Council meeting, 24 April 2018

Council
Meeting Room 2.08
350 Euston Road,
London, NW1 3JN

Agenda

Tuesday 24 April 2018

10:30 - 13:00

M1  Chair’s business
M2  Minutes of the meeting on 28 February 2018
M3  Chief Executive’s Report
M4  Chief Operating Officer’s Report

Break

M5  The PSA’s annual review of our performance for 2016-17
M6  Plans to report on performance against the new Corporate Strategy
M7  Report of the Investment Sub-Committee 2017
M8  Transformation Programme – update
M9  Outcomes for Graduates – analysis of the responses to the consultation and approval for publication
M10 Mental health programme: overview, update and next steps (oral report)
M11 Any other business

M12  * Taking revalidation forward – progress update

Members should notify the Chair a minimum of two days prior to the meeting should they wish to discuss any *starred items. If not then it is assumed that Council wishes to agree the recommendations without discussion.
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Members should notify the Chair a minimum of two days prior to the meeting should they wish to discuss any *starred items. If not then it is assumed that Council wishes to agree the recommendations without discussion.
Council meeting, 24 April 2018

28 February 2018

Council

Draft as of: 9 March 2018

To approve

Minutes of the meeting on 28 February 2018*

Members present

Terence Stephenson, Chair

Steve Burnett
Shree Datta
Christine Eames
Anthony Harnden

Helene Hayman
Paul Knight
Denise Platt

Others present

Charlie Massey, Chief Executive and Registrar
Susan Goldsmith, Chief Operating Officer
Paul Buckley, Director of Strategy and Policy
Una Lane, Director of Registration and Revalidation
Colin Melville, Director of Education and Standards
Mary Morgan-Hyland, Council Secretary
Anthony Omo, Director of Fitness to Practise
Paul Reynolds, Director of Strategic Communications and Engagement
Neil Roberts, Director of Resources and Quality Assurance

* These Minutes should be read in conjunction with the Council papers for this meeting, which are available on our website at http://www.gmc-uk.org
Chair's business

1 Council was noted that apologies had been received from Deirdre Kelly, Suzi Leather and Amerdeep Somal.

2 The Chair welcomed Paul Reynolds who joined the GMC as Director of Strategic Communications and Engagement on 9 January 2018.

3 Council noted a declaration of interest from Steve Burnett with regards to his membership of the Board of Pension Trustees, and the inherent interests of staff present who were members of the Defined Benefit (DB) Scheme and Defined Contribution (DC) Scheme.

4 Council noted that the following had been approved by Council on circulation:
   a The appointment of Joy Hamilton to the MPTS Committee and an update to the MPTS Committee’s statement of purpose.
   b The appointment of Amerdeep Somal to the Board of Pension Trustees.

5 The Chair welcomed the following observers to the meeting:
   a Claire Light, the new Head of Equality, Diversity and Inclusion.
   b Dr Jane Cunningham.

Minutes of the meeting on 12 December 2017

6 Council approved the minutes of the meeting on 12 December 2017 as a true record.

Chief Executive’s Report

7 Council considered the Chief Executive’s Report, noting developments in the external environment, progress on the GMC’s strategic priorities and how the GMC’s major work programmes were progressing, including:
   a The GMC had described the UK’s medical profession as facing a ‘crunch point’ due to the continued pressures on the NHS across all four countries of the UK.
   b The GMC’s response to date to the report from the Northern Ireland Hyponatraemia Inquiry including work with the Department of Health in Northern Ireland which was developing a detailed action plan to address the 96 recommendations in the report.
   c The GMC response following the High Court judgment in the case of Dr Bawa-Garba, handed down on 25 January 2018, including the announcement of a GMC
review, to be chaired by Dame Clare Marx, to explore how the law around gross negligence manslaughter was applied to the medical practice.

d The launch of Corporate Strategy 2018 – 2020 at the GMC Conference.

8 Council and the Senior Management Team commended GMC staff for their hard work and professionalism in their interactions with registrants and responding to extensive media coverage following the High Court judgment in the case of Dr Bawa-Garba.

9 Following discussion, and to assist Council members in responding appropriately to queries, further guidance would be provided on:

a Interim guidance on withdrawal of clinically assisted nutrition and hydration.

b The GMC’s response to Baroness O’Loan’s Conscientious Objection (Medical Activities) Bill, which received its reading debate on Friday 26 January 2018.

Chief Operating Officer’s Report

10 Council noted declarations of interest from Susan Goldsmith, Paul Buckley, Steve Burnett and Paul Knight in relation to their role as directors of GMC Services International.

11 Council considered the Chief Operating Officer’s Report and noted updates on:

a The commentary on operational performance.

b Operational performance against key performance indicators (KPI) and progress on project priorities, including:

i Income and expenditure to the end of 2017. Income was £3,610k over budget and that expenditure was overall £3,902k under budget, mainly driven by operational headcount being significantly under budget.

ii The majority of projects were on track, with further information on amber rated exceptions detailed in the report.

iii Improved performance against Service Level Agreements (SLA) following recruitment to vacant posts. The SLA for responding to ethical/standards enquiries within 15 working days, which had been discussed by Council in December 2017, had been exceeded in November and December 2017.

c Summary information on current judicial reviews and appeals.

c Changes made to the Corporate Risk Register including;
Three new risks had been added to reflect resourcing within Education and Standards, Heath Education England workforce strategy, and circumstances where the GMC’s actions were perceived as contentious.

Risk 22 had been escalated to a significant residual risk to account for the pressures currently experienced by the NHS and wider system.

Initial thinking on the development of benefits-mapping for reporting against the Corporate Strategy.

Report on fund manager investment performance up to quarter 4.

Other operational matters including:

- Publication of the Professional Standards Authority (PSA) report on our performance for 2016-17, confirming the GMC met all 24 of its Standards of Good Regulation.

- Provisional plans for delivering the GMC’s Corporate Strategy ahead of Council’s consideration of progress against the strategy in April 2018.

- Progress of the Transformation Programme which would be aligned to the GMC’s Corporate Strategy.

Council requested:

- A line of governance sight on any whistleblowing activity within the GMC, including sexual harassment, to provide Council with insight into the health of employee relationships within the GMC.


During discussion, Council noted:

- The increased number of International Medical Graduates taking Professional Linguistic Assessment Board (PLAB) tests, current arrangements in place to accommodate the increased demand within the UK and worldwide, the possible drivers for this increase and impact on GMC budget.


- Further to discussion on the marked increase in the number of sexual harassment complaints within many organisations across the UK, confirmation of ongoing monitoring of GMC whistle blowing activity as part of the audit programme.
Improving our consultations: progress and next steps

14 Council considered a report into the GMC’s review of its consultations process and proposals going forward. Council considered:

a Ongoing work to embed good consultation practice within a GMC-wide framework and collaborative work across the GMC to develop a practical guide to ‘Good consultation practice at the GMC.’

b Plans to embed consultation earlier with ongoing and targeted stakeholder engagement to ensure that, as far as possible, the GMC developed consultation proposals with key stakeholders rather than being overly reliant on feedback from formal consultations.

c Proposals for Council to play a more strategic role in the consultation process.

15 Following discussion, Council agreed that it should have a formal, consistent role in strategic consultations that involved significant policy issues and/or bring a degree of risk for the GMC and would fulfil this role by:

a Signing off the need to consult on a particular issue.

b Confirming the key consultation issues.

c Being sighted on analysis findings at an early stage.

d Being involved in early conversations after significant consultations to help shape the GMC’s response, as per the approach taken following the Medical Licensing Assessment consultation in 2017.

e Being informed about consultation outcomes and the GMC’s response.

16 During discussion, Council noted:

a The Board Intelligence app could be used to facilitate Council’s strategic focus on GMC’s consultations as consultation documents could be available on the app for Council as background reading but would not be reviewed during Council meetings.

b Development of more innovative ways to consult with stakeholders outside of workshop sessions, including the use of social media.

c The proposed approach to sensitively evaluating the varying registrant views in consultation/co-production work. It was noted that judgement was required, on a consultation by consultation basis, when analysing and evaluating qualitative feedback from different stakeholders.
d SMT view that early stakeholder engagement prior to formal consultation would not pre-determine the outcomes of consultation but would minimise the risk of unexpected responses and help the GMC to better understand the views of registrants and other stakeholders.

e The expectation that the GMC’s stakeholders would welcome the new approach.

f The change in the GMC’s consultation strategy would require a significant shift in the GMC’s approach which would be carefully considered by management going forward to ensure staff felt sufficiently empowered.

g Plans to ensure patient voices continued to be considered during consultations.

Review of our guidance on Consent

17 Council considered a report on plans to consult on the revised *Decision making and consent* guidance and noted:

a A report providing background to the review and summary of evidence base.

b The revised *Decision making and consent* guidance to be issued for consultation.

c A report outlining the key changes to the guidance paper and the rationale of these changes. As pre-consultation engagement indicated the core principles were sound, the proposed changes were predominately to structure and tone.

d A report on consultation plans.

e The proposed launch date for the consultation was still to be confirmed.

18 Council agreed to delegate to the Executive Board approval of further content changes in the revised guidance and any changes in the consultation plans.

19 Following discussion, Council noted that, when finalising consultation materials, further consideration would be given to:

a Reviewing the tone and language. Whilst it was noted that guidance was provided on the usage of ‘must’ and ‘should’ within the report, further consideration should be given to how this might be received.

b Whether the GMC could answer more questions, rather signpost other guidance.

c Reviewing the current guidance in relation to when written and verbal consent was required and how doctors should record discussions on decisions made.

d Using practical examples to explain complex points.
**Why different hospitals had different policies on written/verbal consent and how the GMC could encourage more consistency in employers own policies based on our guidance.**

20 Council noted that appropriate communications were being developed to accompany the launch of the consultation of the revised guidance and consideration would be given to including in these communications:

a Whether further clarity was required on the GMC’s requests of the wider system.

b Acknowledgement of pressures in the system and the scarcity of time.

c Guidance on implications if doctors persistently breached guidance.

21 During discussion Council noted:

a The balance to be struck in the appropriate level of detail provided.

b The guidance explained that doctors must use their judgement to apply the principles in this guidance to the situations they faced.

**2017 Human Resources Report and Gender Pay reporting**

22 Council considered the annual report on Human Resources and Gender Pay reports for 2017 relating to the GMC as an employer which included reports on:

a HR monitoring

b Equality, Diversity and Inclusion

c Gender Pay Gap.

23 During discussion, Council noted:

a Whilst there was an overall gender pay gap of 15.8%, this was improving year and year and there was much smaller differentials within pay grades. Further work would be undertaken on aligning management roles with the introduction of a new pay system to further prioritise pay progression for staff towards the bottom of their pay bands.

b Pay awards for staff who have taken maternity and adoption leave had been audited to ensure their trend performance level around their period of leave is reflected in their pay progression.

c Coincident with the significant shift of recruitment activity to Manchester, the percentage of job offers to Black Minority Ethnic (BME) candidates had increased to 17.4%.
d The GMC's ongoing unconscious bias training programme was completed by 94 managers in 2017, and roll out of a new module during 2018 for all recruiting managers.

e Staff turnover remained low during 2017 at 8.4% but there was a slight rise in absence levels, with mental health related issues identified as the main reason for employee absence. The GMC has an extensive programme of support for staff with mental health issues and promoting awareness and openness of the subject might encourage greater openness in disclosure of the reason for absence.

Pension Strategy

24 Council noted a declaration of interest from Steve Burnett with regards to his membership of the Board of Pension Trustees, and the inherent interests of staff present who were members of the DB Scheme or the DC scheme.

25 Council considered:

a A report which outlined the proposal from the DB Scheme Trustees for £2.5 million per year for ten years and advice provided to Council by AON, as employer side adviser, who suggested a contribution of £1.4 million per year for two years.

b A letter to the Chair of Council from the Chair of DB Scheme Trustees which outlined the rationale for the proposal.

c Options going forward ranging from making no further contributions to the DB scheme to up to £2.5 million per year.

26 It was noted that, at a Council seminar on 27 February 2018, John Coulthard from AON, had advised Council on the request from the DB Trustees and the alternative suggestion from AON, as employee side adviser, and responded to questions from Council.

27 Following discussion, Council agreed:

a Additional funding of £1.4m per year for 2018 and 2019.

b An additional one off payment of £2.2m, given the GMC's current financial position.

c The 10 year period was supported by Council as an indicative time period.

d Ultimately the GMC were committed to meeting the liabilities of the DB scheme. However, the payments agreed by Council for 2018 and 2019, did not set a precedent for pension strategy and funding post 2020, which would be determined following the next triennial valuation when Council would take further independent advice.
28 During Council noted:

a The funding agreed was in addition to £0.5 million per year from 2017 – 2021 approved by Council in November 2016.

b Consideration would be given to appropriate communications with members of the DB scheme, GMC employees and registrants regarding Council’s pension strategy going forward.

Proposals for Chair and Council member appointments process

29 Council considered a paper which outlined the proposals for the Chair and Council member appointments process scheduled to take place during 2018.

30 Following discussion Council agreed:

a To progress Option 1 as the approach for the appointment process.

b That an executive search agency was appointed to manage the process.

c Proposed amendments to the competencies for Council members.

d The proposed membership of the selection panels.

e That the Chairs of the Audit and Risk and Remuneration Committees should be invited to join the Chair selection panel.

f To formally approach Baroness Usha Prashar to chair the selection panel for the new Chair.

g The time commitment and remuneration for external selection panel members remained unchanged and Council members would not receive additional payment.

31 During discussion, Council noted:

a They should contact the Council Secretary if they were interested in supporting the executive search agency selection panel.

b As the current schedule for the Council member appointments would mean the advertisement would be in place over the summer period, the Council Secretary would liaise with the search agency to consider ways to mitigate the risk of a reduced number of applications.

Council forward work programme 2018

32 Council considered the Council forward work programme for 2018:

33 Council agreed the forward work programme 2018 subject to the following:

www.gmc-uk.org
a To include key pieces of work such as: the Gross Negligence Manslaughter review, the Paterson Inquiry and the report of the Northern Ireland Hyponatraemia Inquiry.

b To revise the report to demonstrate on how the Council’s priorities aligned to the aims of the Corporate Strategy.

c To publish the revised version of Council forward work programme externally.

During discussion, Council noted that people strategy, leadership, culture and organisational design would be included in a report on progress of the Transformation Programme which was being prepared for the April Council meeting.

Amending the list of bodies entitled to award a UK Primary Medical Qualification

Council considered a request to add Plymouth University Peninsula Schools of Medicine and Dentistry (PU PSMD) and University of Exeter Medical School (UEMS) to the GMC’s list of bodies able to award Primary Medical Qualifications.

Council agreed to add PU PSMD and UEMS to the GMC’s list of bodies that can award UK Primary Medical Qualifications.

During discussion Council noted arrangements in place for students who had deferred part way through their studies.

Any other business

Council noted the date of its next meeting on 24 April 2018, in London.

Council members were asked to contact the Council Secretary if they had any queries or feedback on the Board Intelligence app.

2019 Meeting schedule

Council considered and approved the 2019 meeting schedule.

Council noted that Council meetings in June and December 2019 would be held in Manchester. However, consideration would be given to holding further Council meetings in Manchester during 2019. The Council Secretary undertook to confirm meeting locations for Council meetings in 2019 as soon as possible.
Report of the Executive Board 2017

Council noted the report on the Executive Board 2017.

Confirmed:

Terence Stephenson, Chair 24 April 2018
Executive summary
This report outlines developments in our external environment and progress on our strategy since Council last met.

Key points to note:

- With the UK leaving the European Union in less than a year’s time, I have written to the Secretary of State for Health and Social Care seeking clarity on the status that European Economic Area (EEA) doctors will have post-exit.

- We have responded to Health Education England’s workforce strategy up to 2020. The development of the medical workforce across all four countries of the UK has reached a critical moment and we have set out ten areas the final strategy needs to address.

- As part of our evidence to the Williams Review into gross negligence manslaughter in healthcare we have called for doctors’ reflections to be treated as legally protected within criminal proceedings. We have already made clear that we do not ask for doctors' reflective records as part of our fitness to practise processes.

Recommendations
Council is asked to:

a  Consider the Chief Executive’s report.

b  Approve the proposed change to the arrangements for formal engagement, the change to the governance model, and consequent amendments to the Governance Handbook at Annex A.
Developments in our external environment

**Brexit**

1. The UK Government has reached provisional agreement with the European Commission on the proposed transition period which will begin once the UK formally leaves the EU on 29 March 2019. Under the terms of the provisional agreement, the transition period will end on 31 December 2020 and EU nationals arriving in the UK during the transition period will get the same rights as EU nationals here before 29 March 2019.

2. The draft withdrawal treaty indicates that both sides are in agreement that recognition of professional qualifications (RPQ) decisions taken before the end of the transition period will be respected, as will applications for registration that are open at the end of the transition period.

3. Nevertheless, considerable uncertainty remains. I have written to the Secretary of State for Health and Social Care, to seek clarity on a range of issues, in particular, whether or not we need to make contingency plans to treat doctors from the European Economic Area (EEA) coming to work in the UK as International Medical Graduates (IMGs) from 30 March 2019 or at the end of a legally defined transition period. Given that on average over 2,000 EEA doctors per year have been joining the register this is a not insignificant question.

**NHS workforce**

4. Closely linked to Brexit are considerations about the future of the UK medical workforce. We continue to make the case that legislation arising from Brexit provides an opportunity to fix the overly constrained and slow way in which we are required to process applications for IMGs to join the Specialist or GP Register. Reform would not only give more assurance to the NHS that it will be able to continue to see a flow of EEA doctors, but potentially improve the flow of well-trained doctors from around the world. We have also urged the government to take action to address the impact of the Tier 2 visa system.

5. In March 2018 we responded to Health Education England’s *Facing the Facts, Shaping the Future consultation*, on the draft health and care workforce strategy for England to 2027. The response makes clear our view that we have reached a crucial moment in the development of the UK’s medical workforce, and sets out ten key areas which the final strategy will need to address including: the importance of alignment with the other three nations of the UK; a flexible legislative framework for professional regulation; a greater focus on workforce wellbeing; and a resource implementation plan with specific milestones around what types of clinical staff will be needed and when they will be needed.
Inquiries

6 The terms of reference for the non-statutory inquiry into the circumstances and practises surrounding the malpractice of breast surgeon Ian Paterson were published on 27 March 2018. The terms of reference state that the inquiry will be informed by patients’ concerns and will seek to learn from what happened to them, both in the independent sector and in the NHS. The inquiry will consider arrangements for maintaining professional standards and competence of doctors, including revalidation. The inquiry will aim to report in summer 2019.

7 On 31 January 2018 the report of the Northern Ireland independent inquiry into hyponatraemia related deaths of five children was published. As set out previously, we are reviewing the criticisms made against doctors in the report to determine whether further investigation may be necessary. A number of doctors have also self-referred to the GMC in light of the report. We are also finalising our response to the policy issues raised by the report. Several have implications for medical regulation including recommendations for a statutory duty on candour for doctors; that Foundation Trainees should not work in paediatric words; and that Good Medical Practice should be included in doctors’ contracts.

8 Since December 2014 we have been working with the Gosport Independent Panel to assist its inquiry into the deaths of elderly patients at the Gosport War Memorial Hospital. The panel is expected to publish its final report in June 2018.

