues will be carried out by our Human Resources section and reported to the Committee for Diversity and Equality and to Directors.

Producing the Scheme

18. This is the gender component of the second (2008) annual version of the GMC’s Equality Scheme. It is an updated version of the initial Scheme (2007). Before preparing the 2007 Scheme, we carried out a variety of consultation and engagement with patients, the public, doctors and our own staff. We will review the Scheme every year, with a major review every three years; the next major review will be in 2010 before the 2011 scheme is published.

Patient and Public Reference Group

19. The Patient and Public Reference Group (PPRG) is a GMC reference group, comprising 25 patient representatives and members of the public together with six Council members (see membership list at Annex B). The Group, which is made up of 16 women and 13 men includes representatives of the Patients’ Association, the Prevention of Professional Abuse Network, the Relatives and Residents Association, Patient Concern, the Patients’ Forum, the Patient and Carer Advisory Group, the Commission for Patient and Public Involvement in Health, Action for Victims of Medical Accidents and Macmillan Cancer Relief. The Group is responsible for enabling patient and consumer representatives to make an effective contribution to the development of GMC policy and procedures. We liaised with the Group while developing the scheme in 2006 and again in 2007.
In-depth interviews

20. We arranged, through a specialist provider, Research Works, for 16 in-depth interviews in early October 2006 to consider the content of the draft 2007 Scheme. The group of interviewees included a sample of 7 males and 9 females. Interviewees were asked to comment on the draft objectives in the Scheme and to make suggestions for other work with diversity and equality implications.

Wider consultation exercise

21. In October to November 2006 we contacted 170 organisations made up of doctors, patients and the public within the equality strands. These included the following organisations (both UK-wide and in the devolved administrations): Breast Cancer Care, Carers UK, Help the Aged, Home From Hospital (Continuing Care), Stonewall, the Terrence Higgins Trust, Action for Sick Children, the Consumer Association, the National Council for Liberty, the Patients Association, the Relatives Association, the Patients Forum, the British Medical Association, the Gay and Lesbian Association of Doctors and Dentists, the Medical Women's Federation, the Association of GPs in Urban Deprived Areas, the Equal Opportunities Commission, the British Institute of Human Rights and the Equality Commission for Northern Ireland. We tried to involve people with a range of backgrounds, with different conditions and impairments, including seldom-heard-from groups (for example children and the elderly) and those subject to multiple discrimination (such as disabled people from ethnic minorities).

22. We also produced (in October 2006) an Easyread version of our consultation document for the 2007 Equality Scheme, in order to improve accessibility for people with learning disabilities (as well as those not having English as a first language).

23. Where respondents to the consultation made comments, these were taken into account, where appropriate, by amending the draft Scheme. Where detailed comments were made, we sent detailed written responses to respondents.

24. We consulted with staff on the Equality Scheme at the Staff Forum.

Proposed consultation on this Scheme

25. After consulting on the 2007 Scheme, we gave a commitment to conduct further in-depth interviews to review our progress in early 2008 (when the Scheme will have been in place for a year). This will enable us to assess the effect on doctors, patients and the public of the work described in this equality scheme and Action Plan. We will ensure that there is a gender balance of interviewees and ask those interviewed to identify any barriers they might have in accessing our services so that we can find ways to improve our accessibility. We have included that work in our Action Plan (see action 9, Annex A).
26. Because of the significant changes made to the Scheme in 2007/08, we will also be conducting a further wider consultation on this Scheme at the beginning of 2008. As well as consultation with a wide range of organisations, we will again consult with our Patient and Public Reference Group and undertake similar in depth research and focus groups as in 2006.

