

General
Medical
Council

Council Meeting -
28 April 2022

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Council Agenda

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

Thursday 28 April 2022

10:00 – 12:30

Main meeting

- | | | |
|----------------|-----------|--|
| 10:00 – 10:03 | M1 | Chair's business |
| <i>3 mins</i> | | |
| 10:03 – 10:05 | M2 | Minutes of the meeting on session on 24 February 2022 |
| <i>2 mins</i> | | |
| 10:05 – 10:30 | M3 | Chief Executive's Report |
| <i>25 mins</i> | | |
| 10:30 – 11:15 | M4 | Human Resources report 2021 and gender pay gap reporting |
| <i>45 mins</i> | | |
| 11:15 – 11:30 | | Break |
| <i>15 mins</i> | | |
| 11:30 -11:50 | M5 | PSA annual review of our performance |
| <i>20 mins</i> | | |
| 11:50 – 12:15 | M6 | Communications and engagement update |
| <i>25 mins</i> | | |
| 12:15 – 12:20 | M7 | Approval of awarding bodies: (St Andrews/Dundee) |
| <i>5 mins</i> | | |
| 12:20 – 12:30 | M8 | Any other business |
| <i>10 mins</i> | | |

Below-the-line items*

- | | |
|-----------|---------------------------------------|
| M9 | Council members' register of interest |
|-----------|---------------------------------------|

M10 Biannual s40a appeals update

M11 Council forward work programme

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

Contents

	Page
Main meeting	5
M2 - Minutes of the meeting on session on 24 February 2022	5
M3 - Chief Executive's Report	13
Annex A - Performance Annex	22
Annex B - Corporate Opportunities and Risk Register	37
M4 - Human Resources report 2021 and gender pay gap reporting	43
Annex A - Our recruitment, turnover, and absence monitoring data	54
Annex B - Employment EDI targets	58
Annex C - Our profile as an employer in terms of diversity	60
Annex D - Pay data by protected characteristic	70
M5 - PSA annual review of our performance	79
Annex A - Performance Review - GMC 2020/21	85
M6 - Communications and Engagement update	114
Annex A - Four country update	124
Annex B - Data pack	142
M7 - Approval of awarding bodies: (St Andrews/Dundee)	147
Annex A - Open recommendations	152
M9 - Council members' register of interest	153
M10 - Biannual s40a appeals update	162
Annex A - Details of cases considered by the s40A Executive Panel	167
Annex B - A summary of the status of s40A appeals	169
M11 - Council Forward Work Programme	180

Council meeting - 28 April 2022

Agenda item M2

Minutes of the meeting on 25 February 2022

To approve

Minutes of the Meeting on 25 February 2022

Members present

Carrie MacEwen, Acting Chair

Steve Burnett

Vanessa Davies (online)

Anthony Harnden

Philip Hunt

Paul Knight

Deepa Mann-Kler

Raj Patel (online)

Suzanne Shale

Alison Wright

Others present

Charlie Massey, Chief Executive and Registrar

Shaun Gallagher, Director of Strategy and Policy

Una Lane, Director of Registration and Revalidation

Anthony Omo, Director of Fitness to Practise and General Counsel

Neil Roberts, Director of Resources (online)

Colin Melville, Medical Director and Director of Education and Standards

Melanie Wilson, Head of Corporate Governance and Council Secretary

Chair's business (agenda item M1)

- 1 The Chair welcomed members, the Senior Management Team (SMT) and observers to the meeting.
- 2 Council noted that apologies had been received from Paul Reynolds, Director of Strategic Communications and Engagement.
- 3 Council noted that since the last meeting the Chair approved proposed revisions to the Credentials framework using authority delegated by Council at its November 2021 meeting.

Minutes of the meeting on 9 December 2021 and actions log (agenda item M2)

- 4 Council approved the minutes of the meeting on 9 December 2021 as a true record, subject to the amendment of paragraph 26(c) to read as follows:

'Council retains accountability for the management of risk but relies on ARC to advise it of the sufficiency of its system.'

Chief Executive's Report (agenda item M3)

- 5 Council considered the Chief Executive's Report.
- 6 The Chief Executive and other members of SMT gave oral updates. Council noted that:
 - a Due to the rise in Omicron variant Covid-19 cases, the difficult decision was made to cancel all PLAB 2 examinations during January and February 2022 to enable examiners to prioritise their clinical commitments. During February, examinations were offered to some candidates who were already in the UK or had firm job offers/training places agreed at the time of cancellation. We have worked closely with stakeholders and candidates with visa applications.
 - b Following publication of SoMEP, there have been conversations around psychological safety and interest from stakeholders. There are plans to move publication of the report to May 2023 with an interim report published in Autumn 2022.
 - c Guidance for decision makers has been updated to take further account of the pressures the workforce face in the continuing Covid-19 pandemic and reassure doctors that the pandemic context will be taken into account.
 - d Following the reversal of the English government's decision to make vaccination mandatory in the health workforce, the GMC has been asked to strengthen their

guidance to doctors. However, it is felt GMC guidance is already robust in this area and the FtP process is not a way to enforce vaccination.

7 During the discussion, Council noted that:

- a** Due to an increase in contacts and a change of the type of contact, resourcing and strategy in the Contact Centre is being reviewed. As no other call centre with a distinction reports statistics, rather than customer satisfaction, Council reporting will also be reviewed though it was noted that a software solution may be required.
- b** Although 10 section 40a appeals seemed high, this related to only two cases, one case involving nine doctors.

Equality, diversity and inclusion - Annual progress report (agenda item M4)

8 Council considered the annual update on progress against our equality, diversity and inclusion (ED&I) ambitions as both a regulator and as an employer.

9 Council noted that:

- a** The report was based around the four expectations from Council: Robust long-term plans, measures, influences, and how we build on the first year.
- b** The report provides certainty on where we stand with stakeholders and the approach is welcomed across the system.
- c** We have had an encouraging first year, achieved the goals set for the year, and have seen some rapid changes with positive improvements.
- d** Council will receive a more comprehensive view of progress with an in-depth report on each ED&I workstream at Council meetings in 2022.

10 During the discussion, Council noted that:

- a** FtP referrals will be assessed over a period of time and compared to workforce data collected from GMC designated body data.
- b** ED&I targets are very ambitious, and we rely on external changes to culture and other organisations to meet them. The risks of not meeting them were discussed and it was agreed the targets were still the right thing to do. The possibility that we may fail to meet the ambition does not mean these are the wrong targets.
- c** Council was reassured that conversations between the GMC and ROs take place and that the outreach teams engage with trust boards. It was suggested we

should do as much as possible to encourage trust boards to look at data in an effort to reduce disproportionality in referrals, recognising that numbers may be small on an individual trust basis.

- d** Regarding internal processes, employment figures may have been influenced by a volatile job market and changes such as online interviews. Council was reassured our recruitment process is still robust and work has been focused on encouraging applications.

Progress on MAPs (agenda item M5)

11 Council received an update on progress to introduce the regulation of medical associate physicians (MAPs).

12 Council noted that:

- a** The timeline for the introduction of MAPs has slipped and will now be summer 2023 at the earliest. There is understandable disappointment among stakeholders at the delays, and this is impacting on the training and recruiting of MAPs.
- b** Interim *Good medical practice* standards for MAPs are now in place.
- c** The GMC is assisting the Royal Colleges with concerns raised about MAPs until our fitness to practise processes are in place.
- d** There are still questions to consider such as: prescribing, movement between professional qualifications, lack of regulation of MAPs in other countries, and engagement with stakeholders over the role of MAPs.

13 During the discussion, Council noted that:

- a** Consideration will be given to revalidation for MAPs to assist with patient confidence.
- b** It is recognised prescribing is important for MAPs but is a complex issue. The Commission on Human Medicines will make the decision and though the timeline is not yet known, it is likely to be after regulation. The GMC is contributing to conversations with NHSE/I who will put the proposal together. We are looking to embed theory into courses followed by training for MAP prescribers.
- c** There is further work to be done to embed MAPs into the workforce and patient pathways, and the GMC is keeping up the pressure on the Department of Health

and Social Care, NHSE/I and in the devolved nations. There is also work to be done on managing expectations of the role of MAPs within the workforce.

- d Consideration is being given to the potential impact on long term policy areas, such as ED&I, in the event the numbers of MAPs increase more rapidly than anticipated.

GMP review: approval to consult on revised draft (agenda item M6)

14 Council were asked to note the revised draft of *Good medical practice (GMP)* and approve plans to move to a public consultation.

15 Council noted that:

- a The regulation of MAPs was the main driver for the review but it has also been 10 years since the last review of GMP.
- b Feedback from the Council awayday has been taken into account when reviewing GMP and stakeholders have been positive about the revised draft.
- c The review focused on evolution, not revolution. Main changes include: tonal shifts to make it feel more empowering, while the four domains have been retained they are more thematic and the heading names have changed, introduction of 'I will' statements to engender ownership, and a single document for doctors and MAPs.
- d There are risks associated with the review such as: challenge to new duties, internal and external disruption, for example, change of domain names on software providers, there will not be a full consultation on explanatory guidance though there will still be engagement with stakeholders.
- e The consultation is scheduled to go live on 27 April and launched at the GMC conference.

16 During the discussion, Council noted that:

- a Some comments have perceived it as idealistic, for example on global issues. However, we are keen to explain GMP is not an FtP document but is trying to make a more positive statement.
- b Although 'must' statements are referred to as duties, other references to duties will be changed to professional behaviours.
- c It was felt the 'should' action to 'take action if you witness or are made aware of bullying or discrimination' may lead to some MAPs feeling this is difficult to follow

for fear of reprisal. It was agreed this should be included but careful thought given to communications.

- d** Council wondered if more should be added around technology and were reassured this will form part of the consultation.
- e** It was suggested that communications around the consultation also include that the review was based on feedback from stakeholders.

Education Quality Assurance update (agenda item M7)

17 Council received its annual update on education quality assurance.

18 Council noted that:

- a** There has been an increase in universities trying to establish private medical schools, currently catering for overseas students.
- b** There has been good engagement ahead of regulation with the 37 universities providing courses for MAPs.
- c** A review of enhanced monitoring has been undertaken to identify improvements to monitoring.

19 During the discussion, Council noted that:

- a** Members were reminded of the scale of interventions for enhanced monitoring which means not all providers in enhanced monitoring have conditions.
- b** Some providers in long term enhanced monitoring are due to issues in different departments at different times, and not necessarily a failure to remedy issues.
- c** A reduction in the number of clinical academics may become an issue with the increase in medical school places and work is in progress to address this.
- d** Issues with providers in long term enhanced monitoring are discussed at joint strategic oversight group meetings which include all the health regulators.
- e** A blended model of face-to-face visits and virtual visits is likely to become normal.
- f** There was concern some new medical schools may be creating pressure in the NHS training environment, which may also be exacerbated with the training of more MAPs. Members were advised the location of new schools is controlled by

the Department for Health and Social Care; the GMC's role is to accredit and assure, however we are having discussions with NHS bodies about this.

Report of the Investment Committee 2021 (agenda item M8)

20 Council discussed the report of the Investment Committee 2021.

21 Council noted that:

- a** Our fund management CCLA performed very well within the risk envelope given to them.
- b** Asset Risk Consultants (ARC), the Committee's external advisor, were pleased with CCLA's performance.
- c** There is a tendering process underway for the external advice (as provided by ARC.)
- d** The Committee has been making better use of the skills and experience of co-opted members.
- e** The Committee is working with CCLA and ARC to promote an ED&I approach.

22 During the discussion, Council noted that:

- a** Tenderers have been asked to give a view on our current approach to fund management and this may be reviewed in the future.
- b** The impact of global issues is being constantly monitored and the Investment Committee will be notified if funds drop by more than 10%. However, funds have been invested in a long-term strategy and Council should not be concerned if CCLA misses its target in a few quarters.

23 Council approved minor amendments to the Investment Committee's statement of purpose.

Any other business (agenda item M9)

Date of next meeting

24 Council noted that its next meeting is scheduled for Thursday 28 April 2022 in London.

Council meeting - 28 April 2022

Agenda item M2 - Minutes of the meeting on 25 February 2022

Report of the Executive Board 2021 (agenda item M10)

25 Council noted the report of the Executive Board 2021.

2023 Council and Committee planning (agenda item M11)

26 Council noted Council and Committee dates for 2023.

Council 2022 forward work programme (agenda item M12)

27 Council noted its forward work programme for 2022.

Confirmed:

Carrie MacEwen, Acting Chair

28 April 2022

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"> ■ Our temporary emergency register will close on 30 September. 21,000 doctors currently hold temporary emergency registration, and we will ensure they have plenty of time to consider what they need to do next and can move to permanent registration if they would like. ■ Our consultation on the updated <i>Good medical practice</i> guidance will launch on 27 April and will be open for 12 weeks. The consultation will use a variety of methods including questionnaires, meetings and events with a wide range of audiences to ensure a broad range of feedback. ■ This year's national training survey opened on 22 March and will run to Tuesday 3 May. This will give us a comprehensive picture of trainees' and trainers' experiences of training and progression across all four countries of the UK.
Decision trail	Council receives this report at each full meeting.
Recommendations	<ul style="list-style-type: none"> a To consider the Chief Executive's report. b To note the Performance Annex and the Corporate Opportunities and Risk Register
Annexes	<p>Annex A: Performance Annex Annex B: Corporate Opportunities and Risk Register</p>
Author contacts	<p>Iona Twaddell, Head of the Office of the Chair and Chief Executive</p> <p>Any enquiries to: GovernanceTeamMailbox@gmc-uk.org</p>
Sponsoring director/ Senior Responsible Owner	Charlie Massey, Chief Executive

Temporary Emergency Registration

- 1 On 16 March 2022, a [ministerial statement](#) was published announcing the closure of the emergency registers, including the GMC's, on 30 September.
- 2 21,000 doctors currently hold temporary emergency registration. We have let them know about the closure of the temporary emergency register and will ensure that they have plenty of time to consider what they need to do next and can move to permanent registration if they would like. On Wednesday 23 March, the National Day of Reflection and two years since the first lockdown, Una Lane wrote to those holding temporary emergency registration to thank them for their contribution and set out our next steps, including the option to restore their route registration and/or licence to practise.
- 3 At the same time, Charlie Massey wrote to all doctors on our register to thank them for their extraordinary efforts in caring for patients throughout this time. He also reiterated that we will always take context into account and highlighted the importance of supportive, inclusive and collaborative working environments.

Regulatory reform

- 4 We have received the first full draft of the legislation from DHSC and are reviewing it currently. We continue to liaise closely with department officials on policy issues across a range of areas and hope to have a clearer understanding of the implications for the timetable for implementing reforms soon. We will update Council as this work progresses.

Legislation and Parliamentary affairs

- 5 The Professional Qualifications Bill and the Health and Care Bill are nearing completion, with both going through the final stages of consideration of amendments.
- 6 We continued our briefing and engagement with peers on the Health and Care Bill in response to a several iterations of an amendment from Baroness Cumberlege seeking to shift the government's locally-held register of interests to one held by the GMC. Lord Kamall's ministerial response that work was being taken forward to support the development of locally-held registers, and that primary legislation was unnecessary provided sufficient assurance for the amendments not to be pressed.
- 7 Following our submission of written evidence to the Health and Social Care Select Committee's Inquiry into *Workforce: recruitment, training and retention*

in health and social care, we have been invited to attend in person and provide oral evidence to the committee on medical education reform. Our written evidence, including our data, which we provided to the *Future of General Practice Inquiry* was used to underpin questions to stakeholders including RCGP in follow-up sessions. We have also been invited to provide oral evidence to the House of Lords' Public Services Committee Inquiry on *Designing a Public Services Workforce Fit for the Future*.

- 8 Colin Melville, Director of Education and Standards, and Sara Moseley, Head of Wales held a successful meeting with a small group of north Wales MPs to answer their questions around Betsi Cadwaladr Health Board, providing clarity about our role, function and ensuring any outstanding patient safety concerns were addressed.

End of post-EU exit standstill period

- 9 The post-EU exit standstill period came into effect for an initial 24-month period on 1 January 2021. This meant EEA qualifications listed in Annex V of the mutual recognition of professional qualifications Directive became 'relevant European qualifications' and so evidence of knowledge and skills for registration. Therefore, the majority of EEA-qualified doctors could join our register without needing to take PLAB or demonstrating their knowledge and skills through another route. Essentially, this was the same situation as when the UK was an EU member state.
- 10 At a recent meeting with UK health professional regulators, DHSC officials confirmed that there will be a Secretary of State review of the standstill arrangements after the full 24-month period. This review will determine the future of the 'relevant European qualification' route to registration. The review is likely to take place in early 2023 and any legislation needed to implement the results of the review (for example to amend or end standstill) will likely be published for consultation and then laid in Parliament later in 2023.
- 11 This means that we expect the standstill period to continue until at least the end of 2023, and we will continue to register EEA-qualified doctors under our current routes until such time as any change is made in law.
- 12 As has previously been discussed at Council, we are undertaking work on our post-Brexit routes to registration to ensure that EEA doctors can continue to register with us in a timely and streamlined way once the standstill rules end, and we will continue to develop this work over the next 12-18 months.

Equality, diversity and inclusion

- 13 We published the first of our annual report on progress to meet our ED&I targets on 10 March 2022, as Council discussed in February. The report highlighted the range of initiatives underway across the UK to drive improvements and our latest data on progress meeting the targets (though given the longstanding nature of these issues, it is too soon to draw meaningful conclusions from the data). The results showed some positive changes to the employer referral rate and improvements we have made to the representation and progression of ethnic minority staff working at the GMC. The data we have available for medical education and training does not yet show any changes. Responses from stakeholders to the report reiterated our message that more work is needed to meet these targets and recognised the work that we had done so far.
- 14 We held our regular strategic ED&I forum on 15 March 2022, which brings together representatives from a range of organisations representing various groups of doctors. We discussed wide-ranging issues including our project on sex, gender and gender identity, our position on sexual harassment and education reform. We received helpful inputs from our forum members which we will use to develop our work on these areas.

Standards and guidance

- 15 On 15 March 2022, we published a number of factual updates to our guidance on [Treatment and care towards the end of life](#); [Good practice in prescribing and managing medicines and devices](#); and [The professional duty of candour](#). We have made the updates to bring the guidance in line with recent changes to the law or to include reference to the latest terminology used about these topics, rather than a full review of any of the documents.

Good medical practice

- 16 The *Good medical practice* (GMP) consultation launches on 27 April 2022, as Council agreed at the February meeting. The updated draft guidance aims to shift the tone of the guidance to be more empathic and recognise the context medical professionals are working in. It also contains new or amended professional duties on:
- Tackling bias and discrimination in healthcare
 - Patient centred care, decision making and communication
 - Team working (including working in multi-disciplinary teams)

- Leadership and interprofessional behaviours (including civility and sexual misconduct between colleagues).
- 17 The consultation will open for 12 weeks, and will use a variety of methods including questionnaires, meetings and events with a wide range of audiences. We have also commissioned an external behavioural insight specialist (ICE Creates) to conduct research and engagement with over 200 patients with lived experience of the healthcare system who would be less likely to respond to a written consultation.
- 18 We will reconvene the GMP Advisory Forum from September to advise on post-consultation drafting and return to Council with the results.
- 19 Charlie Massey was interviewed by Kat Lay, health editor of the Times, and the resulting story was published on 15 March 2022, highlighting that the update to *Good medical practice* will address professional behaviours. The story also covered the importance of retention and support for the workforce, and rising rates of burnout and wellbeing issues for doctors.

Education and training

National training survey

- 20 This year's national training survey opened on Tuesday 22 March and will run to Tuesday 3 May 2022. The survey will give us a comprehensive picture of trainees' and trainers' experiences of training and progression across all four countries of the UK. The results will support our ongoing work, to help maintain the quality of training as it recovers from the pandemic, and to adapt it for the future. This year we have updated our survey for trainers, so it is shorter and more focused on topics that directly affect their work and professional development.

Weston general hospital

- 21 After an HEE visit in March, we agreed with HEE that we will not allow F1 doctors to return to the Weston site in August. We continue to work closely with HEE on ensuring the site is safe for trainees and patients.

Meeting with Academy of Medical Royal Colleges (AoMRC)

- 22 We joined a meeting with the Academy and Royal College Presidents on 23 February 2022 to present our plans for medical education reform. We asked colleges to work with us on some deep dives into their individual curricula and

assessments, to help identify changes that could reduce the assessment burden whilst maintaining standards and help align curricula more closely with the needs of patients and employers. Several Colleges have responded positively, and we will convene a short-lived group including representatives from these colleges, employers, the GMC and patient voices to take this work forward. We also used the meeting to discuss our work on differential attainment and remind colleges of our ambitions and expectations.

GMC offices

- 23** We have ended social distancing in the GMC offices as of 1 April, when the government's working safely guidance ended. Mask wearing is also now a choice for colleagues. From 3 May, teams will begin new hybrid working patterns, depending on their role and the organisational need. This will mean that the majority of colleagues will be coming into the Manchester and London offices regularly. Arrangements in Scotland, Wales and Northern Ireland vary due to differing government guidance and we have been working with our colleagues in Edinburgh, Cardiff and Belfast on arrangements for those offices.

Inquiries and reviews

Early engagement

- 24** On 18 March 2022, we attended a healthcare roundtable held by the Covid Inquiry Set Up Team to comment on the Inquiry's draft Terms of Reference (ToR). These are high level and broad in nature and we suggested a few changes to better express the wide regulatory contribution from the GMC and others in responding to the pandemic. We also noted the importance of ensuring that the focus on 'lessons learned' within the ToR extends beyond learning for future crises to what the system wants to retain as business as usual. This event was part of the consultation on the draft ToR which is running for four weeks. Once the ToR is finalised, the Inquiry will officially come into being.

Ongoing Inquiry support

- 25** Following our interviews with the East Kent Investigation into maternity services on 17 February and 1 March 2022, we continue to assist the Investigation with evidence gathering ahead of publication later this year.

Inquiry publications

- 26 The Ockenden review into maternity services at Shrewsbury and Telford Hospital NHS Trust was published on 30 March 2022. We were not directly criticised but the review had wider recommendations for us to consider around professional behaviours, culture, and training. The review reiterates the importance of tackling negative cultures to ensure that women and their babies get the safe, high-quality care that they deserve. Addressing the issues in maternity requires a cross-regulatory response and we are working with the NMC and CQC to drive change in culture and in sharing our data to best identify risks earlier and act on emerging issues.
- 27 We have been assisting the Independent Neurology Inquiry in Northern Ireland through engaging with its fact checking process ahead of publication. The Inquiry has been reviewing the circumstances surrounding the Belfast Health and Social Care Trust's recall of neurology patients following concerns about the clinical practice of Michael Watt, with a focus on local clinical governance processes and complaints handling. We anticipate recommendations for the GMC and will brief Council about this Inquiry and any recommendations for us in advance of publication.
- 28 We are also imminently expecting the Department of Health and Social Care to publish its response to the recommendations from the Investigation into the Life and Death of Elizabeth Dixon – a baby whose death could have been avoided. This will include updates on progress against those recommendations – those of particular relevance to the GMC relate to medical professionals' training in clinical error, fostering no blame cultures and the proposal for 'in built' stop mechanisms within professional regulatory systems when investigations point to systematic failures. We have worked with the department to inform this response.

Key implementation activity

- 29 We continue to support the implementation of the Government's response to the IMMDS review (specifically recommendation 8 on Conflicts of Interest) through our attendance on the DHSC's Task and Finish Group. Discussions continue on how a locally led approach to the declaration and publication of Conflicts of Interest (COI) can be implemented across all four countries of the UK.

Operational performance

- 30 The annexed report details performance against our KPIs and priorities agreed in the Business Plan signed off by Council in December 2021. Legislative timeframe delay is the primary driver of exceptions in our change priorities, as well as delay to the Brexit end of standstill date.
- 31 The Contact Centre performance continued to improve in this period resulting in the narrowest miss against our service target since May 2021. This was supported in part by a drop in volumes (caused by little planned comms activity), alongside lower team sickness absence.
- 32 The annexed Corporate Opportunities and Risk Register (CORR) includes a new risk on MAPs regulation because the delivery date is wholly dependent on legislative development, which is outside GMC control. The CORR also includes a new risk on Corporate Social Responsibility (CSR) due to the threat that the organisation could be perceived as not taking appropriate accountability for social responsibility, which could lead to reputational damage to the organisation.

Finance

- 33 Our overall finances remain in good shape and we are confident our medium term financial forecasts are in line with previous projections and consistent with our reserves policy. The February financial update shows we expect to be in a marginally worse off position at the end of 2022 compared to budget. Our planned operational deficit is forecast to be slightly lower, leaving us in an improved position, however due to the volatility of our investments it is prudent to assume a zero return on investments this year.
- 34 The cancellation of PLAB 2 exams in January and February reduces our income to date by £1.6m and our operational expenditure by £0.8m. There are further reductions in expenditure in the early part of the year, such travel and other costs impacted by ongoing restrictions linked to the Omicron variant, which we expect to increase to budget levels as we start new working patterns in May. Our planned vacancy factor was 4% however it currently stands at over 5% which also reduces our expenditure compared to budget.
- 35 There continues to be a number of financial risks which could impact our current forecasts for 2022. These include the potential for change in PLAB candidate volumes linked to pandemic restrictions, the performance of our investments and the rise in inflation, which will impact our 3rd party costs and drive labour market pressures.

- 36** We will continue to monitor our investment performance and the impact of inflation rises closely.

Executive Board

- 37** The Executive Board met on 28 February and 28 March 2022 to consider items on:
- a** The regular Performance and Risk Report, providing a high-level report on performance, including finance and people, customer service and learning, and updates on the key risks to achieving our strategic aims.
 - b** A deep dive on risks relating to Regulatory Reform and ensuring teams were comfortable with each directorate's risk register.
 - c** Plans for ending social distancing in the office and implementing new working patterns.
 - d** The development of the 2022 People Survey, with results due to be shared with Council in November 2022.
 - e** The draft Annual Report, which for the first time includes national reports and the annual report of the Data Protection Officer.
 - f** The [budget setting and scrutiny process](#), reviewing the process for the 2022 budget and proposing some changes for next year's. Although the financial position is reported monthly to the Senior Management Team, we will introduce a formal half year financial review with each directorate into our annual planning cycle.

M3 – Annex A Performance annex

Data presented as at 28 February 2022 (unless otherwise stated)

Working with doctors Working for patients

Operational Key Performance Indicator (KPI) – since last report to Council

Indicator		Jan	Feb	Exception commentary
Operations	Decision on 95% of all registration applications within 3 months	98%	97%	
	Decision on 95% of all revalidation recommendations within 5 working days	98%	96%	
	Respond to 90% of ethical/standards enquiries within 15 working days	98.2%	95%	
	Conclude 90% of fitness to practise cases within 12 months	94%	93%	
	Conclude or refer 90% of cases at investigation stage within 6 months	96%	96%	
	Conclude or refer 95% of cases at the investigation stage within 12 months	96%	96%	
	Commence 100% of Investigation Committee hearings within 2 months of referral	100%	No Cases	
	Commence 100% of Interim Order Tribunal hearings within 3 weeks of referral	100%	100%	
Organisation	2019/20 Income and expenditure [% variance +/- 2%]	2.61%	0.70%	
	Rolling twelve month staff turnover within 8-15%	8.4%	8.3%	
	IS system availability (%) – target 98.8%	99.98%	99.99%	
	Monthly media score	79	4	

Performance Indicators – Making every interaction matter

		2021										2022	
Indicator		Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb
Contact centre operations	Answer 80% of calls within 20 seconds (KPI)	80%	89%	83%	78%	68%	71%	48%	33%	57%	60%	58%	78%
	Answer 90% of emails and letters (enquiries and updates) within 4 working days	96%	97%	92%	87%	80%	84%	59%	50%	53%	91%	96%	87%
	Average wait time (calls – seconds)	26	17	21	34	44	57	96	221	61	73	63	26
	Abandonment rate	5%	3%	3%	5%	6%	9%	15%	34%	9%	11%	10%	4%
<p>Contact Centre performance continued to improve in this period resulting in the best performance against our service target since May 2021. The KPI was narrowly missed in February, when we answered 78% of calls within 20 seconds against a target of 80%.</p> <p>Compared to previous months we saw a marked improvement in also reflected in lower wait times and abandonment rates. This performance was helped by an expected drop in volumes (which were very similar to Feb 2021) due to little planned comms activity. The Team also saw lower sickness absence. We expect to see volumes increase again throughout March / April, partly due to the National Training Survey (NTS).</p>													

Operational Key Performance Indicator (KPI) – 12 month performance summary

Indicator		Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	
Operations	Decision on 95% of all registration applications within 3 months	92%	98%	99%	99%	98%	97%	97%	96%	96%	96%	98%	97%	
	Decision on 95% of all revalidation recommendations within 5 working days	99%	98%	98%	97%	99%	98%	98%	98%	98%	98%	98%	96%	
	Respond to 90% of ethical/standards enquiries within 15 working days	96.5%	97.7%	100%	100%	96.1%	100%	94%	100%	100%	100%	97.5%	98.2%	95%
	Conclude 90% of fitness to practise cases within 12 months	93%	89%	92%	93%	92%	90%	91%	95%	93%	92%	94%	93%	
	Conclude or refer 90% of cases at investigation stage within 6 months	91%	95%	95%	96%	96%	95%	93%	95%	95%	96%	96%	96%	
	Conclude or refer 95% of cases at the investigation stage within 12 months	96%	93%	95%	95%	94%	93%	95%	97%	95%	95%	96%	96%	
	Commence 100% of Investigation Committee hearings within 2 months of referral	No Cases	No Cases	100%	No Cases	100%	No Cases	100%	100%	No cases	100%	100%	No Cases	
	Commence 100% of Interim Order Tribunal hearings within 3 weeks of referral	100%	100%	92%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
Organisation	2019/20 Income and expenditure [% variance +/- 2%]	4.40%	4.03%	3.16%	2.78%	2.63%	3.81%	2.76%	2.80%	2.5%	2.65%	2.61%	0.70%	
	Rolling twelve month staff turnover within 8-15%	4%	4.5%	4.6%	5.2%	6.2%	6.8%	6.8%	7.5%	7.9%	8.2%	8.4%	8.3%	
	IS system availability (%) – target 98.8%	99.99%	99.98%	100%	100%	99.97%	99.99%	99.91%	99.45%	99.6%	100%	99.98%	99.99%	
	Monthly media score	1963	43	175	-152	757	182	544	1016	162	115	79	4	

Corporate Strategy Delivery – Priority activities forecast February - December 2022 investment (project team resource)

Our strategy



Business Plan Priorities



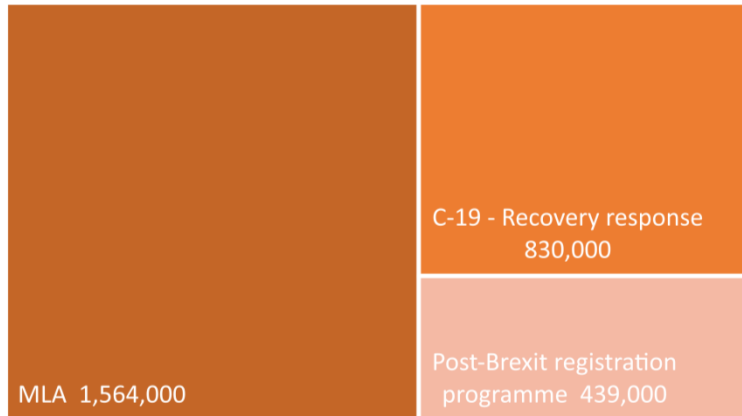
These estimates include the immediate-project team time cost to deliver against our key priorities. This helps us to better quantify the relative size of our commitments and inform prioritisation decisions against their expected impact.

The estimated values on this slide and the next reflect 2022 estimated time-cost of project teams only. They do not account for all associated costs (such as communications support or outreach teams) though we intend to improve our practice on an ongoing basis, which we also expect to improve workload management.

Corporate Strategy Delivery – Priority activities forecast February – December 2022 investment (project team resource)



Developing a Sustainable Workforce



Enabling professionals to provide safe care



Making every interaction matter



Investing in our people





Enabling professionals to provide safe care

- We work with others to improve workplace cultures in healthcare environments across the UK making them safe, inclusive and supportive
- The professionals we regulate can meet the professional standards patients expect and use their judgement to apply our ethical standards and guidance
- We use and share our data and insights to improve environments and address inequalities

2021-23 Priority activities		Status
Review of Good medical practice	<p>Why: Want to make sure our standards for professions we regulate reflect current patient and public expectations – and that our approach to embedding those with the profession maximises their relevance and application to care. Our guidance will be publicly consulted on and we will have launched an updated GMP.</p> <p>When: Complete by Q3 2023 Who: Colin Melville; Mark Swindells</p>	<p>Council and Executive Board considered key elements of our proposals to enhance GMP at [event] and endorsed the areas identified for public consultation. The Team is also finalising the consultation narrative and questions for the main survey.</p>
Fairer Employer referrals	<p>Why? To eliminate differentials in employer fitness to practise referrals</p> <p>When: by 2026 Who: Anthony Omo</p>	<p>Outreach are analysing feedback from their conversations with Designated Bodies to inform the future workplan. Feedback mechanism between Case Examiners and Regional Officers is being implemented. Feedback mechanism on Triage outcomes in development. Comms colleagues have reviewed the shared narrative we have drafted to support collaboration with NHSR and others on the delivery of the NHS England People Plan workstream titled 'Tackling the disciplinary gap'. Narrative to be shared with NHSR early March 2022. Development of training materials to assist Assistant Registrars to more proactively counteract bias is almost complete.</p>
Fairer training cultures	<p>Why? To deliver on our commitment to eliminate discrimination, disadvantage and unfairness for all index measures of fair medical education and training pathways.</p> <p>When: September 2031 Who: Colin Melville</p>	<p>We have now published a breakdown of the trainer population by demographic characteristics within the SOMEPE data tables. This will assist Deaneries as they develop their Action Plans. Quantitative evaluation of the psychiatry exam interventions continues to indicate positive results for those attending, and suggests potential for reduction in differential attainment. Funding has been agreed for three of these courses to run in 2022, to confirm findings and provide Edge Hill university with data for the qualitative analysis. We have agreed with the AoMRC to run a joint workshop for colleges in spring. Engagement meetings we held with stakeholders have included Royal College of Surgeons England (Development of a college action plan to address attainment gap), Royal College of Psychiatry (Review of Curricula Programme of Assessment in the context of FTC), the HEE Y&H EDI Lead (Recruitment and Selection), and the UKFPO Directors Forum to present an overview of FTP programme. Overarching PID has been approved and accepted by planning gateway. Detailed options papers have been provided to workstreams contributors for views, and are now being worked up to move to workshop stage.</p>



Developing a sustainable medical workforce

- We work with workforce organisations to support more professionals who meet the required standards to join and remain in the UK medical workforce.
- Education and training are relevant, accessible and supportive, giving all professionals the skills they need to better meet future patient needs.
- Training for the medical workforce is more flexible, throughout their careers.

2021-23 Priority activities		Status
Introducing the medical licensing assessment	<p>Why? Want to give patients greater confidence that they will receive a consistent level of core knowledge, skills and behaviours from any doctor practising in the UK. UK medical schools will deliver the Assessment embedded within final exams for a UK medical degree, overseen and regulated by us, and we will administer the assessment for IMG doctors. When: Q4 2025 Who: Colin Melville; Judith Chrystie</p>	<p>The overall status is amber – Regular meetings of the joint oversight group have started. Engagement is now moving into details of the piloting stage, and how medical schools will demonstrate that they can meet the GMC’s requirements for compliant applied knowledge tests (AKTs) and clinical and professional skills assessments (CPSAs). Cross-GMC work has now begun in relation to the coordination of programmatic work and planning for overlapping commitments, interdependencies and resource demands across the organisation. The development of future MLA delivery plans is dependent on the output of this cross-cutting work. The team is not yet fully resourced and with an estimated 6 month lead for recruitment we anticipate we will notice the resource gap in Q1 and Q2 2022.</p>
Post-Brexit registration pathways	<p>Why? To ensure we have efficient and effective routes for skilled professionals to gain registration and maximise the number of skilled doctors available to the UK medical workforce. To start, we will expand our Clinical Assessment capacity for international medical graduates to respond to Covid and manage the UKs post-Brexit registration approach for EU professionals. When: Q4 2022 Who: Una Lane; Kirstyn Shaw</p>	<p>The overall status is red - As a result of the delay to the end of standstill date we are undertaking a major rescoping of what is required and by when. We propose to pause work that was in train to stop recognising EU and Irish qualifications and will reprioritise other work strands according to urgency/need. We intend to have completed this rescoping by 14 April - but until then and with the associated change in overall timelines for delivery - the project is red.</p>

*All projects reporting green unless stated



Making every interaction matter

- We have a better understanding of the experiences of people who interact with us, particularly professionals, patients and the public
- We use an improved understanding of people's experiences to make our interactions with all those we work with better
- We regularly review our processes to make sure they are as effective as possible and that we use our resources appropriately and responsibly

2021-23 Priority activities		Status
Regulatory reform and MAPs	<p>Why? To improve the design and delivery of our functions so that we can be more responsive to the changing needs and expectations of patients, the health system, and the professions. To expand the medical workforce and the contribution by our professionals to quality patient care, while continuing to safeguard patients. We will deliver equivalent statutory functions across MAPs and doctors.</p> <p>When: Changes for MAPs to come into effect summer 2023, remaining changes to be implemented by Q4 2024.</p> <p>Who: Shaun Gallagher; Tim Aldrich for Regulatory Reform; Una Lane; Clare Barton for MAPs.</p>	<p>The overall Regulatory Reform status is amber - We continue to meet regularly with DHSC to review the timetable, but we are yet to see a full and settled draft of the new legislation and hope to in early April. Until we see this draft and have had time to understand its implications we remain uncertain about what this means for implementation timeframes. A planning workshop took place on 7 March to review DHSC's updated plan and assess what that means for our plans.</p> <p>The overall MAPs status is red - The Programme is currently graded 'red' because the delivery date is wholly dependent on legislative development, which is outside GMC control. We're expecting to receive a first full draft of the new legislation from DHSC in early April, together with confirmation of parliamentary milestones, and this should provide greater clarity on the potential start date for regulation. We are well advanced in developing the processes and systems needed to regulate PAs and AAs, as set out in our report to February Council. During the past two months we have been meeting individually with all PA/AA course providers to provide feedback on their education quality self-assessments, explain our approach to registering new graduates, and cement these important stakeholder relationships.</p>
Regulatory Fairness	<p>Why? We are focussed on making fairness central to our work and we are reviewing the fairness and transparency of high-stakes decision we make.</p> <p>When: September 2022 Who: Shaun Gallagher</p>	<p>The initial procurement of an expert review of our assurance audits was unsuccessful. The Review has been extended by a month to accommodate the need to undertake a second procurement exercise which went live on 21 Feb. The aim is to award a contract in the first week of May. The High-stakes decision working group has agreed definitions, priority decisions and an anti-bias controls review framework, in principle and have agreed next steps to trial the framework. An interim report on the findings of the learning needs analysis has been received and the learning from this work has been reported to the Regulatory Review Fairness Board.</p>

*All projects reporting green unless stated



Investing in our people to deliver our ambitions

- We will deliver our ambitions with flexibility, sensitivity to the external environment and leadership across all roles
- The GMC is a more diverse and inclusive organisation
- We take a more coordinated approach to our corporate responsibilities, including social, environmental and economic

2021-23 Priority activities	Status
<p>Investing In Our People</p> <p>Why? To ensure our approach as an organisation to leadership, support and ongoing improvement attracts and retains the right people to meet our ambitions – we are expanding the diversity of our people and targeting the barriers some colleagues experience so we can become a more inclusive work environment. We are also working to achieve Gold accreditation under Investors in People (IiP). When: Q3 2023 (IiP), 2026 for wider diversity. Who: Neil Roberts; Andrew Bratt</p>	<p>Our Developing diverse talent & leaders programmes are live and have been received positively with all cohorts for the first half of the year being full, we are currently scheduling two further cohorts for the latter half of 2022 and these are both $\frac{3}{4}$ full. Professional Behaviours eLearning was assigned to all colleagues across the organisation in early January with a completion date of March 31st 2022. Early signs show a good uptake. We are now live with our intern recruitment with a planned start date of July 2022. Our graduate programme was approved at the last planning gateway and we are on track for a go live date of May 22.</p>

*All projects reporting green unless stated



Investing in our people to deliver our ambitions

Our target is to eliminate differentials within our own staffing performance, in minority ethnic recruitment, representation across staffing levels, retention, progression, pay and employee engagement by 2026.

Underlying measures and targets		Actual				Target		
		2021 (%)	2021 (Vol)	2022 ¹ (%)	2022 ¹ (Vol)	2023	% Points Off 2023 target	2026
Increase the level of ethnic minority representation at Level 3 and above	Applications	32.1	253	31.4	285	27%	+4.4%	30%
	Interviews	22.4	60	22.2	58	22%	+0.2%	25%
	Offers	32.1	16	31.4	15	17%	+14.4%	20%
	Workforce	13.3	77	13.7	84	16%	-2.3%	20%
Level of ethnic minority representation at Level 2+		10.8	23	11.7	25	14%	-2.3%	20%
Level of ethnic minority representation at level 3		14.3	54	14.7	59	16%	-1.3%	20%
Increase the level of ethnic minority representation at all levels	Applications	40.0	1,332	40.0	1,407	37%	+3.0%	40%
	Interviews	27.4	260	26.8	269	32%	-5.2%	35%
	Offers	30.2	88	29.8	90	27%	+2.8%	30%
	Workforce	16.0	247	16.4	257	17%	-0.6%	20%
Reduce differential turnover rates for ethnic minority staff compared to the average to improve retention and for rates to be within 1-2% of each other by end of 2023**		0.4	-	ethnic minority (%)	Non-ethnic minority (%)	1-2%	% points between groups	1.0%
				8.8	8.3		0.5%	
Proportion of ethnic minority staff receiving promotion and grade progression is proportionate to our workforce at the relevant grade/level <i>*difference is not set against the 2023 figure, the target is that the proportion of staff will be equal across ethnic minority and Non-ethnic minority staff</i>		3.4	-	ethnic minority (%)	Non-ethnic minority (%)	18%	% points between groups	18%
				16.4	14.5		1.9%	
Pay differentials within a confined band limited to 2% from 2023 ² (table shows the proportion of bands that are outside of the tolerance) <i>1 Rolling 12 month period used to the end of the reporting month</i>		50.0%	6/12	41.7%	5/12	2.0%	N/A	2.0%

² Specialist bands are not included

*difference is not set against the 2023 figure, the target is that the proportion of staff will be equal across ethnic minority and Non-ethnic minority staff

** 2020 is an unrealistic baseline year given the pandemic. Retention rates for ethnic minority staff have historically been outside of this range – in 2019 the difference in retention rates against the average for ethnic minority staff was 3.9%.

