



Approving changes to curricula, examinations and assessments: equality and diversity requirements

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Acknowledgements

This guidance was developed in conjunction with members of the Royal Colleges/Faculties from various backgrounds to ensure that we considered the equality and diversity issues across all aspects of curricula, examinations and assessments.

The members of the group that contributed to the development of this guidance are as follows:

Bill Allum, Clinician –Intercollegiate Surgical Curriculum Programme Surgical Director and Chair, Joint Committee on Surgical Training

David Bailey, Clinician – Director of Training and Assessment, Royal College of Pathologists

Pauline Foreman, Clinician – Chief Examiner, Royal College of General Practitioners

Tim Graham, Clinician – Chair, Joint Committee on Intercollegiate Examinations

Chris Mirner, Quality and Curriculum Manager, Royal College of General Practitioners

Fauzan Palekar, Director of Professional Standards, Royal College of Psychiatrists

Ruth Palmer, Executive Director, Postgraduate Training and Standards, Royal College of General Practitioners

Kim Scrivener, Director of Education Policy and Quality Curriculum, Royal College of Obstetricians and Gynaecologists

GMC staff

Tara Willmott, Head of Approvals

Aishnine Benjamin, Equality and Diversity Manager

Andrea Callender, Head of Diversity

Natalie Fine, Policy Analyst, Education

Raman Patria, Project Officer, Education

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Introduction

The General Medical Council (GMC) sets the educational standards for all UK doctors through undergraduate and postgraduate education and training.

We promote high standards and make sure that medical education and training reflects the needs of patients, medical students and doctors in training, and the healthcare systems across the UK. We also approve postgraduate medical education and training – this includes approving training posts, programmes and assessments.

We are committed to fair and non-discriminatory treatment of all patients, doctors in training, employers and educators affected by the education programmes we approve.

This guidance is supplementary to the equality and diversity information provided in the *Standards for curricula and assessment systems*^{*}.

When colleges and faculties are seeking our approval for changes to curricula, examinations and assessments, they should respond proportionately to equality and diversity issues raised by the changes.

Who is this guidance for?

This guidance explains the principles for the equality and diversity evidence that we require from the medical royal Colleges and Faculties when approving changes to curricula, examinations and assessment systems. It includes some cases studies that show what this might look like in an actual submission.

These principles are particularly relevant for people involved in making or agreeing decisions about the changes. This includes appropriate clinical and non-clinical staff and external advisers.

Our legal responsibilities

Our purpose is to protect, promote and maintain the health and safety of the public. The *Medical Act 1983*[†] sets out our responsibilities for postgraduate medical education. Our role is to make sure that the needs of medical students and doctors in training are met, and to have proper regard to the range of considerations that apply to different groups of medical students and doctors in training.

^{*} Standards for curricula and assessment systems, GMC 2010

[†] HM Government (1983) *Medical Act 1983* available at:

<http://www.legislation.gov.uk/ukpga/1983/54/contents> (accessed 13 April 2015), sections 34H and 34I (subparagraphs 1 and 2)

Protected characteristics

The *Equality Act 2010** makes it unlawful to discriminate against people because of a protected characteristic (see the glossary in [Annex D](#) for further explanation). The protected characteristics are:

- age
- disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race
- religion and belief
- sex
- sexual orientation.

The definition of race includes nationality, national origin, ethnic origin and colour. You may want to consider place of qualification or primary medical qualification as a protected characteristics, as different cohorts of doctors are often associated by nationality and ethnicity.

The public sector equality duty

We expect that bodies involved in aspects of our regulatory activities would consider the relevant equality and diversity issues. As a designated public authority under the Equality Act 2010 ('the Act') we have to comply with the three aims of the public sector equality duty (PSED), which are summarised as follows:

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Act
- advance equality of opportunity between people who share a relevant protected characteristic and those who do not share it
- foster good relations between people who share a relevant protected characteristic and those who do not share it.

More information about the equality duty is in [annex B](#).

Complying with the equality duty requires the GMC to show that we have had considered the three PSED aims when making decisions about approving changes.

* HM Government (2010) *Equality Act 2010* available at:
<http://www.legislation.gov.uk/ukpga/2010/15/contents> (accessed 13 April 2015)

This involves seeking assurance that equality and diversity have been considered as part of each submission.

We will take action where concerns are raised with us about potential non-compliance with the PSED.

Equality and diversity requirements

We expect Colleges and Faculties to take a proportionate approach to identifying and considering the equality and diversity issues raised by a change. This involves showing that the changes have a legitimate aim(s). The importance and benefits of this aim must outweigh any potential discriminatory impacts or effects. They should also explain how they expect to minimise any such effects.

You can provide information in your submission about how equality and diversity has been considered in one of three ways:

- under Domain 5 of the *Curricula and Assessment Change Form*
- using all or part of the template provided at [Annex A](#)
- by providing an equality impact assessment or equality analysis for the change.

The evidence you provide should cover the following categories of information:

- an assessment of the impact of the changes on people that share protected characteristics
- the evidence base for the change
- consultation and engagement
- identifying potential discrimination
- action planning
- monitoring and evaluation

Further information about each of these headings is provided below.

Assessing impact

- Will the change affect stakeholders or interest groups that share protected characteristics?
- Will some groups be affected more than others?

Colleges should set out their understanding of the following points:

- who will be impacted by the proposed change – for example, doctors in training or patients
- the likely impact of the proposed change on people who share any of the protected characteristics.

Access, experience and outcomes

Colleges should identify whether the change might introduce any barriers for, or disadvantage, people with any of the protected characteristics. They should also consider whether the change may result in any differentials in outcomes – for

example, differences in pass rates on examinations and assessments for doctors in training who share protected characteristics.

Some changes may be designed to have a positive impact on people that share protected characteristics and minimise potential discrimination. This should be highlighted if this is the case.

Even when there is no obvious direct impact on people with any protected characteristic, you still need to show that you have also considered any other equality and diversity or fairness issues arising from the change. You will need to anticipate how the change will impact on people who share protected characteristics when it is being implemented. For example, only holding an examination in London may disadvantage those who have a physical disability that might find long distance travel difficult.

Evidence

- What evidence do you have to support this (data, research or other information)?
- In developing the change, have you consulted or involved anyone that shares protected characteristics?

Colleges should demonstrate that they have considered any statistics, research reports or other relevant information in making their assessment of the potential impact of the change. For example, this could include a summary of the findings from your analysis of the data pertaining to doctors in training from a black and minority ethnic background, or it could include consultation with a wide variety of groups.

For further information on collecting data, and examples of diversity monitoring questions, see [Annex C](#).

Data analysis

You should be analysing data on the pool of doctors in training (by protected characteristic), where it is reasonable and proportionate to do so. This will be helpful in helping you to understand whether certain groups of doctors may be affected by the proposed change.

You should also consider whether it is relevant to analyse data about patient groups that share protected characteristics. This may be appropriate if a change would potentially discriminate against or have a positive impact on patients that share protected characteristics.

Types of evidence that may support your analysis include:

- demographic and diversity data in relation to outcome
- consultations and complaints or feedback
- research.

You do not have to submit the actual data. What is important is your interpretation of what the data indicates and your assessment of any potential impacts on people that share protected characteristics.

Where you are unable to provide an interpretation of the data at the time of submission, we suggest that you do the following:

- State this clearly.
- Ask us to approve the change, on the understanding that you will keep it under review and monitor the impact on people that share protected characteristics. In this situation, you should identify some robust actions and how you intend to review the impact of the change.

Consultation and engagement

Colleges should provide a summary of any activities they have undertaken to consult the people with protected characteristics who could be affected by the change. They should also include any feedback on the proposed change from the groups consulted, and how that feedback was considered. This should be proportionate and relevant to the proposed change.

Identifying potential discrimination

- Will the change lead to differential access, experiences or outcomes for people that share protected characteristics?

Consider:

- Does the change have a legitimate aim?
 - Is the change a proportionate way of achieving that legitimate aim?
 - Can differential access, experiences and outcomes be objectively justified?
- Are there any other equality, diversity and/or fairness issues that arise from the proposed change?

Colleges should identify where a change may potentially discriminate against people that share protected characteristics. You may be able to justify this in certain circumstances if there is a good enough reason for doing so. In legal terms, this is known as 'objective justification'.

Legitimate aims

The *Equality Act 2010** sets out that discrimination can be justified if it's a proportionate means of achieving a legitimate aim. The aim is the reason for the action being taken, for example, making a change to a curriculum or an assessment. To be legitimate, this reason must not be discriminatory in itself and it must be genuine.