Our Overall Gender Equality Objectives

27. Our overall diversity and gender equality aims for 2008 are:

   a. Ensuring that our pay and rewards system is fair and transparent and that equal pay issues are effectively identified and resolved. The outcomes of the equal pay audit being undertaken in 2007 will inform the development and any changes to the pay system scheduled for 2008. (see action 28, Annex A);

   b. Assessment of all proposed policies that are relevant to the general duty to identify whether there are any barriers to participation for men, women and transgender people (see action 8, Annex A);

   c. Monitoring the effect of all relevant existing policies on gender equality (see section Monitoring Policies for Adverse Impact at Annex A);

   d. Revising our equality impact assessment process, to ensure that all policies have been assessed in a systematic manner and have no differential impact on gender groups (see action 6, Annex A);

   e. To ensure that in developing procedures and providing services we take into account the needs of men, women and transgender people through engagement and consultation (see action 20, Annex A);

   f. Making sure information about the GMC and our functions and services is accessible and available to members of the public, including gender groups;

   g. Monitoring of the workforce at all levels to ensure everyone can compete on a level playing field; and

   h. Policies and practices that meet the needs of the male, female and transgender workforce;

28. The Action Plan at Annex A sets out the activities we will undertake to achieve those objectives. To develop these objectives our Directors, supported by our Governance Team have reviewed our functions and identified those which are a priority for achieving gender equality. In the first quarter of 2008 we will undertake a review of the gender impact of each of our existing policies and procedures so that we can plan when impact assessments should be completed on each of those policies and procedures.
The gender pay gap

29. In March 2006, a pay analysis was undertaken for levels 2, 3 and 4 (Heads of Section to policy officer level). This analysis was conducted using EU gender statistics as well as the Women and Work Commission February 2006 report, *Shaping a Fairer Future*. This matter was discussed at the Committee for Diversity and Equality and it was decided that a full equal pay audit should be conducted at the end of 2007. Following this audit, we will collect and analyse the data to ensure that equal pay issues are effectively identified and resolved (*action 28, Annex A*). An equal pay review and follow up work will be one of our key overall objectives for 2008. We will update our action plan once the equal pay review has been completed.

Our arrangements for gathering information on the effect of our policies and practices on men and women

30. Gathering information on our policies allows us to test how men, women and transgender people are affected by our policies (and whether people from all groups are equally satisfied with the way we treat them); whether our services are provided effectively to all communities and whether they are suitable and designed to meet different needs (for example by recognising access difficulties or patterns of discrimination or exclusion).

How we gather information on our policies

31. We gather information on our functions and policies for adverse impacts on gender equality in a number of ways:

   a. **Monitoring statistics**: (A) employment: we collect gender monitoring data from staff on recruitment, promotions, grievances and disciplinary procedures. From January 2007 – September 2007, 61% of applications received at recruitment were from females with 56% of offers made to women. We collect information on grievances, though the numbers are small (in September 2007, 2 grievances were from men, 5 from women). Disciplinary issues are balanced with 8 male and 7 female. Information on recruitment, promotion, grievances and disciplinaries is presented periodically to Directors in the monthly management report as well as to the Committee for Diversity and Equality. We will be building on this data collection exercise during 2008 (*see action 30, Annex A*). We collect data from all staff when they join the GMC and seek an update at least every two years. We have been collecting and monitoring this data for over ten years.

   b. Our Human Resources team is responsible for collecting and analysing gender data using the PS Enterprise system. Data is collected using the 2001 census categories. The IT system allows reports to be generated analysing ethnicity and pay and grading. Data on gender is also cross-referenced with records for training participation, disciplinary procedures and formal grievances, so as to produce analysis of the impact of these on men and
women. Employment monitoring will also include an analysis by gender on staff who benefit or suffer detriment as a result of our performance assessment procedures.

c. **Monitoring statistics:** (B) registration: our registration function collects data on the gender of doctors registering. In 2008 we will consider as part of our identification of functions and procedures (see action 4, Annex A), whether we wish to analyse and publish gender data. (C) fitness to practise: we ask complainants, on a voluntary basis, to specify their gender but have not yet analysed this data (see action 16, Annex A). We also collect data on the gender of doctors appearing before Fitness to Practise panels. We have found from this that men are over-represented in our Fitness to Practise procedures and will, accordingly be reviewing these procedures during 2008 to ensure that there is no inadvertent gender bias; (D) education: our Education Directorate monitors UCAS figures for entry to undergraduate medicine. These currently indicate that there are more women in undergraduate medicine than men. Access to education is not, therefore, currently a priority or concern. Rather, we are concerned that inequality may come into play when women begin to practise and, for example, may need access to more flexible working arrangements than men. We will raise this within our equality and diversity forum with the British Medical Association, the Department of Health and NHS Employers to ascertain the action that we could consider internally. **Regular checks:** We conduct a tracking survey every two years, with the next one taking place in 2008. The purpose of the survey is to provide us with insight into the views of the public and the medical profession on key issues facing the GMC. In order to ensure that the results are representative, the research agency is asked to use a large sample size. As part of our engagement strategy we will review the sample that we use in terms of diversity and will investigate how this could better reflect a gender / parent / carers balance (see action 20, Annex A). We also gather feedback from doctors visiting our London offices on registration business via regular visitor surveys, as well as ‘mystery shopper’ and candidate feedback surveys. These allow both male and female doctors to pass on comments about their experience with us.

