Our annual report 2019

Working with doctors Working for patients

General Medical Council

Contents

About this report

Our trustees present this report and financial statements for the year ending 31 December 2019.

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 this 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.

Foreword

The past few months have showcased the great fortitude and resilience of all who work in the health services.

Facing the largest threat ever to confront our healthcare systems, doctors have demonstrated their ingenuity, ability and dedication, at a time when the stakes could hardly be higher.

Our work in 2019 to better understand doctors' and patients' experiences of healthcare has been crucial in shaping our regulatory response to the coronavirus (COVID-19) pandemic.

With this crisis demanding a fundamental shift in the delivery of care, the principles we co-produced in November on remote consultations have also taken on a new significance.

These extraordinary times ask a lot of us all. But for those working on the frontline in fraught conditions, the pressures are especially acute.

Even before the coronavirus dominated workloads in our health services, there were clear warning signs.

Our report, *The state of medical education and practice in the UK*[1], found that 12% of doctors took a leave of absence due to stress[2], while 32% reported working beyond rostered hours every day[3].

At the same time, demand for healthcare services is on the rise, as the population ages and complex diseases, like diabetes and dementia, become increasingly prevalent. Meanwhile, expectations of care remain high.

Many doctors are reacting to growing workloads and rising pressure by voting with their feet and walking away. A fifth of doctors reduced their hours, rising to a third of GPs[4].

[1] The report was based on findings from our 2019 *Barometer survey*, which explored doctors' experiences of the previous 12 months.
[2] page 22, *The state of medical education and practice in the UK 2019*.
[3] page 24, *ibid.*
[4] page 6, *The state of medical education and practice in the UK: the workforce report 2019.*

This pressure has a very real impact on the care patients receive. 34% of doctors found it difficult to provide a patient with the level of care they needed at least once a week[5].

If we're to build the sustainable workforce that today's healthcare systems need now, we have to deal with these ever-changing realities head on.

As a patient safety body, we have to confront the barriers to good care, and work with healthcare partners to overcome them.

That means our role has to evolve. Rather than reacting to events, we have to be proactive.

Throughout 2019, we published a series of reviews we had independently commissioned to identify the issues affecting doctors' ability to deliver care, and to pinpoint practical solutions for overcoming them. We also launched our first-ever survey of specialty and associate specialists and locally employed doctors.

From this research, a number of priority areas emerged, including workplace culture, compassionate leadership, effective induction and feedback, and fairness and inclusion.

Positive and just workplace cultures and wellbeing are vital for doctors to deliver the highest quality of patient care.

We believe we have a role to play in promoting patient safety by supporting doctors, but we can't do it alone. All parts of the health service have to unite behind this agenda to move it forward.

So on the strength of the reviews we published, we started hosting conversations with all parts of the system, across all parts of the UK, to bring about positive change. This important work will continue throughout 2020, in collaboration with our partners.

We've also taken a number of practical measures specifically from our end to advance this agenda.

For example, we rolled out Human Factors training to all our fitness to practise decision-makers and case examiners, so doctors' actions are better understood in the context of the stresses on the health system.

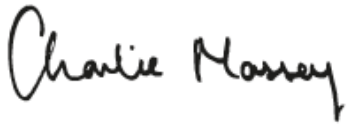
[5] page 95, *The state of medical education and practice in the UK 2019*.

We increased participation in our *Welcome to UK practice workshops* (*WtUKP*) for internationally-qualified doctors by 37%.

And we began working hard on bringing physician associates (PAs) and anaesthesia associates (AAs) into our regulation. This will allow PAs and AAs to maximise their contribution to the workforce and to patient safety as part of multidisciplinary teams comprising other regulated healthcare professions.

In 2019, we made a strong start. But there's much more to do.

Our focus in 2020 is to bring all parts of the health system together, working to promote environments in which doctors can deliver the best possible patient care.



Charlie Massey

Chief Executive and Registrar

Delivering our role

We are the UK's independent regulator of doctors.

Our role is to:

- protect the health, safety and wellbeing of patients and the public
- promote and maintain professional standards for doctors
- oversee UK medical education and training
- take action when the safety of patients, or the public's confidence in doctors, is at risk.

Efficient and effective regulation

Efficient and effective regulation is at the core of all our work.

- We manage the UK medical register – We check every doctor's identity and qualifications before they're able to join the register. And we check with medical schools or previous employers if there are any concerns about a doctor's ability to practise safely.
- We set the standards for doctors – Our standards define what makes a good doctor, including the professional values, knowledge, skills and behaviours required of all doctors working in the UK. When we develop our standards and guidance, we consult with a wide range of people, including patients, doctors, employers and educators.
- We oversee all stages of medical education and training – We make sure doctors get the education and training they need to deliver high-quality care throughout their careers, setting out what outcomes are needed for graduates and approving curricula for postgraduate education. We set educational standards across the UK, and monitor training environments to enable safe and effective learning.
- We help to maintain and improve standards through revalidation – It's important that every licensed doctor in the UK is keeping their knowledge and skills up to date. Revalidation is a fundamental part of clinical governance for doctors. It gives patients and the public assurance that doctors in the UK are part of a governed system, which checks their fitness to practise on a regular basis and supports their continuous improvement and development. It also supports the identification and management of concerns at an early stage.
- We investigate and act on concerns that put patients or public confidence in doctors at risk – When we receive a concern, we assess whether it meets our threshold for investigation. If it does, we investigate and at the end of the investigation decide what action we need to take including whether to close the case, issue advice or a warning to the doctor, or agree with the doctor that they will restrict their practice, retrain or work under supervision. In some situations, we refer the case to the Medical Practitioners Tribunal Service (MPTS) for a hearing.

Developing regulation for physician associates and anaesthesia associates

In July 2019, the Department of Health and Social Care (DHSC) announced that we would regulate physician associates and anaesthesia associates.

We're developing a proposed approach, cost and timetable for regulating medical associate professions. We're also exploring what legislation and policies we'll need to move forward. In March 2020, we presented a scoping report on this subject to the DHSC.

Our performance review

The Professional Standards Authority (PSA) carries out an annual assessment of how we perform as a regulator. Its latest assessment confirmed that we successfully met all 24 standards for good regulation in 2018/19. These include standards relating to fairness, transparency, public protection and timeliness.

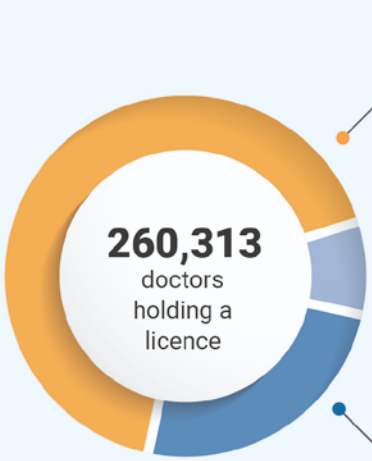
2019 at a glance

These figures are correct as of 31 December 2019.

Visit **Data Explorer** to learn more about the UK's healthcare workforce.

The register

- 71,446 doctors on the GP register
- 97,819 doctors on the specialist register
- 142,076: all other doctors



65% **Graduated in the UK** (169,534)

9% **Graduated in the European economic area (EEA) or in Switzerland** (22,586)

26% **Graduated in the rest of the world** (68,193)

Managing the UK medical register

18,356 applications granted to doctors joining the register

8,537 applications were from doctors who qualified in the rest of the world

7,343 applications were from doctors who qualified in the UK

2,476 applications were from doctors who qualified in the EEA or Switzerland

4,891 new applications to the specialist register

3,010 new applications to the GP register

11,079 candidates took PLAB 1.

8,700 candidates took PLAB 2.

Setting the standards for doctors

Our Outreach team engaged with over 22,700 doctors and over 12,700 medical students across the UK, including at 43 *Duties of a doctor* workshops.

Our Standards team answered over 600 enquiries from doctors, helping them to deal with the ethical challenges they faced.

Our Employer Liaison Advisers held over 1,400 employer liaison meetings with responsible officers.

3,692 doctors attended our Welcome to UK Practice (WtUKP) sessions.

Helping to raise standards through revalidation

We received **66,519** revalidation recommendations.

We made decisions on **98%** of revalidation recommendations within **5** working days.

We revalidated **57,628** doctors.

We approved the deferral of **7,696** doctors.

We approved **78** recommendations of non-engagement[6].

We withdrew **518** licences for doctors failing to meet our requirements.

[6] A recommendation of non-engagement refers to when a doctor has not engaged in the systems and processes that support the revalidation process, or the level of engagement is insufficient to support a recommendation to revalidate.

Overseeing doctors' education and training

Over 75,000
trainers and trainees completed our national training surveys.

Over 6,400
doctors completed our SAS and LE doctors survey.

The **University of Buckingham** and the **University of Central Lancashire School of Medicine** joined our list of approved institutions.

In specialty training, we have approved **56** purpose statements and **10** full curricula in 2019 against our *Excellence by design* standards – meaning in total we have now approved **96** purpose statements and **31** full curricula.

We approved a framework to enable GMC-regulated credentials[7] in five early adopter areas of practice.

We carried out **21** quality assurance visits and found:

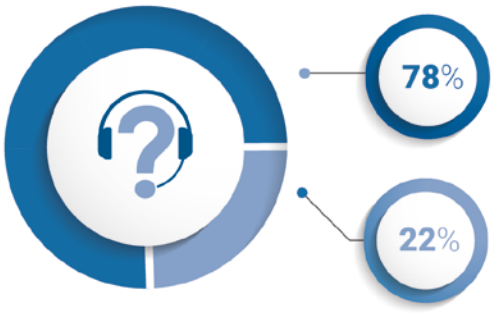
- **9** areas of good practice
- **17** areas where our standards were met, but where we identified improvements that could be made
- **6** areas that required improvement

10 issues were escalated to our enhanced monitoring process[8].

13 enhanced monitoring issues were resolved in 2019.

Customer services

Our Contact Centre answered **178,823** calls and responded to **116,205** emails and letters.



Doctors
229,461
calls and emails were from doctors.

The public and others
64,516[9]
calls and emails were from the public and others.

Our Patient Liaison Service supported **392** patients, relatives, or members of the public who had raised concerns about a doctor.

96% of those surveyed rated their meeting with the service as 'very good' or 'good'.

7 Introducing GMC-regulated credentials, which formally recognise a doctor's expertise in a specific area of practice, is part of our strategy to introduce greater flexibility to education and learning and help address patient safety and resource concerns. For more information on our work on GMC-regulated credentials see page 46.

8 We use enhanced monitoring to promote and encourage local management of concerns about the quality and safety of medical education and training.

9 This can include doctors without a GMC number.

Taking actions on concerns

5,677 concerns were raised by a member of the public.

8,654 concerns about doctors were raised with us.

610 calls to our confidential helpline, through which people can raise a patient safety concern if they don't feel able to do so locally.

1,532 met our statutory threshold for investigation.

602 were considered under provisional enquiry[10].

Outcomes of case examiner decisions

- Concluded with no further action: 719
- Referred to a medical practitioners tribunal: 347
- Warning issued: 85
- Doctor agreed undertakings: 76
- Concluded with advice: 52

Outcomes of provisional enquiries

- Still in progress: 55
- Progressed to investigations: 143
- Closed: 404
- Referred: 0

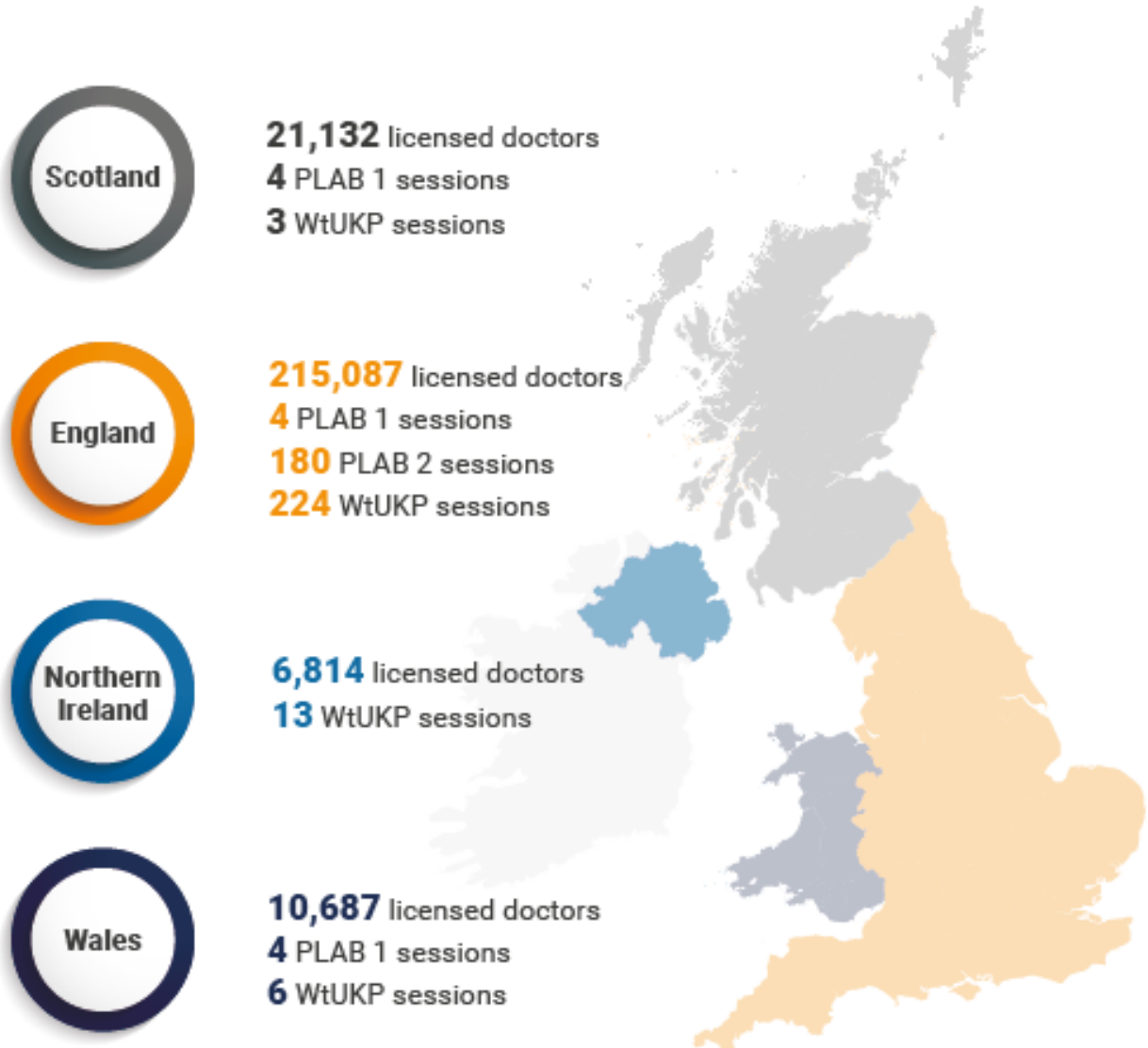
Outcomes of MPTS fitness to practise tribunals

Erasure	55
Suspension	120
Conditions	14
Undertakings	0
No impairment - warning	17
Impairment - no further action	4
No impairment	44
Voluntary erasure	3
Total	**257**

[10] For certain cases, we now make provisional enquiries, where we look at information at an early stage of a case, to provide more swift resolution for patients and doctors. If the evidence shows there isn't a future risk to patients, and regulatory action isn't required, we won't move to a full investigation. For those cases where we have concerns about patient safety, we will carry out a full investigation.

Four country regulation

We have a dedicated presence in all four countries of the UK, with offices in Northern Ireland, Scotland and Wales, and in England in London and Manchester.



Progressing our corporate strategy

Our four strategic aims for 2018–20

Supporting doctors in delivering good medical practice

3,692

internationally-qualified doctors attended our free Welcome to UK practice (WtUKP) induction workshops – a **37**% increase on 2018.

We released our first podcast, **Able medics**, which features disabled doctors talking about their experiences of medical education and practice.

We launched learning materials to support students in becoming a reflective practitioner in their daily life as a student and beyond.

We sparked discussion about doctors' wellbeing and workplace cultures, with reports including *Caring for doctors Caring for patients*.

Promoting better, more supportive work environments for doctors and medical students

The significant impact that system pressures are having on doctors' practice, on their wellbeing and on their ability to provide safe patient care is well known.

Both wellbeing, and positive and just workplace cultures are vital for doctors to deliver the highest quality of patient care, and to protect patient safety more generally. It's also clear that achieving positive change in relation to these factors requires cooperation and investment by all stakeholders in the UK's healthcare systems.

These are the key findings from *Supporting a profession under pressure*, a substantial programme of work we started in 2018 to understand more about the challenges faced by doctors and medical students during their careers.

As part of the programme, in 2019 we published three reports focusing on issues affecting everyday medical practice, and worked on establishing a dialogue with partners in the UK's healthcare sector to achieve positive change, for doctors and for patients.

Delivering change together

The reports we published, described further below, gave us significant insights into the key challenges doctors face working in the UK's healthcare systems in providing safe patient care.

Importantly, they also gave us an opportunity to spark discussions about work environments and doctors' health and wellbeing with our partners across the UK, including other professional regulators, creating a momentum for action.

While each review identified specific recommendations for us and organisations across the UK's healthcare systems, it's clear there are common themes across all three.

Our work on Welcome to UK practice *WtUKP*[11], *Professional behaviours and patient safety*[12] and differential attainment already target some of these areas.

But the change that patients, doctors and healthcare professionals deserve can only happen through further, system-wide efforts, and through clear commitments from all relevant stakeholders in the UK's healthcare sector.

So, at the end of 2019, we started working with partners across the UK's four nations to build on existing good practice and aid implementation of the recommendations from the reports, with support from all. This aspect of our programme of work, aimed at fostering dialogue between regulatory partners and other stakeholders across the UK's different healthcare systems, will continue into 2020, and we will report on it in our next Annual Report.

Below we describe the key findings from each of the reviews we published in 2019.

Caring for doctors Caring for patients: How to transform UK healthcare environments to support doctors and medical students to care for patients – chaired by Dame Denise Coia and Professor Michael West[13]

This review made eight recommendations to support the wellbeing of medical students and doctors, and enable safe, and good, patient care. Together, these recommendations aim to address three key needs that doctors experience in the workplace:

- autonomy/control – the need to have some control over your working life
- belonging – the need to feel part of a supportive, effective and connected team
- competence – feeling enabled in your role and able to deliver clear outcomes, such as high-quality care.

