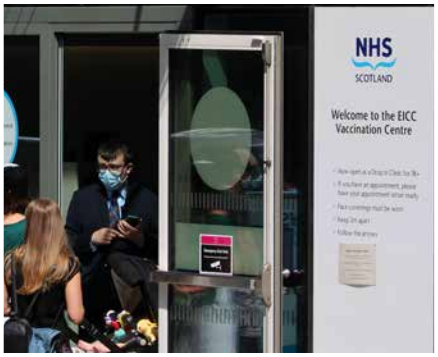
Our annual report 2021

General Medical Council

About this report

Our trustees present this report and financial statement for the year ending 31 December 2021.

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



Contents

Foreword

2021 continued to put our healthcare systems under severe strain. Two years into the COVID-19 pandemic, healthcare professionals were still delivering excellent care under exceptionally difficult circumstances. Some tragically lost their lives, and that loss is deeply felt.

We have seen health services and healthcare workers adapt and innovate rapidly to do the best they can for patients, and their compassion and dedication has been remarkable. But that has taken a toll on doctors' health and well-being. The acute emergency of COVID-19 has now given way to a sustained pressure, and with that come new, longer-term challenges. Our 2021 *The state of medical education and practice in the UK* (SOMEP) report underlined this, with doctors telling us of increasing workloads, fatigue, and burnout, and 23% indicating that they intended to leave the profession.

For doctors to thrive and provide the best patient care, we need inclusive, supportive work environments and compassionate leadership that puts doctors' well-being – and the positive effect it has on patient safety – to the fore. The advantages for patients are clear. Inclusive, communicative teams in which doctors are comfortable asking for help and expressing concerns provide the safest care and create environments where teams learn from mistakes. The GMC has a key role in working alongside employers and doctors to create those environments.

Much or our work in 2021 focused on providing that support at a difficult time for healthcare services across the UK.

In postgraduate training, we approved derogations to curricula so that doctors in training could progress safely and flexibly during the pandemic and, as part of our enhanced monitoring process, we took decisive action to protect patients and doctors in training, including working with health education authorities to remove trainees from training environments where necessary. In undergraduate education, we supported medical schools in making decisions about graduating students whose studies had been disrupted as a result of the pandemic, and continued the rollout of our proactive education quality assurance process to make sure schools maintain the quality of the training they offer even in challenging circumstances.

To reduce pressures on doctors and employers, we rescheduled revalidation submission dates, and worked with colleagues across the system to discuss how appraisals could be used to support doctors to think about and process their experiences of working through the pandemic. In addition, we have taken a flexible and proportionate approach to investigations, knowing that some employers, doctors, and other organisations may take longer to assist with our investigations during this pressurised time, meaning some cases could progress more slowly.

It was also important to us to reassure doctors that we know they are still working in exceptional circumstances. So, we issued updated guidance for decision makers on taking the current context into account when considering complaints. During the winter of 2021 we also launched a campaign of support, reassurance and recognition, in anticipation of seasonal pressures on our health services.

The pandemic also had an impact on our work to support the development of a more sustainable workforce. Enabling international medical graduates to join our health services is essential, and in 2020 this flow was heavily impacted by travel restrictions and social distancing. In order to address this, we opened a second clinical assessment centre, bringing testing capacity back to pre-pandemic levels so that more new doctors can join the UK medical workforce. As a result, over 10,000 international medical graduates joined the UK medical register in 2021.

While significant challenges remain, there are also opportunities that should be embraced. Our 2021 SOMEP report evidenced that supportive, collaborative cultures had improved across healthcare teams. We also saw our health services adapt and innovate rapidly. These are things we must learn from and build upon for the future: the benefits are clear, for both patients and doctors.

2021 was also the year in which we committed to targets to tackle racial inequalities in medicine, working with partners across healthcare services to lay foundations for improvements in fairness.