d. **Specially-commissioned research:** we also carry out, from time to time, specific research on the impact of our policies. For example, in 2006 we commissioned an accessibility audit on communications which considered our policies, procedures and functions relevant to communication. That audit specifically considered whether those policies, procedures and functions were compliant with current gender equality legislation, and found that they compared favourably with what best practice as determined by guidance from (among others) the EOC.

e. **Consultation:** see next section.
Consultation

32. In early 2008, we will be introducing a consultation policy, Conducting GMC consultations – a protocol for staff with the aim of ensuring that the way we conduct consultations is consistent, properly planned and co-ordinated, and makes best use of our resources and the resources of those we are consulting.

33. The consultation policy will remind staff of the importance of complying with their legal duties, including under discrimination law, and urges them to consider the wider audience in any consultation, which it notes is ‘by definition, harder to reach’. For example, when we consulted on our standards document Good Medical Practice, in order to widen its circulation, we sought the advice of an equalities consultant, who provided us with contact details for a large number of groups who might not normally respond to formal, written consultations. This list of contacts has now been incorporated into our main contacts database for consultations. The consultation policy makes specific reference to the need to consult minority groups and to the general duty; and will tie in the consultation policy with our Equalities Impact Assessment tool.

34. We aim to ensure that consultation documents are concise and written in a style accessible to the target audience; and that they can be made available in alternative formats, for example large print or other languages where necessary. For example, in October 2006, we produced an Easyread version of our consultation document for the 2007 equality Scheme (see above).

35. In addition to traditional consultation documents, we will (where appropriate) use other methods of consulting with the public, such as:

a. Online consultation: we currently use an online consultation tool developed for our needs by Community People, an online consultation provider. Our Standards and Education function initially used this tool on a pilot basis. Electronic consultation allows us to reach people who would not be reached by more usual methods – particularly individuals rather than organisations. Our e-consultation tool invites participants to submit demographic data, including on gender, on a voluntary basis. We will use this in order to check whether there any groups with whom we are not consulting effectively (see action 20, Annex A).

b. Research projects: these may be used to obtain the views of those unlikely to respond to written consultations. For example, in our consultation on Good Medical Practice, we made it explicit in the tender for a research project on the views of doctors and the public of the standards expected of doctors that the researches should include individuals from minority groups. The research carried out sought views from older people (aged 70 and over), homeless people and those from minority ethnic groups, as well as from other members of the public.
c. **Seminars**: these may again be a useful way to obtain the views of minority groups. For example, in our 2002 consultation on *Withholding and Withdrawing Life-Prolonging Treatments: Good Practice in Decision Making* we held a consultation seminar to hear the views of, and debate with, a range of organisations including some representing the elderly, young children, faith groups and black and minority ethnic groups.

**Improving information-gathering**

36. In order to improve our information-gathering in terms of gender, we will review the progress we have made in our 2007 plan. We will then assess our evidence and information gathering to ascertain what further information we need about the requirements of gender groups when accessing our services and for those in employment with us. Where this review identifies gaps, we will identify methods of gathering information to ensure we have the most appropriate material for analysis. This will ensure that our information-gathering focuses on any barriers to participation.

37. We benchmark against other comparable organisations i.e. non-Departmental public bodies and Civil Service departments. We also use key reports to analyse our HR processes, including The Women and Work Commission report, *Shaping a Fairer Future*.

**Publishing information gathered**

38. Council papers on policy development or amendment will contain the results of impact assessments and consultation exercises, so that these can be considered at the same time as the policy itself. Council papers are public documents, available from our website or as a paper copy on request.

39. We will also produce an annual report on our monitoring of our gender employment statistics, which will be available on our website.

