General Medical Council – Race Equality Scheme

Introduction

1. By section 71 of the Race Relations Act 1976 (as amended), the General Medical Council is required, in carrying out its functions, to have regard to the need:
   
   a. To eliminate unlawful discrimination; and
   
   b. To promote equality of opportunity and good relations between persons of different racial groups. This requirement is referred to in this Scheme as ‘the general duty’.

2. The Race Relations Act 1976 (Statutory Duties) Order 2006 requires the GMC to publish a Race Equality Scheme, that is, a scheme showing how it intends to fulfil the general duty and its duties under that Order (‘the specific duties’). This Scheme is published in response to that requirement.

3. This Scheme sets out, in particular:
   
   a. Those of the GMC’s functions and policies (or proposed policies) which the GMC has assessed as relevant to its performance of the general duty;
   
   b. The GMC’s arrangements for assessing and consulting on the likely impact of its proposed policies on the promotion of race equality;
   
   c. The GMC’s arrangements for monitoring its policies for any adverse impact on the promotion of race equality;
   
   d. The GMC’s arrangements for publishing the results of this assessment, consultation and monitoring;
   
   e. The GMC’s arrangements for ensuring public access to information and services which it provides;
   
   f. The GMC’s arrangements for training staff in connection with the general and specific duties; and
   
   g. The GMC’s arrangements for meeting its employment duties under the 2006 Order.

The General Medical Council

4. 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.

5. In carrying out our functions we must:

a. Put patient safety first.

h. Support and develop the good medical practice of doctors.

i. Be independent of Government as the dominant healthcare provider and employer of doctors, and independent of dominance by any single interest.

j. Work to command the confidence and support of those with whom we deal.

k. Promote fairness and equality and value diversity.

6. 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.

7. Our guiding principle in meeting the general duty is to place the elimination of unlawful racial discrimination, and the promotion of equality of opportunity and of good race relations, 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.

8. To demonstrate our leadership commitment to meeting the general duty, we have appointed a Director as our ‘champion’ for diversity including racial equality. Paul Buckley, our Director of Strategy and Planning, will ensure that diversity, including racial 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.

9. As an organisation, our key aims for the year ahead are to:
a. Enhance confidence in doctors by continuing to improve our capacity for supporting excellence and best value in medical regulation;

b. Deliver effective, patient-centred regulation by engaging fully with those who use or benefit from our services to ensure their views are properly represented;

c. Support patient-centred care by maintaining an accessible, accurate and up-to-date Medical Register, and by improving further the quality and scope of the information it contains;

d. Enable doctors to deliver high quality care to patients by making best use of our responsibility for setting standards for doctors and co-ordinating all stages of medical education;

e. Enhance patient safety by improving further the procedures for dealing with doctors whose fitness to practise may be impaired.

10. We have prepared our 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 race equality (or other diversity) impact at an early stage.

The Race Equality Scheme

Producing the Scheme

11. This is 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

12. 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 A). 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

13. We arranged, through a specialist provider, Research Works, for 16 in-depth interviews in early October 2006 to consider the content of the draft Scheme. The group of interviewees included a mix of ethnic backgrounds. The draft was set out under the aims of the draft 2007 Business Plan, and people were asked for comments on our proposals and for other suggestions for work with diversity and equality implications which would assist in achievement of our business aims.

Wider consultation exercise

14. In October to November 2006 we contacted 170 organisations representing and made up of doctors, patients and the public within the equality strands. These included the Arab Health Project; the Black Londoners’ Forum; the Centre for Caribbean Health; the Chinese Information and Advice Centre; the Confederation of Indian Organisations (UK); the Council of British Pakistanis; the National Black Carers’ Association; the Race on the Agenda Cremer Business Centre; the Board of Deputies of British Jews; the West Indian Standing Conference; the British Association of Physicians of Indian Origin; the British International Doctors’ Association; the Commission for Racial Equality; the Equality Commission for Northern Ireland; the Northern Ireland Council of Ethnic Minorities; the Diversity Taskforce; the Centre for Education for Racial Equality in Scotland; and the National Resource Centre for Ethnic Minority Health.

15. 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. The latter included the British Association of Physicians of Indian Origin, the British International Doctors’ Association, and the Board of Deputies of British Jews. In the first two cases, we also arranged a meeting between the respondent and the Chair of our Committee for Diversity and Equality (CDE).

Proposed consultation on this Scheme

16. 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 ask those interviewed, who will include representatives of ethnic minorities, to identify any barriers they might have in accessing our services so that we can find ways to improve our accessibility (see action 3, Annex D).

17. 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 (see paragraph 14 above). 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.

