Equality, diversity and inclusion

Targets, progress and priorities for 2022

General Medical Council

Equality, diversity and inclusion: targets, progress and priorities for 2022

Report sections:

Executive summary

1 In 2021, we set targets for us as a regulator and an employer, to tackle persistent areas of inequality.

2 Addressing these inequalities is beyond the control of the GMC alone. In setting these targets, we have aspired to create sustained focus across the health system on these critical areas. If we are successful in achieving these targets, we will fundamentally improve the quality of education, training, and practice environments –and ultimately, the quality of care for patients.

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

4 2021 has represented a strong start. Workstreams have been established to lead and deliver the commitments supported by longer term plans. We have engaged with 90% of the designated bodies (DBs) with referral data indicating disproportionality to

highlight what inclusive and fair environments look like. We have changed our referral process to better understand what local efforts have been put in place to make sure referrals to us are fair. And on fairness in education and training, we have engaged with postgraduate training organisations, medical schools, and medical royal colleges to ensure they have equality, diversity and inclusion (ED&I) action plans in place to support these targets. We have also implemented our own ED&I action plan to improve our own inclusivity. More detail on our work is set out further in this report.

5 Early indications of performance on our regulatory measures shows mixed results. We are cautious in drawing conclusions from this given the longstanding and persistent nature of these challenges.

6 Our data shows that employer referrals have moved in a positive direction, with the gap in referral rates reducing across both measures and the proportion of DBs that are disproportionate slightly declining.

7 Measures of medical education and training remain essentially unchanged when you factor in statistical significance of any variation in the measures. This is not unexpected given that education and training outcomes reflect a complex interplay of inequalities over a 10-to-15-year period in which a doctor is training. But we know there is a huge amount of work going on across the healthcare system, prompted by a collective recognition of the need to act. This incremental change may take time to work through into the target measures, which are lag indicators of change.

8 Performance against our employment targets shows consistent and significant improvement in the first year - contributing to improvements in ethnic minority workforce representation at all levels. Our overall workforce representation is likely to be in line with, or above, our 2023 target. Our staff turnover and progression rates for ethnic minority staff are also improving and are already line with our 2023 targets.

9 We have worked closely with partners across the health service to support our shared ambitions and will continue to do so. We highlight a range of examples of this within this report. But there is more we and our partners across the system need to do and our asks are detailed in the report. They include:

- national, systems, and local bodies, having a stronger focus on addressing the underlying factors driving inequalities across all four countries of the UK.
- employers, educators, trusts and boards having stronger governance and plans on providing inclusive and supportive environments and assuring themselves they are making improvements.
- employers and educators to contribute to building the evidence on 'what works' by evaluating pilot initiatives and sharing their findings with others across the system.

- all health system stakeholders recognise and support the power of data and implement measures to gain insight into the impacts of inequalities in medicine in their jurisdictions.

10 In addition to the targets we have set, in 2021 we committed to reviewing our own regulatory decision-making processes and approach to assure ourselves we are doing everything we can to be as fair and transparent as we aspire to be. This report also explains more about our work to provide greater assurance of fairness in our processes.

Our ambition and targets

11 Our corporate strategy for 2021-2025 renewed our commitment to foster a culture of equality, diversity and inclusion in everything we do as a regulator and employer. The pandemic continues to highlight the need for meaningful action to address longstanding inequalities, and the impacts of racial discrimination and disadvantage.

12 Culture and leadership in workplaces are the most critical factors in enabling doctors to thrive and provide good care. We and our partners across the health service have a shared goal of making the health service a better, inclusive and supportive place to work for all staff. This is rightly top of the NHS's operational planning priorities for 2022-23 and will continue to be central to workforce plans across Wales, Scotland and Northern Ireland.

13 Taking firm steps to address the disparate experience of ethnic minority doctors is an urgent priority. It's the right thing to do and it will also make sure that the skills and experience of ethnic minority doctors can be fully utilised and deployed.

14 Racial disadvantage is not a minority issue. In 2020 38% of all licensed doctors in the UK were from an ethnic minority background and this proportion is growing. These doctors do not have a fair and equitable experience in their medical education and training, and they are significantly more likely to be referred into our fitness to practise process by their employer.

15 In February 2021 we committed to eliminating:

- disproportionality in fitness to practise referrals from designated bodies based on ethnicity and place of primary medical qualification (PMQ) by 2026.
- differences in key index measures of fairness in medical education and training by 2031.

16 Eliminating these differentials will create more inclusive, supportive and fairer local environments. And inclusive environments lead to better patient outcomes and satisfaction.

17 There is also more we can do to assure ourselves that we are a fair and transparent organisation. This includes modelling the behaviours we are expecting of others to create more inclusive local environments.

18 We also want to test that existing systems, controls and approaches on mitigating bias, monitoring differentials and promoting fairness across our regulatory functions are as robust as possible, both for now and the longer-term. We have committed among other things to:

- review our own processes to provide more positive assurance that we actively challenge bias and are transparent about how we work.
- improve our own inclusivity as an employer, eliminating differentials in recruitment, representation, retention, progression, pay and employee engagement by 2026.

2021 progress

19 2021 shows a mixed picture of overall performance. We are cautious in drawing conclusions from this given the longstanding and persistent nature of these challenges. Annual movements in figures over a longer time period will give us clearer trends. Our threshold for success will only be seeing sustained improvements over several years and improvements that are statistically significant.

20 In that context, our data shows that employer referrals have moved in a positive direction, with the gap in referral rates reducing across both measures and the proportion of DBs that are disproportionate slightly declining.

21 Measures of medical education and training remain essentially unchanged when we factor in statistical significance of any variation in the measures. This is not unexpected given the education and training outcomes reflect a complex interplay of inequalities over a 10–15-year period in which a doctor is training. Change is needed to policy and process throughout the whole system from entry into medical education, access to support and learning opportunities and the design of assessments. This is a challenge reflected in broader education and society and will require close ongoing attention. Owing to when data is available, we also do not have a complete set of updated metrics to inform our overall assessment at this time.

22 We have made significant progress on our ambitions to become a more inclusive employer. We have established a *Fostering inclusion* learning programme for all managers and implemented two talent programmes to support ethnic minority staff to develop and progress. We have revised our recruitment processes to make sure we attract more diverse talent and generated beneficial insight on inclusivity within our staff survey.

23 Performance against our employment targets shows consistent and significant improvement in the first year. Our recruitment metrics are on target and this performance is contributing to improvements in ethnic minority workforce representation at all levels. Our overall workforce representation is likely to be in line with, or above, our 2023 target. Our staff turnover and progression rates for ethnic minority staff are also improving and are already line with our 2023 targets. However, we are not complacent and recognise we need to sustain or exceed this performance to be able to meet the overall targets in the long term.

