February Council meeting - Agenda and papers

MEETING
28 February 2018 09:40

PUBLISHED
22 February 2018
Council Meeting Room 2.08  
350 Euston Road,  
London, NW1 3JN

Agenda

Wednesday 28 February 2018

09:40 - 13:00

M1 Chair’s business

M2 Minutes of the meeting on 12 December 2017

M3 Chief Executive’s Report

M4 Chief Operating Officer’s Report

M5 Improving our consultations: progress and next steps

M6 Review of our guidance on Consent

Tea and coffee break

M7 2017 Human Resources Report and Gender Pay reporting

M8 Pension strategy

M9 Proposals for Chair and Council member appointments process

M10 Council forward work programme 2018

M11 Amending the list of bodies entitled to award a UK Primary Medical Qualification

M12 Any other business
M13  *2019 meeting schedule

M14  *Report of the Executive Board 2017

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.
# Contents

<table>
<thead>
<tr>
<th>M1 - Chair’s business</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>M2 - Minutes of the meeting on 12 December 2017</td>
<td>6</td>
</tr>
<tr>
<td>M3 - Chief Executive’s Report</td>
<td>14</td>
</tr>
<tr>
<td>M4 - Chief Operating Officer’s Report</td>
<td>23</td>
</tr>
<tr>
<td>Annex A - Operational Delivery summary</td>
<td>29</td>
</tr>
<tr>
<td>Annex B - Corporate Risk Register</td>
<td>38</td>
</tr>
<tr>
<td>Annex C - Initial thoughts on reporting on strategic delivery</td>
<td>57</td>
</tr>
<tr>
<td>M5 - Improving our consultations: progress and next steps</td>
<td>59</td>
</tr>
<tr>
<td>M6 - Review of our guidance on Consent</td>
<td>64</td>
</tr>
<tr>
<td>M7 - 2017 Human Resources Report and Gender Pay reporting</td>
<td>67</td>
</tr>
<tr>
<td>Annex A - HR Monitoring Overview</td>
<td>72</td>
</tr>
<tr>
<td>Annex B - Equality, Diversity and Inclusion</td>
<td>76</td>
</tr>
<tr>
<td>Annex C - Gender Pay Gap reporting</td>
<td>85</td>
</tr>
<tr>
<td>M8 - Pension Strategy</td>
<td>92</td>
</tr>
<tr>
<td>Annex A - Letter to Employer February 2018</td>
<td>97</td>
</tr>
<tr>
<td>Annex B - Trustee funding request - advice to Council</td>
<td>103</td>
</tr>
<tr>
<td>M9 - Proposals for Chair and Council member appointments process</td>
<td>119</td>
</tr>
<tr>
<td>Annex A - Council Appointments High level timeline</td>
<td>124</td>
</tr>
<tr>
<td>Annex B - Core Competencies for GMC members</td>
<td>127</td>
</tr>
<tr>
<td>M10 - Council forward work programme 2018</td>
<td>131</td>
</tr>
<tr>
<td>Annex A - Council Forward Work Programme</td>
<td>134</td>
</tr>
<tr>
<td>M11 - Amending the list of bodies entitled to award a UK Primary Medical Qualification</td>
<td>137</td>
</tr>
<tr>
<td>M12 - Any other business</td>
<td></td>
</tr>
</tbody>
</table>

Continued on the next page...
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.
28 February 2018

Council

Draft as of: 1 February 2018

To approve

Minutes of the meeting on 12 December 2017*

Members present

Terence Stephenson, Chair
Shree Datta
Christine Eames
Anthony Harnden
Helene Hayman
Deirdre Kelly
Paul Knight
Suzi Leather
Denise Platt
Amerdeep Somal

Others present

Charlie Massey, Chief Executive and Registrar
Susan Goldsmith, Chief Operating Officer
Paul Buckley, Director of Strategy and Communication
Una Lane, Director of Registration and Revalidation
Colin Melville, Director of Education and Standards
Patricia Morrissey, Council Secretary
Neil Roberts, Director of Resources and Quality Assurance
Dame Caroline Swift, Chair of the Medical Practitioners Tribunal Service Committee (for item 9)

* 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 It was noted that apologies had been received from Steve Burnett and Anthony Omo.

2 Council noted a declaration of interest from Deirdre Kelly with regards to her membership of the Board of Pension Trustees, and the inherent interests of staff present who were members of the Scheme.

3 The Chair reported that Michael Farthing had resigned as a Council member on 28 November 2017. Council recorded its thanks to Michael for his significant contribution during his service on Council, his work as Chair of the Audit and Risk Committee and his support of the GMC over a number of years.

4 Council had agreed the committee membership changes arising as a result of the vacancy and noted for the record:
   a The appointment of Deirdre Kelly as Chair of the Audit and Risk Committee.
   b The appointment of Paul Knight to the Board of GMC Services International, and that in light of this role, Paul would step down from the Investment Sub-Committee which would carry a vacancy.

5 Council noted that options for filling the vacancy on Council would be explored further, and that all options would be subject to continuing discussions with the Professional Standards Authority (PSA) and Privy Council. A paper on Council appointments would be considered at the Council meeting on 28 February 2018.

6 Council noted that:
   a Stephen Jones, Assistant Director - OCCE, would leave the GMC in February 2018. Council recorded its thanks to Stephen, for his contribution and support to Council over the last three years.
   b Patricia Morrissey would leave the Governance Team in January 2018. Council recorded its thanks to Patricia for her contribution as Acting Head of Governance and Council Secretary during 2017.

Minutes of the meeting on 7 November 2017
7 Council approved the minutes of the meeting on 7 November 2017 as a true record.

Matters arising
8 In relation to Item 5 of the meeting on 7 November 2017, Council agreed it would be useful to review the process for handling complaints received by members. A memo prepared by the Governance Team on the process for handling complaints addressed to members would be circulated to Council and time would be allocated to the Council forward work programme for 2018.
Chief Executive’s Report

9 Council considered the Chief Executive’s Report, noting developments in the external environment, progress on our strategic priorities and how the GMC’s major work programmes were progressing, including updates on:

a The Government’s consultations on the reform of professional regulation and the future regulation of the Medical Associate Professions.

b Reception to the publication of the GMC’s report on the medical training environment, based on the GMC’s survey of more than 75,000 doctors across the UK.

c The GMC’s ongoing work with Health Education England following re-emerging concerns about the safety and suitability of the training environment within the Emergency Department at North Middlesex University Hospital NHS Trust.

Chief Operating Officer’s Report

10 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 that:

i Income and expenditure to the end of October 2017, and that the expenditure was overall £3,937K under budget, mainly driven by operational headcount being significantly lower than forecast.

ii ‘Taking Revalidation Forward’ was rated red due to postponement of delivery of the review recommendations, which had been agreed in order to avoid overburdening stakeholders.

iii ‘Medical Licensing Assessment’ (MLA) was rated red due to the need for greater clarity on planning for policy implementation, resourcing for MLA would remain amber until the team was in place to support the programme of work.

iv ‘Credentialing’ was rated red as there were concerns about the current clarity on the criteria expected for curricula to meet the Shape of Training principles.

c That an error had been identified in how an ethical/standards enquiries KPI had been reported on a number of occasions in 2017 and how such errors would be avoided going forward. Corrected figures were noted.

d Summary information on current judicial reviews and appeals.
Changes made to the Corporate Risk Register.

Report on Fund manager investment performance up to quarter 3.

Other operational matters including:

i Two exceptions related to KPIs on ‘Answering 80% of calls within 20 seconds’ and ‘responding to 90% of ethical/standards enquiries within 15 working days’, which had been missed due to resource issues. Council noted the action taken to address the resourcing issues. However, it was noted that the enquiries managed by the Standards and Ethics Team were typically extremely complicated, individual cases which required bespoke responses, often involving multiple communications with the enquirer and with colleagues across the organisation to ensure a response in line with our standards guidance and the law.

ii Updates on the Welsh Language Standards, staffing changes, the GMC Valued Awards, the GMC’s annual PSA performance review, and GMC Services International (GMCSI).

Medical Licensing Assessment – Proposals for delivery

Council considered the proposals for delivery of an amended solution for the Medical Licensing Assessment, which had been further developed in light of the response to the consultation. Council agreed:

a Plans to deliver a common on-line test of applied knowledge test to UK graduates and International Medical Graduates (IMGs) by 2022.

b That the GMC should, by 2022, identify key performance indicators of effective practice in medical school Clinical and Professional Skills Assessments (CPSAs), and significantly strengthen the GMC’s assurance that CPSAs at UK medical schools meet these requirements.

c That the GMC should continue to develop Professional and Linguistic Assessments Board Part 2 for IMGs and rebadge it as the MLA CPSA for IMGs by 2022.

d That the GMC’s priority would be to set clear requirements for medical schools skills assessments, and there should be further consideration going forward to the question of whether there should be a single CPSA in the future.

2018 Business Plan and Budget

Council considered the draft business plan, budget and capital programme for 2018, and proposals to reduce fees.
a Approved the 2018 business plan, budget and capital programme.

b Agreed to increase the funds available for investment from £10 million to £50 million.

c Agreed to reduce registration fees and remove fees for payments by both credit card and instalment.

d Agreed to delegate authority to the Chair of Council to amend the GMC Registration Fees Regulations to reflect the agreed reductions.

14 During discussion, Council noted:

a An oral update from Suzi Leather, Chair of Investment Sub-Committee, on the proposal to increase funds available for investments following an external review of the GMC’s investment arrangements, which had highlighted that the current approach to cash management would not provide protection against the real value of our assets being eroded by inflation.

b That proposals would be developed for a phased increased of investments, in line with Council’s original intention to invest £50 million, for consideration by the Investment Sub-Committee in February 2018 and Council in April 2018.

c The importance of including sufficient narrative within the GMC’s ethical policy for funds under investment. Council noted that the Investment Sub-Committee would review the Investment Policy in February 2018 and that Council approval of any changes would be required.

d The changes to the Annual Retention Fee would be announced immediately after the Council meeting and the changes would take effect from 1 April 2018.

Pension Strategy

15 Council considered:

a The outcome of the engagement and consultation process relating to the proposed closure of the Defined Benefits (DB) scheme to future accrual from 31 March 2018.

b The latest financial position relating to the scheme’s funding level, future accrual rate and proposals from Trustees regarding future funding.

16 Council:

a Noted the feedback from the DB Scheme staff consultation and engagement process.
b Confirmed its intention to close the DB Pension Scheme to future accrual from 31 March 2018 and to seek the Scheme Trustee’s agreement to amend the Trust Deed and Rules.

c Considered the Staff Forum proposal to make additional employer contributions to existing DB staff when they joined the Defined Contribution (DC) scheme and noted that, whilst the Forum was the representative voice of all GMC employees, the proposal only represented the collective views and opinions of those members of the DB Scheme.

d Noted the Scheme Trustee proposals for additional funding and agreed to consider these in detail in February 2018.

e Noted the plans to implement the adjustments to the DC scheme as set out in the GNC consultation materials.

17 During discussion, Council noted:

a The impact the decision to close the DB Pension Scheme to future accrual from 31 March 2018 would have on different employees depending on their age, length of service and career trajectory.

b The consideration already given by Council and the Executive to the range of other options. Closing the DB scheme to future accrual and moving to an enhanced version of the existing DC scheme for all staff addressed the issues relating to costs and risks and also sought to achieve a fairer approach to pension provision for all staff.

c That retrospective changes would not be made to the DB scheme, accrued benefits would not be affected by the decision.

d That a full annual report would be provided to Council on the DC scheme. The first report would include an overview of the governance arrangements of the DC scheme and of the investment options available to staff.

e Consideration would be given to how the pension changes would be sensitively communicated to members of the DB scheme which fully explained the context in which the decision was made.

f An impact report would be produced for Council for consideration in 2018, although it was likely that the staff survey results would also reflect the impact.

Report of the Medical Practitioners Tribunal Service Committee

18 Council considered a report from the Medical Practitioners Tribunal Service (MPTS) Committee. The report set out the key activities of the MPTS since the last report to Council in June 2017.
Council noted:

a. The first MPTS annual report was laid before Parliament in July 2017.

b. The MPTS continued to prioritise work to reduce the number of cases that adjourned part heard, including requiring parties to submit evidence bundles for pre-reading by tribunals.

c. The impact to date on the appointment in 2017 of 72 legally qualified individuals as tribune chairs and legal assessors, which would be formally reviewed in March 2018.

d. The proposed MPTS budget for 2018 was £8.5m, reduced from £9.4m in 2017.

During discussion, Council noted:

a. Ongoing training with tribunal members on awareness of unconscious bias and diversity considerations.

b. The MPTS response to the recent audit report considered by the Audit and Risk Committee.

c. Ongoing initiatives to support self-represented doctors and vulnerable doctors.

d. Improvements to the tribunal process including the provision of bundles ahead of hearings for pre-reading and the increase in the number of Black Minority Ethnic tribunal members.

Report of the Audit and Risk Committee

Council considered the report of the Audit and Risk Committee’s activities since its last report on 7 June 2017, noting that the Committee had recommended no changes to its Statement of Purpose.

During discussion, Council noted that enhanced monitoring would be discussed at a future Council seminar.

Report of the Remuneration Committee 2017

Council considered the report of the Remuneration Committee’s activities since its last report on 14 December 2016.

Council agreed the proposed amendments to the Remuneration Committee’s Statement of Purpose to remove the references to the Responsible Officer function to reflect that in practice the function could sit with either the Senior Medical Adviser or another GMC role.
25 During discussion it was agreed that further clarification would be provided to Council on the approval process for the remuneration of GMCSI directors including whether this information was required to be included GMC’s/GMCSI’s annual report and accounts.

Any other business

26 Council noted the date of its next meeting on 28 February 2018, in London.

27 During discussion, it was agreed that options for Council dinners in 2018 should be explored.

Update on plans for Consent guidance consultation

28 Council noted the report on plans for a consultation on Consent Guidance from 14 March to 5 June 2018.

Confirmed:

Terence Stephenson, Chair 28 February 2018
Executive summary
This report outlines developments in our external environment and progress on our strategy since Council last met.

Key points to note:

- The pressures on the NHS across all four countries of the UK continue and we have described how the UK’s medical profession is facing a ‘crunch point’.

- We have committed to reviewing how the law of gross negligence manslaughter is applied to medical practice. Dame Clare Marx will chair the review.

- The report of the Northern Ireland independent inquiry into hyponatraemia related deaths of five children was published in January 2018. We are studying the findings which are relevant to our work in standards, education and fitness to practise.

Recommendation
Council is asked to consider the Chief Executive’s report.
Developments in our external environment

Pressures on the NHS and the medical profession

1 The pressures on healthcare services and the professionals delivering them remain a cause of concern, and the higher incidence of ill-health during the winter period has added to that strain. The effect of these pressures on patient safety, training and the working environment for doctors, raise particular concerns for us as the medical regulator.

2 Our new Corporate Strategy, which runs from 2018-2020, clearly sets out our direction of travel to better support the profession as we strive to keep patients safe. These pressures affect doctors’ experience of training when they enter medicine, and the ability of practising doctors to meet the high standards that we and they expect of their profession. This does not mean that the standards we set should be diluted in ways which compromise good medical practice and patient care. It does mean that, more than ever, there is a need for us to look at how we prepare and support doctors to meet those standards, and that judgements about how our standards are applied are sensitive to the context in which doctors work.

3 In December 2017 we published our analysis of *The state of medical education and practice 2017*. The report recognised the enormous contribution that doctors from all round the world make to UK health services but highlighted that the profession is at ‘a crunch point’ and will suffer increasing pressure over the next 20 years unless action is taken. It highlighted how the supply of new doctors into the UK’s medical workforce has failed to keep pace with changes in demand, with dependence on non-UK qualified doctors increasing at the same time the UK is at risk of becoming a less attractive place for overseas doctors to work in. The report also highlighted the continuing pressure on doctors involved in training and a desire for more flexibility in how they work and train.

Reviews into gross negligence manslaughter

4 We recognise there are concerns about the way in which the law of gross negligence manslaughter (and, in Scotland, that of culpable homicide) is applied to medical practice. We have therefore committed to bring together health professional leaders, defence bodies, patient, and legal and criminal justice experts from across the UK to review this. The work will include a renewed focus on reflection and provision of support for doctors in raising concerns, and I am delighted that Dame Clare Marx, Chair of the Faculty of Medical Leadership and Management, has agreed to lead this four-country review for the GMC.

5 On 6 February 2018, the Secretary of State for Health and Social Care also announced a ‘rapid review’ into the application of gross negligence manslaughter in healthcare, led by Professor Sir Norman Williams. We fully support this initiative and see it as complementary to our work. It will be for the Government to consider
whether the law governing gross negligence manslaughter in England is appropriate for medicine. Our own focus will be on whether the current law, across each of the four nations, is applied appropriately and proportionately by the relevant agencies involved.

**High Court judgment**

6 The High Court judgment on our appeal in the case of Dr Bawa-Garba was handed down on 25 January 2018. The court agreed that the tribunal’s original sanction of suspension was insufficient to maintain public confidence in the medical profession and has replaced suspension with a direction of erasure from the medical register.

7 On 15 February 2018 we received notification of Dr Bawa-Garba’s application for permission to appeal the decision of the Divisional Court. The application will first be considered on the papers and, if granted, a further hearing will take place in due course.

**Inquiries**

8 The Department of Health and Social Care has announced an independent non-statutory inquiry into the circumstances and practices surrounding the malpractice of breast surgeon Ian Paterson. The Bishop of Norwich, the Right Reverend Graham James, is chairing the inquiry. The terms of reference have yet to be published but will be guided by patients and families of Paterson’s victims. We stand ready to assist the inquiry in its work.

9 On 31 January 2018 the report of the Northern Ireland independent inquiry into hyponatraemia related deaths of five children was published. The report of the 14 year inquiry makes profound criticisms of the care the children received and the conduct of both individual doctors and the institutions involved. While the report contains little criticism of the GMC, the content and recommendations are relevant to our work in standards, education and fitness to practise. As we consider our response to the issues that have been highlighted we will work with the Department of Health in Northern Ireland which is developing a detailed action plan to address the 96 recommendations in the report.

**The future of health professional regulation**

10 In October 2017 the Government published its consultation *Promoting professionalism, reforming regulation*. The consultation sets out the Government’s thinking on the future of health professional regulation. We responded to the consultation on 23 January 2018 highlighting the wider benefits changes to our legislation could have for protecting the public, supporting the development of a flexible workforce, and increasing the efficiency and proportionality of the system. To build support for reform, we have been engaging with key stakeholders and parliamentarians. This included a roundtable on 15 January 2018 with patient
organisations from across the UK and we are also working with Baroness Finlay to plan a briefing session for Members of the House of Lords.

**Maintaining a confidential medical service**

11 There have been concerns about how an information sharing agreement between the NHS and the Home Office could undermine public trust in the confidentiality of medical services. The relevant arrangements were set out in a Memorandum of Understanding (MoU) between NHS Digital and the Home Office, which was jointly published by the Department of Health and Social Care and Home Office in January 2017. It sets out the protocol for the disclosure by NHS Digital to Home Office staff of demographic information about individuals who have committed immigration offences, and are not in contact with the Home Office.

12 Following an oral evidence session before the Health Select Committee in January 2018, the Chair Sarah Wollaston MP wrote to NHS Digital to request that they suspend their Memorandum of Understanding (MoU) immediately and once the NHS Code of Confidentiality has been reviewed, undertake a further and more thorough review of the public interest test used in determining when it is applied.

13 We have had concerns for some time about the impact of the MoU for public trust in doctors and wrote to NHS Digital in March 2017 seeking reassurance that it was giving appropriate weight to the public interest in maintaining a confidential medical service when considering disclosures to the Home Office. In January 2018, we responded to the Health Committee’s request for our views on the matter, stating that we think there should be public consultation on how the public interest test is being applied to these cases and that a planned review by Public Health England of the impact of the MoU should be completed in a tighter timeframe than two years. We understand that NHS Digital is yet to respond to the Health Committee’s request.

**Interim guidance on withdrawal of clinically assisted nutrition and hydration**

14 In December 2017 we issued interim guidance jointly with the British Medical Association (BMA) and the Royal College of Physicians (RCP) setting out current standards of good clinical and professional practice applying to decisions about whether to withdraw clinically assisted nutrition and hydration (CANH) in the case of patients in a permanent vegetative (PVS) or minimally conscious state (MCS) following sudden onset brain injury. The guidance met an urgent need for advice and reassurance to health professionals, in the wake of developments in the courts which changed the longstanding requirement, in England and Wales, for all proposals to withdraw CANH in such cases to be referred to court for a ruling.

15 From November 2017 the courts have held that there is no requirement to seek their approval before withdrawing clinically assisted nutrition and hydration (CANH) from a patient in a permanent vegetative (PVS) or minimally conscious state (MCS) where professional clinical guidance has been followed and the healthcare team and those
close to the patient agree that it is not in the patient’s best interests to continue with CANH. This rapid shift of responsibility for making the ‘final’ best interests decision, has created concern among frontline healthcare staff and the health organisations responsible for the care of patients in permanent vegetative (PVS) or minimally conscious state (MCS), as well as challenges from some families and carers.

16 The interim guidance draws out key principles and standards from our End of Life Care guidance, similar BMA guidance, and the RCP clinical guidelines on diagnosing and managing MCS/PVS patients. It is ‘interim’ guidance, because the expert group intends to produce new more comprehensive guidance following public consultation later in the year. This will take account of the outcome of the Supreme Court case scheduled for the end of February 2018 which should clarify which CANH withdrawal decisions do not need to go to court for prior review.

Health Education and Improvement Wales

17 Health Education and Improvement Wales (HEIW) has announced the appointment of a new independent board to support the Chief Executive. HEIW will be responsible for workforce, education and training for all health professionals in Wales, incorporating the functions of the current Wales Deanery and Workforce Education and Development Service. The Chair also announced that the organisation will have a shadow period from April until October 2018 when it will become fully operational. We continue to work closely with the Chair and his new team to mitigate the risks to our work during this transition period, particularly in relation to the quality assurance of training, and to identify opportunities for closer working in the future particularly in relation to the new workforce function.

New GP Contract in Scotland

18 After a long period of co-production between the Scottish Government and the BMA Scotland, on 18 January 2018 BMA Scotland announced that members have voted to accept phase one of the Scottish Government’s new GP contract. The contract aims to re-focus the role of GPs as Expert Medical Generalists, involving a focus on undifferentiated presentation, complex care, and whole system quality improvement and leadership. Our Scotland team is working to support the GP workforce in Scotland as general practice moves to a cluster model: groups of practices in close geographical locations which encourage quality improvement activity between their peers. They have supported the implementation of this framework, advising Scottish Government on new Information Sharing Arrangements between Clusters and Health Boards and more practically supporting the workforce through workshops in Leadership and Management and Consent.
Progress on our strategy

Improving the mental health and wellbeing of doctors

19 As part of our focus on upstream regulation and supporting doctors to give good care, we hosted a symposium on Friday 9 February 2018 looking at how to better support and improve the mental health and wellbeing of all doctors. The symposium brought together medical leaders from across the UK to explore four key themes: stigma; leadership, systems and culture; early intervention; and crisis support and suicide prevention.

20 I am delighted that Dame Denise Coia, an eminent consultant psychiatrist and also Chair of Healthcare Improvement Scotland, will work with Professor Michael West, a senior King’s Fund fellow with specific expertise in compassionate and collaborative leadership, to lead a programme of work for us in this area. Terence and I will be meeting with Denise and Michael in March 2018 to agree next steps.

Doctors in training roundtable

21 On 9 February 2018 we hosted our first doctor in training roundtable of the year, following three successful meetings in 2017. Attendees included the Chair of the BMA Junior Doctors Committee, and representatives from the Academy of Medical Royal Colleges trainee doctors group, the Association of Surgeons in Training, and the Royal College of GPs Associates in Training Committee.

22 As the meeting took place shortly after the High Court’s judgment on our appeal in the Dr Bawa-Garba case, the agenda focused on responding to the outcome of the case, addressing the profession’s concerns. A major concern has been about the supposed use of the doctors’ reflections against them in the criminal court. The Medical Protection Society, who defended Dr Bawa-Garba, has since confirmed that her e-portfolio did not form part of the evidence considered at the criminal trial. The GMC has also publicly reconfirmed that we do not ask doctors to provide their reflective statements if investigating fitness to practise concerns.

23 We reiterated our commitment to working with doctors in training, and other key stakeholders, as we shift the emphasis of our work from acting when things have gone wrong to supporting all doctors in delivering the highest standards of care – as the best way to keep both patients and doctors safe. Discussions focused on collaborating on reflective practice guidance and raising concerns, which will now be taken forward with the group and trainees across England, Northern Ireland, Scotland and Wales in the coming weeks.

Credentialing

24 The Shape of Training Steering Group, chaired by Professor Ian Finlay, published the Shape of Training implementation report in August 2017. Its principles are embedded
in our education framework, *Excellence by design*. Working with colleges and faculties, we have a programme which will evaluate all current 103 curricula against our standards, which will embed the Shape principles by 2020.

25 As part of this, our credentialing framework, which we will begin to introduce from 2019, will seek to assure patients and employers that doctors are trained safely and competently in areas of practice that are not covered by postgraduate training, and we are proposing that GMC regulated credentials will apply to areas of practice with significant patient safety concerns. Other credentials may be developed to support strategic workforce requirements that will be identified and prioritised by members from the UK Medical Education Reference Group through our Curriculum Oversight Group.

26 In February 2018 we wrote to the four UK governments setting out a timetable by which we proposed to have developed a consensus-based model for the credentialing framework. Our letter to the four governments sought their support in identifying priority areas for credentials, as well as highlighting that under our current legislation approving and assuring credentials can only operate through a voluntary scheme, as we cannot set credentials as a regulatory requirement without legislative change.

**Widening access to the medical profession**

27 I have met with Sir Ian Diamond, the Deputy Chair of UCAS, and he has agreed in principle to the inclusion of UCAS data in the [UK Medical Education Database](https://www.medac.org.uk) (UKMED). This data will allow the GMC and our partners, including the Medical Schools’ Council, to improve our understanding of applications to medical school, and will make a significant contribution to the widening participation agenda. There are still governance and technical challenges to resolve around data sharing but we are making good progress. We hope to obtain an initial dataset in Q1 this year, with the longer-term intention being to align UCAS data with the existing UKMED processes.