We know that doctors from ethnic minority backgrounds, or who qualified outside the UK, are significantly more likely to be referred to us by their employers, and that they also face barriers when it comes to medical education and training. Beyond the obvious need to address a situation that is fundamentally unfair, with just under 65% of new doctors identifying as being from a mixed, Black, or Asian ethnic minority background, our health services will not be able to retain the professionals they need, let alone enable doctors to fulfil their potential and maximise their contribution, if we do not offer them the support and inclusivity they should rightly expect. We have identified two targets in this respect: we want to see the end of inequality in referrals by 2026 and in educational attainment by 2031.

These are ambitious targets, and we cannot achieve them alone, so we will continue to engage and work with employers, educators, and other stakeholders to deliver real change. As part of this work, we are also reviewing the fairness of our own processes.

As we look ahead, there are fundamental changes on the horizon for medical regulation.

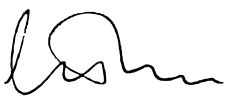
We expect legislative reforms to empower us to be a more flexible and responsive regulator, one that can deal with complaints more quickly and reduce stress for everyone involved. We will also be able to streamline our registration processes to sustain a steady flow of new doctors into the UK's healthcare systems. We will have new powers linked to education and training, so we can support medical professionals through their studies and career. In a historic move for medical regulation, legislative reforms will also bring two new professional groups under our regulatory umbrella: physician associates (PAs) and anaesthesia associates (AAs). PAs and AAs are pivotal to healthcare teams. Our planning to bring these groups under our regulation has been informed by productive engagement with PAs, AAs, and other healthcare professionals and we look forward to continuing to develop these relationships.

We also made further preparations to introduce a new assessment for doctors wishing to join the medical register – the Medical Licensing Assessment. Graduates who pass the assessment will have demonstrated they meet an agreed standard of proficiency – giving patients, employers, and fellow doctors greater confidence in their competence and their skills, wherever they trained. We must also look ahead to our review of *Good medical practice*, the core guidance that outlines the values, knowledge, and behaviours we expect from members of the profession. It underpins not only doctors' practice, but also their education and training, and is at the heart of what it means to be a good doctor.

There is much to do towards recovery, renewal, and reform as we emerge from the most acute phase of the pandemic, but as this report sets out, we have made considerable progress in what was year one of our five-year corporate strategy.

Our role is to make sure medical professionals continue to be trained and supported to deliver the safest and most effective care to patients and the public. We are confident that we remain on course to play this role, working with doctors, employers, and educators to protect and promote patient safety across the UK.

Charlie Massey, Chief Executive



Professor Dame Carrie MacEwen, Chair

Our role in the UK's healthcare systems

We are the UK's independent regulator of doctors. Our role is to protect the health, safety, and well-being of patients and the public. We do this by:

- promoting and maintaining professional standards for doctors
- overseeing UK medical education and training
- taking action when the safety of patients or the public's confidence in doctors is at risk.

How we keep patients safe

Keeping patients safe and protecting public confidence in doctors is at the core of our work.

- We set the standards for doctors. Our standards define what makes a good doctor. They set out the professional values, knowledge, skills, and behaviours required of all doctors working in the UK. To develop our standards and guidance, we consult with patients, doctors, employers, and educators.
- We oversee all stages of doctors' undergraduate and postgraduate education and training in the UK. We make sure doctors get the education and training they need to deliver high-quality care throughout their careers. We do this by setting out the outcomes needed for graduates and by approving curricula for postgraduate education. We also monitor training environments to support safe, effective learning.
- We manage the UK medical register. We check doctors' qualifications before they join the register. When necessary, we check their skills. We also check with medical schools or previous employers to find out if they have any concerns about a doctor's ability to practise safely.
- We make sure doctors keep their knowledge and skills up to date. We do this through revalidation, a system that checks that all doctors have an annual appraisal and that they are following the standards we set. Revalidation is a fundamental part of clinical governance. It gives patients and the public assurance that doctors in the UK are part of a governed system. It also supports the identification and management of concerns at an early stage.
- We investigate and act on concerns about doctors. When someone raises a concern about a doctor with us, we assess whether it meets our threshold for investigation. If it does, we investigate. At the end of the investigation, we decide what action we need to take. This can include taking no action, issuing advice or a warning, or agreeing that the doctor will restrict their practice, retrain, or work under supervision. In some situations, we refer the case to the Medical Practitioners Tribunal Service (MPTS).

