Sharing the challenge, sharing the benefits -

Equality and Diversity in the Medical Workforce

Workforce Directorate

June 2004
Diversity

Diversity is about the recognition and valuing of difference in its broadest sense. It is about creating a working culture and practices that recognise, respect, value and harness difference for the benefit of the organisation and the individual, including patients.

Equality

Equality is about creating a fairer society where everyone can participate and has the opportunity to fulfil their potential. It is backed by legislation designed to address unfair discrimination based on membership of a particular group.

Equality and diversity are not inter-changeable – they need to be progressed together. There is no equality of opportunity if difference is not recognised and valued.
In 2003, the Modernising Medical Careers consultation and the work programme arising from it set the medical profession off on a road towards change. One of the fundamental aspects of this journey will be to ensure equality and diversity is embraced by all as an integral part of modernising the medical workforce.

From an equality and diversity perspective, the medical profession is in many ways unusual. While at one level people might assume it is dominated by the traditional white, male hierarchies – this actually belies an underlying complexity.

Almost 35% of doctors, GPs and dentists are from black and minority ethnic backgrounds. Additionally, some 66% of staff grade doctors and 61% of doctors in associate specialist grades qualified outside the European Economic Area (EEA).

It’s clear that this make-up will continue to change. While currently around 60% of hospital medical staff are male, for instance, over 60% of students entering medical school are female.

Knitted into this picture are reflections of our broader society – the gay and lesbian community and the various religious groups within our modern, diverse communities. And perhaps most complex of all for a profession dedicated to curing people, are questions of how the profession deals with disability and illness – whether it be in relation to students wishing to enter medical school, or the experiences of doctors suffering from stress and mental health problems.

It’s perhaps not surprising, therefore, that the profession has attracted allegations of institutional racism, sexism and homophobia and that there is a sense of injustice felt by those members of the disabled community wishing to enter its elite.

But now the medical profession is looking to dispel these criticisms and tackle some of the challenges inherent in changing attitudes and culture.

The recently published consultation document – Choice and Opportunity: Modernising Medical Careers for Non Consultant Career Grade Doctors – received overwhelming support for its recommendations. We will work with all stakeholders to ensure that these recommendations are implemented. The National Clinical Assessment Authority (NCAA) is also now actively engaged in tackling some of the issues which have a strong equalities dimension – such as suspensions and disciplinary processes.

This agenda carries many challenges for the medical profession, its regulatory and education bodies and NHS organisations themselves. Some of the key challenges are laid out in this consultation document which is intended to stimulate further detailed debate and feedback about how we translate ideas into action.

I give my wholehearted support to this programme and look forward to working with all of you as we progress this shared agenda.

Sir Nigel Crisp
Permanent Secretary, Department of Health and NHS Chief Executive
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1. An introduction from Andrew Foster - Director of Workforce, NHS

Last autumn, I was pleased to be involved in the launch of the Department of Health’s first Equalities and Diversity Strategy and Delivery Plan. The strategy serves as a starting point – it gives us a benchmark for how far the NHS has come in building equalities and diversity into the mainstream of service modernisation; and an assessment of the journey still ahead of us if we are to truly realise these principles across the whole of the NHS workforce.

We can be confident that the strategy has been developed against a robust policy backdrop. Equality and diversity are core principles underpinning the Government’s aim of ensuring that public services are fully accessible and responsive to the diverse needs of the communities they serve.

The NHS Plan and Delivering the HR in the NHS Plan build on this. They commit us to creating organisations which can demonstrate they are investing in training and development; tackling discrimination and harassment; improving diversity; and improving the working lives of staff in a way that directly contributes to better patient care.

I particularly welcome this report as a way to progress one crucial strand of the work we’ve begun – namely, promoting equalities and diversity in the medical workforce. Bringing the equalities and diversity agenda to life for our GPs, doctors and dentists will mean developing a tailored and detailed programme of work which fully recognises the specific challenges faced by these staff and the professional bodies representing them.

We have already started this process. At the Department of Health we have been working with key stakeholders through the Medical Workforce (Equality and Diversity) Reference Group (see page 22) to identify the major equality and diversity issues facing our doctors and dentists and their employer organisations.

Emerging from this early work are three clear challenges:

- improving opportunities for all equalities target groups to access medical education (see ‘Definitions’ box opposite)
- opening up employment opportunities and removing barriers to promotion and recognition for equalities target groups within the medical workforce
- ensuring fair, open and equitable systems for all in respect of discipline and other management procedures.

While we need to acknowledge the scope of work still to be done, I feel there is an encouraging undercurrent of progress. We are now seeing:

- an appetite for change and radical reform in medical training and working lives: I know that the Modernising Medical Careers programme and the Improving Working Lives for Doctors initiative have been warmly welcomed by the profession and stakeholders.
- statistical trends that are challenging the perceived white male domination of the medical arena: the number of female applicants to medical schools has reached record levels in 2004.
- a widening legal framework - including the Disability Discrimination Act, the Sex Discrimination Act, the Race Relations (Amendment) Act 2000 and the Employment Equality (Sexual Orientation) and (Religion or Belief) Regulations 2003 – this is focusing minds and giving organisations firm incentives for real progress.
The task now is to work together in partnership to develop a detailed programme of work tackling the three key challenges. I believe this report and the collaborative approach it endorses is crucial to that. The information it contains aims to:

- open up to a wider audience the themes developed so far through the Reference Group
- stimulate discussion and feedback among stakeholders, including the professional bodies, chief executives, medical directors, deaneries, medical schools and the Royal Colleges
- share a range of local initiatives which may offer us valuable learning in developing the wider programme of work.

I am delighted to be introducing this report and trust it will bring us even further together as partners in progressing this important work.

