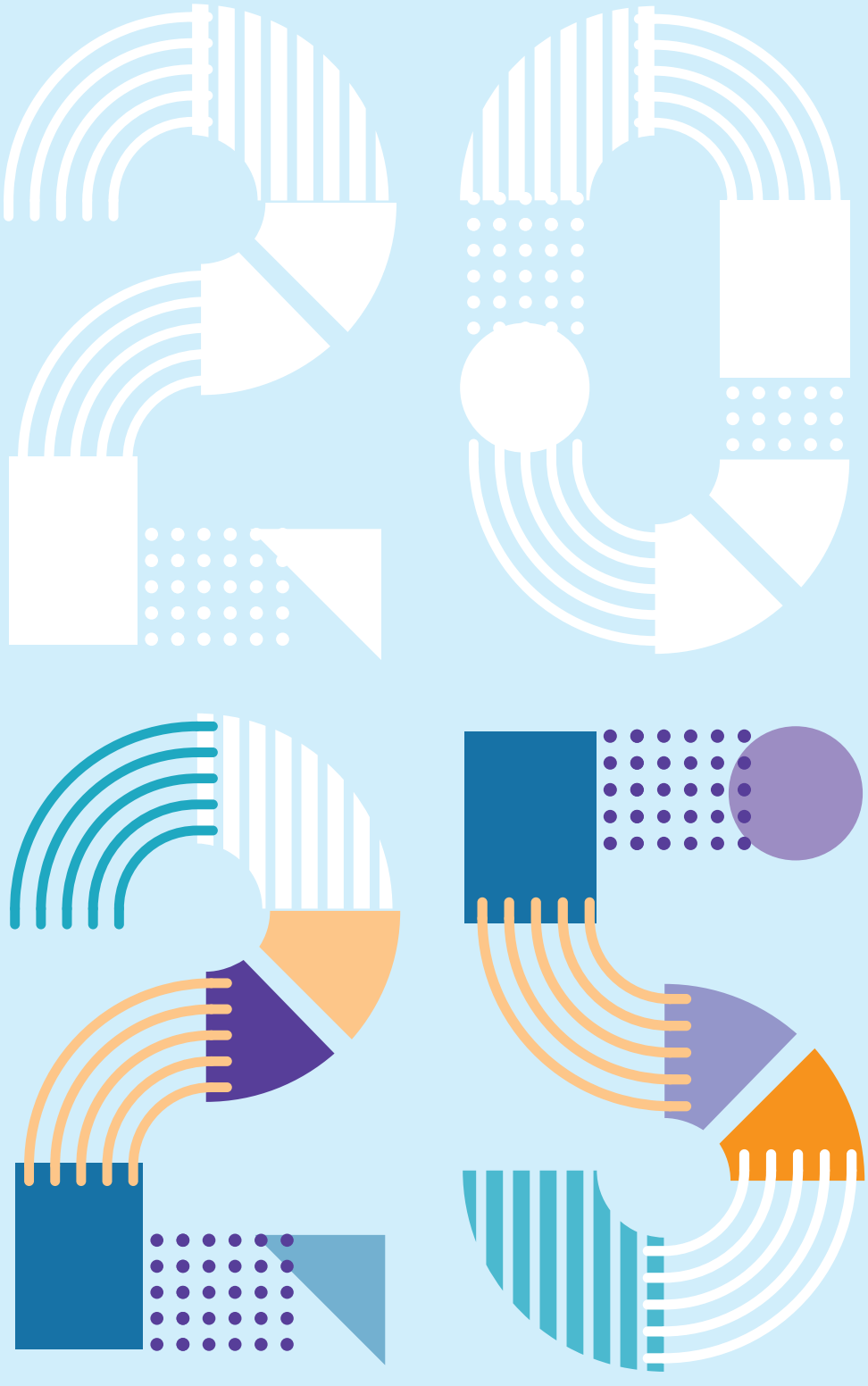
Annual report and accounts

General Medical Council



General Medical Council

Annual report and accounts 2025

Trustees' annual report and accounts for the year ended 31 December 2025

Report presented to Parliament pursuant to section 52A of the Medical Act 1983 as amended by The Health Care and Associated Professions (Miscellaneous Amendments) Order 2008 (SI No.1774).

Accounts presented to Parliament pursuant to paragraph 18 of Schedule 1 to the Medical Act 1983.

General Medical Council

This publication is available at: www.gov.uk/official-documents.

Any enquiries regarding this publication should be sent to us at gmc@gmc-uk.org.

ISBN: 978-1-7391680-6-3

General Medical Council

About this report

Our trustees present this report and financial statement for the year ending 31 December 2025.

They confirm they have taken into account the Charity Commission's public benefit guidance when reviewing our aims and objectives and have had regard to this guidance when exercising any powers or duties or when making a decision to which the guidance is relevant. The trustees are satisfied that at all times we have operated for public benefit and that the activities as described in this report and accounts fully meet the public benefit requirements and support our charitable purpose.

Readers may also be interested in:

- National reports (Our work in Northern Ireland, Scotland, and Wales)
- Fitness to practise statistics and reports
- MPTS annual report
- The state of medical education and practice in the UK reports
- National training survey results
- Equality, diversity and inclusion report

Contents

This publication is available in Welsh on our website.

Mae'r cyhoeddiad hwn ar gael yn Gymraeg ar ein gwefan.

Foreword

Health services across the UK continue to operate in a complex and demanding environment, shaped by rising demand and workforce pressures. As a professional regulator, we set standards for safe patient care, oversee education and training, maintain our registers and respond to concerns about fitness to practise. The Professional Standards Authority confirmed that we met all 18 of its Standards of Good Regulation in 2024–2025. Alongside our core regulatory functions, we work with others on the issues that affect how care is delivered in practice. In doing so, we provide assurance and contribute our analysis and perspective on the challenges facing the UK's healthcare systems.

2025 was the final year of our 2021–25 strategy. Over that five-year period, the composition of the medical workforce has diversified, bringing both opportunities and challenges. 2025 was also the first full year in which we regulated physician associates (PAs) and anaesthesia associates (AAs). In an ever-evolving context, we must continue to deliver our core regulatory responsibilities effectively, recognising that close collaboration and the sharing of insights are more important than ever.

We work with others across the four nations to inform planning for the future of services, drawing on our data and on our landmark reports, which provide a detailed picture of the composition and wellbeing of the medical workforce, as well as the factors affecting recruitment and retention.

In 2025, the data illustrated the importance of supporting internationally-qualified doctors to build sustainable careers within UK health services, and we brought this evidence into conversations with stakeholders to highlight its implications for workforce planning.

As the profile of the workforce changes, it is vital that we continue to prioritise equality, diversity and inclusion. We have continued to focus on practical actions to support doctors who are new to UK practice.

A diverse workforce brings a wider range of perspectives and experiences, which strengthens professional decision making and helps health systems respond to patients' needs. It also requires organisations to make sure that work and training environments are inclusive, supportive and fair. We are taking UK-wide action to address disparities in doctors' experiences across professional practice and training, recognising that supportive work cultures are essential both for retaining skilled professionals and for delivering safe patient care.

As the workforce and healthcare services continue to evolve, it is important that the framework for professional regulation adapts to these changes. Looking ahead to our 2026–30 strategy, a key priority is modernising the legislation that underpins our work. Much of the current legislative

framework dates back more than four decades and was not created with the healthcare systems of today in mind.

Alongside efforts to modernise the legislative framework, we are also working to set the future direction for medical education and training. As population needs change and the workforce transforms, our responsibility is to make sure that our standards keep pace. Education and professional development must be structured to give doctors, PAs, and AAs the skills and knowledge to meet increasingly complex patient needs, while adapting to modern practice and career pathways. Our programme of work in this area will lay the foundations for sustainable careers in UK health services that need stability and retention of talent. This will be the first full review of the education standards in a decade; a substantial undertaking that will take time. Our aim is to make sure the revised model reflects the needs of patients, professionals and the health services now and in the years ahead.

In a pressured and rapidly changing system, our role is to provide clarity, consistency and assurance for the public. We do so through the standards we set, the way we respond when concerns are raised, and by working with partners to support doctors, PAs, and AAs to deliver good, safe care for patients across the UK.

Charlie Massey
Chief Executive

Professor Dame Carrie MacEwen
Chair

2025 at a glance

We registered **24,811** new **doctors**

3,909 **PAs** and

180 **AAs**

We revalidated **37,177** doctors

We held **1,174** meetings with responsible officers

We delivered training on our standards to **29,886** **doctors** across **934** sessions,

and **16,619** **medical students** across **141** sessions

We delivered **257** ***Welcome to UK practice*** workshops to **8,800** **doctors**

50,637 doctors in training completed our **national training survey**

Our **contact centre handled** **99,108** **calls**,

105,827 **emails and letters**, and **57,542** **webchat sessions**

We held **361** fitness to practise liaison meetings with patients and complainants

We conducted **221** visits to check the quality of education and training

We received **13,465** concerns about doctors

We referred **184** cases to the MPTS

Our role in the UK's healthcare systems

We are the independent regulator of doctors, physician associates (PAs), and anaesthesia associates (AAs) in the UK.*

We work with doctors, PAs, AAs, patients and other stakeholders to support good, safe patient care. We set the standards doctors, PAs, AAs and those who train them need to meet, and help them achieve them. If there are concerns these standards may not be met or that public confidence in doctors, PAs, or AAs may be at risk, we can investigate, and take action if needed.

How we promote good, safe patient care

We work with doctors, PAs, AAs, and other stakeholders to:

- set the standards of patient care and professional behaviours doctors, PAs, and AAs need to meet
- give guidance and advice to help doctors, PAs, and AAs understand what is expected of them
- make sure doctors, PAs, and AAs get the education they need to deliver good, safe patient care
- check who is eligible to work as a doctor, PA, or AA in the UK and work with them and their employers to confirm they're keeping up to date and meeting the professional standards we set
- investigate where there are concerns that patient safety, or the public's confidence in doctors, PAs, or AAs may be at risk, and take action if needed.

Our performance

Every year our performance as a regulator is assessed by the Professional Standards Authority (PSA). It is measured across our four core functions: education and training; registration; guidance and standards; and fitness to practise.

The PSA's latest annual assessment, published in December 2025, confirmed that we successfully met all 18 of its Standards of Good Regulation in 2024–2025. We are proud to have met all the standards set by the PSA since they were introduced in 2012. It means we are performing to a high standard as a regulator, and reflects the commitments we make in our work to standards such as:

- transparency
- public protection
- timeliness
- equality, diversity and inclusion.

General standards
5 out of 5

Guidance and standards
2 out of 2

Education and training
2 out of 2

Registration
4 out of 4

Fitness to practise
5 out of 5

Total standards met
18 out of 18

* We began regulating PAs and AAs on 13 December 2024.

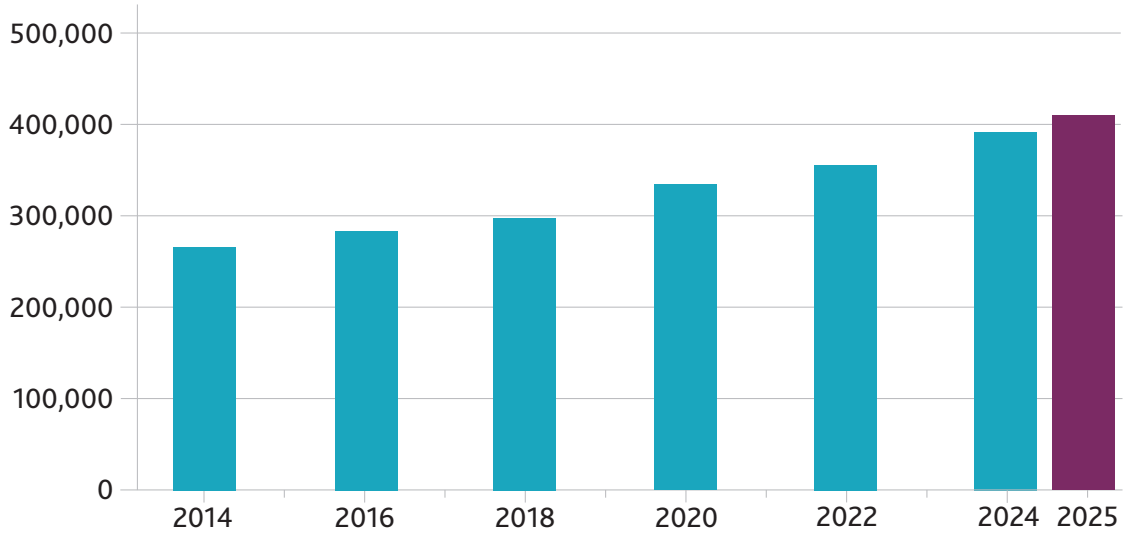
2025 in numbers

The register

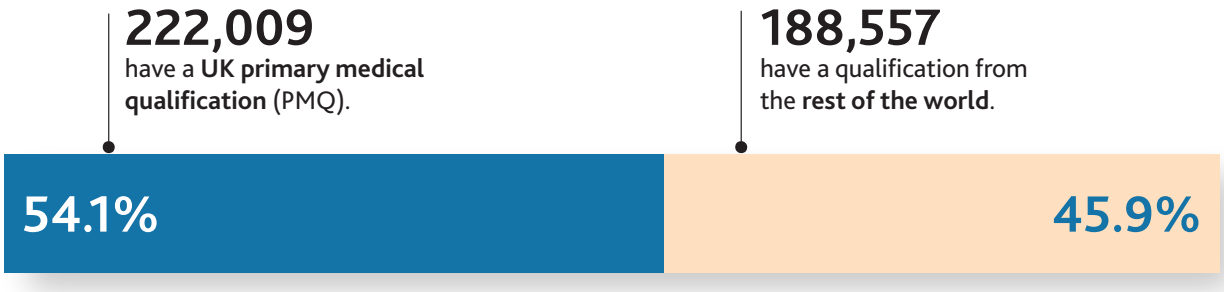
Doctors on the register in the UK

2024	% change	2025
393,357	↑ +4.4%	410,566

Growth in registered doctors 2014–2025



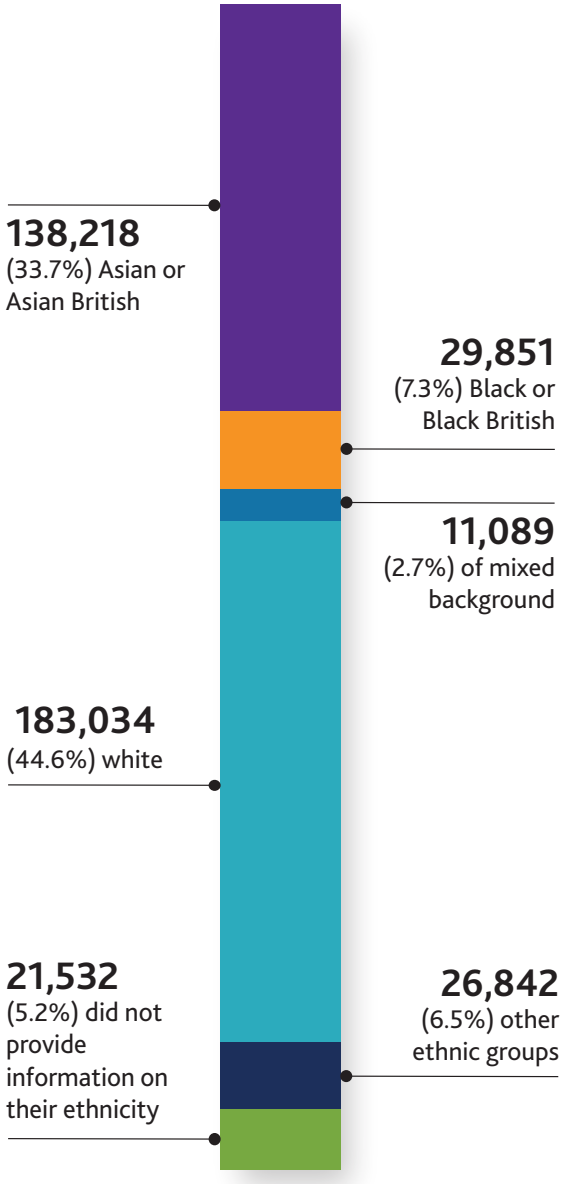
Where they graduated



All figures as of 31 December 2025 and 2024 respectively, unless otherwise specified. All percentages are rounded to the nearest tenth of a percent: in some cases the numbers may therefore not add up to precisely 100%. Visit GMC Data Explorer to learn more about doctors' education and practice in the UK.

Doctors on the register by location*

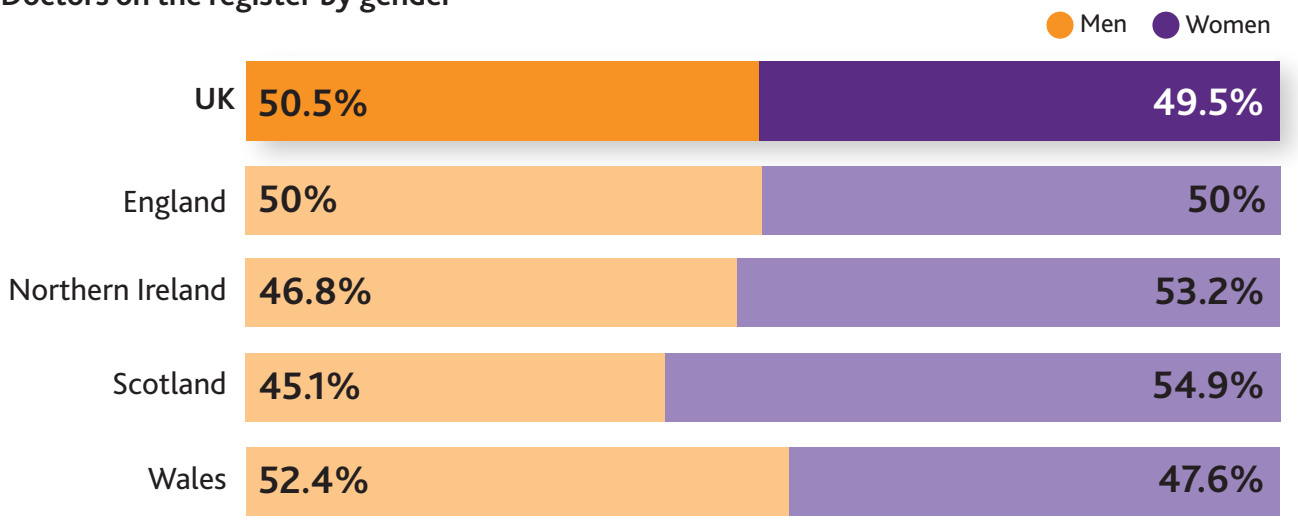
Doctors on the register by ethnicity



* The derived location of registered doctors is calculated using the following hierarchy:
1. where they work based on NHS practice history data
2. their training location based on the National training survey
3. the location of their designated body
4. their registered address.

Registered doctors located in the Channel Islands and the Isle of Man are included in the figures referring to England.

Doctors on the register by gender*



Total doctors on the GP Register

82,415

Up **2.7%** from 2024 (**80,237**)

Total doctors on the Specialist Register

115,587

Up **3.2%** from 2024 (**112,038**)

* This data includes all doctors on the register, with or without a licence to practise. In 2025, we achieved gender parity on the register for doctors with a licence to practise. Find out more on our news archive.

In 2025, we granted:

24,812
applications for first entry to the register.

That is down

13.1% ↓

from 2024 (**28,564**).

9,829
(39.6%) were from doctors with a **UK PMQ**.

14,983
(60.4%) were from doctors with a qualification from **the rest of the world**.

4,023
applications to join the GP Register.

That is down

3.9% ↓

from 2024 (**4,188**).

1,986
(49.4%) were from doctors with a **UK PMQ**.

2,037
(50.6%) were from doctors with a qualification from **the rest of the world**.

5,880
applications to join the Specialist Register.

That is up

6.6% ↑

from 2024 (**5,516**).

3,444
(58.6%) were from doctors with a **UK PMQ**.

2,436
(41.4%) were from doctors with a qualification from **the rest of the world**.

Professional and Linguistic Assessments Board (PLAB)

Doctors who graduate outside the UK, the EEA, or Switzerland usually need to take our Professional and Linguistic Assessments Board (PLAB) test in order to join the UK medical register.* The test is taken in two parts (PLAB 1, delivered in assessment centres around the world, and PLAB 2, undertaken in one of our testing centres in Manchester).

PLAB 1

13,691

candidates took PLAB 1 in 2025, a 35% decrease on 2024 (**21,058**).

8,513 (62.2%) passed the exam.

PLAB 2

14,315

candidates took PLAB 2 in 2025, a 26% decrease on 2024 (**19,346**).

8,564 (59.8%) passed the exam.

* Exceptions to this include international graduates joining the register based on being sponsored by healthcare organisations, or based on postgraduate qualifications. In both these cases, doctors must still provide evidence of their competence and skills. For more information on the different routes to join the register, see www.gmc-uk.org/registration-and-licensing/join-the-register/before-you-apply/evidence-to-support-your-application.