The MPTS is independent in its decision making and operates separately from the investigatory role of the GMC. It produces its own separate annual report.

Our performance

Every year, the Professional Standards Authority assesses our performance as a regulator across our four core functions: education and training, registration, guidance and standards, and fitness to practise.

Its latest annual assessment confirmed that we successfully met all 18 of its Standards of Good Regulation in 2020–2021. This means we are performing to a high standard as a regulator. It also reflects the commitment we make in our work to standards such as:

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

General standards

5 out of **5**

Guidance and standards

2 out of **2**

Education and training

2 out of **2**

Registration

4 out of **4**

Fitness to practise

5 out of **5**

Total standards met

18 out of **18**

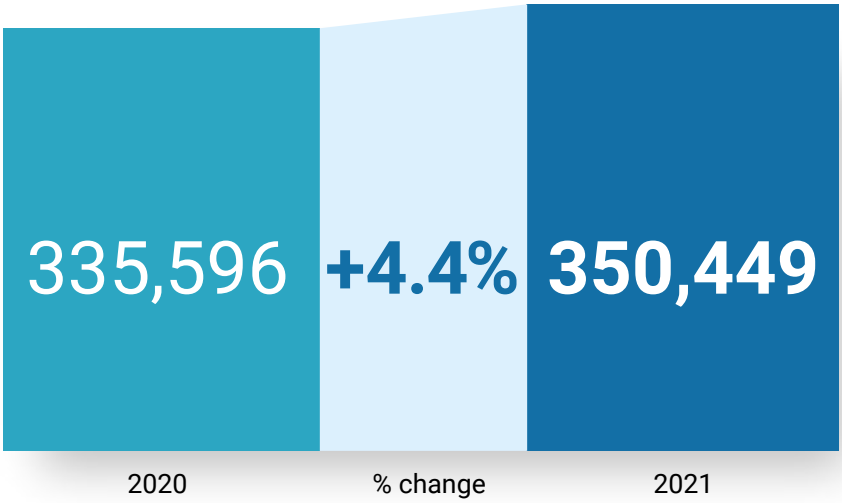
2021 at a glance

2021 at a glance

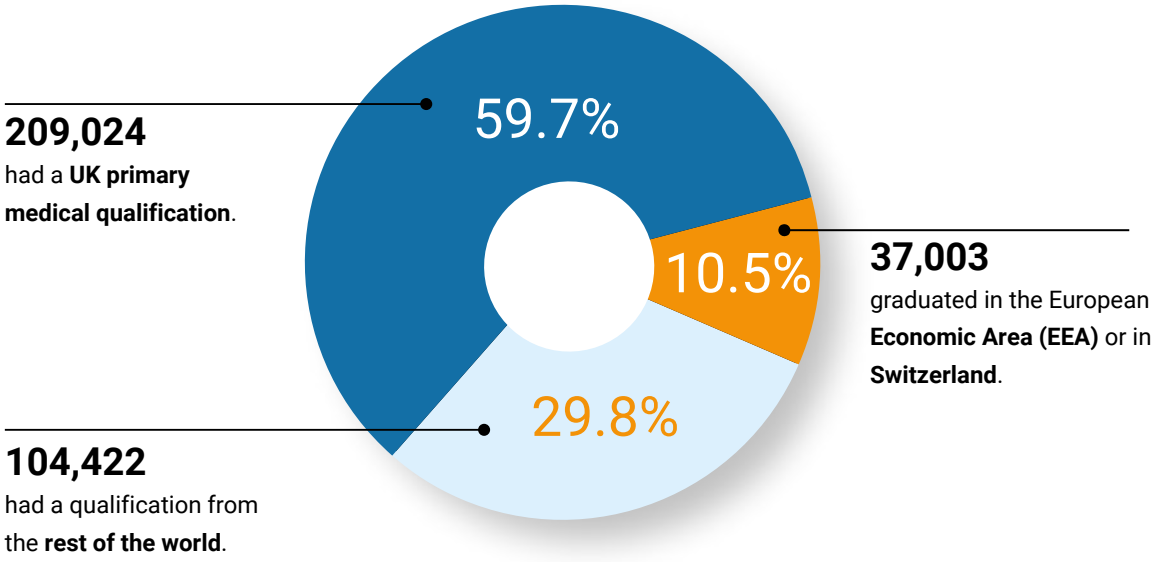
The medical register

All figures as of 31 December 2021 (or 2020) unless otherwise specified.
Visit GMC Data explorer to learn more about doctors' education and practice in the UK.

Total doctors on the register*



Where they graduated



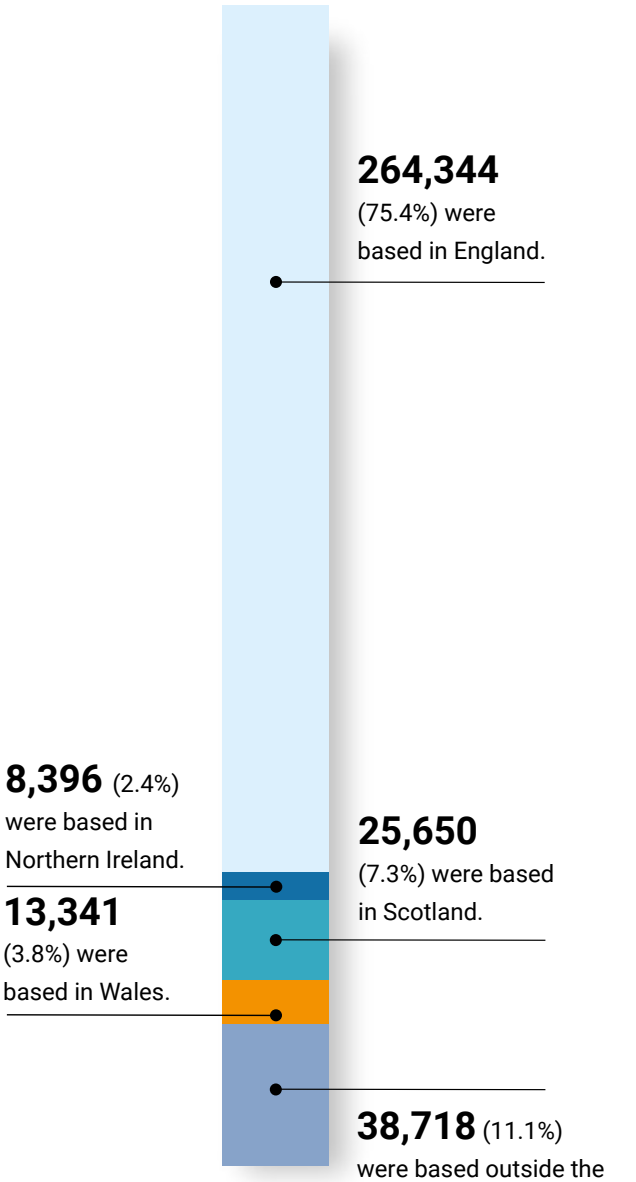
209,024
had a **UK primary medical qualification**.

37,003
graduated in the European **Economic Area (EEA)** or in **Switzerland**.

104,422
had a qualification from the **rest of the world**.

* Including doctors with temporary emergency registration (TER) – see pages 10 and 37 for more information.

Doctors on the register by location*



264,344 (75.4%) were based in England.

