



Royal College  
of Physicians

# A 2020 Vision

An independent report into  
Diversity and Inclusion at the  
Royal College of Physicians

**Ben Summerskill**



It's good that the RCP is doing this.  
Not just good, very good

We should all be saying this is a College  
that's forward looking, rather than  
just dwelling on its 500 year history

You ought to have tried harder to attract  
people like me. This is your opportunity  
to show true leadership. Take it and run  
with it

I'd love the RCP to start representing  
the population of patients it serves  
across the UK

If I saw an advert that was open to  
everyone, and where I'd be competing  
with the whole membership, I wouldn't  
rate my chances. I'd assume the College  
would already have someone in mind

# Foreword

When the College of Physicians was founded in 1518 its fellowship, in the spirit of those times, required a degree from Oxford or Cambridge. Women weren't specifically barred from being fellows; they were simply barred from obtaining the qualification that would enable them to be considered for appointment. Women's professional role as mere helpmates to male doctors – aspiring perhaps to be a matron at best—continued for almost four centuries.

Happily, both the College of Physicians (now Royal) and the wider medical world has changed immeasurably in the intervening 500 years. Today, many of its membership and employees look much more like the global population that both staffs and uses the UK's NHS in 2020.

However, the RCP – with its hugely important role as a leading player in this country's medical profession and globally – will only *deliver* the very best if it *gets* the very best from all the resources available to it. The most extensive of those resources are its 37,000 members and almost 400 employees. That means unlocking the potential contribution of every one of them to the College's work and listening to what they have to say, whatever their background.

That's why it's refreshing that the RCP, as part of its current programme of modernisation, has asked for an external view of whether all its people are being enabled to make the greatest contribution to its work. It's why it's also refreshing that those who've requested this report – particularly the RCP's president, registrar and chief executive – have asked me to be candid.

Some of the reading here might feel slightly uncomfortable. It's clear that some members in particular regard the RCP (and its beautiful premises) as a little distant from the tough front line of their daily lives. However, there's also a wide consensus among members and staff that the RCP's willingness to think about its approach to Diversity and Inclusion is positive.

This report's proposals are intended to be positive too. They're largely managerial and practical and framed in an achievable 'post-crisis' timetable aligned with the RCP's new 2021–2024 strategy. They do not contain many ambitions – as can happen – to 'consider' things that people might still be 'considering' in 5 years' time. I hope they'll help the RCP move the needle, both internally and externally, as it develops its vision for the next 500 years of its remarkable history.

I'm grateful to an insightful advisory panel, each of whom has supported delivery of this work to a tight timetable and given up time to engage with colleagues and members. I'm particularly grateful to Claire Burroughs and Rhona Mackay for their unfailing guidance, good humour and efficiency in recent months.

**Ben Summerskill**

“The RCP will only *deliver* the very best if it *gets* the very best from its 37,000 members and 400 employees

# 1. What we know

The RCP currently records information about members on its CRM database. In addition to the usual personal detail – name, email address etc – the system can capture diversity data. Members are now asked, but not required, to provide details of their gender, ethnicity and age. Data in other diversity fields now commonly captured elsewhere in the healthcare world – including disability, sexual orientation, religion or belief, and gender identity – has never been collected.

Voluntary roles within the RCP involve a wide range of different activities including as trustees, committee members, members of the Patient and Carer Network (a group of ‘experts by experience’ created in 2004 and intended to help inform every stage of the RCP’s work) and examiners. Diversity data, at February 2020, was only available for committee members.

Women comprise 38.7% of RCP UK members, as indicated in Table 1. However, the gender balance shifts sharply across different categories of membership. While almost two-thirds of student members are women, they comprise just 37% of volunteers and 27% of fellows.

	All members	Student members	Volunteers	Fellows
Female	38.7%	64.3%	36.8%	27.0%
Male	61.3%	35.7%	63.2%	73.0%

**Table 1: RCP UK membership by gender at February 2020**

A similar breakdown for ethnicity is shown in Table 2. (The picture is less certain because almost a third of members do not disclose their ethnicity, something not uncommon when people are not aware why such data is being requested, and what useful purpose disclosing it will serve.) The discrepancy, however, is even starker. While almost half of the RCP’s student membership are from a black, Asian or minority ethnic (BAME) background, fewer than a quarter of those appointed to committee roles and fewer than three in ten fellows are.

	All members	Student members	Volunteers	Fellows
White	61.0%	53.3%	75.5%	71.5%
BAME	39.0%	46.7%	24.5%	28.5%

**Table 2: RCP UK membership by ethnicity at February 2020**

*Focus on Physicians*, the annual workforce census for all three of the UK’s physicians’ colleges, is useful for these purposes as it provides a snapshot of the current labour market landscape inhabited by the RCP. In 2019 it recorded that 63% of consultants nationally were men and 37% were women. Data on ethnicity, available for 82% of consultant physicians, shows nationally that 65% of these were white, 28% of Asian or Asian British origin and 2% of black or black British origin. These figures suggest that RCP membership overall is aligned to that in the wider medical world.

It’s surprising that robust efforts are not already being made to measure, and thus ensure, the diversity of the Patient and Carer Network, the 130 people explicitly intended to connect the RCP into the lived experience of the general population. This might be expected given the existing hard evidence base of a range of known health inequalities faced, among others, on the grounds of visible and invisible disability, social and economic background and sexual orientation. The evident discrepancies already emerging in the numbers of BAME people dying from COVID-19 in the UK are a further stark example.

It’s similarly surprising that robust diversity data was, at February 2020, not easily available for the College’s examiners. In the past 3 years, both the British Medical Association (BMA) and the General Medical Council (GMC) have warned about the dangers of ‘unconscious racism’ in medical examinations. NHS England is now investigating this too. (Research published by the RCP itself in 2018 also indicated that white trainee doctors were applying for fewer consultant posts at the end of their training than BAME trainees, but were more likely to be shortlisted and offered a post.)

Should the RCP face challenge in this area, it might significantly weaken any response if it were obliged to admit that it did not have easily available records of the ethnic breakdown of those involved. This should be resolved swiftly.