Financial summary (February)

Financial summary as at Feb 2022	Budget Feb	Actual Feb	Variance		Budget 2022	Forecast 2022	Variance	
	£000	£000	£000	%			£000	£000
Operational expenditure	21,479	19,812	1,667	8%	130,953	128,700	2,253	2%
Capital expenditure	759	758	1	0%	8,833	8,833	0	0%
Total expenditure	22,238	20,570	1,668	8%	139,786	137,533	2,253	2%
Operational income	21,586	19,958	(1,628)	(8)%	133,782	132,239	(1,543)	(1)%
Operational surplus/(deficit)	(652)	(612)	40		(6,004)	(5,294)	710	

Financial summary as at Feb 2022	Budget Feb	Actual Feb	Variance		Budget 2022	Forecast 2022	Variance	
	£000	£000	£000	%			£000	£000
Investment income	317	(2,581)	2,898	914%	1,926	0	1,926	100%
Investment management fees	43	43	0	0%	262	262	0	0%
Net investment return	274	(2,624)	(2,898)		1,664	(262)	(1,926)	
Total surplus/(deficit)	(378)	(3,236)	(2,858)		(4,340)	(5,556)	(1,216)	

Income Forecast

The forecast reflects the cancellation of PLAB 2 tests in January & February and the anticipated knock on effect to new application volumes. The forecast also includes an additional 500 PLAB 1 candidate places compared to budget and 8 additional PLAB 2 circuits planned for later in 2022.

Income financial risks/forecast sensitivity

There continues to be a risk that PLAB 1 tests could be affected by coronavirus throughout the year and there remains a possibility of some form of social distancing measures towards the end of 2022 which would impact our PLAB 2 capacity forecasts. There continues to be a risk of investment volatility which has been heightened due to recent political events.

Expenditure Forecast

The expenditure forecasts reflects the variable cost saving linked to the cancellation of the PLAB 2 tests in January & February, plus the savings to date and further savings linked to plans to return to the office and start our new working patterns. Based on experience to date we have also increase our vacancy factor assumption from 4% to 5%.

Expenditure financial risks/forecast sensitivity

The key risk for expenditure in 2022 is the impact of inflationary pressures both within the staff resource market and through 3rd party suppliers passing on cost increases to us. We will continue to monitor the impacts of inflationary increases throughout the year and adjust forecasts accordingly.

Financial detail (February)

Expenditure as at Feb 2022	Budget Feb	Actual Feb	Variance		Budget 2022	Forecast 2022	Variance	
	£000	£000	£000	%		£000	£000	£000
Staff costs	12,629	12,328	301	2%	79,771	78,836	935	1%
Staff support costs	587	452	135	23%	3,743	3,547	196	5%
Office supplies	210	149	61	29%	1,035	978	57	6%
IT & telecoms costs	836	763	73	9%	5,170	5,069	101	2%
Accommodation costs	1,308	1,290	18	1%	7,898	7,891	7	0%
Legal costs	808	806	2	0%	4,820	4,818	2	0%
Professional fees	411	411	0	0%	3,232	3,239	(7)	(0)%
Council & members costs	50	43	7	14%	439	432	7	2%
Panel & assessment costs	3,203	2,133	1,070	33%	19,505	18,544	961	5%
PSA Levy	137	137	0	0%	858	864	(6)	(1)%
Gateway fund	0	0	0	0%	3,182	3,182	0	0%
Pension top up payment	1,300	1,300	0	0%	1,300	1,300	0	0%
Total operational expenditure	21,479	19,812	1,667	8%	130,953	128,700	2,253	2%

Income as at Feb 2022	Budget Feb	Actual Feb	Variance		Budget 2022	Forecast 2022	Variance	
	£000	£000	£000	%		£000	£000	£000
Annual retention fees	16,973	17,020	47	0%	104,718	104,760	42	0%
Registration fees	797	633	(164)	(21)%	7,115	6,637	(478)	(7)%
PLAB fees	3,151	1,610	(1,541)	(49)%	17,155	15,954	(1,201)	(7)%
Specialist application CCT fees	394	439	45	11%	2,903	2,948	45	2%
Specialist application CESR/CEGPR fees	212	180	(32)	(15)%	1,293	1,261	(32)	(2)%
Interest income	13	19	6	46%	54	124	70	130%
Other income	46	57	11	24%	544	555	11	2%
Total Operational Income	21,586	19,958	(1,628)	(8)%	133,782	132,239	(1,543)	(1)%

GMCSI summary & investments (December)

GMCSI summary as at Feb 2022	Budget Feb	Actual Feb	Variance	
	£000	£000	£000	%
GMCSI income	56	49	(7)	(13)%
GMCSI expenditure	46	46	0	0%
Profit/(loss)	10	3	(7)	

Budget 2022	Forecast 2022	Variance	
£000	£000	£000	%
323	323	0	0%
323	323	0	0%
0	0	0	

Legal summary (as at 14 March 2022)

The table below provides a summary of appeals and judicial reviews as at 14 March 2022:

	Open cases carried forward since last report	New cases	Concluded cases	Outstanding cases
s.40 (Practitioner) Appeals	14	3	3	14
s.40A (GMC) Appeals	11	0	1	10
PSA Appeals	1	2	0	3
Judicial Reviews	3	3	3	3
IOT Challenges	4	0	2	2

Explanation of concluded cases	s.40 (Practitioner) Appeals	<p>a. GMC successful</p> <p>i. 2 appeals dismissed</p> <p>b. 1 GMC unsuccessful – remitted to tribunal</p>
	s.40A (GMC) Appeals	<p>c. GMC unsuccessful</p> <p>i. 1 appeal dismissed</p>
	Judicial Reviews	<p>d. GMC successful</p> <p>i. 2 permission refused</p> <p>ii. 1 withdrawn</p>
New referrals by PSA to the High Court under Section 29 since the last report with explanation, and any applications outstanding	PSA Appeals	There have been two new referrals by PSA to the High Court under Section 29 since the last report, and zero concluded.
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	There have been no new applications in the High Court challenging the imposition of interim orders since the last report, and two concluded (one claim was withdrawn and one where the order was maintained – GMC successful), therefore two challenges outstanding.
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.	

Council meeting - 28 April 2022

Agenda item M3

Chief Executive's Report

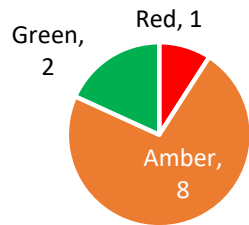
Corporate Opportunities and Risk Register

**General
Medical
Council**

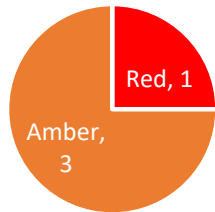
Annex B

Corporate Risk Register (CORR) Overview

Threats - post-mitigation rating summary



Threats - Post-mitigation rating higher than appetite



Opportunities - Post-enhancement rating summary



New Risks:

310 - CSR position (threat) added - Lack of awareness and understanding of our environmental work / position and progress made to date (incl. our net zero ambitions) may mean that the organisation is perceived as not taking appropriate accountability for social responsibility, which could lead to reputational damage to the organisation.

315 - MAPs regulation delay (threat) added – see below

Active Threats above risk appetite

315 - MAPs regulation delay (new threat) – red (critical) after mitigation. If there are further delays to the timescale for commencing regulation of PAs and AAs, we could lose the confidence of stakeholders, and numbers of PA/AAs in education and employment may fail to increase as expected.

148 – Delivery of Statutory Functions - remains amber (significant) after mitigation. If we fail to deliver our core statutory functions, there is a potential impact on patient safety, public confidence, and the GMC's reputation as a leading regulator

120 - ED&I compliance - remains amber (significant) after mitigation. The assurance we can evidence that our regulatory decision-making is fair - is not persuasive to key stakeholders and weakens confidence in regulation

309 – Safeguarding at the GMC remains amber (significant) after mitigation. If there isn't sufficient corporate understanding and visibility of our safeguarding activities, we may not meet our safeguarding obligations as a regulator and as an employer

Opportunities

27 – Deriving more insight from our data capability –gold after enhancement. Developing, sharing and working with others using our insight capability provides an opportunity to shape public debate, influence the external environment and deliver more proactive regulation

28 – Working with patients and public – silver, after enhancement. Understanding and improving the experiences which patients and the public have of our regulatory services and involving them effectively in our work (such as strategy and policy development) will help us gain their trust and confidence as an effective and transparent regulator

Corporate Opportunities & Risk Register (CORR) - March 2022

Id	Classification	Title	Category	Detail	Owner	Likelihood - Inherent	Impact - Inherent	Rating - Inherent	Mitigation / Enhancement	Likelihood - Residual	Impact - Residual	Rating - Residual	Council and / or Board Assurance	Assurance	Further Action Detail	Risk Appetite
315	Operational Threat	MAPs regulation delay	Reputational	<p>If there are further delays to the timescale for commencing regulation of PAs and AAs, we could lose the confidence of stakeholders, and numbers of PA/AAs in education and employment may fail to increase as expected. As well as adversely affecting workforce objectives, this would reduce GMC fee income and further increase our funding requirement from DHSC, which is subject to approval annually.</p> <p>The workforce impact of delay is magnified by the fact that extension of prescribing responsibilities to PAs and AAs is subject to a separate legal process that cannot start until these professions are regulated.</p>	Una Lane	HIGHLY LIKELY	MAJOR	CRITICAL	<ul style="list-style-type: none"> Regular communication with key stakeholders, including promoting achievements from the programme so far and upcoming activity We will maintain some dedicated staffing resources on each workstream until regulation starts, in order to retain expertise and ensure readiness for implementation Programme cost projections updated quarterly and reported to DHSC/GMC Financial Accountability Group, providing advance notice of funding needs Principle clearly established that costs of MAPs regulation will not be met from doctor fees 	HIGHLY LIKELY	MODERATE	CRITICAL			<ul style="list-style-type: none"> Agree joint communication principles with DHSC which recognise the nature of our relationships with key PA/AA stakeholders and the importance of maintaining trust for our continuing progress on regulatory development Use our influence with Governments, SEBs and other stakeholders to press for actions that would help mitigate the workforce impact of continuing delay to regulation Provide a clear narrative to accompany financial bid for 2022/23 and subsequent years, emphasising the impact of further delays to the legislative development timeline on programme costs 	Low
120	Operational Threat	ED&I compliance	Strategic / Policy	<p>The assurance we can evidence that our regulatory decision-making is fair - is not persuasive to key stakeholders and weakens confidence in regulation</p>	Shaun Gallagher	QUITE LIKELY	MAJOR	CRITICAL	<ul style="list-style-type: none"> Equality, Diversity and Inclusion (ED&I) objectives published within the corporate strategy and supported by focused targets based on evidence and routine monitoring and reporting of progress Supporting governance including the Strategic EDI Advisory Forum (external) and ED&I Steering Group (internal) provides senior oversight and guidance to inform action and priorities Skilled ED&I team to provide strategic advice across the GMC Mandatory training for all staff and associates Guidance and tools for equality analysis as a requirement of project and policy activity to consider fairness impacts of approach Past research, fairness audits, Campbell Tickell Governance and Compliance review 	UNLIKELY	MAJOR	SIGNIFICANT	<ul style="list-style-type: none"> Executive Board and Council consideration of Campbell Tickell compliance report (Feb and April 2021) 	<ul style="list-style-type: none"> Strategy and policy ED&I compliance and governance review - Campbell Tickell (2020) Engagement, not personal characteristics, was associated with the seriousness of regulatory adjudication decisions about physicians: a cross-sectional study, Javier A Caballero, Steve P Brown, British Medical Journal (2019) Fairness of decisions to refer doctors to the MPTS interim orders tribunal (2018) Plymouth University Review of decision-making in the GMC's FTP procedures (2014) 	<ul style="list-style-type: none"> Consider key decision-points in our operations for process controls to mitigate the risk of bias or unfairness (such as separated decision making) and our quality assurance regime for decisions Assess staff learning and training needs from first principles through a Learning Needs Analysis (LNA) and the most current evidence base on learning approaches with the greatest impact Consider the adequacy of how we report the timeliness of our regulatory processes to better understand the characteristics of the individual in that process and possible real-time interventions required to address risks of unfairness Review our approach to a regulatory Equal Opportunities Policy Consider the coverage and credibility of past independence assurance on the fairness of our processes in design and operation to identify gaps or required change in approach 	Low
148	Operational Threat	Delivery of statutory functions	Operational	<p>If we fail to deliver our core statutory functions, there is a potential impact on patient safety, public confidence, and the GMC's reputation as a leading regulator</p>	Charlie Massey	QUITE LIKELY	MAJOR	CRITICAL	<ul style="list-style-type: none"> Monitoring and reporting against statutory delivery to Executive Board and Council Forecasting of operational demand is built into budget planning Active engagement with doctors about potential situations which may put patients at risk Outreach structure in place (ensures statutory process for responsible officers to continue effectively) to help identify and manage concerns (pre-investigation) Available staff with relevant training and skills Information exchange with competent authorities informs our processes Documented operational process and procedures, that are subject to regular review and continuous improvement by specialist staff Auditing our decisions on a regular basis GMC SMT oversight of pandemic response and recovery planning Following the cancellation of PLAB 2 exams in January and February 2022 we have worked with affected candidates and their representative organisations to secure them new places. Limited sittings for priority candidates have taken place throughout February, and the Assessments team will be running three circuits concurrently through 2022 in order to accommodate as many candidates as possible. 	QUITE LIKELY	MODERATE	SIGNIFICANT	<ul style="list-style-type: none"> Council <ul style="list-style-type: none"> Review of performance metrics through the quarterly CEO report Executive Board <ul style="list-style-type: none"> Review of performance metrics through the bi-monthly Performance and Risk Report Risk deep dive (November 2020) 	<p>Internal Audit</p> <ul style="list-style-type: none"> Recovery and renewal (November 2021, green-amber) FTP Covid-19 Response (Aug 2021, green-amber) Quality Control Audit CE IOT decisions (Aug 2021) Quality Control Audit CE Rule 8 decisions (July 2021) Review of progress in implementing Outreach (May 2021, green-amber) Quality Control Audit Triage decisions (April 2021) Education Quality Assurance (February 2021, green) Curricula approvals (January 2021 green-amber) Virtual hearings (September 2020, green) Temporary registration (September 2020, green) Interim Order Tribunals (January 2020, green-amber) Standards and Ethics (September 2021, green-amber) 2019, green-amber) Interim Order Review on Papers (May 2019, green-amber) Voluntary and admin erasure (May 2019, green-amber) <p>Other assurance</p> <ul style="list-style-type: none"> Annual PSA Performance review (2020/21) Covid learning reviews (GMC Case Studies): How the regulator responded to emerging evidence of higher prevalence of Covid-19 infection in BAME people; Temporary registration implementation; The impact of the pandemic on the regulator's corporate strategy/the impact of the strategy on the regulator's response (December 2020) 	<ul style="list-style-type: none"> Continue to engage with the Professional Standards Authority and other regulatory partners, coordinating the Covid-19 response and reviewing our approach as the situation evolves We'll consider and triage all new concerns, progressing those requiring investigation The MPTS continues to meet our service level agreement to commence 100% of new interim referrals within 21 days The MPTS continues to hear reviews of all MPT sanctions and IOT orders within statutory deadlines We will seek to secure a new supplier for digital identity checking software and implement an interim solution for managing ID checks in the intervening period. 	Low

149	Operational Threat	Availability of resources	Resource	If we don't secure and retain: an appropriately skilled and experienced workforce; a resilient and secure IT and facilities infrastructure; or maintain a sound financial position, we threaten delivery of our statutory functions and strategic aims.	Neil Roberts	HIGHLY LIKELY	MAJOR	CRITICAL	<ul style="list-style-type: none"> Our HR practices and leadership strategy is aimed towards attracting and retaining a high calibre workforce We have processes in place to identify and manage key staff risks We consider recruitment market surveys and data to identify potential skills shortages. Our Health and safety policies and procedures are robust in regards to our workforce Clear Financial management practice and controls and safeguards including around investment (GMCSI), fraud policies and pensions. New activity, including New Initiative Fund initiatives and existing project work routinely considered by Planning Gateway process to form a cross-organisational recommendation on the priority and deliverability of proposals for SMT to consider collectively Routine monitoring and reporting of operational performance and the volume and complexity of our work Process for regularly mapping workload pressures across teams to help focus resourcing and prioritisation decisions Reactivated Recovery and Renewal Taskforce to coordinate our transition to resuming paused activities and use of office space We are working closely with the Pension Trustees to address the increased scheme liability arising from the Govt decision to align RPI and CPI Financial reserves and management provide financial resilience to risks that are realised and effective business continuity processes manage and minimise the impact of such risk We continually invest in our IT infrastructure and systems to ensure availability and protect against cyber-security threats and maintain ISO 27001 accreditation 	QUITE LIKELY	MODERATE	SIGNIFICANT	<p>Council</p> <ul style="list-style-type: none"> Review of annual budget and Annual Accounts <p>Executive Board</p> <ul style="list-style-type: none"> Executive Board regular review of finance, HR, project and operational performance and risks Risk deep dive (June 2020) 	<p>Internal Audit</p> <ul style="list-style-type: none"> Social engineering: Nov 2021 green/amber Recovery and renewal: Nov 2021 green/amber Payroll (May 2021, green-amber) Procurement (March 2021, green-amber) Fraud arrangements (March 2021, green) Raising concerns arrangements (March 2021, green) Risk Management (October 2020, green) Covid learning review (August, 2020) Assurance Spot-check - Business Planning & Budgeting changes (May 2020 green-amber) Recruitment (September 2019, green-amber) Managing change (August 2019, amber) Transformation Programme (July 2019, amber) Risk Management (June 2019, green-amber) <p>Other assurance</p> <ul style="list-style-type: none"> Covid learning reviews (GMC Case Studies): The impact of the pandemic on the regulator's corporate strategy/the impact of the strategy on the regulator's response (December 2020) 	Medium	
150	Operational Threat	Ability to work with others	Strategic / Policy	If we are unable to work collaboratively with our external partners, we may not be able to achieve the ambitions of the corporate strategy, reducing our potential impact on patient safety and doctors' practice	Paul Reynolds	QUITE LIKELY	MAJOR	CRITICAL	<ul style="list-style-type: none"> Being transparent and managing stakeholders at SMT level Engagement with other regulatory bodies to identify opportunities for collaboration and alignment (such as through the Chief Executive Officer Regulatory Body (CEORB) Group) Proactive engagement on all major policies and issues Development and management of stakeholder relationships of strategic importance at national and regional levels of the UK, supported by annual relationship plans delivered by our external affairs and outreach teams Regular evaluation of our relationships with key partners, through analysis of insights captured in our new Engage system and periodic surveys of our stakeholders' perceptions Active engagement with the four UK Governments over the future of our legislation Contribute to joint work through CEORB group 	QUITE LIKELY	MODERATE	SIGNIFICANT	<p>Council</p> <ul style="list-style-type: none"> Paper: Perceptions Survey 2020 (which included key results from stakeholders) (December 2020) Paper: Four countries update (November 2020) Paper: Annual update on communications and engagement (July 2020) Paper: Four countries update (April 2020) <p>Executive Board</p> <ul style="list-style-type: none"> Four country public affairs update (March 2021) Risk 'deep dive' (July 2020) Public affairs strategy (June 2020) 	<p>Internal audit</p> <ul style="list-style-type: none"> Review of progress in implementing Outreach (May 2021, green-amber) <p>Other assurance</p> <ul style="list-style-type: none"> Quarterly health assessments of our major relationships (last assessments carried out by external affairs teams in July 2021) Corporate strategy and perceptions survey 2020 (published December 2020) Corporate strategy and stakeholder perceptions baseline survey (published March 2019) 	<ul style="list-style-type: none"> Initial adoption programme for Engage system is now complete and system now managed on BAU basis using quality framework Continue to strengthen our collaboration on patient safety issues with our regulatory partners (such as CQC and NMC) following Paterson inquiry report on issues such as maternity care and treatment in the independent sector 	Medium
151	Operational Threat	Responding to a changing environment	Strategic / Policy	Inability to respond effectively to changes in the external environment, including legislation and wider social impact changes, could lessen our influence and reduce public, profession and political confidence in our role	Paul Reynolds	QUITE LIKELY	MAJOR	CRITICAL	<ul style="list-style-type: none"> Proactive, senior-level engagement with stakeholders to understand their agendas Outreach teams structures in place, aligned to UK countries and regions of England, to help us understand and influence national and local systems Contribution to NHS People Plan (England) and Government initiatives across the UK Continuous monitoring of our external environment, including longer term horizon scanning and research (e.g. barometer and perception surveys with the medical profession) Contributing to meetings and networks across the UK and Europe Internal governance in place to process, consider and make decisions on the intelligence we receive about the quality and safety of local practice and training environments (JWIG and PSIF meetings) Intelligence from our external environment is shared on a weekly basis with Senior Leadership team and Council members 	UNLIKELY	MODERATE	LOW	<p>Council:</p> <ul style="list-style-type: none"> Four countries update (November 2020) Update on Outreach implementation (October 2020) Seminar: Four countries update (September 2019) <p>Executive Board:</p> <ul style="list-style-type: none"> Deep dive on Devolution (September 2021) Four country public affairs update (March 2021) Future scenarios for GMC Outreach (December 2020) New public affairs strategy (December 2019) 	<ul style="list-style-type: none"> Review of progress in implementing Outreach (May 2021, green-amber) Regulatory Reform - Spot Check (June 2021, March 2021) Horizon scanning arrangements (June 2020, amber) 	<ul style="list-style-type: none"> Initial adoption programme for Engage system is now complete and system is now managed on BAU basis using quality framework and our engagement and policy teams continue to capture intelligence from our engagement with stakeholders Internal programme established by Strategy and Policy to improve our approach and capabilities for capturing, coordinating, recording and using intelligence from our external environment Media Relations team exploring how new monitoring platform can be exploited to improve content of daily media summary, to make it more relevant to work of teams across GMC 	Low

152	Operational Threat	Unplanned event	Reputational	The impact of an event in the external or internal environment causes our systems to be compromised or our activities to be publicly challenged, potentially leaving us vulnerable to delivery of key functions central to patient safety and reputational damage	Neil Roberts	QUITE LIKELY	MAJOR	CRITICAL	<ul style="list-style-type: none"> Crisis management policies & procedures; pandemic response plan Business continuity champions and emergency response plans in place with regular testing Mandatory e-learning for GMC staff and support from business continuity consultants Responding to public inquiries and reviews, and proactive horizon scanning Analysis of range of qualitative and quantitative information about the external environment through the Patient Safety Intelligence Forum Regular engagement with the Professional Standards Authority to assure them on the exercise of our statutory powers – including emergency powers under section 18A of the Medical Act 1983 (Covid-19) 	QUITE LIKELY	MODERATE	SIGNIFICANT	<ul style="list-style-type: none"> 'Deep Dive' Executive Board (June 2021) Paper: People planning across the United Kingdom (November 2019) 	<p>Internal audit</p> <ul style="list-style-type: none"> Cyber security (July 2021, green-amber) Cyber security (November 2020, green-amber) Cyber security (July 2019, green) <p>Audit and Risk Committee</p> <ul style="list-style-type: none"> Significant Event Review: Fraudulent registration application, Teodora Crisovan (March 2021) Report on Significant Event Review follow-ups (March 2021) Significant Event Review: Fraudulent doctor Zholia Alemi (November 2019) Significant Event Review: Fraudulent registration application, Teodora Crisovan (March 2021) Report on Significant Event Review follow-ups (March 2021) <p>Other assurance</p> <ul style="list-style-type: none"> Covid learning reviews (GMC Case Studies): How the regulator responded to emerging evidence of higher prevalence of Covid-19 infection in BAME people; Temporary registration implementation; The impact of the pandemic on the regulator's corporate strategy/the impact of the strategy on the regulator's response; Approach to producing Covid specific guidance (December 2020) 	<ul style="list-style-type: none"> Response to a range of public Inquiries and Reviews underway including Paterson (now reported), Infected Blood Inquiry, Hyponatraemia, and Historical Public Abuse Continue to engage with the Professional Standards Authority regularly, to assure them of how we use our emergency powers in response to the Covid-19 pandemic arising from section 18A of the Medical Act 1983 	Medium
200	Operational Threat	Regulatory Reform	Strategic / Policy	There is a risk that we do not secure and deliver the full range of benefits that the reforms present	Shaun Gallagher	HIGHLY LIKELY	MAJOR	CRITICAL	<ul style="list-style-type: none"> Governance and controls in place for the programme, including: agreed objectives, defined scope, benefits identified, appropriate risk management and robust plans for delivery Stakeholder influencing plan developed to ensure we secure external support for changes Ongoing engagement with DHSC to maintain good working relationships, enabling us to collaborate effectively and influence their work and manage potential implementation risks associated with drafting of the legislation Cross-directorate working built into programme approach, to ensure that policy is developed in conjunction with operational teams, encouraging a 'one GMC' approach and making sure that opportunities are maximised, and changes can be operationalised as soon as policy agreed 	QUITE LIKELY	MODERATE	SIGNIFICANT	<ul style="list-style-type: none"> Executive Board Risk deep dive (28 March) 	<p>Most recent spot check took place in Nov 2021. Previous spot checks completed in June 2021 and March 2021</p>	<ul style="list-style-type: none"> Combined programme plan developed (in conjunction with DHSC) setting out critical path and clear caveats and assumptions that underpin our planning (Plan being reviewed at regular stocktake meetings with DHSC - next meeting scheduled for 13 April) Use existing structures/communication channels internally as a way of reinforcing messaging and maintain momentum and morale Continue to use internal audit assurance to provide ongoing scrutiny and give assurance that the programme is being run appropriately Be prepared to escalate concerns to senior DHSC stakeholders as appropriate 	Medium
234	Operational Threat	ED&I Strategic Ambition	Strategic / Policy	The actions we take to influence change across the health and education system, and within the GMC, do not deliver progress at a pace to meet our strategic ED&I targets, sustaining known areas of inequality	Shaun Gallagher	HIGHLY LIKELY	MODERATE	CRITICAL	<ul style="list-style-type: none"> Clear timebound targets to focus system-wide efforts Nominated Executive leads for each of our strategic commitments Skilled and resourced teams designing interventions to deliver against the targets Established plans of action to deliver against the targets both internally and externally Annual and bi-annual progress reporting Scrutiny and monitoring and reporting from the ED&I Steering Group, Executive and Council to allow refinement of plans in response to progress Established Outreach and engagement functions to understand and influence the system with broader calls for action and support to facilitate system-wide change Supporting and aligned commitments of others (i.e. reducing differentials in disciplinary processes) Research and data assets including our surveys and insights to highlight relevant issues and support calls for action 	QUITE LIKELY	MODERATE	SIGNIFICANT	<ul style="list-style-type: none"> Council Regular agenda item on ED&I Executive Board Twice yearly review by Executive Board and performance against internal targets embedded in Performance and Risk Reporting Risk 'deep dive' (July 2021) 	<ul style="list-style-type: none"> Strategy and policy ED&I compliance and governance review - Campbell Tickell (2020) 		Medium
310	Operational Threat	CSR position	Reputational	Lack of awareness and understanding of our environmental work / position and progress made to date (incl. our net zero ambitions) may mean that the organisation is perceived as not taking appropriate accountability for social responsibility, which could lead to reputational damage to the organisation.	Paul Sargeson	HIGHLY LIKELY	MAJOR	CRITICAL	<ul style="list-style-type: none"> Regular briefing to Council, Executive Board & ARC so that awareness is maintained at the highest levels External website presence Intranet presence CSR comms plan covering internal and targeted external comms Cross regulatory CSR group (2022) 	UNLIKELY	MINOR	LOW				Medium
309	Operational Threat	Safeguarding at the GMC	Reputational	If there isn't sufficient corporate understanding and visibility of our safeguarding activities, we may not meet our safeguarding obligations as a regulator and as an employer.	Neil Roberts	QUITE LIKELY	MODERATE	SIGNIFICANT	<ul style="list-style-type: none"> Safeguarding Working Group in place since 2019 and Neil Roberts chairs. Advisory Review conducted by BDO using a specialist social worker to review our practices and recommend Action plan Action plan in place – Project team assembled to take forward recommendations SCIE appointed as specialised consultants Presentation given to SMT and Council (Feb 2022) on direction of project 	QUITE LIKELY	MODERATE	SIGNIFICANT			<ul style="list-style-type: none"> Developing our policy and process to ensure we have corporate approach and consistency in decision making Development of training package – level one for all staff to be delivered by e-learning and level two for specialist colleagues Reporting arrangements to be finalised for both workstreams Recruitment to commence for Designated Safeguarding Manager 	Low

27	Operational Opportunity	Deriving more insight from our data capability	Strategic / Policy	Developing, sharing and working with others using our insight capability provides an opportunity to shape public debate, influence the external environment and deliver more proactive regulation	Shaun Gallagher	QUITE LIKELY	MAJOR	GOLD	<ul style="list-style-type: none"> We use our research and insights to highlight key issues facing the medical profession, suggesting courses of action which healthcare systems can take to improve workforce and workplace issues We leverage our communications channels (such as media and social media) and engagement opportunities to raise awareness of our research and insights and secure external support for the issues and recommendations we are highlighting We use our influence to bring regulatory partners and key stakeholders together to drive positive changes in practice and training environments Continue to use data to contribute to mailouts, briefings and external engagement Provide data support to the rest of the GMC in managing our response to the Covid-19 pandemic Exploring innovative ways of collaborating on data and insight with regulatory partners 	HIGHLY LIKELY	MAJOR	GOLD	<ul style="list-style-type: none"> Paper: Review of UK Advisory Forum meetings (December 2019) Executive Board Risk 'deep dive' (March 2021) 	<p>Internal audit</p> <ul style="list-style-type: none"> Arrangements for assessing progress in the delivery of the Corporate Strategy (July 2021, green-amber) <p>Other assurance</p> <ul style="list-style-type: none"> Corporate strategy and stakeholder perceptions baseline survey (published March 2019) Tracking survey, undertaken every two years, currently underway and due to report findings in Q4 2022 	High	
28	Operational Opportunity	Working with patients and public	Operational	Understanding and improving the experiences which patients and the public have of our regulatory services and involving them effectively in our work (such as strategy and policy development) will help us gain their trust and confidence as an effective and transparent regulator	Paul Reynolds	QUITE LIKELY	MODERATE	SILVER	<ul style="list-style-type: none"> Champion for patients established at SMT level to ensure senior-level overview of our engagement Strategic approach to patient and public involvement agreed by Executive Board (in November 2020) Programme governance to direct and oversee work in place Clear information easily accessible for patients and public about how we work and can support them (such as on our website) Regular assessment of patients and the public's perceptions of our work through research (such as our bi-annual perceptions survey) Regular engagement with patient leaders in all four countries of the UK (such as through our roundtable and UKAF meetings) Accessing stakeholder networks to learn how other organisations engage meaningfully and well with patients and public Insights and perspectives from patients regularly shared with the organisation to inform their work (e.g. Brown Bag Lunches and insight reports) 	QUITE LIKELY	MODERATE	SILVER	<p>Council</p> <ul style="list-style-type: none"> Discussions at Council Away days (July 2019) about patient and public engagement in our work and preparation Strategic approach to communications and engagement update (June 2019) <p>Corporate Strategy 2021-2025</p> <ul style="list-style-type: none"> Session on patient and public involvement at Council Away Day (September 2021) Paper: annual update on communications and engagement (July 2020) <p>Executive Board:</p> <ul style="list-style-type: none"> Risk deep dive (February 2021) Paper: Strategic approach to patient and public involvement (November 2020) 	<ul style="list-style-type: none"> Annual perceptions survey showing the public's confidence in how doctors are regulated and feedback on working relationships with patient and public bodies Insights and perspectives from patients shared in weekly external update 	<ul style="list-style-type: none"> Work being re-scoped following rejection of programme plans by Planning Gateway/SMT Planning next meeting of patient roundtable on 18 May 2022 Standards team in process of appointing research provider to support patient engagement for review of Good medical practices. Provider expected to be appointed late Jan/early Feb. Outreach 'signposting' pilot underway with NHS Isle of Wight and Healthwatch Isle of Wight Session on shared decision making at GMC conference, in partnership with The Patients Association, planned for April 2022 Working with NHS England to hold internal workshop on PPI for policy, engagement and operational leads (expected March/April 2022) 	Medium

Action	To approve
Purpose	<p>This report provides a summary of the main HR monitoring data for 2021 including more detailed information on diversity and pay.</p> <p>The report includes the 2021 gender pay figures and an update on the work being undertaken in this area and the latest position ahead of 2021 report being finalised.</p>
Decision trail	Our HR data was considered by the People Board ahead of Council receiving this report. The monitoring data relating to our EDI targets was reported to Council in February and an update for the first quarter of 2022 is included.
Recommendation	The Board is asked to note the 2021 Human Resources and Gender Pay Reports and the update on our EDI targets
Annexes	<p>Annex A: Our recruitment, turnover, and absence monitoring data</p> <p>Annex B: Employment EDI targets</p> <p>Annex C: Our profile as an employer in terms of diversity</p> <p>Annex D: Pay data by protected characteristic</p>
Author contacts	<p>Andrew Bratt, Assistant Director - People</p> <p>Any enquiries to: GovernanceTeamMailbox@gmc-uk.org</p>
Sponsoring director/ Senior Responsible Owner	Neil Roberts , Director of Resources

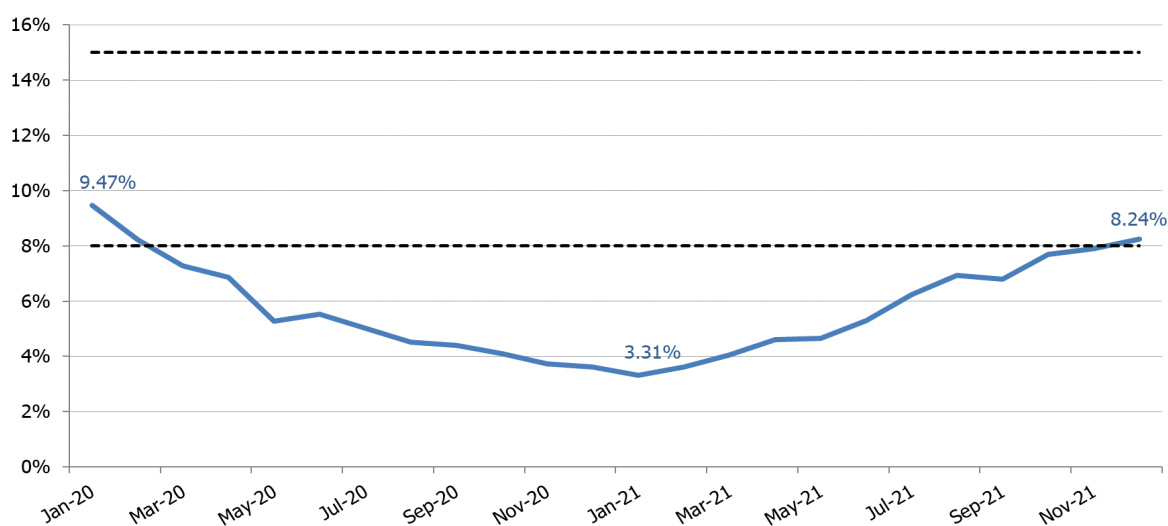
Human Resources Report 2021

- 1 Our People 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 The report covers:
 - a Our recruitment, turnover, and absence monitoring data (Annex A)
 - b Our Employment EDI targets (Annex B)
 - c Our profile as an employer in terms of diversity (Annex C)
 - d Pay data by protected characteristic (Annex D)

HR Data Monitoring

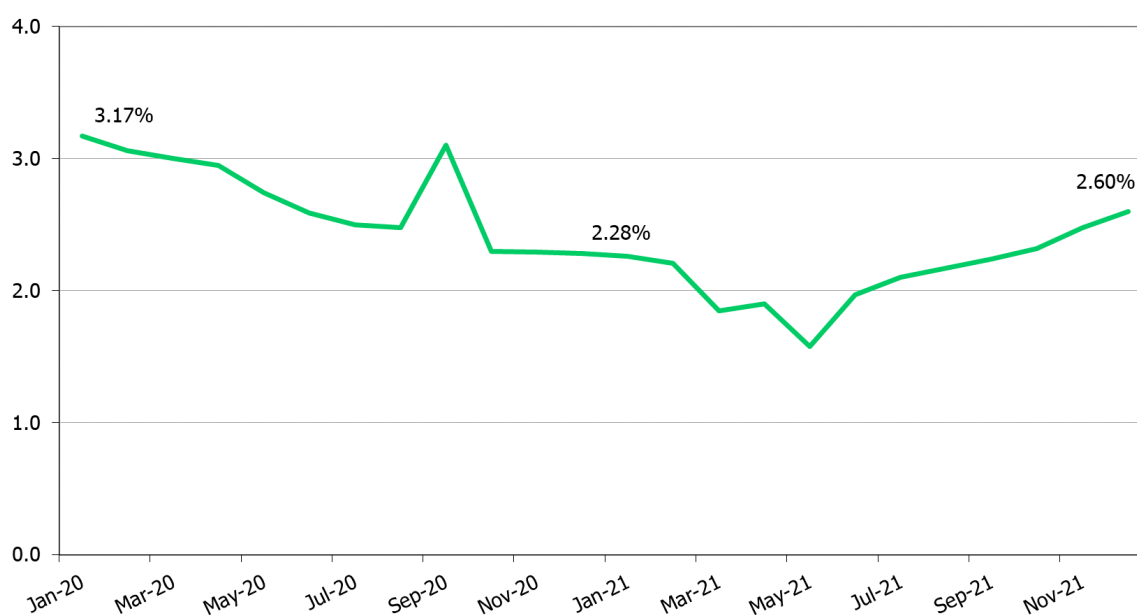
- 3 Our work in 2021 continued to be affected by our response to the pandemic but marked with a shift towards our approach and processes becoming more established. Our 2021 data, along with the staff and regular pulse surveys that tracked our pandemic related support, continues to suggest a good employee relations environment. Colleague feedback has remained positive, but within this overall picture we know the experience of the workplace and our employment practices is less positive for some groups. This year we have included a wider range of data in our report to provide Council a fuller picture on diversity and related trends within our workforce profile, and this includes some initial cross-sectional insights.
- 4 Our pre-pandemic reports reflected some very established trends, but we have seen some changes over the last two years with marked changes in 2020 and a quicker than expected return to 'normal' in 2021.

Turnover



- 5 Voluntary staff turnover has fallen significantly. Our longer-term trend has been at the bottom end of the band we expect turnover to be in (8 to 15%) and in 2020 it fell significantly from 8.8% to 3.6% as job security and a significant reduction in labour market activity had an impact. In 2021 we saw turnover at 8.2%, but despite a very sharp increase in our turnover rate the 2021 figure did not exceed our long-term norm.
- 6 Concerns that turnover would continue to rise have not materialised but the position on recruitment and retention is less strong, and we continue to operate in a very competitive and volatile market for a wider range of roles.
- 7 As well as long-standing 'hot spots' we have seen recruitment and retention pressures in policy, project management, HR and Engagement roles. We have seen pressure on starting salaries and had more unsuccessful campaigns than usual.
- 8 The level of internal staff movement is around four times that of our turnover rate. Promotions in 2021 totalled 45 (60 in 2020) while internal transfers increased from 159 to 202 bringing us to the same rate, we saw in 2019.
- 9 Within all staffing movements we had 13 probation periods extended, and none were failed. This is a slight increase on 2020 when 9 were extended. No 2021 probations were failed. This pattern is not a surprise given the context for induction and support for new joiners.

Absence



- 10 We have historically enjoyed low sickness absence levels but in 2019 we saw a slight increase to 3.15%. This equated to 7.9 days per year and was above the CIPD 2019 average of 5.9 days but below the public sector average.
- 11 In 2020 the rate fell to 2.28% (5.9 days/year) and we have seen a slight increase to 2.60% (6.9 days/year) for 2021, with an increase in Q4. Covid played a role here and was more of a factor in 2021 than 2020 (it accounted for 14.0% of absences during 2021, and 8.0% in 2020).
- 12 Benchmarking data is not yet available for 2021 but we expect to see an increase in comparators and believe we are likely to compare favourably with other organisations. In 2022 our absence rate in January and February was 2.64% with just over a quarter of this caused by covid.
- 13 The underlying causes of absence (other than covid) are broadly unchanged.
- 14 Mental health related issues, specifically anxiety, are the main reason for employee absence. In 2020 it accounted for 28.9% of absences. 62.4% of these absences are ones we would classify as long term (20+ days). For 2021 it accounted for 34.3% of absences 14.4% of these were long term. This is an increase but given the impact of the pandemic we have not seen a significant increase in mental health related absence.
- 15 Mental health is an area where we have an extensive programme of work to support staff and line managers. We have a well-received wellbeing plan, a network of mental health first aiders and supported a programme of pandemic specific support on wellbeing. We have a mental health champions network and an employee lead mental health interest group.
- 16 Our feedback on this area and the support of line managers via our pulse surveys has been very positive which suggests our actions have supported employees and contributed in this area.

Diversity, Equality, and Inclusion

- 17 Council have agreed a series of employment related EDI targets and we updated Council in February. This report sets out in more detail our current position on our staffing profile, recruitment and pay. We have also included some initial analysis on age and sex in relation to our EDI targets to help inform our work. Progress against our targets up the end of March 2022 is set out in Annex B.

- 18 As previously reported to Council we have made good progress against our workforce targets.
- 19 We monitor and analyse our data for equality and diversity data for our major processes and monitor the composition of our workforce. An overview of this is set out at Annex C. We have reported pay data on sex and ethnicity for several years, ahead of the legal requirement on the former. This year we have expanded this reporting and will publish this internally alongside our reporting to Council.
- 20 This data along with our staff survey analysis highlights several areas where we are making progress, and others where we are looking to make significant improvements.
- 21 On recruitment there are two main trends. The first has been a consistent level of attraction for ethnic minority candidates. In 2018 and 2019 ethnic minority candidates made up 30% of applicants and 20% of our appointments.
- 22 2020 saw a continued slight improvement in appointments, but in 2021 we saw a step change with 30% of appointees being from an ethnic minority background. This has supported a small, but steady increase in the diversity of our workforce (slightly ahead of our target) and in management roles (slightly behind).
- 23 It is difficult to predict recruitment patterns in the longer term, but we do have further measures to help sustain progress such as graduate programmes. We have explored and piloted some different approaches to selection, but the basics of our system have not changed significantly.
- 24 We have also seen a much closer alignment on turnover, an important indicator of workplace experience (although we see variances between the experience of different ethnic groups in areas such as engagement levels).