It also highlighted a range of practical examples from across the UK, where employers and clinical teams are already implementing local solutions to address issues affecting the health and wellbeing of doctors.

The report was received positively by the profession and by key organisations, with many calling it a 'landmark' publication. It was downloaded over 3,000 times, and a video featuring our Chair Dame Clare Marx talking about the report was viewed over 45,000 times.

[11] See page 19.
[12] See page 18.
[13] Dame Denise Coia was a clinical psychiatrist and leader in the field of mental health. She sadly passed away in April 2020. Professor Michael West is Professor of Work and Organisational Psychology at Lancaster University Management School. The report is available on our website.

Fair to refer? Reducing disproportionality in fitness to practise concerns reported to the GMC – chaired by Dr Doyin Atewologun and Roger Kline[14]

This research concluded that multiple intricately-linked factors lead some groups of doctors to be referred to us more than others. It set out recommendations in four key areas to help address these issues:

- improving support for doctors new to the UK or the NHS or whose role is likely to isolate them
- addressing systemic issues that may affect doctors' professional performance and how they should be taken into account when assessing practice
- making sure engaged, positive and inclusive leadership is more consistent across the NHS
- developing a UK-wide mechanism to act on the recommendations at local and national levels.

Independent review of gross negligence manslaughter and culpable homicide – chaired by Leslie Hamilton[15]

This review examined the entire process following the unexpected death of a patient, including: local investigations, inquiries by a coroner, procurator fiscal or sheriff, any criminal investigation and our fitness to practise processes.

The report called for greater consistency in the response to an unexpected death. In particular, it stressed that support for, and the involvement of, patients' families must be a priority before, during and after an investigation into an unexpected death.

It also identified recommendations for us and a range of organisations to create a just culture in healthcare, where doctors feel enabled and supported to act on their concerns. And it recognised that our processes are constrained by outdated and inflexible legislation, calling on the UK government to reform the *Medical Act 1983* to give us more discretion over which cases require investigation. We continue to highlight the importance of legislative changes to MPs, seeking their support.

Alongside these reviews, we also:

- commissioned Dr Suzanne Shale, a medical ethics researcher and consultant, to explore the lived experiences of doctors in senior leadership roles. *How doctors in senior leadership roles establish and maintain a positive patient-centred culture* helped to improve our understanding of senior leaders' day-to-day experiences and challenges, so we can better

[14] Dr Doyin Atewologun is a Chartered and Registered Occupational Psychologist. Roger Kline is a Research Fellow at Middlesex University. The report is available on our website.
[15] Leslie Hamilton is a cardiac surgeon with an interest in the medico-legal aspects of practice. The report is available on our website.

support doctors to succeed in these roles. Good leadership and positive cultures are vital to healthcare and patient safety

- launched a new survey of specialty and associate specialist (SAS) and locally employed (LE) doctors[16], helping us to understand more about these doctors' experiences, so we can better support them in these roles
- commissioned further independent research to understand how doctors can be more effectively supported during induction or when returning to work after an extended period.

Improving support for doctors to raise and act on concerns

At our conference in April 2019, Dame Clare Marx announced our new pilot training programme, *Professional behaviours and patient safety* (PBPS).

The programme has two component parts. Firstly, collaboration with organisations to share good practice in creating a working environment where positive professional behaviours of civility and respect can thrive. Secondly, delivery of a workshop that supports doctors to identify unprofessional behaviours, reflect on personal responsibilities and develop skills to help address behaviours that have potential to cause harm. During the pilot period, our Outreach teams have engaged with 39 organisations about their culture change programme and delivered 19 half-day PBPS workshops.

The evaluation is due to be completed in 2020 but initial responses have shown that the doctors who attend the course find it valuable and are more confident in their ability to challenge unprofessional behaviour.

> 'I feel more **empowered** to deal **effectively** with unprofessional behaviour. I have become **more aware** of my behaviour, colleagues' behaviours and organisational **expectations.**'
> – Consultant

> 'Feel **more confident** to **challenge/escalate** inappropriate behaviours from colleagues and **reflect better** on my own behaviour.'
> – Doctor in training

[16] See page 40 for more about the findings from this survey.

We'll continue to work with doctors and stakeholders to make sure this programme drives real improvements in patient care.

As well as this, in October 2019, we released a new resource within our ethical hub, to help doctors to speak up. The resources include practical advice, sources of support and toolkits to help doctors speak up effectively and tackle some of the barriers they face when raising concerns.

To create relevant and applicable advice, we involved doctors from across the UK, our clinical fellows, and England's national Freedom to Speak Up Guardian for England (Henrietta Hughes), as well as employers.

Between October and November, over 4,500 people used these resources.

As part of our commitment to encourage a speak-up culture in the healthcare sector, in Northern Ireland, we support the Institute of Human Resources Development as part of the Being Open subgroup of the Duty of Candour workstream. And in Scotland, our Standards team continues to work with the Scottish Public Services Ombudsman and will make sure our ethical hub is updated to reflect the creation of the Independent National Whistleblowing Officer once it is established.

Increasing participation in our Welcome to UK Practice workshops

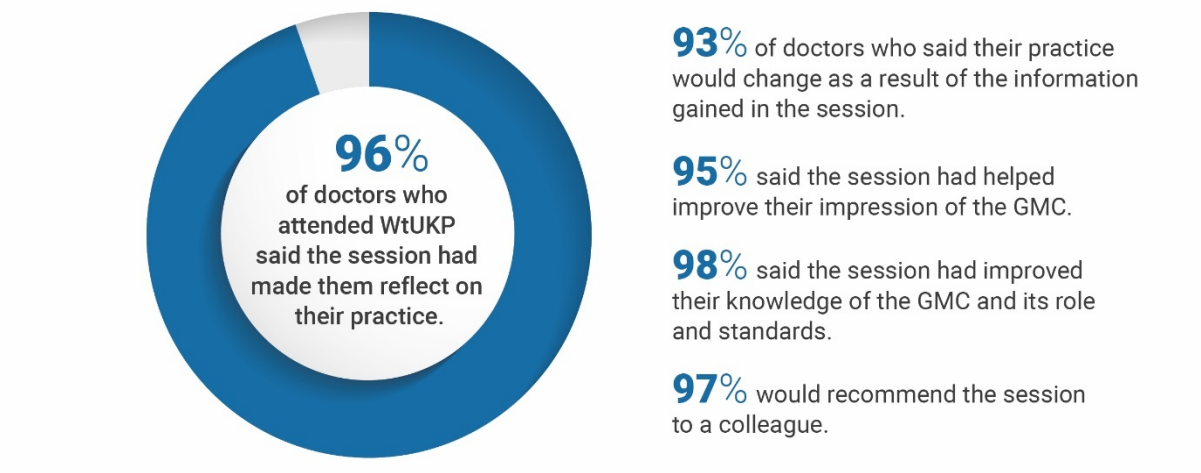
In 2019, 3,692 internationally-qualified doctors attended our free *WtUKP* induction workshops – a 37% increase on 2018.

The short- and long-term impact these workshops have on doctors' practice are highlighted in Newcastle University's independent evaluation of WtUKP[17]. Immediately after attending the workshops, doctors reported significantly improved awareness and understanding of key ethical issues and how to apply our guidance to deliver safe care. And many of these

[17] Published in January 2019.

short-term improvements were sustained after three months. Almost two thirds (62%) of doctors reported that they had made changes to their practice as a result of what they learned in WtUKP.

Doctors attending the workshops consistently tell us they find them very helpful and that their practice would change as a result. They also appreciate the opportunity to connect with others in the same position and discuss common challenges, on the day or after the workshops.



During 2019, we also secured support from organisations across the UK to make the workshops an integral part of their induction processes. This will help to expand the programme further. And it will increase these doctors' chances of having a successful career in the UK right from the start, delivering safe medical practice for patients and the public.

Providing training on Human Factors to fitness to practise staff

We're aware that systemic factors and specific features of work environments and practices can play a role in leading to failings in patient care.

For this reason, we invested in providing Human Factors training to decision makers, case examiners and clinical experts involved in our fitness to practise processes.

Human Factors is a social science which studies and attempts to optimise the interactions of humans, technology and the environment at work. It is a standard tool of safety investigation and improvement in several industries, such as civil aviation, nuclear power and military planning, which seek to balance high risk and high reliability.

In 2019, we partnered with Oxford University's Patient Safety Academy to provide training specifically on this subject to staff in our Fitness to Practise directorate, aiming to make sure that context and systems issues are always fully taken into account when evaluating a doctor's performance. 129 staff attended the training between April and December 2019.

The training initiative is helping to guarantee consistency in how we investigate after things have gone wrong, giving doctors the assurance that their actions will be seen clearly against the backdrop of any system failings. Coupled with the responsibility royal colleges and faculties have to equip doctors in training with basic Human Factors training; this will help to embed a greater understanding across the health system of how environments contribute to patient safety incidents.

We've also been working with responsible officers to make sure a similar approach is consistently applied locally when they are dealing with concerns around doctors' conduct and performance, before those issues are referred to us.

Working with delivery partners to develop the Medical Licensing Assessment

In 2019, we continued to develop the Medical Licensing Assessment (MLA).

UK medical school assessment currently varies from school to school and is, in turn, different from the PLAB (Professional and Linguistic Assessments Board) exam that we set for doctors who are not UK, EEA or Swiss nationals and who gained their primary qualification outside the UK.

The MLA aims to build on recognised effective practice in assessment, to give additional assurance that every newly licensed doctor meets the standards for practice in the UK. The new assessment is in two parts: an applied knowledge test (AKT) and a clinical professional skills assessment (CPSA).

In June 2019, our Council agreed a set of principles for the design and delivery of the AKT. This included plans to allow medical schools to choose when they will deliver the AKT, to suit their curricula and assessment cycle.

Following this, we continued to work closely with colleagues from UK medical schools and with their representatives in the Medical Schools Council to develop the assessment further. This included in-depth conversations with medical school staff about the practical and logistical implications for schools of delivering the AKT and CPSA. We were especially interested to learn about schools' plans in relation to the AKT, as this will be an on-screen assessment provided to medical schools, who will then deliver it to their students.

In September 2019, we published the content map for the MLA, which sets out the skills, knowledge and behaviours that the MLA will test across all its elements. This was developed with input from representatives of medical schools, royal colleges and the Foundation Programme across the UK. We'll update the map over time to reflect changes in medical practice, and we've asked users to tell us how we can enhance it in the future. Publishing the content map was a key step in helping us and our partners begin planning for the introduction of the MLA.

Our Council also agreed to phase the introduction of the MLA, with a pilot year followed by full implementation. Doctors who qualified outside the UK and are not EEA or Swiss nationals[18], who currently take our PLAB exams, will be the first who need to pass the MLA. The requirement will then also apply to UK students. Depending on negotiations between the UK government and the European Union (EU) in light of Brexit, doctors who hold EEA or Swiss nationality may eventually also be asked to pass the MLA.

Supporting medical students to become reflective practitioners

In 2019, we worked with the Medical Schools Council to jointly produce *The reflective practitioner - a guide for medical students*.

We used the views of medical students, doctors and medical educators to explain why being a reflective practitioner is important. Having previously developed broader guidance on reflection, it was clear that providing practical tools early in doctors' careers would help them to develop the skills to reflect effectively, with all the benefits that brings at every stage of medical work.

And we launched learning materials to show students how they can become a reflective practitioner in their daily life as a student and beyond. We based these helpful resources around themes we identified through our engagement with students, including:

- how to have an effective reflective discussion
- how to document it in an appraisal/learning portfolio
- how reflecting can help wellbeing
- how team reflection can improve care across organisations.

[18] Subject to negotiations on the UK's exit from the EU.

The learning materials included a video of a clinical case and two different interactions, which showed how to have an effective reflective discussion. This has been met with positive feedback from both medical students and doctors.

> 'I particularly liked the **contrasting scenarios** and felt they illustrated well how to get the doctor to **reflect effectively**.'
> – Medical student

Our guidance for doctors and medical students sets out the professional values, knowledge, skills and behaviours expected of them in the UK. We listen to the views of doctors, students and the public when developing our guidance, to make sure it's well informed and meets the needs of healthcare professionals and patients. You can read more about consultations relating to our guidance from page 37.

Supporting disabled learners in medical education and training

In May 2019, we published *Welcomed and valued* – new advice for educators on how to support disabled learners and those with long-term health conditions. Making sure that the medical profession is inclusive is vital, and often doctors with health or disability issues are able to provide insight from their own experiences that can improve services for patients.

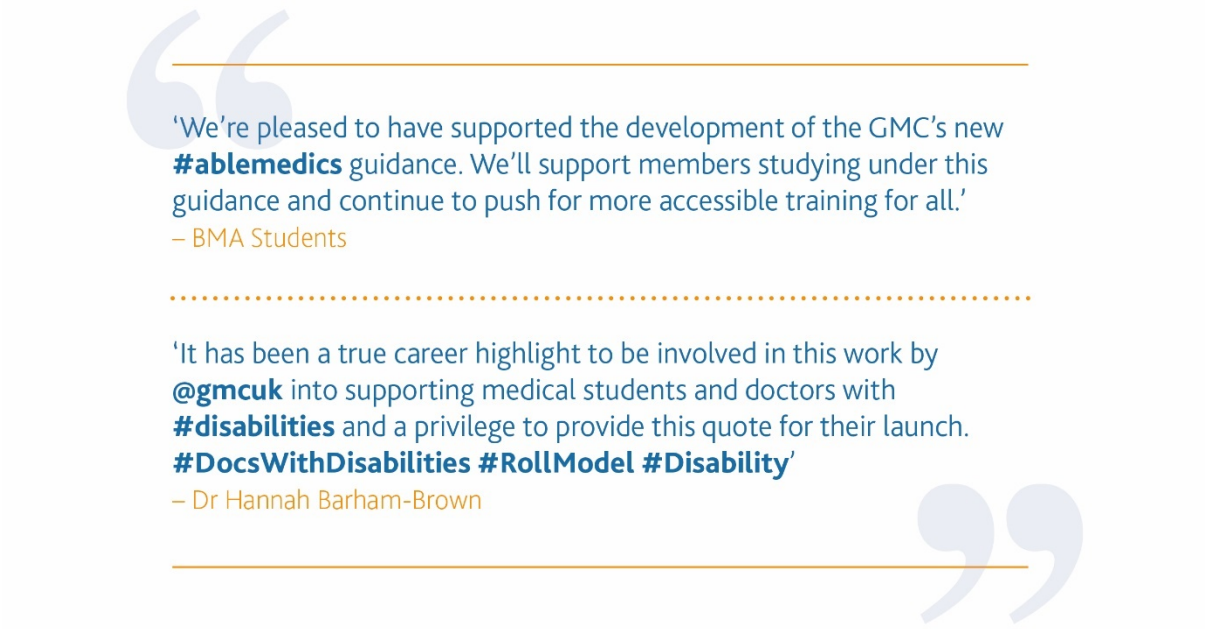
This guidance for medical schools and postgraduate educators builds on our previous guidance, *Gateways to the professions*.

Welcomed and valued includes practical steps for educators to help disabled learners fulfil their potential, such as:

- allocating specific contacts for learners
- agreeing confidentiality arrangements
- creating action plans to make sure learners can meet the demands of their courses or training.

It also includes a summary of relevant legislation and advice on how educators can make reasonable adjustments to support students and trainees through medical school, clinical placements and work settings.

To develop the guidance, we worked with a steering group comprising medical educators, trainers and disabled learners, and we held a number of roundtable meetings to develop practical and relevant guidance.



In July 2019, we released our first podcast series on this subject, *Able medics*. It features disabled doctors talking about their experiences of medical education and practice, as well as the educators who support them. We hope that this, along with our updated guidance, will lead to disabled trainees and students having a more accessible and supportive experience of medical education and training, so they can have fulfilling and sustained careers.

Welcomed and valued is one of a number of the commitments we laid out in our report to UK governments in March 2017, *Adapting for the future: a plan for improving the flexibility of UK postgraduate medical training*.

Strengthening collaboration with our regulatory partners across the health services

We produced our first *Workforce report* to help our partners address the staff shortages across the UK and plan for the future.

We co-produced advice about remote consultations to help doctors.

74% of doctors found the information useful

48% would change their practice as a result

We held **six** UK Advisory Forum meetings in Northern Ireland, Scotland and Wales, engaging with **44** different stakeholders.

Our new Outreach team is helping us build stronger relationships with regulatory partners at local, regional and national levels.

Supporting doctors with additional advice about remote consultations and prescribing

Remote consultations and prescribing – whether by phone, video link or online – have become increasingly popular and offer many benefits.

In recent times, the coronavirus (COVID-19) pandemic has transformed the way we all work, with many doctors delivering care by remote consultations for the first time. While this has been necessary and beneficial, this way of providing care may not always be appropriate or safe in some circumstances. We have previously come across examples of poor practice where patients' safety is put at risk. So, we've worked with other health organisations, doctors and patients to highlight the risks and responsibilities associated with these services.

During the coronavirus pandemic, we are also providing tailored information for doctors switching to remote consultations on our ethical hub.

In November 2019, along with 12 other regulators and health organisations, we co-produced a set of high level principles. The ten principles outline good practice for all healthcare professionals involved in remote consultations and prescribing medication online. They are designed to help protect patient safety and welfare, as well as align guidance across different professions.

Since we published the principles, they have been well received – when prompted for feedback, 74% found the information provided useful and 48% would change their practice as a result.

The healthcare landscape is fast evolving. Since we last updated our advice for doctors on this issue, there has been a significant expansion in the provision of remote consultations and prescribing across the NHS and the independent sector. The coronavirus pandemic has also galvanised momentum for reform of service delivery models to embrace new technology. We want to make sure our guidance is keeping up with the fast pace of change. In 2019, we launched a call for evidence on our remote consultations and prescribing guidance, *Good practice in prescribing and managing medicines and devices.*

We asked organisations and individuals with relevant expertise to share their experiences, views, data and insights about remote consultations and prescribing via telephone, video link or online.

Responses from the call for evidence, together with other information we hold, including the impact of the coronavirus pandemic, are being analysed. This will help us to decide if we should make changes to our guidance and, if so, whether a full public consultation is needed.

Alongside this work, we also used feedback from a patient roundtable, held in June 2019, to shape and inform safety tips for patients accessing healthcare online. The tips were co-produced with other regulators and launched in March 2020.

We have continued to attend cross-regulatory forums to improve safety in online prescribing and consider how to tackle gaps in regulatory oversight. We also share intelligence with other regulators to address specific fitness to practise concerns about health professionals prescribing online.