Data on the RCP’s 400 current staff is somewhat more complete, with up-to-date information available on sex, ethnicity, age, religion or belief and disability, although not sexual orientation or gender reassignment. (This odd exception does leave the RCP exposed should it face an employment tribunal claim of discrimination on one of these grounds.) Figures for gender are shown in Table 3 and for the largest three groups by ethnicity in Table 4.

Pay bands	3–4	5–6	7–8	9–10
Female	76.4%	64.6%	59.0%	60.0%
Male	23.6%	35.4%	41.0%	40.0%

Table 3: RCP staff by gender at February 2020

Pay bands	3–4	5–6	7–8	9–10
Asian/Asian British	10.8%	5.4%	12.8%	0%
Black/Black British	5.7%	8.2%	5.1%	10.0%
White	55.2%	61.2%	69.2%	70.0%

Table 4: RCP staff by ethnicity at February 2020

Only 2% of RCP staff consider themselves to have a disability. This contrasts with the Office for National Statistics’ most recent Family Resources Survey, which puts the figure at 21% for all UK citizens.

As an employer of more than 250 people, the RCP is now obliged annually to publish data on its gender pay gap. In the year to April 2018, the key disparity – average hourly pay – was 10.8%. Bonuses had been paid to 3.7% of men and 4.2% of women. In the year to April 2019, the gap in average hourly pay at the RCP had increased, by 30%, to 14%.

The RCP does have an Equality, Diversity and Inclusion Policy, last updated in 2018. This is not published on its external website. It can be located on Parklife, the internal staff intranet site, however – according to staff – it is not easy to find. The lengthy policy is ‘belt and braces’ in that it’s legally robust, but it focuses mainly on detailed legal compliance and the complexity of complaints procedures, rather than sharing any organisational vision.

The policy makes no provision for measuring effectiveness, or sharing data, or reporting progress. It’s always challenging to secure pan-organisational buy-in to moving the needle on diversity if there are no shared ambitions, at senior level, about what ‘good’ will look like.

And importantly, apart from saying that *all* managers must ‘undertake their duties in accordance with this policy’, it identifies no one at *senior* level who is individually responsible, and therefore accountable, for delivery of the RCP’s Diversity and Inclusion objectives.

## Recommendations

- Announce an ambition that by 2030 those in both voluntary and staff roles across the RCP should reflect the diversity of the qualified medical workforce, at all levels including trustees and Council.
- Feature measurable delivery of diversity outcomes in the performance objectives of all senior staff and senior officers, as well as in their role descriptions. Appraisals (and any discretionary part of their remuneration in the case of staff) should be linked to these, as with other key deliverables.
- Task the chief executive with reporting annually on progress on Diversity and Inclusion – both in voluntary and paid workforce and service delivery – to trustees and Council and publishing the data.

## 2. What people see...

Some members and staff rightly acknowledge the RCP to be ‘increasingly diverse’ and ‘working hard’ to be more diverse. One member was ‘impressed’ by the response to a complaint about initially being rejected for fellowship. However, if people – either in the medical profession or the wider labour market – don’t know an organisation well, they will almost certainly judge a shop by what’s in the shop window rather than the sentiments expressed privately by the shopkeeper.

A ‘mystery shop’ to the RCP website by a potential member – *let’s call him MSA* – found a Board of Trustees made up of 10 men and four women and an Executive Leadership Team that was all white. On finding the RCP’s values – ‘Taking Care, Learning, Being Collaborative’ – they made no explicit reference to Equality, Diversity or Inclusion either among membership or staff, or in its outward-facing work, even if these might be considered internally to be implied. **MSA** could not find a Diversity Policy on the RCP website, something now commonplace elsewhere.

A ‘mystery shop’ to the RCP’s London office by a potential fellow – *let’s call her MSB* – meant sitting for 20 minutes in its waiting area. During that time she saw ten staff at work – three on reception, two liaising with conference hosts, one security guard, one events officer showing potential clients around, one member of staff welcoming another guest, one maintenance man and a cleaner mopping the floor. All were white. The waiting area was overlooked by four portraits of older white men.

**MSA** and **MSB** inhabit a professional world where a range of diversities now exist and where, in 2020, organisations are increasingly upfront about celebrating them. For **MSB** in particular, it will have been very unusual to visit any head office in central London and not see anyone working there from a black, Asian or minority ethnic background.

‘Anyone currently training or who’s a physician should feel comfortable walking into the building’

‘The College does not look like me’

‘The RCP remains far too white, male, private school, London-centric and devoid of LGBT members. It should aim to reflect not just its current membership (a third of which will retire in the next decade) but its future membership’

‘We need more physically disabled and, possibly, learning difficulties people evident in the RCP building. Front desk, cafe, kitchen, garden’

The RCP currently operates, in both London and Liverpool, in a highly competitive labour market. While some of the competencies required of potential staff are specialist, others are transferable. And many workplaces which historically were not necessarily welcoming to staff from a range of backgrounds – for example, pharmaceutical companies – now actively seek them out. In that context, it’s critically important that the RCP’s shop window for staff is appealing too.

A ‘mystery shop’ by a potential employee in London, a health economist from an Indian family – *let’s call him MSC* – leaves him pleased to find a recruitment video that starts with a senior non-white employee. He clicks on the website to see who else on the Executive Leadership Team is BAME. She’s not actually on it, and everyone else is white. Returning to the video, one woman employee makes reference to work–life balance. **MSC** wonders if this applies to men too, but can’t find any reference to it elsewhere on the website. By the end of the video, no one who appears to be of Indian or subcontinent background has featured at all. It doesn’t look like the NHS **MSC** knows. When he gets to the monitoring form on the RCP recruitment portal, **MSC** finds that the name of his faith, Buddhism, is misspelt. *How likely is MSC to apply to work for the RCP?*

Another ‘mystery shop’ is effected by a potential staff member in Liverpool, a qualified graphic designer – *let’s call her MSD*. When she gets to the monitoring form she’s asked her gender and offered a male/female alternative. There’s no reference to gender identity.

She finds that a bit ‘20th century’ as it was being discussed on the *Today* programme that morning as a general election issue. She then gets to the sexual orientation question and is offered a simple choice of ‘heterosexual’ or ‘homosexual’. At 27, **MSD** has only ever heard the word ‘homosexual’ used as an old-fashioned and slightly prejudicial reference to a medical condition. **MSD** has, through a 5-minute Google search, already found six other similar jobs in Liverpool, all of which include positive diversity commitments in their introductory rubric. Which will she focus on?