**Executive Board**

28 The Executive Board met on 18 December 2017 and agreed:

- To automatically and routinely accept an appropriate score in the Occupational English Test (OET), which has been developed for 12 healthcare professions, in addition to the academic version of the International English Language testing System (IELTS). This will apply to overseas doctors who wish to practise medicine in the UK to demonstrate that they have the necessary knowledge of English to communicate effectively and not put the safety of their patients at risk. The change will increase the options available to overseas doctors, allowing for more efficient assessment and for doctors to join the workforce as quickly as possible.
b To the reintroduction of the decisions circular, used to update a wide range of UK / EEA recipients and international regulators about all fitness to practise sanctions and actions on a monthly basis.

c Revised statutory guidance, Guide for doctors: Revalidation and maintaining your licence, which explains our revalidation requirements and how doctors can meet these requirements to maintain their licence to practise. We have reviewed and made changes to this guidance as part of the work to implement Sir Keith Pearson’s recommendation in his report, Taking revalidation forward. The Board also agreed revised guidance on the supporting information that doctors need to collect and reflect on for their annual appraisal for revalidation. The revised guidance clarifies our requirements on supporting information rather than changing them.

d Revised criteria and guidance on breaks in practice. The revised policy on breaks in practice is likely to reduce processing times for some applications, as we will be removing the requirement to refer to a registration panel in certain circumstances. The policy will also enable us to provide clearer information for applicants with a break in practice and manage their expectations about the application process.

29 The Board also noted:

a The appointment of a mandatory Data Protection Officer ahead of the new General Data Protection Regulations (GDPR) due to come into force on 25 May 2018, and reporting to the GMC’s senior management and, if appropriate, the Audit and Review Committee on matters relating to compliance with the GDPR.

b The updated Procurement Policy and agreed that the approval of any minor amendments in future be delegated to the Director of Resources and Quality Assurance.

30 The Executive Board met on 29 January 2018 and considered:

a A number of exit scenarios reflecting the continued uncertainty with Brexit negotiations and our preparations for the operational implications to the GMC of leaving Europe. Key policy areas include registration routes for EEA graduates, CESR and CEGPR routes, minimum training periods and fitness to practise information sharing as well as any implications with respect to Northern Ireland.

b The establishment of the Policy Leadership Group (PLG). This is intended to address a gap identified by an internal audit report in 2017 which recommended that some form of central oversight be established for the coordination and development of policy across the business. The Board approved the Terms of Reference for the PLG and considered the relationship between the PLG and the Executive Board.
The Board also noted:

a A revised publication and disclosure written policy.

b The Modern Slavery Statement 2017 and that in future approval of this should be delegated the Chief Operating Officer.

c The draft of the first annual report to Council on the work undertaken by the Board during 2017.
Executive summary
This report provides an update on our operational performance, key project and programmes, and other operational matters arising including:

- The Transformation Programme
- GMC Services International (GMCSI)
- Professional Standards Authority (PSA) Performance Review 2016-17

Recommendations
Council is asked to:

a  Consider the report and Annex A (operational delivery summary report) and Annex B (corporate risk register).

b  Note the draft revised format for reporting on progress on delivering our corporate strategy at Annex C.
Issue

1 This report provides an update on our operational performance, Council priorities 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 2017.

Operational Key Performance Indicators (KPIs)

2 All operational key performance indicators, at Annex A, were met up to the end of December 2017 other than the exceptions set out below:

a 2016/17 Income and expenditure (7.28% positive variance). As at the end of 2017, income was £3,610k over budget as a result of additional Professional Linguistic Assessment Board (PLAB) candidates, the resulting rise in International Medical Graduate (IMG) applications and a general increase in the number of doctors holding a licence to practice. Expenditure was £3,902k under budget, mainly driven by operational headcount being significantly under budget to date. Additionally, panel and assessment costs and legal costs were lower than anticipated due to a reduction in the average length of hearings. Overall, we have a surplus of £12.9m against a budgeted surplus of £4.1m.

b In October 2017, we achieved 81% against our target of 90% to respond to ethical/standards enquiries within 15 working days. This data was not available at the time of my last report to you in December 2017. The missed KPI was primarily due to staff vacancies and the complexity of enquiries. Since then, two of the four vacant posts have been filled, and the team is also making a number of improvements to the ways enquiries are handled. We saw a positive performance of 95% for November and December 2018 and the team is working hard to sustain this in 2018.

Project updates

3 The majority of projects are on track other than the exceptions set out below. Further detail is at Annex A.

a Legislative reform - We have responded to Department of Health and Social Care consultation on Promoting professionalism, reforming regulation. The prospects for securing legislative reform nevertheless remain extremely uncertain given the appointment of a new Minister, Stephen Barclay MP, and the potential implications of rapid review into the application of gross negligence manslaughter in healthcare recently announced by the Secretary of State for Health. More detail is given in the Chief Executive’s Report.
b Medical Licensing Assessment (MLA) - We are on track against the overall programme plan and the critical path, in line with the proposals which Council approved in December 2017. Progress is reported as amber while we plan the future stages of implementation in greater detail. In a half-day workshop on 23 January, SMT and the Programme Board discussed this with the core team, led by a new Assistant Director who has been appointed to oversee the programme. The team will now build on this, and I expect to be able to report progress to you in April 2018.

c Credentialing - Reported as amber due to the on-going need to ensure shared objectives with the four health departments and others on credentialing. We have listened to the different views and are working to produce a revised definition of credentialing which highlights where it will add real value to professional development and workforce management, for further discussion with our stakeholders. We continue to engage closely with the four UK governments to update them on our progress with implementing the principles of the Shape report, and to ask their support for the legal changes which will be required to implement credentialing.

d Supporting vulnerable doctors - The majority of work within the programme is progressing well. It is reported as amber because we are re-considering the scope of several projects. This includes considering how best to align our work on a National Support Service with our programme to support doctors’ well-being.

e Digital Transformation 2020 - The first release of the new website is on track for delivery by April 2018. Progress is reported as amber as we are considering whether some functionality would need to be delayed beyond the initial launch. However, we do not anticipate this course of action would have a negative impact on overall user experience.

f The four-country implementation plan - this project has closed, and themes from this work will be incorporated under Strategic Aim 4 of the new Corporate Strategy ‘Meeting the changing needs of the health services across the four countries of the UK.’

Revised format for reporting against the Corporate Strategy

4 We have been working with teams around the organisation to create a benefit-map for our new corporate strategy so we can ensure we are impact led. A benefits map is a methodology used to understand the linkages between activities, outputs and capabilities that we will need to deliver to capture the strategic benefits we have defined in our strategy. Council will have the opportunity to consider the detail on our proposals on reporting against our new strategic aims at its meeting in April 2018. In

www.gmc-uk.org
the meantime, a revised and draft format for reporting against our new Corporate Strategy is provided at Annex C.

5 The primary change to the reporting is to shift our focus to one primarily based on measuring the impact of our work [the benefits we are seeking] as opposed to basing out reporting solely on activity measures based around progress, cost and resource. We will still report on activity but on a more exception basis. This is designed to give Council a high-level snapshot of progress in order to give assurance of delivery and confidence that we are measuring the impact of our strategic interventions on stakeholders and GMC business. We still have work to do across the organisation to firm up underpinning strategic benefits and measurements but this is an initial view of how we would like to present this information to Council and stakeholders.

Corporate risk register

6 The full Corporate Risk Register is at Annex B. Three new risks have been added:

a Risk 22A - Recognising the challenges with capacity in delivering the strategic commitments of the Education and Standards agenda.

b Risk 23A - Acknowledging the potential impact on the GMC of the publication of Health Education England (HEE)'s workforce strategy.

c Risk 24A - Reflects the risk of 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.

7 Risk 22 has been escalated to a significant residual risk to account for the pressures currently experienced by the NHS and wider system. We continue to monitor the impact of these, so we can take into account for our regulatory approach.

8 Following the High Court judgement in the case of Dr Bawa-Garba, we will be looking at the wider issues around medical manslaughter. Further detail of this work programme, which was announced by Professor Sir Terence Stephenson on 30 January 2018, can be found in the Chief Executive’s report.

GMC Transformation Programme

9 Progress with the Transformation Programme, which will help us become a more agile and relevant regulator, includes:

a Welcoming Paul Reynolds, our new Director of the newly established Strategic Communications and Engagement Directorate. Paul joined us on 9 January 2018.
The new Strategy and Policy Directorate is also now in place, under the leadership of Paul Buckley. This change will allow us to focus on priorities under our transformation agenda, including a model for more co-ordinated policy development, and closer engagement with key partners and those on the front line.

b  Piloting our new staff feedback process, ‘feedback for success’, with approximately 200 staff, across all levels of the organisation. Following a positive reception we are now looking to roll this out more widely in phased way throughout 2018.

c  Launching a new performance appraisal process in February 2018. The revised process is designed to drive greater emphasis on personal development, behaviours and contributions to the wider team.

d  An update presentation on the progress of the Transformation Programme was well received by the Audit and Risk Committee in January 2018 and we are now working with our internal auditors to “spot check” the initial set-up of the programme.

GMC Services International (GMCSI)

10  GMC Services International Ltd has now completed its first year of operation, with contracts won and delivered in each product line. A major international opportunity is experiencing delay due to external factors; however, the outlook for the future continues to look positive, with market interest registered in each of GMCSI’s key product areas. A recruitment exercise is underway to bring the business development team up to full strength by mid-2018, and we have recently appointed a new Business Development Manager.

Corporate Strategy 2018-2020

11  We have launched our 2018-2020 corporate strategy and we have begun an internal communications exercise with teams across the organisation to discuss what the strategy means for individuals, teams and the wider body-corporate. We have a range of external engagements planned, and we will discuss the key themes at our GMC conference in March 2018.

12  We have also finalised our new Equality, Diversity and Inclusion (ED&I) Strategy. This has been developed to support ED&I opportunities and challenges associated with our new strategic aims. As part of our ambitious new ED&I objectives we will set out to provide leadership and use our influence to identify, understand and address inequalities for doctors and patients in the wider healthcare system; as well as becoming a more inclusive organisation in the way we go about our business. I am grateful for the helpful feedback provided by members when drafting this strategy.
Our new Head of Equality and Diversity, Claire Light is now in place to take this forward.

*Professional Standards Authority (PSA) Performance Review 2016-17*

13 The PSA published its [report on our performance for 2016-17](#) on 8 February 2018. I am delighted that we have again met all of the PSA’s 24 Standards of Good Regulation. This is testament to the dedication and hard work of our staff throughout the business. We will bring a full paper to Council’s meeting in April 2018, setting out a more detailed analysis of the report.
Operational delivery summary

Data presented as at 31 December 2017 (unless otherwise stated)
Commentary accurate as at 2 February 2018
### Project summary (as at 31 December 2017)

<table>
<thead>
<tr>
<th>Project</th>
<th>Progress</th>
<th>Exceptions</th>
</tr>
</thead>
</table>
| **Organisational development** | Items on track  
- GMC Corporate Strategy development – the Corporate Strategy has been launched internally and has been [published on our website](#).  
- Investors in People (IIP) – We are developing a corporate social responsibility strategy, new feedback for success pilots, new performance tools, and the review of the reward and recognition scheme. A supplier has been appointed following a slight delay with procurement, and a planning workshop to agree timescales and the process for applying for accreditation took place 29 January 2018. | Previous | Current period | Delivery Risk Trend | Next period |
| **Responding to legislative change and influencing/driving the UK regulatory reform agenda** | Items on track  
- Understand the implications of, and responding to, emerging government plans for the UK withdrawal from the EU – We continue to monitor government plans for UK withdrawal from the EU, and monthly cross organisational working group meetings are on-going. In November 2017 the Senior Management Team (SMT) explored a number of policy issues and the organisation is now more aware of the implications of Brexit. The Executive Board also considered a number of exit scenarios at its meeting on 29 January 2018. The Regulation Policy and UK, European and International teams will provide an update on Brexit for Council in seminar in February 2018. | Previous | G | A | G |
| **Understand the context in which doctors practise** | Items on track  
- Consent guidance – The draft guidance has received an external legal check and been edited by the Publications team. We are continuing to work on the consultation questions, planning for consultation events, and working towards a launch date in March 2018.  
- Track and advise on impact of Health Board reconfiguration in Scotland and new models of care in England on GMC business including Sustainability and Transformation Plans and Accountable Care Organisations and related discussions in Wales and NI – In Wales, the report on the Parliamentary review was published on 16 January 2018. The recent government situation in Northern Ireland has delayed progress on healthcare reconfiguration. | Previous | G | G | G |
| **Medical Licensing Assessment** | Delays to our work  
- Legislative reform – We have responded to Department of Health and Social Care consultation on [Promoting professionalism, reforming regulation](#). The prospects for securing legislative reform nevertheless remain extremely uncertain given the appointment of a new Minister, Stephen Barclay MP, and the potential implications of rapid review into the application of gross negligence manslaughter in healthcare recently announced by the Secretary of State for Health.  
- Medical Licensing Assessment (MLA) – Progress is reported as amber while we plan the future stages of implementation in greater detail. In a half-day workshop on 23 January 2018, SMT and the Programme Board met with the core team to work towards this, led by the new Assistant Director who has been appointed to oversee the programme. | Previous | R | A | A |
<table>
<thead>
<tr>
<th>Project</th>
<th>Progress</th>
<th>Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 Revalidation review</td>
<td>Items on track - Evaluation of revalidation - In December 2017 we sought internal feedback on the quality and content of UMbRELLA's draft final report. We are developing a communication plan for the publication of the final report. We sent our comments on the draft final report back to UMbRELLA for consideration in January 2018. - Implementing the recommendations from the review of revalidation – Six outputs have now completed, including a decision on how to strengthen the quality assurance of appraisals for doctors without a connection, process changes for supporting doctors without a connection and our review of external revalidation evaluation studies. - Revalidation operations - All KPIs met.</td>
<td></td>
</tr>
<tr>
<td>6 Respond to Shape of Training Review</td>
<td>Items on track - Operationalising Standards for Curricula and Assessment – The curriculum approvals team are continuing to develop a schedule for curricula submissions, working closely with the Royal College and Faculties (RCF). We held meetings with RCFs and the Curriculum Oversight Group in January and February 2018, to set out the expectations for curricula submissions to ensure they comply with the requirements of Flexibility, Shape of Training and Excellence by design.</td>
<td></td>
</tr>
<tr>
<td>7 Fairness and Proportionality</td>
<td>Items on track - Deliver Equality &amp; Diversity (E&amp;D) Strategy 2014-17 – On track. - Differential attainment - We have successfully commissioned a Work Psychology Group to develop a practical guide for organisations delivering or designing training to evaluate the impact of local interventions. We are developing case studies with Southampton Medical School and others on local interventions to support groups at risk of lower attainment for publication in Spring 2018.</td>
<td></td>
</tr>
<tr>
<td>8 Supporting doctors, patients and relatives involved in fitness to practise investigations</td>
<td>Delays to our work</td>
<td></td>
</tr>
</tbody>
</table>

- Vulnerable doctors - Progress is amber as the scope and detail of two workstreams, Investigation Officer’s coordinating GMC wide correspondence and direct early communication with the doctor and their legal representation about the case/process, is not yet finalised. Resource is amber due to the absence of project manager for a brief period. | | | |
**Council meeting, 28 February 2018**

<table>
<thead>
<tr>
<th>Project</th>
<th>Progress</th>
<th>Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Delivery risk greater this period</td>
</tr>
<tr>
<td>9</td>
<td><strong>Communications and engagement</strong>&lt;br&gt;&lt;br&gt;<strong>Items on track</strong>&lt;br&gt;Communications and engagement strategy – Development of the engagement strategy on-going to ensure it is linked to the Corporate Strategy and the vision from the new Director of Strategic Communications &amp; Engagement. Media and development plans delivered and annual evaluation report underway.</td>
<td>G</td>
</tr>
<tr>
<td>10</td>
<td><strong>Develop our use and sharing of data and insight</strong>&lt;br&gt;&lt;br&gt;<strong>Items on track</strong>&lt;br&gt;Intelligence and Insight Unit data sharing projects – The second phase of the GMC Data Explorer had a ‘soft launch’ in December 2017 with no issues occurring. The formal launch will be aligned with the GMC conference in March 2018. The Responsible Officer (RO) Dashboard is now available to all RO’s and Regulators. Further engagement is planned in 2018 with the Care Quality Commission and Healthcare Inspectorate Wales to ensure effective utilisation.</td>
<td>G</td>
</tr>
<tr>
<td>11</td>
<td><strong>Speeding up fitness to practise procedures</strong>&lt;br&gt;&lt;br&gt;<strong>Items on track</strong>&lt;br&gt;FTP operations – All KPIs met.</td>
<td>G</td>
</tr>
</tbody>
</table>

**Delays to our work**
- Digital transformation 2020 - Progress is reported as amber as we are considering whether some functionality would need to be delayed beyond the initial launch. However, we do not anticipate this course of action would have a negative impact on overall user experience.

**Project closed**
- Four-country implementation plan – this project has closed, and planned work will be incorporated into our new, broader project on Ensuring Four Country Regulation which sits under the 2018-2020 Corporate Strategy.
## Operational Key Performance Indicator (KPI) summary

<table>
<thead>
<tr>
<th>Core regulatory objective</th>
<th>Key Performance Indicator (monthly)</th>
<th>Performance</th>
<th>Exception summary/ additional commentary if required</th>
</tr>
</thead>
<tbody>
<tr>
<td>We decide which doctors are qualified to work here and we oversee UK medical education</td>
<td>Decision on 95% of all registration applications within 3 months</td>
<td>Nov: 95%</td>
<td>On track</td>
</tr>
<tr>
<td>and training.</td>
<td></td>
<td>Dec: 98%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Decision on 95% of all revalidation recommendations within 5 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Respond to 90% of ethical/standards enquiries within 15 working days</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>We set the standards that doctors need to follow, and make sure that they continue</td>
<td>Conclude 90% of fitness to practise cases within 12 months</td>
<td>Nov: 95%</td>
<td>On track</td>
</tr>
<tr>
<td>to meet these standards throughout their careers.</td>
<td>Conclude or refer 90% of cases at investigation stage within 6 months</td>
<td>Dec: 90%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Conclude or refer 95% of cases at the investigation stage within 12 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Commence 100% of Investigation Committee hearings within two months of referral</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Commence 90% of tribunal hearings within nine months of referral (MPTS)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Commence 100% of Interim Order Tribunal hearings within 3 weeks of referral (MPTS)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>We take action to prevent a doctor from putting the safety of patients, or the public's</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>confidence in doctors, at risk.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Business support area</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Finance</td>
<td>2017/18 Income and expenditure - % variance (Green:&lt;2.0%, Amber: 2.01-4.0%, Red: &gt;4.1%)</td>
<td>Nov: 7.57%</td>
<td>On track</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dec: 7.28%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HR</td>
<td>Rolling twelve month staff turnover within 8-15%</td>
<td>Nov: 9.61%</td>
<td>On track</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dec: 8.54%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information systems</td>
<td>IS system availability (%) (Green &gt; 98.8% Amber: 98.7-97.7% Red:&lt;97.7%)</td>
<td>Nov: 98.9%</td>
<td>On track</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dec: 100%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Media and engagement</td>
<td>Monthly media score</td>
<td>Nov: 528</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dec: 2251</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Doctors and medical students surveyed who said they would change their practice as a result of</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>attending a Regional Liaison Service or Devolved Offices event (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact Centre</td>
<td>Answer 80% of calls within 20 seconds (2017)</td>
<td>Nov: 89%</td>
<td>On track</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dec: 85%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Financial summary (as at 31 December 2017)

<table>
<thead>
<tr>
<th></th>
<th>Budget Jan - Dec £000</th>
<th>Actual Jan - Dec £000</th>
<th>Variance £000</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operational expenditure</td>
<td>99,116</td>
<td>95,214</td>
<td>3,902</td>
<td>4%</td>
</tr>
<tr>
<td>Change programme</td>
<td>2,730</td>
<td>1,915</td>
<td>815</td>
<td>30%</td>
</tr>
<tr>
<td>New initiatives fund</td>
<td>2,000</td>
<td>1,530</td>
<td>470</td>
<td>24%</td>
</tr>
<tr>
<td>Total expenditure</td>
<td>103,846</td>
<td>98,659</td>
<td>5,187</td>
<td>5%</td>
</tr>
<tr>
<td>Total income</td>
<td>107,982</td>
<td>111,592</td>
<td>3,610</td>
<td>3%</td>
</tr>
<tr>
<td>Surplus/ (deficit)</td>
<td>4,136</td>
<td>12,933</td>
<td>8,797</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Budget Jan - Dec £000</th>
<th>Q3 Forecast £000</th>
<th>Variance £000</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operational expenditure</td>
<td>99,116</td>
<td>95,321</td>
<td>3,795</td>
<td>4%</td>
</tr>
<tr>
<td>Change programme</td>
<td>2,730</td>
<td>1,886</td>
<td>844</td>
<td>31%</td>
</tr>
<tr>
<td>New initiatives fund</td>
<td>2,000</td>
<td>1,550</td>
<td>450</td>
<td>23%</td>
</tr>
<tr>
<td>Total expenditure</td>
<td>103,846</td>
<td>98,757</td>
<td>5,089</td>
<td>5%</td>
</tr>
<tr>
<td>Total income</td>
<td>107,982</td>
<td>111,160</td>
<td>3,178</td>
<td>3%</td>
</tr>
<tr>
<td>Surplus/ (deficit)</td>
<td>4,136</td>
<td>12,403</td>
<td>8,267</td>
<td></td>
</tr>
</tbody>
</table>

### Significant issues / Changes from previous month:

**Staff costs (£2,139k under budget).** Our budgeting process assumes a vacancy rate of 25 roles. At the end of December 2017 we had 91 posts vacant. Of this, 49 posts were in the process of being recruited to, and 42 posts are purposefully being held vacant as either efficiency savings or while the role is being reviewed. We also had 43 un-budgeted staff appointed to cover increased workloads, dual running and maternity leave, so the net variance compared to budget is 48 posts. These figures relate purely to vacancies against budgeted posts, and so are directly linked to the reported underspend on staffing costs.

**ARF income (£1,490k over budget).** We are seeing a continued decrease in the numbers of doctors relinquishing their licence to practise and voluntarily erasing. When revalidation was first introduced some doctors considered that they no longer needed their licence to practise and so relinquished it. That position has now stabilised.

**PLAB income (£1,360k over budget).** PLAB volumes have increased for both tests to date compared to budgeted levels. The budgeted number of PLAB 1 candidates in 2017 was 3,399; the actual number of candidates was 5,410. The number of PLAB 2 candidates budgeted in 2017 was 2,006 and the actual number is 2,968. The number of PLAB 2 test days is 87, compared to the budgeted 59 days.

**Legal costs (£369k under budget).** The majority of the underspend is due to a reduction in barrister costs. This is driven by fewer MPTS hearings days and fewer High Court Extension cases. There has also been a reduction in costs when witnesses provide statements via video link following technology improvements.

**Panel & Assessment costs (£227k under budget).** In MPTS the budgeted number of hearing days in 2017 was 2,429 and the actual number was 2,336. This is due to a reduction in the average hearing length, driven by a combination of improvements in case management, sending out case papers in advance, better management of adjourned hearings, and fewer longer complex hearings. A further underspend is in relation to the Legally Qualified Chairs / Legal Assessor’s recruitment exercise, with application numbers being lower than expected. There are underspends in FTP due to fewer health assessment reports and medical supervisor reports. In Education there is an underspend mainly because of lower expenditure on the visits programme and Differential Attainment Expert Panel work as a direct result of the changes to the triage process. Costs in Registration and Revalidation are over budget due to additional demand for PLAB tests; however this is offset by additional income generated.

