

General
Medical
Council

Council Meeting - 4 November 2020

MEETING
4 November 2020 09:00

PUBLISHED
27 October 2020

Council Agenda

Via MS Teams

Wednesday 4 November 2020

10:25 – 12:00

10:25 – 10:28 **M1** Chair's business
3 mins

10:28 – 10:30 **M2** Minutes of the meeting on 29 September 2020
2 mins

To approve

10:30 – 10:50 **M3** Chief Executive's Report
20 mins

To discuss

10:50 – 11:10 **M4** Equality, Diversity and Inclusion Update (Employment)
20 mins

To discuss

11:10 – 11:30 **M5** Four countries update
20 mins

To discuss

11:30 – 11:50 **M6** Complaints report
20 mins

To discuss

11:50 – 12:00 **M7** Any other business
10 mins

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Draft at 12 October 2020

To approve

Minutes of the meeting held on 29 September 2020

Members present – via MS Teams

Clare Marx, Chair

Steve Burnett

Christine Eames

Philip Hunt

Anthony Harnden

Deirdre Kelly

Paul Knight

Suzi Leather

Rajesh Patel

Denise Platt

Amerdeep Somal

Alison Wright

Others present

Charlie Massey, Chief Executive and Registrar

Paul Buckley, Director of Strategy and Policy

Una Lane, Director of Registration and Revalidation

Anthony Omo, Director of Fitness to Practise and General Counsel

Paul Reynolds, Director of Strategic Communications and Engagement

Neil Roberts, Director of Resources and Quality Assurance

Martin Hart, Assistant Director – Education (deputising for Colin Melville, Medical Director and Director of Education and Standards)

Melanie Wilson, Council Secretary

Chair's business (agenda item M1)

- 1 The Chair welcomed members, the Senior Management Team and observers to the meeting, being held using Microsoft Teams software.
- 2 There were no apologies for absence.
- 3 Council formally noted the reappointment, agreed on circulation, of Professor Jacky Hayden as a member of the MPTS Committee until 31 August 2024.
- 4 The Chair thanked and paid tribute to Amerdeep Somal on the occasion of her last Council meeting, ahead of taking up new responsibilities from 1 October 2020 as Complaints Commissioner for the Financial Conduct Authority, Prudential Regulation Authority and Bank of England.

Minutes of the meeting on 8 July 2020 (agenda item M2)

- 5 Council approved the minutes of the confidential items on 8 July 2020 as a true record.

Chief Executive's Report (agenda item M3)

- 6 Council considered the Chief Executive's Report.
- 7 The Chief Executive gave an oral update, noting that:
 - a The total number of doctors temporarily registered under the emergency arrangements remained almost 30,000 and that arrangement would remain in place while the Secretary of State keeps the state of emergency in effect.
 - b Work was underway to embed some of the positive changes to working cultures and supporting a profession under pressure that have developed during the pandemic.
 - c Legislative reform was expected to be an enormous piece of work for the GMC, with all the changes in a single piece of legislation. Therefore work will be undertaken on prioritisation of the changes, taking into account political considerations.
 - d Professional and Linguistics Assessment Board (PLAB) exams have restarted with social distancing and Medical Practitioners Tribunals have been taking place in person. Total costs for reopening the two premises for these was around £150,000, including building work, fitting out and additional cleaning. There are plans to run a second group of 16 PLAB 2 candidates each day

from October and Council will be asked to consider plans for further expansion of PLAB capacity at the meeting on 4 November 2020.

- e A planned pilot of returning to the office was being re-evaluated following recent government announcements about working from home where possible. Small numbers of staff will return to the office in October where there is operational need, or for individuals with particular personal or practical considerations.
- f The results of the staff survey had shown an impressive 90% response rate and an increase in the engagement score from 73% in 2019 to 80%. There had been improvements in the scores for workload and the way change is managed, which had been a concern in previous years. Scores for questions on bullying, discrimination and harassment had dropped, nonetheless action will be focused on addressing concerns staff have about those issues.

8 During the discussion Council noted that:

- a In addition to PLAB and tribunals, a lot of other business as usual for the GMC had also been restarted, such as investigations and education quality assurance visits, which were almost entirely taking place in virtual form.
- b We are working with the Medical Schools Council and the national medical education bodies to resolve issues with getting clinical teaching up and running, and sustainable through the winter. Changes in the way A level results had been awarded, have resulted in 10% more medical students than planned, so there will also be future challenges with the Foundation Programme's capacity which will need to be addressed in due course.
- c Following the recent tribunal judgment in relation to an associate, the claimant intends to appeal against the ruling that the claim against the GMC was out of time, and the Nursing and Midwifery Council intends to appeal against the claim that was upheld against them.

9 Council:

- a Noted the Chief Executive's report.
- b Noted the Council portfolio and the Corporate Opportunities and Risk Register.

Equality, Diversity and Inclusion Update (agenda item M4)

- 10** Council received an update on our progress with and aspirations for equality, diversity and inclusion (ED&I) as a regulator. The GMC's role as an employer had been explored during a seminar discussion the previous day and future discussions on the standing ED&I agenda item would look at both our regulatory and employer responsibilities.
- 11** Council noted that:
 - a** The plans to demonstrate GMC commitment and strong leadership on ED&I issues as a regulator would set out the tangible difference we want to see, with accountable metrics.
 - b** Areas for focus would include differential attainment in education and training and the disproportionality of Black and minority ethnic (BME) doctors in fitness to practise processes. Both areas are not directly within the regulatory remit of the GMC and would require stakeholder buy-in and action to make progress.
 - c** Targets related to making working environments more inclusive and supportive would have benefits for all.
- 12** During the discussion Council noted that:
 - a** Action needed to take account of the nuanced issues within the category of BME and also for individuals with different combinations of protected characteristics.
 - b** A key function of the GMC's Outreach Service is for Employer Liaison Advisers to discuss referrals with employers to understand and challenge some of the issues around disproportionality.
 - c** Council was scheduled to receive an update in the new year on the development and publication of targets, but would be kept updated on ED&I developments via the standing item on Council meeting agendas.
- 13** Council endorsed the proposed development and publication of targets to reduce disproportionality in outcomes and noted the scale and timeframes for this project.

Corporate Strategy 2021-2025 (agenda item M5)

14 Council received paper setting out for approval the text for the Corporate Strategy 2021-2025.

15 Council noted that:

- a** The previous draft seen by Council had been amended to reflect their feedback to strengthen ED&I references and to highlight innovation post-pandemic.
- b** Any further changes to the text, which were not expected to be substantive, would be agreed by the Chair and Chief Executive.
- c** There was no plan for a big launch of the Corporate Strategy, but it would be presented at the GMC Conference planned for 30 November and 1 December 2020.
- d** Plans for monitoring and evaluation of the Strategy will be shared with Council in the future.