Ethnicity and Gender

- 25 Given the changing pattern of recruitment in 2021 we have looked at this alongside the gender balance within our process. For female applicants, we have historically seen women becoming increasingly well represented as our recruitment process moves forward. In 2019 around 1 in 10 female applicants and around 1 in 20 male applicants were offered a role. So female applicants (the majority) were twice as likely to be appointed. In 2021 these differentials were still apparent, but had reduced:

	Applications		1st Interview		2nd Interview		Offer	
	Count	Percentage	Count	Percentage	Count	Percentage	Count	Percentage
Female	2,265	59.8%	716	64.0%	18	43.9%	227	66.6%
Male	1,525	40.2%	402	36.0%	23	56.1%	114	33.4%

- 26 The positive impact of this is that at Level 3 62.1% of our workforce are women line with the GMC’s gender profile. We also continue to see a steady increase in representation of women in senior management roles with a further increase in women at Level 2 to a similar level (61.4%). This does mean that female managers have typically shorter periods of service in management roles than their male peers, which in part explains some pay differences.
- 27 Despite these improvements, our workforce gender balance (at AD/Director level for women and lower graded roles for men) doesn’t reflect our overall workforce and this remains the main driver of our gender pay gap, as is the under representation of men at lower levels.
- 28 When we look at this pattern for ethnic minority candidates there is a slightly better gender balance for applicants, but it is very close to our overall pattern:

applicants	Female	Male
Ethnic minority	60.2%	39.8%
Non-Ethnic minority	63.4%	36.6%

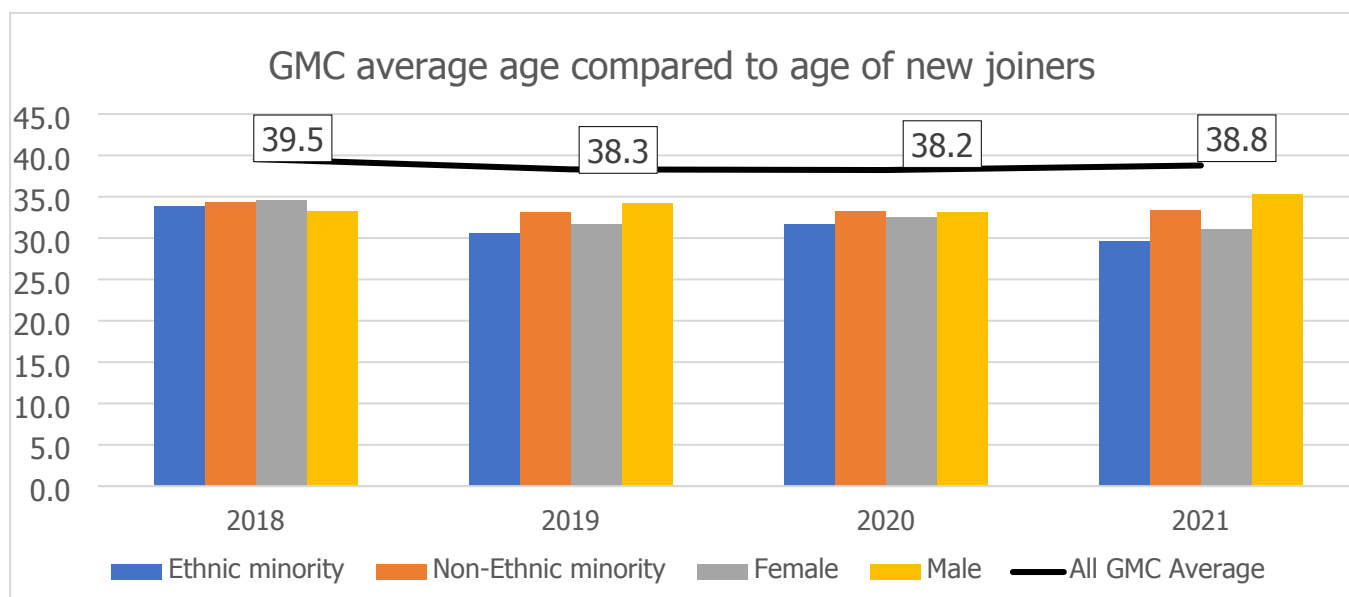
- 29 While ethnic minority candidates do not progress proportionately to applications (a long-term trend) this is much more marked for male ethnic minority candidates; an area to prioritise as part of our outreach work and monitoring:

Ethnic Minority female	Applications	40.6%
	Appointments	29.9%
Ethnic Minority Male	Applications	43.9%
	Appointments	21.6%

Ethnicity and Age

- 30 As well as gender we have looked in more detail at age. This is a factor that will shape our offer to candidates and career support, its particularly important in relation to the overall structure of our EDI programme on training.

- 31** We know that the ethnic minority population is, on average, younger. This brings opportunities for some targeted programmes (e.g., apprenticeships) and some challenges (where age/experience may be a barrier for senior roles). In simple terms we know that these programmes will be attractive to more diverse age cohorts.
- 32** The age profile of the organisation remains stable, and recent lower turnover has reversed a very gradual reduction in average age in recent years. Ethnic minority candidates are, on average, younger and this was a little more pronounced in 2021.
- 33** This younger minority ethnic joiner profile by age applied at almost all levels in the organisation in 2021:



	Ethnic minority	Volume	Non-Ethnic minority	Volume	Age diff.
LEVEL 3	36.5	4.0	42.1	12.0	5.6
LEVEL 3A	39.0	3.0	43.3	3.0	4.3
LEVEL 4	30.3	10.0	33.6	31.0	3.3
LEVEL 4A	29.8	6.0	29.6	7.0	-0.3
LEVEL 5	27.1	15.0	32.2	47.0	5.0
LEVEL 6	27.0	7.0	29.1	22.0	2.1

34 This workforce profile is also influenced by promotion patterns. This is especially significant as ethnic minority colleagues are typically younger than the GMC average and make up a higher percentage of our staff at levels 6 to 4, where there is greater scope to advance through internal promotion. Our experience in 2021 reflects this – with 17.7% of ethnic minority colleagues promoted or transferred compared with 14.3% of other colleagues

35 Age is especially significant as we know from our staff survey work that engagement and inclusion scores are typically lower on average for ethnic minority colleagues, but this is primarily driven by younger employees and differentials close with age. At a GMC level ethnic minority colleagues’ average score do not vary significantly by gender:

	Engagement index	Inclusion index
Ethnic minority men	69.49	66%
Ethnic minority women	71.59	63%
Non-Ethnic minority men	76.83	82%
Non-Ethnic minority women	78.90	78%

36 However, these clear differences are more prominent for younger employees (we do not have sufficient numbers to look at under 25s or over 55s). Here we see engagement levels start to align with age (almost the same for 45 years+) while inclusion levels are close for this age group, they do not follow the same pattern.

	Ethnic minority engagement	Non ethnic minority engagement	Ethnic minority Inclusion	Non-Ethnic minority Inclusion
age 16-24		77.96		80%
age 25-34	66.45	76.47	60%	79%
age 34-44	74.00	77.64	62%	80%
age 45-54	78.57	78.98	77%	78%
age 55+		83.15		80%

37 This overview reinforces the:

- Potential of apprenticeships and graduate programmes to supply our workforce profile ambitions.

- Importance of continuing to invest in early career stage development to support our workforce targets.
- Need to focus on engagement and inclusion for younger employees

Age Profile

38 Our age profile generally has seen little change, but it is clear from our recruitment trends that we see candidates in the 25-34 age group perform best with 32.3% of applicants providing 43.7% of appointees. This is an important area for recruitment and a crucial area in current labour market conditions. It's important that our overall offer to these candidates remains attractive, but also suggest that there may be opportunities to broaden our appeal to later career applicants.

Disability

39 Our monitoring in this area is limited as we have a high percentage of non-disclosure. Our recruitment data does indicate that our processes operate fairly, with 12.9% of candidates being disabled, and this translates to 13.5% of joiners. In terms of workforce profile our analysis is limited we are limited by non-disclosure, but it is noticeable that for our senior management pay band (where we have almost complete data) the percentage of disabled colleagues is very low.

Sexual Orientation

40 As with disability our insights are limited due to our data and very small numbers in some categories (so we cannot publish), but we will expand our reporting on recruitment during this year and work to improve our data to aid monitoring.

Pay and Gender Pay Reporting

41 For 2021 we have also included more detailed monitoring data, including high level pay comparisons covering a wider set of protected characteristics. This is set out at Annex C.

42 This needs to be treated with some caution, in some areas we do not always have complete employee data as some colleagues choose not to disclose. For some protected characteristics small numbers make any comparisons very difficult.

However, at a high level pay and grade information, does give insights into the outcomes of our decisions on recruitment, pay, progression and promotion.

- 43 On pay we see very generally close averages within grades between minority ethnic and other colleagues, but at an organisational level ethnic minority colleagues earn on average £4,800 below the GMC average (£41,400). For black colleagues the difference is more marked (they earn around 75% of the GMC average). However at levels 4 and 5 this is not the case and they earn on average more than other GMC colleagues
- 44 These differentials are mainly driven by representation in management roles for ethnic minority colleagues being below the wider workforce profile. While we have also seen an increase in ethnic minority staff at level 2 our senior staffing is not in line with the make-up of our workforce or the local labour markets we recruit in and addressing this is one of our main targets. Another factor, due to changing recruitment trends, is an increased percentage of ethnic minority joiners who will be new in post, and this will impact on differentials.
- 45 We have 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 2020 and 2021.
- 46 Annex C includes our 2021 equal pay data calculated in line with the Gender Pay Gap Reporting requirements.
- 47 On gender we reported an overall pay gap of 15% for March 2018. For March 2019 the gender pay gap had fallen to 14%. In 2020 it increased to 14.5% and fell again in 2021 figure to 12.4%
- 48 We do not yet know the final 2021 figure and the requirements of pay gap reporting mean a variety of factors in one month (March) will impact on the result. But our initial estimates indicate a further reduction as of March 2021 and the April 2021 pay award will have a further positive impact of at least 0.5%. This is however highly sensitive
- 49 The main cause of our gender pay gap is structural. Our senior management cohort doesn't reflect the make-up of our workforce on gender and our higher paid specialist pay grades (IS and data) have a 65/35 male/female split, the opposite of the GMC overall.

- 50 While we have made progress via recruitment and promotions, we need to do more to address differentials within management pay bands. Differentials are in part driven by our recruitment pattern with an increasing proportion of newer female senior managers. For women in senior manager roles average service at that level is typically shorter (3 years, six months) compared to men (seven years, three months).
- 51 We have structured our annual pay award in a way that has helped narrow differentials at each non-management level working.
- 52 We have modelled the positive impact of this approach through to 2024 but will need further targeted action to see average pay by gender be within a 2% band by this date for management roles and will need to continue our current approach on pay awards to consolidate areas where the position is good.
- 53 To address this, we are continuing to review senior manager salaries to help identify and address anomalies. To give an example, at level 2 in Manchester our pay gap is 7.8%. The pay award will reduce this to 6.7%. If current trends continue it could be around 4.5% by 2024. It would be helped further by more male appointments (assuming starting salary patterns remained the same) and retirements. Accelerating this progress could be handled in different ways but increasing pay at the bottom of the L2 pay scale by a total of around £125,000 produces at 0.5% improvement.
- 54 In this year's report we have included high level pay data on disability and sexual orientation. Disabled colleagues lag on pay in almost every pay band, while a very simple breakdown on sexual orientation shows a mixed picture. We hope to be able to provide a more detailed breakdown as our data improves during 2022.

Our recruitment, turnover, and absence monitoring data

Recruitment and retention

- 1** Recruitment activity continues to be heavily impacted by the global pandemic throughout 2021 with 253 (136-2020) offers being made throughout the year.
- 2** The diversity monitoring aspects of the recruitment process are set out in Annex B.
- 3** We use a range of media for advertising, including social networks and specialist websites and use open evenings to market opportunities for some roles. Our own website plays an increasingly important role and candidates can register for vacancy updates.
- 4** Our recruitment process is based around a competency based application form, anonymised shortlisting, and then a range of assessment options tailored to suit individual job groups. These include competency based interviews, group exercises and ability testing. For senior roles we retain the services of agencies although appointments up to and including Assistant Director level are typically managed in-house.
- 5** Our recruitment processes are all on-line and helping us to run a process that averages four weeks from when an advert goes live, through the selection process to the offer stage.
- 6** All staff go through a probationary review process at three and six month stages before being confirmed in role. The number of staff who have this period extended or their employment terminated remains very low.

Recruitment

- 7** A more detailed analysis of our recruitment outcomes in terms of diversity is set out in Annex B.

Internal Recruitment

	2019	2020	2021
Promotions	83	60	45
Transfers / Temporary Transfers*	203	159	202
Total	286	219	247

Notes:

The numbers reported above for Temporary Transfers, Promotions, and Transfers are based on when the staff member started the post (not when they were appointed).

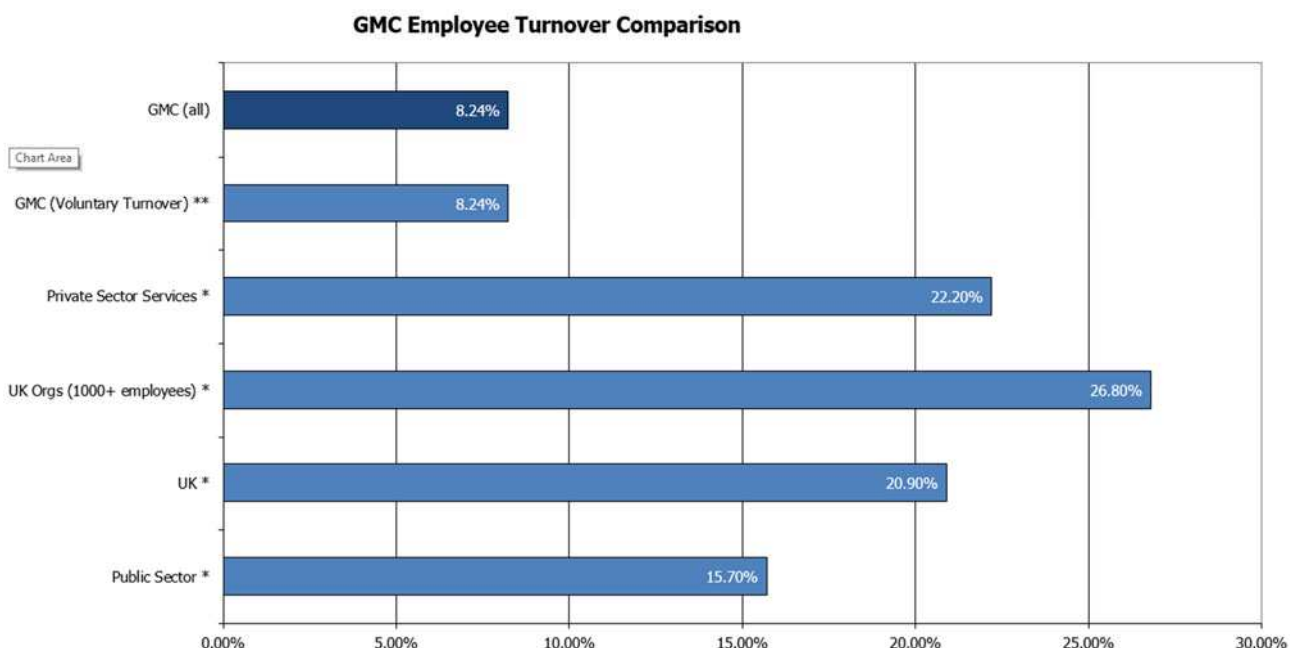
Temporary Transfers includes temporary transfers at the same grade, secondments and temporary promotions.

8 Probation analysis

- In 2021 we have had 13 probation periods extended up from nine in 2020. 9.2% of all probations completed in 2021.
- There were no colleagues dismissed due to not passing their probation during 2021. Two colleagues did not pass their probation in 2020.

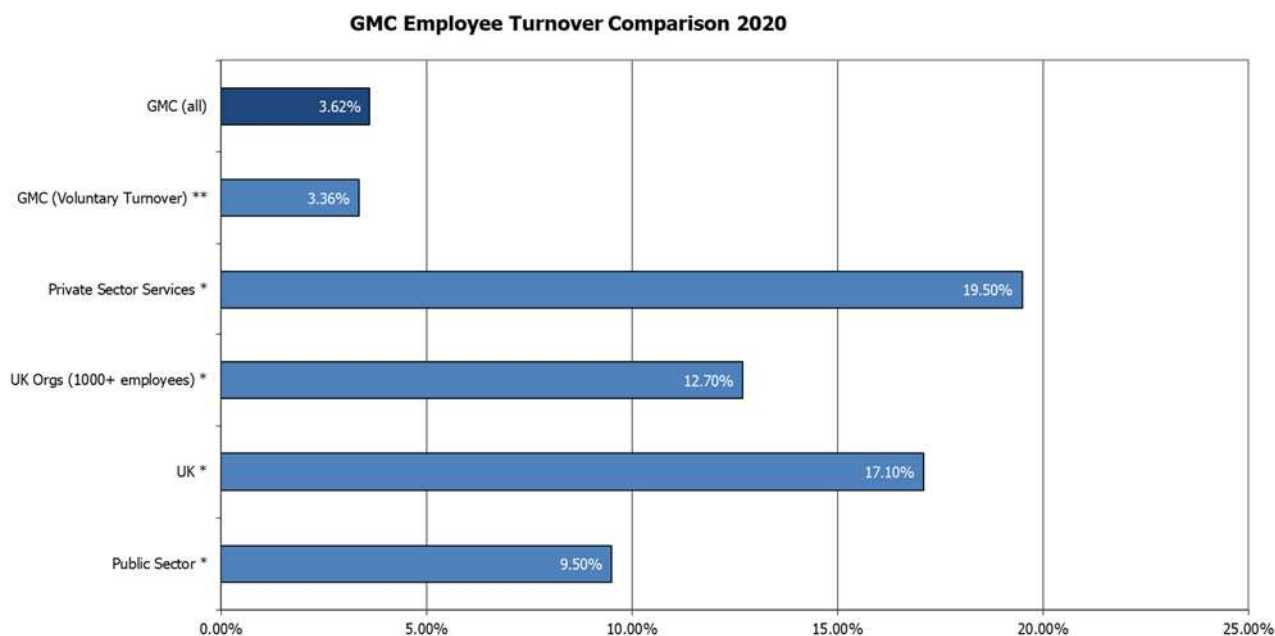
Turnover

- 9** After seeing very few leavers during 2020, we saw the amount of leavers in 2021 return to pre covid levels.



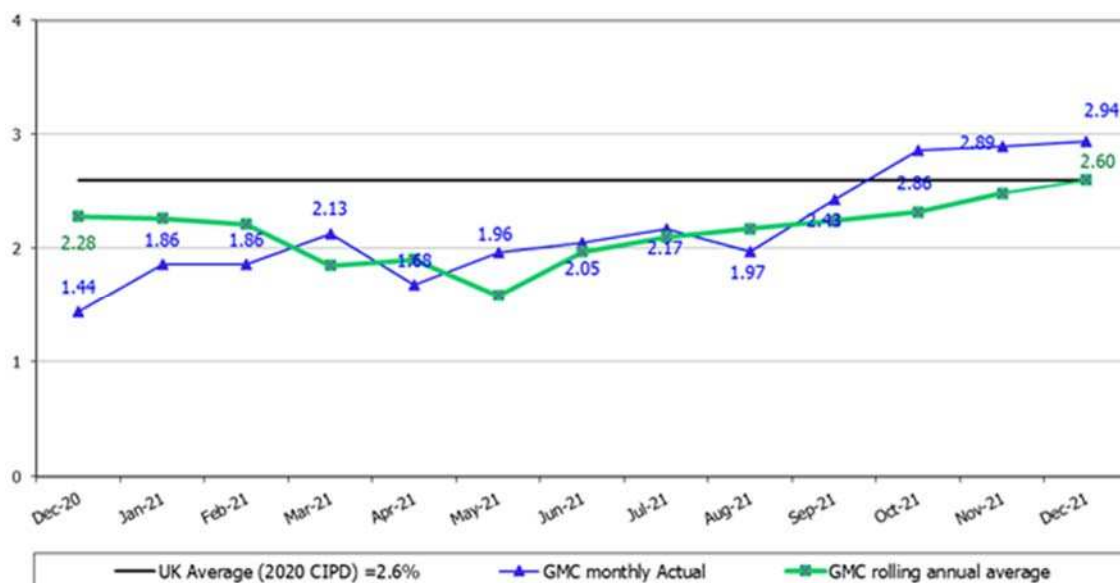
*Labour turnover rates: 2021 XpertHR Survey

**Voluntary turnover includes resignation, voluntary redundancy and normal retirement. Total turnover includes voluntary plus compulsory redundancy, fixed term contracts and dismissal.

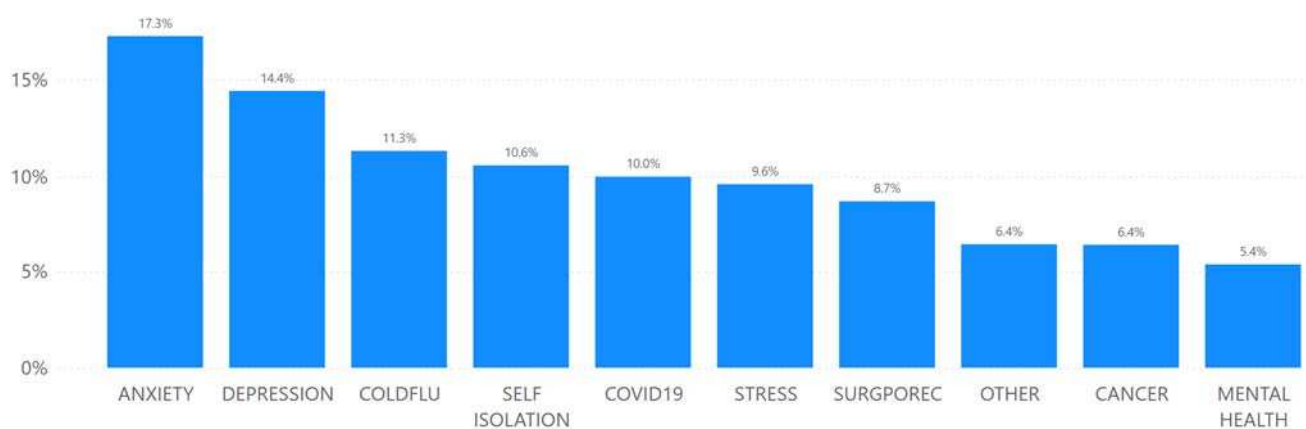


Employee Absence

10 Absence levels increased throughout the year with the peak being towards the end of 2021. December 2021 saw the most days lost to Covid related reasons since the start of the pandemic.



11 Top 10 reasons for sickness absence



Percentage split is only between the top 10 reasons

Covid related absences made up 14.0% of the overall total during 2021 (8.0% in 2020).

12 Figures Sickness absence - average days lost per employee

	2018	2019	2020	2021
GMC average days lost	7.4	7.9	5.9	6.9
CIPD Average days lost (All)	6.1	5.9	5.8	N/A
CIPD Average days lost (Public Sector)	8.5	8.4	8.0	N/A

taken from the CIPD absence management surveys. 2021 data is not available

13 Approximately 49.0% (45.1% in 2020) of all absence would be classified as long term i.e. the absence totals 20 days or more.

Council meeting - 28 April 2022

Agenda item M4

**Human Resources report 2021 and
gender pay gap reporting**

Employment EDI targets

**General
Medical
Council**
Annex B



RECRUITMENT – DIVERSITY TARGETS

		Actual				Target		
		2021 (%)	2021 (Vol)	2022 ¹ (%)	2022 ¹ (Vol)	2023	% points off 2023 target	2026
Underlying measures and targets								
Increase the level of ethnic minority representation at Level 3 and above	Applications	22.8%	170	32.6%	287	27%	+5.6%	30%
	Interviews	15.2%	118	23.5%	63	22%	+1.5%	25%
	Offers	14.6%	36	30.8%	16	17%	+13.8%	20%
	Workforce	11.1%	64	13.7%	84	16%	-2.3%	20%
level of ethnic minority representation at Level 2+		8%	18	11.7%	25	14%	-2.3%	20%
level of ethnic minority representation at level 3		12%	46	14.8%	59	16%	-1.2%	20%
Increase the level of ethnic minority representation at all levels	Applications	29.4%	663	42.4%	1,560	37%	+5.4%	40%
	Interviews	18.2%	118	27.0%	279	32%	+5.0%	35%
	Offers	18.2%	36	30.9%	104	27%	+3.9%	30%
	Workforce	14.3%	211	16.5%	256	17%	-0.5%	20%
Reduce differential turnover rates for ethnic minority staff compared to the average to improve retention and for rates to be within 1-2% of each other by end of 2023**		0.8%	-	ethnic minority (%) 9.5%	Non-ethnic minority (%) 8.4%	1-2%	1.1%	1.0%
Proportion of ethnic minority staff receiving promotion and grade progression is proportionate to our workforce at the relevant grade/level		-1%	-	ethnic minority (%) 15.3%	Non-ethnic minority (%) 13.6%	18%	2.7%	18%
<small>*difference is not set against the 2023 figure, the target is that the proportion of staff will be equal across ethnic minority and Non-ethnic minority</small>								
Pay differentials within a confined band limited to 2% from 2023² (table shows the proportion of bands that are outside of the tolerance)		58.3%	7/12			2.0%	N/A	2.0%

¹ Rolling 12 month period used to the end of the reporting month

² Specialist bands are not included

*difference is not set against the 2023 figure, the target is that the proportion of staff will be equal across ethnic minority and Non- ethnic minority

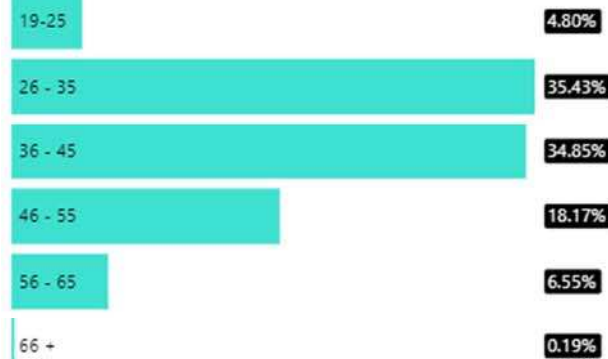
** 2020 is an unrealistic baseline year given the pandemic. Retention rates for ethnic minority staff have historically been outside of this range – in 2019 the difference in retention rates against the average for ethnic minority staff was 3.9%.

Our profile as an employer in terms of diversity

- 1** Our recruitment and promotion practices are central to building and sustaining a diverse and balanced workforce. This annex sets out detailed information on our 2021 recruitment and promotion patterns. As we move closer towards our ED&I targets we are seeing an increase in the diversity of our workforce.
- 2** Our Manchester staffing profile (83.2% non-ethnic minority) is reasonably close to that of our recruitment catchment area. While Manchester's population is 66% non-ethnic minority, the figures for Greater Manchester are 84% and for the North West, 90%. In London we are not as closely aligned with the local labour market. At the end of 2021 25.6% of our London staff were from ethnic minority backgrounds, compared with the London ethnic minority population of around 40%.
- 3** Recruitment plays a significant role in the make-up of our workforce. Within these processes two significant trends have continued. Female applicants increase their representation as our recruitment process proceeds, we continue to see higher levels of women in senior (Assistant Director and above) posts when compared to previous years.

Workforce profile end of 2021

Age



Caring Responsibility



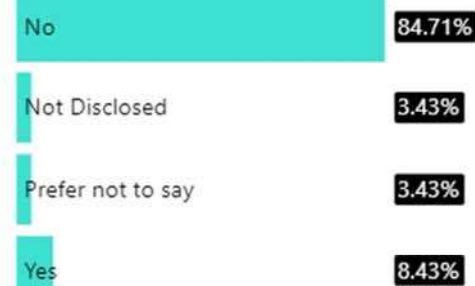
Sexual Orientation



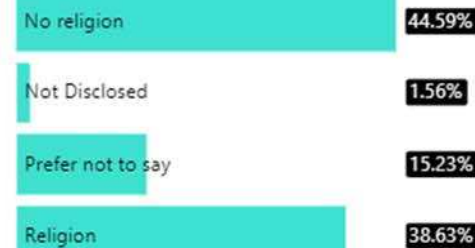
Gender



Disability



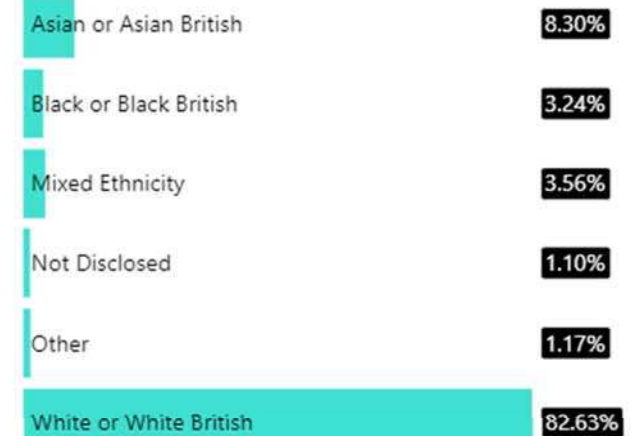
Religion (Grouped)



Ethnic minority / Non-Ethnic minority

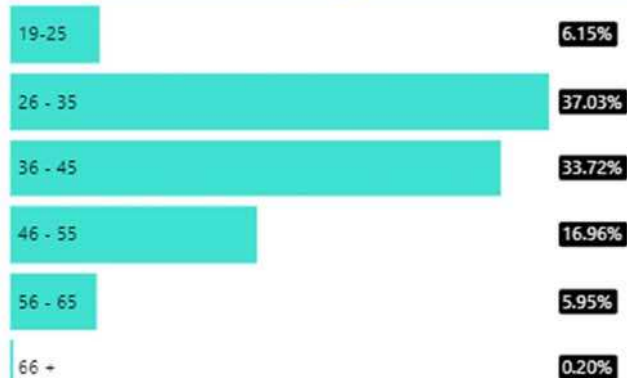


Ethnicity (Grouped)



Workforce profile end of 2020

Age



Caring Responsibility



Sexual Orientation



Gender



Disability



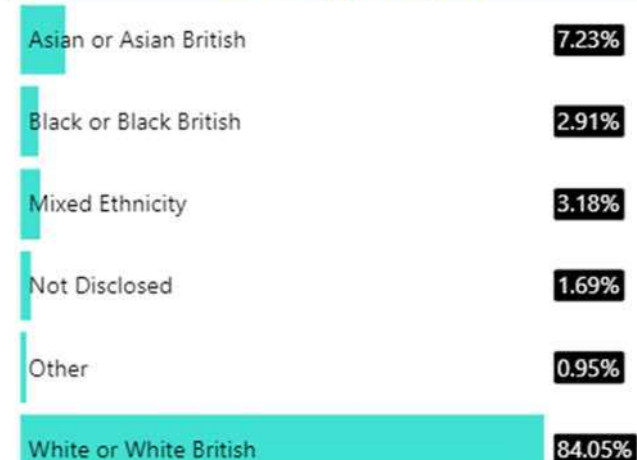
Religion (Grouped)



Ethnic minority / Non-Ethnic minority



Ethnicity (Grouped)

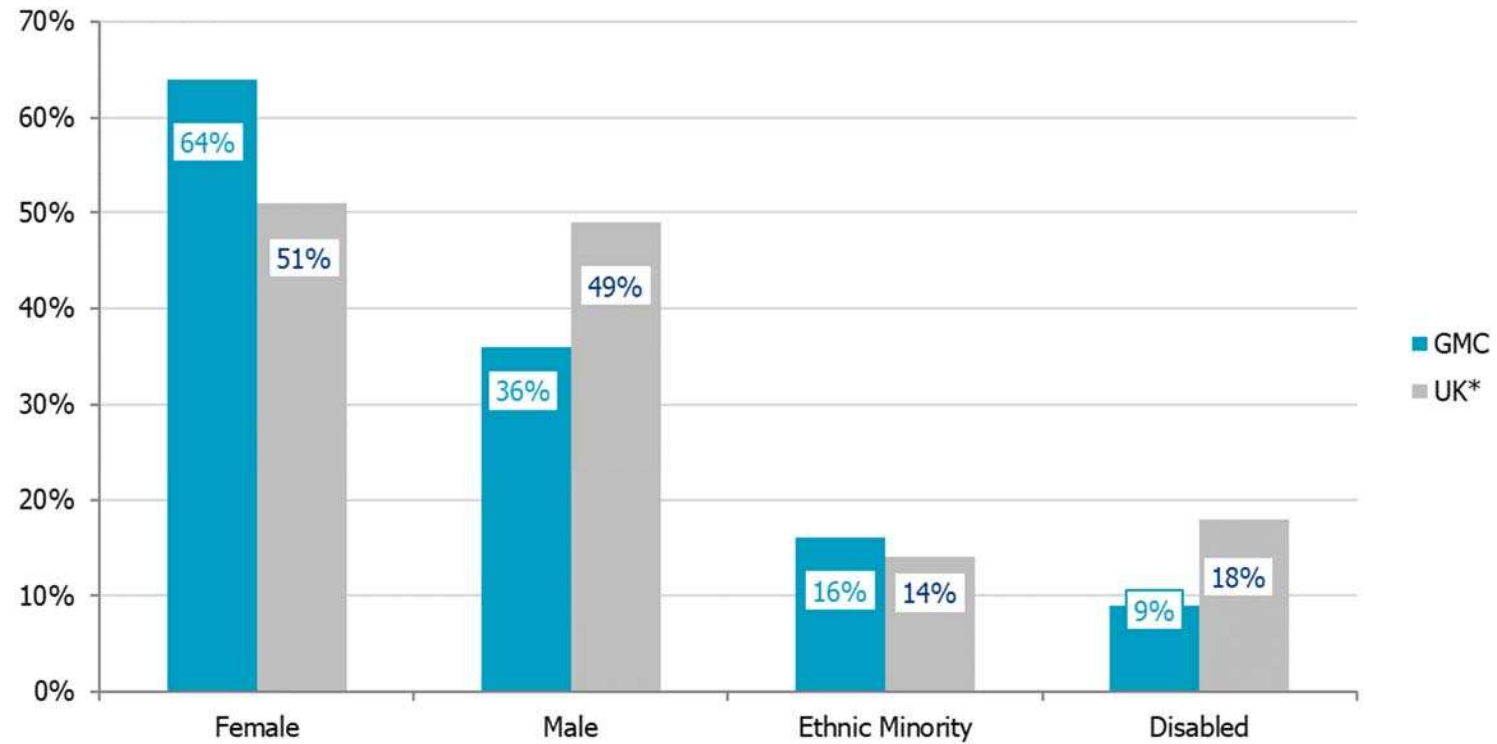


Workforce profile by location and comparison with UK

	GMC London	London Population*	GMC Manchester	Manchester Population*	North West Population*	All GMC
Asian	9.52%	18.49%	8.08%	17.09%	6.20%	8.16%
Black	6.55%	13.32%	2.98%	8.64%	1.39%	3.20%
Mixed	6.55%	4.96%	3.42%	4.60%	1.57%	3.69%
Not responded/Other	4.76%	3.44%	2.30%	3.06%	0.63%	2.48%
White	72.62%	59.79%	83.19%	66.61%	90.21%	82.47%
Sources:						
*2011 Census (ONS)						

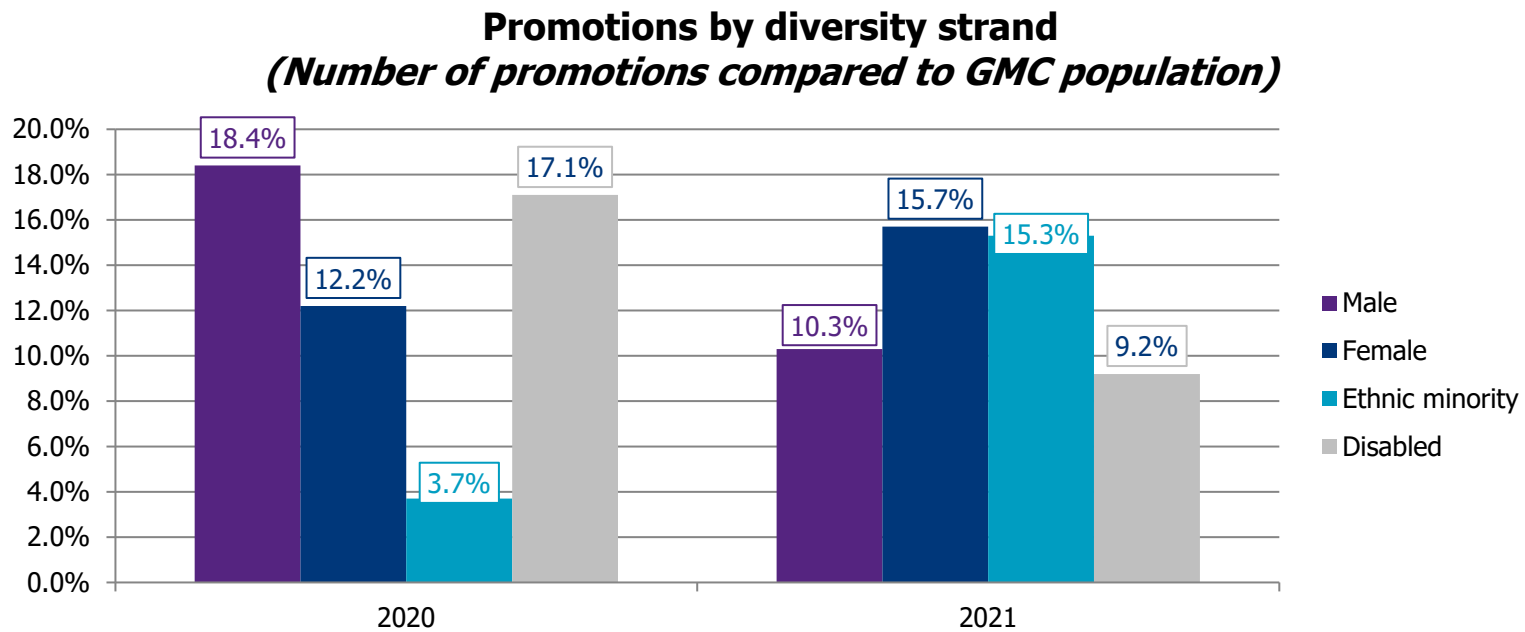
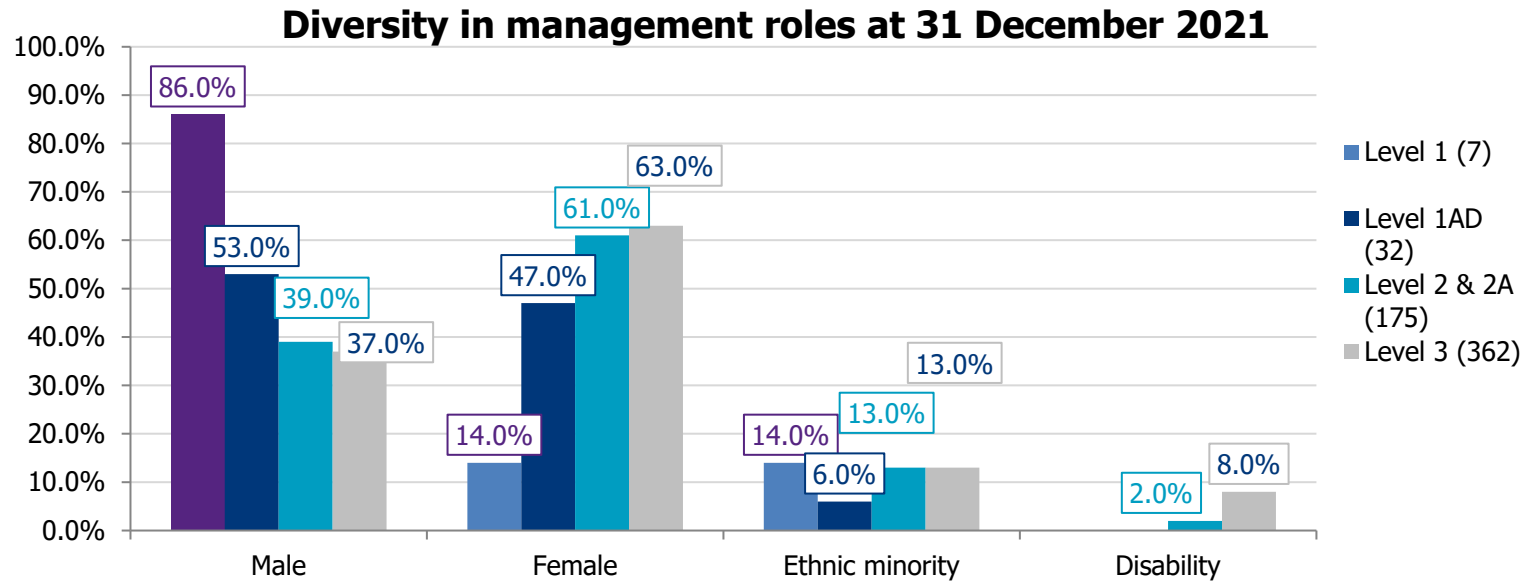
GMC compared to UK population

