Equality, diversity and inclusion

Targets, progress and priorities for 2024

General Medical Council

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Foreword

The composition of the medical workforce is changing. International medical graduates (IMGs) made up more than half of all new joiners to our register last year, while the demography of UK graduates is also increasingly diverse. Yet, for too many doctors, medicine is a story of discrimination and disadvantage. From the early days of education and training, to the leadership positions of latter years, issues of inequality are persistent and pernicious.

This unfairness is deep-rooted and long-standing. It undermines doctors' morale and ability to perform at their best. And it shames our health services. As we expect equity from clinicians in their practice, we, too, must ensure that that equity is extended to doctors themselves. Fair treatment is not the preserve of a select few – it is the right of all doctors, regardless of who they are.

In 2021, we set a series of targets to advance equality, both as an employer and as a regulator. Our targets are ambitious – as they should be. But we have seen than there is real will across the system to deliver meaningful change. And, as this report shows, our efforts are bearing fruit.

There are sustained signs of improvement in terms of disproportionality in employer referrals. We're seeing the attainment gap in specialty training narrowing for IMGs. And we're ahead of schedule on our targets around the representation of ethnic minority colleagues in our own workforce.

But we can't – and won't – shy away from the scale of the challenge. To deliver real change we must be nimble, constantly challenging ourselves and learning from what works and what doesn't. And we must be candid about where we, and others, need to do better. The truth is that progress remains stubbornly slow in some areas. Measures for earlier stages of training, for example, do not show improvement. We've made limited progress in terms of representation at a senior level within the GMC. And while highly targeted initiatives, like better induction, can move the dial relatively swiftly in the short term, systemic and cultural change is harder to achieve.

That's why our sights are set on a longer-term horizon – and we are pushing our system partners to do the same. Efforts to foster equality are not a nice-to-have – they lie at the heart of sustainable health services. And they can't be downgraded when the going gets tough. A workforce that is valued and supported delivers better outcomes than one which is overlooked and undermined. In the face of system pressures, fairness and inclusion are not a distraction from the provision of good care, but absolutely central to it.

There is a practical imperative here, as well as the irrefutable moral one. When diversity is harnessed, not merely tolerated, it can be transformational. There is huge potential in embracing a plurality of viewpoints and experiences, and the improved decision-making that brings. Failing to create a level playing field for all voices means squandering this opportunity.

The GMC is a charity registered in England and Wales (1089278) and Scotland (SC037750).
You are welcome to contact us in Welsh. We will respond in Welsh, without this causing additional delay.

This report shows that change is possible. We can be positive about the improvements we've seen, but not complacent about what is left to achieve. Our commitment is resolute. A fairer system is a stronger system, and it's in all our interests to deliver it.

Charlie Massey
Chief Executive and Registrar

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Executive summary

1 In 2021, we set a range of targets for our work as a regulator and as an employer, to tackle persistent areas of inequality. In setting these targets, we committed to creating a sustained focus on the delivery of improvements across the health system.

2 Last year we reported that we made strong progress in embedding these targets. We established three programmes of work that will help us to meet these aspirations, they are:

- fairer employer referrals (FER)
- fair training cultures (FTC)
- inclusivity within the GMC.

3 We subsequently added the regulatory fairness review (RFR) as an additional programme of work to our strategic ED&I priority programmes. And we report the progress of all four programmes to Council.

4 In reporting the progress made in 2023, we have reached the halfway point for our 2026 targets and aspirations (those up to 2026). For other aspirations we set a longer timeframe, up to 2031. This year (2024) is an important milestone and we had hoped to see more sustained progress—and we have in some, but not all areas.

5 At this point, we continue to see commitment to the outcomes we are striving for across the system. Setting and sustaining these ambitions generated levers for change that, three years on, are showing sustained progress in some areas—in other areas, progress is more challenging. This isn’t uncommon on improvement programmes like this, and it but serves as a reminder that we need to maintain this commitment for the long term if we’re hoping to achieve permanent change.

6 In reporting progress against these measures, we’ve so far been cautious about drawing significant conclusions from the measures. It's vital to set aspirations with defined measures so we can assess our progress towards achieving those aspirations. In reporting the updated progress in 2023, we are still careful about what we can draw from these given the complexity of factors that can influence change and progress.

7 After three years, our progress against the measures has seen:

- consistent improvements on all fairer employer referrals indicators and forecasts—which shows that in principle this could continue to a point where there’s no significant disproportionality in referrals.

- continued progress in relation to some inclusive employer measures—while progress in other areas remains challenging. Our overall workforce target is ahead of schedule, and we expect to meet our 2026 target in 2025 and continued.[*]
- the first signs that organisational action is starting to take effect and narrowing the attainment gap in specialty training. All three measures covering core and higher specialty training (inclusive environment, ARCP and exams) have moved in a positive direction. The improvement is more pronounced for IMGs than UK Black and ethnic minority specialty trainees, perhaps reflecting the focus on initiatives such as Enhanced Inductions and Exam preparation which target this group.
- a number of challenges in place which will need to be overcome if we are to achieve our ambition. There is an up-front cost associated with the pilot initiatives we've shown are effective. Scaling up relies on PG Deans, Employers and Medical Royal Colleges and Faculties being able to access the resources (including educator's time) necessary. While there are clear benefits in terms of trainee retention and progression through to becoming a consultant there will also be other competing priorities for these stretched resources.
- measures for earlier stages of training do not show improvement and this will be an area of greater focus for us in 2024 / 2025. New data on Medical School assessments is due to be published later this year, and in future the Medical Licensing Assessment (MLA). This will help shine a light on inequality embedded in the early years of medical education.

8 All the programmes of work that support these aspirations show continued progress on the planned activities. We have continued to learn and refine the plans and activities of these programmes; our understanding of what action may best achieve change grows.

Table 1 below shows the key areas of progress for all programmes.

Table 1: Summary of progress in 2023

Workstream	Key findings
Fairer employer referrals (FER)	• Forecasts for FER key performance indicators (KPIs) show that we expect to be close to achieving our targets by the end of 2026. • The data show that the proportion of designated bodies (DBs) with disproportionate referrals continued to decrease in 2023. And the gap in referral rates between ethnicity and primary medical qualification (PMQ) groups has also reduced.

[*] We haven't progressed to the stage where we have measures linked to our regulatory fairness programme.

	- The key performance indicators (KPIs) are calculated quarterly, using a five-year rolling period for robust analysis due to small volumes. Given the time lag, it's likely that we will not know with certainty in 2026 if we've achieved the target. But we will have a good indication of the direction of travel. - The FER programme project team have completed two phases of activity to date and are engaged in a third. - There's significant activity underway across the system to address disproportionality in disciplinary proceedings at employer level, but we are scoping research to identify what concrete mechanisms within designated bodies are effective.
Fair training cultures (FTC)	- In PG specialty training, our three index measures show early signs of improvement, particularly for international medical graduates (IMGs) in training with trainees compared to 2019 baseline data. Inclusive environments and postgraduate (PG) exams show a year-on-year narrowing of the gap and indicate that we should be looking to scale up the pilots and interventions which are being tested. The Annual Competency Review of Progression (ARCP) data shows some narrowing, however greater improvements observed in 2021 and 2022 have gone backwards and this needs to be understood. It may be associated with the reversal of the flexibility introduced during the pandemic. - Evaluation evidence suggests that enhanced induction, targeted exam preparation, educator training and mentoring are making a real difference. These shorter-term, highly targeted initiatives are important in demonstrating impact, however systemic and cultural change is essential to sustained improvement for doctors from marginalised backgrounds and remains a longer-term focus of the work programme. These changes take much longer to show up in outcome measures such as exams and ARCP. - The lack of improvement for the two indices for early medical education are disappointing. Education Performance Measure (EPM) scores show no change and Foundation Year 1 preparedness has deteriorated. Work is underway but has a longer lead-time before the impact is expected to be measurable. a. A new recruitment system was introduced by the UK Foundation Programme (UKFPO) this year which aims to remove barriers to marginalised F1 entrants accessing their preferred placements. This affects new starters from Aug 2024. We will be monitoring the impact of this change on widening access and doctors reported preparedness in the 2025 National Training Survey (NTS).

	b. The evaluation of Melanin Medics 'Enrichment Programme' designed to improve preparedness for new Foundation Doctors will publish its final report summer 2024. • A number of barriers to success exist: a. Many initiatives require up-front investment of time and resource. Scaling up will rely on Postgraduate (PG) Deans, Employers and Medical Royal Colleges and Faculties being able to access the resources necessary. There are demonstrable benefits in terms of trainee retention and faster progression through to independent practice but there will be many competing priorities for already stretched resources. b. Some important changes lead to much better outcomes but over a longer term, making it that much more difficult to secure commitments needed. • However, we are making progress. There is clear evidence of positive engagement and activity across both Undergraduate and Postgraduate training organisations, all of which have established action plans which are shared annually with the GMC. These contain system-wide changes which we expect will lead to further improvement in the index measures. • We co-chair a specialty recruitment ED&I working group with Medical and Dental Recruitment and Selection (MDRS) which is removing unfair barriers in person specifications and scoring matrices. There is a long-lead time for the work to have an impact. Changes will be in place in Autumn and will improve access to specialty training programmes for those entering ST1 from Aug 2025. Recruitment itself is not a specific index measure, however it is anticipated that improving access to sought-after specialties and training locations will lead to better ARCP and PG Exam outcomes as learners are in environments they have actively chosen. • We co-hosted the 3rd annual 'Sharing Good Practice' workshop with Academy of Medical Royal Colleges (AoMRC), Conference of Postgraduate Medical Deans (CoPMeD) and the Medical Schools Council (MSC) to ensure that achieving the targets remains high on agendas, to share examples of impactful interventions and encourage collaboration and consistency across educational organisations. • We've completed the final evaluation of the 'CASC Masterclass' (a 2-day exam familiarisation workshop). It shows a significant improvement for CASC exam pass rates for IMG participants: narrowing the attainment gap by 10%. This evidence enables us to strengthen our 'asks' of PTOs and Colleges each with responsibilities for supporting IMG learners to prepare

	for high-stakes exams. However, barriers such as funding and resources will still need to be overcome if this is to be achieved. • Ensuring learning environments are welcoming and inclusive is a key ambition for the programme. To support our QA teams and PTOs to address issues on the ground we have developed new NTS questions on discriminatory behaviours to a provide a deeper insight into the experiences of training locations.
Assuring fairness within the GMC	• We have developed new decision making principles to be applied to our high impact regulatory decision points. • We have explored in detail the regulatory decisions that we make and considered and mapped the processes and approaches that exist now to ensure we are making fair decisions. • We have identified a set of 42 key decision points – that we are describing as High Impact Regulatory Decisions (or HIRDs). The scale of these decisions varies, but collectively this is significant and represents approximately 27,000 each year. • We will review at each of these decision points to identify where fairness assurance could be strengthened. • The focus of our future phases of work will be on these 42 different decision points to ensure we strengthen fairness assurance measures. • The learning and support provided to staff who play a role in decision making has been improved to ensure all staff who are decision makers or decision advisers receive consistent support. Tailored learning will be rolled out to all those working in decision-making roles learning, the delivery of which will continue throughout 2024 and into 2025.

GMC Inclusivity as an employer	• Progress towards our **overall GMC workforce target is ahead of schedule** and we expect to meet our 2026 target in 2025. • Attraction rates for ethnic minority candidates for all our roles remains high (38%), our work here was supported by further recruitment outreach work in 2023. • Our **management profile is 13.9% and currently 3.7 percentage points behind our interim 2024 target,** and without higher turnover we are unlikely to meet our 2026 target. • **Turnover rates show a difference by 2.7 percentage points turnover** for ethnic minority colleagues is 8.9% compared with 6.5% for other colleagues. Our target for 2024 is to have no more than a 1.5 percentage points difference. • **Promotion and grade progression rates for ethnic minority colleagues are 8.5% (compared with 11% for other colleagues).** Our target is a difference of no more than 2%. • **Our inclusion index score fell by 2%.** Engagement scores for ethnic minority (72.08%) and other colleagues (73.21%) continued to get closer on average, our aim was to ensure that we closed the gap in engagement scores, and we are well within our target.

9 We've established a process for forecasting progress for all measures (see Annex C). Some forecasts are not yet reliably informative due to lack of available data, making models unable to detect a trend. But, over time, forecasts will become more valuable in helping us to understand the impact of the programmes of work that we and stakeholders across the system have developed.

10 The early evidence of progress demonstrates that combined effort can deliver change and is something we should promote, albeit cautiously.

11 This report again shows the breadth of collaborative efforts made to address long-standing inequalities across the system. There's clear evidence of continued willingness from stakeholders to collaborate on these issues to achieve change.

12 Over the three years since we set these measures, the understanding and insight that came from these programmes of work have been the catalyst for others to act. The evidence base and learning continue to grow – and they bring new levers and opportunities each year. We will continue to use this report to highlight the evidence and those opportunities throughout the year, and to share progress and reiterate our calls for action.

13 The case for doing so in medicine is clear. Professionals who work in inclusive environments where they can maximise their career potential will provide better and safer services for patients. Achieving inclusive environments is key for the future sustainability of the UK medical workforce. While workforce pressures are an ever-present issue, given the diversity of the medical workforce, these aspirations must remain a priority for all stakeholders. We must engage with stakeholders to make sure further progress in 2024 and beyond is maintained.

14 We will continue to prioritise our ED&I commitments, both as an employer and a regulator. We continue to build a greater understanding of how we can and will use our levers and our regulatory remit to increase the pace of change.

15 We recognise the breadth of ED&I concerns that are present within the wider UK health system are significant and complex. We must make more progress in understanding wider inequalities—for other characteristics and on a more nuanced level. This involves analysing data about different groups and for intersectional characteristics.[*]

16 In this report we evidence some progress we have made in that area, in Education and Training we publish outcomes by a range of characteristics and will publish a multivariate analysis in 2024. We aim to further progress this through the delivery of the next phases of the regulatory fairness review. Improvements to our new monitoring or analysis processes implemented as part of the regulatory fairness review will be delivered in an inclusive way, encompassing all protected characteristics to ensure we can identify insights for other protected groups.

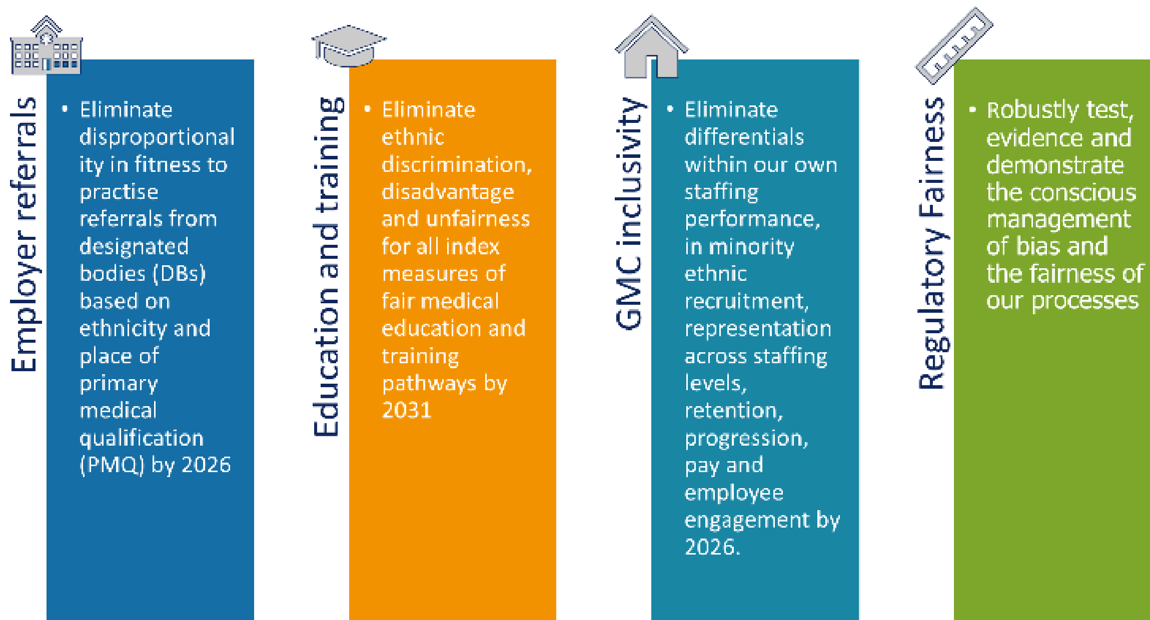
[*] The interconnected nature protected and non-protected characteristics such as race and gender as they apply to a given individual or group, regarded as creating overlapping and interdependent systems of discrimination or disadvantage.

Background to our ambitions and targets

17 In February 2021 we committed to eliminating:

- disproportionality in fitness to practise (FTP) referrals from designated bodies based on ethnicity and place of primary medical qualification (PMQ) by 2026.
- discrimination, disadvantage, and unfairness in medical education and training by 2031.
- differentials within our own staffing performance; in ethnic minority recruitment; representation across staffing levels; retention; progression; pay; and employee engagement by 2026.

18 Our corporate strategy for 2021–2025 renewed our commitment to foster a culture of ED&I in everything we do as a regulator and employer. We set our equality targets to highlight the need for meaningful action to address longstanding inequalities and the effects of racial discrimination and disadvantage.



19 When we launched the targets in 2021, they were well received and supported by external stakeholders. And although we set internal targets for ourselves as an employer, we recognised there was more to do to consider ED&I in our own regulatory functions. As a result, we carried out an extensive review of all the steps we take in our regulatory activity to identify and mitigate bias. We've published the outcome of that review.

Priority commitments and calls to action for 2024

20 On launching these ED&I aspirations we committed to seek to identify priority activities that we believe will contribute to the reduction of these longstanding inequalities – and to call for the system stakeholders to consider implementing these changes where they haven't been implemented already. The workstreams have carefully considered the available evidence to define the list of actions below: -

Calls to action for designated bodies / local education providers

- For DBs to confirm how they identify and use effective and impartial checks prior to making a referral to the GMC to address disproportionality.
- For DBs to share good practice with their peers on tackling disproportionate referrals to the GMC.
- For RO's to ensure they have processes in place so their disciplinary decision making process considers issues relating to equality and diversity, and to share good practice with other RO's.
- For LEPs to define the training and appraisal of Educators in the medical roles recognised by the GMC to ensure that ED&I training specifically covers 'Differential attainment'.
    a. Raising awareness of the existence of an attainment gap across many protected characteristics and the barriers which lead to poorer outcomes for marginalised learners and
    b. Supporting educators to have compassionate and courageous conversations with learners about barriers they may face and working together to identify ways to overcome these.

Calls to action for system leaders

- For the NHS across the UK (and Health and Social Care in Northern Ireland) to mandate the recently launched induction for new international medical graduates (IMGs) that includes the Welcome to UK Practice (WtUKP) induction programme, and covers the topics highlighted in the NHS induction programme for IMGs.
- For the NHS across the UK (and Health and Social Care in Northern Ireland) to ensure that resources are available to Professional Support and Wellbeing Units and

that they have a mandate to consider support for doctors in training from marginalised backgrounds which help remove barriers to progression.

- For the NHS across the UK (and Health and Social Care in Northern Ireland) to develop and deliver a suite of anti-racism resources in partnership with the minority ethnic workforce.
- For system leaders to prioritise ED&I activity through organisational change and workforce plans, as it is central to ensuring a well-supported workforce. And to ensure there is investment in initiatives that address the challenges that exist and support workforce retention.
- For system regulators/improvement bodies to ensure they look at issues relating to fairness as part of their workplace assessments.
- For integrated care boards (ICBs) / integration joint boards (IJBs) / integrated care system (ICS) and other system leaders to make sure they monitor and measure the overall impact of ED&I activity and interventions. Activity and interventions are not an end in themselves, they are a route to achieving outcomes.
- For partners and key stakeholders to communicate and collaborate with each other on ED&I activity to ensure our priorities are aligned and we are amplifying each other's efforts.

Calls to action for leaders across medical education and training

- For Postgraduate Deans to develop improved support for *New to UK learners* based on the increasing evidence of positive impact such as Enhanced induction, exam preparation support, mentoring.
- For all medical royal colleges and faculties to implement the AoMRC principles for exam preparation, feedback and support for candidates to address the awarding gap and ensure that exam candidates are signposted to resources to help them prepare effectively for high stakes assessment.
- For organisations to evaluate the impact of pilot initiatives and to share their lessons learned with others across the system.
- For organisations to put into practice learning from pilot initiatives and their evaluation reports, including the CASC Masterclass Evaluation, Embedding Compassionate Courageous Cross-cultural Conversations into Training, and 'What supported your success?' - A qualitative exploration of the factors associated with an absence of an ethnic attainment gap in post-graduate specialty training.

- For medical royal colleges and faculties, PTOs and Medical Schools to tell us what action they are taking to address attainment gaps in their organisation, region, country, or specialty.
- For MDRS and Medical Royal Colleges and Faculties to deliver on the recommendations of the joint working group to remove unfair barriers within person specifications and scoring matrices.
- For PG Deans and Employers / Local Education Providers to respond to NTS results on Inclusive Environment and Discrimination questions.

Fairer employer referrals (FER)

Fairer employer referrals

21 We set two performance measures to support this target. They reflect the nature of the challenge and require employing designated bodies (DB) to assure themselves that their processes are fair and free from bias. It also requires attention from all employers, regulators, and system partners to affect change.