16 Council:

- a** Approved the text for the Corporate Strategy 2021-2025, agreeing that any final changes were to be approved by the Chair and Chief Executive.
- b** Noted the plans for publication and launch of the strategy.

Update on Outreach Service Implementation (agenda item M6)

17 Council received an update on progress and impact since establishing the new Outreach Service teams on 1 January 2020.

18 Council noted that:

- a** Creating one Outreach service in the Strategic Communications & Engagement directorate was delivering greater alignment and collaboration of Outreach capabilities and resources across the four countries of the UK.
- b** In response to the pandemic, an online version of Welcome to UK Practice was developed, tested and launched a year ahead of its planned schedule.

19 During the discussion Council noted that:

- a** Relevant Council members would be included in the process of feeding back to Council on the outcomes of the autumn round of UK Advisory Forum meetings in Northern Ireland, Scotland and Wales.
- b** Consideration was being given to how locum doctors are supported, especially those international medical graduates practising in the UK for the first time. We are engaging with Responsible Officers and other designated bodies, the Crown Commercial Service, which assesses the suitability of agencies as preferred suppliers to the NHS, as well as non-executive directors of individual agencies, to address some of the issues.
- c** All referrals from Responsible Officers, whether relating to GPs, locums or NHS trusts, come to Employer Liaison Advisers who encourage them to consider systems issues as part of any referral.

20 Council noted the update.

Section 40a Appeals Update (agenda item M7)

21 Council received the biannual update of section 40a appeals heard by the Executive Panel.

22 Council noted that:

- a** There have been no new section 40A appeals in the period since the last update at April Council, as there had been only 19 Medical Practitioner Tribunal outcomes in that period. Of the five of those outcomes that did not match the submission the GMC made, the Legal team concluded that there were no realistic grounds of appeal which would suggest that the MPTS decision was insufficient to protect the public or public confidence in the profession.
- b** In the case of Dr Haris, listed in the annex as 'awaiting judgement', since the report had been prepared we have heard that the judgment was successful and the case remitted to the MPTS.

23 During the discussion Council noted that when the GMC loses the ability to appeal MPTS decisions, the intention is to continue using the Executive Panel to review the outcome of cases and communicate its findings to the Professional Standards Authority as part of their considerations as to whether they wished to appeal.

24 Council noted the update.

Council meeting, 4 November 2020

Agenda item M2 – Minutes of the meeting on 29 September 2020

Any other business (agenda item M7)

25 There was no other business.

Council members' register of interest (agenda item M9)

26 Council received and noted the report setting out the register of Council members' interests.

Confirmed:

Clare Marx, Chair

4 November 2020

Action	To note
Purpose	<p>This report outlines developments in our external environment and progress on our strategy since Council last met. Key points to note:</p> <ul style="list-style-type: none"> ■ We have registered almost 7,000 international medical graduates already this year. Despite the disruption, demand for PLAB places remains high and we are working to expand capacity; ■ We are surveying the doctors who were temporarily registered under the emergency powers to understand who is using the registration, who intends to keep it, and who has no intention to do so and can be removed; ■ We have extended our flexible approach to revalidation to support the healthcare system ahead of the winter and the challenges of a second wave of the coronavirus pandemic.
Decision trail	<p>Council receives this report at each full meeting. Council has previously not received at the November meeting separate annexes with performance data or risk details because of the short gap to the December meeting. Any relevant performance, finance or risk developments can be highlighted in the presentation of the report.</p>
Recommendations	To consider the Chief Executive's report.
Author contacts	<p>Tim Swain, Head of the Office of the Chair and Chief Executive, tim.swain@gmc-uk.org, 020 7189 5317</p>
Sponsoring director	<p>Charlie Massey, Chief Executive, chiefexecutive@gmc-uk.org, 020 7189 5037</p>

EU exit negotiations

- 1 We are prepared for there to be no trade deal between the UK and EU and are ready to revive our ‘no deal’ plans, if needed, following the end of the transition period on 31 December 2020.
- 2 Throughout this year we have been seeking to make sure that the future relationship between the UK and EU allows us to continue to register EEA qualified doctors in a timely and streamlined way. These doctors make an important contribution to our health services, and we will do all we can to support the retention and flow of doctors into the UK.

Registering international medical graduates

- 3 Despite the challenges and disruption caused by the coronavirus (COVID-19) pandemic, we’ve already registered almost 7,000 international medical graduates this year. We’ve also continued to deliver PLAB 1 tests for thousands of candidates in the UK and overseas, and in October we opened an additional 6,000 PLAB 1 seats in venues around the world.
- 4 In August we reopened our Clinical Assessment Centre (CAC) and restarted our PLAB 2 tests. In order to comply with the UK government’s guidance on social distancing and safe workplaces, the number of candidates we’ve been able to test in one sitting has been lower than normal. But after successful pilots, test days and feedback from candidates, we’re now assured that we can double our daily capacity and run test circuits twice a day. This means that almost 1800 candidates will be able to sit PLAB 2 before the end of the year.
- 5 In October we contacted candidates to let them know we’re opening more test places. We’ve release these in stages to prioritise those who’ve had a previous booking cancelled because of the pandemic. We’ve also prioritised those who have job offers in our health services, and those who have refugee status. As soon as we’re able to make more places available, we’ll invite other candidates who have passed PLAB 1 to book their test for PLAB 2.
- 6 We’re continuing to do everything we can to support doctors into UK practice. Next year we’ll have at least 7,000 places available for PLAB 2 candidates in our CAC, and we’re actively exploring how we can increase this number even further. We’re also looking at a range of other options to help international medical graduates demonstrate their knowledge and skills, including improving access to alternative routes to the register and considering whether we can accept alternative exams. In addition, for candidates who passed PLAB 1 after 15 March 2018, [we’ve temporarily extended the validity of their test pass](#) from

two to three years to give them more time to book onto PLAB 2. And we've confirmed that we'll consider, on a case by case basis, whether it is possible to extend the validity of English language evidence for those who've been affected by PLAB cancellations.