GMC compared to the UK population

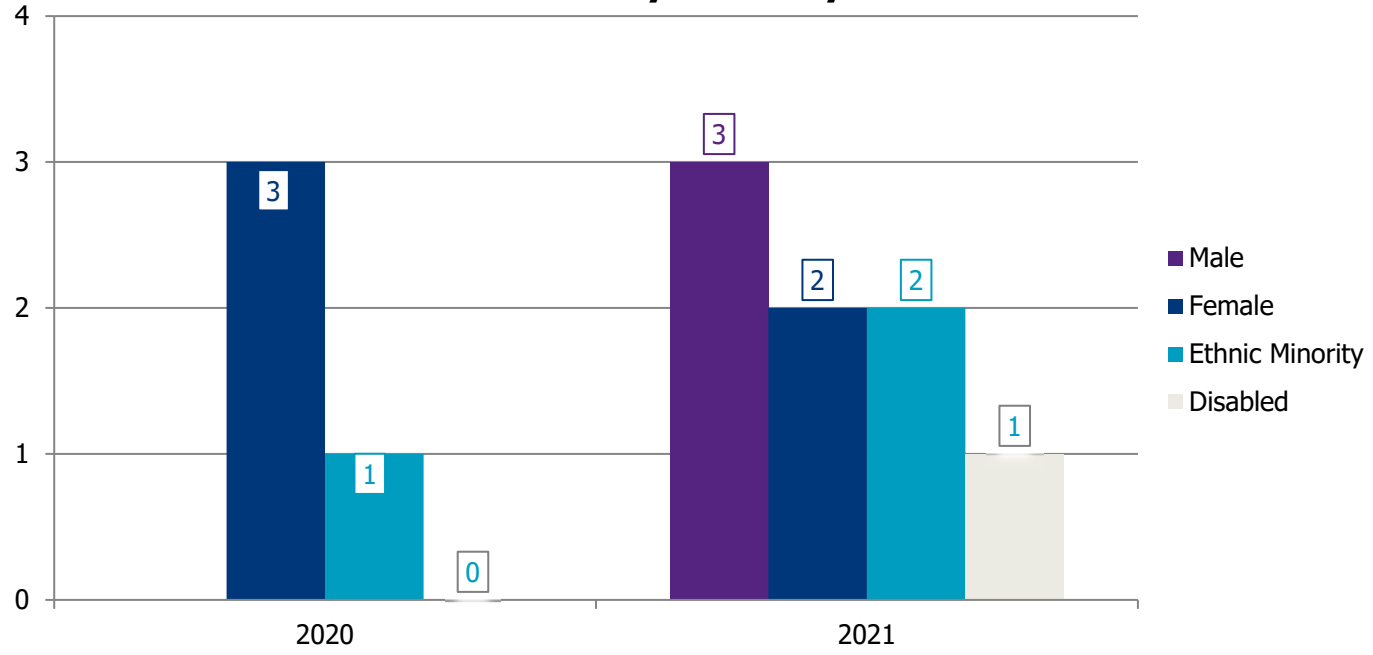


**UK figures from 2011 Census. 2021 Census draft data is only available from late 2022*

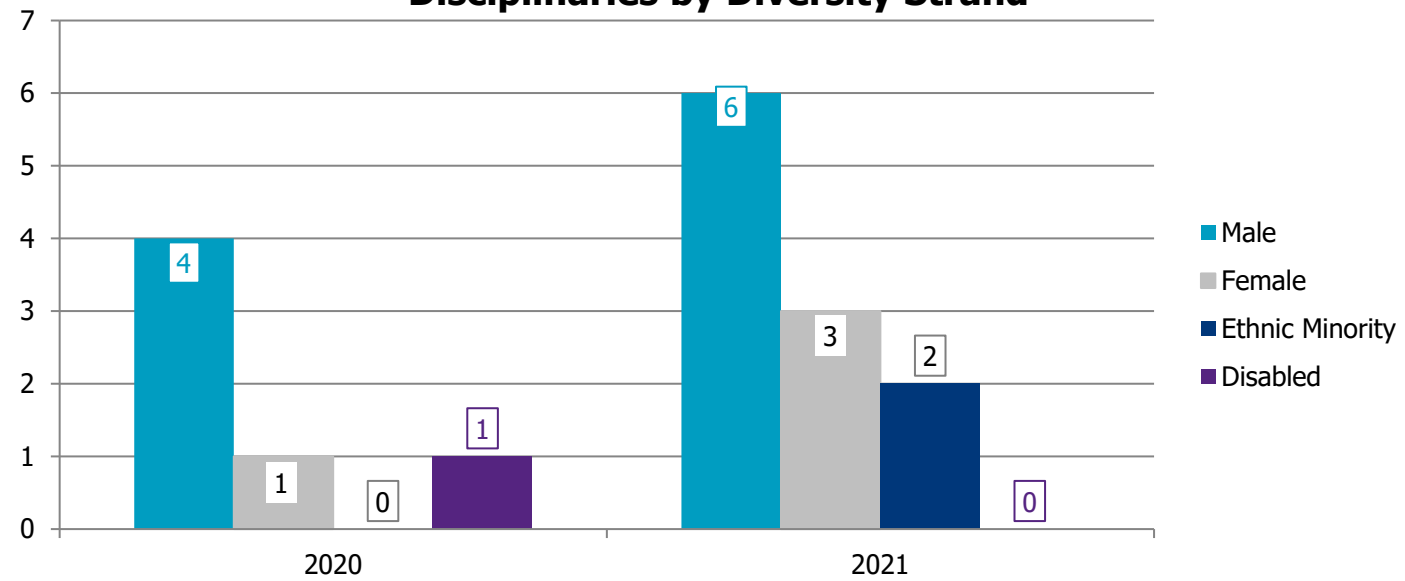
Promotion and Progression



Grievances by Diversity Strand

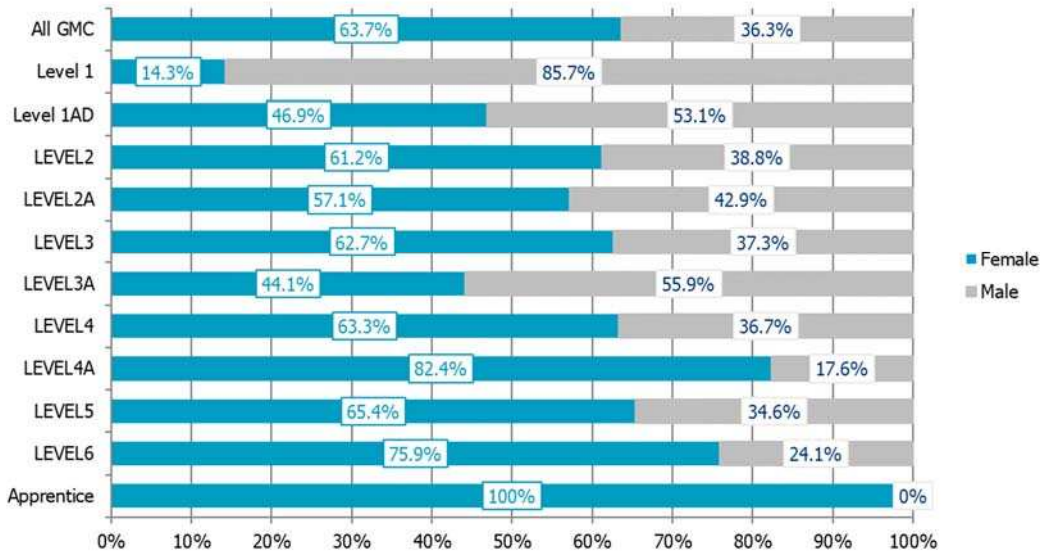


Disciplinary by Diversity Strand

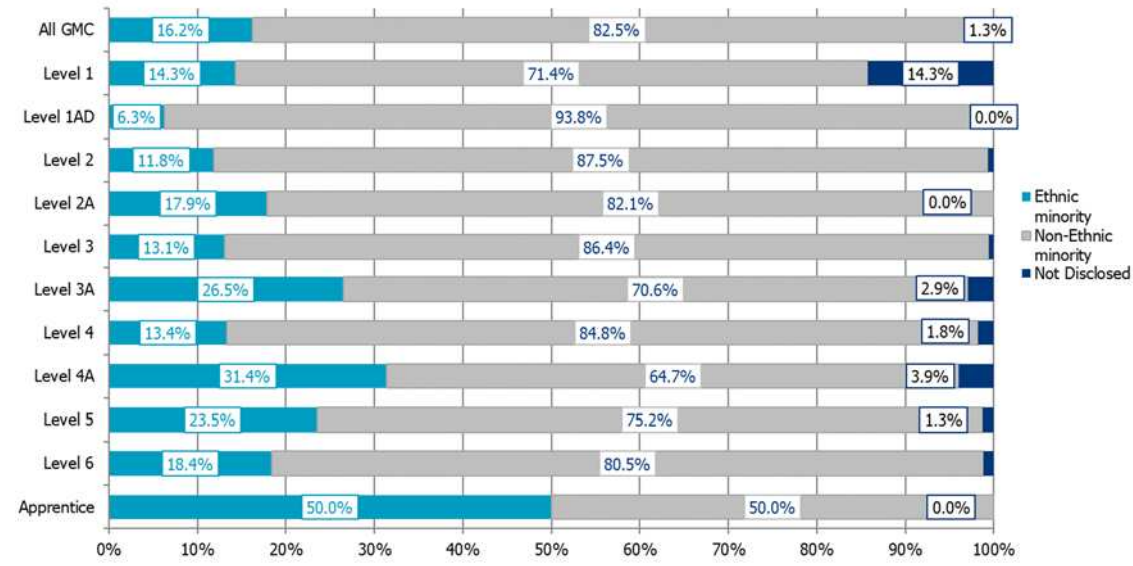


Workforce Profile

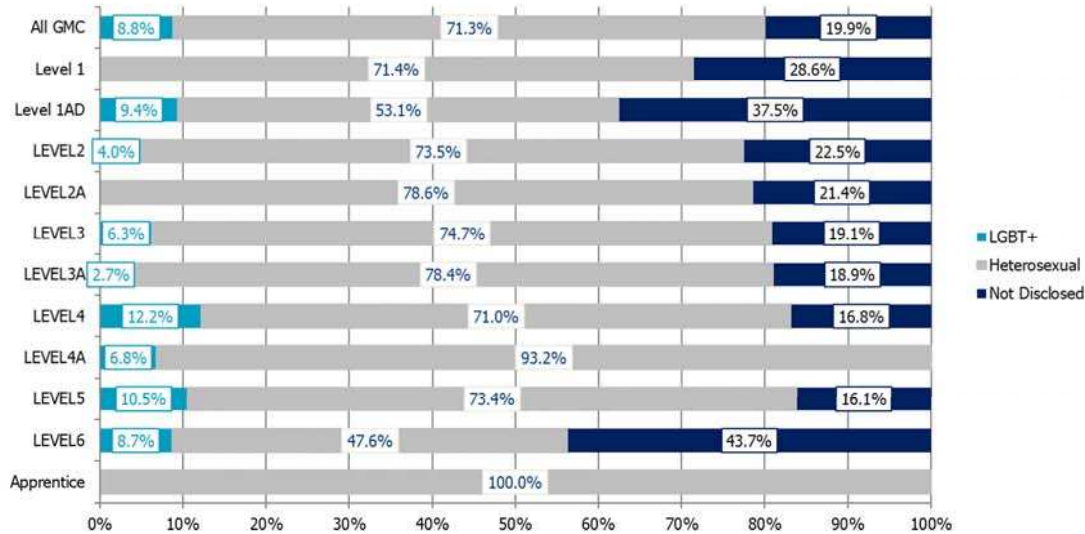
GMC workforce profile - Gender by Level



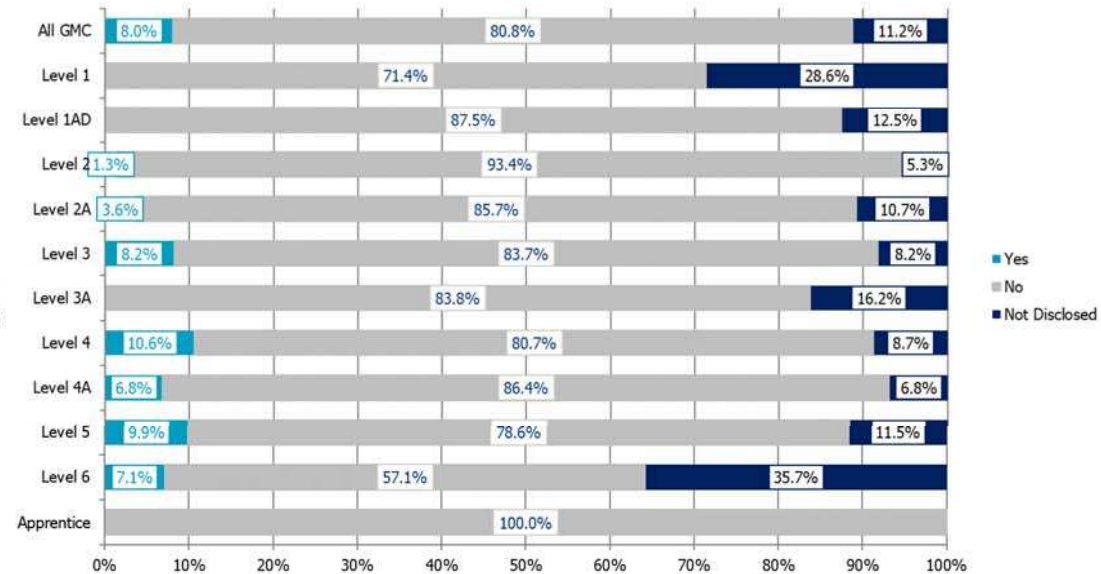
GMC workforce profile - Ethnicity by Level



GMC workforce profile - Sexual Orientation by Level

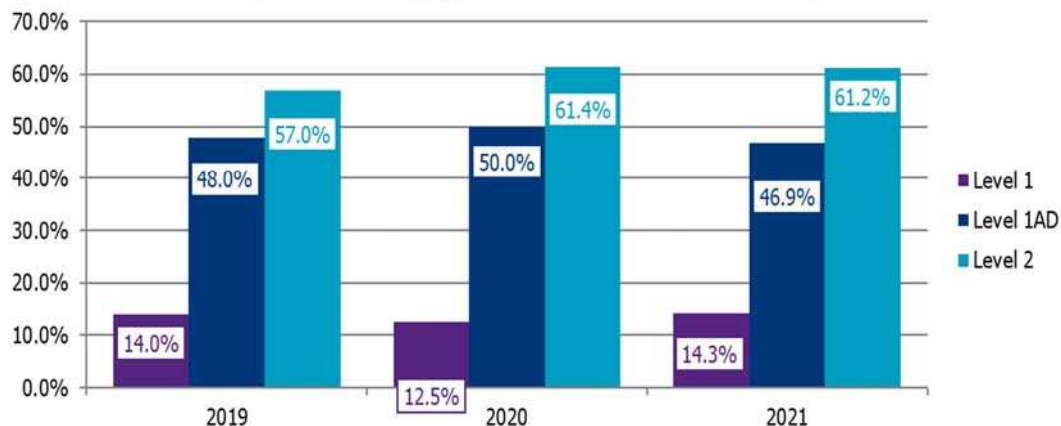


GMC workforce profile - Disability by Level

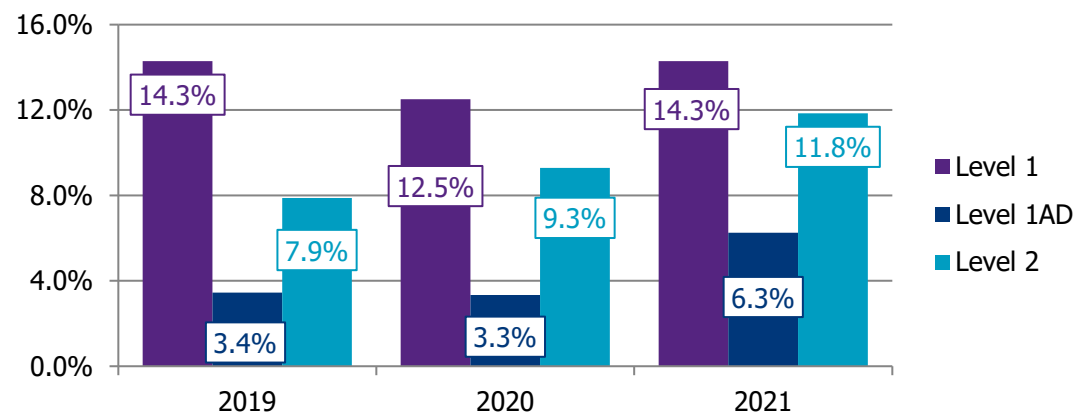


Management Roles 2019-2021

Number of female staff at Management Grades
(GMC female population at Dec 2021 is 63.7%)



Number of ethnic minority staff at Management Grades
(GMC ethnic minority population at Dec 2021 is 16.2%)



Recruitment progression by diversity strands

Diversity	Applications		1st Interview		2nd Interview		Offer	
Ethnic minority	1,517	40.0%	311	27.8%	18	43.9%	103	30.2%
Non- ethnic minority	2,273	60.0%	807	72.2%	23	56.1%	238	69.8%
Female	2,265	59.8%	716	64.0%	18	43.9%	227	66.6%
Male	1,525	40.2%	402	36.0%	23	56.1%	114	33.4%
Disabled	489	12.9%	161	14.4%	6	12.9%	46	13.5%
Totals	3790		1118		41		341	

Attraction, Recruitment and Retention

	Applications (3790)	Offers (341)
Female	59.8%	66.6%
Ethnic Minority	40.0%	30.2%
Disabled	12.9%	13.5%
16-24	17.7%	15.2%
25-34	32.3%	43.7%
35-44	22.7%	24.6%
45-54	14.9%	10.9%
55-64	7.4%	2.6%
65+	1.6%	0.6%
Not Stated	3.3%	2.3%

	Joiners (188)
Female	71.3%
Ethnic Minority	27.1%
Disabled	12.8%
16-24	12.8%
25-34	53.2%
35-44	18.6%
45-54	12.2%
55-64	3.2%
65+	0.0%
Not Stated	0.0%

	Leavers (124)
Female	61.3%
Ethnic Minority	15.3%
Disabled	9.7%
16-24	3.2%
25-34	52.4%
35-44	25.8%
45-54	11.3%
55-64	5.6%
65+	1.6%
Not Stated	0.0%

- Offers include internal transfers/promotions where a full recruitment campaign was run.
- Joiners figures report any staff member who joined the GMC between January and December 2021. Some of these staff may have been recruited during Q4 2020.
- Joiners only contains employees new to the organisation and does not include internal transfers/promotions.

Council meeting - 28 April 2022

Agenda item M4

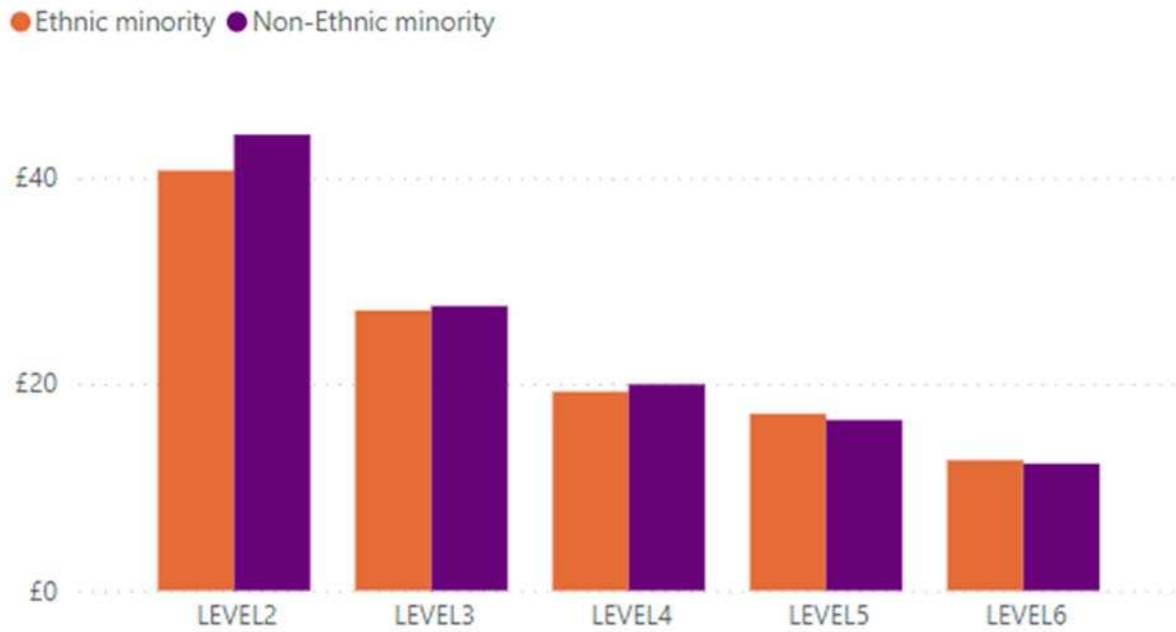
**Human Resources report 2021 and
gender pay gap reporting**

**General
Medical
Council**
Annex D

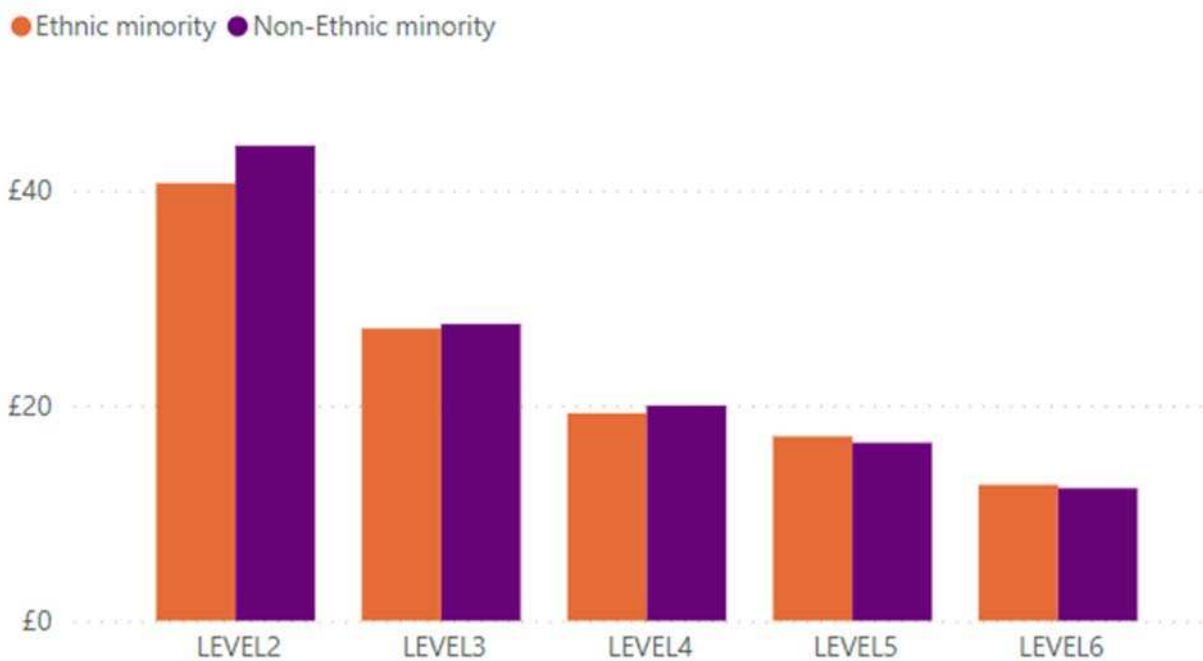
Pay data by protected characteristic

Promotion, Pay & Progression – Ethnicity London

London standard pay bands 2021

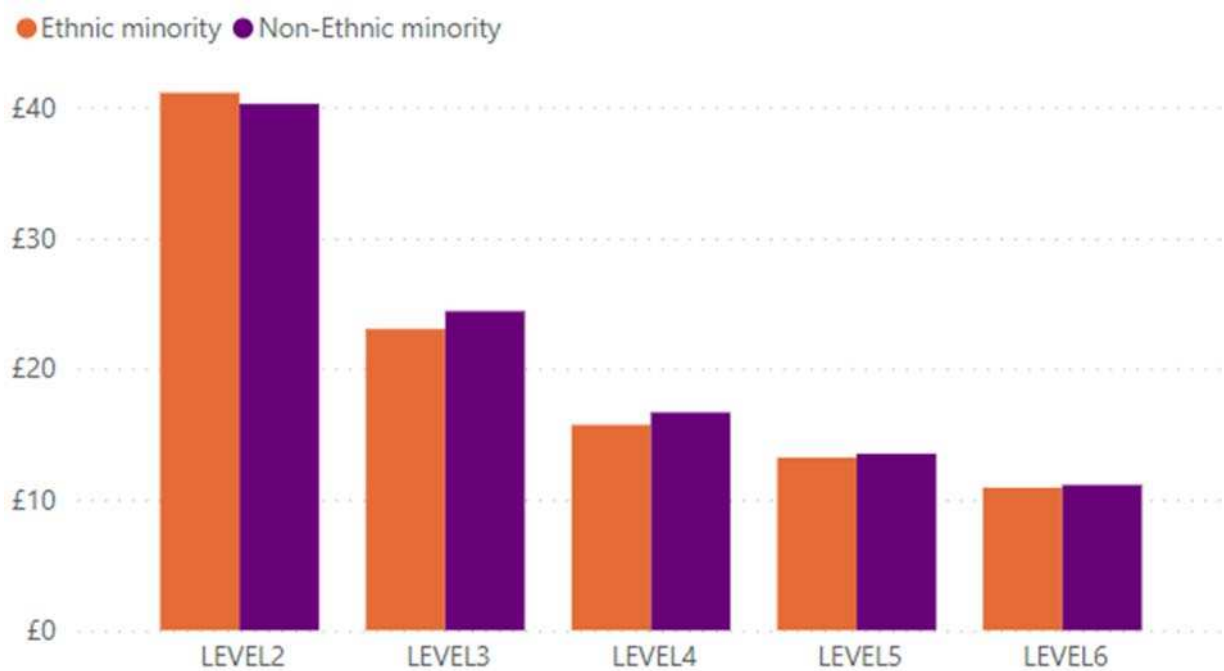


London standard pay bands 2020

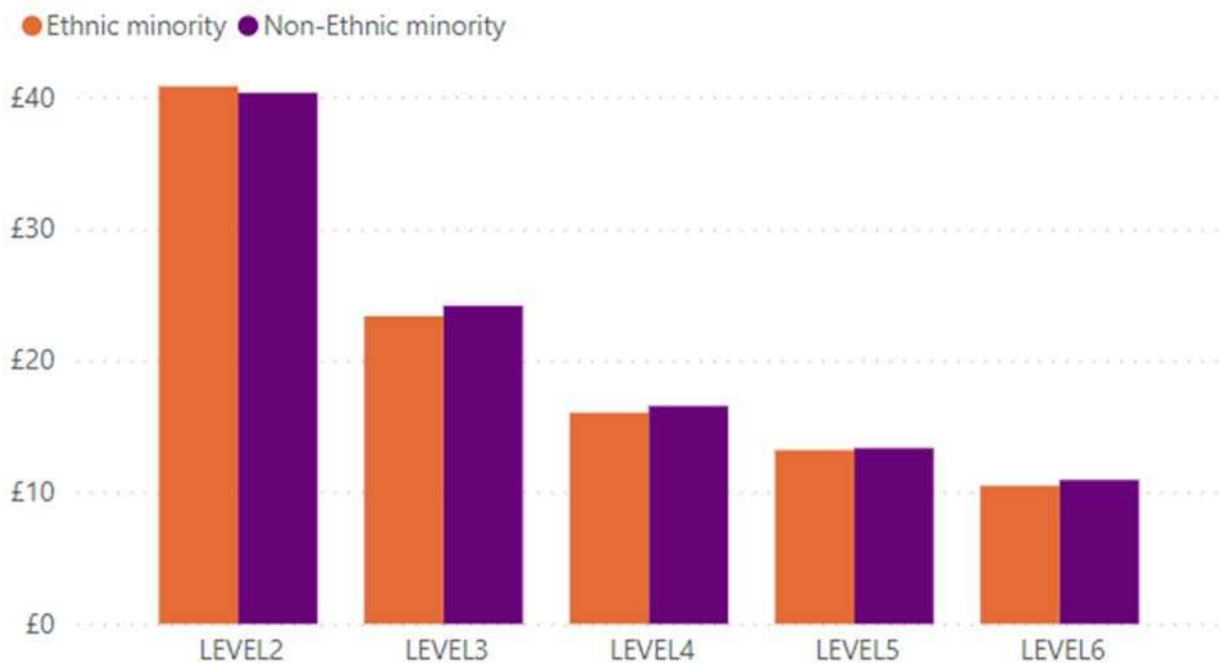


Promotion, Pay & Progression – Ethnicity Manchester

Manchester standard pay bands 2021

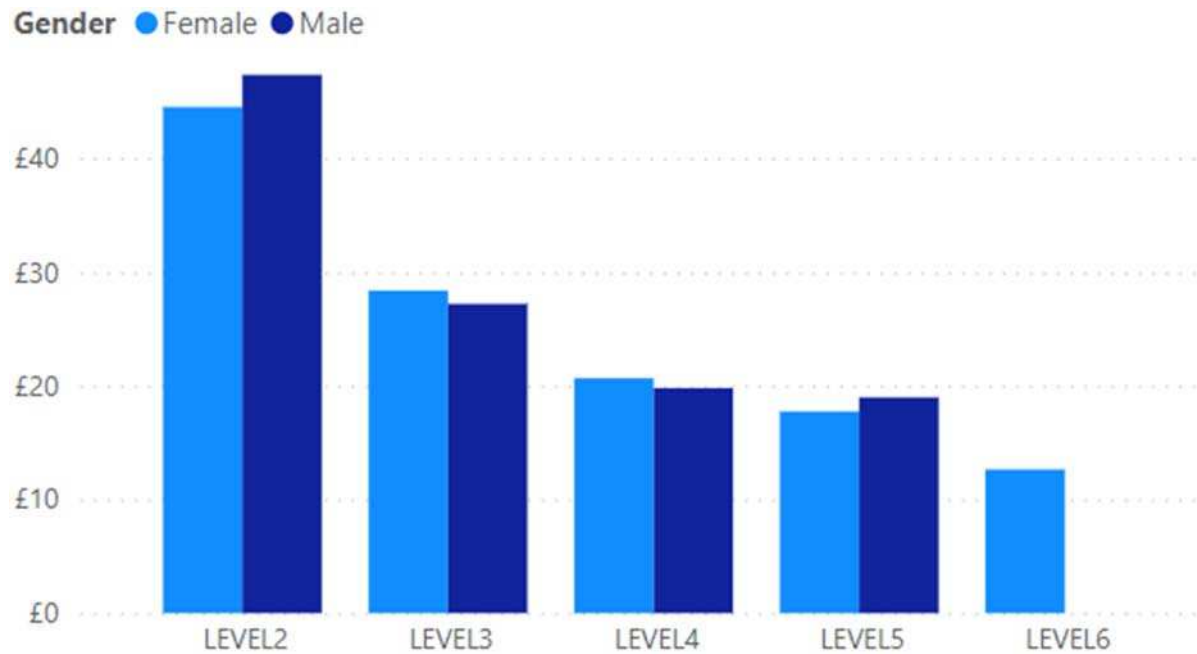


Manchester standard pay bands 2020

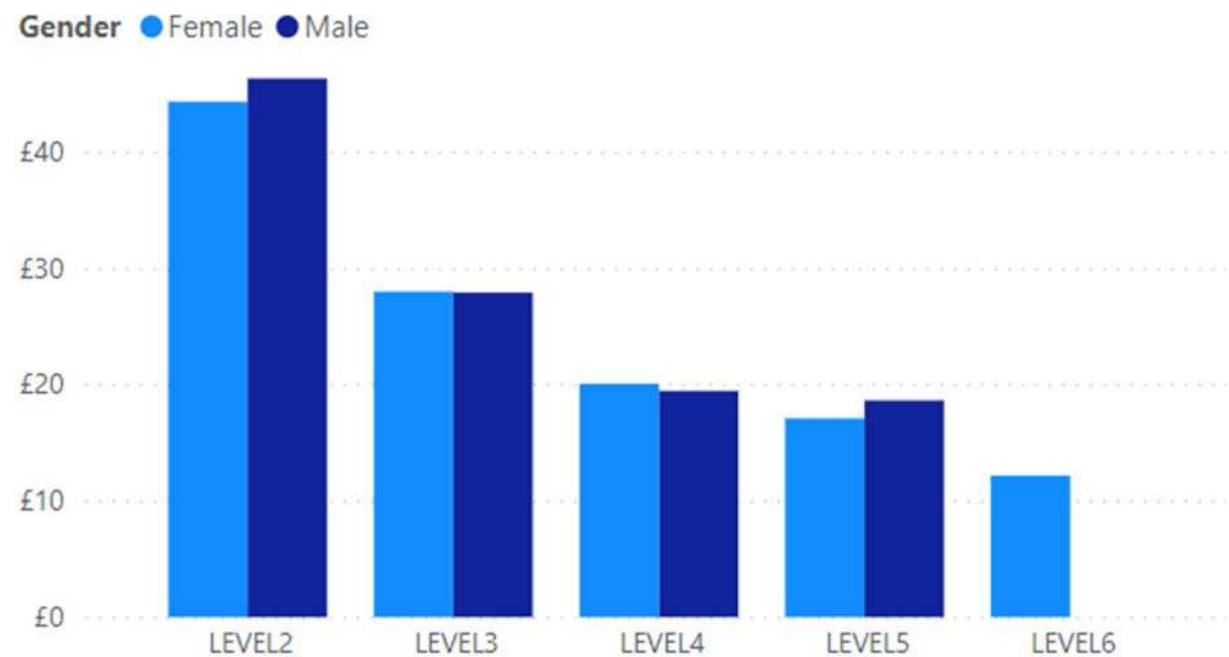


Promotion, Pay & Progression – Gender London

London standard pay bands 2021

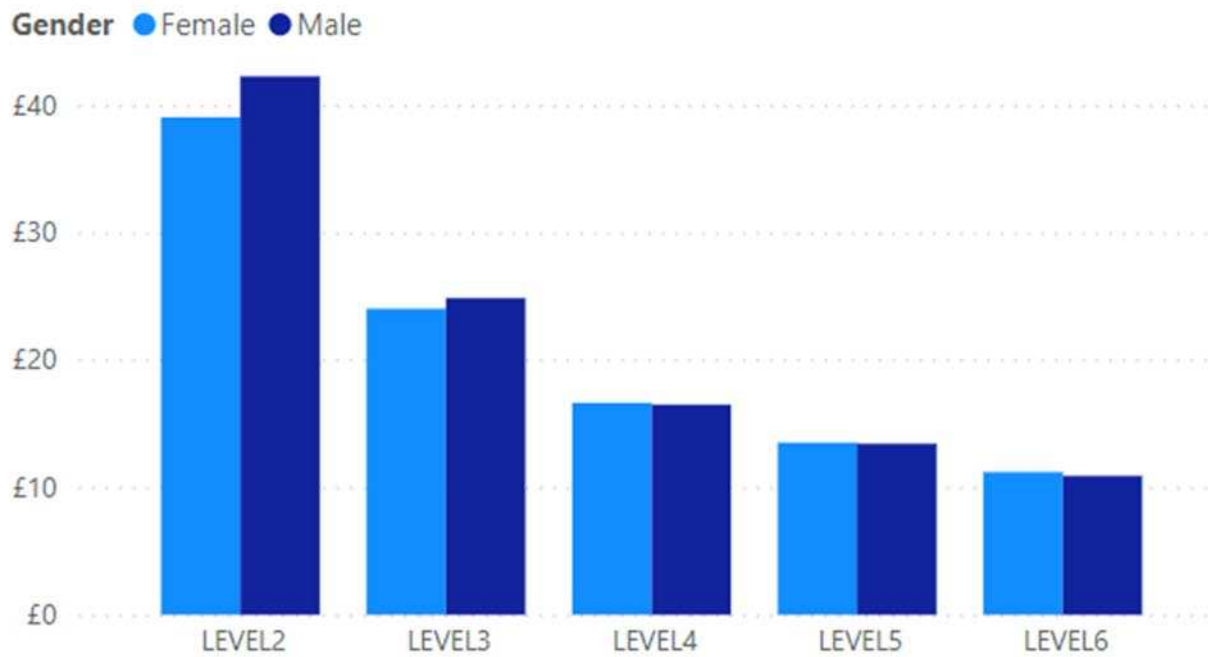


London standard pay bands 2020

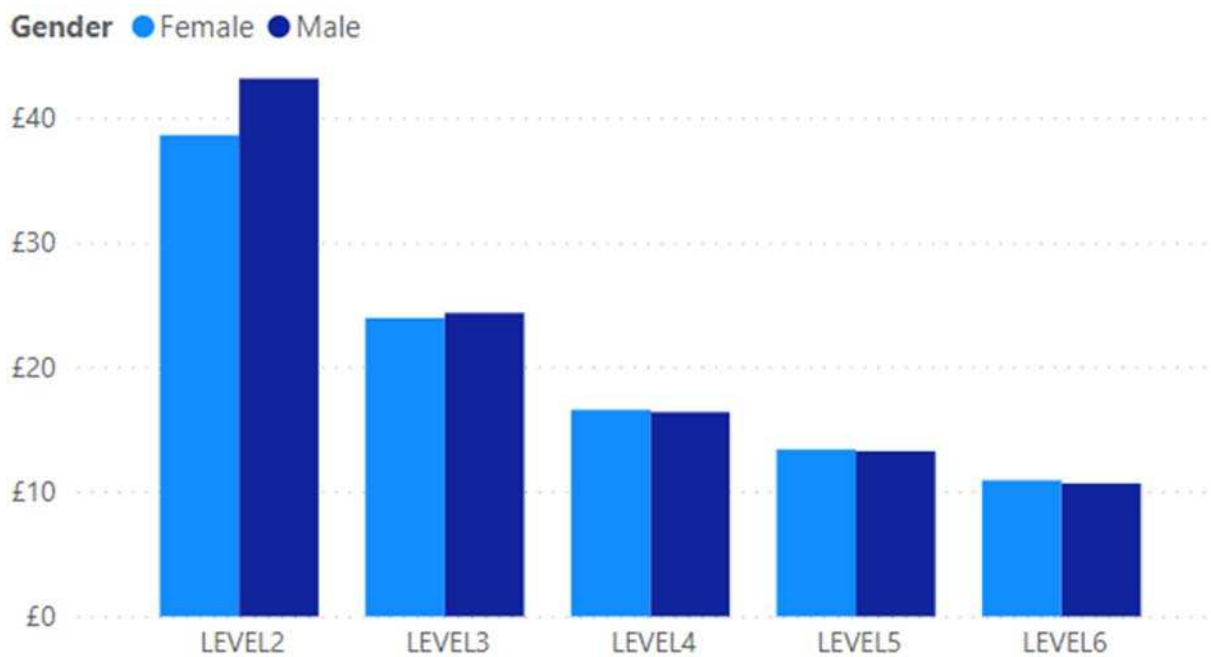


Promotion, Pay & Progression – Gender Manchester

Manchester standard pay bands 2021



Manchester standard pay bands 2020



Gender Pay Gap Reporting

1 Our final 2021 figures are as follows:

- a** the difference between the mean hourly rate of pay of male full-pay relevant employees and that of female full-pay relevant employees
 - 12.4% - This means that based on the average hourly rate female employees are paid 12.4% 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
 - 6.2% - This means that based on the median hourly rate female employees are paid 6.2% less than male employees.
- c** the difference between the mean bonus pay paid to male relevant employees and that paid to female relevant employees
 - 11.0% - This means that based on the average bonus pay female employees are paid 11.0% less than male employees.
- d** the difference between the median bonus* pay paid to male relevant employees and that paid to female relevant employees
 - 23.1% - This means that based on the median bonus payments males employees are paid 23.1% more than female employees. The majority of the bonus payments are part of the valued recognition scheme and are vouchers with the most typical amounts being £50 and £100.
- e** the proportions of male and female relevant employees who were paid bonus pay
 - Proportion of Males receiving bonus – 69.7%
 - Proportion of Females receiving bonus – 64.9%

f the proportions of male and female full-pay relevant employees in the lower, lower middle, upper middle and upper quartile pay bands.

- The results are in the table below

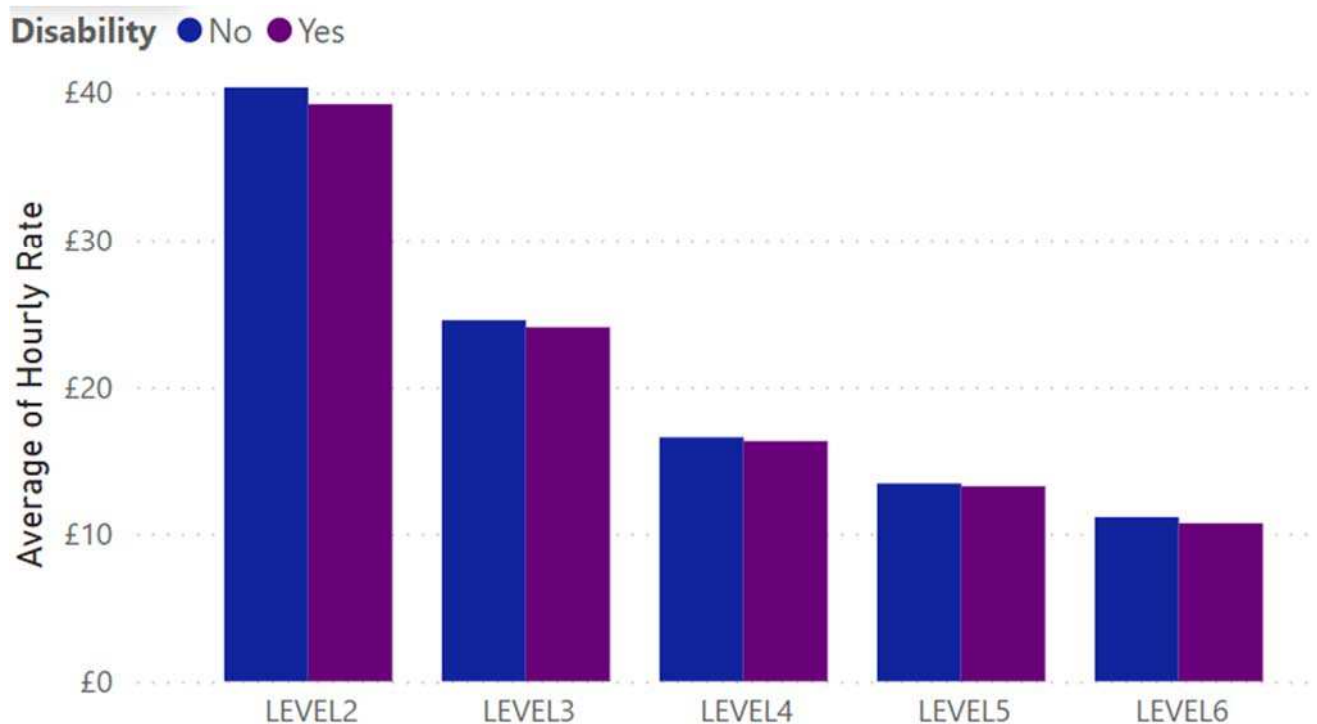
Quartile	Female	Male
lower	64.4%	35.6%
lower middle	65.5%	34.5%
upper middle	61.9%	38.1%
upper	54.9%	45.1%

- Currently the GMC staff gender profile is 63.8% female and 36.2% male

*This terminology is derived from the reporting requirements. The majority of these payments are via our valued awards scheme but also include retention incentive payments and non-consolidated elements of the annual pay award.

