



## Equal values: equal outcomes

A partnership action plan for the  
medical and dental workforce

# Foreword

We are delighted that NHS Employers is launching this action plan to the NHS.

This document seeks to address some core issues which have haunted and hindered the medical and dental professions for several years.

A high proportion of doctors, general practitioners and dentists in the NHS come from black and minority ethnic backgrounds, and thousands of international medical graduates register each year with the General Medical Council or the General Dental Council. Yet, many do not reach the highest positions in the NHS and there are persistent concerns that disciplinary and other mechanisms discriminate against them.

Meanwhile, 58 per cent of medical and 56 per cent of dental students are now women.<sup>1</sup> But, we have yet to fully address the growing needs for flexible training and working patterns of both men and women with caring responsibilities, so they can make a full contribution to their professions. The need for flexibility will increase with the ageing population and the need to prolong careers to retain capacity and expertise in the medical and dental workforce.

Other groups too have issues we must address. For instance, lesbian, gay and bisexual doctors and dentists can face discrimination, or the fear of it should they come out, and transgender people in the medical and dental professions can face prejudice and lack of support. And, we have little information about the number or experiences of medical and dental staff with disabilities or long-term health problems – partly because of their fear that disclosure might impact adversely on their careers.

It is vital that the medical and dental professions and their associated regulatory bodies take action collectively to address any inequality or bias within the system. However, it is equally important that, in addressing issues, we do not inadvertently disadvantage others or compromise standards. It is crucial to our success that all groups are treated equally and are seen to be treated so. Similarly, it is imperative that doctors and dentists do not impose a narrow perspective on the diverse range of patients accessing healthcare services, and that we remember the needs of the patient are paramount.

Taking that work forward is not just a job for NHS Employers: 14 organisations have signed up to this action plan, to the vision it sets out and to the action that needs to be taken. We recognise that this agenda can only be tackled by many different bodies working together in a co-ordinated way that also takes account of other policy developments and commitments in the NHS.

We hope you will join us in welcoming and endorsing this action plan within your respective organisations. The Department of Health looks forward to working with NHS Employers and all the organisations who have signed up to this action plan – as well as many others who haven't formally done so – in making equality and diversity in the medical and dental workforce a reality which can improve the working lives of doctors, dentists and general practitioners and, hence, provide better care for patients.



A handwritten signature in blue ink that reads "Liam Donaldson".

Liam Donaldson  
Chief Medical Officer



A handwritten signature in blue ink that reads "Raman Bedi".

Raman Bedi  
Chief Dental Officer

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# Introduction by Steve Barnett, Director, NHS Employers

Equality and diversity are not interchangeable: there is no equality of opportunity if difference is not valued. A fair society is one where everyone can achieve their potential. A fair employer ensures that opportunity is open to all and differences are recognised and respected.

Equality and diversity are fundamental to what the NHS stands for – both in terms of delivering care and being an employer of more than 1.3 million people. Much has been done in recent years to promote equality and diversity in the NHS workforce and we should pay tribute to the efforts across NHS organisations that have ensured sustained improvements.

But, I recognise that still more needs to be done and NHS Employers is committed to achieving true equality and diversity for all in the NHS workforce.

This action plan is focused on partnership working, constructive dialogue and finding effective solutions to the needs of both the medical and dental workforce and NHS organisations – principles to which NHS Employers is committed. It is the result of work between NHS Employers and a wide range of key stakeholders within the medical and dental professions.

The equality and diversity agenda needs to value and support all – including those from less 'visible' groups such as gay, lesbian and bisexual doctors and dentists, those with disabilities and those with religious beliefs.

We have identified seven key work areas where we feel change has been more difficult and where we believe a renewed focus and partnership working can make a difference:

- removing barriers to medical and dental education and continuing to increase access opportunities for all

- promoting best practice in equalities monitoring by deaneries, medical and dental schools, strategic health authorities and trusts
- promoting the principles of Improving Working Lives (IWL) throughout the whole medical and dental workforce, including independent contractors
- identifying how the NHS can best support international medical and dental graduates in finding employment in the UK and making progress in their careers
- ensuring continuing openness and transparency in clinical excellence awards and other recognition processes
- creating fair and expeditious systems for identifying and dealing with clinical negligence and other competence issues for medical and dental staff
- supporting a zero-tolerance approach to bullying and harassment in the medical and dental workforce.

In this action plan we have necessarily limited ourselves to the headline issues. Underneath each of these there is a full programme of work which needs to be developed and taken forward by the partners in each area.

The task set out is a major one, but not insurmountable with the combined effort of all the stakeholders who have participated and pledged support. The benefits will be considerably greater than the task. I look forward to working with all parties in making this action plan a reality.

“This action plan is focused on partnership working, constructive dialogue and finding effective solutions to the needs of both the medical and dental workforce and NHS organisations – principles to which NHS Employers is committed.”

### Signatories to this action plan

The following organisations have signed up to the programme of work and the commitments detailed in this action plan.

The Academy of Medical Royal Colleges (AOMRC)



The British Dental Association (BDA)



The British Medical Association (BMA)



The Committee of General Practice Education Directors (COGPED)



The Conference of Postgraduate Dental Deans And Directors (COPDEND)



The Conference of Postgraduate Medical Deans (COPMeD)



The Council of Deans of Dental Schools (CDDS)

THE COUNCIL OF DEANS OF DENTAL SCHOOLS

The Council of Heads Of Medical Schools (CHMS)



The Department of Health (DH)



The General Dental Council (GDC)



General Dental Council

The General Medical Council (GMC)

General Medical Council

Regulating doctors  
Ensuring good medical practice

The National Workforce Group (representing strategic health authorities)

National Workforce Group 

NHS Employers



A part of the NHS Confederation  
working on behalf of the 

The Postgraduate Medical Education and Training Board (PMETB)



This action plan has also been endorsed by the British Association of Physicians of Indian Origin (BAPIO); the British International Doctors Association (BIDA); the Gay and Lesbian Association of Doctors and Dentists (GLADD); and the Medical Women’s Federation (MWF).

# The importance of equality and diversity

Inequalities in our society are reflected in the health status of its citizens and their access to medical and dental services.<sup>2</sup> The NHS has a role to play in overcoming these inequalities by ensuring it is a good employer and corporate citizen, and by striving to eliminate prejudice and discrimination.





### Definitions of equality and diversity

The following definitions of equality and diversity are used throughout this action plan:

- **Equality** is about creating a fairer society – one in which everyone can participate and has the opportunity to fulfil their potential. The NHS needs to do its part by opening up medical and dental careers to those who may not traditionally have had access, and by supporting all doctors and dentists in their careers.
- **Diversity** is about the recognition and valuing of difference in its broadest sense. It is about creating a working culture and practices that respect, value and harness difference for the benefit of the organisation and the individual, including patients.

There are powerful business arguments for placing equality and diversity high on the agenda for the NHS. Research has shown that the best performing organisations have systematically integrated equality and diversity into their business culture.<sup>3</sup> There is, of course, a legal imperative, since there is a growing body of legislation outlawing discrimination in employment and/or services on grounds of sex, race, disability, sexual orientation, religion or belief (see page 12, below).

As society changes, so the NHS needs to change with it. The Government has set out clear goals to ensure that public services are fully accessible and responsive to the diverse needs of different groups and communities.<sup>4</sup> We need to make sure the NHS workforce reflects, and responds to, the people it serves.

# The medical and dental workforce

Although the NHS employs well over a million people, this action plan is concerned only with its medical and dental workforce, and with doctors and dentists in training.