Legitimate aims in the context of postgraduate medical education and training often fit under the following categories:

- maintaining or protecting patient safety
- safeguarding the health, safety and welfare of individuals or groups
- meeting the particular training requirements for a role.

An example of a legitimate aim is outlined in case study 2 (allowing conscientious objection to fertility control). The change to the obstetrics and gynaecology curriculum will allow those with certain religious beliefs to demonstrate the required competences by advising patients rather than actually performing particular procedures.

Financial considerations

Financial constraints in isolation (for example, saving costs) are not enough to justify discrimination. Costs can be taken into account as part of the justification if you can show there are other robust reasons.

Being proportionate

Being proportionate in this context means that:

- the aim is actually achieved by your proposed action or change
- the discriminatory effect is significantly outweighed by the importance and benefits of the legitimate aim
- there is no reasonable alternative to the action or change taken.

If the legitimate aim can be achieved by another or less discriminatory means, then this option should be chosen instead.

* HM Government (2010) *Equality Act 2010* available at:
<http://www.legislation.gov.uk/ukpga/2010/15/contents> (accessed 13 April 2015)

An example of a proportionate approach

The Royal College of Psychiatrists introduced a transgender station in the Clinical Assessment of Skills and Competencies component of their RCPsych clinical examination. Some groups of candidates complained about the appropriateness of this type of station, on cultural or religious grounds, and objected to being assessed.

As well as being part of the curriculum, patients with gender dysphoria may need to be assessed in a psychiatric clinic or hospital. There is also an overlap within this patient group with comorbidity – patients can often present with other conditions such as autism, Asperger’s syndrome and depression. Doctors may come into contact with these patients in a general psychiatric setting.

The Royal College of Psychiatrists considered the comments on the introduction of this station, and decided that the approach was proportionate and justified. They felt that it is important to assess doctors in training in this area so that they are able to offer appropriate advice to a transgender patient in a compassionate, empathetic and effective manner, regardless of personal cultural or religious views.

Action planning and monitoring

- What steps will you take to minimise any differential access, experiences and outcomes?
- What steps will you take to remove any unlawful discrimination?
- How will you monitor and review the impact of the change on people who share protected characteristics, post implementation?

Colleges should provide information on what steps they will take to minimise any potential discrimination and/or make sure that the change will be implemented in a way that does not disadvantage people who share protected characteristics. This might include the following:

- Provide training on the equality and diversity issues that are relevant to their role for anyone involved in the development or delivery of examinations and assessments. This would include examiners, assessors and committee members.
- Collect and analyse diversity data on doctors in training, monitoring this data to identify any trends by protected characteristic.
- Make reasonable adjustments for people with disabilities.

Reasonable adjustments

Colleges are required to consider providing reasonable adjustments for people with disabilities. This means taking reasonable steps to do the following.

- Avoid substantial disadvantage where a provision, criterion or practice puts people with disability at a substantial disadvantage;
- Avoid substantial disadvantage, where a physical feature puts people with disability at a substantial disadvantage; this includes removing the physical feature in question, altering it or providing a reasonable means of avoiding it;
- Provide an auxiliary aid where, without one, a person with disability would be put at a substantial disadvantage.

Reasonable adjustments and competence standards

The legal obligation to provide reasonable adjustments does not mean lowering the competence standards required of individuals with disabilities.

A competence standard is defined as 'an academic, medical or other standard applied for the purpose of determining whether or not a person has a particular level of competence or ability'*

Qualification bodies do not have a duty to make reasonable adjustments in their application of competence standards to a person with a disability. However, they do have a duty to make reasonable adjustments in relation to their other activities, particularly the method of assessing competences.

Competence standards must be reviewed on an ongoing basis.

Providing reasonable adjustments: a practical example

A doctor in GP training has right-side hearing loss and facial paralysis. For the Clinical Skills Assessment (a practical examination), the Royal College of General Practitioners made the following adjustments:

- the patient was positioned on her left side so she could hear them better
- the examiner was also on her left side, so they could see her facial expressions.

For more detailed guidance about reasonable adjustments in a medical education setting, refer to our [Gateways guidance](#).*

* General Medical Council *Gateways guidance: 15.7 Support for Disabled Doctors in Training and Reasonable Adjustments* available at: http://www.gmc-uk.org/education/undergraduate/15_7_support_for_trainees.asp (accessed 13 April 2015)

**Equality Act 2010 – Chapter 1. Part 5. Paragraph 54 (6), schedule 13 – Paragraph 4(3).*

Case studies

Making changes to a curriculum

Case study 1: Changing the histopathology specialty training curriculum to make autopsy training optional in the later stages of training

Royal College of Pathologists

Background to the change

- What are the aims or purpose of the change?

The purpose of the change is to remove autopsies as a mandatory component of higher specialist training in histopathology (stages C and D), from the FRCPath Part 2 examination and therefore from the requirements for the award of a CCT in histopathology. Trainees will continue to be expected to either undertake 20 autopsies per year until the end of Stage B (40 – 60 in total) or demonstrate the requirement for knowledge of the principles of the autopsy, and a theoretical knowledge of the techniques involved. Questions requiring trainees to demonstrate a sound knowledge of the principles of autopsies and theoretical knowledge of the techniques involved will remain in the FRCPath Part 1. Trainees who wish to continue to train in autopsies beyond the end of Stage B may do so. A specific curriculum will be written and a new, higher quality, stand-alone examination (Certificate of Higher Autopsy Training) will allow doctors to demonstrate their competence in autopsy at a level required for consultant practice in the UK. The new curriculum and examination are outside the scope of the CCT.

Before the change

All doctors in training in the UK had to undertake autopsy training throughout the 5-year histopathology specialty training programme. They were expected to carry out at least 20 autopsies per year, under supervision, and at least 100 in the programme, including some exposure to paediatric and perinatal autopsies. The autopsy examination was an integral part of the Fellow of the Royal College of Pathologists (FRCPath) examination and the Certificate of Completion of Training (CCT) curriculum.

Why introduce the change?

The main reason the change was introduced was because not all consultant histopathologists in the UK went on to conduct autopsies upon completion of training. Indeed, at the time, fewer than half of the qualified histopathologists in the UK undertook autopsies as part of their service commitments. In addition,

some programmes struggled to deliver the required level of exposure to autopsies for trainees to undertake sufficient numbers required for the award of the CCT. There was also some suggestion that doctors in training interested in a career in histopathology might be put off by the autopsy requirement and therefore not enter the specialty and that removing a component of the curriculum that was not routinely required for UK consultant practice may also help to attract more doctors in training to the specialty.

The College was also aware that doctors in training in some countries outside of the UK could not get exposure to autopsy training and therefore were effectively prevented from taking the FRCPath examination, where the autopsy is a compulsory component (the College has always made its exam available to doctors in training outside of the UK). In addition, there were some examples of cultural and religious objections to the practice, which discouraged such doctors from taking the FRCPath examination.

What is the effect of the change?

Making autopsy training an optional (non-CCT) component in the higher stages (C and D) of training (after stages A and B, which take 24–30 months to complete) should address the issues described above.

The majority of histopathology departments include a mortuary delivering autopsy services. Retaining exposure to autopsy training during stages A and B allows doctors in training to learn about the issues they might encounter when managing a histopathology department. It also enables them to learn about systemic pathology in a way that is difficult to deliver in any other context.

Training in autopsy pathology is not only about learning how to carry out the procedure. It also teaches doctors in training about the effects of pathology beyond single organ systems.

Removing the autopsy examination from the FRCPath, and replacing it with a new, higher quality, stand-alone examination (Certificate of Higher Autopsy Training), supported by a curriculum, allows doctors in training who wish to practice autopsies as a consultant the opportunity to obtain the high quality training certification they require, in addition to their CCT.

This case study was written retrospectively; the information included below has been presented to show how we would have approached this curriculum change had this Equality and Diversity guidance been in place at the time. For example, the evidence presented in this document to support the change and its associated impact exists but was not presented to the GMC in this format at the time of submission of the proposed changes.

In addition, some of these curricular changes were achieved in a step-wise fashion

over a more protracted period of time, but are presented here as a single process for illustration only.

Assessing the impact

- Will the change affect stakeholders or interest groups that share protected characteristics?
- Will some groups be affected more than others?