- **KPI1**: the percentage of DBs active within the last five years, with evidence of disproportionality in their fitness to practise referrals, about either ethnicity or PMQ region**.**
- **KPI2**: the difference in rates of employer fitness to practise referrals between ethnic minority and white licensed doctors**,** and between UK graduated and non-UK graduated doctors**.**

22 Though these metrics only measure referral disproportionality about ethnicity or PMQ region, we also monitor disproportionality about the other five protected characteristics that we collect. These are age, sex, disability, sexual orientation, and religion. We initially focused on ethnicity and PMQ region as indicators, but we also recognised that a local system could produce disproportionate referrals based on other characteristics. We expect that action to improve proportionality about ethnicity and PMQ region will help to make working environments more inclusive for groups defined by all other protected characteristics.

Table 2: Fairer employer referrals key process indicators (KPI)

Target: Eliminate disproportionality in fitness to practise (FTP) referrals from DBs based on ethnicity and PMQ by 2026					
		2016–2020	**2017–2021**	**2018–2022**	**2019–2023**
KPI1: % of DBs with evidence of disproportionality, for ethnicity or PMQ	**Ethnicity or PMQ**	**5.6%** (of 1,213)	**5.3%** (of 1,258)	**4.4%** (of 1,308)	**3.2%** (of 1,394)
KPI2a: Difference in rates of referral between ethnic minority and white doctors	**Ethnicity**	**0.28** 0.58% ethnic minority (out of 112,544) 0.30% white (out of 158,331)	**0.24** 0.50% ethnic minority (out of 121,381) 0.26% white (out of 160,603)	**0.19** 0.41% ethnic minority (out of 131,821) 0.22% white (out of 161,784)	**0.13** 0.31% ethnic minority (out of 144,649) 0.18% white (out of 163,735)
KPI2b: Difference in rates of referral between UK and non-UK doctors	**PMQ**	**0.42** 0.28% UK (out of 184,046) 0.70% non-UK* (out of 105,958) (*made up of 0.73% IMG and 0.63 % EEA)	**0.34** 0.25% UK (out of 188,413) 0.58% non-UK* (out of 112,583) (*made up of 0.59% IMG and 0.56% EEA)	**0.27** 0.21% UK (out of 192,121) 0.48% non-UK* (out of 120,442) (*made up of 0.48% IMG and 0.45% EEA)	**0.16** 0.17% UK (out of 196,205) 0.34% non-UK* (out of 130,082) (*made up of 0.34% IMG and 0.31% EEA)

23 All KPIs improved since last year. From our initial benchmark (2016–2020), the percentage of DBs with disproportionality in their referrals (KPI1) dropped by 2.4 percentage points. This represents a drop of 43 %. Similarly, compared with our initial benchmark, KPI2 metrics dropped by 0.15 and 0.26 percentual points. This means that the referral rate difference between either ethnic minority and white doctors or UK and non-UK graduated, dropped by 54 and 62 % respectively. We will continue to measure

the efficacy of these performance metrics over time and formally review progress against the measures.

24 To draw more robust conclusions out of the small number of referrals we get from each DB, we run our analysis on a five-year rolling period. However, this also means that improvements in disproportionality can take a while to be reflected in our KPIs. After three years of monitoring, we can see that these KPIs can in principle be reduced towards zero.

Forecast performance

25 See Annex C for full forecasts. For each FER KPI, we produced a new forecast of the current direction and compared it with another reference forecast of what we would have expected from 2021 onwards, if none of the drivers underlying the value of the KPIs had changed (see Annex C).

26 The forecasted trajectories of FER KPIs were very similar to those from last year. The percentage of DBs with disproportionate referrals (KPI1) is expected to continue improving towards our target and get close to it by the end of 2026. The referral rate difference between both ethnic minority and white licensed doctors (KPI2a) and between non-UK and UK graduated doctors (KPI2b) are also becoming smaller and are both expected to get very close to the target by the end of 2026.

Key finding: Forecasts show that FER KPIs are expected to continue approaching our targets and are likely to be near them by the end of 2026

Work programme activities in 2023

Completion of phase 2

27 We delivered phase 2 of our action plan between September 2022 and December 2023. Below we have outlined activities completed in phase 2 in 2023.

Table 3: Fairer employer referrals phase timeline

	2021	2022	2023	2024	2025	2026
Phase 1						
Phase 2						
Phase 3						
Phase 4						
Phase 5						

Referral processes

- **Reviewed the changes we made to the Responsible Officer (RO) referral form:** via 6 and 12-month reviews of the changes to assess the effect and identify and deliver further improvements. We found that the process was well embedded with Triage and ROs, and that the quality of the responses to the questions were generally positive.
  a. In 2022 100% of RO referrals had considered – if there were any environmental pressures or systemic issues that may have related to the concern being raised.
  b. In 2022 100% of RO referrals had considered – if the doctor qualified overseas, had completed their first revalidation cycle and if they have more than 5 years' experience of UK practice.
  c. Of the 75 forms received in 2022, the question 'Please confirm whether this referral has been subject to an impartial check' – all but one was completed.
     i. 13 of the 75 forms stated that no check was made.
     ii. 7 of the 13 have then explained that this was because the concern had been discussed with an employer liaison adviser (ELA).
  d. Five out of the 13 the referrers who completed the form stated that the check had been made with the ELA alone. This flagged the need for greater clarity about the need for an impartial check—which is not met by a discussion with an ELA. We are clarifying our guidance to support this process in phase 3.

- **Implemented a new feedback mechanism to ROs about Triage outcomes:** this is similar to the case examiner outcome mechanism we implemented in phase 1. We'll

be looking to evaluate this at the 6 and 12-month mark and will include any improvements in either the rest of the phase 3 plan or in the phase 4 plan, depending on our resource capacity.

- **Reviewed our mechanisms for receiving additional concerns:** these are concerns received about registrants already in our FTP process – and we have identified process changes for phase 3 to support ongoing monitoring and analysis.

Staff learning

- **Extended anti-bias training regarding employer referrals:** this builds on the success of our Assistant Registrars anti-bias training in Triage (phase 1). We've:
  a. delivered additional anti-bias training to case examiners
  b. delivered training to employer liaison advisors about authority bias regarding employer referrals
- **Developed refresher sessions and reflection exercises** to encourage and ensure an ongoing conversation among trained decision makers. Feedback from these sessions indicated that it was helpful to discuss the potential biases specific to our decision making and advice. We will be reflecting on feedback from these sessions and adapting our training accordingly. We will also be updating our anti-bias training to include aspects of cultural competence.

Collaborated and supported system stakeholders

- **Audited our use of GMC levers to deliver the FER target:** This was completed via a survey and workshop to identify whether we are using all GMC levers to the maximum effect to deliver the target. We had good participation in the workshop and gained 16 points of note that we are exploring further in phase 3.
- **Worked with NHS Resolution to support local systems.:** We supported their 'compassionate conversations' training designed to help all involved in local concerns to address matters with compassion. Pilot outcomes were discussed at the November Outreach Development Day.
- **Delivered training to support good local cultures.** Outreach have delivered a wide range of sessions aimed at supporting doctors to build inclusive cultures and workplaces. An example of this is the *Professional Behaviours Patient Safety Training programme.* This aims to support positive culture change through collaboration, communication, and learning how to give constructive feedback on issues at an early stage. The training has been well received in the healthcare service.
  a. 95% of participants rated the training as good or very good overall

b. 99% of participants reported feeling very confident or moderately confident that they could recognise when a behaviour is unprofessional following the training sessions
c. over 90% of participants reported feeling moderately/very confident in challenging and escalating concerns about unprofessional behaviour following training.

- **Collaborated across the UK with a range of bodies to support work in the system.** This included:

  a. In England supporting the MWRES First Five initiative, contributing to the Royal College of Surgeons England SAS strategy developing our understanding of NHS ICSs and their EDI priorities, and contributing to NHS Resolution's training for NHS Boards.

  b. In Scotland working with the Scottish Government on their new Improving Wellbeing and Workforce Cultures Strategy and their Leading to Change Equalities Sub-Group.

  c. In Wales working with HEIW IMG/SAS Expert Group to develop a blueprint for supporting doctors new to the UK or not in training posts.

  d. In N. Ireland facilitating an event to showcase ED&I initiatives across the five HSC Trusts and encourage a regional approach to support and induction for IMGs.

- **Supported consistent induction.** We worked with NHSE to embed the standard IMG induction launched in 2022. We have recently appointed Professor Mala Rao and Partha Kar to support further rollout of IMG induction, and to drive uptake of the Welcome to UK Practice (WtUKP) induction programme. We continue to deliver our WtUKP programme to IMGs and expect to support 11,000 IMGs through the programme this year.

- **Supported effective feedback.** We developed a training session aimed at supporting fairer feedback and will begin piloting this in phase 3.

- **Support locum doctors.** Locum doctors make up a significant proportion of the UK medical workforce, and with current pressures on healthcare there will be a greater reliance on them. Locums often report a poor experience of working environments. They are placed in environments with no proper induction, expected to pick up high volumes of work with no training and development. And when issues arise about their practice, their contracts are often terminated with no feedback or support. We are working with employers to encourage them to induct locums properly, make sure they are working in an inclusive and supportive environment, and are given effective feedback—and that if something does go wrong, it is dealt with fairly.

Improving our insight

- **Scoped research to identify effective interventions.** The research aims to identify what mechanisms are in place in DBs – which may relate to whether their referrals are proportionate. Mechanisms identified as strongly related to having proportionate referrals could then be recommended to other DBs for implementation. Scoping has now been completed and a tender is in the process of being finalised. Commission of this research is being undertaken as part of Phase 3.
- **Carried out a rapid scan to assess what other organisations in regulated sector are doing in the face of disproportionality.** We explored potential differentials seen by other regulatory organisations in the UK (i.e. in the individuals referred into their FTP processes). Looking at the information available, this piece of work found that differentials exist in other regulatory organisations within and beyond healthcare around various protected characteristics and demographics.

Focus on primary care

- **Focus on primary care:** This is monitored on a quarterly basis and the data are shared with Outreach colleagues. We participate in the NHS England Professional standards ED&I working group to consider how to support fair local primary care disciplinary processes and will monitor the impact of this engagement during Phase 3 in 2024.

Evaluation

28 The challenge with the FER programme is understanding how we can be assured that the work we undertake will deliver the changes needed to deliver the target. The most reliable evidence base for the causes of disproportionality is *Fair to Refer?* – which identified the causes as extremely complex and multi-faceted. We relied heavily on this evidence when we designed the programme—which we created to be delivered in phases so we could learn as we progress. We undertook a qualitative assessment and identified interim measures to help us to understand the effects of the work we've delivered through a detailed benefits analysis. However, the time it takes to do reliable and meaningful evaluation means that we are not able to await such outcomes to build the next phase of work. We are working with the intelligence we have available and are adjusting our activity as more reliable information becomes available. We intend to share our findings from the interim measures when ready in future reports to Council.

29 A benefits mapping exercise has been completed for all deliverables and we have also identified baseline measurements. For those benefits where sufficient information is available, we have evaluated the extent to which those benefits are being realised. We

will continue to progress this for other areas as soon as the information needed to complete evaluation becomes available.

Key activity: We have completed two phases of activity and have developed a third.

Phase 3 activity

30 Phase Three is being delivered between December 2023 and September 2024. During Phase Three we will reach the half-way point for the target timeline. In developing Phase Three we utilised our knowledge and understanding gained throughout Phases 1 and 2 and gave careful thought to whether we are maximising our internal levers and external influence. We have looked to identify activities that will be the most impactful at continuing to support the positive trajectory seen so far in our data on disproportionality in employer referrals.

GMC priority actions for 2024

31 **Deliver actions from our staff audit and workshop** to identify any GMC levers to support fair workplace cultures. This action arose from our reflection at the end of phase 1 where we identified that there was a heavy focus on fitness to practise in the project work. We want to make sure that we use all GMC levers across our directorates. In addition, we'll use the evaluation of the audit to explore several ideas, for example, exploring our revalidation processes for mechanisms to embed FER.

32 **Further roll out of anti-bias training to all FTP decision makers** to mitigate the risk of authority bias in dealing with employer referrals to operational staff who collect evidence to support decisions. This builds on the success of our employer referral anti-bias training for assistant registrars, employer liaison advisers and case examiners in phase 1 and phase 2.

33 **To review our mechanisms for using contextual information to support decision making**, following changes to the RO referral form (which collects information about employer referrals). In phase 2 we evaluated the changes we made in phase 1 to the RO referral form including the systematic collection of contextual information surrounding a referral. This review will focus on how we process and assess that contextual information.

34 **A post implementation review of the feedback mechanism** introduced in phase 2 between Triage and ROs. This will help us to identify any further learning points we can

gather from the adoption of this feedback loop – and if there are any additional process changes needed to help this process run more efficiently.

35 **Make changes to our systems to record information referred to us about doctors already in our procedures (AOI**). Since December 2020, ROs have been asked to speak to an ELA before referring additional information that may reach our threshold for investigation. A post implementation review of these changes highlighted that we are currently unable to systematically identify AOI provided by an RO. By categorising the source of AOI in our system, we will be able to analyse proportionality in referral trends more effectively and monitor AOI raised by ROs – to apply targeted interventions through outreach to establish why these concerns were not raised in the initial referral.

36 **Scope the introduction of a referral form for referrals from employers that currently don't come via RO persons acting in a public capacity (PAPC) referral** and make sure they're directed via the RO and ELA. through conversations with operational teams following changes to the RO Referral form in phase 1, we identified that not all employer referrals were channelled through this mechanism. So, we will be exploring the introduction of an additional form to make sure that all employers are considering the fairness questions introduced in phase 1.

37 **Prioritise implementation of recommendations from the Singh / Forde review and the Regulatory Fairness review that support the delivery of the FER target.** We have identified several interdependencies between the FER aims, the Singh Forde, and Regulatory Fairness reviews – so we are looking to use the recommendations from these reviews to support the FER project.

Table 4: Prioritised recommendations

Review	Recommendation	FER phase 3 activity
Singh Forde 1	It is best practice, in cases where there's no immediate risk to patient safety, for concerns to be raised either with one of the GMC's ELAs, where available, or an RO. On receipt of an employer referral, the GMC should ask whether efforts have been made to liaise with the RO and, if not, encourage the referrer to consult with them before taking any further action.	FER will scope the introduction of a referral form for PAPCs to make sure they are directed via an RO and ELA where possible. This will ensure that systemic and environmental issues are considered, and that impartial checks are undertaken to ensure the referral is fair.

<table>
<tr><td>Singh Forde 3</td><td>Trusts and boards across the UK should consider using a digital system to share good practice in the local resolution and handling of complaints – as a means of learning and continuous improvement.</td><td>In phase 2, our outreach team (supported by a clinical fellow) developed a framework to identify and classify and store good practice in local complaint handling.

In phase 3 we'll pilot the mechanisms for collecting good practice and consider how we share it and encourage local organisations to adopt a similar approach.</td></tr>
<tr><td>Singh Forde 13</td><td>The GMC should make sure advice from internal or external experts and/ or training is available to relevant teams on issues linked to a doctor's communication, attitude and/ or behaviours; cultural awareness, competence, and sensitivity; diversity intelligence; and eliminating bias in fitness to practise decision making.</td><td rowspan="2">We will roll out anti-bias training including aspects of cultural competence to FTP and embed the training into induction and mandatory training packages.

We will roll out anti-bias training including aspects of cultural competence to FTP and embed the training into induction and mandatory training packages.</td></tr>
<tr><td>Singh Forde 15</td><td>The GMC should consider how it assures itself that its decision making is fair and unbiased, and whether the systems and processes already in place are appropriate.

This includes proactively monitoring for ethnicity related variations in teams and developing frameworks to review practice.

Given the small numbers involved, case mix considerations, and the risk of confounding, analyses should be used as a tool for internal continuous improvement and explained with care. We also believe that others can make an important contribution in this area.</td></tr>
</table>

Regulatory Fairness 4	All Heads to use HIRD review approach and methodology to consider HIRD, assess risk of decision-making bias and develop and implement an improvement and evaluation plan (RFR 4)	
Regulatory Fairness 12	Education and Standards, Fitness to Practise, Medical Practitioners Tribunal Service and Registration and Revalidation to assess the level of risk of bias that the inclusion of judgements/assessments by external experts in regulatory decision making represents. And develop a proportionate approach to the identification and management of 3rd party bias. And mitigate the risk of authority bias.	

Influencing others

38 **Commission research to identify best practice in local complaint handling:** From qualitive evidence gathered through our Outreach fairness conversations we have identified variations in practice among DBs. This has triggered us to explore this in further detail to gain insight into the trends and differences in practices between proportionate and disproportionate DBs. We will look to publish this research and share good practice identified.

39 **Pilot mechanisms to share good practice with the system following work completed in phase 2 – to develop a framework to identify and classify good practice.** In Phase 2, our outreach team (supported by a clinical fellow) developed a framework to identify good practice. In phase 3 we will pilot the mechanisms for collecting, classifying, and sharing good practice, and encourage local organisations through our outreach teams to adopt a similar approach.

40 **Engage with NHS England's (NHSE) professional standards working groups to identify how to support fairness in primary care, both in decision making and in wider ED&I related activities.** We continue to work closely with NHSE's professional standards working groups to make sure that our messaging on fairness is joined up, and that we remain aware of other impactful work in this sector. We are particularly keen to expand our influence into the primary care setting as work in phases 1 and 2 focused on

secondary care. We recognise that more work is needed to address our targets in this area – if we wish to continue to see a downward trend in disproportional referrals.

41 **Increase RO understanding of the impartial checks they should carry out prior to referral to the GMC – to enhance their effectiveness in supporting fair referrals.** In phase 2 we evaluated the changes we made in phase 1 to the RO referral form. The evaluation highlighted that ROs did not fully understand what an impartial check entails. We will resolve this by making sure that we:

- specify who should be completing an impartial check of the form
- strengthen the form wording to encourage all RO referrals to come via the RO referral form
- continue outreach's *Fairness in Concerns* conversations to encourage ROs to consider fairness earlier on in their discussions, and embed the fairness questions in the referral form
- schedule a further evaluation of this process when these changes have been fully integrated.

42 **Scope further work to support the SAS workforce.** We identified in the SAS survey in 2020 that 30% of SAS doctors had been bullied, undermined, or harassed at work in 2019 – either by colleagues or by patients and their families. We will consider what questions could be included in any future surveys to follow this up. Our outreach team is also exploring further engagement with SAS doctors.

Collaboration

43 **Discuss with the Nursing and Midwifery Council (NMC) opportunities to support fair workplace cultures through joint work to improve multidisciplinary team working**. Share the finding of our research on evidence of good practice with the Nursing and Midwifery Council (NMC). This piece of work came from a horizon scanning/bench marking exercise undertaken in phase 2. By collaborating with the NMC we believe that joint messaging targeting diverse medical teams will be more impactful and wider reaching.

44 **Continue to collaborate closely with NHS Resolution including piloting joint conversations in London** with senior leaders on their disciplinary data, sharing learning from their compassionate conversations programme and our *'Professional Behaviours Patient Safety (PBPS) Programme'* and continuing to support their 'Being Fair 2' initiative. Through these conversations we are looking to build on a long-term relationship with NHSR—that has been highly effective at fostering collaborative and impactful work across all regulators involved in clinical governance. We will consider the results of the pilot to understand if there is value in rolling this out outside of London.

Building our understanding of changes to the local landscape

45 **We'll research key changes in the external environment and develop a narrative on these. We aim to better understand what local changes may underpin improvements in disproportionality data and to enable us to assess and support sustainability**. There are many factors influencing disproportionate referrals. And by understanding changes in the wider environment, we are hoping to build a picture of the external and internal work that has affected on our targets, including work by:

- the Care Quality Commission's (CQC) new framework to assess the inclusivity of local environments.
- the Parliamentary and Health Service Ombudsman (PHSO) complaint standards evaluation report in relation to local complaints handling.
- Patient Safety Incident Response Framework (PSIRF)on encouraging local cultures that focus on learning, not blame.

46 **Continue to work with the devolved nations to understand local landscapes across the four countries.** Through continued focus on our national offices, we are looking to ensure that our progress is sustained throughout the UK.

Key activity: We have reviewed the Fair to Refer? report and all evaluation information we have been able to obtain from Phases 1 and 2 to feed into ou**r Phase 3 plan for 2024**.

Our system asks for the year ahead

- For DBs to share how they identify and use effective and impartial checks prior to making a referral to the GMC to address disproportionality.
- For DBs to share good practice with their peers on tackling disproportionate referrals to the GMC.
- For DBs to scope the establishment of RO advisory groups (ROAGs) with diverse membership to ensure proportionality in disciplinary and referral matters. And for DBs to share best practice regarding the establishment of ROAGs.
- For the NHS across the UK (and Health and Social Care in Northern Ireland) to mandate the recently launched induction for new international medical graduates (IMGs) that includes the Welcome to UK Practice induction programme, and covers the topics highlighted in the NHS induction programme for IMGs.
- For the NHS across the UK (and Health and Social Care in Northern Ireland) to develop and deliver anti-racism resources in partnership with the minority ethnic workforce.

- For system leaders to prioritise ED&I activity through organisational change and workforce plans, as it is central to ensuring a well-supported workforce.
- For system regulators / improvement bodies to consider how they are developing frameworks for assessing workplace fairness and understand the effect of these frameworks. For example, how the Care Quality Commission framework for assessing disciplinary actions for ethnic minority staff is progressing.
- For integrated care boards (ICBs) / integration joint boards (IJBs) / integrated care system (ICS) and other system leaders) make sure they monitor and measure the overall impact of ED&I activity and interventions. Activity and interventions are not an end, they are a route to achieving outcomes.
- For partners and key stakeholders to communicate and collaborate with each other on ED&I activity to ensure our priorities are aligned and we are amplifying each other's efforts.