9 We are currently awaiting developments on a number of other new inquiries, including the non-statutory investigation led by Dr Bill Kirkup into the death of baby Elizabeth Dixon and the Contaminated Blood Inquiry (chaired by Sir Brian Langstaff) which concerns how individuals with haemophilia were given blood infected with the HIV virus and hepatitis C.

Reviews into Gross Negligence Manslaughter and Culpable Homicide

10 We have submitted written and oral evidence to the Department of Health and Social Care’s review, looking at the application of gross negligence manslaughter charges in healthcare settings, led by Sir Norman Williams.

11 While the GMC does not ask for doctors’ reflective records as part of our fitness to practise processes, we do not control the actions of the courts and recorded reflections, such as in ePortfolios, could be requested by a court. In our evidence to the Williams review, we stated that because doctors’ reflections are so fundamental to their professionalism, we believe they should be treated as legally protected. This would require new legislation to deliver, which we would fully support.

12 The GMC has commissioned its own, independent review of the application of the law concerning gross negligence manslaughter and culpable homicide to doctors. Dame Clare Marx is leading the review and is in the process of finalising the composition of
the core group which will support her in this important work. The outputs of the Williams Review will help to inform Dame Clare’s work when she reports her conclusions by the end of 2018.

Dr Bawa-Garba Appeal

Dr Bawa-Garba applied for permission to appeal the decision of the Divisional Court removing her from the medical register in January 2018. We have been informed that Dr Bawa-Garba has been granted permission to appeal and that the judge granting permission has asked that the appeal be heard by July 2018. The appeal will now be listed for a full hearing by three Court of Appeal judges.

Progress on our strategy

Updated guidance on reflective practice

We are on track to publish revised guidance on reflective practice by July 2018. We had initially intended to publish the guidance alongside the revised supporting information guidance for revalidation and appraisal. However, in light of concerns from the profession about recording reflections, we decided to pause the development of the guidance and have a renewed engagement with doctors in training representatives, the Academy of Medical Royal Colleges, Postgraduate Deans and the Medical Schools Council to make sure that the guidance does what is required and receives widespread support. We are in talks with the Academy of Medical Royal Colleges, COPMeD and the Medical Schools Council about co-branding the reflective practice guidance.

Improving the mental health and wellbeing of doctors

As part of our focus on upstream regulation, a programme of work led by Dame Denise Coia and Professor Michael West looking at how to better support and improve the mental health and wellbeing of the profession as a whole is now underway.

National Training Surveys 2018

Our 2018 national training surveys of doctors in training and trainers are currently live. The surveys were launched on 20 March 2018 and are open until midday on 2 May 2018. The surveys will continue to provide a definitive assessment of the training and working environment for both students and educators.

Executive Board

The Executive Board met on 26 February 2018 and agreed:
a A proposal for a public consultation on the revised guidance on health and disability in medical training. We have been undertaking a work programme on health and disability, centred on the revision of our guidance in this area, *Gateways to the professions*. The principles of the previous guidance have been maintained, but the majority of the content has been re-organised to reflect a balance between the role and considerations of the GMC, the medical schools and postgraduate providers in relation to health and disability.

b A revised approach to processing personal data in line with the requirements of the General Data Protection Regulation (GDPR), which comes into force on 25 May 2018. The GDPR requires public authorities to provide a greater degree of transparency when processing personal data. As a public authority, when we are processing personal data to fulfil our functions under the Medical Act we have a lawful basis for doing so. In the words of the GDPR, we are processing data in a way which is ‘necessary for the performance of a task carried out in the public interest or in the exercise of official authority’. In these instances the regulation is clear that we should not seek consent from data subjects because data subjects would not be able to provide truly freely-given consent when engaging with organisations like the GMC and where our statutory role sometimes requires us to disclose data in the public interest, even where consent has been refused. The Board therefore agreed that we will process personal data without consent where this is ‘in the exercise of official authority’. Additionally, we will provide detailed, up-front information to data subjects in respect of our processing activities in the form of a privacy notice. Overall, following legal advice, we are satisfied that our approach brings us into line with this important new regulation and will ensure that data subjects have a clearer understanding of the ways in which we process their personal information.

c The implementation of a revised retention and disposal policy for case records. Our Records Retention and Disposal Policy balances the need to retain information for regulatory purposes with the requirements of the Data Protection Act and other legislation. We are asked to provide increasing volumes of material to public inquiries, often of a historic nature, so it is essential that our processes for maintaining patient safety are open to scrutiny. The revised policy extends the retention period for case records from between five and ten years to between 15 and 20 years, depending on the type of record.

d The pay matrix to apply to the April 2018 pay award, as set out in the Chief Operating Officer’s report.

18 The Board also noted an update on the staff survey, which has moved from a two yearly to a yearly cycle. The update included a detailed timetable, an update on the scope of the survey and a draft set of questions. The new survey will have a slimmed down set of questions and is set to go live on 16 April 2018.

19 The Executive Board met on 26 March 2018 and considered:
a The appointment of property consultants to evaluate and cost options for providing greater capacity for the Clinical Assessment Centre (CAC), our dedicated facility for assessing the clinical and communication skills of doctors. Increasing candidate numbers since 2015 mean the CAC is now working at near full capacity and consideration is required on how we will meet demand moving into 2019.

b The terms of reference for a new internal oversight group on data and research. This group will oversee the programme to support the new corporate strategy and provide the necessary data, analytical and insight capabilities to respond to the external environment and increasingly act as an upstream regulator.

20 The Board also noted updates on:

a Progress against the actions we set out in *Adapting for the future, A plan for improving the flexibility of postgraduate medical training*.

b The first stages of setting up a Local First pilot to support local resolution of concerns about doctors.

c The better signposting programme, which detailed the further work being done to make navigation of healthcare complaints easier for patients and public to understand.

d Our confidentiality guidance to doctors, to bring it in line with the requirements of the GDPR.

*Changes in our approach to formal engagement*

21 A core part of our formal governance structure is our Education and Training Advisory Board (ETAB), chaired by an external chair, as well as our UK Advisory Fora, chaired by the Chair of Council or Chief Executive. Together these form part of our formalised stakeholder engagement. Outside of our formal engagement, the Assessment Advisory Board (AAB) has also provided advice on the content, format and delivery of GMC assessments.

22 While our current arrangements have served us well, the 2017 governance review highlighted the need to reconsider the architecture through which we receive advice on education and assessment issues. As assessment is a key part of education it is logical to align and consider education and assessment together in a single forum. Simplifying our governance arrangements will also make the best use of our resources, and ensure that we achieve timely and appropriate stakeholder input into our work. In light of this, we are proposing that ETAB and AAB are decommissioned and a single Board covering education and assessment across the whole of the GMC is established. The new Board is not simply an amalgamation of ETAB and AAB responsibilities. Chaired by the Director of Education and Standards, it will continue to
deliver the benefits of access to rich debate while promoting a greater coherence and consistency across all stages of medical education and training to improve quality.

23 Pending Council’s approval, the new Education Advisory Board will be constituted until the end of the current corporate strategy in 2020 and will report to the Chief Executive. Council will be provided with updates on significant matters relating to the work of the Board through specific policy projects or through the Chief Executive’s Report, as required. The proposed changes to the Governance Handbook are at Annex A.
Updates to Governance Handbook

Chapter 4: Role of each component of the governance framework

External engagement channels

Education and Training Advisory Board

13 An Education and Training Advisory Board will be convened to provide advice on matters related to medical education and training, on the assessments we run or oversee and on broader policy considerations for the design of curricula and assessment systems, in light of Council’s statutory purpose to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine.

Governance model

23 The diagram on the following page shows the Governance model.
Executive summary
This report provides an update on our operational performance, key projects and programmes, and other operational matters arising including:

- Assistant Director appointments
- Welsh language standards
- GMC Services International
- 2018 Pay award.

Recommendation
Council is asked to consider the report and Annex A (Council portfolio) and Annex B (Corporate Opportunities and Risk Register).
Issue

1 This report provides an update on our operational performance, strategic progress, and other operational matters arising. It is exception-based, highlighting the key issues that Council should be aware of in the delivery of our work programme for 2018.

Operational Key Performance Indicators

2 All operational key performance indicators (KPIs), at Annex A, were met up to the end of February 2018.

Strategic delivery

3 This is the first time that we are reporting to Council against our new 2018-2020 Corporate Strategy. Paper M6, Plans to report on our Corporate Strategy, details our new approach. As well as reporting on progress on activities that will deliver our Strategy, we are shifting our emphasis to how we are making an impact on the wider healthcare system, and whether we are on track to realising actual benefits for stakeholders. Slide 3 of Annex A shows the key benefits which we have identified for each strategic aim, and the activities which will deliver these.

4 The High Court’s judgment in respect of the Dr Bawa-Garba case has had a significant impact on the profession and we have made a number of commitments to address concerns both under our new Corporate Strategy and in the light of recent events, which we are now seeking to show rapid progress on. These include a review led by Dame Clare Marx to look at how manslaughter by gross negligence (and the offence of culpable homicide in Scotland) is applied in medical practice. We are also developing programmes of work around issues such as reflective practice, raising concerns and equality and diversity. To ensure that we can deliver on these commitments while maintaining momentum with other corporate priorities, we have reviewed our 2018 business plan to identify where work can be paused, or stopped, without significant detriment to stakeholders. Council will be updated on the outcomes of this exercise and any effect on the underlying 2018 programme at its June meeting.

5 Annex A shows the detail of our strategic delivery, by exception. We have decided to put one project on hold until 2019, meetings with doctors and patients, as part of the re-prioritisation exercise above.

Our new Corporate Opportunities and Risk Register

6 We have developed a new Corporate Opportunities and Risk Register (CORR), to support our 2018-2020 Corporate Strategy, which can be found at Annex B. This has
involved extensive work across the business to consider the risks and opportunities in implementing our strategic aims, our overall Strategy, as well as revisiting core operational risks to ensure they remain relevant. The CORR was shared during its development with the Audit and Risk Committee and the final format was agreed at the Committee’s meeting in March 2018.

7 A key change to the CORR is to consider our risk appetite more clearly, as shown in the final columns of the CORR. In line with the discussion at Audit and Risk Committee in January 2018, the rating colours follow our risk appetite statement – i.e. a high level of appetite, marked in red, indicates we are prepared to take significant risk for the benefit achievable, medium appetite is amber and low appetite level is green.

8 Since February six new risks have been added to the CORR:

a Risk OST4: Due to recent external developments and media coverage of GMC statutory decisions such as the GMC’s appeal of the Dr Bawa-Garba case, impacting on the reputation of the organisation we may find stakeholders have less confidence in us, and may be less willing to work collaboratively in delivering our key organisational priorities.

b Risk OST6: Because we make a range of complex statutory decisions, there may be circumstances when the profession or public find our actions contentious and, without access to all the evidence, could potentially damage our relationship and reputation with doctors and patients, conflicting with our aspiration to be recognised as supporting the profession.

c Risk T4.2: Following the publication of the hyponatraemia inquiry report in Northern Ireland on 31 January 2018, there is a risk that the GMC does not respond fully or appropriately to the relevant recommendations made in the report, which may compromise the integrity of our four country model of regulation.

d Risk AT1: Due to the need to respond to unplanned events, such as the Secretary of State’s review of the application of Gross Negligent Manslaughter (GNM) and publication of the report of the Inquiry into Hyponatraemia-related deaths, we may lack the capacity to progress our aims and benefits as set out in our Corporate Strategy 2018-2020 at the desired pace.

e Risk AT10: Due to the increasing demand for education policy input and expertise to corporate activities, there is a risk that the Education and Standards Directorate will not have sufficient resource capacity to deliver on its commitment to our 2018 strategic priorities, whilst maintaining a high standard delivery of business as usual.
f Risk AT15: Following the publication of the Health Education England (HEE) draft workforce strategy for consultation in December 2017, we have identified potential areas which may impact on our own policy development and resources. The final Workforce Strategy is due to be published in July 2018. We will continue to use every opportunity for discussions with HEE and organisations responsible for providing health and social care, across England, and the UK in the intervening months.

9 Two risks have been escalated to significant:

a Risk IT11 - Continued stretched resources and finances in the health environment create the potential for increased patient safety incidents which could strategically impact the GMC’s role as the regulator upholding professional standards for doctors and trainees and create operational pressures on fitness to practise referrals and education monitoring services – reflects the potential impact on our statutory functions, in particular of a rising number of Fitness to or enhanced monitoring referrals caused by continuing system pressures. We continue to monitor these areas closely.

b Risk IT15 - The volume and complexity of the programme of work we seek to undertake exceeds our capacity to successfully deliver - has been escalated from low to significant residual risk to reflect the additional work streams and commitments we have made in response to recent external events. A prioritisation exercise has been conducted to ensure we plan delivery of each activity appropriately.

Assistant Director appointments

10 We have recently appointed five Assistant Director roles. This includes two internal promotions. Kirstyn Shaw has been promoted to Assistant Director, Policy, Information and Change in the Registration and Revalidation Directorate and Nico Kirkpatrick has been appointed as Assistant Director, Education Operations in the Education and Standards Directorate.

11 We have also made three external appointments. Mark Swindells has been appointed as Assistant Director in the Office of Chair and Chief Executive, and joins us from the Department for International Development. Tim Aldrich has been appointed as Assistant Director, Strategy, in the Strategy and Policy Directorate. Tim worked on a three month secondment at the GMC in 2017 to support the creation of the Strategy and Policy, and Strategic Communications and Engagement directorates and joins us from KPMG’s regulation consultancy practice. Phil Martin has been appointed as Assistant Director, Education Policy in the Education and Standards Directorate. Phil joins us from the Department for Work and Pensions.
GMC Services International (GMCSI)

12 We have recruited two new Business Development Managers and are also recruiting for an Assistant Director. We are encountering a delay to a potential major international opportunity due to external factors; however, a new consulting contract has been won and progress on the development of new opportunities continues in line with the opportunity pipeline. An update on progress was given to the Investment Sub-Committee on 6 February 2018.

Welsh Language Standards

13 Following our response, and that of others, to the public consultation on the draft regulations which specify the Welsh Language Standards for organisations in the health sector, the Welsh Government has decided to create a separate set of standards for the Professional Health Regulators recognising our UK-wide remit.

14 Informal consultation with us and the other Professional Health Regulators will take place before the Regulations are laid before the National Assembly. Based on previous discussions in November 2017, with Meri Huws, the Welsh Language Commissioner, we expect this to take place by April 2018.

2018 Pay award

15 The 2018 Pay award was agreed by the Executive Board in February 2018. All staff who joined the GMC before 1 January 2018 will receive a pay rise of at least 1.5%, unless they are rated as ‘unsatisfactory.’ Colleagues who are in the middle of their pay band with a successful rating will receive 2.5%. Colleagues who were more than 5% beyond the top of the salary band did not receive an increase in base salary unless there were specific arrangements in place for recruitment and retention purposes such as market allowances. The 2018 award is structured to ensure staff in the lower sections of our pay bands progress more effectively through the pay bands and bring more consistency to salary levels across the GMC.
M4 - Annex A
Council portfolio

Data presented as at 28 February 2018 (unless otherwise stated)
Commentary as at 26 March 2018

Working with doctors Working for patients
### Operational Key Performance Indicator (KPI) summary

<table>
<thead>
<tr>
<th>Core regulatory objective</th>
<th>Key Performance Indicator</th>
<th>Performance</th>
<th>Exception summary</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Jan</td>
<td>Feb</td>
</tr>
<tr>
<td><strong>We decide which doctors are qualified to work here and we oversee UK medical education and training.</strong></td>
<td><strong>Decision on 95% of all registration applications within 3 months</strong></td>
<td>98%</td>
<td>97%</td>
</tr>
<tr>
<td></td>
<td><strong>Answer 80% of calls within 20 seconds</strong></td>
<td>83%</td>
<td>82%</td>
</tr>
<tr>
<td><strong>We set the standards that doctors need to follow, and make sure that they continue to meet these standards throughout their careers.</strong></td>
<td><strong>Decision on 95% of all revalidation recommendations within 5 days</strong></td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td><strong>Respond to 90% of ethical/standards enquiries within 15 working days</strong></td>
<td>93%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>We take action to prevent a doctor from putting the safety of patients, or the public’s confidence in doctors, at risk.</strong></td>
<td><strong>Conclude 90% of fitness to practise cases within 12 months</strong></td>
<td>95%</td>
<td>94%</td>
</tr>
<tr>
<td></td>
<td><strong>Conclude or refer 90% of cases at investigation stage within 6 months</strong></td>
<td>93%</td>
<td>94%</td>
</tr>
<tr>
<td></td>
<td><strong>Conclude or refer 95% of cases at the investigation stage within 12 months</strong></td>
<td>98%</td>
<td>97%</td>
</tr>
<tr>
<td></td>
<td><strong>Commence 100% of Investigation Committee hearings within 2 months of referral</strong></td>
<td>100%</td>
<td>No cases due</td>
</tr>
<tr>
<td></td>
<td><strong>Commence 100% of Interim Order Tribunal hearings within 3 weeks of referral</strong></td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

### Business support area

<table>
<thead>
<tr>
<th>Key Performance Indicator</th>
<th>Performance</th>
<th>Exception summary</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Jan</td>
<td>Feb</td>
</tr>
<tr>
<td><strong>Finance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2017/18 Income and expenditure [% variance]</td>
<td>0.81%</td>
<td>-0.21%</td>
</tr>
<tr>
<td><strong>HR</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rolling twelve month staff turnover within 8-15% (excluding change programme (redundancy) effects)</td>
<td>7.62%</td>
<td>7.59%</td>
</tr>
<tr>
<td><strong>Information systems</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IS system availability (%)</td>
<td>99.92%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Media monitoring</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monthly media score</td>
<td>1,870</td>
<td>-107</td>
</tr>
</tbody>
</table>

**NB** We are currently reviewing our operational KPIs with a view to introducing a revised suite of indicators later in 2018.

Critical coverage around the Dr Bawa-Garba case and related issues continues to have a pronounced impact on coverage. Positive mentions of our decision to accept new English language tests for non-UK doctors.
Strategic delivery – overall view

The diagram below shows the key benefits of the 2018-2020 Corporate Strategy. The RAG ratings indicate our progress with delivery of the activities that will realise these benefits. More detail on exceptions is on Slides 4-6.