This change could potentially affect doctors in training:

- This change could potentially affect doctors in training; who feel they have cultural and/or religious objections to carrying out autopsies
- who are pregnant
- with physical disabilities
- from specific countries where autopsy pathology is not widely practiced

Evidence

- What evidence do you have to support this (data, research or other information)?
 - In developing the change, have you consulted or involved anyone that shares protected characteristics?
- RCPATH workforce data and surveys revealed the percentage of pathologists undertaking autopsies.
 - Annual specialty reports and feedback from deaneries showed the difficulty in providing adequate autopsy training in some regions.
 - Anecdotal evidence from record of in-training assessment (RITA) and annual review of competence progression (ARCP) panels showed the cultural and religious objections to autopsy training raised by some doctors in training.
 - Informal feedback to the examinations and international departments revealed the difficulties faced by doctors in training in some countries where autopsy training is not available.
 - The advisory committee for doctors in training and the RCPATH Fellowship were consulted during the process of developing these changes. Interestingly, informal conversations with religious groups revealed that there are no religions where autopsies are forbidden, although there are

restrictions on how they must be carried out, for example, in the Jewish community.

Identifying potential discrimination

- Will the change lead to differential access, experiences or outcomes for people that share protected characteristics?

Consider:

- Does the change have a legitimate aim?
- Is the change a proportionate way of achieving that legitimate aim?
- Can differential access, experiences and outcomes be objectively justified?
- Are there any other equality, diversity and/or fairness issues that arise from the proposed change?

The change had the legitimate aim of eliminating unnecessary training for the majority of histopathology doctors in training, which increased the provision and standard of autopsy training for those who wished to continue to train to consultant level. To this extent the change was proportionate.

Another effect of this change is that it changed the pool of candidates who could become histopathologists. The change can be justified as the effect was positive: it broadened the pool of potential candidates as it was easier to be included in training. This happened in a number of ways:

- reduction in the total number of autopsies required during training and removal of the autopsy component of the FRCPATH Part 2 examination;
- rewording the curricular requirements to emphasise the requirement for knowledge of the principles of the autopsy, and a theoretical knowledge of the techniques involved, rather than necessarily having to obtain the actual practical experience in autopsy;
- time limited transitional arrangements were also introduced, allowing candidates under the old system to transfer to the new system (including transferring passed components from previous FRCPATH Part 2 examination attempts) .

The E&D issues arising from the change included allowing doctors who had cultural or religious objections to autopsies, as well as disabled or pregnant candidates, (*such that they are unable to physically complete an autopsy without assistance*) to still receive training in the principles of autopsy and the theoretical knowledge of

the techniques involved. The College was unable to identify any doctors in training with protected characteristics who were disadvantaged by the change.

Action planning and monitoring

- What steps will you take to minimise any differential access, experiences and outcomes?
 - What steps will you take to remove any unlawful discrimination?
 - How will you monitor and review the impact of the change on people who share protected characteristics post implementation?
-
- Centres that have good access to autopsy training in each region are already identifiable and recognised. The reduced number of doctors in training who will want to undertake autopsy training subsequent to this change can be rotated to these centres to receive the appropriate training. In addition, for a time-limited period, doctors under the old system will be able to transfer to the new system, thereby minimising differential access, experiences and outcomes.
 - We do not believe that there was any unlawful discrimination before the change.
 - We are monitoring the impact of the change through the ARCP process, through annual deanery and specialty reports and through the new Certificate of Higher Autopsy Training examination process and feedback.

Case study 2: Allowing conscientious objection to acquiring certain skills in the core obstetrics and gynaecology curriculum

Royal College of Obstetricians and Gynaecologists

Background to the change

- What are the aims or purpose of the change?

The aims of the change are to allow conscientious objection to acquiring certain skills in the core obstetrics and gynaecology curriculum.

Before the change

Module 15 of the core obstetrics and gynaecology curriculum – sexual and reproductive health – contains competences relating to medical and surgical termination of pregnancy and contraceptive advice. The learning outcomes for the module are:

- to understand and demonstrate appropriate knowledge, skills and attitudes in relation to fertility control (contraception and termination of pregnancy), and the diagnosis and management of sexually transmitted infections including HIV and sexual dysfunction
- to understand the need to respect women's rights, dignity and confidentiality whilst providing appropriate information and advice.

Why introduce the change?

It is very important that all doctors in training meet the knowledge criteria relating to all methods of contraception and termination of pregnancy. However, some doctors in training will have conscientious objections to carrying out some of the procedures described in the module and this may create difficulty in progressing through the curriculum.

An alternative method is needed for recording skills targets that have not been attempted for reasons of conscientious objection, so that it is clear when this has occurred. This record will also allow doctors in training to progress appropriately.

What is the effect of the change?

We propose to add the following paragraph to the learning outcomes for module 15.

- 'There may be conscientious objection to the acquisition of certain skills within the contraception and abortion components; this does not mean that

meeting the knowledge criteria is not required. Skills targets not attempted for these reasons should be clearly recorded in the logbook and signed off by a trainer.'

We propose to add the following statement to the logbook.

- 'Please mark "CO" (conscientious objection) alongside skills not acquired (see learning outcomes of module with regard to knowledge criteria).'

Assessing the impact

- Will the change affect stakeholders or interest groups that share protected characteristics?
- Will some groups be affected more than others?

- Those doctors in training with certain religious beliefs about contraception and abortion will be positively affected by this change. It will allow them to acquire core knowledge competences without having to compromise their religious beliefs in the performance of such procedures.
- Other groups with protected characteristics will not be affected by this change.

Evidence

- What evidence do you have to support this (data, research or other information)?
- In developing the change, have you consulted or involved anyone that shares protected characteristics?
- Data have been collected by the doctors' in training committee via a confidential survey and similarly from the college tutors. Research has also been carried out by the British Maternal and Fetal Medicine Society about the issue of conscientious objection and its effect on training. The issue has been extensively discussed by the doctors' in training committee, specialty education advisory committee and curriculum committee.
- We obtained data from the confidential survey of doctors in training, which asked respondents to indicate their religious group or belief.

Identifying potential discrimination

- Will the change lead to differential access, experiences or outcomes for people that share protected characteristics?

Consider:

- Does the change have a legitimate aim?
- Is the change a proportionate way of achieving that legitimate aim?
- Can differential access, experiences and outcomes be objectively justified?
- Are there any other equality, diversity and/or fairness issues that arise from the proposed change?

- Yes, the change does have a legitimate aim, as it will enable doctors in training with certain religious beliefs not to carry out certain procedures. The solution put forward will not compromise patient care, as doctors in training will still have to be able to counsel patients on abortion or contraception issues.
- Yes, the change is proportionate. Asking educational supervisors to confirm in the logbook if a procedure has not been carried out because of conscientious objection will not impose an onerous additional burden.
- Yes, the differential in experience can be justified, as it will be an improvement to the training programme for those doctors in training with certain religious beliefs. There are many specialist roles in obstetrics and gynaecology that do not rely on the need and ability to perform contraceptive or termination services. Therefore, the lack of such expertise will not impact on the service or the individual's ability to practise.

Action planning and monitoring

- What steps will you take to minimise any differential access, experiences and outcomes?
- What steps will you take to remove any unlawful discrimination?
- How will you monitor and review the impact of the change on people who share protected characteristics post implementation?

- Information will be provided to all trainers and doctors in training, about the addition of conscientious objection to Module 15.
- Guidance will be developed to assist trainers and doctors in training in deciding whether a skill target can be omitted on the grounds of conscientious objection. It is not anticipated that other individuals (ie who are not from the protected group of religion) will apply for conscientious

objection.

- In the first year after implementation in the ePortfolio, the Royal College of Obstetricians and Gynaecologists will review the ARCP outcomes of those individuals who have applied conscientious objection in this module and see how they compare with overall performance and trends.

A survey will also be carried out on those individuals, to assess how allowing them to exercise their right to conscientious objection has influenced their training progression.

If the ARCP or survey data reveal that adjustments need to be made, these will be taken forward and implemented in the second year after implementation.

Case study 3: Introducing simulation into the surgical curriculum

Joint Committee on Surgical Training

Background to the change

- What are the aims or purpose of the change?

The aim of the change is to introduce simulation into the surgical curriculum.

Before the change

Although simulation has been used in surgical training for at least 50 years, it is not currently recognised as a formal method for teaching and learning. The use of simulation develops a doctor in training's cognitive, clinical, technical and non-technical skills and behaviour. It should be regarded as part of a blended approach to managing teaching and learning, concurrent with supervised clinical practice.

Why introduce the change?

There are several drivers for the introduction of simulation into the surgical curriculum.

- Enhancement of patient safety. The primary aim of simulation is to improve patient care and safety through addressing the learning needs of the doctor in surgical training.
- The potential to deliver more effective education and training. The provision of simulation training will shorten the learning curve in the development of both technical and non-technical skills. Simulation provides more opportunities for practice and thereby also helps to moderate the effects of the European Working Time Regulations.
- Coverage of human factors. This refers to all those factors that can influence people and their behaviour. The significant impact this can have on technical performance and clinical outcomes has highlighted the importance of developing non-technical skills. These skills include:
 - situational awareness
 - decision making
 - communication
 - team working
 - leadership.