Temporary registrant survey

- 7 Earlier this year we gave over 30,000 doctors across the UK temporary emergency registration (TER) with a licence to practise as part of the response to the pandemic. For different reasons we know that the vast majority of these doctors have not been deployed to work in the NHS.
- 8 We are currently surveying these doctors to understand which are using or plan to use their TER to support the pandemic response.
- 9 The survey will help us to plan and implement the removal of TER from some cohorts or groups of doctors including those who have no intention of working, had no idea they hold TER and 'non-responders'. When we start the process of removing TER from some cohorts or groups of doctors we will provide advance written notification, set a deadline for removal and provide them with an option to notify us if their circumstances have changed. We are still looking at timescales for removal but expect the first group to be processed from mid-November 2020.
- 10 The survey will also help us to identify and support those considering staying in practice to transition from TER to routine full registration.

Revalidation

- 11 Given the second wave of the coronavirus pandemic, we've decided to extend the flexible approach to revalidation that we offered doctors earlier this year. We're very aware of the ongoing challenges that the profession and providers are facing, so we want to be flexible in giving them the time and support they need in the uncertain period ahead.
- 12 All doctors who were due to revalidate between March and July 2021, and who have not had their dates previously rescheduled, will have their revalidation dates moved back by four months. Alongside this, we'll offer them the opportunity to revalidate at any time from this autumn right through to their new date.
- 13 This is the exact same approach that we took with the doctors whose revalidation was due this year and means that doctors and responsible officers

(ROs) should not be under any pressure to meet revalidation requirements during the winter months. We'll write to these doctors once we've told ROs about our plans. We'll make it clear that if an appraisal has been missed because of the pandemic, it should not impact on a doctor's ability to revalidate if they're otherwise ready, and ROs have the capacity to make recommendations.

National Training Surveys

- 14 In October we published the results of the shorter, tailored national training survey we ran this summer. The results show how significantly doctors were affected by the first wave of the pandemic and how their working practices and training changed.
- 15 The disruption cannot be underestimated, and the survey shows that trainees and trainers alike believe important training has been missed. This is no surprise, but it is important now that we work with training providers, postgraduate deans and others, to protect training as we cope with this significant and ongoing challenge.
- 16 Despite the challenges, we have also seen many examples of good practice, including where training has been delivered virtually, and excellent teamwork, to address the sudden demands of the pandemic.

Trainee progression

- 17 Supporting trainee progression whilst maintaining standards is one of the most vital things we can do to support the long-term supply of doctors in the UK. As part of our response to the pandemic we enabled the early provisional registration of final year medical graduates. We have set out our position on progression in specialist training to enable progression through the programme and have put in place accelerated curricula approvals process in place to enable changes to assessments to reflect the suspension of exams. We have now approved derogations that have been applied for, confirmed that these will last for the duration of the disruption and have set out circumstances where self-assessment by colleges for changes to assessment are acceptable, in cases where assessments are the same in content but monitored and / or delivered differently.
- 18 More broadly, we want to embed the positive learning from the pandemic as we consider the future of medical education and training in the UK. So, we are convening an education policy summit in November with partners from all four

countries of the UK in autumn to seek agreement about how we move forward together.

Regulation of maternity services

- 19 We are working with the NMC and CQC on joining up our regulatory work in relation to maternity services in England. We are jointly hosting a roundtable on 2 November with other key organisations including the Department of Health and Social Care and NHS England / Improvement. This will focus on confirming consensus on the key underlying issues that cause problems in maternity services, improving how we identify good and bad practice across the system, and, agreeing how we can work collaboratively to improve the situation.

Further changes to the combined programme route to specialist and GP registration

- 20 In May 2020, we began issuing a Certificate of Completion of Training (CCT), rather than a Certificate of Eligibility for Specialist Registration (CESR) or Certificate of Eligibility for General Practice Registration (CEGPR), to doctors on the combined programme who have completed the minimum amount of time training in the UK for their specialty (as defined in the recognition of professional qualifications Directive). The combined programme is a route to specialist and GP registration which allows doctors to enter an approved training programme above the first year, by acknowledging training and/or experience gained outside of a UK training programme. Approximately 120 doctors a year gain specialist/GP registration through this route.
- 21 In October, we extended eligibility for a CCT through the combined programme to also include doctors in specialties which do not have a minimum training time defined in legislation. Both this change, and the change introduced in May, apply retrospectively, so we are awarding CCTs on request to eligible doctors who were previously issued with a CESR/CEGPR through the combined programme. These changes have been welcomed by our stakeholders and are part of our work to improve the flexibility of postgraduate medical education and training.
- 22 While we remain bound by European legislation, we are unable to award a CCT to a trainee who does not meet the minimum training time requirement for their specialty, and must continue to award a CESR/ CEGPR. We intend to look again at the combined programme in future, in order to try and help this final cohort of doctors. This will not be until after the implementation period of our exit from the European Union has ended, and we have clarity over trade deals and legislation. Given the dependency on the concept of minimum training times,

this will probably also be reliant on the outcome of wider debates about whether minimum training times should remain an integral requirement for postgraduate training.

Workplaces

- 23** In light of the pandemic, the overwhelming majority of GMC staff are continuing to work from home. Although this is not without challenges, it has worked very well overall and we have demonstrated flexibility and resilience in functioning effectively in a remote context.
- 24** As you know, we still run some essential public services that can only be delivered in-person. I am very proud of the work that colleagues from across the business have done to enable us to re-start our PLAB testing and running MPTS hearings from St James’s Buildings in a COVID-secure way. This has meant that even though the Manchester area is now under Tier 3 restrictions we are able to continue to provide these essential services.

Executive Board

- 25** The Executive Board met on 21 September 2020 to consider items on:
- a** The draft business and plan and budget for 2021, the final version of which will come to Council on 10 December 2020.
 - b** The regular high-level reports on performance, including finance and people, customer service and learning, and updates on the key risks to achieving our strategic aims.
 - c** The outcomes of the annual staff survey.
 - d** Progress towards meeting the 2018-20 corporate strategy aims, which Council will be updated on at the meeting on 10 December 2020.
 - e** An update on GMC Staff Superannuation Scheme funding and agreed to progress work on changes to life assurance cover to maximise the benefits for scheme members survivors/dependants for consideration by the Remuneration Committee.
 - f** Establishing a programme board to oversee the legislative reform programme, to be chaired by the new Director of Strategy & Policy.

