General Medical Council

Scottish Government review of the operation of the Public Sector Equality Duty in Scotland - GMC Response

25 April 2022

1 We welcome the opportunity to respond to the Scottish Government's consultation on reviewing the operation of the Public Sector Equality Duty in Scotland.

2 Some of the areas in the consultation fall outside our regulatory remit or areas of expertise. We have therefore restricted our comments to a specific number of areas. Additionally, some of our responses do not lend themselves to the format used in the consultation questions. For these reasons, as well as for ease of reading, we are responding to the consultation in the form of a submission.

3 We recognise that many of the proposals (1-7) in the consultation relate to extending the Scottish Specific Duties ('SSDs') under the Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012. These duties apply to those Scottish public authorities listed in Part 3 of Schedule 19 of the Equality Act 2010 and the General Medical Council (GMC) is not listed in Part 3 of Schedule 19.

4 Our comments on the proposals are therefore framed on our own experience of complying with the public sector equality duty and also our perspective on how these changes may support addressing long standing inequalities within the health system.

5 Like many organisations, we have recently reflected on our own aspirations and approach to equality, diversity, and inclusion. We have always taken our role in tackling unfairness and inequalities seriously, but we recognise that disadvantage and discrimination continue to blight the medical profession and the health service as whole.

6 There is now a growing movement for change across the health system and dealing with the disadvantage that pervades medicine is one of the most pressing priorities across the NHS.

7 While there has been much good work to address inequalities, including our own efforts, the pace of improvement has not been proportionate to the scale of the challenge. All stakeholders in the health system have a part to play in making

meaningful progress on these issues. We need real reform across the whole system and we as the regulator have a particular role to play within that.

8 Overall, the reforms proposed to the PSED represent a key opportunity to strengthen the duties placed on public bodies and one that we support as a necessary lever to create the environment that generates an increase the pace and intensity of change.

The GMC's role and remit

9 The GMC is an independent regulator that helps to protect patients and improve medical education and practice across the UK.

- We decide which doctors are qualified to work here and we oversee UK medical education and training.
- We set the professional standards that doctors need to follow, and work to make sure that they continue to meet these standards throughout their careers.
- We take action to prevent a doctor from putting the safety of patients, or the public's confidence in doctors, at risk.

GMC Response

10 The evidence we share demonstrates our approach to robust compliance with the public sector equality duty and indeed significantly beyond achieving simple compliance. We are committed to fostering a culture of equality, diversity, and inclusion (ED&I) in everything we do as a regulator and employer - ED&I are critical to being an effective regulator and employer. Inclusive working, education and training environments are also crucial to doctors' wellbeing and to safe patient care.

11 Our ED&I objectives are embedded in our Corporate Strategy and demonstrate the importance of the collaborative relationships needed with other public sector organisations to enable greater equality outcomes to be achieved.

12 We have strengthened the level of governance and accountability in place for our ED&I agenda and have set targets to eliminate disproportionate complaints from employers about ethnic minority doctors, by 2026, and to eradicate disadvantage and discrimination in medical education and training by 2031. We have also committed to increase diversity, and progression for ethnic minority staff, across all levels including leadership roles.

13 We have committed to publishing details of progress against the targets annually and we believe that setting these targets has been an important way to achieve a sustained focus on these issues and to ensure other organisations to do the same. Annual updates of progress continue to shine a light on the extent to which inequalities

are being addressed and we believe measures are a vital way to demonstrate equality outcomes.

14 The bodies we work with are listed authorities in Part 3 of Schedule 19 of the Equality Act 2010, and we have considered the proposals in the consultation in the context of our collaborative relationships and shared where our own approach and practices are relevant to the changes that the Scottish Government are proposing. Our equality aims include:

- Working with others to embed inclusive leadership and tackling the issue of unfair referrals and bullying and discriminatory behaviours
- Developing ethical standards that reflect diverse needs
- Tackling discrimination and inequality in medicine to help retain doctors working in the UK and to support high quality patient care
- Setting targets to help us all keep focused on creating long-lasting changes
- Ensuring flexible, inclusive, and accessible pathways for education and training which equip the workforce with skills to care for diverse patients / communities, and address healthcare inequalities,
- Addressing differential attainment and reflect diversity in curricula, teaching and learning

Proposal 2: Embedding Inclusive Communications

15 The GMC believes that inclusive communications are key to effective, relevant, and compassionate regulation. We already apply best practice in this area and are supportive of the proposals, particularly if it is conceived and applied with proportionality in mind.