Fair training cultures (FTC)

Fair training cultures

47 Each year we report on key measures to track progress in undergraduate, foundation, and postgraduate training. Our focus continues to be ethnicity and place of medical primary qualification, as these are the strongest predictors of differential attainment.

48 This is an ambitious target, looking to affect change across the entire length of a doctors training journey which can take over 15 years and involves many organisations. Our work centres on tackling the root causes of disadvantage at a system, institutional and individual level. Many of the lessons learned will be relevant across multiple protected characteristics.

49 There’s a significant amount of activity underway both within the GMC and across the system to bring about the changes needed to close the gaps. It will take time for changes to be embedded and there will be a lag before the effect on doctors in training’s outcomes index measures can be observed.

The Index Measures

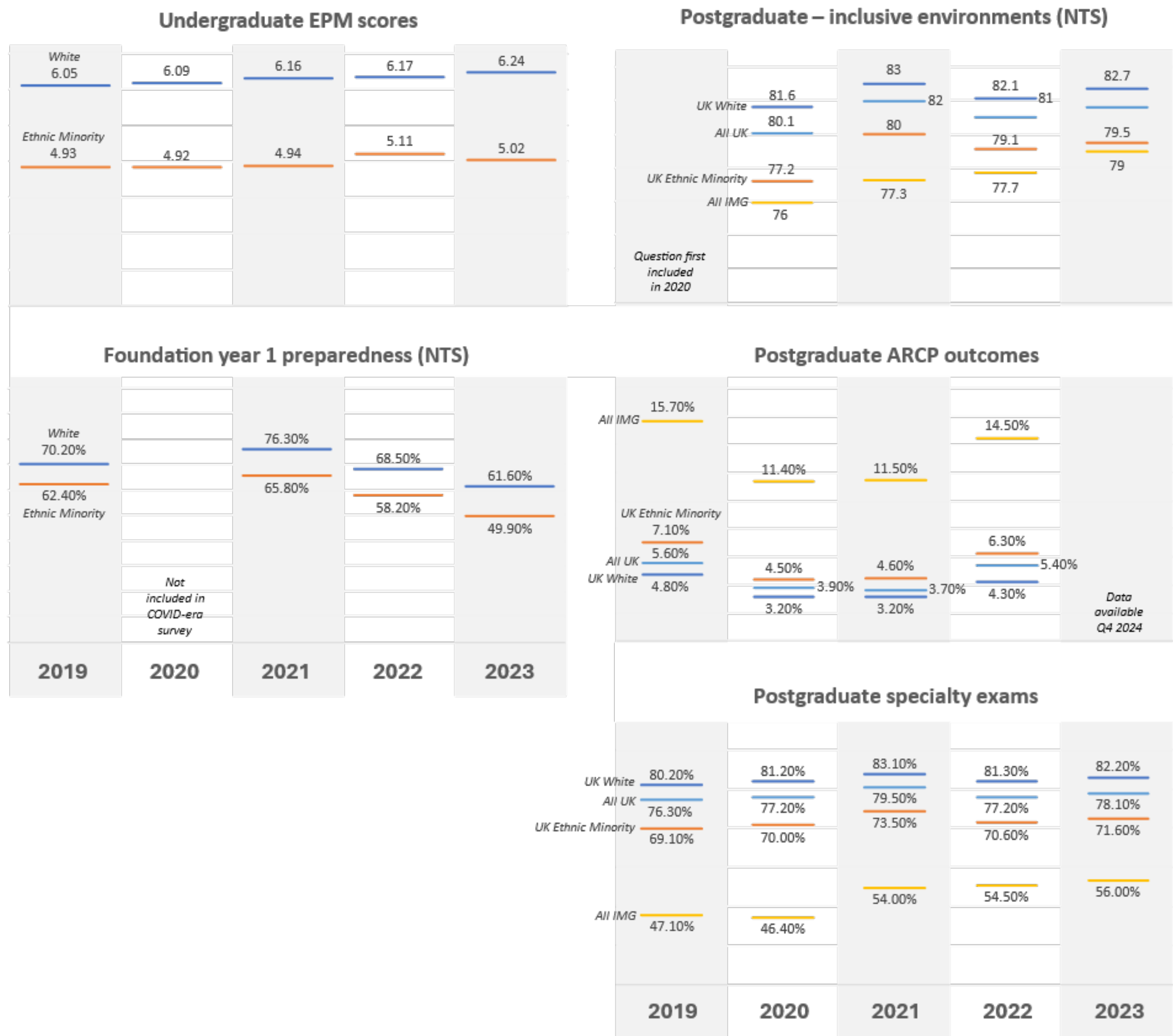
50 The five index measures we report on have been updated since our last report in 2023 (see Figure 1 & Table 4).

51 A significant attainment gap remains across all the index measures we are tracking and remains at levels that warrant continued system wide action.

52 Change in postgraduate measures suggest we may be seeing the early effect of actions taken by PG Deans and Medical Royal Colleges and Faculties. In all three PG measures (inclusive environment, ARCP and exams) the attainment gap has moved in a positive direction for both groups, however the improvement is more pronounced for IMGs than UK Black and ethnic minority specialty doctors in training.

53 This may reflect the large-scale pilots focused on IMG learners or that targeted initiatives such as Enhanced Inductions and Exam preparation are more successful in addressing some of the risks (identified by Kath Woolf) specific to this group such as lack of knowledge and experience of the NHS and lack of experience of UK assessments.

Figure 1: Index Measures for Fair training cultures*



* See footnote below table 4

Table 5: Index Measures for Fair training cultures*

Index measure		2019	2020	2021	2022	2023
Undergraduate EPM scores Difference between mean Educational Performance Measure (EPM) decile scores.	White Ethnic minority **Difference**	6.05 4.93 **1.12**	6.09 4.92 **1.17**	6.16 4.94 **1.22**	6.17 5.11 **1.06**	6.24 5.02 **1.22**†
Undergraduate assessments Difference between mean medical school assessment pass rates.	DATA NOT YET AVAILABLE					
Foundation year 1 (F1) preparedness (NTS) Difference in self-reported preparedness for first F1 post.	White Ethnic minority **Difference**	70.2% 62.4% **7.8pp**	NOT INCLUDED IN COVID-ERA SURVEY	76.3% 65.8% **10.5pp**	68.5% 58.2% **10.3pp**	61.6% 49.9% **11.7pp**
Postgraduate – inclusive environments (NTS) Difference in perceived inclusivity of training environment. Score out of 100.	UK white UK ethnic minority **Difference** All UK All IMG **Difference**	QUESTION FIRST INCLUDED 2020	81.6 77.2 **4.4** 80.1 76.0 **4.1**	83.0 80.0 **3.0** 82.0 77.3 **4.7**	82.1 79.1 **3.0** 81.0 77.7 **3.3**	82.7 79.5 **3.2** 81.6 79.0 **2.6**

* 2020/21 caution note: Annual Review of Competence Progression ARCP) and Exam results from 2020 - 2023 are likely to be affected by COVID. ARCPs included new COVID outcomes, changes brought in and then removed in response to the pandemic. Many exams were postponed or cancelled or changed. Historical EPM data has been revised to reflect new demographic data being obtained from doctors in training. EPM scores will be discontinued post-2023. Alternative measures are being researched. Prior to 2023, post-graduate exams figures included all those who took Royal College exams. This included those outside GMC regulation, such as those who take specialty exams while in core or foundation training. To better reflect outcomes from higher specialty training, figures have been updated to only include those in higher specialty training programmes at the time of examination.

Index measure		2019	2020	2021	2022	2023
Postgraduate ARCP outcomes Difference in proportion of unsatisfactory Annual Review of Competence Progression (ARCP) outcomes for foundation and specialty doctor in training.	UK white UK ethnic minority **Difference** All UK All IMG **Difference**	4.8% 7.1% **2.3pp** 5.6% 15.7% **10.1pp**	3.2% 4.5% **1.3pp** 3.9% 11.4% **7.5pp**	3.2% 4.6% **1.3pp** 3.7% 11.5% **7.8pp**	4.3% 6.3% **2.0pp** 5.4% 14.5% **9.1pp**	AVAIL Q3 2024
Postgraduate specialty exams Difference in mean exam pass rates for specialty trainees.	UK white UK ethnic minority **Difference** All UK All IMG **Difference**	80.2% 69.1% **11.1pp** 76.3% 47.1% **29.2pp**	81.2% 70.0% **11.2pp** 77.2% 46.4% **30.8pp**	83.1% 73.5% **9.6pp** 79.5% 54.0% **25.5pp**	81.3% 70.6% **10.7pp** 77.2% 54.5% **22.7pp**	82.2% 71.6% **10.6pp** 78.1% 56.0% **22.1pp**

Table 5 continued (N numbers)

Undergraduate EPM scores

EPM year		2019	2020	2021	2022	2023
Report by	**PMQ & Ethnic Group**	**N**	**N**	**N**	**N**	**N**
UK Ethnic group	UK White	4368	4200	4042	4098	4157
	UK Ethnic minority	2604	2810	3042	3410	3568

F1 Preparedness (NTS)

Survey year		2019	2020	2021	2022	2023
Report by	**PMQ & Ethnic Group**	**N**		**N**	**N**	**N**
Ethnic group	UK White	4179		3203	3076	3237
	UK Ethnic minority	2448		1990	2275	2504

Postgraduate inclusivity (NTS)

Inclusivity		2019	2020	2021	2022	2023
Report by	**PMQ & Ethnic Group**	**N**	**N**	**N**	**N**	**N**
UK Ethnic group	UK White		15855	23915	23993	23214
	UK Ethnic minority		6781	11675	12273	12523
PMQ	UK		23330	36726	37326	36757
	IMG		3474	7770	8941	9923

Postgraduate specialty exams

Year		2019	2020	2021	2022	2023
Report by		**N**	**N**	**N**	**N**	**N**
UK Ethnic group	UK White	9889	7206	10510	9450	9618
	UK Ethnic minority	4793	3662	5479	5061	5354
PMQ	UK	15159	11209	16579	15014	15446
	IMG	3058	2693	4795	5691	6758

Postgraduate ARCP outcomes

ARCP year		2019	2020	2021	2022
Report by	**PMQ & Ethnic Group**	**N**	**N**	**N**	**N**
UK Ethnic group	UK White	32174	31866	32527	32317
	UK Ethnic minority	15441	15981	16813	17699
PMQ	UK	49200	49458	51011	51613
	IMG	7279	8485	10352	12397

54 It is imperative that Professional Support and Wellbeing Units, PG Deans and Medical Royal Colleges and Faculties work together to embed good quality, targeted initiatives such as those shown to work into core business. This is necessary to ensure overseas-qualified trainees across all specialties have equity of access. This is dependent on the availability of funding for the development and delivery of initiatives. Support from NHS system leaders will be necessary and may be in recognition of the potential contribution to the wider workforce strategies including retention and reduced consultant vacancies, as well as the moral and legal case to be made.

55 The ARCP data shows some narrowing, however greater improvements observed in 2021 and 2022 have gone backwards and this needs to be understood. It may be associated with the reversal of the flexibilities introduced during the pandemic, including allowing trainees to progress without achieving all competencies / assessments usually required.

56 The lack of improvement for the two indices for early medical education is disappointing. EPM shows no change and Foundation Year 1 preparedness has deteriorated which needs to be understood. Work is underway to improve F1 preparedness but has a long lead-time and impact is expected to be measurable from 2025.

Key activity: The three postgraduate measures (inclusive environment, ARCP and exams) attainment gap has moved in a positive direction for both groups, however the improvement is more pronounced for IMGs than UK Black and ethnic minority specialty trainees. This is no improvement for indices focused on undergraduate and foundation training, with the latter having worsened year-on-year since 2019.

Forecast performance

57 We remain committed to tracking the impact of system changes on the index measures. For each index measure, we have produced an updated forecast (Annex C), shown alongside a reference forecast of what would be expected from 2021 if none of the underlying drivers of the metrics changed. Our forecasting models are based on the small number of data points available per index measure. As a result, current direction forecasting models [*]are unable to reliably detect change. This, rather than the models predicting that there will be no change. As such, the forecasts cannot yet provide reliable information about whether we are on track to achieve the targets or not.

[*] Current direction forecasting means to forecast or to try to predict the future value of the metrics. It entails developing models based on previous data which might suggest what values the metrics are likely to take, based on what models could learn out of previous data.

58 There is however clear evidence of a significant increase in activity to address the attainment gap across all educational organisations. And these are expected to lead to improvements in the index measures over different timeframes.

Key activity: There is inherent uncertainty in the ambition to eliminate inequality from across a complex system. Forecasting models have insufficient data to provide meaningful assurances. To mitigate this, our programme governance has built-in regular check points to reflect and evaluate confidence in in the work programme to achieve our ambition.

Work programme overview since last report

59 Fair training cultures has made strong progress in collaboration with external partners on delivering our work programme. We have:

- Challenge educational organisations to develop ambitious action plans to address the attainment gaps in their regions, countries and specialties and to monitor their impact. We've strengthened our own approach to assessing ED&I action plans, to enhance our effectiveness in holding organisations to account and adding value to those organisations tackling the attainment gap.
- Work in partnership with key stakeholder organisations to eliminate systemic inequality through co-creation of guidance, conference and events to stimulate action and joint working groups.
- Progressed the evaluation of pilot initiatives to test their impact and have begun identifying opportunities to embed those that are successful into core business We have focused on:-
    a. Educator support.
    b. Exam preparation and feedback.
    c. Mentorship.
- Publish new data and insights on a wider range of personal characteristics to expand our stakeholder conversations into disparities between different groups.

60 To manage the high degree of uncertainty inherent in this work, a key aspect of our programme governance is to undertake an annual evaluation with stakeholders on the likelihood of the programme of work to successfully address underlying causes of inequality and thereby the eliminate the attainment gap. This includes reviewing evidence arising from pilots.

61 The ARCP data shows some narrowing, however greater improvements observed in 2021 and 2022 have gone backwards and this needs to be understood. It may be associated with the reversal of the flexibilities introduced during the pandemic, including allowing

doctors in training to progress without achieving all competencies / assessments usually required.

62 The lack of improvement for the two indices for early medical education is disappointing. EMP shows no change and Foundation Year 1 preparedness has deteriorated which needs to be understood. Work is underway to improve F1 preparedness but has a long lead-time and impact is expected to be measurable from 2025.

63 Our forecasting models are based on the small number of data points available per index measure. As a result, current direction forecasting models are unable to reliably detect change in the index measures. And so, the forecasts cannot assure us whether reliable information about we are on track to achieve the targets or not.

64 In 2015, we commissioned *Fair training pathways* research to identify the problems that cause differential attainment. Our work programme is based on this and subsequent research, as well as internal and external engagement.

65 If our work is successful in addressing the issues identified, then differential attainment – along with other forms of disadvantage and unfairness – should in turn diminish.

66 Early signs are that our trajectory is positive.

- We've successfully stimulated action and engagement from key stakeholders, including in areas where we have limited regulatory remit.
- Our own interventions – designed to help the system build evidence – have been evaluated positively and are being acted on by stakeholders.
- Our actions are also prompting stakeholders to evaluate their own interventions, offering the potential for yet more evidence to be built.

67 Due to an absence of historical evidence on the impact of interventions, forecasting the effect of work to close attainment gaps continues to be difficult.

- We work with a distributed system (royal colleges, post graduate training organisations, medical schools, and others) – and changes will not be the same.
- The length of training pathways means the effect of any change will take time to show up in the outcome measures.

68 We created a regular qualitative review approach in response to this ongoing challenge. Our qualitative review is designed to assess whether our work is successful. And whether it's likely to continue being successful to address research-identified issues.

69 We will use evidence year-on-year as it grows, to become less hypothetical about our success and, where possible, about its metric impact.

70 We rated our progress in delivering our work programme this year as strong and expect this to be the case in the next period based on our planned work. There is however clear evidence of a significant increase in activity to address the attainment gap across all educational organisations. And these are expected to lead to improvements in the index measures over different time-frames.

71 To manage the high degree of uncertainty inherent in this work, a key aspect of our programme governance is to undertake an annual evaluation with stakeholders on the likelihood of the programme of work to successfully address underlying causes of inequality and thereby the eliminate the attainment gap. This includes reviewing evidence arising from pilots.

Key activity: Forecasting change to attainment gaps remains difficult, however our annual peer-reviewed qualitative review rates our work progress as strong. Our work is aligned to the factors causing differential attainment as surfaced through our commissioned research.

Key activity: There is inherent uncertainty in the ambition to eliminate inequality from across a complex system. Forecasting models have insufficient data to provide meaningful assurances. To mitigate this, our programme governance has built-in regular check points to reflect and evaluate confidence in in the work programme to achieve our ambition.

72 In 2023, our fair training cultures programme has made strong progress in collaboration with external partners on delivering our work programme activities. The key activities include:

- Challenging educational organisations to develop ambitious action plans to address the attainment gaps in their regions, countries and specialties and to monitor their impact. We've strengthened our own approach to assessing ED&I action plans, to enhance our effectiveness in holding organisations to account and adding value to those organisations tackling the attainment gap.
- Working in partnership with key stakeholder organisations to eliminate systemic inequality through co-creation of guidance, conference and events to stimulate action and joint working groups.
- Progressing the evaluation of pilot initiatives and making sure they have impact.
- Developing our approach to test their impact and have begun identifying opportunities to account— and bringing added value to post-graduate training organisations, royal colleges and faculties in their work to tackle the attainment gap & embed those that are successful into core business. We have focused on:
    a. Educator support
    b. Exam preparation and feedback

c. Mentorship.

- Publish new data and insights on a wider range of personal characteristics to expand our stakeholder conversations into disparities between different groups, the barriers people face, and how to tackle these barriers.

Progress since last report

Tackling inequity in recruitment and selection

73 We have established a joint working group with the **Medical and Dental Recruitment and Selection (MDRS)** committee to tackle unfair barriers in specialty recruitment, co-producing ED&I principles to guide Medical Royal Colleges and Faculties responsible for the development of Person Specifications and supporting MDRS to improve their applicants guide. We expect revised ST1/CT1 person specifications to be available for recruitment of new entrants from August 2025, and for recruitment into higher grades from August 2026.

Improving Exam preparation

74 **New Principles for exam support to address the awarding gap have been published** by the Academy of Medical Royal Colleges (AoMRC), co-developed with ourselves and Conference Of Postgraduate Medical Deans (COPMeD). They set out nine principles covering generic and exam specific support for doctors in training and how and when targeted support might be appropriate. This sets a clear direction for all Medical Royal Colleges and Faculties to ensure they are taking appropriate action to eradicate systemic inequalities which contribute to the attainment gap.

75 We will work with the AoMRC to identify ways to monitor the implementation of these important new principles.

76 We have completed the **evaluation of the exam preparation pilot known as "CASC masterclass"** and are planning for the publication of the final report**.** The 2-day clinical exam preparation course was run as a pilot by the Royal College of Psychiatrists funded by the GMC and NHSE. Over 16 months, 183 doctors in training from across England, Wales and Scotland attended a CASC masterclass, predominantly doctors who had qualified overseas.

77 Qualitative interviews were undertaken by Edge Hill University to understand the learning gaps the course addressed. It found the course helped candidates know what to

expect and to practice in a low-stakes, supportive environment. The highly personalised feedback was especially valued by attendees. It addressed knowledge gaps around: -

- Examiner mark schemes, time management and answer structure
- Lack of awareness of resources available to help prepare for exams

78 Some participants commented on the reassurance of meeting examiners from an IMG background themselves. Another said: ***Until now, I've been doing it completely blind. It was like playing a game and what was never really explained was the rules.***

79 We have recorded the outcome of exam attempts for all participants following the masterclass and compared them to exam results for those not part of the pilot. **The results showed a pass rate 10% points higher** for IMG trainees who attended the course compared to those not taking part in the pilot.

80 Next steps: The evaluation report highlighted a number of points for PG Deans, Medical Royal Colleges and the GMC which are being taken forward.

81 Through the **organisational action plans** we receive we can already see an increased interest in support for exam preparation.

Improving formative feedback

82 We recently published a report Improving feedback in the context *of differential attainment.* This work is the culmination of a piece of research by a GMC clinical fellow into the quality of formative feedback received by trainees, and builds on a prior report called *Good conversations, Fairer feedback.*

83 The report contains insights useful for learners and educators, and makes recommendations focused on 3 main areas which we are working within the GMC and with stakeholders to progress:

- Standards
- Training for learners and educators
- Removing barriers such as lack of awareness, time and blame

Working with system leaders to tackle inequity across medical education and training

84 In June we co-hosted the 3rd annual 'Sharing Good Practice' event together with the Academy of Medical Royal Colleges, Conference of Post Graduate Medical Deans, and

Medical Schools Council. The event ensures that this issue remains high on organisational agendas across the educational journey. It spotlights practical interventions which aim to drive real-world system and culture change and promotes cross-system learning. The event includes speakers from Queens University Belfast, Southampton Medical School and Imperial College London as well as NHSE and GMC Clinical Fellows.

85 We continue to present this work at key Educational conferences and events such as the Developing Excellence in Medical Education Conference, and conferences of The Association for the Study of Medical Education, The International Association for Health Professions Education, and NHS Education for Scotland.