Corporate Strategy 2018-2020

1. Supporting doctors in delivering good medical practice
   - Doctors are supported to deliver high quality care
   - Doctors have a fulfilling/sustained career
   - Enhanced trust in our role
   - Increased confidence in the quality of training environments
   - Improved identification of risk

2. Strengthening collaboration with regulatory partners.
   - Reduced regulatory burden
   - Right response by the right organisation, at the right time
   - Enhanced perception of regulation

3. Strengthening our relationship with the public and the profession
   - Public confidence in GMC
   - Enhanced customer service
   - Contribute to public confidence in doctors

4. Meeting the change needs of the health services across the four countries of the UK
   - UK workforce needs better met
   - Maintenance of a coherent model of regulation across the UK
   - We are well prepared for and can influence legislative change

Delay/issue in delivery – overall objective or deadline at risk
Delay/issue in delivery but overall deadline or objective on track
On track
Strategic delivery (by exception)

Strategic aim 1: Supporting doctors in delivering good medical practice

<table>
<thead>
<tr>
<th>Key benefit</th>
<th>Activities to deliver (by exception)</th>
<th>Lead indicators</th>
<th>Lag indicators*</th>
<th>Exception commentary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors are supported to deliver high quality care</td>
<td>Revised consent guidance</td>
<td>Guidance reflects shifts in legal, policy and workplace environments</td>
<td>TBC</td>
<td>Our external consultation was due to launch in March 2018, but due to the existing pressures within the external environment it has been deferred to ensure that we are actively listening to the concerns of the profession and develop guidance to help support the profession in this challenging environment.</td>
</tr>
<tr>
<td></td>
<td>Credentialing programme</td>
<td>Stakeholder consensus on role of credentials</td>
<td>TBC</td>
<td>Stakeholders continue to express differing views about the role of credentials. We wrote to the four UK health ministers on 15 February 2018 setting out our proposed approach to the recommendations in the Shape of Training Implementation Report, including on credentials, and asking for support on the legislative changes needed. Responses received so far indicate a willingness to develop a consensual definition and framework for credentials, but we will need to and we continue to work closely with stakeholders to resolve issues.</td>
</tr>
<tr>
<td></td>
<td>Taking Revalidation Forward</td>
<td>Clearer guidance on supporting information for appraisal for revalidation</td>
<td>TBC</td>
<td>Several workstreams are delayed although we remain on track for overall programme completion by September 2018. We will now launch the patient feedback consultation in September instead of June, to allow for more extensive pre-consultation engagement, and we have also extended the completion date for agreeing an approach to tracking revalidation with stakeholders. This work is progressing well but more time is needed to allow the Revalidation Oversight Group to fully consider and agree to our proposals.</td>
</tr>
<tr>
<td></td>
<td>Evaluation of revalidation</td>
<td>Publication of report</td>
<td>TBC</td>
<td>Publication of the report has been delayed until w/c 16 April to fit with corporate communications scheduling. We are drafting a set of Frequently Asked Questions to accompany the report when it is published.</td>
</tr>
</tbody>
</table>
Strategic delivery (by exception)

Strategic aim 1: Supporting doctors in delivering good medical practice (continued)

Key benefit

Doctors have a fulfilling/sustained career

Activities to deliver (by exception)

Flexibility programme

Lead indicators

Common outcomes and shared components of training

Lag indicators

TBC

Exception commentary

After experiencing resource issues, we have committed to some shared project support with the Academy of Medical Royal Colleges (AoMRC). This will allow work to progress on the key workstreams of reviewing the guidance designed to promote transferability of trainees across different specialties, and develop shared curricula content to broaden exposure and capability to elements of training. We are also securing further GMC resource, which will allow us to progress a curricula mapping exercise to identify commonalities and opportunities across specialty curricula and opportunities.

Strategic aim 2: Strengthening collaboration with our regulatory partners

Key benefit

Enhanced trust in our role

Activities to deliver (by exception)

Pilot of meetings with doctors and patients

Lead indicators

Increased engagement with complainants

Lag indicators

TBC

Exception commentary

We have decided to delay this pilot until 2019, as part of our current re-prioritisation exercise. We will continue to invest in other work to increase engagement with doctors and patients, such as our patient and public engagement strategy.
Strategic aim 3: Strengthening our relationship with the public and the profession

Key benefit: Enhanced customer service

Activities to deliver (by exception): Publication and disclosure

Lead indicators: Revised policy and supporting system changes published

Lag indicators*: TBC

Exception commentary:
On 26 February 2018 we launched our revised policy, supporting system changes, and our new Case Examiner decisions page. These updates were made following public consultation, and designed so that we are both transparent and fair to doctors about historical warnings and sanctions. Our data cleansing exercise required more resource than initially expected but we have now arranged for a data fix to complete outstanding data queries.

Strategic aim 4: Meeting the change needs of the health services across the four countries of the UK

Key benefit: UK workforce needs better met

Activities to deliver (by exception): Regulation of Medical Associate Professionals (MAPs)

Lead indicators: An implementation plan is developed

Lag indicators*: TBC

Exception commentary:
We are still awaiting the outcomes of the Department of Health’s (DH) consultation and as a result the project will be put on hold until we are clear of Department of Health’s intention for regulating MAPs.
## Financial summary

### Finance - Summary

<table>
<thead>
<tr>
<th>Financial summary as at February 2018</th>
<th>Budget Feb £000</th>
<th>Actual Feb £000</th>
<th>Variance £000</th>
<th>%</th>
<th>Budget Jan - Dec £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operational expenditure</td>
<td>16,029</td>
<td>15,958</td>
<td>71</td>
<td>0%</td>
<td>99,680</td>
</tr>
<tr>
<td>New initiatives fund</td>
<td>8</td>
<td>8</td>
<td>0</td>
<td>0%</td>
<td>2,500</td>
</tr>
<tr>
<td>Total expenditure</td>
<td>16,037</td>
<td>15,966</td>
<td>71</td>
<td>0%</td>
<td>102,180</td>
</tr>
<tr>
<td>Total income</td>
<td>18,314</td>
<td>18,194</td>
<td>(120)</td>
<td>(1)%</td>
<td>107,982</td>
</tr>
<tr>
<td>Surplus/ (deficit)</td>
<td>2,277</td>
<td>2,228</td>
<td>(49)</td>
<td>(1)%</td>
<td>5,802</td>
</tr>
</tbody>
</table>

### Capital Programme

| Capital Programme | 845 | 847 | (2) | (0)% | 6,000 |

### Significant issues / Changes from previous month:

**Staffing costs (£67k under budget)** - We have assumed a vacancy rate of 70 roles and at the end of February have 65 vacancies compared to budget. Although we have fewer unfilled roles than expected, staff costs are lower than budget as the average level of those roles are higher than anticipated, i.e. Assistant Director and Head of Section vacancies.

**Efficiency savings (£19k under-achieved)** - Efficiency targets are profiled from February as a cut to budget. MPTS have over achieved their target, through an increased use of Legally Qualified Chairs for hearings, and Resources and Quality Assurance have created some efficiencies through reducing their VAT liability on buildings insurance however overall the efficiency target for February has not been met.

**Investment income (£169k under budget)** - This is due to short term fluctuations in market conditions. The long term target is CPI plus 2%.

**Professional and Linguistic Assessments Board (PLAB) fees and registration fees (£71k over budget)** - Demand levels for candidates taking the PLAB 1 & 2 tests have continued to increase significantly from 2017, resulting in an increase in PLAB days held to the end of Feb. The rise in candidates also drives growth in the volume of International Medical Graduate applications, resulting in further additional income.

Other variances are due to minor timing differences in the pattern of actual expenditure compared to budget. At this stage in the year it is too early to identify any trends and we will continue to monitor spending patterns.
## Financial – detail

### Expenditure as at February 2018

<table>
<thead>
<tr>
<th></th>
<th>Budget Feb £000</th>
<th>Actual Feb £000</th>
<th>Variance £000</th>
<th>Variance %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff costs</td>
<td>9,337</td>
<td>9,270</td>
<td>67</td>
<td>1%</td>
</tr>
<tr>
<td>Staff support costs</td>
<td>500</td>
<td>511</td>
<td>(11)</td>
<td>(2)%</td>
</tr>
<tr>
<td>Office supplies</td>
<td>261</td>
<td>237</td>
<td>24</td>
<td>9%</td>
</tr>
<tr>
<td>IT &amp; telecoms costs</td>
<td>565</td>
<td>556</td>
<td>9</td>
<td>2%</td>
</tr>
<tr>
<td>Accommodation costs</td>
<td>909</td>
<td>876</td>
<td>33</td>
<td>4%</td>
</tr>
<tr>
<td>Legal costs</td>
<td>737</td>
<td>735</td>
<td>2</td>
<td>0%</td>
</tr>
<tr>
<td>Professional fees</td>
<td>192</td>
<td>218</td>
<td>(26)</td>
<td>(14)%</td>
</tr>
<tr>
<td>Council &amp; members costs</td>
<td>65</td>
<td>58</td>
<td>7</td>
<td>11%</td>
</tr>
<tr>
<td>Panel &amp; assessment costs</td>
<td>2,183</td>
<td>2,204</td>
<td>(21)</td>
<td>(1)%</td>
</tr>
<tr>
<td>Depreciation</td>
<td>1,176</td>
<td>1,170</td>
<td>6</td>
<td>1%</td>
</tr>
<tr>
<td>PSA Levy</td>
<td>115</td>
<td>115</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Under-achievement of efficiency savings</td>
<td>(19)</td>
<td>0</td>
<td>(19)</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Operational expenditure</strong></td>
<td><strong>16,021</strong></td>
<td><strong>15,950</strong></td>
<td><strong>71</strong></td>
<td><strong>0%</strong></td>
</tr>
<tr>
<td>New initiatives fund</td>
<td>8</td>
<td>8</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Total expenditure</strong></td>
<td><strong>16,029</strong></td>
<td><strong>15,958</strong></td>
<td><strong>71</strong></td>
<td><strong>0%</strong></td>
</tr>
</tbody>
</table>

### Income as at February 2018

<table>
<thead>
<tr>
<th></th>
<th>Budget Feb £000</th>
<th>Actual Feb £000</th>
<th>Variance £000</th>
<th>Variance %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual retention fees</td>
<td>16,423</td>
<td>16,390</td>
<td>(33)</td>
<td>(0)%</td>
</tr>
<tr>
<td>Registration fees</td>
<td>399</td>
<td>417</td>
<td>18</td>
<td>5%</td>
</tr>
<tr>
<td>PLAB fees</td>
<td>623</td>
<td>676</td>
<td>53</td>
<td>9%</td>
</tr>
<tr>
<td>Specialist application CCT fees</td>
<td>293</td>
<td>321</td>
<td>28</td>
<td>10%</td>
</tr>
<tr>
<td>Specialist application CESR/CEGPR fees</td>
<td>140</td>
<td>154</td>
<td>14</td>
<td>10%</td>
</tr>
<tr>
<td>Interest income</td>
<td>106</td>
<td>118</td>
<td>12</td>
<td>11%</td>
</tr>
<tr>
<td>Investment income</td>
<td>84</td>
<td>-85</td>
<td>(169)</td>
<td>(201)%</td>
</tr>
<tr>
<td>Other income</td>
<td>246</td>
<td>203</td>
<td>(43)</td>
<td>(17)%</td>
</tr>
<tr>
<td><strong>Total Income</strong></td>
<td><strong>18,314</strong></td>
<td><strong>18,194</strong></td>
<td><strong>(120)</strong></td>
<td><strong>(1)%</strong></td>
</tr>
<tr>
<td><strong>Surplus / (deficit)</strong></td>
<td><strong>2,285</strong></td>
<td><strong>2,236</strong></td>
<td><strong>(49)</strong></td>
<td><strong>6,947</strong></td>
</tr>
</tbody>
</table>

---

Council meeting, 24 April 2018

M04 – Chief Operating Officer’s Report
Legal summary (as at 8 March 2018)

The table below provides a summary of appeals and judicial reviews as at 8 March 2018:

<table>
<thead>
<tr>
<th></th>
<th>Open cases carried forward since last report</th>
<th>New cases</th>
<th>Concluded cases</th>
<th>Outstanding cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>s.40 (Practitioner) Appeals</td>
<td>12</td>
<td>4</td>
<td>3</td>
<td>13</td>
</tr>
<tr>
<td>s.40A (GMC) Appeals</td>
<td>4</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>PSA Appeals</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Judicial Reviews</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>IOT Challenges</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

Explanation of concluded cases

<table>
<thead>
<tr>
<th></th>
<th>s.40 (Practitioner) Appeals</th>
<th>s.40A (GMC) Appeals</th>
<th>Judicial Reviews:</th>
<th>New referrals by PSA to the High Court under Section 29 since the last report with explanation, and any applications outstanding</th>
<th>Any new applications in the High Court challenging the imposition of interim orders since the last report with explanation; and total number of applications outstanding</th>
<th>Any other litigation of particular note</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2 appeals dismissed</td>
<td>2 successful appeals</td>
<td>2 permission refused</td>
<td>PSA Appeals: N/A</td>
<td>IOT challenges: 1 dismissed</td>
<td>We continue to deal with a range of other litigation, including cases before the Employment Tribunal, the Employment Appeals Tribunal and the Court of Appeal.</td>
</tr>
</tbody>
</table>
Corporate Opportunities and Risk Register

1 Strategic opportunities and risks in delivering our corporate strategy (denoted OSOP1, OSOP2 etc. for opportunities, and OT1, OT2 etc. for threats) and each of its strategic aims:

- Aim 1 – include in full (denoted OP1.1, OP1.2 etc. for opportunities, and T1.1, T1.2 etc. for threats).
- Aim 2 – in full etc. (denoted OP2.1, OP2.2 etc. for opportunities, and T2.1, T2.2 etc. for threats).
- Aim 3 – in full etc. (denoted OP3.1, OP3.2 etc. for opportunities, and T3.1, T3.2 etc. for threats).
- Aim 4 – in full etc. (denoted OP4.1, OP4.2 etc. for opportunities, and T4.1, T4.2 etc. for threats).

2 Business risks and how we manage them:

- Operational risks we are actively managing (denoted AOP1, AOP2 etc for opportunities AT1, AT2, etc for threats).
- Inherent risks in our business of being a regulator (denoted IOP1, IOP2 etc for opportunities IT1, IT2, etc for threats).
If we clearly articulate our new strategic direction to partners and the profession, we have an opportunity to build a platform from which to start moving 'upstream' in our work and be seen to actively support doctors at all stages of their careers.

We use our reputation for operational excellence to further enhance collaboration with our stakeholders, so that we identify new opportunities to deliver our statutory functions and contribute to patient safety in the wider healthcare system.

Through transforming our engagement across all of our activities, we empower and develop members of staff to build strong and mutually beneficial relationships with stakeholders, and develop understanding of the impact of GMC decisions/interventions, so that we achieve the full impact of our ambition to be collaborative.

If we do not keep abreast of changes in the UK healthcare environment and the wider political/legislative environment, or understand how these impact on individual doctor's practice, we will not be able to provide timely and targeted support to those doctors who need it most, with a consequent impact on patient safety and our ability to be effective regulators.

Overarching opportunities and risks in delivering the Corporate Strategy

<table>
<thead>
<tr>
<th>ID</th>
<th>Threat / Opportunity</th>
<th>Opportunity risk detail</th>
<th>Owner</th>
<th>Vulnerability</th>
<th>Impact</th>
<th>Resilience</th>
<th>Mitigation (or threats)</th>
<th>Enhancement (or opportunities)</th>
<th>Risk appetite</th>
<th>Further action required?</th>
<th>Further action detail</th>
</tr>
</thead>
<tbody>
<tr>
<td>OSOP1</td>
<td>Opportunity</td>
<td>If we clearly articulate our new strategic direction to partners and the profession, we have an opportunity to build a platform from which to start moving 'upstream' in our work and be seen to actively support doctors at all stages of their careers</td>
<td>P. Buckley</td>
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<tr>
<td>OSOP2</td>
<td>Opportunity</td>
<td>We use our reputation for operational excellence to further enhance collaboration with our stakeholders, so that we identify new opportunities to deliver our statutory functions and contribute to patient safety in the wider healthcare system</td>
<td>P. Reynolds</td>
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<tr>
<td>OSOP3</td>
<td>Opportunity</td>
<td>Through transforming our engagement across all of our activities, we empower and develop members of staff to build strong and mutually beneficial relationships with stakeholders, and develop understanding of the impact of GMC decisions/interventions, so that we achieve the full impact of our ambition to be collaborative</td>
<td>P. Reynolds</td>
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<tr>
<td>GST1</td>
<td>Threat</td>
<td>If we do not keep abreast of changes in the UK healthcare environment and the wider political/legislative environment, or understand how these impact on individual doctor's practice, we will not be able to provide timely and targeted support to those doctors who need it most, with a consequent impact on patient safety and our ability to be effective regulators</td>
<td>P. Buckley</td>
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</table>

Operational excellence tracked through:
- Monitoring and reporting on the performance of our core functions to Council, Executive Board, Audit and Risk Committee (ARC) etc.
- Professional Standards Authority (PSA) Performance Review
- Annual Report – provides overview of how we have deployed our resources to achieve our objectives and deliver our core functions
- RLS/SLGs – provide regular advice in relation to our core functional areas (RF), Registration & Revalidation, Standards and Guidance etc.
- Internal audit activities in relation to our core functions
- MLA – addressing core function at entry to register with a licence to practice
- Taking Revalidation Forward (TRF) workstream 1 - Making revalidation more accessible to patients and the public
- Evaluation of revalidation (UMBRELLA) report - The evaluation provides us with a way to independently demonstrate to the profession and the public that revalidation is meeting its regulatory objectives. The findings of the evaluation will help to identify improvements to revalidation that we can make
- Our response to the Department of Health consultation around regulatory reform - opportunity to shape the future of medical regulation and legislation
- Identification, prioritisation and coordination of engagement activities by the new Strategic Communication Directorate
- Empowering and Developing Our People – Transformation Programme
- Impact Assessments
- The MLA programme is being implemented by work streams drawing on experience and expertise from across the GMC and in collaboration with medical schools and other key stakeholders
- Corporate strategy commitments at team level to increase level of ownership and engagement from staff
- L&D functions - delivering support and training to staff members in managing relationships with stakeholders
- Horizon scanning activities
- Patient Safety Intelligence Forum (PSIF)
- Engagement teams – our field force bring insight back into the business which assists us in developing our understanding of the healthcare system
- Better sharing of information and intelligence between engagement teams and business and using information effectively
- Engagement teams – liaison services
- Training/Trainer surveys – State of Medical Education and Practice in the UK (SOMEP) etc
- Medical Profession Matters publication
- Policy Leadership Group (PLG)
- New Strategic Policy Directorate
- GMC Senior Leadership Team engagement within the external environment - with insight gained shared with the rest of the business
- Engagement with Medical Defence Organisations (MDOs) through co-ordinated stakeholder engagement programme
- Improvement of Standards & Ethics advisory service
- MLA – assessment blueprint to be framed in context of changes to the wider environment
- TRF Programme - Reducing burden and improving the appraisal experience for doctors (Workstream 6)

Strategic risks and how we manage them

<table>
<thead>
<tr>
<th>Risk / Threat</th>
<th>Mitigation (or threats)</th>
<th>Enhancement (or opportunities)</th>
<th>Residual risk with controls in place</th>
<th>Further action required?</th>
<th>Further action detail</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transformation Programme</td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td>Work to expand our field forces</td>
</tr>
</tbody>
</table>

Further action detail
- Incremental progress reports to Council each meeting
- Council away days horizon scanning activities
- CE reports to Council each meeting
- Council away days horizon scanning
If we do not have sufficient capacity, experience or expertise within our data functions, then we will not be able to continue to use our data and insights to greater effect in anticipating and highlighting emerging risks, to support doctors in delivering high quality healthcare, and to inform the development of new policies and interventions.

Due to recent external developments and media coverage of GMC statutory decisions such as the GMC’s appeal at the Dr Bawa-Garba case, impacting on the reputation of the organisation we may find stakeholders have less confidence in us, and may be less willing to work collaboratively in delivering our key organisational priorities.

If our external partners have insufficient resources to commit to working with us to achieve our aims, we will not be able to secure the support and traction needed to make the progress required under our Corporate Strategy.

Because we make a range of complex statutory decisions, there may be circumstances when the profession or public fail to act in a proactive and constructive way, and without access to all the evidence, could potentially damage our relationship and reputation with doctors and patients, conflicting with our aspiration to be recognised as supporting the profession.

The table below shows the Risk Assessment Matrix. It is designed to help us identify potential risks, assess their impact and likelihood, and determine the appropriate controls.