16 We recognise and are supportive of publication and transparency being the minimum foundation for public authorities. The provision of improved guidance and national standards, alongside sharing best practice should provide public authorities with important tools to embed a more inclusive approach to communications.

17 We have sought to make improvements in the inclusivity of our communications within our own organisation and examples of our work include:

- Implementing technical and content-related best practice to make sure our website communications comply with the World Wide Web Consortium's Web Content Accessibility Guidelines 2.0 standards – including providing captions and transcripts for audio/video content – and periodically running accessibility checks to make sure we continue to comply with those standards

- Making sure that outward-facing content is in line with our "tone of voice" and "writing" guidance, both of which are based on user-centred content principles, putting the user at the centre, and aiming to develop communications in accessible language that is easy to understand. As part of this, we also implement specific readability checks on content, aiming to for a reading age between 9 and 12 years old, which serves users for whom English is not the first language.

- Providing "Easy read" versions of key documents aimed at patients and the public, as well as documents and reports in alternative formats upon request.

- Offering a range of pathways through which our customers can obtain information from us – for example, in addition to our website, doctors, patients and the public can contact us via telephone, email, letter and webchat.

- Providing dedicated support via specialist staff/teams for patients who raise a concern with us, through our dedicated Patient Liaison Service.

Proposal 3: Extending pay gap reporting to include ethnicity and disability

18 We support the principle of transparency on pay gaps and comply with gender pay gap reporting requirements as an employer and we will expand our published data on pay this year. We view this as one of a number of important measures and indicators of equality and fairness.

19 We also support the need for broad measurement and accountability for equalities and have implemented ED&I aspirations and measures as a regulator and as an employer. We have also encouraged organisations that employ, educate and train doctors to embrace the need for data, measures, and accountability.

20 Although the issue of doctors pay is not within our remit, we are clear that working and training environments that are inclusive and fair are environments that are beneficial to providing safe care. Part of fairness at work does include fairness in reward, recognition, and progression. We are therefore in principle supportive of extending the reporting and publication requirements to ethnicity and disability for organisations that educate, train, or employ doctors.

21 The consultation alludes to the implementation of a consistent and clear formular for calculating pay gaps but does not indicate what the preferred method would be. In considering the methods, we would offer some reflections from our own experiences reporting equality data and pay gaps:

- Consider where the calculations can be sensitive to certain events/changes in behaviour that e.g., uptake of unpaid leave

- Ensure that the terminology used helps to address some of the current complexity with characteristics and concerns about conflating sex and gender

- Consider whether you can break down the analysis of gaps into greater detail for each group (e.g., disaggregated ethnic groups)

Proposal 4: Assessing and reviewing policies and practices

22 The key issues on reviewing policies and practices identified in the consultation document are issues that we recognise and also experience. Over recent years we have been making incremental improvements to our processes and we have shared below some of the changes made that have sought to address these challenges.

23 The GMC has embedded equality impact considerations into its business planning process and assessing the equality impact from the inception of a policy, programme or change is a mandatory requirement. We have developed a new equality screening assessment that is used to structure considerations at the first gateway of our business planning process and a full equality impact assessment is developed on a dynamic basis as the policy, programme or change evolves.

24 This process is co-ordinated and tracked by the business planning team and our ED&I function and reported to our internal ED&I steering group. This process is already in line with the proposed change in duties. Both our equality screening assessment and our equality impact assessment require evidence on how a function proposes to (at screening assessment) and did consult proportionately, including the outcome of consultation activity (at full impact assessment stage) on any changes. The proposed duty to ensure that covers engaging with people who have lived experience, or organisations that represent them, is a duty that we achieve already with our current approach.

25 The GMC is currently planning a review of our guidance including our standards and outcomes. We are developing an approach to help us identify and decide on priority, sequencing and the level of engagement required for each review. Our approach will take account the big changes we are making as a regulator including the introduction of medical associate professionals (MAPs) into regulation and the Medical Licensing Assessment (MLA), our regulatory reform agenda, and updating *Good medical practice*.

26 ED&I considerations are a huge part of this work and will be integral to our decision-making. These considerations will help inform our choices of implementation activity, making sure it contributes to our corporate ED&I targets, including tackling differential attainment, inequality in the workforce, eradicating unfairness, and discrimination in the medical workforce. Below there is a case study of how we have ensured that ED&I are considered throughout the review of our core guidance, *Good medical practice*.

27 The proposals overall seem to be a balanced and reasonable set of recommendations to address the challenges identified.

28 In terms of potential improvements to the proposals, the Scottish government may wish to consider being clearer on the duty to undertake assessments, 'as early as possible', to recommending that this happens (other than in exceptional circumstances) from the inception of a policy development process. The consultation does not suggest how this could be achieved and it may help to provide tools and guidance to help public authorities in embedding this expectation.