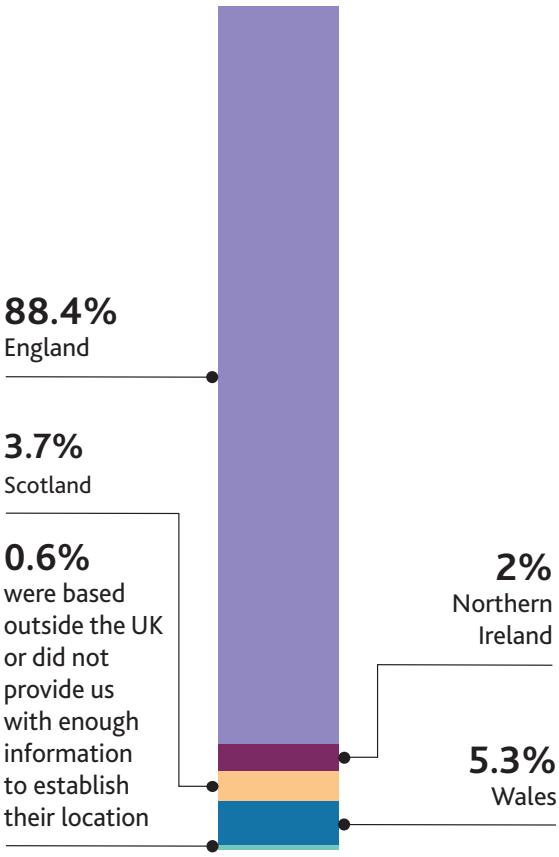
PAs on the register

3,903
PAs on the register **UK-wide**

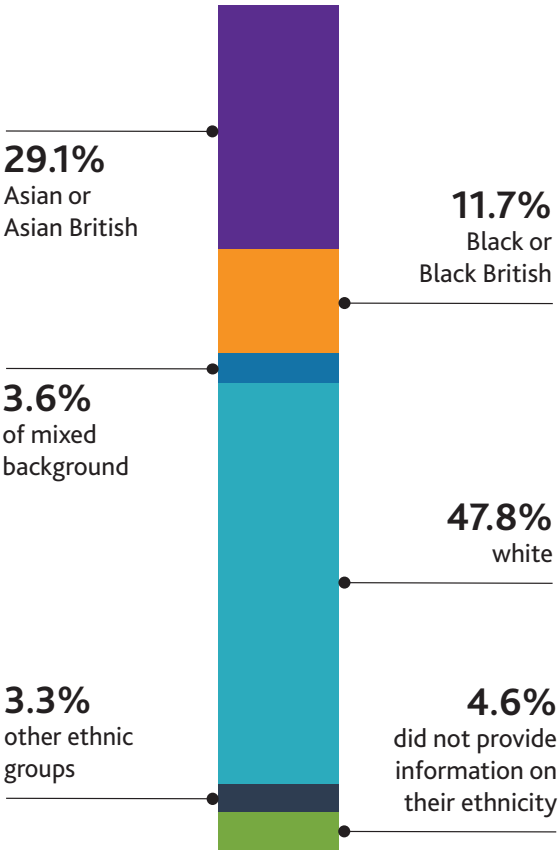
3,909
applications granted for first entry to the register in 2025

PAs on the register by gender

PAs on the register by location



PAs on the register by ethnicity



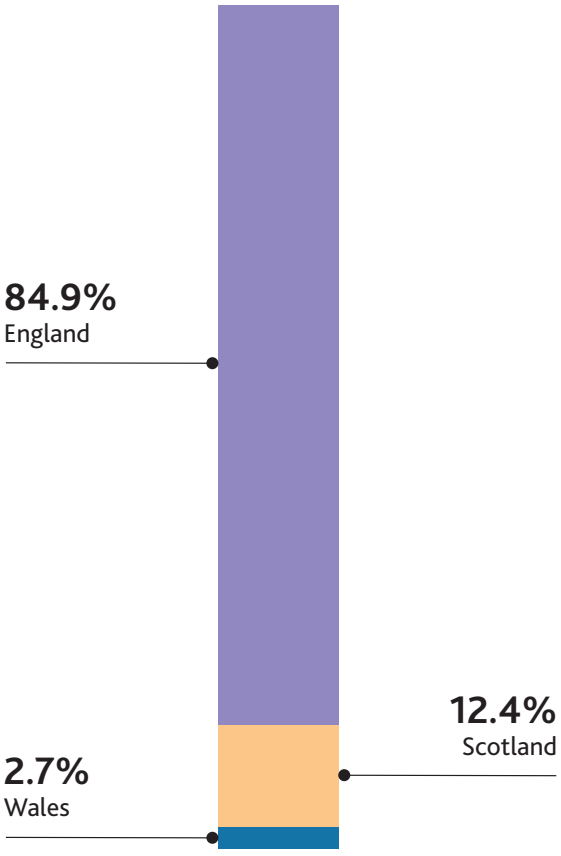
AAs on the register

185
AAs on the register **UK-wide**

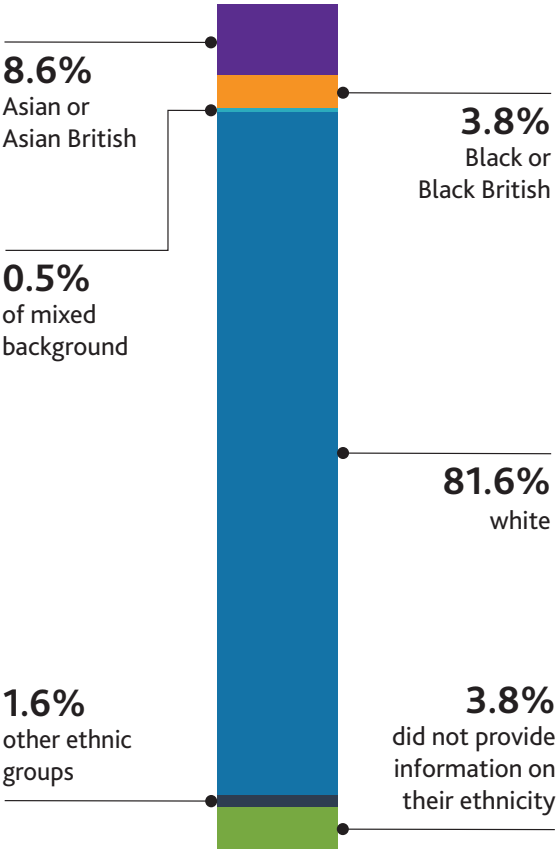
180
applications granted for first entry to the register in 2025

AAs on the register by gender

AAs on the register by location*



AAs on the register by ethnicity



* There were no AAs on the register in Northern Ireland in 2025.

Setting and maintaining standards

Revalidation

Every licensed doctor who practises medicine in the UK must prove they are meeting our standards every five years through a process called revalidation. Revalidation supports doctors to develop their practice, drives improvements in clinical governance, and gives patients confidence that doctors are fit to practise.

In 2025 we received

43,824

recommendations about revalidation.*

37,177

doctors were revalidated in 2025.

We made decisions on

99%

of the recommendations we received **within 5 working days, exceeding our target of 95%.**

5,648

We approved **deferral of revalidation submission dates** for 5,648 doctors.

1,319

We **withdrew the licences** of 1,319 doctors on our register through failure to revalidate.†

* Doctors can receive more than one recommendation.

† If a doctor does not fulfil the requirements of revalidation, provides fraudulent information or fails to provide reasonably requested evidence, we can legally withdraw their licence. This process is different to that of being removed from the register, for example, following an MPTS hearing.

Outreach

Our outreach teams delivered training on our standards to:

29,886
doctors in **934 sessions** across the UK.

That is down
13.1%
from 2024 (34,399).

16,619
medical students in **141 sessions** across the UK.

That is up
5.7%
from 2024 (15,722).

80% of doctors said they would **change their practice** as a result of the session.

Our standards enquiry team answered:

497
enquiries about our guidance.

That is up
9.7%
from 2024 (449).

Our outreach teams also deliver workshops aimed at helping doctors who are **new to UK practice** adjust to working in the UK's healthcare systems.

The team delivered
257
***Welcome to UK practice* workshops** in 2025

involving
8,800
doctors – down **21.6%** from 2024 (**11,223**).

Our employer liaison advisers held
1,174
meetings with responsible officers.

They also provided fitness to practise advice in relation to
3,137 doctors.

Overseeing education and training

We regulate all stages of a doctor's undergraduate and postgraduate education and training, setting standards and carrying out quality assurance (QA) work to make sure these are maintained. From 2025, as part of our statutory duty, we also set standards for providers of PA and AA courses, and we regularly check these are being met through our proactive and reactive QA processes.

Through our proactive QA process, we check that medical schools, postgraduate training organisations, and PA and AA course providers are continuing to meet our standards. We decide which organisations can award a UK primary medical qualification or a UK PA and AA qualification.

Our reactive QA processes promote and encourage local management of concerns about the quality and safety of education and training, through which emerging issues can be raised and monitored. If the issues are not resolved or worsen, cases relating to postgraduate medical training can be escalated into our enhanced monitoring process, which we use to address serious concerns where additional support is required.

In 2025 we carried out **221** education QA visits.

That is up **5.7%** from 2024 (**209**).*

171 of the visits were in **England**.
13 of the visits were in **Northern Ireland**.
18 of the visits were in **Scotland**.
19 of the visits were in **Wales**.

191 were **QA visits to medical schools, or clinical environments** where medical education and training take place.
30 were **enhanced monitoring visits**, promoting the local resolution of concerns about postgraduate training.

From our QA visits, we found:

19 areas of **good practice or working well**.
64 areas where our **standards were met**, but where we **identified improvements** that could be made.
14 areas that **required improvement**.†

As a result of our reactive QA activities:

4 cases relating to postgraduate education **were escalated to our enhanced monitoring process**.‡
4 cases escalated previously **were resolved**.§

* We always carry out a minimum of one education QA activity per organisation per year. We may also carry out follow-up activities based on organisations' recommendations or our findings, which are counted in our totals. This inevitably leads to statistical variation in the number of QA activities we carry out from one year to another.

† Not all QA visits lead to specific findings like those listed here – in some cases, nothing of significance is found, as nothing has changed since the previous visit, or nothing has been found worthy of particular note (ie education and training are working as expected). Here, we only report on the number of areas found to be particular examples of good practice, ie working well, or areas requiring improvement or where improvement is recommended. The figures on findings reported here therefore won't necessarily match the total number of visits we carried out.

‡ Enhanced monitoring cases usually concern a specific unit or department in a local education provider (LEP). Monitoring may relate to more than one concern in the same LEP, and a concern under monitoring may affect more than one unit, or an entire trust or health board.

§ Like with QA visits, not all enhanced monitoring visits result in escalation or de-escalation – in some cases the visits focus on monitoring progress towards the resolution of issues that had previously been escalated. The total number of visits therefore won't necessarily match the number of new or open cases or of cases whose status has changed during the year.

Number of QA visits to PA and AA education providers carried out in 2025

In 2025 we carried out

54

PA/AA QA visits.

49 of the visits were in **England**
2 of the visits were in **Northern Ireland**
2 of the visits were in **Scotland**
1 of the visits was in **Wales**

From our QA visits to PA and AA education providers, we found:

159 areas where our standards were met, but where we identified improvements that could be made.
7 areas that required improvement.

Supporting the people we serve

Fitness to Practise Liaison Service

In 2025, our fitness to practise liaison service held 361 meetings with people who had raised a concern with us.

94% of meeting attendees were satisfied or very satisfied with their meeting experience.

92% of meeting attendees agreed or strongly agreed that staff showed empathy for their situation.

92% of meeting attendees agreed or strongly agreed they were satisfied that their concerns had been understood during the meeting.

92% of meeting attendees agreed or strongly agreed the meetings helped them to understand what action the GMC could take.

Contact Centre

Our contact centre answered

99,108

calls and

105,827

emails or letters.

74.2%

of the calls and emails received were from registrants, and

25.8%

were from members of the public and others.

The contact centre also handled

57,542

webchat sessions.

In 2025, we received

1,366

complaints about our service.

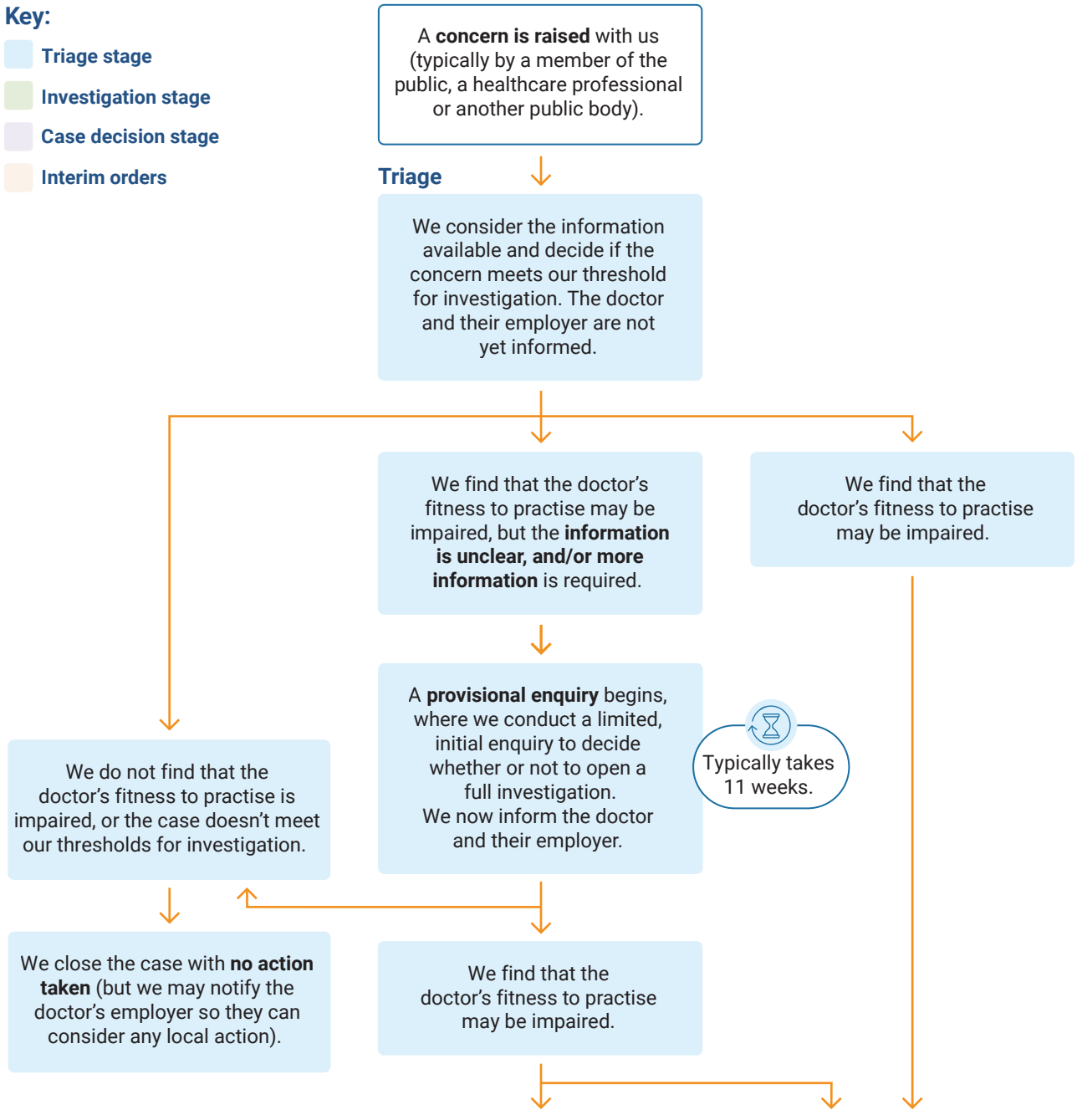
That is down

9.7%

from 2024 (**1,512**).

Investigating and acting on concerns

One of our key roles as a regulator is to investigate and act on concerns raised with us about our registrants. For doctors, we break this process down into three stages, which we call 'Triage,' 'Investigation,' and 'Decision.' We usually reach 'Decision' within six months, but the length of each stage depends on a range of factors and consequently, in some cases, the process can take a number of years. You can find out more about this process via our How we investigate concerns about doctors webpages, and about our process for PAs and AAs via our How we investigate concerns about PAs and AAs webpages.



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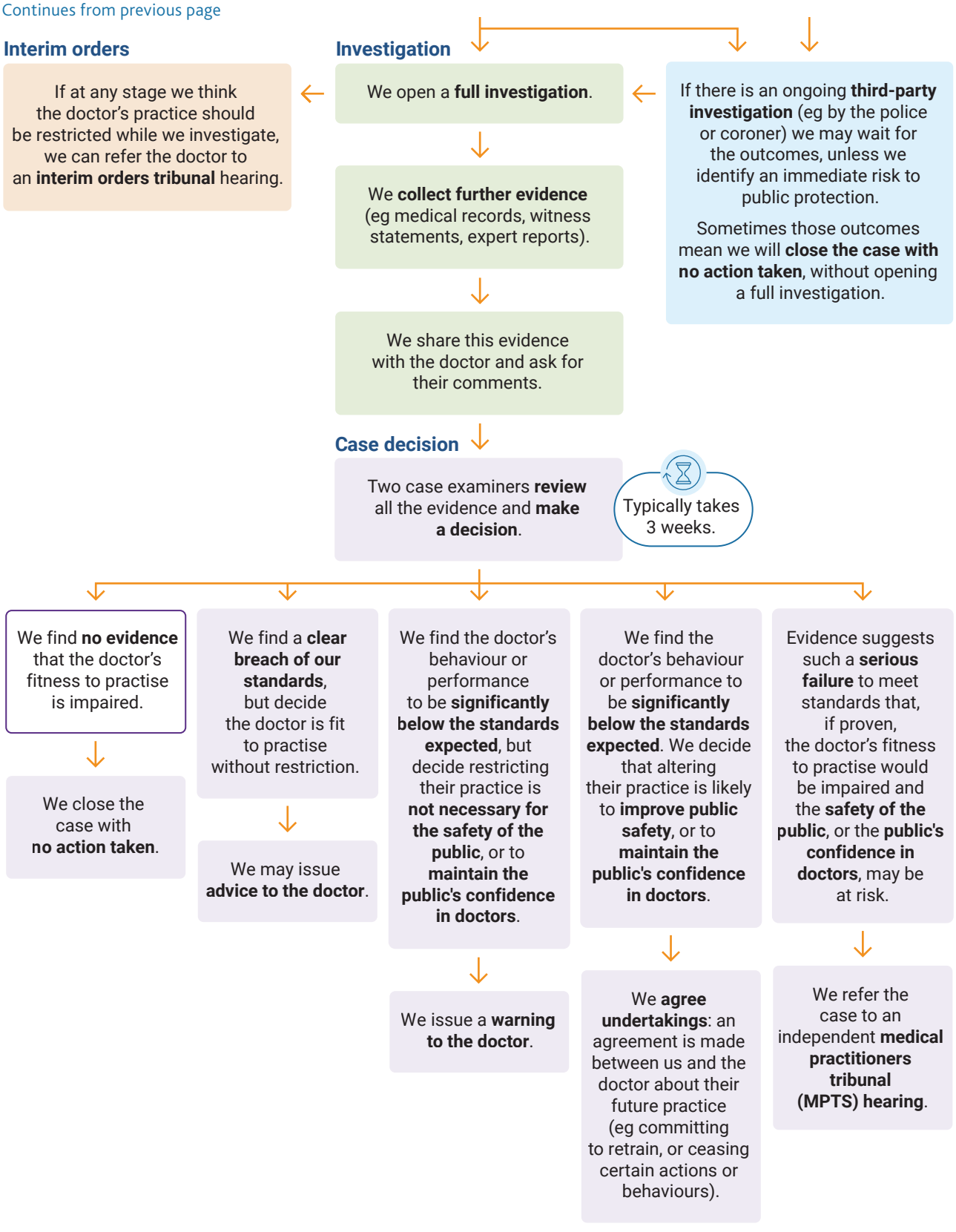
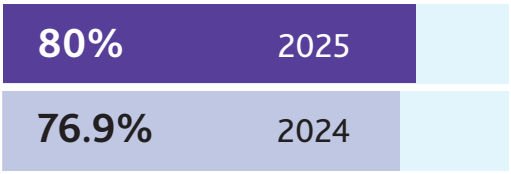


Concerns raised about doctors*

13,465 concerns were raised with us in 2025.

This is a **25%** increase on 2024 (10,769 concerns).

Percentage of concerns raised by the public



Of the 13,465 concerns that were raised with us in 2025, 80% were raised by patients or members of the public. That is higher than 2024 (76.9%).

Investigations

Not all the concerns raised with us meet our threshold for an investigation. Sometimes a concern is best dealt with at a local level or by having a conversation with the doctor, or should be brought before another organisation. We only take action where we find there may be a risk to patient safety or to public confidence in doctors.

997

(**7%**) of the concerns we received in 2025 met our **statutory threshold for investigation**.

That is lower than in 2024 (**8.4%**).

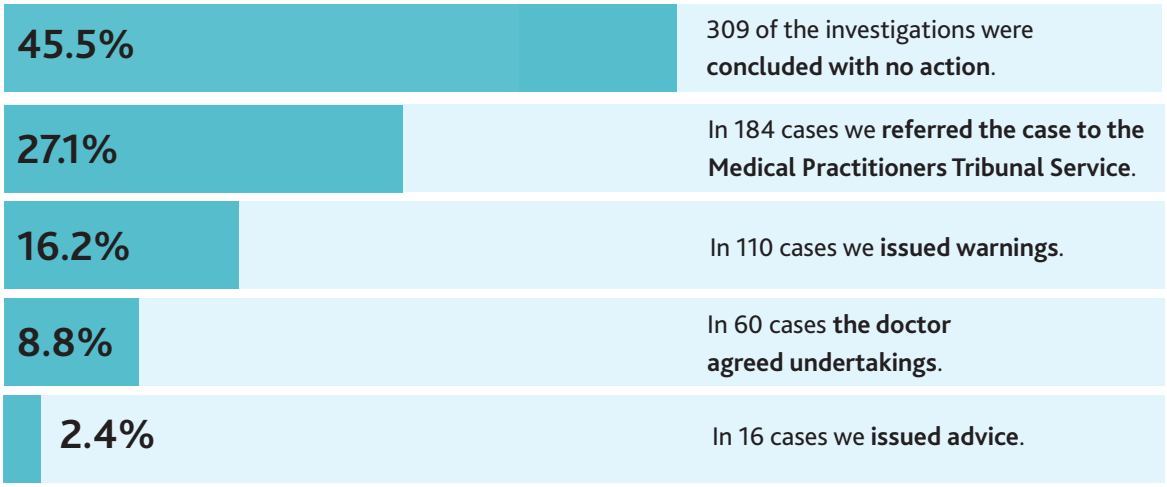
223

(**22.4%**) of these referred to concerns raised by **members of the public**.

That is lower than in 2024 (**26.2%**).

* In 2025, the number of concerns raised about PAs/AAs was not high enough to maintain anonymity when reported. Future publication of PA/AA concerns and outcomes will be reviewed once more data is available.

Outcomes*



* Outcomes of investigations that were concluded in 2025.

Outcomes of MPTS tribunals*

In 2025, the Medical Practitioners Tribunal Service held 160 tribunals.

42.5%	In 68 cases the tribunal **suspended** the doctor.
30%	In 48 cases the doctor was **removed from the register**.
14.4%	In 23 cases the tribunal found **no impairment**.
6.9%	In 11 cases, while the tribunal found no impairment, it **issued a warning**.
4.4%	In 7 cases the doctor had **conditions put on their practice**.
1.3%	In 2 cases the doctor **voluntarily removed themselves from the register**.
0.6%	In 1 case the doctor's practice was found to be impaired but **no further action was taken**.
0%	There were no cases where the doctor agreed to undertakings.

Where we do not agree with the decisions made by a tribunal, we can appeal.

In 2025 we made **10** appeals, compared to **4** in 2024. **3** appeals were successful, **1** appeal was unsuccessful and **6** appeals were outstanding as of 31 December 2025.

* These figures refer to tribunals for doctors only. There were no tribunals for PAs or AAs in 2025.

Delivering our strategy

Our work in 2025 was shaped by our 2021–25 corporate strategy, which set out four themes to help us achieve our 2030 vision.

We have since launched a new corporate strategy, covering 2026 to 2030. Our 2026–30 strategy is in many ways the continuation of our 2021–25 strategy, because our vision remains the same.