Working with partners to address risks to patient safety earlier

We have a vital responsibility, along with national partners, to share our unique insight and intelligence and work with other professional regulators to help prevent patient safety issues.

The most effective way to identify and tackle risks at an early stage is through communication, collaboration and coordination – both across the system and across the GMC.

Using intelligence for cross-system intervention in collaboration with regulatory partners

In 2019, the Emerging Concerns Protocol we developed with regulatory partners in England was triggered five times to prevent serious issues occurring. Together with eight other health and social care regulators, we addressed concerns about:

- faulty surgical equipment
- poor rota design
- prescribing via an online pharmacy
- medicine management processes.

The protocol strengthens our existing arrangements and encourages an open culture, where concerns about risks to patients can be shared at an early stage, and where any necessary actions can be coordinated among relevant organisations.

While the protocol currently only applies in England, as part of our regular engagement with professional regulators we've been working with partners in Scotland and Wales to see how it could apply there:

- In Scotland, together with the Nursing & Midwifery Council (NMC), we initiated a discussion with system regulators about how the protocol could work in the Scottish context through the Sharing Intelligence for Health & Care Group. Following this, Healthcare Improvement Scotland has set up a working group, which we are part of, to take things forward.

- In Wales, we have two regular meetings with various healthcare bodies to share information about risks to patient safety and care. The Wales Concordat includes regulators and inspectorates, who share intelligence at high level. And the Healthcare Inspectorate Wales (HIW) convenes a biannual summit that brings together inspectorates and patient safety organisations specifically to share intelligence about providers.

Working with the independent sector to enhance patient safety

Every patient has the right to expect safe, high quality care, both within the NHS and the independent sector. In 2019, we proactively engaged with the Independent Healthcare Providers Network to share information, so we can make sure high standards of care are upheld within the sector[19]. As part of this collaboration, in October, we supported the network by helping promote its new governance framework, led by Sir Bruce Keogh. The framework will play a critical role in guaranteeing consistency and safe patient care across the independent sector.

Alongside this, our outreach advisers continue to regularly engage with responsible officers across the independent sector more generally. This direct line of communication allows us to share insight across the whole breadth of the UK's healthcare systems, supporting responsible officers to address concerns as they emerge.

Using insight to focus our work

Internally, our Patient Safety Intelligence Forum met six times in 2019 to discuss emerging and ongoing risks to patient safety, medical practice and education.

During these meetings, forum members look at risks, what action we've already taken and whether there's anything further we can do to protect patients. They also review the insights we derive from our work to identify trends, issues and areas relevant to patient safety and medical practice that may require further action. As a result of such review, we may refer the information to another regulator, or we may take action through an operational, regulatory, or policy intervention.

[19] The independent sector delivers care to both NHS and privately funded patients in the UK.

Working with UK and European regulators

In 2019, we hosted and chaired quarterly meetings of the Alliance of UK Health Regulators on Europe (AURE), which bring together the nine health and social care regulators in the UK. Cross-regulator collaboration is crucial to respond to European developments, develop common positions and jointly respond to EU proposals and consultations. Our work in 2019 focused on aligning our planning for EU exit, and in jointly influencing UK government legislation intended to mitigate risks associated with EU exit[20].

Alongside this, we also continued to lead our two European networks of regulators to promote and protect patient safety across Europe. We chaired two meetings of the European Network of Medical Competent Authorities (ENMCA), which were attended by medical regulators from across Europe and also by the European Commission. We produced three issues of the Healthcare Professionals Crossing Borders (HPCB) newsletter and hosted a conference that was attended by over 120 representatives of European healthcare professional regulators, professional bodies, and national governments.

Sharing insights into doctors' experiences and the challenges they face

In 2019, we produced our first *Workforce report* to help our partners address the workforce shortages across the UK.

The report showed that the UK's medical register continues to grow, with many international doctors joining our workforce. It also identified some signs of healthcare systems responding to workforce needs, including more doctors training in general practice and other specialties that are experiencing shortages.

However, our data highlighted that health services must prioritise strategies to retain UK and non-UK trained doctors, in the face of system pressures.

We are working with the NHS, system regulators and governments to make sure we have the right workforce in the right place with the right skills and the right support. Since the publication of the *NHS Long Term Plan* for England in January 2019, we were involved in developing the *interim NHS People Plan*, which NHS Improvement published in June.

As we are seeing workforce pressures throughout the medical profession, we have taken on the role of leading the joint regulatory working group for professional regulators on workforce policy to find opportunities to collaborate and align where possible.

[20] See page 46 for more information on our work to prepare for Brexit.

During the Summer of 2019, we updated our workforce manifesto, a document that sets out what we and others can do to support the workforce in the four countries. We've also been supporting the following initiatives in Northern Ireland, Scotland and Wales:

- progressing actions to achieve the Health and Social Care Workforce Strategy 2026 in Northern Ireland
- working with the Scottish government on finalising an integrated workforce plan
- supporting the development of a health and social care workforce strategy in Wales.

As well as this, we're doing all we can as a regulator to make registration routes as accessible as possible, and to increase capacity for PLAB exams and *WtUKP* workshops.

But further action is needed from all those involved in UK healthcare. Publishing data like this and the data seen in *The state of medical education and practice in the UK* is one way we can bring these issues to the fore.

In our ninth edition of the latter, we included new data and insight on trends in medical education, doctors' wellbeing and the role of strong and supportive leadership on workplace cultures. For the first time, we also included dedicated chapters on the specific issues facing GPs, as well as the impact of system pressures on patient care.

The report drew on findings from surveys of doctors working in the UK across various specialties, including data from our national training surveys.

Our findings pointed to changes in the way that doctors are approaching their work-life balance and career development. They showed that doctors are making deliberate choices to manage their careers and wellbeing in the face of increasing workplace pressures.

In the report, we highlighted a range of solutions to help address our findings, including more flexible training and career options, a joined-up approach to regulation, and improving workplace cultures and wellbeing. It's crucial that everyone responsible for the UK's health services works together to take these forward.

Many of our findings are also consistent with the themes and recommendations in the three other independent reports we published in 2019, as part of our *Supporting a profession under pressure* work programme[21]. We have started working to deliver on these recommendations with key partners across all four countries of the UK in 2020.

Alongside this, our annual UK-wide *national training surveys* allow us to hear directly from over 75,000 trainees and trainers about the quality of training in the UK. In 2019, we saw some positive signs, including three quarters of trainees rating the quality of their training as very good or good. However, the findings also highlighted a range of issues affecting

[21] See page 15 for more information.

doctors' wellbeing, which could ultimately impact on patient care. These survey results are invaluable in providing us with information and evidence on where areas of best practice are, as well as areas where improvements need to be made. We continue to work with postgraduate deans and employers to address any local concerns or issues raised in these surveys.

Our regulatory partners and strategic stakeholders have welcomed these reports. Our research, together with the independent reviews we commission, helps us and others make sure our policies and decisions are based on up-to-date evidence. You can find all published research reports and insight papers on our website.

Strengthening our local connections through our Outreach teams

In 2019, we restructured our Outreach function, so we could work more closely with doctors, patients and local healthcare economies, and support them in the best way possible.

Our Outreach teams are an integral part of our organisation, and play a valuable role in supporting the UK's healthcare systems. Crucially, they will help us to take forward the recommendations from the *Supporting a profession under pressure* programme. Read more about this important work from page 15.

Outreach advisers work with doctors, healthcare providers, educators and other regulators to:

- improve understanding of our role
- promote and support excellence in medical education, training and practice
- learn about the environments in which doctors practise, helping to identify and address risks to patients and doctors before harm occurs
- work with responsible officers to address concerns about doctors and support management with concerns at a local level
- support the continuous development of local clinical governance systems, making sure that revalidation continues.

Under the new model, our outreach work in England is now organised in regions, alongside national offices in Northern Ireland, Scotland and Wales. In England, this aligns us with the direction the NHS is taking, with a shift to more integrated care systems and the regionalisation of NHS England and NHS Improvement.

We've also integrated our Employer Liaison Service into our already well-established national offices, aiming to strengthen existing relationships with stakeholders by delivering an end-to-end experience within the devolved countries.

This new structure will help us:

- have a better understanding of local issues and priorities
- build even stronger relationships with regulatory partners and stakeholders at local, regional and national levels
- use our unique position, data and insight swiftly and effectively to continue to protect patients, reducing the need for us to intervene after things go wrong.

Maintaining an equal and effective regulatory approach across the UK

In 2019, we held six UK Advisory Forum meetings in Northern Ireland, Scotland and Wales, engaging with 44 different stakeholders.

Our advisory forums help us to make sure our regulatory approach takes into account the needs and differences of each of these countries' healthcare systems. The forums include representatives from key interest groups and delivery partners. They give us a platform to share policy developments, priorities and challenges, and are an opportunity for stakeholders to contribute to and influence our work.

The main areas of discussion in 2019 were:

- key themes from our Supporting a profession under pressure programme
- upstream regulation: preventing harm and supporting professionalism
- the medical workforce: quality and safety
- systems and collective assurance.

We are looking at how we can apply the same principles of local working in the regions of England.

Read more about the work we do through our advisory forums.

Establishing a new Strategic Relationships Unit and strengthening our public affairs work

To build on the model in our national offices in Northern Ireland, Scotland and Wales, we established a Strategic Relationships Unit, which is responsible for enhancing the way we work with others in the political and healthcare environment.

The unit works with teams across the GMC to coordinate our relationships with regulatory partners and strategic stakeholders. This group includes fellow regulators, national health bodies, employers, education bodies and colleges, medical defence organisations and national patient groups.

Strengthening our partnerships with other stakeholders in the UK's healthcare systems is helping us achieve the objectives we set out in our corporate strategy. And, ultimately, it will enable us, collectively, to create and maintain environments where doctors are fully supported to deliver high-quality care.

The new unit works in close coordination with our Public Affairs team, which is responsible for maintaining and developing our relationship with the UK government. Thanks to the work of this team, during the 2019 UK general election we made a concerted attempt to influence the manifestos of the four largest parties represented in Westminster. We worked with each of the parties' manifesto writers around specific initiatives we have long advocated for, for example Certificate of Eligibility for Specialist Registration (CESR) and Certificate of Eligibility for GP Registration (CEGPR) reform[22].

In addition, we coordinated an open letter, which was signed by the Chief Executives of all eight UK-wide professional medical regulators, addressed to the main four party leaders. The letter set out, in broad terms, the case for reform of medical regulation, and asked the next government to commit to comprehensive reform of professional medical regulation. It was the first time an open letter involving all of our fellow regulators had been produced. As a result of this effort, we secured commitments to reform in two of the four manifestos.

[22] See page 47 for more information on the improvements we have made to the CESR/CEGPR process while we wait for changes to the legislation.

Strengthening our relationship with the public and the profession

Over
6,400
associate specialists and locally employed doctors took part in our survey to hear their views.

The Patient Liaison Service supported **392** patients, relatives, or members of the public who had raised concerns about a doctor.

96% of those surveyed rated their meeting with the service as 'very good' or 'good'.

7,358
people used our real-time direct messaging service, via our website, enabling people another way to get in touch with our Contact Centre.

616 doctors

93 patients/public

43 Stakeholder organisations

16 RO's/medical directors

Supporting patients who raise a concern about a doctor

Raising concerns about a doctor can be a stressful experience. We always strive to make it clear to patients what they can expect during their interactions with us and provide some reassurance, during what can be a very difficult time.

As part of this, in November 2019, we published our new Charter for patients, relatives and carers. It sets out six commitments that patients and their relatives and carers can expect when they raise a concern with us. We used feedback we received from patients as the basis for the charter and then developed it further, incorporating feedback from patients and their representatives.

One of the commitments, 'communicate in a way that works for you', points to the vital work our Patient Liaison Service (PLS) has been doing since 2015.

In 2019, the PLS team supported 392 patients, relatives, or members of the public who had raised concerns about a doctor. 96% of those surveyed rated their meeting with the service as 'very good' or 'good'.

-

> 'I believe that if this is the general standard of your Patient Liaison Service **the GMC has much to be proud of**. Friendly knowledgeable and entirely approachable professional who talked us through the whole GMC process by putting us at our ease because she listened and managed our expectations whilst balancing the potential outcomes of this complaint.'
> – Patient Liaison Service user

As well as showing patients what they can expect from us, we are keen to learn more from patients about their interactions with us and use this information to make improvements to the services we offer.

In 2019, we set about improving our collaboration with patient groups through our new Strategic Relationships Unit. We delivered two roundtables with patients and public representatives from across the UK, inviting their valuable input into some priority work areas. The events focused on:

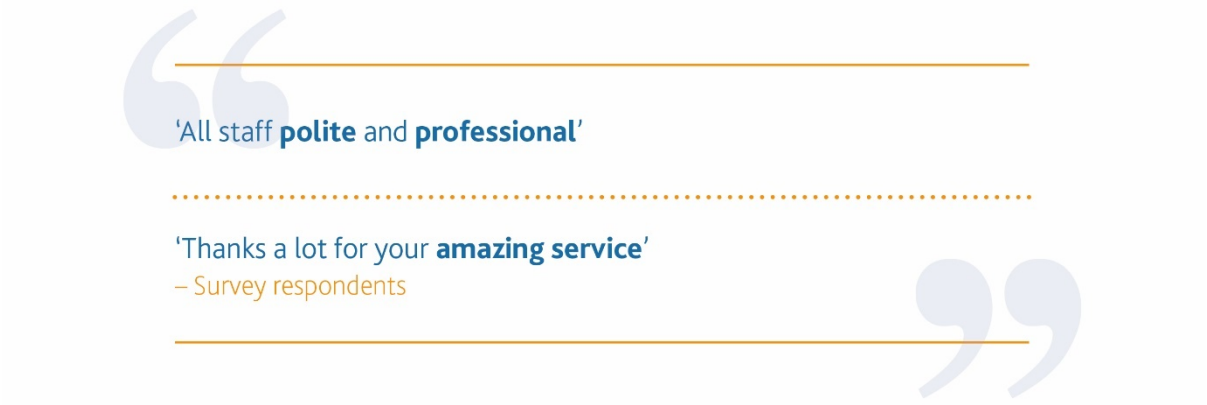
- our better signposting work
- remote prescribing advice for patients
- our patient charter
- our next corporate strategy.

Our new Patient Champion, Una Lane, also attended the roundtable and highlighted our ongoing commitment to making sure the diversity of patient needs continues to be taken into account in our work.

Improving our support for witnesses

Witnesses play a vital role in helping us to protect the public. And, in recent years, we've taken measures to step up our support for them, including appointing a single point of contact for every witness.

In 2019, we introduced a survey to further improve our understanding of witnesses' experiences and to assess the effectiveness of our enhanced support. The positive feedback, particularly in response to our approach to interviewing witnesses and taking their statements, highlighted the impact our improvements were having.



Our commitment to reducing some of the burden associated with being a witness doesn't stop there.

We've rolled out bespoke training for our staff, including our Legal Services team, so they are confident in helping witnesses who may be in distress at hearings.

As well, in February 2019, together with the NMC, we commissioned an independent telephone support service for witnesses from the charity Victim Support. The round-the-clock service offers additional emotional support to witnesses and their family or friends throughout the entire course of an investigation. Since its introduction, we have seen an increase in uptake of the service throughout 2019.

And through our joint work with the MPTS, we're starting to see the benefits of a new witness waiting area, improved witness rooms and clearer communications.

Witnesses are central to our work to keep patients safe. We'll continue to listen to their experiences and develop our people, processes and communications accordingly. Our next focus is improving the experience of giving evidence during the hearing.

Involving the public and doctors in developing our guidance

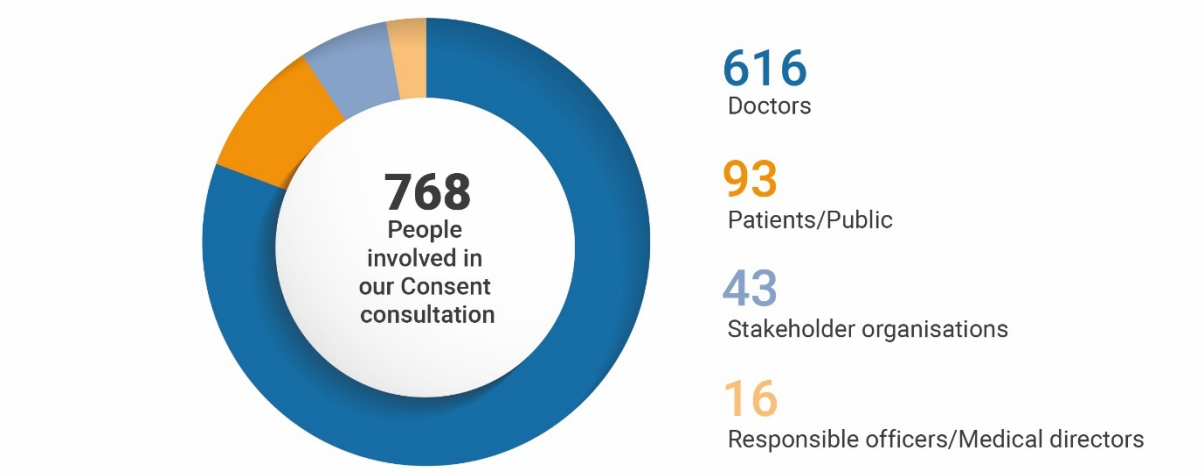
Consultations with the public, doctors and stakeholders are a crucial part of how we shape our policies and guidance.

February 2019 marked the end of a major review of our core guidance, *Consent: patients and doctors making decisions together*. The review included an extensive consultation with patients, members of the public, doctors, responsible officers and other stakeholders.

In the revised guidance, approved by our Council in November 2019, we encourage doctors to focus on the importance of communication and personalised conversations. And we highlight the importance of doctors and patients making decisions about treatment and care together. We've also planned a range of communication and engagement activities to help doctors put the new guidance into practice.

From April to July 2019, we also consulted on new guidance relating to patient feedback for revalidation. Our aim is to make it easier for patients to give their feedback and to increase the value of the feedback for doctors' learning. We also want to support a wider range of patients to be able to give their views about the care they receive.

To support the consultation, we ran a comprehensive communications campaign using all our channels – web, ebulletin, social and more – distributing engaging content including blogs and videos. As a result, we received nearly 800 responses in total, mostly from doctors and members of the public.



Since then, we've analysed the feedback and reported the outcome of the consultation, and we aim to publish the updated guidance in 2020.

Investing in communication with doctors and the public

Our Digital Transformation 2020 programme has been transforming the way we communicate, engage and interact with our customers online – making sure we provide a better experience for the public and for doctors across our digital channels.