**Aims**

18. Our race equality aims for 2008 are to work towards the following:

   a. Working with our key interest groups, including international and ethnic minority interest groups, to gain a better understanding of issues around international medical graduates and fitness to practise;

   b. Assessment of all proposed policies that are relevant to the general duty for any adverse impact on racial groups, and action to avoid or reduce that impact;

   c. Monitoring the effect of all relevant existing policies on racial equality with priority being give to those in fitness to practise;

   d. Making sure information about the GMC and our functions and services reach all members of the public, regardless of racial group; and

   e. A representative workforce at all levels of our organisation.

**Responsibility for the Scheme**

19. 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.

20. 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.

21. 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.
Identifying relevant functions and policies

22. We have assessed whether each of our functions and policies\(^1\) is relevant to the general race equality duty. In doing so, our approach has been that the fundamental question is ‘how does this function or policy affect different racial groups in the community we serve?’ To answer this question, we have considered relevant questions set out in our Equality Impact Assessment tool\(^2\) (see Annex B). A list of functions and policies assessed as relevant is at Annex C.

23. We then considered how relevant each of these functions or policies was to all three strands of the general duty, so as to give them appropriate priority. In doing this, we considered in particular whether there was evidence or reason to believe that racial groups could be differently affected; if so, how much evidence there was; and, in any event, the level of public concern that the function or policy was being carried out in a discriminatory way. In order to do this, we used a grid similar to that suggested by the Commission for Racial Equality in its non-statutory guidance on the general duty\(^3\) and assigned a priority level of high, medium or low accordingly.

24. The result of this assessment was that our Fitness to Practise function was assessed as being of the highest priority in terms of the general duty. Policies within this function were examined to determine which of these was also of high priority (see the list at Annex C). These priorities were then used to draw up an action plan for 2008.

25. We have set a timetable for assessing\(^4\) and reviewing\(^5\) the impacts on race equality of our functions and policies, in accordance with their level of priority (see actions 11, 12, and 13, Annex D).

26. Fitness to Practise will be our highest priority in the year ahead, because of the over-representation of international medical graduates within our Fitness to Practise procedures, and some of the most important current or proposed initiatives in that area are:

a. To roll out the collection of ethnicity data to all registered doctors (a process which began in June 2007). We will report on the outcome of the collection exercise by 29 February 2008.

\(^1\) We interpret ‘functions’ broadly to mean all our duties and powers (including internal functions such as the employment of staff). ‘Policies’ is also interpreted widely, to mean the full range of formal and informal decisions we make in carrying out our duties, and all the ways in which we use our powers (or decide not to).

\(^2\) Namely: (a) what are the aims and purpose of the policy (and why is it necessary)? (b) who will the policy affect, and how? (c) will there be a positive impact on any group of people? If so, what is it and how did you identify it? (d) do any racial groups have different needs, experiences and priorities in relation to the policy? If so, what are they and how did you identify this information? (e) might the policy create particular problems for any racial group, and why?

\(^3\) At p.29.

\(^4\) In the case of functions or policies which have not previously been assessed.

\(^5\) For those which have already been assessed.
b. Thereafter, to undertake an analysis of fitness to practise data with reference to ethnicity, and to publish the outcome of that analysis.

c. To commission further research, through our relationship with the Economic and Social Research Council’s Public Services Programme, on the over-representation of international medical graduates. We propose to commission seven research studies and a research fellowship, including studies to explore:

i. The experiences of medical graduates making transition to the UK workplace. This study will specifically include cohorts of international medical graduates and will seek to recruit black and ethnic minority doctors;

ii. Doctors’ transitions to new levels of medical responsibility. This study will also include international medical graduates;

iii. Identifying biographical and biopsychosocial risk factors among underperforming doctors;

iv. An analysis of data on registration and fitness to practise cases in the context of risk-based approaches to medical regulation.

d. To commission a project to explore why international medical graduates and black and ethnic minority doctors are subject to complaints and how they are handled across the sector (including the question of the proportionality of referrals from public bodies).

e. To hold further round-table discussions on the issues faced by international medical graduates and black and ethnic minority doctors in relation to fitness to practise, to include key interested parties such as the Healthcare Commission and doctor support groups.

27. This work will build on a number of race equality initiatives previously taken in our Fitness to Practise function, which have included the following:

a. In November 2004, we introduced major reforms to the way we handle complaints and concerns about doctors. The aim of these were 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.

b. 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
The 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 people from ethnic minorities, 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 three were from ethnic minority groups, five are women and one is registered disabled.

c. 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, and 23% of our panellists are now from ethnic minority groups. 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.

d. We have undertaken extensive research (both qualitative and quantitative) on the over-representation of international medical graduates within our fitness to practise procedures. The Policy Studies Institute began a study of our fitness to practise procedures under the Council’s Racial Equality Group in 1993, and published reports in 1996 and in 2000. This research work, more recently undertaken by York Health Economics Consortium, continues. For the past two years we have additionally compiled detailed statistical analyses of our fitness to practise statistics, broken down by place of primary medical qualification.

e. Our Indicative Sanctions Guidance for Fitness to Practise Panels was most recently amended in April 2005, and those amendments were subjected to Equalities Impact Assessment. The Guidance begins with an Equality and Diversity statement, and also provides specific guidance

i. On considering references and testimonials; and

ii. On expressions of regret and apology, emphasising the importance of awareness of, and sensitivity to, cultural and language differences in these areas.