40. We also endeavour to use the national and local press to inform the public about our activities, including consultations and their results. We do this by means of press releases and by working with the local press where there is a particular local ‘angle’ to a story. For example, when consulting on our 0-18 years guidance we organised a children’s poster competition. The winner of that competition lived in Northern Ireland and as a result we were able to ensure significant local press coverage of the consultation.

**Sharing information with other public authorities**

41. The GMC has set up a dedicated forum, which meets quarterly, to discuss and share best practice on general diversity issues, including gender, in the medical profession. The forum includes representatives from the Department of Health, NHS
employers and the British Medical Association. The membership of the group will be reviewed during 2008 (see action 11, Annex A)

42. During 2008, we will review the channels used to share best practice in areas of diversity with other organisations (see action 11, Annex A)

Making use of information gathered (and other relevant information) to assist in the performance of the general duty

How we use the information gathered

43. We will use our analysis of the monitoring data we collect, together with the results of other information-gathering activities such as research, to inform policy development in order to improve gender equality. Where monitoring shows that a policy may be having an adverse impact on gender equality, we will take steps, as appropriate, to understand the causes of that impact or to modify the policy to prevent it. For example:

a. We monitor the performance (in terms of practice with regard to diversity and equal opportunities) of the recruitment agencies on our Preferred Suppliers list, and hold bi-annual meetings with the agencies at which diversity practice is central to the agenda. In all cases, an agency’s approach in this area has had a direct impact on whether it has gained or retained Preferred Supplier status. In one case an agency has lost Preferred Supplier status as a result of concerns on diversity practice and policy.

b. Information by a respondent to the written consultation indicated that teenage boys were less likely to use contraception. We therefore requested the 0-18 guidance for all doctors working group to consider whether to include specific guidance alerting doctors to this issue.

c. Feedback obtained from witnesses in our Fitness to Practise procedures highlighted a potential need for improved arrangements for vulnerable witnesses, including women. When a witness is giving evidence at the hearing of doctor alleged to have committed a sexual offence against the witness, the anonymity of the witness is ensured by referring to the witness under a false name. The witness can provide evidence by video link or attend the meeting themselves, but be separated from the doctor and press / public by a screen. We want to improve support for witnesses by compiling a support pack and ensuring it is available on-line (see action 18, Annex A).

Information gathered and the Action Plan

Publishing information gathered

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at the same time as the policy itself. Council papers are public documents, available from our website or as a paper copy on request.

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a. We monitor the performance (in terms of practice with regard to diversity and equal opportunities) of the recruitment agencies on our Preferred Suppliers list, and hold bi-annual meetings with the agencies at which diversity practice is central to the agenda. In all cases, an agency’s approach in this area has had a direct impact on whether it has gained or retained Preferred Supplier status. In one case an agency has lost Preferred Supplier status as a result of concerns on diversity practice and policy.

b. As mentioned in 43 (c), we are planning improvements to our witness protection procedures, following direct feedback from individual witnesses.
c. We will publish fitness to practice statistics with reference to gender to monitor whether there is an over representation of men in the Fitness to Practise procedures (see action 16, Annex A).

Information gathered and the Action Plan

50. We have used the statistical information available to us (from employment monitoring and from the medical register) to identify areas which we need to prioritise in 2008. These areas are understanding the over-representation of men in the fitness to practise procedures and the under representation of women in senior management grades.

51. We will review the steps in our gender equality Action Plan annually in the light of all the information we have gathered on the effect of our policies and practices on men and women.

52. The Governance Policy Manager for Diversity and Engagement (reporting to the Head of Governance) will be responsible for the ongoing monitoring of effectiveness and progress on the scheme. Actions to take will be prioritised and timetabled in consultation with all Directorates.

53. All actions identified as high priority will undergo an Equality Impact Assessment, followed by putting an implementation plan in place for any consequent mitigating action or policy changes.

54. A detailed timetable will be developed for reviewing policies identified as medium priority and low priority as part of business planning for 2009.

55. The information that we will gather to review the action plan will be clearly outlined as an integral part of our action plan.