29 Similarly, in relation to the duty to involve people with lived experience, it may be beneficial to provide tools and guidance to help public authorities in embedding this expectation – including how to do this in a proportionate and efficient way.

Equality Impact Assessment Case Study - Ethical standards and *Good medical practice*

We have a statutory responsibility to set the standards for doctors. In the future, this will also extend to MAPs. Doctors and MAPs will be collectively known as 'medical professionals'. These standards define what makes a good medical professional by setting out the professional values, knowledge, skills, and behaviours required of all medical professionals working in the UK.

When developing our standards, we aim to engage and consult with a wide range of people, including patients, doctors, employers, and educators. An example of this is our current work to update *Good medical practice*, our core guidance on the professional standards expected of the profession.

For all guidance development projects, we start by building an evidence base to understand the issues which we need to reflect in updated or new guidance. The equality impact assessment process is a key part of this as it helps us understand and mitigate any negative or differential impacts on those with protected characteristics.

At each stage of the development process (intelligence gathering, early engagement, public consultation, and launch/implementation), we use our learning from the analysis to inform the design of our engagement and consultation exercises to make sure we include those who might be affected and develop suitable ways to get their input.

As *Good medical practice* applies to all medical professionals and all patients, we have used the equality impact assessment process to help us identify priority groups for consultation and engagement. This aimed to identify in which ways setting and implementing professional standards may have adverse impacts on diverse groups of registrants or patients. An Advisory Forum was set to inform this work.

- For medical professionals this includes female, and ethnic minority professionals, International Medical Graduates and medical professionals

who are disabled or have long-term health conditions as some of the groups where we will focus our engagement activities.

- From a patient perspective, we have identified older people (75+) (including in residential care), people living with a disability/health conditions and people with communication needs (sign language, interpreters, learning disability, low level of literacy) as some of our priority groups.

The equality impact assessment also helped us to design the supplementary activity we plan to run with these groups to support the written consultation on the updated guidance. These more deliberative activities will enable us to gather insight and experience in a structured way.

- **Patient panel:** run by an external agency this project will gather views on the issues raised, for a six-month period starting at consultation launch. The panel will be made up from demographically diverse patients with lived experience of healthcare. Item M6 of our February Council paper provides more information about how ED&I is being addressed as an integral part of this work

- **Independently facilitated workshops:** We are also commissioning independently facilitated workshops with priority groups of patients.

- **Targeted outreach:** deliberative sessions across the UK, run by our Outreach Service with registrant groups we have identified as priority groups, on the issues in the guidance that are most relevant to them but with an opportunity to respond to the short survey too.

- **Online promotion:** to promote the consultation to those who might not normally engage with us and/or on these issues, using our social media channels/website and encourage them to share their views in a light touch way such as online polls, blogs, and community specific discussions.

As well as informing the updated guidance, we also use equality impact assessments to help us develop our plans for engaging and consulting on new professional standards in ways that positively promote equal opportunities, improve access, participation in public life and good relations.

Proposal 5: A new equality outcome setting process

30 We are supportive of the need to clearly state equality aspirations and measure progress and outcomes achieved.

31 As previously stated, last year, we launched new targets to address differentials in referrals to us from organisations that employ doctors and also differentials in medical

education and training. These targets are long term aspirations in areas where we know there have been long standing inequalities for the medical profession. In setting these aspirations, we are expecting other public authorities who are directly responsible for addressing the issues to commit to working towards these outcomes.

32 We have recently published an annual update of the progress we have made and the outcomes achieved.

33 Whilst we are supportive of the need to set outcomes, we would suggest that the Scottish Government might wish to consider if setting outcomes at national level is too restrictive. We wondered whether this could risk organisations focussing entirely on those driven at national level and failing to address some of the specific nuanced issues that either only exist locally or simply are not seen as a national priority outcome. Perhaps, a duty to set outcomes locally for every public authority be more effective.

34 We would also suggest, based on our own experience, that strengthened governance and accountability is a vital measure to sit alongside the implementation of outcomes.

Proposal 7: Procurement

35 We recognise the issues and opportunities documented in the consultation in relation to the current procurement duties. The acknowledgement of the need for proportionality is valid. We are in the process of developing some guidance and an evaluation scoring matrix to aid our contract managers who are considering bids to make more robust, but also fair and proportionate assessment of the equality information provided during a procurement exercise. We would be happy to share this with Scottish Government should it be helpful.