Simulation training in these areas can result in changes in the behaviour and performance of individuals and teams, underpinning reliable and safe practice.

- Learning environment. Simulation offers the doctor in training the opportunity to acquire, develop and improve skills in a non-threatening environment, before undertaking them in supervised clinical practice. The same is also true when new surgical techniques are being introduced.
- There is now a wealth of evidence in the literature supporting the value of simulation in medical education. The Department of Health publication, *Framework for Technology Enhanced Learning*,* sets out a clear vision for technology-enhanced learning and supports the integration of simulation into curricula. As part of a managed learning process, healthcare professionals should learn skills in a simulation environment before undertaking them in supervised clinical practice.

What is the effect of the change?

Simulation will help to ensure that surgical doctors in training develop the knowledge, skills and behaviours required to manage the safe treatment of patients more efficiently and effectively. Because simulation will be used as a formative tool, it should enhance learning through feedback and reduce the risk of medical error. The legitimate aims, therefore, are:

- maintaining or protecting patient safety
- safeguarding the health, safety and welfare of individuals or groups.

Assessing the impact

- Will the change affect stakeholders or interest groups that share protected characteristics?
- Will some groups be affected more than others?
- This change potentially affects all doctors in training, and interest groups, including those who share protected characteristics.
- Doctors in training will be expected to access training facilities locally, sometimes regionally and rarely nationally. Facilities need to be in place as

* Department of Health (2011) *A Framework for Technology Enhanced Learning* available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/215316/dh_131061.pdf (accessed 13 April 2015)

part of the formal educational programme. However, as simulation is not consistently available across the UK, it will be introduced in a phased way.

- Elements that should be achievable and available to all doctors in training have been marked as strongly recommended, while those marked as desirable will be introduced over a more prolonged time period, as more information and data become available.
- Simulation could potentially affect groups with the following protected characteristics:
 - disability
 - pregnancy and maternity
 - religion and belief.
- There should be local flexibility, to reflect the normal working pattern for doctors in training. Typical reasonable adjustments might include the following:
 - timetabling the sessions to be held at different times
 - allowing more time for travel, with funding or assistance
 - altering the timetable, changing the number of breaks
 - using venues that are compliant with the *Equality Act 2010*,* or adjusting premises to make them more accessible
 - modifying equipment, for example using height-adjustable tables
 - providing written materials in alternative formats, for example, appropriate font, font size and paper colour
 - providing choice in the range of types of simulation equipment
 - additional trainer assistance
 - changing the subject matter of scenarios used, according to religion and belief.

Evidence

- What evidence do you have to support this (data, research or other information)?
- In developing the change, have you consulted or involved anyone that

* HM Government (2010) *Equality Act 2010* available at:
<http://www.legislation.gov.uk/ukpga/2010/15/contents> (accessed 13 April 2015)

shares protected characteristics?

- Data to support this change:
 - an audit of facilities across all regions
 - a survey of heads of schools.
- We have consulted:
 - groups of doctors in training who are supportive of this change
 - patient representatives who are supportive of this change.

Identifying potential discrimination

- Will the change lead to differential access, experiences or outcomes for people that share protected characteristics?

Consider:

- Does the change have a legitimate aim?
- Is the change a proportionate way of achieving that legitimate aim?
- Can differential access, experiences and outcomes be objectively justified?
- Are there any other equality, diversity and/or fairness issues that arise from the proposed change?

- Simulation should be formative, with the primary aim of providing feedback to enable doctors in training to develop. It should not result in differential outcomes for surgical doctors in training who share protected characteristics.
- Yes. Simulation is a legitimate aim, as it is essential for patient safety.
- Yes. Formative assessment ensures that it is proportionate.
- Yes. Formative assessment ensures that it should not result in differential outcomes.
- There are potential concerns over the equitability of funding for training across the country and this would need to be addressed before further methods are mandated. However, issues about funding and provision can only be clarified when simulation is explicit in the curriculum.

Action planning and monitoring

- What steps will you take to minimise any differential access, experiences and outcomes?
- What steps will you take to remove any unlawful discrimination?
- How will you monitor and review the impact of the change on people who share protected characteristics post implementation?

- What simulation offers, in certain parts of the syllabus, is a different learning method that will complement and augment clinical training.
- Elements that should be achievable and available to all doctors in training have been marked as strongly recommended, while those marked as desirable will be introduced over a more prolonged time period, as more information and data become available.
- Further work is being undertaken with a wide range of stakeholder groups, including:
 - Association of Simulation Practice in Healthcare
 - Association of Surgeons in Training
 - Better Training Better Care
 - British Orthopaedic Training Association
 - Confederation of Postgraduate Schools of Surgery
 - Health Educational England
 - Higher Education Academy.

Making changes to an examination

Case study 4: Changes to standard setting – introducing the borderline regression method in the MRCPsych

Royal College of Psychiatrists

Background to the change

- What are the aims or purpose of the change?

The aims of the change are to have a more robust marking system and minimise the variability between individuals.

Before the change

The Hofstee method was used, which takes into account the difficulty of each station and the views of the examiners as a whole.

There was a requirement to pass a minimum of 12 out of 16 stations of the objective structured clinical examination (OSCE).

Why introduce the change?

- To have a more robust marking system
- To minimise the variability between individuals. This method provides a more discriminative approach to standard setting ensuring that a candidate's result is based on a series of domains rather than one overall judgement.

What is the effect of the change?

- Borderline regression takes into account all the marks of the examiners.
- Use of the standard error of measurement.

Assessing the impact

- Will the change affect stakeholders or interest groups that share protected characteristics?
- Will some groups be affected more than others?

There is potential that this change may affect groups who share protected characteristics. Modelling analysis demonstrated that it was the UK PMQs who had a greater propensity to achieve scores around the cut score (hence constitute the 'borderline group') more than other groups. However, this is a more robust system for calculating results

Evidence

- What evidence do you have to support this (data, research or other information)?
- In developing the change, have you consulted or involved anyone that shares protected characteristics?

- Data collected at previous examination sitting, scoring candidates using Hofstee, borderline group and borderline regression methods.
- A report has been produced comparing the different methods. Results showed that the new scoring system incorporating the borderline methods of standard setting is capable of producing consistently satisfactory results, with generally higher reliability, in addition to pass rates and pass or fail trends that are consistent with the Hofstee method.
- Data have been collected on the impact on people that share protected characteristics.

Identifying potential discrimination

- Will the change lead to differential access, experiences or outcomes for people that share protected characteristics?

Consider:

- Does the change have a legitimate aim?
 - Is the change a proportionate way of achieving that legitimate aim?
 - Can differential access, experiences and outcomes be objectively justified?
 - Are there any other equality, diversity and/or fairness issues that arise from the proposed change?
- Analysis indicates that this method favours those with a UK primary medical qualification more than international medical graduates (IMGs). However, this is also the case under the current scheme. This new marking scheme is a more robust approach.

- Borderline regression is also fairer, as it takes into account all examiner views.

Action planning and monitoring

- What steps will you take to minimise any differential access, experiences and outcomes?
- What steps will you take to remove any unlawful discrimination?
- How will you monitor and review the impact of the change on people who share protected characteristics post implementation?

- We will continue to monitor results.
- We will work to introduce additional support for those who may need additional training. We have appointed an Associate Dean for Trainee Support, who will work with heads of schools as well as leading on support and training initiatives as Chair of our IMG scoping group.
- The college will also run another IMG conference in autumn 2015, with helpful workshops for IMG doctors in training.
- If the ARCP or survey data reveal that adjustments need to be made, these will be taken forward and implemented in the second year after implementation.

Making changes to an assessment

Case study 5: Introducing an audio-consultation observation tool

Royal College of General Practitioners

Background to the change

- What are the aims or purpose of the change?

The proposed change is to introduce an audio-consultation observation tool (COT) to workplace-based assessment (WPBA), to assess telephone consultation skills in general practice. This is a modification of the current GMC-approved COT used to assess face-to-face consultations.

Before the change

There is currently no formative assessment of telephone consultation skills in the workplace. Telephone consultation skills are assessed as part of the Clinical Skills Assessment (CSA), but not all doctors in training experience a telephone triage case during their examination circuit.

Why introduce the change?

Around 12% of GP consultations are now done over the phone – representing a four-fold increase over the last 20 years. Telephone consultations are increasingly used, both in and out of hours, to try to manage workload and cut down on unnecessary face-to-face consultations.