Action	To consider
Purpose	To update Council on our Equality, Diversity and Inclusion (ED&I) ambitions as an employer.
Decision trail	Council discussed our ED&I priorities, as an employer and regulator on 28 and 29 September respectively. Council approved our current ED&I Strategy in November 2017.
Recommendations	<p>a To consider our ambitions to accelerate progress on ED&I in employment.</p> <p>b To endorse our approach to setting KPIs for our employment activities.</p>
Annexes	Annex A – Summary of ED&I employment priorities
Author contacts	<p>Claire Light, Head of ED&I claire.light@gmc-uk.org 0161 923 6595</p> <p>Robert Scanlon, Assistant Director, CBP & ED&I robert.scanlon@gmc-uk.org, 020 7189 5305</p> <p>Andrew Bratt, Assistant Director, HR andrew.bratt@gmc-uk.org, 0161 923 6215</p>
Sponsoring director	Paul Buckley , Director of Strategy and Policy paul.buckley@gmc-uk.org 020 7189 5022

Background

- 1 In September Council endorsed a step-change in our ambitions to demonstrate stronger leadership on equality, diversity and inclusion as a regulator. This reflects the renewed focus on making meaningful progress in playing our part in a culture to address the persistent and pervasive impact of inequality on patients and the healthcare workforce, and within the GMC as an employer.
- 2 Council agreed to the setting of targets to reduce disproportionality in employer fitness to practise referrals, and differential attainment in education and training. These are areas which have a strong relationship to practice environments and culture. We know that inclusive environments mitigate negative outcomes. By establishing measures and targets to reduce these differentials, we are committed to action to promote behaviour that supports overall inclusivity in all environments, but with the specific target of race equality. Our end-goal must be to promote environments that support doctors, to an inclusive culture, which fosters success and delivers quality patient care.
- 3 We need to model the commitment we are expecting of the system. As an employer, we have an established commitment to inclusivity. This paper proposes a step-change in the pace of our ambition to improve our internal inclusivity. in response to data from staff surveys, and the lived experience of staff from BME backgrounds.

Our current position

- 4 Improving inclusivity has been a sustained ambition for us. In 2019 we commissioned the Employers Network for Equality and Inclusion (ENEI) to undertake an Inclusion Gap Analysis. We were found to be mid-range on their framework between *Equality* and *Inclusion* and had developed a plan to achieve full inclusivity by 2025. The Executive Board endorsed these plans in February 2020 to be implemented as part of our Investors in People programme.
- 5 Agenda item C3 provides an update on the 2020 staff survey. There are many areas of improvement. However, the results highlight groups with lower levels of engagement than average, and challenging feedback on bullying, harassment and discrimination.
- 6 We are committed to making progress. We have listened to our people to better understand their experiences. We have an existing Staff Survey workstream led by Paul Reynolds on openness, fairness and transparency. We've had extensive dialogue with staff and informative workshops with BME members of the BME and Muslim Networks about what being an inclusive organisation means for the

GMC. We've consulted with other staff networks (Christian, LGBTQ+, Mental Health, Parents and Carers, and Women's networks). We have also collaborated with our Freedom to Speak up Guardian who is now supported by Freedom to Speak up Champions in each directorate and leads engagement with colleagues.

- 7 We have some examples of positive performance in some areas of diversity. We continue to see a steady increase in representation of women in management roles with a further increase in women at Level 2 (57% in 2019, up from 54%). This is driven by higher levels of female representation as our recruitment process proceeds.
- 8 We have developed our recruitment process and training support to broaden our intake of BME candidates – in 2019, 33% of our candidates were BME and secured 20% of our job offers. The learnings from these positive changes can be translated across to some of the areas that we need to develop further. A case in point is, although, appointment data for BME staff paints a positive picture, turnover within this group remains twice that of the remaining sections of the workforce.
- 9 In July 2020, the co-chairs of the BME Network shared the frank and sobering reflections of the network members with the Executive Board, and areas for improvement. These include a need for us to recognise and put in place commitments to explicitly tackle racism, for our leadership to be visible role models and demonstrate inclusive behaviours to drive positive change, to address the lack of ethnicity at senior levels of the organisation and support the retention and progression of BME staff.
- 10 In response, we are proposing to accelerate pieces of work that we had previously planned over a five year period for immediate action – targeted on addressing the key issues raised.

Accelerating our progress on internal inclusivity

- 11 We are proposing to accelerate our activity around the following areas:
 - a Establish and **publish targets and measures** to help improve the following:
 - i Close the gender pay gap and achieve ethnicity pay equality/pay parity. On gender this means continuing to reduce in-band differentials where they exist. On ethnicity the pay gap is driven by under-representation in management roles.

- ii Increase the level of BME representation at management levels (level 3 and above) and, in London, at all levels.
 - iii Improve BME staff retention and reduce the differential between the turnover rate for BME staff compared with the GMC average.
 - iv Increase the proportion of BME staff securing promotions.
 - v Improve consistency in experience of workplace inclusivity, with a closer alignment of average staff survey engagement levels between groups and achieve overall improvement across the 8 key index measures for inclusivity.
 - b Create the right environment through improved inclusive leadership and inclusive leadership development.
- 12 We will provide an update to Council in December on the progress we have made with setting KPIs for both our regulatory and employment activities. Council will then be asked to approve these KPIs at their next meeting in February 2021.
- 13 Setting targets to make improvements against representation and progression will require positive action¹ interventions. We will review whether these interventions are delivering the required outcome at regular intervals. They will be moderated or adapted if the targets are not achieved over the set timeframe.
- 14 In the next six months we will update our competency framework to include specific behaviours and skills on inclusion. We will embed this within our performance processes and 360-degree feedback to ensure that from January 2021, reflection on inclusivity is the responsibility of all staff, particularly managers and leaders. This approach will integrate inclusivity into the core elements of how we discuss and reflect on our performance to meaningfully embed inclusive behaviours. In the immediate term though, we know that staff feel we are not best equipped to have the difficult conversations we need to, to follow up on our stated commitment with changed behaviours. We will roll out tailored training and tools to teams on having these conversations.

¹ Positive action is about taking specific steps to improve equality in the workplace. It can be used to meet a group's particular needs; lessen a disadvantage they might experience or increase their participation. It brings benefits to an organisation, including a wider pool of talented, skilled and experienced people.

15 By the end of 2021 we will:

- a** Introduce a tailored career programme for BME staff which will include leadership development support, coaching, mentoring and access to external training targeted below head of section level. This will be supported by positive action measures to support BME colleagues such as the development of BME talent pools at different levels of the organisation and support, where requested, on interviewing and job application.
- b** Ensure that every manager has undertaken unconscious bias training including how these issues relate to our recruitment and performance management processes. This will supplement the existing recruiting manager training content on unconscious bias. Next year we will also introduce a mandatory leadership session on inclusion for level 3 and above.
- c** Include mandatory requirements for recruitment agencies around targets for attraction and diversity of longlists/shortlists for roles, proactive positive action campaigns, utilising different methods for targeted attraction, and establishing external BME talent pools of candidates that we can target roles to in the future.
- d** Improve our routine monitoring and reporting. ED&I is now a standing item at every Council meeting, and Executive Board will now receive a report twice a year on progress against our commitments. We have also made a commitment to publish our ED&I data and plans externally and to update this regularly.