24 It is too soon to say what the concrete solutions are to the challenge of driving further improvement across all our measures. Our response will need to continue to be iterative over time, understanding the impact of interventions and making a coordinated effort to focus attention on a sustained basis.

25 This iterative approach will be the reality of how we must work to understand what has an impact. This highlights the need and value for the annual reflection on progress and recalibration of plans and asks of others. We will vigilantly reassess our interventions and work with others in a more agile way.

26 We will undertake more work to assure ourselves on the validity of our performance approach in the longer term as we have more data points to report on. We need to be sure that our measures remain valid and inform our future projected activity.

27 Many organisations are working towards the same goals and we have been able to collaborate on many initiatives. This report reflects on some of their key initiatives as much as our own. It also reflects our calls to action for others.

2022 calls to action

28 In 2022 we will:

- request Responsible Officers (ROs) advise us how they have assured themselves any fitness to practise referral to us is fair. They will also need to identify what support they have provided to the individual as part of that referral.
- review the quality and insights from these referrals and their local checks and controls to identify best practice to promote and embed more widely.
- target conversations with ROs on best practice on maintaining fair and inclusive environments and identify and share this across the system.
- continue to deliver Welcome to UK Practice (WtUKP) and work with stakeholders to make sure it will be (or remain) a mandatory part of a broader coordinated and appropriate induction for those international medical graduates (IMGs) that are new to practice in the UK.

- ask that all educational organisations contribute to building the evidence on 'what works' by evaluating pilot initiatives. We ask that they share their findings with others across the system so that initiatives can be scaled up and applied in different environments more quickly.

- require medical royal colleges, postgraduate deans and medical schools to submit organisational action plans describing how they will improve outcomes for IMG and ethnic minority learners in their region, country or specialty.

- ask medical royal colleges to improve the diversity and inclusion of high-stakes exams. This includes broadening the diversity of examiners and question-writers. It also includes developing targeted support and feedback for candidates unfamiliar with UK assessment methods, with fewer educational resources to help prepare effectively and coping with the additional anxiety of perceived bias within the assessment.

- ask statutory education bodies, colleges and the UK Foundation Programme Office to review the ED&I impact of the systems and policies around recruitment of learners and to deliver on recommended improvements.

- ask medical schools to provide exam data which will be used to monitor and improve fairness in undergraduate education.

- continue to use our regulatory levers to drive a stronger focus on eliminating ethnicity differentials in education and training providers.

- continue to push for action on ethnicity and race. Some stakeholders have viewed this focus as us shying away from the disadvantage of others. We have a responsibility to tackle inequality for all, however the focus on race is overdue and proportionate based on our data and the scale of the issue. Ultimately, the solution to addressing ethnicity-related differentials –understanding the needs of the individual and providing tailored support – is an approach with universal benefits for all.

- ask national and systems bodies to embed the conclusions of *Fair to refer?** into their understanding and definitions of what good looks like. This will help us build a consensus on the scale of the challenges of bias and discrimination in local environments and acceptance of the need for us all to play a role in actively tackling these challenges.

* * Fair to refer? is research we commissioned to understand why disparity exists in

- ask national, systems, and local bodies, for a stronger focus on closing local disciplinary gaps across all four countries of the UK. Tackling the disciplinary gap is a critical intervention that will drive better focus on ensuring tailored understanding of individual needs and support.

- ask that all health system stakeholders recognise and support the power of data. We will continue our close support of the work and ambitions of the NHS England/Improvement's (NHSEI) Medical Workforce Race Equality Standard (MWRES) as a powerful tool to measure and drive progress in England. We will also consider how we can offer regionalised data to support regional activities across the whole of the UK. We ask that relevant stakeholders in other countries of the UK consider an equivalent measure to gain insight into the impacts of inequalities in the health service in their jurisdictions.

- ask employers, trusts and boards to consider how they assure themselves that they have inclusive and supportive environments in place. This includes their race equality action plans, equality training, inclusive performance objectives for leaders, and networks of coaches and mentors for all staff.

- ask employers who lead on good practice in these areas to openly and proactively share this for others across the system to learn from. We ask those who recognise they need to do more to proactively seek evidence on the approaches that might help them to improve.

- ask anyone defining action plans, pilot interventions, targets and measures, to align them wherever possible to the timeframes of our targets to promote stronger coordination. We also ask for them to design their interventions with a focus on understanding the needs of the individual in a broader sense, so that improvement may have universal benefit across all protected characteristics.

- ask that interventions are supported by investment in evaluating the impact and to share those outcomes. Understanding what works will be key to understanding what initiatives should be scaled up once proven to be effective.

Fairer employer referrals

29 We set two performance measures to underpin this target. They reflect the nature of the challenge which requires attention by employers to assure themselves that their processes are fair and free from bias (KPI1), and it needs national attention across regulators and system partners to affect change (KPI2):

- KPI1 - percentage of DBs with evidence of disproportionality, for either ethnicity or PMQ region in their referral.

- KPI2 - difference in rates of referral between ethnic minority and white doctors and between 'UK PMQ' vs 'non-UK PMQ' at a national level.

30 At the DB level the number of referrals is very small. Our first-year experience of monitoring this has shown that a single referral can move a DB into or outside of the group of DBs with disproportionate referrals. However, this group is relatively recurrent. Of every 10 DBs in this group in any quarter of 2021, 9 were in such group in the previous quarter too. We have used this grouping to target our conversations with employers, and our analysis has highlighted some areas that may benefit from further analysis and consideration.

31 Because of the small number of referrals, a five-year rolling period is used to generate and monitor referral trends. As a result, the benefits from local improvements in environments will take some time to be realised and the visibility of change will be very gradual over time.

32 We are working towards eliminating these differentials in the timeframes set, but we recognise that there may be factors or developments that emerge over the next 5 or 10 years which might affect these reducing to exactly zero. Regular monitoring will allow us all to keep close scrutiny of this. Once we reach the end of our timeframes, we will use regular review mechanisms to check that all the changes continue in the right direction.