In this report we reflect on the progress we made in 2025 against our 2021–25 strategy. Our progress with our 2026–30 strategy will be reported in our 2026 annual report.

Our 2030 vision

We will be an effective, relevant and compassionate regulator for doctors, physician associates, anaesthesia associates, patients and the public, and as an employer.

2021–25 strategic themes

Progress in 2025

Our 2021–25 strategy has guided us through challenging times, including the effects of the pandemic, and has seen us become a multiprofessional regulator. It has allowed us to adapt as a regulator to support our healthcare systems as they faced exceptional pressures. The learning from a mid-point assessment we conducted in 2023 provided us with valuable insight that fed into the development work for our 2026–30 corporate strategy.

Below is a summary of the key activities we have undertaken in 2025 in support of our 2021–25 strategic goals.

Regulating PAs and AAs

On 13 December 2024, we began regulating physician associates (PAs) and anaesthesia associates (AAs), making us a multiprofessional regulator for the first time since the 1950s.* This followed a request in 2019 by the UK Government, supported by the devolved administrations, for us to be the regulator of PAs and AAs, and the passing of legislation in early 2024 to enable this.

Whilst registering with us is not a legal requirement for PAs and AAs until December 2026,† we have warmly encouraged these professionals to register as soon as they are able.

During the first quarter of 2025, we sent personal registration invitations to all members of the pre-existing PA and AA voluntary registers, and followed these up with reminders in June. We also directly emailed all PAs and AAs who completed their qualification and became eligible for registration during the year. As of 31 December 2025, we had registered 3,909 PAs and 180 AAs.

Following engagement with PA and AA course providers by our education quality assurance team in advance of regulation starting, in April 2025 we formally approved 33 PA courses and 3 AA courses as meeting our standards.‡

The Leng review

In November 2024, the Secretary of State for Health and Social Care commissioned an independent review of the PA and AA professions in England. The purpose of the review, led by Professor Gillian Leng, was to gather evidence to consider the safety of the roles and their contribution to multidisciplinary healthcare teams.

Professor Leng published her findings and recommendations on 16 July 2025. She made 18 recommendations in total, eight related to PAs, six related to AAs, and four regarding the wider system.

One of these recommendations is for the GMC, and calls on us to distinguish our regulatory requirements for different professions more clearly, indicating five actions we should implement in order to achieve this.

* The GMC had responsibility for the register of dentists between 1878 and 1921. The Dental Board took over maintaining the Dentists Register in 1921, but disciplinary cases and exam inspection powers were retained by the GMC until 1956 when they were transferred to the newly created General Dental Council.

† This is subject to potential changes that may be brought about by legislation undergoing consultation at the time of publication.

‡ In April 2025 we imposed conditions on the approval of four PA courses, out of the total of 33 that we approved (29 PA courses were approved without conditions). Having a condition on their approval meant that these four PA courses had to make improvements to their educational programmes so that we could be assured that their students were being trained to the standard we expect to maintain patient safety. All four of these courses have since provided evidence to assure us that standards are now being met, so we fully removed the conditions on the approval of three courses, and approved one course still with conditions, in December 2025.

We have since been considering the recommendations in detail and what they mean for us and others across the system, and have already started some work to implement them. We stand ready to join conversations at a system level to support the coordination of next steps.

A key measure Professor Leng has recommended is changing the PA and AA titles to 'physician assistant' and 'physician assistant in anaesthesia'. We are planning to implement this change once the titles that are set out in law are updated. Until then, we will continue to use the current titles and respective abbreviations, in all our documentation and communications.

Regulatory reform

On 12 May 2025, the UK Government confirmed its commitment to prioritising the reform of healthcare professional regulation. We have long advocated for reform, and welcomed this announcement as a significant step towards creating a framework that better serves patients, and the professionals we regulate.

The current legislation, parts of which are now over 40 years old, is overly complex and rigid. Modernising it will give us a responsive framework that promotes public confidence, better supports doctors, PAs, and AAs, and helps us respond more quickly and flexibly to changes in the UK healthcare system.

Regulatory reform is a complex and technical process, and it will take time to draft, scrutinise, and implement the new legislation. However, we are confident that through continued collaboration with key partners, we can deliver a regulatory model that enhances patient safety and maintains public trust in doctors, PAs, and AAs.

The current focus of this work is on modernising the regulatory framework for doctors, with work already underway to draft legislation that will replace the Medical Act (1983). Following that, updates will be made to the legislation underpinning the work of other healthcare professional regulators, such as the Health and Care Professions Council and the Nursing and Midwifery Council.

Throughout 2025 we have been working closely with the UK Government's Department for Health and Social Care (DHSC) as they develop the new legislation: The General Medical Council Order. We have also been working internally to prepare for how we approach transition – for example, how to transfer cases from the current legislative framework to the new one, or how we will migrate key data, such as registration records. We have shared our requirements with the DHSC so they can be reflected in the transitional provisions that will accompany the new legislation. We have also provided feedback on several iterations of The GMC Order over the course of 2025, and have made preparations to review the version that undergoes consultation.

Alongside the legislative work, we have been involving key audiences in shaping the future of regulatory reform. In particular, we have continued to engage with a panel made up of members of the public, doctors, PAs, and AAs, to explore and test specific topics that will sit under the new legislative framework. The panel is convened and managed via a third-party contractor, and has been consulted on a variety of topics so far – including, during 2025, on our role in relation to quality assuring education. We are using the panel's insights to help us make sure that any changes currently being designed and implemented are clear, fair and easy

to understand. We published an evaluation of this engagement work on our website in November 2025. Because this approach has been so valuable, we have commissioned a further phase of this work, to allow us to continue hearing directly from these groups on specific topics (in addition to a formal consultation), before The GMC Order is introduced.

The consultation on our proposed future regulatory framework took place between 24 March and 23 June 2026, and, subject to parliamentary time, the DHSC expects to lay the legislation before the UK and Scottish Parliaments before the end of the year.

The future of education and career development (Future Ed)

Health services across the UK are changing, shaped by innovation, evolving patient needs and a more diverse workforce. To make sure medical education keeps pace, we are undertaking a major review of our standards, outcomes and guidance in relation to this area, aiming to introduce an updated education framework by 2030.

Our work on the Future Ed programme is organised around three main policy areas: assessment, career development, and the review of our education framework. These policy areas reflect our core regulatory functions, overseeing all stages of medical education and training. As an independent regulator, we work to make sure that education and training prepare doctors, PAs and AAs to deliver good, safe patient care across the UK. We set the standards for their education and training, approve undergraduate and postgraduate programmes and the assessments they must pass, and oversee quality across learning environments through reviews and regular monitoring. We also engage widely across the system to understand their experiences and support high-quality learning.

Our Future Ed work on assessment, career development and the education framework ensures these functions remain aligned with modern practice, support good, safe patient care, and respond flexibly to the changing needs of learners, educators and employers across the UK.

In 2025, we broadened our engagement across the four nations to understand what needs to change. This included discussions with a wide range of stakeholders, including educators, employers, medical school staff, healthcare partners, representatives of patients and the public, and doctors themselves. Their insights are helping us build a clearer picture of the challenges and opportunities ahead.

Supporting educators remains a priority. Evidence shows they are under significant pressure, yet their role is central to high-quality learning and patient care. We are exploring how the system can better recognise and support this workforce, including through protected time, clearer expectations and more diverse routes into educational practice.

We are also considering how learning can be more flexible and better aligned with the needs of today's population. This includes exploring how curricula can support more rounded learning, how we enable patient-centred care, and how training can reflect the realities of practice across different settings and communities.

Improving access to training for all doctors is another key focus. The growth in locally-employed roles highlights the need for more inclusive and adaptable learning pathways, so that the skills and experience doctors in these roles gain across our healthcare systems can be recognised and used to support career development. We are working with partners to explore how standards and quality processes can apply consistently across learning environments.

Importantly, equality, diversity and inclusion, together with the experiences of patients and the public, have a key role in shaping our thinking in relation to this area. The perspectives we gain from engagement around these topics are helping us to make sure our proposals reflect the needs of the whole population, and we are committed to creating more opportunities for meaningful input as the work develops.

In 2026, we will continue to test emerging ideas with stakeholders and prepare for further engagement. This will include a comprehensive survey of the UK's locally-employed and specialty and associate specialist (SAS) doctors — the first since 2019 — to better understand their experiences and their opportunities to access training.

Ongoing collaboration and engagement will be essential as we develop a framework that supports a sustainable workforce and delivers high-quality care for patients across the UK.

Delivering our core functions

Like in previous years, in 2025 we continued to maintain a strong focus on the effective delivery of our core areas of work.

- Despite an unprecedented rise in the number of complaints received about our registrants compared to previous years,* the time taken to progress these fitness to practise cases at the early stages has not been impacted. While we have seen some fluctuations in timeliness measures, we remain focused on risk assessing and progressing all casework as efficiently as possible.

- We have continued to run Professional and Linguistic Assessments Board (PLAB) tests complying with the requirements of the Medical Licensing Assessment (MLA) we introduced in 2024. PLAB being MLA-compliant means that internationally-qualified doctors who pass the test have demonstrated skills and knowledge that are equivalent to those of doctors starting their second year of foundation training in the UK, meaning they can apply for full registration with a licence to practise from the GMC.

- Following the introduction of PA and AA regulation, during the course of 2025, 21 candidates sat the anaesthesia associate registration assessment (AARA) knowledge test, and 12 AARA clinical capability assessments were submitted for review.

- From September 2025, the PA National Exam was replaced by the PA Registration Assessment. We continue to be responsible for the quality assurance of the exam, which is delivered by the Royal College of Physicians.

* Please see the *2025 in numbers* chapter earlier in this report for more information.

- We continued to review postgraduate curricula and their programmes of assessment to make sure they meet our standards, and – through our national training survey – gathered the views of 71,000 doctors in training and trainers about the quality of training.
- We continued to work with training providers to check they are meeting the standards we set. In 2025, we escalated four departments involved in postgraduate medical training that were not meeting our standards to 'enhanced monitoring'. This level of scrutiny aims to promote and encourage local management of concerns about the quality and safety of medical education and training. If the standards we set for training are not met and we do not see sufficient improvement, we can set conditions on our approval of specific training programmes. If, and when, the situation improves we can de-escalate or close the enhanced monitoring case. In 2025, we successfully de-escalated four cases from enhanced monitoring.

Using data, research and insight

As part of our work, we produce and share data, research and insights on education and practice, to support our understanding of current trends in the sector and the development of wider healthcare policies and plans across the UK.

In 2025, we contributed to the call for evidence for the 10 Year Workforce Plan, and the Care Quality Commission's consultation on *Better regulation, better care*, both relating to England.

In Northern Ireland, we responded to the Department of Health's Duty of Candour and Being Open Policy Proposals, having initially responded to the consultation on the topic in 2021. And we responded to a call for written evidence on the Northern Ireland Assembly's Adult Protection Bill, as well as to a consultation on the Revised Code of Practice for the Mental Health Order.

In Scotland, we contributed to the consultation on the proposed creation of the NHS Delivery body. Furthermore, we worked closely with the Scottish Government on the Future Medical Workforce Project by sharing the data, insights and intelligence we've gathered through our Future Ed programme so far.

In Wales, colleagues responded to range of consultations, including Health Education and Improvement Wales (HEIW)'s call for evidence on its education strategy, its consultation on the All Wales Competency Framework for Palliative and End of Life Care, and Health Inspectorate Wales's (HIW) 2026–2030 strategy consultation. We also contributed to the Welsh Government's consultation on the NHS Wales Bursary.

Much of what we contributed and shared stemmed from our regular work to understand the workforce and the factors affecting retention, as well as our work to quality assure training environments for doctors in postgraduate training. This work included:

- the national training survey 2025, which showed several improvements compared with previous years, including more doctors in training reporting positive induction experiences, lower levels of burnout, and more trainers able to use their allocated training time. The survey also highlighted ongoing challenges, however – for example rota gaps, and the persistence of discriminatory behaviours in some workplaces. Our report on the findings from the survey calls for meaningful reform and greater

flexibility in medical training to avoid losing talented professionals from the workforce.

- our 2025 *The state of medical education and practice in the UK: workforce report*, which showed an increase in the numbers of internationally-qualified doctors relinquishing their licence in 2024, and a lower proportion of doctors managing to secure employment in the UK compared to recent years. The report also evidenced that while the number of internationally-qualified doctors applying for postgraduate training has increased, UK-qualified doctors continue to have far higher rates of being accepted into training programmes. And it included a special feature on women leading in medicine since 1859, to celebrate the workforce as a whole reaching parity in terms of the number of male and female doctors present on our register.
- our 2025 *The state of medical education and practice in the UK: workplace experiences report*, which indicated some gradual improvements in doctor's wellbeing, with overall satisfaction up and risk of burnout down. While this was the second year in a row that saw some improvements, the data indicated that many challenges persist: for example, the percentage of doctors witnessing patient safety being compromised in 2024 remained high, and similar to the proportions seen in 2023 and 2022. And while GPs remained under the most pressure, workload pressures were also visible across the board, with doctors reported to be taking steps to reduce their workload and trainer responsibilities, painting a worrying picture of potential risk to future workforce supply.
- a survey on doctors migrating to the UK, the last in a series of strategic research pieces we have commissioned to better understand the drivers of international migration trends that shape the UK's medical workforce. The survey, which we presented at the 2025 conference of the International Association of Medical Regulatory Authorities, focused on the factors that motivate internationally-qualified doctors to pursue their careers in the UK or go elsewhere. Its results can support workforce planners and policy makers in their efforts to attract and retain a sustainable medical workforce.
- other commissioned research, including our interim perceptions survey (the first including PAs and AAs), research on doctors' experiences of using AI, and research into maintaining public confidence in the professions we regulate.

Our data and research work in 2025 has strengthened our position as a key health commentator and influencer on workforce issues. Through reports including *The state of medical education and practice in the UK* and our national training survey, we've informed workforce planning and highlighted pressure points such as those around training capacity, supervision gaps, and burnout. Our use of data has also allowed us to monitor, assure, and develop the way we make regulatory decisions, ensuring we remain a fair regulator; for example, in 2025 we made progress towards setting up and running monitoring, reporting and external assurance measures for fairness and bias in 41 high-impact regulatory decisions that span our functions.

Protecting the environment

We launched our net zero plan in 2023, setting a target for us to become a net zero organisation by 2040, meaning our impact on the environment will be neutral. We have an intermediate aim to reach net zero emissions for scopes 1 and 2 by 2030,* underpinned by a commitment to reduce our emissions as much as possible before offsetting any residual emissions.

We have reduced our combined scope 1 and scope 2 market-based emissions† in 2025 because of a switch to renewable electricity tariffs at all our office sites. These emissions have reduced from 556 tonnes in 2019 to 155 tonnes in 2025. Alongside this, our overall electricity consumption has fallen in recent years due to energy efficiency projects we have undertaken. We replaced our UPS batteries with greener alternatives, installed additional LED lighting, reduced kit on desks, and added secondary insulation and glazing at one of our sites.

Our procurement and supply chain represents our largest area of emissions overall, and we have taken steps to engage with our top suppliers about their own sustainability credentials.

Our business travel emissions have also reduced since 2019 (from 727 tonnes of carbon dioxide to 312 tonnes in 2025), as we switched to more virtual ways of working post-pandemic. Our Green Travel Plan is helping us to explore what we can do to reduce our travel emissions further, and in 2025 we ran our third annual travel and homeworking survey which collects actual data from colleagues.

We also strengthened our approach to sustainability and climate action by reviewing how these themes could be reflected in medical education expectations, and reflecting on how medical schools and other education providers could improve things in practice. Our Future Ed programme identifies sustainability and climate action as a priority area for development, and we expect to do more work in this area in the coming years.

And as part of an annual awareness-raising competition we hold in collaboration with the Medical Schools Council, we asked medical students to create engaging online content exploring why sustainability in healthcare is included as a duty within the GMC's core guidance for doctors. The winning entry was a short video by a second-year medical student at King's College London, which the judges praised for its innovative approach.

* Scope 1 emissions are the greenhouse gasses controlled and emitted directly by an organisation, which for the GMC are mainly due to gas consumption. Scope 2 indirect emissions are those that are generated through the purchase and use of electricity.

† Market-based emissions are emissions from electricity that organisations have intentionally chosen to purchase through contracts they procure: for example, by choosing suppliers who utilise renewable energy.

Investing in our people

During the year we also made further progress on the 'investing in our people' theme of our strategy.

- We successfully rolled out our *Building Inclusive Cultures* programme, designed to promote fair and inclusive development and progression across the organisation.
- We achieved our target for 20% of our workforce to be from an ethnic minority background (while acknowledging we need to make further progress to also ensure appropriate representation at senior levels).
- We updated the criteria of our performance management system in order to enhance its fairness.
- We ran another highly successful intern programme, marked by 60% ethnic minority representation.
- Following a successful promotional campaign, our defined contribution pension scheme saw its membership grow to 100%.

Equality, diversity and inclusion

Equality, diversity and inclusion (ED&I) are integral to all our work as a regulator, and as an employer.

In 2021, we established two key targets in relation to ED&I:

- to eliminate disproportionate fitness to practise referrals in relation to ethnicity and origin of medical qualification by 2026
- to eliminate discrimination, disadvantage and unfairness in medical education by 2031.

We have been running programmes of work designed to help achieve each of these targets, as well as improvements in two other areas: inclusivity within the GMC and regulatory fairness.

We report on all of these programmes to our Council, and publish an ED&I annual report to share the progress made towards these targets and what next steps we think that we and others need to take to improve.

Promoting social responsibility

In 2025 we welcomed seven apprentices to different teams across the GMC, including business planning, information services, investigations, and the Medical Practitioners Tribunal Service. Apprenticeships provide exciting and varied career opportunities to those who may not have access to further education, or who particularly benefit from on-the-job training.

We also started to use apprenticeships for current colleagues across the organisation, with heads of section joining leadership programmes, and several colleagues in data, research and insights enrolling on data-related courses.

We believe young people must have a fair and equal opportunity to become our doctors of the future, so widening participation in medical education continues to be a priority for us. In 2025 we hosted events for two London-based organisations, Melanin Medics and The Aspiring Medics, which each support ethnic diversity and widening participation in UK medical training and

careers for students from a low socio-economic background. These events provided a day packed with tutorials and speakers for attendees.

> “I liked how the day had a range of different sessions to keep everyone engaged. I also liked the opportunity to ask the panel of doctors questions.”

Foundation year student, Leeds Medical School

We also invited students from medical schools at Edge Hill, Leeds, Lancaster and Leicester universities to visit our office in Manchester. All these students had joined medical training through a widening participation scheme.

> “I really liked how interactive the whole event was. It really engaged us as listeners and gave us insight into how the GMC operates and how we can thrive in medical school.”

Foundation year student, Leicester Medical School

Looking to the future

In January 2026, we launched our 2026–30 corporate strategy.

The new strategy builds and expands on the ambitions of our 2021–25 strategy, aiming to achieve our 2030 vision of being an effective, relevant and compassionate regulator – one that works in partnership with others, guided by evidence and by our commitment to equality, diversity and inclusion.

In developing the new strategy, we made significant efforts to hear and understand the views of patients, the professionals we regulate, students, partners in the UK’s healthcare systems and the people who work for us. We also considered the pressures that the healthcare system has faced during the implementation of the 2021–25 strategy.

While our vision remains unchanged, in our new strategy we have been clearer about what relevant, effective and compassionate mean in practice.

We have also retained the flexibility of our previous strategy, while being more granular about our objectives, how they relate to success, and how we will use the ambitions of our new strategy to make choices about where best to focus our efforts.

Our 2026–30 corporate strategy has four strategic themes:

- **Supporting good, safe patient care**: we will work with others to create healthcare environments that are inclusive, supportive and fair.
- **Delivering better, fairer regulation**: we will modernise our processes to make them faster, fairer, and better able to support good practice.
- **Making every interaction matter**: we will make our services accessible and treat everyone with kindness, respect, and efficiency.
- **Being an inclusive and well-run organisation**: we will invest in our people and culture, and use resources responsibly, to maximise our impact.

2026–30 strategic themes

Our work across the UK

Our outreach teams engage directly with doctors, physician associates (PAs), anaesthesia associates (AAs), students, employers, educators and other stakeholders to support the delivery of good, safe patient care.

The strong local relationships they build allow us to promote good practice and to influence positive, constructive change for doctors, PAs, AAs, patients and other stakeholders in the UK's healthcare systems.

The teams include regional or national liaison advisers, employer liaison advisers, senior advisers, operational coordinators and assistants, business and project managers, and more than 20 associates working across England, Northern Ireland, Scotland and Wales.

In England, the teams are organised to reflect the seven geographical NHS England regions: with the exception of London, each England outreach team covers two NHS England regions. In Northern Ireland, Scotland and Wales, the teams cover the entirety of the respective nation. This approach ensures that each region or nation is considered separately, so that productive relationships and engagement happen at the right level, through teams of a manageable and effective size.

In particular, the teams:

- train doctors, PAs, AAs and students on the professional standards and how to apply them
- advise clinicians, responsible officers, employers and others on promoting positive leadership and culture and protecting wellbeing in the workplace
- advise responsible officers and others on fitness to practise and revalidation issues, improving the quality of referrals, and on good clinical governance, including the fair and effective local resolution of concerns
- work closely with colleagues responsible for overseeing education to check that the standards for education and training are met, and to address challenges in training environments when these emerge.

This external engagement builds positive relationships across our healthcare systems, helping also to improve understanding of who we are and what we do, fostering trust in our work.

In this section of the report, we highlight some of the work our outreach teams have done in collaboration with partners in 2025. Each example helps to demonstrate the breadth of our outreach work and the positive impact of targeted, timely frontline support. They also show the value of building strong relationships and sharing expertise, with the aim of promoting good, safe patient care and improving work environments for doctors, PAs, AAs, and those who work with them.

You can find out more about our work in Northern Ireland, Scotland and Wales by reading our latest national reports.

Supporting internationally-qualified doctors to talk about end of life care

We know from our outreach work that internationally-qualified doctors can feel less confident holding end of life care conversations than UK-trained ones. Depending on how long they have been practising in the UK, standard UK practices and cultural habits with regard to end of life may be new to them, and approaching these conversations (especially where language barriers may still exist) can be daunting.

To support internationally-qualified doctors to develop skills to manage and talk about this emotive and sensitive subject more effectively, our Regional Liaison Advisers in the North of England began working with NHS England end of life care clinical strategic and project leads to identify ways we could help.

Together, they developed a virtual end of life care training session for internationally-qualified doctors working in the North East, Cumbria, and Yorkshire and Humber, and started delivering it in 2025.

The session covers aspects such as communication and cultural perspectives with guidance and information on our professional standards, including with regard to end of life.