Tone of voice

As well as expanding our communication channels, throughout 2020, we're rolling out training to help colleagues communicate more clearly and compassionately.

Effective communication is essential for the public and doctors to be able to understand and engage with us easily. Whether it's our email correspondence, standards, or instructional information, we aim to tailor our approach to all our audiences' needs.

In a dynamic healthcare context, it's essential for us to routinely review our communications and train colleagues in best practice.

In 2019, we initiated a series of training workshops for teams across the organisation, helping them to optimise accessibility, clarity and empathy in their communications.

This builds on our existing e-learning course for effective communications, as well as our community of Tone of Voice Champions who provide local support.

Live Chat

From March to December 2019, we piloted Live Chat, a new, user-friendly way for people to get in touch with our Contact Centre online. In 2019, 7,358 people used this real-time direct messaging service, offered via our website.

Surveys sent to users after the chats ended revealed that 93.3% of them were 'very satisfied' or 'satisfied' with the service.

This digital chat option will help us improve the services we currently offer. It gives members of the public and doctors more options to contact us, in a way that suits them. And it's beneficial to those people who may find it difficult to contact us using the phone.

The insight we can gain from Live Chat will also help us to improve and tailor our website, so the public, doctors and other stakeholders can find what they need more quickly and easily.

And providing this additional service should ultimately reduce the number of phone calls – meaning we can provide an even more efficient service for the public and for doctors.

Following the pilot, we've been refining and improving the service based on what we have learned, to maximise its effectiveness in the future.

Twitter takeover by one of our clinical fellows

In August 2019, Dr Latifa Patel, one of our clinical fellows, took over our Twitter channel as part of *#TipsForNewDocs*.

This annual social media campaign encourages healthcare professionals to share advice for incoming foundation doctors.

The initiative generated a positive conversation with doctors at various stages of their careers.

Throughout 2019, we also continued to share more user-centred information via our *GMC news for doctors* email bulletin. We tailor the content specifically to help different types of doctors, including international medical graduates, GPs, specialists and doctors in training.

Raising awareness of our ethical guidance

New social trends and the rise of technology have brought about some exciting opportunities for doctors. But they've also made certain interactions with patients more sensitive and complex. We've been working to raise awareness of our guidance to support doctors with some of these emerging challenges through the British Medical Journal's Careers Clinic advice column. The feature is made up of independent advice from three different sources.

In 2019, we weighed in on topics, including:

- *What to do if a patient wants to record a consultation*
- *A patient has complained about me online. What should I do?*
- *Whether doctors can endorse commercial products or apps*
- *Can I use a family member as a patient's translator?*
- *What doctors should do if a patient makes a bequest to them in their will*
- *Whether doctors should report to the Driver and Vehicle Licensing Agency if a patient continues to drive against medical advice.*

It's been heartening to see users engaging with the content, and thinking about what the guidance means in practice for example. The piece on patient recordings was hugely popular on social media – garnering 98 likes, 67 retweets and 20 comments.

We will keep making contributions in 2020 to support doctors with issues arising from the coronavirus pandemic. We are confident in doctors' expertise and hope this guidance provides some reassurance.

Understanding more about specialty and associate specialists and locally employed doctors

Specialty and associate specialists (SAS) and locally employed (LE) doctors make a hugely valuable contribution to the UK's health services. More than 45,000 doctors on the medical register are SAS or LE doctors, and the number of doctors choosing to work in these roles is increasing.

To help widen our understanding of their workplace experiences, in May 2019, we launched a new survey dedicated to gathering their views. Over 6,400 doctors from across the UK took part.

Many of the doctors surveyed said they are satisfied with their role and feel supported by colleagues and leaders where they work. However, a significant proportion told us they face challenges related to their role, including:

- difficulties accessing training and continuous professional development opportunities
- unsupportive work environments, bullying and undermining
- inconsistent awareness of and access to SAS specific guidance and support
- feeling burnt out due to their work.

Our initial findings report explores these key areas, and sets out what we intend to do next.

Many of the themes from this survey relate closely to the recommendations in *Caring for Doctors Caring for patients* and *Fair to refer?,* which we commissioned as part of our *Supporting a profession under pressure* programme of work[23]. We're now focusing on how we can take all this work forward and work with partners to drive lasting change, improving the working lives of doctors across all roles and specialties.

Strengthening our relationship with medical students

A key part of our work is helping to prepare medical students for practice by making sure they learn what they need to know to be a good doctor.

In 2019, our Outreach teams engaged with over 12,700 students studying medicine across the UK. The teams delivered sessions for medical students on a range of topics, including *Good medical practice*, reflection, and health and wellbeing. Documents like *The reflective practitioner - a guide for medical students* have demonstrated the significance we place on supporting the future medical workforce with practical guidance.

[23] Read more about the *Supporting a profession under pressure* programme of work on page 15.

We have a range of resources for medical students on our website and keep students up to date about our work through our e-bulletin *GMC news for students.*

In September 2019, we launched our annual *Welcome to medicine* guide for first year medical students. It features links to relevant guidance and support, practical tips for life at medical school, and advice from fellow students.

We invited students to let us know what they thought about the guide, so we can continue to improve the resource and tailor it to students' needs. The positive feedback we received shows us the value of this resource for students. 323 students responded to our call for feedback, and told us they had learned about guidance and professionalism, as well as about the support available to them.

> 'The GMC **cares about medical students** from the start and work hard to ensure medical schools are training new doctors to the **best of their ability** in order to **support patients** in the future.'
> – Survey respondent

Over the Summer of 2019, we also ran our fourth annual professionalism competition with the Medical Schools Council. We asked students to create a teaching session to help their peers understand what our joint guidance, *Achieving good medical practice,* says about speaking up. We received 48 entries, nearly 20% more than the previous year. 72 students were involved, and they represented all year groups and 24 medical schools from across the four countries of the UK.

Meeting the changing needs of the health services across the four countries of the UK

Following the opening of our new Clinical Assessment Centre, we are now able to test around

11,000

doctors each year, meeting the rising demand for internationally-qualified doctors.

We began a phased introduction of **credentials**, which will provide assurance for patients about a doctor's skills, as well as more flexibility for doctors.

We continued to explore options for allowing greater flexibility, accessibility and speed for doctors to join the **Specialist and GP registers**.

We continued to prepare for Brexit by engaging with stakeholders to make sure that exiting the EU does not deter EEA doctors from coming to work in the UK and contributing to the NHS.

Meeting the rising demand for exam places for internationally-qualified doctors

Patient safety depends on the existence of a well-resourced and well-developed medical workforce, across different sectors of the UK's healthcare systems and within different specialties. And, as with other healthcare professions, this depends on a regular influx of international doctors moving to live and work in the UK.

Our new Clinical Assessment Centre

In August 2019, our new Clinical Assessment Centre hosted its first PLAB test. The test is the main route for internationally-qualified doctors to demonstrate to us they have the skills and knowledge to provide excellent patient care.

Demand has grown steadily for the assessment. The new centre comprises two test circuits, each catering for 18 candidates at a time – doubling our existing capacity. This means we are now able to test around 11,000 doctors each year, twice the number we were able to accommodate previously.

Doctors taking the assessment face a series of practical scenarios, in specially designed consultation rooms, where their ability to care for patients is tested and monitored by examiners. The scenarios reflect real-life consultations, some with animatronic models and others with actors playing the roles of patients.

Ahead of the centre's official launch, we held a media open day, giving the public a rare chance to see our work behind the scenes and get an insight into the rigorous assessments internationally-qualified doctors must pass to work in the UK.

The reception area at our new Clinical Assessment Centre at 3 Hardman Square, Manchester

72 doctors, who qualified in countries as diverse as Libya, Ukraine and the Philippines, were the first to take the rigorous half-day assessment of their practical skills at the new centre at 3 Hardman Square in Manchester.

Between then and the end of 2019, 4,760 candidates took PLAB 2 exams across 68 sessions in the new centre.

International doctors make an important and valuable contribution to the UK's health services. That's why we want to offer candidates as much flexibility as we can, and help doctors prepare for UK practice as quickly as possible, while retaining the high standards we require.

We expect the new centre will reduce waiting times for doctors who want to relocate to the UK, ultimately helping ease pressure on already stretched health services across the four countries.

Extending our services across the four countries of the UK

In order to meet the needs of the UK's health services, we've also extended the range and location of other services we offer to international doctors across the UK, with a particular focus on expanding the services available in Northern Ireland, Scotland and Wales[24].

The map on page 45 shows the number of licensed doctors in each of the four countries of the UK, at 31 December 2019, based on where they gained there primary medical qualification.

Besides opening our new Clinical Assessment Centre in Manchester, we now also offer our PLAB 1 test in each of the four countries in the UK, after opening the doors of our new Belfast office to candidates for the first time.

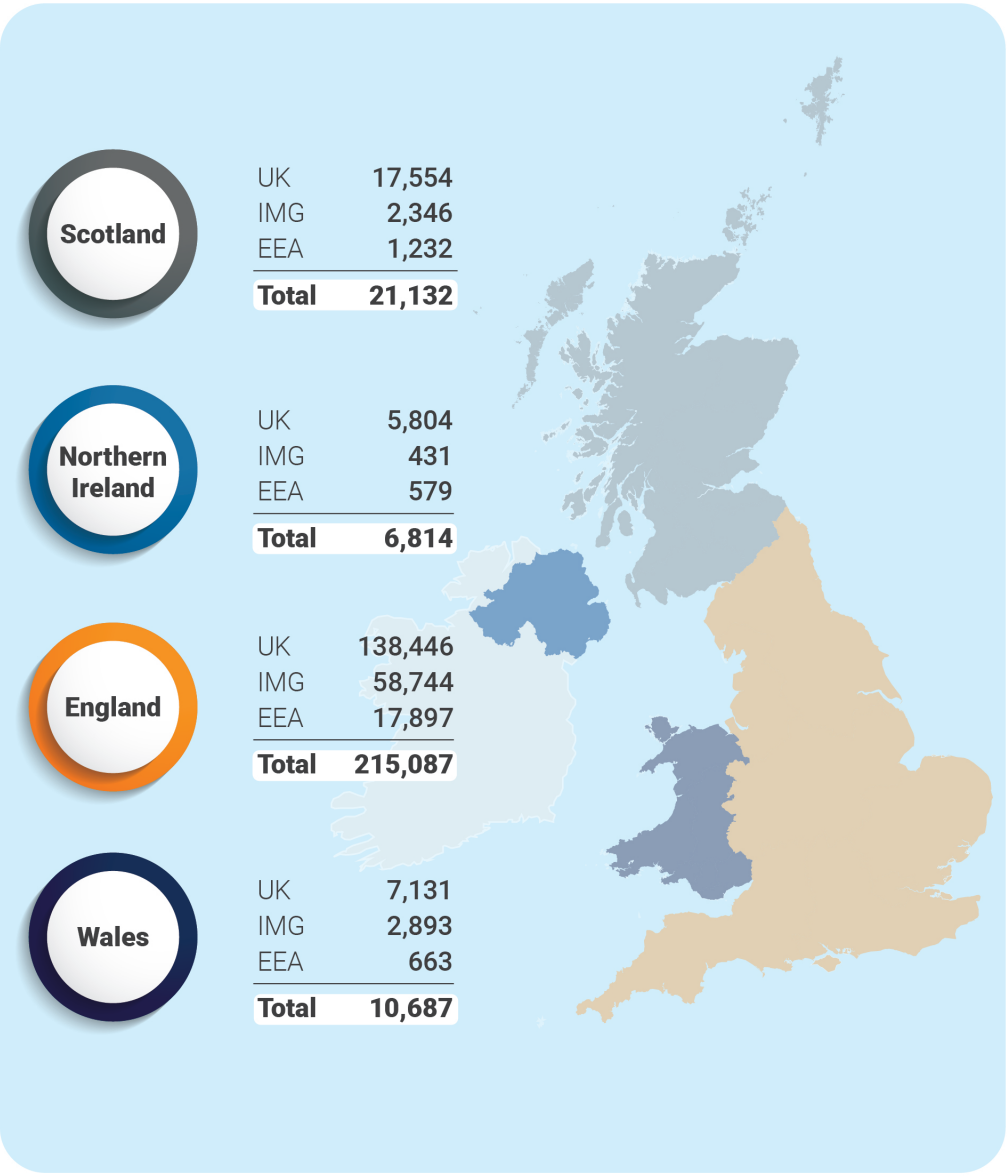
We also increased the availability of PLAB 1 around the world. Most PLAB venues worldwide are now holding PLAB 1 four times a year, increased from twice a year, creating over 1,500 additional places annually. Candidates will also be able to sit the test in mainland Europe, as we'll be running PLAB 1 also in France.

To help internationally-qualified doctors adapt to medical practice in the UK, we also increased the number of *WtUKP* workshops we offer across the four countries[25].

[24] See page 12 for more information about extending our services across the UK.
[25] See page 19 for more information on our *WtUKP* workshops.

By increasing the flexibility and speed with which international doctors can join the UK medical register, and supporting them in adapting to UK practice, we're helping to relieve the pressure on doctors and on the UK's healthcare systems.

Number of licensed doctors at 31 December 2019



Scotland

UK	17,554
IMG	2,346
EEA	1,232
Total	**21,132**

Northern Ireland

UK	5,804
IMG	431
EEA	579
Total	**6,814**

England

UK	138,446
IMG	58,744
EEA	17,897
Total	**215,087**

Wales

UK	7,131
IMG	2,893
EEA	663
Total	**10,687**

Other

UK	599
IMG	3,779
EEA	2,215
Total	**6,593**

Total

UK	169,534
IMG	68,193
EEA	22,586
Total	**260,313**

'Other' comprises doctors for whom we don't have a UK address.

Introducing GMC-regulated credentials

In February 2019, we completed engagement on a draft framework for introducing GMC-regulated credentials, hearing from stakeholders across the UK at approximately 50 meetings and through 175 written submissions.

GMC-regulated credentials are intended to improve patient safety by enabling doctors to train in a specific area of practice outside of specialty training where there is a patient safety need or a significant service requirement. They are designed to help the profession to adapt to the future needs of patients and to maintain consistent standards across the UK and will help to make training more flexible.

In June 2019, our Council approved the credentialing framework, subject to a phased introduction starting with a small number of early adopters and with a review point once they are developed.

We have approved the following areas as early adopters: liaison psychiatry, interventional neuroradiology (acute stroke), pain medicine, cosmetic surgery, and rural and remote medicine. They provide an opportunity to introduce regulatory oversight in areas with a significant need.

We will evaluate the impact of the credentials and or related processes before accepting any further submissions.

Preparing for Brexit

On 31 January 2020, the UK formally left the EU and is now in a transition period until 31 December 2020.

Doctors holding EEA nationality are a vital part of the UK medical workforce. So we've continued to engage with stakeholders to make sure that exiting the EU does not deter doctors who are EEA nationals from coming to work in the UK and contributing to the NHS.

As part of this, we've been working to influence the negotiations between the UK and the EU, to make sure we can continue to register EEA nationals promptly and efficiently. We're also working with officials and our international counterparts to make sure that patient safety is recognised and protected in any future trade agreements signed between the UK and other countries.

In the Republic of Ireland, we continue to regularly meet with the Medical Council of Ireland. Together, we're drafting a memorandum of understanding, which will allow us to continue to share fitness to practise and registration information with each other also after the transition period. This is a priority for us as it enables us to make sure that patient safety continues to be protected across the island of Ireland.

Doctors from the EEA will continue to seek registration in the UK, so we must continue to work with other regulators and EEA countries to understand their regulatory regimes. It's also important that we maintain an influence on European legislative developments.

Increasing the flexibility and speed for doctors to join the specialist and GP registers

We continue to explore options for allowing greater flexibility and accessibility for doctors wishing to gain GP and specialist registration. Throughout 2019, we engaged with key stakeholders to explore our initial policy ideas for improving the existing processes to apply for a CESR or CEGPR.

In January 2019, we held workshops with representatives from each of the medical royal colleges and faculties. We intended through these to explore our initial policy thinking around improving the existing CESR/CEGPR process, as well as challenges and barriers to implementing change. Throughout May 2019, we also engaged with SAS doctors, responsible officers, doctors in training and employer organisations.

Interestingly, similar themes arose at each of the different stakeholder events, with attendees raising the same challenges and barriers to the existing process. This initial phase of engagement also cemented the validity of our policy proposals and highlighted some areas where further exploration is needed.

Throughout 2020, we'll continue to explore how we can address the challenges that stakeholders have shared with us.

Equality, diversity and inclusion

We are committed to representing, reflecting and supporting the diversity of the UK in everything we do.

Equality, diversity and inclusion (ED&I) are integral to us being a fair, effective regulator and employer. So we continue to invest in this important area – championing equality and diversity in all our activities, and making sure everyone feels connected, engaged and able to fulfil their potential.

Embedding equality and diversity in our work and culture

In the second year of our *Equality, diversity and inclusion strategy 2018–20*, we have advanced on our ED&I work through the following initiatives.

Improving understanding of equality and diversity within the wider healthcare environment

- As part of our *Supporting a profession under pressure* programme, we published *Fair to refer?*, an independent report exploring why we receive referrals involving some groups of doctors more or less frequently than others. The findings, along with details about how we'll take forward the recommendations, are summarised on page 17.
- We held conversations with responsible officers about local safeguards, to make sure clinical governance arrangements for doctors are fair and free from bias and discrimination. This will give us the assurance that concerns being raised with us by responsible officers have been through a robust and fair local process.
- We engaged closely with the royal colleges and faculties on their role in tackling differential attainment, achieving commitment from stakeholders across the education system to work collaboratively and in a coordinated way to deliver fair training pathways.
- We began developing guidance and signposting on personal beliefs for medical education and training providers.

Engaging in discussions about equality and diversity

- Our new external ED&I Strategic Advisory Forum, which provides helpful advice on the delivery of our ED&I objectives as a regulator, held its first meeting in 2019.
- We continued to engage with our Black and Minority Ethnic (BME) Doctors Forum to respond to BME doctors' needs.
- We supported discussions about the formation and implementation of the NHS Workforce Race Equality Standard.
- We actively supported the PSA pilot on the implementation of a new Equality and Diversity standard as part of their standards of good regulation.

Continuous improvement

- We appointed a new supplier who will carry out an audit into how we check for fairness in our fitness to practise activities.
- We conducted an internal audit into the way we record and act on the communication requirements of people with disabilities, to make sure we are effectively taking steps to consider and meet their needs.
- We conducted an internal audit to identify how we might strengthen our management of our equality impact assessment (EqIA) processes, making sure we have effective, measurable and monitored quality standards in place for EqIAs.