Andrew Foster

Definitions

‘Equalities target groups’ is a generic term used throughout this document. It refers to groups – such as black and minority ethnic people, disabled people, women, gay, lesbian, transgender and bisexual people – that may be under-represented in specific parts of the workforce. It also includes those who feel they have been, or may be, discriminated against or disadvantaged due to factors such as social background, age or religion.
2. Facts and figures

1. What does the medical workforce look like?

The statistics shown here are correct as at 30 September 2003 and relate to the 80,851 hospital, public health and community health service medical and dental staff in England. In addition to these staff, there are 32,593 GPs in England and the 110,091 other staff working within GP practices. There is currently limited data on ethnicity available for GPs and staff working within practices.

There are also 20,000 dentists in the UK for whom we have limited data in respect of their ethnicity and disability.

NOTES:
1. Figures should be treated with caution as they contain a mixture of 2001 categories and older information based on the 1991 population census categories.
2. Ethnic categories have been grouped together as follows:
   - Asian or Asian British includes: Indian, Pakistani, Bangladeshi, Chinese and other Asian.
   - Black or Black British includes: Black Caribbean, Black African, and Black Other.
2. What social backgrounds do medical school applicants and entrants come from?

Source: Universities and Colleges Admissions Services (UCAS) Department of Research and Statistics as cited in Medical Schools: Delivering the doctors of the future (DH 2004)

Table 1: Socio-economic background of all UK applicants to medicine

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<th>Socio-economic classification</th>
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Table 2: Socio-economic background of all UK accepted applicants to medicine

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3. Snapshot statistics

- just under 60% of UK applicants to UK medical schools in 2003 were female
- the minority ethnic (non-white) share of UK applicants to medicine rose from 31.2% in 1994 to 32.3% in 2003, and their share of UK accepted applicants from 23.1% in 1994 to 26.8% in 2003
- the number of women hospital and community health service consultants has grown from 17% in 1993 to 24% in 2003
- 39% of the registrar group of grades are women – which suggests that the percentage in the consultant grade is set to rise further
- 62% of public health medicine and community health service dental staff are women
- 39% of GPs in England are women
- almost 35% of doctors, GPs and dentists are from black and minority ethnic backgrounds
- 66% of staff grade doctors and 61% of doctors in associate specialists grades qualified outside the European Economic Area (EEA)
- the proportion of overseas qualifiers appearing at the GMC’s Preliminary Proceedings Committee increased from 48% in 1997 to 58% in 2001.

3. Three key challenges

1. Improving access to medical education

One of the signs of success in improving equality and diversity within the medical workforce is getting increased numbers of black and minority ethnic (BME), disabled and other equalities target groups into medical education. This means examining closely how the pathways to medical and dental schools can be made more inclusive and open to a diverse range of students.

Disabled and chronically ill doctors

For any student, the route to medical and dental school is likely to be a challenging one. For disabled or chronically ill people, however, access to adequate information about the school; access to the learning materials on offer; as well as physical access to buildings and premises, are all crucial considerations.

All students must of course be confident that they understand and meet the ‘fitness to practice’ principles set out by the General Medical Council in Good Medical Practice. But beyond this, are disabled students meeting unnecessary barriers to medical and dental school admissions?

This is difficult to measure. But a recent study into how far UK medical, dental and veterinary schools reflect the needs of people with disabilities in the admissions information they provide on their websites has proved an interesting ‘proxy’ measure. The report The Sequel to Pushing the Boat Out highlights the broad range of different approaches, with some schools barely sparing a few lines for students with disabilities and others successfully mainstreaming this information and providing valuable and inclusive web material. (See case study 1)

While education has been within the scope of the Disability Discrimination Act since 2001, the pending Disability Bill – due to come into force on 1 October 2004 – is likely to force the pace of change by placing further responsibility on employers to promote equality of opportunity for disabled people. We need to work with all of our partner organisations to ensure we are ready to meet these legal requirements.

Reaching students from deprived backgrounds

The recently published Department of Health report, Medical Schools: Delivering the Doctors of the Future, emphasises the need to attract medical students from a broader range of social backgrounds. It shows that social classes I and II make up 37% of the working age population and yet account for over 70% of accepted medical school applicants. Universities & Colleges Admissions Service (UCAS) data for 1999 to 2001 shows that over a third of accepted applicants to medical schools had attended independent schools.

The minority ethnic (non-white) share of UK applicants to medicine rose from 31.2% in 1994 to 32.3% in 2003, and their share of UK accepted applicants from 23.1% in 1994 to 26.8% in 2003. Yet the minority ethnic population accounts for only 7% of the working age population. (See ‘Facts and figures’ on page 6)

However, while overall minority ethnic groups are not under-represented in admission to medical school, more detailed information indicates that significantly higher proportions of Asian and mixed race applicants and accepted applicants to medicine come from social class 1 and attended independent schools,
than do their white or black counterparts. In short, not only are successful minority ethnic applicants to medical schools as middle class as their white counterparts, they are even less representative of the socio-economic make-up of the general population.

While the report clearly demonstrates the scope for more progress, it also showcases a number of important initiatives within new and established medical schools to attract students who, under normal circumstances, wouldn’t consider a career in medicine as a realistic option. These range from four-year ‘fast-track’ courses for graduate entrants from other disciplines, to projects which actively reach out to local communities from which applications to join the medical profession are rare. (See ‘Snapshots’)

Key action 1

Identify and remove barriers to medical education for disabled people and those from disadvantaged backgrounds

Top ideas

- utilise ‘Positive Action’ provisions to increase recruitment of disadvantaged and under-represented groups into medical schools
- identify champions for disabled people within trusts, deaneries, medical schools and the Royal Colleges
- produce a toolkit or web resource to help medical schools, trusts, deaneries and colleges improve their communications and provision for disabled doctors

Your ideas – do you know about any other good practice and what would make these ideas work at local level?