‘I’d like to see a statement about equality and diversity being visible when you advertise for roles’

‘The organisation can better meet the needs of its many audiences if the people involved in running the RCP have first hand knowledge of their needs, and those of the wider population’

‘As a person of colour, and talking to other people of colour, we seem to accept that to progress in our careers we have to work harder and be prepared to earn less than our white counterparts’

Any welcome offered by the RCP’s built environment to members and staff of all backgrounds, and the accompanying signal about embracing all sorts of diversity, is not just *visual*. It’s *physical* too.

While senior staff insist that guests – if wheelchair users – are treated with great care, others report different experiences.

‘Anyone with a physical impairment visiting the Regent’s Park site is viewed as a bother, something to be worried about, someone who takes up time’

‘I have difficulty using stairs and for years the RCP seemed unable to maintain the lift that went to every floor (now replaced)’

‘For disabled people, the access across the estate is not very good’

‘I’ve never seen anyone mentally or physically disabled at the RCP’

Widely publicised plans for the RCP’s new £35m Liverpool base, *The Design of The Spine*, show a series of 14 dramatic wide steps populated by ‘pods’ of cushions. Small groups of staff are shown on them having informal meetings of the sort customary in many modern office environments. There’s no indication that any but the first of these 14 meeting areas would be accessible to someone in a wheelchair. There are 110 ‘avatars’ in the plan, showing people inside and outside the building, but not one has a visible physical disability. Managerial efforts to make the building accessible have simply not been communicated.

## Recommendations

- > Review the RCP website at points of entry and furnish it up front with strong examples of senior role models, both members and staff, from a range of backgrounds.
- > Include at the beginning of all application packs, for both voluntary and paid roles, a prominent rubric emphasising the RCP’s keenness to recruit in the complexion of the wider medical workforce and patient base.
- > Update recruitment monitoring forms to use 21st-century language unlikely to deter potential applicants.
- > Review visual representation of members, past and present, in reception areas so that they better represent the RCP’s ambitions for breadth of membership.
- > Execute an access audit for both the RCP’s existing London premises and The Spine, with disabled staff and members enabled to contribute to its findings.

# 3. What people think...

Too many members feel that voluntary roles at the RCP are not entirely open to the wide range of people the College serves in 2020. Given that any recruitment process involves investment of time and some personal stress, if well-qualified people from less well-represented backgrounds feel that voluntary appointments are made on the old-fashioned basis of a 'tap on the shoulder', they're less likely to put themselves forward.

‘Many of the low-profile but interesting leadership roles are still awarded “on the nod” through an old boys’ network’

‘There are so many trustee/committee roles where it feels there’s a sense of favouritism in getting selected’

‘Despite being a white, male, London-based fellow I do feel the college is too much like me!’

‘My experience is that you’ll make progress within the RCP if you know the right people and fit into the status quo and general perception of how things are and should be done. There’s little room for innovation and creativity’

‘The RCP does well employing a diverse workforce. At Committee level I suspect that there is a bias of old white males (like myself)’

There’s some uncertainty among many members about what voluntary roles involve – in terms of experience, contribution and time – unless someone known to them is already in one. There’s also a belief that there are traditional ‘ways of behaving’ that are both expected and central to effective operation in such roles.

‘Jobs are not always advertised or accessible. The workings of the College are rather an arcane mystery’

‘Advertising, educating, and promoting opportunities will improve awareness, and over time, make everyone feel they have the right to “go for it”’

‘I’m unsure how to apply or what roles there may be. I don’t know of any LGBT representation at the RCP’

‘In my experience, volunteering with the RCP as a lay member requires an advanced level of literacy and the need to conform to a set of behaviours that are likely to exclude or deter a wide range of people from taking part’

‘When one applies for a College role and is declined there is no feedback given and often not even a thanks but no thanks’

There also appears to be no consistency or particular guidance across the RCP on how the huge range of non-elected vacancies should be drawn to members’ attention, how a recruitment process should take place, how a panel interview should be conducted and how roles – and the work involved in them – should be explained to potential applicants. Where there is such vagueness, potential applicants from historically under-represented groups are more likely to think that such roles will be allocated ‘on the nod’.

‘One barrier is looking for very polished people who have been doing it for years and who are well educated. This stops a whole range of people from taking up leadership roles’

‘You could do more to guide people in middle grade roles, especially SAS doctors. We can contribute immensely and be an invaluable resource for the College’

If you’re from a black, Asian or minority ethnic background and value your own cultural identity or religion then the institution is not attractive to you. If you actually have an Indian, not a public school, accent people react differently. I’ve seen it in Council’



‘Many women feel that they should only apply for positions where they 100 per cent cover the criteria. It’s important to encourage them to realise that they can apply with less and emphasise what they can bring to the College’

‘As a woman, if I’m interviewed by a panel of five men, I am wondering are they going to appoint me?’

The benefits that diverse groups of people bring to more careful consideration, better decision-making and better risk management are acknowledged in the wider professional world. They’re the reason that many large bodies have been persuaded that diversity is in their organisational self-interest. In areas such as examinations, good diversity practice also results in a better perception of fairness, with the reputational benefits that brings too.

‘I’m sometimes the only female, Asian examiner. That could be daunting for some. Others have mentioned this to me feeling: “Am I part of this?”, “Am I heard?”’

‘I’ve only met one other person of colour in the Patient & Carer Network. It’s not very diverse. I don’t know if I’m the only black volunteer’

There is also evidently some concern that the way in which existing members are asked to become fellows is, at best, slightly opaque. Allowing individuals to apply themselves, something they’ve been able to do in recent years, clearly acts as a corrective for this. However, any application process needs to be perceived to be rigorously fair.