Creating more inclusive environments

Promoting and supporting diversity involves creating an inclusive environment – one where everyone feels valued, able to participate and able to achieve their potential.

In 2019, we carried out a gap analysis to understand how we can become a more inclusive organisation. And we ran workshops with colleagues to shape how we could implement the recommendations from this analysis as part of a five-year plan starting in 2020.

We also worked to enhance inclusion through the activities below.

Reducing the gender pay gap

In January 2019, we made changes to our pay bands, to help reduce our gender pay gap. This was supplemented with changes to our pay system that we applied from April 2019. Our gender pay gap in 2019 was 14% (compared with 15% in 2018). We're continuing to review our strategies in this area, aiming to further reduce the gap.

Investing in staff networks

Our staff networks bring people across the organisation together, providing a supportive forum and raising the profile of individual's experiences and views.

- We established two new staff networks – the Black and Minority Ethnic network and the Muslim network, bringing the number of our diversity staff networks to six.
- Network chairs now meet on a bi-monthly basis to collaborate and adopt an intersectional approach to their work. This has resulted in several joint awareness raising initiatives, for example, the LGBTQ+ Network and Mental Health Network delivering a joint event to raise awareness of mental health issues experienced within the LGBTQ+ community.
- Throughout the year, our networks delivered several successful campaigns to raise awareness of key events, such as Black History Month, Mental Health Awareness Week, LGBT History Month and International Women's Day.
- The networks also delivered a range of awareness-raising activities – for example, our Muslim network delivered Hajj Awareness Workshops, to help colleagues understand the importance of Hajj for Muslims, and how to support staff and colleagues going on Hajj.

Improving awareness of inclusion

We have also continued to invest in general awareness and communication activities about equality, diversity and inclusion in the wider regulatory environment.

For example, in 2019, Dr Michael Brady, the first National Advisor for LGBT Health at NHS England, talked to our staff about his role to address health inequalities for LGBT individuals and improve experience in the NHS.

We also invited three disabled doctors to discuss the challenges they face in studying and practising medicine. As part of this, Dr Robina Shah gave a presentation on the University of Manchester's Doubleday Centre for Patient Experience and its ground-breaking work to involve patients and the public in doctor training.

We value diversity within the medical profession and within the GMC very highly, and we have made a lot of progress embedding equality and inclusivity in everything we do. But there is more we can do in this very important area, and we are committed to building on the vital work we have already done.

Improving our performance

Our ability to deliver our role effectively rests on our people, systems and ways of working.

Throughout 2019, we continued to invest in embedding our values – integrity, excellence, collaboration, fairness and transparency – in every aspect of our work. From investing in people and championing equality and diversity, to finding more sustainable solutions to our everyday activities, we are committed to improving our performance.

Investing in our people

Our greatest strength in delivering our work is our people, who are committed to going the extra mile to protect patients and support doctors.

Our annual staff survey provides us with a detailed picture of how our colleagues experience different aspects of working at the GMC and highlights areas we can improve.

Training and development

- We continued to invest in development secondments, which give staff opportunities to learn new skills and knowledge within another area of the organisation. In 2019, eight colleagues took part in development secondments.
- As part of our efforts to support leaders and managers in their work, in January 2019, we introduced a new training programme designed to further enhance their leadership skills. The programme comprises face-to-face sessions, webinars and online self-assessment exercises, aimed at helping staff better understand and apply the critical leadership behaviours that are in line with our values and our goals.
- In line with our commitment to increase autonomy and empowerment in our staff, we launched an empowerment training curriculum. This course gives colleagues in operational roles the skills and resources to become more effective in making decisions relating to their work.
- We rolled out a programme of Human Factors training[26] for our fitness to practise case examiners, and the medical experts used involved our fitness to practise processes.
- We continued to develop and expand the 360-degree feedback programme we introduced in 2018. The programme, called Feedback for success, aims to encourage open discussions between staff and their manager to help them structure their personal development, based on feedback from colleagues.

[26] See page 20.

Health and wellbeing

Our independent report *Caring for doctors, Caring for patients*[27] highlighted the importance of health and wellbeing at work. As well as our work to support doctors, we have developed a number of initiatives to support the health and wellbeing of our colleagues. This includes developing a network of wellbeing champions who actively promote a positive and healthy working environment, and calm spaces for staff to take a break.

We also worked on developing a Health and Wellbeing plan, uniting all our current initiatives and clearly laying out our commitment to supporting our people. And we continue to review and enhance our wellbeing and resilience provisions, to meet the needs of our staff.

Investors in People

In November 2019, Investors in People[28] acknowledged that our continued work to develop and support our staff had put us on track to achieve their gold award in 2021. This builds on the silver accreditation we achieved in 2018.

In recognition of the key role our staff have in delivering our purpose, our next corporate strategy for 2021 to 2025 will also have a strong focus on continuing to invest in our people.

Freedom to speak up

Safe, positive work environments are crucial – for everyone who works for us and with us. In 2019, we made progress towards achieving a successful speak-up culture, where issues that could threaten these working environments are raised and addressed.

Since Lindsey Mallors, Assistant Director for Audit and Risk Assurance, became our Freedom to Speak Up Guardian in March 2019, we have appointed 16 cross-organisational Freedom to Speak Up Champions. Collectively, they provide a safe place and an alternative route for colleagues to raise concerns. As well as helping to address concerns, the champions build confidence in our speak-up culture by sharing communications and messages about the themes arising from concerns raised and how they are being addressed.

Throughout October 2019, which is Speak-up Month, we made a special effort to raise awareness of speaking up, along with other healthcare organisations. As part of this, we

[27] See page 16.

[28] The Investors in People accreditation is a recognised standard of high performance in business and people management, and a well-known sign of a good employer.

welcomed Dr Henrietta Hughes, National Guardian for the NHS, to talk to us about NHS cultures, the impact of the guardian's network and the types of issues that are raised.

Actively promoting opportunities to raise concerns is a clear way to put our transparency and integrity values into practice. We'll continue to develop a culture where colleagues can speak up openly and without the worry of detriment to their wellbeing or their professional development.

Social responsibility initiatives

We strive to contribute to society and the environment by making socially responsible decisions that have a positive impact on the people and the world around us. In 2019, we:

- improved recycling facilities across all our offices – an initiative driven by our staff-led Green Group, which influences our sustainability policies
- made sure that 98% of waste created from fitting out our new Clinical Assessment Centre was diverted away from landfill, with 89% being recycled
- supported staff in participating in a number of charity and fundraising initiatives, including donating coats to Wrap Up Greater Manchester and essential items to Mustard Tree
- worked with the Social Mobility Foundation to encourage people from diverse backgrounds to consider a career in medicine.

Throughout 2019, our Corporate Social Responsibility Working Group promoted and embedded our social responsibility initiatives across the organisation.

As well as these initiatives, we are proud to be a Living Wage employer. We've been committed to always paying our staff above the Living Wage since 2014. And in our standard supplier contract, we specify that all staff employed by our suppliers must be paid a living wage as a minimum.

From standalone initiatives, to everyday activities, social responsibility is at the core of our organisational culture. And, in 2020, our corporate social responsibility agenda will play an even stronger and more strategic role in every aspect of our work.

Our structure, governance and management

Council and other governance groups

Council is our governing body. Its role is to provide strategic direction, hold the executive to account and take major high-level policy decisions. It comprises 12 members from the four countries of the UK, six of whom are medical members and six of whom 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 PSA's guidance for making appointments to healthcare professional regulatory bodies.

The trustees between 1 January 2019 and 31 December 2019 were:

- Mr Steven Burnett, FIA
- Dr Shree Datta, MBBS BSc (Hons) MRCOG LLM MD (resigned as of 2 December 2019)
- Lady Christine Eames, OBE LLB MPhil
- Professor Anthony Harnden, MB ChB MSc FRCGP FRCPCH
- The Rt Hon Lord Hunt of Kings Heath PC OBE
- Professor Deirdre Kelly, CBE MD FRCP FRCPI FRCPCH DL
- Professor Paul Knight, OBE, MBChB, FRCP (Edinburgh, Glasgow, London) FRCPI
- Dame Suzi Leather, DBE MBE MA BA BPhil CQSW LLD (Hon) FRCOG (Hon) FRSH (Hon) DL
- Dr Michael Marsh (appointed 1 January 2019, resigned with effect from 31 March 2019)
- Dame Clare Marx, DBE DL FRCS
- Dame Denise Platt, DBE BSc Econ FRSA AIMSW
- Miss Amerdeep Somal, LLB

Dame Clare Marx was appointed by the Privy Council as the new Chair of the General Medical Council, succeeding Professor Sir Terence Stephenson in January 2019. All Council members participated in appraisal reviews in 2019, which included consideration of any learning and development needs, and revisiting actual or perceived conflicts of interest to make sure any conflicts identified are manageable.

In 2019, the Council has continued to monitor delivery against the action plan created following the 2018 Council Effectiveness Review, which highlighted that trustees are confident in their compliance in most areas.

Council members are also asked to declare any conflicts of interests. The register of interests, which contains the declared interests of Council members, is published on our website[29].

As a charity, the GMC takes into account the seven principles set out in the Charity Governance Code (2017) and can demonstrate how it uses these principles to guide its work on an 'apply or explain' basis.

There are two exceptions to the Code, which we explain rather than apply. Firstly, our Council and committees operate without a formally appointed vice or deputy chair. However, provisions are made in the Governance Handbook for chairs to nominate a deputy to assist during periods of absence. Secondly, as our appointments process is well established and thorough and is overseen by the PSA, a nominations committee is not considered necessary.

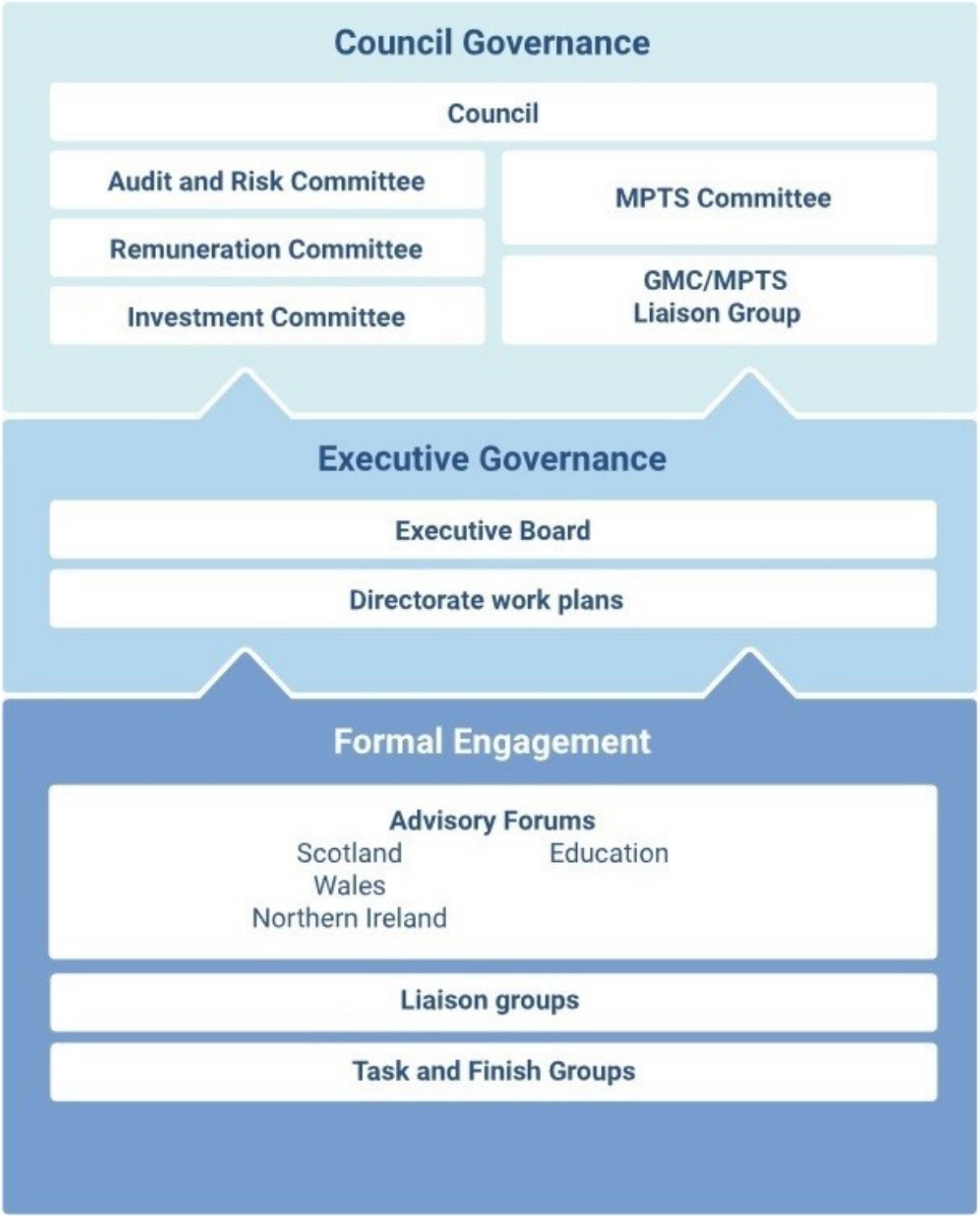
The Governance Handbook is the governing document of the organisation. It was reviewed in early 2019 to further incorporate the Charity Governance Code.

The Corporate Governance team is charged with supporting the Council in maintaining high standards of governance, on an 'apply or explain' basis, in line with the good practice set out within the Charity Governance Code. The team also provides training and advice to the organisation on matters of governance. Each committee accounts to the Council through a formal report, and the Council and each committee undertakes to review its effectiveness in delivering its statement of purpose, which is reviewed annually.

The diagram on page 56 shows the different governance groups that assist Council in discharging its responsibilities. These have all been agreed by Council to help it oversee our work effectively. The roles and activities of these groups are described in the pages that follow.

Council business is conducted in an open and transparent manner and the agenda and papers for each meeting are published on our website[30].

[29] See www.gmc-uk.org/about/how-we-work/governance/council/council-member-register-of-interests.
[30] See www.gmc-uk.org/about/how-we-work/governance/council.


Council Governance
Council
Audit and Risk Committee
Remuneration Committee
Investment Committee
MPTS Committee
GMC/MPTS Liaison Group
Executive Governance
Executive Board
Directorate work plans
Formal Engagement
Advisory Forums
Scotland
Wales
Northern Ireland
Education
Liaison groups
Task and Finish Groups

Audit and Risk Committee

During 2019, Professor Deirdre Kelly chaired the Audit and Risk Committee. You can find its report from page 72.

The current external co-opted members of the Committee are Ms Elizabeth Butler and Mr Kenneth Gill. The latter replaced Mr John Morley in September 2019.

Remuneration Committee

Dame Denise Platt chairs the Remuneration Committee. It advises Council on the remuneration, the terms of service and the expenses policy for Council members, including the Chair. It also determines the appointment process for the Chief Executive and MPTS Chair and the remuneration, benefits, and terms of service for the Chief Executive, Chief Operating Officer/Deputy Chief Executive, directors, and MPTS Chair and MPTS Committee members. It is also responsible for making sure the assessment and measurement of performance and the assessment of recruitment and succession planning take place within an appropriate framework for the senior management roles within its remit.
The Committee reports annually to Council. The last meeting of the committee took place on 12 December 2019.

Investment Committee

Dame Suzi Leather chairs the Investment Committee.

Its external co-opted members during 2019 were Mr Tim Scholefield, Mr Keith MacKay and Mr David Stewart.

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 and monitoring performance.

The Committee also has responsibility for overseeing the GMC's investment in GMC Services International Limited (GMCSI), including ensuring compliance with the GMC's Investment Policy, and scrutinising GMCSI's business plan, assessing the potential levels of investment risk and return.

The Committee reports on investment performance to Council via post-meeting circulars, and reports on the performance of the portfolio to Council on an annual basis.

GMC Services International

On 16 December 2016, Council agreed to the establishment of GMC Services International Limited (GMCSI) as a wholly owned trading subsidiary of the GMC. The main objective of GMCSI is to introduce new revenue streams and so reduce our reliance on doctors' fees.

Council has robust and effective governance arrangements in place to ensure the protection of our interests and effective management of our relationship with GMCSI.

While Council has overall responsibility for GMCSI, 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.

Dr Andrew McCulloch chairs the GMCSI Board. The Board comprises (in addition to the Chair) Mr Paul Buckley, Mr Steven Burnett, Mr Paul Knight and Mr Paul Reynolds.

Board of Pension Trustees

A board of trustees manages the GMC's defined benefit staff superannuation scheme 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.

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

Professor Jim McKillop chairs the Board. Mr Steven Burnett, Professor Deirdre Kelly and Miss Amerdeep Somal are employer-nominated trustees. Dr Danny Dubois, Mr John Foley, Mr Anthony Egerton and Mr Finlay Scott are member nominated trustees.

Medical Practitioners Tribunal Service

The Medical Practitioners Tribunal Service (MPTS) is responsible for overseeing the adjudication of fitness to practise hearings. Dame Caroline Swift, as Chair, and Mr Gavin Brown, as Executive Manager, oversee the MPTS.

The MPTS Committee and joint GMC/MPTS Liaison Group are a core part of our governance framework.

Dame Caroline Swift chairs the MPTS Committee. It oversees the delivery of the hearing service for doctors, and makes sure the service meets its responsibilities under the *Medical Act 1983*. The GMC/MPTS Liaison Group is chaired by the Chair of Council. It oversees the working relationship between the MPTS and the functions of the GMC with which it interacts.

Executive Board

Charlie Massey, our Chief Executive, chairs the Executive Board. The Executive Board acts as a decision-making forum to promote collective executive decision making by the Senior Management Team. The structure makes sure that the Chief Executive is part of significant discussions on strategy, policy, performance, risk, staffing and talent management.

UK Advisory Forums

In 2013, we established advisory forums in Northern Ireland, Scotland and Wales.

The forums make sure we have effective engagement and consultation with interest groups and that our policies are suited to all parts of the UK.

They are an addition to our existing arrangements for engagement and are intended to give a structured setting for us to engage on medium- and long-term priorities, and to share and discuss any early-stage views on policy development. They report on their work to the Executive Board twice a year.