28. We will review our assessment of our priority functions and policies annually as we undertake our business planning process. This goes beyond the statutory requirement to review the list every three years, but enables us to ensure that our work fits in with our business planning process. Our governance team will lead on this work, in partnership with our planning team.

29. Our arrangements for meeting this specific duty (to identify relevant functions and policies) are set out in actions 4 and 5 of the Action Plan at Annex D.
Our arrangements for assessing and consulting on the likely impact on the promotion of race equality of proposed policies

Assessment

30. We assess the likely impact of our proposed policies on the promotion of racial equality by using our Equality Impact Assessment tool (Annex C), 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 all racial groups from the start of policy development.

31. 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 (for example) all racial groups; and that consultation is therefore usually the most effective way to gather information and to test the proposed policy outside the GMC.

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

33. The sources of information available to staff carrying out impact assessments as to the impact of a policy on different racial groups include the following:

   a. Ethnic monitoring data. We currently hold ethnic monitoring data on our own staff (see 'Employment' below), and we are in the process of compiling such data for all registered doctors (see above). We also hold data, in respect of our fitness to practise function, broken down by place of primary medical qualification (international, UK, EU or other Europe) and produce annual reports for Council analysing those figures.

   b. Consultation responses, particularly those from representatives of ethnic minority groups (see ‘Consultation’, below).

   c. Specially-commissioned research and other information: for example, in 2006, we commissioned external consultants to carry out a communications accessibility audit to identify ways in which we could improve accessibility, including for ethnic minority groups, to patients, public and doctors. 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.
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.

We are currently proposing to carry out a review of our Regulatory Impact Assessment procedures, including the Equality Impact Assessment procedure (see action 6, Annex D). We believe that we can strengthen our EIA tool further and give our staff further support in using the tool, and in identifying and mitigating any adverse impact. We expect to add a screening tool, as well as guidance on sources of evidence and support for staff; on implementation; and on monitoring potential impact. We also expect to take steps to ensure that accessibility to our services is considered when assessments are being conducted. We will, moreover, consider whether any further training is necessary and, if so, introduce a training package in 2008. This work has already begun and will continue into 2008.

Consultation

A consultation policy, Conducting GMC consultations – a protocol for staff will be implemented in early 2008, 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.

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.

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 (e.g. 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, in order to improve accessibility both for people with learning disabilities and those for whom English is not their first language.
39. 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.

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 faith groups, black and minority ethnic groups, the elderly and young children.

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

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

41. Where an equality impact assessment identifies an adverse impact on one or more racial groups, 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 nevertheless a sound and proportionate justification for continuing to implement the policy; and will consider measures to mitigate, or compensate for, the impact.

42. 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 (see action 10, Annex D).

b. In 2007, we conducted two pilot schemes on collecting ethnicity data from doctors on our register which informed the main data collection exercise later in the year.

43. Where consultation responses identify impacts on particular racial groups, or other race equality concerns, we will feed these into the policy development process and modify draft policies as appropriate. For example, comments by respondents to our Good Medical Practice consultation led to the addition of ‘ethnic or national origin’, ‘religion’ and ‘marital or parental status’ to the list of grounds upon which doctors should not discriminate6. Similarly, feedback from the consultation seminar on the guidance on withholding life-prolonging treatments raised concerns about making provision for doctors with faith-based or other conscientious objection to be able to withdraw from a patient’s care. A paragraph on conscientious objection was, accordingly, added to the text.

44. 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. For example, in our consultation on withdrawing life-prolonging treatments, we sent re-drafted sections of the guidance (including a specific reference to addressing a patient’s spiritual needs) to a targeted selection of groups, including Muslim, Jewish and Christian organisations.

45. Where impact assessment or consultation identify positive impacts on minority groups, we will use these to highlight and promote good practice in subsequent policy-making.

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

a. Monitoring: we will monitor the impact of our policies, including on ethnic minority groups - see section on monitoring below.

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;

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6 Good Medical Practice, §§7 and 46.
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.

47. Our arrangements for meeting this specific duty (on assessment and consultation) are set out in actions 6, 7, 8, 9, and 10 of the Action Plan at Annex D.

Our arrangements for monitoring policies for adverse impact

48. Monitoring our policies allows us to test how different racial groups 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 (e.g. by recognising language difficulties or patterns of discrimination or exclusion).