What is the effect of the change?

It will ensure that GP doctors in training develop the skills required to safely assess patients over the telephone.

Assessing the impact

- Will the change affect stakeholders or interest groups that share protected characteristics?
- Will some groups be affected more than others?

This change could potentially affect candidates with hearing impairment and those whose first language is not English.

Evidence

- What evidence do you have to support this (data, research or other information)?
- In developing the change, have you consulted or involved anyone that shares protected characteristics?

- GP doctors in training who have hearing impairments regularly request reasonable adjustments for the CSA, which may include a telephone consultation case. Some of these candidates use aids to enhance their telephone consultations in the workplace. To date, we have not had a candidate who has been unable to conduct a telephone consultation at all.
- We have consulted the Membership of the Royal College of General Practitioners (MRCGP) Disability Lead, who is an expert in this area.
- We have piloted the audio-COT among doctors in training and trainers in Wessex, Oxford, East and West Midlands and West Scotland deaneries. This sample included international medical graduates. No adverse outcomes have been reported.
- We have consulted the RCGP Associates in Training committee, who are supportive of this change.

Identifying potential discrimination

- Will the change lead to differential access, experiences or outcomes for people that share protected characteristics?

Consider:

- Does the change have a legitimate aim?
 - Is the change a proportionate way of achieving that legitimate aim?
 - Can differential access, experiences and outcomes be objectively justified?
- Are there any other equality, diversity and/or fairness issues that arise from the proposed change?

- This is a formative assessment tool, so it should not result in differential outcomes for GP doctors in training who share protected characteristics.
- It is possible that a severe or profound hearing-impaired doctor in GP training will be unable to conduct telephone consultations at all, even when reasonable adjustments are made for their disability. They would not be

able to complete this assessment.

- Yes. Safe telephone conversations are essential for patient safety.
- Yes. Formative assessment and feedback on telephone consultations should ensure that GP doctors in training develop the skills required to safely assess patients over the telephone.
- Yes. Candidates with severe or profound hearing impairment who are unable to conduct telephone consultations with reasonable adjustments will not be assessed on audio-COT.

Action planning and monitoring

- What steps will you take to minimise any differential access, experiences and outcomes?
 - What steps will you take to remove any unlawful discrimination?
 - How will you monitor and review the impact of the change on people who share protected characteristics post implementation?
- The MRCGP Disability Lead will provide specific information for assessing telephone consultations in hearing-impaired GP doctors in training, on the RCGP website.
 - Candidates with severe or profound hearing impairment who are unable to conduct telephone consultations with reasonable adjustments will not be assessed on an audio-COT.
 - We will monitor the performance of audio-COTs through the ARCP process.

Case study 6: Categorising existing workplace-based assessment encounters as being either explicitly formative (for learning), or explicitly summative (of learning)

Royal College of Obstetricians and Gynaecologists.

Background to the change

- What are the aims or purpose of the change?

The aim is to implement changes to how WPBA is delivered within the obstetrics and gynaecology training programme.

Before the change

Some WPBA tools are used only for summative assessments (assessments of performance), without a formative approach.

Why introduce the change?

The main impetus of the changes is to categorise existing WPBA encounters as being either explicitly formative (for learning), or explicitly summative (of learning), as follows:

- Supervised learning events will be formative assessments. The purpose of the encounter will be for the doctor in training to receive feedback on their performance
- Assessments of performance will be summative assessments. A decision regarding the competence of the doctor in training will be made in light of the performance observed in the encounter.

What is the effect of the change?

This change will ensure that all WPBA tools can be used for both formative and summative purposes, in separate encounters.

Identifying encounters in this way, as being either explicitly formative or explicitly summative, will ensure that assessments are better equipped to achieve their stated purposes. Specifically, it will address the present confusion caused by certain tools being applied as both summative and formative assessments concurrently, which limits their impact with regard to each of these aims.

Assessing the impact

- Will the change affect stakeholders or interest groups that share protected

characteristics?

- Will some groups be affected more than others?

Yes, the changes will affect doctors in training and trainers who share protected characteristics. However, the changes are unlikely to disproportionately affect these groups.

Evidence

- What evidence do you have to support this (data, research or other information)?
- In developing the change, have you consulted or involved anyone that shares protected characteristics?

- In a 3-month pilot exercise conducted by the London Deanery, the outcomes of summative WPBAs (those potentially impacting ARCP decisions) were analysed in relation to those groups sharing protected characteristics. It was found that the change to WPBAs did not produce significantly different outcomes in comparison to the existing system.
- During the pilot, focus groups were conducted for various groups of doctors in training and trainers. The group was asked to consider and discuss potential unfairness in relation to protected characteristics. No concerns were raised.
- The focus groups that took place during the pilot involved trainers and doctors in training who shared protected characteristics. The focus groups were constructed to ensure that groups sharing protected characteristics were fairly represented. The views of all doctors in training were formally recorded and reviewed by the WPBA Implementation Group.

Identifying potential discrimination

- Will the change lead to differential access, experiences or outcomes for people that share protected characteristics?

Consider:

- Does the change have a legitimate aim?
 - Is the change a proportionate way of achieving that legitimate aim?
 - Can differential access, experiences and outcomes be objectively justified?

- Are there any other equality, diversity and/or fairness issues that arise from the proposed change?

- Yes, the change does have a legitimate aim. WPBA encounters that are explicitly formative will be identified, and these will be carried out, in addition, to the existing summative WPBA encounters. This will ensure that doctors in training will benefit from increased learning experience from formal, documented trainer or supervisor input.
- Yes, the change is proportionate. It is in line with the GMC guidance on important themes in delivering WPBA, presented in *Learning and Assessment in the Clinical Environment* (2011).^{*} It is also in line with subsequent work carried out by the Academy of Medical Royal Colleges regarding the implementation of these themes in practice.
- Based on the results of the pilot exercise, outcomes for people sharing protected characteristics are unlikely to be affected. The experience for all doctors in training is likely to improve, as they will be able to undertake formative WPBAs before undertaking summative assessments of performance. Analysis based on the pilot exercise suggests that there will be no differences in access, experience or outcomes.

Action planning and monitoring

- What steps will you take to minimise any differential access, experiences and outcomes?
- What steps will you take to remove any unlawful discrimination?
- How will you monitor and review the impact of the change on people who share protected characteristics post implementation?

- Before assessing doctors in training, trainers have to complete an online course, which outlines the assessment criteria and uses a series of example videos to calibrate assessor judgments. This is to help remove any unconscious assessor bias.
- All trainers have to undertake equality and diversity training through their employer.

^{*} General Medical Council (2011) *Learning and Assessment in the Clinical Environment: The Way Forward* available at http://www.gmc-uk.org/Learning_and_assessment_in_the_clinical_environment.pdf_45877621.pdf (accessed 13 April 2015)

- Trainers or doctors in training who feel that they are not able to undertake all or some of the WPBA programme, because of a disability, will be able to contact the college. Reasonable adjustments will be made to ensure they are not at a disadvantage.
- Outcome data (both quantitative and qualitative) will be monitored regularly, to identify any patterns of concern in relation to groups sharing protected characteristics.
- The college will also outline the complaints policy clearly on its website, to ensure that any concerns regarding unlawful discrimination can be easily reported. Any such claims will be thoroughly investigated.
- Regular monitoring of outcome data will take place, as outlined above.
- After one year of implementation, a formal review will be conducted looking at outcomes for doctors in training who share protected characteristics. A survey will be used to collect data from trainers and doctors in training. This will include a question about the impact on particular groups.

Annex A: Template for providing equality and diversity evidence (optional)

Background to the change

- What are the aims or purpose of the change?

Proposed change: ...

Before the change

- ...

Why introduce the change?

- ...

What is the effect of the change?

- ...

Assessing the impact

- Will the change affect stakeholders or interest groups that share protected characteristics?
- Will some groups be affected more than others?

- ...

Evidence

- What evidence do you have to support this (data, research or other information)?
- In developing the change, have you consulted or involved anyone that shares protected characteristics?

- ...

Identifying potential discrimination

- Will the change lead to differential access, experiences or outcomes for

people that share protected characteristics?

Consider:

- Does the change have a legitimate aim?
- Is the change a proportionate way of achieving that legitimate aim?
- Can differential access, experiences and outcomes be objectively justified?
- Are there any other equality, diversity and/or fairness issues that arise from the proposed change?

■ ...

Action planning and monitoring

- What steps will you take to minimise any differential access, experiences and outcomes?
- What steps will you take to remove any unlawful or potentially unlawful discrimination?
- How will you monitor and review the impact of the change on people who share protected characteristics post implementation?