‘Roles are limited to fellows and I don’t see the benefit of paying £500 extra for a change of letter from M to F in my postnominal’

## Recommendations

- Advertise all voluntary roles, and include clear details of the expectations of time and expertise necessary. Introduce and advertise a presumption that such roles can be job-shares. Re-advertise such roles after an appropriate, RCP-wide tenure such as 6 or 8 years.
- Introduce ‘observer’ opportunities for all members, inviting them to attend committee meetings or examination panels and ‘shadow’ officers, subject to appropriate protections around confidentiality.
- Adopt an organisational *ambition* of having a similar number of men and women on interview panels (for both voluntary roles and staff) and a *requirement* that at least one person on all such panels be a woman (or a man) and one from an under-represented group unless unavoidable.
- Review whether any roles currently restricted to fellows might be opened to non-fellows, including SAS members.
- Request that all members of any appointment panel engage in a light-touch training module in unconscious bias provided by the RCP. Require chairs of such panels to have used such a module.
- Engage in a focused communications drive with the NHS and trusts to emphasise the importance of RCP roles for the NHS and the profession.
- Review the *objective* criteria for appointment as a fellow, and monitor the diversity of appointments annually. Consider how the nomination process might be more transparent, eg by publishing the names of referees.

# 4. Keeping the best people

As any marketing guru will testify, investment in attracting new customers is pointless if the – much easier – effort of keeping existing customers is not successful too. Exactly the same maxim applies both to those who perform voluntary roles for an organisation and to its staff.

Engaging with an institution with a 500-year history might well be something that many can do with facility. Understanding committee ritual and age-old tradition might seem like fun. (*What does a 'garden fellow' do? Mix ground hollyhock with mouse phlegm as a cure for the ague?*) However, the best contributions to the RCP's committee and examining work might not be secured if there's insufficient induction, support and explanation.

‘The College uses jargon and acronyms a lot – this is disenfranchising if you're not “in the know”. It needs to use plain English’

‘It's made up of the usual people who enjoy a boys' chat with people similar to them. Meetings are catered to the old boy structure’

‘I'm from a comprehensive school background with no formal debating or chairing experience and I find those situations intimidating. I often feel that I'm an imposter’

While extensive guidance on technical governance and procedural issues is given to committee chairs on appointment, there's just a brief reference to ‘respectful behaviour’, after details of seating plans. They're not given specific guidance on how to listen to all the voices in a room, how to ensure that people from all backgrounds are heard and supported in new roles, and how both chairs and whole committees can endeavour to avoid unconscious bias in their deliberations.

‘For two years running the Patient & Carer Network chose the Day of Atonement for its autumn Workshop so I could not attend’

Just as the way in which different voluntary roles are recruited seems to vary on an ad hoc basis across the RCP, so the management of those voluntary groups appears to differ too. (In the case of the Patient and Carer Network, incidentally, there also doesn't appear to be any formal safeguarding structure in place, something that might be expected in any charity where sometimes vulnerable volunteers are being engaged.)

While many of the roles in which RCP members engage are connected to their professional work, they're usually unremunerated or partly remunerated. As with all volunteering, that makes it even more important to make people feel organisationally appreciated and thanked. (That's why volunteer management has in recent years become a discrete professional skill.)

‘It's not just about widening access to roles. You should be looking at valuing people already doing such roles’

‘It isn't so much the money, it's respect for you in the role and the time you've spent reading the papers, considering the issues and attending the meeting’

‘I wouldn't say reduce the time commitment, but rather recognise formally the time commitment involved’

‘The least the College could do is recognise you. You're paying for your own travel card, yet the College never really says thank you’

Many recognise that the RCP is unlikely to reimburse full pay lost when engaging in voluntary roles, and which they often have difficulty recovering from their own NHS employer. However, some members in voluntary roles also feel there to be an inconsistent approach to paying travel expenses.

‘Unfortunately as a female member, not London based, with significant carer responsibilities and working for a charitable organisation, where backfill is not feasible without funding, it’s not been possible to offer any time. My gender, my region and my specialty is under represented’

Just as those in voluntary roles perform better and are more loyal when they’re supported and acknowledged, the same is true for employees. In a sector where staff will not necessarily earn as much as they might command elsewhere, ‘emotional pull’ to an employer is even more important.

‘A well-supported diverse workforce is a happier, more imaginative, more representative and more ethical workforce. As a healthcare charity the RCP should be at the forefront of fighting against discrimination and bias in healthcare provision. To be doing that we need to sort out our own house first’

The brief for this report included a request to ‘establish whether development of an explicit Equality and Diversity policy is necessary’. That none of the staff involved in developing that brief were aware that such a policy already existed is no criticism of them. It does, however, suggest that those who say the RCP’s current approach to staff diversity is ‘a bit lacklustre’ and ‘has no zing’ may be right.

‘I’d like to see RCP at Pride in London and now Liverpool at least, showing its role in promoting inclusion within the wider community’

Unlike many smaller colleges, there are no network support groups for particular cohorts of staff, no membership of external diversity bodies which have the capacity to support good practice in retention and development, and no regular publication of diversity data to signal seriousness of intent. When these things are done well, they’re all signals – to both existing and potential staff – that enhance organisational emotional pull.

## Recommendations

- > Extend guidance issued to all committee chairs on appointment to include awareness of Diversity and Inclusion. Require chairs within 6 months of appointment to engage in a light-touch RCP training module in unconscious bias.
- > Regularise the management of volunteers across the RCP – including development of volunteer agreements, performance review and the payment of all travel expenses.
- > Carry out a feasibility review to consider the possibility of funding child- or other care expenses incurred by those in voluntary roles, both women and men.
- > Require that the Equality and Diversity training now provided to staff at the point of recruitment is refreshed every 3 years.
- > Pilot goal-driven staff network groups for some cohorts of staff (eg women and BAME employees) tasked with supporting RCP business objectives such as closing the gender pay gap and delivering the Workforce Race Equality Standard. Engagement in such network groups should be regarded as an organisational investment, not a cost.

# 5. Using data wisely

Hundreds of organisations in the UK's medical sector now routinely monitor the backgrounds of those who *apply* to work for them, either as staff or volunteers. More important, they also routinely monitor the backgrounds of their current workforce, those who've been *successful* in their attempts. They acknowledge a universal truth of Diversity and Inclusion; what isn't measured doesn't matter.


This is now usually done across an individual's current legally protected characteristics – of age, disability, ethnicity, faith, gender, gender reassignment and sexual orientation. For some years there was a suggestion – often made by those of a more traditional perspective – that asking for details of, say, someone's faith or sexual orientation would be unreasonably intrusive. Good monitoring addresses that by enabling people to 'Prefer not to say' should they wish.