Key activity: Our investments in research and evaluation in key areas of interest (Educator support, Exam Preparation, Feedback and Mentoring) have highlighted practical solutions and shown that we can narrow the attainment gap. We have stimulated action by stakeholders and will follow this up during 2024 with a focus on embedding the lessons into our Quality Assurance guidance and policy.

Understanding wider inequalities

86 The GMC set targets directed at the groups with the widest inequality of outcomes, although our work is designed to have cross-applicability. Following last year's publication of enhanced progression reports with descriptive and univariate analysis of a broad range of demographic characteristics including socio-economic status, we also commissioned a multi-variate analysis of postgraduate exams to help us understand more about where inequalities are the predictive validity of a range of characteristics, including prior attainment, measures of socio-economic status and educational privilege and intersectional impacts.

87 This is in addition to analysis of **new national training survey (NTS) questions on discriminatory behaviours** which were published for the first time in 2023. Responses to the NTS questions showed that:

- one in five doctors in training said they'd received unfair or overly critical feedback
- one in ten doctors in training said that they'd been intentionally humiliated in front of others
- specialties with higher proportions of negative responses to most of these questions (surgery, emergency medicine, obstetrics and gynaecology) have higher proportions of doctors in training stating they have been a victim of, or have witnessed bullying or harassment in their post (12%, 10% and 16% respectively, compared to 8% of all doctors in training)

- doctors in the early stages of their training experienced more negative work cultures than their colleagues at higher training levels. With 38% of Foundation Programme doctors in training saying they hear insults, stereotyping or jokes on the grounds of a person's protected characteristics (compared to 24% of doctors in training in specialty or core posts).

88 We require PTOs and others to examine the results of the NTS as they apply to them, and act where needed. Our quality assurance teams will be monitoring relevant quality assurance processes, including action plans for evidence this is taking place.

Key activity: New NTS questions on discriminatory behaviours provided deeper insight into the experiences of doctors in training. Analysis and quality assurance may help us and those we regulate to improve conditions for doctors in training who experience discriminatory behaviours.

Focus for 2024

89 We will continue to work on the key initiatives we have outlined and move into the phase of delivering on key recommendations from our research and evaluations.

90 However, we continue to be mindful that many of these have implications for stretched NHS resources and that progress will rely on the ability to secure these resources. Many factors are outside our direct control—that results rely on the work of our stakeholders, and in many cases outside the control of educational organisations. Resources are vulnerable to more pressing priorities and disruptive events.

91 Maintaining stakeholder momentum will be key for us to manage over the coming year. Our priority for 2024 is to support our stakeholders to maintain momentum and deliver meaningful change.

Strategic partnering with stakeholders

92 MDRS/GMC joint working group to monitor colleges implementation of new principles into specialty person specifications in time for the '2025 recruitment round' which opens in 2024.

93 AoMRC exam support principles was launched, and; we will work with them to ensure that Colleges are implementing these important principles.

Building on our data, research and evaluations to advance change

94 The development of a multi-variate analysis, and work to further explore the results of the new NTS questions.

95 Engaging with training organisations to respond to recommendations from recent evaluations and research in priority areas: Educator support, exam preparation, mentoring and feedback. We will look to co-create new guidance and strengthen our quality assurance focus in response to new the evidence where we are seeing impact. We have initiated a new piece of work which focusses on the impact and barriers to mentoring programmes in postgraduate training. The data gathering phase is now complete and we will provide further updates in future 2024 reports as this work progresses.

96 Press for implementation of the recommendations from our recently published report on improving formative feedback and engage with AoMRC as they develop new guidance on post-exam feedback.

Strengthen our processes and support for our stakeholders:

97 Continually reviewing our quality assurance processes, and the questions which we ask our stakeholders.

98 Development of the Outreach-delivered cultural support course for trainers

Our system asks for the year ahead

99 For LEPs to define the training and appraisal of Educators in the medical roles recognised by the GMC to ensure that ED&I training specifically covers 'Differential attainment'.

- Raising awareness of the existence of an attainment gap across many protected characteristics and the barriers which lead to poorer outcomes for marginalised learners and
- supporting educators to have compassionate and courageous conversations with learners about barriers they may face and working together to identify ways to overcome these.

100 For the NHS across the UK (and Health and Social Care in Northern Ireland) to ensure that resources are available to Professional Support and Wellbeing Units and that they have a mandate to consider support for doctors in training from marginalised backgrounds which help remove barriers to progression.

101 For partners and key stakeholders to communicate and collaborate with each other on ED&I activity to ensure our priorities are aligned and we are amplifying each other's efforts.

102 For Postgraduate Deans to develop improved support for *New to UK learners* based on the increasing evidence of positive impact such as Enhanced induction, Exam preparation support, mentoring.

103 For all medical royal colleges and faculties to implement the AoMRC principles for exam preparation, feedback and support for candidates to address the awarding gap and ensure that exam candidates are signposted to resources to help them prepare effectively for high stakes assessment.

104 For organisations to evaluate the impact of pilot initiatives and to share their lessons learned with others across the system.

105 For organisations to put into practice learning from pilot initiatives and their evaluation reports, including the CASC Masterclass Evaluation, Embedding Compassionate Courageous Cross-cultural Conversations into Training, and 'What supported your success?' - A qualitative exploration of the factors associated with an absence of an ethnic attainment gap in post-graduate specialty training.

106 For medical royal colleges and faculties, PTOs and Medical Schools to tell us what action they are taking to address attainment gaps in their organisation, region, country, or specialty.

107 For MDRS and Medical Royal Colleges and Faculties to deliver on the recommendations of the joint working group to remove unfair barriers within person specifications and scoring matrices.

108 For PG Deans and Employers / Local Education Providers to respond to NTS results on Inclusive Environment and Discrimination questions.

Assuring fairness within the GMC

109 In 2021 we started a regulatory fairness review (RFR). Its primary aim was to test and make sure that the existing controls on mitigating bias, monitoring differentials, and promoting fairness across our regulatory functions are as robust as possible (for now and the longer-term). The programme of work to implement the recommendations is the fourth pillar of our ED&I aspirations and one that will sit alongside our other long-term commitments.

110 The review did not aim to demonstrate that there was no bias in our processes. A fundamental principle of our approach was to systematically look for the risk of bias in our activities and assess the controls we have in place to manage that risk.

111 The review and associated reports were published in February 2023, and contained recommendations, which fall into five main areas:

- **Introducing a single set of decision-making principles** – these will be applied across the identified high impact regulatory decision points to promote consistency across all our different functions.
- **Strengthening fairness assurance for high impact regulatory decisions**[*] – to assess anti-bias controls and provide assurance in priority areas of our regulatory decision making.
- **Our approach to seeking external assurance on the fairness of our work** – these will be more targeted and focus on the areas of our work where we've identified that external assurance is needed to assess the robustness of safeguards and mitigations for fairness and bias.
- **Tailoring ED&I training** – to meet the specific learning requirements of staff in different roles.
- **Publishing more detailed data about our fitness to practise processes** – to hold ourselves to account on how the changes we'll make will work in practice.

[*] These decision points were referred to in the RFR as high stakes decision points – we are now referring to these as high impact regulatory decisions.

- **Continue to embed fairness and ED&I into how we'll work in the future** – specifically when the Department of Health and Social Care (DHSC) introduce a new regulatory framework for health professionals.

Progress in 2023

Decision making principles

112 We've worked with policy and operational leads across the GMC, and drawn on good practice from other bodies to develop a single set of decision-making principles. These principles will enable consistency and help us to achieve a proportionate approach to our statutory regulatory decision-making. We've published full principles on our website – it covers:

- proportionality
- objectivity
- transparency
- fairness
- ensuring decisions are taken by appropriate decision makers.

113 They are taking into account the technicalities and complexities of our decision-making processes and will be embedded in guidance that supports decision making across the organisation.

114 We've assessed the extent to which we're currently demonstrating the decision-making principles in our regulatory decision making. We are confident that we currently demonstrate these the principles through a combination of activities, including:

- operational guidance and policies
- peer review and checking of decisions
- learning from audits and other activities
- mechanisms in place to induct staff
- ongoing training and advice to support staff.

115 However, we are also clear that there are opportunities for us to strengthen the way we demonstrate these principles – and achieving this will form the basis of the other phases of our regulatory fairness programme.

High Impact Regulatory Decisions (HIRDs)

116 Defining the priority points in our regulatory decision making processes is a crucial part of this work. Once we've identified these points, we can ensure we have robust assurance on the fairness of our decision making and strengthen anti-bias measures.

117 We held detailed workshops across the GMC to explore our decision points and the existing assurance measures. To help us assess whether these explicitly featured fairness and anti-bias within them. We'll continue to determine how we might further strengthen how fairness and anti-bias measures are integrated into decision-making activities. Eg within guidance, peer review activities etc. We will report on that later this year.

118 Following the workshops, we've agreed on a final number of 42 HIRDs. The full list of HIRDs is published on our website. We've estimated the volume of decisions that we make every year for each HIRD and calculated that the scope of this work covers approximately 27,000 decisions made each year.

119 The work that directorates have been undertaking to further improve and refine potential assurance measures for fairness and bias will inform the content of their directorate action plans.

Decision makers and advisers

120 One HIRD may have multiple decision makers or may have someone who advises a decision maker. Some involve group decision making and some individual decision making. It is vital to ensure that we support both staff and associates who are in decision making roles (or support regulatory decision making) to engage with the strengthened expectations of them in relation to actively seeking and managing bias.

121 The scope of this work involves **333 staff** across the GMC. ***276 of whom are in decision-maker roles*** such as investigation officers, case examiners and applications decision-makers. ***57 of whom are in advisory roles*** such as employer liaison advisers and voluntary erasure, restoration and license application advisers.

122 There are also **554 associates** within the scope of this work, the majority of which fall within Medical Practitioners Tribunal Service (MPTS).

Learning & support for decision makers and advisers

123 We've been working with an external supplier to develop a '**Fairness in Decisions for Regulatory Professionals'** training for HIRDs decision makers. It will be rolled out from quarter three 2024. The full day training will be interactive with case studies focusing on how to address bias in scenarios that HIRD decision makers might face – e.g. working

with third-party organisations, challenging and giving/receiving feedback about bias etc. It will also focus on how to apply professional curiosity to HIRD decision making.

124 We have also completed integrating the decision-making principles into our corporate/culture change work by revising the behavioural competencies – these are based around four themes:

- being inclusive
- continuously learning
- thriving together
- leading the way.

125 These competencies set out the attitudes and ways of working expected of all in the GMC and are called 'OneGMC behaviours' – they apply to staff at all levels. We've also embedded requirements to make sure staff have annual performance objectives set relating to fairness and inclusivity relevant to their role.

126 Most of the cohorts of associates agreed that ED&I training is relevant to their roles. We are reviewing the existing training and improving it where needed to reflect the decision-making principles. We're also ensuring that the ED&I training helps cohorts of associates to actively seek and manage bias.

Focus for 2024

127 We've identified opportunities to further strengthen how we can embed the decision making principles into our decision making processes. This will form the basis of our next phase of work and will cover:

- reviewing quality assurance processes to further strengthen how we assure for fairness and bias in our regulatory activities
- enhancing data monitoring analysis across all HIRDs
- embedding fairness and bias within peer review processes
- ensuring our continuous improvement audits are aligned to HIRDs
- reviewing guidance for decision-makers to further strengthen consideration of fairness and bias. Such as third-party bias and supporting decision-makers around seeking degree of assurance from third-party organisations.

128 The regulatory fairness review (RFR) also recommended introducing a programme of rolling external audits. The RFR recommendation was initially developed to achieve a more valuable, and consistently scheduled audit programme. We sought views from HIRDs decision-makers and operational leads. We identified significant challenges with

proposed methods, and whether such audits will, at this stage, be able to assess fairness when we want – given we have yet to implement strengthened assurance measures on fairness. We've reflected on this feedback and concluded that we should, for now at least, shift to an approach which focuses on aligning our in-house audit capability to make sure it's focused on HIRDs. And to ensure broader and more robust assurance mechanisms are put in place to fill gaps in external assurance in relation to fairness and bias in the 42 HIRDs activities. We will, therefore, be reviewing (and report further progress on this later this year):

- gaps in external assurance activities (current and future)
- which of these HIRDs should be the subject of external assurance activity, in which sequence and with what regularity.

129 Functions across the GMC will be developing their own detailed implementation plans. An implementation toolkit will be developed to support teams in developing and delivering their own action plans. The toolkit will include information on how to:

- communicate with teams to support them to engage with this work
- explore biases in different settings and consider how their impact can be eliminated on decisions made or advice given
- consider, apply, and embed the decision-making principles in regulatory activities and recruitment for HIRD roles
- make sure assurance and mitigation measures for fairness and bias are applied.

130 We've made significant progress since last year by finalising the new regulatory decision-making principles and identifying a final list of HIRDs. Both are important milestones, and they form the foundation on which we can build the other phases of implementation work to follow.

131 Although we have more progress to achieve on the assurance measures and developing local implementation plans, we are well placed to take those next steps. The progress made on the learning delivery and wider changes that support long term culture change are helping to support the staff and associates.

Inclusivity as an employer in the GMC

Inclusivity as an employer in the GMC

132 Council has agreed a series of employment targets relating to ethnicity. These are:

- a more ethnically diverse workforce with 20% of ethnic minority colleagues and a management profile that reflects this
- close pay gaps and maintain alignment on pay where it exists
- create a more consistent workplace experience across all our workforce, measured via our engagement and inclusion index.

133 Our aim, by 2026, is for 20% of our workforce to be from an ethnic minority background and for our management profile to reflect this. We are on track to meet our overall workforce target by 2026 but are not on track to meet this target at management level if we maintain the workforce trends of the last two years. We do expect to meet our targets on engagement and pay gaps.

Recruitment

134 Our recruitment performance will see us meet our workforce target, probably next year. While our overall recruitment outcomes are in line with our expectations, we do see a disproportionate reduction in ethnic minority candidates at each stage. We have undertaken further work to understand this, in particular looking at the advantages existing staff have when our internal candidate pool is not as diverse as our external applicant cohort.

135 To maintain our high attraction levels, we've expanded our outreach work and support for candidates. We also quality assure job descriptions and train our decision makers.

Overall workforce

136 The work that we've undertaken (explained in more detail below) has been particularly helpful in sustaining high attraction rates. Recruitment and retention remain central to all our workforce targets, and we are confident that we will achieve the overall workforce target.

Key activity: Our overall recruitment performance is likely to support achievement of our workforce target ahead of 2026.

Management profile

137 Our management profile is broadly unchanged since we last reported. In headcount terms we have seen two ethnic minority managers take up roles in 2023. With an overall increase in our headcount our position is almost exactly as it was at the end of 2022.

138 The scope to reach our targets is limited by the very low levels of turnover. It was 0% at assistant director level in 2023, 4% at level 2, and 6% at level 3. Given current trends and our age profile (suggesting relatively few retirements), we may see fewer than 10 senior manager roles filled in 2024.

139 To help us understand possible options available to us, we conducted a detailed analysis of our internal talent pools. From this year we are likely to run more internal campaigns for management roles where the diversity of internal recruitment pools is stronger.

140 We're also exploring different options to help us achieve our ambitions, which are part of our priority activity in 2024.

Key activity: Our management profile is broadly unchanged and progress towards our targets is highly dependent on turnover.

Turnover

141 Our target for 2023 was to get the difference in turnover rates to between 1 and 2 percentage points. We know that turnover rates below management level (level 3 and below) are usually higher and our workforce within levels 3–6 is more diverse. Narrowing the gap depends to a degree on achieving our workforce targets at all levels within the organisation. In 2023 the turnover rate for ethnic minority colleagues was 8.9% (compared with 6.7% for other colleagues). This is outside our target, but an improvement when compared with 2022—when the differential was 3.7 percentage points.

142 Limited opportunities for career advancement are a critical factor here. And despite some progress, we know that the workplace experience is not as positive for some groups of colleagues. Further work on our People Survey outcomes (particularly bullying and harassment) are underway. And we have a new exit interview reporting process to support our work.

Key activity: Turnover shows a slightly lower differential than in 2022.

Progression

143 We define progression as a move to a higher pay band or level within the GMC. This is almost always through a recruitment process, but we do have some job re-grades and areas where we have an agreed progression route after a period of training.

144 We have a more diverse workforce at lower levels, and while ethnic minority colleagues have typically shorter period of service and are younger, we would expect progression rates to be similar.

145 Our target is for no more than a two percentage point difference and we were just within this range in 2023 with 8.6% of ethnic minority colleagues progressing (compared with 11.5% of other colleagues). The gap was slightly narrower in 2022 (ie 1.77 percentage points).

Key activity: Progression still shows a differential but is within our target range.

Pay gaps

146 Ten of our twelve main pay bands show a pay differential of under two percentage points. This is an improvement on the trend seen in 2022—when seven out of ten pay bands had a differential.

147 While a more diverse appointee pool will have an effect, change to pay bands implemented in February 2023 and the structure of our pay award in 2023 had a positive impact on pay differentials.

Performance management outcomes

148 We've seen differences in 2022 performance ratings between ethnic minority and other staff's 2022 performance reviews. We've updated our guidance and run sessions for over 300 managers on assessing performance fairly. While we continue this work, our link between pay and performance is relatively limited. This year, we are reviewing our overall approach including piloting a range of approaches, as well as delivering more support to managers.

Workplace experience

149 Our overall aim is for the workplace experience of colleagues from all backgrounds to be comparable. We measure this through our employee engagement score, and we've made some good progress here. Our original target was for the ethnic minority colleague average to be within 5% of the GMC average. This reflected the progress we needed to

make when our targets were set. This measurement is now within 2% (ie 72.08 vs 73.21per cent of staff engaged).

150 This is an area that shows good progress, but there are areas for that need further improvements. While some groups are above the GMC average (Asian/Asian-British 77.78%)), Black (68.59%) and Mixed heritage (63.20%) lag a little—although the score for Black colleagues are the most improved over recent years.

Key activity: We are currently within our target range for engagement scores but need to continue

Table 6: Inclusivity in employment measures

2023 Measures		Actual performance						Target measures	
		2020	2021	2022	2023	2023 (vol)	Percentage points from target	2023 Target	2026 Target
Increase ethnic minority representation at Level 3+	Applications	22.8%	32.1%	34.9%	34.9% —	430	+7.9	27%	30%
	Interviews	15.2%	22.4%	23.1%	20.1% ↓	52	-3.0	22%	25%
	Offers	14.6%	32.1%	12.1%	14.8% ↑	8	-2.2	17%	20%
	Workforce	11.1%	13.3%	14.0%	13.9% ↓	90	-2.1	16%	20%
Level of ethnic minority representation at Level 2+		8%	10.8%	12.7%	12.6% ↓	27	-1.4	14%	20%
Level of ethnic minority representation at Level 3		12%	14.3%	14.7%	14.6% ↓	63	-1.4	16%	20%
Increase ethnic minority representation at all levels	Applications	29.4%	40.0%	44.4%	45.3% ↑	2,370	+8.3	37%	40%
	Interviews	18.2%	27.4%	28.1%	30.7% ↑	329	-1.3	32%	35%
	Offers	18.2%	30.2%	24.3%	23.2% ↓	66	-4.8	27%	30%
	Workforce	14.3%	16.0%	17.3%	18.7% ↑	317	+1.7	17%	20%

Reduce differential turnover rates for ethnic minority staff	0.8 percentage points	0.4 percentage points	3.7 percentage points	2.2 percentage points ↑	-0.2	1-2%	1.0%
Proportion of ethnic minority staff receiving promotion and grade progression is proportionate to our workforce at the relevant grade/level ** Difference is not set against 2023 figures – the target is that the proportion of staff will be equal across ethnic minority and other staff*	-1 percentage points	3.4 percentage points	1.8 percentage points	2.9 percentage points ↓	n/a	18%	18%
Pay differentials within a confined band limited to 2% from 2023[1] *(table shows the proportion of bands that are inside the tolerance)*	50.0%	41.7%	58.3%	83.3% ↑	16.3	100%	100%

Forecast performance

151 Please see Annex C forecasts. For each measure of inclusivity within the GMC, we produced a fresh forecast of the current direction of travel and compared it with another forecast of what we would have expected from 2021 onwards as a reference. Such comparing indicates good chances to achieve our aspirations in a few areas, while highlighting other areas that still need further improvement.

152 Of the 14 measures of inclusivity, all but one were forecasted to show little or no change for the foreseeable future. This is largely due to recent performance that suggested our progress may continue to plateau without further intervention. The only exception was the percentage of ethnic minority among staff at all levels, which is forecasted to continue increasing and exceed the target sometime during 2024—if the drivers underlying it stay about the same.

153 Further, among the 13 measures that are plateauing, 11 did so below their respective targets. The other two measures were those of the representation of ethnic minorities in applications for roles at levels 3 and above and for roles at all levels, which plateaued beyond our targets.

154 There's a persistent pattern in the observed data and forecasts where the representation of ethnic minorities is lower in interviews than in applications, and then lower in job offers than in interviews. This is for roles at all levels or at levels 3 and above. All measures related to this have plateaued, so further intervention will be needed to bring them all past our targets.

155 Our management profile forecasts remain the most concerning. They show that ethnic minority representation at levels 3, 2, and above are expected to remain well below target. Ethnic minority representation across all levels is increasing and is expected to continue doing so. So, altogether this means that this rise in ethnic minority representation is mostly due to higher representation of ethnic minorities in levels 4 and below, rather than in managerial roles.

156 The turnover rate for ethnic minorities is currently higher than that of other staff. With the difference in turnover rates forecasted to be plateauing outside the target band.