Latest figures show 86,996 medical and dental staff working in hospitals and public and community health services in England; 34,085 general practitioners; and 19,841 dentists with NHS contracts.<sup>5</sup> There are also 24,800 medical and 3,300 dental students, a number that is set to rise over the next few years.<sup>6</sup>

The ethnic and gender makeup of the medical and dental workforce is not reflective of the population as a whole. 38 per cent of hospital and community health services' (HCHS) medical and dental staff have black and minority ethnic (BME) backgrounds (the equivalent figure for the population of England and Wales is 7.9 per cent), while 37 per cent of the HCHS medical and dental workforce, 40 per cent of GPs (excluding retainers) and 32 per cent of registered dentists are women (equivalent figure for England and Wales is 51.4 per cent).<sup>7,8</sup>

Meanwhile, 33 per cent of UK (home) medical students and 54 per cent of UK (home) dental students have BME backgrounds.<sup>9</sup> In relation to gender, 58 per cent of medical students and 56 per cent of dental students are women.<sup>10</sup>

This certainly does not mean there are no barriers left to overcome from an equality and diversity perspective. The proportion of students accepted into medical schools from households headed by unskilled, partly skilled and skilled manual workers remains at about 12 per cent even though they make up 40 per cent of the population.<sup>13</sup> Dental schools also recruit disproportionately from more affluent households.<sup>14</sup>

Young black and minority ethnic doctors can find it difficult to secure interviews and jobs<sup>15</sup> and there are long-standing concerns about the number of doctors who occupy staff-grade and associate specialist posts and whose primary medical qualification was gained outside the UK: 65.6 per cent of staff-grade doctors and 60.7 per cent of associate

specialists qualified outside the European Economic Area (EEA).<sup>16</sup>

The British Medical Association (BMA) has concluded that 'racism towards minority ethnic doctors is still prevalent throughout the medical profession, at all stages'.<sup>17</sup> In addition, a recent inquiry into mental health services within the NHS concluded that 'institutional racism is present throughout the NHS', with the result that 'black and minority ethnic communities are not getting the service they are entitled to'.<sup>18</sup>

Less is known about the situation of medical and dental students, doctors and dentists with disabilities and long-term medical conditions, partly because there is a lack of centrally-collated data. There is a feeling in some quarters that the lack of data is also because many people are afraid to speak out for fear of limiting or even ending their careers.<sup>19</sup> The BMA's recent committee monitoring exercise revealed that, of the 50 per cent of committee members who responded to the question about disability, 4 per cent identified themselves as having a disability.<sup>20</sup>

### Case study: The BMJ's chronic illness matching scheme

This initiative provides the opportunity for doctors who have a chronic illness or disability to receive informal career advice from another doctor. They can request to be matched with a doctor who either has the same illness or disability or to someone without a chronic illness who is working in a certain specialty, including general practice.

In September 2004, 670 doctors and medical students were members of the BMJ's chronic illness matching scheme.

More details of the scheme can be found at [www.bmjcareers.com/chill](http://www.bmjcareers.com/chill)



The NHS also needs to address the discrimination that can be faced by less 'visible' minority groups in its workforce, including lesbian, gay and bisexual (LGB) doctors and dentists. There are problems in monitoring the numbers of LGB doctors and dentists. They are often afraid to identify themselves due to fear of resulting discrimination.

The BMA document, *Career barriers in medicine: doctors' experiences*, contains statements from doctors confirming that homophobia is experienced throughout the medical profession, fear of discrimination is prevalent, and career choices are influenced by perceptions of homophobia being worse in some specialties. Similar views were found in response to The Gay and Lesbian Association of Doctors and Dentists' (GLADD) survey of its membership: although 76 per cent of the respondents thought it was important to come-out at work, 39 per cent were out to close work colleagues only and 1 per cent were out to their superiors.<sup>21</sup>

There is also a need to identify and meet the needs of those in the medical and dental professions with religious or other beliefs.

Finally, more must be done to ensure the NHS medical and dental workforce reflects other changes in society. Flexible training and careers are often seen as responses to the increasing number of women in the medical and dental workforce, but men are starting to demand a greater role in parenting and caring. And, as the population ages, flexibility (for example, flexible retirement) will be needed at the end and at certain times during the course of careers.

# Action on equality and diversity in the NHS

There is a challenging equality and diversity agenda facing those who devise health policy and regulate the NHS; those who oversee and deliver medical and dental education; employing organisations; representative bodies and lobby groups; students; medical staff; representatives of the public; and, indeed, the public themselves.





There are solid foundations to build on. In 2000 the Government published the NHS Plan, detailing its ten-year commitment to investment and reform. The plan set out a substantial workforce agenda, including a major expansion of medical school places, the introduction of new ways of working and more flexible career opportunities.<sup>22</sup>

The workforce elements of the NHS Plan were followed up, in April 2002, in the HR in the NHS Plan. This aims to make the NHS a model employer, ensure it offers model careers, improve staff morale and develop people management skills.<sup>23</sup>

Equality and diversity were addressed directly in the October 2003 DH report, *Equalities and diversity in the NHS – progress and priorities*.<sup>24</sup> This aimed to build equality and diversity 'into the fabric of reform' by integrating it into the HR in the NHS Plan and the new schemes and bodies set up to deliver the plan on the ground. For the purposes of this action plan, the most important of these schemes are the NHS National Recruitment Campaign, which works through NHS Careers to raise the profile of careers in the NHS, recruit from a wider base and attract returners; and Improving Working Lives (IWL) – the standard for good employment practice in the NHS – which all applicable organisations are expected to achieve.

Linked to IWL is Positively Diverse – a strategic programme that enables trusts to manage change relating to equality and diversity. Positively Diverse training has been delivered to over 290 NHS organisations.

The Positively Diverse programme encourages innovation while building on best practice. It helps organisations build equality and diversity into their strategic plans and day-to-day operations.

A key challenge is developing this work to reach the entire medical and dental workforce. For example, many dentists work outside of the salaried career paths as independent contractors. New approaches need to be developed to recognise this, and to ensure that all NHS medical and dental staff receive the support and guidance they need to build in the principles of equality and diversity throughout their working lives.

## Action in other policy areas and by other groups

Initiatives in other policy areas, legislation and the work and experiences of non-governmental bodies all have an impact on equality and diversity.





## Other policy areas

We should recognise the influence on equality and diversity of actions and reforms in other policy areas.

The Government's quality agenda has given rise to the National Clinical Assessment Service (formerly the National Clinical Assessment Authority), which provides advice and assessments for doctors in difficulty, and the National Patient Safety Agency (NPSA), which was set up in 2001 to promote an open reporting culture in the NHS and ensure that it learns from errors and 'near misses'. This action plan must also be mindful of the recommendations arising from the publication of the Shipman Inquiry's fifth report – specifically those parts that relate to complaints, professional standards and regulation – and should recognise the corresponding equalities issues.

From April 2005, the Healthcare Commission has introduced a new system of performance assessment for the NHS to replace star ratings. NHS Employers has sought to ensure that the seven areas to be measured – safety, clinical and cost effectiveness, patient focus, accessibility and responsive care, care for the environment, amenities and public health – all have equality and diversity integrated into them.

The reforms proposed under Modernising Medical Careers (MMC) will have huge implications for the equality and diversity agenda, for example in the roles junior doctors take on and the time they take to reach senior positions. It is felt by some that a tension exists in the new MMC Foundation Programme between satisfying the needs of both UK graduates and international medical graduates. If additional resources are identified as part of the solution, these need to be found. It is also important to note that equality and diversity are part of the MMC core curriculum.

## Legislation

Legislation is another important driver of the equality and diversity agenda and will continue to play a key role in this field. A solid body of legislation exists within the UK and Europe and more is on the way.

The UK has already implemented various European Directives outlawing discrimination in employment on the grounds of race and ethnic origin, gender, sexual orientation and religion and belief. In accordance with the European Employment Directive (Council Directive 2000/78/EC), the UK is obliged to introduce further legislation prohibiting discrimination on the basis of age by 2006.

The Disability Discrimination Bill currently before Parliament represents another step in extending rights and opportunities for disabled people.<sup>25</sup> It proposes to amend the existing Disability Discrimination Act by placing a legal requirement on public bodies to promote equality for disabled people – similar to the duties already enshrined in the Race Relations Act.