■ ...

Annex B: The statutory framework

The *Equality Act 2010**

The *Equality Act 2010* lists nine protected characteristics also referred to as diversity or equality strands. The protected characteristics are:

- age
- disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race
- religion and belief
- sex
- sexual orientation.

The general equality duty (or the public sector equality duty)

The general equality duty is a statutory duty on public bodies to help achieve equality. It requires public bodies to consider all individuals when carrying out their day-to-day work – in shaping policy, in delivering services and in relation to their own employees.

The equality duty supports good decision making. It encourages public bodies to understand how different people will be affected by their activities, so that their policies and delivery of functions are appropriate and accessible to all, and meet different people's needs.

In Schedule 19 of the Act, the GMC is listed as a public authority 'with respect to its public functions'. This means that we are subject to the public sector equality duty in how we deliver our functions. This includes the regulation of medical education and training.

The general equality duty is in section 149(1) of the *Equality Act 2010*. It states:

'A public authority must, in the exercise of its functions, have due regard to the need to:

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act

* HM Government (2010) *Equality Act 2010* available at:

<http://www.legislation.gov.uk/ukpga/2010/15/contents> (accessed 13 April 2015)

- advance equality of opportunity between persons who share a relevant protected characteristic and those who do not share it
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.'

The Act defines 'advancing equality of opportunity' as meaning:

- 'removing or minimising disadvantages suffered by people due to their protected characteristics'
- 'taking steps to meet the needs of people from protected groups where these are different from the needs of other people'
- 'encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.'

It also defines 'fostering good relations between different groups' as meaning 'tackling prejudice and promoting understanding between people who share a protected characteristic and those that do not'.

What is a public function?

The Act lists the GMC as a public authority 'with respect to its public functions'. Public functions are not only carried out by public authorities. They may also be carried out by private or voluntary organisations, for example, when a private company manages a prison or when a voluntary organisation takes on responsibilities for child protection.

The Act states that a public function has the same meaning as a 'function of a public nature' for the purposes of the *Human Rights Act 1998*.^{*} In relation to private or voluntary organisations, this would cover activities that are carried out on behalf of the state and that are not similar in kind to services that could be performed by private persons.

^{*} HM Government 1998 *Human Rights Act 1998* available at:
<http://www.legislation.gov.uk/ukpga/1998/42/contents> (accessed 13 April 2015)

The *Equality Act 2010 Technical Guidance on the Public Sector Equality Duty*^{*} sets out the factors to be taken into account when determining whether a function is a function of a public nature. These include:

- where it is carrying out activities on behalf of the State and which are not similar in kind to services that could be performed by private persons.
- it is publicly funded, or has significant reliance on public funding
- it is exercising powers of a public nature directly assigned to it by statute, or it is taking the place of central or local government
- it is providing a public service
- it is acting in the public interest
- its structures and work are closely linked with that of the delegating or contracting-out state body
- there is a close relationship between the private body and any public authority
- it is supervised by a state regulatory body
- it is exercising coercive powers devolved from the state.

Qualifications bodies

Section 53 of the *Equality Act 2010*[†] imposes a duty on qualifications bodies not to discriminate in the conferment of relevant qualifications. It also imposes a duty on them to make reasonable adjustments for disabled people.

The GMC is a qualifications body under Section 53 of the *Equality Act 2010*. Royal colleges are also qualifications bodies in their function of conferring qualifications.

Qualifications bodies do not have a duty to make reasonable adjustments in their application of competence standards to disabled persons. However, they do have a duty to make reasonable adjustments in relation to their other activities, particularly the method of assessment of competences.

^{*} Equality and Human Rights Commission 2013 *Equality Act 2010 Technical Guidance on the Public Sector Equality Duty England*

http://www.equalityhumanrights.com/sites/default/files/documents/PSD/technical_guidance_on_the_public_sector_equality_duty_england.pdf (accessed 18 June 2015)

[†] HM Government (2010) *Equality Act 2010* available at:

<http://www.legislation.gov.uk/ukpga/2010/15/contents> (accessed 13 April 2015)

Northern Ireland

The *Equality Act 2010* does not apply to Northern Ireland. The legislation is very similar to the Great Britain legislation.

In Northern Ireland, the statutory duties of *Section 75 of the Northern Ireland Act 1998*^{*} require designated public authorities to have *due regard to the need* to promote equality of opportunity in relation to the nine equality categories and to have *regard to the desirability* of promoting good relations between persons of different religious belief, political opinion and racial group.

The nine categories are:

- persons of different religious beliefs
- political opinion
- racial group
- age
- marital status
- sexual orientation
- men and women
- persons with a disability and persons without
- persons with dependents and persons without

The *Disability Discrimination Act 1995*[†] Section 49A requires designated public authorities to have due regard to the need to promote positive attitudes towards disabled persons, and to the need to encourage participation by disabled persons in public life.

There is more information about equality legislation in Northern Ireland on the website for the [Equality Commission for Northern Ireland](http://www.equalityni.org).[‡]

^{*} Office of the First Minister and Deputy First Minister *Section 75 of the Northern Ireland Act 1998* available at: http://www.ofmdfmi.gov.uk/section_75 (accessed 13 April 2015)

[†] HM Government (1995) *Disability Discrimination Act 1995* available at: <http://www.legislation.gov.uk/ukpga/1995/50/contents> (accessed 13 April 2015)

[‡] Equality Commission for Northern Ireland available at: www.equalityni.org (accessed 13 April 2015)

Annex C: Collecting data on equality and diversity

The Equality and Human Rights Commission 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'.^{*}

Some diversity data are classified as sensitive under the *Data Protection Act 1998*,[†] so you have to take a proportionate approach to collecting this data. A proportionate approach means that:

- the data processing must be adequate, relevant and not excessive in relation to the purposes for which the data are collected and/or further processed
- consideration has been given to why you are collecting the data, how it will be used, how it will be stored and who will have access to it.

If you do not plan to analyse the data you collect, you should think whether it will be of use to the organisation in the future. If not, it may not be proportionate to collect the data.

When collecting information for all diversity characteristics, you should clearly state the purpose for collecting it and how you will make sure it is held securely and confidentially. Providing information about protected characteristics should be optional.

Some suggested categories for monitoring diversity, based on best practice, are presented next. Some of these are protected characteristics as defined by the

^{*} Equality and Human Rights Commission (2011) *Guidance. Equality Information and the Equality Duty: A Guide for Public Authorities. England (and Non-devolved Public Authorities in Scotland and Wales)* available at:
http://www.equalityhumanrights.com/sites/default/files/documents/EqualityAct/PSED/ehrc_psed_equality_information_web.pdf (accessed 13 April 2015)

[†] HM Government 1998 *Data Protection Act 1998* available at:
<http://www.legislation.gov.uk/ukpga/1998/29/contents> (accessed 13 April 2015)

Equality Act 2010 – others are listed because they may be relevant and useful to collect.

Examples of diversity monitoring questions

Age

Guidance note: Collecting the full date of birth lets us manipulate that information or use it in different ways. Date of birth does not change with time. It is a “live” data item, whereas age is not. However for one-off data collection, collecting age bands can be easier to analyse, for example, in consultations or surveys.

What is your age?

| | |
|-------------------|--------------------------|
| 0–18 years | <input type="checkbox"/> |
| 19–24 years | <input type="checkbox"/> |
| 25–34 years | <input type="checkbox"/> |
| 35–44 years | <input type="checkbox"/> |
| 45–54 years | <input type="checkbox"/> |
| 55–64 years | <input type="checkbox"/> |
| 65+ years | <input type="checkbox"/> |
| Prefer not to say | <input type="checkbox"/> |

What is your date of birth?

Disability

Guidance note: Use question A *or* B. Question A is taken from the 2011 census for all four countries and can be used to directly compare to the results of the census. However, question B is the preferable and standard question.

Question C is optional and lists types of impairment and can be used in addition to A and B. This question was developed with advice from the Business Disability Forum. Alternatively you can use a free text box to allow individuals to explain their impairment.

A: Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months?

| | |
|-----------------------|--------------------------|
| Yes, limited a lot | <input type="checkbox"/> |
| Yes, limited a little | <input type="checkbox"/> |
| No | <input type="checkbox"/> |
| Prefer not to say | <input type="checkbox"/> |

B: Do you have a disability, long-term illness or health condition?

| | |
|-------------------|--------------------------|
| Yes | <input type="checkbox"/> |
| No | <input type="checkbox"/> |
| Prefer not to say | <input type="checkbox"/> |

The *Equality Act 2010** defines a person as disabled if they have a physical or mental impairment, which has a substantial and long-term (ie has lasted or is expected to last at least 12 months) and adverse effect on the person's ability to carry out normal day-to-day activities.