157 Promotion and grade progression rates seem to have stopped declining away from our targets. This might suggest that our interventions in this regard have been effective in turning promotion and grade progression measures, if only to plateau. So, similar interventions might be effective in bringing promotion and grade progression rates up to our targets, as well as reducing the existing differentials in these and other GMC inclusivity measures.

158 The percentage of pay bands where the ethnicity pay gap is below 2% increased substantially in the last year, but forecasts still expect it to plateau substantially below our target.

Work programme activities in 2023

159 We have a substantial programme of work that supports our ED&I strategy. This includes dedicated ED&I initiatives alongside our wide employment arrangements that have ED&I considerations integrated (such as our 360 feedback process, People Survey, and leadership training.

Our recruitment work

- **Expanded our outreach activities** by attending a wide range of careers fairs in the Northwest to promote vacancies and reach out to diverse prospective applicants. These events saw increased traffic to our careers page, an increase in the number of candidates who signed up to an account and job alerts on our recruitment system. In 2024 we will expand this further to other locations, such as London. We will also explore how we can further promote our brand and the work we do in Northern Ireland, Wales, and Scotland.
- **Networked and built connections**, particularly with Manchester Jobcentre Plus as part of our attraction activity for specific campaigns, for example the Clinical Assessment Centre (CAC) and Contact Centre. Through this process, candidates

were offered an application and cover letter best practise workshop – delivered by the National Career Services (NCS) with our support.

- **Launched an interview skills workshop** for colleagues, holding 11 sessions across 2023 with over 100 attending and three of these sessions were set aside for colleagues from an ethnic minority background who had been unsuccessful at interviews. We will run more sessions in 2024 and develop a workshop focused on CV and cover letter writing.
- **Competed a successful intern programme** in the summer of 2023 across eight areas (for example, with our National Offices and Outreach, Medical Practitioners Tribunal Service, Legal, Communications, Learning and Organisational Development and Information Services), and in varied locations (Manchester, London and Scotland). We received over 300 applications – 72% applicants were from ethnic minority backgrounds and two thirds of offers were to applicants from an ethnic minority background. Feedback from both interns and managers has been very positive and we'll be running the scheme again in 2024, with further work on how this can feed into future recruitment processes.
- **Gained Disability Confident employer status (level 2)** after gaining the Disability Confident committed status (Level 1) in 2021 we've embedded the guaranteed interview scheme for candidates with a disability who want to opt-in to this scheme if they meet the essential criteria. This has included amending our job descriptions to replace key skills with essential and desirable criteria, removing jargon, and making our job description more accessible for people with disabilities. We have achieved Disability Confident employer status (Level 2) in June 2024, and we've established a working group which will meet regularly to review all the areas required to support our achievement of Disability Confident Leader (level 3). We have established an action plan to address any missing areas and hope to achieve this status by 2026.

Our 2023 learning and development work

- Progressing on developing a new career development programme for ethnic minority staff, started with inclusive leadership sessions for over 200 people leaders.
- Completed ED&I refresher training for 230 colleagues and introduced new collaborating inclusively sessions.
- Developed and delivered leadership everywhere (a two part programme with a significant ED&I element.
- New 'OneGMC behaviours' and 2024 objective templates to include focus on fairness in decision making as an integral part of our performance management process.

- Appointed a new ED&I learning provider and developed a refreshed new starter session – we started a pilot in January 2024
- Continued to maintain a diverse pool of internal coaches and supported their professional development—our coaching, mentoring, and shadowing programmes are open to all.
- Continued delivery of our empowerment programme and ensured cohorts were diverse (20%+ ethnic minority completed the programme in 2023).
- Provided development day support to teams where they looked at our People Survey themes.
- Ensured all new starters received professional behaviours digital learning.
- Expanded our training support to include neurodiversity – worked with external organisations to deliver sessions on neurodiversity themes, dyslexia, ADHD, autism etc.

Our employment arrangements:

160 Continued to review and update all our policies to ensure ED&I good practice. We undertook a detailed review of talent and succession to inform our recruitment options.

161 Reviewed our 2022 performance review outcomes, undertook further checks and ran sessions for over 300 managers on fairer assessment decisions—and we launched new guidance on reviewing performance.

Future focus for the year ahead

162 Our priorities for 2024 are:

- close turnover and progression differentials
- sustain our progress on reducing employee engagement differential, with a specific focus on lower scoring groups
- complete the delivery of our career support programme
- maintain our overall progress on recruitment and identify options for achieving more progress in senior roles.

Recruitment

163 We will continue to expand our outreach work and support for candidates. We are confident that we can sustain our current workforce progress. And identify some areas

where we can build on existing initiatives, for example our intern intake is very diverse and we are exploring ways in which we can link this to future vacancies.

164 Develop a diverse central pool of interviewers ensuring recruiting managers use a colleague from a different Directorate from this pool. This will help involve a variety of perspectives in the interview process by including colleagues with different experiences, in turn helping to make the process impartial which is particularly important for internal candidates. It also provides a development opportunity to give colleagues unique insights into the skills, experience and behaviours needed for other roles. This will in turn help their career progression. We will also make it mandatory for L3+ roles to have at least one ethnic minority panel member and for senior roles to try and include an external interviewer on the panel.

165 We will also look to undertake some other initiatives such as quality assuring outcomes from recruitment campaigns for L3+ positions, implementing redaction software for CVs, adapting our application form and review our interview style trialling value based and behavioural based questions. Our career development support has the capacity to help achieve our ambitions at senior level, but we need to consider how we might generate more career advancement opportunities. This might include further use of our development secondment scheme and developing more structured paths to management roles.

Pay and performance

166 Pay gaps are closing and we can report on good progress. Further focused reviews and adjustments will continue, but a priority will be to review the fairness and consistency of performance management decisions. Including our framework and guidance as well as looking at the link to pay. We aim to complete this work ahead of our 2025 performance management cycle.

Workplace experience

167 We’ve made very good progress towards a more consistent workplace experience as measured by our engagement index.

168 We know that some negative experiences are more likely to be reported by some groups of colleagues and so, our work on inclusion, bullying and harassment will continue. We will launch our next People Management Essentials module – Professional Behaviours: Championing Respect and Inclusion. We have also introduced a new exit interview process with half year reporting to the People and Development Board.

169 We will continue to support teams and the Freedom to Speak Up Guardian on addressing potential issues at an early stage, with further work on encouraging colleagues to report issues.

Learning

170 Our priority is the delivery of our career support programme and the engagement of people managers alongside this. We will deliver new joiner training from the start of 2024 and update our *‘treating people fairly’* training module by June this year.

171 We will also deliver a one-day programme for high impact decision makers which will be focused on how they can make sure they consider fairness and bias in the context of their decision-making.

172 From the start of this year (2024), we’ve implemented new and updated objectives and behaviours frameworks, with a stronger focus on ED&I, and decision making. This will feed through to our 360 system during 2024.

Conclusion

173 Since launching the ED&I aspirations and targets in 2021, we've established a process of monitoring our progress and reporting this at regular points to Council. The way we track and forecast progress has evolved and is informing our assessment of progress. Shining light on progress made, and repeating and sustaining the call for action are important parts of motivating further commitment to tackle these inequalities.

174 It's clear at this point in our journey that we are seeing benefits generated from regular reflection, review, and assessment of the interventions and activities within our programmes. This report gives evidence throughout the dynamic learning that's ongoing within these programmes and with other stakeholders—and how this is shaping future priorities and activities.

175 The decision to set these targets, and the targets themselves were ambitious. But we continue to see that they've brought traction for change that may not have otherwise happened. The challenge remains, for all of these ambitions, that the inequalities we are seeking to address are longstanding and complex causes, and whether these are inside or outside our direct control they will take time to achieve.

176 Since we set these aspirations three years ago, we have seen some early signs of improvement and progress has been sustained across all three years. We've been careful from the outset commenting on any signs of improvement, but the forecasts for some of the measures, such as the referral measures, show that progress is likely to be maintained and we can be positive, but not complacent about this indication. However, in some measurable progress has plateaued or is yet to be seen and we need to continue on the path we committed to three years ago and continue to sign a light on this lack of progress, be clear that this is not what we had hoped to see – and robustly call for the continued collaboration and action that this evident across the system.

177 We are yet to have a complete set of data that we can update for some of the measures, and we aim to iron out those challenges in sequencing of reporting to ensure we can achieve this next year.

178 This is the halfway point for some of the aspirations we set, and we now know change is possible, and there is the potential for this to be built upon and maintained. We recognise that we aren't seeing this for all the aspirations, but three years into this journey we are confident that there's evidence that continuous progress can be achieved. We are constantly challenging ourselves and reflecting on the evidence of progress – and where and how we aim to see more of this.

179 We want to make sure that ED&I also remains a top priority in organisations across the health system and is at the forefront of their workforce plans. Progress is evident and we believe there’s the potential to see real long-term improvements.

180 Our ED&I aspirations demonstrate that we are committed to this for the long term. We recognise that ED&I must remain a top priority for us, both as an employer and a regulator.

Annex A: Working with others – four country contexts

England

In 2023 we launched our first ever RO Briefings and used these to support ROs to understand our expectations of them as leaders in relation to the updated version of *Good medical practice* (GMP).

Our key focus for these events was to encourage ROs and their teams to implement the new standards on fair, compassionate cultures, and tacking discrimination. We covered this in more detail at every RO network meeting and this laid the groundwork for a thematic review we'll be undertaking throughout 2024. During these reviews, we'll be checking progress on GMP implementation as part of our routine RO engagements. We supplemented this work with similar events with relevant organisations – eg NHS Employers for their senior leaders event.

We continue to engage with a wide range of doctors to raise awareness of the updated version of *Good medical practice*, and in particular, the guidance around creating inclusive and supporting working environments. As part of this, we've developed a range of supporting engagement material to encourage conversations around a range of ED&I related topics. As a result, we've discussed ED&I at over 200 of our workshops and conferences throughout 2023.

We prioritised our support offer for doctors by delivering training aimed at improving their working environment and how they support each other. This included delivery of:

- 'Welcome to UK Practice' induction programme – for new international medical graduates (IMGs)
- 'Professional Behaviours: Patient Safety' training – aimed at helping doctors challenge unprofessional behaviour
- Raising concerns training – aimed at supporting doctors to share concerns appropriately.

In London, we partnered with NHS London, the British Medical Association (BMA), the Medical Protection Society (MPS), and other stakeholders to support Trusts with embedding Welcoming and Valued – the induction programme for new international medical graduates. Our work in identifying good practice and sharing it, as well as supporting Trusts around the challenges they face, will continue into 2024.

Employer Liaison Advisors in the south and London regions who manage locum agencies have been looking at ways to better support locum doctors, who are often IMGs and from an ethnic minority background, and those commissioning their services.

Targeting reductions in referrals of these doctors involved the development of a training package for staff who work in agencies to help them understand our role, how they can support locums, and how to better ensure appropriate placement and induction. We also developed training materials for locums to support with issues around revalidation and also how best to raise concerns about patient safety issues when on short term placements.

As another example of our work, we have worked with a trust that have devised a new approach to managing concerns. There's a formal procedural guidance document which primarily sets out

the investigation process which follows Maintaining High Professional Standards (MHPS), the trust hopes few cases will reach that stage as they shift the focus to timely, local resolution. The guidance was developed to support those who manage concerns when they arise, and so all doctors know what to expect. We shared thoughts on the draft guidance including considering whether the doctor is an IMG, along with whether they have a protected characteristic.

We offered challenge about what the ED&I Strategic Lead would bring to the conversation. We applauded positive inclusions in the policy such as a desire to embed the behaviours expected by all staff at the trust, and we referenced to WtUKP. We flagged the NHS IMG induction which the trust weren't aware of. As a result, the trust included our feedback as part of its updated policy and guidance and will assess the effect of these changes over time.

We participated in a wide variety of conferences and meetings on fairness issues, including speaking at the Better Together Conference hosted by North East London Foundation Trust, delivering the keynote at the Medical Association of Nigerians Across Great Britain, and speaking at the British International Doctors Association on a range of ED&I topics.

Northern Ireland

Northern Ireland (NI) continues to experience growth in the number of IMG doctors. Over the last five years there's been an 87% increase in the number of IMG doctors practising in NI, the largest increase in the UK. With IMG doctors currently making up 8.5% of our workforce. The Northern Ireland Medical and Dental Training Agency (NIMDTA) highlighted a sharp rise in the number of IMG doctors taking up ST1 (specialty training) General Practice (GP) training between 2021 and 2023, showing how increasingly diverse our workforce is becoming. Our liaison advisers have worked with NIMDTA to provide induction and ongoing support for these cohorts.

A clinical fellow joined the team in August 2023, working collaboratively between the GMC and NIMDTA. Their project is focused on ED&I and IMG induction. To date an ED&I training package has been developed and implemented which will be delivered to all second foundation year (F2) doctors in Northern Ireland.

This year we brought together a variety of local stakeholders to showcase ED&I initiatives across Northern Ireland at the event titled, The Changing Medical Workforce in Northern Ireland. The event was supported by the Department of Health (NI) Permanent Secretary and Deputy Chief Medical Officer. And was attended by representatives from all five health and social care trusts in Northern Ireland, NI Medical Dental Training Agency, Queen's University, and Ulster University. This provided a unique opportunity for attendees to consider support for international students and graduates, and individuals from minority ethnic backgrounds. The event provided a platform for sharing best practice across the region. We heard directly from individuals about their lived experiences as international medical graduates and students, and doctors with disabilities.

Support for IMG doctors was a theme at our Autumn UK Advisory Forum where there was a consensus that doctors new to NI require additional support and there's a need for trainers to be educated and supported to facilitate this. There are currently low numbers of IMG doctors in trainer roles highlighting further need for widening leadership opportunities.

In November we delivered a seminar to support GMC Council members in their understanding of the Northern Ireland political and healthcare landscape. Discussions enabled members to gain an insight into the issues faced by the workforce in NI particularly in relation to primary medical qualification (PMQ), ethnicity, and gender imbalances.

We continue to deliver local WtUKP sessions for all new IMG doctors for both the deanery and local trusts. We've expanded upon this with the delivery of a follow up session, 'Thriving in UK Practice' – which is delivered to IMG doctors who have been in for six months or longer.

Our Employer Liaison Adviser (ELA) continues to support responsible officers to address emerging fitness to practise concerns, consider local resolution where appropriate, and confirm steps have been taken to make sure GMC referrals are fair and consistent.

Scotland

We continue to share our ED&I data with the Scottish Government, education bodies, and medical representative organisations to help inform and shape policy decisions.

We fed in further thoughts to the latest draft of Scottish Government's new Improving Wellbeing and Workforce Cultures framework and action plan, a section of which focuses on equalities. Areas of priority we highlighted included fostering cultural competence, continuing to support minority ethnic staff and leaders via the NHS National Ethnic Minority Forum (EMF), and co-production of anti-racism resources.

We collaborated with the EMF, and BMA Scotland's Race Equalities Forum, via the newly established Scottish Fairer Working Cultures Joint Working Group. The group aims to improve the fairness of healthcare training and working environments for minority ethnic doctors and international medical graduates (IMGs) in Scotland. Priority areas for this group will include:

- induction and exit processes
- educational and clinical supervision
- local processes regarding performance concern
- workplace bullying
- discrimination
- harassment
- improving education of doctors concerning privilege.

We continued to work with the Scottish Government's Leading to Change Equalities Sub-Group which aims to create, support, and embed an anti-racist culture across health, social care, and social work.

Our Autumn (UK Advisory Forum) UKAF dinner brought together key stakeholders to consider actionable steps towards improving the experience and retention of IMGs in Scotland. Discussions at UKAF focused on the importance of promoting good workplace cultures in Scottish healthcare, including working to address discrimination.

Nicola Cotter spoke at the British Association of Physicians of Indian Origin (BAPIO) Scotland,

about the GMC's work, both in Scotland and UK-wide, to address differential attainment and disparities in employer fitness to practise (FtP) referrals by ethnicity.

Our recent education roundtable included discussion of our fair training cultures work, and what more can be done in Scotland to promote fairness in medical education and training.

We continue to deliver Welcome to UK Practice workshops and we've collaborated with health boards and NHS Education for Scotland to expand the induction support we can offer to IMGs. We are also working with these organisations with the intention to make sure that all IMGs joining the NHS in Scotland attend a WtUKP session.

Our Employer Liaison Adviser (ELA) continued to support responsible officers to address emerging fitness to practise concerns, consider local resolution where appropriate, and confirm the steps ROs have taken to make sure GMC referrals are fair and consistent. Our newly appointed ELA will continue to take this work forward.

Meanwhile our liaison advisers (LAs) led sessions with trainers, consultants, students, and equalities groups on ED&I. They also led sessions on our *Fair to Refer?* report to highlight the role they can play in reducing the disproportionality that exists in employer referrals and educational attainment. Our newly appointed LAs will continue this work.

Wales

We held our UK Advisory Forum in October. The forum brought together senior stakeholders from Welsh Government, the Welsh NHS, and other system stakeholders. And included presentations and discussion around creating open and supportive cultures and enhancing professionalism and fairness in the Welsh NHS.

Our education roundtable in November brought together senior stakeholders from across the medical education and training landscape in Wales. And included discussion around working collectively to achieve better training cultures and embedding the updated *Good medical practice* sections on fairness and inclusive cultures in training experiences.

Maria Chatters, Regional Liaison Adviser for South and Mid Wales, attended the Welsh Government's Anti-Racist Wales Conference in September, reporting key insights back to the wider GMC Wales team.

In November 2023, Gethin Matthews-Jones, Head of GMC Wales, presented at Cardiff University's 8th Welsh Simulation and Teaching Symposium – the theme was EDI in Healthcare Education. Gethin's presentation included insights relating to international medical graduates in Wales; the updated *Good medical practice* sections relating to fairness and discrimination; and our targets and work around differential attainment.

Our work to prepare and comply with the Welsh Language Standards (WLS) requires the application of a principle of equality in our treatment of Welsh and English. By enhancing our Welsh language offer, we are recognising and responding to the diverse needs of patients, students, and registrants – an important commitment in Wales as a four-country regulator.

Judith Chrystie, Assistant Director for the Medical Licencing Assessment and Gethin Matthews-Jones, Head of GMC Wales, addressed delegates at the Minority Languages in Health Education Conference held by Cardiff University School of Medicine in June 2023. They discussed the effect

that our work on compliance with the Welsh Language Standards has had on awareness of the Welsh language and bilingualism across the organisation—and the link between improved Welsh language provision, patient safety, and patient-centred care.

Over the course of 2023, the Wales Outreach team engaged with Health Boards to discuss areas in which we can support executive teams in achieving better ED&I outcomes. Examples included sharing data on IMG doctors to enhance opportunities to attend Welcome to UK Practice workshops. This has led to opportunities to share further GMC support for IMG doctors including sessions on GMC guidance and how to contextualise this guidance within day-to-day clinical practice. In turn, this has helped increase engagement with and attendance by IMG doctors at our sessions/workshops.

Specific examples of such engagement include a questionnaire and table discussion delivered by Ian Jones, Liaison Adviser for North Wales, at Betsi Cadwaladr University Health Board's IMG Induction Fair to enhance our understanding of what support IMG doctors would most value. We shared these insights with colleagues to inform planning. In South Wales our Liaison Adviser worked closely with Aneurin Bevan University Health Board to develop a bespoke enhanced induction programme for IMG doctors. The programme has been positively received and will be delivered on a regular basis at Aneurin Bevan University Health Board (ABUHB) and piloted in other boards throughout 2024.

We continue to build on our collaboration with Health Education and Improvement Wales (HEIW) on enhanced support for IMG doctors. This includes:

- bi-annual, two-day joint input sessions (Spring and Autumn)
- the local GMC/HEIW West Wales Enhanced Support to Doctors in training programmes
- our ongoing contributions to the HEIW expert advisory group on support for IMGs and specialty and associate specialist (SAS) doctors.

Our GMC Employer Liaison Adviser (ELA) Katie Laugharne has worked to enhance support for SAS doctors in Wales including contribution to the Wales SAS conference; the RCP Wales SAS network and BMA SAS committee; and meeting with the Wales SAS advocates and tutors to better understand how GMC Wales can support them and those they represent. This engagement activity will feed into the Wales Outreach Team business plan for 2024.

Our ELA also led discussions with responsible officers (ROs) about fairness of local processes. This included interactive sessions considering scenarios on fairness and supporting a group of ROs who wish to pilot a process for reviewing the impartiality of their decision making. Our ELA also delivered a series of workshops aimed at ROs, their deputies, and professional concerns leads on fitness to practise processes and thresholds. It included a session on fairness and on the new standards relating to discrimination and fair inclusive cultures contained within *Good medical practice*. We also engage regularly with the Wales Lead Adviser for the Practitioners Performance Advisory Service (PPAS) with fairness being one of the key themes for discussion. We are also engaging with the HEIW programme which focuses on improving employee investigations, with further partnership work planned for 2024.

Annex B: Explanation of FTC measures

EPM scores

Data are for the previous full academic year. The Educational Performance Measure (EPM) is a measure of clinical and nonclinical skills, knowledge, and performance up to the point of application to postgraduate education. It is used in applications to foundation training. Score is out of 10, with 1 the lowest and 10 the highest and best performing decile. Data is provided by Oriel (the UK wide portal for recruitment to postgraduate medical, dental, public health, healthcare science, and foundation pharmacy training).

Foundation – F1 preparedness

Data at March 2023 National Training Survey (NTS) census date. We asked Foundation Year 1 doctors the question ‘I was adequately prepared for my first foundation post’. The measure shows the proportion of respondents that agreed or strongly agreed with the statement.