Table 1 – Fairer referrals measures

TARGET: Eliminate disproportionality in fitness to practise referrals from			
		2016-2020 (pooled data)	**2017-2021** (pooled data)
KPI1: % of DBs with evidence of disproportionality, for ethnicity or PMQ	**Ethnicity or PMQ**	**5.6%**	**5.3%**
KPI2a: Difference in rates of referral between ethnic minority and white doctors	**Ethnicity**	**0.28%** 0.58% ethnic minority 0.30% white	**0.24%** 0.50% ethnic minority 0.26% white
KPI2b: Difference in rates of referral between UK and non-UK doctors	**PMQ**	**0.42%** 0.28% UK 0.70% non-UK (made up of 0.73% IMG and 0.63 % EEA)	**0.34%** 0.25% UK 0.58% non-UK (made up of 0.59% IMG and 0.56% EEA)

*N.B. We have enhanced the accuracy of all KPIs, including the initial benchmarks. The enhanced accuracy' of the data for these indicators has been achieved following a data improvement exercise**.** Since the last reporting time in February 2021, there has been a slight decrease in the proportion of DBs showing disproportionality (KPI1) and in overall employer referral disproportionality (KPI2), which is our key target for differences based on both ethnicity and PMQ

33 From our initial benchmark, KPI1 improved by about 5 % and KPI2 metrics dropped by about 16 and 19 % respectively. But we will continue to measure the efficacy of these performance metrics over time and formally review progress against the measures at the mid-way point.

34 After the first year of monitoring, our view is that, though these KPIs can in principle be reduced towards zero, in practise it is unlikely that they will become exactly zero. The 5-year rolling period is necessary for robust analysis but means that if disproportionality improves in the first year, it will take time to show in the overall measure. If the improvement was small, it could take up to 5 years to be fully seen in the overall measure.

35 For example, for KPI1, if a DB with disproportionality starts referring proportionately, the assessment of its proportionality will be based on data that is partly disproportionate and partly a proportionate period of referral. For the next 4 years it will have older data in its pooled 5-year sample. This may not be enough for the DB to become statistically proportionate in the 5-year rolling period. Also, an unusual referral pattern may result in a DB to newly join the group of DBs with disproportionate referrals, increasing KPI1 off zero for a short period. For KPI2, the rates of referral may become more similar, but may not become equal to make KPI2 exactly zero.

36 The ongoing pressure on the system from responding to the pandemic is impacting our ability to have some conversations both nationally and locally. However, the pandemic itself continues to expose the need to tackle these and other areas of inequality affecting minority ethnic members of the health service and the public.

2021 action

Fairness conversations

37 We have met with approximately 90% of the DBs identified as having referral data indicating disproportionality. These conversations will continue on an ongoing basis.

38 The focus of these meetings is to understand what local action is linked to the key findings in *Fair to refer?* (FTR). The conversations so far indicate that all ROs recognise it is important to take forward the recommendations of FTR in the form of more supportive and inclusive working environments, and there is work underway across the system. However, there is variance in the levels of expertise to address the key findings, and the resource and commitment to do so. Some positive examples of work we have heard about from DB's are:

- race equality action plans and race equality training.
- inclusion as part of objectives for leaders.

- networks of coaches and mentors for all staff.
- IMG fellowship scheme for non-training grades (formalised recruitment, shadowing, induction period).

39 Some examples of areas that need more work are:

- mixed levels of ability and confidence across their organisation in giving feedback to colleagues.
- few DBs are aware of staff support networks, but some considering links for future work.
- a single DB told us they do not have inductions that support the transition of doctors into UK culture but are looking at how they welcome doctors from overseas.

40 From our detailed look at many of the trusts and boards in the dataset, it is clear the context of referrals might be significant and, if understood, could influence the appropriate engagement with a DB. We have taken the approach of engaging with ROs across the system to understand how they are progressing activity to embed the recommendations from FTR and mitigate risk of bias. As part of this work, we are inviting ROs to identify what they believe is good practice that we can then share with others and identify areas where we can provide support through activities such as providing additional data.

Referral form changes

41 We updated our employer referral form to require ROs to confirm the steps they have taken to ensure a referral is fair and appropriate before it is submitted to us. This includes questions about:

- any systems issues related to the events.
- for doctors new to UK practice, any induction about what is expected when things go wrong.
- support provided since the concerns were identified about any improvement needed.
- impartial checks undertaken of whether a GMC referral is appropriate at that time.

42 This followed a three-month pilot where ROs were supportive of these changes, although some felt that they were already giving system factors due consideration. Where we did receive a referral with questions answered, this detailed a series of attempts to support the doctor and in-depth checking of the fairness of the referral.

Feedback mechanisms

43 We are refining our process to provide feedback to ROs about the outcome of cases referred to us. A workshop explored mechanisms for developing, recording, and sharing feedback. This includes premature referrals that do not meet our threshold for investigation and where more local support is appropriate.

Future action plan and 2022 focus areas

44 As successful delivery of this target relies on substantial cultural change in external organisations, we are using an iterative approach to taking forward actions. This will enable us to monitor and take account of changes in the external environment and to reflect learning from that in our approach.

1 Our action plan is front-loaded with activity. We will undertake annual reviews and use that to inform the next phase of actions. During the review points, we will also consider engaging the system to collate feedback and develop our future phases.

2 At the core of these interventions will be our continued commitment to embedding the key recommendations and learnings from FTR into the understanding and definitions of what good looks like. We will continue to ask national stakeholders to make sure their work is predicated using FTR as a source of common and good practice and using data sources similar to the NNHSEI MWRES data as measures of success.

45 We cannot deliver this target alone. We continue to collaborate with national and regional stakeholders who have similar aspirations to tackle inequalities. In particular, the Working Race Equality Standard (WRES) team is currently planning their priorities for 2022 with an increased focus on the work to address the NHS England People Plan workstream entitled 'tackling the disciplinary gap' in spring 2022.

46 Linked to this, we are currently agreeing a shared understanding with NHS Resolution (NHSR) on the importance of this work, what our pooled data shows, effective interventions and why healthcare organisations should prioritise it. We have approached NHSEI, the Care Quality Commission and the Nursing and Midwifery Council to join the work to help draw a more complete and common understanding of the challenge and potential solutions.

47 Given the pressure on the system across the four countries of the UK, there has been a common concern about progressing this work and the need for reasonable expectations about the pace of change. There are varied views on what good looks like and some organisations to continue to question the validity of our role in this area. Some of the challenges we have heard about across the system are centred around lack of expertise, resource, and capacity, such as:

- a lack of time to focus on this given other support needs, such as wellbeing support through the pandemic.

- lack of time and money to release doctors for learning.
- a lack of expertise in what works in specific settings – it cannot be a 'one size fits all' approach.
- releasing support staff for managing projects and evaluating what works.
- buying and embedding new systems that might make a difference such as a feedback system for all doctors.