How we monitor our policies

49. We monitor our functions and policies for adverse impacts on racial equality in a number of ways:

a. Ethnic monitoring statistics: we currently collect ethnic monitoring data for our staff (see the section below on the employment function) and we are in the process of rolling out the collection of such data from all registered doctors (see the section below on the fitness to practise function). This data will allow us to analyse the impact on all racial groups of both our fitness to practise and registration functions (including the impact of revalidation procedures for doctors, when these are introduced). We also intend to consider the feasibility of collecting ethnicity data from complainants in our fitness to practise procedures. We will undertake the feasibility study in 2008.

b. 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 with an effective spread across all ethnic groups. 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 doctors from all racial groups to pass on comments about their experience with us.
c. **Specially-commissioned research**: we also carry out, from time to time, specific research on the impact of our policies on different racial groups. For example, our 2006 accessibility audit on communications considered the impact on different racial groups of our policies and procedures; our arrangements for face-to-face contact; our communications; our Contact Centre; our website (where a ‘road test’ of the site was carried out with members from the Black Health Agency in Manchester); and our engagement with the public. Recommendations from the audit\(^7\) have been included in the business plan and equality scheme for 2007 and, where relevant, 2008. Another example is our proposed research on the experience of international medical graduates and black and minority ethnic doctors in the fitness to practise system (see above).

Monitoring our fitness to practise function

50. Monitoring our fitness to practise function is a high priority because of the over-representation of international medical graduates (see above), and we have been engaged in research and analysis in this area since 1993.

51. We prepare a detailed annual analysis of fitness to practise statistics by place of primary medical qualification (broken down into the categories UK, International, EU and Other Europe), covering:

a. Fitness to practise enquiries;

b. The outcome of our initial filtering stage (known as ‘triage’)\(^8\);

c. The decisions of Case Examiners on whether to refer a case to hearing, accept undertakings form the doctor, give a warning, conclude the case with advice, or conclude it with no action;

d. The outcome of Fitness to Practise Panel hearings (including the proportion of doctors from each group subject to the various sanctions\(^9\), the number found to have an impairment but on whom no sanction is imposed; the number found to have no impairment to their fitness to practise; and the number voluntarily erased from the register).

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\(^7\) Including the following: improving accessibility of public facing portals for website; improving information and signposting for those wishing to make a complaint about a doctor and publicising more widely the role of the GMC; carrying out an external review of decisions in Fitness to Practise cases at the investigation stage; developing guidance for doctors on diversity principles in Good Medical Practice; improving consultation processes by improving exchanges with ‘hard to reach’ groups; further measures for witness support; and improving collection rates for doctors’ ethnicity information.

\(^8\) Where complaints are separated into (1) those raising serious allegations; (2) those raising less serious allegations and (3) those raising no question about the doctor’s fitness to practise.

\(^9\) Namely: erasure; suspension; conditions; undertakings; warning; reprimand.
A summary of this detailed analysis, together with a qualitative description of the patterns found, is presented in an annual paper to Council, together with recommendations for further action, for example, to explore and understand equality and diversity issues as these relate to fitness to practise procedures.

52. We have also commissioned detailed independent research on the available fitness to practise data. For example, in 2005, York Health Economics Consortium carried out a descriptive analysis of fitness to practise data for 2005 complaints. This analysis also made recommendations for future research, which have informed our ongoing research programme (see above).

53. Our regulatory and IT teams deal with the collection and annual analysis of our data relating to doctors and the data is monitored using a Siebel customer relationship management system.

Monitoring our employment function

54. We collect ethnic monitoring data both from job applicants and from staff. Applicants are asked to complete an equal opportunity monitoring questionnaire, and for the 18 recruitment campaigns conducted since January 2007, 27% of those completing the questionnaire were black or minority ethnic applicants. We collect data from all staff when they join the GMC and seek an update at least every two years. We currently have 448 staff, of whom 12.2% are from ethnic minorities; 11.8% are white non-British; and 74.9% are white British. We have been collecting and monitoring this data for over ten years.

55. Our Human Resources team is responsible for collecting and analysing ethnic monitoring 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 ethnicity 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 different racial groups. Employment monitoring will also include an analysis by ethnicity on staff who benefit or suffer detriment as a result of our performance assessment procedures. An update on the ethnicity of our workforce, setting out key statistics as well as qualitative analysis and an update on current and proposed Human Resources work on equality, is provided to the Committee for Diversity and Equality annually.

How we measure our race equality performance

56. We aim to measure our race equality performance by comparing, or base marking, it against the relevant population group. For example, when analysing fitness to practise data, we consider the actual numbers of international medical graduates at various stages of the procedure against the expected numbers given

10 1.1% of employees have not provided ethnic origin information.
the percentage of such graduates in the NHS workforce\textsuperscript{11}, as well as against the numbers expected given the number of initial complaints. We base mark our employment data against the proportion of ethnic minority groups in the relevant local population (e.g. that population in London or Manchester in respect of our London or Manchester offices respectively).