16 We understand targets can drive a range of unintended consequences and Council explored these as part of our discussion on our external ambitions. However, we believe that clear accountability for delivering measurable change in a set timeframe in these key areas is fundamental to improving inclusivity within the organisation. Organisations focus on recruitment, progression, leadership and pay equality in setting key performance indicators, as these are the elements that support an inclusive environment. From our research, most organisations focus on incremental changes over a fixed time period and set ambitious targets. Setting the specific targets and timeframes will be done in ongoing consultation with colleagues.

17 We have seconded the chairs of the BME network into our ED&I team to help us progress this work. Dr Raj Patel and Lord Hunt met with both Miriam Bonabana and Dionne Gordon, the network chairs, to learn about BME representation at the GMC, and some of the challenges that BME staff experience in the workplace. Their discussion explored not only whether we

were focussing on the right areas, which we believe we are, but how Council could assist on this agenda.

- 18** Members of the BME Network have felt that they have seen an increased willingness and confidence to engage in issues about racism on the back of the data emerging from the pandemic and UK/international racist incidents. It is important we continue to build on this. Part of our progress is the acknowledgement at senior levels of the significance of the issues and a willingness to engage in difficult conversations. We will explore opportunities for Council members who may wish to share their own experiences, as part of networking and mentoring support for GMC staff, to help with career progression and development. Council members in their external engagements can further the cause by promoting the GMC's commitment to change and encouraging stakeholders to engage with our endeavours.
- 19** This year's Staff Survey introduced an inclusivity index which will form part of our baseline for future measurement. Based on key questions identified as giving insight to the inclusivity of an environment, the overall 2020 score sits at 63%. BME staff and staff of mixed or multiple-ethnic backgrounds have a lower inclusion score, at 50% and 47% respectively. This compares unfavourably with the score across white staff, which sits at 67%. Reducing these differentials and raising our overall score will be key. Although the index is a pilot, and it may be refined over time, one of the KPIs will be focused on ensuring year on year improvements in the inclusivity index score.
- 20** Another key consideration will be addressing the bullying, harassment and discrimination scores – agenda item C3 provides some examples of the interventions we will put in place, for example, training for managers, and setting clear expectations on behaviour through a new set of competencies that will feed into performance management. However, we will engage with colleagues, to identify other interventions that might be required.
- 21** The implementation of these measures will be supported by a communications plan, that reflects Council's earlier expressed views that this must be part of a coherent and robust narrative about inclusivity that recognises the importance of but extends beyond race. Our commitment also includes:

 - a** Our aim to become a Disability Confident employer from 2021, and work over the following 3 - 4 years to move from level 1 'Committed' employer under the scheme to a level 3 'Leader'. Targets to support this work could include attraction, recruitment and retention within disability.

- b** The work of our staff networks² could help us explore targets across the spectrum of diversity.
 - c** In 2021 we will conduct a training needs analysis, to identify knowledge, skills and behaviours different groups of staff might need on ED&I. Targets could include completion rates for ED&I training, and other leadership training, but also access to training and development for different groups.
 - d** Our existing work within recruitment, for example, our recruitment agencies supporting race equality aspects of accelerating progress on ED&I plan activities by implementing diverse candidate list requirements. This could be extended across to other areas of diversity such as age, gender, or disability, but also socio-economic background.
- 22** The above changes complement the existing support and training that we have in place for all staff. We have an intranet hub with information to support achieving a more inclusive workplace and an existing programme of communications activity. We also have mandatory training for all staff on 'Treating People Fairly' and provide tailored and bespoke training to teams on unconscious bias, inclusive leadership, micro-behaviours and how to have conversations about discrimination.
- 23** We would welcome Council's endorsement of the proposed areas to accelerate progress and their broader reflections on their experiences and opportunities to improve our inclusivity.

² In addition to the BME Network, we have a Muslim Network, Christian Network, Parents and Carers Network, LGBTQ+ Network, Mental Health Network and Women's Network.

Summary of accelerated ED&I employment priorities

Activity	Deliverable / action	Timeline
Establish and publish targets and measures for diversity in employment	<p>Set a target to increase the level of BME representation at Level 3 and above</p> <p>Set a target for BME candidate levels for recruitment at Level 3 and above campaigns</p> <p>Set a target to reduce differential turnover rates for BME staff compared to the average to improve retention</p> <p>Increase the proportion of BME staff receiving promotion and progression, including consideration of secondments</p> <p>Set a target to reduce differentials between staff survey engagement levels between groups and improve our overall inclusivity index score</p> <p>Set a measure to help us close the gender pay gap and achieve ethnicity pay equality/pay parity</p>	KPIs identified by December 2020 and considered by Council in February 2021
Leadership - inclusive leadership, leadership development and objectives	Update our competency framework to include specific behaviours and skills on inclusion. Embed this within our existing performance processes and 360-degree feedback to ensure ED&I is the responsibility of all staff, particularly managers and leaders.	January 2021
	Include a specific ED&I element in all Personal Development Plans (with a focus on ensuring all leaders are including ED&I in their personal development journeys)	In 2021 personal development plans
	Appoint an Executive Sponsor for all diversity staff networks	Q2 2021

Activity	Deliverable / action	Timeline
	Review our BME talent pools at each level – L2, L3, L4 and ladder or lattice development potential and consider setting targets for each level.	From Jan 2021 (after 2020 performance reviews complete)
	Implement a talent management programme for BME staff that includes leadership development support, coaching, mentoring and enhanced access to external training targeted below head of section level.	Scope in Q1/Q2 2021 and start delivery from Q3
	Develop and rollout mandatory leadership development sessions on inclusion for level 3 and above	
	Develop a new curriculum on ED&I which we will deliver as part of the training needs analysis which we will conduct in 2021.	Q4 2021
Support retention and progression of BME staff	Introduce mentoring, reverse or reciprocal mentoring and sponsorship to support the career progression of BME colleagues – including ensuring all BME staff who want a coach or mentor have access to one.	2021
	Move to external recruitment as our standard approach on all L3 and above posts alongside attracting and supporting internal underrepresented candidates. (N.B. - some exceptions exist such as maternity cover).	November 2020 (unless specific requirement to advertise internally e.g. maternity cover)
	Work with recruitment agencies to increase diverse attraction levels on L3+ roles by setting targets for specific campaigns and scrutinising their general requirements for diversity shortlists etc. Deliver specific sessions to recruiting managers to raise awareness of their responsibility to deliver against this when briefing agencies in relation to vacancies and build in tighter requirements on this into future contractual requirements and embed in future procurement exercises for recruitment agencies.	Ongoing