> “Case scenario examples from practice, and opportunities to ask questions, helped translate learning into real-world application.”
>
> **Doctor who attended the end of life care session**

Everyone involved in planning and delivering the sessions found them particularly rewarding to work on, saying they were making a tangible, positive contribution in supporting sensitive and practical patient care at what can be an incredibly difficult time not only for patients and their families, but also healthcare professionals.

Interest in the session was very high, with 76 doctors attending the first two, and more than 100 signing up to a waiting list by the end of the year. We are now delivering further sessions, and are working with colleagues to consider rolling out the training to other areas of the UK.

> “Eye opening session with a lot of materials to help us learn.”
>
> **Doctor who attended the end of life care session**

Developing training and networks for responsible officers

Our employer liaison advisers (ELAs) work with responsible officers (ROs) around the UK to support them in managing concerns about doctors and their revalidation. An RO is a senior doctor (often a medical director) who is responsible for ‘clinical governance,’ which focuses on the behaviour and performance of other doctors. Among other things, they evaluate a doctor’s fitness to practise and make a revalidation recommendation to us.

ROs in England receive training and induction for their roles from NHS England. Until 2023, this was provided by an external company, with GMC input. In 2023, however, NHS England decided to work directly with us and NHS Resolution to begin providing this training and induction.

Our outreach and revalidation teams developed and delivered a dedicated training package for ROs to prepare them for the day-to-day challenges of their role, and to make sure they understand the governance responsibilities they have when it comes to managing patient safety concerns and involving doctors effectively in the process.

The training encourages ROs and their teams to consider and challenge their organisational culture and internal governance when responding to concerns about doctors, ensuring fair and consistent processes regardless of a doctor's background, experience or protected characteristics.

It comprises new materials describing the core role of an RO, the role of our outreach advisers, and our fitness to practise and revalidation processes. The team also developed a set of case studies with examples of local concerns ROs might face.

In partnership with NHS England and NHS Resolution, we now deliver full-day training sessions for ROs based on this model at our offices in Manchester and London, with ELAs available to support discussions and provide advice and guidance.

We have also developed an online follow-up session which is delivered approximately six months after the initial training. This gives ROs the chance to check in and ask any questions after more experience in their role, creating a community of peers and the opportunity to continue conversations around fairness in processes.

In 2025 we hosted ten training days as part of this initiative, supplemented by follow-up sessions for around 200 new ROs and their teams to share experiences and any areas of concern.

> "The training was excellent and answered all of my concerns."
>
> **Feedback from an RO about new training**

The direct involvement of ELAs in developing and delivering the training is not only helping ROs at the very start of their journey – it also helps reinforce good practice in the longer term, as it contributes to building ever stronger relationships with these professionals.

Our London outreach team has also been instrumental in supporting ROs working in the pharmaceutical industry, identifying the need for and establishing a peer network specifically for this niche group.

Following a number of conversations with ROs in these positions, our outreach ELAs identified the need for specialised content to support their work, as well as a practical mechanism to share that content with ROs that are spread across the country.

As these ROs do not work under a single Higher Level RO who can coordinate and run a support network, our ELA arranged a pilot meeting and established clear terms of reference.

Since then, we have identified and approached more pharmaceutical ROs and designated bodies that might benefit from joining the network, and by the end of December 2025 the network comprised over 20 ROs and their teams.

> "Good interaction and lots of opportunities to ask questions."
>
> **Feedback from an RO about new training**

As well as providing a platform for us to share key updates on our guidance and help upskill pharmaceutical ROs on relevant topics such as AI in healthcare, the new network has also already played a pivotal role in designated bodies updating their local fitness to practise policies, based on discussion and inputs from network participants.

Welcoming PAs and AAs into regulation

In December 2024, we began regulating PAs and AAs.

To help these professionals understand what it means to be regulated, in 2025 we implemented a dedicated programme of communications, aimed at introducing them to the GMC and providing them with a clear understanding of our role and the support we provide.

As part of this, newly-registered PAs and AAs have been receiving a monthly e-newsletter, with each edition focusing on a different aspect of our role as a regulator.

In 2025, we sent an introductory 'Welcome to the register' email to 3,978 newly-registered PAs and AAs. The email has so far been opened by 85% of recipients. We have also seen similar average open rates (80%) for the further nine editions of the new e-newsletter for PAs and AAs.

In a perceptions survey we ran to assess how well our communications had been received, 67% of PAs/AAs said they felt they had received the right amount of communication from the GMC; 89% agreed the information had been clear and easy to understand, and 73% agreed it had been helpful and empathetic.

> "I cannot tell you how much your newsletter has made my day. The kindness and confidence you share in your words is so encouraging."
>
> **Physician associate**

Alongside our written communications, our outreach teams across the UK also delivered in-person and virtual sessions to PAs, AAs, and students of these professions, to welcome them to professional regulation and help them understand how it works. The sessions also introduced PAs and AAs to *Good medical practice* standards so they can begin to see how to apply these in their work with patients and colleagues.

We also delivered a session designed specifically to help employers understand the systems they will need to have in place to confidently manage any concerns that may be raised about PAs' and AAs' practice, and how they can help these professionals keep their knowledge and skills up to date.

In total our outreach teams delivered 43 sessions to around 1,500 PAs, AAs and students, and more than 250 employers.

> "[This session gave] clarity on roles and responsibilities of all organisations involved, and acknowledgment of work still in progress."
>
> **Employer who attended a session**

Supporting good, safe maternity care

Everyone should get maternity care that is safe and compassionate. But we know that hasn't always happened. Some women and families have had very traumatic and tragic experiences that changed their lives.

As an organisation that learns and improves, we are working to engage more closely with women and families to listen to their concerns and take action where it's needed. Part of our role includes supporting the Ockenden Maternity Review into maternity services in Nottingham, as well as the national investigation into NHS maternity and neonatal services.

In 2025 we engaged with women and families in Nottingham, giving them the choice about whether to meet with us independently or jointly with the NMC to avoid them having to re-tell the traumatic events that happened to them.

Our outreach teams across England and Wales also worked with key stakeholders to raise awareness of who we are and what we do as a regulator, aiming to support women and families who have concerns about the maternity and neonatal care they received.

We want to make sure that women and families affected by issues in maternity care receive the right advice and support from the right organisations, which includes explaining what we do, the types of concerns we look at, and how to raise a concern about registered professionals if they want to.

As part of this, we worked with UK maternity charities to produce a new resource about our role that can be shared with women and families who had difficult experiences and have concerns about their care.

We also reviewed and updated some of our public-facing resources and our website to make sure they are as helpful as possible.

In addition, in England we engaged with Maternity and Neonatal Voices Partnership leads and fitness to practise liaison teams in local areas in England where women and families have raised concerns, and with UK maternity charities who work with and on behalf of families.

In Wales, we worked with Llais, the patient voice body, to support their work with women and families around maternity care, and we contributed as a member of the Welsh Government's stakeholder panel for a national assessment of maternity and neonatal services. We also joined the Nursing and Midwifery Council (NMC), Health Improvement Wales, and NHS Resolution on a regulator panel at the Swansea Bay Maternity and Neonatal Learning Conference, attended by patients and professionals. Our outreach teams across the UK continue to work with partners to support improvements in maternity and neonatal care, and we have worked with the NMC to deliver joint sessions for doctors and nurses in obstetrics and midwifery as part of our wider programme of work on professional behaviours and positive cultures.

Facilitating fairer feedback conversations

Tackling discrimination and inequality is an urgent priority for everyone working in our health services. It's the right and fair thing to do. It is also vital in helping retain doctors working in the UK and supporting high-quality patient care.

Our data and research continue to show that rates of training and career progression in medicine are different when we look at groups based on protected characteristics, and particularly ethnicity.

We have identified areas of inequality which we and other organisations can work together to address and have set targets to help us all keep focused on creating long-lasting changes. As mentioned in the *Delivering our strategy* chapter earlier in this report, one of these focuses on discrimination, disadvantage, and unfairness in undergraduate and postgraduate medical education and training. We want to eliminate this by 2031.

In Northern Ireland, GP training has greatly diversified in recent years, with almost 30% of current GP trainees being internationally-qualified. In recognition of the issues doctors from ethnic minorities face when it comes to training, our outreach team in Northern Ireland helped to pilot 'Fairer feedback conversations', a half-day interactive workshop which aims to raise awareness of differential attainment in healthcare.

> "I have more awareness of how sayings and phrases can be interpreted differently, and how this applies in feedback."
>
> **Workshop attendee**

Primarily aimed at clinical supervisors who facilitate formal feedback conversations, the workshop covers the role feedback conversations have in trainee attainment and explores various ways in which participants can proactively facilitate fairer feedback conversations. Attendees are also encouraged to reflect on their own worldview, how it may differ from those that they have supervisory responsibilities for, and what impact that might have.

Through our work with Northern Ireland Medical and Dental Training Agency (NIMDTA), we are now delivering the new workshop to all GP trainers across Northern Ireland. In 2025, it was delivered to over 120 participants across two of the five locality trainer groups. We are looking forward to rolling this out further in 2026.

> "I feel more aware of cultural bias, and how we can continue to work towards being an inclusive workplace for everyone."
>
> **Workshop attendee**

Supporting the Scottish Government to nurture a workforce fit for the future

The Scottish Government's NHS Renewal work aims to explore and understand the challenges and opportunities for Scotland's medical workforce over the next 15–20 years, and the route to deliver a workforce with the right skills and expertise for the population need.

A key part of this is the Future Medical Workforce Project, led by the Government's medical education and training unit. The first phase of the project in 2025 included extensive engagement across Scotland to map out population need and doctors' expectations. A report outlining phase one findings, capturing how 2,000 doctors across Scotland see the realities of working in today's health system and their hopes for the future, was published by the Scottish Government in December 2025.

Our Scotland team, supported by education policy and data and research colleagues, engaged extensively with the Scottish Government on this important phase one project, working in collaboration alongside many other partners in the country.

We offered policy insight and expertise developed through our *Future of education and career development* project, as well as workforce and data and insight derived from our register and from research.

We were also pleased to be part of the Scottish Government's Research Advisory Group, contribute to a data roundtable, and join stakeholder workshops. Through these we sought to ensure that their work was positively informed by our data and insight.

The report on phase one of the project reflects how the medical workforce is changing, and how doctors' education, training and development will need to change and adapt in the future. That aligns with our own ambitions, which include a comprehensive review of medical education and training to ensure we build education programmes that provide doctors with flexible, fair and innovative learning, and that equip them with the skills they need to provide the best patient care.

Phase two of the project is underway in 2026, focusing on co-designing solutions with the profession, and we look forward to continuing to collaborate on this vital work.

> "Thank you for your openness and insight during this exploratory stage. Your engagement has been critical in shaping the [report's] findings."
>
> **Neil Gray, Cabinet Secretary for Health and Social Care, Scottish Government**

Our structure, governance and management

Council and other governance groups

Council is our governing body. It provides strategic direction, holds the executive to account, and takes major high-level policy decisions. It comprises 12 members from the four countries of the UK. Six are registrant members and six are lay members.

We are a registered charity and our Council members are also the trustees of the organisation.

They are all independently appointed by the Privy Council through a process that follows the Professional Standards Authority's guidance for making appointments to healthcare professional regulatory bodies.

The trustees between 1 January 2025 and 31 December 2025 were:

- Dame Carrie MacEwen (Chair)
- Alison Wright*
- Deepa Mann-Kler
- Douglas Millican
- Jane Ramsey
- Jeeves Wijesuriya
- Keith Lloyd
- Olamide Oguntimehin
- Raj Patel
- Suzanne Shale
- Vanessa Davies
- Wendy Williams.

All Council members are also asked to declare any conflicts of interest. These are listed in a register of interests published on our website.

Council members participate in regular one-to-one meetings with the Chair, annual appraisal reviews, and in a 360-degree feedback process that takes place every two years. The process includes consideration of any learning and development needs and revisits actual or perceived conflicts of interest to make sure any potential conflicts identified are manageable.

As a charity, we take into account the eight principles set out in the new version of the Charity Governance Code (published in November 2025). As with the previous version of this code, we use it to help us identify areas for improvement and aim to apply or explain all elements. Our governance team has reviewed the 'suggested evidence and assurance' for each principle and is satisfied, but in summer 2026, we plan to undertake a more formal stocktake against this new code on an apply or explain basis. As part of this we expect to move to an annual cycle for Council effectiveness reviews, as with those undertaken for other committees.

The Governance Handbook sets out the role of the GMC and each element of the governance framework of the organisation. In December 2024, we reviewed it to re flect the introduction of the Anaesthesia Associates and Physicians Associates Order (AAPAO). Changes were made to reflect that the GMC is now the regulator of doctors, PAs, and AAs. The schedule of authority (or scheme of delegation from Council) was updated and introduced Authorised Decision Makers to perform

* Alison Wright stepped down from Council on 12 December 2025 as she took up her post as President of the Royal College of Obstetricians and Gynaecologists following an election process during the summer. Lucinda Etheridge was appointed as a registrant member by the Privy Council from 1 March 2026 following an open recruitment campaign to fill the vacancy. Therefore at the date of signing for this report, the trustees were as listed above, but with Lucinda Etheridge in place of Alison Wright.

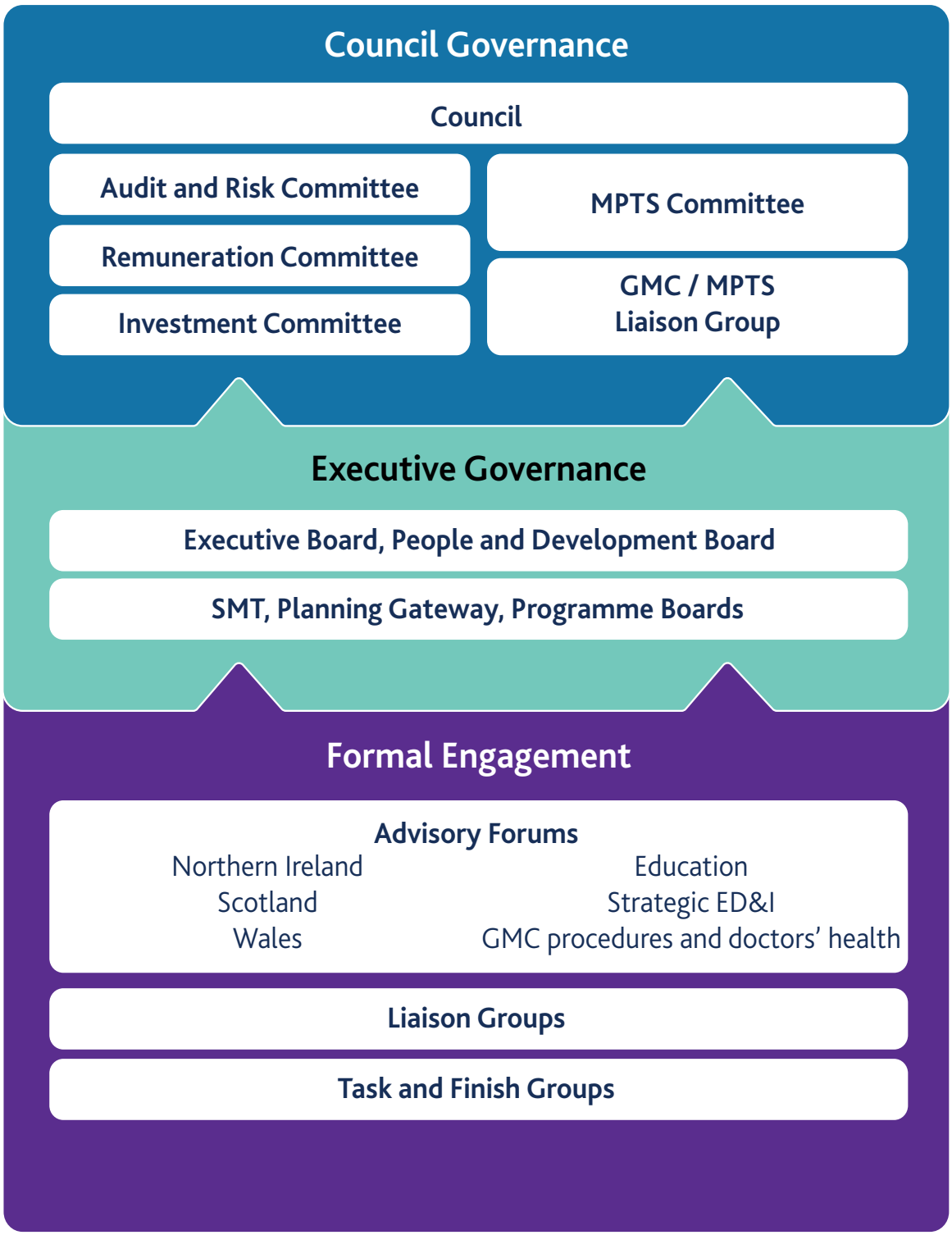
roles under the AAPAO which are similar in nature to the roles performed by Assistant Registrars under the Medical Act. Any other updates are made with Council's approval on an ongoing basis.

As well as supporting Council in maintaining high standards of governance, our corporate governance team also provides training and advice to the organisation on matters of governance. Each committee accounts to Council through a formal report, and Council and each committee undertake to review the committee's effectiveness in delivering their statement of purpose, which is reviewed annually.

Council business is conducted in an open and transparent manner and the agenda and papers for each meeting are published on our website.

Council generally meets six times a year. It meets in London, in Manchester and once in either Belfast, Cardiff or Edinburgh. In addition, a strategic away day takes place once a year.

The diagram on the following page shows the different governance groups that assist Council in carrying out its responsibilities effectively. These have all been agreed by Council. The roles and activities of these groups are described in the pages that follow.


Council Governance
Council
Audit and Risk Committee
Remuneration Committee
Investment Committee
MPTS Committee
GMC / MPTS Liaison Group
Executive Governance
Executive Board, People and Development Board
SMT, Planning Gateway, Programme Boards
Formal Engagement
Advisory Forums
Northern Ireland
Scotland
Wales
Education
Strategic ED&I
GMC procedures and doctors' health
Liaison Groups
Task and Finish Groups

Audit and Risk Committee

In 2025 the Audit and Risk Committee (ARC) was chaired by Vanessa Davies. Its external co-opted members were Jon Hayes and Aneen Blackmore.

The Committee plays a key part in our governance, providing Council with independent assurance about:

- the integrity of our financial statements
- the effectiveness of internal control, governance, and risk management systems
- the delivery of internal and external audit services.

The Committee met five times in 2025, and provided a short briefing note on key issues to Council after each meeting. It also formally reported to Council twice, in June and December. You can find more about its work in the *Audit and Risk Committee report* section later in this report.

Remuneration Committee

In 2025, the Remuneration Committee was chaired by Alison Wright.

The Committee advises Council on the remuneration, the terms of service and the expenses policy for Council members, including the Chair. It oversees the recruitment process of the Chair and Council members before their appointment by the Privy Council. It determines the appointment process for the Chief Executive and Medical Practitioners Tribunal Service (MPTS) Chair, and the remuneration, benefits and terms of service for the Chief Executive, Directors, MPTS Chair and MPTS Committee members.

In 2025, the Committee was actively engaged in the process to recruit a new Chair of the MPTS and one new Council member. It is also responsible for making sure the assessment and measurement of performance, recruitment and succession planning take place within an appropriate framework for the senior management roles within its remit. The Committee reports annually to Council and met twice in 2025.

Investment Committee

Douglas Millican chaired the Investment Committee (IC) in 2025. The Committee's external co-opted members during 2025 were Mike Jennings, Keith Mackay (until 30 April) and Paul Cox (from 26 May).

The Committee is responsible for:

- implementing and reviewing our investment policy
- making sure the management of assets is consistent with the policy
- appointing and managing fund managers
- monitoring performance
- overseeing treasury management
- overseeing our investment in GMC Services International Limited (GMCSI).

The Committee reports on investment performance to Council at each Council meeting, and it reports on the performance of the portfolio to Council on an annual basis. It met five times in 2025.

GMC Services International

GMC Services International (GMCSI) was established by Council in 2016 as a wholly owned trading subsidiary of the GMC. Its main objective is to offer the GMC's support and expertise to countries and institutions working to improve standards of healthcare, who have less experience with the regulation of healthcare professionals and of medical education. Robust and effective governance arrangements are in place to make sure that our interests are protected and that our relationship with GMCSI is managed effectively.

Council has overall responsibility for GMCSI; the Investment Committee oversees our investment in GMCSI; and the Audit and Risk Committee considers the risks to the GMC from the operation of GMCSI, conducting routine internal audit and spot checks as appropriate.

Andrew McCulloch chaired the GMCSI Board until 31 May 2025. Jay Verma assumed the chair from May onwards. The Board comprised (in addition to the Chair) Paul Reynolds, Alison Wright, Deepa Mann-Kler, Colin Melville (until the end of June 2025), Pushpinder Mangat (from July 2025) and Helen Featherstone. Thalia Georgiou and Victoria Cheston were independent Board members during 2025. The Board met five times in 2025.

Jay Verma and Thalia Georgiou stepped down from the board in December 2025, with effect from 11 Jan 2026. Alison Wright stepped down from the board when she left Council in December 2025.

Board of Pension Trustees

The GMC's defined benefit staff superannuation scheme, which is now closed, is managed and administered by a board of trustees in accordance with the scheme's trust deed and rules. The trust makes sure the pension scheme's assets are kept separate from those of the employer and is a separate entity to the GMC. Accordingly, it reports via its own, separate annual report.

The scheme's trustees are responsible for the proper running of the scheme, including the collection of contributions, the investment of assets and payment of the pension benefit commitments made by the employer.

Graeme Caughey chaired the Board during 2025. He is an employer-nominated trustee, along with Vanessa Davies, Raj Patel and Ian Hodgson. John Foley, Paula Robblee, Samantha Anthony, Martin Hart (until 30 April) and Helen Sinclair (from 1 May) are member-nominated trustees.

MPTS Committee

The Medical Practitioners Tribunal Service (MPTS) runs hearings that make independent decisions about whether doctors, PAs and AAs are fit to practise in the UK. It operates separately from the investigatory role of the General Medical Council. A key part of our governance structure is the statutory MPTS Committee, which makes sure the MPTS meets its responsibilities under the Medical Act 1983 and the AAPAO. Her Honour Judge Deborah Taylor was the Chair of the MPTS until May 2025, when she stepped down in order to chair the Nottingham Inquiry. Gill Edelman, a member of the MPTS Committee, served as Interim Chair for the remainder of the year.

The GMC / MPTS Liaison Group is another core part of our governance framework. It is chaired by the Chair of Council and oversees the working relationship between the MPTS and the functions of the GMC with which it interacts.