Postgraduate education – inclusive environments

Data at March 2023 NTS census date. The responses to the survey question ‘my department/unit/practice provided a supportive environment for everyone regardless of background, beliefs or identity’ were converted into a score out of 100, with higher scores indicating higher levels of support.

Postgraduate education – ARCP

Data are for previous full academic year. Difference in rates of 'Developing’ outcomes for annual review of competency progression (ACRPs), across all specialties and training levels. Data provided by postgraduate deans.

Postgraduate education – exam

Data is for previous full academic year. Difference in specialty examination pass rates, across all UK specialties and training levels, and for all attempts. Data provided by royal colleges and faculties.

Annex C - Index of abbreviations

AOI	Allegation of Impairment
AoMRC	Academy of Medical Royal Colleges
ARCP	Annual Competency Review of Progression
BAPIO	British Association of Physicians of Indian Origin
BITC	Business in the Community
BMA	British Medical Association
CAC	Clinical Assessment Centre
CASC	Clinical Assessment of Skills and Competencies
CoPMeD	Conference of Postgraduate Medical Deans
CQC	Care Quality Commission
DB	Designated Body
DHSC	Department of Health and Social Care
EEA	European Economic Area
ELA	Employer liaison adviser
EMF	NHS National Ethnic Minority Forum
EMP	Education Performance Measure
EPM	Education performance measure
FER	Fairer Employer Referrals
FTC	Fairer Training Cultures
FTP	Fitness to Practise
HEIW	Health Education and Improvement Wales
HIRD	High Impact Regulatory Decision
HSC	Health and Social Care
ICB	Integrated Care Board
ICS	Integrated Care System
IJB	Integrated Joint Board
IMG	International Medical Graduate
KPI	Key performance indicator
LEP	Local Education Providers
MDRS	Medical and Dental Recruitment and Selection
MHPS	Maintaining High Professional Standards
MPTS	Medical Practitioners Tribunal Service
MSC	Medical Schools Council
MWRES	Medical Workforce Race Equality Standard
NCS	National Career Service
NIMDTA	Northern Ireland Medical and Dental Training Agency

NMC	Nursing and Midwifery Council
NTS	National Training Survey
PAPC	Persons acting in a public capacity
PG	Postgraduate
PHSO	Parliamentary and Health Service Ombudsman
PMQ	Primary Medical Qualification
PSA	Professional Standards Authority
PSIRF	Patient Safety Incident Response Framework
PTO	Postgraduate Training Organisation
RCP	Royal college of practitioners
RFR	Regulatory Fairness Review
RO	Responsible Officer
ROAG	Responsible Officer Advisory Groups
SAS	Specialty and Associate Specialist
UKAF	UK Advisory Forum
UKFPO	UK Foundation Programme
WLS	Welsh Language Standards
WtUKP	Welcome to UK Practice

Annex D: Current statistical KPI forecasts

Summary

We show the historic data on all the ED&I key performance indicators (KPIs) about fairer employer referrals (FER), fair training cultures (FTC), and inclusivity within the GMC – alongside statistical forecasts of them, suggesting possible future trajectories.

Crucially, though we used best-established cutting-edge methods of forecasting, we should keep in mind that forecasts are unlikely to be the reality that materialises. Still, they represent our best expectation of the future given data so far, which among many other drivers, likely reflects any fully embedded past interventions.

For each KPI we have:

- included a one-sentence headline interpretation of the forecasts, on the title of each chart
- crafted a forecast on the current possible 'direction of travel' given recent historic data (shown in orange on the charts below and labelled 'current forecast')
- crafted another forecast (whenever data allowed) on the status-quo remaining unchanged, starting with 2021 (shown in blue on the charts below), right before our targets were agreed and published. This serves as a reference. An encouraging sign would be that historic KPI data observed from 2021, as well as the forecast of its current direction of travel, separate from the forecast of the status quo remaining unchanged, in a direction closer to our targets. If so, it could be argued that the drivers of the KPIs have positively changed since January 2021. We would expect that to be partly due to our own actions to improve the value of the KPIs.

Summary suggestions from forecasts

- As in our report last year, forecasts of FER KPIs suggest good chances of getting close to our targets by the end of 2026.
- For FTC, it remains highly premature for forecasts of current direction of travel to be reliably informative. Therefore, such forecasts must not be taken as a suggestion that nothing is currently changing or that nothing will change in the future. We currently have very few FTC data points available for forecasting models to be trained on. The values taken by those data points are also currently insufficient for most models to reliably 'detect' that there is change – eg trends are not yet stronger than the ups and downs. Therefore, most models have automatically remained at their default detection that there is no evidence for change in any of the KPIs. In addition, it remains very challenging to forecast reliably so far into the future. The drivers for FTC are very complex, systemic change will take time to have an impact, and attaining targets is expected to take up to 10 years. Despite this, for two FTC metrics, forecasting models have started to detect trends. Both the difference in postgraduate ARCP outcomes between ethnic groups and the difference in postgraduate exam pass rates between UK graduates and IMGs, appear to be turning towards their aspired targets.

- For our targets as an employer, the data, and forecasts of KPI about inclusivity within the GMC suggest that our efforts have been highly effective in some areas while surfacing areas of further improvement.

Interpretational notes

Forecasts are interpreted as the best expectations of the future given the data observed so far.

- All forecasts assume that the drivers behind the data (historic data) remain unchanged. This is critical to keep in mind given that our aspiration is to contribute to modify such drivers via intervention where they relate to disproportionality.
- Also, the actual data may be naturally bounded. For instance, percentages cannot go below 0% or above 100%. Models currently cannot reliably incorporate the effect of getting close to those bounds; this is seen in some expected forecasts and uncertainty bands crossing such bounds, rather than being limited by them. The drivers underlying real data often change when data gets close to such bounds. And it is very difficult to anticipate how so. Therefore, making hard (and most of the time unnecessary in practice) to make models to incorporate the effect of such bounds.

The farther we forecast into the future, the more uncertain a forecast tends to become, as shown by uncertainty bands (95% prediction intervals) surrounding each expected forecast. Regardless, the forecasts here represent our best evidence base, given existing data, and are useful to guide our decisions ahead.

Important to note.

For FER

- Forecasts of the current direction of travel start from November 2023, using available data up to October 2023.
- Though we have a reasonable amount of data, we are forecasting a long time into the future. A time span comparable to that of the historical data itself, so cautious interpretation is advised.

For FTC

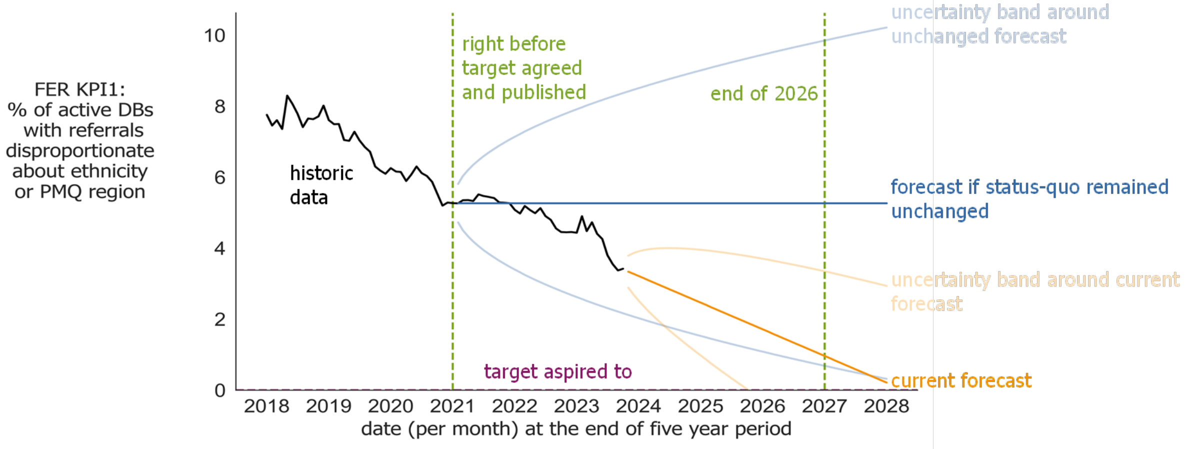
- Data are annual and taken as of the 31 of December of each year. This causes that, for instance, a point on 31 of December 2016 may appear to correspond to 2017.
- FTC data takes a long time to be generated and verified, so the most recent currently available is from 2022, except for NTS metrics that were available for 2023. Therefore, we forecast from 2023 and 2024 onwards, respectively.
- We are using data from as far back as we consistently have it. For most metrics, the first point in charts is shown on the 31 December 2016. For some of the metrics, this means that these data points are from the 2015/2016 academic cycle, so they encompass 2015 data.

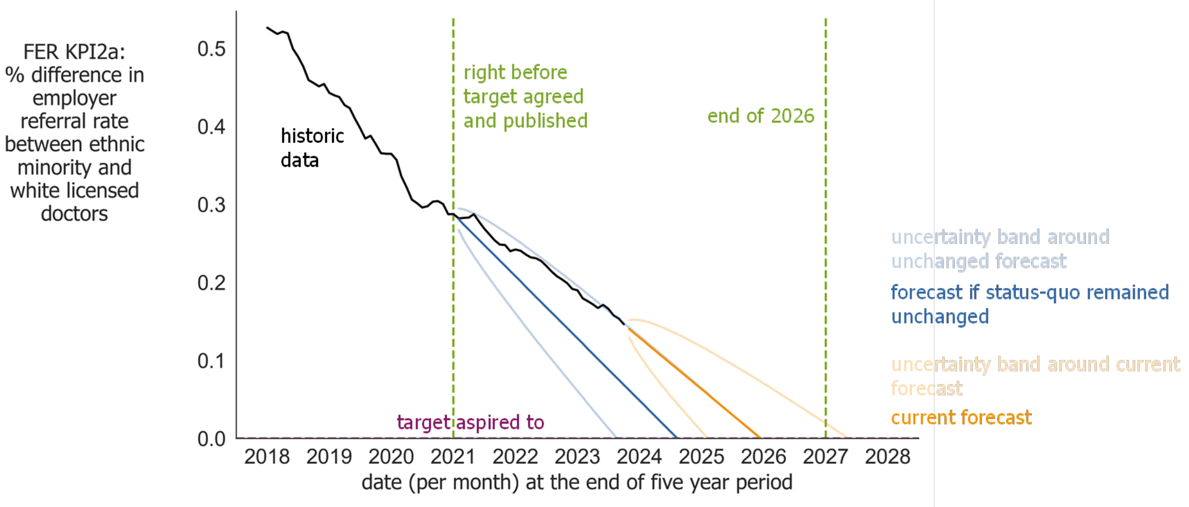
- For two metrics, there was no data before 2020. For these, we project this starting value as a reference, rather than showing a reference forecast.

For Inclusivity within the GMC

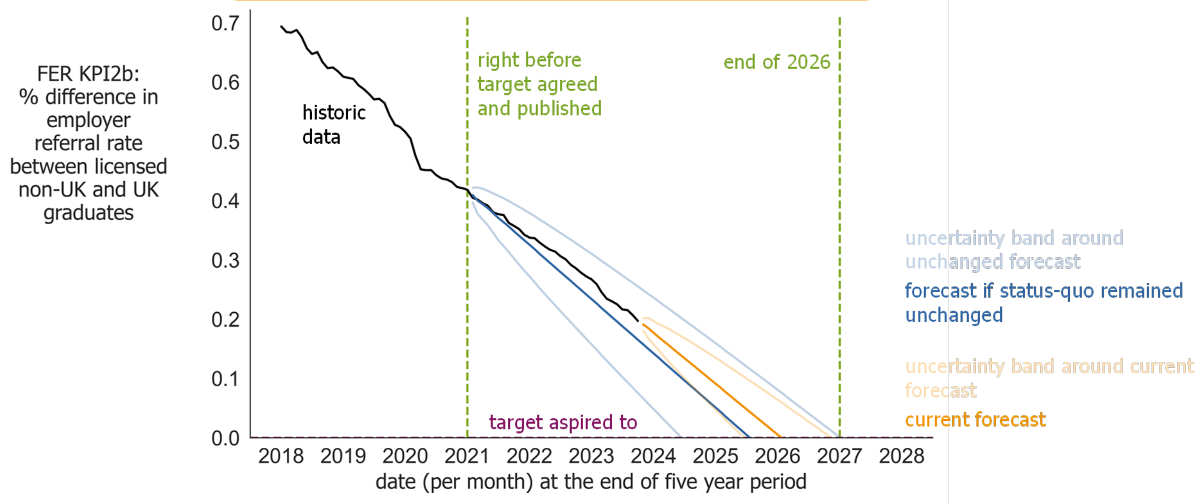
- Forecasts of current direction of travel start from November 2023, there were no historic data before December 2020. Therefore, instead of a reference forecast, we extended the value of the KPIs then, as a fixed reference.

Fairer employer referrals' forecasts

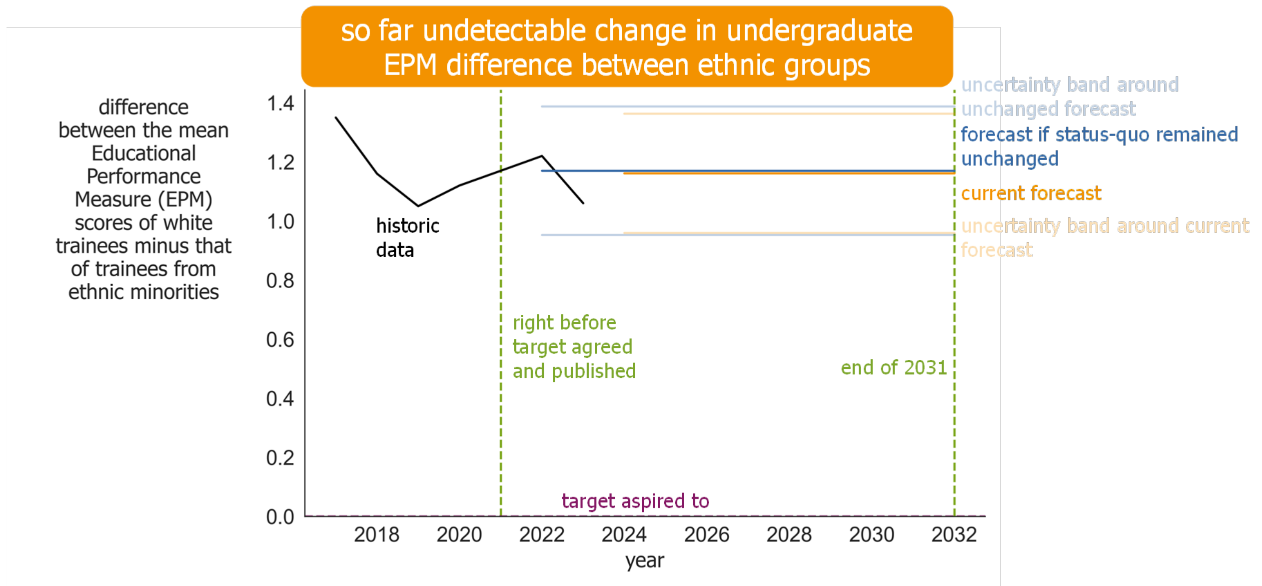


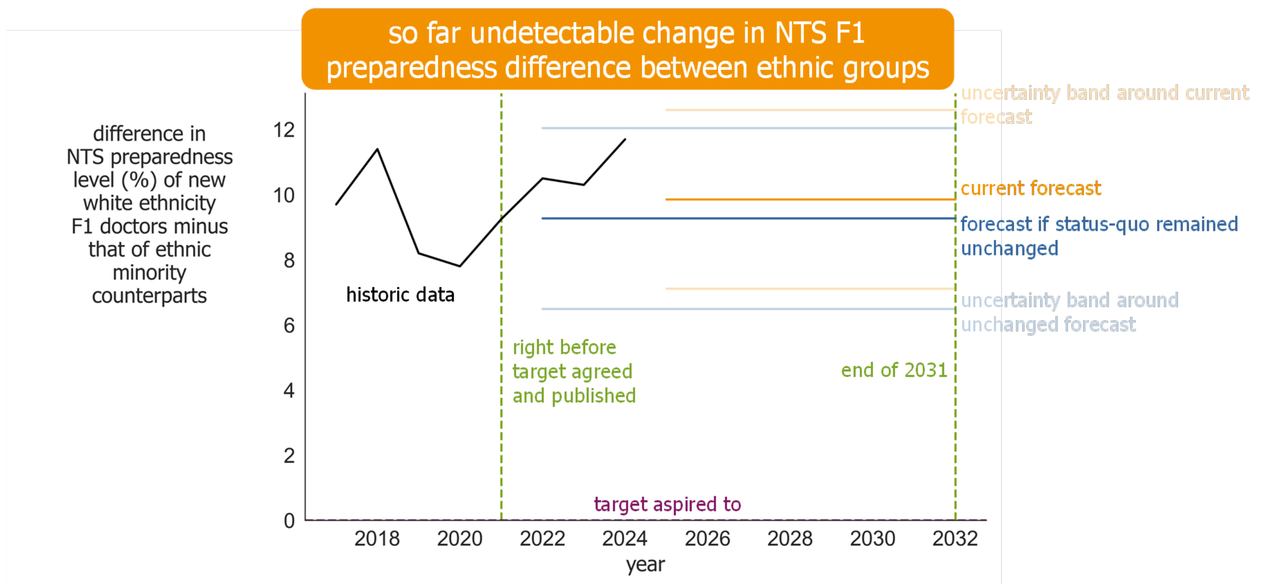


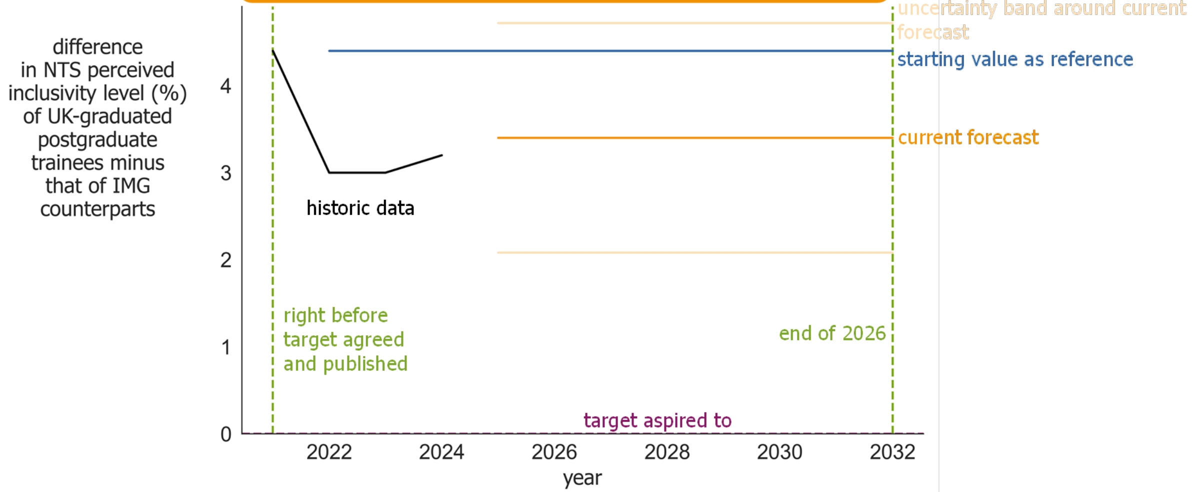
the referral rate difference between PMQ region groups is improving towards target