Such 'across the board' monitoring is now regarded as almost commonplace, in particular by most people under 40. (Sixteen-year-old recruits to the armed services have been providing such information for some years.) And there's labour market evidence that when such questions are not asked, even younger people not from minority backgrounds can regard an employer or professional body as slightly out of touch with their own lives. (Where the sort of questions asked, as currently by the RCP, are 'Are you homosexual?', such old-fashioned language can similarly be alienating not just to younger lesbian, gay and bisexual people, but to their straight counterparts too.)

When monitoring is effected, alongside reassurances that the data gathered will help an organisation perform better, it helps signal internally and externally that a commitment to Diversity and Inclusion is in an organisation's DNA. When such data is subsequently deployed thoughtfully as an operational asset, it can help organisations get a better understanding both of current success and of trend. A culture of unpicking what might have gone well, or less well, over time means simply that you can resolve to do more of the former and – equally important – less of the latter, both in employment practice and in service delivery.

(Bodies such as the Department of Health routinely now go much further than just counting the staff in relation to diversity characteristics. They slice their annual staff survey so that they can – usefully – identify whether pockets of, say, bullying or harassment are affecting employees from different backgrounds.)

Where Diversity and Inclusion sit authentically at the heart of managerial thinking, this sort of intelligence isn't only collected but is publicised regularly. However, as the first section of this report identifies, comprehensive data is not currently available across much of the RCP's volunteer or staff base. Not collecting data, or indeed not disseminating it when it has been collected, doesn't stop people from making assumptions about what it might tell them.

 'It remains far too white, male, private school, London-centric and devoid of lesbian, gay, bisexual and trans members'

It's worrying – as also reported in Section 1 – that contributors to such important parts of the RCP's external-facing work as the Patient and Carer Network and examinations are evidently not being effectively monitored. In the first case, stakeholder engagement of the sort done by the Patient and Carer Network needs to be authentic and representative if the RCP is to serve its 21st-century patient base properly. In the second, and in an area where many medical colleges currently face challenge, there's a risk that people will not have confidence that RCP examination panels are fair-minded if their diversity is not being measured and publicised.

 'Once I was appointed as an examiner, I stuck out like a sore thumb. Out of 32 examiners there were only seven women. I'm used to there being more diversity in a workplace'

Data for RCP staff is evidently rather more complete than for those in voluntary roles; however, the sometimes painful difficulty felt in actually extracting that data for this report suggests that it's not often sought and that the approach of the RCP's HR function might well be reactive rather than proactive in this area. (In many similar organisations, it would be available at the press of a button.)

While social background is not currently a 'protected characteristic' for legal purposes, differential treatment on the basis of what was once called 'class' remains an understandable issue of anxiety for many in the medical profession. (In 2016, the Social Mobility Commission reported that only 4% of doctors came from working class backgrounds.) That anxiety has been reflected in responses received from both RCP volunteers and staff.

So, in surveying members and staff for this report, we tested a question in the accompanying monitoring form: 'Did you go to a fee-paying school?' This received negative feedback from just two respondents, of 1,090. That indicates a very low level of resistance to enquiry about a proxy metric that might in future be usefully monitored.

As noted above, the RCP is now obliged to publish annual data on gender pay. This is an example of where data – if considered usefully – can help senior staff think about why such movement has occurred.

The government is currently considering whether employers should be obliged to publish similar data on the 'ethnicity pay gap'. Since it's highly likely that this will be required within the next 5 years, many thoughtful employers are contemplating whether to approach this on the front foot.

One defensive response to greater transparency with organisational data is too often that it might lead to the establishment of quotas, and thus 'positive discrimination' to ensure the appointment of some applicants. There's little evidence that this approach actually works, not least because of the high risk that underqualified candidates find difficulty in effectively carrying out a specific role once appointed. That's why quotas are firmly not recommended here.

On the other hand, there is a strong case that 'positive action' to remedy under-representation can actually work. Officers and senior staff can enter into mentoring arrangements to support the professional development of more junior members and staff. This need not be an onerous responsibility; an hour four or six times a year is usually sufficient. However, it's a way that senior figures within an organisational ecology can demonstrate personal commitment to a shared vision of Diversity and Inclusion. (The 'mentor' in such relationships often reflects afterwards that she or he has learnt as much as the 'mentee'.)

## Recommendations

- > Execute and publish annual 'snapshot' surveys of the make-up of all volunteer groups – including trustees and Council – and staff, featuring all the current 'protected' characteristics and also school background and London/non-London breakdown.
- > Introduce a programme of mentoring and 'reverse mentoring' to support both staff and members from under-represented backgrounds in developing within the RCP.
- > Enter one of the diversity benchmarking exercises for employers, such as Stonewall's (cost-free) Workplace Equality Index, to test the assumption that the RCP performs well as an employer. Extend the engagement to other benchmarking exercises over time.
- > Consider piloting annual publication of data on the ethnicity pay gap in advance of it becoming a legislative requirement.
- > Adjust people systems for staff, as they're renewed, to reflect all diversity strands for purposes of constructive management analysis of progression, disciplinary action and training support etc.

# 6. Ways of working

Too many senior staff across the health sector still see Diversity and Inclusion as a matter of human resources solely involving the make-up – paid or voluntary – of an organisation’s workforce. That’s unsurprising, as it often reflects the approach to ‘equalities’ taken at the beginning of their careers.

However, it’s now recognised among many RCP stakeholders that the reason for delivering better Diversity and Inclusion outcomes isn’t merely to be a better employer, or to increase productivity among valued staff and volunteers (both, of course, happy outcomes). The most important reason for promoting Diversity and Inclusion in the third decade of the 21st century is to help deliver better outcomes for *patients*, nationally and globally.

‘The College could take a more active public interest in issues such as health inequalities. If you’re seen to take leadership on issues it gives a really important signal’

‘An inclusive and diverse framework of advisory groups would address the needs of the whole population that the RCP aims to benefit’

‘There has to be much more outreach to get to under-represented groups involved, including LGBT and cultural groups experiencing different patterns of illness’

The RCP may need to be more direct in referencing Diversity and Inclusion, even where it believes there’s already a shared understanding of an organisational commitment. In September 2018, the College presented the Queen with the RCP500 Charter, its collective vision for its work in the 500 years ahead. But had Her Majesty read it out to Prince Philip upon returning home, neither he nor she would have noted any explicit reference to difference or inclusion.