Table 2: Fairer referrals action plan

2021 launch	2022 phase 1	2023 phase 2	2024 phase 3	2025 phase 4	2026 phase 5
Action plan: Shared narrative on the disciplinary gap Review of adverse information data AR training on handling employer referrals Amend RO referral form Enhance feedback to ROs on triage and investigation outcomes	**Action plan:** Collaborate with system partners on the disciplinary gap Analysis of RO referrals and outcomes Ongoing review of our approach to referrals Cycle evaluation: Progress against agreed activities Learning & feedback (internal/external) to inform next cycle	**Action plan:** Evaluation and monitoring of impact on referrals and our handling Other activities TBC Cycle evaluation: Progress against agreed activities Learning & feedback (internal/ external) to inform next cycle	**Action plan:** Board engagement Support with fairness/ inclusivity Further activity TBC dependant on outcome of trajectory review Cycle evaluation: Progress against agreed activities Learning & feedback (internal/ external) to inform next cycle	**Action plan:** Board engagement Support with fairness/ inclusivity Further activity TBC, dependant on outcome of trajectory review Cycle evaluation: Progress against agreed activities Learning & feedback (internal/ external) to inform next cycle	**Action plan:** Further activity TBC, dependant on outcome of trajectory review Cycle evaluation: Progress against agreed activities Learning & feedback (internal/ external) to inform next cycle
Ongoing RO conversations and board engagement					

Fairer education and training cultures

48 Our Council approved an index of six measures and since the initial benchmarking in February 2021, there have been updates to educational performance measure (EPM) scores and the national training survey measures. The Annual review of competency progression (ARCP), exam and undergraduate assessment analysis will be available in May 2022. The full update to the index measures is in Table 3 below.

Table 3 – Index measures for fairer training cultures

Index measure	Baseline	2020	2021
Undergraduate EPM scores- 2019 Difference between mean educational performance measure (EPM) scores	White: 6.05 Ethnic Minority: 4.93 **Gap: 1.12***	White: 6.09 Ethnic Minority: 4.92 **Gap: 1.17***	White: 6.16 Ethnic Minority: 4.94 **Gap: 1.22***
Undergraduate exams - Differences in medical school exam pass rates Data not available to baseline until May 2022			
Undergraduate – F1 preparedness (NTS) - Difference in preparedness levels of new F1 doctors		White: 70.2% Ethnic Minority: 62.4% **Gap: 7.8%***	White: 76.3% Ethnic Minority: 65.8% **Gap: 10.5% ***
Postgraduate – inclusivity (NTS) - Difference in perceived inclusivity levels		UK White: 81.6% UK Ethnic Minority: 77.2% **Gap: 4.4*** ALL UK: 80.1% ALL IMG: 76.0% **Gap: 4.1***	UK White: 83.0% UK Ethnic Minority: 80.0% **Gap: 3.0*** ALL UK: 82.0% ALL IMG: 77.3% **Gap: 4.7***
Postgraduate – ARCP outcomes - 2018/19 - Difference in rates of unsatisfactory outcomes	UK White: 4.8% UK Ethnic Minority 7.1% **Gap: 2.3%*** ALL UK: 5.6% ALL IMG: 15.7% **Gap: 10.1%***	Data not available until May 2022	
Postgraduate education – exams 2018/19 - Difference in exam pass rates	UK white: 77.7%, UK Ethnic Minority: 65.4% **Gap: 12.3%*** ALL UK: 73.2% ALL IMG: 43.8% **Gap: 29.4%***	Data not available until May 2022	

*N.B. Not statistically significant difference

49 The differentials in the key measures remain persistent and consistent with the trend observed since 2015. The small annual fluctuations do not represent meaningful worsening or improvements in outcomes.

Postgraduate training organisations

50 Annual engagement meetings with all the postgraduate training organisations have taken place with a strong focus on differential attainment. This is the third year these conversations have taken place. We ask that postgraduate training organisations document their action plan to record what they are doing to address the attainment gaps in each region.

51 Differential attainment data have been refreshed and provided to organisations to allow them to track progress and update their action plans which are due to be resubmitted in January 2022.

52 We held an annual quality leads meeting with postgraduate training leads across the UK to bring organisations together to share ideas and practice. Improving fairness is high on the agenda. Health Education England (HEE), for example, have established an ED&I strategy group to coordinate change across England and invested a significant budget in developing interventions within general practice. The number of projects running simultaneously could affect the momentum of work because there will evidently be a lot of change and reform.

Medical schools

53 The annual quality leads meeting focused on our ED&I targets and our proactive quality assurance process to oversee medical school action plans.

54 The first set of medical school assessment data has been received and will inform our proactive quality assurance process in 2022.

55 The Medical Schools Council established an ED&I Alliance. In December 2021, they published a framework for supporting medical schools to make their environments and processes more inclusive.

56 Medical schools are undertaking a significant amount of work such as:

- revising curriculum and assessment material to represent a diverse patient population.
- student engagement on their experiences of racism.
- development of reporting tools for concerns relating to ED&I issues.
- adopting the British Medical Association's racial harassment charter.
- broadening support packages for different groups of students.

- ensuring recruitment panels are fair and have recruited staff that is representative.

Medical royal colleges and faculties

57 In November 2021, we launched a new ED&I action plan for medical royal colleges and faculties. This requires colleges and faculties to submit evidence of the work they are doing to tackle the attainment gap in 2022. We held a quality leads meeting to introduce the action plan with representation from every college and faculty and received a positive response. They have been asked to report on specific areas which will inform the future development of fair assessment and curricula, which are:

- diversity of examiners and exam boards.
- support for Educational Supervisors.
- support for learners and developing inclusive programmes of learning and assessment.

58 Building up evidence about which interventions are most effective is critical to achievement of our targets. We have partnered with HEE and the Royal College of Psychiatrists to fund a pilot to support exam preparation training. The first cohort achieved a very promising 70% pass rate. Although we need to be cautious of drawing conclusions from a single cohort, this compares favourably to the 33% pass rate for IMG candidates nationally. This initiative will continue through 2022 with 170 trainees taking part in total and is being evaluated by Edge Hill University through qualitative and quantitative evidence.

59 A new grant has also been issued to Melanin Medics to fund an enrichment programme focused on peer-support and mentorship for final year medical students of black African and Caribbean heritage and to evaluate its impact.

60 We know there is a huge amount of work that is going on across the system. For example HEE have just published a report after the first 12 months of their ED&I programme. We know similar work is going on within the UK Foundation Programme Office, Medical Schools Council, Medical Royal Colleges, Health Education and Improvement Wales, NHS Education for Scotland and the Northern Ireland Medical & Dental Training Agency.

Future action plan and 2022 focus areas

61 This is a complex programme, with many causal factors. There is no single solution and system-wide change is necessary. To deliver our targets we will need to work in

collaboration with statutory education bodies, local education providers, medical royal colleges, and medical schools across the UK.

62 Evidence of effective solutions is limited. We will take an iterative approach to testing, evaluating, scaling up interventions and identifying new work.

63 There is a genuine appetite to address our targets for the good of all trainees and students. Many organisations are trying to find the right initiatives that works for them and their learners. This means there may be a lot of initiatives happening simultaneously and trialling different approaches in the early years of this programme of work.