**Efficiency savings (£673k above target).** In total savings of £3,229k have been identified against a target to date of £2,556k. The majority of savings are driven by headcount being lower than budget. A proportion of the savings are one off in nature, where work is being covered for a limited period within existing resources but where the longer term aim is to fill the vacancy. Where staff savings are recurring they are now reflected in the 2018 budget.
## Financial – detail (as at 31 December 2017)

### Expenditure as at December 2017

<table>
<thead>
<tr>
<th></th>
<th>Budget Jan-Dec £000</th>
<th>Actual Jan-Dec £000</th>
<th>Variance £000</th>
<th>%</th>
<th>Budget Jan-Dec £000</th>
<th>Q3 Forecast £000</th>
<th>Variance £000</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Staff costs</strong></td>
<td>55,315</td>
<td>53,217</td>
<td>2,098</td>
<td>4%</td>
<td>55,315</td>
<td>53,456</td>
<td>1,859</td>
<td>3%</td>
</tr>
<tr>
<td><strong>Staff support costs</strong></td>
<td>3,270</td>
<td>3,400</td>
<td>(130)</td>
<td>(4)%</td>
<td>3,270</td>
<td>3,251</td>
<td>19</td>
<td>1%</td>
</tr>
<tr>
<td><strong>Office supplies</strong></td>
<td>2,093</td>
<td>1,960</td>
<td>133</td>
<td>6%</td>
<td>2,093</td>
<td>1,998</td>
<td>95</td>
<td>5%</td>
</tr>
<tr>
<td><strong>IT &amp; telecoms costs</strong></td>
<td>3,226</td>
<td>2,996</td>
<td>230</td>
<td>7%</td>
<td>3,226</td>
<td>2,958</td>
<td>268</td>
<td>8%</td>
</tr>
<tr>
<td><strong>Accommodation costs</strong></td>
<td>6,106</td>
<td>5,950</td>
<td>156</td>
<td>3%</td>
<td>6,106</td>
<td>5,950</td>
<td>156</td>
<td>3%</td>
</tr>
<tr>
<td><strong>Legal costs</strong></td>
<td>4,698</td>
<td>4,329</td>
<td>369</td>
<td>8%</td>
<td>4,698</td>
<td>4,346</td>
<td>352</td>
<td>7%</td>
</tr>
<tr>
<td><strong>Professional fees</strong></td>
<td>2,078</td>
<td>2,080</td>
<td>(2)</td>
<td>(0)%</td>
<td>2,078</td>
<td>1,972</td>
<td>106</td>
<td>5%</td>
</tr>
<tr>
<td><strong>Council &amp; members costs</strong></td>
<td>397</td>
<td>407</td>
<td>(10)</td>
<td>(3)%</td>
<td>397</td>
<td>399</td>
<td>(2)</td>
<td>(1)%</td>
</tr>
<tr>
<td><strong>Panel &amp; assessment costs</strong></td>
<td>13,245</td>
<td>13,018</td>
<td>227</td>
<td>2%</td>
<td>13,245</td>
<td>13,215</td>
<td>30</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Depreciation</strong></td>
<td>7,308</td>
<td>7,149</td>
<td>159</td>
<td>2%</td>
<td>7,308</td>
<td>7,068</td>
<td>240</td>
<td>3%</td>
</tr>
<tr>
<td><strong>PSA Levy</strong></td>
<td>707</td>
<td>708</td>
<td>(1)</td>
<td>(0)%</td>
<td>707</td>
<td>708</td>
<td>(1)</td>
<td>(0)%</td>
</tr>
<tr>
<td><strong>Unallocated efficiency savings</strong></td>
<td>673</td>
<td>0</td>
<td>673</td>
<td>0%</td>
<td>673</td>
<td>0</td>
<td>673</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Total expenditure</strong></td>
<td>99,116</td>
<td>95,214</td>
<td>3,902</td>
<td>4%</td>
<td>99,116</td>
<td>95,321</td>
<td>3,795</td>
<td>4%</td>
</tr>
<tr>
<td><strong>New initiatives fund</strong></td>
<td>2,000</td>
<td>1,530</td>
<td>470</td>
<td>24%</td>
<td>2,000</td>
<td>1,550</td>
<td>450</td>
<td>23%</td>
</tr>
<tr>
<td><strong>Change programme</strong></td>
<td>2,730</td>
<td>1,915</td>
<td>815</td>
<td>30%</td>
<td>2,730</td>
<td>1,886</td>
<td>844</td>
<td>31%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>103,846</td>
<td>98,659</td>
<td>5,187</td>
<td>5%</td>
<td>103,846</td>
<td>98,757</td>
<td>5,089</td>
<td>5%</td>
</tr>
</tbody>
</table>

### Income as at December 2017

<table>
<thead>
<tr>
<th></th>
<th>Budget Jan-Dec £000</th>
<th>Actual Jan-Dec £000</th>
<th>Variance £000</th>
<th>%</th>
<th>Budget Jan-Dec £000</th>
<th>Q3 Forecast £000</th>
<th>Variance £000</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual retention fees</strong></td>
<td>95,569</td>
<td>97,059</td>
<td>1,490</td>
<td>2%</td>
<td>95,569</td>
<td>96,988</td>
<td>1,419</td>
<td>1%</td>
</tr>
<tr>
<td><strong>Registration fees</strong></td>
<td>4,138</td>
<td>4,467</td>
<td>329</td>
<td>8%</td>
<td>4,138</td>
<td>4,292</td>
<td>154</td>
<td>4%</td>
</tr>
<tr>
<td><strong>PLAB fees</strong></td>
<td>2,467</td>
<td>3,827</td>
<td>1,360</td>
<td>55%</td>
<td>2,467</td>
<td>3,830</td>
<td>1,363</td>
<td>55%</td>
</tr>
<tr>
<td><strong>Specialist application OCT fees</strong></td>
<td>2,661</td>
<td>2,580</td>
<td>(81)</td>
<td>(3)%</td>
<td>2,661</td>
<td>2,576</td>
<td>(85)</td>
<td>(3)%</td>
</tr>
<tr>
<td><strong>Specialist application CESR/CEGPR fees</strong></td>
<td>819</td>
<td>845</td>
<td>26</td>
<td>3%</td>
<td>819</td>
<td>812</td>
<td>(7)</td>
<td>(1)%</td>
</tr>
<tr>
<td><strong>Interest income</strong></td>
<td>623</td>
<td>632</td>
<td>9</td>
<td>1%</td>
<td>623</td>
<td>616</td>
<td>(7)</td>
<td>(1)%</td>
</tr>
<tr>
<td><strong>Investment income</strong></td>
<td>260</td>
<td>607</td>
<td>347</td>
<td>133%</td>
<td>260</td>
<td>508</td>
<td>248</td>
<td>95%</td>
</tr>
<tr>
<td><strong>Other income</strong></td>
<td>1,445</td>
<td>1,575</td>
<td>130</td>
<td>9%</td>
<td>1,445</td>
<td>1,538</td>
<td>93</td>
<td>6%</td>
</tr>
<tr>
<td><strong>Total Income</strong></td>
<td>107,982</td>
<td>111,592</td>
<td>3,610</td>
<td>3%</td>
<td>107,982</td>
<td>111,160</td>
<td>3,178</td>
<td>3%</td>
</tr>
</tbody>
</table>

**Surplus / (deficit)**

<table>
<thead>
<tr>
<th></th>
<th>Budget Jan-Dec £000</th>
<th>Actual Jan-Dec £000</th>
<th>Variance £000</th>
<th>%</th>
<th>Surplus / (deficit) £000</th>
<th>Variance £000</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>4,136</td>
<td>12,933</td>
<td>8,797</td>
<td>213%</td>
<td>4,136</td>
<td>12,403</td>
<td>8,267</td>
</tr>
</tbody>
</table>
## Financial investments summary (as at 31 December 2017)

<table>
<thead>
<tr>
<th>Capital value of funds invested</th>
<th>Original value</th>
<th>Current value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£10,000</td>
<td>£10,579</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Asset Allocation</th>
<th>GMC thresholds</th>
<th>Current allocation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equities</td>
<td>20% - 50%</td>
<td>40.9%</td>
</tr>
<tr>
<td>Fixed interest</td>
<td>0% - 25%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Cash and near-cash</td>
<td>25% - 65%</td>
<td>47.5%</td>
</tr>
<tr>
<td>Infrastructure and operating assets</td>
<td>0% - 20%</td>
<td>5.5%</td>
</tr>
<tr>
<td>Property</td>
<td>0% - 10%</td>
<td>1.9%</td>
</tr>
<tr>
<td>Other</td>
<td>0% - 10%</td>
<td>4.2%</td>
</tr>
</tbody>
</table>

### Investment returns

<table>
<thead>
<tr>
<th>Investment returns</th>
<th>Annual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target (CPI + 2%)</td>
<td>5.00%</td>
</tr>
<tr>
<td>CCLA* performance</td>
<td>5.71%</td>
</tr>
</tbody>
</table>

*CCLA is the GMC's fund manager.
# Legal summary (as at 12 January 2018)

The tables below provide a summary of appeals and judicial reviews as at 12 January 2018:

<table>
<thead>
<tr>
<th>Case Type</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>6</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td>s.40A (GMC) Appeals</td>
<td>12</td>
<td>2</td>
<td>10</td>
<td>4</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>8</td>
<td>1</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>IOT Challenges</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

**Explanation of concluded cases**

- **s.40 (Practitioner) Appeals**
  - 5 appeals dismissed
  - 1 withdrawn

- **s.40A (GMC) Appeals**
  - 7 successful appeals
  - 1 unsuccessful
  - 2 withdrawn
  - 4 outstanding appeals

- **Judicial Reviews**
  - 3 permission refused
  - 1 withdrawn
  - 2 dismissed

**New referrals by the PSA to the High Court under Section 29 since the last report with explanation, and any applications outstanding**

- **PSA Appeals**
  - N/A

**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**

- **IOT challenges**
  - 2 new challenges
  - 2 withdrawn
  - 1 outstanding application

**Any other litigation of particular note**

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.
Corporate Risk Register

1. Corporate risk register
## Inherent business risks and how we manage them

### Strategic aim 1 - Making the best use of intelligence

<table>
<thead>
<tr>
<th>ID</th>
<th>Risk</th>
<th>Owner</th>
<th>Likelihood</th>
<th>Impact</th>
<th>Assessment</th>
<th>Controls in place to mitigate risk</th>
<th>Residual risk with controls in place</th>
<th>Council and/or Board Review</th>
<th>Assurance</th>
<th>Comment</th>
</tr>
</thead>
</table>
| 1 | Data Breach of the Data Protection Act (DPA) and/or Human Rights Act (HRA) may result in financial loss and/or reputational damage | N.Roberts | Highly Likely | Major | Critical | • Certified to ISO 27001, IG Toolkit and the Payment Card Industry information security standard PCI DSS  
• Certified to BSI 10008 standard  
• Monthly Information Security Working Group oversees controls  
• Security incident reporting process in place  
• All staff have performance objective to promote information security supported by mandatory training programme | | | | | | - |
| 2 | Delivery partners | P.Buckley | Highly Likely | Major | Critical | • GMC processes and systems have other relevant checks/controls  
• Individual process controls exist around major interfaces  
• Systems regulators: Care Quality Commission (CQC); Healthcare Inspectorate Wales; Healthcare Improvement Scotland; Regulation & Quality Improvement: Deanees and LETBs  
Medical Royal Colleges  
Public protection agencies  
NHS agencies / employers  
• Working closely with the Health and Social Care Regulators Forum to improve collaboration  
• Attendance at Special Measures and Challenge Provider Oversight Group (every two months)  
• External release of Organisational Dashboard to Responsible Officers (ROs) and CQC mid-July 2017 and release of GMC data explorer September 2017  
• Presenting at National Quality Board on data and insight and discussing how the systems in England share information (Nov 2017 and 2018 tbc) | | Council  
• Discussion at Council Seminar (April 2017)  
• Update on UKMED and Data Strategy (Jan 2017) | | | Internal Audit  
• ISO27001 Review (August 2017, green)  
• ISO10008 (August 2017, no major non-conformities)  
• Independent cyber security audit (August 2017, no critical findings)  
• ISO27001 and BS10008 Review (September 2016, green)  
• Penetration testing (August 2016 - green) | | - |
| 3 | Data Breach of the Data Protection Act (DPA) and/or Human Rights Act (HRA) may result in financial loss and/or reputational damage | N.Roberts | Highly Likely | Major | Critical | • Certified to ISO 27001, IG Toolkit and the Payment Card Industry information security standard PCI DSS  
• Certified to BSI 10008 standard  
• Monthly Information Security Working Group oversees controls  
• Security incident reporting process in place  
• All staff have performance objective to promote information security supported by mandatory training programme | | | | | | - |
Inherent business risks and how we manage them

<table>
<thead>
<tr>
<th>ID</th>
<th>Function / Activity</th>
<th>Owner</th>
<th>Likelihood</th>
<th>Impact</th>
<th>Assessment</th>
<th>Controls in place to mitigate risk</th>
<th>Residual risk with controls in place</th>
<th>Council and/or Board Review</th>
<th>Assurance</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>External environment</td>
<td>P. Reynolds</td>
<td>Quite likely</td>
<td>Moderate</td>
<td>Significant</td>
<td>- Understand and respond to political and health environment - skilled and resourced teams consider and manage developments in the external environment including: Regulation Policy (Horizon Scanning, Inquiries &amp; Reviews); Media and Campaigns; UK, European and International Affairs Team; Devolved Office (DO) and Intelligence Unit(s).&lt;br&gt; - Council membership, DO, Regional Liaison Service (RLS), Patient Safety Intelligence Forum (PSIF), and Advisory Forums provide insight across all UK countries and inform our work programme.&lt;br&gt; - Engagement programme for Chair and Chief Executive&lt;br&gt; - Performance monitoring and reporting&lt;br&gt; - Risk management framework - escalations&lt;br&gt; - Research agenda&lt;br&gt; - Quarterly UK Advisory Forum (UKAF) meetings in the devolved countries&lt;br&gt; - Joint Working Information Group (JWIG), meeting of GMC colleagues who provide services within a geographical area across four countries&lt;br&gt; - New Strategy function created within Strategy &amp; Policy Directorate&lt;br&gt; - Quarterly horizon scanning updates provided to the Executive Board</td>
<td>Quite likely</td>
<td>Moderate</td>
<td>Significant</td>
<td>Council&lt;br&gt; - Chair Exec report to each meeting covers the external environment &amp; strategic engagements&lt;br&gt; - Paper on GMC Corporate Strategy 2018 - 2020 (Feb 2017) together with research report on The Future Operating Environment of Professional Medical Regulation&lt;br&gt; - Corporate Strategy discussed at Council Seminar (Sept 17) and Council meeting for approval (Nov 17)&lt;br&gt; - Discussion of key issues from corporate strategy e.g upstream regulation at Council Away day (July 2017)</td>
</tr>
<tr>
<td>20</td>
<td>External environment</td>
<td>S. Goldsmith</td>
<td>Quite likely</td>
<td>Moderate</td>
<td>Significant</td>
<td>- Chair’s annual letter to the profession&lt;br&gt; - Monitoring and forecasting of Fitness to Practise case loads&lt;br&gt; - Monitoring of workforce information from NHS Digital re NHS staff shortages and skills gaps, and other external sources of quantitative and qualitative data, through horizon scanning (Data, Research and Insight team)&lt;br&gt; - Ongoing engagement with Department of Health (England) (DH(E)), Health Education England, and other stakeholders&lt;br&gt; - Monitoring external environment&lt;br&gt; - Active engagement with doctors about potential situations which may put patients at risk&lt;br&gt; - Enhanced monitoring process in place</td>
<td>Quite likely</td>
<td>Moderate</td>
<td>Significant</td>
<td>Council&lt;br&gt; - Fitness to Practise performance against Service Level Agreement (SLA) reported to each Council through the COO report&lt;br&gt; - Fitness to Practise performance against Service Level Agreement (SLA) reported to each Council through the COO report</td>
</tr>
</tbody>
</table>
### Inherent business risks and how we manage them

<table>
<thead>
<tr>
<th>ID</th>
<th>Risk</th>
<th>Function / Activity</th>
<th>Owner</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>ID Risk Controls in place to mitigate risk</td>
<td>Education - quality assuring providers</td>
<td>C. Melville</td>
<td>Assurance Council and/or Board Review Assurance of residual risk with controls in place</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Quite likely</td>
<td>Moderate</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Documented process and procedures to investigate and monitor concerns</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• ‘Cheque’ and thematic quality assurance enable short focussed visits to explore specific issues</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Trained and available staff and Associates</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Enhanced Monitoring Information Published on our website quarterly</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Relationships with other delivery partners</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Sharing of information across the organisation (PSF and RLS, Employer Liaison Service (ELS) via Joint Working Intelligence Group)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Operational Key Performance Indicators (KPIs) reported each meeting</td>
<td></td>
</tr>
</tbody>
</table>
|    | | | • Patient Safety Intelligence Forum
  • Considers patient risk dimension at each meeting | | |
|    | | | • Enhanced Monitoring Audit (November 2016, greenamber) | | |
|    | | | • Adoption of the new Standards in a regional QA visit review – phase 2 (September 2016, greenamber) | | |
|    | | | • Adoption of new standards in regional QA visit (May 2016, green) | | |
|    | | | • Review of regional quality assurance visits (July 2015, amber) | | |
| 4  | ID Risk Controls in place to mitigate risk | Revalidating doctors | U.Lane | Assurance Council and/or Board Review Assurance of residual risk with controls in place |
|    | | | Quite likely | Moderate | Low |
|    | | | • Documented process and procedures | | |
|    | | | • Regular performance monitoring and reporting | | |
|    | | | • Trained and available staff | | |
|    | | | • Local clinical 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 | | |
|    | | | • Support and guidance for Responsible Officers making recommendations through the Employer Liaison Service | | |
|    | | | • Work ongoing as part of the Taking Revalidation Forward programme to refine the protocol for those making RO recommendations, making our advice clear | | |
|    | | | • Operational KPIs reported each meeting | | |
|    | | | • Activity volumes and service target performance reviewed each meeting | | |
|    | | | • Internal Audit compliance review (November 2016, greenamber) | | |
|    | | | • UMBRELLA Report - commitment to ongoing study (final report due Q1 2018) | | |
|    | | | • Professional Standards Authority (PSA) Performance Review 2015/16 Standards of good regulation met | | |
|    | | | • Shaping the future of medical revalidation Interim report (January 2016) | | |
| 7  | ID Risk Controls in place to mitigate risk | Ethical standards & guidance | C. Melville | Assurance Council and/or Board Review Assurance of residual risk with controls in place |
|    | | | Quite likely | Moderate | Low |
|    | | | • Internal oversight group | | |
|    | | | • Established, documented procedures Public consultation used to develop and validate guidance | | |
|    | | | • Trained and available staff | | |
|    | | | • Extensive outreach and engagement activities to promote ethical guidance | | |
|    | | | • Proactive communications strategy and website improvements | | |
|    | | | • Use of the digital strategy and new products to enhance doctors’ use of the guidance, and app (launch December 2016) | | |
|    | | | • Transformation of our online digital offer - through Digital Media Strategy | | |
|    | | | • Agreement to provide cosmetic guidance update (Feb 2016) | | |
|    | | | • Regular updates during guidance development (ongoing) | | |
|    | | | • Annual tracking survey 2015 and 2017 indicated good awareness of our guidance | | |
|    | | | • Working with the Continuous Improvement team on Guidance development and capacity building project during 2017 and 2018 | | |
### Inherent business risks and how we manage them

<table>
<thead>
<tr>
<th>ID</th>
<th>Function / Activity</th>
<th>Risk</th>
<th>Owner</th>
<th>Likelihood</th>
<th>Impact</th>
<th>Assessment</th>
<th>Controls in place to mitigate risk</th>
<th>Residual risk with controls in place</th>
<th>Council and/or Board Review</th>
<th>Assurance</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>• Documented process and procedures</td>
<td>Quite likely</td>
<td>Omo A</td>
<td>Major</td>
<td>Critical</td>
<td></td>
<td>• Regular performance monitoring and reporting</td>
<td>• Training and available staff (general)</td>
<td>• Employer liaisons with ROs ensures all relevant information is considered during investigations</td>
<td>• ELA engagement with ROs to help identify and manage concerns (pre-investigation)</td>
<td>• Reform agenda to drive process improvements</td>
</tr>
<tr>
<td>2</td>
<td>• Documented process and procedures (Adjudication Manual)</td>
<td>Quite likely</td>
<td>Brown K</td>
<td>Major</td>
<td>Critical</td>
<td></td>
<td>• Regular performance monitoring and reporting</td>
<td>• Trained and available staff (including MPTS inductions)</td>
<td>• Tribunal members training and assessment (including induction programme)</td>
<td>• S60 changes implemented to bring further assurance to MPTS process including binding case management decisions.</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>• Case Review Team - documented processes and skilled resources</td>
<td>Unlikely</td>
<td>Omo A</td>
<td>Major</td>
<td>Significant</td>
<td></td>
<td>• Sanctions are listed on the List of Registered Medical Practitioners</td>
<td>• Notification of overseas regulators (if required)</td>
<td>• Publication of public hearing minutes</td>
<td>• Employer controls help protect patient safety</td>
<td>• Daily downloads of the register are sent to primary and secondary healthcare organisations</td>
</tr>
</tbody>
</table>

### Strategic aim 3 - Improving handling of complaints and concerns about patient safety

- **Internal Audit**
  - Review of Legal Services (June 2017, green-amber)
  - Review of the use of independent expert witnesses in FTIP activity (June 2017, green)
  - Provisional enquiries (April 2017, green-amber)
  - Implementation of Section 60 requirements (March 2016, green)

- **Other assurance**
  - Professional Standards Authority (PSA) Performance Review 2015/16 Standards of good regulation met
  - Field Fisher external audit of 100 closed cases completed June 2017 and found: “We considered that the GMC was conscious of its statutory obligations and acted proportionately in the context of the apparent risk and seriousness of the case in question. It is clear that those making case decisions on behalf of the GMC are experienced and knowledgeable decision makers who understand the principles of good regulation and robust investigation”

- **Executive Board**
  - • Operational FTIPs reported each meeting
  - • FTIP Annual Statistics Report (June 2016)

- **NHS Provider**
  - • SANCTIONS - doctors under conditions or undertakings do not comply with their sanctions and patients are harmed as a consequence
  - • SANCTIONS - doctors under conditions or undertakings do not comply with their sanctions and patients are harmed as a consequence

- **GMC**
  - • Medical Practitioners Tribunal Service – data integrity review (November 2017, amber)
  - • S60 operational review (November 2016, green-amber)
  - • Implementation of Section 60 requirements (March 2016 - green)
  - • MPTS system compliance of QA arrangements (February 2015, green-amber)

- **Other assurance**
  - Professional Standards Authority (PSA) Performance Review 2015/16 Standards of good regulation met
  - Review of MPTS outcomes and affected characteristics, no issues identified with bias toward gender or ethnicity (Feb 2017)
## Inherent business risks and how we manage them

<table>
<thead>
<tr>
<th>ID</th>
<th>Risk</th>
<th>Owner</th>
<th>Risk pre-controls</th>
<th>Controls in place to mitigate risk</th>
<th>Residual risk with controls in place</th>
<th>Council and/ or Board Review</th>
<th>Assurance</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Legislation</td>
<td>P. Buckley P. Reynolds</td>
<td>High</td>
<td>Highly Likely</td>
<td>Medium</td>
<td>Critical</td>
<td>Moderate</td>
<td>Significant</td>
</tr>
<tr>
<td>19</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>P. Buckley P. Reynolds</td>
<td>High</td>
<td>Highly Likely</td>
<td>Medium</td>
<td>Critical</td>
<td>Moderate</td>
<td>Significant</td>
</tr>
</tbody>
</table>
### Inherent business risks and how we manage them

<table>
<thead>
<tr>
<th>ID</th>
<th>Risk</th>
<th>Owner</th>
<th>Likelihood</th>
<th>Impact</th>
<th>Assessment</th>
<th>Controls in place to mitigate risk</th>
<th>Residual risk with controls in place</th>
<th>Council and/or Board Review</th>
<th>Assurance</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td>Global environment</td>
<td>The GMC’s regulatory effectiveness, credibility and reputation may erode over time if we don’t keep abreast of widening political agendas in the devolved nations and England and adapt accordingly, as highlighted by the outcome from the EU referendum and national elections</td>
<td>P. Reynolds</td>
<td>Quite likely</td>
<td>Moderate</td>
<td>Significant</td>
<td>• Understand and respond to political and health environment - skilled and resourced DO teams consider and manage developments in the external environment with consideration at regular four country strategic risk meeting&lt;br&gt;• UK Advisory Forums&lt;br&gt;• UK Regional dinners with key stakeholders&lt;br&gt;• Full implementation of DO Review&lt;br&gt;• Action plan developed to implement outcomes of Council seminar paper “The vote to leave the EU and regulating in a four country and international context” July 2016&lt;br&gt;• Brexit internal working group set up&lt;br&gt;• We secured external support from a member of KPMG who joined the GMC on a 3 month secondment on 8 May 2017 to explore how we improve coherence at a national and regional level within England</td>
<td>Quite likely</td>
<td>Minor</td>
<td>Low</td>
</tr>
</tbody>
</table>

---

44
<table>
<thead>
<tr>
<th>ID</th>
<th>Risk</th>
<th>Owner</th>
<th>Likelihood</th>
<th>Impact</th>
<th>Assessment</th>
<th>Controls in place to mitigate risk</th>
<th>Residual risk with controls in place</th>
<th>Assurance</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Registering doctors</td>
<td>U.Lane</td>
<td>Quite likely</td>
<td>Moderate</td>
<td>Critical</td>
<td>• Documented process and procedures: UK graduates EEA IMG Specialist and GP applications</td>
<td>• Identify and document checks face to face and physical document checks</td>
<td>Unlikely</td>
<td>Moderate</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Post-registration primary source verification conducted on a risk based sample of newly registered doctors</td>
<td>• Revised Decision maker’s guidance (launched 2016)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Regular performance monitoring and reporting</td>
<td>• Trained and available staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Information exchange with competent authorities informs our processes (Including Internal Market Information alert mechanism)</td>
<td>• Daily downloads of the register are sent to primary and secondary healthcare organisations</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Use of Royal colleges for clinical input into CESR and CEGPR applications</td>
<td>• Skilled and resourced media team to handle media enquiries</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Communications activities to raise awareness of our role:</td>
<td>• Co-ordinated campaign planning with policy directorates</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• News bulletins to stakeholders and key audiences in 4 countries</td>
<td>• Proactive media and social media campaigns about our role</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Professional and active corporate presence on all main social media channels</td>
<td>• GMC processes and systems have other relevant checks/control:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Digital Media Strategy includes audience plans</td>
<td>• Governance - media principles agreed by Chair &amp; Chief Executive</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Communication activities to emphasise independence of GMC role from MPTS</td>
<td>• Development of Media Strategy includes audience plans</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>particularly around decision making</td>
<td>• Digital Media Strategy - improving channels of communication for key stakeholders and providing more interactive communications</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Strategic aim 4 - Working more closely with doctors, medical students and patients

<table>
<thead>
<tr>
<th>ID</th>
<th>Risk</th>
<th>Owner</th>
<th>Likelihood</th>
<th>Impact</th>
<th>Assessment</th>
<th>Controls in place to mitigate risk</th>
<th>Residual risk with controls in place</th>
<th>Assurance</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td>Media</td>
<td>P. Reynolds</td>
<td>Low</td>
<td>Moderate</td>
<td>Significant</td>
<td>• Skilled and resourced media team to handle media enquiries</td>
<td>• Receive daily media cuttings</td>
<td>Unlikely</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Communications activities to raise awareness of our role:</td>
<td>• Receive GMC press releases</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Co-ordinated campaign planning with policy directorates</td>
<td>• Informal session on the work of the media team (April 2016)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• News bulletins to stakeholders and key audiences in 4 countries</td>
<td>• Media performance reviewed at each Council</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Proactive media and social media campaigns about our role</td>
<td>• Governance - media principles agreed by Chair &amp; Chief Executive</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Professional and active corporate presence on all main social media channels</td>
<td>• Development of Media Strategy includes audience plans</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• GMC processes and systems have other relevant checks/control:</td>
<td>• Digital Media Strategy includes audience plans</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Digital Media Strategy - improving channels of communication for key stakeholders and providing more interactive communications</td>
<td>• Communication activities to emphasise independence of GMC role from MPTS particularly around decision making</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Inherent business risks and how we manage them