The 4-year strategy on which the RCP is currently consulting, with its strong commitment to addressing health inequalities, is certainly something driven by an appreciation of Diversity and Inclusion. However, it’s only explicit about that once.

‘As an insider I’m more aware of how the RCP is working to be more diverse. But from the perspective of the outside world the RCP is not representative’

‘There should be work on replacing the image of the RCP as being for older, male, white doctors. Who was the first black physician, the first trans physician, the first LGBT physician? Who are they and how are they represented in the RCP?’

Thankfully much progress in Diversity and Inclusion can be measured, when appropriate vehicles are in place to make that happen, and can be driven by specific organisational changes. However positive developments are also often dependent on organisational ‘tone’, a willingness internally and externally to be seen to be promoting a 21st-century vision.

The advantage of deploying an organisation’s communications function to help ‘turbo-charge’ a commitment to Diversity and Inclusion is that it involves little marginal cost. Most of the personnel and vehicles needed to make progress are already in place; they may just need to be deployed slightly differently. And have attention drawn to them. (#ThisDoctorCan is a highly imaginative series of RCP blogs already promoting the diversity and effectiveness of RCP membership. However, you have to navigate the RCP website quite carefully to find it if you don’t know about it.)

‘There’s no discussion regarding the “old boys’ network” and how this still exists in many hospitals today. The RCP should be leading discussions on getting rid of that stale culture and promoting one of inclusion’

As well as RCP communications staff focusing on the promotion of its commitment to Diversity and Inclusion, senior officers have an important role to play too, both in terms of what they say publicly and how they structure events held by the RCP. Some members and staff say they've never heard senior officers address issues of Diversity and Inclusion.

‘At an RCP conference the other day only two out of 11 speakers were women. No more than two women deemed worthy of presenting? The flipside of that is that as a woman I then don't want to attend. Of course it's the same for other under-represented groups. Ten years ago I might not have noticed these things but now it feels very obvious’

‘Often at RCP events the panel is middle-aged, white and male. It doesn't represent the audience’

There's clearly much support, among both members and staff, for the opening of the RCP's Liverpool base in 2021. It's acknowledged that this will help address the 'London-centric' bias of many medical organisations. Alongside this, there's a strong case for addressing difficulties that face many non-London members in putting themselves forward for voluntary roles.

‘Each time we have a meeting with a conference call we have to ask IT to set it up. It should be at the press of button. All these things should be seamless and they're not’

‘If you live in a geographically remote part of the country when you attend it's at least a complete day out and, if finishing late or starting early, possibly more. So RCP involvement always favours those who work in the London area’

‘For someone from the North, attending a two-hour committee meeting requires seven hours' time’

‘I work less than full time and it can be offputting to apply for RCP roles for those with carer commitments who aren't London based, due to the travel required’

‘We use video technology to consult with patients on remote islands – it shouldn't be hard for us all to work like that and save money, travel time and the environment in the process’

## Recommendations

- > Make explicit reference in the RCP's new 4-year strategy to the importance of Diversity and Inclusion in support of its external work in areas such as national and global health inequalities.
- > Senior officers, trustees and senior staff should commit to individually promoting Diversity and Inclusion through each of their usual communications vehicles.
- > Invest in appropriate IT infrastructure and training so those in voluntary roles based outside London or with caring responsibilities can much more easily engage fully in meetings.
- > Ensure that *all* panels at RCP conferences, education and training events comply with recently introduced guidelines to include speakers from a range of backgrounds.

# Action Plan 2021–2024

The plan summarised below details recommendations made within this report. Some are strategic, some operational and some cultural. They're each categorised as 1-, 2-, 3- or 4-year actions from September 2020. This doesn't indicate a degree of importance. It simply acknowledges practicable timeframes for implementation. To accelerate action within the suggested timeframe, it also notes which individuals or directorate within the RCP might be responsible for delivery.



- > Announce an ambition that by 2030 those in both voluntary and staff roles across the RCP should reflect the diversity of the qualified medical workforce, at all levels including trustees and Council. **(1) President/chief executive**
- > Feature measurable delivery of diversity outcomes in the performance objectives of all senior staff and senior officers, as well as in their role descriptions. Appraisals (and any discretionary part of their remuneration in the case of staff) should be linked to these, as with other key deliverables. **(1) Chief executive, HR and all directorates**
- > Task the chief executive with reporting annually on progress on Diversity and Inclusion – both in voluntary and paid workforce and service delivery – to trustees and Council and publishing the data. **(1) Chief executive**



- > Review the RCP website at points of entry and furnish it up front with strong examples of senior role models, both members and staff, from a range of backgrounds. **(1) CP&R**
- > Include at the beginning of all application packs, for both voluntary and paid roles, a prominent rubric emphasising the RCP's keenness to recruit in the complexion of the wider medical workforce and patient base. **(1) HR, CQID, MSGE**
- > Update recruitment monitoring forms to use 21st-century language unlikely to deter potential applicants. **(1) HR**

- > Review visual representation of members, past and present, in reception areas so that they better represent the RCP's ambitions for breadth of membership. **(1) LAMS, MSGE**
- > Execute an access audit for both the RCP's existing London premises and The Spine, with disabled staff and members enabled to contribute to its findings. **(1) CS**



- > Advertise all voluntary roles, and include clear details of the expectations of time and expertise necessary. Introduce and advertise a presumption that such roles can be job-shares. Re-advertise such roles after an appropriate, RCP-wide, tenure such as 6 or 8 years. **(1) MSGE, CQID**
- > Introduce 'observer' opportunities for all members, inviting them to attend committee meetings or examination panels and 'shadow' officers, subject to appropriate protections around confidentiality. **(1) MSGE**
- > Adopt an organisational *ambition* of having a similar number of men and women on interview panels (for both voluntary roles and staff) and a *requirement* that least one person on all such panels be a woman (or a man) and one from an under-represented group unless unavoidable. **(1) HR, MSGE**
- > Review whether any roles currently restricted to fellows might be opened to non-fellows, including SAS members. **(2) MSGE**
- > Request that all members of any appointment panel engage in a light-touch training module in unconscious bias provided by the RCP. Require chairs of such panels to have used such a module. **(1) HR, MSGE**