\textit{How we use the information gathered}

57. We use our analysis of the data we collect, together with the results of other monitoring activities such as research, to inform policy development in order to improve race equality. Where monitoring shows that a policy may be having an adverse impact on race 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. Our analysis of employment monitoring data for 2007 showed that while 27\% of applicants were from black or minority ethnic groups, this was not translated into appointments. We therefore decided to review our recruitment processes with the aim of tackling this problem. As a result of this review, we have introduced includes a revised application form and further development of our selection techniques. The current advertising review tender has included detailed requirements regarding diversity (see further the section on our employment duties, below).

c. Our latest annual analysis of fitness to practise statistics showed that, as in previous years, a greater proportion of enquiries about international medical graduates are investigated as opposed to being closed at triage, and that a greater proportion of such cases are referred for adjudication by Case Examiners. We are therefore commissioning further comprehensive research to understand the reasons for this (see above).

d. Our communications access audit recommended that publications specifically targeted at patients and public (especially information leaflets) should be accessible to non-English speaking communities. As a result of this we arranged for our ‘How to complain about a doctor’ leaflet and our

\textsuperscript{11} NHS workforce statistics give a more accurate picture of the proportion of international medical graduates in actual practice than statistics for doctors on the register. This is because the register contains individuals who do not practise at this time, or in this country. The NHS figures exclude doctors who are solely in private practice but are, nevertheless, more representative.
complaint form to be translated into Arabic, Bengali, Hindi, Punjabi, Urdu and Welsh. These are currently available for downloading from our website.

58. Our arrangements for meeting this specific duty (on monitoring) are set out in action points 11, 12, 13, and 14 of the Action Plan at Annex D.

Our arrangements for publishing the results of assessments, consultation and monitoring

59. 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.

60. 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.

61. We produce a report annually on our fitness to practise procedures, including analysis of cases by place of primary medical qualification (see above), and we will also produce an annual report on our monitoring of our race relations employment duty. Both reports will be available on our website.

62. When publishing the results of assessment, consultation and monitoring we will, where appropriate, include the following points:

   a. Why the assessment, consultation or monitoring took place;
   b. How it was carried out;
   c. A summary of the responses or views it produced;
   d. An assessment of the policy options; and
   e. What the GMC is proposing to do.

63. 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

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12 With the full reports available on request.
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.

64. Our arrangements for meeting this specific duty (on publication) are set out in action points 15 and 16 of the Action Plan at Annex D.

Our arrangements for ensuring public access to our information and services

65. We want to ensure that the GMC’s services work for everyone. In particular, we want to make sure that all groups, including people from ethnic minorities (patients and the public as well as doctors) are aware of what we do, are confident about interacting with us and do not meet barriers when doing so.

Public access to information and services

66. The main areas in which we provide information and services to the public (including to doctors) are:

a. Taking action when fitness to practise standards have not been met;

b. Controlling access to the Medical Register;

c. Determining the principles and values underpinning good medical practice; and

d. Setting the educational standards for medical schools.

67. We have offices in London, Manchester, Belfast, Cardiff and Edinburgh, with most of our operational work being conducted in London and Manchester. Doctors, patients and the public interact with us in a number of ways, as follows.

68. **Face-to-face contact:** Doctors, patients and the public can visit our Reception Areas in our London and Manchester offices: doctors attend there for ID checks, advice on registration or (if international graduates) to take the Professional and Linguistic Assessments Board. The public also make general enquiries. Doctors, patients and the public may also attend our offices as a result of being involved with either the investigation or adjudication process for fitness to practise. We have recently extended our reception hours to 8am to 6pm Monday to Friday, with a Saturday rota for peak periods, to allow more people to visit us at times when they are not working. Because some international medical graduates seeking initial registration may have limited English, when advertising posts for Registration Consultants working at the registration reception area, we have specified a working knowledge of a language other than English as advantageous in the job description and key skills for the post.
69. Witnesses in Fitness to Practise cases also have face-to-face, and other, contact with us and we make provision for identifying and managing vulnerable witnesses. Our Fitness to Practise function is currently carrying out a project to improve provision for witnesses generally. This will include a support pack on the internet. We will consider issues for black and minority ethnic witnesses when we put this pack together – for example, by flagging up the availability of leaflets in other languages and our willingness to provide translations or interpreters (which we provide through an agency) (See action 17, Annex D).