Proposal 8: Intersectional and disaggregated data analysis

36 In principle, we are in support of this proposal. As a regulator, having diversity information about those whom we regulate and support is vital. Collecting this information, along with other data, provides us with a fuller picture to help identify any issues, and to address them, by giving us an understanding of where our registrants might face inequalities or discrimination. We have used diversity information to analyse and report on statistical trends in medical education and practice in the UK and to drive improvements to address inequalities.

37 Our experience of working with other public bodies would suggest that capturing protected characteristics is not the core challenge – rather this lies with the quality of data held or with the ability to analyse the data to assess impacts.

38 We are continually taking steps to improve the quality of diversity information that we hold. In 2019 we delivered a specific campaign to encourage doctors to provide us with diversity data across the six protected characteristics that we currently collect –

age, gender, ethnicity, religion or belief, disability, and sexual orientation. We began collecting data on sexual orientation, religion or belief and disability from new registrants in 2016 and our aim was to drive up fill rates particularly in these areas across the full registrant base. This exercise did achieve improvements in data quality for our registrants, but we also found some were reluctant to declare their characteristics.

39 Equally, collecting diversity data as an employer is essential in order to enable us to understand issues faced by diverse groups of staff across our employment activities. Collecting this information has resulted in the development of bespoke interventions to support staff such as development programmes for different cohorts of BME staff as well as employment targets.

40 This year we are embarking on a project to improve the way we collect and use diversity data. This is a multi-phase programme of work – the first phase will deliver an ED&I data framework and strategy, including research and evidence gathering to inform approach in policy and guidance.

41 We will then identify how we can improve collection including formalising 'informal' data collection touchpoints, as well as how and whether we can collect more diversity data from the patients who raise concerns with us to help us build our understanding of any barriers that they may face in engaging with our fitness to practise activities. As part of this work, we will be looking at how we analyse and report intersectionality. We already do this to a certain extent through, for example, our State of Medical Education and Practice reports and our National Training Survey. However, we want to further strengthen intersectional data analysis to examine the multi-dimensionality of diversity, identity and its impacts to foster and drive business improvements.

42 In relation to how listed authorities could be supported to meet this requirement, guidance might be needed to help organisations understand how they might build an intersectional model as different elements will rely on variables and data that measures the context and background.

43 Some of the barriers to organisations adopting an intersectional approach is that they might not have the data analytics or expertise to know how to develop and use such a model, as well as potential gaps in their equality evidence base. The GMC is fortunate enough to have specialist data and insight experts who are able to support with the statistical models as we further develop and build our approach to intersectionality. We regularly commission research and as part of our data improvement work we will consider how intersectionality could be strengthened within research activities.

44 Therefore, if there was a requirement to gather and use international data, we would be in a position to proactively take steps to comply with this requirement and work towards building robust data analytics and models over time to ensure an effective approach to intersectionality. We would of course welcome any guidance and

information to enable us to develop the most effective models and sophisticated approaches to intersectional data analysis.

Proposal 10: Coverage

45 We have reviewed the current list of authorities who are covered by the SSD and considered whether this list appropriately covers all authorities involved in the delivery of healthcare services or the education and training of medical professionals. We do not believe there is a need to expand this list, this represents the organisations that we engage and work with on equalities concerns impacting on the medical profession.

46 The consultation has sought views on whether regulators should be encouraged to do more to improve their public sector equality duty performance within their sector. We recognise that we have an important role to play, and our recent ED&I annual report provides evidence of how we are achieving this.

47 The report details how we have aspired to create sustained focus across the health system on these critical areas. If we are successful in achieving these targets, we will fundamentally improve the quality of education, training, and practice environments – and ultimately, the quality of care for patients.

48 Our report reflects on progress so far to meet these targets, as well as future actions for us and our partners to create sustained improvements. It will play a regular part in how we hold ourselves and others to account for progress and we hope it will be an ongoing catalyst for engagement and collaboration across the health service.

Conclusion

49 As a professional regulator, we are well placed to shine a light on the inequalities and challenges that exist across the health system, and we aim to use our own powers and other indirect levers to influence change. The existing duties may represent the foundation of our ED&I approach, but our aspirations and commitments are beyond this.

50 We, and many other organisations across the health system, have plans to address inequalities that impact those who access healthcare services and those who work in the health sector. But this is not seen consistently across the system and achieving real outcomes in addressing entrenched inequalities and driving out routine and systemic discrimination can often be lacking.

51 The proposals to strengthen the duties for public bodies we believe will be a catalyst for more concerted and consistent action that brings improved and sustained outcomes for the health system and the wider public sector.