- > Engage in a focused communications drive with the NHS and trusts to emphasise the importance of RCP roles for the NHS and the profession. **(3) MSGE, CP&R**
- > Review the *objective* criteria for appointment as a fellow, and monitor the diversity of appointments annually. Consider how the nomination process might be more transparent, eg by publishing the names of referees. **(2) MSGE**



- > Extend guidance issued to all committee chairs on appointment to include awareness of Diversity and Inclusion. Require chairs within 6 months of appointment to engage in a light-touch RCP training module in unconscious bias. **(1) MSGE**
- > Regularise the management of volunteers across the RCP – including development of volunteer agreements, performance review and the payment of all travel expenses. **(3) MSGE, CQID**
- > Carry out a feasibility review to consider the possibility of funding child- or other care expenses incurred by those in voluntary roles, both women and men. **(2) MSGE, CQID**
- > Require that Equality and Diversity training now provided to staff at the point of recruitment is refreshed every 3 years. **(1) HR**
- > Pilot goal-driven staff network groups for some cohorts of staff (eg women and BAME employees) tasked with supporting RCP business objectives such as closing the gender pay gap and delivering the Workforce Race Equality Standard. Engagement in such network groups should be regarded as an organisational investment, not a cost. **(2) HR**



- > Execute and publish annual ‘snapshot’ surveys of the make-up of all volunteer groups – including trustees and Council – and staff, featuring all the current ‘protected’ characteristics and also

school background and London/non-London breakdown. **(2) MSGE, HR, CP&R**

- > Introduce a programme of mentoring and ‘reverse mentoring’ to support both staff and members from under-represented backgrounds in developing within the RCP. **(2) HR, MSGE**
- > Enter one of the diversity benchmarking exercises for employers, such as Stonewall’s (cost-free) Workplace Equality Index, to test the assumption that the RCP performs well as an employer. Extend the engagement to other benchmarking exercises over time. **(1) HR**
- > Consider piloting annual publication of data on the ethnicity pay gap in advance of it becoming a legislative requirement. **(2) HR**
- > Adjust people systems for staff, as they’re renewed, to reflect all diversity strands for purposes of constructive management analysis of progression, disciplinary action and training support etc. **(4) HR**



- > Make explicit reference in the RCP’s new 4-year strategy to the importance of Diversity and Inclusion in support of its external work in areas such as national and global health inequalities. **(1) CP&R**
- > Senior officers, trustees and senior staff should commit to individually promoting Diversity and Inclusion through each of their usual communications vehicles. **(1) Strategy Executive**
- > Ensure that *all* panels at RCP conferences, education and training events comply with recently introduced guidelines to include speakers from a range of backgrounds. **(1) Conferences, Education, MSGE**
- > Invest in appropriate IT infrastructure and training so those in voluntary roles based outside London or with caring responsibilities can much more easily engage fully in meetings. **(2) CS**

**CP&R** Communications, Policy and Research; **CQID** Care Quality Improvement; **CS** Corporate Services; **HR** Human Resources; **LAMS** Library, Archive and Museum Services; **MSGE** Membership Support and Global Engagement.

# What people say...

These are some further compelling quotations from RCP members and staff.

- ‘A diverse membership and workforce is critical in enabling the RCP to truly reflect and support its membership in delivering high-quality care’
- ‘Widening access to RCP roles is an important way that the RCP can remain relevant and in touch with the profession and the general population’
- ‘The quote “if you can’t see it you can’t be it” seems apt. The RCP needs to find ways of promoting and enhancing the visibility of the diversity already involved to encourage more diversity in new membership/appointees’
- ‘There are high-quality members of under-represented groups operating to a high level. It’s not a lack of knowledge of how a meeting or organisation works. It’s just been a closed shop for too long’
- ‘The RCP is very much a who you know network. I definitely do not feel included in this’
- ‘Diversity should include gender, race, ethnicity, sexual orientation, type of practice e.g. teaching hospital versus DGH and geography, such as individuals who work outside the M25’
- ‘At strategic level the RCP is dominated by white, middle class people. It doesn’t represent its membership or the population of the country. Because of this, it puts off people getting involved as they fear being judged and not accepted’
- ‘Fortunately, I’ve only experienced homophobia three times in my life. Unfortunately, two of those were at RCP’
- ‘I have not so far seen any commitment from the RCP to equality and diversity beyond words’
- ‘Roles within the college are not very defined so people outside don’t know how or why to apply’
- ‘It always was a mystery how certain individuals popped up on various committees’
- ‘There’s an old guard at the College who are quite inflammatory and they get away with it. So if you’re from a BAME background there’s not a level playing field in committees’
- ‘There’s relatively little information in job descriptions of detail about who you can contact to discuss a role. Putting people in touch with people of similar backgrounds who’ve been successful in similar roles would help’
- ‘Raising the profile of people of black and minority ethnic backgrounds is the most fundamental thing that could be done in terms of changing cultures’
- ‘I cannot in good conscience be involved in an organisation that flies the diversity flag without following through on its words’
- ‘Well done for asking the state school question. The principal challenge for E&D in Britain is not race, gender, religion or any of the protected characteristics. The main challenge is social class’
- ‘I appreciate the manner in which I was educated is a marker of parental affluence, but really!’
- ‘I completed the Emerging Women Leaders programme which I thought was fantastic. I’m also impressed by the @ThisDoctorCan campaign’
- ‘There’s no sight of physically or mentally disabled people in the cafe or on the front desk’

‘The RCP has always appeared to me as a London-centric, teaching-hospital-based organisation of pale, male and stale officers. However, I also am aware that it has made massive strides towards change over the last few years, as evidenced by its recent presidents and its new Liverpool arm’

‘I did have a role at the College when they were forced to appoint me in to as no one else applied. They made me feel unwelcome and it was the worst role I ever did. It was a group of men at the top, an old boys’ club. I would not do it again’

‘I can’t do a role for free when if it falls on a non-working day, I have a mammoth task to arrange appropriate care for dependents and this is not included in expenses’