In May 2004 the Government proposed the creation of a new Commission for Equality and Human Rights (CEHR). Over the next four to five years, it is planned that the CEHR will have functions in relation to all aspects of equality and diversity, including age, religion and belief, and sexual orientation. Support for human rights will also be included within its remit.<sup>26</sup>

“The NHS has much to learn from the work and experiences of non-governmental bodies in the field of equality and diversity.”

### Action by other groups

The NHS has much to learn from the work and experiences of non-governmental bodies in the field of equality and diversity. It is crucial that this work is shared.

The BMA, for example, has undertaken extensive work on access to medical schools and the experiences of black and minority ethnic doctors.<sup>27</sup>

The General Medical Council (GMC) and the General Dental Council (GDC) have recently reviewed their fitness to practise procedures and, as part of these reviews, their complaints procedures. In both cases, they have taken account of equality and diversity issues.

GLADD has been working to persuade the DH and now NHS Employers to ensure that policies and practices to prevent discrimination on the grounds of sexual orientation are introduced widely and swiftly throughout the NHS and other healthcare providers.

### Case study: GLADD's *Dignity at work* guidance

Since 2002, the Gay and Lesbian Association of Doctors and Dentists (GLADD) has suggested ways that policies and practices to prevent discrimination on the grounds of sexual orientation should be introduced widely and swiftly throughout the NHS and other healthcare providers. GLADD has produced guidance, endorsed by the GMC, to help NHS trusts, general medical and dental practices, medical and dental schools, and individuals address sexual orientation issues in the workplace and to support NHS employers in implementing the Improving Working Lives standard and government anti-discrimination legislation.<sup>28</sup>

# Background to this action plan

This action plan has its roots in the establishment, in April 2003, of an equality and diversity reference group, drawn from various parts of the medical and dental professions and associated professional bodies and regulators.

The reference group identified key issues and areas of work, which were then discussed and explored with stakeholders.

## *Sharing the challenge, sharing the benefits*

This DH consultation recognised that bringing the equality and diversity agenda to the medical workforce means addressing specific challenges faced by this group of staff.<sup>29</sup>

These challenges fall into three areas:

- improving access to medical education
- removing career barriers
- developing open and equitable disciplinary systems.

## **Improving access to medical education**

*Sharing the challenge, sharing the benefits* argued that one of the signs of success in improving equality and diversity within the medical workforce is increased numbers of people from BME, disabled and other target groups in medical education. Two issues need particular attention: opening up routes into medical school for people with disabilities and chronic illnesses, and reaching students from more disadvantaged backgrounds without compromising or lowering professional standards.

## **Removing career barriers**

The consultation also argued that successfully opening up career opportunities for target groups means more than just attracting and training doctors and dentists from these groups. It also means ensuring their career progression is fair and equitable and that any changes do not inadvertently disadvantage international medical graduates or work to the detriment of UK graduates.

*Sharing the challenge, sharing the benefits* identified some issues to address, including: better data and monitoring; flexible career opportunities; support for doctors and dentists with disabilities or chronic illnesses (including mental health problems); opening up pathways for doctors who have trained overseas; and ensuring that the new clinical excellence awards operate openly and fairly.

## **Open and equitable disciplinary systems**

The consultation argued that doctors need to know that disciplinary systems will operate fairly. It also reported that international medical graduates are disproportionately represented as a group at disciplinary hearings of the GMC.

"[*Sharing the challenge, sharing the benefits*] is an excellent piece of work, particularly with regard to 'top ideas' which provide tangible solutions to improve equality and diversity in the medical workforce."

Dorset and Somerset Strategic Health Authority

*Sharing the challenge, sharing the benefits* was widely circulated. Almost 40 responses were received from Royal Colleges and other national bodies; deaneries; professional groups; strategic health authorities and trusts; and individuals. The responses supported much of the thinking within the consultation.

### NHS Employers

On 1 November 2004 a new employers' organisation for the NHS in England started work. NHS Employers aims to represent the views of employers in the health service and act on their behalf. It also aims to improve the working lives of staff and, through staff, to provide better care for NHS patients. It has taken over much of the operational HR work of the DH, including employment and diversity.

So, although this action plan builds on work started within the DH, it is issued by NHS Employers, and the work outlined in it will be taken forward by NHS Employers in partnership with the signatories and others.

NHS Employers is committed to putting equality and diversity at the heart of its HR work. This work includes negotiating pay and conditions for many NHS staff, running the recruitment, retention and return to work campaigns and promoting the IWL and Positively Diverse initiatives.

<b>April 2003</b>	Establishment of equality and diversity reference group - drawn from medical and dental professions and associated professional bodies and regulators - key issues and areas of work identified and discussed with stakeholders
<b>June 2004</b>	Launch of DH consultation, <i>Sharing the challenge, sharing the benefits</i>
<b>November 2004</b>	NHS Employers starts work
<b>April 2005</b>	<i>Equal values: equal outcomes</i> partnership action plan outlines work to take forward the <i>Sharing the challenge, sharing the benefits</i> consultation

# The seven key areas of work and our commitments





The signatories to this action plan believe there are seven areas within which work needs to be focused to make real progress over the next five years:

- removing barriers to medical and dental education and continuing to increase access opportunities for all
- promoting best practice in equalities monitoring by deaneries, medical and dental schools and trusts
- promoting the principles of Improving Working Lives throughout the whole medical and dental workforce, including independent contractors
- identifying how the NHS can best support international medical and dental graduates in finding employment in the UK and making progress in their careers
- ensuring continuing openness and transparency in the clinical excellence awards and other recognition processes
- creating fair and expeditious systems for identifying and dealing with clinical negligence and other competence issues for medical and dental staff
- supporting a zero-tolerance approach to bullying and harassment in the medical and dental workforce.

These areas and the associated commitments which the partner organisations have made are examined on the following pages.

# Removing barriers to medical and dental education and continuing to increase access opportunities for all

Equal access to education should be a fundamental right for every individual, regardless of their age, sex, sexual orientation, social class, ethnic or religious background or disability. Medical education should be no different from any other form of education in this respect.

Currently, 33 per cent of UK (home) medical students and 54 per cent of dental students come from BME backgrounds;<sup>30</sup> furthermore, 58 per cent of medical students and 56 per cent of dental students are women.<sup>31</sup>

Moreover, both medical and dental schools are known to attract more candidates, and to recruit more entrants, from relatively affluent backgrounds than from less privileged ones.<sup>32</sup>

As part of its commitment to expanding the medical workforce, the Government has expanded medical schools and established new ones which, amongst other things, are committed to attracting students from non-traditional backgrounds – for instance, where the parents are from lower socio-economic groups. Four-year graduate entry courses have also been developed to broaden the field from which potential doctors are recruited.

Another issue, identified during the *Sharing the challenge, sharing the benefits* consultation process, is the barriers which face disabled people and those with long-term health problems as they seek to enter and progress within the medical and dental world.

There is currently relatively little information about how many medical and dental students or staff have disabilities and long-term health problems.

As already mentioned, this is partly because they may be reluctant to disclose this information for fear of limiting their career opportunities. The Disability Discrimination Bill currently before Parliament means there is an urgent need for education providers to address the requirements of the existing Disability Discrimination Act in respect of access.

## View from the front line:

### Dr Ruth Chambers

*Dr Ruth Chambers is Clinical Dean at Staffordshire University, works with Stoke on Trent Teaching Primary Care Trust, and is a GP.*

“I am interested in enabling doctors with disabilities to remain at work. One of the issues that we face is that we do not know how many people we are talking about because doctors with impairments tend to disguise them or only partially deal with them. They do this because disability is often seen as a stigma. So, the NHS needs to evolve a culture in which people with disabilities are not made to feel as if they are inferior.

“For example, a doctor recently told me that he only had vision in one eye and had never told anybody because he was afraid people would stop him working. I told him that if he knew he had a problem and he took measures to deal with it, such as taking a little bit longer over consultations, then he would be fine – in fact, he’d be a better doctor than someone too sure of their abilities. His fear had, however, blighted his career.