Activity	Deliverable / action	Timeline
Recruitment of BME staff	Apply candidate diversity targets after agency filtering and requirement to have detailed diverse attraction/marketing plans (N.B. - some exceptions exist such as maternity cover).	January 2021 at the earliest
	Establish a database of external BME talent from candidates in previous processes and keep in touch to signpost to future roles.	Q1 2021
	Complete a review of the current recruitment process to define the approach to keeping campaigns open until we get a diverse pool. Deliver process revisions and guidance for those involved in the process that includes defining how we determine a target for diversity of the pool, what we do if we don't get there and how we extend campaigns or use positive action attraction including social media. Develop a plan for monitoring, engagement and communications aimed at recruiting managers who have a key role to play and will be responsible to deliver in this area. Recruitment team to define and test options to improve positive action attraction and clear targets to assess the impact of pilot approaches.	Pilot from 2021
Acting on our routine monitoring and reporting	Build our evidence base to better understand performance and hold ourselves to account through a new inclusivity index in the Staff Survey.	Complete and ongoing
	Publish all our EDI data twice yearly.	Publish March and September
	Implement improved monitoring and reporting to Council, through a standing EDI agenda item for Council consideration.	Complete and ongoing
	Use and act on our monitoring data and report regularly to Executive Board level twice per year.	Annually and half yearly

Action	To note.
Purpose	This update provides Council with a summary of our public affairs and stakeholder engagement activities across the four countries of the UK over the past six months.
Decision trail	Council previously discussed four country working on 23 April 2020 and received a similar update at that meeting.
Recommendation	To consider progress to date on our four-country engagement work and how we are flexing our approach in response to the external environment in light of the pandemic.
Annexes	Annex A - Engagement in the Devolved Nations and the English regions.
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Background

- 1 This paper provides an update on our public affairs and stakeholder engagement across the four countries of the UK. This builds on the update Council received in April which outlined our plans to implement a flexible approach to the external environment in light of the pandemic.
- 2 Our engagement approach aims to:
 - a Broaden our key stakeholders' knowledge about the GMC's mission and role ensuring we have more receptive audiences when we seek to introduce a new policy or reform. By ensuring more politicians across the four countries understand our priorities they are more likely, in future, to propose reforms, amendments or legislation that support the GMC's corporate strategy and ambitions.
 - b Position the GMC in the political arena as a thought leader on addressing medical workforce challenges such as recruitment and retention, culture and leadership, and the wellbeing of the workforce in all four countries of the UK.
 - c Ensure we do not place undue pressure on stakeholders during the pandemic, by tailoring our engagement approach in each country. In England we have focused on supporting the government's response to the pandemic, supporting the development of the People Plan and engaging with officials on legislative reform. In Northern Ireland (NI) we have considered the impact of multiple senior stakeholders in the Health and Social Care (HSC) system leaving their roles and the various ongoing reviews and inquiries. The political interest in the Cumberledge review has informed our engagement with stakeholders in Scotland. In Wales we continue to work with key stakeholders around sharing workforce data to shape the future Implementation Plans for the new Workforce Strategy.

Engagement with UK parliamentarians

- 3 Following the announcement that the GMC would be asked to grant temporary registration to doctors under our emergency powers, we worked with government officials in England, NI, Scotland and Wales to provide statistics and information they required to answer parliamentary and assembly questions on this subject.
- 4 We also adopted a proactive approach to updating parliamentarians and assembly members about our progress on temporary registration. In March we started providing regular updates, initially clarifying that our role did not extend

to deploying the temporary workforce. We set out our achievements and highlighted ways they could support our work and the national effort to increase the healthcare workforce. We also contacted the offices of MPs who commented negatively or were misinformed about the temporary registration programme. We provided clarification and up to date data. This engagement was positively received.

- 5 We adopted a targeted engagement approach with medically qualified members of the House of Lords and members of the UK Parliament Health and Social Care Select Committee (HSCSC), including the Chair, Jeremy Hunt MP. We hosted virtual introductory meetings with our Chair, which focused on our pandemic response and the case for regulatory reform. We also submitted written evidence to the HSCSC's inquiries into the Covid-19 pandemic, burnout in the health service workforce, and maternity services in England.
- 6 We have also established relationships with the health policy leads in the four biggest Westminster parties. We have held at least one meeting with each of these and secured a commitment from them for regular follow ups. This was helpful, for example, as we prepared for the ministerial statement on the outcomes of the Cumberlege Review.
- 7 Alongside our outreach work, and since the April Council meeting, we have taken the opportunity to reflect internally on how we measure the impact of our public affairs work. We have agreed a set of criteria to be measured on a regular basis, including an analysis of GMC mentions in the four legislatures, and meetings and interactions logged on our Engage (CRM) system. This will complement and build on the work of the annual parliamentary perceptions surveys we will continue to run through YouGov.

UK wide stakeholder engagement

- 8 Day to day engagement activity across the four UK countries is co-ordinated through the Senior Corporate Engagement Plan, which is reviewed every eight weeks. This plan identifies opportunities for the Chair, Chief Executive and Directors to meet key partners across the UK in line with our Strategic Relationship Framework.
- 9 Most engagement in the last six months has taken place virtually or by telephone; we continue to keep this under review as guidance from the four governments changes. In England we supported the Chair and Chief Executive to participate in over 150 external engagements, including regular meetings with medical royal colleges, Care Quality Commission (CQC), Nursing and

Midwifery Council (NMC), British Medical Association (BMA), NHS Providers and patient groups. In NI we provided support for seven virtual meetings, in Scotland 13 and in Wales five. Highlights of our engagement activities across England and the devolved nations is outlined in Annex A.

