To consider

**Collecting additional diversity data on registrants**

**Issue**

1. We would like to extend our collection of diversity data on registrants to include additional protected characteristics.

**Recommendation**

2. The Strategy and Policy Board is asked to agree:

   a. In principle that we should begin to move towards collecting data on registrants for the protected characteristics of disability, sexual orientation, and religion or belief.

   b. That the Performance and Resources Board should oversee the further detailed work that will be required, including consideration of implementation and communication plans.
Collecting additional diversity data on registrants

Issue

3 The Equality Act (2010) identifies nine groups of people who share protected characteristics that are covered by the legislation: age, disability, sex, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, and sexual orientation.

4 We currently collect diversity data on registrants during two activities: at the point of registration and during the National Training Survey (NTS).

a During registration we collect information on three protected characteristics: a doctor’s sex, age, and race (which includes ethnicity, place of primary medical qualification and national origin).

b The NTS collects data on whether respondents share the protected characteristic of disability (in addition to age, gender and ethnicity).

5 In July 2008 Council agreed that we should collect disability data on registrants, and that we should review our position on collecting data on sexual orientation and religion and belief on an annual basis. A plan for collecting disability data was developed and was put on hold pending the coming into force of the Equality Act. The Developing the Registers project and the collection of scope of practice data for revalidation were on the horizon, and it was felt that this might provide a robust and cost-effective route for collecting this data.

6 The proposal is to extend our collection of diversity data from registrants to include the protected characteristics of disability, sexual orientation and religion/belief. These characteristics are relevant to our work as a regulator, for example, the relationship between personal beliefs and medical practice is increasingly important, and the provision of reasonable adjustments for practical clinical procedures specified in our standards for medical education and training is relevant to a proportion of medical students and trainees. Having access to this data will bring us closer to, and so give us a better understanding of, the profession that we regulate in relation to issues that are directly relevant to medical practice. By contrast, collecting data on other matters, such as whether doctors on the register are married or in a civil partnership, or have children, are personal and would not have a clear purpose or be proportionate. (Gender reassignment can be ascertained from the number of doctors that change their gender on the register.)

Principles for collecting E&D data

7 A cross-directorate group of staff has been meeting to standardise how we collect diversity data across the GMC. The principles for this work are to ensure that we are consistent and proportionate in how we collect and analyse this type of data.
Statutory requirements

8 The equality regulator has produced guidance on the collection and use of diversity data:

‘What the general equality duty requires is information. Although there is no explicit legal requirement to collect and use equality information across the protected characteristics, in order to have due regard to the aims of the general equality duty, public authorities must understand the impact of their policies and practices on people with protected characteristics. Collecting and analysing equality information (including from engagement, where relevant) is an important way for public authorities to develop this understanding.’*

9 We have taken legal advice on a number of issues related to the collection and sharing of diversity data. Counsel’s opinion is that whilst the equality duty does not impose a specific obligation on us to collect particular kinds of equality information, the collection and analysis of this kind of information can be ‘of great assistance’ in demonstrating compliance with the duty. Counsel also suggested that a strategy should be developed to fill any gaps where these are identified (having given consideration to whether information collected is relevant and will be used).

10 The GMC is also designated as a ‘qualifications body’ under section 53 of the Equality Act. Counsel’s advice is that we should follow the equality regulator’s guidance to collect data on the disability of ‘people that are applying for or a qualification or people that hold a qualification’. In the wake of the BAPIO judicial review, the medical Royal Colleges are moving towards expanding the categories of equality and diversity data that they collect on candidates and examiners.

How we would use the data

11 Our Equality and Diversity Strategy 2014-17 explains our vision of being a fair regulator. This includes a commitment to improving our evidence base and understanding of the impact of our work on doctors from the protected groups.

12 We propose to transition to collecting this data over a number of years, rather than undertaking a standalone exercise as we did with the ethnicity ‘census’ in 2007. This will mean that we are likely to have relatively small datasets for each characteristic during the first phase, and that it will take several years to develop a significant amount of data for each group on the register. Doctors would be under no obligation to provide this data to us: it will be a purely voluntary matter. This underlines the need for us to communicate effectively why need the data, what we will do with it and how we will safeguard it (so that, for example, any such data an individual doctor

* Equality information and the equality duty: a guide for public authorities; EHRC; December 2011
had provided would not be visible to anyone dealing with a complaint about that doctor.