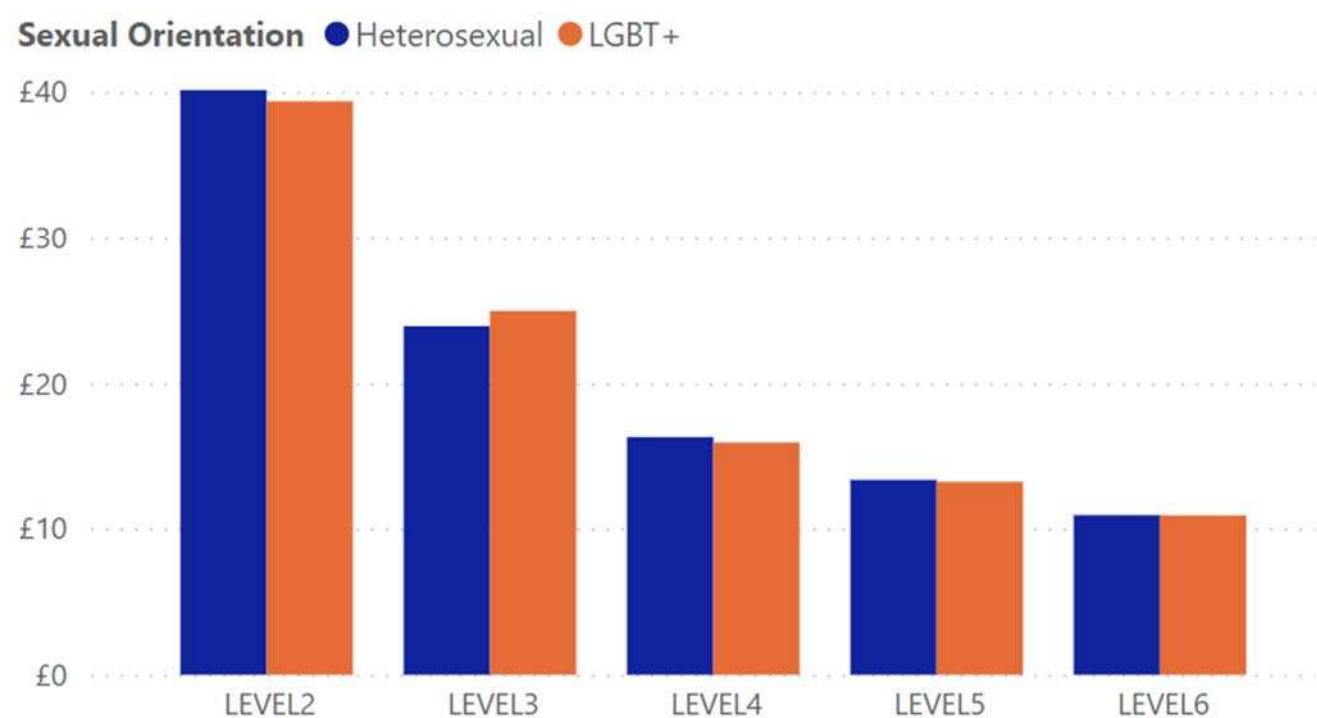
Promotion, Pay & Progression – Disability Manchester

Manchester standard pay bands 2021



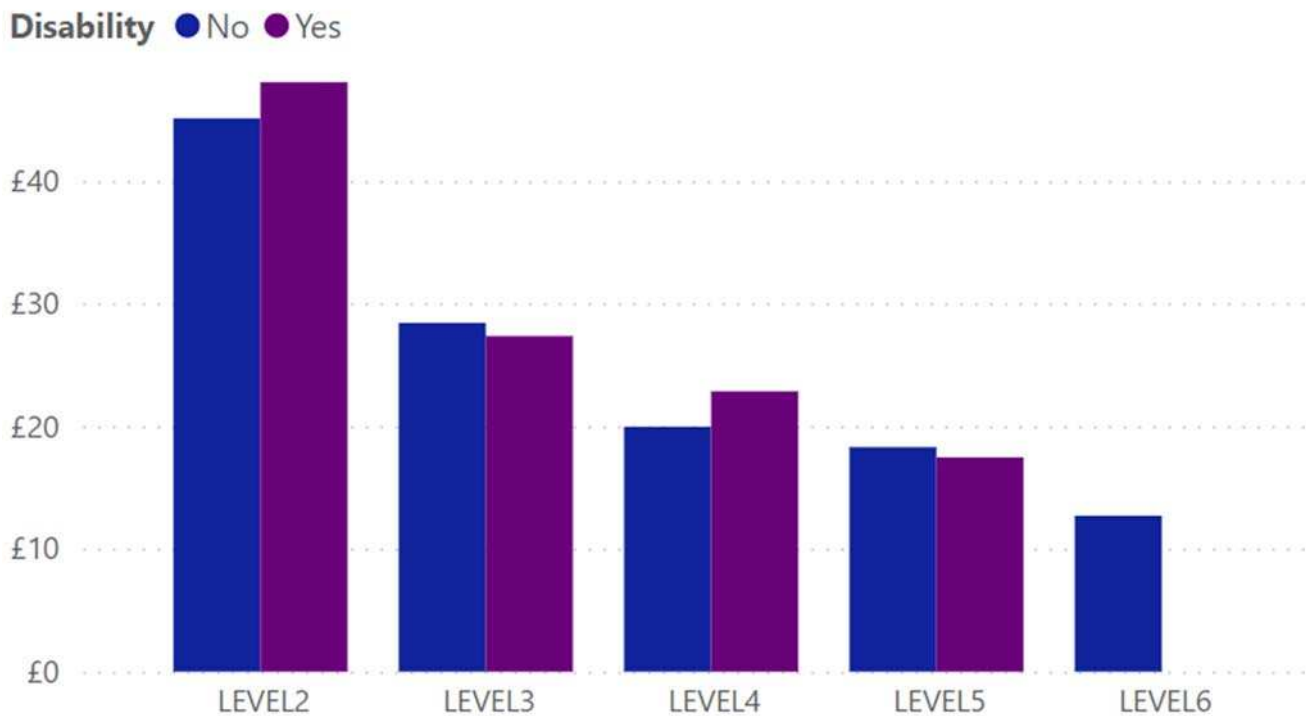
Promotion, Pay & Progression – Sexual Orientation Manchester

Manchester standard pay bands 2021



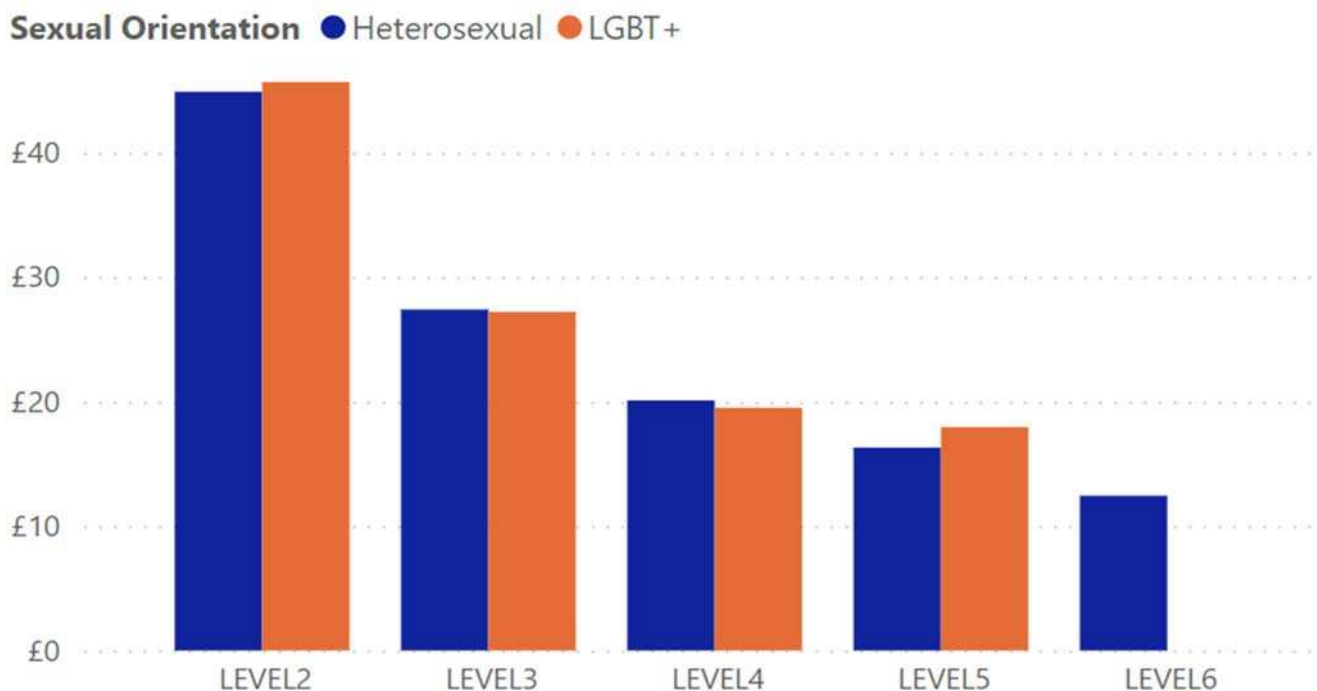
Promotion, Pay & Progression – Disability London

London standard pay bands 2021



Promotion, Pay & Progression – Sexual Orientation London

London standard pay bands 2021



Agenda item M5

PSA annual review of our performance

Action	To note
Purpose	<p>The purpose of this a paper is to consider the findings of the Professional Standards Authority (PSA) review of our performance for 2020/21 against the standards of good regulation.</p> <p>The report confirms that we have met all of the standards for this period building on our track record of having met the standards every year since their introduction in 2012.</p> <p>Council members are invited to share their reflections on the report and their areas of interest.</p>
Decision trail	The report was shared with members by Council circular on 8 March 2022.
Recommendation(s)	Council is recommended to consider and note the report.
Annexes	Annex A: Performance Review - GMC 2020/21
Author contacts	<p>Sarah Barlow, Head of Business Planning and Reporting</p> <p>Any enquiries to: GovernanceTeamMailbox@gmc-uk.org</p>
Sponsoring director/ Senior Responsible Owner	Shaun Gallagher , Director of Strategy and Policy

Background

- 1** The Professional Standards Authority for Health and Social Care (PSA) is responsible for overseeing the work of the GMC, and nine other statutory health and social care regulators. The performance review is the Authority's annual check on how well regulators are protecting the public and promoting confidence in their professionals and themselves.
- 2** The performance review involves an assessment of evidence about a regulator's performance against the Standards of Good Regulation¹. The Standards cover our statutory functions and five *General Standards*. There is a supporting evidence framework of what the PSA consider in making its assessment of performance against each standard.²
- 3** The assessment considers a range of information (both publicly available and internal data and documents that we provide) including Council papers, policy and guidance documents, volumes and timeliness of processes, and a check of the Register. The PSA also invite third party feedback from stakeholders and the public. If the PSA decide that further information is required to decide on whether the Standards have been met, a *targeted review* follows.
- 4** This report covers our performance for the period 1 September 2020 to 31 August 2021. Over this period, we engaged with our PSA scrutiny team on a monthly basis to discuss our performance throughout the period, and the process included a *targeted review* to consider some of our areas in greater depth.

Key findings and lessons

- 5** We were found to meet all the Standards of Good Regulation. This continues a track record of meeting all the standards every year since their introduction in 2012. The report recognises:
 - a** Our equality, diversity and inclusion targets as having the potential to 'stimulate real improvements'. It recognises that the targets are 'ambitious (but not unreasonable)' and that achieving these objectives relies on our ability to influence the behaviour of external organisations.

¹ https://www.professionalstandards.org.uk/docs/default-source/publications/standards/standards-of-good-regulation-2018-revised.pdf?sfvrsn=ce597520_11

² [https://www.professionalstandards.org.uk/docs/default-source/publications/standards/proposed-new-standards-of-good-regulation---evidence-framework-\(june-2018\).pdf?sfvrsn=270c7220_6](https://www.professionalstandards.org.uk/docs/default-source/publications/standards/proposed-new-standards-of-good-regulation---evidence-framework-(june-2018).pdf?sfvrsn=270c7220_6)

- b** Positive feedback from a doctors' representative organisation about how we had communicated positively with registrants and kept them well informed during the pandemic.
 - c** The broader improvements we put in place as part of our pandemic response, including additional routes to registration, and updates to our ethical guidance.
- 6** The focus of the Authority's attention during the *targeted review* included:
 - a** Understanding the research, data, and rationale that underpins our ED&I targets.
 - b** The scope of our regulatory fairness work and how we were learning from the Mr Karim employment tribunal judgement to assure ourselves of the fairness of our decision-making.
 - c** Clarification on the role of Employer Liaison Advisers in the referral process.
 - d** Our plans for monitoring and evaluating changes introduced during the pandemic such as new routes to registration, changes in appraisal as part of the revalidation process, and our handling of allegations of low-level violence and dishonesty.
 - e** Our approach to complaints handling (customer style complaints from their interactions with us rather than fitness to practise complaints) – and how we learn and improve the tone and approach to their handling.
 - f** How we were acting on the findings of the Maternity Safety inquiry to help support the shift from a culture of blame to a culture of learning.
- 7** Notwithstanding the positive outcome from this assessment, the PSA's March Board meeting signalled a firmer position for future assessments of meeting or failing the standard around two focus areas explored in more detail below.

Fitness to Practise recovery plans

- 8** The Authority is taking a close interest in the handling of FTP case backlogs across all regulators and our report notes it will be monitoring our recovery

plans (and progress against them) closely³. It considers two key measures in assessing performance of FTP timeliness: median time from receipt of concern to final disposal (with anything 90 weeks or over attracting their attention), and total cases over 12 months old. The Authority acknowledges the interplay between these measures where closing older cases drives up the median – so considers this data holistically in its assessment. Our latest data against these performance measures from our quarterly data return to the PSA is set out below.

Data submission timeliness measures		2020/21
17	Median time from receipt of referral to final FTPC determination/or other final disposal of the case	103.90 weeks
18	Number of open referrals and cases (at the end of the quarter) which are older than 52 weeks – 103 weeks	642
	104 weeks – 155 weeks	303
	156 weeks and above	203

- 9** The PSA note that smaller regulators which have relatively few fitness to practise cases appear to have recovered from any pandemic impact. Their caseloads and timescales are not of concern (General Chiropractic Council, General Osteopathic Council, Pharmaceutical Society of Northern Ireland).
- 10** Of the remaining regulators, only ourselves and Social Work England are noted as having backlogs of concern while still meeting the fitness to practise standards of good regulation in their last performance assessments.
- 11** The Nursing and Midwifery Council, General Pharmaceutical Council, Health Care Professionals Council, General Optical Council, and General Dental Council also have backlogs of concern. They had not met the fitness to practise standards in their last performance assessment before the pandemic.
- 12** The PSA Board discussion in March centred on the balance to be struck between crediting regulators for their efforts to 'manage a response' against making a more absolute assessment of performance based on hard data. The

³ https://www.professionalstandards.org.uk/docs/default-source/board/board-papers-and-agendas/board-meeting-16-march-2022-item-07-paper-04-ftp-backlog.pdf?sfvrsn=aa704820_2

Chair's conclusion intimated that the Authority would not find it appropriate to 'pass' regulators in future assessments who have ostensibly deteriorating performance.

- 13** This position would present a more marked challenge to our own fitness to practise assessment in future years. We have resourced our investigation teams based on a proven ratio of officers-to-case-numbers that enables us to maintain an efficient throughput of cases while balancing costs. The primary source of delay we are experiencing now is from employers and the broader health sector – where we require inputs to our processes (information, witnesses, experts) from a system that will be suffering a considerable backlog of care for the foreseeable future. This may put us in a potentially difficult position where we are failed against the standard but with no clear 'way out' to meeting the standard without counterintuitively providing a more assertive demand on the health system to support our processes. We continue to be clear in our engagements with the Authority about the obvious tensions we are trying to balance in our approach.

ED&I competence

- 14** At the same March Board discussion, the PSA considered its ED&I Action Plan.⁴ Developed in response to the Authority's reflections on its role and an independent audit of its performance – it commits to a series of actions to improve their internal inclusivity and to enhance regulatory coverage of ED&I through the performance review.
- 15** This discussion mirrored the consideration of FTP backlogs with a much firmer appetite to enforce a stricter pass/fail assessment. The discussion suggested any regulator should fail the ED&I standard if:
- a** any of their processes contribute to further disproportionality or that the regulator isn't clear if they do/don't contribute to disproportionality.
 - b** there is no action/plan on upstream interventions re disproportionate referrals for minority ethnic registrants.
 - c** panels are not diverse in composition
- 16** The discussion indicated that the published action plan would likely be reviewed – but we reasonably anticipate some review of the evidence framework that

⁴ https://www.professionalstandards.org.uk/docs/default-source/board/board-papers-and-agendas/board-meeting-16-march-2022-item-11-paper-15-edi-action-plan.pdf?sfvrsn=3a724820_2

underpins the ED&I standard by 2023, and a potentially more probing assessment of performance in the current period.

Changes to the performance review process

- 17** This year the PSA is transitioning to a revised process of performance reviews. It will continue to make an annual assessment of performance but the depth of review informing that assessment will vary. We are scheduled to have two relatively lighter-touch reviews followed by a more substantive Periodic Review in 2024. We still expect to have considerable scrutiny through the process on the areas outlined above.

Council meeting – 28 April 2022

Agenda item M5

PSA annual review of our performance

Performance Review - GMC 2020/21

**General
Medical
Council**
Annex A



Snapshot

Annual review of performance 2020/21

Regulator reviewed: **General Medical Council**



Key facts & figures:

- Regulates **doctors** in the **United Kingdom**
- **348,784 professionals** on the register as at 30 September 2021
- **£408** annual fee for registration

Standards of good regulation met

General Standards	5/5
Guidance and Standards	2/2
Education and Training	2/2
Registration	4/4
Fitness to Practise	5/5

We look carefully at a range of evidence to decide whether each Standard is met or not. The total number of Standards met does not on its own give the full picture of how a regulator is performing. Read the full performance review to find out more.

Find out more about our performance reviews at:
www.professionalstandards.org.uk/performancereviews

Focus on: How the GMC is meeting the Standards

In our annual review of performance, we sought further information from the GMC about some areas of its work. We concluded that the GMC continues to meet all our Standards of Good Regulation.

GENERAL STANDARDS: EQUALITY, DIVERSITY AND INCLUSION

The GMC published targets to eliminate disadvantage experienced by some groups of doctors in two areas. It aims to eliminate disproportionate fitness to practise referrals from employers about ethnic minority doctors by 2026, and to eliminate disproportionality and discrimination in medical education and training by 2031. The targets are ambitious and achieving them will rely on the GMC's ability to influence the behaviour of other organisations. We can see the potential for its targets to stimulate real improvements.

We also sought information about how the GMC ensures fairness in its own processes. It published an independent audit of fitness to practise decisions, which found that all decisions complied with the relevant guidance. The GMC has work in progress to ensure that its processes promote fairness, including independent assessments of its guidance and a review of critical decision points. The GMC's work on fairness includes action in response to an employment tribunal in June 2021, which upheld a doctor's complaint that the GMC had discriminated against him on the grounds of race. The GMC has appealed this decision, and the appeal is yet to be heard. We agree that it is appropriate for the GMC to seek to learn from the tribunal findings, regardless of the outcome of the appeal. The outcomes of this work will be important in demonstrating the GMC's commitment to ensuring its processes promote fairness. We will closely monitor its progress in this area.

REGISTRATION: NEW ROUTES TO REGISTRATION

The GMC launched two new pathways to registration this year. One pathway was developed in response to disruption to its exams for overseas-qualified doctors during the pandemic. The GMC identified three exams which it accepts as comparable to its own test for doctors who qualified abroad to allow them to practise in the UK, provided applicants meet certain conditions. The other new pathway arose from the transitional arrangements following the UK's exit from the EU. The GMC said it is now able to carry out additional checks on doctors who hold qualifications from the EEA, such as verifying their qualification and requiring evidence of their knowledge of English. Both these new pathways have scheduled reviews.

FITNESS TO PRACTISE: CASE PROGRESSION

It took the GMC longer to conclude fitness to practise cases this year. We expected this to occur, because of the disruption associated with the pandemic. The GMC has developed plans to help it recover from the disruption. It also introduced some new guidance for decision-makers. The GMC has plans to review the guidance, including feedback from decision-makers and reviewing decisions and data about outcomes. We will monitor the progress of its recovery plan.

You can find out more details in the full report which is available on our website www.professionalstandards.org.uk/performance-reviews

performance review 2020/21

GENERAL MEDICAL COUNCIL





ABOUT THE PERFORMANCE REVIEW PROCESS

We aim to protect the public by improving the regulation of people who work in health and care. This includes our oversight of 10 organisations that regulate health and care professionals in the UK. As described in our legislation, we have a statutory duty to report annually to Parliament on the performance of each of these 10 regulators.

Our performance reviews look at the regulators' performance against our [Standards of Good Regulation](#), which describe the outcomes we expect regulators to achieve. They cover the key areas of the regulators' work, together with the more general expectations about the way in which we would expect the regulators to act.

In carrying out our reviews, we aim to take a proportionate approach based on the information that is available about the regulator. In doing so, we look at concerns and information available to us from other stakeholders and members of the public. The process is overseen by a panel of the Authority's senior staff. We initially assess the information that we have and which is publicly available about the regulator. We then identify matters on which we might require further information in order to determine whether a Standard is met. This further review might involve an audit of cases considered by the regulator or its processes for carrying out any of its activities. Once we have gathered this further information, we decide whether the individual Standards are met and set out any concerns or areas for improvement. [These decisions are published in a report on our website.](#)

Further information about our review process can be found in a [short guide, available on our website](#). We also have a [glossary of terms and abbreviations](#) we use as part of our performance review process available on our website.

The regulators we oversee are:

General Chiropractic Council • General Dental Council • General Medical Council • General Optical Council • General Osteopathic Council • General Pharmaceutical Council • Health and Care Professions Council • Nursing and Midwifery Council • Pharmaceutical Society of Northern Ireland • Social Work England



Find out more about our work
www.professionalstandards.org.uk

General Medical Council

performance review report 2020/21

At the heart
of everything
we do is
one simple
purpose:
protection
of the public
from harm

Contents

- 01** At a glance - key facts and statistics about how the General Medical Council is meeting the Standards for 2020/21

- 02** Executive summary

- 04** How the General Medical Council has performed against the Standards of Good Regulation
 - 04** **General Standards** Five Standards

 - 10** **Guidance and Standards** Two Standards

 - 11** **Education and Training** Two Standards

 - 12** **Registration** Four Standards

 - 16** **Fitness to Practise** Five Standards

- 22** Useful information and links



The General Medical Council

key facts & stats

The General Medical Council (GMC) regulates doctors in the United Kingdom.

As at 30 September 2021, the GMC was responsible for a register of:

348,787 professionals

Annual registration fee is: £408

The GMC's work includes:

- ▶ setting and maintaining standards of practice and conduct;
- ▶ maintaining a register of qualified professionals;
- ▶ assuring the quality of medical education and training;
- ▶ requiring doctors to keep their skills up to date through continuing professional development; and
- ▶ taking action to restrict or remove from practice registrants who are not considered to be fit to practise.

Standards of Good Regulation met for 2020/21 performance review

	General Standards	5/5
	Guidance and Standards	2/2
	Education and Training	2/2
	Registration	4/4
	Fitness to Practise	5/5

Meeting, or not meeting, a Standard is not the full story about how a regulator is performing. You can find out more in the full report.

The General Medical Council

Executive summary

How the GMC is protecting the public and meeting the Standards of Good Regulation



This report arises from our annual performance review of the General Medical Council (GMC) and covers the period from 1 September 2020-31 August 2021. The GMC is one of 10 health and care professional regulatory organisations in the UK which we oversee. We assessed the GMC's performance against the [Standards of Good Regulation](#) which describe the outcomes we expect regulators to achieve in each of their four core functions.

To carry out this review, we collated and analysed evidence from the GMC and other interested parties, including Council papers, performance reports and updates, committee reports and meeting minutes, policy, guidance and consultation documents, our statistical performance dataset and third-party feedback. We also used information available through our review of final fitness to practise decisions under the Section 29 process¹ and conducted a check of the accuracy of the GMC's register. We used this information to decide the type of performance review we should undertake. Further information about our review process can be found in our [Performance Review Process guide](#), which is available on our website.

The GMC's performance during 2020/21

We conducted a targeted review of the GMC's performance against Standards 3, 4, 11, 15 and 18. We concluded that it met all the Standards.

Key developments and findings

Equality, diversity and inclusion

The GMC published targets to eliminate disadvantage experienced by some groups of doctors in two areas. It aims to eliminate disproportionate fitness to practise referrals from employers about ethnic minority doctors by 2026, and to eliminate disproportionality and discrimination in medical education and training by 2031. The targets are ambitious and achieving them will rely on the GMC's ability to influence the behaviour of other organisations. But the GMC has explained how it decided on these targets and what it will measure to understand whether they are being achieved. It will report annually on progress. This will be important to maintain focus on working towards the targets. We can see the potential for its targets to stimulate real improvements.

We also sought information about how the GMC ensures fairness in its own processes. It published an independent audit of fitness to practise decisions, which found that all decisions complied with the relevant guidance. The GMC has work in

¹ Each regulator we oversee has a 'fitness to practise' process for handling complaints about health and care professionals. The most serious cases are referred to formal hearings in front of fitness to practise panels. We review every final decision made by the regulators' fitness to practise panels. If we consider that a decision is insufficient to protect the public properly we can refer them to Court to be considered by a judge. Our power to do this comes from Section 29 of the [NHS Reform and Health Care Professions Act 2002 \(as amended\)](#).

progress to ensure that its processes promote fairness, including independent assessments of its guidance and a review of critical decision points. It will publish more information about how it considers fairness across all of its work. The GMC's work on fairness includes action in response to an employment tribunal in June 2021, which upheld a doctor's complaint that the GMC had discriminated against him on the grounds of race. The GMC has appealed this decision, and the appeal is yet to be heard. We agree that it is appropriate for the GMC to seek to learn from the tribunal findings, regardless of the outcome of the appeal. The outcomes of this work will be important in demonstrating the GMC's commitment to ensuring its processes promote fairness. We will closely monitor its progress in this area.

New routes to registration

The GMC launched two new pathways to registration this year. One pathway was developed in response to disruption to its exams for overseas-qualified doctors during the pandemic. The GMC considered several overseas examinations and identified three exams which it accepts as comparable to its own Professional and Linguistic Assessment Board (PLAB) exams,² provided applicants meet certain conditions. The other new pathway arose from the transitional arrangements following the UK's exit from the EU. The GMC said it is now able to carry out additional checks on doctors who hold qualifications from the EEA, such as verifying their qualification and requiring evidence of their knowledge of English. Both these new pathways have scheduled reviews.

Fitness to practise case progression

It took the GMC longer to conclude fitness to practise cases this year. We expected this to occur, because of the disruption associated with the pandemic. The GMC has developed plans to help it recover from the disruption, including an increase in hearings capacity. It also introduced some new guidance for decision-makers. The GMC has plans to review the guidance, including feedback from decision-makers and reviewing decisions and data about outcomes. We will monitor the progress of its recovery plan.

Supporting people involved in fitness to practise cases

The GMC continues to work on how it supports people involved in fitness to practise cases. Its corporate strategy includes commitments to ensure that people can access GMC services and support. It made changes to its website to help members of the public raise a concern. Its charter for patients, relatives and carers includes a link to the Independent Support Service, and its Patient Liaison Service reports high levels of satisfaction. The GMC is considering how it can evaluate its services against the commitments in the charter.

The GMC published two reports about its work to support doctors involved in fitness to practise cases. One included an account of the changes it has made since an independent review in 2015. The other made recommendations for how the GMC can encourage doctors to engage in investigations. The GMC told us it has plans to map out the fitness to practise journeys for registrants, complainants and patients to identify opportunities for improvement.

² A two-part test for doctors who qualified abroad to allow them to practise in the UK.

How the General Medical Council has performed against the Standards of Good Regulation

General Standards

Standard 1: The regulator provides accurate, fully accessible information about its registrants, regulatory requirements, guidance, processes and decisions.

- 1.1 The GMC publishes information on its website about its regulatory activities, statutory purpose and role. This year, the GMC commissioned an assessment of its website which suggested some areas for improvement; for example, the GMC plans to incorporate two interactive tools into its main website, which are currently on external platforms.
- 1.2 The GMC continues to provide information on its website about registration, revalidation, medical education, and raising concerns about a doctor. It also continues to publish reports about revalidation, fitness to practise and specialist applications, as well as decisions about warnings and undertakings, and investigation committee and appeal decisions. Its interactive data explorer tool offers a range of data about the register, revalidation, fitness to practise, and training. The GMC published information about the progress of its work leading to the regulation of Physician Associates (PAs) and Anaesthesia Associates (AAs).

Conclusion against this Standard

- 1.3 The GMC provides information about its registrants, regulatory requirements, guidance, processes, and decisions for registrants and the public. We are satisfied that this Standard is met.

Standard 2: The regulator is clear about its purpose and ensures that its policies are applied appropriately across all its functions and that relevant learning from one area is applied to others.

- 2.1 The GMC's corporate strategy 2021-25³ includes four themes:
 - Enabling professionals to provide safe care
 - Developing a sustainable medical workforce
 - Making every interaction matter
 - Investing in people to deliver.
- 2.2 The GMC says the corporate strategy has been developed with, and for, patients, medical professionals, partners and colleagues. The GMC used findings of its perceptions survey⁴ to inform the corporate strategy. The strategy in turn informs the GMC's 2021-23 business plan.⁵

³ www.gmc-uk.org/about/how-we-work/corporate-strategy-plans-and-impact/corporate-strategy

⁴ www.gmc-uk.org/about/what-we-do-and-why/data-and-research/research-and-insight-archive/corporate-strategy-and-perceptions-tracking-2020

⁵ https://www.gmc-uk.org/-/media/documents/business-plan-2021-23-final_pdf-85320965.pdf

2.3 Last year, the GMC told us that its work to support the profession is part of protecting, promoting and maintaining the health, safety and wellbeing of the public. We acknowledged that the GMC's approach is informed by research and that it is important that it has the confidence of the profession, but that the GMC should continue to monitor potential risks and conflicts. We have not seen anything this year to cause concern that the GMC has strayed outside its remit, and it has appropriately provided support to registrants throughout the pandemic.

Conclusion against this Standard

2.4 Given that supporting the profession is an ongoing area of work for the GMC, we will continue to monitor the GMC's activities in this respect. We are satisfied that the Standard is met.

Standard 3: The regulator understands the diversity of its registrants and their patients and service users and of others who interact with the regulator and ensures that its processes do not impose inappropriate barriers or otherwise disadvantage people with protected characteristics.

The GMC's fairness targets

3.1 In May 2021 the GMC published targets to eradicate two disadvantages that some doctors face. The targets are:

- to eliminate disproportionate complaints from employers about ethnic minority doctors, by 2026
- to eradicate disadvantage and discrimination in medical education and training, by 2031.

3.2 It has also set targets for itself as an employer, including to increase the proportion of staff from minority ethnic backgrounds in senior positions.

3.3 The targets in relation to registrants rely on factors outside the GMC's direct control, so we sought more information about how it had chosen these targets and timescales.

3.4 The GMC acknowledges that the targets are ambitious and that the contributing factors are not all within its control. It set targets as a focus for efforts and reporting. It noted that evidence shows that more inclusive and supportive working environments reduce the differences in education and fitness to practise referrals, and support better patient outcomes. It proposes to use its influence with the organisations that have a direct impact on the targets, for example through increased engagement with responsible officers, designated bodies and education and training bodies. The GMC will meet with responsible officers to understand local culture, and with the organisation's board if necessary. It will set up a feedback loop between fitness to practise, the outreach team, and responsible officers about the outcomes of investigations.

3.5 The GMC analysed its data and engaged with stakeholders to determine the appropriate timescales for its targets. These are also aligned to other relevant work, for instance with NHS England's commitment to reduce disproportionality in local disciplinary processes.⁶ The GMC set a longer timescale for its target in

⁶ <https://www.england.nhs.uk/wp-content/uploads/2019/07/closing-the-ethnicity-gap.pdf>

relation to differential attainment in education, because of the additional complexity of the issue and the time it takes for medical trainees to complete their training.

- 3.6 The GMC will publish its progress against the measures annually. It will measure progress by using several sources of data. These include the number and type of fitness to practise referrals received from employers, information about how supported doctors felt in postgraduate training, and exam pass rates for undergraduate and postgraduate training. Where the data suggests disproportionality, the GMC will take action.
- 3.7 It was reasonable for the GMC, having identified significant disproportionality affecting registrants on the basis of protected characteristics, to set specific targets to eliminate that disproportionality. It has developed interventions to work towards the targets and an evidence base to measure progress. The success of such an approach will depend in part on the GMC's ability to influence the behaviour of other organisations. We will follow this work with interest.

Ensuring fairness in the GMC's own processes

- 3.8 The targets announced by the GMC related principally to disproportionality in other organisations and settings. We also considered what the GMC is doing to promote fairness in its own processes. From 2021 the GMC's equality and diversity commitments are embedded in its corporate strategy and are a standing agenda item at Council meetings. An independent review found its governance and compliance arrangements for equality, diversity and inclusion legislation and standards to be robust.

Fitness to practise fairness audit

- 3.9 Last year, the GMC had commissioned an independent audit of fairness in its fitness to practise process. The report⁷ was published in September 2021. It considered whether decisions made by GMC staff at triage, provisional enquiry, and case examiner stage, were in line with guidance. It concluded that all the decisions reviewed were in line with the guidance provided and there was no evidence of bias in the interpretation of guidance. It said that if it had found non-compliance, it would have gone on to examine the personal characteristics of the doctors involved, but this was not necessary as all the decisions were compliant.
- 3.10 We did not see a separate analysis in the audit report of whether the guidance itself promotes fairness in decisions. We asked the GMC how it is addressing this matter. The GMC said it has an ongoing programme of work in relation to fairness, aimed at ensuring its guidance, as well as decisions, is fair. The GMC is working to ensure its processes are fair, consistent and free from bias. It says it will:
- commission independent assessments of its guidance
 - create a new approach to how it audits all regulatory functions, including learning from the findings of a review of all past research and audits about fairness

⁷ www.gmc-uk.org/-/media/documents/audit-of-the-fairness-of-decisions-in-the-gmc-fitness-to-practise-procedure-final-report-13-87644310.pdf

- review critical decision points in its processes to improve how they promote and maintain fairness, which will include looking at equality, diversity and inclusion guidance and training provided to staff
 - regularly publish more information about how it considers fairness across all its work.
- 3.11 The GMC plans to have completed this work by August 2022. It will implement and report on changes in the meantime.

Fair to refer?

- 3.12 We asked the GMC for an update on its work taking forward the recommendations of *Fair to refer?*, a report published in 2019. Of the five recommendations directed at the GMC specifically, it had completed one and had substantially addressed six other recommendations in collaboration with other organisations. The other recommendations directed at the GMC alone are now being taken forward in its work to eliminate disproportionate fitness to practise referrals, discussed above.
- 3.13 The GMC had paused some activities because of the pandemic. It also told us that the pandemic had affected the priorities of other organisations involved in the recommendations from *Fair to refer?*; for example, there is now a much stronger focus on the findings of *Fair to refer?* in relation to workforce sustainability. It said it is continuing to engage with other organisations and to advocate for the findings and recommendations of the research. Its targets to eliminate disproportionality in fitness to practise referrals and training will help to maintain the focus on the need for supportive and inclusive environments.
- 3.14 We are satisfied that it was reasonable for the GMC to incorporate its response to the recommendations of *Fair to refer?* into other relevant work. It is important for the GMC to demonstrate continuing progress, so that registrants and the public can be assured that the important findings of the research continue to be a matter of appropriate priority.

Employment tribunal ruling

- 3.15 In June 2021, an employment tribunal upheld a doctor's complaint that the GMC had discriminated against him on the grounds of race, in relation to an investigation it conducted between 2014 and 2018. The GMC has appealed this decision. It told us that regardless of the outcome of the appeal, it is conducting a learning review of the issues raised by the tribunal.
- 3.16 It is clear that this ruling has adversely affected trust in the GMC, particularly given the GMC's intention to appeal the decision. For a long time, it has been recognised that there is a disproportionate pattern in relation to fitness to practise referrals received by the GMC. However, the judgment suggested that there may be bias in the GMC's processes.
- 3.17 We are encouraged that the GMC plans to take learning from the case regardless of the outcome of the appeal, as well as the steps outlined above to ensure its processes and guidance are free from bias. Decisions within the process are made by human beings on its staff and it would be surprising if every decision were perfect. It is important that the GMC should ensure that its processes ensure consistency and fairness in practice and we will continue to monitor this area closely.

Gender markers on the register

- 3.18 We received several concerns about the GMC having a process to allow individuals to change their gender on the register. The GMC confirmed to us that the process has been in place for a number of years and it has processed around 50 name and gender changes since 2000, less than three per year on average.
- 3.19 We recognise that this is a complex area with competing rights and responsibilities. We fully support the rights of transgender professionals to gain full recognition of their acquired gender and to live their lives free from discrimination. It is also important that the public can be assured about a professional's fitness to practise, including any current sanctions. The GMC said it is developing how any fitness to practise history arising prior to transition of gender would relate to the new registration record. It confirmed that none of the doctors who had changed gender on their registration record up to this point had fitness to practise matters to display.

Guide for LGBT patients

- 3.20 The GMC published its first guidance⁸ aimed specifically at LGBT patients, with an LGBT rights charity and an LGBT doctors' organisation. The guidance makes it clear that all patients should be treated fairly, regardless of their sexual orientation or gender identity and trans status. It also includes information about what LGBT patients should and should not expect from their doctor.

Conclusion against this Standard

- 3.21 The GMC's approach of setting targets to eliminate two identified areas of disproportionality is ambitious but not unreasonable. It addresses some of the key problems facing minority registrants and we can see the potential for its targets to stimulate real improvements. It is right for the GMC to report annually on progress against these targets, particularly as the overall timescales for completion are relatively long. This will be important to maintain the focus on the targets, including how they address the areas for action identified by *Fair to refer?* in 2019.
- 3.22 We also note that the GMC has a programme of work in progress to review the fairness of its own processes, including work in response to the employment tribunal verdict. We are pleased that the GMC is reviewing its processes notwithstanding its appeal against the verdict. The outcomes of this work will be important in demonstrating the GMC's commitment to ensuring its own processes promote fairness. We will closely monitor its progress in this area. We are satisfied that the Standard is met.

Standard 4: The regulator reports on its performance and addresses concerns identified about it and considers the implications for it of findings of public inquiries and other relevant reports about healthcare regulatory issues.

- 4.1 The GMC publishes various reports about its performance each year. These include its annual report, fitness to practise report and the report of the MPTS.

⁸ www.gmc-uk.org/Ethical-guidance/Patient-guides-and-materials/LGBT-patient-guide?utm_source=press&utm_medium=press%20release&utm_campaign=LGBT

- 4.2 Last year (2019), the GMC commissioned an independent audit to review its customer complaints. The audit made several recommendations for improvement. The GMC told us it has actioned all those recommendations, as well as some it had identified itself from complaints. The changes included customer service and process improvements.
- 4.3 In October 2020, the GMC produced a report for its Council about the GMC's learning from the pandemic. The report summarises the GMC's response and identifies areas for learning in respect of each one. It is positive that the GMC has reflected on its response to the pandemic and we will monitor how it addresses the learning it has identified.
- 4.4 The GMC has cooperated with and responded to public reviews and inquiries. This included some recommendations made directly to the GMC, such as the recommendations of the Cumberlege Review⁹ and the inquiry by the House of Commons Health and Social Care Committee into the safety of maternity services in England.¹⁰

Conclusion against this Standard

- 4.5 The GMC has addressed concerns raised with it and reflected on its learning from Covid-19. We are satisfied that this Standard is met.

Standard 5: The regulator consults and works with all relevant stakeholders across all its functions to identify and manage risks to the public in respect of its registrants.

- 5.1 The GMC has restructured its outreach service to enable it to work more collaboratively. It said the new model allowed it to develop strong regional relationships, including with regional leaders from the Care Quality Commission (CQC), Nursing and Midwifery Council (NMC), Health Education England and NHS England/NHS Improvement.
- 5.2 The GMC is also working with the NMC and CQC in relation to maternity services in England, as well as with other organisations to share data about the English medical workforce. The GMC continued to engage with contacts throughout the UK during the pandemic.
- 5.3 The GMC published its latest perceptions survey in December 2020. The survey includes doctors, medical students and members of the public.
- 5.4 We received positive feedback from a doctors' representative organisation about how the GMC had communicated with it and kept registrants informed during the pandemic.

Conclusion against this Standard

- 5.5 The GMC has not carried out any public consultations in this review period. However it has continued to engage with a range of stakeholders about several areas of its work. We are satisfied that this Standard is met.

⁹ <https://www.immdsreview.org.uk/Report.html>

¹⁰ <https://committees.parliament.uk/publications/6578/documents/73151/default/>

Guidance and Standards

Standard 6: The regulator maintains up-to-date standards for registrants which are kept under review and prioritise patient and service user centred care and safety.

- 6.1 The GMC's primary standards document for doctors is *Good Medical Practice*, which was last updated with a minor change in April 2019. This year the GMC announced plans to review *Good Medical Practice*. It set up an external advisory group and will run a public consultation in 2022. It aims to complete the review by the end of 2023.
- 6.2 As part of its review of *Good Medical Practice*, the GMC considered how other regulators in the UK and internationally approach standards, and it considered the strengths and weaknesses of each approach. We welcome this evidence-based approach to its work.
- 6.3 The GMC is due to start regulating Medical Associate Professionals (MAPs) in 2023. It is producing interim guidance for Physician Associates (PAs) and Anaesthesia Associates (AAs). The guidance will be interim because the review of *Good Medical Practice* will include standards for all registrants. The GMC will also develop additional resources to help PAs and AAs apply the principles in practice, as well as creating a PA and AA standards hub on its website.

Conclusion against this Standard

- 6.4 We welcome the GMC's review of *Good Medical Practice* and its approach to the review. We will continue to monitor the GMC's work to develop standards for PAs and AAs. We are satisfied that this Standard is met.

Standard 7: The regulator provides guidance to help registrants apply the standards and ensures this guidance is up to date, addresses emerging areas of risk, and prioritises patient and service user centred care and safety.

- 7.1 The GMC provides guidance to supplement *Good Medical Practice*, which includes explanatory guidance that the GMC expects all newly qualified doctors to be familiar with.
- 7.2 In November 2020, the GMC's updated guidance on decision making and consent¹¹ came into effect. It published an accompanying fact sheet outlining the key legislation and case law.
- 7.3 The GMC has also published updated guidance for doctors about providing supporting information for appraisal and revalidation.¹² The main change was to give doctors increased flexibility about how they gather feedback.

¹¹ www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/decision-making-and-consent

¹² www.gmc-uk.org/registration-and-licensing/managing-your-registration/revalidation/guidance-on-supporting-information-for-appraisal-and-revalidation

- 7.4 In April 2021, the GMC published updated guidance on prescribing,¹³ which makes it clear that the same standards apply when prescribing remotely as when seeing a patient face to face. The document also has specific guidance for doctors prescribing remotely with patients in nursing homes and hospices, and patients based overseas.
- 7.5 The GMC continued to add guidance about Covid-19 to its ethical hub in this review period, including information about vaccines.

Conclusion against this Standard

- 7.6 The GMC continues to provide guidance for registrants which address problems as they arise. We are satisfied that this Standard is met.

Education and Training

Standard 8: The regulator maintains up-to-date standards for education and training which are kept under review, and prioritise patient and service user centred care and safety.

Recovery from the pandemic

- 8.1 In June 2021, the GMC reported that as part of its operational recovery and renewal from the pandemic, it made 77 derogations to curricula in 2020 to enable safe progression of trainees during the pandemic. It produced a guidance document about these temporary derogations which covers several scenarios, including progression without exams and extensions to training. The guidance includes safeguards to ensure the flexibility does not go too far in approving people through courses without evidence of the necessary skills.

Medical Licensing Assessment (MLA)

- 8.2 The GMC plans to introduce the Medical Licensing Assessment (MLA) in 2024-25. The MLA will comprise the Applied Knowledge Test (AKT) and the Clinical and Professional Skills Assessment (CPSA). It is intended to be an assessment for UK medical students and international medical graduates, with the aim of creating a common threshold for safe practice. In this review period the GMC approved a proposal from the Medical Schools Council to deliver the AKT through a test that would be regulated and overseen by the GMC.

Medical Associate Professionals (MAPs)

- 8.3 The GMC engaged with universities that deliver MAPs programmes ahead of the expected start of statutory regulation in 2023. It will also seek feedback about the draft education framework for MAPs.

Conclusion against this Standard

- 8.4 The GMC continues to clearly set out the standards for education and training, which refer to *Good Medical Practice*. The GMC is working on several projects including new areas of work, such as education standards for MAPs and the MLA. We are satisfied that this Standard is met.

¹³ www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-practice-in-prescribing-and-managing-medicines-and-devices

Standard 9: The regulator has a proportionate and transparent mechanism for assuring itself that the educational providers and programmes it oversees are delivering students and trainees that meet the regulator's requirements for registration, and takes action where its assurance activities identify concerns either about training or wider patient safety concerns.