<table>
<thead>
<tr>
<th>ID</th>
<th>Function / Activity</th>
<th>Owner</th>
<th>Likelihood</th>
<th>Impact</th>
<th>Assessment</th>
<th>Residual risk with controls in place</th>
<th>Council and/or Board Review</th>
<th>Assurance</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>Governance</td>
<td>S.Jones</td>
<td>Highly likely</td>
<td>Major</td>
<td>Overall</td>
<td>Unlikely</td>
<td>Material</td>
<td>Low</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Our governance arrangements may not enable the Trustees to discharge their accountabilities effectively</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Governance arrangements in place including Council, executive and external engagement and in relation to GMC Services International Ltd</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Performance management system for members and staff</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Business planning &amp; budget setting process</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Risk Management Framework</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Performance monitoring &amp; reporting</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Policies and procedures</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Internal audit</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Council member training and annual appraisal in place</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Regular governance reviews</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Governance and Council effectiveness review- independent report on governance framework received and discussed by Council in November 2017. Follow up paper to Council was considered in December 2017.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4-yearly review of the Schedule of Authority was signed off by Council in December 2017</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Financial controls (fraud) and expenditure</td>
<td>N.Roberts</td>
<td>Quite likely</td>
<td>Moderate</td>
<td>Self-assessed</td>
<td>Low</td>
<td>Material</td>
<td>Low</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Our anti fraud procedures and processes may not prevent internal or external parties from committing fraud and thereby the GMC resulting in monetary loss</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Business planning &amp; budget setting process to ensure funds are allocated appropriately</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Monthly management reporting and review</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Financial Regulations and financial controls including delegated authorities by the Exec Board</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fraud-control processes including policy, training, response plan, public interest disclosure policy and anti-fraud and corruption policy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Gifts and hospitality policy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Oversight of Investment Policy by Investment Sub Committee</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Anti-fraud mandatory training launched (Oct 17)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Training to support procurement processes include Sourcing, Purchasing (e-learning) and Contract Management</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Strategic aim 5 - Working better together to improve our effectiveness in delivery of regulatory functions**

- Governance:
  - CE and CDO reports at each meeting
  - Report of the Performance & Resources Board (February 2017)
  - Council forward work programme 2017 (February 2017)
  - Report of the Audit and Risk Committee (June 2017)
  - Review of Council effectiveness (ongoing)

- Financial controls (fraud) and expenditure:
  - Annual Report & Accounts 2016 (June 2017)
  - Fitness to Practice Annual Report 2016 (June 2017)
  - Financial performance reported as part of CDO report each meeting

- Executive Board:
  - Financial performance reviewed at each meeting

- Audit & Risk Committee:
  - Review of annual accounts (May 2017)
  - Review of gifts and hospitality register, fraud and procurement exceptions (January 2017)

- Council:
  - Performance reporting to Council (September 2016, green)
  - Change programme risk management (June 2016, green)
  - Equality and diversity review (June 2016, green)
  - Risk benchmarking review (January 2016, green)
  - Operational risk management (June 2015, green-amber)
  - Review of whistleblowing arrangements spot-check (March 2015)
  - Gifts and hospitality spot check (March 2015)
  - HR performance data reporting (February 2015, green)

- Other Assurance:
  - Four year scheduled review of Governance in 2017
  - External audit of financial accounts, 2016, 2015
  - Expenses audit (September 2017, green)
  - Payroll audit (October 2017, green)
  - Expenses spot check (August 2017, green)
  - Contract management arrangements review (May 2017, amber)
  - Contract management arrangements review (October 2016, amber)
  - Budget management and monitoring (October 2016, green)
  - Anti-fraud arrangements (May 2015, green)
  - Financial controls review (October 2015, green)
  - Procurement review (March 2015, green)
  - External audit of financial accounts 2016, 2015
<table>
<thead>
<tr>
<th>ID</th>
<th>Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>Work programme delivery</td>
</tr>
<tr>
<td>16</td>
<td>Staffing</td>
</tr>
</tbody>
</table>

**Inherent business risks and how we manage them**

<table>
<thead>
<tr>
<th>Function / Activity</th>
<th>Owner</th>
<th>Likelihood</th>
<th>Impact</th>
<th>Assessment</th>
<th>Controls in place to mitigate risk</th>
<th>Residual risk with controls in place</th>
<th>Assurance</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Internal Audit</td>
<td></td>
</tr>
<tr>
<td>Work programme delivery</td>
<td>C. Massey (S. Goldsmith)</td>
<td>Quite likely</td>
<td>Major</td>
<td>Critical</td>
<td>• Business planning &amp; budget setting process</td>
<td>• Delivery progress update as part of CDO report at each meeting</td>
<td>Council</td>
<td>• Business planning (November 2017, green-amber)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Risk Management (including risk escalation matrix incorporating SLA variation triggers)</td>
<td>• 2017 Business Plan &amp; Delivery (Dec 2016)</td>
<td>Executive Board</td>
<td>• Risk Management in Projects (June 2017, amber)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Monthly monitoring of delivery progress and reporting</td>
<td>• Programme Management Office spot check follow up (November 2016, green-amber)</td>
<td>Internal Audit</td>
<td>• Review of Change Programme Benefits Realisation (June 2017, green-amber)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Centralised Corporate Business Planning team embed processes and systems across Directorates</td>
<td>• Change Programme Risk Management (June 2016, green-amber)</td>
<td>Other assurance</td>
<td>• Programme Management Office spot check (May 2016, green-amber)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Trained and skilled staff in project management</td>
<td>• Change Programme planning (March 2016, green-amber)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• PPM methodology and reporting: update on risks and project delivery every month via highlight reports with daily availability of progress for all including Portfolio Lead, Sponsor, Project Manager, PNO and CDO</td>
<td>• Operation risk management (June 2015, green-amber)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Corporate Business Planning Manager stage gate reviews for corporate projects</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staffing</td>
<td>N. Roberts</td>
<td>Quite likely</td>
<td>Major</td>
<td>Critical</td>
<td>• Talent and leadership programmes builds capacity</td>
<td>Council receive an annual HR report</td>
<td></td>
<td>• Review of induction planning (August 2016, green)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Corporate record keeping systems and requirements enable central record for corporate memory</td>
<td>Executive Board</td>
<td>• HR appraisal review (June 2015, green-amber)</td>
<td>• HR conducting annual review of succession planning</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Directors and ADs identify unique knowledge, skills and relationships to ensure suitable mechanisms in place to record transfer</td>
<td>Internal Audit</td>
<td>• Internal checks are carried out on the quality of the performance management system throughout the year</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Annual performance management cycle and learning and development function identify staff training needs and prioritise and support staff development as required</td>
<td>Other assurance</td>
<td>• Internal checks are carried out on the quality of the performance management system throughout the year</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• 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.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Working with our PSL partners to source candidates and temps to ensure core functions are supported.</td>
<td></td>
<td>Transformation Portfolio set up June 2017 to oversee delivery of enhancing our organisational capabilities. Programmes of work are designed around embedding a clearer sense of purpose and impact; empowering and developing our people; injecting more pace, agility and cross-organisational working; and enhancing our engagement with the healthcare system</td>
<td></td>
</tr>
</tbody>
</table>
## Inherent business risks and how we manage them

<table>
<thead>
<tr>
<th>ID</th>
<th>Risk</th>
<th>Owner</th>
<th>Likelihood</th>
<th>Impact</th>
<th>Assessment</th>
<th>Controls in place to mitigate risk</th>
<th>Residual risk with controls in place</th>
<th>Council and/or Board Review</th>
<th>Assurance</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>17</td>
<td>Business Continuity</td>
<td>N.Roberts</td>
<td>Quite likely</td>
<td>Major</td>
<td>Critical</td>
<td>• Business continuity plans in place including periodic testing - focused on core business as usual areas to ensure patient safety protection&lt;br&gt;• Alternative routing procedures and systems in place to manage faults when they arise&lt;br&gt;• Investment programme in resilience components to proactively avoid faults&lt;br&gt;• Cyber security plan&lt;br&gt;• Regular programme of penetration tests&lt;br&gt;• Programme of phishing education for staff and random testing&lt;br&gt;• Regular programme of installing software patches to address identified vulnerabilities&lt;br&gt;• Suite of security products in place including virus identification, web filtering, email filtering, firewalls&lt;br&gt;• Testing of process recovery&lt;br&gt;• Information security processes protect against IS failures&lt;br&gt;• Business Continuity mandatory training launched (May 17)&lt;br&gt;• Business Continuity Champions appointed for each directorate across GMC sites</td>
<td>Unlikely</td>
<td>Moderate</td>
<td>Low</td>
<td>Business Continuity Working Group - (2 monthly)&lt;br&gt;Annual report to Executive Board for review&lt;br&gt;• Attendance from Business Continuity Working Group to Executive Board&lt;br&gt;Council circular&lt;br&gt;• 15.5.17 following widespread ransomware attack</td>
</tr>
<tr>
<td>18</td>
<td>Operation of DB pension scheme</td>
<td>N.Roberts</td>
<td>Quite likely</td>
<td>Major</td>
<td>Critical</td>
<td>• Maintaining adequate reserves&lt;br&gt;• Future liabilities restricted by scheme closure and benefits changes&lt;br&gt;• Full implementation of Trustees de-risking investment strategy</td>
<td>Unlikely</td>
<td>Moderate</td>
<td>Low</td>
<td>Council have concluded a strategic review.</td>
</tr>
<tr>
<td>23</td>
<td>GMC Services International Ltd</td>
<td>C. Massey</td>
<td>Quite likely</td>
<td>Major</td>
<td>Critical</td>
<td>• Governance framework established and agreed with Council (April 2017)&lt;br&gt;• GMC/GMCSI Forum now meeting monthly with GMC Directors given early sight of opportunities&lt;br&gt;• GMC Services International Ltd Operating Agreement (June 2017)&lt;br&gt;• Ongoing and regular updates to CDD on projects&lt;br&gt;• The ethical guidelines and what if developed and agreed with the GMCSI Chair and Board were presented to the GMC Council as part of an ethics session in December 2017</td>
<td>Unlikely</td>
<td>Moderate</td>
<td>Low</td>
<td>Council&lt;br&gt;• Quarterly Report Sept 2017&lt;br&gt;• Governance arrangements April 2017</td>
</tr>
</tbody>
</table>
Current active risks and how we are reducing them

<table>
<thead>
<tr>
<th>ID</th>
<th>Risk</th>
<th>Owner</th>
<th>Existing controls (incl. Local QA where relevant)</th>
<th>Residual</th>
<th>Further mitigating actions to be implemented (with target date)</th>
<th>Council and/or Board Review</th>
<th>Internal Audit coverage</th>
<th>Comment (incl. external assurance where relevant)</th>
<th>Risk target</th>
<th>Corporate Risk that Action Plan relates to</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Strategic aim 1 - Making the best use of intelligence

- **Data Strategy**
  - Patient Safety Intelligence Forum
  - Quality Architecture Project Group
  - Quarterly surveillance groups consider risk with CQC
  - Existing specialist data teams and Siebel analytics capability
  - Regular (8 weekly) intelligence sharing meetings in place (Regional Information Forums)
  - MiDr: Healthcare Inspectorate Wales, TDA and RQIA, Health Improvement Scotland
  - DO protocol for escalation processes - JWIG meeting brings together DOs, RLS, RQIA & Education to share information.
  - Existing employer controls to protect patient safety
  - Systems regulators, professional regulators, professional bodies, education institutions activity overseeing patient safety
  - Revision of escalation process and RLS operating model (June 2016)
  - Central Analytics Team now in place with responsibility for co-ordinating data sharing
  - Evaluation of data sharing agreements completed by CAT (April 2017)
  - Engaging with CQC/HEE/NHSI Oversight Group
  - Working closely with the Health and Social Care Regulators Forum to improve collaboration
  - Work on escalation criteria

- **Intelligence Forum Manager and Stakeholder Intelligence Sharing Manager now in post**
  - External release of Agora (March 2018)
  - First release took place in September, 2nd release took place Dec 2018
  - Release of Organisation dashboard for Responsible Officers in all four countries
  - Development of an Intelligence Strategy which was discussed at the Patient Safety Intelligence Forum (Oct 17)

**Performance & Resources Board**
- Resourcing the data strategy (June 2016)
- Developing the online medical register (December 2016 and Feb 2017)
- Evening seminar - Risk Based regulation (April 2017)
- Drop in session at Council away day on Intelligence & Insight Unit offering (June 2017)

**Data Strategy and Intelligence follow up**
- August 2016, green-amber
- Intelligence review (Nov 2015, amber)

**Intelligence review**
- Feb 2015, green

**By not effectively sharing the information we hold throughout the organisation or broader health service, we could contribute to a risk to patient safety**

P Buckley
<table>
<thead>
<tr>
<th>ID</th>
<th>Function / Activity</th>
<th>Owner</th>
<th>Risk</th>
<th>Existing controls (incl. Local QA where relevant)</th>
<th>Residual</th>
<th>Further mitigating actions to be implemented (with target date)</th>
<th>Council and/or Board Review</th>
<th>Internal Audit coverage</th>
<th>Comment (incl. external assurance where relevant)</th>
<th>Risk target</th>
<th>Corporate Risk that Action Plan relates to</th>
</tr>
</thead>
<tbody>
<tr>
<td>44</td>
<td>Equality, Diversity and Inclusion</td>
<td>S. Goldsmith</td>
<td>Low</td>
<td>Quite likely</td>
<td>Moderate</td>
<td>Line</td>
<td>Single</td>
<td>Strategy &amp; Policy Board</td>
<td>Council</td>
<td>E&amp;D operationalisation (July 2016, green)</td>
<td>Moderate</td>
</tr>
<tr>
<td></td>
<td>Equality, Diversity and Inclusion Strategy 2018-2020 developed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>RAND Europe Research and Seminar on fair decision making (November 2017)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Directorate action plans</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Skilled and resourced team to promote E&amp;D in our work</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Equality analysis undertaken as a component of major project activity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Equality and diversity training for all staff and associates</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E&amp;D Steering Group (chaired by COO)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unconscious Bias training delivered to key staff and associates involved in making decisions about doctors</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>We took legal advice on our compliance with Sections 15 and 22 of the Gender Recognition Act (GRA) 2004 in how we handle and share information about transgender patients in our FTP activities. FtP &amp; Info Gov have agreed an action plan.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Work on reasonable adjustments and supporting disabled people</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Joined AoMRC working group to develop guidance on making reasonable adjustments in high stakes exams</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Scrutiny of Curriculum Advisory Group (CAG) submissions for their E&amp;D evidence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Developed supplementary E&amp;D guidance for promoting excellence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Current active risks and how we are reducing them**

- **We do not comply with our statutory obligations on Equality and Diversity and Human rights, leading to unfair outcomes**
  - Equality, Diversity and Inclusion Strategy 2018-2020 developed
  - RAND Europe Research and Seminar on fair decision making (November 2017)
  - Directorate action plans
  - Skilled and resourced team to promote E&D in our work
  - Equality analysis undertaken as a component of major project activity
  - Equality and diversity training for all staff and associates
  - E&D Steering Group (chaired by COO)
  - Unconscious Bias training delivered to key staff and associates involved in making decisions about doctors
  - We took legal advice on our compliance with Sections 15 and 22 of the Gender Recognition Act (GRA) 2004 in how we handle and share information about transgender patients in our FTP activities. FtP & Info Gov have agreed an action plan.
  - Work on reasonable adjustments and supporting disabled people
  - Joined AoMRC working group to develop guidance on making reasonable adjustments in high stakes exams
  - Scrutiny of Curriculum Advisory Group (CAG) submissions for their E&D evidence
  - Developed supplementary E&D guidance for promoting excellence

**Strategy & Policy Board**
- Consider and update on 2016 plans & priorities (May 2016)

**Council**
- Update via COO report (ongoing)
- Seminar on Fairness & Proportionality (April 2016)
- Update on implementation of our strategy (Sept 2016)
- Council Seminar on new E&D Strategy (June 2017)
- Evening seminar to seek views on strategic aims of new E&D strategy (June 2017)
- Discussion on new E&D Strategy (Oct/Nov 2017)

**Education and Training Board**
- Will consider how to ensure reasonable adjustments within the continuum of medical education and training (Oct 2016)
### Current active risks and how we are reducing them

<table>
<thead>
<tr>
<th>ID</th>
<th>Risk</th>
<th>Owner</th>
<th>Existing controls (incl. Local QA where relevant)</th>
<th>Residual</th>
<th>Further mitigating actions to be implemented (with target date)</th>
<th>Council and/or Board Review</th>
<th>Internal Audit coverage (incl. external assurance where relevant)</th>
<th>Comment</th>
<th>Risk target</th>
<th>Corporate Risk that Action Plan relates to</th>
</tr>
</thead>
</table>
| 10A | Educational Management | C. Melville | • Governance arrangements in place, a Programme Board chaired by the CEO providing oversight (and reporting to Council via Executive Board)  
• A dedicated Assistant Director has been appointed to MLA (January 2018)  
• 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 materially informing programme development  
• ERG subgroups for Applied Knowledge Test and Clinical and Professional Skills Assessment established (June 2017), contributing content expertise to programme development | High | • Actions being taken forward following the amber rating from the internal audit (April - December 2017)  
• Ongoing resource planning and recruitment to reflect developing programme planning. | | | | | | |
| 14A | Working with regulatory partners | S. Goldsmith | • Information sharing agreement in place with CDC  
• Working closely with the Health and Social Care Regulators Forum to improve collaboration  
• Education enhanced monitoring process in place  
• Internal processes to manage communications  
• Trained and available staff | High | • 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 and other regulatory partners causing an adverse reputational impact for the GMC | | | | | | |

### Strategic aim 2 - Raising standards in medical education and practice

- 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 timeframe and budget.
- 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 bodies, 1A - reducing the risk of external oversight and potentially unsafe environments for doctors and patients.
- Within the NHS, there is a significant number of doctors and other health and care professionals working together to deliver high-quality care. However, there is a need for greater collaboration and sharing of information between different parts of the healthcare system, 1A - ensuring that doctors and other health and care professionals are fully informed of relevant developments and able to work effectively together.
- We are currently undertaking a lessons learned exercise, including whether there are ways to improve our joint working with other regulators and regulatory partners causing an adverse reputational impact for the GMC.

| Strategy & Policy Board | Initial business case May 2015  
• Adopted MLA Programme Board as its task and Finish Group February 2017 (transferred to Executive Board June 2017)  
• Governance arrangements in place, a Programme Board chaired by the COO (June - September 2017), programme manager appointed  
• Expert Reference Group (ERG) appointed, meeting regularly from October 2016 and materially informing programme development  
• ERG subgroups for Applied Knowledge Test and Clinical and Professional Skills Assessment established (June 2017), contributing content expertise to programme development | High | • Actions being taken forward following the amber rating from the internal audit (April - December 2017)  
• Ongoing resource planning and recruitment to reflect developing programme planning. | | | | | | |
### Current active risks and how we are reducing them

<table>
<thead>
<tr>
<th>ID</th>
<th>Risk</th>
<th>Owner</th>
<th>Existing controls (incl. Local QA where relevant)</th>
<th>Residual Control</th>
<th>Further mitigating actions to be implemented (with target date)</th>
<th>Council and/or Board Review</th>
<th>Internal Audit coverage</th>
<th>Comment (incl. external assurance where relevant)</th>
<th>Risk target</th>
<th>Corporate Risk that Action Plan relates to</th>
</tr>
</thead>
<tbody>
<tr>
<td>13A</td>
<td>Utilising data</td>
<td>P.Buckley</td>
<td>Further historical abuse cases involving doctors come to light which call into question the GMC’s actions at the time and impact on our reputation as a patient safety organisation</td>
<td>High/Low</td>
<td>Review of historical child abuse cases January 2018 - March 2018</td>
<td>Council</td>
<td></td>
<td></td>
<td>Quite likely</td>
<td>Moderate</td>
</tr>
</tbody>
</table>

#### Strategic aim 3 - Improving handling of complaints and concerns about patient safety

- Regular media monitoring of historic abuse cases
- Internal Historic Abuse Inquiries Project Group to monitor and manage interactions with all inquiries and take forward internal review of historic abuse cases
- Scanning of bound volumes of historic fitness to practise cases dating back to 1945 is complete
- Engaging with CQC/HEE/NHS Oversight Group
- We shared the outcome of Sir Anthony Hooper’s Review of Dr Fraser case with the Historical Abuse Inquiry in England
- Anthony Omo attended Historic Abuse Inquiry (England) seminar in September 2017, as part of a series of seminars to gather information and views… and to identify matters for further investigation and scrutiny. There was no criticism of the GMC during the seminars and our guidance, webpages and tools were commended.

- Further mitigating actions to be implemented (with target date)
  - Eversheds review of historic abuse cases January 2018 - March 2018
  - The review will be overseen by the Historical Abuse Inquiries Project Group, and findings will be reported to Council in due course
- We completed our analysis of GMC cases for the wider review in January 2018 and will report to Council and Audit and Risk Committee in Spring 2018.
Current active risks and how we are reducing them

<table>
<thead>
<tr>
<th>ID</th>
<th>Risk</th>
<th>Owner</th>
<th>Existing controls (incl. Local QA where relevant)</th>
<th>Residual</th>
<th>Further mitigating actions to be implemented (with target date)</th>
<th>Council and/or Board Review</th>
<th>Internal Audit (incl. external assurance where relevant)</th>
<th>Comment (incl. external assurance where relevant)</th>
<th>Risk target</th>
<th>Corporate Risk related to</th>
</tr>
</thead>
<tbody>
<tr>
<td>17A</td>
<td>S&amp;C directorate restructuring</td>
<td>C. Massey, S. Goldsmith</td>
<td>The planning and restructuring of the current Strategy and Communication Directorate in to separate Strategy &amp; Policy and Strategic Communication &amp; Engagement directorates, and their integration with the existing directorates, is not supported with the appropriate level of resource and capability detracting from our ability to continue to deliver business as usual and undermining staff morale.</td>
<td>Unlikely</td>
<td>Quite likely, Moderate, Significant</td>
<td>Council private session CEO update February 2017</td>
<td></td>
<td></td>
<td></td>
<td>Council private session CEO update February 2017</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Current Director of Strategy and Communication to continue oversight of existing directorate until a new appointment is made</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Appointment of Director of Strategic Communications and Engagement – Paul Reynolds – start date tbc</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Policy Leadership Group set up to help develop new ways of working in Strategy &amp; Policy Directorate</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Implementation developed for the setting up of two new directorates</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Project Management support secured to support implementation of two new directorates</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Development of new directorates being monitored through the Transformation Programme</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18A</td>
<td>Working with HEE</td>
<td>C. Melville</td>
<td>Due to the proposals for structural changes and staff reductions at Health Education England, there is a risk that their ability to provide us with the data and support that we need for quality management, clarity around their roles and responsibilities and capacity to respond to problems locally and engage in support of the GMC training surveys may be impaired</td>
<td>Unlikely</td>
<td>Quite likely, Moderate, Significant</td>
<td>Executive Board</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Teams are having regular discussions and meetings with HEE at strategic and operational levels</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Ongoing continuous improvement work to reduce the monitoring burden on HEE.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Resource restrictions are being taken into account within the Development of the Quality Assurance Cycle project</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Surveys team provide support to HEE teams during NTS data validation, and survey operational phases.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Process for approving training posts/programmes has been improved to reduce admin burden on HEE teams.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Strategic aim 5 - Working better together to improve our effectiveness in delivery of regulatory functions

17A

The planning and restructuring of the current Strategy and Communication Directorate in to separate Strategy & Policy and Strategic Communication & Engagement directorates, and their integration with the existing directorates, is not supported with the appropriate level of resource and capability detracting from our ability to continue to deliver business as usual and undermining staff morale.

- Current Director of Strategy and Communication to continue oversight of existing directorate until a new appointment is made.
- Appointment of Director of Strategic Communications and Engagement – Paul Reynolds – start date tbc.
- Policy Leadership Group set up to help develop new ways of working in Strategy & Policy Directorate.
- Implementation developed for the setting up of two new directorates.
- Project Management support secured to support implementation of two new directorates.
- Development of new directorates being monitored through the Transformation Programme.

Quarterly action:

- Develop agreed operating framework.
- Comms programme to be developed for affected colleagues to be kept update to date with progress.
- Early engagement with 2018 business planning process to ensure new directorates have capacity to deliver work programmes for 2018, which should involve more stringent scrutiny of proposed work programmes.
- Recruitment of new roles to begin shortly.

18A

Due to the proposals for structural changes and staff reductions at Health Education England, there is a risk that their ability to provide us with the data and support that we need for quality management, clarity around their roles and responsibilities and capacity to respond to problems locally and engage in support of the GMC training surveys may be impaired.

- Teams are having regular discussions and meetings with HEE at 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.
- Surveys team provide support to HEE teams during NTS data validation, and survey operational phases.
- Process for approving training posts/programmes has been improved to reduce admin burden on HEE teams.

Quarterly action:

- Ongoing Chief Executive and Director of Education and Standards and HEE.
- Corporate risk to be reviewed following the review of HEE Wessex, which is planned for Q2 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 GMC (e.g. NTS, ARCP, trainer recognition) less burdensome for local teams.

Executive Board

- Discussed as an emerging risk and agreement to add to Corporate Risk Register.

Corporate risk to be reviewed following the review of HEE Wessex, which is planned for early 2018. This will be the first review since the new framework has been in place.
<table>
<thead>
<tr>
<th>ID</th>
<th>Risk</th>
<th>Owner</th>
<th>Existing controls (incl. Local QA where relevant)</th>
<th>Residual</th>
<th>Further mitigating actions to be implemented (with target date)</th>
<th>Council and/or Board Review</th>
<th>Internal Audit coverage</th>
<th>Comment (incl. external assurance where relevant)</th>
<th>Risk target</th>
<th>Corporate Risk that Action Plan relates to</th>
</tr>
</thead>
<tbody>
<tr>
<td>19A</td>
<td>Data Protection</td>
<td>N. Roberts</td>
<td>Due to lack of legal clarity on requirements for implementation of the General Data Protection Regulation (EU) 2016/679, we may not be adequately prepared for when the regulation comes into force on 25 May 2018 and therefore be in breach of the regulation with potential for financial and reputational impact.</td>
<td>Unlikely</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20A</td>
<td>Medical Licensing Assessment</td>
<td>C. Metville</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>Quite likely</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- 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
- Bi monthly working group with the ‘Consent’ project leads to discuss progress, dependencies and emerging risks
- Bi 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
- GMC contributed to the GDPR consultation
- Completed engagement with S&C to develop a GDPR communications plan which will include Council and Directorates updates (November 2017)
- 2018 Business Planning review ensured directorates are capturing the resource requirements from their area that is needed for GDPR work (November 2017)
- CBP Stage gate reviews conducted by the R&QA Corporate Business Planning Manager
- The draft GDPR bill was published on the 14 September 2017 and is making its way through the legislative process. It had its second reading in the House of Lords on the 10 October. On the 30 October the GDPR was reviewed by the House of Lords Committee.