Information gathered and subsequent Gender Equality Schemes

56. We will review this Scheme in the light of all information gathered (whether by way of monitoring, consultation, research or otherwise) and of other relevant information, for example, from workforce surveys nationally when revising the Scheme annually and when carrying out our major three-yearly review of the Scheme. Responsibility for this review will lie with the Head of Governance and the Governance Policy Manager – Diversity and Engagement, with board-level responsibility taken by the Diversity Champion. Our Committee for Diversity and Equality will also oversee all work relating to the Equality Scheme.

Information gathering and the gender impact assessment process

57. We will include consideration of this topic in our forthcoming review of the gender impact assessment process.
**Information sharing internally**

58. Information about the impact of our policies and functions on men and women will be shared internally in a variety of ways. For example:

a. Our staff intranet site includes dedicated pages on the equality scheme. We will update these during the course of the year, as appropriate, to reflect new information which becomes available.

b. Different directorates within the GMC will share their action plans as necessary.

c. Staff representatives are able to raise any issues of concern at a staff forum – this may include an issue relevant to a gender group. Flexible working has been a matter addressed at the staff forum. Human Resources might also raise an issue at a forum if it is subject to a review.

d. The Governance Policy Manager – Diversity and Engagement will act as a ‘centre of excellence’ with specialist expertise on gender equality issues.

**Assessing the impact of existing and proposed policies and procedures on gender equality**

**Our Existing Equality Impact Assessment Process**

59. We assess the likely impact of our proposed policies on gender equality by using our Equality Impact Assessment tool (see action 6, Annex A) which has been used on our developing policies since 2002. This tool, which sets out a number of questions about the impact of a proposed policy on different groups, requires staff developing policies and procedures to consider the impact on men and women from the start of policy development. We aim to conduct gender equality impact assessment as a means to achieving real, practical improvements in gender equality ‘on the ground’, rather than as an end in itself.

60. Guidance on making the assessment is given to staff in the tool itself: in particular, the tool points out that an individual member of staff is unlikely to have sufficient information to be able to make an assessment of the impact of a policy on minority groups; and that consultation is therefore usually the most effective way to gather information and to test the proposed policy outside the GMC.

61. The opening questions of the impact assessment tool provide an informal ‘screening’ process so that staff can determine which policies need full gender equality impact assessments. We propose to introduce a more formal screening process as part of our proposed Regulatory Impact Assessment review (below).

62. The sources of information available to staff carrying out impact assessments as to the impact of a policy on men and women include the following:
a. **Monitoring data.** We currently hold significant monitoring data relating to gender on our own staff and we plan to expand our data collection activities in this area (see above). We also collect gender information from doctors in FTP cases and from complainants on a voluntary basis (see above).

b. **Consultation responses,** particularly those from organisations representing patients, female doctors, and carers (see for example the list of groups consulted on the 2007 Equality Scheme, above): see further under ‘consultation’, above.

c. **Specially-commissioned research** and other information: for example, in 2006, we commissioned external consultants to carry out a communications accessibility audit (see above). We also regularly engage in fact-finding initiatives which have included a tracking survey of patient, public and professional attitudes towards regulation and the work of the GMC; Candidate Feedback Surveys (for doctors registering); GMC visitor surveys and a ‘mystery shopper’ report on our reception and contact centre services.

63. Policy developers and managers are responsible for their own work in carrying out impact assessments, but must submit a report on the assessment to their Director at the time the policy is submitted to a committee or Council. When Council papers are submitted to the Chief Executive for approval, report authors are asked to confirm that they have conducted an impact assessment and to pass the report to the Secretariat. Information on the assessment is included in the Council paper.

*Improving Gender Impact Assessment*

64. We are currently proposing, as set out in our Action Plan (see action 6, Annex A) to carry out a review of our Regulatory Impact Assessment procedures, including the Equality Impact Assessment procedure as it relates to gender. The review of the EIA procedure will cover the following (among other things):

a. Strengthening our EIA tool further and giving our staff further support in using the tool, and in identifying and mitigating any adverse impact.

b. Ensuring that impact assessment addresses missed opportunities to promote equality of opportunity.

c. Involving stakeholders in impact assessment.

d. Adding a screening tool, including criteria for identifying whether a full assessment is needed (for example, because a policy is a major one in terms of its scale or significance for the GMC’s activities; or because it is a minor policy with a clear indication of likely major impact on gender equality).
Giving guidance and support for staff on sources of evidence; on implementation; and on monitoring potential impact.