9.1 Last year the GMC paused in-person quality assurance visits due to the pandemic, and carried out virtual visits instead. This year the GMC took a blended approach as restrictions eased. The GMC told us this year that it is reviewing the effect of these changes and will hold workshops around themes of activity in relation to education quality assurance.

9.2 The GMC continued to take action in relation to concerns about training environments, including through its enhanced monitoring process. In April 2021, trainees were removed from one hospital where the required standards were not being met.

Medical training quality assurance review

9.3 The GMC has implemented new process for its quality assurance programme, moving away from large-scale visits every five years to a risk-based approach where organisations will be required to sign a declaration and complete a self-assessment which will then be assessed by the GMC. The GMC reported that all medical schools and postgraduate training organisations will complete their first declaration and self-assessment by the end of 2021.

9.4 The GMC commissioned an internal audit of its quality assurance function, including the enhanced monitoring process. This included assessing impacts from the pandemic and equality, diversity and inclusion considerations. The audit found it had passed all benchmarks.

Conclusion against this Standard

9.5 It is appropriate for the GMC to review the changes it made to its quality assurance visits during the pandemic, to see whether it can learn from them. We will continue to monitor the implementation of its new education quality assurance process. We are satisfied that this Standard is met.

Registration

Standard 10: The regulator maintains and publishes an accurate register of those who meet its requirements including any restrictions on their practice.

Fraudulent entry to the register

10.1 Last year, because of the pandemic, the GMC paused the follow-up checks it was doing after an incident of fraudulent registration which came to light in 2018. Following a review this year, the GMC decided not to pursue these checks further. It had already verified all the doctors who joined its register by the route involved in the fraudulent registration.

- 10.2 A further instance of fraudulent registration came to light in 2020. The individual was removed from the register five months after joining it. The GMC carried out a significant event review to establish what had happened. The applicant registered as an EEA national, which at the time meant the GMC was not entitled to carry out primary source verification of their qualifications.¹⁴ Furthermore, the GMC had paused in-person identity checks because of the pandemic. The GMC described the incident as a complex fraud and said it would be providing more regular fraud awareness training for staff. It was also carrying out checks on a sample of people who joined the register without an identity check.

The temporary register

- 10.3 The GMC reported in August 2021 that around 24,000 doctors remained on the temporary register and about 470 from that register had transitioned to full registration. The GMC contacted those who have temporary registration to confirm whether they want to continue to hold it. It will also tell these doctors how they can transition from temporary to full registration.

Register check

- 10.4 We checked a sample of entries on the register and found no causes for concern.

Conclusion against this Standard

- 10.5 While it is concerning that individuals were able to join the GMC register fraudulently, these were isolated incidents which occurred some years apart, in relation to different application routes, neither of which still operates in the same way. We do not consider that the more recent incident casts doubt on the adequacy of the GMC's response to the previous one. In the context of the number of registrations processed without concern by the GMC, we do not consider that they cast doubt on the overall integrity of its process. The GMC has taken steps to learn from what happened. We will continue to monitor its work in this area. We are satisfied that this Standard is met.

Standard 11: The process for registration, including appeals, operates proportionately, fairly and efficiently, with decisions clearly explained.

New routes to registration

- 11.1 This year the GMC has introduced two new pathways to registration. One of these is for doctors who have graduated from a medical school outside the UK or Switzerland. This pathway was introduced due to the disruption of the PLAB exams during the pandemic. The GMC mapped a selection of exams against the requirements of PLAB to determine whether they were acceptable. Applicants with passes in the registration exams for the USA, Canada or Australia will be eligible for the new route, providing they meet certain criteria, including if they have completed an internship and passed the registration exam in four attempts or fewer. The GMC told us that this pathway will likely remain in place until October 2023, when it will assess whether to retain it. If so, the GMC

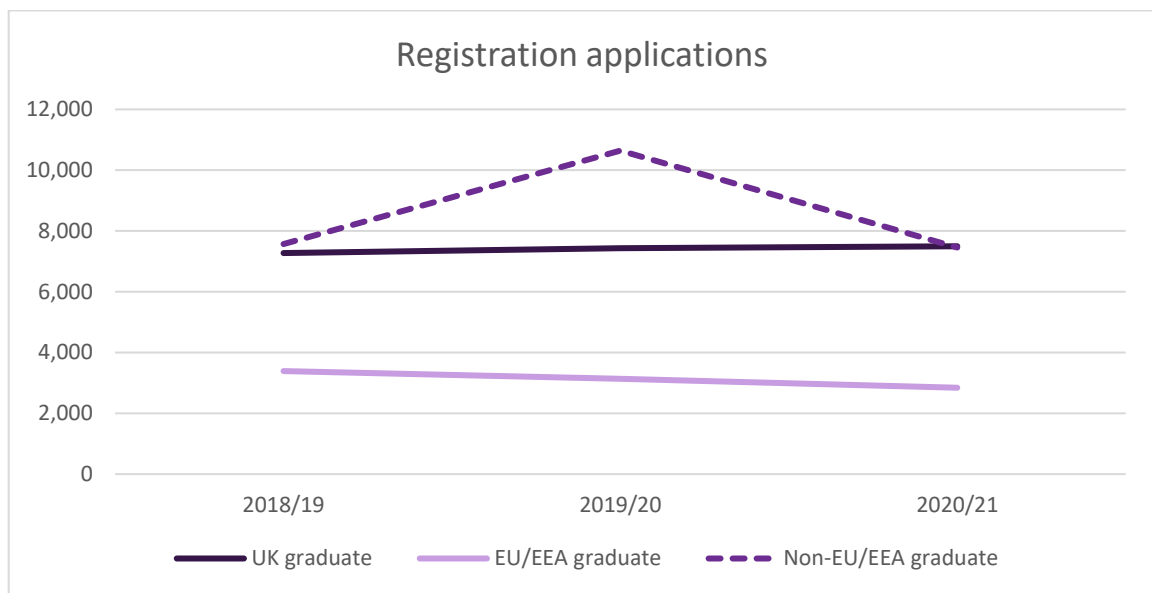
¹⁴ As explained at paragraph 11.2 below, the GMC now has the ability to seek primary source verification of EEA qualifications.

will develop a quality assurance process to reassess the acceptability of each exam.

- 11.2 The second route to registration introduced by the GMC this year is for graduates with a relevant qualification from the EEA and Switzerland. The GMC published a list of relevant European qualifications, based on those listed in the EU Directive of Recognition of Professional Qualifications on the day the UK left the EU. This route was introduced as a result of Brexit transitional arrangements and will fall away when those arrangements end. The GMC told us that the transitional arrangements allowed it to implement additional requirements such as verifying the doctor’s qualification and requiring evidence of their knowledge of English.

Application processing data

- 11.3 The graph below shows the number of applications received by the GMC in the last three financial years.



- 11.4 The data shows that there has been a very slight increase in registration applications from UK graduates this year, while applications from international graduates have decreased. There was a significant decrease in applications from non-EU/EEA due to the impact of the pandemic on the movement of international medical graduates. There was disruption to the PLAB 2 exams, which the GMC was able to resume in August 2020 with reduced numbers.

- 11.5 The table below sets out the median time taken in working days to process the different types of registration application.

Median days to process registration applications:	2018/19	2019/20	2020/21
UK graduate	1	1	1
EU/EEA graduate	24	28	28
Non-EU/EEA graduate	16	18	16

- 11.6 These figures show that the time to process applications remains consistent with previous years and that the time to process non-EU/EEA applications has improved slightly since last year.

Conclusion against this Standard

- 11.7 We are satisfied that the GMC's registration processes continue to work efficiently and fairly. We have seen that the GMC has developed new routes to registration which appear reasonable in the circumstances, and we note that there are plans in place to review them. We are satisfied that this Standard is met.

Standard 12: Risk of harm to the public and of damage to public confidence in the profession related to non-registrants using a protected title or undertaking a protected act is managed in a proportionate and risk-based manner.

- 12.1 Information on the GMC's website makes it clear that doctors must have a licence to practise and if they do not, the GMC will investigate. This page also provides contact information and guidance for people to report someone to the GMC who they believe to be practising illegally, as well as a link to the medical register for the user to check a doctor's registration. The website explains the action the GMC can take if it receives information that an individual is practising illegally.
- 12.2 We have not received any information this year to suggest that there are concerns about the GMC's approach to these cases. We are satisfied that this Standard is met.

Standard 13: The regulator has proportionate requirements to satisfy itself that registrants continue to be fit to practise.

- 13.1 The GMC provides detailed information on its website about revalidation, tailored to doctors, patients, and members of the public. Revalidation requires different types of information and processes depending on the level of supervision of doctors' work in and the environment in which they practise. It includes requirements to obtain feedback from patients.

Guidance on supporting information for appraisal and revalidation

- 13.2 Last year, the GMC consulted on changes to revalidation requirements for patient feedback, and invited responses from both doctors and patients. The GMC published this updated guidance¹⁵ in November 2020. It gives doctors more flexibility about the tools they use to obtain feedback, such as apps or focus groups. The GMC said this should make the process simpler.

Covid-19

- 13.3 At the start of the pandemic, the GMC pushed back revalidation dates for some doctors by one year to ease pressure on doctors and responsible officers. Since then, the GMC has rescheduled revalidation dates for further groups of doctors due to the ongoing demands of the pandemic. In April 2021, the GMC began

¹⁵ www.gmc-uk.org/registration-and-licensing/managing-your-registration/revalidation/guidance-on-supporting-information-for-appraisal-and-revalidation

routinely contacting doctors to give them four months' notice of their revalidation submission dates. It acknowledged that not all doctors will be ready to revalidate on their scheduled date, but there are options available to them, such as a deferral recommendation submitted by the responsible officer. The GMC said it will continue to be as flexible as possible in its approach to revalidation.

Conclusion against this Standard

- 13.4 This year we have seen the GMC take a flexible approach to revalidation, in terms of moving revalidation dates due to the pandemic and providing doctors with more flexibility in how they obtain patient feedback for revalidation. We think that the GMC ought to review the impact of the changes that it has made to assess whether the temporary measures could be continued without adversely affecting doctors' continuing fitness to practise. We are satisfied that this Standard is met.

Fitness to Practise

Standard 14: The regulator enables anyone to raise a concern about a registrant.

- 14.1 The GMC continues to publish information about how to raise a concern about a doctor and we have not received any concerns to suggest the GMC cannot be contacted to raise concerns.
- 14.2 The GMC's *Charter for patients, relatives and carers*, ('the Charter'),¹⁶ launched in 2019, sets out to provide a high standard of service when a patient, relative or carer raises a concern. One of the promises in the Charter is that, if the concern is not something the GMC can deal with, it will try to help the complainant find someone who can deal with it. The GMC has guidance for staff about signposting complainants to other organisations and its analysis has shown that signposting to other organisations is increasing. The Charter includes a link to the Independent Support Service, a service provided by Victim Support for those who have raised concerns with the GMC and the NMC.
- 14.3 The data we collect about referrals received and decisions made at the early stages of the fitness to practise process does not suggest concerns about the GMC's performance in this area. We are satisfied that this Standard is met.

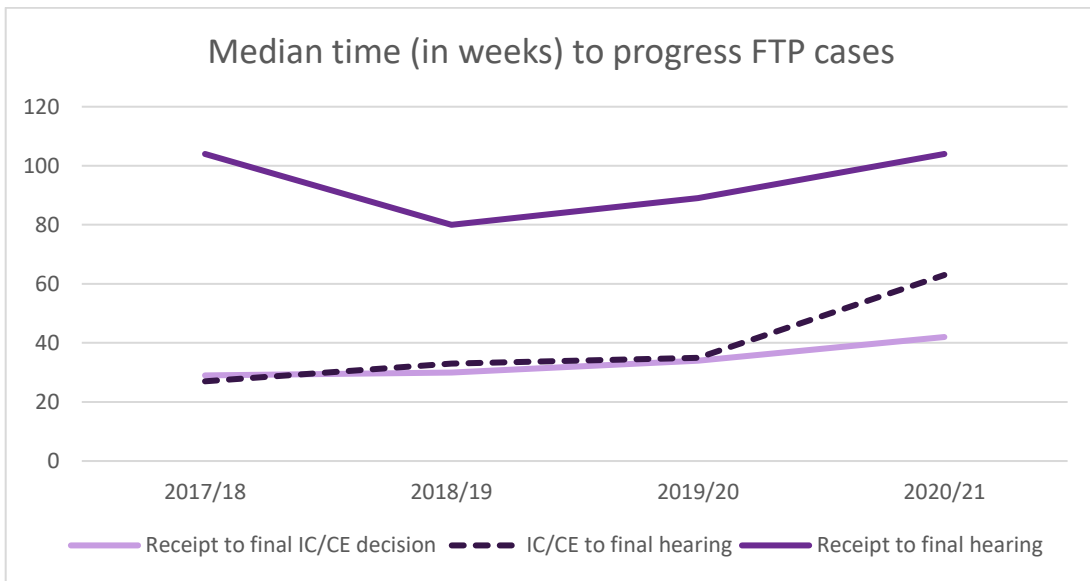
Standard 15: The regulator's process for examining and investigating cases is fair, proportionate, deals with cases as quickly as is consistent with a fair resolution of the case and ensures that appropriate evidence is available to support decision-makers to reach a fair decision that protects the public at each stage of the process.

Timeliness in fitness to practise

- 15.1 According to this year's dataset, the GMC's performance has deteriorated in all three of the main timeliness measures since last year. The annual figures this

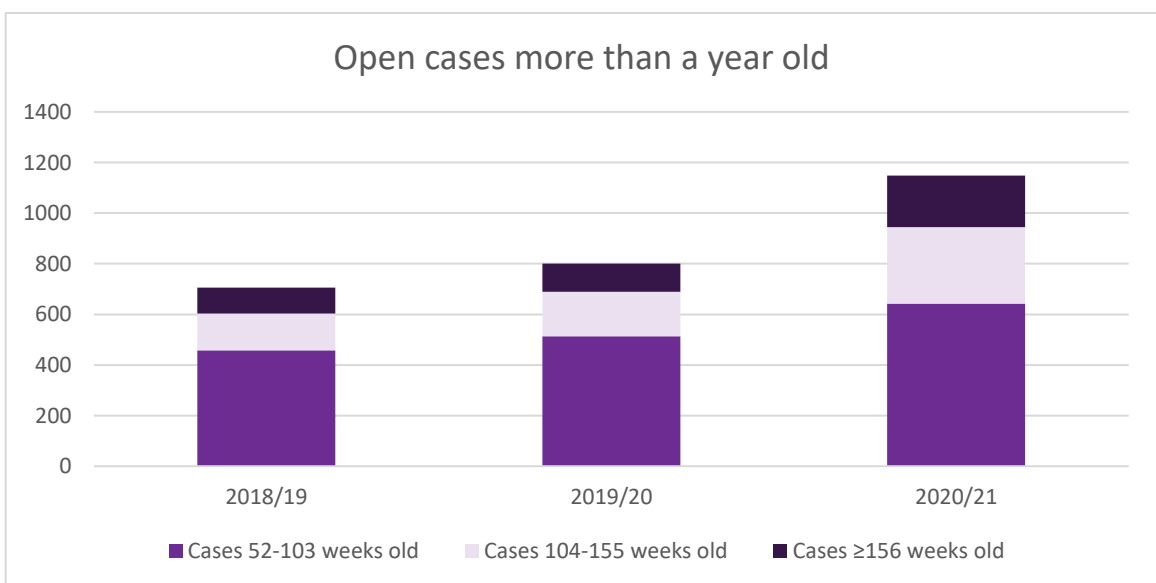
¹⁶ www.gmc-uk.org/about/what-we-do-and-why/charter-for-patients-relatives-and-carers

year include the early stages of the pandemic, and due to the disruption caused we would expect to see significant delays in the investigation stages.



15.2 The GMC told us that it remains difficult to obtain information from third parties, particularly because they will frequently be concentrating on the increased demands of the pandemic. Since the pandemic began, the GMC has not put pressure on them to provide information, leading to investigations taking longer. The GMC says that cases are now being progressed as efficiently as possible. It also has more staff resource, which should increase its capacity to deal with cases.

15.3 The chart below shows that there has been an increase in older cases since last year. The GMC has plans in place to progress cases through both the investigations and hearings stages and reduce this number.



Fitness to practise recovery plans

- 15.4 In March 2021 the GMC's Executive Board outlined its recovery plan to clear backlogs in fitness to practise, by speeding up investigations and accelerating progress on concerns being addressed locally in the first instance. The GMC said that there was a clearer expectation that Responsible Officers should seek advice from an Employer Liaison Adviser before making a referral. Referrals will be accepted without such advice, but the GMC will follow up with the Responsible Officer afterwards. We think it is important that the GMC should monitor the impact of this to ensure that case which ought to be referred are not being inappropriate diverted to local resolution.
- 15.5 The Medical Practitioners Tribunal Service (MPTS) told us that it has increased the number of hearings it is running each day to cover the hearings days that were lost in 2020 and to return to pre-pandemic levels. It expects to achieve this by early 2023.

New guidance for decision makers

- 15.6 In September 2020 the GMC introduced guidance¹⁷ for decision-makers on Covid-19, to 'assess the risk to public protection posed by a doctor as a result of concerns about their practice during the pandemic'. The guidance states that Covid-19 related circumstances, their impact on the system within which the doctor was working, and the impact on the doctor's practice/conduct should be considered.
- 15.7 It was appropriate for the GMC to recognise that there was a need for this guidance to reflect the circumstances of the pandemic. It was introduced promptly, therefore allowing the circumstances of the pandemic to be considered in referrals arising from Covid-19.
- 15.8 In March 2021 the GMC introduced guidance for decision makers on allegations of low-level violence and dishonesty. The changes to the GMC's approach were introduced following research¹⁸ it conducted in 2018, which showed that most respondents felt that the GMC should take no action or issue warnings in cases of low-level violence or dishonesty. Previously, the GMC had a presumption of impairment with allegations of violence and dishonesty which meant they should be referred for a hearing unless there were exceptional reasons not to do so. The GMC said this meant a number of cases were concluded with no action at hearings as the doctor's fitness to practise was found not to be impaired. The guidance will allow greater discretion on the action that can be taken to address these concerns. The GMC also updated its guidance for the Investigating Committee and case examiners so that guidance for all decision-makers is consistent.
- 15.9 The GMC plans to review the guidance with feedback from decision makers and will use data to understand the impact of the guidance, both in terms of case outcomes and the numbers of decisions which are subject to challenge.

¹⁷ www.gmc-uk.org/-/media/documents/dc13028-guidance-for-decision-makers-on-covid-19--external-version-pdf-83985701.pdf

¹⁸ www.gmc-uk.org/-/media/documents/promoting-and-maintaining-public-confidence-in-the-medical-profession---final-report-pdf-78718694.pdf

Conclusion against this Standard

- 15.10 The GMC's performance against our timeliness measures has deteriorated this year. We expected this, given the disruption associated with the Covid-19 pandemic. The GMC has developed a recovery plan and we will monitor the GMC's performance in this area. We do not consider that the decline in the GMC's performance is such as to cause concern at this stage and are satisfied that this Standard is met this year.

Standard 16: The regulator ensures that all decisions are made in accordance with its processes, are proportionate, consistent and fair, take account of the statutory objectives, the regulator's standards and the relevant case law and prioritise patient and service user safety.

Medical Practitioners Tribunal Service (MPTS) hearings

- 16.1 The MPTS Quality Assurance Group regularly reviews a proportion of written tribunal determinations. Its reviews inform future tribunal member training. The learning points which are issued to tribunal members can be viewed on the MPTS website.
- 16.2 The MPTS reported to the GMC Council in December 2020 that internal auditors carried out a learning review of the virtual hearings process and gave it a 'green' risk rating. It noted specifically the MPTS's rapid response and the quality assurance of all new guidance documents.

The fairness of decisions

- 16.3 As noted at paragraph 3.9 above, an independent audit of fitness to practise decisions at the earlier stages of the process found that all decisions were consistent with GMC guidance.

The dataset

- 16.4 The GMC's case examiners made fewer decisions this year than last, because of the impact of the pandemic on investigations. However, the breakdown of outcomes is very similar to last year, suggesting consistency in the GMC's decision-making.
- 16.5 We continue to review MPTS decisions and in this review period we were notified of 374 final decisions. We exercised our power of appeal in two cases and joined the GMC's appeal in another. All those appeals were upheld in this review period.
- 16.6 We also continue to write to the GMC and MPTS to share learning points identified from the cases we review. We identified learning points in only a small number of cases this year. The GMC and MPTS replied to the learning points we shared in one case and outlined action they will take in response.

Conclusion against this Standard

- 16.7 The data we saw this year did not give us any cause for concern. The GMC continues to have measures in place to ensure the quality of decision-making. We are satisfied that this Standard is met.

Standard 17: The regulator identifies and prioritises all cases which suggest a serious risk to the safety of patients or service users and seeks interim orders where appropriate.

The dataset

- 17.1 The time from receipt of a complaint to interim order decision has increased slightly this year compared to last year.¹⁹ However, the median is still lower than the previous three years. The GMC continued interim order hearings throughout the pandemic and the time to interim order decision from the point where a possible need for one identified has stayed consistent with last year. This demonstrates that the GMC was able to continue scheduling interim order hearings despite the pandemic.
- 17.2 There has been an increase in High Court extension applications compared to last year.²⁰ Given the disruption to investigations due to the pandemic, and the consequent ageing caseload, this is not surprising. We note that the GMC has a recovery plan in place.

Conclusion against this Standard

- 17.3 The data indicates a very slight decline in the GMC's performance in the time from receipt of referral to interim order decision this year. However, it is not out of line with figures we have seen in previous years, and, particularly in the context of the pandemic, is not a significant concern. We are satisfied that this Standard is met.

Standard 18: All parties to a complaint are supported to participate effectively in the process.

Corporate strategy

- 18.1 'Making every interaction matter' is a theme of the GMC's new corporate strategy. It recognises that some people feel their interactions with the GMC are impersonal. This endorses some of the concerns that we receive ourselves. In its corporate strategy, the GMC says it will:
- make sure that healthcare professionals and members of the public 'are met with empathy, fairness and professionalism'
 - learn from the feedback they provide
 - make sure that everyone can access GMC services in a way suited to them, for example in another format or language, or providing additional support to enable someone to raise a concern.
- 18.2 The GMC says it will work with patients and the public to improve processes, as well as working with diverse groups of medical professionals to understand their experiences of practice.

¹⁹ A median of 8.1 weeks as against 7.8 weeks last year, an increase of two days.

²⁰ 306 as against 262 last year, an increase of 17%.

Support for doctors

- 18.3 In this review period the GMC published a report²¹ about the changes it has made to support doctors through the fitness to practise process since a review²² in 2015. There have been over 25 changes to the GMC's investigation process. The changes aimed to ensure that only complaints that require GMC action are referred in the first place, increase support for doctors, and improve the sensitivity of correspondence.
- 18.4 The GMC published a report²³ in February 2021 about how it can encourage engagement from registrants during a fitness to practise investigation, which set out considerations for the GMC when redesigning the fitness to practise process. These included that correspondence should be more personable, supportive and should clearly state all potential outcomes of the case, guidance on the information that registrants should consider providing the GMC at the start of the investigation, and wider engagement with defence organisations.

Support for other parties to the process

- 18.5 The GMC's annual report noted that over 90% of people surveyed after using the Patient Liaison Service between 2018 and 2020 were happy with the service they received. It also reported that patients' awareness of the GMC has increased since 2018.
- 18.6 The GMC told us that it has also improved its website to better support members of the public who want to raise a concern and will continue to improvements in the light of feedback. We asked the GMC if it had considered applying any of the recommendations about engagement with registrants to other parties in the fitness to practise process. It told us that it has plans to map out the fitness to practise journeys for registrants, complainants and patients to identify opportunities for improvement. It is considering how it can evaluate its services against the commitments outlined in the Charter.

Conclusion against this Standard

- 18.7 We did not receive evidence this year of significant concerns about how the GMC supports people in the fitness to practise process. There is, however, clear potential for further improvements to be made to its communications with and support for doctors. The GMC recognises they may also apply to its correspondence with patients, families, and the public. The GMC recognises there is more to do in this area. We will continue to monitor its progress. We are satisfied that this Standard is met.

²¹ <https://www.gmc-uk.org/-/media/documents/report-on-supporting-vulnerable-doctors-programme-december-2020.pdf>

²² www.gmcuk.wordpress.com/2016/04/07/putting-mental-health-safety-at-the-heart-of-the-fitness-to-practise-process/

²³ <https://www.gmc-uk.org/-/media/documents/gmcftp-engagement-insight-report-v30.pdf?la=en&hash=7EF3D0F8403DC0C657D6831490A6934010081C93>

Useful information

The nature of our work means that we often use acronyms and abbreviations. We also use technical language and terminology related to legislation or regulatory processes. We have compiled a glossary, spelling out abbreviations, but also adding some explanations. You can find it on our website [here](#).

You will also find some helpful links below where you can find out more about our work with the 10 health and care regulators.

Useful links

Find out more about:

- [the 10 regulators we oversee](#)
- [the evidence framework we use as part of our performance review process](#)
- [the most recent performance review reports published](#)
- [our scrutiny of the regulators' fitness to practise processes, including latest appeals](#)

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Action	To note
Purpose	To update Council on our work to build trust and confidence in the organisation through the impact of our communications and engagement activity with audiences and stakeholders around the UK.
Decision trail	N/A
Recommendation(s)	To note our achievements and the priorities we have identified for our work in the future.
Annexes	Annex A: Four country update Annex B: Data pack
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Sponsoring director/ Senior Responsible Owner	Paul Reynolds , Director of Strategic Communications and Engagement

Introduction

- 1 In this paper, we update Council members on our work to build trust and confidence in the organisation through the impact of our communications and engagement activity with audiences and stakeholders around the UK.
- 2 This paper combines two reports which we have presented separately to Council in the past: our directorate's annual update on communications and engagement activity, and our four-country update (received by Council members twice a year). Therefore, this paper (and its supporting annexes) contains a significant amount of detail about our work over the last period.

Background

- 3 In our corporate strategy, we say that we want to be an 'effective, relevant and compassionate regulator'. We can only achieve this with good communications and engagement as an organisation. As a directorate, we enable this by:
 - a creating and delivering engaging, relevant content for our internal and external audiences through the channels which we own or have access to
 - b building positive relationships with organisations that can help us to deliver our regulatory functions and strategic priorities
 - c identifying intelligence and insights from our external environment and sharing them internally
 - d facilitating the delivery of the GMC's statutory functions through the relationships we hold with Responsible Officers and their organisations
 - e helping the organisation to shape the legislative framework and policy environment in which we operate as a regulator
 - f supporting the leadership, culture and transformation of the organisation through good communications with the people who work for us
 - g and fostering the development of relevant, effective and compassionate communications and engagement by the organisation as a whole, to help our audiences and stakeholders have a good experience when they interact with us.
- 4 We have improved our capabilities as a directorate by delivering two significant change programmes in recent years. These changes have been the subject of audit reviews over the past 12 months:

- a We have brought together our employer liaison and regional liaison services to form a single, combined Outreach function. In the summer of 2021, an internal audit found:

'...good evidence of a general enhancement in collaboration and communication with local healthcare systems, especially in England... There are particularly positive developments with local engagement with both regulators such as the NMC and CQC and the local healthcare systems.'

- b We have also improved our systems and processes for managing our stakeholder relationships across the four UK nations. An audit received by the Audit and Risk Committee in March 2022 concluded:

'Overall, stakeholder relationship arrangements are well managed with proportionate controls in place to ensure key strategic relationships between the GMC and key stakeholders are properly planned, managed and recorded... a large amount of time and investment has been made to enhance stakeholder engagement...'

Looking back

- 5 For much of 2021, our work as a directorate has been dominated by the ongoing effects of the Covid-19 pandemic. We have supported the organisation and its recovery from this in the following ways:

- a Our Outreach teams have engaged with partners at national, regional and local levels to provide advice about our requirements, support organisations with changes to our processes, manage communications between the GMC and the most challenged providers, and capture feedback and insights which have aided the GMC's work and decision-making.
- b Throughout the pandemic, we have promoted our ethical guidance to the medical profession and delivered messages to help them feel psychologically safe. Our aim has been to help doctors feel supported by us as a professional regulator and reassured about how our processes operate (for example, about how our fitness to practise investigations take the context and pressure of doctors' working environments into account). As the Professional Standards Authority noted in its review of the GMC's performance in 2020/21:

'We received positive feedback from a doctors' representative organisation about how the GMC had communicated with it and kept registrants informed during the pandemic.'

pages to support international medical graduates taking our PLAB assessment.

- b** creating communities of interest around particular pieces of work – for example, our review of *Good medical practice* and our work to bring Medical Associate Professionals into regulation. We support each community with a dedicated e-newsletter.
 - c** developing a communications and engagement strategic plan for medical students. As part of this we have launched a corporate account on Instagram. We have also enhanced our digital campaign that supports final-year medical students through the process of applying for provisional registration – a key transition point in their medical career and relationship with us as a regulator.
- 9** We can demonstrate our increasing effectiveness as a directorate (and the impact of initiatives such as increased segmentation) through the data which we capture about our performance – see **Annex B**. This shows:
- a** increased levels of engagement by our people with the news stories that we publish on our intranet
 - b** the attraction of more visitors to our website and increased levels of satisfaction with its content (in particular, with content about our ethical guidance)
 - c** a high volume of doctors and medical students engaged through the sessions delivered by our Outreach teams on professional and ethical issues
 - d** continued positive relationships with our national-level stakeholders
 - e** healthy levels of engagement with our audience e-bulletins, above an external benchmark relevant for our sector
 - f** the volume of media coverage about the GMC and MPTS with a positive sentiment has been above target
 - g** high levels of satisfaction from doctors with the sessions delivered by our Outreach teams
 - h** and a high conversion rate for cases meeting the threshold for an investigation that are referred by Responsible Officers, demonstrating that

the advice given to them by our employer liaison advisers ensures that the right cases are referred to us.

Reflections on our external environment

- 10** The pressure of the Covid-19 pandemic combined with the usual challenges faced by healthcare providers over the winter period have limited our engagement over the past few months. Providers are principally focused on capacity and resource, and we are not seeing any powerful or coordinated effort to address issues related to ED&I beyond high level agreement that this is an important area. This will impact on the pace of our ambitions.
- 11** While some organisations have started to request face to face engagement with us, many areas continue to prefer this to happen virtually. Our Outreach teams have managed the change to virtual provision well. However, this method of delivery impacts on our ability to build new relationships and collect intelligence about local issues.
- 12** Once the Health and Care Bill is passed into law, it will bring about a series of changes to our relationship landscape in England. Health Education England and a number of other agencies will join with NHS England. The Bill will also establish integrated care boards and integrated care partnerships across England and dissolve Clinical Commissioning Groups (CCGs). At a national level, we are speaking with Health Education England and NHS England to ensure HEE's responsibilities for medical education continue after the merger. At a regional level, the merger of HEE and NHS England and the development of integrated care systems are, quite understandably, consuming the focus of our partners. We need to understand the impact which these structural changes will have on our role as a regulator and the influence we want to have.
- 13** Over the past 12 months we have seen several bills relevant to the work of the GMC make their way through the UK Parliament. Where we have had concerns about draft legislation, we have engaged with ministers, officials, other interested organisations and political stakeholders to secure changes. This work demonstrates the strength of our relationships in Westminster and our increasing capability to influence in this area. We have developed a strong relationship with a cohort of politicians – particularly members of the House of Lords with a medical background. A recent survey of our political stakeholders by YouGov found over two thirds (77%) were confident in the way that we regulate the medical profession. Not surprisingly, we saw the highest levels of confidence among members of the House of Lords (88%).

- 14 The decision by an MPTS tribunal to grant voluntary erasure to Michael Watt has affected our relations in Northern Ireland. The same recent survey of our political stakeholders by YouGov found a drop in confidence in our regulatory processes among members of the Northern Ireland Assembly. Public, political and media interest in our investigations linked to inquiries remains high. We have prioritised our engagement with patients and their families who are affected.
- 15 The broader political situation in Northern Ireland remains challenged. Elections for the Northern Ireland Assembly will be held in May 2022. The Northern Ireland Executive ceased to exist in February following the resignation of the First Minister. This affected the ability of the country's Department of Health to make decisions about the future of the country's healthcare services and medical workforce. We wait to see what impact these events will have on the fortunes of Northern Ireland's political parties and the consequences this will have for the make-up of the Assembly and the Northern Ireland Executive. Our team in Northern Ireland will monitor developments closely. Following the elections in May, they will work on building the trust and confidence of Assembly members in the GMC's processes.
- 16 The debate about Scotland's independence has been relatively quiet since elections were held for the Scottish Parliament in 2021. We expect this to change as we progress through 2022. The Scottish National Party wishes to hold a referendum in 2023, and we expect rhetoric from nationalist and unionist sides to increase. We will monitor the debate closely and consider what this might mean for the GMC.
- 17 The pandemic has rightly dominated the media agenda for the last two years. Nonetheless, our media relations team has maintained a positive media profile for the organisation (see **Annex B**). The team has focused on amplifying our messages about the organisation's work and its priorities for the future, making the most of opportunities such as the speeches delivered by our Chair and Chief Executive.

Looking forwards: our priorities for the future

- 18 The changing external context, both in terms of the structural changes resulting from new legislation and as the NHS emerges from the pandemic will very much drive our strategic communications and engagement activity over the coming period. This will shape the conversations and influence we want to achieve at a national, regional and local level in support of our key strategic objectives.

19 Our priorities for 2022 are to:

- a** enable the delivery of the organisation's priorities for the medical workforce, in particular the progress we want to make on ED&I.
- b** help the organisation with its ongoing recovery from the Covid-19 pandemic
- c** engage widely with patients, doctors, employers and others and build their support for the changes that we want to make to our professional standards and regulatory services
- d** build and sustain the confidence of our stakeholders and audiences in the GMC's role
- e** continue to increase the impact and influence of our work as a directorate.

20 We will work with our partners in healthcare systems to bring our ED&I targets alive with practical examples of change. We will look at how we can support systems to make meaningful changes to the experiences of doctors.

21 We will roll out our professional behaviours and patient safety programme with the Nursing and Midwifery Council to maternity providers in England, in collaboration with our regional and local partners.

22 In late April, we will support the GMC's public consultation on changes to *Good Medical Practice*. Every team in our directorate will be involved in promoting this consultation to ensure a healthy response from our stakeholders and audiences.

23 In the autumn, we expect the Department of Health and Social Care to launch its consultation on the Section 60 order that will deliver regulatory reform. We will support this consultation and engage widely with our audiences and stakeholders to ensure the changes to our regulatory functions receive a strong mandate for the future.

24 We expect the Privy Council will confirm our new Chair of Council shortly and we will follow this with a public announcement. We will develop a comprehensive programme to support our new Chair's induction into the organisation. This will include an engagement plan to help them build their relationships with our key regulatory partners and stakeholders.

25 With the loosening of restrictions across the UK, we plan to return to face to face meetings of our UK Advisory Fora this spring. Our theme will be

'supporting the workforce'. We will discuss our role in the promotion of inclusive and open cultures that support the recruitment and retention of the workforce.

- 26 It is likely that we will see Welsh language standards introduced for healthcare regulators over the next few months. Our team in Wales is leading a review of our organisation's preparedness for this change and has engaged closely with politicians, officials and those who are likely to use Welsh language services (such as medical schools). The standards will require the GMC to make some improvements to its services and documentation. We will help the organisation to be ready for these changes in a way that is both positive and proportionate.
- 27 In May, we will hold our annual stakeholder conference 'Better healthcare together', with 'people, place and culture' as the key themes. We will run a series of workshops about our strategic priorities for the medical workforce. More than 300 people have registered to attend the conference so far. We will continue to market the conference in the coming weeks to increase the number of delegates taking part.
- 28 Over the next few months, we will experience a number of high profile and sensitive issues which could affect confidence in our work. We will support the organisation with its response to these issues, communicating openly and honestly with our stakeholders and audiences to help them understand our position and the steps we always take to listen, learn and improve.
- 29 In the early summer, we will begin fieldwork for our 2022 perceptions survey. We reported the results of our 2020 survey to Council in December of that year. We will report the results to Council towards the end of 2022 or early 2023.
- 30 Improving our engagement with patients and the public remains a key priority for our directorate. We will take steps to increase their involvement in our work, using the opportunity that regulatory reform gives us to make our services as an organisation more sensitive to those who use them. We will build relationships with new and diverse patient groups, improve our internal co-ordination, and revive a cross-regulatory group on patient and public involvement. Our organisation's approach to patient engagement will be the subject of an internal audit during 2022.
- 31 When we begin to regulate medical associate professionals, we will become a multi-profession regulator for the first time. This has implications for our organisation's identity and the way we describe our work. During 2022 we will roll out new document templates to the organisation plus a set of updated standard 'descriptors' which will explain our role in simple, accessible terms.

- 32** Finally, we will continue to improve the quality and relevance of our communications with the medical profession, medical students and medical associate professionals. We will segment our content for different groups within the profession (including groups at key transition points of their careers) where we can. We will also complete work on a new strategy that will make our website more effective at responding to the needs of our audiences.

Conclusion

- 33** This annual update demonstrates the breadth of our involvement in the organisation's work to keep patients safe and help doctors practise well. We enable this in many ways: through our content, services, channels, relationships insights and advice.
- 34** We were formed as a directorate in 2018. Since then, as indicated by two recent audits, we have continued to grow and improve. Our data also shows the increasing effectiveness and impact of our work.
- 35** We will continue to find ways to improve what we do, using data and insights to help us understand what works best with our stakeholders and audiences. However, our structure and performance as a directorate are fundamentally sound. As such, we can train our attention fully towards helping the organisation with the delivery of its strategic priorities.

Four country update

Introduction

- 1 This update provides an overview of the engagement we have delivered with our partners and stakeholders in the four countries of the UK. Our last 'four country update' for Council was in November 2021.
- 2 The update looks at each UK country in turn and covers the following themes:
 - a regulatory alignment and co-operation
 - b partnership work to support our corporate priorities (such as ED&I and wellbeing)
 - c broader relationship building, engagement and influencing (including public affairs activity)
 - d monitoring and responding to inquiries and reviews
 - e and future priorities.

Country update: Scotland

Theme: Regulatory alignment and co-operation

- 3 In March we signed the Framework for Sharing Intelligence in Scotland (which includes an Emerging Concerns Protocol). We and our partners are now focused on implementing this, and the principles are already providing a mechanism for signatories to share potentially serious concerns at a system or service level at any time. Separately we have been considering what support we can provide to ensure that existing patient safety mechanisms and quality assurance functions are working to their full potential.
- 4 We have continued to work with other healthcare professional regulators in Scotland through a Professional Regulators Group. In 2021 the Group collaborated on areas including the development and implementation of the framework for sharing intelligence, and the Scottish Government's National Care

Service consultation. The Group also held a joint stand at the virtual NHS Scotland conference.

- 5 Our liaison advisers in Scotland are working increasingly closely with the Nursing and Midwifery Council (NMC). They are currently running joint sessions with medical, nursing and midwifery students at Aberdeen Medical School, and are planning to do this with other medical schools, starting with Edinburgh. They are also planning a series of online sessions about professional behaviours for maternity staff at NHS Greater Glasgow and Clyde. Other health boards are moving ahead with organising professional behaviours sessions, which we are engaging with the NMC on.

Theme: Partnership work to support our corporate priorities

- 6 We continue to have conversations with stakeholders about our equality, diversity and inclusion (ED&I) agenda. Through these conversations, we are able to understand the work they are doing to promote fairness in medicine and identify areas for shared learning or collaboration. There is work already happening across Scotland. It includes the provision of unconscious and active bystander training in education and training, the introduction of ED&I leads in health boards, and the establishment of national ED&I groups and forums. We are committed to offering our support to the Scottish Government and other stakeholders in relation to this work and to helping them meet their ED&I commitments more generally.
- 7 We continue to offer Outreach sessions in Scotland to support our contribution to doctors' wellbeing, targeted at doctors in the Foundation Programme during their induction but also available to all doctors. Sessions also cover fitness to practise reforms and how we have regulated the profession during the Covid pandemic. These sessions have had a good uptake and we will continue to offer them.

Theme: Broader relationship building, engagement and influencing

- 8 In our last 'four country update', we said that we would focus on developing our relationship with Scotland's Cabinet Secretary for Health and Social Care and seek to work more closely with Scottish Government officials on areas where our policy priorities align.
- 9 In November 2021 the GMC's Chief Executive had a successful introductory meeting with the Scottish Cabinet Secretary, Humza Yousaf MSP. They discussed the impact of the pandemic on the workforce, work we are doing to support wellbeing, and our ED&I targets. The Cabinet Secretary spoke positively

about regulatory reform and his engagement with the Department for Health and Social Care in Whitehall. We want to grow this relationship further. His officials have suggested our next discussion should be about our approach to enhanced monitoring, our data and how this can support the Scottish workforce. This suggestion follows the successful implementation of quarterly data sharing meetings between us and officials.

- 10 Following the Scottish Parliament elections in May 2021, we have completed a set of introductory meetings with opposition party health leads. We have established quarterly meetings with the Shadow Cabinet Secretary for Health, Dr Sandesh Gulhane MSP (Conservative). Our parliamentary perceptions survey for 2021 shows strong levels of confidence amongst MSPs in the way in which the GMC regulates doctors. However, we hope to increase this figure in 2022 with the aid of a refreshed public affairs strategy for Scotland.
- 11 Finally, we continue to work closely with BMA Scotland and the Scottish Academy to support doctors through our participation and collaboration in the Medical Workforce Wellbeing Stakeholder Group. A highlight of the group's work was a wellbeing appraisal roundtable in October 2021, involving the Scottish Government and NHS Education for Scotland (NES). It was agreed to commission the Revalidation Delivery Board for Scotland, to review the appraisal content in Scotland, including its focus on medical wellbeing. Alongside the BMA and the Scottish Academy, we will be a member of the short-life working group established to ensure that any re-modelled appraisal continues to meet our revalidation requirements.

Theme: Monitoring and responding to inquiries and reviews

- 12 In response to the recommendations of the Independent Medicines and Medical Devices Safety Review, the Scottish Government is progressing with the establishment of the Patient Safety Commissioner for Scotland. In our response to its consultation, we highlighted the challenge experienced by many patients in navigating the healthcare complaints landscape. We suggested that identifying gaps, enhancing communications, and working collaboratively across organisations that support patients raising concerns will improve patients' experience. We also noted the importance of information sharing between the Commissioner and regulators. Following this, we sat on the Scottish Government's Patient Safety Commissioner Specialist Reference Group. This was tasked with mapping out the roles and responsibilities of existing bodies and policies to ensure the proposals put forward for the Commissioner would add value and not duplicate existing processes and structures.

- 13** We are monitoring the progress of several public inquiries in Scotland, including the inquiry into infection control at the Queen Elizabeth University Hospital in Glasgow. Likewise, we continue to follow the progress of three Scottish Health Boards as they work to meet the recommendations of external reviews into the services they provide, through the routine meetings which our employer liaison adviser for Scotland has with the Responsible Officers of these Boards.