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</thead>
<tbody>
<tr>
<td>OST2</td>
<td>Threat</td>
<td>Low</td>
<td>P. Buckley</td>
<td>Quite Likely</td>
<td>Moderate</td>
<td>Strategy and Policy Directorate – Regulatory Policy Teams &amp; Policy Leadership Group – more evidence-led policy</td>
<td>Yes</td>
<td>Yes</td>
<td>Next phase of Data Strategy</td>
</tr>
<tr>
<td>OST3</td>
<td>Threat</td>
<td>Medium</td>
<td>P. Reynolds</td>
<td>Quite Likely</td>
<td>Moderate</td>
<td>Work to align our communications activity to avoid overwhelming our stakeholders or creating engagement fatigue</td>
<td>Yes</td>
<td>No</td>
<td>Medium 40 Action detail</td>
</tr>
<tr>
<td>OST4</td>
<td>Threat</td>
<td>Medium</td>
<td>P. Reynolds</td>
<td>Moderate</td>
<td>Significant</td>
<td>Communications Team have developed a handling plan and continuously monitor media coverage</td>
<td>Yes</td>
<td>No</td>
<td>Low</td>
</tr>
<tr>
<td>OST5</td>
<td>Threat</td>
<td>Medium</td>
<td>P. Buckley</td>
<td>Quite Likely</td>
<td>Medium</td>
<td>ELS/RLS engagement activities - bringing back insights from the external environment as to where resource pressures exist so that we can consider what (if any) support we can provide, and/or factor into our planning</td>
<td>No</td>
<td>No</td>
<td>Medium</td>
</tr>
<tr>
<td>OST6</td>
<td>Threat</td>
<td>Medium</td>
<td>P. Reynolds</td>
<td>Quite Likely</td>
<td>Medium</td>
<td>Daily media and social media and political monitoring</td>
<td>Yes</td>
<td>No</td>
<td>Medium</td>
</tr>
</tbody>
</table>

The table below shows the Risk Assessment Matrix. It is designed to help us identify potential risks, assess their impact and likelihood, and determine the appropriate controls.
### STRATEGIC AIM 1 - Supporting doctors in maintaining good practice

**Description:** The MLA will be a touchpoint for all International Medical Graduates (IMGs) and potentially EEA, with an assessment blueprint covering ethics and professionalism — information packs or Welcome to UK Practice sessions for IMGs could potentially be linked to MLA stages (eg, first application, passing AKT, passing CPD).

**Mitigation:** We use our contacts with the large cohort of international and European medical graduates who join the Register each year, to make sure they understand our role and the ways in which we can support them, enhancing their ability to achieve and maintain good practice and their perception of us as their regulator.

**Opportunity:**

<table>
<thead>
<tr>
<th>No.</th>
<th>Opportunity</th>
<th>Due to inadequate planning and management, the MLA project may not engage the right resources and capability at the right time, with a consequent impact on the programme's ability to deliver to the agreed timescale and budget.</th>
</tr>
</thead>
<tbody>
<tr>
<td>OPI. 1</td>
<td>Opportunity</td>
<td>Colin Melville/ P. Reynolds/Moderate</td>
</tr>
</tbody>
</table>

**Threat:**

<table>
<thead>
<tr>
<th>No.</th>
<th>Threat</th>
<th>Due to lack of a clear and shared understanding of the programme's aim, or ineffective communications, the MLA does not command the confidence and support of the public and stakeholders, which undermines its deliverability, with potential impact on patient safety and the reputation of the GMC.</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1.2</td>
<td>Threat</td>
<td>Colin Melville/ P. Reynolds/Moderate</td>
</tr>
</tbody>
</table>

**Threat:**

<table>
<thead>
<tr>
<th>No.</th>
<th>Threat</th>
<th>If we do not understand the behaviours and culture of the multi-disciplinary teams within which doctors practice, the impact of our interventions to support doctors in maintaining good practice may be limited, and we may not focus our resources in the most effective way.</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1.3</td>
<td>Threat</td>
<td>S. Goldsmith/ P. Reynolds/Liy/Quite Likely</td>
</tr>
</tbody>
</table>

**Likelihood:**

<table>
<thead>
<tr>
<th>No.</th>
<th>Likelihood</th>
<th>Quite Likely</th>
<th>Quite Likely</th>
<th>Quite Likely</th>
</tr>
</thead>
</table>

**Impact:**

<table>
<thead>
<tr>
<th>No.</th>
<th>Impact</th>
<th>Moderate</th>
<th>Major</th>
</tr>
</thead>
</table>

**Likelihood:**

<table>
<thead>
<tr>
<th>No.</th>
<th>Likelihood</th>
<th>Quite Likely</th>
<th>Quite Likely</th>
<th>Quite Likely</th>
</tr>
</thead>
</table>

**Risk appetite:**

<table>
<thead>
<tr>
<th>No.</th>
<th>Risk appetite</th>
<th>LOW</th>
<th>LOW</th>
<th>Mod</th>
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</thead>
</table>

**Further Action:**

<table>
<thead>
<tr>
<th>No.</th>
<th>Further Action required?</th>
<th>Yes</th>
<th>Yes</th>
<th>Yes</th>
</tr>
</thead>
</table>

### Governance arrangements in place; a Programme Board chaired by the OGD providing oversight (and reporting to Council via Executive Board).

- Formal project and project team established, with programme planning and management, and regular reporting via the MLA Programme Board.
- Resource and budget planned, allocated and regularly reviewed.
- Consultants reviewed structure, governance and communications for the project (June - September 2016). Programme manager appointed. Consultants produced detailed cost and impact analysis of a range of MLA options (June - October 2016).
- Expert Reference Group (ERG) appointed, meeting regularly from October 2016 and monthly following programme development.
- ERG subgroups for Applied Knowledge Test and Clinical and Professional Skills Assessment established (June 2017), contributing content expertise to programme development.

### A public consultation launched in January 2017 and closed in April 2017.

- Council discussed consultation outcomes and proposed ways forward, and agreed these for discussion with stakeholders (September 2017).
- Regular engagement with the Medical Schools Council, the Medical Schools Council Assessment Alliance, individual medical schools and other stakeholders and partners.
- Dedicated MLA Communications Manager in role (September 2017): engagement plan in place to liaise with a range of key stakeholders including all UK administrations.

### Strategies & Policy Board

- MLA Programme Board as its task and Finish Group February 2017 (transferred to Executive Board June 2017).

### Review of the Medical Licensing Assessment programme structure, governance and resource planning (April 2017, amber)

- Actions being taken forward following the amber rating from the internal audit (April - December 2017).
- Ongoing engagement with key stakeholders to follow up on the consultation.

### Further action detail

- Review the outcomes for graduates (2017-2018).
- Ongoing engagement with key stakeholders to follow up on the consultation.

### Further action detail

- The MLA assessment blueprint will be based on revised Outcomes for Graduates. QPDs and other sources with strong emphasis on CPD. In the development process we will talk to clinical practitioners and assessors so we can share any insights from those conversations.

### Further action detail

- Increase participation in Welcome to UK Practice by 20% in 2020.
- Digital Transformation 2020 programme - changes to the information on our website, making it easier to navigate and personalise
### STRATEGIC AIM 2 - Strengthening collaboration with our regulatory partners across the health services

<table>
<thead>
<tr>
<th>ID</th>
<th>Threat / Opportunity</th>
<th>Owner</th>
<th>Opportunity/ risk detail</th>
<th>Likelihood</th>
<th>Impact</th>
<th>Residual Risk</th>
<th>Council and/or Board Review</th>
<th>Assurance</th>
<th>Further Action required?</th>
<th>Further action detail</th>
</tr>
</thead>
</table>
| T2.1 Threat | In cases where there are high profile patient safety issues and potentially unsafe environments for doctors and doctors in training, there are challenges in working effectively and collaboratively with other regulatory partners causing an adverse reputational impact for the GMC. | Susan Goldsmith | Quite Likely | Major | CRITICAL | • Information sharing agreement in place with CQC.  
• Working closely with the Health and Social Care Regulators Forum to improve collaboration.  
• Educationenhanced monitoring process in place.  
• Internal processes to manage communications.  
• Trained and available staff. | Council and/or Board Review | Assurance | Further Action required? | Yes |
| | | | | | | | | | | |
| T2.2 Threat | Because our partners in the system have different standards and approaches, as well as focusing their efforts on maintaining the service which compromises the quality of medical education provided, we may need to adopt a common position which is below the standard we are ideally seeking, with a consequent impact on the level of assurance we are able to provide, and potentially the speed at which we are able to develop and provide collective assurance. | P. Reynolds | Highly Likely | Moderate | CRITICAL | • The MLA will establish a minimum threshold clearly linked to our regulatory function and the need to ensure patient safety: demonstrating that an individual is capable of functioning safely on the first day of clinical practice in the UK. If stakeholders accept that, we will be in a better position to drive consistent future improvement.  
• Our quality assurance role involves us ensuring our standards are met. Our review of QA allows us to look at how we hold quality management organisations to account and ensure high standards. This involves looking at what good or notable practice is identified, shared and maintained.  
• Regular communications and engagement between GMC senior leadership and the Department of Health and Systems regulators across the four countries. | Council and/or Board Review | Assurance | Further Action required? | No |

#### Description:
- **Q&A update at next meeting**
- **CEO/COO update at each meeting**
- **Acting Chief Executive’s Report (June 2016), North Middlesex Audit and Risk Committee**
- **CE gave evidence to the Health Select Committee about the impact of Brexit on medical regulation (February 2017)**

#### Further Action:
- Working towards information sharing agreements in other regulators including devolved nations.
- We are currently undertaking a lessons learned exercise, including whether there are ways to improve our joint working with other regulators.
- Health and Social Care Regulators Forum have agreed actions and work streams to improve collaboration across the system.
- Develop a shared escalation protocol.
- Influence existing structures and fora to support information sharing.
- Agree a process for defining and communicating roles and responsibilities.
- Improve the use of data and insight - GMC to set up working group and feedback on analysis of current practice.
- Develop a culture of proactively sharing information and briefings.
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<tbody>
<tr>
<td>OP3.1</td>
<td>Opportunity</td>
<td>If we clarify how we want to strengthen relationships with members of the public, we will target our efforts appropriately and be able to demonstrate the impact our work is having which will impact on our reputation as an effective and transparent regulator in the eyes of the public and the profession.</td>
<td>P.Reynolds</td>
<td>LOW</td>
<td>MODERATE</td>
<td>SIGNIFICANT</td>
<td>Yes</td>
<td>Market research (2016) indicated public support for the principle of the MLA. We could build on this and align MLA communications with wider messaging and further audience research.</td>
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<tr>
<td>OP3.2</td>
<td>Opportunity</td>
<td>We have the opportunity to be a more proactive regulator and demonstrate our understanding of the environment in which the profession is working as well as showing a willingness to speak up about issues facing the profession, allowing us provide further support to doctors.</td>
<td>P.Reynolds</td>
<td>LOW</td>
<td>MODERATE</td>
<td></td>
<td>Yes</td>
<td>Being more vocal about the pressures in our narratives to external world.</td>
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**Strategic Aim 3 - Strengthening our relationship with the public and the profession**
### STRATEGIC AIM 4 - Meeting the changing needs of the health services across the four countries of the UK

<table>
<thead>
<tr>
<th>ID</th>
<th>Threat/ Opportunity</th>
<th>Risk appetite</th>
<th>Further action required?</th>
<th>Further action detail</th>
<th>Mitigation (for threats)</th>
<th>Residual risk with controls in place</th>
</tr>
</thead>
<tbody>
<tr>
<td>T4.1 Threat</td>
<td>Central Brexit Working Group</td>
<td>Low</td>
<td>Yes</td>
<td>Ongoing engagement with DH and provision of data on risks associated with EEA doctors and impact of changes to route to recognition and introduction of testing.</td>
<td>• In June 2017, the UK Government published its policy paper on the status of European Economic Area (EEA) nationals after the UK’s withdrawal from the European Union (EU).</td>
<td>• Review and Inquiries Group in place to consider GMC response to recommendations.</td>
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<tr>
<td></td>
<td>• Review and Inquiries Group in place to consider GMC response to recommendations.</td>
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<td>• Review and Inquiries Group in place to consider GMC response to recommendations.</td>
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<td></td>
<td>• Review and Inquiries Group in place to consider GMC response to recommendations.</td>
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<tr>
<td>T4.1 Threat</td>
<td>Global briefing</td>
<td>Medium</td>
<td>Yes</td>
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<td></td>
<td>General Council</td>
<td>Medium</td>
<td>Yes</td>
<td>Project team in place to ensure effective co-ordination of all aspects of our work and preparation of our formal response to the HSC.</td>
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<td>T4.2 Threat</td>
<td>Global briefing</td>
<td>Low</td>
<td>Yes</td>
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<tr>
<td></td>
<td>Global briefing</td>
<td>Low</td>
<td>Yes</td>
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<tr>
<td></td>
<td>Global briefing</td>
<td>Low</td>
<td>Yes</td>
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<tr>
<td>T4.3 Threat</td>
<td>Global briefing</td>
<td>Medium</td>
<td>Yes</td>
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<tr>
<td></td>
<td>Global briefing</td>
<td>Medium</td>
<td>Yes</td>
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<tr>
<td></td>
<td>Global briefing</td>
<td>Medium</td>
<td>Yes</td>
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<tr>
<td>T4.4 Threat</td>
<td>Global briefing</td>
<td>Low</td>
<td>Yes</td>
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<tr>
<td></td>
<td>Global briefing</td>
<td>Low</td>
<td>Yes</td>
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<tr>
<td></td>
<td>Global briefing</td>
<td>Low</td>
<td>Yes</td>
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### Risk appetite
- Low
- Medium
- High
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<tbody>
<tr>
<td>AT1</td>
<td>Threat</td>
<td>Due to the need to respond to unplanned events, such as the Secretary of State’s review of the application of Gross Negligent Manslaughter (GNM) and Hyponatraemia final report, we may lack the capacity to progress our aims and benefits as set out in our Corporate Strategy 2018-2020 at the desired pace.</td>
<td>Susan Goldsmith</td>
<td>Highly Likely</td>
<td>Moderate</td>
<td>CRITICAL</td>
<td>Re-prioritisation of non-critical work such as Scope of Practice</td>
<td>Complete mapping of the benefits of the Corporate Strategy against planned work and capabilities needed, in order to inform further prioritisation (April 2018)</td>
<td>Council</td>
<td>Yes</td>
<td>Further review of resource capacity, in particular within policy areas.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AT2</td>
<td>Threat</td>
<td>The UK and European legislative frameworks in which we operate as well as political agenda and ambitions, restrict our ability to deliver functions to full effect or efficiency and develop as a regulator.</td>
<td>Paul Buckley &amp; Paul Reynolds</td>
<td>Highly Likely</td>
<td>Moderate</td>
<td>CRITICAL</td>
<td>Domicile legislation - active engagement with DH(E) including over the use of s.60 orders to amend the Medical Act</td>
<td>Chief Executive legislation group has been reformed to assist regulators to develop common positions around future shape of regulation</td>
<td>Council</td>
<td>Yes</td>
<td>Internal Legislative Reform and EU exit group established.</td>
<td></td>
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</table>

Business risks and how we manage them

<table>
<thead>
<tr>
<th>ACTIVELY OPERATIONAL RISKS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk pre-controls</td>
</tr>
</tbody>
</table>

1. Re-prioritisation of non-critical work such as Scope of Practice
2. Complete mapping of the benefits of the Corporate Strategy against planned work and capabilities needed, in order to inform further prioritisation (April 2018)
3. Domestic legislation - active engagement with DH(E) including over the use of s.60 orders to amend the Medical Act
4. Chief Executive legislation group has been reformed to assist regulators to develop common positions around future shape of regulation
5. European legislation - skilled and resourced team to monitor and represent our interests at the European level and advise the organisation about any new EU developments. We continue to engage with EC officials, DH(E) and Business Innovation and Skills on the Recognition of Professional Qualifications engagement and implementation. We also convene the Alliance of UK Health Regulators on Europe and jointly coordinate the European Network of Medical Regulators on Europe to develop common positions when new European policy and legislative initiatives emerge and jointly engage with decision-makers, if required. UK is compliant with RPQ Directive provisions
6. Analysed outcome of General Election 8 June 2017 and implications for GMC of the Queen’s Speech heard 31st June. Nearty formed UK European & International Affairs Team will continue to monitor and support the GMC engagement with the new Government and the initiatives announced in the Queen’s speech.
7. Internal EU exit working group established.
<table>
<thead>
<tr>
<th>ID</th>
<th>Threat</th>
<th>Risk detail</th>
<th>Owner</th>
<th>Likelihood</th>
<th>Impact</th>
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<th>Further action detail</th>
<th>Risk appetite</th>
</tr>
</thead>
<tbody>
<tr>
<td>AT3</td>
<td>Threat</td>
<td>Brexit: The impact of changes resulting from the European referendum are not yet clear, providing uncertainty as to the future implications of the GMC’s work</td>
<td>Paul Buckley</td>
<td>Quite Likely</td>
<td>Major</td>
<td>CRITICAL</td>
<td>Establishment of cross-Directorate Brexit working group led by the UK, European and International Affairs team to scope challenges and opportunities for the GMC to define legislative priorities; and to review the potential impact on the legislation affecting our work (monthly meetings)</td>
<td>Ongoing engagement planned with Governments and key stakeholders</td>
<td>Council</td>
<td>Yes</td>
<td>Medium</td>
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- Establishment of cross-Directorate Brexit working group led by the UK, European and International Affairs team to scope challenges and opportunities for the GMC to define legislative priorities; and to review the potential impact on the legislation affecting our work (monthly meetings)
- Ongoing engagement planned with Governments and key stakeholders
- Active engagement with key influencers to influence post Brexit proposals for healthcare regulation and accountability
- Programme of active engagement and influence with the HSC through 2017, including response to inquiry on impact of Brexit on the health sector
- Liaison with UK and European regulators to ensure influence and leadership of key networks is maintained
- Publication of analyses of licensed doctors with an EEA PMQ and of doctors with EEA nationality
- Design and implementation of engagement campaign to try to ensure that post Brexit legal framework does not prohibit application of MLA to EEA doctors or impede reforms under flexibility review

- In June 2017, the UK Government published its policy paper on the status of European Economic Area (EEA) nationals after the UK’s withdrawal from the European Union (EU)
- We continue to make the case for reform to the RPL framework to enable us to check the competency of EEA doctors and to ensure a single route to the medical register for all doctors, regardless of where they qualified, in the future
- The UK Department of Health is currently exploring what amendments would be needed to the Medical Act in the event of the various EU exit scenarios. We are working with the Department both to identify which pieces of primary and secondary legislation impact on our work and may need re-drafting
- In Northern Ireland we are working on a project to identify the range of regulatory issues that need to be considered further as the Executive’s policy to increase the cross border delivery of healthcare is implemented
- Charlie Massey wrote to Jeremy Hunt on 26 March 2017 to push for reform of health professions provisions in RPL Directive
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<th>Mitigation (for Threat)</th>
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<tbody>
<tr>
<td>AT4</td>
<td>Threat</td>
<td>Difficulties in the recruitment and retention of staff and associates with the required skills and experience may challenge our ability to deliver our functions effectively.</td>
<td>Neil Roberts</td>
<td>Medium</td>
<td>Low</td>
<td>Data Strategy, Quality Architecture Project Group, Quarterly surveillance groups consider risk with Care Quality Commission (CQC).</td>
<td>No</td>
</tr>
<tr>
<td>AT5</td>
<td>Threat</td>
<td>By not effectively sharing the information we hold throughout the organisation or broader health service, we could contribute to a risk to patient safety</td>
<td>Paul Buckley</td>
<td>Medium</td>
<td>Low</td>
<td>Equality, Diversity and Training for all staff and associates and further work to develop this to incorporate inclusion.</td>
<td>No</td>
</tr>
<tr>
<td>AT6</td>
<td>Threat</td>
<td>We do not comply with our statutory obligations on Equality and Diversity and Human rights, leading to unfair outcomes.</td>
<td>Susan Goldenhill</td>
<td>Medium</td>
<td>Low</td>
<td>E &amp; D team linked into key strategic forums, i.e. new Policy Leadership Group and Research Forum</td>
<td>No</td>
</tr>
</tbody>
</table>