70. **Telephone contact**: we receive over 800,000 telephone calls per year, mainly relating either to doctors’ registrations (mostly calls from doctors) or to fitness to practise matters (calls from patients, the public, doctors’ employers and doctors themselves).

   a. **Registrations**: we operate a telephone Contact Centre which deals with all aspects of doctors’ registrations (including the PLAB test for international medical graduates) and receives over 400,000 calls per year. The Centre is open from 8am to 8pm Monday to Friday and 9am to 5pm on Saturday. We also operate a 24-hour service for certain urgent matters. In 2006, 95% of calls to the Centre were answered within 15 seconds\(^\text{13}\). We have sought, as for the Reception Area, to recruit staff with knowledge of languages other than English to the Contact Centre.

   b. **Fitness to practise**: we have a telephone helpline for patients which is advertised in our leaflets (available on the internet in a number of minority ethnic languages) and on the web. In July 2007, this helpline was transferred to our Contact Centre in order to improve levels of service\(^\text{14}\). Calls are sometimes from members of the public who are extremely distressed or who have mental health issues; our staff have to be particularly sensitive and adept at managing such calls. All staff have received appropriate customer service training, and 12 people in the Fitness to Practise directorate have additionally received training from the Samaritans. For those complainants with hearing or speech difficulties, we offer a Talk Type facility.

71. **Our website**: our website contains an extensive accessibility section and we strive to ensure that it is maintained and enhanced according to accessibility best practice. It works with a number of screen readers and offers users the option to have web pages and PDFs read to them at no cost via Browsealoud. The site performs well on a Vischeck (colour blindness simulator) test and has scalable text. Our 2006 access audit (which included a black and minority ethnic ‘road test’ of the site) described the diversity of images throughout the site as ‘very positive’, commenting on the use of images of White, Asian, Chinese and Black men and women. The ‘vacancies’ page includes a diversity statement as one of four main links on the page. The Arabic, Bengali, Hindi, Punjabi, Urdu and Welsh versions of

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\(^{13}\) Against an industry average of 80% of calls answered in 20 seconds.  
\(^{14}\) For service levels in the Contact Centre, see above.
How to complain about a doctor, and of the complaints form, appear on our website. We are embarking on a major overhaul of our site in the first half of 2008 and will look at how easily accessible these publications are from within the site at that time. We are aware of the need to disseminate information to people without access to the internet and, as a result, we distribute some of our leaflets, where appropriate, to a range of individuals and organisations depending on the content of the leaflet and the target audience.

72. Users will be able to download this Equality Scheme 2008 and its annexes online.

73. Written communications: we produce a large number of written communications. Our guidance leaflets are available in English and, where necessary, Welsh. We will consider requests for translating into other languages, including Easy Read English \(^{15}\), or using Braille, tape or large font where this would remove a barrier to accessing our services. We will also use the services of a translator or interpreter where it is in the public interest to do so. This will normally arise in the context of Fitness to Practise where, for example, we have used a translation agency to translate testimonials provided from the Asian community on behalf of a particular ethnic minority doctor. Decisions on the best way to apply our resources in this area are usually made by the relevant senior manager and director. All our publications are available on our website and in hard copy (on request from our call centre or by post).

74. Among the most important of our leaflets, available via our website or in hard copy, are the following:

a. **Guide for patients – how to complain about a doctor**: this leaflet is available in English, Welsh, Arabic, Bengali, Hindu, Punjabi and Urdu. The production of leaflets in the last five languages implemented one of the recommendations of our 2006 access audit that it was vital that this leaflet, being specifically targeted at patients and the public, was accessible to non-English speaking communities. We are also in the process of producing the leaflet in Chinese and Gujarati.

b. **A guide for doctors referred to the GMC**: this booklet provides a guide to procedures and explains the various stages of fitness to practise procedures. More information can be obtained via direct telephone contact with the Contact Centre (above) or by downloading factsheets from our website.

c. **Referring a doctor to the GMC: A guide for health professionals**: this advises medical directors, trust chief executives and clinical governance managers on what to do if they are concerned about a doctor. Our access audit found that a chart in the leaflet explaining the GMC’s processes was

\(^{15}\) As set out above, we produced an Easyread version of our 2006 Equality Scheme consultation.
‘comprehensive, informative and easy to follow’, and praised the fact that the leaflet made clear that anyone dissatisfied by the outcome of local procedures could contact the GMC for advice.

75.  **Good Medical Practice** is a highly important core publication detailing the principles of good medical practice and standards of competence, care and conduct expected of doctors in all aspects of their professional work. A new version was launched in November 2006, and was distributed to health sector employers and GP practices in both the public and private sectors, along with posters which we requested should be displayed in waiting rooms and other public areas. We also made available, upon request, the same poster translated into Arabic, Chinese, Gujarati, Hindi, Punjabi, Urdu and Welsh. Prior to launching the new version of this publication, we undertook two consultation exercises, including one formal three month public consultation. During the period of the latter consultation we also ran a number of public meetings to discuss issues raised in **Good Medical Practice**. The meetings were open to all and advertised in the local press and on local radio. The meetings were recorded and transcripts analysed and incorporated into the analysis. We also commissioned Picker UK to undertake research on patient (and professional) views, including views from black and minority ethnic patients and the public. Picker are now carrying out further research to find out whether and how patients and the public might want to access the guidance, and we are developing a web ‘e-learning’ package which is designed to be accessible to both patients and doctors (**see action 21, Annex D**).