All research and reports referred to throughout this document can be found in ‘Further Reading’ on page 25.

Case study 1

Partners in Practice

Bristol School of Medicine has run a disability equality course for undergraduates since 1993. Disabled people are involved in planning and delivering the course and, more recently, in assessment.

Now, however, the school has teamed up with the University of the West of England and the Peninsula Medical School to develop a framework curriculum that aims to embed disability equality in the education of all health care professionals.

As a starting point, the three-year collaborative ‘Partners in Practice’ project (PiP) held a workshop for disabled people to raise issues that they felt were important for health professionals to learn about. The points raised at the workshop and through a broader consultation process have now been turned into learning outcomes.

Some of the top outcomes include the need to:

- understand that people with long-term conditions are often experts on their medical problems and lifestyle issues
- recognise that different disabled people have different needs, identities and preferences
- recognise that not all problems have a medical solution
- recognise the danger of excluding other diagnoses based on preconceptions about people with an impairment
- see the person as capable of making rational life decisions
- be able to communicate effectively with people with communication impairments.

Also in the top 15 learning outcomes is the need for health professionals to practice disability equality in employment – a theme which,
according to project lead Margaret Byron, has important implications for how well future health care professionals accept and support disabled staff in their own workplaces.

“The main focus of the PiP project is on educating health care workers to work more effectively with disabled patients – but the expectation is that this will have a positive longer-term effect within the workforce itself,” she explains.

Margaret, who trained as a consultant rheumatologist but now focuses on disability equality, adds: “We have recently run our first disability equality module for those who teach medical students and other health professionals.

“It challenges participants to look at their teaching practice, their language and their choice of patients for teaching. They act as role models for training health practitioners and as such can have a major impact on the health professionals of the future”.

Contact: Margaret Byron on Margaret.byron@bristol.ac.uk

Read more about the PiP project at www.bris.ac.uk/pip/index.htm

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**View from...Dr Rhona MacDonald**

Editor of Career Focus in BMJ Careers, senior editor of the Student BMJ and member of the Medical Workforce (Equality and Diversity) Reference Group.

“The general lack of clarity and consistency in the information medical schools are offering potential students with disabilities and illnesses have been two of the major obstacles for those wanting to start training as a doctor.

Anne Tynan’s recent report The Sequel to Pushing the Boat Out was a tremendously helpful piece of research. It showed the vast discrepancy in admissions information being offered to disabled people by dental, medical and veterinary schools. Above all, it highlighted the general reluctance to actually define ‘disability’.

The Royal College of Veterinary Surgeons (RCVS) was one exception. Its guidance on the admission of students with disabilities to the professional veterinary degree course includes advice about specific disabilities. If we don’t define, we end up implicitly excluding whole groups of potential students. We need to be explicit – talk openly about what qualities and competencies are actually required to be a successful doctor or dentist.

The GMC’s report Tomorrow’s Doctors goes some way to addressing this. It begins to move us more helpfully to a competency-based system. Another positive step is the introduction of disability assessment officers in some medical schools. This will help break down some of the assumptions and attitudes which are currently keeping doors closed for these students.

Changing how people think about disability and chronic illness is in fact the biggest challenge. So often, people who have disabilities have come through very tough times and they are resilient, determined and focused – exactly the sort of qualities which would make them excellent medical students and good doctors. They don’t want special treatment. They want an even playing field.”
2. Employment, progress and recognition – removing career barriers

Successfully opening up career opportunities for equality target groups within the medical workforce is not only about ensuring we attract and retain doctors and dentists from these groups, but also ensuring their pathway to career progression and recognition is as fair and open as possible. We need to make particular progress in the following areas:

a) Better data monitoring

It has long been recognised that we need better NHS workforce data and better monitoring both centrally and locally.

The issues surrounding the collection and reliability of statistical data is not unique to medical staff. These are issues for the whole NHS workforce. Now, however, this is being addressed through discussions within the Department of Health between the Equalities and Diversity Team and colleagues in the Statistics Division. The BMA is also developing guidelines on monitoring to help trusts and other organisations think about how they collect and present data and hopefully encourage them to adopt similar approaches so the information can be more easily compared and analysed. The Electronic Staff Record (ESR) should be another useful aid for the future.

b) Embracing flexibility

Throughout the NHS, flexible working opportunities such as part-time, term-time and annualised hours, plus more support for parents through the NHS Childcare Strategy, are becoming valuable tools for recruiting and retaining staff. But there is less certainty about how far these improvements are being embraced by the medical workforce – in particular by hospital doctors who have tended to worry that flexible working means limited career choices and progression.

There is, however, clear momentum in the right direction:
• all NHS organisations have now attained IWL Practice standard – showing they are improving the working lives of staff through a wide range of policies and procedures
• a target date of March 2006 has been set for all organisations to reach the Practice Plus standard where they will have to show evidence that IWL policies are reaching all staff groups
• Eric Waters, former Medical Director at Salisbury NHS Hospital Trust, has been appointed as Improving Working Lives Champion for Doctors. He will promote key areas of IWL to the medical profession such as staff training and development, tackling discrimination, improving diversity and access to childcare.

Flexible working is one of the key strands of the IWL initiative. With record levels of women applying to medical school – 59.4% in 2003 – the expansion of flexible working opportunities will be critical in improving the recruitment and retention rates for doctors and GPs. The Flexible Careers Scheme – part of the IWL initiative – provides 3-year salary cost funding on a sliding scale to help encourage trusts to create more opportunities for flexible working and career breaks.

To date:
• almost 400 hospital doctors are in post, have returned to the NHS or are training through the Flexible Carers Scheme (FCS)
• over 770 GPs are working in FCS posts and over 140 GPs are currently undertaking or have completed refresher training under the return to practice scheme
• of the doctors currently on the FCS, 297 are male and 1011 are female.