Theme: Future priorities

- 14** The Scottish Government recently published its workforce strategy for health and social care. The plan is built around five pillars – plan, attract, train, employ and nurture – and contains many elements that are relevant to our priorities. This presents us with an opportunity to continue to engage with the Government and to use our data and insights to positively inform implementation (particularly in the areas of leadership, wellbeing and inclusivity). We will work with the Medical Workforce Wellbeing Stakeholder Group to consider how we can strengthen our input to the strategy through our collaboration with partners.
- 15** We continue to monitor the legislative environment in Scotland, making sure we offer our input on developing legislative issues and ensuring that the GMC takes account of these in the way it operates as a four-country regulator. For example, we responded to the Scottish Government's consultation on updating the Public Sector Equality Duty. We are considering the possible impact that the updated Scottish duties might have for us and our registrants, and will continue to follow its passage through the Scottish Parliament. We will also be keeping a close eye on the proposed legislation to support assisted dying. While the GMC takes no view on the issue, we will work to ensure doctors are supported to practice within the law.
- 16** Our work to support the workforce in Scotland includes our commitment to improving the environments in which doctors work. This is reflected in our ongoing focus on wellbeing and leadership. Indeed, in 2022 our Medical Workforce Wellbeing Stakeholder Group, which includes BMA Scotland and the Scottish Academy, intends to give greater focus to the promotion of inclusive and compassionate leadership within the health service. We hope to positively support implementation of the Scottish Government's forthcoming Workforce Plan on these areas. Our Outreach sessions with health boards and the SAS network will also focus on areas including wellbeing and professional behaviours. Sessions are being aimed at organisational and team leaders and will emphasise the leadership responsibilities of all doctors. Our liaison advisers

in Scotland are also developing joint meetings with ROs/Medical Directors and Directors of Medical Education to target sessions and interventions.

- 17 Our attempt to organise Welcome to UK Practice sessions through NHS Education for Scotland (NES) last year had limited success. On the advice of NES, our Outreach team in Scotland is now focused on arranging sessions directly with individual territorial boards and with regions (the NES board regions of North, East, South East and West). So far sessions have been organised at Highland and Tayside boards, and with the North region. Sessions are being planned for the other areas.

Country update: Northern Ireland

Theme: Regulatory alignment and co-operation

- 18 Northern Ireland has an established forum of regulators which has agreed to review the arrangements in place across the UK to share information about patient safety. The NI Joint Regulators Forum is committed to establishing a process akin to an Emerging Concerns Protocol and will establish a sub-group to co-ordinate a programme of work to take this forward.
- 19 Members of the Joint Regulators Forum facilitated a regulation-focused seminar at the October 2021 conference of the Northern Ireland Confederation of Health and Social Care (NICON). The session explored themes of system improvement and our responses to Covid-19. This session was an opportunity to demonstrate the role of regulation in supporting workforce retention and our commitment to sharing information and intelligence to enhance patient safety.
- 20 In March 2022 Charlie Massey had a successful introductory meeting with Briege Donaghy, the Chief Executive of the Regulation and Quality Improvement Authority.
- 21 Our relationship with the Northern Ireland Medical and Dental Training Agency (NIMDTA) continues to improve. They provided positive feedback on our new quality assurance process.

Theme: Partnership work to support our corporate priorities

- 22 We collaborated with health and social care trusts in Northern Ireland to deliver a seminar on equality, diversity and inclusion at the NICON conference in October 2021. Heather Moorhead, the Director of NICON, welcomed the GMC's support to drive conversations about ED&I issues forward in Northern Ireland.

- 23** We collaborated with the Northern Ireland Medical and Dental Training Agency (NIMDTA) to support the development of virtual induction and refresher courses for trainees across different specialties, who have taken time out of their approved training programme.

Theme: Broader relationship building, engagement and influencing

- 24** In January 2022 we met with the Clerk of the Northern Ireland Assembly Health Committee to discuss the benefits of regulatory reform and provide assurance that we will consult NI stakeholders on the rules sitting under any new legislation.
- 25** We worked collaboratively with Queen's University and Ulster University to run a training event in October 2021 for staff involved in managing medical student fitness to practise cases.
- 26** We have responded to the Department of Health (Northern Ireland)'s consultations on advanced care planning and the introduction of a statutory opt-out system for organ donation.
- 27** In February 2022 we commented on the Department of Health's second workforce action plan, offering to share our data and insights on factors that influence medical workforce retention. Also in February, we met with Department of Health officials about the changes to the Medical Profession (Responsible Officers) Regulations which are being made to facilitate the merger of the Health and Social Care Board with the Department. We will work with officials to co-ordinate our communications to GPs, whose designated body will change as a result of the merger.

Theme: Monitoring and responding to inquiries and reviews

- 28** We continue to monitor the progress of the many inquiries and review relevant to Northern Ireland's health and social care services. We held an introductory meeting with the counsel for the Urology Services Inquiry in November 2021 and are now engaging with the Muckamore Abbey Hospital Inquiry. We are preparing for the publication of the Neurology Inquiry report. However, we understand that this won't be published before the Northern Ireland Assembly election in May 2022.
- 29** In October 2021, we welcomed the opportunity to provide evidence to the Northern Ireland Assembly Health Committee about our role investigating the practice of Michael Watt. Following the decision in October by an MPTS tribunal to grant voluntary erasure to Michael Watt, we have prioritised engagement

with individual patients and their families. We are committed to working with Northern Ireland's Patient and Client Council to facilitate meetings with patients. We supported the Chief Executive with his meeting with the Minister for Health, Robin Swann MLA, about the case.

Theme: Future priorities

- 30 The decision by an MPTS tribunal to grant voluntary erasure to Michael Watt has affected our relations in Northern Ireland. Following this decision, we predicted a drop in confidence in our regulatory processes among members of the Northern Ireland Assembly. This was borne out in the recent parliamentary perceptions survey results. Following the Assembly elections in May, our immediate focus will be to build members' trust and confidence in the GMC processes. We will schedule an introductory rolling programme of engagement with the five main parties' health spokespeople, using our annual report to the Northern Ireland Assembly as an engagement tool.
- 31 We continue to work with officials in the UK Government, the Northern Ireland Executive and the Irish Medical Council to explore options to establish a form of emergency cross-border registration between the Republic of Ireland and Northern Ireland.
- 32 Our liaison advisers are working to develop a hybrid delivery model, combining face to face and online interaction, which will allow us to increase the number of sessions we can deliver to doctors. They will deliver bespoke sessions on raising concerns, candour and leadership within those health and social care trusts that have been impacted by inquiries and reviews.

Country update: Wales

Theme: Regulatory alignment and co-operation

- 33 In February, we held the first meeting of a task and finish group to discuss terms of reference for an Emerging Concerns Protocol for Wales. Healthcare Inspectorate Wales is the systems regulator for Wales and will assume overall ownership of the Protocol. We will provide support in overseeing its development and ensuring buy-in from other partners. We are working closely with colleagues in England to learn from their experience of developing a similar protocol with partners in their country.
- 34 At the end of 2021, we held a data workshop with Welsh regulatory and inspection bodies to explore what we all hold in terms of data and examine how

it can be better used to identify risk and improve focus and quality. We agreed to develop a plan to achieve this and underpin improvement.

- 35** In January, we held the first of our bi-monthly meetings with the NMC to discuss priorities for joint Outreach working. We agreed to collaborate on a range of issues regarding equality, diversity and inclusion – such as inductions, promoting professionalism and leadership, and supporting accountability and delegation. We also agreed to work together to deliver a professional behaviours and patient safety (PBPS) programme at Cwm Taf Morgannwg University Health Board. The Board has been the subject of concern over the quality of its maternity and neonatal care following a review by the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives. The Welsh Government has set up an Independent Maternity Services Oversight Panel to ensure the Health Board addresses the concerns.

Theme: Partnership work to support our corporate priorities

- 36** The previous three UKAFs in Wales centred on equality and diversity and resulted in a number of actions for the Wales team. We continue to meet these actions through engagement with a wider set of stakeholders around our ED&I targets and around our support for SAS and IMG doctors.
- 37** In December, we took part in the SAS Advocates' induction day to hear about this new role in supporting SAS doctors. We presented our research and insights in this area as well our work to improve organisational cultures and the support we offer to SAS doctors. The network meets monthly to share good practice and challenges.
- 38** We are a founding member of a new SAS/IMG Expert Advisory Group in Wales set up to align and strengthen work in the country to improve differential attainment and the wider environments that lead to unfair referrals, including induction. This Advisory Group comprises GMC, Health Education and Improvement Wales, and the Medical Directors of Health Boards. It was established following a presentation we gave about our ED&I targets to the Medical Directors in September 2021.
- 39** Our Clinical Fellow is conducting research to examine the SAS doctor experience in Wales, which has both ED&I and workforce implications. The work seeks to identify what makes for a positive experience and how we can build on this. This has received a lot of interest and support externally, with a range of participants contributing to the research and findings.

- 40** Our Outreach advisors in Wales are working closely with Aneurin Bevan University Health Board to tackle differential referrals and improve induction for IMGs, as well as improve support for SAS doctors. They have completed one virtual induction, which was successful, and have made significant headway in embedding a bespoke biannual workshop in the Health Board's workplans.

Theme: Broader relationship building, engagement and influencing

- 41** Throughout the pandemic we have engaged with stakeholders virtually. This includes all Outreach sessions and meetings between our Employer Liaison Advisers and Responsible Officers. We keep our approach under consideration, as the guidance across the four countries of the UK diverges and is updated.
- 42** We have prioritised keeping officials in each country up to date on our continuing response to the pandemic, including the management of temporary emergency registration and derogations to post graduate medical training programmes.
- 43** We have focused on developing our relationship with the new Minister for Health and Social Services, Eluned Morgan MS. We liaised with her and her officials and with the Minister for Education around our role in quality assuring the applications for new medical schools and programmes. We advised the Ministers on the fastest route to ensure that the programme is established before the next election, and we offered our support during this process.
- 44** We have held meetings with the Welsh Language Commissioner and their team around preparations for the introduction of the Welsh language standards for healthcare regulators and we have kept other healthcare regulators informed of the discussions.
- 45** We plan to hold our UKAF meeting in Wales in early June. If conditions allow, we will hold this in person. The meeting will focus on the workforce: the current pressures they are experiencing and plans for creating a sustainable workforce in a post-pandemic climate.

Theme: Monitoring and responding to inquiries and reviews

- 46** Our Employer Liaison Adviser continues to inform the Independent Maternity Services Oversight Panel, which is looking at the maternal and neonatal care at Cwm Taf Morgannwg Health Board, about our thresholds for fitness to practise investigations.

- 47** In 2021, a number of reviews and inspections at the Grange Hospital, part of Aneurin Bevan Health Board, highlighted concerns around poor patient care, infection control, waiting times and staffing issues. In December, we met with Healthcare Inspectorate Wales and the Royal College of Physicians Wales to discuss their findings. Our Outreach team is working well with the Responsible Officer of this Health Board and have developed a programme to support clinical leadership and governance, and to address ED&I issues particularly around disproportionate referrals.
- 48** We are responding to recent reports published into failings at Betsi Cadwaladr University Health Board and are working closely with the Health Board around a plan for support focusing on three areas: fitness to practise support and advice; targeted training by our Outreach advisors; and working with senior staff and the Board to raise awareness of standards and expectations and examine how they can support improvement.

Theme: Future priorities

- 49** It is likely that Welsh Language Standards will be introduced for healthcare regulators over the next few months. We have been getting ready both through reviewing our preparedness across the GMC and engaging with the Commissioner, Welsh Government Officials, the Minister for Education and Welsh Language and those who are likely to use Welsh language services such as medical schools. We are aiming for an approach which is positive and proportionate. The standards will require some improvements to our services in terms of application forms, publishing documents, correspondence, and legal proceedings and we are making sure we are ready for these changes.
- 50** We want to further our work around patient safety through greater regulatory alignment and data sharing in Wales. The delivery of an Emerging Concerns Protocol for the country is key to this, as is providing good quality updates for the bi-annual Healthcare Summit and sharing relevant data and intelligence regularly in between these meetings.
- 51** Since the Welsh Assembly elections in May 2021, we have influenced parliamentarians through our public affairs strategy by creating strong relationships with political decision makers in order to improve and protect patient safety and medical education in-line with our regulatory functions and strategic priorities. We will have a higher profile by attending political party conferences and working with other regulatory bodies to highlight our roles and where we can provide support and influence.

- 52** Our work on equality and diversity will gather pace, particularly once the Welsh Government's *Race Equality Action Plan* is launched. Our differential attainment data and ambitions form part of this plan. We will focus on working with Health Education and Improvement Wales to support fairer training pathways. Our programme of work with Health Boards, to get upstream of referrals with better induction and training, will deepen and we will continue to work with as will BMA Cymru to encourage fairer working environments.

Country update: England

Theme: Regulatory alignment and co-operation

- 53** At a national level, we have worked with other professional regulators to align and collaborate on regulatory issues, particularly in relation to the pandemic. Our relationships (with organisations such as the NMC) are positive and productive, with a number of inter-regulatory groups sharing expertise, best practice and intelligence. Key examples of this collaboration include:
- a** reiterating our joint statement of support for staff working together to tackle the pandemic
 - b** aligning our approach to vaccinations monitoring and responding to inquiries and reviews
 - c** working with other regulators through the Alliance of UK Health Regulators on Europe (AURE) to amend the Professional Qualifications Directorate and seek clarification from the UK Government about the end of the EU standstill arrangements for EU doctors.
- 54** Healthcare regulators in England agreed an Emerging Concerns Protocol in 2018. The Protocol provides a clear mechanism for organisations with a role in the quality and safety of patient care to share information and intelligence that may indicate risks to patients or healthcare professionals. To ensure that the protocol is fit for purpose in a changing landscape, the Health and Social Care Regulators' Forum (of which the GMC is a member) commissioned a standing working group, made up of all signatories, to provide scrutiny. We have worked closely with partners on this working group and last year we helped to drive a revision to the Protocol to improve its utility as we found that there was variable knowledge of when and how to use the protocol across the many organisations involved. The working group has led to strengthened relationships between us and NHS England & NHS Improvement (NHSE&I). As a result, we were invited to comment on early drafts of documentation for the National Quality Board, including its new quality guidance. Through this, we have been able to secure

changes that mean the GMC (and other professional regulators) are named as part of relevant information sharing processes owned by NHSE&I.

- 55** We are working closely with the NMC and the Health and Care Professions Council (HCPC) which have services similar to our Outreach function. We meet with the leads of these services on a regular basis to explore ways we can align our work. We have seconded a member of Outreach to the HCPC to help them develop their outreach offer. Recently, we have supported them to develop their own version of Welcome to UK Practice.
- 56** We continue to engage in conversations about the quality and risk of local care environments with regional partners through the regular Joint Strategic Oversight Groups (JSOGs) and Perinatal Oversight Groups. As part of this engagement, we have delivered presentations to regional JSOGs about the role of the national training survey and how we work with Healthcare Education England and providers to ensure high quality training is delivered. This has led to greater involvement of integrated care systems in the quality assurance process for organisations that are in enhanced monitoring.
- 57** Internally, we have worked more closely with the GMC's Education Quality Assurance team to incorporate Outreach support within the enhanced monitoring process and develop a 'one GMC' response to concerns which impact on training environments. This involves information sharing, provider discussions, and joined up activity (such as professionalism sessions, and engagement by our employer liaison advisers with Responsible Officers and Postgraduate Deans).

Theme: Partnership work to support our corporate priorities

- 58** At a national level, we have engaged stakeholders about our equality, diversity and inclusion (ED&I) work throughout 2021. On launching our measures in May 2021, we secured 12 supportive statements from stakeholders (such as the medical colleges, the BMA and employer groups). As our ED&I plans require change at system level, we need support from those operating at a senior level to meet our targets. Through the strategic engagement which we plan and manage, we have worked to turn the far-reaching support into action and collaboration. One example of this engagement is the recent meeting which our Chair and Chief Executive had with the Presidents of the medical colleges and faculties, where they discussed the issue of differential attainment and reiterated our support for them in helping them draft their action plans.

- 59** Since 2019 we have working with the Medical Workforce Race Equality Standard (MWRES) to produce a standardised induction framework to support the induction of international medical graduates (IMGs). We have co-authored the framework, which mandates Welcome to UK Practice as a key component which employers must provide access to. We have also included other components which our research highlights as important for supporting IMGs and achieving greater fairness. The work paused for a while during the pandemic but is now at final project stages and an implementation study is underway.
- 60** As we have done in the other UK countries, we have engaged with Responsible Officers from a range of providers about the research we commissioned into the fairness of referrals in order to identify actions linked to the key findings which are being pursued locally. Our conversations to date indicate that all Responsible Officers recognise it's important to take forward the research's recommendations and that there is work underway across the system to improve fairness and inclusivity. However, we also see variation in the levels of expertise which are available to address the findings, as well as in the resource and commitment to do so. In the next phase of our work, we will look at how we can support Responsible Officers to deliver measurable change in their organisations.
- 61** In the North West of England, our conversations about the fairness of referrals have led to Health Education England (HEE) in the region updating its processes. Every referral will now be scrutinised by the organisation's ED&I lead who will now also join their Doctors and Dentists Review & Responsible Officer Advisory Group. The group meets monthly to discuss cases and agree support for the professionals involved. We are talking to HEE North West about how we can share this good practice with other HEE regions.
- 62** In the Midlands, we have worked with partners to develop a wellbeing charter to share resources and best practice around this subject. The charter aims to prioritise the restoration of postgraduate medical education and training impacted during the COVID-19 pandemic and beyond. It will also establish the blueprint for best practice in postgraduate training for the future. We have supported a number of evening webinars for doctors in training and trainers across the region, with content focused on wellbeing and ED&I. The initiative won the BMJ award for workforce and wellbeing in 2021. We are now actively involved in developing the second version of the charter, ensuring its focus is on tackling inequalities and supporting the GMC fairness targets.
- 63** Almost 6,500 doctors took part in our Welcome to UK Practice programme during 2021. This means we exceeded our target for this programme for the

first time ever. This was in the final year of the expansion programme which we had to change rapidly from a model predicated on in-person delivery linked to ID checks to an online version we now provide as a business-as-usual service. During 2021, we also worked closely with HEE to support the development of their CaReForMe programme (an induction for returners). This programme is an adaption of our Welcome to UK Practice Programme for returners. An evaluation of this programme shows it has been successful.

- 64** We continue to use Responsible Officer (RO) networks and their conversations with our employer liaison advisers (ELAs) to share good practice around the handling of concerns about locum doctors, and to better understand local governance processes and information flows about locum doctors when concerns arise. This is supported by an ongoing programme of training and updated guidance for our ELAs. We are also developing a supportive training offer specifically for locum doctors. We also continue to work directly with locum doctors, for whom we have developed bespoke workshops with NHS Professionals and Medacs Healthcare. Finally, we have piloted the first network event specifically for ROs of locum doctors. These are aimed at helping them to share experiences and learn from each other, while also ensuring that they are working in line with the requirements of our Clinical Governance Handbook.

Theme: Broader relationship building, engagement and influencing

- 65** We now have annual relationship plans in place for our most strategic and complex relationships. Some plans are now in their second year. These plans have helped us to grow our relationships and improve the internal co-ordination of our engagement.
- 66** We are working to build and maintain our relationships with organisations that represent patients and the public. We hosted a roundtable meeting in November, attended by 15 representatives, where we discussed a range of issues including unitary boards, medical appraisals, and our work on sex, gender and gender identity data. We have continued to play an active role in collaborative meetings on patient involvement, including attending NHS England's People and Communities Forum. This has been valuable for bringing best practice back into the GMC.
- 67** We have continued to improve our relationships with organisations representing the medical profession. In the last six months, we have attended two meetings of the BMA's Professional Regulation Committee. In November, we updated the Committee on our review of Good medical practice and our audit of fitness to practise. In February, our Director of Education and Standards provided a

broader update about the GMC's work. Both meetings were productive and we have built a positive relationship with the new Chair of the committee – Dr Mark Corcoran. We also attended the BMA's Annual Representation Meeting (ARM) in September 2021, holding a breakfast meeting for delegates with our Chair and Chief Executive. Approximately 90% of attendees rated the GMC's participation as excellent or good.

- 68** We have also continued to build positive relationships with the medical colleges and faculties which are key to many aspects of our work. Throughout February, we have held meetings with the medical colleges about the data in our 2021 SOMEF report. As mentioned above, our Chair and Chief Executive met recently with the presidents of the medical colleges and faculties. This was a key moment for us to progress discussions around postgraduate training. The medical colleges were positive about the GMC's response to the pandemic and were open to continuing conversations about postgraduate reforms. We will convene a short-lived group including representatives from the medical colleges, patients, employers to look in detail at some individual curricula, including assessments.
- 69** Our public affairs team has been kept busy over the past 12 months, with several bills relevant to the work of the GMC making their way through the UK Parliament. Our work on these pieces of legislation demonstrates the strength of our relationships in Westminster and our increasing capability to influence. We have developed a strong relationship with a cohort of politicians – particularly peers with a medical background – who understand our asks and are willing to make interventions on our behalf.
- 70** Those bills include:
- a** The Health and Care Bill – the original wording of the bill gave powers to the Secretary of State for Health and Social Care enabling them to abolish individual health and care professional regulatory bodies. Our aim has been to secure a commitment from the UK Government that it would maintain the principle of regulatory independence.
 - b** The Professional Qualifications Bill – as drafted, the bill would have introduced a process requiring the GMC to assess whether someone has a particular overseas qualification that is 'substantially the same as' a UK qualification, thus potentially giving an automatic entitlement to practise for IMGs on the same basis as UK graduates. The draft bill also stated that an individual could apply to us for a determination that their qualification is 'substantially the same as' as UK qualification. This would be extremely

challenging for us to manage operationally given the thousands of IMGs who apply for registration with us each year.

- c The Police, Crime, Sentencing and Courts Bill – the draft bill risked overriding long-standing provisions protecting the confidentiality of patients, forcing doctors to share information with the police. As highlighted to Council last November, our aim has been to secure a commitment from the UK Government to amend information sharing requirements on Clinical Commissioning Groups in England and Health Boards in Wales.

71 We have carefully monitored the progression of these bills. Harnessing the relationships which they have developed in both Parliament and Whitehall, our public affairs team has briefed, influenced and secured changes that will safeguard our independence as a regulator, maintain our ability to protect patients, and preserve doctors' ability to provide good, safe care for their patients:

- a The Health and Care Bill – In October 2021, the Minister for Health Edward Argar MP confirmed *'there [were] no plans to abolish the GMC, because clearly there would always be a need for continued regulation of medical practitioners.'*
- b The Professional Qualifications Bill – After we engaged with officials, parliamentary counsel were instructed to draft a set of technical amendments to address our key concerns.
- c The Police, Crime, Sentencing and Courts Bill – Following a meeting we attended with Home Office and Department of Health and Social Care officials, the UK Government brought forward a set of amendments to protect and minimise the risk to patient confidentiality.

72 In January 2022, we commissioned YouGov to run a short perceptions survey with members of the House of Lords and House of Commons, as well as with members of the devolved legislatures. We commissioned similar surveys in 2020 and 2021. The survey includes a range of questions designed to ascertain:

- a their confidence in the way doctors are regulated by the GMC
- b whether the GMC is focussing on the right issues as a professional regulator
- c if our regulatory approach responds to the needs of the four countries of the UK

d and their awareness of regulatory reform.

- 73 Across all our political stakeholders, over two thirds (77%) said they were confident in the way doctors are regulated by the GMC. We saw the highest levels of confidence among members of the House of Lords (88%) and lower levels among members of the House of Commons (73%) and the devolved legislatures (69%). As highlighted in an earlier section of this paper, we saw the lowest levels of confidence among politicians in Northern Ireland which have dropped significantly since our last survey in 2021.
- 74 The survey also found political stakeholders' awareness of regulatory reform and its benefits remains low. Almost two-thirds of respondents say they do not know what effect the proposed reforms would have on the medical workforce, rising to three quarters amongst devolved legislatures. However, those who do have a view are most likely to say the effect will be positive. We saw an increase among MPs in those who saw the reforms as positive compared to 2021.
- 75 At a regional level in England, we have been exploring how we can use board engagement (beyond our routine engagement with Medical Directors/Responsible Officers) to enhance our connections with local healthcare providers and find new ways to influence enduring organisational change. We are piloting an approach in the South of England where we engage with those networks already attended by board members (and senior leaders and influencers on ED&I issues) across the region. The pilot has focused entirely on issues of 'fairness', in particular the disproportionality which is present in NHS disciplinary processes and GMC fitness to practice referrals from employers. We have sought to raise awareness of the GMC's targets, data and publications, with the hope of identifying further opportunities for collaboration with system partners. We are exploring similar opportunities across the rest of England.

Theme: Monitoring and responding to inquiries and reviews

- 76 The Independent review of maternity services at Shrewsbury and Telford Hospital NHS Trust by Donna Ockenden published its final report at the end of March. During the review, our Outreach team in the Midlands and East of England initiated contact with the review team and worked with the NMC and our regulation policy team to establish an approach for responding and working together.

Theme: Future priorities

- 77 During 2022 we will roll out our *professional behaviours and patient safety* (PBPS) programme with the NMC to maternity providers, in collaboration with regional/local partners (including the Regional Perinatal Oversight groups). In England we have a target of delivering a minimum of 15 PBPS maternity sessions this year.
- 78 The programme is designed to improve the culture at a provider with a focus on professional behaviours. Its first element involves working with the provider to establish their engagement and appetite in supporting the intervention and the work that will be required to embed the learning. In the second element, we deliver a workshop with follow up to support attendees in not only recognising, challenging and improving professional behaviours, but developing approaches in their workspace to support colleagues in taking this agenda forward with senior support.
- 79 In 2021 we focused on developing a virtual version of PBPS and a suite of maternity-focused case studies. We completed joint training for GMC and NMC liaison advisers in January 2022. A pilot is now underway in Mid and South Essex NHS Foundation Trust and should be completed in April. We are discussing with our system partners where we should target further interventions across England. The identification of potential providers will be informed by our wider discussions with Regional Chief Midwives and Regional Perinatal Oversight groups about local maternity services where there are concerns.

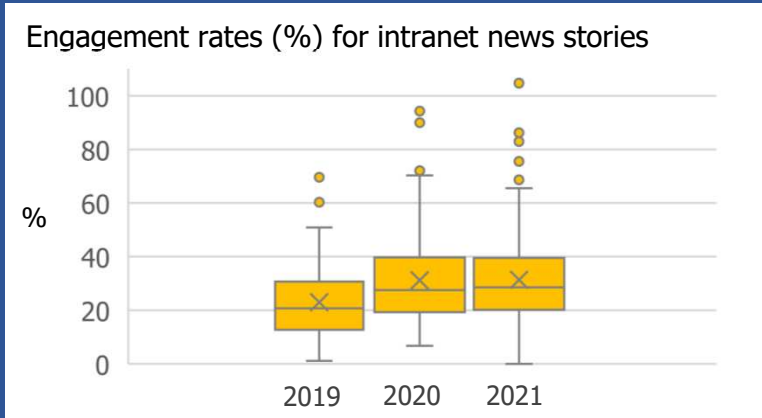
Item M6 – Communications and Engagement update

Annex B – Data pack

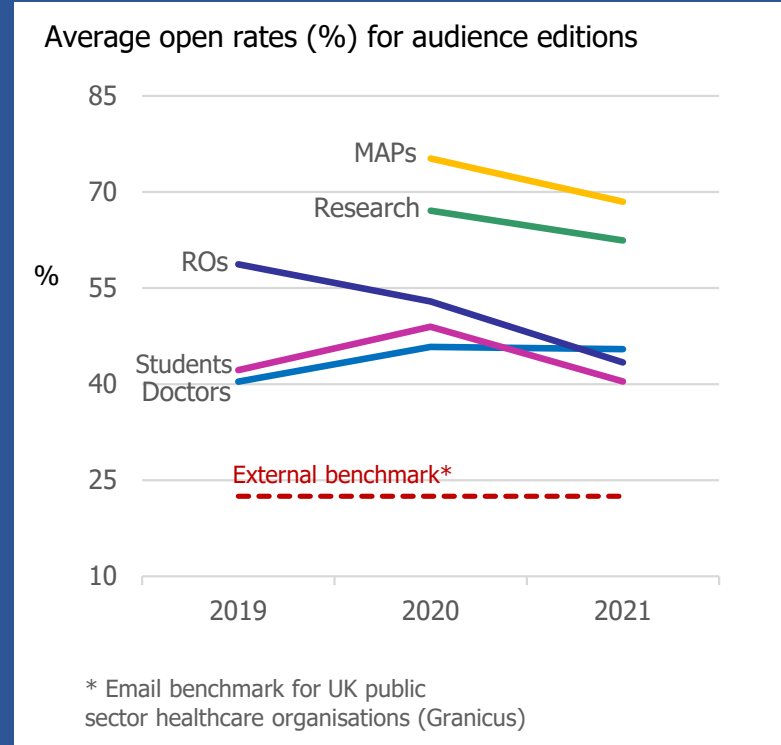
Working with doctors Working for patients

Communications

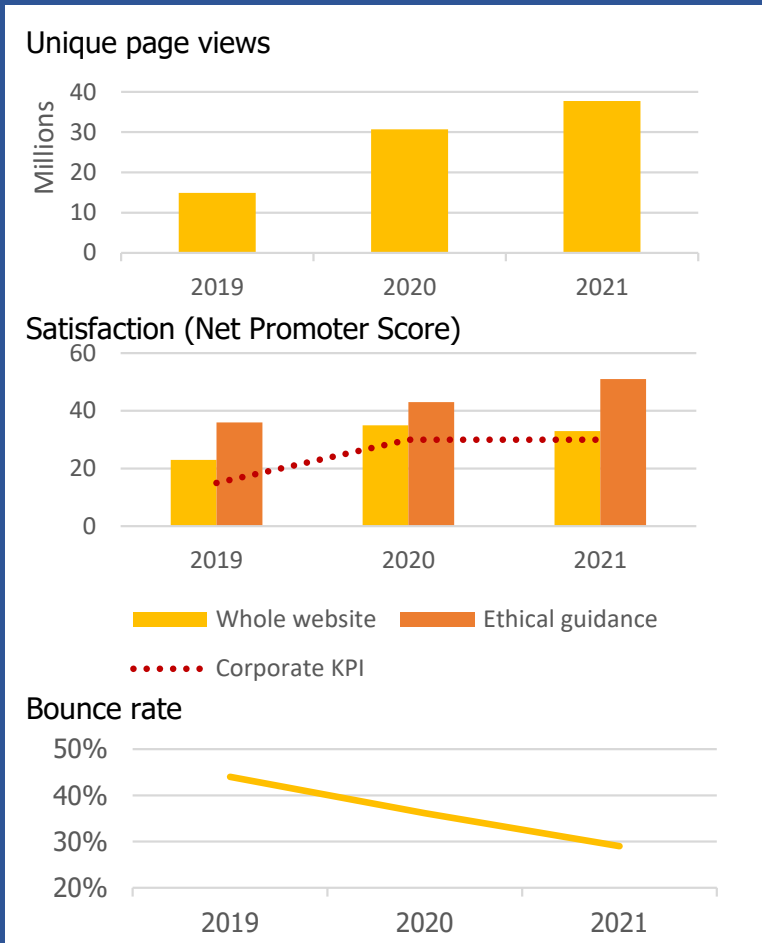
GMC intranet



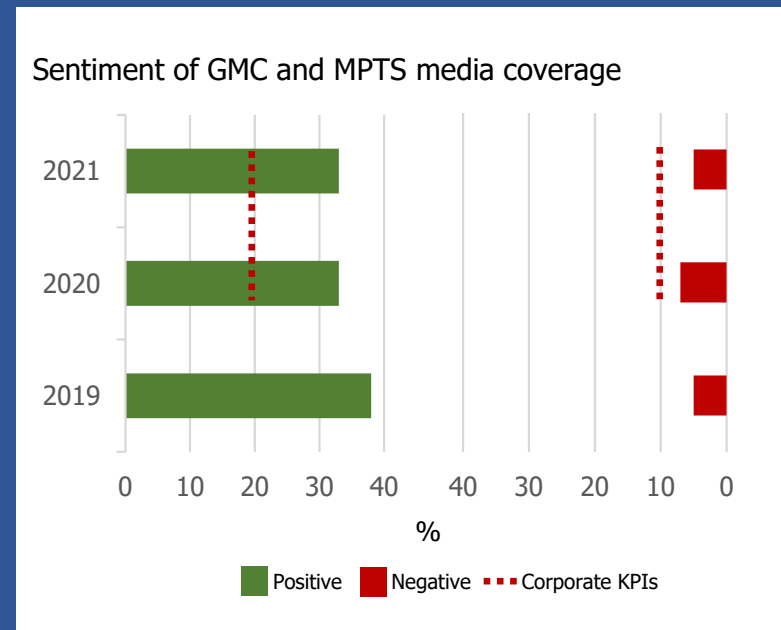
GMC audience e-bulletins



GMC website



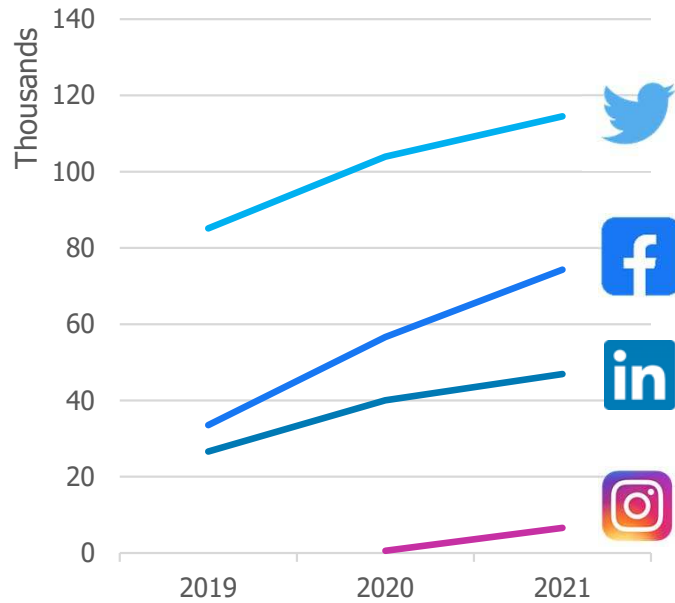
Media coverage



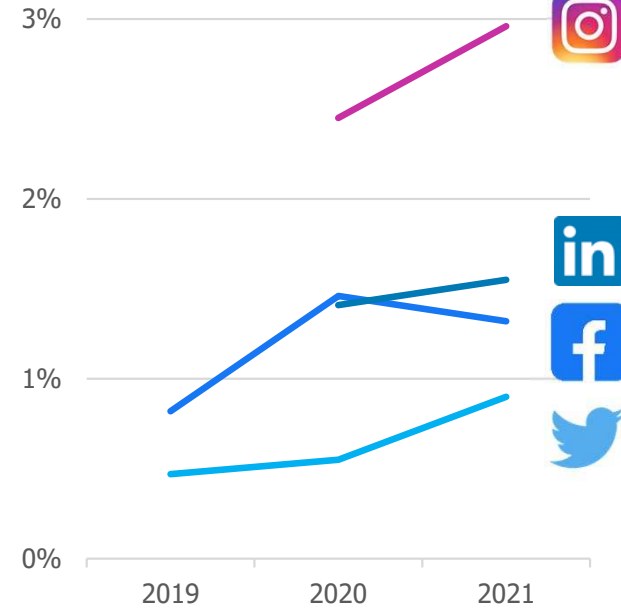
Communications

GMC social media accounts

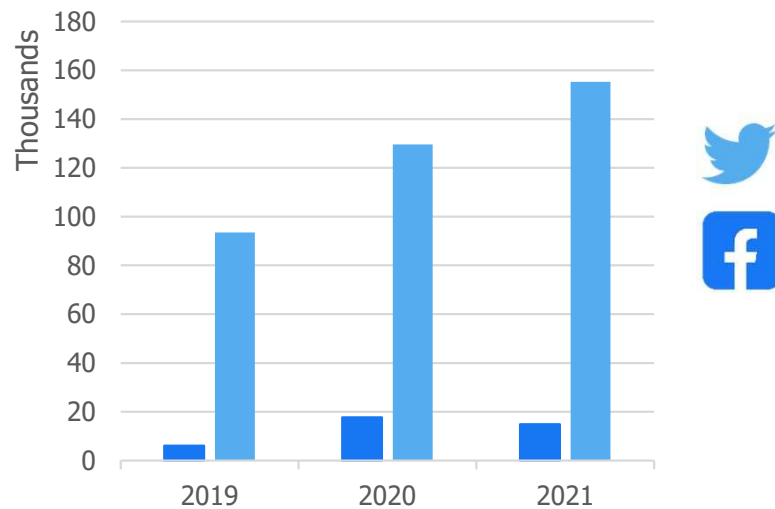
Followers



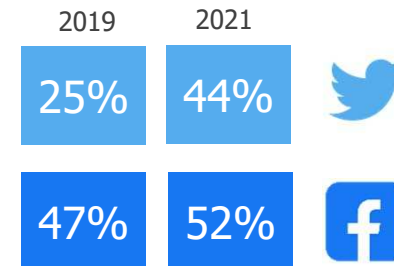
Average engagement rates for GMC content



Average reach of GMC content

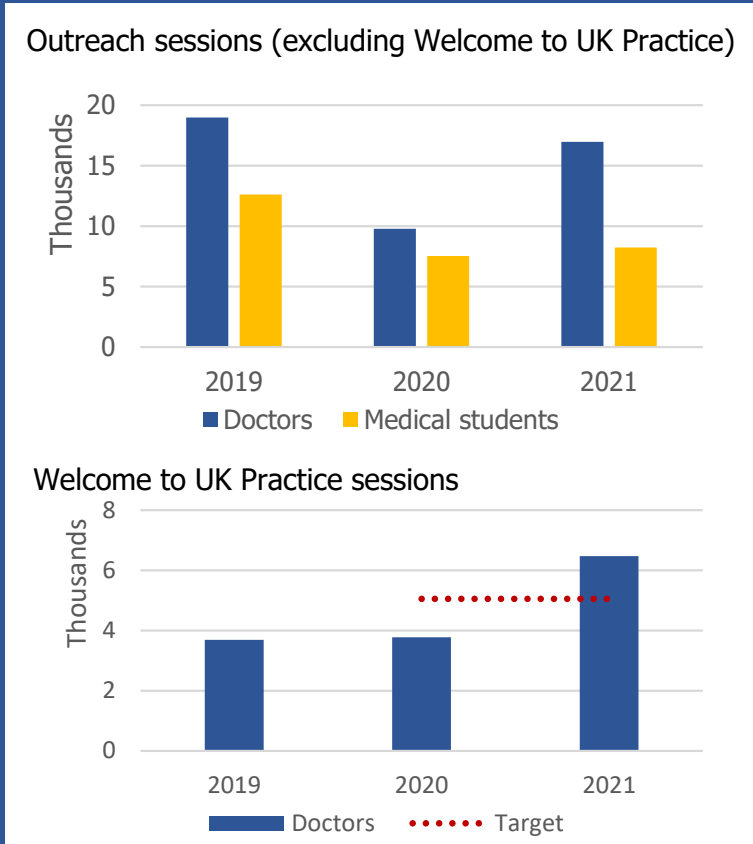


Audience segmentation (% of GMC-posted content on social media targeting particular segments of medical profession)

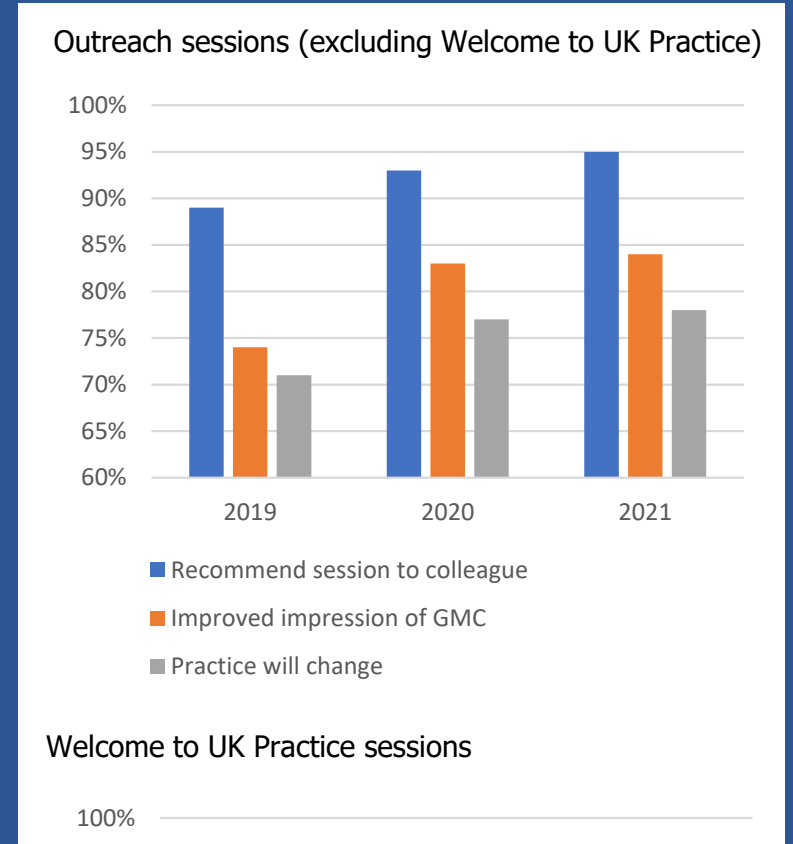


Outreach

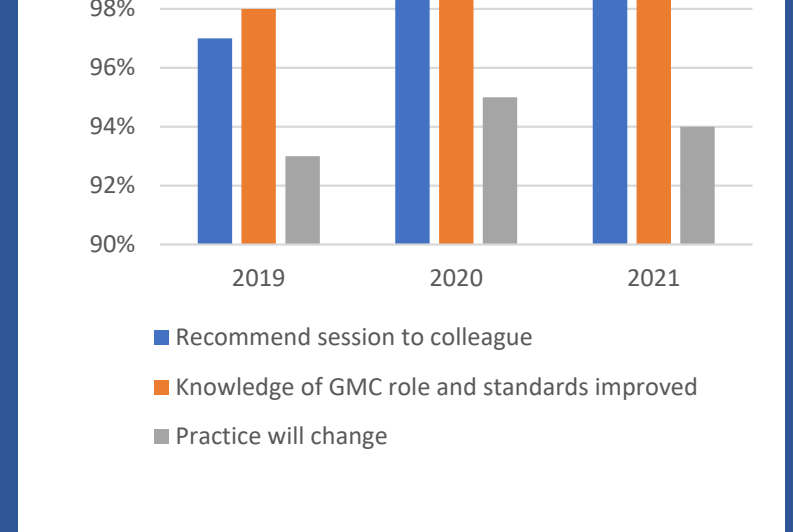
Reach and engagement



Experience and satisfaction



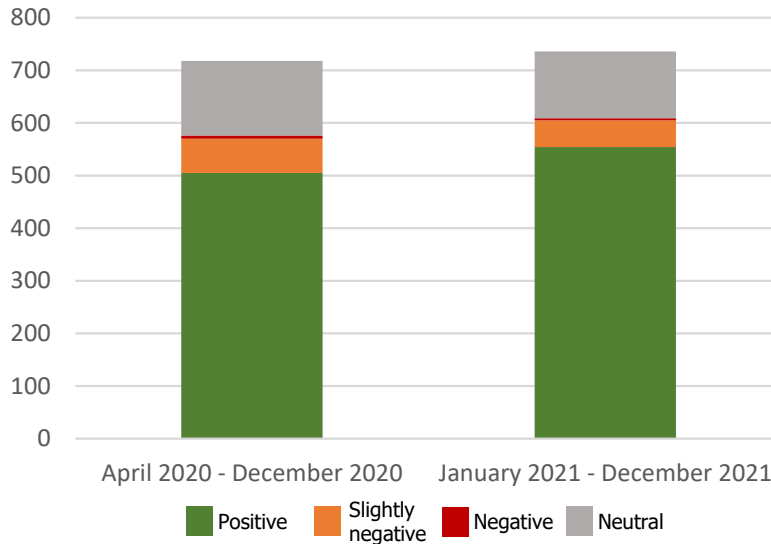
Effectiveness



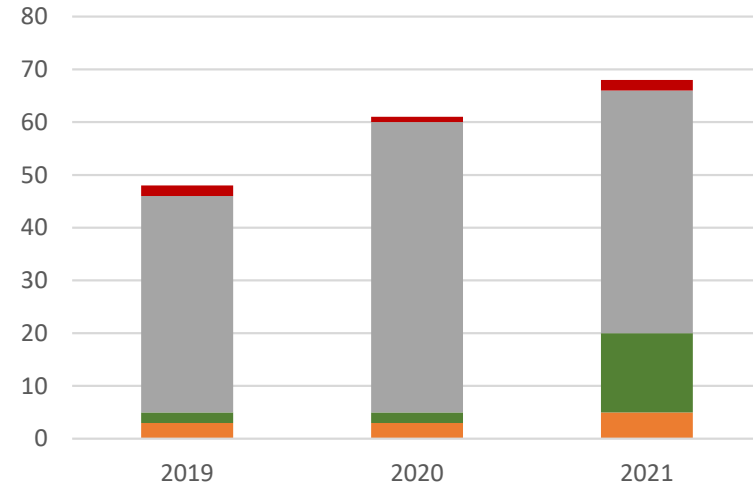
External affairs and engagement

Engagement

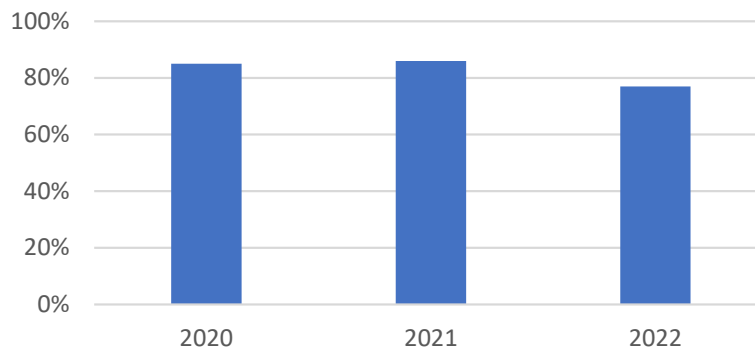
Volume and sentiment of engagements with regulatory partners and strategic relationships captured in GMC's Engage system



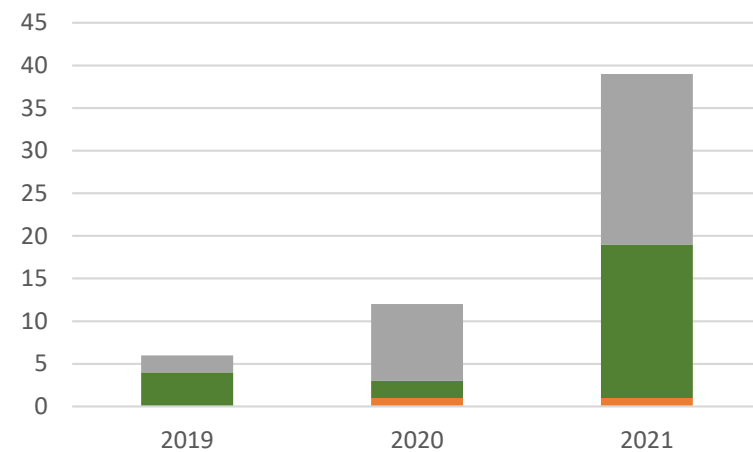
Volume and sentiment of GMC mentions in the House of Commons*



Percentage of parliamentarians and assembly members confident in how doctors are regulated by GMC



Volume and sentiment of mentions of GMC in the House of Lords*



Source: YouGov

* Source: Theyworkforyou.com

Action	To approve an addition to the GMC's list of bodies that can award UK Primary Medical Qualifications (PMQs).
Purpose	This paper summarises progress of the quality assurance of the Scottish Graduate Entry Medicine (ScotGEM) programme delivered by both the Universities of Dundee and St. Andrews School of Medicine. It gives an overview of the programme, the QA process undertaken and areas of note/concern.
Decision trail	The Director and Assistant Director of Education and Standards have approved this recommendation to Council to amend the GMC's list of awarding bodies.
Recommendation(s)	To approve <i>a combination of the universities of Dundee and St. Andrews</i> being added to the GMC's list of bodies that can award UK Primary Medical Qualifications (PMQs).
Annexes	Annex A: Open recommendations
Author contacts	Kate Bowden , Education QA Programme Manager Any enquiries to: GovernanceTeamMailbox@gmc-uk.org
Sponsoring director/ Senior Responsible Owner	Colin Melville , Medical Director and Director of Education and Standards

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](#).
- 2 Standards of proficiency are 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 rolling 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.
- 4 In 2016 we received a joint application from the University of Dundee and the University of St. Andrews to establish a Scottish Graduate Entry to Medicine (ScotGEM) programme. Since then, the application has been subject to our new school quality assurance process.