**ACTI VE OPERATIONAL RISKS**

<table>
<thead>
<tr>
<th>Task</th>
<th>Council and/or Board Review</th>
<th>Assurance</th>
<th>Further Action required?</th>
<th>Further action detail</th>
<th>Risk appetite</th>
</tr>
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<tbody>
<tr>
<td>Task</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Low</td>
</tr>
<tr>
<td>Task</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Medium</td>
</tr>
<tr>
<td>Task</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Low</td>
</tr>
</tbody>
</table>

**Risk assessment**

- **Residual risk with mitigation and action plan**
  - **Risk pre-controls**
    - Task and leadership programmes builds capacity
    - Corporate record keeping systems and requirements enable central record for corporate memory
    - Directors and ADs identify unique knowledge, skills and relationships to ensure suitable mechanisms in place to record/transfer
    - Annual performance management cycle and learning and development function identify staff training needs and prioritise and support staff development as required
    - Working with our advertising company, LinkedIn and outreach activities to target our marketing activity helping to increase our external profile as an employer of choice
    - Working with our HR, to source candidates and ensure to core functions are supported
  - **Residual risk with mitigation and action plan**
    - Task and leadership programmes builds capacity
    - Corporate record keeping systems and requirements enable central record for corporate memory
    - Directors and ADs identify unique knowledge, skills and relationships to ensure suitable mechanisms in place to record/transfer
    - Annual performance management cycle and learning and development function identify staff training needs and prioritise and support staff development as required
    - Working with our advertising company, LinkedIn and outreach activities to target our marketing activity helping to increase our external profile as an employer of choice
    - Working with our HR, to source candidates and ensure core functions are supported

**Risk Assessment**

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<thead>
<tr>
<th>Risk</th>
<th>Likelihood</th>
<th>Impact</th>
<th>Assessment</th>
<th>Mitigation (for Threat)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Task</td>
<td>Quite Likely</td>
<td>Low</td>
<td>LOW</td>
<td>Data Strategy, Quality Architecture Project Group, Quarterly surveillance groups consider risk with Care Quality Commission (CQC).</td>
</tr>
<tr>
<td>Task</td>
<td>Quite Likely</td>
<td>Moderate</td>
<td>SIGNIFICANT</td>
<td>Equality, Diversity and Training for all staff and associates and further work to develop this to incorporate inclusion.</td>
</tr>
<tr>
<td>Task</td>
<td>Unlikely</td>
<td>Moderate</td>
<td>Low</td>
<td>E &amp; D team linked into key strategic forums, i.e. new Policy Leadership Group and Research Forum</td>
</tr>
<tr>
<td>----</td>
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</tr>
<tr>
<td>AT7</td>
<td>Threat</td>
<td>Further historical abuse cases involving doctors come to light which call in to question the GMC’s actions at the time and impact on our reputation as a patient safety organisation</td>
<td>Paul Buckley</td>
<td>Highly Likely</td>
</tr>
</tbody>
</table>
### ACTIVELY OPERATIONAL RISKS

<table>
<thead>
<tr>
<th>ID</th>
<th>Threat / Opportunity</th>
<th>Risk detail</th>
<th>Owner</th>
<th>Likelihood</th>
<th>Likelihood of Mitigation (for Threats)</th>
<th>Likelihood of Assurance (for opportunity)</th>
<th>Council and / or Board Review</th>
<th>Assurance</th>
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</thead>
<tbody>
<tr>
<td>AT9</td>
<td>Threat</td>
<td>Providers of formative and summative feedback to Health Education England, it is a risk that</td>
<td>Colin Melville</td>
<td>Unlikely</td>
<td>Very Likely</td>
<td>Very Likely</td>
<td>Low</td>
<td>Low</td>
<td>Discussed as an emerging risk and agreement to add to Corporate Risk Register</td>
<td>Yes</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td></td>
<td>feedback is not consistently provided, as the processes have changed in how it is delivered</td>
<td>Neil Roberts</td>
<td>Unlikely</td>
<td>Likely</td>
<td>Likely</td>
<td>Low</td>
<td>Low</td>
<td>Discussed as an emerging risk and agreement to add to Corporate Risk Register</td>
<td>Yes</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td></td>
<td>and that there is variability in the quality of feedback</td>
<td></td>
<td>Unlikely</td>
<td>Likely</td>
<td>Likely</td>
<td>Low</td>
<td>Low</td>
<td>Discussed as an emerging risk and agreement to add to Corporate Risk Register</td>
<td>Yes</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td></td>
<td>from their area that is needed for GDPR work</td>
<td></td>
<td>Unlikely</td>
<td>Likely</td>
<td>Likely</td>
<td>Low</td>
<td>Low</td>
<td>Discussed as an emerging risk and agreement to add to Corporate Risk Register</td>
<td>Yes</td>
<td>Low</td>
</tr>
<tr>
<td>AT10</td>
<td>Threat</td>
<td>Due to the increasing demand for education policy input and expertise from corporate activities, it is a risk that</td>
<td>Colin Melville</td>
<td>Unlikely</td>
<td>Likely</td>
<td>Likely</td>
<td>Low</td>
<td>Low</td>
<td>Discussed as an emerging risk and agreement to add to Corporate Risk Register</td>
<td>Yes</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Education and Standards Directorate will not have sufficient resource capacity to deliver on its</td>
<td></td>
<td>Unlikely</td>
<td>Likely</td>
<td>Likely</td>
<td>Low</td>
<td>Low</td>
<td>Discussed as an emerging risk and agreement to add to Corporate Risk Register</td>
<td>Yes</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td></td>
<td>commitment to our 2018 strategic priorities, while maintaining a high standard delivery of business as usual</td>
<td></td>
<td>Unlikely</td>
<td>Likely</td>
<td>Likely</td>
<td>Low</td>
<td>Low</td>
<td>Discussed as an emerging risk and agreement to add to Corporate Risk Register</td>
<td>Yes</td>
<td>Low</td>
</tr>
<tr>
<td>AT11</td>
<td>Threat</td>
<td>There is a risk that lack of clarity on key engagement points across the business for the short to medium term may prevent communications teams from developing a co-ordinated, deliverable and effective engagement plan. This could lead to significant stakeholder fatigue and/or conflicting messages, ineffective planning by individual teams could also impact on other parts of the business who are providing support, or where there are critical project dependencies</td>
<td>Paul Reynolds</td>
<td>Unlikely</td>
<td>Likely</td>
<td>Likely</td>
<td>Low</td>
<td>Low</td>
<td>Discussed as an emerging risk and agreement to add to Corporate Risk Register</td>
<td>Yes</td>
<td>Low</td>
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</table>

#### Mitigation (for Threats)
- Teams are having regular discussions and meetings with HEE on strategic and operational levels
- Ongoing continuous improvement work to reduce the monitoring burden on HEE
- Resource restrictions are being taken into account within the Development of the Quality Assurance Cycle project (to begin in June)
- Surveys team provide support to HEE teams during NTS data validation, and survey operational phases
- Process for approving training post/programmes has been improved to reduce administrative burden on HEE teams
- Ongoing Shif Executive and Director of Education and Standards and HEE catch-ups
- Corporate risk to be reviewed following the review of HEE Wessex, which is planned for Q3 2018. This will be the first review since the new framework has been in place
- April 2018 - HEE planning to implement a central trainer/trainer database, which in theory will make data submissions to GRC (eg NTS, AREP, trainer recognition) less burdensome for local teams
- Cross-directorate programme board established to prepare for and implement the new legal duties
- Programme risk register established which is reviewed monthly at the Programme Board
- A monthly working group with the ‘Consent’ project leads to discuss progress, dependencies and emerging risks
- A monthly meeting with Work stream lead to discuss progress and emerging risks
- Regular monitoring of the public domain to catch all updates
- Government official identified and contact has been established
- GRC contributed to the GDRP consultation
- Completed engagement with S&C to develop a GDPR communications plan which will include Council and Directorate updates (November 2017)
- 2018 Business Planning review assumed direct consequences are capturing the resource requirements from their area that is needed for GCRP work (November 2017)
- Growth bids submitted and approved through the 2018 business planning process, approx 20 posts (December 2017)
- Agreed local arrangements to start recruitment process in 2017 to ensure posts are filled early in 2018 and minimise the time lag whilst new staff are inducted and trained
- Resourcing requirements have been submitted to HEE
- Quarterly business planning reviews to assess resource requirements
- Identifying roles where temporary cover could be obtained
- Engaging with HEE to identify key roles where priority needs to be given to recruitment
- Transition plan in place to cover work of AD Operations, Valits until a successful recruitment has been made
- Quarterly business planning reviews to assess the timetables for strategic priorities and what should be prioritised or deprioritised
- Monthly monitoring of recruitment through Education & Standards Senior Team (ESST) meetings
- Regular discussions with HR at ESST about shifting trends and recruitment

#### Assurance
- GDPR - Data Protection officer appointment (Dec-17)
- GDRP and Consent (Jan-18)
- Internal audit scheduled for Q1

#### Further Action
- Recruitment for posts underway, AD interviews were held end January Feb
- Transition arrangements in place for departure of AD Operations at end of Jan
- Engaging with EDRC to develop a GDRP communications plan which will include Council and Directorate updates (target date tbc)
- Using S&OP editorial board in a more strategic way – understanding what other products and their messages are coming up in the year
- Further detail on 2018 engagement activity for projects with stakeholder impact (Jan 2018)
- Communications and business planning process mapping exercise (Feb 2018)
### ACTIVE OPERATIONAL RISKS

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<tr>
<th>ID</th>
<th>Threat / Opportunity</th>
<th>Risk detail</th>
<th>Owner</th>
<th>Lead</th>
<th>Associated</th>
<th>Mitigation (for threats)</th>
<th>Enhancement (for opportunities)</th>
<th>Council and/or Board Review</th>
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<tbody>
<tr>
<td>AT12</td>
<td>Thread</td>
<td>Due to inadequate planning and management, the MLA project may not engage the right resource and capability at the right time, with a consequent impact on the programme's ability to deliver to the agreed timeline and budget</td>
<td>Colin Melville</td>
<td>Quite Likely</td>
<td>Minor</td>
<td>• Governance arrangements in place, a Programme Board chaired by the OOD providing oversight (and reporting to Council via Executive Board)</td>
<td></td>
<td></td>
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<td>Low</td>
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<tr>
<td>AT13</td>
<td>Threat</td>
<td>Due to lack of a clear and shared understanding of the programme’s aim, or ineffective communications, the MLA does not command the confidence and support of the public and stakeholders, which undermines its deliverability, with potential impact on patient safety and the reputation of the GMC</td>
<td>Colin Melville</td>
<td>Quite Likely</td>
<td>Minor</td>
<td>• A public consultation launched in January 2017 and closed in April 2017</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td>Low</td>
</tr>
<tr>
<td>AT14</td>
<td>Threat</td>
<td>In cases where there are high profile patient safety issues and potentially unsafe environments for doctors and doctors in training, there are challenges in working effectively and collaboratively with other regulatory partners causing an adverse reputational impact for the GMC</td>
<td>Susan Goldsmith</td>
<td>Quite Likely</td>
<td>Minor</td>
<td>• Information sharing agreement in place with CQC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Medium</td>
</tr>
<tr>
<td>AT15</td>
<td>Threat</td>
<td>Following the publication of the HEE workforce strategy (December 2017), the review references potential areas of work that may impact on the GMC’s resources and highlights areas of uncertainty that may impact on GMC policy development</td>
<td>Colin Melville</td>
<td>Quite Likely</td>
<td>Minor</td>
<td>• Response led by Education and Standards directorate and the new Strategy and Policy Development team (January 2018)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Low</td>
</tr>
<tr>
<td>AT16</td>
<td>Capacity</td>
<td>Due to the continuing increase in headcount there is the potential for us to hit space issues before we have time to acquire and/or reconfigure office space</td>
<td>Neil Roberts</td>
<td>Quite Likely</td>
<td>Minor</td>
<td>• Capacity statistics are monitored monthly</td>
<td>• Headcount forecasts produced by Finance are reviewed monthly</td>
<td>• Architects/property consultants HTS are engaged to carry out a more in-depth examination of how we use our accommodation</td>
<td></td>
<td></td>
<td>Medium</td>
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</table>
## INHERENT OPERATIONAL RISKS

<table>
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<th>Mitigation (for threats)</th>
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| IT1 | Threat | Application of key controls and processes lead us to reach the wrong conclusion in investigating a doctor’s fitness to practise with an impact on patient safety, registers, witnesses and/or the reputation of the GMC | Anthony Omo, Una Lane | Medium | Low | • Documented process and procedures:  
  - Regular performance monitoring and reporting  
  - Training and available staff (general)  
  - Employer Liaison Advisor (ELA) engagement with Responsible Officers (ROs) ensures all relevant information is considered during investigations  
  - ELA engagement with ROs to help identify and manage concerns (pre-investigation)  
  - Reform agenda to drive process improvements  
  - Employer controls help protect patient safety  
  - ReH - new BAU and expanded to include single clinical incidents, as more investigation undertaken earlier in the process. Nov 2017 – decision to be made to approve SICs as a BAU process and to consider adding of SICs - Single Clinical Concerns  
  - Notify Employer/Notify RO to place for less serious concerns, supporting local first initiative  
  - Documented process and procedures:  
  - Regular performance monitoring and reporting  
  - Training and available staff  
  - Local governance systems identify and address performance concerns  
  - Local quality assurance processes review the set up and operation of appraisals and revalidation recommendations  
  - Employer controls help protect patient safety  
  - Daily downloads of the register are sent to primary and secondary healthcare organisations  
  - Use of Royal colleges for clinical input into CEPD and CEFR applications | Operational KPIs reported each meeting  
  - RvP Annual Statistics Report (June 2016)  
  - Internal Audit  
  - Review of Legal Services (June 2017, green)  
  - Review of the use of independent expert witnesses in FTP activity (June 2017, green)  
  - Provisional enquiries (April 2017, green-yellow)  
  - Implementation of Section 60 requirements (March 2016, green)  
  - Significant | No | Medium |
| IT2 | Threat | We register an individual who is not properly qualified and/or fit to practice with an impact on patient safety and our reputation | Una Lane | Low | Low | • Documented process and procedures:  
  - UK graduates  
  - EEA  
  - HMG  
  - Specialist and GP applications  
  - Identity and document checks face to face and physical document checks  
  - Post-registration primary source verification conducted on a risk based sample of newly registered doctors  
  - Revised Decision maker’s guidance (launched 2016)  
  - Regular performance monitoring and reporting  
  - Training and available staff  
  - Information exchange with competent authorities informs our processes (including Internal Market Information alert mechanisms)  
  - Daily downloads of the register are sent to primary and secondary healthcare organisations  
  - Use of Royal colleges for clinical input into CEPD and CEFR applications | Operational KPIs reported each meeting  
  - RvP Annual Statistics Report (June 2016)  
  - Internal Audit  
  - Review of Registration Appeals (November 2016, green)  
  - Review of the adoption of changes arising from the new WIG directive audit (November 2016, green-yellow)  
  - Adoption of Recognition Professional Qualification (October 2015, green)  
  - UK Graduate Application (May 2015, green)  
  - Practical testing (November 2015)  
  - Training programme for decision makers at the end of the investigation stage (September 2017)  
  - Radiation and disclosure - revised written policy (January 2016)  
  - Other Assurance  
  - Professional Standards Authority (PSA) Performance Review 2016/17 Standards of good regulation met | No | Low |
| IT3 | Threat | We revalidate an individual who is not fit to practice with an impact on patient safety and our reputation | Una Lane | Moderate | Medium | • Documented process and procedures:  
  - Regular performance monitoring and reporting  
  - Training and available staff  
  - Support and guidance for Responsible Officers making recommendations through the Employer Liaison Service  
  - Work ongoing as part of the Tackling Revalidation Forward programme to refine the protocols for those making RO recommendations, making our advice clearer | Operational KPIs reported each meeting  
  - RvP Annual Statistics Report (June 2016)  
  - Internal Audit  
  - Review of Legal Services (June 2017, green)  
  - Professional Standards Authority (PSA) Performance Review 2016/17 Standards of good regulation met | No | Low |

### Risk appetite
- **Low**: We are developing a system of enhanced pre-registration primary source verification checks - due to launch in June 2018.
- **Medium**: We are revising our criteria for Section 19 and Section 21B applications. The new criteria will launch in April 2018.
- **High**: Shaping the future of medical education and practice criteria for Section 19 and Section 21B (June 2016).

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<table>
<thead>
<tr>
<th>ID</th>
<th>Threat</th>
<th>Risk detail</th>
<th>Owner</th>
<th>Likelihood</th>
<th>Impact</th>
<th>Mitigation (for threat)</th>
<th>Residual risk with control in place</th>
<th>Council and Board Review</th>
<th>Assurance</th>
<th>Further Action required?</th>
<th>Further action detail</th>
<th>Risk appetite</th>
</tr>
</thead>
<tbody>
<tr>
<td>IT4</td>
<td>Threat</td>
<td>Our quality assurance processes do not support compliance with standards for education, training and curricula, with a potential impact on patient outcomes for doctors</td>
<td>Colin Melville</td>
<td>Quite Likely</td>
<td>Moderate</td>
<td>Documented process and procedures to investigate and monitor concerns</td>
<td>Yes</td>
<td>Regional QA visit review – phase 2 (September 2016, green-amber)</td>
<td>Low</td>
<td>No</td>
<td></td>
<td>Medium</td>
</tr>
<tr>
<td>IT5</td>
<td>Threat</td>
<td>Low awareness and use of our ethical guidance by doctors affects the impact on raising standards of medical practice with a consequent impact on patient care</td>
<td>Colin Melville</td>
<td>Low</td>
<td>Low</td>
<td>Internal oversight group</td>
<td>No</td>
<td>Professional Standards Authority (PSA) Performance Review 2016/17 Standards of good regulation met</td>
<td>Low</td>
<td>No</td>
<td></td>
<td>Low</td>
</tr>
<tr>
<td>IT6</td>
<td>Threat</td>
<td>Patient safety is impacted and/or reputational damage is caused by not providing an effective and timely adjudication process</td>
<td>Gavin Brown</td>
<td>Major</td>
<td>Low</td>
<td>Documented process and procedures (Adjudication Manual)</td>
<td>No</td>
<td>Annual tracking survey 2016 and 2017 indicated good awareness of our guidance</td>
<td>Low</td>
<td>No</td>
<td></td>
<td>Low</td>
</tr>
<tr>
<td>IT7</td>
<td>Threat</td>
<td>Doctors under conditions of suspension and patients are treated as a consequence</td>
<td>Anthony Ono</td>
<td>Major</td>
<td>Low</td>
<td>Case Review Team - documented processes and skilled resources</td>
<td>No</td>
<td>Adoption of new Standards in a regional QA visit review – phase 2 (September 2016, green-amber)</td>
<td>Low</td>
<td>No</td>
<td></td>
<td>Low</td>
</tr>
<tr>
<td>ID</td>
<td>Threat</td>
<td>Mitigation</td>
<td>Further Action</td>
<td>Risk appetite</td>
<td></td>
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</tbody>
</table>

### IT8 Threat
- **Description**: Our response to emerging risks is unlikely or inappropriate enabling a perception or ineffective performance.
- **Owner**: Paul Buckley
- **Likelihood**: High to Likely
- **Impact**: Minor

#### Inherent Operational Risks
- **Assurance**:
  - Compliance with applicable laws and regulations.
  - Regular internal audits.
- **Monitoring**:
  - Monthly performance reviews.
  - Quarterly executive board reviews.
- **Mitigation**:
  - Development of a response plan.
  - Regular training exercises.