C : Please place an X in the relevant box or boxes if any of the below apply to you.

| | |
|---|--------------------------|
| Blind or sight loss | <input type="checkbox"/> |
| Deaf or hearing loss | <input type="checkbox"/> |
| Mobility – eg difficulty walking short distances or climbing stairs | <input type="checkbox"/> |
| Manual dexterity | <input type="checkbox"/> |
| Learning disability, where a person learns in a different way – eg dyslexia | <input type="checkbox"/> |
| Mental illness – eg schizophrenia, depression | <input type="checkbox"/> |
| Speech impairment | <input type="checkbox"/> |
| Cognitive disability – eg brain injury, autism, attention deficit hyperactivity disorder or Asperger's syndrome | <input type="checkbox"/> |
| Other impairment – eg epilepsy, cardiovascular conditions, asthma, cancer, facial disfigurement, sickle cell anaemia, or progressive condition such as motor neurone disease. | <input type="checkbox"/> |
| Prefer not to say | <input type="checkbox"/> |
| Other (please specify) | <input type="checkbox"/> |

* HM Government (2010) *Equality Act 2010* available at:
<http://www.legislation.gov.uk/ukpga/2010/15/contents> (accessed 13 April 2015)

Race/Ethnicity

Guidance note: These categories are based on 2011 census categories for England.

What is your ethnicity?

Choose *one* section from A to E, then tick the appropriate box to indicate your ethnic group.

| |
|--|
| A: White |
| <input type="checkbox"/> British, English, Northern Irish, Scottish or Welsh |
| <input type="checkbox"/> Irish |
| <input type="checkbox"/> Gypsy or Irish traveller |
| <input type="checkbox"/> Any other white background, please specify |
| B: Mixed or multiple ethnic groups |
| <input type="checkbox"/> White and Black Caribbean |
| <input type="checkbox"/> White and Black African |
| <input type="checkbox"/> White and Asian |
| <input type="checkbox"/> Any other mixed or multiple ethnic background, please specify |
| C: Asian or Asian British |
| <input type="checkbox"/> Indian |
| <input type="checkbox"/> Pakistani |
| <input type="checkbox"/> Bangladeshi |
| <input type="checkbox"/> Chinese |
| <input type="checkbox"/> Any other Asian background, please specify |
| D: Black, African, Caribbean or black British |

| |
|---|
| <input type="checkbox"/> Caribbean <input type="checkbox"/> African <input type="checkbox"/> Any other black British, African or Caribbean background, please specify |
| E: Other ethnic group |
| <input type="checkbox"/> Arab <input type="checkbox"/> Any other ethnic group, please specify |
| F. Prefer not to say |

Gender or sex

Guidance note: For monitoring purposes, the sex of an individual refers to whether they regard themselves as a man or a woman, at the point they are asked the question.

What is your gender?

| | |
|--------|--------------------------|
| Female | <input type="checkbox"/> |
| Male | <input type="checkbox"/> |

Gender reassignment

Guidance note: Do not monitor gender reassignment unless you are working to specifically target or improve services for individuals changing their gender. If you are monitoring gender reassignment, any member of staff that has access to the non-anonymised data must be made aware of Section 22 of the *Gender Recognition Act 2004*,* which prohibits organisations from making known the former gender of an individual who is protected by the Act. This carries criminal sanctions. Absolute confidentiality must be guaranteed.

* HM Government 2004 *Gender Recognition Act 2004* available at:
<http://www.legislation.gov.uk/ukpga/2004/7/contents> (accessed 13 April 2015)

The following questions have been provided by the Gender Identity Research and Education Society).* If you intend to monitor gender reassignment, you may want to remove the separate question on gender or sex.

1. Sex

What is your current sex?

| | |
|-------------------|--------------------------|
| Male | <input type="checkbox"/> |
| Female | <input type="checkbox"/> |
| Intersex | <input type="checkbox"/> |
| Other | <input type="checkbox"/> |
| Prefer not to say | <input type="checkbox"/> |

2. Gender

A: Gender identity – do you identify:

| | |
|-------------------|--------------------------|
| As a man | <input type="checkbox"/> |
| As a woman | <input type="checkbox"/> |
| In some other way | <input type="checkbox"/> |
| Prefer not to say | <input type="checkbox"/> |

B: Gender nonconformity – does your gender identity match completely the sex you were registered at birth?

This question is optional, but you may answer it *in addition to* the above or, if you prefer, *instead of* the above question.

| | |
|-----|--------------------------|
| Yes | <input type="checkbox"/> |
| No | <input type="checkbox"/> |

* Gender Identity and Research Society (2014) *Monitoring Gender Nonconformity – a Quick Guide* available at: www.gires.org.uk/assets/Workplace/Monitoring.pdf (accessed 13 April 2015)

| | |
|-------------------|--------------------------|
| Prefer not to say | <input type="checkbox"/> |
|-------------------|--------------------------|

C: Gender reassignment – have you gone through any part of a process, or do you intend to (including thoughts or actions), to bring your physical sex appearance, and/or your gender role more in line with your gender identity? (This could include changing your name, your appearance and the way you dress, taking hormones or having gender-confirming surgery)

| | |
|-------------------|--------------------------|
| Yes | <input type="checkbox"/> |
| No | <input type="checkbox"/> |
| Prefer not to say | <input type="checkbox"/> |

Religion and belief

Guidance note: The recommended question below was used in the 2011 census for England. The Office for National Statistics (ONS) has carried out extensive testing on the question and response categories for religion and belief. Testing has found that the question 'what is your religion?' best meets the requirements of collecting good quality data on religious affiliation.

The question is recommended by ONS for use in England only. Different questions are used in Scotland, Wales and Northern Ireland.*

What is your religion?

| | |
|-------------|--------------------------|
| No religion | <input type="checkbox"/> |
| Christian | <input type="checkbox"/> |
| Buddhist | <input type="checkbox"/> |
| Hindu | <input type="checkbox"/> |
| Jewish | <input type="checkbox"/> |

* The Office for National Statistics provides further details and guidance on the questions to be used in other parts of the UK and points to be taken into account when comparing. See: Office for National Statistics *Religion* available at: www.ons.gov.uk/ons/guide-method/measuring-equality/equality/ethnic-nat-identity-religion/religion/index.html (accessed 13 April 2015)

| | |
|------------------------------|--------------------------|
| Muslim | <input type="checkbox"/> |
| Sikh | <input type="checkbox"/> |
| Prefer not to say | <input type="checkbox"/> |
| Any other religion, write in | |

Sexual orientation

Guidance note: Whether there is a free text box for 'other' will depend on whether the system can capture and record free text.

These are the categories suggested by Stonewall when monitoring staff, customers and service users.*

Which of the following options best describes your sexual orientation?

| | |
|--------------------------|--------------------------|
| Bisexual | <input type="checkbox"/> |
| Gay man | <input type="checkbox"/> |
| Gay woman or lesbian | <input type="checkbox"/> |
| Heterosexual or straight | <input type="checkbox"/> |
| Prefer not to say | <input type="checkbox"/> |
| Other | |

Socioeconomic status

Guidance note: Socioeconomic status is not a protected characteristic under the *Equality Act 2010*.[†] However, in the context of medical education and practice, it is

* Stonewall (2012) *Using Monitoring Data* available at: www.stonewall.org.uk/other/startdownload.asp?openType=forced&documentID=3339 (accessed 13 April 2015)

[†] HM Government (2010) *Equality Act 2010* available at: <http://www.legislation.gov.uk/ukpga/2010/15/contents> (accessed 13 April 2015)

an important social issue. These questions were adapted from the template in the *Social Mobility Toolkit for the Professions*.*

Did any of your parent(s) or guardian(s) complete a university degree course or equivalent (eg BA, BSc or higher)?

| | |
|------------|--------------------------|
| Yes | <input type="checkbox"/> |
| No | <input type="checkbox"/> |
| Don't know | <input type="checkbox"/> |

What type of school did you mainly attend between the ages of 11 and 16?

| | |
|--|--------------------------|
| A state-run or state-funded school – selective on academic, faith or other grounds | <input type="checkbox"/> |
| A state-run or state-funded school – non-selective | <input type="checkbox"/> |
| Independent or fee-paying school | <input type="checkbox"/> |
| Attended school outside the UK | <input type="checkbox"/> |
| I don't know | <input type="checkbox"/> |

Did either (or both) of the following apply at any point during your school years?