Executive Board and People and Development Board

The Executive Board is the senior decision-making and oversight forum providing strategic direction, scrutiny and reporting to Council by the GMC's senior management team. The Board meets monthly (except for August) and reports to every meeting of Council through the Chief Executive's report and via a separate annual report.

The People and Development Board is chaired by the Chief Executive and meets five times a year to bring focus to our people strategies. The outcome of its work is reported to Executive Board, and on to Council.

UK Advisory Forums

We have well-established Advisory Forums in Northern Ireland, Scotland and Wales, which make sure we have effective engagement and consultation with key interest groups in each country, and that our policies are suited to all parts of the UK. Through the forums we share and discuss early-stage views on policy development, which allows us to focus on medium and long-term priorities in dialogue with our partners.

Dame Carrie MacEwen chairs the three forums, which are also attended by the Chief Executive and nation-specific Council members and senior staff from the GMC. The wider invited membership differs from country to country and reflects the diverse range of those who have an interest and expertise in the areas under our regulation across the UK. The forums report on their work to the Executive Board twice a year.

Strategic Equality, Diversity and Inclusion Forum

Our Strategic Equality, Diversity and Inclusion (ED&I) Forum helps us make sure that our activities respond to the needs of diverse groups of registrants. Paul Reynolds, Director of Strategic Communications and Engagement, chairs the Forum which comprises organisations representing registrants with shared protected characteristics. It helps us meet our ED&I objectives by providing feedback and advice on our policies and strategies and raising issues and concerns requiring our attention in relation to ED&I. The work of our Race Equality Forum brings together a range of stakeholders with a specific interest in race equality to sit alongside our overarching Strategic ED&I Forum to provide a more specific focus. In 2025, the Strategic ED&I Forum discussed:

- our regulatory reform programme
- reviewing our ED&I engagement forums
- issues arising from the conflict in the Middle East
- our corporate strategy
- education reform
- MPTS sanctions banding guidance.

GMC Procedures and Doctors' Health Forum

Our Advisory Forum on GMC Procedures and Doctors' Health provides expert advice to our Executive Board on how we engage with vulnerable doctors in GMC processes. The Forum may, as required, advise on GMC policies, guidance and training for staff.

Membership includes representatives from the Royal College of Psychiatrists, the Royal College of GPs, the Faculty of Occupational Health, the Conference of Postgraduate Medical Deans, and NHS Providers.

Education Advisory Forum

The Education Advisory Forum engages with our key interest groups on education, training and assessment matters, making sure we are able to develop and promote a strategic approach to this work across all countries of the UK.

Member attendance at Council, Boards and Committees in 2025*

Member	Council attendance†	Committee attendance
Dame Carrie MacEwen (Chair)	6/6	NA
Vanessa Davies	6/6	10/10
Deepa Mann-Kler	5/6	8/10
Douglas Millican	6/6	6/6
Raj Patel	6/6	6/7
Suzanne Shale	5/6	9/9
Jeeves Wijesuriya	5/6	7/7
Alison Wright	6/6	7/7
Keith Lloyd	5/6	4/5
Olamide Oguntimehin	6/6	3/4
Jane Ramsey	6/6	2/2
Wendy Williams	6/6	3/4
Aneen Blackmore (ARC co-opted member)	N/A	4/5
Jon Hayes (ARC co-opted member)	N/A	5/5
Michael Jennings (IC co-opted member)	N/A	4/4
Keith Mackay	N/A	1/1
Paul Cox (IC co-opted member)	N/A	3/3

* Attendance reflects the number of meetings for which attendance was possible.

† Includes six Council meetings.

Management

In 2025, our staff were under the direction of Chief Executive Charlie Massey. He is supported by a team of directors, who as of 31 December 2025 were:

- Shaun Gallagher, Director of Strategy and Policy
- Una Lane, Director of Registration and Revalidation
- Pushpinder Mangat, Medical Director and Director of Education and Standards*
- Anthony Omo, General Counsel and Director of Fitness to Practise
- Paul Reynolds, Director of Strategic Communications and Engagement
- Neil Roberts, Director of Resources.

Key management personnel: remuneration policy

The Remuneration Committee is responsible for determining the remuneration, benefits and terms of service for the Chief Executive, Chair of the MPTS and directors. The Committee sets all aspects of salary or honoraria, the provision of other benefits, and any other arrangements or contractual terms for this group of staff. The Committee also oversees terms and conditions for Council members (including the Chair) by benchmarking and seeking independent market advice when necessary.

The Committee considers that we should provide remuneration and rewards that will attract and retain the high-calibre staff necessary to enable us to fulfil our statutory remit and deliver our strategic objectives.

In setting the base pay for individual posts, the Committee will take external advice on roles within its remit and align salaries with an appropriate market rate subject to resource considerations.

An annual consolidated pay award is considered with reference to the organisation's level of performance, the financial implications of any award, the award agreed for other GMC employees and wider market trends. An annual variable non-consolidated element is considered, reflecting personal performance and the same considerations applied to any consolidated award. We review the effectiveness of these arrangements on an annual basis.

Staff within the Remuneration Committee's remit will usually be entitled to the benefits package available to all GMC employees on the same terms. The Committee retains the ability to withdraw, adjust or change any benefits for staff within its remit, subject to any consultation and contractual requirements. The Committee considers any additional benefits in kind (such as relocation payments) on a case-by-case basis.

New external staff appointees within the Committee's remit are automatically enrolled into our defined contribution pension scheme. Where employees have existing agreed pension arrangements, such as membership of our defined benefit scheme, they retain this for the course of their employment, subject to any changes to the rules agreed by Pension Scheme trustees and the employer.

The Committee makes sure that the equality and diversity implications of remuneration policy and related decisions are considered appropriately. Specifically, it makes sures that:

* Pushpinder Mangat became Medical Director and Director of Education and Standards on 1 July 2025 after a brief handover and induction period working alongside Colin Melville, who retired from the role in June 2025.

- any salary differentials are supported by a formal job evaluation or independent external market advice
- any decisions relating to variable pay are supported by an objective assessment of performance
- any adjustment or changes to remuneration arrangements do not discriminate unlawfully.

Other decisions relating to terms of service are supported by appropriate advice on any equality and diversity implications.

2025 financial review

The accounts for the year ended 31 December 2025 have been prepared in accordance with the Charities Statement of Recommended Practice (FRS 102).

Our free reserves, which are total reserves less the defined benefit pension deficit and fixed assets, were £56.7 million at the end of 2025, up from £48.9 million at the end of 2024, primarily driven by an operational surplus, which leaves reserves in the upper half of our target range.

- Total income increased by £4.3 million and total expenditure by £4.1 million.
- We saw a reduction in the level of income generated from Professional and Linguistic Assessments Board (PLAB) examinations and anticipate this trend will continue into the medium term.
- We continued to fund the work to replace our finance and people team systems during the course of 2025 and expect this to continue to the end of 2026.
- Fee increases in 2025 matched CPI inflation, using the September 2024 rate, as part of the budget setting process.
- We made an adjustment to the 2024 balances, as there had been an over release of income in prior years, totalling £2.9 million, which reduced the level of free reserves brought forward.

Our total income and expenditure in 2025

In 2025, we generated unrestricted income of £169.8 million, which was £5.7 million higher than 2024. This was due to the increase in the number of doctors on the medical register, however this was offset by a reduction in PLAB income of £6 million.

We have a further £1.7 million of restricted income in our accounts, from the UK Government's Department of Health and Social Care (DHSC), to cover the net cost, after accounting for physician associate (PA) and anaesthesia associate (AA) fee income, of regulating PAs and AAs.

We introduced a registration fee for PAs and AAs at the point regulation began on 13 December 2024, which is designed to recover the costs of regulation from those professions, in accordance with schedule 4, para 8 (3) of The Anaesthesia Associates and Physician Associates Order 2024.

Schedule 3, para 6 (b) of the Order also requires us to consider the impact of any changes to fees on the workforce of the health service in the United Kingdom, PAs, AAs, and the regulator. In December 2025 Council approved an inflationary uplift to the fee of 3.8%, to take effect in April 2026. We consider that a fee increase of this level will have no material impact on either the workforce or PAs and AAs, however it does allow us, the regulator, to continue to recover costs in line with schedule 4, para 8 (3) of the Order.

We generated £1.4 million in fees from registering PAs and AAs. During 2025 the cost of regulating PAs and AAs was fully met through PA and AA fees and funding provided by the DHSC.

As regulation commenced in December 2024, the intangible IT development costs, which were funded in prior years, have been amortised in line with our policy, resulting in £2.6 million of costs contained within the statement of financial activities.

Our unrestricted charitable expenditure in 2025 was £158.4 million, an increase of £6.3 million on 2024. This growth in expenditure was the result of inflation on our cost base.

The charity had no fundraising activities requiring disclosure under S162A of the Charities Act 2011.

Reserves policy and going concern

Our level of reserves and our reserves policy are reviewed annually, and any financial implications are addressed as part of the budget-setting process.

Our total reserves are made up of free reserves, reserves backed by fixed assets, and pension reserves.

We hold free reserves:

- to provide working capital to undertake our normal day-to-day business
- to provide funds to deal with any risks that materialise
- to provide funds to respond to new initiatives, opportunities and challenges that present themselves
- to cover the period before any changes to fee levels take full effect.

A significant proportion of our total reserves is represented by fixed assets, which cannot easily be converted into cash without adversely affecting our ability to fulfil our charitable aims and statutory obligations. The value of fixed assets is therefore disregarded for reserves policy purposes.

The value of pension reserves is also disregarded for reserves policy purposes. Our defined benefit scheme was closed to future accruals in 2018, and any deficit or surplus in the scheme can be managed over the medium term, with no immediate impact on free reserves.

There is no standard formula that can be used to calculate the ideal level of free reserves. We follow the Charity Commission's guidance and set a target range based on our cash flow requirements and an assessment of the risks facing the organisation. We aim to hold free reserves at a level that is not excessive but does not put our solvency at risk. Over the medium-term we target the mid-point of a reserves range between 20% to 35% of the annual expenditure for the next 12 months, unless there are clear reasons to hold a different level within our target range. We accept fluctuations within the range over the short-term. We ended 2025 towards the upper end of our reserve range, with reserve levels being 33% of budgeted total expenditure for 2026.

We will also continue to review the purpose and scope of our reserves policy on an annual basis to make sure the thresholds reflect our current risk profile, cash flow requirements and operating environment.

Our total reserves at the end of 2025 were £74.8 million, increasing from the previous year by £4.1 million, driven mainly by the operating surplus.

Free reserves constituted £56.7 million of the balance of total reserves, with a further £25.7 million of reserves being represented by fixed assets, with both currently being partially offset by our pension deficit. We expect that reserves at the end of 2026 will remain within the parameters of our reserves policy.

Most of our income comes from registration fees paid by doctors. All doctors must be registered with us to practise medicine in the UK, and so our income is relatively certain. Trustees remain of the view that the GMC is a going concern for the foreseeable future and have therefore prepared the financial statements on a going concern basis.

There are no material uncertainties related to events or conditions that cast significant doubt on our financial stability for the foreseeable future.

Investment policy

Our Council is responsible for determining and reviewing the overall investment policy, objectives, risk appetite and target returns. It has delegated responsibility for implementing the investment policy, appointing and managing fund managers, and monitoring performance, to the Investment Committee, which regularly reports to Council.

Our funds can be separated into four categories: those which are required as working capital for the normal day-to-day operation of the business; those which we may invest under management; those which we may invest in a trading subsidiary; and any residual cash balance.

We hold working capital for normal cash flow purposes. This is held in instant access bank accounts and provides sufficient flexibility to avoid temporary borrowing and/or the need to liquidate investments to deal with short-term variations in operational income and expenditure.

Council is responsible for determining the level of risk for funds invested under management. We have a low-risk appetite with the aim of generating returns while protecting against volatility and capital loss. The target maximum value at risk (VAR) is 10% on a forward-looking basis.

Within our risk constraint the objectives of investing funds under management are to provide protection against inflation; to generate a modest level of return; and to diversify our funds to reduce the risk of capital and/or revenue loss. Our target rate of return on funds invested under management is inflation (CPI) plus 2% over a rolling five-year period.

Sustainable investment policy

We have adopted a comprehensive ethical investment approach. We believe that investing in certain companies or sectors would conflict with our charitable aims or may create reputational damage. We do not wish to profit directly from, or provide capital to, activities that are materially inconsistent with our charitable aims, and so we specifically exclude investment in companies which derive more than 5% of revenues from tobacco (including vaping), alcohol, adult entertainment, gambling, high interest lending, and thermal coal and oil sands. We also exclude all companies with any exposure to cluster munitions and landmines.

Within our portfolios we also aim to promote good or improving environmental or social characteristics, provided that the companies in which the investments are made follow good governance practices. In acknowledgement of the climate crisis, asset managers representing the GMC must have a credible net zero policy and report progress against that policy to the Investment Committee on an annual basis.

We invest only through fund managers who demonstrate the strongest environmental, social and governance (ESG) credentials and can report their ESG monitoring activities and approach.

Our approach to investing aims to deliver positive impact by changing company behaviours for the better through active ownership. We expect companies in which we invest to demonstrate responsible employment and corporate governance practices, to be conscientious with regard to environmental and social issues, and to deal fairly with customers and the communities in which they operate. When appointing fund managers, we take into consideration how they incorporate an assessment of a company's performance on ESG issues into their stock selection in addition to how they engage and influence the companies they invest in to improve their sustainability over time.

We also ensure their monitoring arrangements highlight companies that are under investigation for, or have been found guilty of, tax evasion or money laundering.

We chose CCLA Investment Management (CCLA) to manage our investments because of their strong track record and high standards in ethical investing. CCLA invest in a manner that prioritises environmental, social and governance factors, working with companies to urge them to commit to producing healthier products which are more accessible and more affordable.

Investment returns

Our funds under management were valued at £62.7 million at the end of 2025, compared with £61.9 million at the start of the year. Since increasing the funds under management to £50 million in June 2019, we have generated returns at a compounded annual growth rate of 3.57%, boosting the value of funds under management to £62.7 million.

Any cash not held as working capital or invested is held in medium-term deposits and/or interest-bearing accounts. We revised our investment policy in 2025, which now includes the use of common deposit funds. This allows us to reduce the risk of bank failure in our cash holdings, while improving liquidity and returns.

We generated interest of £2.3 million on our cash balances, equivalent to an average annual rate of return of 3.72%. Cash held as working capital, and any residual cash, is shown on our balance sheet within current assets.

GMC Services International (GMSCI) Limited

The GMCSI trading subsidiary was incorporated as a private company limited by shares on 16 December 2016. It is a wholly owned subsidiary of the GMC which utilises knowledge gained from the core activities of the GMC to provide services on a commercial basis, including consultancy, training, and accreditation. Any profits derived from these activities are gifted back to the GMC for the purpose of delivering the GMC's charitable aims.

The GMC invested £0.6 million as share capital in GMCSI. In its early years of operation GMCSI generated net losses but has recently been able to generate modest profits. In 2025, GMCSI generated a net profit of £46,000 and ended the year with net assets of £403,000. No profits have been gift-aided back to the GMC in 2025. GMCSI is projected to generate profits over the medium term.

The accounts presented here are consolidated group accounts to include our trading subsidiary GMCSI. The statement of financial activities shows the consolidated position for the GMC and GMCSI combined. The balance sheet shows separate columns for the group position (GMC and GMCSI combined) and the parent charity position (GMC). Separate company accounts have been prepared for GMCSI.

Trustees' responsibilities for the financial statements

Our trustees are responsible for preparing the trustees' annual report and the financial statements in accordance with applicable law and United Kingdom Generally Accepted Accounting Practice (United Kingdom Accounting Standards). The law applicable to charities in England, Scotland and Wales requires the trustees to prepare financial statements for each financial year which give a true and fair view of the state of affairs of the charity and the group, and of the incoming resources and application of resources of the group for that period.

In preparing these financial statements, the trustees are required to:

- select suitable accounting policies and then apply them consistently
- observe the methods and principles in the Charities Statement of Recommended Practice (SORP)
- make judgements and estimates that are reasonable and prudent
- state whether applicable accounting standards have been followed, subject to any material departures being disclosed and explained in the financial statements
- prepare the financial statements on the going concern basis (unless it is inappropriate to presume that the charity will continue in business).

The trustees are responsible for keeping adequate accounting records that are sufficient to show and explain the charity's transactions, and to disclose, with reasonable accuracy at any time, the financial position of the charity, enabling them to make sure that the financial statements comply with the Charities Act 2011, the Charity (Accounts and Reports) Regulations 2008, the Charities and Trustee Investment (Scotland) Act 2005, the Charities Accounts (Scotland) Regulations 2006 (as amended), the Privy Council Directions issued under the Medical Act 1983, and the provisions of the charity's constitution. They are also responsible for safeguarding the assets of the charity and the group and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

Related party transactions

We require that all trustees and senior managers disclose details of any organisations in which they (and their close family members and business partners) hold a position of authority or other material interest, and whose business could bring them into financial contact with the GMC. Details of any actual transactions between the GMC and related parties in the year must also be disclosed. We also publish a register of interests on our website.

In 2025 all disclosures were made and there were no points of concern.

Audit and Risk Committee report

The Audit and Risk Committee (ARC) plays a key role in our governance. It provides Council with independent assurance about:

- the integrity of our financial statements
- the effectiveness of internal control, governance and risk management systems
- the delivery of internal and external audit services.

It also monitors our anti-fraud policies, which we expanded this year as the Economic Crime and Corporate Transparency Act 2023 came into force; any risks relating to the General Data Protection Regulation; and reviews arrangements for raising concerns.

The Committee bases its advice and decisions on guidance issued by the Financial Reporting Council, the Charity Commission, the Office of the Scottish Charity Regulator and, where appropriate, independent external advice.

The Committee has seven members: five Council members and two co-opted members. Co-opted members enhance the work of the Committee by bringing valuable additional skills and experience to the independent scrutiny of finance, risk and governance. All members of the Committee participate in an annual appraisal process.

Vanessa Davies was appointed Chair of the committee when Paul Knight stepped down at the end of 2024. Council wishes to extend its thanks to Paul for his service to the Committee and the GMC.

The Committee undertakes a risk-focused annual work programme. The Corporate Opportunities and Risk Register (CORR) records the key strategic and operational risks we manage. The Committee's oversight and scrutiny play a valuable role in assuring that risks are being managed effectively, and opportunities are enhanced, through effective systems of governance, internal control and risk management arrangements.

In 2025, the Committee met five times, providing Council with an immediate update on the urgent or emerging issues it discussed. Two formal reports were also made to Council on the Committee's work.

As part of its 2025 work programme, members had the opportunity to learn more about specific areas of the business and their associated risks in seminars scheduled ahead of each ARC meeting. This year these included risk and assurance considerations in relation to the new corporate strategy 2026–2030, the development of our new Enterprise Resource Planning system and our *Future of education and career development* programme.

Key activities during 2025

During 2025, the Committee followed a planned programme of work, which included:

- consideration and approval of the 2025 annual internal audit plan and associated resources
- receipt of the Head of Internal Audit's annual opinion for 2024,* which provided substantial assurance that the systems of governance, risk management and internal control in operation during the year were generally well designed and working effectively to support the achievement of the GMC's objectives
- scrutiny of 12 pieces of internal audit work and reporting, which further evidenced that there are generally sound systems of internal control in place at the GMC
- monitoring the implementation of recommendations made in previous audit reports to make sure they were being addressed effectively, which was confirmed by a formal review of action progress by our Internal Auditors
- overseeing the annual review of the Internal Audit Charter
- supporting the development of a new Internal Audit Strategy
- reviewing the draft Trustees' Annual Report and Accounts 2024 and the draft national reports for Northern Ireland, Scotland and Wales
- approving the external auditor's terms of engagement, plan, scope and audit fee for the 2025 accounts
- reviewing the performance of the internal and external auditors. For the internal auditors, this included monitoring progress in delivering the agreed annual Quality Assurance Improvement Plan
- scrutiny of the Business Assurance Framework, which maps the main sources of assurance in the organisation and if there are any gaps
- receiving the *Freedom to Speak Up Guardian Annual Report 2024*,† the *Annual Report of the Data Protection Officer 2024*, and the *Annual Safeguarding Report 2024*
- reviewing the revised guidance and delegated authority arrangements in relation to significant event reviews and reporting to the Charity Commission
- scrutiny of the revised Risk Management Framework for onward consideration and approval by Council
- reviewing its Statement of Purpose.

In addition to the above, at each of its meetings the Committee also:

- begins each meeting with an unscripted discussion of emerging risks and issues and hears from senior management how these are being managed (this includes risks which are driven by external events as well as those arising in relation to the general running of the GMC's business)
- considers the CORR (this is available as part of the Executive Board and Council papers published on our website and is updated on a regular basis).

* For the Head of Internal Audit's assessment for 2024, see Council papers, June 2025.

† For the Freedom to Speak Up Guardian's Annual Report for 2024, see Council papers, June 2025.

Risk management

Effective risk management is embedded in our culture and ways of working. It is front of mind when we write policy and make decisions. The risk management process supports the delivery of our corporate strategy and statutory functions. It is an important part of our business planning, and helps us identify risks in the way we regulate in relation to patients, doctors, physician associates, anaesthesia associates, those in training, and the public. At the GMC, we believe that risk is everyone's responsibility.

We have an established Risk Management Framework, which brings together our overarching risk principles, risk appetite statements and practical guidance on how risks should be managed, escalated, and de-escalated. This ensures that we:

- have a shared view about the opportunities and threats to our aims and objectives across the organisation
- make informed decisions about where to prioritise our focus when allocating resources
- approach delivery of activities in a consistent and considered way across teams and projects.

We manage opportunities as well as threats, which have the potential benefit in the medium and longer term to strengthen patient and public protection.

A Risk Manager is in post, with clear responsibility and accountability for ensuring the Risk Management Framework is embedded across the organisation. The Head of Internal Audit also assesses the overall effectiveness of our risk management processes. The Audit and Risk Committee has delegated authority to provide Council with assurance that risk management arrangements are robust and working in practice. After extensive engagement in 2025, we updated the Risk Management Framework, including our approach to risk appetite, and introduced new categories of risk that are more aligned to our current ways of working. This was launched in May 2026.

Business resilience, and the ability to respond and adapt to incidents, whether operational or reputational are also features of robust risk management. The GMC has a comprehensive set of business continuity and disaster recovery processes, and arrangements for managing reputational issues. These are tested through exercises on a regular basis, and some have been activated to address real incidents during 2025.

The Committee considers the CORR at every meeting, and the register is regularly reviewed by the Executive Board and by Council. The register considers risks to the delivery of our strategic corporate themes (which we consider essential to control and successfully deliver our objectives) and operational and programme threats that have been escalated through our risk structure and are significant at a corporate level. The full CORR is available as part of the Executive Board and Council papers published on our website and is updated regularly. Summary information on our most significant risks and how these are managed is set out below.