#### Control Objectives
- **Mitigation**:
  - Development of a response plan.
  - Regular training exercises.

#### Risk Pre-controls
- **Mitigation**:
  - Development of a response plan.
  - Regular training exercises.

#### Residual Risk with Control Objectives
- **Mitigation**:
  - Development of a response plan.
  - Regular training exercises.

### IT9 Threat
- **Description**: The flow of information between the GMC and other bodies who contribute to our overall impact in protecting patient safety is limited and harm is consequently caused to patients.
- **Owner**: Paul Buckley
- **Likelihood**: Low to Likely
- **Impact**: Minor

#### Inherent Operational Risks
- **Assurance**:
  - Regular internal audits.
  - Regular external audits.
- **Monitoring**:
  - Monthly performance reviews.
  - Quarterly executive board reviews.
- **Mitigation**:
  - Development of a response plan.
  - Regular training exercises.

#### Control Objectives
- **Mitigation**:
  - Development of a response plan.
  - Regular training exercises.

#### Risk Pre-controls
- **Mitigation**:
  - Development of a response plan.
  - Regular training exercises.

#### Residual Risk with Control Objectives
- **Mitigation**:
  - Development of a response plan.
  - Regular training exercises.

### IT10 Threat
- **Description**: Breach of the Data Protection Act (DPA) and/or Human Rights Act (HRA) may result in financial loss and/or reputational damage.
- **Owner**: Neil Roberts
- **Likelihood**: High to Likely
- **Impact**: Minor

#### Inherent Operational Risks
- **Assurance**:
  - Regular internal audits.
  - Regular external audits.
- **Monitoring**:
  - Monthly performance reviews.
  - Quarterly executive board reviews.
- **Mitigation**:
  - Development of a response plan.
  - Regular training exercises.

#### Control Objectives
- **Mitigation**:
  - Development of a response plan.
  - Regular training exercises.

#### Risk Pre-controls
- **Mitigation**:
  - Development of a response plan.
  - Regular training exercises.

#### Residual Risk with Control Objectives
- **Mitigation**:
  - Development of a response plan.
  - Regular training exercises.
## INHERENT OPERATIONAL RISKS

### IT1 Threat

<table>
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<tr>
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</tr>
</thead>
<tbody>
<tr>
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<td>Ongoing engagement with Department of Health (England); NHS England, Health Education England, other National bodies, the regulator upholding professional standards for doctors and trainees and create operational pressures on fitness to practise referrals and education monitoring services</td>
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<tr>
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<tr>
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<td>Moderate</td>
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### IT2 Threat

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<tr>
<th>Risk pre-controls</th>
<th>Residual risk with controls</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Governance arrangements in place including Council, executive and external engagement and in relation to GMC Services International Ltd</td>
<td>Low</td>
<td>No</td>
</tr>
<tr>
<td>Performance management system for members and staff</td>
<td>Low</td>
<td>No</td>
</tr>
<tr>
<td>Business planning &amp; budget setting process</td>
<td>Moderate</td>
<td>No</td>
</tr>
<tr>
<td>Risk Management Framework</td>
<td>Low</td>
<td>No</td>
</tr>
<tr>
<td>Performance monitoring &amp; reporting</td>
<td>Low</td>
<td>No</td>
</tr>
<tr>
<td>Policies and procedures</td>
<td>Low</td>
<td>No</td>
</tr>
<tr>
<td>Internal audit</td>
<td>Low</td>
<td>No</td>
</tr>
<tr>
<td>Council member training and annual appraisal in place</td>
<td>Low</td>
<td>No</td>
</tr>
<tr>
<td>Regular governance reviews</td>
<td>Low</td>
<td>No</td>
</tr>
<tr>
<td>Governance and Council effectiveness review - independent report on governance framework received and discussed by Council in November 2017. Follow up paper to Council due in December 2017</td>
<td>Low</td>
<td>No</td>
</tr>
<tr>
<td>4-yearly review of the Schedule of Authority due for Council sign off in December 2017</td>
<td>Low</td>
<td>No</td>
</tr>
</tbody>
</table>

### IT3 Threat

<table>
<thead>
<tr>
<th>Risk pre-controls</th>
<th>Residual risk with controls</th>
<th>Further action required?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Business planning &amp; budget setting process to ensure funds are allocated appropriately</td>
<td>Low</td>
<td>No</td>
</tr>
<tr>
<td>Monthly management reporting and review</td>
<td>Low</td>
<td>No</td>
</tr>
<tr>
<td>Financial Regulations and financial controls including delegated authorities by the Executive Board</td>
<td>Low</td>
<td>No</td>
</tr>
<tr>
<td>Fraud control processes including policy, training, response plan, public interest disclosure policy and anti-fraud and corruption policy</td>
<td>Low</td>
<td>No</td>
</tr>
<tr>
<td>Gifts and hospitality policy</td>
<td>Low</td>
<td>No</td>
</tr>
<tr>
<td>Oversight of Investment Policy by Investment Sub Committee</td>
<td>Low</td>
<td>No</td>
</tr>
<tr>
<td>Anti-Fraud mandatory training launched (Oct 17)</td>
<td>Low</td>
<td>No</td>
</tr>
<tr>
<td>Training to support procurement processes include sourcing, Purchasing (e-learning) and Contract Management</td>
<td>Low</td>
<td>No</td>
</tr>
</tbody>
</table>

### IT4 Threat

<table>
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<tr>
<th>Risk pre-controls</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Internal audit</td>
<td>Low</td>
<td>No</td>
</tr>
<tr>
<td>Social media spot check (June 2017, green)</td>
<td>Low</td>
<td>No</td>
</tr>
<tr>
<td>Writing with impact and tone of voice (July 2016, green)</td>
<td>Low</td>
<td>No</td>
</tr>
</tbody>
</table>

### Other Assurance

<table>
<thead>
<tr>
<th>Risk pre-controls</th>
<th>Residual risk with controls</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Fitness to Practise performance against Service Level Agreement (SLA) reported to Council</td>
<td>Low</td>
<td>No</td>
</tr>
<tr>
<td>Media performance reviewed at each Council meeting</td>
<td>Low</td>
<td>No</td>
</tr>
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<td>Regular governance reviews</td>
<td>Low</td>
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<td>Unlikely</td>
<td>No</td>
</tr>
<tr>
<td>ID</td>
<td>Threat / Opportunity</td>
<td>Risk detail</td>
</tr>
<tr>
<td>----</td>
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</tr>
<tr>
<td>IT15</td>
<td>Threat</td>
<td>The volume and complexity of the programme of work we seek to undertake exceeds our capacity to successfully deliver</td>
</tr>
<tr>
<td>IT16</td>
<td>Threat</td>
<td>An external incident, including a cyber attack, which affects our infrastructure, security systems and/or delivering our key functions</td>
</tr>
<tr>
<td>IT17</td>
<td>Threat</td>
<td>Adverse economic events create a significant deficit in the Defined Benefit (DB) Scheme which the employer needs to cover</td>
</tr>
<tr>
<td>IT18</td>
<td>Threat</td>
<td>Due to operating a global trading subsidiary, there is a risk GMCSI activities create reputational harm which may impact on our charitable mission and our ability to effectively deliver some aspects of core regulatory services</td>
</tr>
</tbody>
</table>
Executive summary

On 8 February 2018, the Professional Standards Authority (PSA) published their Annual Review of Performance 2016-2017 for the GMC. The report confirms that we have met all of the PSA’s 24 Standards of Good Regulation for this performance review period, and sets out how this conclusion has been reached. This paper considers the findings of the report, which focusses on provisional enquiries, fitness to practise timeframes and GMC appeals, to see what learning can be applied.

Recommendations

Council is asked to consider:

a The PSA’s report on our performance for the 2016-17 performance review period, which concludes that we have met all of their Standards of Good Regulation.

b How we will take forward learning and continue to provide assurance on how we meet the PSA’s Standards of Good Regulation.
The PSA’s annual review of our performance for 2016/17

Background

1 The Professional Standards Authority (PSA) for Health and Social Care is an independent body accountable to the UK Parliament that oversees the work of the GMC, and the other eight bodies that regulate health professionals in the UK and social workers in England. As part of their work to review regulators’ performance and check whether people on their registers are fit to practise, the PSA undertake an annual ‘performance review’ against their Standards of Good Regulation.

The performance review process and outcome

2 The final report (Annual Review of Performance 2016-2017) was published on 8 February 2018. It sets out the PSA’s assessment of our performance, for the period 1 April 2016 to 31 August 2017. During the review, the PSA considered a range of information including Council papers, policy and guidance documents, a statistical performance dataset we provide throughout the year, third party feedback, and a check of the Register.

3 After considering this evidence, the PSA determined that a further ‘targeted review’ was needed in order to reach a conclusion against the following Fitness to Practise Standards:

   ■ Standard 1 - Anybody can raise a concern, including the regulator, about the fitness to practise of a registrant.

   ■ Standard 3 - Where necessary, the regulator will determine if there is a case to answer and if so, whether the registrant’s fitness to practise is impaired or, where appropriate, direct the person to another relevant organisation.

   ■ Standard 6 – Fitness to practise cases are dealt with as quickly as possible taking into account the complexity and type of case and the conduct of both sides. Delays do not result in harm or potential harm to patients and service users. Where necessary the regulator protects the public by means of interim orders.

   ■ Standard 7 - All parties to a fitness to practise case are kept updated on the progress of their case and supported to participate effectively in the process.

4 Following our submission of additional information and evidence on our provisional enquiry (PE) process, timeliness of case and progression and support for vulnerable

* A targeted review involves the PSA examining our performance against specific standards in more detail – Performance Review Process

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Council meeting, 24 April 2018  

Agenda item M5 – The PSA’s annual review of our performance for 2016/17

witnesses, on 4 December 2017 we received notification from the PSA that we had met Fitness to Practise Standards one, three, six and seven.

5 We welcome the finding from the PSA that we met all of their 24 Standards of Good Regulation. The report draws attention to several aspects of our work to continually improve our processes and relevance. This includes new initiatives such as our work to reform medical education through streamlining standards for education providers and prioritising themes such as patient safety, team working and other fundamental aspects of professional behaviour and practice, through our new standards for curricula. It also highlights development of the Medical Licensing Assessment (MLA) and our independent review of revalidation, *Taking Revalidation Forward.*

Areas of note and things to reflect on in the report

6 The Report provides a useful reflection of our performance over the 2016-17 review period. As part of the review process this year a number of colleagues were involved in meetings and workshops to help the PSA better understand the context in which we work, particularly in relation to fitness to practise and registration processes. We appreciate the time taken by the PSA to meet with us, in particular during the targeted review stage.

7 It is important that we continue to learn and to improve, and we set out below the key areas that we have reflected on from the Report.

Provisional enquiry (PE) process

8 The PSA decided to carry out a targeted review of our performance against Standard one (FtP) and requested further information to better understand our PE process and its impact on fitness to practise. We met with the PSA on 16 October 2017 to explain the process in more detail and in particular how decisions are made, the guidance available to staff making those decisions, as well as how PE decisions are quality assured. We also provided the PSA with the audit report on the PE process, which was conducted by Moore Stephens in May 2017.

9 The report notes the significant impact the PE process is having on the number of cases referred for investigation. In particular paragraph 6.21 highlights that if we had not introduced the PE process in 2016, 1,912 cases would have been referred for full investigation rather than 1,460 cases.

10 The PSA were satisfied with how the GMC quality assures the decisions made at the PE stage, highlighting that the PE process is proportionate, allowing us to successfully identify and close cases which do not require regulatory action at the early stages of the fitness to practise procedure. The report also comments that the information we provided on our PE process provides assurance that public protection is not being compromised in any way.
During 2018 we will be exploring other types of cases where PE might be appropriate and could add value. Any further expansion of PE will include a pilot phase which will include significant oversight of decisions and the development of appropriate safeguards to ensure effective decision making through our quality assurance and audit processes.

**Timeliness of our fitness to practise processes**

This year the PSA remained concerned about the timeliness of our fitness to practise processes. They decided to carry out a targeted review of our performance against Standard six because the data we provided demonstrated that the median times in each of their three key timeliness indicators – from receipt of complaint to final fitness to practise decision; from investigating committee decision to final fitness to practise decision; and from receipt of initial complaint to final investigating committee decision – had continued to increase during the reporting period of 2016/17.

The report notes at paragraph 6.46 that the number of older cases continued to decrease during the reporting period of 2016/17 which has an impact on the overall median closure times, but at paragraph 6.52, there appears to be an assumption that we should be improving our timeliness, and an implied criticism that we have not provided the PSA with an action plan to improve our timeliness. This does not reflect some of the issues we have highlighted previously regarding complexity and third party delays.

The report does however conclude that as the reduction of older cases is a positive indicator, which is balanced against the PSA concerns about our median timeframes. Although the median timeframes are lengthy, the progress we have made in reducing the number of older cases was sufficient for us to meet this Standard during 2016/17.

We currently have a number of measures in place to monitor and improve where possible the timeliness of casework. Our extensive review of individual cases includes, reviews by managers, the senior management team and Director. We have had significant success using this method to reduce our older cases, and will continue this extensive monitoring of individual cases in 2018.

**2017-18 performance review**

We will continue to provide detailed information on our fitness to practise caseload and registration processes through the PSA’s quarterly dataset, and additional commentary in order to be as open and transparent as possible. After consultation with all the regulators last summer, the PSA have now produced a revised dataset which includes additional questions in relation to fitness to practise.

The PSA are currently developing a revised set of standards with which to measure regulators performance against and plan to consult with each of the regulators and other stakeholders during the summer of 2018. We met with the PSA on 6 March 2018 to discuss our initial thoughts on the proposed changes to the Standards and will be responding to the public consultation which is expected to launch in May 2018.
Executive summary
In common with similar organisations and the majority of other regulators, we have historically demonstrated strategic progress by measuring our success in undertaking activities. Our new 2018-2020 Corporate Strategy presents an opportunity for us to monitor the actual benefits that accrue from our work, so that we can:

- Demonstrate to wider stakeholders how we are contributing to patient safety by supporting doctors to deliver good standards of healthcare.
- Adjust our delivery approach if measures indicate that our actions are not having the desired effect.

This means we need to focus our planning, monitoring and evaluation around the positive changes we want to make towards patient and doctor safety. A benefits-first approach provides a way to better understand the impact of our work and contribution to the wider healthcare system. This in turn will allow us to better plan, prioritise and monitor our work to fulfil our strategic goals.

Recommendations:
Council is asked to:

a  Note the approach taken to developing a benefits model for the GMC, which provides a framework for understanding how we can maximise our impact on patient and doctor safety in the wider healthcare system.

b  Consider how we plan to report against the Corporate Strategy, so that Council can hold the Executive to account for delivery of these benefits.
Issue

1 Our reporting on strategic progress has to date focused on tracking the delivery of activities linked to our strategic aims. This approach hasn’t always allowed us to clearly see where we are delivering the actual benefits that accrue from our work. Our new, ambitious 2018-2020 Corporate Strategy (the Strategy) presents an opportunity to report more on outcomes and impact, through delivery of benefits. Our stakeholders will have a keen interest in how we demonstrate impact. This will also help the Executive, and Council who holds the Executive to account for implementation of the Strategy, to better understand how our day to day activities are contributing to patient safety.

What is a benefits-led approach and how will it benefit the GMC?

2 Understanding the benefits we want to deliver, and thinking of these first when we are implementing our Strategy, is a significant shift in approach that will allow us to bring our impact to life.

3 In the context of this report, a benefit is a measurable improvement which is perceived as positive by one or more stakeholder groups. The Association for Project Management (APM) defines benefits management as: ‘The identification, definition, planning, tracking and realisation of business benefits.’ We believe this provides the right framework to demonstrate our impact.

4 Benefits can help us articulate the positive changes we want to make. By becoming benefits-led in our implementation of the Strategy we will be using our resources to better effect, and be more confident in the impact we are making. This applies both to day to day activities, and how we carry out our core statutory functions; and longer-term, strategic investment programmes such as the Medical Licensing Assessment. It is part of an approach rooted in continuous impact assessment, where we are alive to the changes we are making, and the needs of our stakeholders.

5 This will be a new way of working for the GMC. Our Change Programme, which completed in 2017, is an example of where we have successfully realised financial benefits. However, an internal audit undertaken on benefits realisation within the Change Programme in 2016 found that, in common with other public sector organisations, we are less mature in our approach to managing non-financial benefits. Often described as ‘intangible benefits’, they are more challenging to identify and measure, because their impact cannot be directly quantified.

6 Many of the benefits set out in our 2018-2020 Corporate Strategy are ‘intangible’. Our goal of supporting doctors to have a fulfilling and sustained career, for example, will be difficult to evidence directly. There will be a wide range of factors which contribute to doctors’ experience of their career, including many beyond our immediate control, such as availability of funding. The National Audit Office’s good practice guide,
Performance measurement by regulators, acknowledges the challenge for regulators of attributing change directly to their work.

7 However, this should not prevent us from taking steps, both as an individual organisation and in partnership with others, which will make a positive difference to patient and doctor safety. This approach fits well with research and regulatory theory about how organisations such as the GMC can aim for public benefit. There will be a challenge in terms of introducing a new cultural mind set. However, we have already laid some of the ground work for this through our Transformation Programme, which seeks to make us more responsive and impactful.

8 Annex A shows how a benefits-led approach would work in practice. We have previously reported on activities to deliver against objectives such as ‘understand the context in which doctors practise’, by showing our delivery against the projects that were linked to these objectives. However, we didn’t routinely report against the actual benefit to doctors that this would bring.

9 With our new approach, objectives are described in terms of the benefit they bring, for example ‘regulatory model and interventions are relevant, effective, appropriate, and better meet the needs of the four countries.’ We will make use of a range of indicators to demonstrate whether the activities designed to realise this benefit are working as intended. This will make our reporting to Council more insightful in terms of impact. They will also help us to signpost what is coming next and when, during the implementation of a change. More detail on measurements is set out from paragraph 13.

The benefits model applied to our 2018-2020 Corporate Strategy

10 The actual benefits model which we have developed to implement our Strategy, as shown below, has been informed by current best practice and learning from other public sector organisations.