Ensuring that accessibility to our services is considered when assessments are being conducted.

Considering whether any further training on EIA is necessary and, if so, introducing a training package in 2008.

This work has already begun and will continue into 2008.

**Our priorities for carrying out impact assessment of existing policies**

65. In the first quarter of 2008 we will review the gender impact of each of our existing policies and procedures taking into account the key areas of impact and proportionality (see action 4, Annex A). We will then plan when impact assessments should be completed on each policy or procedure. We will review these priorities annually.

**Using the results of assessment in policy development**

66. We strive to carry out equality impact assessment early in the policy development process, and as an integral part of that process ³, so that the policy proposal can be drawn up in a way which minimises adverse impact on particular groups.

67. Where an equality impact assessment identifies an adverse impact on gender equality, we will consider whether there is another way of achieving our policy objective which does not have a negative impact and, if so, we will change our proposed policy or procedure. Where we believe that we cannot make an adjustment, we will engage with interest groups and those affected to seek their views and work with them to find an alternative solution. Where an unavoidable adverse impact nevertheless remains, we will consider whether there is a sound and proportionate justification for continuing to implement the policy; and will consider measures to mitigate, or compensate for, the impact.

68. We will also consider piloting policies and implementing procedures in stages so that the impact can be tested and monitored before full implementation. For example:

a. In 2005, we conducted a pilot tracking survey, in association with MORI and NOP, to consider (among other things) the reasons patients and the public gave for not engaging with the GMC. The pilot survey was successful and was, therefore, updated in 2006 to take account of developments in medical regulation. The next survey will take place in 2008;

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³ This is sometimes described as ‘mainstreaming’ gender equality issues.
b. In 2007, we conducted two pilot schemes on collecting ethnicity data from doctors on our register. In 2008 we propose to consult on extending data collection to other equality groupings.

69. We will also, where appropriate, carry out follow-up after consultation exercises – for example, by seeking comments on re-drafted sections of a policy from key interest groups.

70. Where impact assessment or consultation identify positive impacts for gender equality, we will use these to highlight and promote good practice in subsequent policy-making.

71. We will monitor, review and evaluate new policies after implementation by the following methods:

   a. **Monitoring:** we will, where appropriate and feasible, monitor the impact of our policies, including on women and men - see section on information-gathering above.

   b. **Post-implementation review and evaluation (PIRE) process:** we use this process to review significant policy (including IT) implementations; for example, we recently carried out a PIRE process on our Freedom of Information policy. The PIRE process considers:

      i. How well we performed in implementing a project;

      ii. What went well, or otherwise;

      iii. Whether there are any lessons which may inform future projects;

      iv. Whether (where relevant) the product does the job we intended;

      v. Whether any remedial action is indicated.

In 2007 we added questions about impact assessment and diversity outcomes to the PIRE process.

**Publishing gender impact assessments**

72. Council papers on policy development or amendment will contain the results of impact assessments and consultation exercises, so that these can be considered at the same time as the policy itself. Council papers are public documents, available from our website or as a paper copy on request. Impact assessments will be freely available to colleagues and Council Members to assist in developing and implementing policies which might have a similar impact, and will also be available to members of the public on demand. Where relevant we will also include a copy of an impact assessment in any consultation document.
73. From 2008, we will report annually to our Committee for Diversity and Equality on the number of impact assessments which have been completed, whether there was any consultation on the assessment and, if so, how it was conducted; whether the policy options were identified as having an impact; and how we took forward the policy proposal. The Committee will include a summary of this information in its annual report to Council, which will be available on our website.

74. We will also produce an annual report on our monitoring of our gender employment statistics, which will be available on our website.

Consulting employees, service users and others

75. The steps we have taken or intend to take on consulting employees, service users and others in relation to the general and specific duties are set out above:
   a. As to preparation of the Scheme, see paragraphs 18 to 26;
   b. As to consultation on the impact of our policies and practices on men and women, see paragraphs 32 to 35.

Achieving the fulfilment of our overall gender equality objectives

76. The steps we propose to take towards fulfilment of our overall gender equality objectives are set out in the attached action plan at Annex A. This sets out key actions, target dates, intended outcomes, evidence of completion and lead responsibility.