76. In the coming year (2008), we will be considering whether to produce a short guide to the GMC to be circulated to public libraries and similar centres, with information about how to obtain our publications on standards, complaints forms, etc.

77. We have also produced a style guide, which enables us to maintain a distinct GMC visual identity while ensuring that publications are appropriate for the diverse audiences and subjects they cover. We have established good practice in ensuring that our publications are accessible by working with the Plain English Campaign and the Word Centre. We have been awarded a Crystal Mark by the Plain English Campaign for a number of our publications, including **Principles of good medical education and training**, **Continuing Professional Development** and **The New Doctor (UK edition)**.

78. **Freedom of information**: under the provisions of the Freedom of Information Act 2000, we have a publication scheme which is approved by the Information Commissioner. That scheme, and general information on the Act, is available on our website.

79. **Improving dialogue with ethnic minority groups**: we are always aiming to improve our dialogue with ethnic minority groups, both by the steps set out above relating to communications and accessibility and by involving those groups in policy-making. For example, we are currently setting up an advisory panel of ethnic minority
doctors on fitness to practise research issues. An ethnic minority patients’ group has also been invited to be involved in this process.

80. What we will do if we identify barriers to access: if we identify barriers to equitable access to information and services, we will work to remove these. For example, following research undertaken by Stonewall which highlighted difficulties which gay and lesbian people encountered when accessing healthcare, we have produced a leaflet *Protecting Patients: your rights as lesbian, gay and bisexual people* which has been widely distributed by Stonewall and ourselves and is available on our website. Another example (above) is the translation of our patient leaflets into Arabic, Bengali, Hindu, Punjabi and Urdu.

81. Integrating accessibility considerations: we have sought to integrate accessibility considerations into our arrangements for review, impact assessment, monitoring and consultation. For example:

   a. we held a series of ‘citizen’s juries’ and a children’s poster competition when consulting on our 0-18 policy;

   b. we held a number of public meetings (for doctors and members of the public) when revising *Good Medical Practice* in 2006 (see above);

   c. we issued an Easyread version of our consultation on the 2007 Equality Scheme.

82. Our arrangements for meeting this specific duty (on public access) are set out in action points 17 to 21 of the Action Plan at Annex D.

**Our arrangements for training staff in connection with the race equality duties**

83. We aim to provide our staff with training to ensure that they are aware, to an appropriate extent, of the general and specific duties – and that they have the necessary skills to carry them out.

84. 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 statutory duty *(see action 22, Annex D)*. In addition, we have offered e-learning courses for staff on equality (including race 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 23, Annex D)*.

85. We are also making specific arrangements to meet the role-specific training needs of the staff responsible for managing and delivering the race equality
scheme\textsuperscript{16}. From January 2008, 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 (e.g. 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 and requirements.

86. We have a training strategy, reviewed every three years, which responds to issues raised by the strategic and operational plans, themes emerging from staff appraisals (all of which we review), individual staff needs and any legal or best practice dimension raised by a corporate lead (e.g. financial management, procurement, confidentiality). The strategy will also identify the roles within the GMC requiring training and guidance beyond the mandatory programme. Staff appraisals are the key vehicle for implementing this strategy. The training strategy identifies diversity as one of six key areas from the Business Plan and Training Needs Analysis and provides for mandatory diversity awareness training for all staff. Our planned recruitment and selection training programme covers equality, diversity, and direct, indirect and unfair discrimination.

87. All our employees undertake an annual appraisal and their individual training needs are identified from this process. If, for example, a member of staff had not undergone appropriate race equality training, this would be identified at annual appraisal, and such training would be included in the staff member’s training plan for the following year. We are currently revising and updating the pay (including performance pay) system and as part of this we propose to link mandatory diversity training more clearly to acceptable performance; and to make specific reference to diversity in the competence framework. The updated pay and competence system will also identify specific roles where additional advanced diversity and cultural awareness training is required, and will identify posts where detailed training on impact assessment is a requirement of the role. Attendance and application of learning on these programmes will be assessed through staff appraisal. We aim to produce the revised pay system in draft by February 2008 and to publish it by March 2008 (see action 27, Annex D).

88. All our training programmes are subject to Quality Assurance procedures and participant review. From January 2008, all programmes will be screened to ensure that issues relating to the general and specific duties are incorporated where relevant.