64 Connected with this, there is a likely gap in investment in evaluating the impact of the changes that are made because of time and resource constraints. We will continue to push for appropriate evaluation so that we understand, and support, business cases to scale up initiatives once proven to be effective.

65 Our action plan focuses on the deliverables for phase one of the 10-year work programme. Impact of individual deliverables will be tracked during phase one and the impact of all work collectively evaluated at the of this phase. The phases will overlap as different workstreams progress at different rates.

66 Systematic change is required at multiple points across the system. That is reflected in the six workstreams we are developing to leverage our regulatory power to set standards for medical education and training. Our focus will be:

- ***Quality assurance of recruitment and selection*** – evaluating the ED&I impact of the current system including opportunity for ethnic minority and IMG learners to access their preferred specialty and training location.
- ***Personalised support for learners and early intervention*** - setting new expectations of support for learners and developing reliable mechanisms to identify an individual's learning needs earlier in training.
- ***Quality assurance of inclusive learning environments*** - refining how we quality assurance training environments including a review of the quality of the evidence we gather.
- ***Quality assurance of approved trainers and support for trainers*** – *refining* our quality assurance of trainers to ensure they have the skills to support a diverse group of learners and are supported by postgraduate deans.
- ***Building our data and evidence on what works*** – enhancing reports which meet the needs of our quality assurance functions and empower stakeholders to take action and monitor impact. In 2022 we will publish more granular

demographic groupings to enable more targeted interventions. We will continue partnering with others to build evidence on which interventions make a difference.

- ***Fair assessments and curricula*** – enhancing our requirements and quality assurance to make sure that learners are supported to understand and meet the standards outlined in curricula and assessments, particularly those less familiar with UK training.

Table 4: Fairer training cultures action plan

2021 – 2024 phase 1 Scope, external engagement and initiate transformation of QA processes and testing interventions	**2024 – 2028 phase 2** Scale up, embed new standards or guidance, reassess scope of phase 2 in response to learning and evidence of impact	**2028 – 2031 phase 3** Iterative monitoring, evaluation of impact and refinement of scope
Action plan: **WS1**: Initiate EDI impact assessment of recruitment & selection processes against our standards **WS2:** good practice guidance on supporting 'higher risk' learners, QA 'deep-dive' into action plans in priority regions, development of early needs analysis tools and testing interventions to build 'what works' evidence **WS3**: Modelling to identify concerning learning environments & build evidence on interventions which improve inclusive local cultures **WS4**: Develop QA of and support for Trainers (linked with Outreach, Good medical practice and regulatory reform) WS5: Publish expanded EDI data & improve visibility and links with MWRES **WS6**: Define QA requirements for curricula and assessments – college and medical school ED&I action plans established	**Action plan:** Evaluate evidence from Phase 1 and impact on KPIs within pilot regions – scale up effective interventions and identify gaps to be addressed in phase 2 & 3 through new workstreams **WS1**: potential to create new standards for recruitment and selection **WS2:** Consider new standards on personalised learning and recommended interventions for learners at higher risk (e.g. New to UK) **WS3**: – 6: Embed and expand QA of QAMI, data and research, trainers and curricula and assessments	**Action plan:** Impact on KPIs – identify any further gaps to be addressed in phase 3 through new workstreams Monitor impact of establishment of new standards, systems and monitoring
External engagement with partners		

Assuring fairness of the GMC

67 The most recent audit of our fitness to practise decisions was completed in May 2021 by law firm FieldFisher, in partnership with the University of Edinburgh. The auditors considered 119 fitness to practise cases and found no evidence of bias in the way our decision makers interpreted the guidance. This complements past, similar research where we have sought to assure ourselves, we are not contributory to discriminatory outcomes.

68 While we were assured by the audits, we know that bias and disadvantage is a significant issue in the health system and broader society. If we are to learn and improve, our fairness audits need to be designed and delivered in a way that seeks out and finds the instances of bias so that we, and others, can learn from them.

69 In June 2021 an Employment Tribunal upheld a claim that we had racially discriminated against a doctor in our fitness to practise processes. We understand stakeholders' disappointment with that outcome, and our decision to appeal. In response we began a broader review of how we assure ourselves that our regulatory processes clearly demonstrate fairness in decision making, and proactively demonstrate where potential fairness concerns may exist. We will complete this programme of work later this year, under the following focus areas.

Future proofing through regulatory reform

70 The UK Government's proposed reforms to how we regulate brings many benefits and opportunities. This is a unique chance to redesign our processes and embed fairness across everything we do. It has the potential to fundamentally change what concerns we investigate and how. We want to ensure that fairness is central to how we design these processes and to be transparent with our stakeholders about how we have taken account of the equality dimension of our proposals. We also want to support our people to do this to the best of our ability. In response we:

- delivered supplementary training during October to our teams working on our regulatory reform programme on our approach to equality impact assessment and targeted training on human rights
- will publish our equality impact assessments that underpin our proposals when we publicly consult
- will externally and independently quality assure our final equality impact assessments. These will reflect the feedback of stakeholders during our consultation. And we will publish them to demonstrate our confidence in the approach we adopt and our openness to scrutiny of the fairness of our proposals.

Improving our current processes

71 From November 2021 through to March 2022, we are delivering workshops across all our functions to understand the equality, inclusion, and fairness learning needs of our people, targeted to their role. This builds on our existing ED&I mandatory staff training, to provide more targeted learning support. We are using this output to complete a refreshed learning needs analysis that is clear on how we can skill and support our people to not just be fair and inclusive, but to proactively challenge bias and discrimination.

72 We have created two working groups to:

- systematically review high-stakes decision points in our processes and identify if we can strengthen the controls for fairness in the short term. This includes single vs. group decision-making, quality assurance arrangements, and the adequacy of guidance

- review how we use protected characteristics data in our process performance reporting. We want to be transparent about how our processes operate and the individuals within them. We have challenges meeting the wide range and specificity of requests from stakeholders and they often result in numbers so low that they hit our suppression rules. This can contribute to perceptions of a lack of transparency. This work will develop an approach to standardised reporting on a regular and routine basis of how our processes work from a fairness perspective.

Independent assurance

73 In January 2022, we commissioned an external, expert review of our past research on the fairness of our processes to identify and apply any learnings from this. This includes listening to doctors that have been through our processes to understand their perceptions of bias in our approach, so that future audits can test these elements.

74 We will use the output of this review to implement a rolling programme of routine fairness audits of our processes and publish the results and learnings of where bias exists in ours, and others, processes.

Inclusivity within the GMC

75 Our aim is to build an organisation that is diverse at all levels and that the employment and workplace experience of all colleagues is inclusive, positive and provides fair access to opportunities for all. To do this, we are committed to eliminating differentials by protected characteristic in recruitment, representation across staffing levels, retention, progression, pay and engagement. These are currently most marked when we look at ethnicity.