“Students from disadvantaged areas may be doubly disadvantaged by the economic deprivation of the area within which they live and the impact of that deprivation on educational provision. Consequently, many students, particularly boys from black and minority ethnic communities, may not achieve their full potential.”

Royal College of Paediatrics and Child Health

“Another problem is that doctors who are physically disabled may not be able to access some parts of a hospital. Even if individual departments are accessible, it may not be easy to move between them. It can also be hard for doctors with physical disabilities to attend courses and conferences (especially breakout rooms).

“The Disability Discrimination Act may help a bit, but deeper, cultural issues are not going to be touched by it. If, during a meeting of senior doctors, you look around the room, you will rarely see a person with a physical disability – they do not fit the stereotype of the sort of person who is expected to get those sorts of jobs. It would be different if you went to a meeting in a social care setting.

“We need everybody to take action to change that stereotype. This action plan really needs to make a difference. There is a great tendency in the NHS to talk about things and never act on them. I’d challenge NHS Employers to have an audit in six months, and see what’s changed.”

### Case study: The Newham Opportunity Scheme

Newham Opportunity is an access scheme giving local students whose backgrounds might prevent them from getting the required A-level entry grades needed for medical school the opportunity to spend a year on a structured work placement at Newham General Hospital. There, they are mentored by senior staff, including consultants, they undertake varied work experience and are given the chance to show they can make good doctors.

Throughout the year, their progress is assessed and successful students are offered a place at Barts and The London Queen Mary’s School of Medicine and Dentistry. The scheme is a partnership between Newham University Hospital NHS Trust, Barts and The London Medical School and the local sixth-form and further education colleges. The core aim of the programme is to provide an alternative route or pathway into medicine which specifically targets young people living in Newham.

Carmel Rooney, Learning and Development Manager at Newham University NHS Trust, says the scheme started three years ago with just one student. It enrolled two students in its second year and four this year. The three students who have already completed their placement have now started their medical training and are making good progress.

“One of our students last year had received most of his education in Ghana. On arriving in the UK, he went straight into the local sixth-form college and was keen to do medicine. Because of his adjustment to education in this country he may have had difficulties achieving the required entry A-level grades. However, →



due to his commitment, enthusiasm and academic references from his tutors, he was accepted on to the scheme and is now in the second year of his training at university.”

Students are given a bursary of £500 a month during their placement which is funded by regeneration monies through the Newham Neighbourhood Renewal Fund.

Ms Rooney says that links are now being made with the local primary care trust for the scheme, which could double the number of students accepted next year. She identifies the key to Newham Opportunity’s success as being good links between the colleges, the hospital and the medical school, and the commitment of the mentors and the trust staff who facilitate the clinical placements.

“The support of the consultants and the trust staff has been fantastic,” she says. “We have four consultants who act as mentors for the students – they spend time setting and reviewing assignments, teaching and supporting the students with their learning and reflection on their clinical experiences.”

## Our commitments

### The Department of Health (DH) will:

- support the work of the Council of Heads of Medical Schools (CHMS) in researching selection to medical education
- work in partnership with the CHMS and the Council of Deans of Dental Schools (CDDS) to identify and encourage good practice in out-reach programmes, mentoring schemes, and other support to disadvantaged students
- review financial support available to disadvantaged medical and dental students

- continue to fund and support the Aimhigher healthcare strand projects in partnership with the Department for Education and Skills.

### NHS Employers will:

- work with the DH, the British Medical Association (BMA), the British Dental Association (BDA), the General Medical Council (GMC) and the General Dental Council (GDC) to promote medicine and dentistry as careers of choice
- ensure that any promotions positively address the image of the NHS to disabled people and the gay and lesbian community – using the expertise of interested bodies such as the Gay and Lesbian Association of Doctors and Dentists (GLADD), the Doctors Support Network and the BMA
- work with NHS trusts to identify and implement initiatives that will target under-represented groups as potential members of the medical workforce
- work with the Committee of General Practice Education Directors (COGPED) to consider whether their proposed national recruitment system for entry into GP training could be applied to other areas of the medical workforce
- encourage strategic health authorities to work with the CHMS and the CDDS to promote partnerships between medical and dental schools and their local schools and communities, to encourage applications from under-represented groups
- encourage strategic health authorities to work with the CHMS and the CDDS to promote targeted out-reach programmes (open days, road shows, summer schools and similar initiatives) to encourage applications from under-represented groups
- ensure that all this work also addresses the needs of disabled applicants and students and those with long-term medical conditions

- ensure that the learning from this is extended to other promotional campaigns in respect of the NHS workforce in a way that ensures sexual orientation, religion, gender, race, disability and age are equally represented in posters, leaflets and other materials.

**The CHMS and the CDDS will:**

- work in partnership with the DH and NHS Employers to ensure that the intake of medical and dental schools is better co-ordinated with the workforce planning processes within the NHS
- work with the DH and NHS Employers on the policy implications, in respect of training and employment, of the increasing proportion of female medical and dental students
- work with medical and dental schools to ensure that their websites and student recruitment materials are appropriate for and accessible to all potential students, including those with disabilities and long-term medical conditions
- investigate the need for, and success of, mentoring schemes to match students from non-traditional backgrounds or those with disabilities with doctors or dentists with similar backgrounds or disabilities.

**The Royal Colleges will:**

- consider how the competency requirements of each specialty in medicine might affect disabled people seeking to enter the profession and/or those who become disabled during their employment.

**The BMA and the BDA will:**

- support the CHMS, the CDDS and medical and dental schools in promoting the development of enhanced pastoral support and mentoring for selected entrants from under-represented groups
- support the CHMS, the CDDS, the GMC, the GDC, the Royal Colleges, the Postgraduate Medical Education and Training Board (PMETB) and deaneries in producing guidelines for incorporating education and training on equality and diversity into the undergraduate and postgraduate curricula, and promoting a general understanding of equality and diversity issues.

# Promoting best practice in equalities monitoring by deaneries, medical and dental schools, strategic health authorities and trusts

Successfully opening career opportunities for all is not just about attracting and retaining doctors and dentists from all sections of society, but also ensuring their career progression and recognition is as fair and open as possible.

To tell whether this is happening or not we need good baseline data and to be able to monitor change over time. It has long been recognised that we need better NHS workforce data and improved monitoring, both centrally and locally.

This is a particular issue for disability since, despite the provisions of the Disability Discrimination Act, data collection about people with disabilities and long-term medical conditions is still abysmal. Similarly, despite the provisions of European Directives, there is relatively little information about the number of gay, lesbian and bisexual medical and dental staff, or the numbers holding religious beliefs.

The BMA is currently seeking further information from the Royal Colleges in order to update their 2004 report on equalities monitoring. The BMA have received guidance from the Commission for Racial Equality on the importance of Royal Colleges collecting and analysing equality monitoring data in order to comply with the Race Relations Act. The findings and any associated recommendations will be published with the aim of sharing best practice in the collection and presentation of equality monitoring data. The focus of this work is principally on the Royal Colleges, although the report will be of interest to other organisations, including the PMETB.

## View from the front line:

### Dr Rachel Hogg

*Dr Rachel Hogg is a GP in Hackney, east London, and is lecturer in general practice at Barts and The London School of Medicine and Dentistry (Queen Mary, University of London). She is also co-chair of GLADD.*

“Gender, race and ethnicity are visible issues; sexual orientation is not, particularly as some gay and lesbian people who grow up knowing they are different and internalise homophobic attitudes, are reluctant to come-out. So, it is important to make this issue more visible.

“If I wasn’t gay myself, I wouldn’t know the stress and anxiety it can cause. Many doctors in GLADD have heard homophobic comments from colleagues. If you are uncertain about coming-out in a particular job, you monitor the banter, wondering if it is safe to talk about going to a gay venue or about your partner. This can result in feeling isolated and unhappy at work.