- 10 Engagement focused on collaborating with the system, employers and regulators during the peak of the pandemic to ensure a joined-up approach. These conversations have been focused on how we can support and work with others to lock in the positive changes that have happened as a result of Covid-19. Stakeholders provided positive feedback on our approach.
- 11 We have also increased our engagement with UK patient organisations, liaising with Action against Medical Accidents, HealthWatch and the Patients Association on remote consultations, our next corporate strategy and the new *Consent and decision-making* guidance.
- 12 Our next patient roundtable, planned for November, will be hosted virtually. At the roundtable we will explore patients' views on the GMC's long-term ambition for patient and public involvement across the UK, our remote consultations guidance, Medical Associate Professions (MAPs) regulation and consent guidance.
- 13 We have developed country specific plans to progress the Supporting a Profession Under Pressure (SAPUP) work programme. This builds on the partnership strategies agreed at the four *Delivering Change Together* round-tables, hosted in each country of the UK in February. Since April we have focused on providing advice and guidance, supporting partners with their activities where possible, and identifying and collating good practice. This has been shared with Outreach to inform their discussions with, and provide support to, Responsible Officers. In all four countries of the UK this work is seen as critically important and we want to support partners to deliver positive change.
- 14 In England we have played an active role in the development of the People Plan, feeding in SAPUP data and findings where possible. In NI we are collaborating with the Department of Health (NI)'s Improving Junior Doctors and Dentists Working Lives Group on recommendations to improve the wellbeing of trainees and meeting the HSC Leadership Centre to discuss how we can support their medical leadership programmes. In Scotland we are feeding into the Scottish Government's new Leadership, Wellbeing and Culture division and we have co-established a medical workforce wellbeing stakeholder group alongside BMA Scotland and the Scottish medical royal colleges. In Wales we responded to the Health Education and Improvement Wales (HEIW)

consultation on Compassionate Leadership Principles, offering our support in the development of action frameworks to put the principles into practice.

United Kingdom Advisory Fora

- 15** The Autumn 2020 UK Advisory Forum meetings in NI, Scotland and Wales were held virtually for the first time. The meetings focused on Covid-19, our pandemic recovery plans and opportunities to promote professionalism and wellbeing, as well as positioning the GMC as a proactive partner with our stakeholders in learning the lessons of the pandemic. Updates on the SAPUP work programme in each country were also provided by each Director sponsor for the devolved government relationship.
- 16** Across the three meetings fora members highlighted their concerns about levels of burn out amongst colleagues working in the NI, Scotland and Wales healthcare systems, but also highlighted the positive changes that the pandemic had brought. Members welcomed capturing those changes implemented during the pandemic to support doctors in the future, as well as discussing the challenges to maintain progression in medical education. The importance of increased regulatory alignment to support good clinical leadership and enhance patient safety was also widely noted, as well as a focus on compassionate leadership, induction and on issues relating to equality and diversity. For example, at the meeting in Scotland, Healthcare Improvement Scotland (HIS) specifically offered to work collaboratively with us to align our views on what good leadership looks like.

Focus on the next six months

- 17** In the next six months we will continue to prioritise our programme of virtual engagement with key stakeholders, taking into account the impact of a second wave of Covid-19.
- 18** This autumn we will also hold a UK-wide Education Summit with senior education stakeholders. The purpose of this event is to obtain early agreement on priorities in medical education, to build on the positive changes that have taken place as a result of the pandemic. We hope to develop a clear set of agreed principles that can be used across the UK to underpin decisions about the structure and quality of education and training.
- 19** In NI, Scotland and Wales we will be required to present annual, nation specific reports to devolved legislatures as part of our upcoming new duty under the S60 legislative reforms, as proposed in the Professional Standards Authority's Promoting Professionalism, Reforming Regulation report.

- 20** Work is progressing to produce the three reports which will be submitted before the end of 2020. We are taking into consideration the needs and sensitivities of the devolved administrations, with content tailored to each legislature.

Engagement in the Devolved Nations and the English regions

England

- 1 At a national level in England we are working hard to engage senior politicians, their officials, and their advisors:
 - Throughout the pandemic we have met with the Secretary of State, Matt Hancock MP, and the Minister for Care, Helen Whately MP, whose responsibilities include professional regulation. We have also met with their shadows in the main opposition parties.
 - We have also maintained communication with senior officials at DHSC, particularly Lee McDonagh, the Director-General for Acute Care and Workforce. We also attended stakeholder briefings with the Chief Medical Officer (CMO) and Deputy CMO.
 - Political appointees inside Number 10 have established a taskforce to review the performance of the health service, and the Government's manifesto commitments to health. We are now implementing a plan to influence this process.
- 2 We are also developing a stronger focus on engaging with elected politicians on local issues through our public affairs and outreach teams. For example:
 - Routinely sharing intelligence, e.g. letters from MPs about local issues are now forwarded to the regional outreach teams so that they are aware of emerging concerns, as well identifying any trends.
 - Intelligence is shared ahead of meetings with MPs to understand any significant local concerns.
 - The Public Affairs team now also support Outreach colleagues at Joint Working Intelligence Group meetings in England, where information is shared about emerging issues and the GMC response is discussed. This mirrors the approach already embedded in the National Offices.
- 3 Day to day stakeholder engagement activity across the four UK countries is informed by our Strategic Relationship Framework and co-ordinated through

our senior corporate engagement plan, which is reviewed every eight weeks. This plan identifies opportunities for the Chair, Chief Executive and Directors to meet partners across the UK, based on our internal priorities and the changing external environment.

- 4 We continuously review this plan in light of external developments, our emergency priorities and those of our key stakeholders. Teams managing stakeholder relationships across the UK worked closely to ensure our approach was proportionate, co-ordinated and focused on our strategic objectives.
- 5 Since April, our engagement has focused on:
 - **Supply** - ensuring doctors are able to register efficiently.
 - **Retention** - ensuring the current workforce feel we appreciate the practical and emotional issues they have faced over the last few months, and that we're alive to further challenges coming down the track, particularly with regards to wellbeing.
 - **Supporting change** - ensuring our approach to regulation enables change and does not create barriers.
 - **Legislative reform** - supporting the UK Governments' agendas on post-pandemic regulatory and system reforms.
 - **Flexible medical education and training** - encouraging and contributing to a more flexible approach.
 - **People Plan** - demonstrating we are an active partner in delivering the ambitions of the People Plan and contributor to further developments.
 - **Inquiries** - demonstrating that we are a listening and compassionate organisation, proactively reflecting on our engagement and communication with patients across the UK.
- 6 At a national level within England, Outreach is working with partners across the system. This includes cross-regulatory groups and networks, which are looking at more effective information sharing, particularly around areas of regulatory risk and collaboration. For example, we are working with the National Guardian to look at how we can support speaking up cultures at Trusts; and with NHS England/NHS Improvement (NHSEI) and Health Education England (HEE) to look at how we support better induction for international graduates and returners.

- 7 Across England, Outreach has been developing and enhancing relationships with stakeholders on a region-by-region basis. The Outreach update at September Council highlighted some examples of such regional engagement:
- The new England Regional Heads have established strong and productive relationships with senior regional leaders from CQC, NMC, HEE and NHSEI.
 - We are also reaching out to 'friendly' Board members at several NHS Trusts to explore ways to engage on areas of potential mutual interest.