76 Our performance targets and performance for 2021 are set out in Table 5 below:

Table 5: Inclusivity in employment measures

		Actual				Target		
		2020 (%)	2020 (Vol)	2021 (%)	2021 (Vol)	2023	2021 percentage points from 2023 target	2026
Increase the level of ethnic minority representation at Level 3 and above	Applications	22.8%	170	32.1%↑	253	27%	+5.1%	30%
	Interviews	15.2%	118	22.4%↑	60	22%	+0.4%	25%
	Offers	14.6%	36	32.1%↑	16	17%	+15.1%	20%
	Workforce	11.1%	64	13.3%↑	77	16%	-2.7%	20%
Level of ethnic minority representation at Level 2+		8%	18	10.8%↑	23	14%	-3.2%	20%
Level of ethnic minority representation at level 3		12%	46	14.3%↑	54	16%	-1.7%	20%
Increase the level of ethnic minority representation at all levels	Applications	29.4%	663	40.0%↑	1332	37%	+3.0%	40%
	Interviews	18.2%	118	27.4%↑	260	32%	-4.6%	35%
	Offers	18.2%	36	30.2%↑	88	27%	+3.2%	30%
	Workforce	14.3%	211	16.0%↑	247	17%	-1.0%	20%
Reduce differential turnover rates for ethnic minority staff		0.8%	-	Ethnic Minority (%)	White (%)	1-2%	0.4%	1.0%
				8.2%↑	7.8%			
Proportion of ethnic minority staff receiving promotion and grade progression is proportionate to our workforce at the relevant grade/level **difference is not set against the 2023 figure, the target is that the proportion of staff will be equal across BME and Non-BME*		-1%	-	Ethnic Minority (%)	White (%)	18%	3.4%	18%
				17.7↑	14.3			
Pay differentials within a confined band limited to 2% from 2023[1] *(table shows the proportion of bands that are outside of the tolerance)*		50.0%	6/12	41.7%	5/12	2.0%	N/A	2.0%

N.B. - ↑ identifies improving measures

2021 action

Workforce profile and career development

77 We have made solid early progress and our workforce trends are on track:

- turnover and progression are in line with our 2023 targets
- our recruitment metrics are on target, albeit with a fall off from application to interview

- our overall staffing make up is likely to be in line, or above, our 2023 target.

78 Our latest projections suggest that current turnover and appointment trends will take us to, or close to our targets.

79 Sustaining these trends will be helped by further planned activities targeted at graduates and apprentices, and we expect our in-house training to support improved internal progression. We will also expand our recruitment outreach work to better identify, support and attract a pipeline of diverse talent.

80 Increased external recruitment has had a positive impact on these results. We need to balance this against ensuring our investment in existing staff from under-represented groups translates into career progression for them also.

81 While we are happy with our progress, the recruitment market is volatile, and turnover is higher at our lower levels. We will need to work hard to retain staff and maintain this level of performance. Our planned programmes for graduate and apprentice programmes (starting this year) are expected to have an additional positive impact on our workforce profile (and management roles in 4 to 5 years).

82 We have seen a solid, but more limited level of progress in our more senior roles compared with than we have at other levels. Our 2026 targets are ambitious and progress towards them is sensitive to turnover. Our current projections are that we would, in terms of headcount and current, be 8 below our target in 2026, 3 below in 2027. Forward planning and supporting early retirements may help. While our recruitment experience is generally positive, we will ensure we take every opportunity over the coming years to progress further on senior hires We expect that our internal development programmes and an increasing diverse workforce will see us close this projected shortfall.

83 Alongside this work on our workforce projections, we have also started to look at the wider impact of changes to our turnover, recruitment and promotion patterns. This at an early stage, but this will inform our ongoing work, especially around recruitment where we can potentially identify groups where we are less successful on attracting or progressing candidates, while consolidating good practice where we are making progress

84 Our work on the relationships between different protected characteristics is at an early stage, but there are some clear patterns from our 2021 data. Over the last four years we have seen a small average increase in the percentage of our staff who are women (62% to 63.1%). We know female applicants are increasingly well represented as our recruitment process progresses. This is slightly more marked for ethnic minority candidates. In 2021 ethnic minority candidates were 60.2% female and 39.8 % male, but the appointment ratio was 69.2% female and 30.4% male, so a potential area for further review.

85 The other area we have considered is age. Ethnic minority colleagues are younger on average, and this became more marked in 2021. In 2018 ethnic minority colleagues were 2.1 years younger on average, in 2021 it was 3.7 years. Ethnic minority applicants are on average 29.6 years old compared to 33.4 years for other candidates.

86 This highlights the potential value of our internal development programmes, the importance of career ladders and retention in meeting our longer term aims.

87 It also provides some reassurance that further recruitment via graduate and apprenticeship schemes. Is likely to support tour aims.

88 While our current focus on more external recruitment has proved successful, we can see the longer-term benefits of supporting the progression of an increasingly diverse internal workforce. It also highlights the potential challenge in diversifying our senior leadership in the short and medium term where younger candidates face extra challenges.

89 We have a programme of learning and development initiatives to support achieving our aspirations. This includes two programmes delivered by an external training provider. These supplement our existing leadership offering for all staff, to make sure colleagues from ethnic minority groups currently underrepresented at a senior level are supported to reach their potential:

- Developing diverse leadership - for colleagues at levels 2, 3 and 4
- Developing diverse talent - for colleagues at levels and 5 and 6.

Workplace experience

90 As an important foundation for our inclusion aspirations, we embedded inclusivity into our OneGMC behaviours at the start of 2021. This included making sure inclusivity considered and integrated into staff objectives and promoting our internal and external aspirations widely across the organisation. This will become a more integral part of our approach to 360° feedback.

91 In October 2021 we launched our *Fostering inclusion* programme, designed to help managers build more inclusive teams. Leaders and managers are starting their learning journey with initial self-evaluation and self-led learning modules. The programme will be rolled out in cohorts, each one including managers from a mix of levels and directorates. All people managers will take the course over the next 18 months.

92 We completed the first phase of an anti-racist allyship programme, training five separate cohorts for a total of 50 allies across all directorates and levels (three all

staff cohorts, one Head of section/Assistant director cohort and one for our Senior management team).

93 It is harder to assess the trends on workplace experience for colleagues. We have seen black colleagues move closer (on average) to our GMC average engagement score with a four-point improvement against generally falling scores. Conversely, colleagues who identify as Indian and colleagues who identify as 'other' ethnic minority groups are just outside our 5% target.