- 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
- Formal recommendation for next steps of the MLA were agreed by Council (December 2017)

- Review the outcomes for graduates (2017-2018)
- Ongoing engagement with key stakeholders to follow up on the consultation
- Review of the Medical Licensing Assessment (programme structure, governance and resource planning) (April 2017, amber)

- Update to be provided to September Executive Board on revised approach to consent
- Council: Update to be provided to September Council via COD report.
- Executive Board: Update provided to September Exec Board with all further updates being communicated on an exceptions basis.
- Internal audit scheduled for Q1 2018
<table>
<thead>
<tr>
<th>ID</th>
<th>Risk</th>
<th>Owner</th>
<th>Function / Activity</th>
<th>Likelihood</th>
<th>Impact</th>
<th>Assessment</th>
<th>Residual</th>
<th>Further mitigating actions to be implemented (with target date)</th>
<th>Council and/or Board Review</th>
<th>Internal Audit coverage</th>
<th>Comment (incl. external assurance where relevant)</th>
<th>Risk target</th>
<th>Corporate Risk that Action Plan relates to</th>
</tr>
</thead>
<tbody>
<tr>
<td>21A</td>
<td>Communications planning &amp; engagement</td>
<td>P. Buckley</td>
<td></td>
<td>Quite likely</td>
<td>Moderate</td>
<td>Significant</td>
<td></td>
<td>Further mitigating actions to be implemented (with target date)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Creation of Strategic Communications &amp; Engagement directorate to ensure better co-ordination and scheduling of communications and messages to stakeholders</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Effective engagement with Business Planning process for 2018 - and embedding engagement with communications and policy teams early on in project development process.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Increased communications with teams requiring engagement activity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Due to the increased demand, the large volume of activity planned for 2018 and the current resource capacity, there is a risk that the Education and Standards directorate will not be able to deliver on its commitment to our 2018 strategic priorities, while maintaining a high standard of business as usual.</td>
<td>Quite likely</td>
<td>Moderate</td>
<td>Significant</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Growth bids submitted and approved through the 2018 business planning process, approx 20 posts (December 2017)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>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.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Resourcing requirements have been submitted to HR.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Quarterly business planning reviews to assess resource requirements</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22A</td>
<td>Directorate capacity</td>
<td>C. Melville</td>
<td></td>
<td>Moderate</td>
<td></td>
<td>Significant</td>
<td></td>
<td>Further mitigating actions to be implemented (with target date)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Recruitment for posts underway, AD interviews to be held end Jan/early Feb</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Transition arrangements in place for departure of AD Operations at end of Jan</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23A</td>
<td>HEE workforce strategy</td>
<td>C. Melville</td>
<td></td>
<td>Moderate</td>
<td></td>
<td>Significant</td>
<td></td>
<td>Further mitigating actions to be implemented (with target date)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Draft consultation response for SMT discussion in Jan/Feb 2018</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ID</td>
<td>Risk Description</td>
<td>Existing controls (incl. Local QA where relevant)</td>
<td>Remarks</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>----</td>
<td>------------------</td>
<td>--------------------------------------------------</td>
<td>---------</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24A</td>
<td>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.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Function / Activity**
- Daily media and social media and political monitoring
- Analysis of weekly media issues log
- Monthly high profile case reviews
- Proactive stakeholder management handling on a case by case basis
- Monthly report to CEO on Rule 12, complaints, correspondence from high profile figures or organisations and other high profile issues
- Field forces to provide intelligence reports and help us respond on emerging or live issues

**Residual Likelihood**
- Quite likely

**Residual Impact**
- Significant

**Residual Assessment**
- Quite likely

**Further mitigating actions to be implemented (with target date)**
- SMT standing agenda item on complex and contentious decisions being made
- Council to receive a 6 monthly complaints analysis and trend briefing note
- Review and refresh our rapid response process, April

**Council and/or Board Review**
- Council
- Briefings on sensitive issues each meeting by CEO and General Counsel and Director of RvP
- Council circulars between meetings on key matters

**Internal Audit coverage**
- Following the High Court judgement in the case of Bawa-Garba, we will undertake through our 2018 business plan to look at the wider issues around medical manslaughter. Further detail of this work programme, which was announced by Professor Sir Terence Stephenson on 30 January 2018, can be found in the Chief Executive’s report.
M4 - Annex C

Initial thoughts on reporting against strategic delivery

Working with doctors Working for patients
Reporting on strategic projects - revised

Strategic aim 1: Supporting doctors in maintaining good practice

<table>
<thead>
<tr>
<th>2020 benefit target</th>
<th>Lead indicator Progress</th>
<th>Lag indicator Progress</th>
<th>Activities to deliver, by exception</th>
<th>Commentary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greater assurance of doctors’ capabilities</td>
<td>Expand Welcome to UK Practice (WtUKP) for doctors new to register</td>
<td>Participation in WtUKP for doctors new to practice will have increased from 33% to 80%</td>
<td>Welcome to UK Practice rollout</td>
<td>Description of exceptions and how they are being addressed…</td>
</tr>
<tr>
<td></td>
<td>Taking Revalidation Forward recommendations implemented</td>
<td>Reduce revalidation-related regulatory burden</td>
<td>Patient Multi-Source Feedback</td>
<td></td>
</tr>
</tbody>
</table>

N.B. dummy data

Updates to Corporate Risks for Strategic Aim 1

E.g. New mitigations added to Strategic Risk #4, in relation to resource capacity for teams delivering WtUKP…
Executive summary

This paper provides Council with an update on our review of how we approach our consultations and the progress we have made in improving how we consult to date. It includes:

- An explanation of our review and key areas for improvement that we identified.
- The work we have done to embed good consultation practice within a GMC-wide framework, and the collaborative work we are doing across the organisation to inform and produce a practical guide to ‘Good consultation practice at the GMC’.
- Our proposals for further work to embed earlier, ongoing and targeted stakeholder engagement into our work so that, as far as possible, we develop our consultation proposals with our key stakeholders rather than being overly reliant on formal consultation to ask them what they think. This will be a step change in how we consult. We will achieve this through further developing our strategic relationship management functions.
- Our proposals outlining how Council could play a more strategic role in the consultation process.

Recommendations

a  To note the progress that has been made on improving how we consult to date.
b  To note our proposed areas for further work and provide any comments.
c  To consider our proposals about Council playing a more strategic role in the consultation process.
Background

1 Following Council’s consideration of the List of Registered Medical Practitioners (LRMP) consultation in February 2017, we agreed to carry out a review of how we approached this consultation and to consider how we consult more generally.

Our review and key areas for improvement

2 We reviewed the internal evaluation of the LRMP consultation, 2017 policy audit and had discussions with policy colleagues. These highlighted areas for improvement in how we consult, including:

a The need for more effective early engagement with key audiences to fully understand their concerns.

b Monitoring the external environment (both when planning consultations and before launch) to make sure that the timing and environment is conducive to launching the consultation.

c The need to uniformly document pre-engagement outcomes and communicate how we’ve acted on these.

Our work to date

3 To address these and other areas for improvement, we are working with colleagues across the GMC to develop revised guidance to bring greater transparency and consistency to how we consult: see an outline of ‘Good consultation practice at the GMC’ at Annex A. This is also informed by external good practice, including that of other professional regulators and best practice guidance from The Consultation Institute.

4 We have also embedded good consultation practice into a GMC-wide policy framework which we will implement this year.

5 This work is key to achieving the values set out in our corporate strategy:

a Integrity: listening to our partners whilst remaining independent.

b Excellence: we are a learning organisation, committed to achieving high standards.

c Collaboration, fairness and transparency.
Key discussion points

6 This paper outlines two key discussion points:

a Our proposals to embed earlier, ongoing and more targeted stakeholder engagement into GMC culture by further developing our strategic relationship management function. This will enable us to better identify our key stakeholders, develop our consultation proposals with them and ensure that their views are fully taken into account throughout the policy development process, instead of being overly reliant on formal consultation.

b Our proposals about how Council could play a more strategic role in the consultation process in future.

Proposed approach: earlier, ongoing and targeted stakeholder engagement

7 We will achieve this by further developing our strategic relationship management function which will help us to evolve our consultation culture.

8 This will have a number of components:

a Coordinated work between policy and strategic communications teams to enable consistent, comprehensive and effective stakeholder mapping which identifies priority stakeholder groups for each consultation. This will enable targeted stakeholder engagement tailored to key audiences through a formal strategic engagement communications plan.

b Earlier and ongoing stakeholder engagement outside of the formal consultation period. This will enable us to fully understand the views of key stakeholders and do our best to respond to them early. This will require us to be clear about our initial views and share them, rather than waiting until we have fully formed positions, and be confident about doing this. We will also need to proactively invest in our stakeholder relationships by being more open, transparent and continuing to act with integrity to maintain trust.

c Whilst testing early ideas brings some risk, the resulting benefits - more robust policies that take better account of stakeholder concerns - outweigh this. The new Strategy and Policy directorate and Strategic Communications and Engagement directorate will work together to mitigate this risk.

d Based on feedback from our stakeholders, Council and our own staff, we won’t consult on every possible option but will put forward the most credible options. This will demonstrate that we’re listening and responding to stakeholder views at an early stage and taking a more strategic approach to our consultations.
e) Segmenting stakeholder views in our consultation analysis and taking this into account in our conclusions. Consultation is not a referendum but an exercise in judgement – our overriding objective when developing policy is to protect the public and we aim to have broad support and consensus across our key interests. So we need to know what our key interests say individually and whether there are differences of opinion between them. We will also continue to take particular note of the views of those most affected by our proposals (stakeholder mapping is vital to identify whose views matter most for each consultation).

f) Being transparent about our decision-making processes and demonstrating that we listen and learn by telling key stakeholder groups how we’ve taken their feedback into account.

Implications for the GMC

9 Whilst this paper doesn’t raise any specific equality and diversity implications, it’s worth noting that many of the people affected by our consultations are likely to share one or more of the protected characteristics.

10 The proposed approach should enable us to consult in a way that is more targeted and transparent. We also intend to increase and improve our engagement with patients and the public. We will report back to Council once we have further developed our thinking on this.

Proposed approach: Council playing a more strategic role in consultations

11 The Executive Board has agreed that, where appropriate, it will consider the high level approach to GMC-led consultations including the purpose, questions, communications and engagement strategies. Approval of detailed documents will take place within directorates (subject to any feedback received from Council as explained in paragraphs 12 and 13 below).

12 We propose that Council has a formal, consistent role in strategic consultations that involve significant policy issues and/or bring a degree of risk for the GMC. It could fulfil this by:

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

b) Confirming the key issues we’re consulting on.

c) Being sighted on analysis findings at an early stage.

d) Being involved in early conversations after significant consultations to help shape our response (as per our approach in responding to the Medical Licensing Assessment consultation last year).
e Being informed about consultation outcomes and how we’re acting on these.

13 We value the fresh perspectives Council can bring to informing the tone and content of detailed consultation documents. Council will have access to consultation documents involving significant policy issues via the Board Intelligence app and will have opportunities to submit feedback. However, detailed consultation documents would not be reviewed during Council meetings to free up time for more strategic discussions about consultations.

14 This approach has been piloted for Council paper M6 – Review of our guidance on Consent.

Timescales

15 Over 2018, we will be doing further work to embed earlier, ongoing and targeted stakeholder engagement into our work. We will achieve this through finalising the consultation guide and implementing GMC-wide use of this alongside the policy framework.
Executive summary

We have worked with a task and finish group to revise our 2008 Consent guidance to ensure that it remains compatible with the law and relevant to medical practice. This paper, the annexes and the additional reference papers summarise:

- Our approach to re-drafting the guidance.
- The background to the review and summary of evidence.
- Key changes that have we have made to the guidance.
- Our plans for consultation.

Recommendations

Council is asked:

a To note the: draft Decision making and consent guidance (paper AR (ii)), Background to the review and summary of evidence base paper (paper AR (i)), (both documents available in the additional reading bundle in the Board Intelligence app.)

b To note the key changes to the guidance paper, at Annex A, and consider our consultation plans, at Annex B.
Background to the review

1. We are updating our 2008 Consent guidance, to ensure it remains compatible with the law and relevant to medical practice.

2. We carried out a number of pre-consultation activities in 2016 and 2017 to develop the evidence base for the review. For example we ran surveys for doctors, patients and other interested parties and met with key stakeholders to gather feedback on the current guidance and identify areas that needed updating.

3. We also commissioned Community Research to carry out focus groups with doctors to explore their attitudes to consent and the challenges they face implementing our guidance in practice. This research took place in February 2017, and the report Doctors’ attitudes to consent and shared decision making is published on our website.

4. This pre-consultation engagement indicated that whilst the guidance principles are sound, doctors can sometimes find it difficult to meet the standards in practice. There also continues to be anxiety and misunderstanding surrounding the impact of the Supreme Court judgment in Montgomery vs Lanarkshire 2015.*

5. More detail on our pre-consultation engagement and the evidence base we developed can be found in the reference documents section.† In February 2017 we established a multidisciplinary task and finish group, chaired by Professor Deborah Bowman, to oversee the revision of the guidance. Short biographies of the members of this group are available on our website.

Key changes to the core guidance

6. Key changes to the core guidance are summarised at Annex A. The revised guidance for consultation can be viewed in the additional reading bundle in the Board Intelligence app.‡

7. We have not made significant changes to the core principles, as our pre-consultation engagement assured us that these were sound. Most of the changes are to its

* Further details of this case can be found in the Background to the review and summary of evidence base AR 6 (i) which can be viewed in the ‘Additional reading’ bundle for February in the Board Intelligence app.

† Paper AR6 (i) Background to the review and summary of evidence base which can be viewed in the 'Additional reading' bundle for February in the Board Intelligence app.

‡ Paper AR (ii) Decision making and consent: supporting patient choices about health and care
structure and tone, and although the new draft guidance is slightly longer than the current guidance, we believe it is easier to navigate and to apply in practice.

8 Our intention is to bring about a shift in the way (some) doctors approach decision making with their patients, changing the focus from ‘consenting a patient’ to thinking more about the quality of the dialogue and the decision making process, and improving communication with patients.

9 There is an increased focus on doctors tailoring the information they share, and the way in which they share it, to the individual patient’s needs and preferences.

Consultation plans

10 We plan to consult on the draft guidance for 12 weeks, approximately from the end March 2018 onwards. The final launch and closing date are to be confirmed. As with our confidentiality consultation, we will be engaging with doctors and patients across the UK using questionnaires, meetings and events during the consultation period.

11 We have also commissioned Ipsos MORI to undertake work with groups who may have particular needs or vulnerabilities, including people who live in care homes and their relatives, people who don’t speak English as a first language and people who have health conditions that may affect their capacity.

12 Further detail about our consultation plans is at Annex B.

Next steps

13 Following consultation we will revise the guidance with the support of the task and finish group, which will meet in late summer 2018.

14 We plan to invite the Executive Board to approve the amended guidance for publication and to approve communication and implementation plans at its meeting in October 2018. We will then bring the guidance back to Council ahead of publication. We plan to do this at the Council meeting in November 2018.

15 The publication date is still to be confirmed but we expect it to be early 2019. For key ethical guidance, we normally set an implementation date three months after publication to allow doctors time to familiarise themselves with the guidance.

16 Please note that we have identified the implementation phase of this project as a key priority. Launch of the guidance should therefore only be seen as a starting point. We plan to launch a range of learning materials, such as case studies and flow charts to support it. We will also consider how to present the final guidance, using a digital first approach, to ensure that it is easy for doctors to find the advice they need.
Agenda item: M7

Report title: 2017 Human Resources Report and Gender Pay reporting

Report by: Andrew Bratt, Assistant Director – Human Resources, Resources and Quality Assurance, andrew.bratt@gmc-uk.org, 0161 925 6215

Considered by: Executive Board

Action: To consider

Executive summary
This report provides an overview of the main HR monitoring data for 2017 including more detailed information on diversity and pay. The 2017 report also includes the data required by the Gender Pay reporting requirements.

Recommendation
Council is asked to consider the 2017 Human Resources and Gender Pay reports.
Human Resources Report 2017

1 Our Human Resources (HR) policies, procedures and infrastructure exist to ensure that we recruit, retain and develop a diverse, talented and committed workforce while meeting our statutory obligations as an employer.

2 Our 2016 re-location programme mean that 2017’s data relates to a workforce increasingly based in Manchester, but despite this we have seen limited changes in the GMC’s workforce profile.

3 Our monitoring data is at Annex A. Our annual report also includes our profile as an employer in terms of diversity at Annex B and pay data by gender and ethnicity at Annex C. This pay data also includes the information required by the Gender Pay Reporting Regulations. We have published pay data by gender and ethnicity for a number of years and have included comparisons with prior years.

HR Data Monitoring

4 Our 2017 data, along with the last staff survey, continues to suggest a good employee relations environment. While 2017 had a challenging employee relations issue (pension reform) we continue to enjoy good levels of staff engagement. At a local level, we had a small number of individual employee relations issues with relatively few disciplinary or grievance issues.

5 From our 2017 data there are two trends to highlight. These are the continued fall in staff turnover and a gradual rise in absence levels.

6 Our voluntary turnover (which excludes redundancy) for 2017 remained low (at 8.4%). This is at the bottom end of the band we expect turnover to be in (8 to 15%) and is a continuation of a downward trend reflecting, perhaps, our position as a stable employer in a more uncertain working environment.

7 We have historically enjoyed low sickness absence levels but in 2017 we saw a slight rise taking us closer to the national average. Mental health related issues, specifically depression, are the main reason for employee absence. This increased in 2017 to account for 24% of absences. External comparators suggest a mixed picture: recent Office of National Statistics (ONS) surveys give a UK average of 11.5% of total days lost whereas the Chartered Institute of Personnel Development (CIPD) absence survey of 2016 shows increasing numbers of employers reporting mental health as a major cause of absence.

8 Mental health is an area where we have an extensive programme of work to support staff and line managers. This has included extensive training events with 200 staff attending mental health awareness training and a network of well-being champions across the GMC. Our work to support those with mental health issues and
encouraging greater openness may have increased the levels reported. Further details are set out alongside the absence data in Annex A.

HR Systems

9 During 2017 we completed a major programme of work to launch a new development and performance management system, enabling a much stronger focus on personal and career development. The new system is now live for the 2018 business planning year.

Learning and Development

10 In 2017, as part of the Transformation Programme, we set out an Empowering and Developing our People programme (EDP) to support a significant expansion in the personal and career development support for our staff. This has included the development of a new 360 feedback system for all staff and changes to the performance management system.

11 Our central team coordinated the delivery of a wide range of corporate programmes; we have increased our internal capacity to support individual development through an internal network of accredited coaches. We have also further expanded our online learning resources.

Diversity, Equality and Inclusion

12 Our new Equality, Diversity and Inclusion Strategy aims include: having a workforce that reflects our local labour markets; increasing the number of job offers made to applicants from under-represented groups and; improving the percentage of under-represented groups at senior levels.

13 To support this work we monitor and analyse our data for equality and diversity (E&D) for our major HR processes and monitor the composition of our workforce. An overview of this is set out at Annex B.

14 Our workforce profile over recent years has remained relatively stable. We did anticipate some changes to our workforce profile as a result of the re-location process but the overall impact on the Black Minority Ethnic (BME) / Non-BME work force profile has been limited.

15 Coincident with the significant shift of recruitment activity to Manchester the percentage of job offers to BME candidates has risen; this is welcome progress. In 2016 BME candidates accounted for 30% of our applications and 14% of our job offers. In 2017 BME candidates accounted of 28% of applications and 17.4% of our
offers for both internal and external campaigns, with external campaigns producing a higher level of offers to BME candidates.

16 In 2017 we asked Ernst and Young to conduct an independent review of our recruitment process to help us better understand these patterns. This work did not identify any specific problems with our overall approach but has suggested a range of action points we are now taking forward. These relate to our public profile as an employer, guidance to candidates and some adjustments to our processes.

17 To support fair and objective decision making we have a training programme for managers which covers unconscious bias. A total of 94 managers undertook this course in 2017. In March 2018 we will deliver a further programme of unconscious bias training for recruiting managers through an online learning module. Our aim is for all recruiting line managers to undertake this training.

18 For female applicants, we had an established pattern, with women becoming increasingly well represented as our recruitment process moves forward. In 2016 51% of our applicants were female and they secured 58% of our job offers. In 2017 this trend was reversed slightly with women making up 42.4% of our applicants and securing 37.6% of our job offers.

19 In line with our historical trends we continue to see a steady increase in representation of women in management roles. At the end of 2016 62.3% of our Level 3 managers, just over 51% of our level 2 (section head managers) and nearly 38.4% of our Assistant Directors were women. At the end of 2017 these figures were 63.4%, 53.7% and 45.8% respectively.

Gender Pay reporting

20 We have publicly reported pay by gender and ethnicity on an annual basis since 2012. To allow comparisons we have included updated data for each grade by gender and ethnicity as of 31 December 2016 and 2017.

21 Annex C includes our equal pay data calculated in line with the Gender Pay Gap reporting requirements.

22 On gender we can see an overall pay gap of 15.8%, with much smaller differentials within pay grades. The main driver for this is the higher proportion of men in more senior roles. Although far from ideal this is an area where we have made progress in recent years, our 2013 pay data would have shown a pay gap of approximately 23%.

23 At Director level comparable roles are paid the same salary. Assistant Director positions cover a range of different areas and we reviewed these posts in 2017 to
better align comparable roles in terms of salary. At the end of 2017 female Assistant Director salaries averaged 0.88% more than their male peers.

24 Where we have larger groups of identical roles salaries are typically very closely aligned, however we do need to undertake further work on some management roles. Our new pay system will further prioritise pay progression for staff towards the bottom of their pay bands. We have also audited pay awards for staff who have taken maternity and adoption leave to ensure their trend performance level around their period of leave is reflected in their pay progression.

25 BME and non BME pay by grade been closely aligned in recent years. Our data at the end of 2017 shows BME staff were paid, on average, more than non BME staff in almost every pay band.
Recruitment activity continued to be a significant part of our work in 2017. The main recruitment driver is voluntary turnover and this fell over the year. The high proportion of new joiners in late 2016 is a factor in the 2017 trend.

A significant factor in the level of recruitment activity has been the number of internal moves. Although these fell in 2017, we continue to have a significant number of staff changing roles.
3. Our recruitment performance remains strong, with our average advert to offer stage less than six weeks, and advert to start averaging just over 10 weeks. While we meet most recruitment requirements through a mix of external and internal campaigns we do have some challenging areas, such as in Data Analysis. To help meet our future staffing needs we have reinstated our graduate recruitment scheme and continue to run an apprentice programme.

4. All new staff go through a probation process and this provides an indicator of how successful our recruitment processes have been. In 2017, six appointees had their probation period extended, none failed.

5. The diversity monitoring aspects of the recruitment process are set out at Annex B.

Pay and Benefits

6. Our performance management and pay systems were reviewed by external pay and reward consultants, Mercer, and a new performance management framework was introduced at the start of this year.

7. The performance management system is on-line and operates well with completion rates for all of the relevant stages close to 100%. It is subject to quality assurance and peer review by a group of Assistant Directors.

8. Our 2017 pay award was implemented in April. Our system does not have incremental progression and individual pay awards have core and performance related elements.

9. In 2017 employees saw pay increases range from 0 to 5.5%. Employees in the middle section of their pay band who were assessed as ‘successful’ received a 3% pay award. The 2017 award had an increased focus on progression for staff towards the bottom of their pay band to support fairer and more equitable pay levels within each pay band.

Employee Absence

10. While historically we have had absence rates below national or public sector rate we have seen a rise in sickness related absence in 2017.

www.gmc-uk.org
11 These rates equate to seven days per full-time employee per year for the GMC.

12 There has also been a further trend towards mental health related absence being the predominant cause of absence. This can be seen in comparing the 2016 and 2017 data:
13 We define long term absence as over 20 working days and 44% of absences fall into this category. For depression the long term absences make up 73% of the total days lost. Fourteen employees had absences totalling 50 or more working days and of these six were over 100 working days. Absence for this category is not concentrated in any particular area and reflects the GMC’s staff profile in terms of age and gender.

Wellbeing

14 Over the last five years more organisations have reported mental health as one of their top five causes of absence (CIPD survey). But there is a significant change in our data from the 2016 report with around 40% of absence related to depression, stress or work-related stress. Alongside this there has been a significant rise in awareness of mental health issues and the measures employers can take to support staff.

15 We have a well-established and wide-ranging programme of support and it is possible that this work and an increased profile for wellbeing issues has encouraged staff to disclose the reason for their absence more openly.

16 Our programme includes a network of 50 trained wellbeing champions, an employee assistance programme, health checks for all employees, along with training programmes for staff and managers. In 2017, 200 staff attended mental health awareness sessions, 52 attended a supporting staff mental health programme with another 350 places being taken up on related programmes. In addition we have a range of staff led activities; these include exercise related wellbeing activities and directorate specific programmes.

17 We also have access to occupational health advice and a range of procedures to adjust working practices to support staff during a period of illness and on their return to work.
Equality, Diversity and Inclusion

1 As part of our ambition to be fair and inclusive employer our recruitment and promotion practices aim to build and sustain a diverse and balanced workforce. Our aim to be an inclusive organisation relates very directly to our work as an employer. This includes embedding equality and diversity into our training programmes, feedback mechanisms for staff and our HR policies.

2 Our aims include having a workforce that reflects our local labour markets; increasing the number of job offers made to applicants from under-represented groups and; improving the percentage of under-represented groups at senior levels. This annex sets out detailed information on our 2017 recruitment and promotion patterns along with our overall workforce profile.

3 The GMC has seen very little change to its workforce profile, despite the re-location process seeing our staffing requirements in London fall and more posts being based in Manchester.

4 Recruitment plays a central role in the make-up of our workforce. Within these processes we have seen two established trends in recent years: female applicants increased their representation as our recruitment process proceeded; the opposite pattern has been evident for BME candidates.

5 In 2017 we saw some movement in these trends. On gender the pattern we have seen in recent years became more balanced, with women (43% of applicants) securing 37% of job offers.

6 On ethnicity there has been an increase in offers to BME candidates. This has previously been an area of concern for us in recent years with a relatively low number of job offers to BME candidates (around 12-14%) compared with the profile of applicants (in the 25-30% range). In 2017 job offers rose to 17.4%, with external campaigns producing a higher success rate for BME candidates.
In 2017 we also took independent external advice to help us review our recruitment data and processes, to help identify any further steps we might take. This review did not identify any problems with our current approach but we have developed an action plan aimed at further improving our process.