13 There are potential benefits which could be realised over time by collecting the data:

a Making us a better regulator by helping us to understand the diversity of the profession that we regulator.

b Enhancing our reputation as a fair regulator by sending a signal about our commitment to understanding whether there are any barriers or unintended consequences for any group of doctors arising from our regulatory activities.

c Improving our understanding of how our work may affect particular cohorts of doctors, for example, by providing some baseline information for other work to identify whether there are differentials in outcomes arising from the delivery of our statutory functions.

d Extending the collection of diversity data to include disability, sexual orientation and religion/belief will help us over time to understand if these characteristics influence a doctor’s practice. In the same way that collecting the ethnicity data has enabled us to understand some of the ‘risk factors’ for a black and minority ethnic (BME) doctor or international medical graduate (IMG) of being involved in our fitness to practise procedures, and provided an evidence base for further work on the differentials in attainment in medical education and training.

e Supporting our compliance with the equality duty by demonstrating that we are taking steps to consider the aims of the duty in relation to all of the protected characteristics that are relevant to our work as a regulator.

f Aligning our approach with good practice. For example, the Nursing and Midwifery Council collects data on all of the protected characteristics. The General Optical Council will mirror this approach as a result of its recent consultation.

14 NHS Trusts collect data across these six characteristics for their workforce, in line with their duties under the Health and Social Care Act 2012.

Consultation and engagement

15 In 2008 we undertook a survey of some of the organisations with an interest in this area, and an overview of respondents is at paragraph 21. There is support for us collecting more data from a number of organisations including the BMA, GLADD, Stonewall and others. The BMA has indicated that it is happy to publicly endorse this approach and to promote it to its members.
Health and disability

16 Doctors make a declaration about their fitness to practise in relation to health when applying for registration. Our guidance says that if a doctor shows that they are managing their health, there should be no impact on their application for a licence. Some health conditions will be classified as disabilities under equality legislation.*

17 Doctors also provide us with information on their ethnicity and other personal data as part of the application process. Data on an individual’s physical and mental health, sexual orientation and religion or belief are classified as sensitive data under the Data Protection Act (1998). We would need to ensure that there isn’t a link between the health declaration and a doctor telling us that they have a disability, and to communicate that this is the case effectively.

Next steps

18 This is work in progress, subject to agreement of the high level principle that we should collect this data. Moving towards implementation will involve developing a phased approach spread over a number of years, including the steps outlined below.

a Further discussion with the Registration and Revalidation and Fitness to Practise directorates about the impacts of collecting this data.

b Considering dependencies between this work and other programmes of work such as the Data Strategy and the review of data held on the List of Registered Medical Practitioners (LRMP).

c Analysis of the implications and timing of the necessary changes to Siebel, GMC Online, and other operational requirements.

d Colleagues in the Strategy and Communication directorate developing a communications plan to support the implementation of the changes, which will explain why and how we will use this data.

* A person has a disability for the purposes of the Equality Act 2010 if he or she has a physical and mental impairment which has a substantial and long term adverse impact on their ability to carry out normal day to day activities.
Supporting information

How this issue relates to the corporate strategy and business plan

19 Strategic aim 1: Make the best use of intelligence about doctors and the healthcare environment to ensure good standards and identify risks to patients and/or planning (in the business plan).

How the issues support the principles of better regulation

20 Moving towards collecting data on the three protected characteristics suggested in this paper supports regulation that is proportionate, transparent and targeted. It is part of our work to ensure that we treat doctors fairly. It will also make our diversity data collection consistent with other organisations in the healthcare environment.

What engagement approach has been used to inform the work (and what further communication and engagement is needed)

21 In 2008 we asked a number of organisations whether collecting additional E&D data would help us to meet our legal obligations at the time. The survey included the Department of Health (England) and NHS Employers, the BMA, medical defence organisations, networks of disabled doctors, Stonewall, the Guild of Catholic Doctors, the Christian Medical Fellowship, and other professional regulators.

22 This proposal is based on our engagement with our interest groups with protected characteristics since then, including GLADD, Stonewall, and the BMA’s E&D Committee. We would need to develop a communications plan to explain why we are collecting this information and how it will be used, and to continue our engagement with those interest groups affected by these proposals.

What equality and diversity considerations relate to this issue?

23 The E&D considerations that relate to the collection of data on additional protected characteristics are outlined throughout the paper and include the following issues.

a Whether collecting this data is proportionate and fair, and/or disadvantages any cohort of doctor.

b How we will use the data, how it will be stored and who will have access to it.

c Whether collecting the data assists us in complying with our legal obligations, and supports our commitment to be a fair regulator.

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