Risk	Key controls
Delivery of statutory functions If we fail to deliver our core statutory functions, there is a potential impact on patient safety, public confidence, and the GMC's reputation	• Monitoring and reporting against statutory delivery to Executive Board and Council. • Forecasting of operational demand is built into budget planning. • Active engagement with stakeholders and registrants. • Information exchange with competent authorities to inform processes. • Continuous improvement of documented processes, procedures and supporting guidance.
Availability of resources If we do not secure and retain appropriate and adaptable resources, including our workforce, systems and finances, this may impact the delivery of our statutory functions	• People practices and leadership strategy aim to attract and retain a high-calibre workforce. • Comprehensive policies and procedures including fraud and safety. • Robust financial management and control, backed by regular stress testing. • Rigorous routine performance reporting. • Ongoing investment in our IT infrastructure, systems and security, maintaining ISO27001 accreditation. • Redundancy and backup systems in place for critical IT infrastructure.
ED&I compliance If our measures to ensure compliance with the public sector equality duty are insufficient, we risk legal challenge and weakened confidence in our regulation	• Skilled ED&I team provide strategic advice across the organisation. • ED&I objectives and evidence-based targets are routinely monitored. • Mandatory training programme for all staff and associates.
Ability to work with others If we are unable to work collaboratively with our external partners, we may reduce our impact on patient safety and those we regulate	• Comprehensive stakeholder engagement and relationship plans. • Interaction with other regulatory bodies to identify opportunities for collaboration and alignment. • Proactive engagement on all major policies and issues, including active engagement with the four UK Governments over the future of our legislation. • Regular evaluations and feedback.
Responding to a changing environment If we are unable to respond effectively to changes in the external environment, we risk reducing our influence and relevance, and weakened confidence in our role	• Proactive, senior-level engagement with stakeholders to understand their agendas. • Contribution to government and system initiatives across four nations. • Outreach teams structured to aid understanding and influence in national and local systems. • Continuous monitoring of our external environment. • Mechanisms to share and evaluate the insights and intelligence we receive.

Risk	Key controls
Unplanned event If our systems are compromised or our activities are publicly challenged, this may impact the delivery of functions central to patient safety and cause reputational damage	• Robust and regularly tested crisis management policies, procedures and emergency response plans. • Established business continuity structure with champions across the organisation. • Mandatory e-learning for all colleagues. • Annual training and exercises for all incident responders. • Continuous proactive monitoring of the external environment. • Health and safety management system.
Regulatory reform – benefits There is a risk that we do not secure and deliver the full range of benefits that the reforms present	• Comprehensive governance and programme controls. • Cross-directorate working built into programme approach to maximise opportunities. • Stakeholder influencing plan to make sure we secure external support for change. • Ongoing engagement with the Department of Health and Social Care (DHSC) to maintain good working relationships, collaboration and influence. • Escalation protocols.
Pension deficit Economic volatility could negatively impact the scheme's funding position and require additional employer contributions.	• Trustees meet regularly, supported by professional advisers. • Joint working between the employer and trustees to make sure suitable funding arrangements are in place. • Annual payments are budgeted. • Regular monitoring of the funding position. • 2025 update to the GMC reserves policy records financial support for the scheme if a value at risk event occurs.
ED&I strategic ambition If our actions 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, we risk sustaining known areas of inequality	• Clear timebound targets to focus system-wide efforts • Nominated Executive leads for each strategic commitment. • Action plans in place to deliver against internal and external targets. • Skilled and resourced teams design interventions. • Annual and bi-annual progress reporting. • Scrutiny from the ED&I Steering Group, Executive and Council allows refinement of plans in response to progress. • Research and data assets to highlight issues and support calls for action.

Risk	Key controls
Regulatory reform – securing arrangements for the GMC Order If we do not effectively engage with the DHSC, this risks issues and delays in implementing the new Order, or may create an Order that is unworkable	• Planning discussions with the DHSC and regular review of plans and critical path to set realistic expectations on programme milestones. • Proactive engagement with DHSC to make sure plans remain realistic, scheduling the work effectively to minimise impact on busy teams.
Uncertainty around our touchpoints and engagement with NHS England Uncertainty may impact the effectiveness of some GMC operational processes	• Ongoing engagement with DHSC and NHS England officials. • Relationships established with the new national co-medical directors at NHS England. • Ongoing monitoring of external sources. • Senior team engagement. • Secured National Quality Board membership on behalf of NHS-facing regulators.
GMC finance and HR system If we are unable to migrate our ERP system in the required timeframe, we may risk operating on unsupported systems	• Formal programme structure and governance. • Project streams prioritised and resourced to meet the plan, including backfill. • Scrutiny from the Executive and ARC.
Welsh Language Standards implementation If we do not ensure continued compliance with the standards, we risk legal, reputational and financial consequences	• Approved plan to embed the guidance, learning and processes into business as usual. • Creation of a network of Welsh Language Champions. • Corporate Review Team oversight of complaints. • Partner in place for translation and interpretation needs.
Medical Licensing Assessment (MLA) exam delivery If an incident occurs impacting delivery of the MLA, this could risk invalidating the Primary Medical Qualification being awarded by the medical school(s)	• MLA compliance now embedded into our new schools process. • Regular contact with all schools and contingency plans checked as part of routine assurance and oversight. • Regular meetings with the Medical Schools Council to address issues.

Risk	Key controls
Regulatory reform – DHSC approach to drafting the GMC Order The approach and timescale for drafting could mean errors or omissions are undetected, leading to an Order that is unworkable, or that fails to secure the potential benefits of change; the approach may also risk staff burnout, demotivation or attrition	• Retain constructive and open communication lines with DHSC colleagues. • Support mechanisms for colleagues including pausing work / backfilling resource. • Early feedback approach adopted.

During the year, the Committee's wider discussions on risk factors for the GMC included consideration of the GMC's arrangements to respond to external reviews, covering the Leng Review, the ongoing Lord Mann review into antisemitism and all forms of racism, and maternity reviews. The Committee also considered updates on doctors with overseas sanctions (addressing press allegations) and the risks associated with significant increases in triage volumes in the fitness to practise directorate.

Learning from events and issues

A component of organisational resilience is the willingness and ability to review and learn when things emerge suddenly or something goes wrong. We are committed to demonstrating a culture of continuous improvement, learning not only from internal events, but also considering the learning identified in reports and reviews which are published in relation to other organisations that have experienced difficulties and challenges.

We have a robust approach to undertaking significant event reviews (SERs) if something has, or has the potential to, impact the organisation in a more serious way. For example, externally, this might be in relation to the action of others which has a detrimental impact on the GMC, and internally this could be where there has been a failure of a key organisational control.

In 2025, three SERs were formally reported to the Committee. The first, sadly, was in relation to a doctor who died by suicide while under GMC fitness to practise processes. The remaining two SERs were in relation to data breaches, which were reported to the Information Commissioner and the Charity Commission. The first information security breach related to sharing a registrant's personal financial information, and the second related to sharing information of a safeguarding nature that had the potential to cause harm.

Whilst learning from SERs is critical for improving future performance, we have many other mechanisms for learning and sharing better practices across the business. These include:

- consideration of external research and publicly available reports, such as those published by the Charity Commission or by other regulators, including the Professional Standards Authority
- independent reports from external assessors such as Investors in People, the International Standards Organisation, British Standards Institute, and Institute of Customer Service
- regular liaison with other healthcare regulators
- peer review and local team quality control exercises and audits undertaken by our internal corporate Quality Assurance team
- post-implementation reviews of new initiatives and projects
- a community of practice to share experiences of project management and supporting change
- broader insight from the work of internal audit.

Our work in 2026

The Committee has a full programme of work for 2026, with risk and assurance remaining the key focus of planned activities. As well as scrutinising the reports from the internal audit programme it approved in January 2026, and the trustees' Annual Report and Accounts 2025, it will be taking time to:

- support the roll out of the refreshed Risk Management Framework, considering also the GMC's arrangements for risk horizon scanning and identifying emerging risks
- oversee the further development of the Business Assurance Framework to link this more closely to risk appetite
- undertake a tender for internal audit services
- continue to assure itself of the understanding and management of risks in delivering change, including regulatory reform, and the new enterprise resource planning system which will go live in 2026.

The Committee will, however, remain flexible in its work to ensure it is able to take account of and respond to emerging threats and opportunities.

Approved by the trustees on 1 July 2026 and signed on their behalf by:

Professor Dame Carrie MacEwen

Independent auditors' report to the trustees of the GMC

Opinion

We have audited the financial statements of General Medical Council ('the charity') and its subsidiary ('the group') for the year ended 31 December 2025 which comprise Consolidated Statement of Financial Activities, Consolidated and Parent Balance Sheet, Consolidated Cash Flow Statement and notes to the financial statements, including significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and United Kingdom Accounting Standards, including Financial Reporting Standard 102 The Financial Reporting Standard applicable in the UK and Republic of Ireland (United Kingdom Generally Accepted Accounting Practice).

In our opinion the financial statements:

- give a true and fair view of the state of the group's and of the parent charity's affairs as at 31 December 2025 and of the group's incoming resources and application of resources, including its income and expenditure for the year then ended;
- have been properly prepared in accordance with United Kingdom Generally Accepted Accounting Practice; and
- have been prepared in accordance with the requirements of the Charities Act 2011 and the Charities and Trustee Investment (Scotland) Act 2005 and regulations 6 and 8 of the Charities Accounts (Scotland) Regulations 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the group in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the trustees' use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the charity's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the trustees with respect to going concern are described in the relevant sections of this report.

Other information

The trustees are responsible for the other information contained within the annual report. The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Matters on which we are required to report by exception

We have nothing to report in respect of the following matters in relation to which the Charities (Accounts and Reports) Regulations 2008 require us to report to you if, in our opinion:

- the information given in the financial statements is inconsistent in any material respect with the trustees' report; or
- sufficient and proper accounting records have not been kept by the parent charity; or
- the financial statements are not in agreement with the accounting records and returns; or
- we have not received all the information and explanations we require for our audit.

Responsibilities of trustees

As explained more fully in the trustees' responsibilities statement set out on page 54 , the trustees are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the trustees determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the trustees are responsible for assessing the charity's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the trustees either intend to liquidate the charity or to cease operations, or have no realistic alternative but to do so.

Auditor's responsibilities for the audit of the financial statements

We have been appointed as auditor under section 151 of the Charities Act 2011, and section 44(1)(c) of the Charities and Trustee Investment (Scotland) Act 2005 and report in accordance with the Acts and relevant regulations made or having effect thereunder.

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Details of the extent to which the audit was considered capable of detecting irregularities, including fraud and non-compliance with laws and regulations are set out below.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Extent to which the audit was considered capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We identified and assessed the risks of material misstatement of the financial statements from irregularities, whether due to fraud or error, and discussed these between our audit team members. We then designed and performed audit procedures responsive to those risks, including obtaining audit evidence sufficient and appropriate to provide a basis for our opinion.

We obtained an understanding of the legal and regulatory frameworks within which the charity and group operates, focusing on those laws and regulations that have a direct effect on the determination of material amounts and disclosures in the financial statements. The laws and regulations we considered in this context were the Medical Act 1983, Charities Act 2011 and The Charities and Trustee Investment (Scotland) Act 2005 together with the Charities SORP (FRS102) 2019. We assessed the required compliance with these laws and regulations as part of our audit procedures on the related financial statement items.

In addition, we considered provisions of other laws and regulations that do not have a direct effect on the financial statements but compliance with which might be necessary to the charity's and group's ability to operate or to avoid a material penalty. We also considered the opportunities and incentives that may exist within the charity and the group for fraud. The laws and regulations we considered in this context for the UK operations were General Data Protection Regulation (GDPR), and employment legislation.

Auditing standards limit the required audit procedures to identify non-compliance with these laws and regulations to enquiry of the Trustees and other management and inspection of regulatory and legal correspondence, if any.

We also considered the opportunities and incentives that may exist within the charity and group for fraud. We identified the greatest risk of material impact on the financial statements from irregularities, including fraud, to be within estimates surrounding legal provisions and dilapidations, the timing and recognition of GMCSI income and the override of controls by management. Our audit procedures to respond to these risks included enquiries of management, internal audit, legal counsel and the Audit & Risk Committee about their own identification and assessment of the risks of irregularities, sample testing on the posting of journals, reviewing accounting estimates for biases, reviewing regulatory correspondence with the Charity Commission and reading minutes of meetings of those charged with governance.

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations (irregularities) is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of irregularities, as these may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. We are not responsible for preventing non-compliance and cannot be expected to detect non-compliance with all laws and regulations.

Use of our report

This report is made solely to the charity's trustees, as a body, in accordance with Part 4 of the Charities (Accounts and Reports) Regulations 2008 and Regulation 10 of the Charities Accounts (Scotland) Regulations 2006. Our audit work has been undertaken so that we might state to the charity's trustees those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the charity and the charity's trustees as a body, for our audit work, for this report, or for the opinions we have formed.

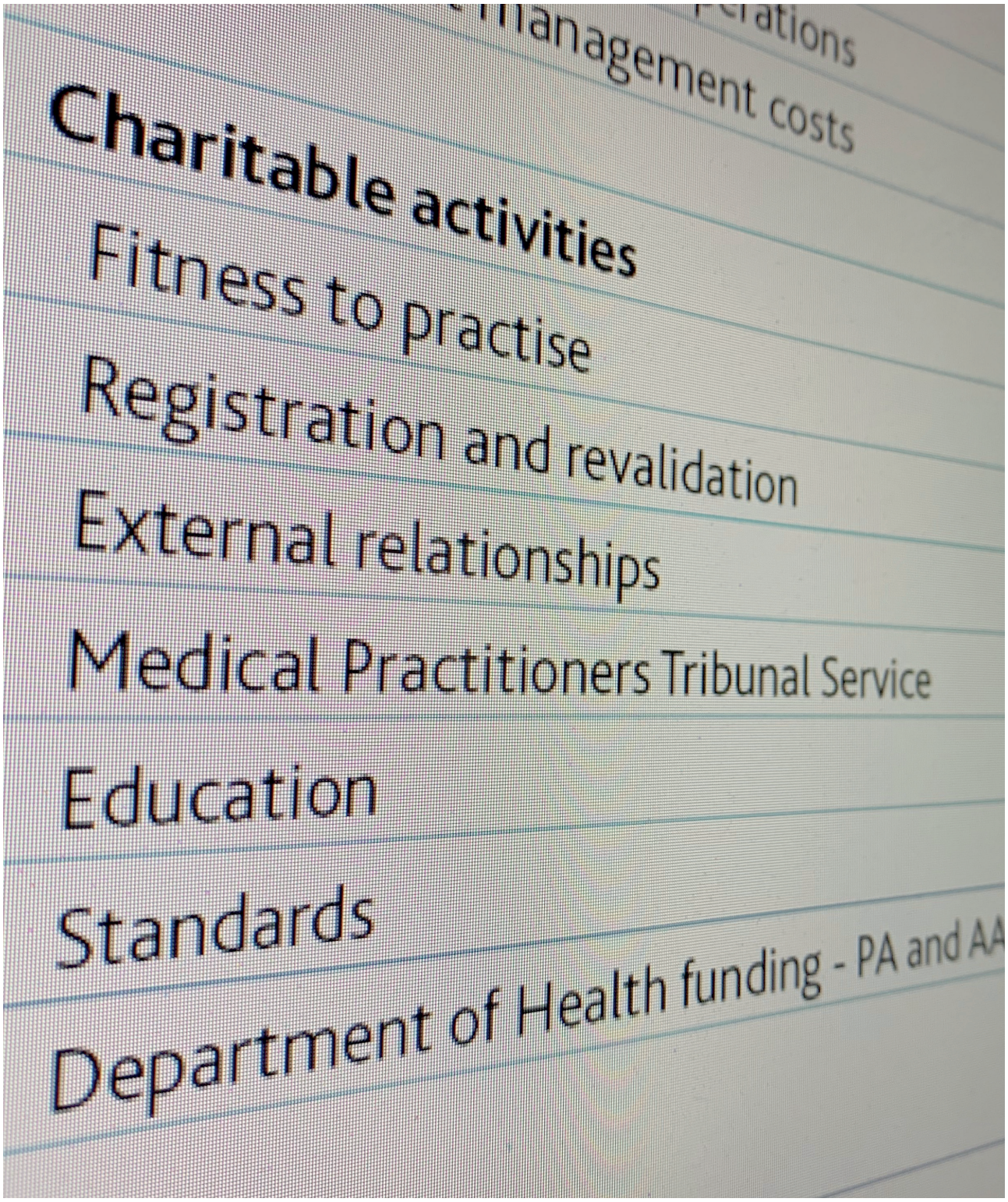
Crowe UK LLP

Crowe U.K. LLP
Statutory Auditor
London

Date: 8 July 2026

Crowe U.K. LLP is eligible for appointment as auditor of the charity by virtue of its eligibility for appointment as auditor of a company under section 1212 of the Companies Act 2006.

Accounts 2025



Consolidated statement of financial activities for the year ended 31 December 2025

	Note	Unrestricted funds £'000	Restricted funds £'000	Total 2025 £'000	As restated Total 2024 £'000
Income					
From charitable activities					
Registration	2	159,486	-	**159,486**	**154,549**
Specialist and GP registration	2	6,541	-	**6,541**	**5,997**
Revalidation	2	269	-	**269**	**225**
Other trading activities	3	253	-	**253**	**284**
Commercial trading operations	3	427	-	**427**	**410**
Investments	3	2,304	-	**2,304**	**2,531**
Department of Health funding – PA and AA regulation	3	-	1,710	**1,710**	**3,106**
Other	3	558	-	**558**	**141**
Total incoming resources		169,838	1,710	**171,548**	**167,243**
Expenditure					
Raising funds					
Commercial trading operations	4	380	-	**380**	**386**
Investment management costs	4	289	-	**289**	**288**
		669	-	**669**	**674**
Charitable activities					
Fitness to practise	4	56,181	-	**56,181**	**52,074**
Registration and revalidation	4	50,169	-	**50,169**	**50,531**
External relationships	4	20,900	-	**20,900**	**19,610**
Medical Practitioners Tribunal Service	4	14,475	-	**14,475**	**14,586**
Education and standards	4	15,355	-	**15,355**	**15,330**
Department of Health funding – PA and AA regulation	4	1,365	2,584	**3,949**	**2,685**
		158,445	**2,584**	161,029	154,816
Other expenditure					
Legal provision	11	(1,204)	-	**(1,204)**	**684**
Dilapidations provision	11	(397)	-	**(397)**	**(162)**
		(1,601)	-	**(1,601)**	**522**
Total expenditure	4	157,513	2,584	**160,097**	**156,012**
Operating surplus		12,325	(874)	**11,451**	**11,231**
Net gains on investments	8	1,120	-	**1,120**	**573**
Net income/(Net loss)		13,445	(874)	**12,571**	**11,804**
Other recognised gains and losses					
Actuarial gain/(loss) on defined benefit pension scheme	16	(8,406)	-	**(8,406)**	**11,030**
Net movement in funds		5,039	(874)	**4,165**	**22,834**
Total funds brought forward		68,104	2,543	**70,647**	**47,813**
Total funds carried forward		73,143	1,669	**74,812**	**70,647**

The General Medical Council incorporated a wholly owned trading subsidiary on 16 December 2016 with the purpose of providing services on a commercial basis including consultancy, training and accreditation. The Charity has taken exemption from presenting its unconsolidated profit and loss account.

The parent charity movement in funds for the year is £4,165,000 with subsidiary undertakings accounting for £46,000.

2024 figures have been restated as an over release of income in previous years, including 2024, was identified in 2025. Income from registration in 2024 has been reduced by £301,000 and total funds brought forward have been reduced by £2,880,000.

The Department for Health and Social Care (DHSC) provided funding in 2025 to cover the cost of bringing physician associates (PAs) and anaesthesia associates (AAs) into regulation. Funding was restricted in nature, and was fully spent in the year. A proportion of the prior year funds paid for IT System Development and, as the asset is in use, the depreciation is shown on the statement of financial activities in restricted funds. The net impact on GMC reserves is (£874,000). The balance of the restricted funds will reduce as the asset is amortised.

Balance sheet

	Note	2025 Group £'000	2025 Charity £'000	As restated 2024 Group £'000	As restated 2024 Charity £'000
Fixed assets					
Intangible fixed assets	6	22,493	22,493	19,151	19,151
Tangible fixed assets	7	3,224	3,224	4,412	4,412
Investments	8	62,683	63,086	61,852	62,209
		88,400	**88,803**	**85,415**	**85,772**
Current assets					
Debtors and prepayments	9	37,882	37,948	35,475	35,555
Cash and bank balances		63,098	62,569	61,303	60,817
		100,980	**100,517**	**96,778**	**96,372**
Liabilities					
Creditors: amounts falling due within one year	10	(97,634)	(97,574)	(98,807)	(98,758)
Net current assets/(liabilities)		3,346	2,943	(2,029)	(2,386)
Total assets less current liabilities		**91,746**	**91,746**	**83,386**	**83,386**
Provisions for liabilities and charges	11	(9,364)	(9,364)	(10,965)	(10,965)
Net assets excluding pension scheme liability		**82,382**	**82,382**	**72,421**	**72,421**
Defined benefit pension scheme liability	16	(7,570)	(7,570)	(1,774)	(1,774)
Total net assets		**74,812**	**74,812**	**70,647**	**70,647**
Unrestricted income funds		80,713	80,713	69,878	69,878
Restricted income funds		1,669	1,669	2,543	2,543
Pension reserve		(7,570)	(7,570)	(1,774)	(1,774)
Total funds	12, 13	**74,812**	**74,812**	**70,647**	**70,647**

The financial statements were approved by the trustees and authorised for issue on 1 July 2026.
They were signed on behalf of trustees by:

Professor Dame Carrie MacEwen
Chair of Council

2024 figures have been restated as an over release of income in previous years, including 2024, was identified in 2025. Creditors: amounts falling due within one year in 2024 have been increased by £2,880,000 and unrestricted income funds have been reduced by £2,880,000.