The challenge ahead is to find effective ways of embedding the principles of Improving Working Lives more firmly in the medical profession.

c) Attracting and retaining disabled and chronically ill doctors

As well as concerns about disabled people accessing medical education, there are also concerns about how far disabled and chronically ill doctors, GPs and dentists are supported and retained within the NHS.
Attitudes based on assumptions about what disabled and ill doctors can and can’t do, and lack of knowledge within NHS organisations about how to support these staff, are both central to the problem. The legal requirement under the Disability Discrimination Act for employers to make reasonable adjustments to physical features of premises where these may put disabled people at a disadvantage, will in many ways stimulate progress. But work still needs to be done to improve understanding and attitudes among the workforce, and in particular occupational health departments.

Educating the public and patients in their attitudes towards disabled doctors is another important challenge. They need to be confident that someone in a wheelchair, for example, can be just as competent a doctor or clinician as someone who can walk.

d) Opening pathways for doctors who have trained overseas

Doctors who have trained overseas but have moved permanently or temporarily to the UK, are already making a valuable contribution to services and patient care in the NHS. The Department of Health’s International Fellowship Scheme has been hugely successful in attracting overseas consultants to the NHS, offering doctors a six-month supported placement. More than 220 fellows have accepted offers through the scheme. The department’s Global Recruitment Scheme is another successful route to help match overseas doctors to trusts on a permanent basis, with 79 consultants and 174 GPs already appointed. Where they are in post, trusts are giving positive feedback about their commitment, enthusiasm and high-quality contribution.

But overseas doctors wanting to work or seeking to progress in the NHS do face difficulties.

i) Improving the immigration process – While immigration applications are being considered, many doctors are expected to exist without their passports for considerable periods of time, meaning they can not travel for either work or family purposes. In addition, passports are needed when applying for jobs as proof of the right to work in the UK. Should doctors request to have their passports returned, their applications are considered as having been withdrawn.

ii) Delays in finding employment – As many as 90% of the doctors passing the Professional and Linguistic Assessment Board (PLAB) test – the GMC’s assessment of medical knowledge and skills – eventually find employment in the NHS. But they often face lengthy and frustrating delays between passing PLAB and finding a post.

This is partly due to a surplus of PLAB-Qualified doctors compared to the vacancies available. The GMC provides clear guidance on its website advising overseas doctors to research opportunities open to them before entering the UK and sitting PLAB. But there may be further scope for stakeholders to work together to enhance the information available to doctors seeking to work in the UK, and help to manage expectations at an early stage.

And to ensure those coming from overseas are competing for posts on a level playing field, we also need to consider how well post-PLAB doctors are supported – especially in terms of application and interview techniques.

There has already been significant progress in developing valuable training and support programmes for refugee doctors through the work of the Refugee Health Professional Steering Group. The work, supported by DH funding, includes language and communication courses, clinical skills courses to prepare refugee doctors for PLAB, mentoring schemes and job clubs. Positive next steps could include
building on this approach to support the wider community of overseas doctors.

**iii) Reforming the non-consultant career grade** - The latest NHS workforce statistics show that 65% of doctors in non-consultant career grades (NCCGs) are from ethnic minority backgrounds with only 20% at consultant level.

The Department of Health report Choice and Opportunity - Modernising Medical Careers for Non-Consultant Career Grades - rightly stresses that the vast majority of doctors and dentists in the non-consultant career grade are making an enormous contribution to NHS services. Yet it also says that for too long the grade has been viewed as a professional cul-de-sac. There are two crucial issues to consider: how many of these doctors see the grade as the only available option; and why do many in the grade see themselves as overlooked in terms of professional development, study leave and discretionary points?

The wholesale reform of these grades recommended in the Choice and Opportunity report represent real progress for these doctors. Among the recommendations are:

- to ensure doctors only enter a career grade when they have met clear educational standards and can demonstrate specialty-specific competencies
- to introduce competency-based assessment similar to doctors in formal training. This will mean their skills are formally recognised and they can work independently at the appropriate level. It will also aid movement between the training grades and NCCG structures
- the provision of resources and infrastructures for continuing professional development (CPD).

We need to support the implementation of these recommendations and work to ensure that equalities and diversity issues are fully recognised within the reform process.

**iv) Tackling regulatory red tape** – The UK has a number of locum, staff grade and associate specialist (SAS) doctors either with a combination of training done partly in the UK and partly overseas, or with qualifications not considered to be equivalent to the Certificate of Completion of Specialist Training (CCST).

These doctors may have the potential to become consultants but are currently unable to do so because of the restrictions in the existing regulatory framework. There is no option at present to ‘top up’ their training in the UK. This is because there is no provision for doctors to go on to the Specialist Register on the basis of specialist medical training done partly overseas and partly in the UK – regardless of the individual doctor’s skills or abilities.

The recently established Postgraduate Medical Education and Training Board (PM ETB) will be an important partner in exploring these issues. In addition to focusing on education and training, the Board has included in one of its key aims the need to promote and continuously improve standards in assessment and accreditation.

**e) Fairness in clinical excellence awards**

The original discretionary points award scheme has been one of the main mechanisms for rewarding consultants beyond their basic salaries. But research suggests that under the old scheme, ethnic minority and women consultants are less likely to receive awards than their white, male counterparts. In addition, monitoring the awards process has not been uniform, depending instead on the vigilance of individual trusts.

The new awards scheme – introduced in April 2004 – is an important step forward in promoting fairer rewards for equalities target groups. The new clinical excellence awards scheme for consultants will bring a stronger emphasis on quality and fairer distribution of awards between specialties; across geographic areas; and throughout different NHS organisations. It will bring more openness and transparency to the process and will reward consultants with the greatest sustained levels of performance and commitment to the NHS.
Crucially for the equalities and diversity agenda, the new scheme will place particular emphasis on ensuring women consultants and consultants from minority ethnic groups are fully and fairly considered for all levels of award.