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*Performance measurement by regulators*, National Audit Office, November 2016

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The benefits model has been applied to our four strategic aims. This has allowed us to identify the specific benefits we want to achieve, the outcomes that we expect to see, the capabilities that will be needed, and the projects and changes to our business as usual (BAU) already underway to deliver these benefits in the 2018 business plan. We have sought input from colleagues from a broad range of teams to ensure that we consider the delivery of our core statutory functions as well as major ‘strategic’ projects and programmes such as the Medical Licensing Assessment (MLA). An example of how it has been applied is shown below.

A benefits-led approach will enable us to successfully implement our Strategy as we will be able to:

a) Improve prioritisation of our projects and Business As Usual (BAU) changes, by comparing the value of the benefits we want to achieve, with available resource.

b) Monitor whether planned activities are on track to realise expected benefits, and adjust our delivery approach as needed, making us more responsive and agile.

c) Evaluate the impact of our work in a more structured way, against a clearer baseline and using measurements which align with the benefits we set out to achieve.

d) Use learning from our evaluation of activities to inform future interventions in a more systematic way.

Measuring benefits realisation and impact on stakeholders

We will still need to report on delivery of the activities that underpin our Strategy, and some of these will be useful ‘lead’ indicators. These are measures that ‘lead’ to attainment of an outcome. Monitoring lead measures help to provide an early warning where performance is deviating from the plan. Monitoring lead measures help to provide an early warning where performance is deviating from the plan.

However to really understand and demonstrate our impact to patient and doctor safety, as part of the wider healthcare system, we will need to make use of a wider
range of impact measures. Described as ‘Lag’ indicators, these reflect the impact of something that has already occurred.

15 We will develop, and monitor, lead and lag indicators for benefits to inform our management and oversight of activities. In many cases, we will need to use proxy measures. A proxy is an indirect measure of the desired outcome or benefit, linked to the outcome. Measuring the quality of a doctor’s practice through patient satisfaction, in conjunction with other measures, is one example.

16 In many cases, the full impact of the benefits will be realised beyond the lifetime of the Strategy. We already measure the impact of some of our longer-term interventions, and Annex B gives examples of large-scale evaluations the GMC has recently undertaken. These show that to give meaningful information, the method of measurement needs to be carefully selected. Evaluation can be extremely costly, and we need to be sure that it will give meaningful information about our impact, which we can use to inform future interventions. We will also need to make sure our measurements are well co-ordinated, so that we can guard against survey fatigue.

17 The measures chosen need to be those which we think will give the most valuable insights into our impact, balanced against the need to minimise any further regulatory burden to our stakeholders, and the time and cost to develop and implement. Measurements will also need to be interpreted carefully and with understanding that in many cases, we will be unable to attribute changes we see over time directly to our individual work.

Next steps

18 We are now planning to develop the success measures for key benefits, and to establish a baseline. We are considering how some of the measures could be used to enhance the evidence based of the GMC Impact Report in future years.

19 The gaps identified in our current strategic delivery plans will be prioritised in 2019 business planning. A Benefits Management Framework will be drafted to guide staff in taking this approach. Training and documentation to support the implementation of the Framework will be developed and will be rolled out to support staff in adopting a benefits-first approach.
M6 - Annex A
Developing the benefits model

Working with doctors Working for patients
Reporting on strategic progress

Reporting against our 2014-17 Corporate Strategy focused on delivery of activities:

We will shift to measuring our impact using benefits, lead and lag indicators in the new approach against our 2018-2020 Corporate Strategy:

<table>
<thead>
<tr>
<th>Key benefit</th>
<th>Activities to deliver (by exception)</th>
<th>Lead indicators</th>
<th>Lag indicators*</th>
<th>Exception commentary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulatory model and interventions are relevant, effective, appropriate, and better meet the needs of the four UK countries</td>
<td>Field forces</td>
<td>Progress towards field forces being aligned</td>
<td>Speed of response based on field force intelligence improved</td>
<td>Commentary provided on any exception in delivery, or adverse indicator.</td>
</tr>
</tbody>
</table>
Measuring our impact

Below is an example of how we are developing our methodology to measure key strategic benefits:

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Lead indicators</th>
<th>Lag indicators</th>
<th>Measurement methodology</th>
</tr>
</thead>
</table>
| Regulatory model and interventions are relevant, effective, appropriate, and better meet the needs for the four UK countries. | Progress towards understanding issues/complaints from legislative issues, and toward what specific legislative changes GMC needs (if any) to regulate effectively | Appropriate handling approaches developed and in place                          | • Handling plan signed off  
• Legislation assessment signed off  
• Complaints data analysis                                                  |
| Progress toward data analysis and publication created at country level/with four country context                                          |                                                                                                       | • Devolved Office (DO) feedback shows improved satisfaction with service  
• Stakeholder feedback reports improved view of GMC information and communication | • Survey and interviews                                                                 |
| Level of four-country context accounted for in decision making                                                                          |                                                                                                       | • DO feedback shows increased engagement internally  
• Project and programme board documentation shows consideration given         | • Interview with DOs  
• Project and board paper analysis  
• Interview with project managers and Senior Responsible Owners                |
| Progress towards field forces being re-aligned                                                                                        |                                                                                                       | • # tailored/localised interventions  
• Influence of field forces and GMC increased  
• Speed of response based on field force intelligence improved  
• Reputation and perceptions improved                                         | • KPI/count  
• Internal survey/project outcomes  
• KPI/actions from Joint Working Intelligence Groups (JWIGs)  
• Stakeholder survey                                                         |
Refining the benefits maps

We have developed detailed ‘benefits maps’ for each Strategic Aim. These have been used to identify appropriate indicators, and the key benefits which we will regularly report on progress against to Council.

- Detailed maps for each Strategic aim showing benefits, capabilities, outputs, outcomes, projects and indicative measures
- For use by the organisation to monitor progress against all benefits identified
- Detail of ‘lead’ and ‘lag’ indicators and for indicative success measures for each key benefit
- Reporting on key benefits by exception to Executive Board and Council
The diagram below shows the key benefits of the 2018-2020 Corporate Strategy.

1. Supporting doctors in delivering good medical practice
   - Doctors are supported to deliver high quality care
   - Doctors have a fulfilling/sustained career
   - Enhanced trust in our role
   - Increased confidence in the quality of training environments
   - Improved identification of risk

2. Strengthening collaboration with regulatory partners.
   - Reduced regulatory burden
   - Right response by the right organisation, at the right time
   - Enhanced perception of regulation

3. Strengthening our relationship with the public and the profession
   - Public confidence in GMC
   - Enhanced customer service
   - Contribute to public confidence in doctors

4. Meeting the change needs of the health services across the four countries of the UK
   - UK workforce needs better met
   - Regulatory model and interventions are relevant, effective, appropriate, and better meet the needs of the four UK countries
   - We are well prepared for and can influence legislative change
Glossary of terms used in benefits management

- **Benefit** - the measurable improvement from change, which is perceived as positive by one or more stakeholders and which contributes to organisational objectives. E.g. money saved, improved customer satisfaction, increased revenue, reduced risk etc.

- **Benefits management** - the identification, quantification, analysis, planning, tracking, realisation and optimisation of benefits.

- **Benefits map** - mapping exercise to identify the outputs, capabilities, outcomes and benefits for a project or strategic aim.

- **Direct benefits** - benefits which we can directly influence.

- **Intangible benefits** - subjective benefits that cannot be measured in monetary terms.

- **Lag indicator** - Measures that ‘lag’ the change and which reflect the impact of something that has already occurred.

- **Lead indicator** - Measures that ‘lead’ to attainment of an outcome. Monitoring lead measures help to provide an early warning where performance is deviating from the plan.

- **Proxy-indicators** - An indirect measure of the desired outcome which is itself strongly correlated to that outcome. Commonly used when direct measures of the outcome are unobservable / unavailable.

- **Tangible benefits** - benefits that can be quantified in terms of time and money

- **Wider benefits** - benefits in the wider healthcare system which will be influenced by factors beyond our control, but which we can contribute towards through achievement of direct benefits.
Evaluation case studies

1 This annex gives a brief overview of two large scale evaluations of individual programmes the GMC has recently commissioned. This brief overview, together with some general reflections, should provide some useful context when considering the GMC’s approach to measuring impact.

Case Study 1 - Duties of a Doctor (DoaD) Evaluation

2 This research aims to evaluate the impact of the duties of a doctor (DoaD) programme - a professional support programme developed and run by the regional liaison service (RLS). The programme aims to promote professional development by enhancing doctors’ confidence and capabilities in dealing with common professional dilemmas and increasing doctors’ awareness of GMC guidance through face-to-face sessions with a regional liaison adviser.

3 The ultimate aim of the DoaD programme is to enhance doctors’ long term behaviours, by providing additional guidance on standards and professional conduct in a UK context. It is hoped that by changing their behaviours, doctors will be clearer about what professional expectations of them are and so, among other benefits, less likely to be referred to the GMC in the future.

4 The evaluation, commissioned from researchers at University College London, consists of two phases. Phase 1, a qualitative phase, involved interviewing members of the RLS, interviewing doctors who have taken part in DoaD and also observing some of the DoaD sessions. Phase 2, a quantitative phase, involves all of the doctors who take part in DoaD completing three questionnaires; before the first session, directly after the final session and three months after the completion of the final session.

5 Phase 1 is completed, while phase 2 of the research is ongoing, with final results expected in May 2019.
Case Study 2 - Welcome to UK Practice

6 This research aims to evaluate the Welcome to UK Practice (WtUKP) programme. WtUKP is a free half-day training workshop and online self-assessment tool to help doctors new to practice, or new to the UK, to understand the ethical issues that will affect them and their patients on a day to day basis. The project was commissioned after the DoaD evaluation, so where possible key learnings were taken forward.

7 The evaluation, commissioned from researchers at Newcastle University, has two key objectives. Firstly, to develop our evidence base of the short and long term impact of WtUKP on participants and their practice. Secondly, to identify ways of improving the content and delivery of WtUKP. Through this we are seeking to answer the question, how effective is the WtUKP programme in preparing overseas qualified doctors for UK practice?

8 The evaluation is a mixed-methods design. WtUKP attendees will complete surveys before the workshop, straight after the workshop and then again after three months. This will include a set of scenario based questions to attempt to objectively test changes in the attendees’ knowledge and understanding of key areas of ethical practice covered in WtUKP.

9 The qualitative elements of the evaluation will be extremely important in helping us to understand how and why any changes have occurred, and the extent to which these can be attributed to WtUKP. We will conduct focus groups after selected workshops, as well as telephone interviews with a sample of attendees at the three month follow-up stage. We also plan to consult with two other groups: supervisors of attendees, and those who signed up but could not attend on the day.

10 Evaluation activities will be taking place in WtUKP workshops up until mid-April 2018, data-collection will then continue until the end of July 2018. An interim report is planned to be delivered at the end of April 2018, with final results due in October 2018.

General learning

11 Any evaluation needs to be proportionate for instance to its goals/objectives, the audience for findings the scale of the intervention and the available resources and needs to be designed accordingly. For example, small scale evaluations can often be done internally by the GMC. However, it is potentially more appropriate to consider using an independent external organisation for larger scale and/or more complex projects, such as in case of the above projects. External suppliers will have dedicated resources and specialist expertise. It is also important that evaluations are seen as credible. If the results are going to be published externally commissioning a supplier can enhance the perceived credibility of the findings due to the supplier’s independence from the GMC.

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12 However, the above projects have demonstrated that the use of external agencies/academics can be expensive, especially for large scale, multistage projects so this does need to be considered.

13 Establishing causal links is important in evaluations. However, it is also important to be realistic regarding undertaking evaluations of real world interventions. It is not always possible to carry out interventions that are appropriate for laboratory style random control trial (RCT) forms of evaluation, which are widely seen as the gold standard. Often, a more feasible approach would be to use a comparator group (i.e. a non-intervention group that is similar to the intervention group, but not identical, as would be the case for a control group in an RCT). While still robust, using comparator groups is usually more feasible in a real world context. This was found to be the case with the DoaD evaluation.

14 It is also important to consider that measuring the impact of an intervention is often challenging. There can often be multiple direct, indirect and proxy measures that might be used for any phenomenon. The most desirable measure, e.g. direct observation of practice, may be unethical or unfeasible so an alternative, e.g. a questionnaire about behaviour change might be used instead. These different types of measures can work together, so in the above case several indirect measures might be used to triangulate results, e.g. a questionnaire, follow up interviews with the doctor involved in the intervention and feedback from one of their colleagues instead of direct observation.

15 Depending on what is being evaluated, evaluations may need to run for long periods of time – for instance when investigating if an intention to change is translated into actual change or if change is sustained. This can take from several months to several years. It’s important to factor this into planning. It’s also important to allow time for the tendering of external institutions if an evaluation is being commissioned.

16 While an externally contracted organisation will carry out the majority of the work it’s important to allocate sufficient internal resources to support this. Even externally commissioned projects can require considerable internal resources, e.g. arranging for data to be shared, providing input on evaluation instruments, administrative tasks etc.

17 It is important to be realistic when planning evaluations and to make considered projections about timescales. Delays can be common, for a variety of reasons, so it is important to have a continuity plan.

18 It is also incredibly important to try to plan the evaluation as you are planning the intervention. In this way, where necessary, small changes can be made to the intervention that will enable the evaluation to work more effectively.

19 There may be circumstances where learnings from an evaluation can be applied prior to the evaluation finishing. This is often possible as evaluations commonly have one or more interim reporting points and often they will look at processes as well as outcomes. For example, on the DoaD evaluation it was very apparent from phase 1
that peer networks were not being formed as anticipated; there was no need for phase 2 to confirm this. However, caution must be taken when acting on interim findings and this should only be done when the evidence is sufficiently robust.
Executive summary
The Investment Sub-Committee is required by its Statement of Purpose to report annually to Council on its activities. This report outlines the Investment Sub-Committee’s work since its last report to Council on 23 February 2017.

In 2017 the Sub-Committee engaged an external professional adviser to undertake a review of investment arrangements. This report provides a summary of the recommendations of this review and outlines the action taken by the Sub-Committee to date in response.

The Sub-Committee also uses its annual report to review the Investment Policy and its Statement of Purpose and decide whether any amendments should be recommended to Council outside of any ad-hoc changes that have been made during the course of the year.

Recommendations
Council is asked to:

a  Consider the report of the Investment Sub-Committee 2017.

b  Consider proposed amendments to the Investment Policy at Annex A.

c  Consider proposed amendments to the Investment Sub-Committee’s Statement of Purpose at Annex B.
Report of the Investment Sub-Committee’s activities in 2017

1 The Investment Sub-Committee is required by its Statement of Purpose to report annually to Council on its activities. This is the third annual report to Council outlining the Investment Sub-Committee’s work.

2 Since its last report to Council on 23 February 2017, the Sub-Committee has met four times (May, September, November 2017 and February 2018).

Membership

3 The Investment Sub-Committee’s membership currently includes four Council members, two external co-opted members, the Director of Resources and Quality Assurance and the Assistant Director of Finance and Procurement.

4 There have been several membership changes in 2017:

   a Paul Knight and Anthony Harnden took up their Council appointments on 1 January 2017 and attended their first Investment Sub-Committee meeting on 25 January 2017.

   b Jeremy Beckwith, co-opted member, resigned in January 2017.

   c The Chief Operating Officer stood down from the Investment Sub-Committee due to her appointment as Managing Director of GMC Services International (GMCSI) in December 2016.

   d Denise Platt joined the Sub-Committee following Council approval on 23 February 2017.

   e Paul Knight stepped down from the Investment Sub-Committee in December 2017 to join the Board of GMCSI.

Changes to the Investment Sub-Committee Statement of Purpose during 2017

5 Council approved the following changes to the Investment Sub-Committee Statement of Purpose in 2017:

   a At its meeting on 23 February 2017 Council agreed:

      i To remove the Chief Operating Officer from the membership of the Investment Sub-Committee.

      ii To increase Sub-Committee membership from four to five Council members.
At its meeting on 26 April 2017 Council approved changes to further clarify the role of the Investment Sub-Committee in approving and monitoring investment in trading subsidiaries.

**GMC funds under management**

**Funds under management with CCLA**

6 GMC funds are held in a combination of CCLA’s COIF Charities Ethical Investment Fund and their COIF Charities Deposit Fund.

7 During 2017, the Sub-Committee developed a dashboard to monitor performance which is considered at each meeting alongside a detailed quarterly investment report. CCLA fund managers attended two meetings to present to the Sub-Committee and respond to questions. The Sub-Committee also received monthly statements from CCLA.

8 Investment performance has been reported to Council on two occasions in 2017 through an additional annex to the Chief Operating Officer’s (COO) Report. A summary of financial performance of funds under management during 2017 was included as an annex to the COO report in February 2018 and a summary of ongoing performance will continue to be included in each COO during 2018.

9 Where CCLA considers it appropriate, they actively engage with and influence the corporate behaviour of companies the GMC invests in via their ethical engagement activity, this includes:

   a Engagement focused on social and environmental issues that are a priority for CCLA clients.

   b Voting and engagement on governance issues to protect shareholder value and address excessive remuneration.

   c Setting constraints on investment and exposure to activities considered unacceptable by CCLA’s clients.

   d Responsibilities under the UK Stewardship Code and the UN Principles for Responsible Investment.

**Annual report of quantitative and qualitative data for fund managers**

10 The dashboards and detailed reports on fund manager performance show both quarterly and annual data. For 2017 CCLA achieved an investment return of 5.71% against a benchmark of 5%. They complied fully with our investment policy, including our ethical exclusions, and there were no significant changes of ownership, structure or key staff during the year.
Performance management framework for monitoring fund managers

11 The Sub-Committee will conduct its annual review of its performance management framework for monitoring fund managers at its meeting in November 2018.

External periodic review/health-check of investment arrangements and proposed changes to the Investment Policy and Investment Sub-Committee Statement of Purpose.

Linchpin’s review of investment arrangements

12 The Sub-Committee’s Statement of Purpose allows the Sub-Committee to engage external professional advisers to undertake a periodic review/health-check of the investment arrangements. At its meeting in September 2016 the Sub-Committee agreed to conduct its first review in 2017 as, after two years of work, it was considered an appropriate time to consider if arrangements in place are fit for purpose.

13 The tender process to appoint an external reviewer was completed in the first quarter of 2017 and Linchpin IFM Limited were appointed. The review took place in second quarter of 2017.

14 Linchpin were asked to review:

   a The arrangements for investing to ensure that they are consistent with good practice.

   b The actual investments to ensure that they are appropriate in the market environment.

   c The Sub-Committee’s governance and monitoring of the investment in the GMC’s new trading subsidiary.

   d Any recommended strategy against the assets held in the GMC Staff Superannuation Scheme (‘the Pension Fund’).

Key recommendations

15 The Sub-Committee received a report and presentation from Linchpin at its meeting on 22 September 2017.

16 In their report Linchpin made a number of financial and governance recommendations on: our investment strategy arrangements to date for funds under management and investment in the GMC’s trading subsidiary, the investment strategy going forward and suggestions on our Investment Policy and governance arrangements, in line with best practice.

17 The key recommendation from Linchpin was that the current approach to cash management would not provide protection against the real value of our assets being...
eroded by inflation and endorsement of the original strategy of investing up to £50 million with a single manager.

**Investment Sub-Committee’s action plan**

18 The Sub-Committee reviewed the recommendations from Linchpin at its meetings on 14 November 2017 and 6 February 2018 and agreed which actions should be progressed. The Sub-Committee developed an action plan to implement the recommendations, subject to Council approval where required. Where the Sub-Committee agreed it was unnecessary to implement Linchpin’s recommendations the rationale was recorded in the action plan.