Consolidated cash flow statement

	2025		As restated 2024	
	£'000	**£'000**	£'000	£'000
Cash flows from operating activities				
Net cash provided by/(used in) operating activities (note i below)		10,841		13,853
Cash flows from investing activities				
Dividends, interest and rents from investments	2,267		2,531	
Purchase of property, plant, equipment and intangibles	(11,313)		(9,892)	
Net cash used in investing activities		**(9,046)**		**(7,361)**
Change in cash and cash equivalents (note ii below)		**1,795**		**6,492**

Note (i)

Cash flow from operating activities		
Net (outgoing)/incoming resources	12,571	11,804
Investment income and interest	(2,304)	(1,988)
Net investment movement	(831)	(279)
Non-cash items – depreciation and amortisation	9,073	7,744
Non-cash items – assets written off	87	22
Pension scheme contribution	(2,574)	(3,572)
(Increase)/decrease in debtors	(2,407)	(4,500)
Increase/(decrease) in creditors and provisions	(2,774)	4,622
Net cash provided by/(used in) operating activities	**10,841**	**13,853**

Note (ii)	**Cash at bank and in hand**	**Total**
Cash and equivalents	**£'000**	**£'000**
Balances at 1 January 2025	61,303	**61,303**
Net increase in cash and cash equivalents	1,795	**1,795**
Balances at 31 December 2025	63,098	**63,098**

2024 figures have been restated as an over release of income in previous years, including 2024, was identified in 2025. Net (outgoing)/incoming resources has been reduced by £301,000 and Increase/(decrease) in creditors and provisions has increased by £301,000.

Notes to the accounts

General information

We are a statutory body governed by the Medical Act 1983 and are registered with the Charity Commission for England and Wales (1089278), and with the Office of the Scottish Charity Regulator (SC037750).

1. Principal accounting policies

(i) Accounting convention

The financial statements have been prepared to give a 'true and fair' view and have departed from the Charities (Accounts and Reports) Regulations 2008 only to the extent required to provide a 'true and fair' view. This departure has involved following the Charities SORP (FRS 102) first published on 16 July 2014, updated 1 October 2019.

Our financial statements have been prepared on a going concern basis and in accordance with the Charities Statement of Recommended Practice (FRS 102) – effective 1 October 2019, applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland, the Charities Act 2011, the Charities and Trustee Investment (Scotland) Act 2005, the Charities Accounts (Scotland) Regulations 2006 and UK Generally Accepted Practice as it applies from 1 October 2019. As detailed in the Trustees' Report, the Trustees remain of the view that the GMC is a going concern and there are no material uncertainties related to events or conditions that cast significant doubt on our financial stability for the foreseeable future. The GMC meets the definition of a public benefit entity under FRS 102.

(ii) On 16 December 2016 the GMC incorporated a trading subsidiary, GMC Services International LTD, company number 10530157, which is wholly owned by share capital by the General Medical Council.

(iii) A separate statement of financial activities has not been presented for the charity alone as this is not considered to be materially different from the consolidated statement of financial activities (SOFA). For the parent charity, the net movement in funds is shown beneath the SOFA, with commercial activities from our subsidiary being separately identified on the face of the SOFA on page 70.

(iv) The principal accounting policies adopted in the preparation of the financial statements, which have been applied consistently, are detailed below.

Incoming resources

Income is included in the statement of financial activities when all of the following criteria are met:

- Entitlement – control over the rights or other access to the economic benefit has passed to the GMC
- Probability – it is more likely than not that the economic benefits will flow to the GMC
- Measurement – the value can be measured reliably.

The following specific policies apply:

- Annual retention fees relate to services associated with regulation over a 12-month period, starting on the renewal date of the annual retention fee. Income is deferred and released to the statement of financial activities on a straight-line basis over the period to which the income relates.
- Registration fees, including provisional registration fees, are recognised when registration is granted.

- Professional and Linguistic Assessments Board (PLAB) fees are recognised when the examinations are sat.
- Income from investments and funds held on deposit is recognised when it is receivable and the amount can be accurately measured.

All income is recognised gross.

Basis for recognising liabilities

Expenditure includes staffing costs, office costs, committee costs, legal costs, accommodation costs, purchase of assets, and financial, actuarial and professional costs.

Resources expended are included in the statement of financial activities on an accruals basis.
All liabilities are recognised as soon as there is a legal or constructive obligation committing the charity to expenditure.

Basis for allocation of resources expended

The majority of our resources are expended directly in pursuit of our charitable aims, and are identified as such in the statement of financial activities.

Accommodation costs, governance costs and other support costs are apportioned to charitable activities on the basis of staff head count across the organisation.

Irrecoverable VAT

Any irrecoverable VAT is charged to the statement of financial activities as part of the relevant item of expenditure, or capitalised as part of the cost of the related asset where appropriate.

Taxation

We apply appropriate exemptions from taxation on income and gains available to charities, so no taxation is payable on the net incoming resources of the charity. The charity's subsidiary company is subject to Corporation Tax in the same way as any commercial organisation.

Debtors

Trade and other debtors are normally recognised at the settlement amount due after any trade discount offered. Prepayments are normally valued at the amount prepaid net of any trade discounts due.

Creditors and provisions for liabilities

Creditors and provisions are recognised when the charity has a present legal or constructive obligation as a result of a past event. They are recognised when it is probable that a transfer of economic benefit will be required to settle the obligation and a reliable estimate can be made of the amount of the obligation. Creditors and provisions are normally recognised at their settlement amount after allowing for any trade discounts due.

Critical accounting judgments and key sources of estimation uncertainty

The key sources of estimation uncertainty that have a significant effect on the amounts recognised in the financial statements are:

- All unsettled claims for legal costs made against the GMC are reviewed on a case-by-case basis at the year end. Provisions are based on historical experience and a detailed assessment of the specific details of current cases. The final settlement of cases is dependent on a number of factors, so the accuracy of the provision is subject to a significant degree of uncertainty.

- Provisions for property dilapidation costs are made for all leased buildings. They are assessed on a case-by-case basis reflecting the different configurations of leased buildings and the cost to revert to their original state. We apply annual inflationary increases in line with CPI, and periodically seek third-party advice to ensure our estimates remain appropriate.

- The present value of the GMC defined benefit pension scheme depends on a number of factors that are determined on an actuarial basis using a variety of assumptions. The assumptions used in determining the net cost of income for pensions include the discount rate. Any changes in these assumptions, which are disclosed in note 16, will impact the carrying amount of the pension asset or liability. The FRS 102 valuation is based on a full actuarial assessment of the scheme liabilities as at 31 December 2024.

Tangible fixed assets

Tangible fixed assets are stated at cost, net of depreciation and any provision for impairment. Expenditure is only capitalised where the cost of the asset or group of assets acquired exceeds £5,000.

Intangible fixed assets

Intangible fixed assets comprise computer software. They are stated at cost, net of amortisation and any provision for impairment. Expenditure is only capitalised where the cost of the asset or group of assets acquired exceeds £5,000.

Depreciation

Depreciation is provided so as to write off the cost, less estimated residual value, of the assets evenly over their estimated lives.

The estimated useful lives are as follows:

- leasehold buildings and leasehold improvements – the lesser of five years or the remaining term of the lease
- furniture, fixtures, and office fittings – the lesser of five years or the remaining term of the lease
- information Technology (IT) equipment – three years
- intangible assets: (IT software) – three years
- other office equipment – three years for IT-related items and five years for all other items.

Depreciation rates are reviewed on a regular basis comparing actual lives of assets with the accounting policy rates.

Licensed IT software

Development costs for implementing new IT systems are capitalised and depreciated over the lesser of three years or the useful life of the asset. The first year licence costs are capitalised as they are necessary to bring the asset into use, subsequent year licence costs are treated as operating expenditure.

Operating leases

Rent payable under operating leases is charged to the statement of financial activities on a straight-line basis over the period of the lease.

Financial instruments

The charity has financial assets and liabilities of a kind that qualify as basic financial instruments. Basic financial instruments are initially recognised at transaction value and subsequently measured at amortised cost. Financial assets held at amortised cost consist of cash and bank balances, short-term deposits (cash flow statement), investments held in cash deposits (note 8), together with trade and other debtors (note 9). Financial liabilities held at amortised cost comprise trade and other creditors, tax and social security creditors, and accruals (note 10).

Investments

Our investment policy separates our funds into four categories: those which are required as working capital for the normal day-to-day operation of the business; those which we invest under management; those which we may decide to invest in a trading subsidiary; and the remaining cash balance which fluctuates during the year. Funds held as cash for the normal day-to-day operation of the business are shown on the GMC's balance sheet within current assets, while funds held for the longer term are shown as investments.

Pensions

We have a defined benefit pension scheme for permanent employees. The scheme was closed to new members on 30 June 2013, and for future accrual to existing members on 31 March 2018, and replaced by a defined contribution scheme. The surplus or deficit of the defined benefit scheme is recognised on the balance sheet. Changes in the assets and liabilities of the scheme are disclosed and allocated as follows:

- Charges relating to current or past service costs, and gains and losses on settlements and curtailments, are included within staff costs and charged to the statement of financial activities.
- Interest on the net defined benefit asset/liability is shown as a net amount of other finance costs or as an incoming resource alongside investment income and interest. Actuarial gains and losses are recognised immediately in other recognised gains and losses on investments.
- The assets, liabilities and movements in the surplus or deficit of the scheme are calculated by qualified independent actuaries as an update to the latest full actuarial valuation. Details of the defined benefit scheme assets, liabilities and major assumptions are shown in the notes to the accounts.
- Our defined contribution pension scheme was set up on 1 July 2013. Contributions to the scheme are charged to the statement of financial activities in the year in which they are payable to the scheme.

Funds and reserves

The majority of our funds are unrestricted, and so can be expended at the trustees' discretion in pursuit of our charitable aims. Restricted funds will be expended in line with the purpose of the funding.

Termination payments

Termination payments are accounted for as soon as the organisation is aware of the obligation to make the payment.

2. Income from charitable activities

	Unrestricted funds £'000	**Total 2025 £'000**	Unrestricted funds £'000	**As restated Total 2024 £'000**
Registration				
Annual retention fees	132,273	**132,273**	121,941	**121,941**
Registration fees	7,540	**7,540**	6,904	**6,904**
Provisional registration fees	273	**273**	267	**267**
PLAB fees	19,286	**19,286**	25,335	**25,335**
Other fees	114	**114**	102	**102**
	159,486	**159,486**	154,549	**154,549**
Specialist and GP registration				
Certificates of Completion of Training fees	4,170	**4,170**	3,918	**3,918**
Certificate of Eligibility for Specialist Registration/ Certificate of Eligibility for General Practitioner Registration fees	2,319	**2,319**	2,025	**2,025**
Other fees	52	**52**	54	**54**
	6,541	**6,541**	5,997	**5,997**
Revalidation				
Revalidation annual return	236	**236**	168	**168**
Revalidation assessment	33	**33**	57	**57**
	269	**269**	225	**225**

2024 figures have been restated as an over release of income in previous years, including 2024, was identified in 2025. Annual retention fee income in 2024 has been reduced by £301,000.

3. Income from raising funds

	Unrestricted funds £'000	Restricted funds £'000	**Total 2025 £'000**	Unrestricted funds £'000	Restricted funds £'000	**Total 2024 £'000**
Activities for raising funds						
Other trading activities*	253	-	**253**	284	-	**284**
Commercial trading operations†	427	-	**427**	410	-	**410**
Other‡	558	-	**558**	141	-	**141**
	1,238	-	**1,238**	835	-	**835**
Investment income						
Other finance income – pension scheme (note 16)	37	-	**37**	-	-	**-**
Bank interest	2,267	-	**2,267**	2,531	-	**2,531**
	2,304	-	**2,304**	2,531	-	**2,531**
Department of Health funding						
Funding to cover expenditure on PA and AA regulation§	-	1,710	**1,710**	-	3,106	**3,106**

* Other trading activities include the reimbursement of costs of staff seconded to external bodies.

† Income from commercial trading operations is derived from GMC Services International Ltd, a wholly owned subsidiary, which provides services on a commercial basis including consultancy, training and accreditation.

‡ Other income includes reimbursement of legal fees from appeals.

§ The Department of Health and Social Care has provided funding for the GMC to implement the regulation of PAs and AAs, which commenced on 13 December 2024.

4. Total expenditure

Charitable activity and support cost allocation

	Direct staffing costs £'000	Direct costs £'000	Allocated costs £'000	Total 2025 £'000	Direct staffing costs £'000	Direct costs £'000	Allocated costs £'000	Total 2024 £'000
Expenditure on								
Commercial trading operations	332	48	-	**380**	325	61	-	**386**
Investment management costs	-	289	-	**289**	-	288	-	**288**
Total expenditure on raising funds	332	337	-	**669**	325	349	-	**674**
Fitness to practise	25,523	6,282	24,376	**56,181**	23,821	6,336	21,917	**52,074**
Registration and revalidation	18,461	10,602	21,106	**50,169**	17,239	14,104	19,188	**50,531**
External relationships*	11,924	736	8,240	**20,900**	11,146	815	7,649	**19,610**
Medical Practitioners Tribunal Service	5,301	3,550	5,624	**14,475**	5,227	4,072	5,287	**14,586**
Education and standards	8,792	222	6,341	**15,355**	9,006	226	6,098	**15,330**
Department of Health funding – PA and AA regulation	1,986	1,962	-	**3,948**	1,704	981	-	**2,685**
Total charitable expenditure	71,987	23,354	65,687	**161,028**	68,143	26,534	60,139	**154,816**
Other expenditure – legal provision	-	(1,204)	-	**(1,204)**	-	684	-	**684**
Other expenditure – dilapidation provision	-	(397)	-	**(397)**	-	(162)	-	**(162)**
Total group expenditure	72,319	22,090	65,687	**160,096**	68,468	27,405	60,139	**156,012**

* External relationships include the work done by our Regional Liaison Service, strategic relationships, our devolved offices, and our European and international development activities.

Support costs allocated to charitable activities

	Management £'000	IT £'000	Human resources £'000	Finance £'000	Procurement £'000	Facilities £'000	Governance £'000	Total 2025 £'000	Management £'000	IT £'000	Human resources £'000	Finance £'000	Procurement £'000	Facilities £'000	Governance £'000	Total 2024 £'000
Fitness to practise	5,145	8,457	3,164	1,132	226	4,648	1,604	**24,376**	4,379	7,364	2,458	1,006	241	4,982	1,487	**21,917**
Registration and revalidation	4,455	7,321	2,740	980	196	4,025	1,389	**21,106**	3,834	6,447	2,152	881	211	4,361	1,302	**19,188**
External relationships*	1,739	2,859	1,070	383	76	1,571	542	**8,240**	1,528	2,570	858	351	84	1,739	519	**7,649**
Medical Practitioners Tribunal Service	1,187	1,951	730	261	52	1,073	370	**5,624**	1,056	1,776	593	243	58	1,202	359	**5,287**
Education and standards	1,338	2,200	823	295	59	1,209	417	**6,341**	1,218	2,049	684	280	67	1,386	414	**6,098**
Total charitable expenditure	13,864	22,788	8,527	3,051	609	12,526	4,322	**65,687**	12,015	20,206	6,745	2,761	661	13,670	4,081	**60,139**

Support costs are allocated to charitable activities on the basis of staff head count across the organisation.

Support cost recharges have been made to both the trading subsidiary, GMC Services International Ltd, and the PA and AA regulation project throughout the year on a direct basis, using the logic of allocation outlined above, and are therefore treated separately to the year end allocation.

Group expenditure by type

	Charitable activities 2025	**Expenditure on raising funds 2025**	**Department of Health funding – PA and AA regulation 2025**	**Other expenditure 2025**	**Total 2025**	Charitable activities 2024	Expenditure on raising funds 2024	Department of Health funding – PA and AA regulation 2024	Other expenditure 2024	**Total 2024**
	£'000	**£'000**	**£'000**	**£'000**	**£'000**	£'000	£'000	£'000	£'000	**£'000**
Staffing costs	103,057	332	1,986	-	**105,375**	97,039	325	1,704	-	**99,068**
Office costs	1,224	31	965	-	**2,220**	1,567	45	788	-	**2,400**
Council and committee costs	426	-	-	-	**426**	454	-	-	-	**454**
Panel and assessment costs	18,487	-	124	-	**18,611**	20,132	-	120	-	**20,252**
Legal costs	4,291	-	-	(1,204)	**3,087**	4,414	-	-	684	**5,098**
Accommodation costs	8,508	-	-	(397)	**8,111**	9,020	-	-	(162)	**8,858**
Financial, actuarial and professional costs	4,803	306	-	-	**5,109**	4,463	304	-	-	**4,767**
Purchase of assets – charged to revenue	8,387	-	-	-	**8,387**	7,349	-	-	-	**7,349**
Assets written off	87	-	-	-	**87**	22	-	-	-	**22**
Depreciation	2,614	-	-	-	**2,614**	2,215	-	-	-	**2,215**
Amortisation	5,195	-	873	-	**6,068**	5,457	-	73	-	**5,530**
	157,079	669	3,948	(1,601)	**160,095**	152,132	674	2,685	522	**156,013**

Total resources expended

	2025	2024
	£'000	£'000
Operating lease costs: leasehold property and equipment	4,139	4,408
Audit fees	57	55

5. Staff

Total costs of all staff	2025 £'000	2024 £'000
Salaries	**78,068**	74,908
Social security costs	**10,425**	8,444
Superannuation costs defined benefit scheme	**-**	-
Superannuation costs defined contribution scheme	**12,159**	11,502
Redundancy costs	**442**	165
Other staffing costs	**4,281**	4,049
	105,375	99,068

During the year the General Medical Council made termination payments of £359,000 (2024: £80,000) which included £135,000 relating to and accrued in 2024. At year end payments of £218,000 were outstanding (2024: £135,000).

Average staff numbers in the year by category	2025	2024
Fitness to practise	**476**	460
Registration and revalidation	**412**	403
External relationships	**161**	161
Medical Practitioners Tribunal Service	**110**	111
Education and standards	**124**	128
Governance and management	**199**	194
Resources	**270**	255
	1,752	1,712
GMC Services International Ltd	**1**	1
	1,753	1,713

The number of staff whose total employee benefits (excluding employer pension contributions) fell into higher salary bands was:

	2025	2024
GMC		
£60,000-£70,000	72	74
£70,001-£80,000	50	50
£80,001-£90,000	46	44
£90,001-£100,000	39	40
£100,001-£110,000	22	11
£110,001-£120,000	8	8
£120,001-£130,000	10	10
£130,001-£140,000	9	11
£140,001-£150,000	12	4
£150,001-£160,000	5	3
£160,001-£170,000	1	2
£170,001-£180,000	1	1
£210,001-£220,000	-	-
£220,001-£230,000	-	4
£230,001-£240,000	6	2
£270,001-£280,000	-	-
£280,001-£290,000	1	1
	282	265
MPTS		
£60,000-£70,000	3	2
£70,001-£80,000	2	2
£80,001-£90,000	2	-
£90,001-£100,000	1	2
£120,001-£130,000	-	1
£130,001-£140,000	1	1
	9	8
Total	291	273

	2025	2024
Number of staff included above for whom retirement benefits are accruing		
GMC defined contribution pension scheme	290	271
	290	271

The senior management team includes the Chief Executive, six permanent directors and one temporary director to cover a secondment in 2025. The total employee benefits (including employer pension contributions) of the senior management team was £1,986,753 in 2025 (2024: £1,888,896).

Senior management team remuneration	**Basic salary 2025**	Basic salary 2024
	£'000	£'000
Charlie Massey – Chief Executive	286	277
Paul Reynolds – Director of Strategic Communications and Engagement	233	226
Shaun Gallagher – Director of Strategy and Policy	233	226
Una Lane – Director of Registration and Revalidation	233	226
Neil Roberts – Director of Resources	233	226
Professor Colin Melville – Director of Education and Standards*	116	226
Pushpinder Mangat – Director of Education and Standards†	142	-
Anthony Omo – Director of Fitness to Practise‡	214	184
Elizabeth Jenkins – Director of Fitness to Practise§	19	42

* Colin Melville left the role of Director of Education and Standards on 30 June 2025.

† Pushpinder Mangat started the role of Director of Education and Standards on 19 May 2025.

‡ Anthony Omo was seconded to the Nursing and Midwifery Council on the 28 October 2024 until 1 February 2025.

§ Elizabeth Jenkins was temporarily the Director of Fitness to Practise from 28 October 2024 to 31 January 2025.

All GMC staff, including the senior management team, are entitled to pension contributions of 15% of salary into the GMC Group Personal Pension Plan and may exchange contributions for salary.

The Chief Executive and Directors receive non-consolidated pay. In 2024 payments were below 3% of basic salary for all members of the senior management team. In 2025 payments were equivalent to or less than 1% of basic salary for all members of the senior management team.

All GMC staff, including the senior management team, are entitled to buy and sell leave and to the taxable benefit of private medical insurance. These costs and benefits are not included in the table above.

The Chief Executive's salary is 7.6 (2024: 7.6) times the median salary and 11.9 (2024: 11.8) times the lowest salary.

There were no related party transactions in the year that require disclosure other than payments made to Trustees as disclosed in notes 17 and 18.

6. Intangible fixed assets

Group and charity

	Computer software and systems development £'000
Cost	
Balance at 1 January 2025	**42,804**
Additions	**9,851**
Disposals	**(7,766)**
Impairment	
Balance at 31 December 2025	**44,889**
Amortisation	
Balance at 1 January 2025	**23,653**
Amortisation charge for year	**6,477**
Disposals	**(7,734)**
Impairment	
Balance at 31 December 2025	**22,396**
Net book value at 1 January 2025	**19,151**
Net book value at 31 December 2025	**22,493**

Intangible assets incorporates all IT software development costs including, but not limited to, the development of our strategic applications, Siebel and Livelink, the development of IT security systems, facilities management systems and website. Intangible assets also include the systems to support working from home and mobile applications.

7. Tangible fixed assets

Group and charity

	Buildings	Fixtures, furniture and equipment	IT equipment	Total
	£'000	£'000	£'000	£'000
Cost				
Balance at 1 January 2025	1,819	16,883	5,633	**24,335**
Additions	-	651	811	**1,462**
Disposals	-	(890)	(185)	**(1,075)**
Balance at 31 December 2025	1,819	16,644	6,259	**24,722**
Depreciation				
Balance at 1 January 2025	1,819	13,396	4,708	**19,923**
Depreciation charge for year	-	998	1,598	**2,596**
Disposals	-	(836)	(185)	**(1,021)**
Balance at 31 December 2025	1,819	13,558	6,121	**21,498**
Net book value at 1 January 2025	-	3,487	925	**4,412**
Net book value at 31 December 2025	-	3,086	138	**3,224**

8. Investments

Managed funds	Group		Charity		
	Listed investments	Total	Listed investments	Equity investment in group undertakings	Total
	£'000	£'000	£'000	£'000	£'000
The valuation at the end of the year consisted of					
As at 1 January 2025	61,852	**61,852**	61,852	357	**62,209**
Additions	12,756	**12,756**	12,756	-	**12,756**
Disposals	(13,045)	**(13,045)**	(13,045)	-	**(13,045)**
Gain on investments	1,120	**1,120**	1,120	-	**1,120**
Reversal of impairment*	-	**-**	-	46	**46**
Balance at 31 December 2025	**62,683**	**62,683**	**62,683**	**403**	**63,086**

* The General Medical Council incorporated a wholly owned trading subsidiary on 16 December 2016. Having previously been impaired by £243,000 due to trading losses incurred, we have revalued the investment by £46,000 in 2025 as a result of profits generated by the company thereby increasing its net assets.