94 The inclusion index, which has a more focused set of questions, illustrates the progress we need to make. Analysis of our survey results suggests that some specific groups of ethnic minority staff are well below the GMC average (75%). Our other staff surveys that occur at various times of the year, covering specific issues show similar patterns on ethnicity. Another related indicator (turnover) is more positive.

Action plan for future activity and 2022 focus areas

95 We have developed activity plans for the duration of the measures in three domains, our projected activities are shown below in Tables 6 - 8.

96 Most of our planned interventions are at an early stage, so it is too early to assess progress through our people survey in July, but we will continue to monitor on a monthly basis performance against the delivery of these plans and how these are impacting on our performance measures. Our targets are challenging and the output from the 2022 survey will be crucial in assessing any initial impact and next steps.

97 For 2023/24, assuming we continue to make progress against our targets we would expect to focus on a sustainable model that consolidates our progress and meet our wider organisational needs.

98 Our approach from 2024 will be governed by our experience in the previous years and any changing skills requirements as a result of regulatory reform and broader changes. We will also need to make sure that we keep pace with changing candidate expectations and new processes. For example, increasingly virtual/remote recruitment and its equality implications.

99 Our longer-term approach will include:

- diverse intake options, such as graduates and apprentices, continuing
- a shift towards career pathways - graduates, fast-track, professions maps – should result in management roles filled from a diverse internal pool
- an increasing focus on specific under-represented groups

100 Our internal development support for colleagues will be reviewed and updated for 2024. This is a typical pattern for leadership programmes. We expect to maintain a commitment to support all staff and continue to address the barriers some groups of colleagues' face. Our initial thinking is that our next generation of programmes will do both, with core elements for all colleagues and options that allow an individual to build a personalised programme that addresses their individual needs.

Table 6 – Action plan for recruitment and workplace diversity

2021 launch	2022 phase 1	2023 phase 1	2024 phase 2	2025 phase 1	2026 phase 2
Recruitment and workplace diversity					
Completed: Briefing sessions for all recruiting managers and toolkit. Level 3 + vacancies advertised externally. Diverse candidate list implemented. Briefings to recruitment agencies on targets & monitoring.	**Action plan:** Develop outreach recruitment processes Approved apprentice, interns, and graduate programmes Deliver People Manager Essentials – Recruiting managers training Develop a structured process for diverse shortlist and interview panels Disability Confident Employer – Level 1 - launch a guaranteed interview scheme in line with Disability Confident	**Action plan:** Next phase of outreach recruitment function delivered Deliver the approved apprentice and interns' programme. Recruitment agency tender & apply targets to the contract. Review People Manager Essentials & recruiting managers training Expand publication of monitoring data to cover all characteristics	**Action plan:** Deliver the approved apprentice, intern and graduate programme Start new People Manager Essentials – Recruiting manager's programme Develop new career pathways model (consider trainee/fast track routes) Achieve Disability Confident Level 2 - Disability Confident Employer	**Action plan:** Continue to deliver the approved apprentice, intern and graduate programme New fast-track/trainee route to be considered Achieve Disability Confident Level 3: Disability Confident Leader	**Action plan:** Recruitment agency tender & apply targets to the contract. Continue to deliver the approved apprentice, intern and graduate programme

Table 7: Action plan for learning and development

2021 launch	2022 phase 1	2023 phase 1	2024 phase 2	2025 phase 1	2026 phase 2
Learning and development					
Completed: New competency framework - Embed inclusion into OneGMC behaviours & PDPs. Allyship programme and network of Allies. Delivery of People Manager Essentials – Absence and Health. Launch Fostering Inclusion Programme for all Leaders Increase diversity of coaching & mentoring pools. Ensure all leaders have access to leadership development programme, Leading at the GMC.	**Action plan** Roll out of Professional Behaviours module Embed OneGMC Behaviours into performance cycle Update of 360 & all colleagues to have 360 feedback Access to coaching for all colleagues. Talent programmes for ethnic minority staff CPD / support to Allies, coaches, and mentors. Launch Leadership Everywhere programme Refreshed Treating People Fairly e-learning	**Action plan:** Deliver our Leadership Everywhere programme. Deliver our Inclusion Programme for all People Leaders. 360 feedback for remaining staff Deliver our talent programmes for ethnic minority colleagues Assess impact of talent programmes to inform next round in 2024. Assess the impact of our Fostering Inclusion and Professional Behaviours Maintain skilled coaching/ mentoring pool.	**Action plan:** Phase 2 of talent programmes. Phase 2 of inclusion programmes - all staff and leaders Development of training on bullying, harassment, and discrimination. Phase 2 leadership development - focus on organisational change & regulatory reform. Review suite of development programmes and digital content Review and update behaviours/competence framework Maintain a skilled coaching/ mentoring pool.	**Action plan:** Phase 3 of talent programmes – new integrated model Phase 3 of inclusion programmes - all staff and leaders Next phase of leadership development, with a focus on supporting organisational change arising from regulatory reform. Maintain a comprehensive suite of development programmes and digital content Updated 360 process based on 2024 behaviours review	**Action plan:** Phase 4 of talent programmes – new integrated model Phase 4 of inclusion programmes - all staff and leaders Next phase of leadership development, with a focus on supporting organisational change arising from regulatory reform. Maintain a comprehensive suite of development programmes and digital content

Table 8: Action plan for staff engagement and workplace inclusivity

2021 launch	2022 phase 1	2023 phase 1	2024 phase 2	2025 phase 1	2026 phase 2
Staff engagement and workplace inclusivity					
Completed: Developing future working arrangements including flexibility guidance. Providing HR support to networks. Tracking progress through our people survey and EDI elements of pulse surveys.	**Action plan:** Updating our job evaluation framework Review our benefits offering to ensure suitability and value for money Introduce a new employee assistance service Ensure all managers access to mental health training Maintain our wellbeing champions and mental health first aid networks Assess impact on new Valued award process. Introduce expanded retirement/late career guidance support	**Action plan:** Take further steps to reduce the gender and ethnicity pay gaps within pay bands to under 2% by 2023. Occupational health service contact review Ongoing programme of policy review and development of associated EQIAs Expand support on pensions and financial planning through total reward statements, staff seminars Maintain wellbeing champions and mental health first aid networks	**Action plan:** New preparation for retirement programme Review our progress against IIP gold standard/Wellbeing standards Ensure all managers have continued access to mental health training Maintain our wellbeing champions and mental health first aid networks Employee assistance programme contract review 2024 staff survey	**Action plan:** Programme of policy review and development of associated EQIAs Ensure all managers have continued access to mental health training and complete people manager essentials on absence Maintain our wellbeing champions and mental health first aid networks Review our progress across IIP gold standard 2025 staff survey	**Action plan:** Programme of policy review and development of associated EQIAs Ensure all managers have continued access to mental health training and complete people manager essentials on absence Maintain our wellbeing champions and mental health first aid networks Review our progress across IIP gold standard 2026 staff survey

Working with others – four country context

England

101 We continued to facilitate group engagement at RO networks across England. We have developed specific case studies to help share good practice and to drive forward the thinking of some in the network, such as:

- providing feedback to locum doctors to help identify future career options
- better flow of information around the system to make sure locums are properly regulated and supported
- equip management teams with skills and mindset to tackle low level issues appropriately.