Your household received income support:

| | |
|------------|--------------------------|
| Yes | <input type="checkbox"/> |
| No | <input type="checkbox"/> |
| Don't know | <input type="checkbox"/> |

You received free school meals:

| | |
|------------|--------------------------|
| Yes | <input type="checkbox"/> |
| No | <input type="checkbox"/> |
| Don't know | <input type="checkbox"/> |

* Professions for Good (2012) *Social Mobility Toolkit for the Professions* available at: <http://www.raeng.org.uk/publications/other/social-mobility-toolkit> (accessed 13 April 2015)

What was the postcode of the house you grew up in?

| | |
|-----------------------------|--------------------------|
| Postcode | |
| I did not grow up in the UK | <input type="checkbox"/> |
| Don't know | <input type="checkbox"/> |

Caring responsibilities

Guidance note: Carer status is not a protected characteristic under the Equality Act 2010. It is increasingly recognised that people with caring responsibilities may need specific support.

Do you have caring responsibilities? Please tick all that apply.

| | |
|---|--------------------------|
| None | <input type="checkbox"/> |
| Primary carer of a child or children (under 18 years) | <input type="checkbox"/> |
| Primary carer of disabled child or children | <input type="checkbox"/> |
| Primary carer of disabled adult (18 years and over) | <input type="checkbox"/> |
| Primary carer of older person or people (65 years and over) | <input type="checkbox"/> |
| Secondary carer | <input type="checkbox"/> |
| Prefer not to say | <input type="checkbox"/> |

Marriage and civil partnership, and pregnancy and maternity

Guidance note: Neither of these categories would usually need to be monitored in a non-employment context for data to be analysed. You may want to work through your human resources or another service to ascertain whether they hold relevant data to assess. For example, the number of people who have taken a break from study due to pregnancy or maternity. It is also important to consider that these are not permanent characteristics and may only be relevant to a specific point in time.

Are you married or in a civil partnership?

| | |
|-------------------|--------------------------|
| Yes | <input type="checkbox"/> |
| No | <input type="checkbox"/> |
| Prefer not to say | <input type="checkbox"/> |

As a woman, are you pregnant, on maternity leave or returning from maternity leave?

| | |
|-------------------|--------------------------|
| Yes | <input type="checkbox"/> |
| No | <input type="checkbox"/> |
| Prefer not to say | <input type="checkbox"/> |

Annex D: Glossary

Equality, diversity and discrimination

Equality: challenging discrimination, removing barriers faced by people from different groups, and creating a fairer society where everyone can participate and has the same opportunities to fulfil their potential.

Diversity: recognising, respecting and valuing the differences that everyone has, as well as gaining advantages from the opportunities that different people bring to the work.

Fairness: conforming with rules and standards; the ability to make judgments free from bias, discrimination and dishonesty; and being just to everyone.

Direct discrimination: less favourable treatment because of a protected characteristic (includes perceived and associated discrimination).

Associated discrimination: where a victim of discrimination does not have a protected characteristic but is discriminated against because of their association with someone who does, for example, the parent of a child with disability.

Perceived discrimination: discrimination against someone in the belief that they have a protected characteristic, whether or not they do have it.

Indirect discrimination: a condition, rule, policy or even a practice in an organisation, that applies to everyone but particularly disadvantages people who share a protected characteristic.

Discrimination arising from disability: treating a person unfavourably because of something arising as a consequence of their disability, in a way that cannot be objectively justified. This only applies if you know or could reasonably be expected to know that person has a disability.

Harassment: unwanted conduct related to a relevant protected characteristic, which has the purpose or effect of violating an individual's dignity or creating an intimidating, hostile, degrading, humiliating or offensive environment for that individual.

Harassment applies to all protected characteristics, except for pregnancy and maternity, and marriage and civil partnership.

People can complain of behaviour they find offensive – even if it is not directed at them.

Reasonable adjustments: Where a person with disability is at a substantial disadvantage in comparison with people with no disability, there is a duty to take reasonable steps to remove that disadvantage by:

- changing provisions, criteria or practices
- altering, removing or providing a reasonable alternative means of avoiding physical features
- providing auxiliary aids.

What is considered reasonable will depend on all the circumstances of the case, including the size of an organisation and its resources, what is practicable, the effectiveness of what is being proposed and the likely disruption that would be caused by taking the measure in question, as well as the availability of financial assistance.

Victimisation: occurs when an employee is treated badly because they have made or supported a complaint, or raised a grievance under the *Equality Act 2010*,* or because they are suspected of doing so.

Characteristics and beliefs

Age: where this is used, it refers to a person belonging to a particular age group (eg aged 32 years) or range of ages (eg aged 18–30 years).

Disability: under the legislation, a person has a disability if he or she has a physical or mental impairment that has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities.

The type of disability can be broken down into the following categories:

- learning disability or difficulty (such as Down’s syndrome or dyslexia), or cognitive impairment (such as autistic spectrum disorder)
- long-standing illness or health condition (such as diabetes or HIV)
- mental health concern, such as depression or schizophrenia
- physical impairment, such as difficulty using one’s arms, or mobility issues that mean using a wheelchair or crutches
- sensory impairment, such as being deaf or deafblind, or having a serious visual or hearing impairment.

* HM Government (2010) *Equality Act 2010* available at:
<http://www.legislation.gov.uk/ukpga/2010/15/contents> (accessed 13 April 2015)

Gender reassignment (see also *Transsexual or trans person*): a person has the protected characteristic of gender reassignment if he or she is proposing to undergo, is undergoing or has undergone a process (or part of a process) for the purpose of reassigning their sex, by changing physiological or other attributes of sex.

Gender or sex: a man or a woman.

Marriage or civil partnership: marriage is the legally or formally recognised union of a man and a woman (or, in some jurisdictions, two people of the same sex) as partners in a relationship. Same-sex couples can also have their relationships legally recognised as civil partnerships. Civil partners must be treated in the same way as married couples, on a wide range of legal matters.

Maternity or pregnancy: pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth. In the context of employment, it is linked to maternity leave.

In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth, and this includes treating a woman unfavourably because she is breastfeeding.

Pregnancy and maternity-related discrimination can occur outside of the workplace if a woman is treated unfavourably because:

- of her pregnancy
- she has given birth (within the past 26 weeks) and, in particular, because she is breastfeeding.

Pregnancy and maternity-related discrimination can occur in employment if a woman is treated unfavourably because:

- of her pregnancy
- of pregnancy-related illness
- she is on compulsory maternity leave (2 weeks or 4 weeks if she is working in a factory)
- she is exercising her right to take ordinary or additional maternity leave.

Protected characteristics: the legal term for the grounds upon which discrimination is unlawful, as listed in the *Equality Act 2010*.^{*} The characteristics are:

- age
- disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race
- religion and belief
- sex
- sexual orientation.

Race or ethnicity: Refers to the protected characteristic (see definition) of race. The legal definition of race as covered by the *Equality Act 2010*[†] states that race includes:

- colour
- nationality
- ethnic or national origins.

Religion and belief: religion has the meaning usually given to it but belief includes religious and philosophical beliefs, including lack of belief (eg atheism). To be included in the definition, a belief should generally affect life choices or the way a person lives.

Sexual orientation: whether a person's sexual attraction is towards their own sex, the opposite sex or both sexes. This includes heterosexual, homosexual, gay, lesbian and bisexual individuals.

Socioeconomic status: a person's social and economic position in relation to others, based on income, education and occupation.

Transgender: a person whose self-identity does not conform unambiguously to conventional notions of male or female gender.

Transsexual or trans person (see also *Gender reassignment*) refers to a person who has the protected characteristic of gender reassignment. This may be a woman who has transitioned or is transitioning to be a man, or a man who has

^{*} HM Government (2010) *Equality Act 2010* available at:
<http://www.legislation.gov.uk/ukpga/2010/15/contents> (accessed 13 April 2015)

[†] HM Government (2010) *Equality Act 2010* available at:
<http://www.legislation.gov.uk/ukpga/2010/15/contents> (accessed 13 April 2015)

transitioned or is transitioning to be a woman. The law does not require a person to undergo a medical procedure to be recognised as transsexual.

Annex E: Useful links

Equality and Human Rights Commission www.equalityhumanrights.com

Office for National Statistics www.ons.gov.uk

The Equality Act 2010 www.legislation.gov.uk/ukpa/2010/15

Email: gmc@gmc-uk.org

Website: www.gmc-uk.org

Telephone: **0161 923 6602**

General Medical Council, 3 Hardman Street, Manchester M3 3AW

Textphone: **please dial the prefix 18001** then
0161 923 6602 to use the Text Relay service

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