One area for further work is the balance between external and internal recruitment – the former produces more balanced outcomes in terms of ethnicity, the latter has helped us achieve a better gender balance at senior levels. Our increasing headcount, having a predominantly female workforce and high levels of internal recruitment have created circumstances that have supported our ambitions around a better gender balance at senior levels.

To help us achieve progress towards a more ethnically diverse workforce we will need to consider further external recruitment initiatives, such as an expanded graduate and apprentice programmes, along with more targeted programmes such as secondments and paid internships.

While we have made some progress in 2017 on recruitment the impact on our overall workforce profile is very limited. For example our increase in offers to BME candidates was offset by a very similar number of leavers.

On gender profile, senior management roles don’t fully reflect the GMC’s workforce, but we have seen progress over the last five years with an increase in the percentage of female staff management roles:

<table>
<thead>
<tr>
<th>Diversity</th>
<th>Applications</th>
<th>1st Interview</th>
<th>2nd Interview</th>
<th>Offer</th>
</tr>
</thead>
<tbody>
<tr>
<td>BME</td>
<td>1145</td>
<td>28.09%</td>
<td>170 20.66%</td>
<td>13 15.85%</td>
</tr>
<tr>
<td>Non BME</td>
<td>2767</td>
<td>67.89%</td>
<td>623 75.70%</td>
<td>69 84.15%</td>
</tr>
<tr>
<td>Female</td>
<td>1727</td>
<td>42.37%</td>
<td>337 40.95%</td>
<td>25 30.49%</td>
</tr>
<tr>
<td>Male</td>
<td>2267</td>
<td>55.62%</td>
<td>472 57.35%</td>
<td>56 68.29%</td>
</tr>
<tr>
<td>Disabled</td>
<td>73</td>
<td>1.79%</td>
<td>14 1.70%</td>
<td>0 0.00%</td>
</tr>
</tbody>
</table>

Diversity Applications 1st Interview 2nd Interview Offer
<table>
<thead>
<tr>
<th>Level</th>
<th>2012</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 3</td>
<td>61.9%</td>
<td>63.4%</td>
</tr>
<tr>
<td>Level 2</td>
<td>47.3%</td>
<td>50.5%</td>
</tr>
<tr>
<td>Level 2a</td>
<td>50.0%</td>
<td>78.7%</td>
</tr>
<tr>
<td>Assistant Director</td>
<td>33.3%</td>
<td>45.8%</td>
</tr>
</tbody>
</table>
Workforce profile comparison - 2015 to 2017

GMC Workforce profile - Ethnicity 2015-2017

GMC Workforce profile - Age 2015-2017

GMC Workforce profile - Gender 2015-2017

GMC Workforce Profile - Disability 2015-2017
Workforce Profile

GMC workforce profile - Gender by Level

GMC workforce profile - Ethnicity by Level

Council meeting, 28 February 2018
Agenda item M7 – 2017 Human Resources Report and Gender Pay reporting
Management Roles 2013-2017

Number of female staff at Management Grades 2013-2017
(GMC female population at December 2017 is 62.08%)

Number of BME staff at Management Grades 2013-2017
(GMC BME population at December 2017 is 12.04%)
Comparison to other organisations – Ethnicity

GMC Ethnicity compared to other organisations

- All GMC: 86.41% Non-BME, 12.04% BME
- GMC Devolved Offices & Homeworkers: 88.61% Non-BME, 8.86% BME
- GMC Manchester: 67.36% Non-BME, 11.18% BME
- GMC London: 77.55% Non-BME, 20.47% BME
- Equality and Human Rights Commission: 81.00% Non-BME, 16.00% BME
- Nursing and Midwifery Council: 60.00% Non-BME, 37.00% BME
- CIPD: 82.00% Non-BME, 13.00% BME
- Information Comission: 81.00% Non-BME, 9.00% BME
- Manchester Council: 74.88% Non-BME, 18.74% BME
- FCA: 72.00% Non-BME, 21.00% BME
- Metropolitan Police: 94.02% Non-BME, 5.98% BME
- Greater Manchester Police: 9347.00% Non-BME, 6.00% BME

* Benchmark 2016/17 data taken from organisations websites.
Comparison to other organisations – Gender

GMC Gender compared to other organisations

- All GMC: 62.08% Female, 37.92% Male
- GMC Devolved Offices & Homeworkers: 54.43% Female, 45.57% Male
- GMC Manchester: 61.96% Female, 38.04% Male
- GMC London: 67.72% Female, 32.28% Male
- Equality and Human Rights Commission: 61.00% Female, 39.00% Male
- Nursing and Midwifery Council: 64.00% Female, 36.00% Male
- CIPD: 69.00% Female, 31.00% Male
- Information Commission: 60.35% Female, 39.65% Male
- Manchester Council: 66.16% Female, 33.84% Male
- FCA: 52.00% Female, 48.00% Male
- Metropolitan Police: 40.32% Female, 59.68% Male
- Greater Manchester Police: 40.83% Female, 59.17% Male
Gender Pay Gap reporting

1 We report annually on pay differentials by ethnicity and gender, setting this data out by grade as at 31 December 2017. The 2017 HR report also includes the data required by the Gender Pay Gap reporting. To allow the national data to be comparable there are strict definitions and methodologies which have to be complied with.

2 For these calculations we include ‘full pay relevant’ employees. This means we exclude employees who are not paid their usual salary for any reason from the calculations (e.g. staff whose sick pay has expired).

3 The GMC’s data, using our April 2017 pay data:
   a The difference between the mean hourly rate of pay of male full-pay relevant employees and that of female full-pay relevant employees shows female paid 15.8% less than male employees.
   b The difference between the median hourly rate of pay of male full-pay relevant employees and that of female full-pay relevant employees is 6.7%.

4 The definition for bonus payments, brings our valued recognition scheme within the scope of the reporting requirements. These are vouchers with the most typical values of £50 and £100 so a very small part of our overall pay and reward package in terms of financial value.
   a The difference between the mean bonus pay paid to male relevant employees and that paid to female relevant employees 1.8%, with the mean bonus pay for women higher.
   b The difference between the median bonus pay paid to male relevant employees and that paid to female relevant employees is 100%, with the female median higher.
   c The proportions of male and female relevant employees who were paid bonus pay, predominantly through the valued award scheme, was:
Males – 19.8%

Female – 18.5%

The proportions of male and female full-pay relevant employees in the lower, lower middle, upper middle and upper quartile of our total pay range for all employees in April 2017 was.

<table>
<thead>
<tr>
<th>Quartile</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lower pay band</td>
<td>62.7%</td>
<td>37.3%</td>
</tr>
<tr>
<td>Middle pay band</td>
<td>65.9%</td>
<td>34.1%</td>
</tr>
<tr>
<td>Upper pay band</td>
<td>63.7%</td>
<td>36.3%</td>
</tr>
<tr>
<td>Upper Quartile pay band</td>
<td>50.7%</td>
<td>49.3%</td>
</tr>
</tbody>
</table>

Our current gender profile by individual grade and in total is set out below and highlights the main factor in our gender pay gap being the higher proportion of men in senior roles.

<table>
<thead>
<tr>
<th>Grade</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>LEVEL1</td>
<td>28.6%</td>
<td>71.4%</td>
</tr>
<tr>
<td>LEVEL1AD</td>
<td>45.8%</td>
<td>54.2%</td>
</tr>
<tr>
<td>LEVEL2/A</td>
<td>50.5%</td>
<td>49.5%</td>
</tr>
<tr>
<td>LEVEL3</td>
<td>63.4%</td>
<td>36.6%</td>
</tr>
<tr>
<td>LEVEL4</td>
<td>65.0%</td>
<td>35.0%</td>
</tr>
<tr>
<td>LEVEL5</td>
<td>56.7%</td>
<td>43.3%</td>
</tr>
<tr>
<td>LEVEL6</td>
<td>72.0%</td>
<td>28.0%</td>
</tr>
<tr>
<td>APPR</td>
<td>50.0%</td>
<td>50.0%</td>
</tr>
<tr>
<td>All Staff</td>
<td>62.08%</td>
<td>37.92%</td>
</tr>
</tbody>
</table>
However, depending on pay grade, women are typically paid between 3% more and 9% less than male counterparts. At Director level comparable roles are paid at the same level. At Assistant Director level the average salary for men and women is less than 1% apart. For our main operational areas identical posts are closely aligned, mainly through fixed starting salaries. At management levels, where we have a wide range of roles, sometimes very specialist, salaries are not as closely aligned. Some of these differences relate to specific skills requirements and market allowances, but management roles are an area for further work. As part of the 2018 pay round we are taking further steps to improve the situation.

To close the gender pay gap at an organisational level we would need to see an increasing proportion of women in senior management roles. We have made good progress in recent years with an increasing percentage of female senior managers. This increase has contributed to differences in average pay falling from 23.5% in 2013 to 14.3% at the end of 2017.

The UK’s gender pay gap, based on average hourly earnings in April 2017 was 9.1% (Office for National Statistics).

We know that performance review outcomes and length of service are very similar for men and women, so a further focus on starting/promotion salaries will be part of our equality and diversity work in 2018.

We set aside part of the 2017 pay award to make salary adjustments where anomalies were identified. We will repeat this process as part of the 2018 pay award process. We have also completed a review of pay progression for staff who take maternity/adoption leave to ensure that their performance over an extended period is reflected in salary progression and they are not impacted adversely by this leave.

**Pay and Ethnicity**

There are currently no requirements to provide pay data by ethnicity, but this has been an integral part of our annual HR reporting. As with gender, our senior roles do not reflect the GMC’s workforce profile (as set out at Annex A). In terms of pay we have had a very close alignment of BME and non-BME staff salaries by pay band. In almost all pay bands across London and Manchester, BME staff have slightly higher average pay than non-BME peers.
Pay & Ethnicity London

Equal Pay - London Average Hourly Rate (£) by ethnicity by grade 2016

Equal Pay - London Average Hourly Rate (£) by ethnicity by grade 2017
Pay & Ethnicity Manchester

Equal Pay - Manchester Average Hourly Rate (£) by ethnicity by grade 2016

Equal Pay - Manchester Average Hourly Rate (£) by ethnicity by grade 2017
Pay & Gender London

Equal Pay - London Average Hourly Rate (£) by gender by grade 2016

Equal Pay - London Average Hourly Rate (£) by gender by grade 2017
Pay & Gender Manchester

Equal Pay - Manchester Average Hourly Rate (£) by gender by grade 2016

Equal Pay - Manchester Average Hourly Rate (£) by gender by grade 2017
<table>
<thead>
<tr>
<th>Agenda item:</th>
<th>M8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report title:</td>
<td>Pension Strategy</td>
</tr>
<tr>
<td>Report by:</td>
<td>Andrew Bratt, Assistant Director – Human Resources, Resources and Quality Assurance, <a href="mailto:andrew.bratt@gmc-uk.org">andrew.bratt@gmc-uk.org</a>, 0161 923 6215</td>
</tr>
<tr>
<td>Action:</td>
<td>To consider</td>
</tr>
</tbody>
</table>

**Executive summary**

The closure of the GMC’s defined benefit (DB) scheme to future accrual, its current financial position and recent guidance from the Pensions Regulator make this an appropriate time for Trustees to review their funding objectives for the scheme.

Trustees have set out a proposal for additional funding and this has been reviewed by the employer’s advisor.

**Recommendations**

a Note the Scheme Trustees’ proposal and rationale for additional funding.

b Agree additional funding of £1.4m per year for 2018 and 2019 with future funding to be determined by the next actuarial valuation process.
Background

1. The GMC’s Defined Benefit (DB) scheme will close to future accrual on 31 March 2018. The scheme’s Trustees must consent to this and we have been working with them to make the necessary changes to the trust deed and rules ahead of the closure date.

2. The scheme’s current financial position, recent guidance from the Pensions Regulator and the savings the employer will see from changing its pension arrangements, make this an appropriate time for Trustees to review their funding objectives.

3. Trustees have set out a proposal for additional funding in a letter to the Chair of Council, at Annex A.

Funding Strategy

4. The Trustees’ funding strategy is to achieve what is known as ‘self-sufficiency’, the point at which the Trustees could run the scheme without expecting to rely on the employer for further contributions. The Trustees are aiming to reach this target within a 10 year timeframe, with a 75% confidence level.

5. Ultimately, the Trustees wish to have the assets to be able to ‘buy-out’ the scheme. In very simple terms, this is when Trustees would be able to go to an insurer and effectively pay them an amount to meet all of the scheme’s future pension obligations.

6. This objective fits with Trustees’ primary duty to maximise the security of the pension benefits that the employer has promised. For the employer, this provides a point where reduced support is needed (if self-sufficiency is achieved) and no further financial support is required (if full buy-out funding is achieved).

7. If there was no agreement on the amount of cash contributions that are paid, the mechanism for addressing this would be the next actuarial valuation due at 31 December 2018. Here, the Employer and Trustees must agree to the contributions payable (subject to the Scheme Actuary certifying they are no lower than had they set them).

8. Over recent years, the Trustees have made significant changes to their investment approach to reduce risk.

9. Trustees have also put in place arrangements to hedge against changes in inflation and interest rates, and these measures provided the scheme with a level of protection against the economic changes that we saw in 2016.
10 The scheme currently has 30% of its assets in a ‘matching portfolio’. These are assets that behave in a similar way to the scheme’s liabilities. 70% of the scheme is invested in growth assets. This ‘return-seeking portfolio’ is expected generate a return that exceeds liabilities in the long term.

11 Taking further steps to reduce the risks presented by the scheme is an area where the Trustees and the employer have closely aligned interests.

**Trustee funding proposal**

12 Trustees have considered the very latest funding position and have requested that Council consider allocating a further £2.5m per year until the self-sufficiency position is reached.

13 Trustees continue to assess the employer covenant as strong. This means that Trustees have a positive view of the employer’s ability and willingness to support the scheme.

14 The Trustees have also concluded that additional funding at this level would make it very unlikely that they would need to seek additional funding following the 2018 triennial valuation.

15 The benefits in acting now as proposed by Trustees include:

   a Reducing the period of time the scheme is reliant on the employer.

   b Providing additional insurance against ‘bad outcomes’ e.g. investment downturn.

   c Increasing the opportunities to de-risk the investment strategy.

   d Allowing investments to be made earlier will mean greater expected returns as they will be invested for a longer period.

   e It is preferable to make payments when they are affordable (e.g. when cost savings on pensions are being made and/or reserves allow).

   f An opportunity to send a positive message to scheme members and reinforce the point that the changes were to reduce risk and avoid cost increases rather than to make savings.

   g Addressing funding well ahead of a time in the future where the scheme, with very few active employee members, might receive less management attention.
16 Ultimately, Council has a finite amount of funding. If more monies are diverted to the DB Scheme, then this comes at the expenses of other potential uses of cash. Paying more into the DB scheme could mean less funding is available for other priorities, which might include wider remuneration priorities (including the DC scheme). However, Council is potentially making cash savings on moving from DB to DC.

17 Paying more into a DB scheme, all else being equal, means there is a lower chance of higher contributions being needed in future. This can be to the benefit of the wider staff group whose remuneration arrangements could be sensitive to the GMC’s overall financial position.

18 The Trustees’ proposal of aiming to achieve self-sufficiency within 10 years, rather than when every member is a pensioner (the default approach under the current funding arrangement) is likely to increase the costs of running the scheme, compared with the status quo. There is a trade-off between increasing the expected cost and being able to reduce the amount of risk Council is exposed to in bad scenarios, which needs to be considered.

GMC adviser’s view

19 Council will have an opportunity to consider the employer-side adviser’s view on future funding options in advance of considering this report (Annex B). But at the Council meeting in December 2017, we reported an initial view that an additional funding would be appropriate, but at a lower level and not guaranteed for 10 years. This would reflect:

a The prudent assumptions made by the Trustees.

b The high level of confidence that the proposed funding plan targets.

c The strong financial position of the GMC.

d The proximity of the next valuation process.

e The improved funding position since the decision to close to future accrual.

f The possibility of significantly over-funding the scheme.

20 In light of these factors the employer-side adviser has suggested additional funding, but at a lower level and broadly reflecting the level of cost reduction saving from the closure to future accrual. This would amount to £1.4m per year for 2018 and 2019, with any additional funding from 2020 onwards determined through the next triennial valuation.
21 As part of the consultation process we have stated that the proposed changes place the employer in a better position to support the scheme financially so this proposal would be compatible with this.

22 Post valuation the employer adviser has suggested giving consideration to the scheme taking on its own running costs (actuarial advice and administration). This would need to be considered as part of any revised funding arrangements beyond 2019, but would be in line with the scheme’s overall self-sufficiency objectives.

**Integrated Risk Management Plan**

23 Any agreed additional funding would be set out in an updated schedule of contributions, effective from 1 April 2018, to coincide with the closure of the scheme to future accrual.

24 The plans to reduce risk and move to self-sufficiency would be set out by Trustees in an Integrated Risk Management Plan. This would include the agreed self-sufficiency funding target, the revised employer contributions and the Trustees' investment strategy. It would also cover the agreed approaches to both falling behind the target and making progress ahead of schedule.
Letter to employer

1. The General Medical Council Staff Superannuation Scheme – next steps regarding closure to accrual.
15 February 2018

Professor Sir Terence Stephenson
Chair of Council
Regent’s Place
350 Euston Road
London
NW1 3JN

Dear Terence

The General Medical Council Staff Superannuation Scheme – next steps regarding closure to accrual

I am writing on behalf of the Trustees of the Scheme following the Trustees’ meeting on 1 February 2018. At that meeting we discussed the next steps following Council’s decision to close the Scheme to further accrual from 1 April 2018 and we have been working on finalising a revised deed and rules for both parties to sign to allow the change to be implemented.

We and our advisers have considered the position carefully and I have set out in this letter our requests from Council.

Proposal

The Trustees agree that it is in the interests of Scheme members and the Council for the Scheme to reach a position where there is little risk of needing the Council to fund a large deficit. At that point the Scheme would be 'Self-Sufficient' and there would be little chance of needing any further contributions from the Employer.

Trustees believe this Self-Sufficiency position should be reached within 10 years through a combination of extra contributions and investment returns.

The Trustees request the Employer increases its additional contributions from the current £0.5M p.a. to £3.0M p.a. and these remain fixed for the next 10 years. This would provide greater certainty of contributions and a 75% chance that this Self-Sufficiency position is reached by 2027.

The rest of this letter sets out the rationale for this proposal.
Roles of Employer and Trustees
As a reminder, the roles of the Employer and Trustees are as follows:

- The Trustees are responsible for the day-to-day management of the Scheme
- The Trustees have responsibility for determining the investment strategy of the Scheme, having consulted with the Employer
- The long term strategy, funding principles and resulting contributions are agreed jointly between the Trustees and the Employer
- The Employer and Trustees both need to agree to amend the Scheme to close it to future accrual.

The two key areas where we request your agreement are the long term strategy for the Scheme and the level of Employer contributions to support this.

The current funding position and agreed contributions

As at 31 December 2017, the Scheme had assets of £233.4M and the estimated amount needed to provide the benefits already earned by members, known as the "Technical Provisions", was £245.0M. There is therefore a deficit of £11.6 million and the Scheme is 95% funded. This has improved since 31 December 2016 where there was a deficit of £18.1 million (Technical Provisions of £231.7M less assets of £213.6M). This improvement is due to strong returns from the Scheme's growth portfolio.

The Council is currently contributing 22.8% of salaries whilst members accrue further benefits, plus annual lump sums of £500,000 and the insurance premiums to cover the death in service lump sum benefit.

Future strategy

The future of the Scheme should be considered in 3 stages:

1. Reaching a position where the Scheme is 'Self-Sufficient'
2. Getting from a Self-Sufficient position to a position where the Scheme can be bought out with an insurance company
3. Actually securing members benefits with an insurance company.

Stage 1 - Reaching Self-Sufficiency

Trustees request the Council's agreement to the Trustees' Self-Sufficiency target and the plan to reach it.

The Self-Sufficiency Target

As explained in our previous letter of 7 September 2017, reflecting Pensions Regulator guidance, we have a target of reaching 'Self-Sufficiency'. Self-Sufficiency is where the Scheme is invested in a way that reduces the risk of not being able to provide members' benefits. It minimises the potential need for additional
contributions, the probability of a large future deficit arising and reliance on the Employer's ongoing covenant. Reaching this position is in the interests of Scheme members and the Council.

Our measure of Self-Sufficiency uses all the same financial and demographic assumptions as the Technical Provisions, with the exception of the discount rate.

The Technical Provisions have been agreed between the Council and Trustees every 3 years at each valuation. The Council and Trustees have agreed for many valuations the principle that the Technical Provisions discount rate is 2% p.a. above the return on UK Government Gilts before members retire and in line with the return on UK Government Gilts after members retire. This structure allows the Scheme to have sufficient money to invest in assets that match the pension payments once members retire. In order to generate the additional 2% return pre-retirement, investment risk is currently being taken.

The Self-Sufficiency measure assumes that all future investment returns will be in line with the return on UK Government Gilts plus 0% p.a. This means once the Scheme reaches Self-Sufficiency, investment risk can be significantly reduced.

All of the other assumptions (ie other than the discount rate) would be reviewed at each valuation and be the same in both the Self-Sufficiency and the Technical Provisions targets. As a result the Self-Sufficiency target will always be higher than the Technical Provisions. As at 31 December 2017 the Self-Sufficiency target was £309.6M, giving a Self-Sufficiency deficit of £76.2M.

**How much would risk be reduced once Self-Sufficiency is reached?**

Trustees have previously taken steps to reduce the funding risk in the Scheme by around a third. However, if we had a bad year such as might arise once in every 20 years an extra deficit of £29M could arise.

Once we reach Self-Sufficiency, we would reduce this risk significantly by reducing the allocation to return-seeking assets. This is important because it would mean any future call on cash from the Employer would be very significantly reduced.

**The plan to reach Self-Sufficiency**

Trustees believe that the Scheme should aim to reach Self-Sufficiency through a combination of investment returns and additional contributions. The higher the contributions, the greater the chance of reaching Self-Sufficiency. With the agreed £0.5M p.a. contributions the Scheme only has a 61% chance of reaching Self-Sufficiency within 10 years.

Increasing contributions by £2.5M p.a., to a total of £3M p.a., would increase the chance of Self-Sufficiency being achieved by 2027 to 75%. Trustees agree this is the right strategy that balances affordability and risk.
The sooner additional contributions are invested in the Scheme, the longer they will be invested for, so the greater the expected returns. It will also provide greater opportunity to de-risk the investment strategy sooner, reducing the likelihood of further cash calls from the Employer.

The table below summarises the impact of a range of additional contribution options over the period from 2018 to 2027:

<table>
<thead>
<tr>
<th>Extra contribution above the £0.5M p.a. already agreed</th>
<th>£2M p.a. extra contribution</th>
<th>£2.5M p.a. extra contribution</th>
<th>£3M p.a. extra contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Probability of reaching Self-Sufficiency in 10 years</td>
<td>72%</td>
<td>75%</td>
<td>78%</td>
</tr>
</tbody>
</table>

Whilst Trustees believe an extra £2.5M p.a. (ie a total of £3M p.a.) is the right strategy, if the Employer wished to make greater contributions, this would be very welcome and accelerate the timescale to achieving our goal.

**Stage 2 – Getting from Self-Sufficiency to Buy-Out**

Once Self-Sufficiency is reached the need for contributions from the employer would stop. The Trustees’ expectation is that once the Scheme has achieved full funding on the Self-Sufficiency measure it will de-risk the investment strategy very significantly to reduce the risk of a large deficit arising and hence the need for extra Employer contributions.

This position would be maintained until the Trustees can afford to purchase (or 'buy-out') individual annuities for members.

The Trustees expect that for pensions in payment the cost of 'buy-out' will be lower than Self-Sufficiency. For deferred pensioners the cost of 'buy-out' will be higher than Self-Sufficiency. The gap between Self-Sufficiency and this full 'buy-out' would therefore be expected to narrow as more members retire. The Self-Sufficiency target has been chosen such that the gap to reaching full buy-out is expected to be within reach within a reasonable timeframe and the Scheme does not need to wait until all deferred members have retired.

**Stage 3 – Securing members benefits with an insurance company**

Ultimately all UK defined benefit pension schemes will secure members’ benefits with an insurance company and be wound up. Only at that point will all risk be removed.
Future Contributions Changes

Trustees appreciate they are requesting the Employer to commit to a strategy of additional contributions for the next 10 years. Trustees feel this is important as it helps the Trustees to plan the most efficient way of achieving the goal of Self-Sufficiency by 2027.

The Trustees propose that if the Employer agrees to the Trustees' request then although the position should be reviewed at each valuation, the principle which the Trustees would want to work to is that:

Contributions do not increase even if the deficit has increased, subject to a reasonable recovery plan being possible

This principle would give the Employer and Trustees more certainty over the level of contributions. In addition, the Trustees agree contributions at the proposed level mean there is no need to have a separate 'legally binding contingency plan' as the Pensions Regulator would expect if the proposed contributions were not being paid.

Next steps

We would appreciate confirmation of the following items:

- Agreement to a long-term strategic objective of being fully funded on the Self-Sufficiency measure by 2027, and significantly reducing risk once this is achieved
- Agreement that this should be achieved through a combination of investment returns and contributions
- Agreement to an extra £2.5M p.a. (ie a total of £3M p.a.) of contributions that would then be expected to remain constant through actuarial valuations.

If the Employer agrees to these then we would update the Scheme's schedule of contributions before 1 April 2018 in the normal way and also set out the details of the above plan in an Integrated Risk Management document in accordance with the Pensions Regulator's guidance.

Yours sincerely

Jim McKillop

Chair of Trustees

On behalf of the Trustees of the General Medical Council Staff Superannuation Scheme
Pension Strategy - Trustee funding request – advice to Council
GMC Staff Superannuation Scheme
Long term plan and future scheme funding

Prepared by John Coulthard FIA, Ian Graham FIA
February 2018
Aon Hewitt | Retirement & Investment
Presentation to General Medical Council
Agenda

The Trustees have requested that the Council increase contributions to the pension scheme following closure to accrual in order to target self-sufficiency in 10 years’ time. We will cover the reasonableness of the proposal along with the wider future of the DB scheme.