“NHS staff must use non-gender specific language, and ask people if they are in a relationship rather than simply whether they are married. There shouldn’t be the assumption that everyone is heterosexual.

“Medical schools and nursing colleges need to integrate sexual orientation into the normal curriculum – not just when students are studying psychiatry or sexual health; and ensure students practice role-plays with gay and lesbian patients. →



“NHS Employers needs to provide training for HR staff so they understand the problems facing their lesbian, bisexual and gay staff and how they might be supported. Job adverts and contracts should not be discriminatory; and the Positively Diverse initiative should cover sexual orientation.

“Given a supportive environment, most staff wish to come-out, and this can improve morale and team-working. However, employers need to be proactive in reassuring staff that they will be supported, and provide a contact person in the organisation.

“GLADD’s main concern is the publicity of the Employment Equality (Sexual Orientation) Regulations 2003. These bring sexual orientation within UK employment law for the first time. There is useful information on the DTI website.<sup>33</sup> A systematic approach is needed from the DH and NHS Employers to ensure that NHS managers and staff know about these regulations. As yet, this hasn’t happened, and there has already been one successful case against an employer. I’m concerned that the first time HR directors will hear about the regulations is when they find themselves facing an employment tribunal.”

## Our commitments

### NHS Employers will:

- initiate discussions with NHS trusts, the CHMS, the CDDS, medical and dental schools and postgraduate deaneries on how the monitoring of sexual orientation, religion and age can best be integrated into any monitoring systems – using the expertise of outside expert bodies and voluntary organisations
- work in partnership with trusts, deaneries and medical schools to produce guidance on monitoring, using the experience and knowledge of Positively Diverse lead sites
- support NHS trusts so they can actively incorporate equalities monitoring into their HR and business planning processes.

### The CHMS and the CDDS will:

- promote the adoption of monitoring guidance by medical and dental schools.

### Postgraduate deaneries will:

- adopt monitoring guidance for their planning and development purposes.

# Promoting the principles of Improving Working Lives throughout the whole medical and dental workforce, including independent contractors

Improving Working Lives (IWL) has proved to be one of the most successful vehicles for promoting equality and diversity introduced in the last five years. A number of schemes are in place to open up flexible training and career paths, and flexible working is also a component of the IWL standard against which trusts are judged.

IWL and the Positively Diverse programme that is linked to it have been so successful in promoting equality and diversity because they require proof of performance and because they come with toolkits and other supporting material. Nevertheless, there has been a sense, which also came through in the *Sharing the challenge, sharing the benefits* consultation, of the medical workforce being bypassed in this process – and it is now vital that we collectively address and correct this.

The dental workforce in particular is in a unique position, with the majority of dentists working as independent contractors, and so, to date, largely falling outside of the remit of these schemes. A key task is to address the challenges that this raises, and find suitable ways of consistently promoting equality and diversity in a way that is inclusive to the various working arrangements found within the medical and dental workforce.

## View from the front line:

### Dr Janet Prentice

*Dr Janet Prentice has a professional background in public health and is involved in the Doctors Support Network – a self-help group for doctors with a range of mental health problems.*

*“I was a doctor, I had mental health problems, and I took early retirement because of a lack*

*of flexibility. I had a couple of periods of sick leave and then, because I was in a training post, my consultant told me that my national training number had been withdrawn. There was no attempt to find another role for me, no thinking outside the box at all.*

*“I hope things might be better now, but we [Doctors Support Network] still get junior doctors coming to the end of their contracts and just disappearing from the system. The medical establishment has a problem with the idea that doctors with mental health problems can work, and needs to tackle the huge stigma attached to mental illness. People are scared to go off sick in case they don’t get a reference from their consultant or get labelled as weak. We also need more focus on rehabilitation and return to work.*

*“I have heard good stories about flexible training and flexible careers. If some of the adverts could focus on people with a mental health problem, that would be wonderful. But part of me doesn’t like these schemes because they make something special out of part-time working. Nurses often work a couple of days a week or only do days, and that is accepted. Doctors are still expected to work heroic hours. There needs to be a change in attitude, and an acceptance that people have different working patterns – and different careers.*

*“A major issue for me was being upgraded from registrar to senior registrar. I was happy being a registrar, but my post was time-limited, so there was no way out. We need the scope to let people stand still for a while for whatever reason, and then get going again.”*

**The Doctors Support Network helpline:  
0870 321 0642.**

“We welcome the increasing recognition given to changing patterns of personal, family and working lives across society, together with the challenges they present. For both men and women who enter medicine, with the extended training this entails, those changes must be matched by well-structured flexible arrangements both for training and, subsequently, ensuring fulfilling working lives that benefit the service.”

Professor Carol Black CBE, President, Royal College of Physicians

## Women in the workforce

Women are well represented overall in public health and the community medical and dental service, where 60 per cent of the workforce is female.<sup>34</sup> Conversely, only 25 per cent of hospital consultants are women, which suggests there are barriers to women progressing in hospital careers – although the proportion of women in registrar posts (39 per cent) suggests that more women will become consultants in the future.<sup>35</sup>

The BMA's 2004 report, *Women in academic medicine – challenges and issues*, highlighted some of the issues facing women. These include:

- difficulty re-entering the workforce after taking a career break, for example to have children or for family commitments – measures of academic success, such as the Research Assessment Exercise (RAE), do not take such breaks into account, so women are further disadvantaged by gaps in their CVs
- the existence of a glass ceiling to higher level positions in academic medicine – university departments must be made more accountable, particularly in relation to senior appointments
- the lack of mentoring and role models for women working in academic medicine
- the need for a more structured career path into academic medicine, with both clinical and academic commitments recognised – as part of the academic component, greater recognition needs to be given to teaching
- part-time working not being taken seriously and lack of recognition of the pressures of an academic research career, which may often be combined with clinical commitments
- the unrealistic and unreasonable job expectations of a medical academic position – the importance of reasonable expectations is highlighted, particularly in relation to RAE, which does little to take part-time working into account.

## View from the front line:

### Dr Selena Gray

*Dr Selena Gray is president of the Medical Women's Federation, is a public health doctor and reader in public health at the University of the West of England, Bristol. She is also part-time associate dean with responsibility for the Flexible Careers Scheme and Flexible Training in the Severn and Wessex Deanery.*

“A number of things still get in the way of women achieving their potential and making the fullest contribution they can to the profession, to the health service and to patient care.

“Access to flexible training is unsatisfactory. At the moment, there is an element of ‘grace and favour’ and in some parts of the country long waiting lists exist. Instead, there should be an expectation that anyone who qualifies gets it, without long delays. Also, part-time training is expensive, hence many employers are creating job shares; but that can cause difficulties if one person goes on maternity leave or gets another job. Changes are being made to funding to create more flexible opportunities, and these need to be pursued.

“NHS trusts need to be more open-minded about creating less-than-full-time consultant posts. The new consultant contract, with its focus on team working, should help but I think there is a bigger issue to tackle – the notion of constructing careers over a life-course.

“A working life can be 40 years so, even if people need to work part time when they have children under five, they may be able to go back into full-time work later, if we don't lose them in the meantime. The Returner Programme from NHS Professionals is fantastic, but it needs to reach more people. We need more crèches, properly funded and open for the right hours. →



“We need to think through some of the issues around the European Working Time Directive. As hours have tightened, people have gone from being on call to working full shifts – and a week of nights is not good for family life.

“We also need to think about people at the end of their careers, which is not just about them winding down. As the population ages, the number of people in their 60s with parents in their 80s and 90s will increase and people may need to work flexibly to care for them.

“But, none of this should be seen as a problem. There is a lot of talk about a new medical professionalism, and a new relationship with patients, and women are at the vanguard of that. We need to get flexibilities at the right points in their careers to make sure they can make their full contribution.”

## Our commitments

As NHS trusts move towards seeking IWL Practice Plus status by March 2006:

### The Department of Health (DH) will:

- continue to support the drive to embed the principles of IWL right across the NHS workforce as an important step towards becoming a model employer.