**Key actions**

1. **To develop guidance on equalities monitoring for trusts, deaneries and medical schools**

   **Top ideas**
   - create IWL champions and role models within deaneries and trusts
   - build on good practice developed for junior doctors – such as the Hospital at Night project and the introduction of night nurse practitioners within some trusts
   - promote the wider take-up of the Flexible Careers Scheme among hospital doctors

2. **Help the medical workforce apply the principles of Improving Working Lives**

   **Top ideas**
   - DH to work with the Home Office to address obstacles in the immigration process
   - work with all stakeholders to develop a one-stop web facility for overseas doctors, including information on the current DH recruitment policies and programmes, the roles of the different stakeholder bodies, estimates on how long it can take to register and obtain employment, and signposts to more detailed information and advice.
   - explore with stakeholders the need to develop enhanced and proactive support and feedback channels to help overseas doctors compete fairly for posts

3. **Identify and remove cultural and organisational barriers for disabled people**

   **Top ideas**
   - actively recruit disabled non-executives
   - work in partnership with occupational health providers and disability organisations

4. **Minimise the obstacles for overseas doctors seeking employment in the UK**

   **Top ideas**
   - encourage trusts to monitor by ethnicity/gender/disability and sexual orientation – reporting to the Advisory Committee on Clinical Excellence Awards (ACCEA)
   - run workshops at trust level to raise awareness of equalities issues and promote better monitoring and greater openness

5. **Create greater openness and transparency in the clinical excellence awards and recognition process**

   **Top ideas**
   - introduce greater publicity for both the process and the award winners.

**Your ideas** – how can we make these ideas work and what other support do trusts need to implement more transparent systems and ensure all doctors benefit from fair opportunities and recognition?
Case study 2 –
Disability equality – not just awareness

For Joyce Carter – consultant in public health medicine at Central Liverpool PCT – the real priority in keeping medical opportunities open for disabled people is a comprehensive programme of disability equality training, delivered where possible by disabled people.

“Disability equality is not the same as ‘awareness’,” she stresses. “Disability awareness training is about etiquette – for example how to talk to disabled people. Disability equality is about giving people an understanding of the barriers that disabled people face from a civil rights perspective. There are strong parallels between disability equality and race equality.”

Joyce is passionate about challenging the attitudes and assumptions that result in disabled people being marginalised. Her personal perspective gives her added credibility. She had juvenile chronic arthritis when at primary school and then, in 1990, in her second year as a consultant, she was diagnosed with rheumatoid arthritis. Although her employers were keen for her to stay in work, no-one knew what help was available to support her.

“The Health Authority and the occupational health department both said ‘Let us know what you need and we’ll make sure you get it’. That was great, except I simply didn’t know what was available, or what support was possible.”

Eventually she approached the MOSIAC team, established in Liverpool by a former colleague to support young disabled people as they moved from childhood to adulthood. They were able to help her find out about equipment that might help – such as a draughtsperson’s table to hold books and papers and a leg rest to avoid joint damage while sitting.

As her condition deteriorated, using a pen or conventional keyboard became increasingly painful. She found help in overcoming this from a disabled person who demonstrated the voice recognition software he used and advised her on how to get funding through the government’s Access to Work programme.

“For the first time I was getting practical advice not only about equipment and support which would help me stay in work, but also about where to get these and how to pay for them,” says Joyce.

According to Joyce, the recruitment and job application processes are other important areas for progress.

“Interviews must be held in accessible venues, not just for the benefit of the candidates, but also so that disabled people can be on the interview panel.”

Joyce is now involved in developing a web-based disability equality training package for the NHS. Together with the trust’s Disability Equality Officer, she is also working with the University of Liverpool Medical School to develop a curriculum on disability for medical students.

Contact: Joyce Carter on Joyce.Carter@centralliverpoolpct.nhs.uk

Snapshots
Other positive practice at a glance

• Liverpool School of Tropical Medicine has developed a one-year, part-time diploma course in European Medicine for doctors who have trained overseas and want to work in the UK. The course supports doctors by combining lectures to get them through the necessary examinations, with clinical attachments in hospitals or primary care to give them experience of how the NHS works.

• The North East Programme for the Professional Integration of Refugee Health Workers is a scheme run by the Centre for Primary and Community Care Learning at Northumbria University which aims to help health professionals currently living in the North East get their professional registration and find a job in the UK.
For instance a significant number (65%) of non-consultant career grade doctors are from ethnic minority backgrounds. To a great extent this is a structural issue – when the grade was created, no-one foresaw the implications this would have for a huge number of BEM doctors.

The Modernising Medical Careers initiative has begun to address this but it isn’t the whole answer. For example, we need to be looking at why the bulk of locum doctors are from BEM backgrounds and are not able to access the same opportunities for career progression and professional development.

We also need to explore more transparent processes for job applications – less than 10 per cent of job applications for medical jobs involve any form of ethnic monitoring.

Much of this activity needs to happen at local level – the challenge is encouraging and supporting trusts to take this on as a priority against an already pressured agenda.

Other key areas of concern include the Professional and Linguistic Assessment Board (PLAB) and International English language Testing System (IELTS) examinations. Consideration must be given to ensure that the content is relevant and that the time and costs are not prohibitive.

Overseas doctors would also benefit from support in areas such as interview technique. These doctors are often fully proficient clinically – but may lack the skills which will enable them do justice to their experience and competencies in an interview situation.

At the BMA we are currently putting together a report on career barriers. One of the things coming out of this is a clearer picture of the obstacles faced by overseas doctors coming into the UK to work.