102 We engage with the WRES team on a bi-monthly basis to support the commitment in the NHS England's People Plan to address the ethnicity gap. We are also exploring opportunities to align messaging with NHS Resolution's professional performance advisory service and the safety and learning directorate.

103 Within London, we are working collaboratively with NHSE&I and HEE counterparts to help providers develop a three-to-five-year change programme to address the disparities in the MWRES data and support doctors locally.

104 Across the North of England, we have collaborated with partners across the system including NHSE&I, the BMA and providers to raise the issues from FTR at a number of local and regional events. We have also worked with an NHSE&I IMG induction pilot task and finish group which secured funding for two induction pilots in the Northeast which we will support with local WtUKP.

105 In the Midlands, we have partnered with HEE and NHSE&I to support the development and promotion of the Midlands Charter for training and wellbeing guide which received the 2021 British Medical Journal's Wellbeing award.

106 In the South of England, we have shared the findings from FTR with the regional NHSE&I Human Resource director network, an ED&I leads network and the NHSE&I regional ED&I working group. We are currently helping to pilot a regional RO/Medical Director (MD) ED&I working group with NHSE&I to consider how best to work together to support ROs/MDs around the NHS disciplinary gap and the disproportionality within referrals. We are also engaging with a trust Director of Organisational Development to support their work to improve organisational culture, with a focus on fairness and professionalism.

Northern Ireland

107 Northern Ireland has a comparatively low proportion of IMG and minority ethnic doctors. Gender and sexual orientation are generally higher on the ED&I agenda and stakeholders cite Norther Ireland's different equality legislation. We have collaborated with NHS Confederation and Health and Social Care (HSC) Trusts to deliver an ED&I seminar at the Northern Ireland Confederation for Health and Social Care annual conference. At this event, we secured a commitment that ED&I issues would be raised at the HSC Leadership Council.

108 Although we see many issues in Northern Ireland take greater priority, there have been positive outcomes for ED&I:

- WtUKP is now a mandatory requirement for all doctors new to Northern Ireland, to be completed within their first three months.
- 25% of Queen's University medical students are from ethnic minorities. This is not reflective of the Northern Ireland population. They have an established programme of interventions to support ethnic minority students but have been unable to secure support for changes to dress codes in HSC trusts, such as disposable sleeves.

109 Since the re-establishment of the Northern Ireland Joint Regulators Forum in spring 2021, there is a platform to share information, novel approaches, and ideas about improving the impact and effectiveness of regulation. ED&I issues are regulatory discussed by the Forum.

Scotland

110 We have discussed our targets with stakeholders in Scotland, including at our UK Advisory Forum. We have heard about positive work happening across Scotland, but also that some organisations need to review their own practices, including leadership. Sessions and interactions with medical education managers and supervisors has produced positive feedback, with a common comment on the need to broaden our remit to include women, disabled doctors, and consider intersectionality. Across all interactions there has been a common concern about the challenge of progressing this work amidst current pressures.

111 We are aware of several changes and improvements taking place across Scotland at the moment, including:

- a group looking into creating a system similar to the MWRES for Scotland
- a new system of ED&I leads and champions across the health boards
- the provision of unconscious bias and active bystander training in undergraduate and postgraduate training.

Wales

112 We have been working closely with a specific Health Board and plans are in place to embed WtUKP in sessions in 2022. And we are making progress with Health Education Improvement Wales to get WtUKP included in their week-long induction programme for IMGs.

113 We are part of the new Specialty and associate specialists (SAS)/IMG Expert Advisory Group that is looking specifically at our differential attainment data and the wider environments that lead to unfair referrals. This group includes Health Education Wales and Health Board Medical Directors and was set up on the back of our presentation on our ED&I targets to the Wales Medical Directors in September.

114 Most stakeholders in Wales have placed ED&I as a top priority. IMGs and ethnic minority healthcare workers make up a large proportion of the workforce in Wales. Work underway includes:

- Welsh Government's race equality action plan for public services, which covers several areas and includes our own ED&I targets.
- NHS Wales' SAS charter and NHS's respect and resolution policy. These are important policies to create positive work cultures but still need to be fully embedded.
- British Association of Physicians of Indian Origin (BAPIO) Wales's memorandum of understanding with Health Boards. This focuses on early intervention and early resolution, taking a local first approach.

Conclusion

115 In setting these aspirations and targets, we knew these were ambitious. We committed to using our levers and our regulatory powers to increase the pace of change. We intended for the targets to generate collective and collaborative efforts, and this annual progress report is an opportunity for us to continually share progress and our calls for action.

116 We have made significant progress in delivering the key actions we intended to put in place to pursue the targets and we believe this demonstrates a solid foundation for a first year of activity. However, it is too soon to draw a meaningful conclusion on progress against the metrics themselves. Given the longstanding nature of these issues, we would need to see sustained and meaningful progress over a longer timeframe.

117 The pace of delivery in year one has undoubtedly been fast. We continue to reflect on the need to balance pace with the importance of maintaining the quality of our

approach and ensuring we build in time to secure buy-in from all relevant stakeholders.

118 We have recognised that we need to maintain an iterative approach to make sure we understand what has an impact, and to vigilantly reassess our interventions and work with others in a more agile way.

119 We are working to develop an estimated picture of long-term change on the measures and targets. We need to undertake more work to assure ourselves on the validity of the approach.

120 We said from the outset that we're not alone in aspiring to shift the dial on addressing inequalities, and this remains true. Many of our partners have active and wide-ranging agendas to address inequalities and we know that some are showing positive progress. But the challenge remains for us all to make sure this activity is delivering real improvement and on that, we have a long way to go.

121 When we launched our ED&I aspirations, we were cognisant that we did so during a pandemic. Despite this, we received universal support for the areas we focused on, and for setting targets. A number of stakeholders told us that they felt it was an important signal from the regulator to the system. Although the pressures of the pandemic remain, we have not sensed or seen any diminished commitment to tackling these issues. Instead, stakeholders have remained sharply focussed on delivering change, but inevitably there will be challenging and ongoing demands for scarce resources across the health service for the foreseeable future.

122 We have sought to make it clear in this progress report where we think other stakeholders must play a role. We recognised that we need to be clearer with our ask of partners and stakeholders across the health system and how we intend to use our regulatory levers to good effect in the future.

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