About ScotGEM

- 5 The ScotGEM programme is a 4-year graduate entry programme delivered by a combination of the Universities of Dundee and St. Andrews and is designed to develop doctors interested in a career as a generalist practitioner within NHS Scotland, with a focus on remote and rural medicine. There are 55 student places in each cohort.
- 6 The University of Dundee is already on the GMC's list of bodies that can award a PMQ awarding bodies. Prior to legislation passed by the Scottish Parliament in 2021, St Andrews was prohibited from awarding a PMQ by the Universities (Scotland) Act 1966. University of St Andrews (Degrees in Medicine and Dentistry) Act 2021 addressed this and so we now wish to add *a combination of the universities of Dundee and St. Andrews* to the list of awarding bodies. If the University of St. Andrews decides to apply to become an awarding body in its own right, this will require a separate QA process.
- 7 Years one and two of the programme are led by St. Andrews School of Medicine and years three and four are led by Dundee School of Medicine (the schools). For the first year of the programme students spend time studying in local GP

practices in NHS Fife. From the second year onwards, students spend periods of time living and studying in remote and rural areas in the Highlands and Dumfries and Galloway. For each year, the students are supervised by General Clinical Mentors (GCMs).

- 8 Students with Home (Scotland) fee status have their tuition fees paid for by the Scottish Government. Those from England and Wales are self-funded for the first year, although they can apply for support from their local student finance company and have assistance from the NHS for years two to four. Those from Northern Ireland have no tuition fee support.
- 9 Students are offered a 'return of service' bursary, a grant worth up to £16,000 in total, in exchange for working in NHS Scotland for up to four years. The scheme is administered by NHS Education for Scotland (NES) and offers students a bursary of £4,000 per student per annum in return for a year of service up to a maximum of four bursaries and four equivalent years of service. For students opting to participate, the 'return of service' arrangement becomes effective at the beginning of their foundation training.

Quality assuring ScotGEM

- 10 The Quality Assurance – Monitoring & Improvement (QAMI) team, with support from medical education associates, has undertaken a range of quality assurance activities since 2017. The team has visited the programme each academic year (except 2019/20 which was affected by the pandemic), speaking to students and various groups of staff, alongside paper-based reviews of policies and processes.
- 11 Due to COVID-19 we were unable to visit the programme in the 2019/20 cycle as planned. Instead, we conducted a survey of students and GCMs, and requested written updates from the senior management team to obtain the information which would have been provided at the visit.
- 12 We have identified a number of areas working well through our QA activities. Medical students have repeatedly praised the support they received from their GCMs and GP tutors. Students also praise the IT facilities available to them. We found that all staff both at the school, and on placement are well engaged and enthusiastic about the programme. However, over the course of our visit cycles we have identified some concerns. These are described in more detail below.
- 13 In addition, the MLA team have met with both schools as part of their recent engagement to discuss the clinical and professional skills assessment (CPSA).

Following this, they have awarded ScotGEM a RAG rating of green which means they have no concerns over plans. The team will be running similar meetings with all schools between March and May 2022 to discuss the applied knowledge test (AKT) however they do not have any current issues with either school.

Addressing concerns

- 14 Following our first cycle of activity in 2018/19 we asked the school to review ScotGEM staff and student representation on school committees. We also raised concerns over the sustainability of the GCM's workload as they were all working additional hours to complete their roles. We set requirements in both these areas alongside three recommendations for the schools to consider.
- 15 During the 2019/20 visit cycle, we were unable to visit the programme due to COVID-19 and through the written updates from the school and survey responses from students and GCMs, we were satisfied that work was ongoing to address concerns identified in the previous cycle, however the pandemic had delayed some of their plans. In addition, we identified two additional concerns from the survey responses and set two recommendations as a result.
- 16 The school showed evidence of improvement over the following twelve months and following a virtual visit in March 2021 we were able to close one requirement and one recommendation, and the school provided evidence about how they were in the process of addressing the remaining concerns. In addition, we set two further recommendations for the school to consider.
- 17 Our final visit took place in February 2022. At this visit there was clear evidence that the schools had sought to address remaining concerns which allowed us to close the one remaining requirement and all remaining recommendations except one. We did set two further recommendations; however we are confident that none of the outstanding recommendations will adversely affect students' ability to demonstrate how they meet the *Outcomes for graduates*. These recommendations are set out in **Annex A**. None of these outstanding recommendations should affect Council's decision to add the combination of the universities of Dundee and St Andrews to the list of bodies entitled to award a PMQ.
- 18 A reduced visit team will conduct a final visit to the schools to observe an OSCE in May 2022. Any new or remaining areas of improvement will be monitored through our routine quality assurance processes.

Recommendation

- 19** Both universities have responded well to the requirements and recommendations we have set, and while the majority of these have been closed as the schools have satisfactorily addressed our concerns, there remain three outstanding recommendations which we will follow up through our routine QA processes. Throughout this new school process, we have found the schools to be responsive, engaged and committed to providing a high-quality experience to their students, and we would therefore have no concern in recommending to Council that *a combination of the Universities of Dundee and St. Andrews* should be added to the GMC's list of awarding bodies.

Open recommendations

	Theme	Standard/ requirement	Recommendation
1	Theme one: Learning environment and culture	R1.19	The school should consider monitoring access to IT systems in secondary care placements.
2	Theme three: Supporting learners	R3.2b	The school should consider providing students with more specific medical career advice.
3	Theme four: Supporting educators	R4.5	The school should consider formalising networking and support between GCMs and GP tutors.

Action	To note
Purpose	<p>Members of Council (and the Senior Management Team) are asked to update their Register of Interests biannually, and whenever a material change is required. This register is published on the GMC's website.</p> <p>In order to enhance this practice and to maintain awareness of each other's interests and areas of expertise, the Register of Council Members' Interests is included below. This will continue to be presented to Council to note on an annual basis. SMT interests continue to be published on the website, but Council members, as the Charity's trustees, will also have their register noted by Council.</p>
Decision trail	Presented to Council on an annual basis.
Recommendation	Council is asked to note the Register of Members' Interests.
Annexes	N/A
Author contacts	<p>Melanie Wilson, Head of Corporate Governance and Council Secretary</p> <p>Any enquiries to: GovernanceTeamMailbox@gmc-uk.org</p>
Sponsoring director/ Senior Responsible Owner	Sophie Brookes , Assistant Director, Corporate

Background

- 1 In accordance with best practice, members of Council (and indeed the Senior Management Team) are asked to update their Register of Interests biannually, and whenever a material change is required. This register is published on the GMC's website.
- 2 In order to enhance this practice and to maintain awareness of each other's interests and areas of expertise, the Register of Council Members' Interests is included below. This will continue to be presented to Council to note on an annual basis. SMT interests continue to be published on the website, but Council members, as the Charity's trustees, will also have their register noted by Council.
- 3 The Corporate Governance team is available for advice and support on any matter in relation to the register of interests. There may be rare occasions where a declared interest is not published on the website, but this is managed on a case-by-case basis depending on assessed risk and the potential for a conflict to arise, by the Corporate Governance team.

The Register of Interests

- 4 The Register of Interests is published on the GMC website at the following address: <https://www.gmc-uk.org/about/how-we-work/governance/council/council-member-register-of-interests>
- 5 The current Register of Interests is published as follows for each Council member:

Professor Dame Carrie MacEwen (GMC Ref No: 2553610)

Organisation	Position
NHS Tayside	Consultant Ophthalmologist
University of Dundee	Honorary Professor
Royal College of Ophthalmologists	Fellow (Past President)
Royal College of Surgeons (Edinburgh)	Fellow
Royal College Surgeons and Physicians of Glasgow	Honorary Fellow

Royal College of General Practitioners	Honorary Fellow
Royal College of Pathologists	Honorary Fellow
Faculty of Sport and Exercise Medicine	Honorary Fellow
College of Optometrists	Honorary Fellow
British and Irish Orthoptic Society	Honorary Fellow
Faculty of Medical Leadership and Management	Senior Fellow
Scottish CMO	Specialty Advisor
Scottish Government	Clinical leader National Eyecare Workstream
Moorfields Eye Charity	Trustee
Exeter University	Member of Council
Healthcare Quality Improvement Partnership (HQIP)	Chair
Oxford Ophthalmological Congress	Member of Council
The Worshipful Company of Barbers of London	Honorary Freeman
Eye (Nature group)	Associate Editor
MDDUS	Member
BMA	Member
Academy of Medical Royal Colleges	Past Chair
Faculty of Public Health	Honorary Fellow
Royal Society of Edinburgh	Fellow

Mr Steven Burnett

Organisation	Position
Theatre Clwyd North Wales	Voluntary Board Member (until April 2022)
GMC Pension scheme	Trustee
Steve is the former Chair of the Government Internal Audit Agency and a retired fellow of the Institute of Actuaries.	

Dr Vanessa Davies

Organisation	Position
Quality Assurance Agency for Higher Education UK	Non-exec Board member; Chair of its Advisory Committee on Degree Awarding Powers
House of Lords Conduct Committee	Lay member
Law for Life	Trustee
Crown Office and Procurator Fiscal	Non exec Director, member of Audit and Risk Committee
Honourable Society of the Inner Temple	Governing Bencher
GMC Pension Scheme	Trustee
Scottish Government	Decision Maker for complaints about Ministers or former Ministers
Occasional consultancy for professional regulators and for the Good Law Project.	
Family connections to King's College London and Newcastle University.	

Professor Anthony Harnden (GMC Ref No: 2807869)

Organisation	Position
Morland House Surgery, Wheatley, Oxfordshire	Partner
University of Oxford	Professor of Primary Care
St Hugh's College, University of Oxford	Governing Body fellow
Royal College of General Practitioners	Fellow
Medical Defence Union	Member
Joint Committee on Vaccination and Immunisation	Deputy Chairman
British Medical Association	Member
Morland House Healthcare Ltd	Director
GMC Services International Ltd	Board member
Daughter is a doctor on the Yorkshire Rheumatology training programme.	

Lord Hunt of Kings Heath

Organisation	Position
House of Lords	Labour Member
Privy Council	Counsellor
Institute of Health & Social Care Management	President
British Fluoridation Society	President
Health Care Supply Association	President
Hospital Caterers Association	President

National Water Fluoridation Alliance	Patron
Foundation for Liver Research	Trustee
Royal College of Physicians	Honorary Fellow
Royal College of GPs	Honorary Fellow
Faculty of Public Health	Honorary Fellow
Faculty of Dental Surgery, Royal College of Surgeons	Honorary Fellow
GS1 UK	President
Philip Hunt Consultancy	Self-employed consultant
Eden & Partners	Consultant and trainer
SweatCo Ltd	Advisory Board Member
Philip was Advisory Board Chair at Octopus TenXHealth until February 2022, when the board ceased to exist.	
Brother-in-law owns Happy Computers, which also trades as Happy ltd, and has undertaken training for some GMC staff up to 2015.	
Step daughter-in-law undertakes market research/business intelligence for market research agencies on behalf of pharmaceutical companies.	
Philip Hunt was appointed a non-executive director of the Heart of England NHS Trust in October 2010 and subsequently became Chairman in April 2011 serving until July 2014. [Surgeon Mr Ian Paterson was excluded from practice at the trust in May 2011. The Independent Review led by Sir Ian Kennedy was commissioned and reported under his Chairmanship].	
Philip was Health Minister from 1999-2003 and in 2007 which involved some responsibilities in relation to the matters reviewed by the Gosport Independent Panel and also in relation to the matters being reviewed by the Infected Blood Inquiry.	

Professor Paul Knight OBE (GMC Ref No: 2343239)

Organisation	Position
Social Security Scotland	Chief Officer (Health and Social Care Operations)
Glasgow University Medical School	Honorary Professor
Royal College of Physicians Edinburgh	Fellow
Royal College of Physicians and Surgeons of Glasgow	Fellow
Royal College of Physicians in Ireland	Fellow
Royal College of Physicians in London	Fellow
British Geriatrics Society	Past President / Member
European Union Geriatric Medicine Society	Past President
Glasgow City Health and Social Care Partnership	Consultant Geriatrician and older people's adviser
Swedish Research Council review panel for Clinical Therapy Research	Member
Chief Medical Officer for Scotland's Professional Advisory Group	Member

Professor Deepa Mann-Kler

Organisation	Position
Equality Commission NI	Commissioner
Public Health Agency NI	Non-Executive Director
Registers of Scotland	Non-Executive Director
Neon*	Chief Executive

Ulster University	Visiting Professor in Immersive Futures
Pharmaceutical Society of Ireland	Member of the Professional Conduct Committee
DHSC Public Appointments Unit	Independent Panel Member

* Neon creates virtual and augmented reality apps and experiences, often focussing on health and wellbeing, by facilitating and working directly with consumers and patients.

Dr Raj Patel MBE (GMC Ref No: 3103487)

Organisation	Position
NHS England and NHS Improvement	Deputy Medical Director for Primary Care
Royal College of General Practitioners	Fellow
British Medical Association	Member
Medical Defence Union	Member
GMC Pension Scheme	Trustee
Raj is listed as a director in his partner's retail company. The business has no links with healthcare.	

Dr Suzanne Shale

Organisation	Position
Oxleas NHS Foundation Trust	Non-Executive Director
The Ethicist Ltd	Director
Suzanne was previously a GMC Education Associate, prior to being appointed as a Council member.	
Suzanne was Chair of the charity Action against Medical Accidents from 2015-2020.	

Miss Alison Wright (GMC Ref No: 3498288)

Organisation	Position
NHS England and NHS Improvement	National Speciality Adviser for personalised care in Obstetrics
HCA Hospitals	Vice Chair, Medical Advisory Committee, Portland Hospital
Royal Free London NHS Foundation Trust	Consultant Obstetrician and Gynaecologist
GMC Services International Ltd	Board member

Action	To note
Purpose	<p>As agreed with Council, we established with effect from the beginning of 2019 a new s40A Executive Panel to consider whether we exercise our right of appeal in specific cases. The decisions of the s40A Executive Panel are published on the GMC website on the Recent Appeal Decisions page.</p> <p>This paper is the sixth update to Council on the operation of the s40A Executive Panel. There have been 10 new s40A appeals in the period since the last update at September Council. An update on the progress of existing s40A appeals is annexed.</p>
Decision trail	Council receives an update on Section 40A appeals twice a year.
Recommendation	Council is asked to note the contents of this update.
Annexes	<p>Annex A: Details of cases considered by the s40A Executive Panel</p> <p>Annex B: A summary of the status of s40A appeals</p>
Author contacts	<p>Sophie Brookes, Assistant Director, Corporate Directorate.</p> <p>Jim Percival, Deputy General Counsel, GMC Legal</p> <p>Any enquiries to: GovernanceTeamMailbox@gmc-uk.org</p>
Sponsoring director/ Senior Responsible Owner	Anthony Omo , General Counsel and Director of Fitness to Practise

Background

- 1 The GMC's right of appeal was introduced following the separation of its investigation and adjudication functions with the creation of the Medical Practitioners Tribunal Service (MPTS). It has made it possible for the GMC to exercise our own right of appeal in cases where we consider that Medical Practitioners Tribunals (MPTs) have made decisions which are not adequate to protect the public, which includes public confidence in the profession.
- 2 The terms of the GMC's right of appeal are contained in s40A Medical Act 1983. Section 40A(3) provides as follows:

"The General Council may appeal against a relevant decision to the relevant court if they consider that the decision is not sufficient (whether as to a finding or a penalty or both) for the protection of the public."

- 3 The PSA retains its right to refer cases to the High Court under s29 of the National Health Service Reform and Health Care Professionals Act 2002. However, if the GMC issues a s40A appeal, the PSA cannot also refer under s29. Instead, they can choose to join the GMC's appeal as a party pursuant to s40B Medical Act 1983.

The s40A Executive Panel

- 4 With effect from January 2019, decisions as to whether to exercise the GMC's right of appeal are no longer be taken by the Registrar alone, having regard to legal and other advice, but are instead taken by an Executive Panel consisting of the Chief Executive and Registrar (acting as chair), the Medical Director and Director of Education and Standards and the General Counsel and Director of Fitness to Practise (or their nominated Deputies if not available).
- 5 There is an established, three stage process supporting the s40A Executive Panel in its decision-making:
 - a Firstly, an assessment is undertaken by senior GMC lawyers (with input from the external counsel who conducted the case at the MPTS) of the determinations in all concluded MPT hearings where the tribunal's decision did not meet the GMC submission on sanction. This assessment is to determine whether there are, in principle, any realistic grounds of appeal and which would suggest that the MPTS decision is insufficient to protect the public or public confidence in the profession.

The s40A Executive Panel's Decisions

- 10 During the six-month period which this update covers (1 August 2021 and 28 February 2022 inclusive) a total of 253 cases have been heard by the MPT. In 145 of those cases (57 %), the outcome matched (or, as in 6 cases, exceeded) the sanction submission which the GMC made to the Tribunal.
- 11 The remaining 108 cases (43%), where the outcome did not match the GMC's submission, were assessed by senior members of our legal team in the first stage of the appeals process, as described in paragraph 5a. In 89 of these cases it was felt 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. The other 19 cases were referred to the s40A Executive Panel for their consideration.
- 12 Accordingly, in this period there were nine further meetings of the s.40A Executive Panel during which it has considered whether to exercise the GMC's right of appeal in relation to a total of 19 Doctors.
- 13 Details of the dates of the meetings, the Doctors whose cases were considered by the Panel at those meetings and the outcome of the s40A Executive Panel's consideration of each case are set out in the table at Annex A.
- 14 As that table confirms, the s40A Executive Panel have decided to exercise the power to appeal in 2 cases, concerning 10 doctors, since the last update. In other cases, where the s40A Executive Panel ultimately decided that it was not appropriate to appeal, issues have been identified with the MPT's determination on which the Panel considered it appropriate to provide feedback to the MPTS. For example, in certain cases MPTs have failed to direct reviews in cases where a review should have been directed (a failure which the GMC then itself had to remedy by exercising its powers to direct a review under s35D(4B) Medical Act 1983).
- 15 Each of the appeals which have been issued has now been listed for hearing:
 - a Nine of these appeals (in the so-called "WhatsApp Doctors" cases) were the subject of one Executive Panel meeting (and decision) and are listed at a joint hearing on 10 and 11 May 2022 (lines 4 -12 of the table at Annex A). The Professional Standards Authority has also joined these appeals as a second appellant pursuant to its powers under s40B Medical Act 1983.
 - b The other appeal (in the case of Dr Mok) is listed for hearing on 14 June 2022. The Professional Standards Authority is currently considering whether

to join this appeal as a second appellant pursuant to its powers under s40B Medical Act 1983.

- 16 Judgment in the sole s40A appeal which remained outstanding at the date of the previous update, that of Dr Ahmed, was finally handed down by the High Court on 25 February 2022. Murray J dismissed the GMC's appeal in that case which had involved concerns that the MPT had inappropriately reduced the period of suspension which the Doctor should have served, having been found impaired by reason of sexual misconduct in relation to a patient.
- 17 Whilst he accepted that the MPT's use of language was, in places, "unfortunate" or "infelicitous", lending some support to the GMC's supposition that the MPT had considered a sanction of six months as appropriate but had then impermissibly gone on to deduct from that the four months which the Doctor had served as an interim suspension, he ultimately concluded that that was not their actual reasoning in concluding that a suspension of only two months was appropriate in this case.
- 18 Annex B therefore gives an update on the outcomes and status of all of the s40A appeals issued since the GMC acquired the right to appeal with effect from 1 January 2016.
- 19 You will note that we have been successful in 27 (71%) of the 38 cases that have concluded, with four cases (11%) having been withdrawn and 7 (18%) having been dismissed by the court (either initially or on appeal to the Court of Appeal). We await the hearings and outcomes in the 10 remaining cases.
- 20 Council is asked to note this update.

Council meeting - 28 April 2022

Agenda item M10

Biannual s40a appeals update

Details of cases considered by the s40A Executive Panel

	Last Name	First Name	Doctor UID	S40A Executive Panel Meeting date	Appeal Issued?	Case/Allegation Type
1.	Khawaja	Dr Faryal Rauf	7610669	07/09/2021	No	Clinical Misconduct/Dishonesty
2.	Alam	Mr Mahbub	4625805	08/09/2021	No	Non-clinical Misconduct
3.	Kurz	Dr Roger	7069887	16/09/2021	No	Sexual misconduct
4.	Patel	Dr Ashik	7134640	05/11/2021	Yes	Non-clinical Misconduct
5.	Graichen	Dr Yannic Navyno Pachon	7082955	05/11/2021	Yes	Non-clinical Misconduct
6.	James	Dr Jason Jeyanthan	7403102	05/11/2021	Yes	Non-clinical Misconduct
7.	Sarnowski	Dr Alexander Kenneth	7451051	05/11/2021	Yes	Non-clinical Misconduct
8.	Jayasinghe	Dr Gihan Shantha	7134736	05/11/2021	Yes	Non-clinical Misconduct
9.	Cameron	Dr Paul Alexander	7083931	05/11/2021	Yes	Non-clinical Misconduct
10.	Tappouni	Dr Andrew	7486271	05/11/2021	Yes	Non-clinical Misconduct
11.	Fijten	Dr Rik Gerald Frits	7450904	05/11/2021	Yes	Non-clinical Misconduct
12.	Smith	Dr Robert David Thomas	7134693	05/11/2021	Yes	Non-clinical Misconduct
13.	Walker	Dr Daniel Mark	7134574	05/11/2021	No	Non-clinical Misconduct
14.	Alhejazi	Dr Muhammad Basim Rajab Hamzeh	2817000	18/11/2021	No	Clinical Misconduct

15.	Maksoud	Dr Hisham Hashim Abdel	4146159	30/11/2021	No	Sexual misconduct
16.	Khan	Dr Mazhar	6030507	30/11/2021	No	Sexual misconduct
17.	Oladipo	Dr Olanrewaju	7026256	14/12/2021	No	Sexual misconduct
18.	Austin	Dr Hannah	6163270	10/01/2022	No	Dishonesty
19.	Mok	Dr Jonathan Edward Gar-Wai	7602231	14/01/2022	Yes	Sexual misconduct

Council meeting - 28 April 2022

Agenda item M10

Biannual s40a appeals update

A summary of the status of s40A appeals

General
Medical
Council

Annex B

Council meeting - 28 April 2022

Number	Name	Siebel Ref/ Court Ref	Hearing date	Allegation type	Outcome
1	GMC v Jagjivan UID: 6075454	L1-1444389032 CO/3140/2016	9/05/2017	Sexual Misconduct	<u>Appeal successful</u> Finding of sexual motivation – remitted to MPT to consider impairment and sanction. Remitted hearing listed before MPT on 8-23 October 2018 (includes further allegation) Doctor erased from register at remitted MPT hearing.
2	GMC v Theodoropoulos UID: 4751410	L1-1599950541 CO/710/2017	21/06/2017	Dishonesty	<u>Appeal successful</u> Doctor erased from register
3	GMC v Nwachuku UID: 6101174	L1-1607149904 CO/778/2017	08/06/2017	Dishonesty	<u>Appeal successful</u> Finding of impairment substituted for finding of no impairment and warning. Remitted to MPT to consider sanction. MPT on remittal suspended Doctor's registration for 4 months.
4	GMC v Raychaudhuri UID: 6109032	L1-1618777528 CO/1126/2017	19/07/2018 (CA) 06/07/2017 (HC)	Dishonesty	<u>Appeal Dismissed in Court of Appeal</u> <u>(GMC having previously succeeded on appeal in the High Court)</u> (MPT decision not to find dishonesty or impairment ultimately upheld in Court of Appeal)

5	GMC v Narayan UID: 5208737	L1-1524876695 CO/5041/2016	04/10/2017	Sexual Misconduct	<u>Appeal successful</u> Direction for conditional registration for 9 months quashed and case remitted to MPT to re-consider sanction. MPT on remittal suspended Doctor's registration for 2 months.
6	GMC v Chaudhary UID: 5205264	L1-1497534246 CO/4371/2016	05/10/2017	Dishonesty	<u>Appeal successful</u> Court substituted for finding of no impairment a finding of impairment in relation to the probity, honesty and trustworthiness issues. Judge directed no further action be taken on sanction.
7	GMC v Stone UID: 2387262	L1-1501400463 CO/4470/2016	06/10/2017	Sexual Misconduct	<u>Appeal successful</u> Doctor erased from register
8	GMC v Chandra [Restoration] UID: 5195270	L1-1660529241 CO/1976/2017	18/07/2018 (CA) 11/10/2017 (HC)	Sexual Misconduct	<u>Appeal successful in Court of Appeal</u> <u>(GMC having initially been unsuccessful in the High Court)</u> Awaiting outcome of remitted hearing.
9	GMC v Krishnan UID: 5151835	L1-1697292022 CO/2490/2017	17/10/2017	Dishonesty	<u>Appeal successful</u> decision that Respondent's conduct was not dishonest, was not impaired, and to issue a warning all quashed;

					<p>remitted to MPT to re-consider dishonesty, impairment and sanction.</p> <p>On remittal, MPT found dishonesty and impairment, and suspended Doctor's registration for a period of 6 weeks.</p>
10	GMC v Lamming [Restoration] UID: 3581720	L1-1622384571 CO/1200/2017	19/10/2017	Dishonesty	<p>Appeal successful</p> <p>Decision to restore quashed. Remitted for fresh decision on restoration.</p> <p>Remitted hearing listed before MPT on 10 -18 December 2018</p> <p>[Originally listed in June 2018, but Medical Member had to be recused]</p> <p>Restoration Application refused on Remittal</p>
11	GMC v Nooh [Restoration] UID: 4169929	L1-1651558081 CO/1714/2017	24/10/2017	Dishonesty	<p>Appeal dismissed</p> <p>(MPT Order for restoration upheld)</p>
12	GMC v Aranmolate [Restoration] UID: 5186837	L1-1651558086 CO/1712/2017	25/10/2017	Sexual Misconduct	<p>Appeal withdrawn</p>

13	GMC v Thornley UID: 2734833	L1-1702467011 CO/2730/2017	07/11/2017	Dishonesty	Appeal withdrawn – Dr applied for and was granted VE.
14	GMC v Patel UID: 6148938	L1-1702637694 CO/2684/2017	16/11/2017	Dishonesty	Appeal Successful Direction that no action be taken quashed and case remitted to MPT to reconsider sanction. MPT on remittal suspended Doctor’s registration for 4 months.
15	GMC v Brooke UID: 3090697	L1-1666565801 CO/1976/2017	21/11/2017	Dishonesty	Appeal Allowed by Consent Direction that no action be taken quashed and substituted with an order that the Doctor’s registration be suspended for a period of 3 months
16	GMC v Banerjee [Restoration] UID: 7023741	L1-1683357782 CO/2198/2017	22/11/2017	Dishonesty	Appeal withdrawn
17	GMC v Brito-Babapulle UID: 2456641	L1-1760637541 CO/3843/2017	28-29/11/2017 (listed together with s.40 appeal)	Dishonesty	Appeal Allowed by Consent Direction that the Doctor be suspended quashed Doctor erased from the register.
18	GMC v Taylor	L1-1683357888	30/11/2017	Dishonesty	Appeal withdrawn

	[Restoration] UID: 6029437	CO/2196/2017			
19	GMC v Somuah-Boateng UID: 6087851	L1-1754185171 CO/3606/2017	05/12/2017	Sexual Misconduct	Appeal successful Doctor erased from register
20	GMC v Bawa-Garba UID: 6080659	L1-1718420822 CO/3089/2017	25-6/07/2018 (CA) 07/12/2017 (HC)	Conviction for Gross Negligence Manslaughter (Clinical)	Appeal Dismissed in Court of Appeal (GMC having initially been successful in High Court) (MPT decision to suspend the Doctor ultimately upheld in Court of Appeal)
21	GMC v Osman UID: 6099725	L1-1741732223 CO/3503/2017	13/12/2017	Dishonesty	Appeal successful Doctor erased from register
22	GMC v Khetyar UID: 5202361	L1-1826219493 CO/5469/2017	19/03/2018	Sexual Misconduct	Appeal successful Doctor erased from register
23	GMC v Nyamasve UID: 5071770	L1-1841325581 CO/5808/2017	27/03/2018	Dishonesty	Appeal successful Suspension of four months quashed and remitted to MPT for a fresh decision on sanction. MPT on remittal erased Doctor from register.

24	GMC v Mehta UID: 4679086	L1-1919503581 XA30/18	24/10/2018	Sexual Misconduct	<u>Appeal Dismissed</u> (MPT decision to take no action following finding of impairment upheld by High Court)
25	GMC v Mmono UID: 3292451	L1-1937246101 CO/1585/2018	31/10/2018	Sexual Misconduct	<u>Appeal Successful</u> Doctor erased from register
26	GMC v Srivastava UID: 4780355	L1-1990761931 CO/2396/2018	N/A	Clinical Misconduct	<u>Appeal Allowed by Consent</u> Decision to find the doctor not impaired quashed and substituted with a finding of impairment, with undertakings agreed.
27	GMC v Sledzik UID: 6119259	L1-2001195566 CO/2511/2018	13.12.18	Clinical Misconduct	<u>Appeal Successful</u> Direction for conditions quashed and case remitted to MPT to reconsider sanction in light of judgment. At the remitted hearing, MPT imposed a further direction for conditions. Dr later appeared for a 'new and review' hearing and was erased.
28	GMC v X		22-23.01.19	Sexual Misconduct	<u>Appeal Dismissed</u>

	(references not included due to anonymity order)				(MPT decision to suspend the Doctor upheld by High Court)
29	GMC v Zafar UID: 5207520	L1-2362172511 CO/2396/2019	11.03.2020	Dishonesty	<u>Appeal Successful</u> Doctor erased from register
30	GMC v Saeed UID: 7398648	L1-2371654786 CO/2687/2019	21.01.2020	Conviction for Assault and controlling and coercive behaviour	<u>Appeal Successful</u> Suspension of 12 months quashed and remitted to MPT for a fresh decision on sanction. Doctor erased from register by MPT at remitted hearing.
31	GMC v Walton UID: 2805795	L1-2382278361 CO/2757/2019	05.12.2019	Dishonesty	<u>Appeal Successful</u> MPT findings on certain facts, and directions on impairment and sanction based on those factual findings quashed and the relevant issues of fact, impairment and sanction remitted to the MPT to be determined in light of this judgment. MPT found additional dishonesty allegation proven and imposed a further 7 month suspension (taking account of 5 month suspension already undertaken prior to determination of appeal)
32	GMC v Haris UID: 7017372	L1-2528904441 CO/4728/2019	29.04.2020	Sexual misconduct	<u>Appeal Successful</u> and <u>Upheld in the Court of Appeal</u>

			CoA hearing 13.05.2021		<p>Court substituted a finding of sexual motivation and remitted for a fresh decision on impairment/ sanction</p> <p>Dr H was granted permission to appeal to the Court of Appeal, in respect of the substituted finding of sexual motivation, but the Court of Appeal dismissed his appeal.</p> <p>MPT on remittal made finding of impairment and suspended Doctor's registration for 9 momths.</p>
33	GMC v Awan UID: 6032816	L1-2542551905 CO/4891/2019	10.06.2020	Sexual misconduct	<u>Appeal Dismissed</u>
34	GMC v Armstrong UID: 4632658	L1-2611110766 CO/572/2020	03.03.2021	Dishonesty	<p><u>Appeal Successful</u></p> <p>Court substituted for finding of no impairment a finding of impairment and remitted to MPT on sanction.</p> <p>MPT on remittal erased Doctor from register.</p>
35	GMC v Udoye UID: 6094869	L1-2625976751 CO/801/2020	25.05.2021	Dishonesty	<p><u>Appeal Successful</u></p> <p>Court quashed MPT findings on Facts and no misconduct/impairment and remitted to MPT for a fresh hearing by a different Panel.</p>

					<p>Dr Udoye’s application for permission to appeal to Court of Appeal refused.</p> <p>Remitted hearing listed in October 2022.</p>
36	GMC v Donadio UID: 4653770	L1-2651206311 CO/1188/2020	23.02.2021	Dishonesty	<p><u>Appeal Successful</u></p> <p>Suspension of 12 months quashed and remitted to MPT for a fresh decision on sanction.</p> <p>MPT on remittal erased Doctor from register.</p>
37	GMC v Ahmed	L1-2860883431 CO/4282/2020	29.06.2021	Sexual Misconduct	<p><u>Appeal Dismissed</u></p> <p>(MPT decision to suspend the Doctor for 2 months without a review upheld by High Court)</p>
38	GMC v Bramhall	L1-2913159301 CO/155/2021	13.07.2021	Violence	<p><u>Appeal Successful</u></p> <p>Suspension for 5 months quashed and remitted to MPT for a fresh decision on sanction.</p> <p>MPT on remittal erased Doctor from register.</p>
39	GMC v Patel	L1-3261561181	10 – 11.05.2022	Other non-clinical Misconduct	
40	GMC v James	L1-3261561189	10 – 11.05.2022	Other non-clinical Misconduct	

Council meeting - 28 April 2022

Agenda item M10 - Biannual s40a appeals update

41	GMC v Samowski	L1-3261561201	10 – 11.05.2022	Other non-clinical Misconduct	
42	GMC v Jayasinghe	L1-3261561206	10 – 11.05.2022	Other non-clinical Misconduct	
43	GMC v Cameron	L1-3261561211	10 – 11.05.2022	Other non-clinical Misconduct	
44	GMC v Tappouni	L1-3261561216	10 – 11.05.2022	Other non-clinical Misconduct	
45	GMC v Fijten	L1-3261561221	10 – 11.05.2022	Other non-clinical Misconduct	
46	GMC v Smith	L1-3261561226	10 – 11.05.2022	Other non-clinical Misconduct	
47	GMC v Graichen	L1-3261561251	10 – 11.05.2022	Other non-clinical Misconduct	
48	GMC v Mok	L1-3319893391	14.06.2022	Sexual Misconduct	

Date and time:	Meeting:
Tuesday 21 June (evening seminar) and Wednesday 22 June 2022 (Meeting) 09.00 – 13.00 – Manchester	Council
Evening seminar <ul style="list-style-type: none"> ▪ GMCSI ▪ Regulatory reform 	
Confidential items <ul style="list-style-type: none"> ▪ GMCSI 	
Meeting <ul style="list-style-type: none"> ▪ Chief Executive’s report ▪ Equality, diversity and inclusion – Regulatory fairness review interim update ▪ Sex, gender and gender identity consultation ▪ Report of the MPTS Committee ▪ Freedom to speak up guardian annual report ▪ Report of the Audit and Risk Committee ▪ Trustees’ Annual Report and Accounts 2021 ▪ Fitness to Practise Statistics Report 2021 ▪ Update on Brexit standstill 	
Below the line <ul style="list-style-type: none"> ▪ Compliments and Complaints report ▪ 2022 Council forward work programme 	

Date and time:	Meeting:
Tuesday 12/Wednesday 13 July 2022 Council Away Day Fawsley Hall, Northamptonshire	Council

Date and time:	Meeting:
Wednesday 28 September (evening seminar) and Thursday 29 September 2022 (meeting) 09:00 – 13:00- virtual	Council
Seminar <ul style="list-style-type: none"> ▪ Safeguarding ▪ 	
Confidential items <ul style="list-style-type: none"> ▪ Outline draft Business Plan and Budget 2023 ▪ SoMEP report – early messages 	
Meeting <ul style="list-style-type: none"> ▪ Chief Executive’s report 	

<ul style="list-style-type: none"> ▪ Equality, diversity and inclusion – fairer training pathways ▪ Biannual s40a Appeals Update ▪ <i>Adapting to the future</i> report [Approvals team] ▪ Update on Education reform ▪ Pensions update – re triennial valuation [tbc]
<p>Below the line</p> <ul style="list-style-type: none"> ▪ Council members’ register of interest ▪ 2022 Council forward work programme

Date and time:	Meeting:
Wednesday 2 November (evening seminar) and Thursday 03 November 2022 (Meeting) 09.00 – 13.00 Edinburgh	Council
<p>Evening seminar</p> <ul style="list-style-type: none"> ▪ Scotland focus plus stakeholder dinner 	
<p>Confidential items</p> <ul style="list-style-type: none"> ▪ 	
<p>Meeting</p> <ul style="list-style-type: none"> ▪ Chief Executive’s report ▪ Equality, diversity and inclusion – regulatory fairness report ▪ SOMEF report – final draft ▪ Compliments and Complaints report [Jenny Broadley] ▪ Update on regulatory reform ▪ PPI update ▪ Pensions update – re triennial valuation [tbc] ▪ Update on the staff survey 	
<p>Below the line</p> <ul style="list-style-type: none"> ▪ 2022 Council forward work programme 	

Date and time:	Meeting:
Wednesday 13 December (evening seminar) and Thursday 14 December 2022 (Meeting) 09.00 – 13.00 - London	Council
<p>Evening seminar 17:00 – 19:00 to be followed by dinner</p> <ul style="list-style-type: none"> ▪ GMP review ▪ Perceptions audit [tbc] 	
<p>Confidential items</p> <ul style="list-style-type: none"> ▪ GMCSI 	
<p>Meeting</p> <ul style="list-style-type: none"> ▪ Chief Executive’s report ▪ 2023 Business Plan and Budget 	

- Three-year business plan (activities, monitoring/reporting, evaluating)
- Report of the Medical Practitioners Tribunal Service Committee 2022
- Report of the Audit and Risk Committee 2022
- Report of the Remuneration Committee 2022
- Update on regulatory reform
- MLA – update on MSC pilots (tbc)
- Equality, diversity and inclusion: fairer referral

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- Council forward work programme 2023 [Melanie Wilson]
- Committee membership 2023 [Melanie Wilson]
- Annual report on DC pension scheme [Neil Roberts/Samuel Curtis]