### NHS Employers will:

- actively recruit NHS trusts to the Positively Diverse programme, promote its principles to the NHS and engage the medical and dental workforce in that process
- continue to develop and promote the IWL good practice database in order to help NHS trusts identify options for flexible working practices and share experiences of good practice

- promote the principle of mentoring as a valuable tool for aiding the personal and professional development of doctors, and publicise good practice in this respect.<sup>36</sup>
- prioritise informing NHS organisations about the Employment Equality (Sexual Orientation) Regulations 2003 and the Employment Equality (Religion or Belief) Regulations 2003 and offer guidance and support as necessary for organisational change
- ensure that the issues of sexual orientation and religion or belief delivered through any Positively Diverse or associated training are covered on an equal basis to race, disability, gender and age
- actively initiate work in conjunction with the DH, the GDC and the BDA to consider how best to develop suitable methods of extending the support and promotion of IWL principles to independent contractors.

### Postgraduate deaneries will:

- continue to work actively with the MMC UK Strategic Group to ensure that principle six of the Key Principles and Standards for Postgraduate Medical and Dental Education Training Programme – that programmes must promote equality and value diversity within the profession – is fully and properly integrated into all programmes.

# Identifying how the NHS can best support international medical and dental graduates in finding employment in the UK and making progress in their careers

Doctors who have trained overseas already make a valuable contribution to the NHS. Indeed, as at September 2004, over 27 per cent of the doctors in the NHS and 32 per cent of HCHS doctors (excluding hospital dentists) qualified outside the European Economic Area.<sup>37</sup>

Half the doctors newly registered with the GMC each year have trained overseas.<sup>38</sup> The DH's international recruitment campaigns have also brought doctors to the NHS at consultant level. Similar initiatives are currently being undertaken in order to address the shortage of qualified dentists in the UK.

Inevitably, doctors and dentists wanting to move to the UK will face various practical challenges and difficulties. Specific problems faced by doctors include obtaining accurate information about the opportunities available in this country, difficulties with the immigration service and delays in finding employment after passing the GMC's Professional and Linguistic Assessments Board (PLAB) test. There are similar issues for overseas-qualified dentists after passing the GDC's International Qualifying Examination (IQE).

The guidance for international medical graduates on the GMC's website has been significantly improved in recent months and most of the postgraduate deaneries across England provide support for these doctors. The GDC's website provides comprehensive information about the IQE and the postgraduate dental deaneries provide varying degrees of support. There is, however, more that could be done by all parties involved in advising and assisting doctors and dentists wanting to move to the UK and supporting them after they arrive here.

Doctors who have come to Britain as refugees are an under-used resource. We need to find ways of continuing some of the work started by the Refugee Health Professionals Steering Group, to ensure that we do not lose the valuable skills of these doctors.

Doctors who have trained overseas can face problems in moving up the career ladder. For example, the latest NHS workforce statistics show that 60 per cent of staff-grade and associate specialist doctors are from minority ethnic backgrounds, while only 22 per cent of consultants come from such backgrounds.<sup>39</sup>

In July 2003 the DH published *Choice and opportunity – modernising medical careers for non-consultant career grade doctors*, which highlighted some of the problems faced by this group, and made 14 recommendations for progress.<sup>40</sup> In summer 2004, following consultation, the Health Secretary announced that the DH had accepted and would implement all of these recommendations. NHS Employers has since been asked to take forward work to consider the appropriateness of the current pay and contractual arrangements for this group of doctors.

**“A lot of the overseas doctors coming into the NHS looking for jobs are sitting idle, partly because there are not as many jobs as they thought. We need a single portal of information: one website where people can get a clear and honest breakdown of what the opportunities are.”**

**Dr Aneez Esmail, co-chair,  
BMA equal opportunities committee**

"We particularly endorse the need to develop a one-stop web facility for international medical graduates. This should be achieved as a matter of urgency and we would be keen to play a full part."

General Medical Council.

### View from the front line:

#### Dr Ramesh Mehta

*Dr Ramesh Mehta is a consultant paediatrician at Bedford Hospitals Trust and is president of the British Association of Physicians of Indian Origin (BAPIO).*

"I am greatly concerned with the way ethnic minority doctors are treated in the NHS. They are used as foot soldiers with few opportunities for career progression. It has been recognised that institutional racism and inequality exist in the NHS. I am delighted with Sir Nigel Crisp's ten-point programme for NHS equality. The appointment of a new director for equality and human rights is also a step in the right direction. However, there is still a lot that needs to be done. There is a tremendous potential out there amongst ethnic minority doctors, which is not explored.

"Urgent steps are required to reduce the misery of newly arrived overseas doctors. We believe there are several hundred post-PLAB doctors who have been unemployed for more than a year. They also have great difficulties in obtaining clinical attachments. Let us not forget that each of them is worth nearly £300,000 to the country (the cost of training a doctor). It is vital that they are looked after and cultivated for the greater benefit of the NHS. There has to be a centralised clearing system to place these doctors in various hospitals as observers for a three-month period, where they could be inducted into the modern NHS. During this time, they should be given free accommodation and an honorarium to sustain them.

"We know there is a major shortage of senior doctors in this country, but we already have a pool of very experienced

doctors in the form of staff and associate specialists who have been working in the UK for several years. They could be an answer to reducing waiting lists and filling vacant senior positions. They deserve respect and dignity. Following assessment of their competency (to ensure quality) many of them could become independent practitioners.

"I hope that in the modern NHS we can develop a culture of mutual respect and opportunities for all to progress in their careers."

### Our commitments

#### The Department of Health will:

- work in partnership with the GMC, the GDC and the Royal Colleges to ensure there is consistent, accurate and high-quality information available to international medical and dental graduates before they come to the UK.

#### NHS Employers will:

- work in partnership with the Postgraduate Medical Education and Training Board (PMETB), the Royal Colleges, postgraduate deaneries and NHS acute and primary care trusts to fully implement the recommendations from *Modernising medical careers for non-consultant career grade doctors*
- work with the DH, the GMC, the BMA, the Royal Colleges and others in developing a central database of international medical graduates who are registered and seeking employment – particularly those who have passed the PLAB test.

# Ensuring continuing openness and transparency in clinical excellence awards and other recognition processes

A crucial part of engaging the confidence and improving the morale of any workforce is for them to have confidence in the systems and processes that determine their pay and rewards.

Consultants were traditionally rewarded beyond their basic salaries through the discretionary points award scheme. However, research suggests that female consultants and those from BME backgrounds were less likely to receive rewards than their white, male counterparts.

A new clinical excellence awards scheme was introduced in April 2004. It puts a stronger emphasis on quality and on distributing awards more fairly between specialties, across geographic areas and throughout different NHS organisations. However, more work is required to restore confidence in the system. The clinical excellence awards must be both fair and seen to be fair.

**“It is not sufficient to encourage trusts to monitor clinical excellence awards by ethnicity, gender and disability; we must ensure that they do and that this information is reported widely. Furthermore, we would contend that proper, formal and detailed feedback is given to unsuccessful applicants on why their application failed.”**

**Hospital Consultants and Specialists Association**

## **Our commitments**

### **NHS Employers will:**

- work with the Advisory Committee on Clinical Excellence Awards (ACCEA) to ensure that any guidance developed on the national and local elements of the clinical excellence awards complies with equalities legislation and best practice
- work with NHS trusts, to:
  - ensure that local awards committees actively promote and demonstrate openness and transparency and embrace the principles of equality
  - monitor who receives clinical excellence awards in terms of ethnicity, gender, age, disability, religion/belief and sexual orientation
  - ensure that members of local awards committees and other selection panels receive equal opportunities awareness training.