Among the main issues is the lack of information available to them about employment in the NHS. We are working with the Department of Health to facilitate the development of support networks for overseas and internationally-recruited doctors so that they can make contact with each other and also with other supportive organisations.
3. Open and equitable disciplinary systems

A report to the General Medical Council (GMC) (Professor Isobel Allen 2002) highlighted that overseas qualifiers were more likely than UK qualifiers to be referred to the Professional Conduct Committee and to be found guilty of serious professional misconduct.

The story in the statistics

The report showed that the proportion of overseas qualifiers appearing at the GMC’s Preliminary Proceedings Committee had steadily increased over the period between 1997 and 2001 from 48% to 58%. Other research exploring the experiences of doctors from overseas or from ethnic minorities reports the possibility of similarly disproportionate outcomes for these groups. The report shows that 58% of doctors appearing in front of the GMC’s committees are from ethnic minority backgrounds.

More generally, the National Audit Office in its report The Management of Suspension of Clinical Staff in NHS Hospital and Ambulance Trusts (November 2003) has highlighted the cost of suspensions to the NHS. The report estimated that at any one time there are about 60 doctors or dentists suspended (either formally or informally) for more than three months – with suspensions sometimes lasting as long as four years.

As many as 36% of long-term suspended consultants are from ethnic minority backgrounds – yet ethnic minorities account for only 20% of the total consultant workforce.

A new approach

New guidance issued by the Department of Health in December 2003 seeks to address some of the problems identified by the NAO report. The new approach recognises the importance of seeking to tackle performance issues through training or other remedial action rather than solely through disciplinary action. However it is not intended to weaken accountability.

The National Clinical Assessment Authority (NCAA), which has been established to improve arrangements for dealing with the poor clinical performance of doctors, has also helped NHS organisations to avoid suspensions and other authorised absences from work in 85% of its cases. (See ‘In focus’ page 18)

Bullying and harassment in the medical workforce

The long-standing perception about bullying and harassment within the medical profession is borne out by the personal experiences of the doctors who contributed to Naaz Coker’s report – Racism in Medicine – An Agenda for Change.

A recent survey carried out by the Commission for Health Improvement (CHI) – now the Health Commission – is further testament that bullying and harassment are still prevalent within the NHS. The survey found that 37% of staff had been harassed, bullied or abused in the last 12 months and that 15% had been physically attacked.

Some organisations are making real progress in implementing zero tolerance policies – but it is vital that the NHS as a whole tackles this issue head on and learns from the positive practice which is already making a tangible difference to doctors in some parts of the service.

Key action 1

Develop a programme of activity which contributes to the creation of fair, equitable and speedy systems for identifying and dealing with clinical negligence and competence issues for doctors.

Top ideas

• analyse GMC and NCAA disciplinary cases to ascertain patterns and underlying reasons for the high level of suspended and disciplined doctors from black and minority ethnic backgrounds
Key action 2
Support a zero tolerance approach to bullying and harassment in the medical workforce

Top ideas
• use external experts – including the National Clinical Assessment Authority – for mediation in bullying and harassment cases
• promote monitoring and recording of harassment and bullying claims by trusts and strategic health authorities
• promote a structure which supports those who have been bullied and those accused of bullying.

Your ideas – what other measures can support the creation of fairer disciplinary and management processes? And what other activities will help root out bullying and harassment among doctors at all levels?

In focus – equality and diversity in the NCAA

What is the NCAA?
The National Clinical Assessment Authority (NCAA) was set up in 2001 as a special health authority. Playing a central part in the NHS’s work to improve quality, the NCAA’s main role is to support acute trusts, primary care organisations and strategic health authorities who are facing concerns about the performance of a doctor or dentist.

Its key functions
The NCAA is an advisory body which:
• gives advice and support to SHAs and trusts about the local handling of cases
• carries out clinical performance assessments on doctors and dentists
• makes recommendations on how problems relating to performance might be resolved.

Facts and figures
In its first three years:
• the NCAA has handled over 1000 referrals
• approximately 40% of these have involved doctors and dentists from ethnic minority backgrounds
• where possible suspension cases have been referred to it, the NCAA has been able to recommend an appropriate alternative to suspension in 85% of instances.

Mainstreaming equality and diversity
The Authority has appointed an Equality and Diversity Project Manager, Ian Bettison, to lead a programme of work to embed equality and diversity best practice within the organisation itself and within its assessment and advisory procedures.

Ian says: “We are a small organisation with about 90 staff – but we have a high-profile. So it’s crucial we have our own house in order in terms of ensuring equality and diversity best practice flows through our own structures and everything we do.

“As a starting point we’ve carried out a very successful staff survey based on the excellent Positively Diverse model. The fact that almost 90% of staff responded has been very encouraging and indicates that staff not only feel engaged in the process but feel it can bring about real cultural change in the organisation.”

Spreading this enthusiasm and commitment to the organisation’s processes has also been a priority.
The NCAA’s aim is to ensure doctors and dentists are treated fairly and its processes are free from discrimination. According to Ian, the organisation has already made good progress:

- demographic data, including information about a doctor’s ethnicity, sex and age will no longer be available to NCAA advisors who are responsible for dealing with specific referrals and deciding how to progress each case
- an equality and diversity sub-group has just been launched as part of the Authority’s wider Assessment Framework Forum. The group will ensure that all stages of the assessment framework are fair and free from bias and discrimination
- NCAA has commissioned language experts at the Department of Education and Professional Studies at King’s College, London to investigate the potential for indirect discrimination in the language used by the assessors during practice-based discussions. The discussions form part of the assessment process where assessors observe a doctor in practice and talk about what they’ve seen with the individual doctor
- an external Equality and Diversity Reference Group – including representatives from the British International Doctors Association, the Women’s Medical Federation and experienced doctors with disabilities or from ethnic minority backgrounds – offers advice and support to the Authority on these and other programmes.
Case study 4

Tackling bullying in post-graduate training

At the beginning of 2000, Kent, Surrey and Sussex Deanery took the fight against workplace bullying to a new level.