‘The RCP needs to reflect on its 500-year history but really focus on how it makes itself relevant for the vibrant new doctors coming through the system today. Many people don’t know the breadth of what the College does’

‘The RCP needs to be shaken up – it has a longstanding appearance of elderly white Anglo-Saxon male domination’

‘Many young women, and fellows and members working outside London, feel excluded and still see the College, perhaps unfairly, as London-centred and difficult to become involved with’

‘The RCP has a responsibility to promote diversity. Unfortunately as a female member, not London based, with significant carer responsibilities and working for a charitable organisation, where backfill is not feasible without funding, it has not been possible to offer any time. My gender, my region and my specialty is under-represented’

‘I doubt you have many members who grew up in a working class household’

‘It’s good to see that the RCP recognises that despite the very important progress it has made, the broader issues of discrimination and the old boy network are far from resolved’

‘The RCP can play an important role in promoting good health in addition to its essential role of fostering medical education and training of excellent quality. An inclusive and diverse framework of advisory groups in its organisation will address the needs of the whole population that the RCP aims to benefit’

‘Ingrained and frequently accepted prejudice has long been a stain on the character of the medical profession. It is excellent to see the RCP moving to reduce this’

‘It is really fantastic to see the RCP showing it wants to change to become more inclusive’

‘How can you expect fellows to get involved while you continue to gain financial benefit from engaging with countries that consider homosexuality illegal and punish it with death? It is easy to fly the rainbow flag once a year but actions speak louder than words’

‘I’ve always felt the RCP does want wider access to roles but it’s not shouting it from the rooftops’

‘The RCP is doing well with female role models in presidents, but it needs to ensure females are represented at updates and training days’

‘The external perception of the RCP is of an outdated, stuffy white men’s club. This is not reflective of the medical workforce’

‘This is a manufactured issue created by advocacy groups’

‘I rather think the RCP would have something better to do than investigate “inclusivity”’

‘Please publish some of the negative comments that you usually hide away’

# The report

## Brief

**(a)** To review the RCP's current level of performance on Equality and Diversity within its workforce, with a strong focus on the various volunteer posts where members or others undertake work for the College. The classes of posts will include, but not be limited to:

- > Trustees
- > Elected College posts
- > Appointed College posts (eg junior officers, committee memberships or examiner/ assessor posts)

**(b)** To provide a report to the Board of Trustees and Council, outlining the findings.

**(c)** To make recommendations to Council and the Board of Trustees as to any improvements necessary in the College's Equality and Diversity monitoring and reporting in these areas, and whether the development of an explicit Equality and Diversity policy is necessary. Further, to feed into the development of a new RCP strategy and make recommendations on how the College can improve in areas where the need for development is identified, including those outlined in the 2017 RCP Equality and Inclusion Task Group report.

**(d)** To be more ambitious than ensuring statutory compliance on Equality and Diversity issues (eg with the Equality Act 2010) and look at how to become a best practice organisation in the health sector.

## The panel

The report was supported by an advisory panel of staff from across the RCP:

- > **Linda Asamoah**  
Director Human Resources
- > **Rhona Buckingham**  
Executive Director Care Quality Improvement
- > **Laura Burling**  
Patient Involvement Adviser
- > **Claire Burroughs**  
Director Communications, Policy and Research
- > **Teena Chowdhury**  
Operations Director Audit and Accreditation
- > **Simon Land**  
Head of Professional Governance
- > **Rhona Mackay**  
Policy Officer External Affairs
- > **Chiraag Panchal**  
Senior HR Business Partner
- > **Jane Ratford**  
Head of Assessment Unit
- > **Dan Sumners**  
Head of Policy and Campaigns, London
- > **Tricia Wombell**  
Head of Membership

## Interviewees

The panel carried out 22 face-to-face interviews with a range of RCP stakeholders, including both members and employees. They included people from a range of personal backgrounds and at different stages in their careers. These were:

<b>Fellow</b>	Consultant, male, London
<b>Staff member</b>	Female, London
<b>Fellow</b>	Consultant, male, outside London
<b>Collegiate member</b>	Trainee, female, London
<b>Patient and Carer Network member</b>	Female, outside London
<b>Former member</b>	Consultant, male, London
<b>Collegiate member</b>	Trainee, female, London
<b>Fellow</b>	Consultant, male, outside London
<b>Patient and Carer Network member</b>	Female, outside London
<b>Staff member</b>	Male, outside London
<b>Collegiate member</b>	Trainee, female, outside London
<b>Officer</b>	Male, outside London
<b>Fellow</b>	Consultant, female, outside London
<b>Non-member</b>	Surgeon, female, outside London
<b>Fellow</b>	GP, male, outside London
<b>Fellow</b>	Consultant, female, outside London
<b>Physician associate student</b>	Female, outside London
<b>Fellow</b>	Professor, male, London

<b>Fellow</b>	Consultant, female, outside London
<b>Collegiate member</b>	Trainee, female, outside London
<b>Staff member</b>	Female, London
<b>Fellow</b>	Consultant, female, outside London

A further 1,090 members and staff responded between October 2019 and January 2020 to an easily accessible online survey. (Of respondents who declared their backgrounds confidentially, 42% were female, 31% were from BAME backgrounds, 11% were lesbian, gay or bisexual, 14% were disabled and 36% had attended a fee-paying school.)

## The author

Ben Summerskill was chief executive of Stonewall from 2003 to 2014, where he grew its nascent Diversity Champions programme – advising major employers and service providers on good practice – from 35 to 650 organisations, employing six million people. By 2014 it had become the largest non-governmental intervention of its kind in the world.

Between 2003 and 2014 the proportion of women employed at Stonewall rose from 35% to 55%, the proportion of black and minority ethnic staff in London rose from 6% to 20% and the proportion of disabled staff rose from 5% to 11%. These staff were employed at all levels.

Previously Ben worked in Fleet Street for a range of newspapers, latterly as assistant editor and chief leader writer at *The Observer*. He is on the Board of ACAS and the Honours Committee for Community and Voluntary Services and was previously a commissioner at the Equality and Human Rights Commission.



Royal College  
of Physicians

# A 2020 Vision

An independent report into Diversity and Inclusion  
at the Royal College of Physicians

[www.rcplondon.ac.uk](http://www.rcplondon.ac.uk)

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