# Creating fair and expeditious systems for identifying and dealing with clinical negligence and competence issues for medical and dental staff

The issue of patient safety and competent practice is central to the credibility of the medical and dental professions. It is, therefore, imperative that adequate systems and processes are in place to ensure doctors and dentists are fit to practise, and that these procedures “work effectively for the protection of patients and are also fair to doctors”.<sup>41</sup>

A 2002 report highlighted that a disproportionate number (58 per cent) of doctors appearing in front of the GMC’s committees were from BME backgrounds.<sup>42</sup> Similarly, figures show that as many as 36 per cent of long-term suspended consultants are from BME backgrounds, yet this group accounts for only 20 per cent of the total consultant workforce.<sup>43</sup>

It is important that these systems are not seen as punitive, but as supportive, because, in the words of Dame Janet Smith, “the most important aim is to improve clinical performance”. In this respect, the recently announced new disciplinary procedures for doctors and dentists are particularly welcomed by NHS Employers.

As model employers, there is an inherent duty on NHS employers to ensure that any doctor, GP or dentist who is identified as not meeting the standards and competencies laid down by the profession, is adequately supported and given every opportunity to learn and reach those standards.

The recent announcement by the DH to review all of the recommendations of the Shipman Inquiry – including looking at the remit and functions of the GMC – have been universally welcomed. This will, however,

inevitably delay some reforms in respect of revalidation and licensing and fitness to practise procedures. But, in the meantime, there is much that we can and need to do to help local NHS trusts deal with any clinical negligence or competence issues.

## Our commitments

### NHS Employers will:

- work in partnership with the DH, the BMA, the National Clinical Assessment Authority (NCAA) and other relevant bodies to develop nationally available support services for doctors in difficulty
- agree with all stakeholders a regular, open and informative mechanism for monitoring cases of clinical negligence and competence to ensure that any issues of bias or discrimination are identified and addressed
- support NHS trusts in implementing and operationalising the new disciplinary procedures for doctors and dentists.

### The GMC, the GDC, the BMA and the BDA will:

- continue with or devise new strategies to ensure that their own internal processes and procedures are fair, objective, transparent and free from unfair discrimination.

# Supporting a zero-tolerance approach to bullying and harassment in the medical and dental workforce

Harassment and bullying have no place in a modern NHS. As the UK's largest employer, and as one that strives to be an employer of excellence, the NHS has a moral, social and legal duty to eradicate harassment and bullying. With the rising costs of litigation and the increasing numbers of people taking employers to employment tribunals, there is also a very strong business case for ensuring that the risk of this happening is minimised and that the appropriate policies and procedures are in place if a claim has to be defended.

There is evidence that bullying and harassment exist within the NHS workforce, and this is reflected in the personal experience of some doctors.<sup>44</sup>

A recent survey for the Commission for Health Improvement (now the Healthcare Commission) found that 37 per cent of staff questioned had been harassed, bullied or abused in the preceding 12 months and that 15 per cent had been physically attacked. Many more work in a bullying environment.<sup>45</sup>

Dentists face slightly different issues, in that many work in single-handed practices where they may find it hard to access support for bullying or other emotional issues.

*"Research has found that complaints about bullying are often directed towards black and minority ethnic doctors, once they get into management positions. Some of those people might be bullies, but there is a feeling that once they've struggled up into these positions they become a target."*

**Dr Aneez Esmail, co-chair,  
BMA equal opportunities committee**

## View from the front line:

### Anita Houghton

*Anita Houghton used to be an associate dean of flexible training at the London Deanery, and now works as a coach and consultant in workplace issues through her own business, The Working Lives Partnership. She is also an associate of the organisation, Bullyproof, a consultancy that specialises in preventing and dealing with bullying in the workplace.*

"As an associate dean, it was not uncommon to receive complaints about bullying. Flexible trainees often felt there was a prejudice against part-timers. Some complained of being side-lined when it came to getting operating time or practical experience, some of being excluded from social events. Others experienced being shouted or sworn at, or being humiliated in front of patients.

"A major problem in tackling bullying in medicine is the lack of consensus as to what constitutes acceptable and non-acceptable behaviour. While one trainee may be severely traumatised by being shouted at, another may accept it as part of normal behaviour for a particular consultant. It is not uncommon in medical circles to hear phrases such as 'if you can't stand the heat, stay out of the kitchen'. But, we have to ask ourselves, do we really want a culture in which only the tough survive? The consequences of condoning aggressive behaviour is not only the suffering and →

“The control of bullying needs to be part of performance monitoring and appraisal, and personal behaviour needs to figure more strongly in the clinical excellence awards.”

possible departure of those who can't tolerate it but, inevitably, the perpetuation of these behaviours as those who survive take their seniors as role models.

“If we are going to tackle bullying, we need to have a consensus as to acceptable behaviour. We need safe ways for people to come forward. Surveys have shown that junior doctors rarely make a complaint about bullying, through fear of being seen as troublemakers and being given a poor reference. And we need to support people whose styles are inappropriate, so they can be tackled in supportive, rather than punitive, ways.

“Most trusts these days have policies on bullying, but experience of training in organisations has shown that all too often staff are unaware of it. There is also much in the way of good practice out there, such as the appointment of bullying advisers to provide confidential advice and support. But, there needs to be more incentive to tackle bullying. Bullies are often in senior positions and it is much easier for trusts to let their juniors leave than it is for them to tackle powerful and aggressive consultants. The control of bullying needs to be part of performance monitoring and appraisal, and personal behaviour also needs to figure more strongly in the clinical excellence awards.”

## Our commitments

### NHS Employers will:

- work closely with the DH to initiate a national campaign to reinforce the policy of zero tolerance to bullying and harassment
- work in partnership with postgraduate deaneries and the BMA to audit the current provision of support for doctors seeking advice and support in respect of bullying and harassment – within the context of the section on ‘treating colleagues fairly’ in the GMC’s *Good medical practice*
- develop a model or template approach for tackling harassment and bullying, identify beacon sites for good practice and encourage its adoption by NHS trusts and other organisations working within the medical profession
- investigate the viability of introducing a national bullying helpline for doctors and dentists.

# Conclusions





There is a challenging agenda for equality and diversity in the NHS medical and dental workforce. Much still needs to be done to ensure that all medical and dental students, doctors, GPs and dentists can enter medicine and then make the most of their careers and potential, no matter what their class or ethnic background, disability status, age, gender, sexual orientation or their religious and other beliefs.

However, as this action plan shows, there is much good work to build on, and considerable support for moving forward. There is enthusiasm from a wide range of NHS bodies, medical schools and deaneries, employers, representative groups and staff, as well as individuals for progressing the agenda set out in *Sharing the challenge, sharing the benefits*.

Many of these organisations have come together to sign up to the aspirations contained in this action plan, and have committed themselves to taking forward seven key areas for work and specific initiatives outlined within them. A primary objective of all parties must also be to ensure that the nature and causes of unfair discrimination are made explicit at every opportunity.

It must be re-emphasised that in this action plan we have necessarily limited ourselves to the headline issues. Underneath each of these there is a full programme of work which needs to be developed and taken forward by the partners in each area.

NHS Employers' final undertaking is to seek to establish a small group of equality and diversity experts with an interest in medical and dental workforce issues to objectively review progress in a year's time. This will ensure that the programme of work remains focused and also brings about real and tangible change.

We have created this action plan because we believe in the importance of the equality and diversity agenda for current and future NHS staff and for the patients they serve. The signatories to this action plan all recognise that this is a challenging agenda, and one that we cannot tackle alone. It will require engagement from many different bodies working together in a co-ordinated way – postgraduate deaneries, medical and dental schools, strategic health authorities, primary care trusts and acute trusts – and collaboration from other bodies working with the NHS, such as the National Patient Safety Agency and the Healthcare Commission.

However, if we successfully achieve change in the areas identified in this action plan we will improve patient outcomes through a happier, more motivated workforce and one which better reflects the communities it serves and, therefore, better serves those communities.