19 Key elements of the action plan are:

a Recommending to Council that the original strategy of investing up to £50 million through a bespoke investment portfolio should be implemented during 2018.

b Implementing minor changes to our governance processes and documentation in line with good governance practice.

c Proposing changes to the Investment Policy to ensure that our ethical investment is clear, appropriate for the GMC and in line with current good practice, with the rationale for exclusions clearly articulated.

d Appointment of an additional external co-opted member to bring the number of co-opted members on the Sub-Committee back up to three.

e Appointment of an independent external adviser to the Sub-Committee.

20 In December 2017 Council approved in principle the implementation of the original strategy of investing up to £50 million through a bespoke investment portfolio. The timescales and investment plan is currently being developed, in conjunction with CCLA, for consideration by Council in June 2018.

21 In order to implement the action plan, the Sub-Committee propose to Council a number of changes to its Statement of Purpose, and the Investment Policy.

22 The Sub-Committee will continue to implement its action plan during 2018 as appropriate and in liaison with Audit and Risk Committee where required.

23 The Sub-Committee has extended the length of its meetings in 2018 to accommodate implementation of the action plan.
Proposed changes to the Investment Policy

24 The proposed changes to the Investment Sub-Committee Statement of Purpose, shown in track changes at Annex A, are recommended to Council in order to:

a Articulate the Investment Policy in more detail (including legal powers, objectives, rationale, risk, diversification and decision-making).

b Define more clearly the funds available for investment, and the treatment of the remaining cash balances.

c Clarify the target rate of return, and the funds to which the target applies. It is proposed that the target rate of return on funds invested under management is changed from inflation (Consumer Prices Index (CPI)) + 2% to 5% to CPI + 2%. The target rate reflects the low appetite for risk.

d Articulate more clearly the rationale for excluding investments for ethical reasons and further exclusions relating to climate change and tax.

25 The current Investment Policy includes reference to ethical exclusions. Further to advice from Linchpin to articulate the Investment Policy in more detail, the Sub-Committee propose to include further information on the GMC’s ethical exclusions, including the thresholds in place with our fund manager. The Sub-Committee propose to include reference to: excluding investment in companies that derive more than 10% of their revenue from: tobacco; alcohol; gambling; pornography; high-interest rate lending; cluster munitions and landmines; and the extraction of thermal coal or oil sands.

26 It is common practice to apply a threshold to ethical exclusions due to the difficulties of assuring the entire supply chain for the companies in which the investment is made. Should investments infringe the ethical investment limit of more than 10%, appropriate exit plans would be actioned.

Proposed changes to the Investment Sub-Committee Statement of Purpose

27 The proposed changes to the Investment Sub-Committee Statement of Purpose, shown in track changes at Annex B, are recommended to Council in order to:

a Clarify the governance arrangements of the Sub-Committee including the role of external co-opted members.

b Clarify the working arrangements of the Committee including reporting arrangements for fund managers and trading subsidiary management at Sub-Committee meetings.

c Clarify delegated authorities for setting asset allocations.

d Clarify reporting arrangements to Council on the summary of performance of funds invested under management and funds invested through a trading subsidiary.
GMC Services International

28 The GMC established GMCSI, as a trading subsidiary, in December 2016.

29 At its meeting on 3 May 2017, the Sub-Committee approved equity investment in GMCSI of £600,000.

30 The Investment Sub-Committee is responsible for overseeing the GMC’s investment in GMCSI, including ensuring compliance with the GMC’s Investment Policy, scrutinising the GMCSI’s business plan and assessing the potential levels of investment risk and return. As set out in the Investment Policy, the Sub-Committee also considers and approves any investment in GMCSI. The Sub-Committee is the principal route through which the GMC's investment in GMCSI is monitored. However, its role is not to monitor the general performance of GMCSI and the Sub-Committee is not privy to detailed information on pricing, operating costs and contracts.

31 The Sub-Committee considered a report and performance dashboard from GMCSI from September 2017 onwards. The GMCSI Managing Director and /or management attended two further Sub-Committee meetings in 2017 and the Chair of GMCSI attended the Sub-Committee meeting on 6 February 2018. When in attendance, GMCSI directors/management presented their report to the Sub-Committee and responded to questions.

32 The Sub-Committee is satisfied with the reporting structures in place.

Treasury management

33 The Sub-Committee considered a report on the GMC’s treasury management activities at each of its meetings.

34 The GMC’s cash balances, after working capital held in instant access accounts, ranged between £73 – 102 million during the year. The cash held during the year is typically higher than the GMC’s free reserves because a larger proportion of doctors pay their annual retention fee in advance. Fees paid in advance are held on the balance sheet as deferred income and not included in free reserves.

35 In 2017 we generated interest of £0.6m on our cash balances, equivalent to an annual rate of return of 0.7%.

Investment Risk-Register

36 The Sub-Committee considered the Investment Risk Register at each of its meetings. During 2017 the Sub-Committee:

a Added a risk on the potential for the inflation rate to increase.

b Added a risk on the potential risk of capital loss of the GMC’s investment in GMCSI and the risk GMCSI did not provide an adequate return.

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c Revised Risk 13 to include “monitoring and active treasury management” as a mitigating action.

d Added on a risk the potential impact of Brexit on investments.

e Agreed that the format and content of the Investment Risk Register would be revised during 2018 in light of external review of investments arrangements.
Executive summary
This report provides an update on the Transformation Programme outlining: overall goals, progress to date and further details of specific areas of the programme linked to culture change and people development.

Recommendation
Council is asked to consider this update on the progress of the development of the Transformation Programme including the ongoing monitoring and assurance within the programme structure and via oversight of the Audit and Risk Committee.
Background

1. Our Chief Executive set out the aims for the transformation programme to staff in the following terms:

   ‘Our ambition is to become a more agile, confident and connected regulator that harnesses the talent of all our staff in everything we do. And a regulator that is bolder in shaping relevant wider debates, a regulator that remains highly relevant in the healthcare system during a period of continuing pressure on the frontline.’

2. Given our ambitious new Corporate Strategy and challenging external environment (continued healthcare system pressures, Brexit and increasing divergence of healthcare and politics in the four countries of the UK) we need to look internally at our capabilities and capacity to deliver.

3. We are a successful organisation with external validation of our operational excellence and we have high staff engagement with low turnover and stability within our leadership cadre. We had also just delivered significant financial restructuring changes through a successful Change Programme. However, the Change Programme and the incoming thoughts of a new Chief Executive have crystallised some areas where the organisation would be “even better if” it could transform the way it worked together and with others.

What is the Transformation Programme seeking to change?

4. Key focus areas for the programme are:

   a. Improving our responsiveness and flexibility.
   b. Improving our hierarchical structure and behaviours.
   c. Improving cross directorate working.
   d. Increasing our capacity and capability in both strategy and policy development and communications and engagement.

5. Key to this is how we recruit, develop and empower the people within our organisation.

6. The projects and activities that make up the Transformation Programme address these areas but these will not be quick fixes and will take some time to fully complete.

7. We have mapped in detail the benefits we are seeking to deliver at both project and programme level and these benefits will be used, along with lead and lag indicators of
success, to judge the success of the programme which are summarised at a high-
level at Annex A.

8 Ultimate delivery of the 2018-2020 Corporate Strategy is also dependent on the
enabling factors delivered by this Transformation Programme and this will be tracked
for Council and reported on at each Council session.

Delivery structure

9 We have aligned the portfolio into four sub programme areas that each seek to
address these major areas of transformation.

10 Our programmes are:

GMC Transformation Programme

<table>
<thead>
<tr>
<th>Envision</th>
<th>Empower</th>
<th>Enact</th>
<th>Engage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clearer sense of purpose; greater prioritisation and measuring of impact</td>
<td>Empowering and developing our people</td>
<td>Pace, agility and cross-organisational working</td>
<td>Enhanced engagement with the healthcare system</td>
</tr>
<tr>
<td>- Development of Strategic Policy Directorate</td>
<td>- Investors in People accreditation</td>
<td>- Developing an Agile working proposition</td>
<td>- Development of a Strategic Communication and Engagement Directorate</td>
</tr>
<tr>
<td>- Delivery of Corporate Strategy</td>
<td>- Pay, performance, reward &amp; recognition review</td>
<td>- Improving management information</td>
<td>- Digital Transformation</td>
</tr>
<tr>
<td>- Model for coordinated policy production</td>
<td>- Performance Mgmt redesign</td>
<td>- Governance streamlining</td>
<td>- Developing Strategic Relationships</td>
</tr>
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<td></td>
<td>- Implementation of 360 feedback</td>
<td>- Customer service roadmap</td>
<td>- Patient and Public engagement</td>
</tr>
</tbody>
</table>

11 The portfolio is governed by a steering group led by the Chief Operating Officer
(COO) which reports to the Executive Board through the GMC’s operational risk and
performance reporting and to Council through the COO report. Audit and Risk
Committee (ARC) has also been given the role of oversight, as with the preceding
Change Programme, and utilises internal audit capacity to regularly spot check our
progress. The first of these spot checks on the programme was reported to ARC in
March 2018 and received a green rating for governance, communications and general
portfolio management set-up.
A snapshot of the ongoing work of projects across the four sub programme areas

Empowering and developing our people (Empower)

12 The Empower programme is currently, amongst other areas of concentration, working on:

a Roll out 360 feedback to all our staff to drive a receptive and feedback orientated culture.

b Making changes to delegation and decision making throughout the organisation so that the right people at the right level make and take decisions.

c Implementing a series of changes to performance management, pay and flexible working which we feel will drive greater strategic cohesion, encourage our people to think about how they deliver their work, not just what they deliver, and allow us to be more flexible and responsive in the way we resource our priorities. This latter exercise includes working with external partners to understand our Leadership training needs.

13 In addition, we are seeking to achieve the Investors in People accreditation for the whole organisation which brings many of these people orientated strands of the programme together through external validation of our efforts.

Pace, agility and cross-organisational working [Enact]

14 The Enact programme is defining what agility* means for the GMC and where we need to be more agile, including:

a A rapid resource deployment framework.

b Setting up an internal Linkedin type platform within our Aspire performance management system.

c Baking-in generic leadership skills into our new Leadership Development offering and competencies.

d Implementing new technologies for collaboration across geographies and working environments.

* In this context we are defining agility as both workforce flexibility and operational responsiveness and flexibility as definitions given by organisations such as CIPD and Agile Future Forum.
e Clarifying our governance thresholds and pace so that decisions are made at the appropriate level of the organisation.

f Aiding us to understand our key business metrics and performance thresholds better so that we can more rapidly understand issues and seek to rectify them.

Clearer sense of purpose; greater prioritisation and measuring of impact [Envision] programme and Enhanced engagement with the healthcare system [Engage] programme

15 Within both the **Envision** and **Engage** programmes we are enhancing our capacity and capability to deliver, at pace and at scale, strategic innovation and pro-active communication and engagement aimed at repositioning the organisation as a leader within the healthcare environment.

16 Central to the **Engage** programme is how we change the way we communicate and engage with stakeholders on the front-line of care. We started this process by building an increased capacity and capability in our new Strategic Communications and Engagement directorate under our new director, Paul Reynolds. Work under this programme also includes:

a Increased visibility and external engagements for the Senior Management Team.

b Further work to deliver our Digital Transformation, including a new website based on customer-journey mapping.

c Developing our strategic relationships strategy and process. We are also defining our patient and public involvement strategy as part of this work.

17 Within **Envision** we have already delivered a new corporate strategy and we are also driving a “benefits first” approach to planning under our new strategy and seeking to hone the measurement of our regulatory impact on stakeholders we work with, not least the medical profession. We’ve established a new Strategic Policy directorate under the leadership of Paul Buckley. Work under this programme includes:

a Defining a new policy development framework.

b Establishing a policy “profession” within and across the organisation.

c Establishing a data and insight “profession” within and across the organisation.

Initial impact following changes made to date

18 We are already starting to see evidence of responsiveness and flexibility in how we are responding to the current context post the Dr Bawa Garba case. The organisation
is working hard to deal with increased policy and communication demands while reprioritising our workplan, at pace and without deleterious effects on statutory performance. Some of the aspects we have set in train during the transformation process are helping us deal with this additional workload / work prioritisation pressure, not least our work to think though secondments and resource planning and the creation of a new policy leadership group and policy profession that works across directorates. The senior management team has also been reflecting on, and implementing changes to, how it works to model the inclusive and “One GMC” behaviours we are trying to encourage within the wider the organisation especially around setting the tone, reducing deference and thinking across “silos”.

19 We have also received positive feedback from staff on the inclusive nature of changes being made including the communication of our ambitions and how we are running the various elements of the programme. We hope positive reinforcement continues in the up and coming staff survey exercise which will be crucial in helping us to monitor early progress toward our transformation goals.

**How will Council be updated on progress?**

20 Council will continue to be provided with regular updates through the Chief Operating Officer’s report. There will also be periodic review of elements of the programme with ARC and our internal auditors. The next spot check will concentrate on benefits definition and tracking, we intend to report to the ARC meeting in May 2018.
M8 - Annex A
Transformation Programme
update

April 2018

Working with doctors Working for patients
Transformation programme video and branding
Communications with Staff

“To support our new strategy and make sure we stay relevant and trusted for our doctors and stakeholders, we need to make some changes. Both to the way we behave as individuals, and to the way we work as teams.

Our Transformation Programme is about helping the organisation become more responsive to an increasingly dynamic external environment. Not everything needs to change. Our reputation for operational excellence is down to the hard work and dedication of staff. But to become more agile, we need to be willing to take risks and give colleagues permission to take responsibility and make things happen. We need to encourage and enable cross-directorate working and improve our active listening.

When we are working together as One GMC, we will be better at responding to our ever changing external environment and able to lead the debate about medical practice and the future of healthcare.”
Envision - Clearer sense of purpose; greater prioritisation and measuring of impact

**Objective**

We are developing a clear and measurable organizational strategy and effective policy framework, which will help determine our future regulatory purpose.

**Key benefits**

- We are better able to track the impact of our actions on our stakeholders.
- We determine a clearer sense of purpose through more co-ordinated policy.

**Activities to deliver**

- Develop an evaluation framework
- Creation of a new Strategy and Policy directorate
- Development of the Policy Leadership Group
- Implement a policy framework
- Embed a policy profession
Empower – Empowering and developing our people

**Objective**
To have empowered and developed our people so we can maximise our potential

**Key benefits**
- A culture of learning rather than blaming
- Greater opportunities for staff development
- Full range of staff experience and knowledge utilised

**Activities to deliver**
- Investors in People (IIP) accreditation
- Pay, Performance, Reward and Recognition review
- Performance management re-design
- New feedback model implemented
Enact – Pace, agility and cross-organisational working

Objective
We want to be pacier, more agile and with greater cross-organizational working

Key benefits
- More efficient and robust decision-making
- Clearer prioritization of activities and allocation of resources
- Enhanced customer service

Activities to deliver
- Development of ‘real time’ dashboards on operational performance
- Streamlined governance structures and clear thresholds for decision-making
- Portfolio approach to planning and reporting
- Revising our suite of operational KPIs
**Objective**

We have enhanced engagement with the healthcare system as a whole

**Key benefits**

- More shared insight with other organisations
- More targeted and impactful communication
- Better understanding of perspectives of others

**Activities to deliver**

- Creation of Strategic Communications and Engagement directorate
- Increased SMT engagement on the front line
- Digital Transformation 2020
- Patient and public engagement
- Strategic relationship management
Council meeting, 24 April 2018

Executive summary
The external action plan for Taking Revalidation Forward was published on 20 July 2017.

Both the GMC and healthcare sector partners have made significant progress in delivering against the commitments made. A formal progress update was published on our website in January 2018.

We have updated and improved a number of pieces of statutory guidance to make them clearer and more accessible for doctors and responsible officers. We have published and promoted information and case studies highlighting the role and importance of patient involvement in revalidation. And we have enhanced our web content through the use of videos and infographics.

We are on track to complete the overall programme of work by September 2018.

Recommendation
Council is asked to note the progress update on Taking Revalidation Forward as outlined in this report.
Taking Revalidation Forward Action Plan

1 Following the publication of Sir Keith Pearson’s review of revalidation, *Taking Revalidation Forward* in January 2017 and his recommendations to improve some aspects of revalidation, we published our action plan for the Taking Revalidation Forward Programme (TRF programme) on 20 July 2017.

2 The action plan is organised into six work streams, with 37 actions in total – 18 for the GMC and 19 for other organisations. Delivery of the plan is overseen by the Revalidation Oversight Group (ROG), chaired by the GMC’s Chief Executive, with membership from key stakeholder organisations across the four countries.

Key progress to date

GMC actions

3 Working in collaboration with our partners, we have made significant progress in delivering against our commitments. As of March 2018 we have:

a Worked with patients to write a simple narrative that explains how revalidation works and the importance of patient feedback for doctors.

b Developed and shared case study examples of patient involvement in local revalidation processes at two hospital trusts.

c Updated our *Supporting information for appraisal and revalidation guidance*, including new overarching principles; provided more guidance on the balance between quality and quantity of supporting information; and a new section specifically for doctors in training. We engaged widely with stakeholders to deliver this improved guidance and have received overwhelmingly positive feedback on the final version.

d Updated the *GMC protocol for making revalidation recommendations* to clarify areas such as sharing information between organisations and multiple deferrals, and introduced a new requirement for responsible officers to discuss a doctor’s recommendation where the doctor has raised a public interest concern.

e Secured collective agreement across the four countries on a set of core principles to govern information sharing about doctors, which have been approved by ROG.

4 The outputs listed above were launched in conjunction with the new GMC website in April. We have also made substantial improvements to the format and content of revalidation information on the website. The website includes a video explaining revalidation, an information ‘hub’ for responsible officers, and new tools and advice
for specific groups of doctors (for example, new registrants, doctors working in multiple settings and retiring doctors). We have also expanded the tool that helps doctors identify their designated body. These changes make revalidation information more accessible for patients too.

**Actions by our partners**

5. Our partners have also completed a number of actions. Highlights include publication of a report on lay involvement in revalidation by Sol Mead (ROG lay member), drafting of new guidance for locum doctors by NHS England, and development of a programme of quality assurance visits to cover all designated bodies in Wales.

6. A full report of progress up to January 2018 can be found in the [Taking Revalidation Forward Progress update](#).

**Actions to be completed**

7. We remain on track to complete the overall programme by September 2018.

8. Between May and September, we will:

   a. Publish improved advice on holding a licence to practise, for both doctors and employers.

   b. Update the [revalidation governance handbook](#) – our guidance on clinical governance for revalidation aimed at boards and produced jointly with other system regulators.

   c. Secure agreement from partners on developing a proportionate approach to tracking the impact of revalidation.

   d. Review the GMC requirements for patient feedback for revalidation. We have moved the expected launch date of the patient feedback consultation from June to September 2018 to allow for more extensive pre-consultation engagement.

**Supporting the GMC’s public sector equality duty**

9. As part of the TRF programme we have identified opportunities to improve revalidation information and processes for those who share protected characteristics. Progress against these objectives is regularly reported to the TRF programme board and directorate senior management.

10. To develop the revalidation narrative for patients we held a number of workshops with the public, reaching out to communities that represent patient groups such as
LGBT (lesbian, gay, bisexual and trans), BME (black and minority ethnic), and those with learning disabilities in partnership with Mencap. For doctors, we have produced new guidance aimed at supporting individuals who are in the later stage of their careers, working as locums, taking a break in practice or are new to UK practice.