1. Introduction
2. Trustees’ proposal
3. Analysis of proposal
4. Summary – Outline potential response
1. Introduction – Benefit review and upcoming valuation

- Council has completed the benefit reform consultation – DB members will move to DC from 1 April 2018, subject to Trustees consenting to Rule change
  - DB benefits retain salary link while in GMC employment
  - DC benefits to be enhanced for all: 15% Council contributions
- Primary driver for change was to reduce risk. But, also potential cost savings: if deficit contributions were unchanged, the initial net annual saving would be about £1.4M† based on current DB contributions (or about £3M if DB costs re-measured using 31/12/2017 market conditions and payroll). These cost savings reduce over time as the DB payroll falls
- Next actuarial valuation due at 31 December 2018
  - Contributions agreed by Trustees/Council, subject to Scheme Actuary confirming no lower than had they set them
  - Needs to be signed off by 31 March 2020
- Pensions Regulator is encouraging trustees to focus on long term planning and Integrated Risk Management (IRM)
- Trustees seeking to agree additional contributions outside of the regular three-yearly valuation cycle

†Estimated savings provided as part of April 2017 advice on benefit changes, based on information available at the time.
The funding position has improved over 2017, with the Technical Provisions deficit reducing from £18.1M (at 31/12/2016) to £11.6M (at 31/12/2017).

Moreover, over 2017, further evidence has come to light that members are not living as long was previously expected. This is bad news for members, and good news for pension schemes. We believe that taking into account latest industry mortality data would reduce the value placed on liabilities by about 3%.

This has a more material impact on the deficit positions, due to gearing. In particular, allowing for this new data, the funding position at 31/12/17 would be about a £4M deficit on a Technical Provisions basis (which the current deficit contributions of £0.5M p.a. would cover over a relatively short period), and about a £67M deficit on a self-sufficiency target.

Please note: Actual funding position at 31/12/2018 is likely to be different, due to changes in markets over 2018, and also due to recalibrating results using up-to-date member data.
1. Introduction – What next?

- The benefit reform has stopped the build up of further liabilities
- Over time, the technical provisions funding target (used for the valuation) blends into a low risk or “self-sufficiency” approach, for reasons explained later in this note
- The scheme is in a good place compared with many UK schemes. But, existing liabilities represent a substantial risk (e.g. in a 1 in 20 bad outcome, position would be about £87M† worse than expected over 10 years). And there is mutual advantage if the scheme can achieve self-sufficiency more quickly
- The route to self-sufficiency is largely cash contributions and asset outperformance. In practice GMC and Trustees are likely to have different views on the best combination of contributions vs asset outperformance. Ordinarily any difference in view would need to be resolved as part of a triennial funding valuation discussion
- Looking further ahead, full funding on self-sufficiency would mean the Trustees have a realistic opportunity to fully insure the pension scheme, if the current competitive pricing remains in place

†Estimated VaR provided as part of April 2017 advice on benefit changes, based on market conditions at the time.
1. Introduction – Integrated Risk Management (IRM)

- **December 2015: Pensions Regulator’s guidance on IRM**
  - Trustees should consider funding, investment and covenant risks together
  - Prioritise risks
  - Apply better risk management strategies now
  - Develop contingency plans for how to deal with material risks as they emerge in the future
- **May 2017: Pensions Regulator’s annual funding statement**
  - Focused on IRM again and long term plans
  - Legally binding contingency plans
- **April 2018: We expect Pensions Regulator’s annual funding statement to again focus on long term planning, and contingency plans**
2. Trustees’ proposal

Trustees propose to aim to reach **self-sufficiency** (defined as Gilts+0%) in 10 years’ time with a 75% probability. This requires contributions of £3M p.a. (£0.5M plus an additional £2.5M) for 10 years

- Contributions would be fixed for 10 years (unless this would result in an unreasonably long recovery plan)
- Trustees feel that a 10-year commitment on contributions would remove need for a separate IRM contingency plan
- Trustees suggest that making contributions more certain will aid Council planning

Broadly this would mean that:

- Just under half of the c.£67M self-sufficiency shortfall is corrected by additional cash contributions to the Scheme, with the rest made up of investment outperformance (above a pure gilt yield)
- The likelihood of achieving self-sufficiency is improved from about 61% (if £0.5M p.a. is maintained) to about 75% (with the additional £2.5M x 10)
3. Review of proposal – Self-sufficiency target

- The proposed long term target is “self-sufficiency”, based on the Technical Provisions (TPs) approach but using a Gilts+0% p.a. discount rate. This is a prudent approach.

- As a reminder, the TPs uses a “split discount rate”, of Gilts+2% before retirement, and Gilts+0% during retirement. Therefore, the TPs will blend over time into the proposed self-sufficiency target (once all members have retired). This is illustrated by the top chart: currently the self-sufficiency target is about 25% higher than TPs. The gap falls to about 10% in 10 years’ time, and to about 2% in 20 years’ time. The proposal is in our view reasonable and not dissimilar to what will happen anyway.

- In current market conditions, the cost of buying out benefits with an insurer is higher than self-sufficiency, although currently for pensioners only the insurance costs are cheaper (see bottom chart).
Aon’s Global Pension Risk Survey 2017

Timescales to long-term objectives by scheme size

- Under £100m: 26% (6 years); 20% (10 years); 37% (11 to 15 years); 14% (16 to 20 years); 3% (over 20 years)
- £100m to £1bn: 11% (6 years); 34% (10 years); 30% (11 to 15 years); 18% (16 to 20 years); 7% (over 20 years)
- Over £1bn: 7% (6 years); 32% (10 years); 37% (11 to 15 years); 16% (16 to 20 years); 9% (over 20 years)

Factors determining the time to long-term objective

- Fixed timescale: 6%
- Amount of risk we are willing to take: 37%
- The level of long-term interest rates: 27%
- The level of corporate bond yields: 4%
- The employer’s ability to make contributions: 23%
- Resources to execute our plan: 3%
- The level of experience: 11%
- The level of volatility: 10%
- The level of the economy: 9%
- The level of dividends: 8%
- The level of inflation: 7%
- The level of government policies: 6%
- The level of market conditions: 5%
- The level of competition: 4%
- The level of technology: 3%
- The level of human resources: 2%
- The level of social conditions: 1%
- The level of environmental conditions: 0%

Our survey shows that:

- A 10-year indicative timescale is fairly typical, although slightly shorter than average
- Only 6% of schemes have a fixed timescale. We would not recommend agreeing to achieve full funding within a fixed timescale (as opposed to an indicative target)

The agreed timescale should:

- Be long enough to enable asset returns to help to bridge the gap to self-sufficiency, if the aim is to control cash contributions
- Seek to use any future good experience to support a shorter timeframe or accelerated de-risking or both
- Leave sufficient time for other actions, for example GMP equalisation, member options exercises, etc.
- Reflect the strength of covenant i.e. Trustees should be more flexible where the employer is strong

10 years is a reasonable timescale, provided it is indicative
3. Review of proposal – Contributions (1 of 2)

- The additional £2.5M p.a. of contributions is reasonable if Council wants a 75% chance of achieving self-sufficiency over 10 years, and is content to pay more than it would have done had the scheme remained open to achieve this. However, committing an extra £25M would represent a major change in how the scheme is financed compared with the approach agreed by the Council and Trustees at the last actuarial valuation.

- At the other extreme, one could make a case for no additional contributions being needed:
  - The TPs are already prudent, and include a natural pathway to self-sufficiency (albeit a relatively slow path that requires all members to have retired).
  - The Trustees are in a better risk position by virtue of the Scheme being closed to new accrual, and so all else being equal should not need additional cash contributions.
  - While the Pensions Regulator is keen for Trustees to agree “legally binding contingency plans” in practice few employers have done so to date.

However, this would require Council to accept that the gap between Technical Provisions and self-sufficiency is corrected only through asset outperformance (and so effectively is aspirational), and would leave it exposed to risks for longer.

- The Council is making considerable savings as part of the benefit reform, which were a by-product rather than purpose of benefit reform. In our view it would be reasonable to recycle the savings into the scheme to help get to a lower risk position more quickly, which could benefit all members (including DC members whose job prospects / benefits could be imperilled by a materially underfunded scheme).

£25M hard to rationalise, but advantage to Council in subsidising a quicker journey to self-sufficiency.
3. Review of proposal – Contributions (2 of 2)

- We have estimated that the benefit reform proposals reduce the cost of benefits by about £1.4M in the first year, comprising:
  - £2.7M of savings on moving from the current 22.8% employer contribution rate to 12% DC, LESS
  - (£1.2M) of costs for moving all members to 15% DC, LESS
  - (£0.1M) of costs for incapacity/death benefits

  (Saving is closer to £1M in 2018 as only 9 months’ of savings if changes effected on 1 April 2018.)

- Using 31 December 2017 market conditions, then the 22.8% employer contribution rate would increase to about 30%. Arguably a better measure of the cost saving would therefore be £3M in the first 12 months. This comes down as the DB payroll reduces (e.g. the £3M would reduce to about £1M by year 10)

- We suggest paying £1.4M to the scheme for 2018 and 2019 as a compromise approach, and to incentivise the Trustees agree to the Rule change. Contributions beyond 2019 can be discussed as part of the 2018 valuation, where a number of other issues can be considered in the round – such as new mortality data and the role of member option exercises in closing the gap to self-sufficiency.

Possible alternative

- Additional £1.4M p.a. (total £1.9M p.a.) committed for 2 years only and reviewed at next valuation
- Same target of self-sufficiency in 10 years
- £1.4M p.a. if paid for 10 years would give a 68% chance of reaching target (half-way between Trustees’ proposal and status quo)

Suggest two-year offer of £1.4M x 2, with commitment to consider further at next triennial valuation
3. Review of proposal – Wider considerations

Flight plan to self-sufficiency

- Check that proper safety valves and monitoring will be in place to avoid unnecessary contributions if reach self-sufficiency earlier and to minimise risk of trapped surplus:
  - Regular monitoring with contributions to cease once target reaches
  - Surplus over self-sufficiency to enable future expenses to be paid from Scheme assets
- Discuss investment de-risking triggers with the Trustees:
  - Will investment outperformance be allowed to reduce the time to self-sufficiency or be spent on accelerating de-risking (or a combination of both)
  - Will investment returns help to bridge (any) gap from self-sufficiency to buy-out?

Ultimate goal of buy-out?

- Insurance company buy-out is the ultimate goal for most closed schemes:
  - Secure members’ benefits in full through annuity contracts and pass risk to insurance company
  - Some issues to be ironed out before buy-out
    - Cannot insure future salary link – would need to re-consult members on a different approach
    - GMP equalisation (a technical issue that would likely (slightly) increase the cost)
- Other levers can be used to help close the gap to self-sufficiency and ultimately buy-out, for example:
  - Member options at retirement, such as transfer values and pension increase exchange
  - Purchase annuities in stages when pricing is attractive (“partial buy-ins”)

Wider considerations could be worked through with Trustees over 2018
4. Summary – Outline of potential response to Trustees

- Council supports the Trustees' broad vision for the future of the scheme and wants to reach a lower risk, self-sufficiency target.

- Agree a 10 year indicative timescale, and to use a long term self-sufficiency target as proposed by the Trustees.

- The balance of additional contributions vs asset outperformance is more debatable. A 75% confidence level is considered excessive given the level of prudence in the target basis and relatively short timescale. Council not convinced that committing an extra 10x£2.5M=£25M is warranted at this time: it would be a major change to strategic direction at a time when the proposed closure in itself reduces risks materially.

- Accept the principle that some additional contributions may be merited to help bridge gap to self-sufficiency more quickly than is implied by TPs.

- Believe triennial valuations are main opportunity to review contributions, and note that at 31 December 2018 valuation would expect deficit to fall as a result of changes to national life expectancy, and there are other potential levers available to bridge the gap to self-sufficiency funding such as a Pension Increase Exchange exercise that should be explored in the run up to the valuation date, along with a discussion of the safeguards and triggers in place to de-risk if the funding position improves.

- With this in mind, propose paying an additional £1.4M for 2018 and 2019, with further consideration given as part of the triennial actuarial valuation due as at 31 December 2018 valuation, and based on the funding position at the time.
This presentation has been prepared in accordance with the framework below.

TAS compliance

This presentation, and the work relating to it, complies with ‘Technical Actuarial Standard 100: Principles for Technical Actuarial Work’ (‘TAS 100’) and ‘Technical Actuarial Standard 300: Pensions’ (‘TAS 300’). The compliance is on the basis that the General Medical Council are the addressees and the only users and that the presentation is only to be used in considering high-level funding plans and responding to the Trustees’ letter referenced. If you intend to make any other decisions after reviewing this presentation, please let me know and I will consider what further information I need to provide to help you make those decisions.

The presentation has been prepared under the terms of the Services Agreement for employer advice between the General Medical Council and Aon Hewitt Limited on the understanding that it is solely for the benefit of the addressee.

This presentation should be read in conjunction with:

- The Trustees letter to the GMC dated February 2018
- Our initial advice of 24 November 2017 on the Trustees’ request for additional contributions
Council meeting, 28 February 2018

**Agenda item:** M9

**Report title:** Proposals for Chair and Council member appointments process

**Report by:** Lindsey Mallors, Assistant Director, Office of the Chair and Chief Executive, Lindsey.Mallors@gmc-uk.org, 020 7189 5188  
Mary Morgan-Hyland, Head of Governance, Office of the Chair and Chief Executive, mmhyland@gmc-uk.org, 0161 923 6678

**Action:** To consider

---

**Executive summary**

Arrangements need to be put in place to agree the approach for appointments to the Chair of Council and two Council members as the Chair and one Council member will demit office at the end of 2018 and one Council member stood down from Council in November 2017.

This paper outlines recommendations to run two separate campaigns; to recruit the Chair of Council first and then two Council members. The paper also outlines proposals to secure a recruitment agency to manage the process, membership of the appointments selection panels and revisions to the core competencies document.

---

**Recommendations**

Council is asked to agree:

- **Option 1** as the approach to the appointment process.
- **b** That an executive search agency be appointed to manage the process.
- **c** Proposed amendments to the competencies at Annex B.
- **d** The proposed membership of the selection panels.
- **e** That the chairs of the Audit and Risk and Remuneration Committees be asked 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 panel members remains unchanged.
Introduction

1 Chair of Council, Professor Sir Terence Stephenson, and Council member Baroness Helene Hayman will demit office at the end of 2018. In addition, Professor Michael Farthing stood down from his Council member position as of 28 November 2017. An open competition now needs to be run to appoint a Chair and two new members.

2 The campaign or campaigns, will be open to both registrant and lay applicants. In order to keep the balance of Council, the appointments process will recruit one lay member and two medical members.

3 The appointments process will be carried out in accordance with the Professional Standards Authority’s (PSA) *Good Practice in Making Council Appointments* guidance and the principles of merit, fairness, transparency and openness and inspiring confidence. The guidance deems Council responsible for ensuring that the process for appointment is undertaken appropriately and in a timely manner, and for allocating sufficient resources to it.

Approach

4 As we are seeking to appoint a Chair and members, there are three options for approaching the process:

- Option 1 – to appoint the Chair first, followed by a second appointment exercise to recruit two members. This has the advantage of allowing the incoming Chair, subject to Privy Council approval being timely, to take part in the member appointment process. It also enables selection of members to take in to account the skills brought by the incoming Chair, and the specific induction processes for the Chair-designate to begin before that for the new Council members. Its key disadvantage is the additional cost and time required to manage two processes. The estimated cost for this option is £145,000. This includes the cost of the recruitment agency, running two advertising campaigns and remuneration of both selection panels.

- Option 2 – to undertake a single recruitment and selection campaign for all roles, open to lay and registrant applicants who would need to indicate if they would like to be considered for the Chair of Council role, a Council member role or both. The advantage here is a potentially quicker timeframe and reduced cost but these may be offset by the additional complexities with handling applicants who may be interested in only the Chair role or applicants having to do two interviews, one for member and one for Chair. PSA guidance also acknowledges that this approach can bring unforeseen additional problems. The cost for this option is estimated to be £100,000.
Option 3 – to run a joint advertising campaign but with parallel timelines to allow for appointing the Chair first, followed by the members. The main disadvantage is that the member applicants may be put off by the lengthy time period between application and selection for interview and may find other roles in the meantime or just withdraw from the process. The estimated cost for this option is £110,000.

The recommended approach is option 1, to run two separate appointment campaigns, the Chair first. This follows the same process for the open competition used in 2014 and 2016. Following the Chair appointment, a second campaign would then be launched to recruit the two Council members. Dependent on the outcome of the Chair recruitment, this process would either be for one registrant and one lay Council member or for two registrant Council members.

Based on previous open competitions, the estimated timeline (at Annex A) for running two campaigns would be approximately seven months, with the Chair of Council expected to be confirmed by the Privy Council before the summer recess if possible and during September 2018 if not; and confirmation of Council member appointments expected in November 2018. This includes time for the required stages of the PSA scrutiny process and Privy Council approval process.

Assessing Council’s future needs

Council undertook a detailed skills audit prior to the 2016 appointments process and many of the identified gaps in knowledge and expertise were addressed with the recruitment of the four new members. As part of the 2017 Council Effectiveness Review, Council members and the Senior Management Team considered the skills mix of the current Council cohort. The core competencies document (at Annex B) has been refreshed to reflect these considerations. The additional competencies and experience required for the Chair remain unchanged.

The advertising strategy and communications campaign for the recruitment process will be designed to attract a strong and diverse field of suitable candidates with a focus on encouraging applications from candidates with the specific skills and profiles identified as currently limited on Council. This might include for example, doctors with an International Medical Graduate (IMG) background, Speciality and associate specialist (SAS) doctors, trainee doctors, as well as candidates with disabilities, from different age groups and socio-economic backgrounds.

No changes are proposed to the time commitment and remuneration packages for the Chair of Council or Council member roles.
Procuring the services of a non-executive recruitment agency

10 As with previous campaigns we propose to use the services of an executive search agency to manage the process in order to secure the experience and expertise required for non-executive appointments. Work has begun on the tendering process to ensure a preferred supplier can be appointed in March 2018. The proposed panel for procuring the agency would include one Council member (this cannot be a member who will sit on the selection panel or a member considering an application for the role of Chair), the Director of Resources and Quality Assurance and the Assistant Director Audit and Risk Assurance.

Selection Panel

11 Running two campaigns is likely to require two different selection panels, the first to oversee the process for the appointment of the Chair and the second for Council members. The role of each panel will be to assess candidates against the published criteria, in accordance with the published process, and then decide which candidates to recommend for appointment.

12 In accordance with PSA’s guidance, selection panels should consist of at least three and no more than five members and should be credible to inspire confidence in the integrity of the process. Panels must also include at least one member who is independent of the regulator in order to bring an impartial perspective. An independent member is also required to provide a report to the PSA at the end of the selection process.

13 We are proposing that for the Chair panel, we have five members, three external and two from Council. We believe involving current Council members gives helpful insight from Council’s work when considering applicants’ skills, experience and expertise and suggest that the Chairs of the key governance committees, Audit and Risk, and Remuneration, would provide a good overview of Council’s strategy and activities. The PSA also suggests that Council panel members should be those who are not eligible for reappointment and both committee chairs are in their second terms of appointment.

14 To provide credibility with our key interest groups and confidence in the process we propose the panel should include three external members who are independent of the GMC and Government. It may be helpful for us consider the strategic benefits of drawing experienced members from an employer organisation, a devolved nation and a patient representative body. We have approached Baroness Usha Prashar, who was the independent member on the most recent Council member appointments process in 2016, and understand she would be willing to participate as Chair of the panel if recommended by Council and confirmed by the PSA.
15 If timescales permit we propose that the selection panel for Council member roles should include the Chair-designate, a further Council member and three external members. Depending on availability, the Panel membership may not necessarily be the same members as for the Chair process.

16 In the interests of time and to ensure the availability of panel members we have refreshed the long list of potential external panel members agreed for the 2016 appointments and will ask the Chair of Council to approve who we should approach, based on the agreed criteria and PSA’s requirements.

17 We propose that the remuneration for the services of panel members should remain at the levels agreed in 2014 and 2016, namely a daily rate of £400 plus expenses and £465 per day plus expenses for the independent panel member who is required to produce an independent report to the PSA. This report will be needed at the end of both recruitment processes.

Next steps

18 Council is asked to agree:

a Option 1 as the approach to the appointment process.

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

c The amendments to the competencies.

d The proposed membership of the selection panels.

e That the chairs of the Audit and Risk and Remuneration committees be asked to join the Chair selection panel.

f Whether they would like to formally approach Baroness Usha Prashar to chair the selection panel for the new Chair.

g The remuneration for panel members.

19 Subject to Council’s approval of the proposed approach and arrangement, we will update the PSA and the Privy Council about our plans and the timetable for this work.
M9 – Proposals for Chair and Council member appointments process

Council Appointments High level timeline
## Timeline – Chair appointment

<table>
<thead>
<tr>
<th>Project</th>
<th>Feb ’18</th>
<th>Mar’18</th>
<th>Apr’18</th>
<th>May’18</th>
<th>Jun’18</th>
<th>Jul’18</th>
<th>Aug’18</th>
<th>Sep’18</th>
<th>Oct’18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Council to consider a paper setting out our proposed approach to appointment of the Chair and two Council members.</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-executive recruitment agency appointed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Submit Advance Notice to PSA (3 weeks prior to advertising)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chair role advertised (PSA guidance advises minimum 4 weeks: schedule proposes 26 March – 30 April 2018)</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sifting by search firm (w/c 7 May)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Longlisting with selection panel (w/c 7 May)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preliminary interviews (by agency w/c 14 &amp; 21 May)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Shortlisting meeting with panel (w/c 21 May)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Final interviews (w/c 4 &amp; 11 June)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Selection panel make offer of recommendation (w/c 18 June)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>PSA and Privy Council approval (allow 5 weeks)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Confirmation of appointment (w/c 23 July)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Announcement of appointment (w/c 31 July)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Induction of new Chair prior to taking up post – October – December (to include attending Council meetings as observer)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
## Timeline – Council member appointment

### Project Timeline

<table>
<thead>
<tr>
<th>Project</th>
<th>Feb ’18</th>
<th>Apr’18</th>
<th>June’18</th>
<th>July’18</th>
<th>Aug’18</th>
<th>Sept’18</th>
<th>Oct’18</th>
<th>Nov’18</th>
<th>Dec’18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Council to consider a paper setting out our proposed approach to appointment of the Chair and two Council members.</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-executive recruitment agency appointed</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Submit Advance Notice to PSA (3 weeks prior to advertising)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Council member roles advertised (minimum 4 weeks)</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sifting by search firm</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Longlisting with selection panel</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preliminary interviews (by agency)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Shortlisting meeting with panel</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Final interviews</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Selection panel make offer of recommendation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>PSA and Privy Council approval (allow 5 weeks)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Confirmation of appointment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Announcement of appointment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Induction of new members prior to taking up post</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

### Status

- **Delayed**
- **In Progress**
- **Complete**
Proposed amendments to the core competencies for GMC Council members

The following are the competencies and expertise required for Council member and Chair of Council roles, as agreed by Council in 2012 and used to constitute the membership of the current Council. Amendments (shown as track changes with the document) are suggested to: Competency 3 Ability to influence and communicate effectively to more accurately reflect the role of Council members in this area; the additional desirable knowledge and skills section to include experience in new media and communications; and to refine reference to acting as an ambassador. This is to clarify that Council members do have ambassadorial roles for the GMC at events such as the GMC Conference, UK Advisory Fora etc.

Core competencies for GMC Council members

Competency 1

*Ability to command the confidence and capacity to understand the priorities of the GMC’s key interest groups*

a. Knowledge and experience of working in partnership and promoting inclusion and involvement of one or more of the GMC’s key interest groups; or capacity to understand the GMC’s aims and priorities of its key interest groups.

b. Knowledge/experience in any of the following areas: governance, regulation, healthcare delivery, consumer engagement, audit and risk, finance and assurance, commercial sector, community or voluntary sector, professional/higher education, professional ethics and standards.

c. Understanding, knowledge or experience of managing external relationships and engaging with the public and/or the medical profession.

d. Knowledge and understanding of equality and diversity issues.
Competency 2

*Ability to contribute to strategic direction*

- **a** Knowledge/experience of strategic planning, including the development and delivery of an organisation’s strategy for the medium and long term, including the development of the governing body to be effective.

- **b** Understanding strategic and business plans, systems of internal governance, and ability to interrogate performance data, exercise robust board level accountability, and uphold the principles of effective corporate governance.

- **c** Contributing openly to debates and discussions to reach decisions which achieve corporate objectives.

- **d** Challenging and probing constructively and effectively to achieve the best outcome for the organisation in fulfilling its charitable and statutory purpose.

Competency 3

*Ability to influence and communicate effectively*

- **a** Highly developed interpersonal and influencing skills with ability to establish credibility, demonstrate awareness of the external environment and provide knowledge and insight on the views of the GMC’s key interest groups across the four nations, and effective working relationships with the GMC’s key interest groups.

- **b** Influencing and persuading others using well-reasoned arguments, experience of participating in group discussions, and working effectively in a team of people.

- **c** Good communication skills and ability to put views across clearly, persuasively and sensitively.

- **d** Experience of participating in group discussions, proven ability to promote the role of an organisation externally, and commitment to the promotion of equality and valuing diversity.

Competency 4

*Analytical skills and sound judgment*
a Knowledge/experience of analysing and understanding complex information and situations before reaching an independent and objective conclusion.

b Willingness to modify thinking in the light of new information/dialogue, and to respect the differing views of others.

c Ability to think creatively, analytically and contribute constructively to the collective decision-making process.

Additional desirable knowledge and skills required

In addition, the Council is seeking candidates who are able to demonstrate knowledge and skills gained in one or more of the following areas:

a Significant level chairing experience: track record of board level leadership in a non-executive role; ability/knowledge and experience of chairing boards/committees; ability to make sense of complex information/situations and to build consensus and arrive at concrete decisions; ability to act as an ambassador for the organisation and to develop and maintain constructive collaboration, networking and consultation with key interest groups at national, European and international level; ability to use complex influencing strategies using extended networks of influence.

b Significant experience of leading organisations: knowledge/experience of leading organisations or senior level experience, including, for example, charities, regulatory bodies, consumer or medical representative bodies, non-departmental public bodies, commercial bodies, community/voluntary bodies.

c Significant level governance experience: knowledge and experience of governance work in the public or private sector in any of the following areas: regulation, charity trusteeship, strategic planning, audit and risk, financial management, healthcare education and provision.

d Significant expertise in any of the following areas: commercial acumen; financial/business management; investment income generation; information systems and communication technology; the legal sector; new media and communications.