Fair training cultures' forecasts






so far undetectable change in NTS postgraduate inclusivity difference between PMQ groups
difference in NTS perceived inclusivity level (%) of UK-graduated postgraduate trainees minus that of IMG counterparts
uncertainty band around current forecast
starting value as reference
current forecast
historic data
right before target agreed and published
end of 2026
target aspired to
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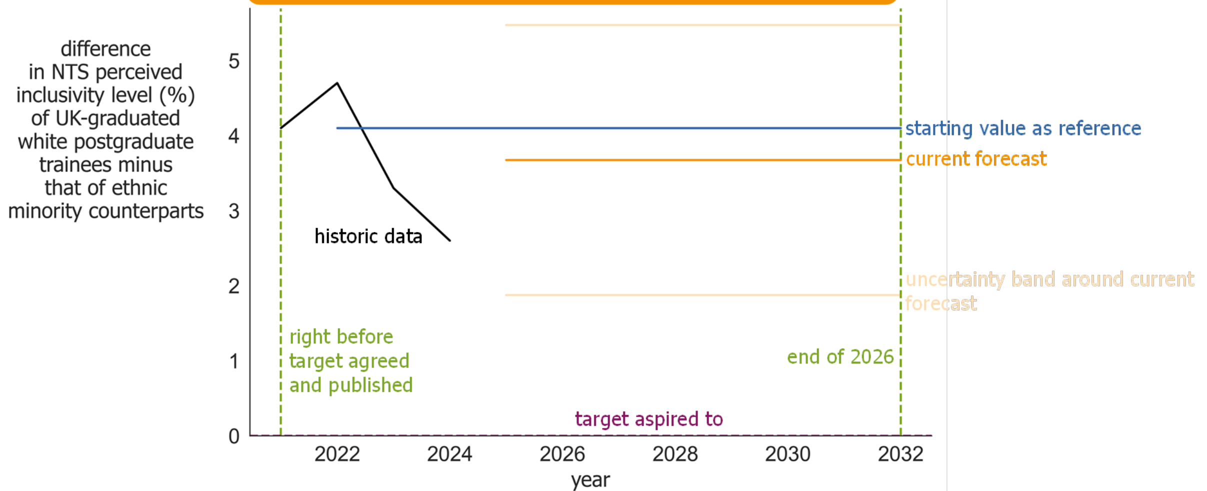
so far undetectable change in NTS postgraduate inclusivity difference between ethnic groups
difference in NTS perceived inclusivity level (%) of UK-graduated white postgraduate trainees minus that of ethnic minority counterparts
starting value as reference
current forecast
historic data
uncertainty band around current forecast
right before target agreed and published
end of 2026
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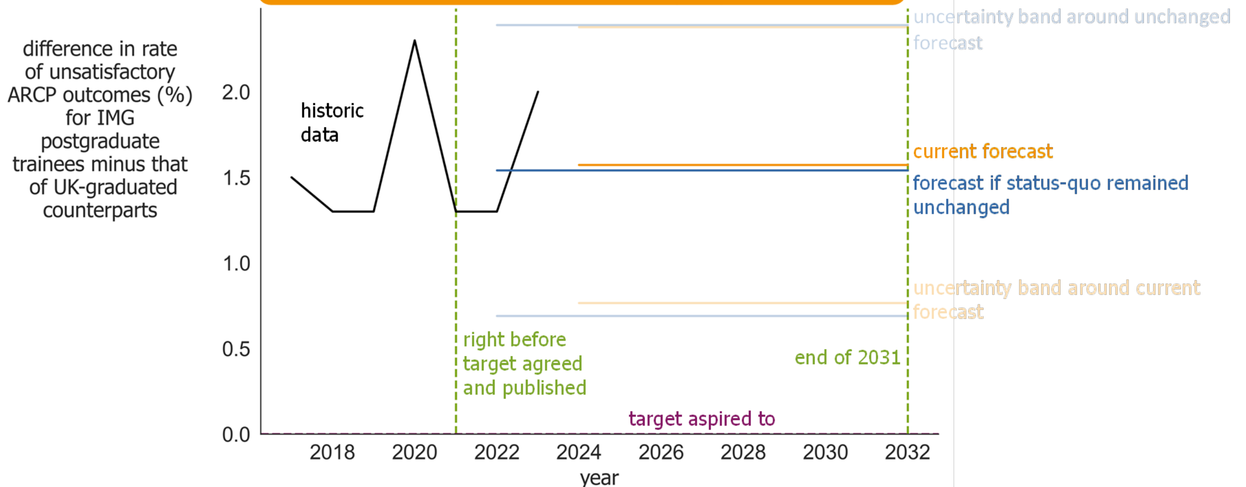
so far undetectable change in postgraduate ARCP results' difference between PMQ groups
difference in rate of unsatisfactory ARCP outcomes (%) for IMG postgraduate trainees minus that of UK-graduated counterparts
uncertainty band around unchanged forecast
historic data
current forecast
forecast if status-quo remained unchanged
uncertainty band around current forecast
right before target agreed and published
end of 2031
target aspired to
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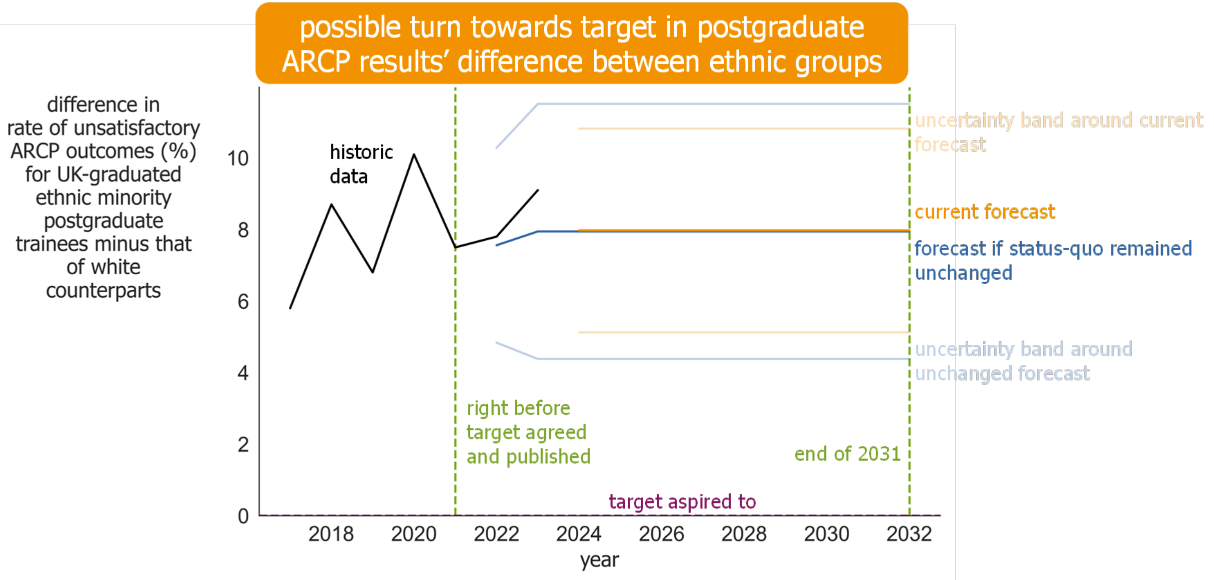
possible turn towards target in postgraduate ARCP results' difference between ethnic groups
difference in rate of unsatisfactory ARCP outcomes (%) for UK-graduated ethnic minority postgraduate trainees minus that of white counterparts
historic data
uncertainty band around current forecast
current forecast
forecast if status-quo remained unchanged
uncertainty band around unchanged forecast
right before target agreed and published
end of 2031
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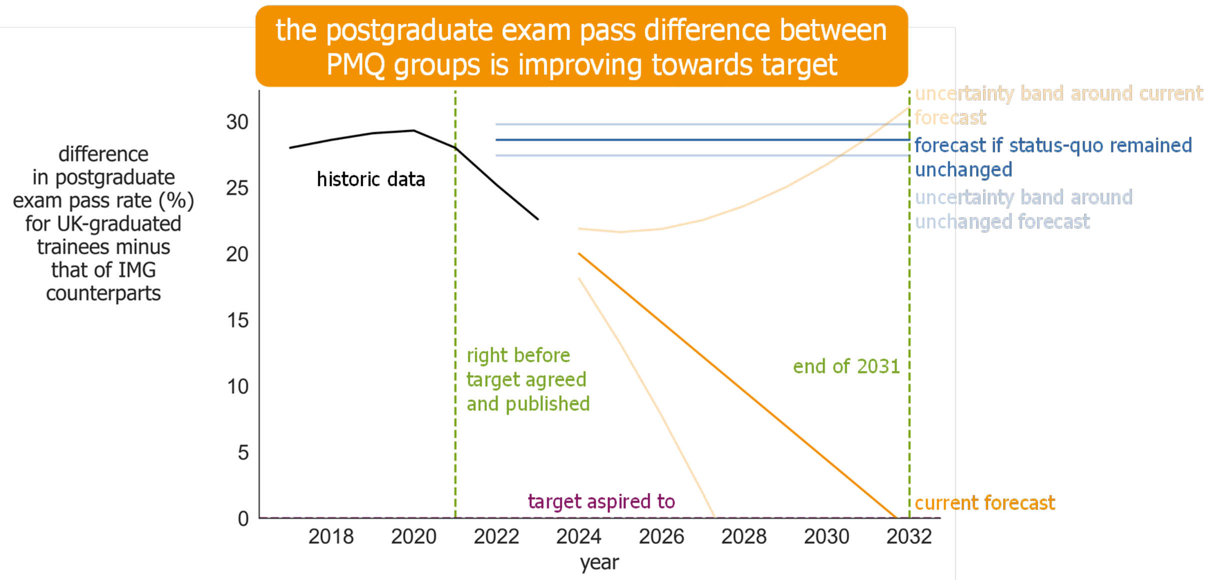
the postgraduate exam pass difference between PMQ groups is improving towards target
difference in postgraduate exam pass rate (%) for UK-graduated trainees minus that of IMG counterparts
historic data
uncertainty band around current forecast
forecast if status-quo remained unchanged
uncertainty band around unchanged forecast
right before target agreed and published
end of 2031
target aspired to
current forecast
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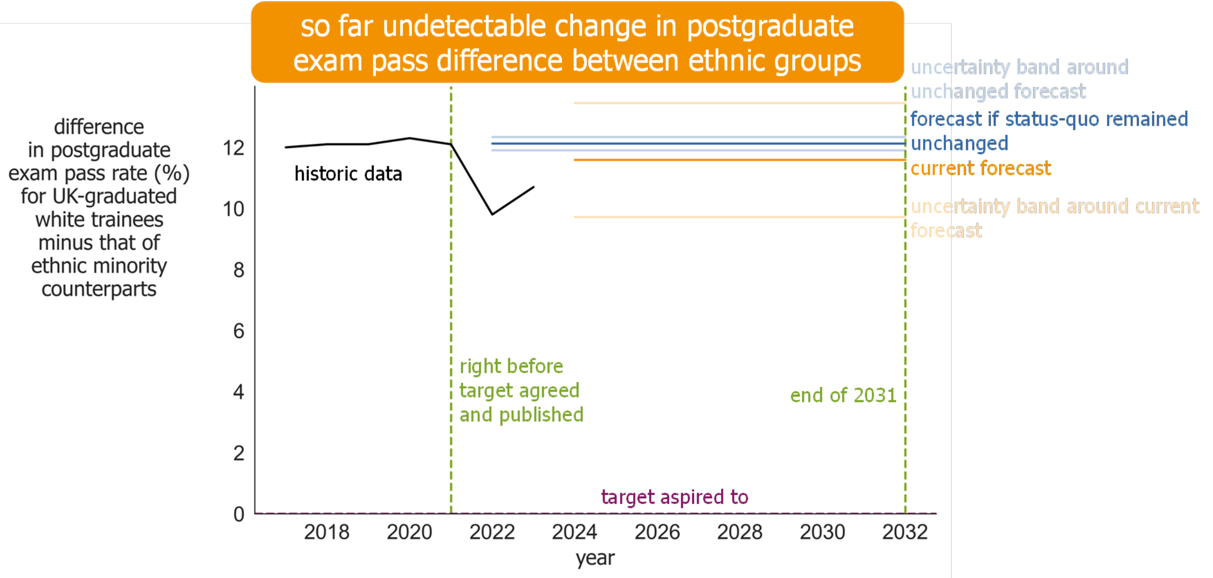
so far undetectable change in postgraduate exam pass difference between ethnic groups
difference in postgraduate exam pass rate (%) for UK-graduated white trainees minus that of ethnic minority counterparts
12
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historic data
right before target agreed and published
end of 2031
target aspired to
2018
2020
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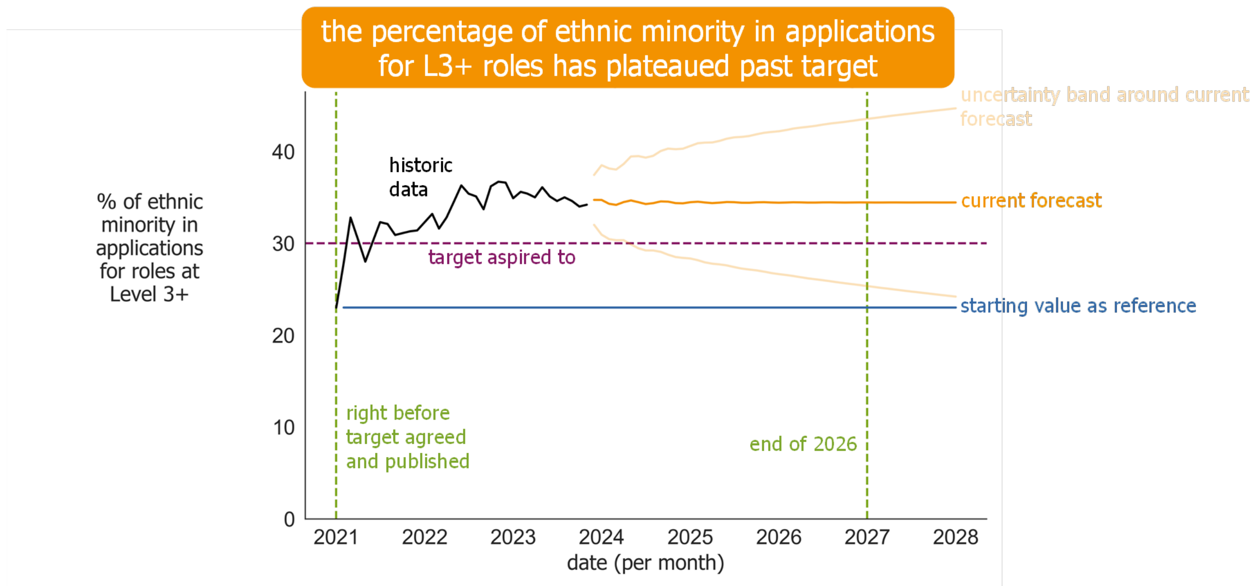
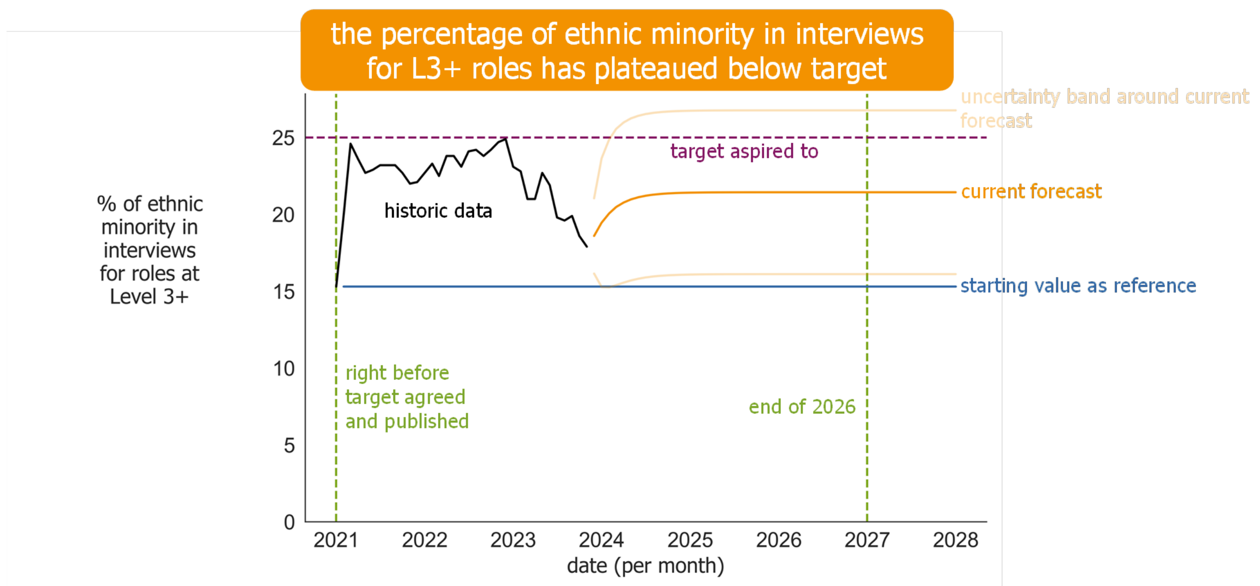
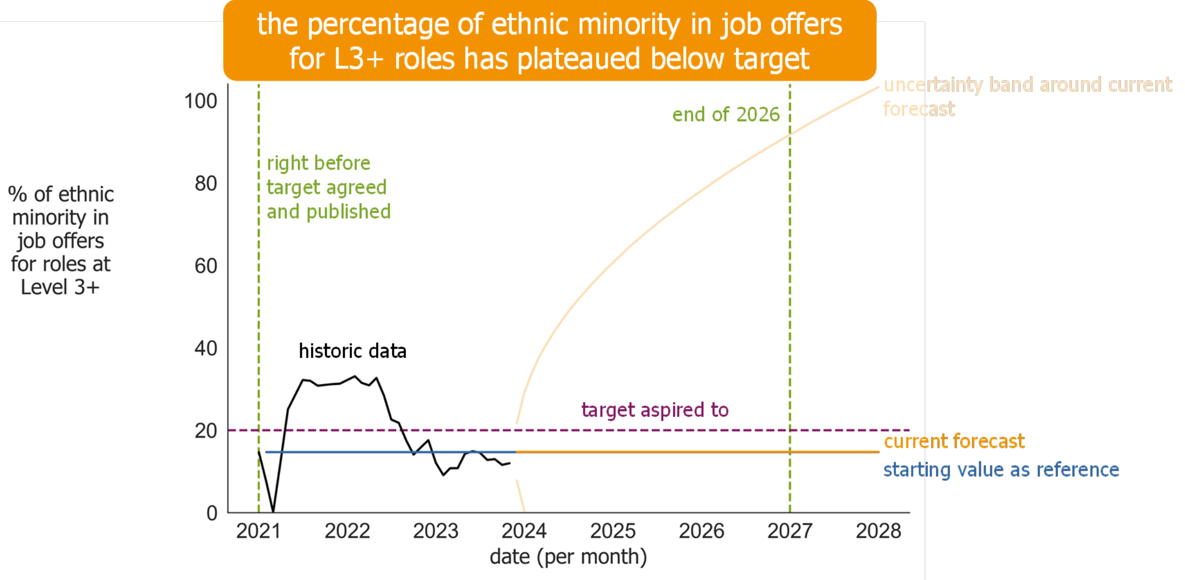
year
uncertainty band around unchanged forecast
forecast if status-quo remained unchanged
current forecast
uncertainty band around current forecast

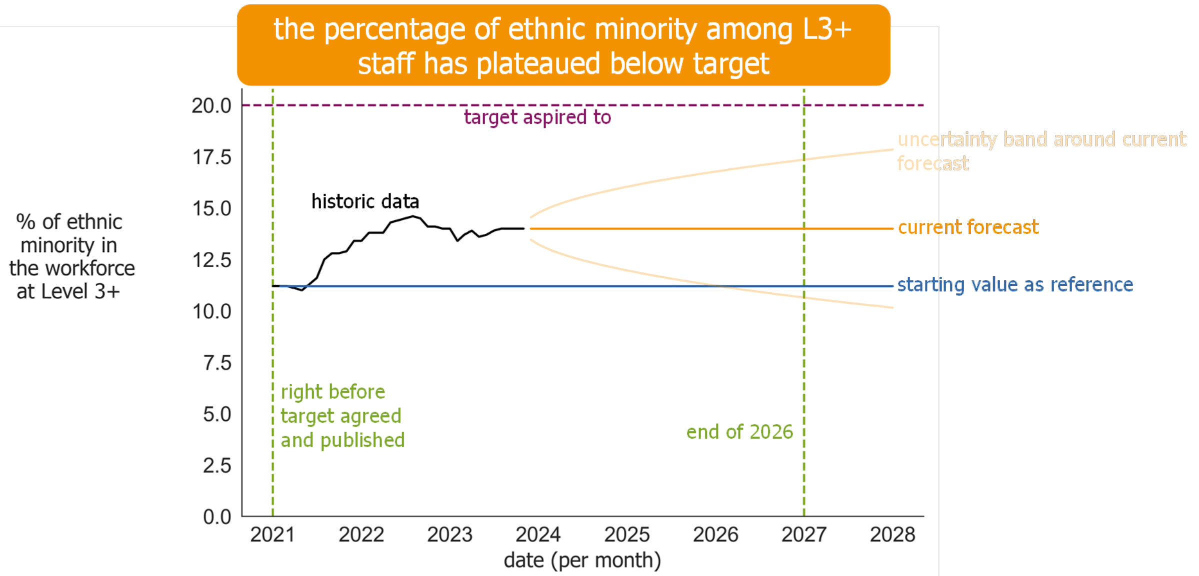
Inclusivity within the GMC forecasts



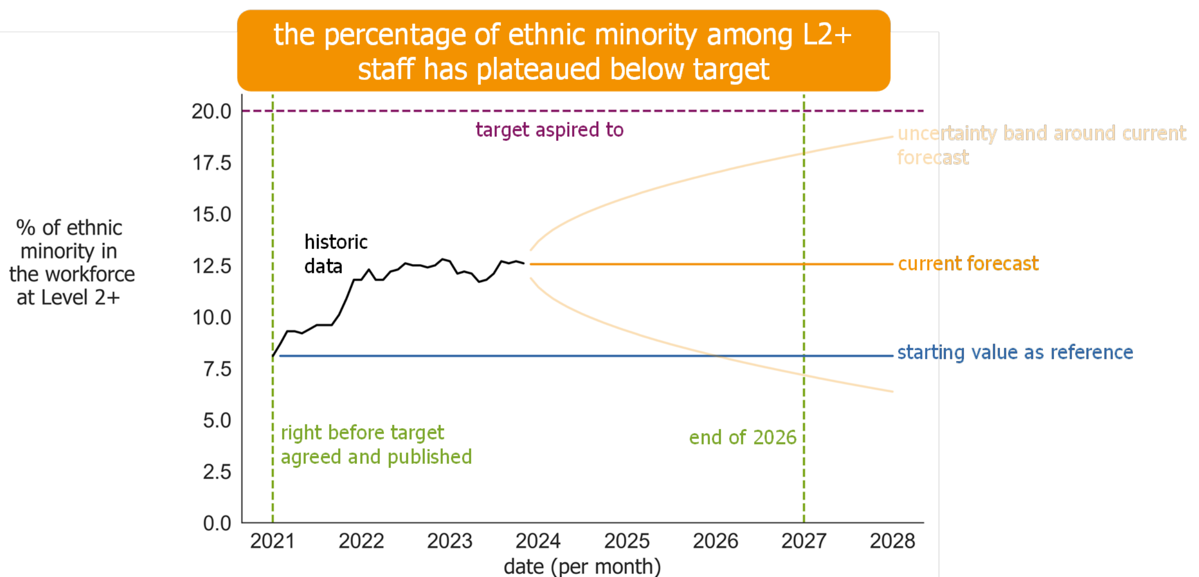




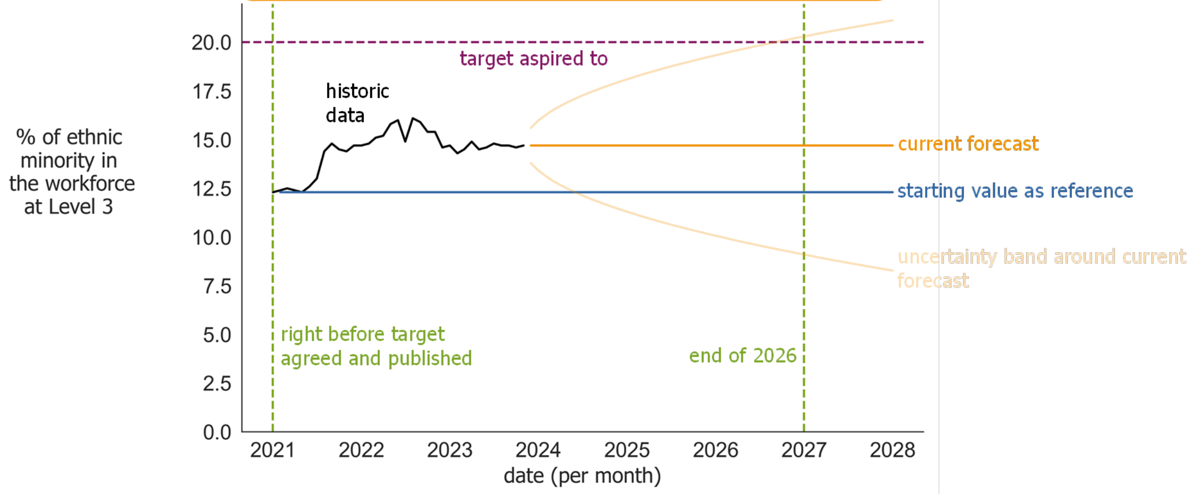
the percentage of ethnic minority in job offers for L3+ roles has plateaued below target
% of ethnic minority in job offers for roles at Level 3+
100
80
60
40
20
0
right before target agreed and published
end of 2026
historic data
target aspired to
uncertainty band around current forecast
current forecast
starting value as reference
2021
2022
2023
2024
2025
2026
2027
2028
date (per month)