89. Our arrangements for meeting this specific duty (on staff training) are set out in action points 22, 23, 24, 25, 26, 27, and 28 of the Action Plan at Annex D.

\textsuperscript{16} 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.
Our arrangements for meeting our employment duties

90. We are required\textsuperscript{17} to have in place\textsuperscript{18} arrangements for fulfilling, as soon as possible, certain monitoring requirements – and to fulfil those requirements in accordance with those arrangements.

91. We are required to, [and do,]\textsuperscript{19} monitor (by reference to the racial groups to which they belong, using the 2001 Census categories) the numbers of:

   a. Staff in post;

   b. Applicants for employment, training and promotion;

   c. Staff receiving training\textsuperscript{19};

   d. Staff benefiting or suffering detriment as a result of our performance assessment procedures;

   e. Staff involved in grievance procedures;

   f. Staff subject to disciplinary procedures; and

   g. Staff ceasing employment with us.

92. We use PS Enterprise to store personal employee information and records. This allows reports to be generated analysing ethnicity and pay, grading, promotion and employment ceasing. We can also cross-reference ethnicity data with the separate records in place for training participation, disciplinary and grievance procedures. Performance assessment results are also monitored and can be cross-referenced back to employment records.

93. As well as PS enterprise (our IT system), we also use a series of local systems to collate and analyse employment data. These include attendance logs for training, management reports, and recruitment statistics\textsuperscript{20}. We also require recruitment agencies to record ethnic monitoring information for us when they run recruitment campaigns.

94. Our Human Resources team monitor this data and report to directors as part of their regular scrutiny of management information. This is part of the monthly management review process. Quantitative and qualitative information on numbers of staff receiving training, and on the impact of performance assessment procedures, is reported quarterly to directors, and all items are subject to an annual report and summary in January. This annual report will also cover updates on the GMC’s

\textsuperscript{17} By Article 3 of the Race Relations Act 1976 (Statutory Duties) Order 2006.
\textsuperscript{18} Before 2 March 2007.
\textsuperscript{19} Requirements (iii) to (vii) apply because we have more than 150 full-time equivalent staff.
\textsuperscript{20} Often using Microsoft Excel.
training programmes on diversity (including participation rates), and a review of our policy and procedures on diversity and employment. This annual report is considered by our Committee for Diversity and Equality and published on the GMC website. Information in the report is used to identify areas where action may be needed or where further staff training or development is necessary. All recruitment campaign statistics are subject to review and periodic reporting to Directors.

95. Recruitment has been our main HR priority over the last three years. During that period we have made 360 appointments. We have continued to develop and implement initiatives to maintain our good practice on recruitment at all stages, from defining the job specification, advertising and selection through to appointment.

96. We seek to communicate with a wide and diverse group of potential applicants for employment – for example, by attending recruitment fairs with a diversity theme and using a range of external media that targets ethnic minority groups. We also now review all our printed advertisements to ensure that the branding and style fits with our policies and aims on diversity, including race equality. We will also be further developing our on-line recruitment presence since work we have already undertaken suggests that increased use of the web allows us to market ourselves to a wider and more diverse group of potential applicants, and to communicate our commitment and good practice on diversity to candidates very effectively. Our aim is to handle all posts through a single web presence by the end of 2008; ahead of this we have already established a network of recruitment sites with a diversity focus.

97. We are currently conducting a tender for our recruitment advertising work, (scheduled to complete by December 2007), a process that will ensure our profile is maintained as an employer on equal opportunity and diversity issues. The ability to support our programme and policies on diversity will be a key factor in awarding the contract, and the tender documents reflect this.

98. If ethnicity data did reveal adverse impacts on particular groups, we would work to understand these impacts and to eliminate them by making changes to the relevant (recruitment, training, appraisal etc) procedures.

99. We have recently reviewed our testing procedures and updated our application form, and have recruitment training scheduled for all GMC managers. We believe that these steps are a further enhancement of our recruitment practice, helping to ensure that it is fair and transparent. We are also considering open evenings as a way of attracting candidates who may not have previously considered the GMC as a potential employer. We believe that opening up as many communication channels as possible facilitates applications from under-represented groups.
100. We will comply with our obligation to publish, annually, the results of our employment monitoring\(^{21}\) by publishing those statistics through a Council paper (which is a public document and is available on our website). The first publication will be the 2007 statistics, to be published in the first quarter of 2008 (see action 30, Annex D).

101. Our arrangements for meeting these specific duties (on employment) are set out in action points 29 to 32 of our Action Plan at Annex D.

Our race equality Action Plan

102. An Action Plan is annexed (Annex D) setting out details of the actions to be taken by the GMC and how, when and by whom they are to be completed, in relation to each of sections above.

\(^{21}\) Required by article 3(2) of the 2006 Order.