Additional competencies and experience required by the Chair of Council

In addition to the core competencies and areas of experience required for Council members, the Chair of Council should be able to demonstrate that they:

a Are recognised as demonstrating outstanding leadership with a record of achievement in a substantial, high profile leadership role in a complex environment.

b Have significant level chairing/board level leadership experience.
c Have a proven record of managing and building effective and positive relationships and commanding the confidence and support of key interest groups at national, European and international level, and proven ability to act as an ambassador for Council at these levels.

d Have long term strategic thinking capabilities to steer the GMC through the next four years, including the delivery of the Corporate Strategy 2018 - 2020, leading the Council in setting the future vision, and responding effectively to future challenges in healthcare regulation.

e Have highly developed communication skills, including the ability to use complex influencing strategies using extended networks of influence, and to develop credible and effective working relationships internally and externally.
Executive summary
The Council forward work programme for 2018 has been developed to reflect the strategic aims (our 2020 goals) of the GMC’s Corporate Strategy 2018-2020, the Business Plan for 2018 and to enable the effective conduct of its work, in line with the recommendations from the governance and Council effectiveness review.

The proposed work programme is not a static document and may be subject to change given the potential for developments or changes in our external environment to impact on the work programme and the need to keep work under review to reflect priorities throughout the year.

Council needs to consider the proposed work programme and decide whether any changes need to be made.

Recommendation
Council is asked to agree its forward work programme for 2018.
Issue

1 Council’s work programme for 2018, at Annex A, has been derived from ongoing and new work arising from the Corporate Strategy, 2018 Business Plan and Council corporate governance responsibilities, and reflects corporate priorities and issues which flow from its strategic aims for consideration.

2 Council has in previous years expressed a particular interest in spending time at Council meetings on a range of significant policy and operational areas which the forward work programme seeks to reflect. The key areas highlighted for Council’s consideration in 2018 include:

a The reform of professional regulation.

b The regulation of medical associate professions.

c Brexit.

d Implementation of the flexibility review, including credentialing.

e Strategic communications and engagement.

f Medical Licensing Assessment.

g GMC Services International.

h Pressure on the NHS and understanding the context in which doctors’ practise.

i Implementation of the transformation programme.

3 The work programme reflects the anticipated timetable associated with issues requiring reporting to or consideration by Council, and may be subject to further changes as priorities change, as new issues arise, or because of external factors which impact on the work.

4 The programme also takes account of securing Council’s input at an early, interim and end stage to inform key strategic and high level policy issues. It also reflects the outcomes of the governance and Council effectiveness review, particularly in relation to the structure of the agenda and keeping the number of confidential items to a minimum, in accordance with set criteria as outlined in the Governance Handbook, to enable greater transparency and accountability.

* NB: The list of key areas for consideration are not prioritised or in any particular order.
5 It has been developed in light of discussions with Directors and has informed the Executive Board’s forward work programme for 2018. This work has been undertaken in parallel with the 2018 Business Plan and Budget, which was approved by Council at its meeting on 12 December 2017.

6 The work programme is kept under review by the Chair of Council and Executive. Council will be informed of any substantive changes as part of the agenda updates circulated between meetings as required.
Council forward work programme 2018 - working version

<table>
<thead>
<tr>
<th>Date and time:</th>
<th>Meeting:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wednesday 28 February 2018 09.00 – 13.00</td>
<td>Council</td>
</tr>
</tbody>
</table>

Meeting
- Chief Executive’s report
- Chief Operating Officer’s report
- Improving our consultations: progress and next steps
- Consent guidance – review of pre-consultation draft and consultation plans
- Human Resources Report 2017
- Pension future funding strategy
- Council appointments
- Council forward work programme 2018
- Amending the list of bodies entitled to award UK Primary Medical

Below the line
- Report of Executive Board
- 2019 meeting schedule

<table>
<thead>
<tr>
<th>Date and time:</th>
<th>Meeting:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tuesday 24 April 2018 09.00 – 13.00</td>
<td>Council</td>
</tr>
</tbody>
</table>

Meeting
- Chief Executive’s report
- Chief Operating Officer’s report
- PSA Annual Review of our performance
- Plans to report on performance against the new Corporate Strategy
- Report of the Investment Sub-Committee 2017 and review of Investment Policy
- Update on transformation programme
- Outcomes for Graduates – analysis of the responses to the consultation and approval for publication
- Mental health programme: overview, update and next steps

Below the line
- Taking revalidation forward update

---

**Date and time:**
Wednesday 06 June 2018 09.00 – 13.00

**Meeting:**
- Chief Executive’s report
- Chief Operating Officer’s report
- Report of the MPTS Committee
- Trustees Annual Report and Accounts 2017
- Fitness to Practise Statistics Report 2017
- Report of the Audit and Risk Committee
- Complaints report
- Enhancing our strategic communications and engagement
- Reform of professional regulation
- The regulation of medical associate professions

Below the line
- Expansion of medical schools

---

**Date and time:**
Thursday 27 September 2018 09.00 – 13.00

**Meeting:**
- Chief Executive’s report
- Chief Operating Officer’s report
- Annual report on DC pension scheme
- Update on implementation of the publication and disclosure of appeals
- Mental health programme: Update and next steps
- Update on implementing the Corporate Strategy

Below the line
-
<table>
<thead>
<tr>
<th>Date and time:</th>
<th>Meeting:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tuesday 06 November 2018 09.00 – 13.00</td>
<td>Council</td>
</tr>
<tr>
<td>Meeting</td>
<td></td>
</tr>
<tr>
<td>▪ Annual review of corporate complaints</td>
<td></td>
</tr>
<tr>
<td>▪ Credentialing update</td>
<td></td>
</tr>
<tr>
<td>▪ Report of Consent consultation outcomes - analysis of the responses to the consultation</td>
<td></td>
</tr>
<tr>
<td>▪ Information policy</td>
<td></td>
</tr>
</tbody>
</table>

Below the line

<table>
<thead>
<tr>
<th>Date and time:</th>
<th>Meeting:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wednesday 12 December 2018 09.00 – 13.00</td>
<td>Council</td>
</tr>
<tr>
<td>Meeting</td>
<td></td>
</tr>
<tr>
<td>▪ Chief Executive’s report</td>
<td></td>
</tr>
<tr>
<td>▪ Chief Operating Officer’s report</td>
<td></td>
</tr>
<tr>
<td>▪ 2019 Business Plan and Budget</td>
<td></td>
</tr>
<tr>
<td>▪ Report of the Medical Practitioners Tribunal Service Committee 2017</td>
<td></td>
</tr>
<tr>
<td>▪ Report of the Audit and Risk Committee</td>
<td></td>
</tr>
<tr>
<td>▪ Report of the Remuneration Committee 2018</td>
<td></td>
</tr>
<tr>
<td>▪ Report of the Investment Sub-Committee</td>
<td></td>
</tr>
<tr>
<td>▪ Council forward work programme 2019</td>
<td></td>
</tr>
<tr>
<td>▪ Committee membership 2019</td>
<td></td>
</tr>
<tr>
<td>▪ Brexit</td>
<td></td>
</tr>
</tbody>
</table>

Below the line

▪ Report of the Executive Board
Executive summary

Peninsula College of Medicine and Dentistry (PCMD) was established as a joint venture between Plymouth and Exeter universities and ran an undergraduate course in medicine from 2002. In 2012, the two universities separated with the aim of developing their own medical schools: Plymouth University Peninsula Schools of Medicine and Dentistry (PU PSMD) and University of Exeter Medical School (UEMS).

Since the decision to decouple in January 2012, the GMC has been quality assuring the development of both new medical schools in line with our new schools application process. Over the course of this rolling quality assurance process, the visiting teams overseeing the process have set several requirements and recommendations to improve the way in which PU PSMD and UEMS deliver medical education to their students. Both schools: PU PSMD and UEMS have remained fully engaged in the process and responded positively to all requirements and recommendations set by the GMC.

Overall, the visiting teams are satisfied that PU PSMD and UEMS are meeting our standards for education and training as set out in Promoting Excellence, and should be added to the GMC’s list of awarding bodies.

Recommendation

Council is asked to agree that PU PSMD and UEMS are added to the GMC’s list of bodies that can award UK Primary Medical Qualifications.
Introduction

1 Maintaining the list of bodies entitled to award primary medical qualifications (PMQs) is a key component of our regulation of undergraduate medical education. The current list of bodies and combinations of bodies entitled to award UK PMQs is published on our website at:
http://www.gmcuk.org/education/undergraduate/awarding_bodies.asp

2 The standard of proficiency is currently set out in Promoting excellence: standards for medical education and training (2016) and compliance with the standard is demonstrated through the Quality Assurance Framework, which includes annual returns from medical schools and a programme of visits.

3 As per the Schedule of Authority of the Governance Handbook, Council is required to maintain and amend, as required, a list of bodies and combinations of bodies entitled to hold examinations for the purpose of granting one or more primary UK qualifications.

About Plymouth University Peninsula Schools of Medicine and Dentistry and University of Exeter Medical School

4 Plymouth University Peninsula Schools of Medicine and Dentistry (PU PSMD) and University of Exeter Medical School (UEMS) each offer a five year degree programme (BMBS) which leads to a primary medical qualification. PU PSMD has approximately 80-90 students per year and UEMS has approximately 130 students per year. The first students at both schools commenced their studies in the September 2013 academic year and this cohort is now in the fifth and final year of the programme at each school.

5 Between May 2013 and January 2018, the education quality team has undertaken visits to both PU PSMD and UEMS each academic year, speaking to students and various groups of staff at the school; visits to local education providers, assessment observations and attended Examination Boards. This visit activity, alongside paper based reviews of policies and processes, is a core part of the quality assurance process for all new schools or programmes.

6 Several areas of good and notable practice have been identified over the course of our quality assurance activity. At PU PSMD, these relate to the pastoral and academic support that the school provides for their students; feedback on performance and raising concerns which were addressed following GMC feedback. At UEMS, both students and educators praise the facilities and pastoral support; UEMS’ ‘Inspire’ programme, which encourages student participation in research and includes funding students to work with research teams over the summer, is well received and popular; in the 2016 visit, the high quality of clinical supervision and teaching that
students receive on placement was also identified as an area of good practice; students are very positive about the clinical pathway placements, problem based learning, and small group teaching.

7 At PU PSMD, the main concerns highlighted through this review have related to raising concerns, the use of on the spot judgements, educational capacity planning and the representation of education at board level in one of the school’s education providers. At UEMS, the main concerns highlighted through this review have related to involvement of public and patients in policies, processes and development of the curriculum, interprofessional learning, and the clarity of professionalism judgements and how they were monitored and acted upon.

Addressing concerns

PU PSMD

8 The visiting team identified concerns regarding the school’s use of on the spot judgements as a summative assessment and set a requirement for the school to address. In response to this requirement the school set up a working group to look into the process and rationale of on the spot judgements and the school now undertakes on the spot judgements on a formative basis which is welcomed by the visiting team.

9 In 2013, we found the structures and guidance around raising concerns about education and training and patient safety to be lacking and set a requirement for the school to address. The school has worked to address this issue and since its identification the visiting team have identified two areas of good practice around raising concerns. Thus, the school now has highly effective, robust procedures and has gone above and beyond to rectify their processes and develop a culture where students feel able to raise concerns.

10 PU PSMD has responded well to the requirements and recommendations that we have set over the course of our quality assurance cycles. There are two open requirements and two open recommendations which were identified during the final visit, to ensure better alignment of educational and clinical governance.

UEMS

11 The visiting team identified concerns regarding patient and public involvement in the development and delivery of the programme. A requirement was set for the school to ensure the views of patients and the public contribute to policies, processes and the development of the curriculum. In response to this requirement the school has made significant progress towards embedding meaningful patient public involvement in
medical education, including the recruitment of lay people from a range of personal and professional backgrounds to join a Patient Involvement in Medical Education Steering Group with a larger group available to contribute to curriculum development. We have closed the requirement.

12 The 2015/16 cycle raised concerns over the understanding, from both the students’ and educators’ perspectives, of how professionalism is assessed. The school has continued to improve their assessment of professionalism by taking a longitudinal view across all years rather than making isolated annual judgements. This was identified as an area that is working well in the 2017 visit. Students now understand the principle of on the spot judgements.

13 The 2016/17 cycle raised concerns that interprofessional learning as a principle was present but that more could be done to embed it. In response to this, UEMS has appointed a new director of interprofessional learning. We heard that the newly implemented year 5 simulation sessions jointly held with nursing students are highly valued by learners. There is further potential to work with learners from the new academy of nursing and plans to create interprofessional learning opportunities with radiographers.

14 UEMS was asked to clarify how academic support is being developed and specifically how they intend to ensure education and teaching capacity and fair distribution of work. In response to this, the school created workload models (SWARM profiles) for academic staff. These indicate if staff are overworked and there is guidance for adjusting the workload for those that are. In terms of recruitment, there have been joint appointments of some doctors in training at NHS partners for the clinical skills and life sciences teaching.

15 The school was encouraged to review its teaching of basic sciences to ensure improvement for learners. Changes to the curriculum will be introduced in September 2018-2019 for years 1, 3 and 5 and in 2020 for years 2 and 4. The anatomy team has already made several changes following the results of the external review of the School’s teaching of basic sciences, surveys and student feedback and the school has a plan for further refreshing basic science teaching.

16 UEMS has responded well to the requirements and recommendations that we have set over the course of our quality assurance cycles. Before the most recent visit, there were two open requirements and six open recommendations, all of which were closed after the latest visit. There is only one open requirement identified during the final visit to ensure better alignment of educational and clinical governance.

17 PU PSMD and UEMS are aware that they must work on the few areas we have identified and they will be submitting action plans to outline how they plan to address the issues we identified during our final visit. The visiting teams are confident that PU
PSMD and UEMS will address the open items in the same way that they have addressed previous issues. Additionally, they provide updates through the Medical School Annual Return (MSAR) which acts as a quality management reporting mechanism to the GMC. Both PU PSMD and UEMS have robust educational governance and quality management structures in place resulting in high quality MSAR submissions and they ensure we are sighted on any issues they may be experiencing.
Agenda item: M13
Report title: 2019 Meeting schedule
Report by: Mary Morgan-Hyland, Head of Governance, Office of the Chair and Chief Executive, mary.morgan-hyland@gmc-uk.org, 0161 923 6678
Action: To consider

Executive summary
This paper sets out the proposed dates of Council, Committee and UK Advisory Forum meetings in 2019.

Recommendation
Council is asked to agree the 2019 schedule of meetings.
Council

1 The draft schedule of Council meetings for 2019 is at Annex A. In 2015 Council agreed that it should meet six times each year, as the work programme requires this for Council’s business, and to have an awayday. We propose that Council should continue to meet with this frequency and that the dates will be utilised for meetings, and/or seminars and closed session discussions, subject to the requirements of the forward work programme as it develops.

Committees and UK Advisory Forums

2 The draft schedule of Committees (Audit and Risk Committee, Remuneration Committee, Investment Sub-Committee, and the Board of Pension Trustees), UK Advisory Forums and other group meetings is at Annex B. The frequency of meetings has been determined in accordance with the working arrangements set out in their statements of purpose.

3 As usual, it will be open to Chairs to propose alternative dates, in consultation with other members, and to decide as the work programmes develop, whether there is a need to hold all of the proposed meetings scheduled, or indeed if additional meetings are required.

4 It was agreed at the Council awayday on 6 July 2016, that two Council meetings per year would be held in Manchester. We propose that Council should continue to meet in Manchester twice yearly, in June and December 2019.

5 We have taken into account dates of school holiday periods and major religious festivals. We avoided scheduling meetings in early January, late July, August and late December 2019. However, due to the number of dates required and the fact that half terms and summer holidays vary between schools and different regions, and in each of the four countries, we have not been able to completely avoid these periods. For the most part, we have also succeeded in avoiding scheduling meetings on the dates and observations of major religious festivals.

6 We have also considered the reporting arrangements required and have sought to achieve a schedule that links with the production of timely performance and financial information. Given the range of meeting dates to be scheduled throughout the year and a number of fixed meeting dates for reporting purposes, the dates proposed, as far as possible, allow for Council’s review of appropriate and timely data.
2019 Council meetings

The proposed meeting schedule for Council is as follows:

- Tuesday 26 February 2019, 18:00-20:00 (Evening seminar)
- Wednesday 27 February 2019, 09:00-13:00
- Monday 29 April 2019, 18:00-20:00 (Evening seminar)
- Tuesday 30 April 2019, 09:00-13:00
- Tuesday 11 June 2019, 18:00-20:00 (Evening seminar)
- Wednesday 12 June 2019, 09:00-13:00
- Tuesday 9 / Wednesday 10 July 2019, Council away day – Residential/overnight
- Wednesday 25 September 2019, 18:00-20:00 (Evening seminar)
- Thursday 26 September 2019, 09:00-13:00
- Tuesday 5 November 2019, 18:00-20:00 (Evening seminar)
- Wednesday 6 November 2019, 09:00-13:00 (Closed session)
- Wednesday 11 December 2019, 18:00-20:00 (Evening seminar)
- Thursday 12 December 2019, 09:00-13:00
2019 Committee and other group meetings

Audit and Risk Committee
- Thursday 24 January 2019
- Thursday 14 March 2019
- Thursday 16 May 2019
- Thursday 18 July 2019
- Thursday 12 September 2019
- Thursday 14 November 2019

Investment Sub-Committee
- Wednesday 30 January 2019
- Wednesday 8 May 2019
- Thursday 19 September 2019
- Tuesday 19 November 2019

---

1 Meeting dates are subject to agreement with Board/Committee Chairs/members. GMC Services International meeting dates are not included in this annex due to the independent operation of the Board.
Remuneration Committee
   Tuesday 19 March 2019
   Thursday 17 October 2019

Board of Pension Trustees
   Wednesday 6 March 2019
   Wednesday 22 May 2019
   Thursday 27 June 2019
   Wednesday 18 September 2019
   Thursday 28 November 2019

GMC/MPTS Liaison Group
   Tuesday 21 May 2019
   Wednesday 27 November 2019

MPTS Committee
   Wednesday 6 February 2019
   Wednesday 8 May 2019
   Tuesday 10 September 2019
   Tuesday 19 November 2019

UK Advisory Forums in Scotland, Northern Ireland and Wales
   Tuesday 12 March 2019 (Northern Ireland)
   Wednesday 20 March 2019 (Scotland)
   Wednesday 27 March 2019 (Wales)
   Tuesday 8 October 2019 (Northern Ireland)
   Wednesday 16 October 2019 (Wales)
   Tuesday 29 October 2019 (Scotland)
<table>
<thead>
<tr>
<th>Agenda item:</th>
<th>M14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report title:</td>
<td>Report of the Executive Board 2017</td>
</tr>
</tbody>
</table>
| Report by:      | Charlie Massey, Chief Executive  
chifexecutive@gmc-uk.org, 020 7189 5037 |
| Considered by:  | Executive Board            |
| Action:         | To note                    |

**Executive summary**
This report summarises the work undertaken by the Executive Board during 2017. The report also sets out key items considered by the former Performance and Resources Board (PRB) and Strategy and Policy Board (SPB) prior to the establishment of the Executive Board in June 2017.

**Recommendation**
Council is asked to note the Report of the Executive Board 2017.
Background

1 The Executive Board was established as part of a wider package of changes within the organisation to support our ambition to become a more agile, confident and connected regulator, help streamline our governance structures and inject greater pace and agility into our decision-making. Council approved the establishment of the Executive Board, and the dissolution of the Strategy and Policy Board (SPB) and Performance and Resources Board (PRB), at its meeting on 26 April 2017.

2 Unlike the predecessor Boards which were advisory, the new Executive Board was established as a decision-making forum and was intended to operate in a different way to promote collective executive decision-making by the senior management team (SMT). The structure ensures that the Chief Executive is part of significant discussions on performance, risk, staffing and talent management for which the predecessor arrangements did not provide.

3 The Board met seven times during 2017 since being established: on 5 June, 26 June, 24 July, 18 September, 3 November, 20 November and 18 December 2017.

4 Over the period of this report, the Executive Board has undertaken a programme of work which fulfils its duties and responsibilities, as set out in the Board’s Statement of purpose. Council has received regular updates on the Board’s work through the Chief Executive’s and Chief Operating Officer’s reports to Council.

Key matters considered by the Executive Board in 2017

Working arrangements for the new Board

5 At its first meeting on 5 June 2017, the Board agreed its statement of purpose, working arrangements and a revised approach to reporting operational performance and risk information as well as handling of legacy oversight issues from the predecessor Boards.

6 At its meeting on 18 December 2017, the Board considered a post-implementation review of its first six months of operation, which included recommendations from the GMC Light Touch Governance Review 2017 conducted by GE Healthcare. The Board noted that a number of areas were working well and that its establishment had contributed towards realising our ambition for promoting greater pace and agility in our decision-making. However, there were a number of areas where the operation of the Board could be further refined, including clarity around decision making routes and the interplay between SMT and Executive Board and a better strategic focus for Board discussions centred around the GMC’s corporate rhythm.
Strategies

7 At its meetings on 26 June, 18 September and 20 November, the Board discussed draft versions of the new Corporate Strategy and Equality, Diversity and Inclusion Strategy, prior to consideration by Council, giving particular consideration to the overall structure, vision, objectives and outcomes, and how the organisational design will support the delivery of the Corporate Strategy.

8 The Board also considered the draft Business Plan and Budget for 2018 at its meeting on 20 November 2017, for review by Council in December 2017, along with high-level changes proposed for corporate reporting against the business plan and the 2018 budget and capital programme.

Operational Performance and Risk Review

9 The Board considered high level reports of our performance and information on corporate risks and mitigations at alternate meetings, with any urgent matters relating to performance or risk brought to other meetings via an exceptions report. The Operational Performance and Risk Reviews have provided updates on the major external factors which might have an effect on our operational performance, our performance against our Operational Plan and Strategic Aims, and our key performance indicators and targets.

10 The Board regularly discussed potential emerging risks and considered any changes in both the external and internal environment and mitigating actions which might be needed as well as where monitoring was required, either through the Corporate Risk Register or through a specific directorate update.

11 Council has been updated throughout the year on corporate risks, and by exception, on significant issues potentially affecting operational performance and the delivery of our operational plan through the Chief Operating Officer’s report to Council and by the Chief Executive’s report to Council which also reports major decisions made by the Board. The Audit and Risk Committee has been updated at each of its meetings on risk issues and changes to the Corporate Risk Register.

Upstream regulation

12 At its meeting on 20 November 2017, the Board conducted a wide-ranging review of the various pieces of work going on across the organisation to deliver our vision for moving regulation upstream and considered the next steps and longer term planning and coordination of our upstream activity. The Board noted plans for research into fitness to practise outcomes to explore how and why some doctors struggle to comply with certain aspects of Good Medical Practice, improving participation rates in Welcome to UK Practice sessions and longer-term changes to the revalidation model to more closely align with our upstream approach.
Guidance on sharing information with the police and with social services

At its meeting on 24 July 2017 the Board approved guidance (and supplementary guidance for decision makers) on sharing information with the police if we have a reasonable belief that criminal conduct has taken place. We are not under any legal obligation to refer suspected criminal conduct to the police, but the Medical Act gives us a discretionary power to do so and the new guidance will help staff identify information which may need to be shared with the police and to do so appropriately, ensuring any disclosure is proportionate and lawful.

The Board also approved guidance (and supplementary guidance for decision makers) on sharing information with social services if we believe that a child or vulnerable adult is at risk of harm. It is important that we are able to share information with other statutory bodies that have legal responsibilities to safeguard the most vulnerable members of society.

Vulnerable doctors

In 2015 Professor Louis Appleby, a leading mental health expert, reviewed our approach to cases relating to a doctor’s health and helped us to develop proposals for improvements. At its meeting on 5 June 2017, the Board agreed in principle to the creation of a new advisory group on mental health to draw together clinical experts on mental health, and act as a sounding board to inform and test our policy thinking at an early stage in its development.

At its meeting on 24 July 2017, the Board reviewed and approved the *Interacting with vulnerable doctors – identifying and responding to vulnerability* guidance. The Board noted that training of staff on dealing with vulnerable doctors was key and that this training should be available to all those across the organisation who engage with vulnerable doctors. The Board also noted a paper setting out the objectives, benefits, costs and savings associated with the roll out of the Supporting Vulnerable Doctors programme.

Publication and disclosure of orders and warnings

In April 2016 Council agreed to the introduction of time limits for the publication of historical fitness to practise information (such as sanctions that have expired or been revoked) on a doctor’s online record. At its meeting on 5 June 2017, the Board agreed that interim and immediate orders would cease to appear on a doctor’s record as soon as the orders expire, in line with other regulators.

Following a review of our policy on publishing and disclosing warnings, SPB decided in February 2017 that we should reduce publication periods for warnings from the current five years to two years. At its meeting on 18 September 2017, The Board agreed that the new two-year time limit would not be applied to existing warnings and that warnings would continue to be disclosed indefinitely to current employers.

www.gmc-uk.org
This followed from our consultation on the Indicative Sanctions Guidance and the role of apologies and warnings in 2014, the outcomes of which were brought to Council in February 2015.

**Human Resources issues**

19 On 26 June 2017 the Board held a wide-ranging discussion on the Empowering and Developing our People work stream of the Transformation Programme. The Board agreed a series of proposals, including an annual cycle of staff surveys, a simpler model for setting objectives, the introduction of 360 degree feedback for all staff and increased opportunities to access coaching, mentoring and shadowing programmes and secondments. On 3 November 2017 there was a further discussion on the progress of this work and the Board noted the plans for the next phases of 360° feedback and plans for talent mapping feedback in 2017 and agreed a reporting cycle of for Executive Board discussion of talent at Assistant Director and Head of Section level (with summary data covering all staff).

**Other issues**

20 A summary of all the reports and updates received by the Executive Board is available in the additional reading bundle on the Council meeting February 2018 reading shelf. (AR14-i)

**Predecessor Boards**

21 The Performance and Resources Board (PRB) met on 24 January, 1 March and 19 April 2017.


23 A summary of matters considered by PRB and SPB during 2017, as previously reported in the Chief Executive’s report to Council, is available in the additional reading bundle on the Council meeting February 2018 reading shelf. (AR 14-ii).

**Next steps**

24 Further work has been undertaken during January and February 2018 to implement the actions identified in the post-implementation review and a full review of the way the Board works will be conducted to coincide with the first year of operation around June 2018.