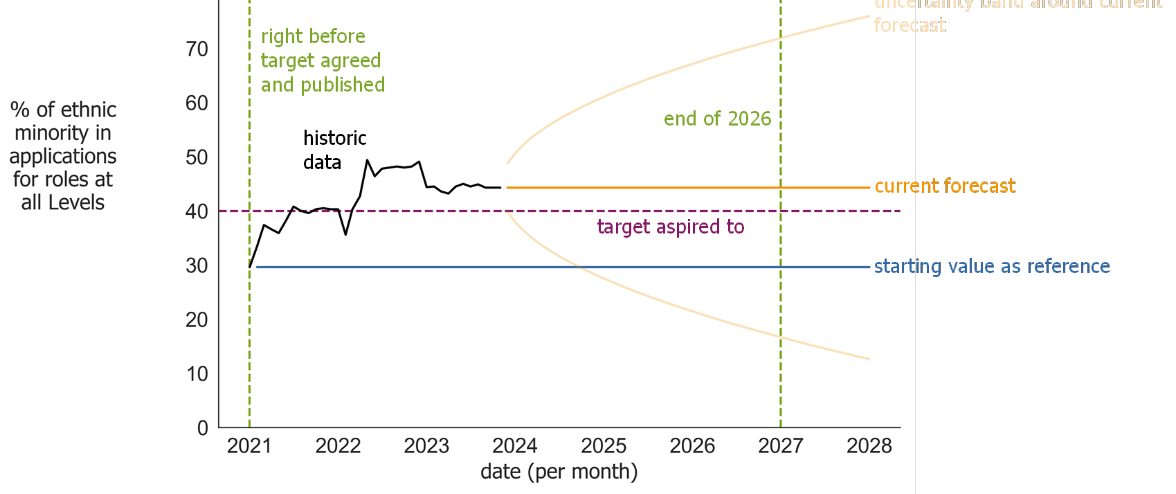


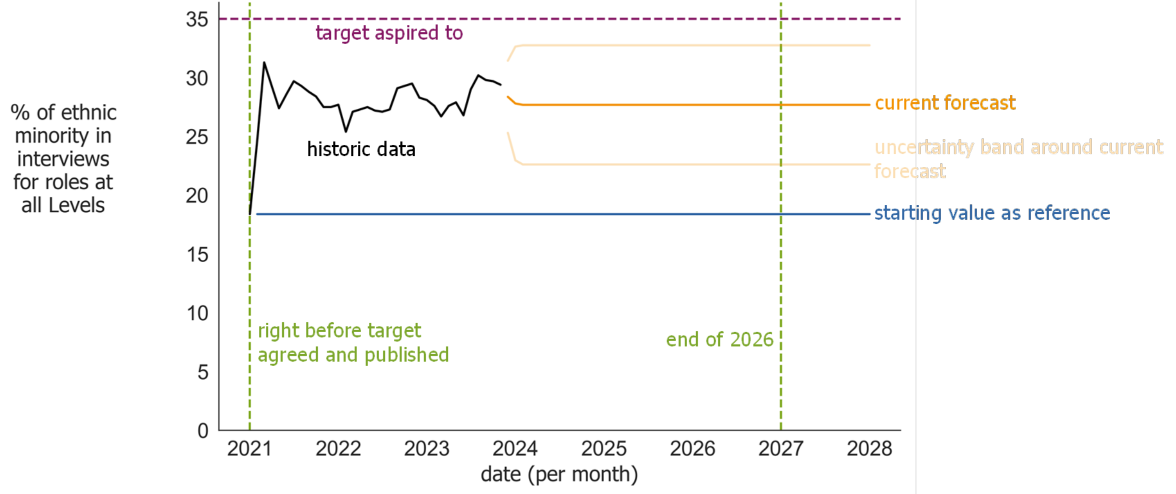
the percentage of ethnic minority among L3+ staff has plateaued below target
% of ethnic minority in the workforce at Level 3+
20.0
17.5
15.0
12.5
10.0
7.5
5.0
2.5
0.0
target aspired to
historic data
uncertainty band around current forecast
current forecast
starting value as reference
right before target agreed and published
end of 2026
2021
2022
2023
2024
2025
2026
2027
2028
date (per month)

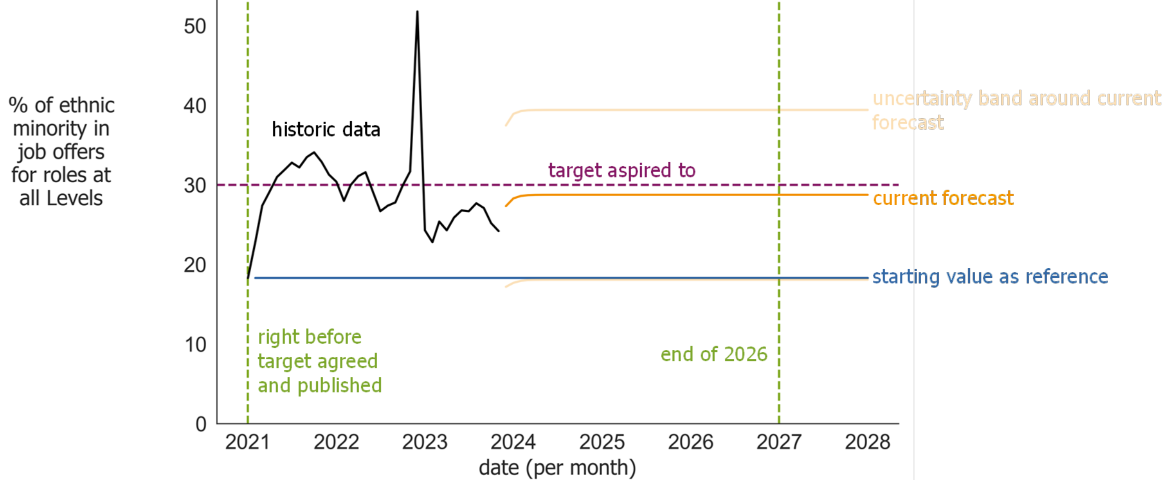


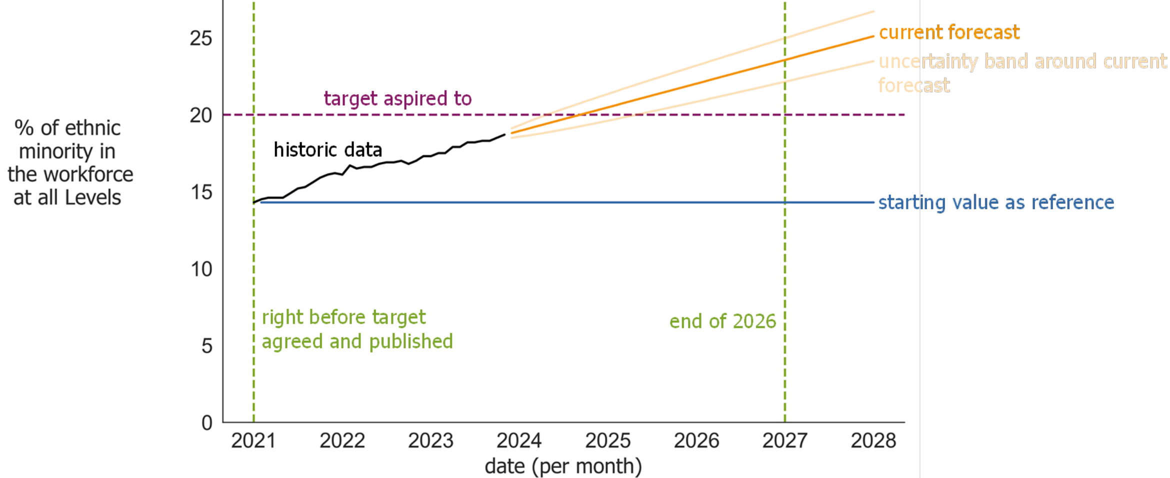
the percentage of ethnic minority among L2+ staff has plateaued below target
% of ethnic minority in the workforce at Level 2+
20.0
17.5
15.0
12.5
10.0
7.5
5.0
2.5
0.0
target aspired to
historic data
uncertainty band around current forecast
current forecast
starting value as reference
right before target agreed and published
end of 2026
2021
2022
2023
2024
2025
2026
2027
2028
date (per month)

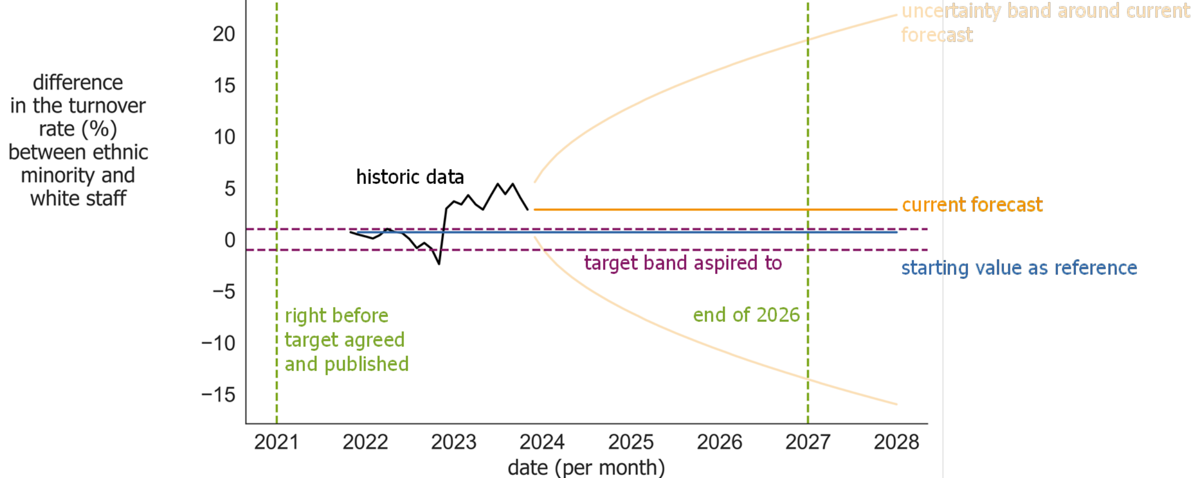

the percentage of ethnic minority among L3 staff has plateaued below target
% of ethnic minority in the workforce at Level 3
20.0
17.5
15.0
12.5
10.0
7.5
5.0
2.5
0.0
target aspired to
historic data
current forecast
starting value as reference
uncertainty band around current forecast
right before target agreed and published
end of 2026
2021
2022
2023
2024
2025
2026
2027
2028
date (per month)

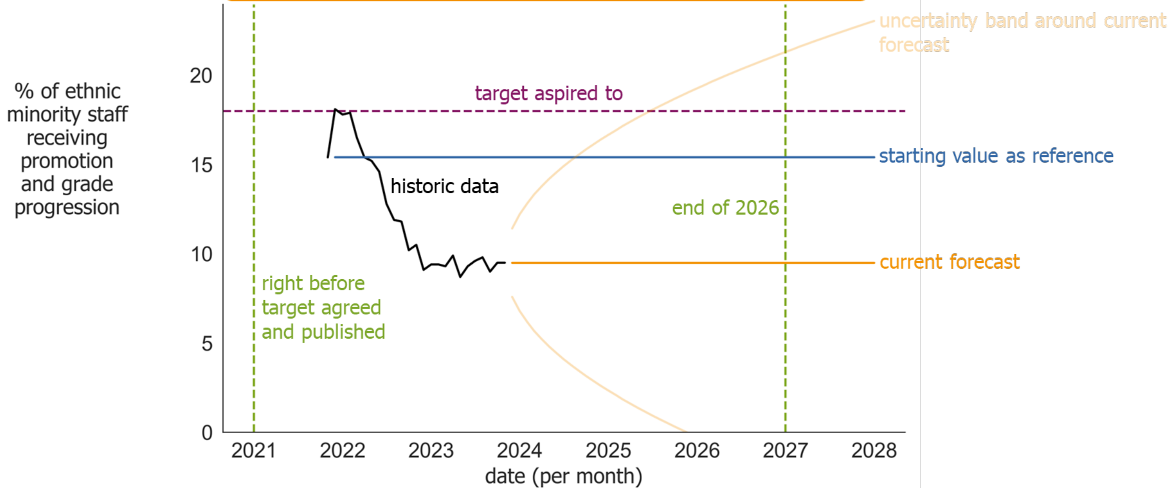

the percentage of ethnic minority in applications for roles at all levels has plateaued past target
% of ethnic minority in applications for roles at all Levels
70
60
50
40
30
20
10
0
uncertainty band around current forecast
right before target agreed and published
end of 2026
historic data
current forecast
target aspired to
starting value as reference
2021
2022
2023
2024
2025
2026
2027
2028
date (per month)

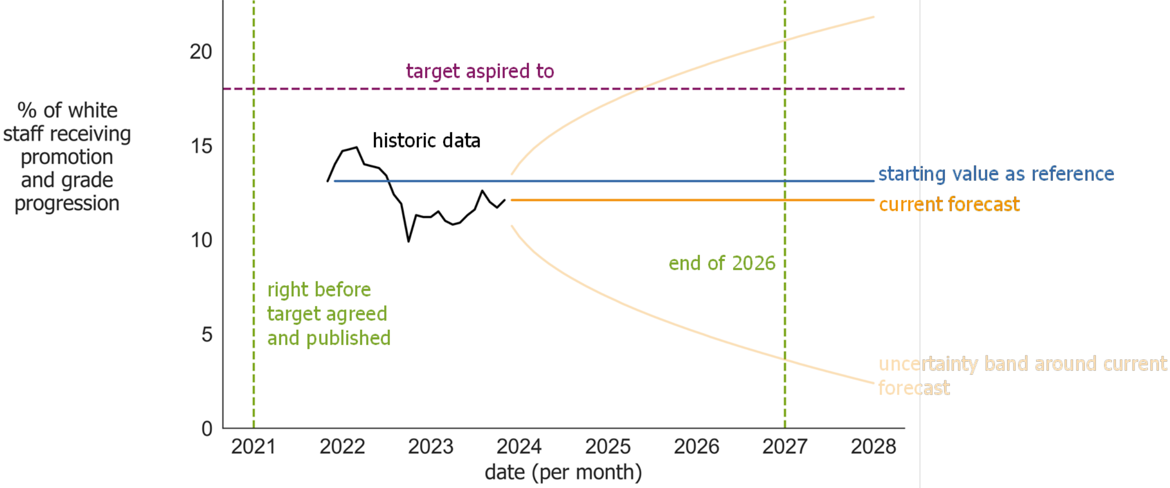

the percentage of ethnic minority in interviews for roles at all levels has plateaued below target
% of ethnic minority in interviews for roles at all Levels
35
30
25
20
15
10
5
0
target aspired to
current forecast
historic data
uncertainty band around current forecast
starting value as reference
right before target agreed and published
end of 2026
2021
2022
2023
2024
2025
2026
2027
2028
date (per month)

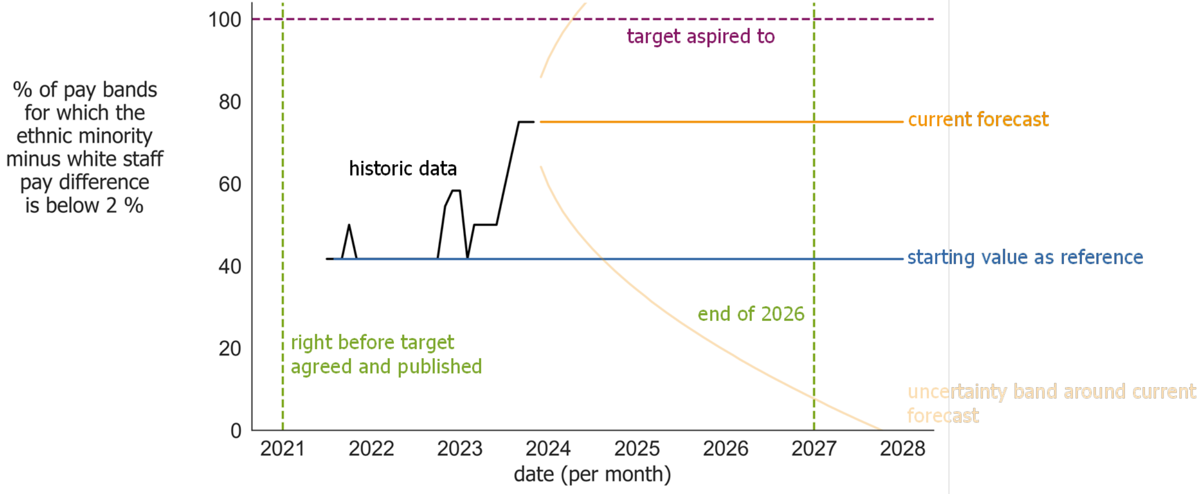

the percentage of ethnic minority in job offers for all roles is expected to plateau about target
% of ethnic minority in job offers for roles at all Levels
historic data
target aspired to
uncertainty band around current forecast
current forecast
starting value as reference
right before target agreed and published
end of 2026
date (per month)


the percentage of ethnic minority staff at all levels is increasing towards target
% of ethnic minority in the workforce at all Levels
current forecast
uncertainty band around current forecast
target aspired to
historic data
starting value as reference
right before target agreed and published
end of 2026
date (per month)


turnover rates plateauing for all and difference between ethnic groups plateauing off target
difference in the turnover rate (%) between ethnic minority and white staff
uncertainty band around current forecast
historic data
current forecast
target band aspired to
starting value as reference
right before target agreed and published
end of 2026
date (per month)


the percentage of ethnic minority promoted or grade-progressed has plateued below target
% of ethnic minority staff receiving promotion and grade progression
target aspired to
historic data
starting value as reference
end of 2026
current forecast
right before target agreed and published
uncertainty band around current forecast
date (per month)


the percentage of white ethnicity promoted or grade-progressed has plateaued below target
% of white staff receiving promotion and grade progression
target aspired to
historic data
starting value as reference
current forecast
end of 2026
right before target agreed and published
uncertainty band around current forecast
date (per month)


the percentage of pay bands with etnicity pay gap below 2 % has plateaued below target
% of pay bands for which the ethnic minority minus white staff pay difference is below 2 %
target aspired to
current forecast
historic data
starting value as reference
end of 2026
right before target agreed and published
uncertainty band around current forecast
date (per month)

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I ofyn am y cyhoeddiad hwn mewn fformat neu iaith arall, ffoniwch ni ar **0161 923 6602** neu e-bostiwch ni ar **gmc@gmc-uk.org**.

You are welcome to contact us in Welsh. We will respond in Welsh, without this causing additional delay.

Mae croeso i chi gysylltu â ni yn Gymraeg. Byddwn yn ymateb yn Gymraeg, heb i hyn achosi oedi ychwanegol.

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