Listed investments are managed by CCLA Investment Management Ltd. Investment management fees of £289,216 were incurred (2024: £287,693).

9. Debtors

	2025		2024	
	Group	**Charity**	Group	Charity
	£'000	**£'000**	£'000	£'000
Amounts falling due within one year				
Registration debtors	**29,199**	**29,199**	26,772	26,772
Prepayments and accrued income	**7,692**	**7,794**	7,168	7,274
Other debtors	**991**	**955**	1,535	1,509
	37,882	**37,948**	35,475	35,555

10. Creditors

	2025		As restated 2024	
	Group	**Charity**	Group	Charity
	£'000	**£'000**	£'000	£'000
Amounts falling due within one year				
Trade creditors	**1,938**	**1,937**	1,221	1,220
Tax and social security	**2,439**	**2,433**	2,155	2,153
Holiday pay	**1,209**	**1,209**	1,193	1,193
Accruals	**6,525**	**6,475**	8,393	8,352
Deferred income	**85,523**	**85,520**	85,845	85,840
	97,634	**97,574**	98,807	98,758

Charity deferred income

Income from annual retention fees is deferred and released to the statement of financial activities on a straight-line basis over a 12-month period from the date of renewal. All deferred income brought forward from the previous year is released to the statement of financial activities in the following year. Professional and Linguistic Assessments Board (PLAB) fees are deferred to the date the examination is sat. Revalidation assessment fees are deferred to the date the assessment takes place. Commercial income is recognised at the point the service is delivered.

	As restated Annual retention fees	**PLAB fees**	**Revalidation assessment fees**	**Commercial activities**	**As restated Total**
	£'000	**£'000**	**£'000**	**£'000**	**£'000**
Deferred income at 1 January 2025	76,383	9,426	31	5	**85,845**
Resources deferred during the year	81,192	4,284	44	3	**85,523**
Amounts released from previous years	(76,383)	(9,426)	(31)	(5)	**(85,845)**
Deferred income at 31 December 2025	**81,192**	**4,284**	**44**	**3**	**85,523**

2024 figures have been restated as an over release of income in previous years, including 2024, was identified in 2025. Deferred income at 1 January 2025 has been increased by £2,880,000.

11. Provisions

Group and charity

	2025	2024
	£'000	£'000
Dilapidations	**3,915**	4,312
Legal claims	**5,449**	6,653
	9,364	10,965

Dilapidations – each year we review our property leases and make a provision for dilapidations, where the cost can be reasonably estimated.

Legal claims – each year we make a provision for potential costs related to ongoing legal cases. On 10 June 2026 Council made a decision following the outcome of an employment tribunal that will have implications for a wider group of individuals. This decision is reflected in the legal claims provision above. Further details in relation to ongoing cases cannot be provided in order to avoid prejudicing proceedings.

Events after the reporting period are set out in note 19.

	Dilapidations	Legal claims	Total
	£'000	**£'000**	**£'000**
Provisions at 1 January 2025	4,312	6,653	**10,965**
Provisions created during the year	104	988	**1,092**
Utilisation of provision	(202)	(1,966)	**(2,168)**
Amounts released from previous years	(299)	(225)	**(524)**
Provisions at 31 December 2025	**3,915**	**5,450**	**9,365**

12. Group fund movements in the year

Group and charity

	Unrestricted funds	Restricted funds	Pension fund	2025 Total
	£'000	£'000	£'000	£'000
At 1 January 2025	69,878	2,543	(1,774)	70,647
Net incoming/(outgoing) resources	10,835	(874)	(5,796)	4,165
At 31 December 2025	**80,713**	**1,669**	**(7,570)**	**74,812**

	As restated Unrestricted funds	Restricted funds	Pension fund	As restated 2024 Total
	£'000	£'000	£'000	£'000
At 1 January 2024	61,525	2,122	(15,834)	47,813
Net incoming/(outgoing) resources	8,353	421	14,060	22,834
At 31 December 2024	**69,878**	**2,543**	**(1,774)**	**70,647**

2024 figures have been restated as an over release of income in previous years, including 2024, was identified in 2025. Unrestricted funds at 1 January has been reduced by £2,579,000 and Net incoming/(outgoing) resources has been reduced by £301,000.

13. Net assets by fund

Group and charity

Fund balances at 31 December 2025 are represented by

	Unrestricted funds	Restricted fixed asset funds	Pension reserve	2025 Total funds
	£'000	£'000	£'000	£'000
Intangible fixed assets	20,824	1,669	-	22,493
Tangible fixed assets	3,224	-	-	3,224
Investments	62,683	-	-	62,683
Current assets	100,980	-	-	100,980
Current liabilities	(97,634)	-	-	(97,634)
Provisions for liabilities and charges	(9,364)	-	-	(9,364)
Pension scheme liability	-	-	(7,570)	(7,570)
Total net assets	**80,713**	**1,669**	**(7,570)**	**74,812**

Fund balances at 31 December 2024 are represented by

	Unrestricted funds	Restricted fixed asset funds	Pension reserve	As restated 2024 Total funds
	£'000	£'000	£'000	£'000
Intangible fixed assets	16,608	2,543	-	19,151
Tangible fixed assets	4,412	-	-	4,412
Investments	61,852	-	-	61,852
Current assets	96,778	-	-	96,778
Current liabilities	(98,807)	-	-	(98,807)
Provisions for liabilities and charges	(10,965)	-	-	(10,965)
Pension scheme liability	-	-	(1,774)	(1,774)
Total net assets	**69,878**	**2,543**	**(1,774)**	**70,647**

The restricted intangible asset represents the capitalised cost of the IT system developed to regulate physician associates and anaesthesia associates.

2024 figures have been restated as an over release of income in previous years, including 2024, was identified in 2025. Current liabilities have been reduced by £2,880,000.

14. Capital commitments

Capital expenditure authorised and contracted but unspent at 31 December 2025 amounted to £187,930. The equivalent figure for 2024 was £306,041.

15. Operating lease commitments

	Land and buildings		Equipment	
	2025	2024	**2025**	2024
Expiry date	**£'000**	£'000	**£'000**	£'000
Within one year	**4,773**	4,445	**38**	38
In years two to five	**13,935**	17,353	**94**	38
After more than five years	**-**	1,339	**-**	94
	18,708	23,137	**132**	170

Commitments include our obligations under our buildings and equipment leases. They are calculated up to the first lease break clause or lease end where there is no break clause in the agreement. Commitments are calculated on a cash basis rather than incorporating rent free benefits.

16. Superannuation schemes

The GMC has two staff pension schemes:

GMC Group Personal Pension Plan

This is a defined contribution pension scheme, which was set up on 1 July 2013. We started auto enrolment on 1 November 2013. At the end of 2025 there were 1,765 members of staff contributing to this scheme. It meets the Government's requirements following the introduction of automatic enrolment. Individuals can choose to make additional contributions by deduction from salary to the scheme. Under the terms of FRS102, contributions are accounted for as a defined contribution scheme based on actual contributions paid through the year.

GMC Staff Superannuation Scheme

This is a funded scheme of the defined benefit type, providing retirement benefits based on final salary. The top-up arrangement is an unfunded scheme.

This scheme was closed to new members on 30 June 2013, and replaced by the GMC Group Personal Pension Plan. The scheme was closed to future accruals, other than those linked to salary changes, for existing members on 31 March 2018, therefore at the end of 2018 there were no members of staff contributing to this scheme.

The FRS 102 valuation has been based on a full assessment of the liabilities for the scheme as at 31 December 2024. The present values of the defined benefit obligation, the related current service cost and any past service costs were measured using the projected unit credit method.

Actuarial gains and losses have been recognised in the period in which they occur (but outside the profit and loss account) through the Other Comprehensive Income (OCI).

The GMC recognises surplus in accordance with the requirements of FRS 102 Section 18. The trustees of the scheme do not have the unilateral right to commence wind-up of the scheme. Thus, the GMC assumes that the ascheme continues in existence until the last benefit payments are made to members, at which point any residual assets are returned to the GMC in line with the rules of the scheme.

The GMC made a top up payment to the scheme of £2.5 million in 2025. A further £2.036 million will be paid each year until 2031 under the terms of the recovery plan agreed as part of the 2024 triennial valuation.

Responsibility for investing pension scheme assets rests with pension trustees. The Pensions Act 1995 requires trustees to draw up a Statement of Investment Principles, setting out the scheme's investment strategy. Pension trustees are required to consult the employer (GMC) when drawing up the strategy, but do not require the employer's formal agreement.

The principal assumptions used by the independent qualified actuaries to calculate the liabilities under FRS102 are set out below.

Main financial assumptions

	31 December 2025	31 December 2024
	%pa	%pa
Retail prices index inflation	2.9	2.9
Consumer price index inflation	2.6	2.6
Rate of general long-term increase in salaries	3.6	3.6
Pension increases (excess over guaranteed minimum pension)	2.6	2.6
Discount rate for scheme liabilities	5.7	5.5

Mortality assumptions

The mortality assumptions are based on standard mortality tables which allow for expected future mortality improvements. The assumptions are that a member currently aged 65 will live on average for a further 22.1 years (2024: 22 years) if they are male and for a further 24 years if they are female (2024: 24 years).

For a member who retires in 2045 at age 65 the assumptions are that they will live on average for a further 22.7 years (2024: 23.1) after retirement if they are male and for a further 25.1 years (2024: 25.1) after retirement if they are female.

Scheme asset allocation

	31 December 2025		31 December 2024	
	£'000	**%**	£'000	%
Delegated consulting services	**133,160**	**99%**	131,420	99%
Other	**889**	**1%**	773	1%
Total	**134,049**	**100%**	132,193	100%

The Delegated Consulting Service (DCS) is a fiduciary management solution that invests in a wide range of underlying assets in order to meet the scheme's specific investment objectives. The underlying asset allocation changes over time, based on the views of the fiduciary manager within the overall bounds set by the trustees. Under this approach the majority of scheme assets are invested in pooled funds. The managers of the pooled funds are required to have in place a policy on social, environmental and ethical considerations.

None of the scheme assets are invested in the Company's financial instruments or in property occupied by, or other assets used by, the GMC.

Reconciliation of funded status to balance sheet

	31 December 2025	31 December 2024
	£'000	£'000
Fair value of assets	**134,049**	132,193
Present value of funded defined benefit obligations	**(140,824)**	(133,167)
Funded status	**(6,775)**	(974)
Present value of unfunded defined benefit obligation	**(794)**	(800)
Asset/(liability) recognised on the balance sheet	**(7,569)**	(1,774)

Amounts recognised in income statement

	31 December 2025	31 December 2024
	£'000	£'000
Financing cost		
Interest on net defined benefit liability/(asset)	**(37)**	543
Pension expense recognised in profit and loss	**(37)**	543

Amounts recognised in Other Comprehensive Income (OCI)

	31 December 2025	31 December 2024
	£'000	£'000
Asset gains/(losses) arising during the year	**(4,053)**	(24,197)
Liability gains/(losses) arising during the year	**(4,353)**	35,226
Actuarial (loss)/gain on defined benefit pension scheme	**(8,406)**	11,029

Changes to the present value of the defined benefit obligation during the year

	31 December 2025	31 December 2024
	£'000	£'000
Opening defined benefit obligation (DBO)	**133,967**	165,831
Current service cost	**-**	-
Interest expense on DBO	**7,261**	7,213
Actuarial (gains)/losses on liabilities	**4,353**	(35,226)
Net benefits paid out	**(3,963)**	(3,851)
Closing defined benefit obligation	**141,618**	133,967

Changes to the fair value of scheme assets during the year

	31 December 2025	31 December 2024
	£'000	£'000
Opening fair value of scheme assets	**132,193**	149,999
Interest income on scheme assets	**7,298**	6,670
Gain/(loss) on scheme assets	**(4,053)**	(24,197)
Contributions by the Company	**2,574**	3,572
Net benefits paid out	**(3,963)**	(3,851)
Closing fair value of scheme assets	**134,049**	132,193

Actual return on scheme assets

	31 December 2025	31 December 2024
	£'000	£'000
Interest income on scheme assets	**7,298**	6,670
Gain/(loss) on scheme assets	**(4,053)**	(24,197)
Actual return on scheme assets	**3,245**	(17,527)

17. Related party transactions

	2025	2024
	£	£
Trustee honoraria		
Dame Carrie MacEwen (Chair)	110,000	110,000
Steve Burnett*	-	18,000
Vanessa Davies	18,000	18,000
Professor Anthony Harnden*	-	18,000
Lord Philip Hunt†	-	1,500
Professor Paul Knight*	-	18,000
Professor Deepa Mann-Kler	18,000	18,000
Dr Raj Patel	18,000	18,000
Professor Suzanne Shale	18,000	18,000
Dr Alison Wright‡	17,087	18,000
Dr Jeeves Wijesuriya	18,000	18,000
Douglas Millican	18,000	18,000
Olamide Oguntimehin§	18,000	-
Wendy Williams§	18,000	-
Keith Lloyd§	18,000	-
Jane Ramsey§	18,000	-

* Demitted as Council member December 2024

† Demitted as Council member January 2024

‡ Demitted as Council member December 2025

§ Appointed as Council member January 2025

Honoraria payments are permitted by the governing document of the General Medical Council, The Medical Act 1983, paragraph 17, schedule 1.

Medical Practitioners Tribunal Service Committee members	2025	2024
Her Honour Judge Deborah Taylor*	38,605	120,832
Gill Edelman (Gillian Gordon)	47,015	3,720
Joy Hamilton†	-	413
Jacky Hayden‡	-	7,440
Simon Mackenzie§	-	3,607
Barbara Larkin¶	3,818	3,292
Stephen Webb‖	3,934	930
Richard Vautrey#	3,458	-

* Demitted as Chair of the Medical Practitioners Tribunal Service April 2025
† Demitted as MPTS Committee member February 2024
‡ Demitted as MPTS Committee member December 2024
§ Demitted as MPTS Committee member December 2024
¶ Appointed as MPTS Committee member February 2024
‖ Appointed as MPTS Committee member October 2024
Appointed as MPTS Committee member April 2025

Audit and Risk Committee co-opted members	2025	2024
Aneen Blackmore	-	-
Jon Hayes	4,577	3,315

Investment Committee co-opted members	2025	2024
Keith Mackay*	903	1,300
Paul Cox†	1,463	-
Michael Jennings	3,001	1,755

* Demitted as Investment Committee member April 2025
† Appointed as Investment Committee member May 2025

GMC Services International Ltd	2025	2024
Andrew McCulloch*	728	1,950
Jay Verma†	-	-
Thalia Georgiou‡	1,950	975
Victoria Cheston‡	1,625	-

* Demitted as Chair of the Board of GMC Services International Ltd May 2025
† Appointed as Chair of the Board of GMC Services International Ltd June 2025
‡ Appointed as GMCSI Board member May 2024

2025 figures for some individuals include payments for historic holiday pay and pensions contributions, triggered by a change in employment status to worker.

18. Travel and subsistence expenses claimed in 2025

	2025	2024
	£	£
Trustees		
Dame Carrie MacEwen (Chair)	6,696	3,248
Steve Burnett*	302	2,703
Vanessa Davies	3,975	5,129
Anthony Harnden*	93	1,375
Philip Hunt†	-	-
Paul Knight*	-	4,797
Deepa Mann-Kler	6,872	7,380
Raj Patel	1,663	2,630
Suzanne Shale	1,091	1,169
Alison Wright‡	921	330
Jeeves Wijesuriya	3,033	2,661
Douglas Millican	3,794	2,040
Olamide Oguntimehin§	849	-
Wendy Williams§	2,112	-
Keith Lloyd§	614	-
Jane Ramsey§	298	-

* Demitted as Council member December 2024

† Demitted as Council member January 2024

‡ Demitted as Council member December 2025

§ Appointed as Council member January 2025

Variations in expenses reflect that the trustees, committee members and the Senior Management Team live in different parts of the UK and are required to travel around the UK on GMC business, including to our offices in London, Manchester, Edinburgh, Belfast and Cardiff, and occasionally outside the UK. This also reflects that different numbers of meetings and events are attended by individuals. Deepa Mann-Kler is based in Belfast, and Vanessa Davies is based in Edinburgh.

Adjustments are also made for those with disabilities, which may mean that additional expenses are incurred for travel and accommodation according to specific needs.

Medical Practitioners Tribunal Service Committee members	2025	2024
Her Honour Judge Deborah Taylor*	24	90
Gill Edelman (Gillian Gordon)	4,074	528
Joy Hamilton†	-	-
Jacky Hayden‡	-	582
Simon Mackenzie§	-	758
Barbara Larkin¶	1,689	2,038
Stephen Webb‖	792	330
Richard Vautrey#	286	-

* Demitted as Chair of the Medical Practitioners Tribunal Service April 2025
† Demitted as MPTS Committee member February 2024
‡ Demitted as MPTS Committee member December 2024
§ Demitted as MPTS Committee member December 2024
¶ Appointed as MPTS Committee member February 2024
‖ Appointed as MPTS Committee member October 2024
Appointed as MPTS Committee member April 2025

Audit and Risk Committee co-opted members	2025	2024
Aneen Blackmore	-	237
Jon Hayes	468	310

Investment Committee co-opted members	2025	2024
Keith Mackay*	-	-
Paul Cox†	411	-
Michael Jennings	152	69

* Demitted as Investment Committee member April 2025
† Appointed as Investment Committee member May 2025

GMC Services International Ltd	2025	2024
Andrew McCulloch *	-	125
Jay Verma†	-	-
Thalia Georgiou ‡	205	111
Victoria Cheston ‡	74	-

* Demitted as Chair of the Board of GMC Services International Ltd May 2025

† Appointed as Chair of the Board of GMC Services International Ltd June 2025

‡ Appointed as GMCSI Board member May 2024.

Senior management team	2025	2024
Charlie Massey – Chief Executive	5,006	8,792
Paul Reynolds – Director of Strategic Communications and Engagement	5,450	10,339
Shaun Gallagher – Director of Strategy and Policy	2,042	4,759
Una Lane – Director of Registration and Revalidation	3,944	4,195
Neil Roberts – Director of Resources	7,079	7,938
Professor Colin Melville – Director of Education and Standards*	7,498	9,895
Pushpinder Mangat – Director of Education and Standards†	2,161	-
Anthony Omo – Director of Fitness to Practise‡	4,375	3,423
Elizabeth Jenkins – Director of Fitness to Practise§	47	2,395

* Colin Melville left the role of Director of Education and Standards on 30 June 2025.

† Pushpinder Mangat started the role of Director of Education and Standards on 19 May 2025.

‡ Anthony Omo was seconded to the Nursing and Midwifery Council on 28 October 2024 to 1 February 2025.

§ Elizabeth Jenkins was temporarily the Director of Fitness to Practise from 28 October 2024 to 31 January 2025.

19. Events after the end of the reporting period

In May 2026, management decided to cease Professional and Linguistic Assessment Board activities at Hardman Square from 2027, due to a reduction in candidate volumes. As such they consider the underlying lease to have become onerous after the reporting date. The financial impact of this non-adjusting event cannot be reliably estimated at the date of the approval of the financial statements due to the inherent uncertainty in relation to future premises costs that may be incurred.

There have been no other significant events after 31 December 2025 that require adjustment to, or disclosure in, the financial statements, other than those set out in note 11.

Reference and administrative information

We are independent of government and of those we regulate, and are accountable to UK and Scottish Parliaments. Our powers are given to us by the UK Parliament through the Medical Act 1983 and by the Scottish Parliament through the Anaesthesia Associates and Physician Associates Order.

We are registered with the Charity Commission for England and Wales (1089278), and with the Office of the Scottish Charity Regulator (SC037750). We are not currently required to be registered separately with the Northern Ireland Charity Commission.

Our principal places of business are 3 Hardman Street, Manchester M3 3AW and Regent's Place, 350 Euston Road, London NW1 3JN. We also have offices in Belfast, Cardiff and Edinburgh; a centre for hearings, where the Medical Practitioners Tribunal Service is based, at St James's Buildings, 79 Oxford Street, Manchester M1 6FQ; and a Clinical Assessment Centre, in 3 Hardman Square, Manchester M3 3EB.

Our trustees have a duty to act impartially and objectively, and to take steps to avoid any conflict of interest arising as a result of their membership of, or association with, other organisations or individuals. As trustees, members have a duty to avoid putting themselves in a position where their personal interests conflict with their duty to act in the interests of the charity, unless authorised to do so. To make this fully transparent, we publish a register of members' interests on our website.

Day-to-day management of the organisation is delegated to the Chief Executive, Charlie Massey. You can read more about our governance and management arrangements earlier in this report.

We work with the Professional Standards Authority (PSA), an independent body, which is accountable to Parliament and scrutinises and oversees our work, together with other health and social care professional regulatory bodies in the UK.

Information requests

In 2025, we received 640 requests for personal information under the UK General Data Protection Regulation (GDPR). This was an increase of 32% from 2024. We also received 1,014 information requests under the Freedom of Information Act, up 29% from 2024.

We achieved 82% against our target to respond to 80% of personal information requests within the statutory timeframe. For Freedom of Information requests, we achieved 86% against our target of responding to 90% within 20 working days.

Our registration reference with the Information Commissioner's Office is Z7423389.

Paying for goods and services

We paid 96% of valid and undisputed invoices within 30 days and did not pay any interest to suppliers due to late payment in excess of 30 days.

Professional advisers

Bankers	National Westminster Bank Plc 250 Bishopsgate London EC2M 4AA
Investment adviser	Mercer Limited 1 Tower Place West Tower Place London EC3R 5BU
Solicitors	The majority of our legal work is carried out by our in-house legal team.
Auditors	Crowe U.K. LLP 2nd Floor, 55 Ludgate Hill London EC4M 7JW
Actuary and pension scheme adviser	Aon Parkside House, Ashley Road Epsom Surrey KT18 5BS

Email: **gmc@gmc-uk.org**
Website: **gmc-uk.org**
Telephone: **0161 923 6602**

General Medical Council, 3 Hardman Street, Manchester M3 3AW

Textphone: **please dial the prefix 18001** then **0161 923 6602** to use the Text Relay service.

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To ask for this publication in another format or language, please call us on **0161 923 6602** or email us at **gmc@gmc-uk.org**.

I ofyn am y cyhoeddiad hwn mewn fformat neu iaith arall, ffoniwch ni ar **0161 923 6602** neu e-bostiwch ni ar **gmc@gmc-uk.org**.

You are welcome to contact us in Welsh. We will respond in Welsh, without this causing additional delay.

Mae croeso i chi gysylltu â ni yn Gymraeg. Byddwn yn ymateb yn Gymraeg, heb i hyn achosi oedi ychwanegol.

Published August 2026

Code: GMC/AR2025/0826