Education Advisory Forum

The Education Advisory Forum, which replaced the Education and Training Advisory Board and the Assessment Advisory Board, began work in February 2019. The forum engages widely and effectively with our key interest groups on education, training and assessment matters, making sure we are able to best develop and promote a strategic approach to this work across all countries of the UK. Professor Colin Melville, Medical Director and Director of Education and Standards, chairs the Forum, and the invited membership reflects the diverse range of those who have an interest and expertise in medical education, training and assessment across the UK. The Forum reports its work to the Chief Executive and to Council through the Chief Executive's report.

Member attendance at Council, boards and committees in 2019[31]

Member and trustee	Number of meetings attended
Mr Steven Burnett	
Council	7/7
Board of Trustees of the GMC's Superannuation Scheme	5/5
UK Advisory Forums – Wales	2/2
GMCSI	4/4
Dr Shree Datta	
Council	3/6
Remuneration Committee	1/2
Investment Committee	1/4
Lady Christine Eames	
Council	7/7
Audit and Risk Committee	6/6
Remuneration Committee	2/2
UK Advisory Forums – Northern Ireland	2/2
Professor Anthony Harnden	
Council	7/7
Remuneration Committee	2/2
Investment Committee	4/4
Lord Philip Hunt	
Council	6/7
Audit and Risk Committee	6/6

[31] Includes six Council meetings and one strategic away day. Council member attendance at the forum meetings is on a voluntary basis on the invitation of the Chair of Council.

Member and trustee	Number of meetings attended
Professor Deirdre Kelly	
Council	6/7
Board of Trustees of the GMC's Superannuation Scheme	5/5
Audit and Risk Committee	6/6
Professor Paul Knight	
Council	7/7
Audit and Risk Committee	5/6
UK Advisory Forums – Scotland	2/2
GMCSI	4/4
Dame Suzi Leather	
Council	6/7
Audit and Risk Committee	4/6
Investment Committee	4/4
Mr Michael Marsh[32]	
Council	1/7
Remuneration Committee	1/2
Dame Clare Marx	
Council	7/7
GMC/MPTS	2/2
UK Advisory Forums – Scotland	2/2
UK Advisory Forums – Northern Ireland	1/2
UK Advisory Forums – Wales	2/2

[32] Resigned with effect from 31 March 2019.

Member and trustee	Number of meetings attended
Dame Denise Platt	
Council	7/7
Investment Committee	3/4
Remuneration Committee	2/2
Miss Amerdeep Somal	
Council	7/7
Audit and Risk Committee	6/6
Board of Trustees of the GMC's Superannuation Scheme	4/5

External co-opted members

External co-opted members sit on the Investment Committee and Audit and Risk Committee respectively. Their attendance at meetings during 2019 is listed below[33].

Investment Committee	
Mr Keith MacKay	4/4
Mr Tim Scholefield	4/4
Mr David Stewart	2/2
Audit and Risk Committee	
Ms Elizabeth Butler	6/6
Mr Kenneth Gill	2/2
Mr John Morley	3/4
GMCSI	
Dr Andrew McCulloch	4/4

[33] Attendance data reflects the total number of meetings where attendance was possible.

Management

At the beginning of 2019, our staff were under the direction of Chief Executive Charlie Massey and Chief Operating Officer and Deputy Chief Executive Susan Goldsmith.

In September 2019, Ms Susan Goldsmith left the organisation after five years in service.

In conjunction with her departure, the roles and responsibilities of our Senior Management Team were reviewed, and some changes were applied. As part of this:

- The Corporate Business Planning and Equality, Diversity and Inclusion sections became part of our Strategy and Policy directorate.
- Ms Una Lane, Director of Registration and Revalidation, took on the role of Patient Champion and chair of our Patient Forum.
- Mr Paul Reynolds, Director of Strategic Communications and Engagement, became chair of the new Strategic Equality, Diversity and Inclusion Advisory Forum and our Customer Service Advisory Board.

On 31 December 2019, the directors were:

- Mr Paul Buckley, Director of Strategy and Policy
- Ms Una Lane, Director of Registration and Revalidation
- Professor Colin Melville, Medical Director and Director of Education and Standards
- Mr Anthony Omo, General Counsel and Director of Fitness to Practise
- Mr Paul Reynolds, Director of Strategic Communications and Engagement
- Mr 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, Chief Operating Officer/Deputy Chief Executive, Chair of MPTS and directors. The Committee sets all aspects of salary or honoraria, the provision of any other benefits, and any other arrangements or contractual terms for this group of staff.

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, with regard to 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 trustees and the employer.

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

- 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.

2019 financial review

The accounts for the year ended 31 December 2019 have been prepared in accordance with the *Charities Statement of Recommended Practice (FRS 102)*.

Our total income and expenditure in 2019

In 2019, we generated a total income of £114.4 million, and our total expenditure was £114.6 million, resulting in a small, sustainable and planned deficit. Our income in 2019 increased by £4.5 million compared with 2018. The number of registered doctors increased over the year and demand for PLAB tests was significantly higher than anticipated. Our investment income was significantly higher in 2019, in part because we increased the level of funds invested through a fund manager, and in part because of strong investment performance.

Our expenditure in 2019 increased by £9.9 million compared with 2018, an increase of 9.5%. This was mainly due to an increase in PLAB running costs driven by increased demand, an expansion of our outreach work to boost support to doctors and build working relationships across the UK health environment, additional investment in education and the development of the United Kingdom Medical Licensing Assessment (UKMLA), and running more MPTS hearing days. The increase in demand for PLAB tests generates additional income which offsets the increase in costs.

In 2019, we set an efficiency target to generate savings of £1.8 million (2% of directorate budgets), which we felt was a realistic target that wouldn't impact on quality standards. We were able to generate significant savings of £1.9 million through a range of initiatives including: the use of legally qualified chairs in place of separate chairs and legal assessors on MPTS hearings; bringing in-house the assessment of a doctor's professional performance (test of competence) that we carry out as part of a fitness to practise investigation; and deferring recruitment to vacant posts.

Our defined benefit pension scheme was closed to new joiners on 1 July 2013 and replaced by a defined contribution scheme. On 1 April 2018, the defined benefit scheme was closed to future accruals to address the combination of growing financial risk due to the increased size of the scheme; affordability due to the projected increases in contributions that would be required to maintain the scheme's viability; and to remove the inequity with members of the defined contribution scheme. Council made a payment of £1.9 million into the defined benefit scheme in 2019, and agreed further payments of £1.3 million from 2020 onwards.

During 2019, we spent £12.1 million on major projects to improve our information systems infrastructure and accommodation, including the creation of a new clinical assessment centre to handle the increased demand for PLAB tests.

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 time 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 at short notice 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. While the operation of the defined benefit pension scheme does create a financial risk for the organisation, any deficit or surplus in the scheme can be managed over the medium term, and so has no immediate impact on free reserves in the short term.

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.

Based on our analysis of cash flows and the risks facing the organisation, our policy is to maintain free reserves in the range of £25 million to £45 million. However, we recognise that the level of reserves will inevitably fluctuate year on year, reflecting variations in actual levels of income and expenditure compared with the budget. Our policy is to maintain actual free reserves in line with the target level over the medium term. If our actual reserves vary significantly from the target range set out in the reserves policy, we take action to

address the variation as part of the annual budget-setting process to bring actual reserves back into line within a reasonable period.

Our total reserves at the end of 2019 were £72.6 million, made up of free reserves of £44.2 million, plus £19 million of reserves represented by fixed assets, and a pension reserve of £9.4 million.

The defined benefit pension scheme surplus of £9.4 million comprised assets of £258.1 million and liabilities of £248.7 million, valued for accounting purposes under the financial reporting standard FRS 102. This is set out in more detail in note 16 of the accounts.

We have delivered significant operational savings over recent years, including relocating 150 roles from London to Manchester, reducing our property footprint in London, streamlining our fitness to practise procedures and hearings, and closing the defined benefit pension scheme to future accruals. These savings have helped us fulfil our commitment to reduce the cost of regulation on doctors.

Council decided to reduce the 2018-19 annual retention fee for all doctors and introduce a package of additional fee reductions for doctors in their early years on the register. In 2019-20 Council increased fees in line with the Consumer Price Index (CPI). We estimate that our free reserves will reduce to around £40.2 million at the end of 2020, due to the ongoing impact of fee changes coupled with planned growth in our activities. This is consistent with our aim to maintain free reserves towards the middle of our target range over the medium term.

At the time of approval of these financial statements, the coronavirus (COVID-19) continues to develop and has been designated a global pandemic by the World Health Organisation. Both short-term and long-term effects of the rapidly escalating situation are unknown.

We are continuing to support doctors and patients at this challenging time, in line with UK government advice on the coronavirus, and are still delivering many of our services. Our Contact Centre remains open, we are continuing to process applications for registration, and running online courses for doctors new to UK practice. PLAB tests and tribunals have been temporarily postponed. We've also made some changes to our regulatory activities so doctors can spend more time on clinical care. This includes deferring revalidation dates and postponing our national training surveys. We have considered the potential financial impact of the coronavirus under a range of scenarios and our initial projections indicate that reductions in income will be offset by reductions in our expenditure. We have created a task group to develop detailed plans to recommence operational activities post-coronavirus. This work is ongoing and will allow us to refine our financial projections further.

The majority 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. The exception to this is the impact of the coronavirus on global financial markets and the value of our investments, but we expect markets to recover over time and so we aim to manage the investment risk over the longer term.

Despite the current circumstances, trustees remain of the view that the GMC is a going concern for the foreseeable future, and therefore have 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

Council is responsible for determining and reviewing the overall investment policy, objectives, risk appetite and target returns. Council has delegated to the Investment Sub-Committee responsibility for implementing the investment policy, appointing and managing fund managers, monitoring performance and reporting to Council.

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 may invest under management
- those which we may invest in a trading subsidiary
- any residual cash balance.

We hold a minimum of £15 million as 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.

After taking account of our working capital requirement we increased the level of funds invested under management from £20 million at the start of 2019 to £50 million by the end of June 2019. Council reviews this amount annually.

Our target rate of return on funds invested under management is inflation (CPI) plus 2% over a rolling five-year period. This reflects our cautious approach to risk. We seek 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.

We have adopted a comprehensive ethical approach to investments. We believe that investing in certain companies or sectors would conflict with our charitable aims, or may

create reputational damage. We do not wish directly to profit from, or provide capital to, activities that are materially inconsistent with our charitable aims and so we specifically exclude investment in companies that derive more than 10% of their revenue from: tobacco, alcohol, gambling, pornography, high-interest rate lending, cluster munitions and landmines, and the extraction of thermal coal or oil sands. We do not invest in companies that are under investigation for, or have been found guilty of, tax evasion or money laundering in the past three years.

We may invest in companies whose activities are consistent with, or supportive of, our charitable aims. 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 people and the communities in which they operate. We may also use our position as an investor to actively engage with and influence the corporate behaviour of those companies we invest in.

We invest only through fund managers who demonstrate the strongest environmental, social and governance (ESG) credentials. When appointing fund managers, we take into consideration how they incorporate an assessment of companies' performance on ESG issues in their stock selection.

At the end of 2019, our funds under management were valued at £54.8 million compared with a sum of £50 million originally invested. We generated a return of 10.5% in 2019 compared with a target of 3.3%.

We invested £0.6 million as share capital in GMCSI, a trading subsidiary of the GMC, at the end of 2016. Our investment at the end of 2019 was valued at £0.2 million.

Any residual cash not held as working capital or invested is held in medium-term deposits and/or interest-bearing accounts. We generated interest of £0.4 million on our cash balances, equivalent to an average annual rate of return of 0.89%.

The 2019 accounts show cash required for normal day-to-day working capital on our balance sheet within current assets, and cash held for the longer term is shown as investments.

GMC Services International Limited

The trading subsidiary was incorporated as a private company limited by shares on 16 December 2016. It is a wholly owned subsidiary of the GMC and provides services on a commercial basis, including consultancy, training and accreditation. One of its main objectives is to introduce new revenue streams and so reduce the GMC's reliance on core financial resources. It will do this by gifting its profits 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 2017 and 2018 GMCSI generated net losses totalling £396,945, and generated a profit of £21,185 in 2019 so no profits have been gift-aided back to the GMC. GMCSI ended 2019 with net assets of £224,241. GMCSI is projected to generate further profits over the medium term.

The accounts presented here are consolidated group accounts to include our trading subsidiary GMCSI. The accounts show separate columns showing 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

The 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 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 disclose, with reasonable accuracy at any time, the financial position of the charity and enable them to ensure 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 all trustees and senior managers to 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 2019, all disclosures were made and there were no issues of concern.

Audit and Risk Committee report 2019

The Audit and Risk Committee plays a key part in our governance. The Committee 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.

The Committee also monitors our anti-fraud policies and any risks relating to the *General Data Protection Regulation*. And it reviews arrangements for raising concerns, including the work of the Freedom to Speak Up Guardian, a role which was introduced to the GMC in March 2019.

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.

During 2019, there were seven members on the Committee – five Council members and two co-opted members[34]. Co-opted, or independent, members enhance the work of the Committee by bringing valuable additional skills and experience to the independent scrutiny and challenge on finance, risk and governance. In line with good governance practice, we have now introduced annual appraisals for independent members, conducted by the Committee Chair.

Following the departure of John Morley, external member, after reaching the end of an eight-year tenure, Kenneth Gill joined the Committee as a new co-opted member in September 2019.

In 2019, the Committee met six times and submitted two formal reports on its work and findings to Council. As well as this, Committee members had the opportunity to learn more about, and scrutinise, specific areas of the business and their risks, in six seminar sessions.

[34] See page 54.

Key activities during 2019

The Committee continues to use risk as the basis for its approach to oversight and scrutiny. It balances forward-looking at risks and issues with retrospective reviews of audit work, to gain assurance on systems of internal control and risk management.

During 2019, the Committee:

- discussed a wide range of strategic risks to provide an important backdrop to its understanding of the challenges and opportunities the GMC faces and the work that goes on across the organisation to mitigate threats and enhance opportunities
- challenged the corporate opportunities and risk register at every meeting
- ran a seminar on risk for Council, looking at the lessons learned where governance, systems of control and poor financial practices had led to organisational failure in other contexts
- continued support for risk maturity evolution in line with the principles of effective risk management set out in the international guidance standard (ISO 31000:2009)
- oversaw delivery of the 2019 internal audit programme
- scrutinised all audit findings to satisfy itself that the actions proposed were appropriate, and monitored the implementation of recommendations to make sure they were being managed effectively by senior management
- approved the external audit letter of engagement, scrutinised the Annual Report and Accounts 2018 and reviewed the outcome of the external auditor's work on the financial statements and annual report
- commissioned an independent test of the GMC's cyber security control arrangements and an independent review of the GMC's arrangements for compliance with BS 10008 – the standard for Evidential Weight and Legal Admissibility of Electronic Information – to which the GMC became fully accredited in 2016
- reviewed the findings and lessons learned from work undertaken in relation to significant adverse events.

Risk management

The GMC's primary objective is to keep the public safe and we work with doctors to do this. However, we continue to operate in a complex healthcare and regulatory landscape. To be effective, we must work with others so that we manage the risks and implications of external events and internal activities sensitively.

But with risk, comes opportunity: to contribute to external debate with partners and the UK Government, and to constantly improve the way we conduct our activities so they remain relevant, efficient and focused on our overall goals.

Risk thinking is inherent in our discussions and operations at all levels of the business. Actively identifying, monitoring and managing local operational and project risks through risk registers and escalating to the Executive Board for action when needed, supports our ability to be responsive to emerging events in a turbulent external environment.

Our corporate opportunities and risk register is published regularly on our website through the Chief Executive's report to Council[35].

Managing risks in 2019

Throughout 2019, we continued to manage ongoing risks and opportunities, as well as responding to those that emerged throughout the year.

Supporting a profession under pressure

In 2019, three major independent reviews we commissioned as part of our *Supporting a profession under pressure* programme came to fruition. You can read more about these reviews from page 15, including how they have improved our understanding of the environments that doctors are working in, and what we're doing to address the key issues raised.

We launched this important programme of work in 2018 as part of our commitment to becoming a more proactive regulator. And these reviews complement three other workstreams that form part of this programme, including:

- working with partners across the health services to make sure doctors at all career stages feel supported to raise and act on concerns
- expanding and improving induction and return to work support for doctors and trainees, such as *WtUKP* workshops[36]
- rolling out a programme of human factors training for our fitness to practise case examiners, and the medical experts used in our fitness to practise processes[37].

To deliver the outcomes envisaged through this programme of work, we cannot work alone. During the latter part of 2019, we turned our attention to working closely with others in the system, across all four UK countries, to explore the opportunities to achieve lasting change for patients and doctors. This continues to be a key focus of our work in 2020.

[35] See www.gmc-uk.org/about/how-we-work/governance/council/council-papers.
[36] See page 19.
[37] See page 20.

Monitoring and managing the impact of Brexit

Leaving the EU will have a significant impact on the regulation, movement and education of doctors, as well as consequences for the UK's medical workforce.

The ongoing uncertainty around Brexit has been a major challenge for us. Throughout 2019, we continued to monitor and manage this risk by planning for a range of scenarios.

One practical challenge has been the continued notable increase in the number of international medical graduates seeking to join the UK medical register. So we were delighted to open our new Clinical Assessment Centre in August 2019 in response to this increasing demand[38].

As described on page 33, we are working with the UK Government to look at how more flexible legislation can help the system and processes by which international doctors can join the UK medical register in a more efficient and responsive manner.

Working towards introducing the Medical Licensing Assessment[39]

Work on the introduction of the MLA has continued throughout 2019, and we now have our blueprint for the applied knowledge test. We have also established an Expert Reference Group, which, together with key stakeholders, we work closely with to address the risks and opportunities in developing the detail of the MLA. This collaboration is crucial for us to achieve our ambition of having greater assurance that doctors newly joining the register have the knowledge and the skills necessary to practise medicine and provide safe care in the UK.

Checking Commonwealth route doctors' qualifications

Effective risk management includes an organisation's ability to recover when an issue emerges.

As the end of 2018, we found that an individual (Zholia Alemi) was able to join the register using fraudulent documents in 1995.

We took immediate action in response to this case, proactively working with partners across the four UK countries, and setting up a helpline for patients or members of the public who wanted information, advice or support.

We then conducted a review of the qualifications of 3,117 licensed doctors who, like Alemi, joined the register using the now-abolished 'Commonwealth route'. Working in partnership with the Educational Commission for Foreign Medical Graduates, we checked the

[38] See page 43 for more information.
[39] See page 21 for more information.

qualifications of all licensed doctors who had gained registration via this route. We found all their primary medical degrees to be genuine.