Northern Ireland

Programme of senior level engagement

- 8 An introductory meeting with Health Minister Robin Swann MLA and the GMC Chair and Chief Executive in July 2020. The meeting was attended by the Permanent Secretary of Department of Health (NI) (DoH (NI)) and CMO, who was complimentary about proportionate regulatory response to the pandemic, including the efficient registration of FiY1 doctors.
- 9 In late Spring, the Chair held a series of virtual meetings with NI representatives from medical royal colleges. These meetings informed Council's understanding of the impact of pandemic on the profession in NI.
- 10 Una Lane, Director of Registration and Revalidation, is the Director sponsor for the DoH (NI). In her first formal engagement as sponsor, Una attended the HSC Medical Leaders Forum in September 2020 and provided an update on our pandemic response. We have been invited to attend the Forum again in six months.
- 11 In October the Chair and Chief Executive had a successful introductory meeting with the Interim Chair and Interim Chief Executive of RQIA. Agreement was reached to review our information sharing arrangements and to consider opportunities for collaboration to enhance patient safety in NI.

Ulster University Graduate Entry Medical School (UUGEMS)

- 12 In June 2020 we wrote to the NI Executive Ministers for Health, Finance and the Economy to provide clarity about the GMC's role in granting approval for new medical schools. On 31 July 2020 UUGEMS successfully passed stage six of the multi-stage approval process and remains on target to admit its first cohort of 70 students in September 2021.

Inquiries and Reviews

- 13 Anthony Omo, Director of Fitness to Practice, and Joanne Donnelly, NI Employer Liaison Adviser, gave evidence to the Independent Neurology Inquiry on 8 September 2020. We are currently collating additional written evidence requested by the Inquiry.
- 14 The GMC continues to receive updates on the progress of the Inquiry into Hyponatremia-related Deaths (IHRD) workstreams, work was paused during the pandemic.
- 15 In September 2020 the Health Minister announced he will establish a public inquiry following publication of an independent review into leadership and governance at Muckamore Abbey Hospital (MAH). When the terms of reference are published, we will consider our engagement with the Inquiry.

DoH (NI) Surge Planning Strategic Framework

- 16 In September 2020 we responded to DoH (NI)'s consultation on its Covid-19 Surge Planning Strategic Framework. We welcomed DoH (NI)'s commitments to ensure that education and training needs of students and doctors in training are not overlooked in any second wave of Covid-19. We were encouraged to note the draft framework's focus on the importance of resilience and the provision of appropriate support for staff. We highlighted our work to support IMGs entering the medical workforce, and our resources available for doctors treating patients virtually.

Scotland

Programme of senior level engagement

- 17 We facilitated a series of engagement opportunities for the Chair, Chief Executive and Directors throughout the pandemic. Meetings have taken place with senior stakeholders including the Director General of the Scottish Government's Health and Social Care Directorate, the Scottish Government's new Workforce Director, the Acting Chief Executive of NHS Education for Scotland, the Chair of Healthcare Improvement Scotland (HIS), and Chairs of the Scottish medical royal colleges.
- 18 This enabled productive discussions on the impact of changes in medicine as a result of the pandemic and allowed us to reinforce our commitment to supporting the Scottish Government on workforce planning, culture and

wellbeing. Anthony Omo has also taken up the role of sponsor for the Scottish government and is carrying out a range of meetings in that role.

- 19 At the Autumn UK Advisory Forum meeting in Scotland, HIS specifically offered to work collaboratively with us to align our views on what good leadership looks like.

Briefing MSPs on the Cumberlege Review

- 20 A small cross-party group of MSPs have been interested in our approach to handling cases relating to failed vaginal mesh removal procedures. In June we held a constructive meeting with this group, which provided us an opportunity to clarify the GMC's fitness to practice role, the process of registering eminent international doctors and successfully make a case for legislative reform. Ahead of the parliamentary debate on the Cumberlege review we circulated a briefing to MSPs. During the debate David Stewart MSP (Labour) welcomed the GMC's work to improve decision making and consent.
- 21 Following the Cabinet Secretary for Health and Sport, Jeanne Freeman MSP's announcement to Parliament that the Scottish government will accept all the recommendations of the review, we have engaged with officials on the creation of a Patient Safety Commissioner for Scotland and a conflicts of interest register. The Chief Executive met with the Cabinet Secretary in October; she confirmed the Scottish Government's Declarations of Interest working group would welcome engagement with the GMC.

Consultations

- 22 The GMC Scotland team have provided input to Scottish Government consultations on the regulation of non-surgical cosmetic procedures and the amendment of legislation prohibiting the University of St Andrews from awarding medical degrees. The team worked with officials to help them understand the GMC's role in approving new medical courses at UK universities.

Wales

Consultation on Welsh Language Standards

- 23 In early October, we submitted our response to the Welsh Government's consultation on the draft Welsh Language Standards for healthcare regulators. An internal Welsh Language Advisory Group (WLAG) comprising members of each directorate, as well as our in-house legal team, provided us with the

evidence to support our response. We welcome the introduction of standards, but stress that proportionality and mitigating any risks to patient safety are key.

Programme of senior level engagement

- 24 Following the decision not to proceed with the Spring Wales UK Advisory Forum due to the pandemic the Chair and Chief Executive had a bilateral meeting on 17 March 2020 with the Chair, Chief Executive and Medical Director of Health Education and Improvement Wales (HEIW). The meeting focused on workforce issues and the pandemic.
- 25 We also co-ordinated virtual engagements for the Chair, Chief Executive and Directors to meet with senior stakeholders and offer support during the pandemic. In April, the Chair met virtually with several members of the Academy in Wales to set out our work to date on temporary and provisional registration. She also met with Chris Jones, Chair and Tom Lawson, Post Graduate Dean of HEIW to discuss how trainees can progress at various stages, particularly in the specialties that have been put on hold and to offer our support in provisional licensing for FiY1's.
- 26 In June, the Chief Executive and Neil Roberts, our Welsh Government Sponsor met with Chris Jones, Deputy CMO (in place of the Minister for Health and Social Care). Chris welcomed the GMC's flexibility during the pandemic and highlighted the considerable workforce challenges in Wales, as services are restored, particularly if we are faced with a second peak.
- 27 Also, in June, we were invited to join a stakeholder workforce group, led by the Royal College of Physicians Wales. Members include the BMA, HEIW and Healthcare Inspectorate Wales (HIW). We have shared workforce data to inform discussions around the future implementation plans for the Workforce Strategy, holding two introductory sessions on our Data Explorer.