A recent survey had shown them some worrying figures. Of 2,400 trainee doctors at all grades, as many as 34% indicated they had been bullied in the last year – with 7% reporting that they had experienced persistent bullying behaviour.

The deanery’s approach was to work towards changing the system in which bullying was tolerated, rather than tackling individuals themselves. The first major step was to develop a detailed anti-bullying policy which made clear the deanery’s zero-tolerance approach to bullying, including any form of discrimination or victimisation on the grounds of race, sex, sexuality or disability.

The policy was also explicit in identifying the range of inappropriate behaviours that should be avoided – including verbal abuse, shouting, humiliation, unreasonable expectations, victimisation and demonstrable undervaluation of colleagues.

Crucially, all formal contracts between the trusts and the deanery now include a mandatory clause outlining that bullying or intimidation of doctors in training are not to be tolerated. It also states that trusts are required by the deanery to have in place their own anti-bullying policies and to take suitable, fast action where bullying is taking place.

Additionally, the deanery is making it easier for trainees affected by bullying to access help, including a confidential counselling service detached from both the deanery and trusts, which acts as a safe first haven for those anxious that reporting their experiences will affect their careers.

Professor Brendan Hicks, Post-Graduate Dean for Kent says: “Awareness of bullying has certainly increased among consultants and we are also encouraged by questionnaire responses from pre-registration house officers (PRHOs) which show fewer are indicating they have been bullied in their current or previous PRHO post.

“But the challenge ahead is to move on from policies which are essentially responsive and remedial to make real changes in the culture.”

Current pilot workshops are ….

• targeting senior specialist registrars and new consultants with a specific programme to explore bullying and raise awareness of their own considerable power to create positive working environments for their clinical teams

• looking at ways of empowering trainees as individuals and groups to handle aggression and bullying in a confident and effective way.

Contact: Professor Brendan Hicks at BHicks@kssdeanery.ac.uk
View from...Dr Umesh Prabhu

Medical Director
Bury NHS Trust,
secondary care
advisor for the
National Clinical
Assessment
Authority and
member of the
Medical Workforce (Equality and
Diversity) Reference Group

In the NHS, disproportionately
more ethnic minority doctors face
disciplinary action. As many as 60%
of doctors appearing before the
GMC conduct committee are from
ethnic minority (EM) backgrounds.
Added to this, 70% of doctors
charged with manslaughter and 36%
of long-term suspended consultant
are from EM backgrounds – yet they
make up only 28% of total medical
workforce and 18% of the
consultant workforce.

Similarly, of the 1200 doctors
referred to the National Clinical
Assessment Authority (NCAA) to
date, 28% are Asians. However,
these doctors make up only 23%
of the workforce.

With increasing performance
management systems in place
for doctors such as appraisal,
revalidation and clinical governance,
more and more doctors will be
identified and more EM doctors,
particularly from the primary care
setting, will be referred to
organisations like the NCAA and
GMC. Most of these doctors need
support, help and retraining rather
than disciplinary action.

Many ethnic minority GPs work as
single-handed, inner-city GPs with
poorer resources, facilities and
clinical governance systems in place.
It is important to understand the
system failure that contributes to
poor performance by some doctors.

It’s also essential that we now focus
real effort on taking bias out of
disciplinary systems. The NCAA and
the GMC need to take steps to
ensure that advisors and screeners
do not see information about a
doctor’s age, ethnicity and sex when
reviewing a case. They must also
consider carrying out research on the
300 plus cases they have handled
involving EM doctors. This would
help to identify trends, training
needs and any future action than
can be taken by us or the NHS to
support these doctors at an earlier
stage.

But of course, it will take more than
this to solve the problem. We need
to look at the make-up of the
medical workforce at its highest
levels. The decision to refer a doctor
to the GMC or NCAA is made
locally, usually at medical director
level. But out of more than 480
trusts, there are only a handful of
medical directors from black and
ethnic minority backgrounds.

We need to tackle this huge under-
representation and a start has
already been made with the
Leadership Centre now providing
leadership training to many black
and ethnic minority doctors and
nurses."
4. The Medical Workforce (Equality and Diversity) Reference Group

The Medical Workforce (Equality and Diversity) Reference Group has been established by the Department of Health to increase the participation and achievement of equalities target groups within the medical workforce.

The group reports to the Department of Health’s Equalities and Diversity Delivery Board and it has six key objectives:

- to identify some of the key issues and challenges facing equalities target groups in the medical workforce
- to ensure that these issues and challenges are communicated and understood by all of those working within the medical profession
- to suggest how some of these issues and challenges might be overcome
- to recommend different approaches for increasing the achievement of equalities target groups within the medical profession, based on good practice
- to recommend policy changes which will help to address any inequalities which may exist within the medical profession
- to develop – in partnership with key stakeholders within the medical workforce arena – actions and activities which will initiate change.

The members (in alphabetical order)

External representatives

Kate Adams
British Medical Association

Ian Bettison
Equality and Diversity Manager, National Clinical Assessment Authority

Edwin Borman
Chair of the Race, Equality and Diversity Committee, General Medical Council

Judy Curson
Associate Dean, Isle of Wight and Hampshire Workforce Development Confederation

Beryl de Souza
Plastic Surgery Registrar, Chelsea and Westminster Hospital

Aneez Esmail
Vice President of the Medical Practitioners Union

Hilary Forrester
Senior Policy Executive, Equal Opportunities Committee, British Medical Association

Romesh Gupta
Chairman, British Association of Physicians of Indian Origin (BAPIO)

Rachel Hogg
Co-Chair of Gay and Lesbian Association of Doctors and Dentists (GLADD)

Rhona MacDonald
Editor of Career Focus, BMJ Careers

Kwame J McKenzie
Senior Lecturer in Psychiatry, University College London

Shaaz Mahboob
Health Strategy Consultant (International Recruitment and Marketing) London Workforce Programme Office and DH

Kwee Matheson
Regional Clinical Director, NHS Professionals (Doctors).