We are confident that our current arrangements, including undertaking primary source verification of medical qualifications, are robust. However, we recognise that we must remain vigilant so that our activities, processes and engagement ensure patient safety and public confidence in an everchanging and complex healthcare landscape.

Responding to public inquiries

Inquiries and reviews help us reflect on our systems and practice, identifying lessons for us and the system as a whole.

During 2019, we responded to a number of important public inquiries, including:

- disclosing material and a witness statement to the Infected Blood Inquiry
- engaging closely with the Department of Health in Northern Ireland and relevant stakeholders regarding the proposed implementation of a statutory duty of candour with criminal sanction in Northern Ireland following the Inquiry into Hyponatraemia-related Deaths
- preparing a learning review report for the Independent Inquiry into Child Sexual Abuse in England and Wales, and for the Scottish Child Abuse Inquiry
- providing material to the Paterson Inquiry, which reviewed the circumstances surrounding Ian Paterson's malpractice.

As a listening and learning organisation, we will continue to assist inquiries and reviews in the work they do and provide as much assistance and information as possible.

Beyond 2019

As we look ahead to our next corporate strategy in 2021, it's more important than ever that we can confidently share our voice in the wider healthcare environment, working with partners in the whole of the UK system to influence and bring about real change for patients and doctors.

We operate in an increasingly complex and dynamic external world, so it's essential for us to be flexible and agile in our approach to risks. And to fulfil our commitment to high-quality patient care, we must continue to anticipate change, listen and learn, and challenge ourselves to take advantage of every opportunity.

The current coronavirus (COVID-19) pandemic has thrown into sharp relief the need for our strategy and operational activities to be flexible and light-footed. Over recent weeks, we have seen what may have seemed a remote risk materialise in an unprecedented way, the impact changing societal, family and working lives beyond recognition.

In responding to COVID-19, we have demonstrated that we are a resilient regulator, able to adapt quickly to the needs of our people, the doctors we regulate and the patients we serve. In this increasingly uncertain, complex and dynamic external world, it's essential for us to remain alert to ongoing and emerging risks. And to fulfil our commitment to high-quality patient care, we must continue to anticipate change, listen and learn, and challenge ourselves to take advantage of every opportunity.

Approved by the trustees on 8 July 2020 and signed on their behalf by:

Dame Clare Marx

Chair of Council

Independent auditor's report to the trustees of the General Medical Council

We have audited the financial statements of the General Medical Council for the year ended 31 December 2019 which comprise Consolidated Statement of Financial Activities, Balance Sheet, Consolidated Cash Flow Statement and notes to the financial statements, including a summary of 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, which is 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 the charitable company's affairs as at 31 December 2019 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 Companies Act 2006, the Charities and Trustee Investment (Scotland) Act 2005 and Regulations 6 and 8 of the Charities Accounts (Scotland) Regulations 2006 (amended).

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

We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:

- the trustees' use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the trustees have not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the group's or the charitable company's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

Other information

The trustees are responsible for the other information. 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, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, 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 there is a material misstatement in the financial statements or a material misstatement of the other information. 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.

Opinions on other matters prescribed by the Companies Act 2006

In our opinion based on the work undertaken in the course of our audit:

- the information given in the trustees' report, which includes the directors' report and the strategic report prepared for the purposes of company law, for the financial year for which the financial statements are prepared is consistent with the financial statements; and
- the strategic report and the directors' report included within the trustees' report have been prepared in accordance with applicable legal requirements.

Matters on which we are required to report by exception

In light of the knowledge and understanding of the group and the charitable company and their environment obtained in the course of the audit, we have not identified material misstatements in the strategic report or the directors' report included within the trustees' report.

We have nothing to report in respect of the following matters in relation to which the Companies Act 2006 and the Charities Accounts (Scotland) Regulations 2006 require us to report to you if, in our opinion:

- adequate and proper accounting records have not been kept; or
- the financial statements are not in agreement with the accounting records and returns; or
- certain disclosures of trustees' remuneration specified by law are not made; 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 70, the trustees (who are also the directors of the charitable company for the purposes of company law) 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 group's or the charitable company'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 charitable company 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 44(1)(c) of the Charities and Trustee Investment (Scotland) Act 2005 and under the Companies Act 2006 and report in accordance with the Acts and relevant regulations made or having effect thereunder.

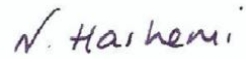
Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee 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.

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.

Use of our report

This report is made solely to the charitable company's members, as a body, in accordance with Chapter 3 of part 16 of the Companies Act 2006, and to the charitable company's trustees, as a body, in accordance with Regulation 10 of the Charities Accounts (Scotland) Regulations 2006. Our audit work has been undertaken so that we might state to the charitable company's members and 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 charitable company, the charitable company's members as a body and the charitable company's trustees as a body, for our audit work, for this report, or for the opinions we have formed.



Naziar Hashemi
Senior Statutory Auditor
For and on behalf of
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Statutory Auditor
St Bride's House
10 Salisbury Square
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17 July 2020

Accounts 2019

Consolidated Statement of Financial Activities for the year ended 31 December 2019

	Note	Total 2019 £'000	Total 2018 £'000
Income			
From charitable activities			
Registration	2	**103,258**	103,966
Specialist and GP registration	2	**3,828**	3,531
Revalidation	2	**173**	172
Other trading activities	3	**264**	142
Commercial trading operations	3	**494**	198
Investments	3	**5,722**	1,166
Department of Health funding - MAPS *	3	**220**	-
Other	3	**400**	707
Total incoming resources		**114,359**	**109,882**
Expenditure			
Raising funds			
Commercial trading operations	5	**473**	535
Investment management costs	5	**142**	30
		615	**565**
Charitable activities			
Fitness to practise		**43,918**	43,480
Registration and revalidation		**28,127**	22,781
External relationships		**16,435**	14,629
Medical Practitioners Tribunal Service		**12,971**	12,146
Education		**10,392**	9,177
Standards		**1,880**	1,878
Department of Health funding - MAPS		**220**	-
Total expenditure	5	**114,558**	**104,656**
(Net Loss)/Net income		**(199)**	**5,226**
Other recognised gains and losses			
Actuarial (loss)/gain on defined benefit pension scheme	16	(24,826)	14,432
Net movement in funds		**(25,025)**	**19,658**
Total funds brought forward		97,606	77,948
Total funds carried forward		**72,581**	**97,606**

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 charity movement in funds for the year is £25,025,000.

* The Department for Health and Social Care (DHSC) provided funding in 2019 for a scoping study to develop a framework for regulating physician associates and anaesthesia associates (MAPS). Funding was restricted in nature, and was fully spent in the year so the net impact on GMC reserves is nil. All GMC reserves at the year-end are unrestricted.

Balance sheet

	Note	2019 Group £'000	2019 Charity £'000	2018 Group £'000	2018 Charity £'000
Fixed assets					
Intangible fixed assets	7	9,744	9,744	9,252	9,252
Tangible fixed assets	8	9,254	9,254	5,113	5,113
Investments	9	65,049	65,273	60,758	60,961
		84,047	**84,271**	**75,123**	**75,326**
Current assets					
Debtors and prepayments	10	21,149	21,045	19,296	19,263
Cash and bank balances		30,667	30,350	40,963	40,653
		51,816	**51,395**	**60,259**	**59,916**
Liabilities					
Creditors: amounts falling due within one year	11	(71,394)	(71,197)	(67,514)	(67,374)
Net current liabilities		(19,578)	(19,802)	(7,255)	(7,458)
Total assets less current liabilities		**64,469**	**64,469**	**67,868**	**67,868**
Provisions for liabilities and charges	12	(1,279)	(1,279)	(1,569)	(1,569)
Net assets excluding pension scheme asset		**63,190**	**63,190**	**66,299**	**66,299**
Defined benefit pension scheme asset	16	9,391	9,391	31,307	31,307
Total net assets		**72,581**	**72,581**	**97,606**	**97,606**
Unrestricted income funds		63,190	63,190	66,299	66,299
Pension reserve		9,391	9,391	31,307	31,307
Total Funds	13	**72,581**	**72,581**	**97,606**	**97,606**

The financial statements were approved by the trustees and authorised for issue on 8 July 2020.

They were signed on behalf of trustees by:

Dame Clare Marx
Chair of Council

Consolidated cash flow statement

	2019		2018	
	£'000	**£'000**	£'000	£'000
Cash flows from operating activities:				
Net cash provided by/(used in) operating activities (note i below)		1,335		(2,875)
Cash flows from investing activities:				
Dividends, interest and rents from investments	443		735	
Purchase of property, plant, equipment and intangibles	(12,074)		(7,220)	
Net cash used in investing activities		**(11,631)**		**(6,485)**
Change in cash and cash equivalents		**(10,296)**		**(9,360)**

Note (i)

Cash flow from operating activities	
Net (outgoing)/incoming resources	(199)	5,226
Investment income and interest	(1,394)	(1,124)
Net investment movement	(4,291)	(7,179)
Non-cash items – depreciation and amortisation	7,415	6,931
Non-cash items – assets written off	26	118
Pension past service cost and curtailment	-	57
Pension scheme current service cost	-	1,845
Pension scheme contribution	(1,959)	(5,687)
(Increase)/decrease in debtors	(1,853)	1,617
Increase/(decrease) in creditors and provisions	3,590	(4,679)
Net cash provided by (used in) operating activities	**1,335**	**(2,875)**

Note (ii)

Cash and equivalents	**Short-term deposits £'000**	**Cash at bank and in hand £'000**	**Total £'000**
Balances at 1 January 2019	-	40,963	**40,963**
Net decrease in cash and cash equivalents	-	(10,296)	**(10,296)**
Balances at 31 December 2019	-	30,667	**30,667**

Notes to the accounts

The legal form and registered office of the GMC is disclosed in the reference and admin page of the trustees' report.

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) published on 16 July 2014 rather than the Accounting and Reporting by Charities: Statement of Recommended Practice effective from 1 April 2005 which has since been withdrawn.
- Our financial statements have been prepared on a going concern basis and in accordance with the Charities Statement of Recommended Practice (FRS 102), 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 January 2015. The GMC meets the definition of a public benefit entity under FRS 102.
- At the time of approval of these financial statements, the coronavirus (COVID-19) virus continues to develop and has been designated a global pandemic by the World Health Organisation. The majority 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. Despite the current circumstances, trustees remain of the view that the GMC is a going concern for the foreseeable future, and there are no material uncertainties about the charity's ability to continue as a going concern.

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. 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 to be provided over a 12-month period. 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 can take advantage of the exemptions from taxation on income and gains available to charities, so no taxation is payable on the net incoming resources.

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 judgements 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 assessed on a case-by-case basis, close to the lease end date when a reasonable estimate of costs can be made.
- Provisions for holiday pay are based on the actual level of accrued days and salaries of each staff member.

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. In the case of leased assets, the cost is written off over the period of the lease. The period of the lease is determined as the period up to the first break clause, unless our intention is not to exercise the break.

The estimated useful lives are as follows:

- Leasehold buildings and leasehold improvements – the period of the lease or the useful economic life of the asset.
- 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 item

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

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, investments held in cash deposits together with trade and other debtors. Financial liabilities held at amortised cost comprise trade and other creditors, tax and social security creditors and accruals.

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.

A small number of staff who transferred to the GMC on the merger with the Postgraduate Medical Education and Training Board (PMETB) contribute to the NHS multi-employer scheme and 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

Our funds are unrestricted, and can be expended at the trustees' discretion, in pursuit of our charitable aims.

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

	Total 2019 £'000	Total 2018 £'000
Registration		
Annual retention fees	**88,179**	93,718
Registration fees	**4,198**	3,441
Provisional registration fees	**418**	403
PLAB fees	**10,357**	6,300
Other fees	**106**	104
	103,258	**103,966**
Specialist and GP registration		
Certificates of Completion of Training fees	**2,680**	2,524
Certificate of Eligibility for Specialist Registration/Certificate of Eligibility for General Practitioner Registration fees	**1,104**	969
Other fees	**44**	38
	3,828	**3,531**
Revalidation		
Revalidation annual return	**116**	114
Revalidation assessment	**57**	58
	173	**172**

3. Income from raising funds

		2019		2018	
		£'000	**£'000**	£'000	£'000
Activities for raising funds					
Other trading activities*			**264**		142
Commercial trading operations **			**494**		198
Other:					
	Transaction fees	**150**		550	
	Reimbursement of legal fees	**250**		157	
			400		707
			1,158		1,047
Investment income					
Other finance income – pension scheme (note 16)			**951**		389
Bank interest			**443**		735
Investment income ***			**4,328**		42
			5,722		1,166
Department of Health funding					
Funding to cover expenditure on Medical Associate Professionals regulation ****			**220**		-

* Other trading activities include sales of the medical register, external hire of the Clinical Assessment Centre, the reimbursement of costs of visiting overseas medical schools and 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.

*** Investment management fees of £142,373 were incurred to generate the investment income return of £4,328,000.

**** The DHSC have provided funding for the General Medical Council to carry out a scoping exercise to understand the work involved and costs associated with regulating physician associates and anaesthesia associates. The result of the scoping exercise was reported to the DHSC in March 2020.

4. Financial instruments

	Total 2019 £'000	Total 2018 £'000
Financial assets measured at amortised cost	**58,121**	96,831
Financial liabilities measured at amortised cost	**14,008**	13,312
Financial instruments held at fair value	**54,765**	20,578
The entity's income, expense, gains and losses in respect of financial instruments are summarised below:		
Total interest income for financial assets held at amortised cost	**443**	735

5. Total expenditure

	Direct Staffing Costs £'000	Direct Costs £'000	Allocated Costs £'000	Total 2019 £'000	Total 2018 £'000
Expenditure on:					
Commercial trading operations	397	76	-	**473**	535
Investment management costs	-	142	-	**142**	30
Department of Health funding – MAPS	175	45	-	**220**	-
Total expenditure	572	263	-	835	565
Fitness to practise	18,704	7,315	17,899	**43,918**	43,480
Registration and revalidation	9,683	7,688	10,756	**28,127**	22,781
External relationships*	9,137	881	6,417	**16,435**	14,629
MPTS	3,911	5,164	3,896	**12,971**	12,146
Education	5,949	414	4,029	**10,392**	9,177
Standards	1,069	10	801	**1,880**	1,878
Total charitable expenditure	48,453	21,472	43,798	**113,723**	104,091
Total group expenditure	49,025	21,735	43,798	**114,558**	104,656

* 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	IT	Human Resources	Finance	Procurement	Facilities	Governance	Total 2019	Total 2018
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Fitness to practise	3,469	5,252	2,172	644	184	4,616	1,562	**17,899**	16,960
Registration and revalidation	2,084	3,156	1,305	387	111	2,774	939	**10,756**	9,391
External relationships*	1,243	1,883	779	231	66	1,655	560	**6,417**	5,477
MPTS	755	1,143	473	140	40	1,005	340	**3,896**	3,394
Education	781	1,182	489	145	41	1,039	352	**4,029**	3,476
Standards	155	235	97	29	8	207	70	**801**	766
Total charitable expenditure	8,487	12,851	5,315	1,576	450	11,296	3,823	**43,798**	39,464

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

Group expenditure by type:

	Charitable activities 2019 £'000	Expenditure on raising funds 2019 £'000	Department of Health funding – MAPS 2019 £'000	Total 2019 £'000	Charitable activities 2018 £'000	Expenditure on raising funds 2018 £'000	Total 2018 £'000
Staffing costs	68,494	397	175	69,066	63,306	299	63,605
Office costs	2,422	68	45	2,535	2,394	75	2,469
Council and committee costs	401	1	–	402	515	3	518
Panel and assessment costs	16,227	–	–	16,227	14,123	–	14,123
Legal costs	4,145	–	–	4,145	4,597	–	4,597
Accommodation costs	7,267	–	–	7,267	5,626	–	5,626
Financial, actuarial and professional costs	3,952	149	–	4,101	3,509	188	3,697
Purchase of assets – charged to revenue	3,374	–	–	3,374	2,972	–	2,972
Assets written off	26	–	–	26	118	–	118
Depreciation	2,337	–	–	2,337	2,114	–	2,114
Amortisation	5,078	–	–	5,078	4,817	–	4,817
	113,723	615	220	114,558	104,091	565	104,656

Total resources expended include:

	2019	2018
Operating lease costs: leasehold property and equipment	3,873	2,847
Audit fees	42	48

6. Staff

	2019 £'000	2018 £'000
Total costs of all staff		
Salaries	**52,297**	47,501
Social security costs	**5,438**	4,830
Superannuation costs defined benefit scheme	**-**	1,548
Superannuation costs defined contribution scheme	**7,256**	5,637
Redundancy costs	**85**	-
Other staffing costs	**3,990**	4,089
	69,066	63,605

During 2019, the General Medical Council made termination payments of £87,000 (2018: £0), and £0 was outstanding at year-end (2018: £31,000).

	2019	2018
Average staff numbers in the year by category		
Fitness to practise	**417**	403
Registration and revalidation	**251**	223
External relationships	**149**	130
Medical Practitioners Tribunal Service	**91**	81
Education	**94**	83
Standards	**19**	18
Governance & Management	**135**	120
Resources	**197**	175
	1,353	1,233
GMC Services International Ltd	**2**	3
	1,355	**1,236**

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

	2019	2018
GMC		
£60,000-£70,000	57	46
£70,001-£80,000	29	25
£80,001-£90,000	29	19
£90,001-£100,000	7	7
£100,001-£110,000	7	5
£110,001-£120,000	10	11
£120,001-£130,000	6	3
£130,001-£140,000	4	5
£140,001-£150,000	2	-
£150,001-£160,000	-	-
£160,001-£170,000	-	1
£170,001-£180,000	-	-
£180,001-£190,000	1	-
£190,001-£200,000	2	5
£200,001-£210,000	3	1
£210.001-£220,000	-	-
£220,001-£230,000	-	-
£230,001-£240,000	-	-
£240,001-£250,000	1	1
£280,001-£290,000*	1	-
	159	129
MPTS		
£60,000-£70,000	3	2
£70,001-£80,000	1	-
£80,001-£90,000	1	1
£90,001-£100,000	2	2
	7	5
Total	166	134

* This includes contractual payments relating to the end of employment.

Number of staff included above for whom retirement benefits are accruing

	2019	2018
GMC defined benefit pension scheme	-	-
GMC defined contribution pension scheme	163	132
NHS defined benefit pension scheme	1	1
Not in scheme	2	1
	166	134

The Senior Management Team included the Chief Executive, Chief Operating Officer and six directors in 2019. The Chief Operating Officer left on 13 September 2019 and the role has been removed from the Senior Management Team structure. The total amount of employee benefits (including employer pension contributions) of the senior management team was £1,948,556 in 2019. The equivalent figure for 2018 was £1,843,329.