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- <sup>37</sup> DH medical and dental workforce census. September 2004
- <sup>38</sup> Source: GMC
- <sup>39</sup> DH medical and dental workforce census. September 2004
- <sup>40</sup> *Choice and opportunity – modernising medical careers for non-consultant career grade doctors*. DH, 2003  
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- <sup>41</sup> Fifth report of Shipman Inquiry, 2004
- <sup>42</sup> *Summary and conclusions from an analysis of the nature and outcome of complaints received by the GMC, considered by the PPC in 1999, 2000 and 2001*. Professor Isobel Allen, 2002
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- <sup>45</sup> *Sharing the challenge, sharing the benefits: equality and diversity in the medical workforce*. DH, 2004

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# Appendix:

## Summary of our commitments

### NHS Employers will:

- work with the DH, the BMA, the BDA, the GMC and the GDC to promote medicine and dentistry as careers of choice
- ensure that any promotions positively address the image of the NHS to disabled people and the gay and lesbian community – using the expertise of interested bodies such as GLADD, the Doctors Support Network and the BMA
- work with NHS trusts to identify and implement initiatives that will target under-represented groups as potential members of the medical workforce
- work with the Committee of General Practice Education Directors (COGPED) to explore whether their national recruitment system for entry into GP training can be applied to other areas of the medical workforce
- encourage strategic health authorities to work with the CHMS and the CDDS to promote partnerships between medical and dental schools and their local schools and communities, to encourage applications from under-represented groups
- encourage strategic health authorities to work with the CHMS and the CDDS to promote targeted out-reach programmes (open days, road shows, summer schools and similar initiatives) to encourage applications from under-represented groups
- ensure that all this work also addresses the needs of disabled applicants and students and those with long-term medical conditions
- ensure that the learning from this is extended to other promotional campaigns in respect of the NHS workforce in a way that ensures sexual orientation, religion, gender, race, disability and age are equally represented in posters, leaflets and other materials
- initiate discussions with NHS trusts, the CHMS, the CDDS, medical and dental schools and postgraduate deaneries on how the monitoring of sexual orientation, religion and age can best be integrated into any monitoring systems – using the expertise of outside expert bodies and voluntary organisations
- work in partnership with trusts, deaneries and medical schools to produce guidance on monitoring, using the experience and knowledge of Positively Diverse lead sites
- support NHS trusts so they can actively incorporate equalities monitoring into their HR and business planning processes
- actively recruit NHS trusts to the Positively Diverse programme, promote its principles to the NHS and engage the medical and dental workforces in that process
- continue to develop and promote the IWL good practice database in order to help NHS trusts identify options for flexible working practices and share experiences of good practice
- promote the principle of mentoring as a valuable tool for aiding the personal and professional development of doctors, and publicise good practice in this respect – the DH has recently produced guidance for the mentoring of career grade doctors
- prioritise informing NHS organisations about the Employment Equality (Sexual Orientation) Regulations 2003 and the Employment Equality (Religion or Belief) Regulations 2003 offer guidance and support as necessary for organisational change



- ensure that the issues of sexual orientation and religion or belief delivered through any Positively Diverse or associated training are covered on an equal basis to race, disability, gender and age
  - actively initiate work in conjunction with the DH, the GDC and the BDA to consider how best to develop suitable alternative methods of extending the support and promotion of IWL principles to independent contractors
  - work in partnership with the Postgraduate Medical Education and Training Board (PMETB), the Royal Colleges, postgraduate deaneries and NHS acute and primary care trusts to fully implement the recommendations from *Modernising Medical Careers for non-consultant career grade doctors*
  - continue to work with the DH, the GMC, the BMA, the Royal Colleges and others on developing a central database of international medical graduates who are registered and seeking employment – particularly those who have passed the PLAB test
  - work with the Advisory Committee on Clinical Excellence Awards (ACCEA) to ensure that any guidance developed on the national and local elements of the clinical excellence awards complies with equalities legislation and best practice work with NHS trusts to:
    - ensure that local awards committees actively promote and demonstrate openness and transparency and embrace the principles of equality
    - monitor who receives clinical excellence awards in terms of ethnicity, gender, disability, religion/belief and sexual orientation
    - ensure that members of local awards committees and other selection panels receive equal opportunities awareness training
  - work closely with the DH to initiate a national campaign to reinforce the policy of zero tolerance to bullying and harassment
  - work in partnership with postgraduate deaneries and the BMA to audit the current provision of support for doctors seeking advice and support in respect of bullying and harassment – within the context of the section on 'treating colleagues fairly' in the GMC's *Good medical practice*
  - develop a model or template approach for tackling harassment and bullying, identify beacon sites for good practice and encourage its adoption by NHS trusts and other organisations working within the medical profession
  - investigate the viability of introducing a national bullying helpline for doctors and dentists
  - work in partnership with the DH, the BMA, the National Clinical Assessment Authority (NCAA) and other relevant bodies, to develop nationally available support services for doctors in difficulty
  - agree with all stakeholders a regular, open and informative mechanism for monitoring cases of clinical negligence and competence to ensure that any issues of bias or discrimination are identified and addressed.
- The Department of Health (DH) will:**
- support the work of the Council of Heads of Medical Schools (CHMS) in researching selection to medical education
  - work in partnership with the CHMS and the Council of Deans of Dental Schools (CDDS) to identify and encourage good practice in out-reach programmes, mentoring schemes, and other support to disadvantaged students

- review financial support available to disadvantaged medical and dental students
- continue to fund and support the Aimhigher healthcare strand projects in partnership with DfES.
- initiate research into the many issues surrounding the diverse needs of medical and dental students with disabilities and long-term health problems and identify ways in which their needs can be met, based on their experience in medical education (and employment)
- continue to support the drive to embed the principles of IWL right across the NHS workforce as an important step towards becoming a model employer
- work in partnership with the GMC, the GDC and the Royal Colleges to ensure there is consistent, accurate and high-quality information available to international medical and dental graduates before they come to the UK.

#### **The CHMS and the CDDS will:**

- work in partnership with the DH and NHS Employers to ensure that the intake of medical and dental schools is better co-ordinated with the workforce planning processes within the NHS
- work with the DH and NHS Employers on the policy implications of the increasing proportion of female medical and dental students
- work with medical and dental schools to ensure that their websites and student recruitment materials are appropriate for and accessible to all potential students, including those with disabilities and long-term medical conditions
- investigate the need for, and success of, mentoring schemes to match students from non-traditional backgrounds or those with disabilities with doctors or dentists with similar backgrounds or disabilities
- promote the adoption of monitoring guidance by medical and dental schools.

#### **The Royal Colleges will:**

- consider how the competency requirements of each specialty in medicine might affect disabled people seeking to enter the profession and/or those who become disabled during their employment.

#### **The BMA and the BDA will:**

- support the CHMS, the CDDS and medical and dental schools in promoting the development of enhanced pastoral support and mentoring for selected entrants from under-represented groups
- support the CHMS, the CDDS, the GMC, the GDC, the Royal Colleges, PMETB and deaneries in producing guidelines for incorporating education and training on equality and diversity into the undergraduate and postgraduate curricula, and promoting a general understanding of equality and diversity issues.

#### **Postgraduate deaneries will:**

- adopt monitoring guidance for their planning and development purposes
- continue to work actively with the Modernising Medical Careers UK Strategic Group to ensure that principle six of the Key Principles and Standards for Postgraduate Medical and Dental Education Training Programme – that programmes must promote equality and value diversity within the profession – is fully and properly integrated into all programmes.

#### **The GMC, the GDC, the BMA and the BDA will:**

- continue with or devise new strategies to ensure that their own internal processes and procedures are fair, objective, transparent and free from unfair discrimination.

Equality and diversity are crucial issues for the NHS and for its medical and dental workforce.

This action plan – the result of work between NHS Employers and key stakeholders – seeks to address core issues which have hindered the medical and dental professions for several years. It outlines the seven key work areas within which work needs to be focused and details the commitments which NHS Employers and its partners have made in order to achieve real progress over the next five years.

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