Shiv Pande
National Chairman, British International Doctors’ Association (BIDA)

Paul Philip
Director of Fitness to Practice, GMC
Prof Umesh Prabhu
Medical Director, Bury NHS Trust and secondary care advisor for the NCAA

George Rae
Chair, Equal Opportunities Committee, BMA

Aly Rashid
Professor of Primary Health Care, De Montfort University and Deputy Director of Postgraduate GP Education, LNR Deanery

Alan Ryan
National Project Director, Modernising Medical Careers

Babinder Sandhar
Consultant Anaesthetist, Royal Devon and Exeter Hospital

Aideen Silke
Policy Officer, Council of Heads of Medical Schools (CHMS)

Jim Sykes
Conference of Postgraduate Medical Deans (CoPMED)

Eric Waters
Improving Working Lives for Doctors Champion

Amanda Watson
Director of Education and Registration, GMC

Department of Health representatives

Lutfur Ali
Equalities and Diversity, Workforce Directorate

Paul Deemer
Project Manager, Equalities and Diversity Team, Workforce Directorate

Melanie Field
Equality Strategy Unit

Paul Loveland
Head of Learning and Development Policy

Debbie Mellor
Head of Workforce Capacity

Alexandra Mortimer
Business Manager, Medical Regulation

David O’Carroll
Deputy Branch Head, Health Regulatory Bodies

Claire Potter
Section Head, Learning and Personal Development
5. Feeding your ideas back to us

This report is a consultation document. In sharing the thinking and ideas so far, the aim is to gather experiences, best practice and feedback from the wider stakeholder group. This will play a crucial part in the development of a more detailed programme of work to progress realistic, effective and workable solutions for building equality and diversity into everyday practices within the medical workforce.

These goals are achievable, but your input is essential. The Equalities and Diversity Team want to hear your views – just email your comments, ideas and best practice to:

EQuALITIES@doh.gsi.gov.uk
6. Further reading

Bringing together the key research and reports referenced throughout this document plus other sources of support on equality and diversity in the medical workforce.

a. General

Equalities and Diversity in the NHS - Progress and Priorities (DH October 2003)
http://www.dh.gov.uk/publications and use the publications library

Equalities and Diversity Strategy and Delivery Plan to Support the NHS (DH Oct 2003)
http://www.dh.gov.uk/consultations and use the consultations library

HR in the NHS Plan - more staff working differently (DH June 2002)

Delivering HR in the NHS Plan (DH June 2003)
http://www.dh.gov.uk/hr

Modernising Medical Careers
http://www.mmc.nhs.uk/

Hospital, public health medicine and community health service medical and dental workforce statistics for England
http://www.publications.doh.gov.uk/stats/s_bulletins.htm

b. Improving access to medical education

Reports and Research

Pushing The Boat Out - and The Sequel to Pushing the Boat Out - studies by Anne Tynan of DIVERSE into admissions to medical school for applicants with a disability, (2003 & 2004).
http://www.ltsn-01.ac.uk/resources/features/pushing_the_boat_out

Tomorrow's Doctors - Recommendations on undergraduate medical education (GMC July 2002)


Medical Schools: Delivering the Doctors of the Future (DH 2004)
http://www.dh.gov.uk/publications and search the publications library

Support

BMJ Careers Advice Zone
http://www.bmjcareersadvicezone.synergynewmedia.co.uk/

National Advice Centre for Postgraduate Medical Education
www.britishcouncil.org/health/nacpme/index.htm

Conference of Postgraduate Medical Deans and Deaneries across the UK
www.copmed.org.uk/deaneries
c. Employment, progress and recognition – removing career barriers

Reports and Research

Thriving and surviving at work: Disabled people’s employment strategies - Alan Roulstone, Lorraine Gradwell, Jeni Price and Lesley Child, Joseph Rowntree Foundation (ISBN 1 86134 522 4)
www.jrf.org.uk

Choice and Opportunity - Modernising Medical Careers for Non Consultant Career Grade Doctors (DH July 2003)
http://www.dh.gov.uk/consultations and use the consultations library


Ethnic and Sex Bias in Discretionary Awards - James Raftery (BMJ 2003; 326: 671-672 March)
http://www.advisorybodies.doh.gov.uk/accea/ annual.htm#2002

Support

Improving Working Lives
http://www.dh.gov.uk and follow the model employer link.

The Flexible Careers Scheme
www.wymas.flexiblecareersscheme.nhs.uk

BMJ Careers Chronic Illness Matching Scheme
http://www.bmjcareers.com/chill/

Doctors’ Support Network –
www.dsn.org.uk

Guidance

http://www.dh.gov.uk/publications and use the publications library

Gay and Lesbian Association of Doctors and Dentists, Dignity at Work Guidelines
http://www.gladd.dircon.co.uk/iwl.htm

Support

Dealing With Discrimination: Guidelines for BMA Members
www.bma.org.uk/ap.nsf/content/discrimination

The NHS National Staff Survey 2003 - Summary of Key Findings - Commission for Health Improvement (CHI)
www.chi.nhs.uk/eng/surveys/ nss2003/ key_findings.pdf


Guidance

Maintaining High professional Standards in the Modern NHS: a framework for the initial handling of concerns about doctors and dentists in the NHS - Department of Health
http://www.dh.gov.uk/publications and use the publications library