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.

From November 2018, the Remuneration Committee allowed the senior management team the flexibility to exchange employer pension contributions for salary. A similar arrangement is available to all staff. The change is cost neutral to the GMC as any increase in employers NI liability is paid by the employee as a deduction from salary.

7. Intangible fixed assets

Group and charity

	Computer software and systems development £'000
Cost	
Balance at 1 January 2019	**43,261**
Additions	**5,570**
Disposals	**(21,401)**
Balance at 31 December 2019	**27,430**
Amortisation	
Balance at 1 January 2019	**34,009**
Amortisation charge for year	**5,078**
Disposals	**(21,401)**
Balance at 31 December 2019	**17,686**
Net book value at 1 January 2019	**9,252**
Net book value at 31 December 2019	**9,744**

Intangible assets incorporate all IT software development costs including, but not limited to, the development of our strategic applications, Siebel, Livelink and Agresso, 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.

8. Tangible fixed assets

Group and charity

	Buildings £'000	Fixtures, furniture and equipment £'000	IT equipment £'000	Total £'000
Cost				
Balance at 1 January 2019	2,171	9,370	8,356	**19,897**
Additions	282	4,178	2,044	**6,504**
Disposals	(181)	(334)	(1,927)	**(2,442)**
Balance at 31 December 2019	2,272	13,214	8,473	**23,959**
Depreciation				
Balance at 1 January 2019	1,976	5,587	7,221	**14,784**
Depreciation charge for year	41	1,385	911	**2,337**
Disposals	(181)	(308)	(1,927)	**(2,416)**
Balance at 31 December 2019	1,836	6,664	6,205	**14,705**
Net book value at 1 January 2019	195	3,783	1,135	**5,113**
Net book value at 31 December 2019	436	6,550	2,268	**9,254**

9. Investments

Managed funds

	Group			Charity			
	Cash & cash equivalents £'000	Listed Investments £'000	Total £'000	Cash & cash equivalents £'000	Listed Investments £'000	Equity Investment in Group Under-takings £'000	Total £'000
The valuation at the end of the year consisted of:							
As at 1 January 2019	40,180	20,578	**60,758**	40,180	20,578	203	**60,961**
Additions	-	30,000	**30,000**	-	30,000	-	**30,000**
Disposals	(29,896)	-	**(29,896)**	(29,896)	-	-	**(29,896)**
Gain on investments	-	4,187	**4,187**	-	4,187	-	**4,187**
Reversal of impairment*	-	-	-	-	-	21	**21**
As at 31 December 2019	**10,284**	**54,765**	**65,049**	**10,284**	**54,765**	**224**	**65,273**

* The General Medical Council incorporated a wholly owned trading subsidiary on 16 December 2016. Having previously been impaired by £397k due to trading losses incurred, a reversal of the impairment of £21k at the end of 2019 has been recognised as a result of the profit generated by the company increasing its net assets.

Listed investments are managed by CCLA Investment Management Ltd.

10. Debtors

	2019		2018	
	Group £'000	**Charity £'000**	Group £'000	Charity £'000
Amounts falling due within one year				
Registration debtors	**15,952**	**15,952**	14,800	14,800
Prepayments and accrued income	**4,835**	**4,835**	4,100	4,100
Other debtors	**362**	**258**	396	363
	21,149	**21,045**	19,296	19,263

11. Creditors

	2019		2018	
	Group £'000	**Charity £'000**	Group £'000	Charity £'000
Amounts falling due within one year				
Trade creditors	**1,379**	**1,374**	895	894
Tax and social security	**1,601**	**1,580**	1,502	1,483
Holiday pay	**922**	**922**	855	855
Accruals	**11,707**	**11,552**	11,563	11,443
Deferred income	**55,785**	**55,769**	52,699	52,699
	71,394	**71,197**	67,514	67,374

Charity deferred income

Income from annual retention fees is deferred and released to the statement of financial activities on a straight-line basis over the period to which the income relates. All deferred income brought forward from the previous year is automatically released to the statement of financial activities in the following year.

Trading subsidiary deferred income

Income from sponsorship contracts and deposits for hiring the Clinical Assessment Centre is deferred and matched to the relevant time period.

	Annual retention fees £'000	**PLAB fees £'000**	**Specialist and GP registration fees £'000**	**Revalidation assessment fees £'000**	**Transaction charges £'000**	**Trading subsidiary deferred income £'000**	**Total £'000**
Deferred income at 1 Jan 2019	49,049	3,576	6	63	5	-	**52,699**
Resources deferred during the year	51,864	3,819	21	65	-	16	**55,785**
Amounts released from previous years	(49,049)	(3,576)	(6)	(63)	(5)	-	**(52,699)**
Deferred income at 31 Dec 2019	**51,864**	**3,819**	**21**	**65**	**-**	**16**	**55,785**

12. Provisions

Group and charity

	2019 £'000	2018 £'000
Dilapidations	**1,109**	1,208
Legal claims	**170**	330
Change Programme	**-**	31
	1,279	1,569

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.

Change Programme – On 10 December 2015, we decided to embark on a major Change Programme to reduce costs and increase income over the medium term. A provision was created in 2018 for the remaining restructuring costs associated with this Change Programme.

	Dilapidations £'000	**Legal Claims £'000**	**Change Programme £'000**	**Total £'000**
Provisions at 1 January 2019	1,208	330	31	**1,569**
Provisions created during the year	15	170	-	**185**
Amounts released from previous years	(114)	(330)	(31)	**(475)**
Provisions at 31 December 2019	**1,109**	**170**	**-**	**1,279**

13. Group fund movements in the year

Group and charity

	Unrestricted funds * £'000	**Pension fund £'000**	**2019 Total £'000**
At 1 January 2019	66,299	31,307	97,606
Net outgoing resources	(3,109)	(21,916)	(25,025)
At 31 December 2019	**63,190**	**9,391**	**72,581**

*Unrestricted funds include £3,305 of grant funding which will be utilised in 2020. (2018: £5,000)

	Unrestricted funds £'000	Pension fund £'000	2018 Total £'000
At 1 January 2018	65,247	12,701	77,948
Net incoming/(outgoing) resources	1,052	18,606	19,658
At 31 December 2018	66,299	31,307	97,606

14. Capital commitments

Capital expenditure contracted but unspent at 31 December 2019 amounted to £63,518. The equivalent figure for 2018 was £152,442.

15. Operating lease commitments

	Land and buildings		**Equipment**	
	2019	2018	**2019**	2018
Expiry date	**£'000**	£'000	**£'000**	£'000
Within one year	**3,598**	3,549	**97**	97
In years two to five	**14,211**	13,754	**48**	145
After more than five years	**3,673**	4,637	**-**	-
	21,482	21,940	**145**	242

Lease payments are recognised as an expense in the year and lease commitments are prepared on the cash basis and assumption lease break options are triggered.

16. Superannuation schemes

The GMC has three 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 2019, there were 1,383 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 FRS 102, contributions are accounted for as a defined contribution scheme based on actual contributions paid through the year.

NHS Multi-Employer Scheme

We have two members of staff who contribute to the NHS multi-employer scheme, which is a defined benefit scheme. These staff transferred to the GMC on the merger with PMETB. The scheme operates as a pooled arrangement, with contributions paid at a centrally agreed rate. The trustees are unable to confirm the GMC's share of the underlying assets and liabilities of the NHS scheme and so, under the terms of FRS 102, contributions are accounted for as if the scheme were 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 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 2018. 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 Scheme 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 £1.9 million in 2019 and will contribute a top-up payment to the scheme of £1.3 million each year between 2020 and 2025.

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. Following consultation with the GMC, in 2014 the pension trustees adopted a fiduciary management approach to the investment of the scheme's assets.

The principal assumptions used by the independent qualified actuaries to calculate the liabilities under FRS 102 are set out below.

Main financial assumptions

	31 December 2019 %pa	31 December 2018 %pa
Retail Prices Index inflation	3.1	3.4
Consumer Price Index inflation	2.2	2.5
Rate of general long-term increase in salaries	3.2	4.9
Pension increases (excess over guaranteed minimum pension)	2.2	2.5
Discount rate for scheme liabilities	2	2.9

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 22.6 years (2018 22.8 years) if they are male and for a further 24.4 years if they are female (2018 25.2 years).

For a member who retires in 2038 at age the age of 65 the assumptions are that they will live on average for a further 24.5 years after retirement if they are male and for a further 26.8 years after retirement if they are female.

Scheme asset allocation

	31 December 2019		31 December 2018	
	£'000	**%**	£'000	%
Delegated Consulting Services	**256,418**	**99%**	228,233	99%
Other	**1,725**	**1%**	1,969	1%
Total	**258,143**	**100%**	230,202	100%

Delegated Consulting Services (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 is 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 2019	31 December 2018
	£'000	£'000
Fair value of assets	**258,143**	230,202
Present value of funded defined benefit obligations	**(247,603)**	(197,783)
Funded status	**10,540**	32,419
Present value of unfunded defined benefit obligation	**(1,149)**	(1,112)
Asset/(liability) recognised on the balance sheet	**9,391**	31,307

Amounts recognised in income statement

		Year ending 31 December 2019	Year ending 31 December 2018
		£'000	£'000
Operating cost:			
	Current service cost	-	1,845
	Past service cost	-	57
Financing cost:			
	Interest on net defined benefit liability/(asset)	**(951)**	(389)
Pension expense recognised in profit and loss		**(951)**	1,513

Amounts recognised in Other Comprehensive Income (OCI)

	Year ending 31 December 2019 £'000	Year ending 31 December 2018 £'000
Asset gains/(losses) arising during the year	**21,588**	(12,619)
Liability gains/(losses) arising during the year	**(46,414)**	27,051
Actuarial gain/(loss) on defined benefit pension scheme	**(24,826)**	14,432

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

	Year ending 31 December 2019 £'000	Year ending 31 December 2018 £'000
Opening defined benefit obligation (DBO)	**198,895**	220,612
Current service cost	**-**	1,845
Interest expense on DBO	**5,735**	5,490
Actuarial (gains)/losses on liabilities	**46,414**	(27,051)
Net benefits paid out	**(2,292)**	(2,058)
Past service cost	**-**	57
Closing defined benefit obligation	**248,752**	198,895

Changes to the fair value of Scheme assets during the year

	Year ending 31 December 2019 £'000	Year ending 31 December 2018 £'000
Opening fair value of Scheme assets	**230,202**	233,313
Interest income on Scheme assets	**6,686**	5,879
Gain/(loss) on Scheme assets	**21,588**	(12,619)
Contributions by the Company	**1,959**	5,687
Net benefits paid out	**(2,292)**	(2,058)
Closing fair value of Scheme assets	**258,143**	230,202

Actual return on Scheme assets

	Year ending 31 December 2019 £'000	Year ending 31 December 2018 £'000
Interest income on Scheme assets	**6,686**	5,879
Gain/(loss) on Scheme assets	**21,588**	(12,619)
Actual return on Scheme assets	**28,274**	(6,740)

17. Honoraria

Trustees	2019 £	2018 £
Dame Clare Marx (Chair) *	**110,000**	-
Professor Terence Stephenson (Chair) **	**-**	110,000
Mr Steve Burnett	**18,000**	18,000
Dr Shree Datta***	**16,500**	18,000
Lady Christine Eames	**18,000**	18,000
Professor Anthony Harnden	**18,000**	18,000
Baroness Helene Hayman****	**-**	18,000
Lord Philip Hunt*****	**18,000**	-
Professor Deirdre Kelly	**18,000**	18,000
Professor Paul Knight	**18,000**	18,000
Dame Suzi Leather	**18,000**	18,000
Dr Michael Marsh******	**4,500**	-
Dame Denise Platt	**18,000**	18,000
Miss Amerdeep Somal	**18,000**	18,000

* Dame Clare Marx was appointed as Council Chair on 1 January 2019.

** Professor Terence Stephenson demitted as Council Chair on 31 December 2018.

*** Dr Shree Datta demitted as a Council Member on 30 November 2019.

**** Baroness Helene Hayman demitted as a Council Member on 31 December 2018.

***** Lord Philip Hunt was appointed as a Council Member on 1 January 2019.

****** Dr Michael Marsh was appointed as a Council Member on 1 January 2019 and demitted on 31 March 2019.

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

Medical Practitioners Tribunal Service advisory committee members	2019 £	2018 £
Dame Caroline Swift (Chair)	**94,255**	91,479
Mrs Joy Hamilton	**3,720**	3,668
Professor Jacky Hayden	**6,200**	3,720
Dr Patricia Moultrie	**3,720**	3,720
Mrs Judith Worthington	**3,720**	3,720

Audit and Risk Committee co-opted members	**2019** **£**	2018 £
Ms Elizabeth Butler	**2,985**	2,790
Mr Kenneth Gill*	**2,465**	-
Mr John Morley **	**1,085**	1,705

* Mr Kenneth Gill was appointed as a co-opted member of the Audit and Risk Committee on 12 September 2019.
** Mr John Morley demitted as co-opted member of the Audit and Risk Committee on 18 July 2019.

Investment Committee co-opted members	**2019** **£**	2018 £
Mr Keith Mackay	**1,240**	1,550
Mr Tim Scholefield	**1,550**	2,170
Mr David Stewart*	**620**	-

* Mr David Stewart was appointed as a co-opted member of the Investment Committee on 4 September 2018.

GMC Services International Ltd	**2019** **£**	2018 £
Dr Andrew McCulloch	**930**	1,860
Professor Vikas Shah *	**-**	-

* Professor Vikas Shah was appointed as a director of GMCSI on 1 June 2017 but has yet to claim fees or expenses.

18. Travel and subsistence claimed in 2019

Trustees	2019 £	2018 £
Dame Clare Marx (Chair)*	**6,008**	-
Professor Terence Stephenson (Chair)**	**-**	14,436
Mr Steve Burnett	**2,670**	2,960
Dr Shree Datta***	**461**	932
Lady Christine Eames	**6,157**	6,956
Professor Anthony Harnden	**1,904**	1,502
Baroness Helene Hayman****	**-**	382
Lord Philip Hunt*****	**1,095**	-
Professor Deirdre Kelly	**3,639**	5,104
Professor Paul Knight	**3,777**	4,800
Dame Suzi Leather	**2,659**	3,761
Dr Michael Marsh******	**165**	-
Dame Denise Platt	**2,485**	2,395
Miss Amerdeep Somal	**6,131**	5,780
Total	**37,151**	**49,008**

* Dame Clare Marx was appointed as Council Chair on 1 January 2019.

** Professor Terence Stephenson demitted as Council Chair on 31 December 2018.

*** Dr Shree Datta demitted as a Council Member on 30 November 2019.

**** Baroness Helene Hayman demitted as a Council Member on 31 December 2018.

***** Lord Philip Hunt was appointed as a Council Member on 1 January 2019.

****** Dr Michael Marsh was appointed as a Council Member on 1 January 2019 and demitted on
31 March 2019.

Medical Practitioners Tribunal Service advisory committee members	2019 £	2018 £
Dame Caroline Swift (Chair)	**1,910**	2,174
Mrs Joy Hamilton	**329**	532
Professor Jacky Hayden	**341**	153
Dr Patricia Moultrie	**543**	981
Mrs Judith Worthington	**754**	856

Audit and Risk Committee co-opted members	2019 £	2018 £
Ms Elizabeth Butler	**512**	652
Mr Kenneth Gill*	**777**	-
Mr John Morley**	**595**	1,070

* Mr Kenneth Gill was appointed as a co-opted member of the Audit and Risk Committee on 12 September 2019.

** Mr John Morley demitted as co-opted member of the Audit and Risk Committee on 18 July 2019.

Investment Committee co-opted members	2019 £	2018 £
Mr Keith Mackay	**77**	155
Mr Tim Scholefield	**-**	-
Mr David Stewart*	**64**	-

* Mr David Stewart was appointed as a co-opted member of the Investment Committee on 4 September 2018.

GMC Services International Ltd	2019 £	2018 £
Dr Andrew McCulloch	**195**	104
Professor Vikas Shah *	**-**	-

* Professor Vikas Shah was appointed as a director of GMCSI on 1 June 2017 but has yet to claim fees or expenses.

Senior management team	2019 £	2018 £
Mr Charlie Massey (Chief Executive)	**9,884**	10,426
Ms Susan Goldsmith* (Chief Operating Officer and Deputy Chief Executive)	**19,760**	12,487
Mr Paul Buckley – Director of Strategy and Policy	**6,742**	7,720
Ms Una Lane – Director of Registration and Revalidation	**13,318**	8,407
Professor Colin Melville – Director of Education and Standards	**18,270**	31,025
Mr Anthony Omo – Director of Fitness to Practise	**9,744**	12,197
Mr Paul Reynolds – Director of Strategic Communications and Engagement	**26,354**	14,990
Mr Neil Roberts – Director of Resources	**14,161**	15,177

* Susan Goldsmith left her role as Chief Operating Officer and Deputy Chief Executive on 13 September 2019.

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.

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

19. Post-balance sheet events

At the time of approval of the financial statements, the spread of the coronavirus continues to impact on global financial markets. The long-term impact on investment values, charity investments and pension scheme investments is currently unknown. The charity trustees will continue to monitor the situation and its impact on investment valuations.

Reference and administrative information

We are independent of the UK government and the medical profession and accountable to Parliament. Our powers are given to us by Parliament through the *Medical Act 1983*.

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 MPTS 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 from page 54.

We work with the 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 2019, we received 471 subject access requests under the *General Data Protection Regulation (GDPR)*. This was an increase of 21.1% from 2018.

The number of information requests that we received under the *Freedom of Information Act 2000* in 2019 was 626. This was an 2.1% decrease from 2018.

We achieved 86.6% against our target of responding to 80% of subject access requests within the statutory timeframe.

We achieved 89.8% against our target of responding to 90% of freedom of information requests within 20 working days.

Paying for goods and services

We paid 97% 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	The Royal Bank of Scotland 250 Bishopsgate London EC2M 4AA
Solicitors	The majority of our legal work is carried out by our in-house legal team.
Auditors	Crowe U.K. LLP St Bride's House 10 Salisbury Square London EC4Y 8EH
Actuary and pension scheme adviser	Aon Parkside House, Ashley Road Epsom Surrey KT18 5BS

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

General Medical Council, Regent's Place 350 Euston Road, London NW1 3JN.

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

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