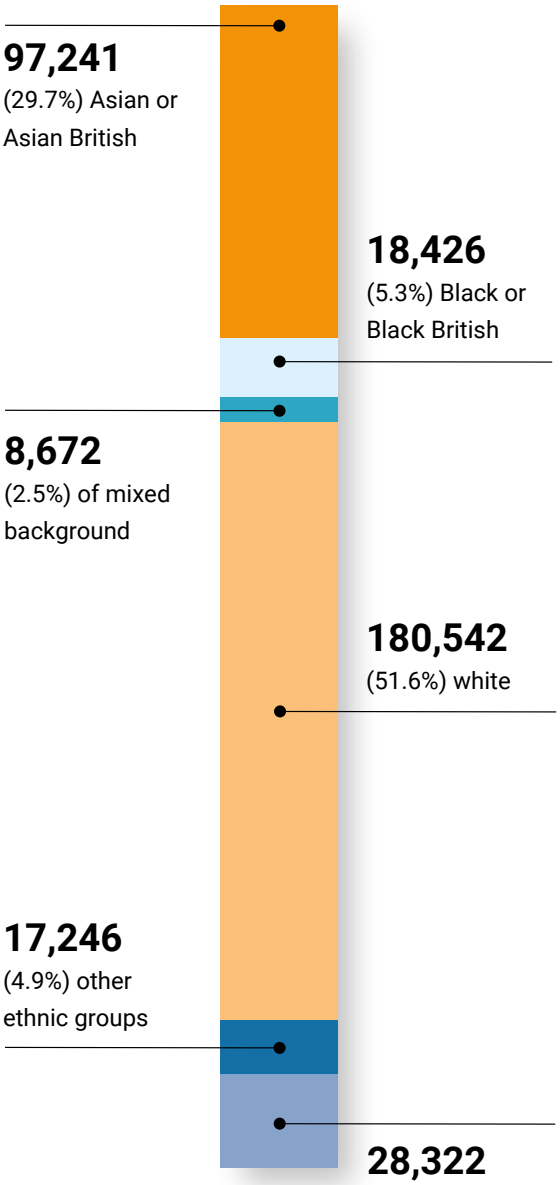
8,396 (2.4%) were based in Northern Ireland.

25,650 (7.3%) were based in Scotland.

13,341 (3.8%) were based in Wales.

38,718 (11.1%) were based outside the UK or did not provide us with enough information to establish their location.

Doctors on the register by ethnicity



97,241 (29.7%) Asian or Asian British

18,426 (5.3%) Black or Black British

8,672 (2.5%) of mixed background

180,542 (51.6%) white

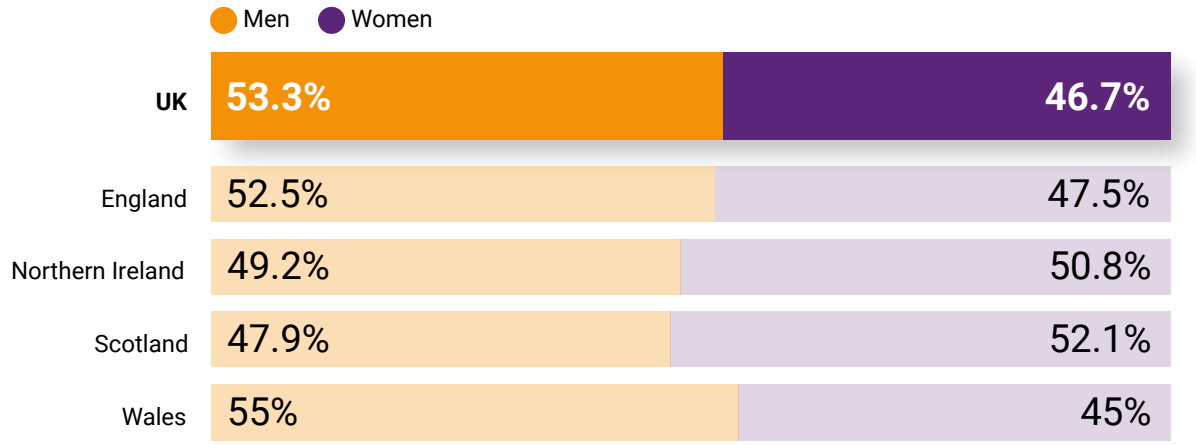
17,246 (4.9%) other ethnic groups

28,322 (8%) did not provide information on their ethnicity

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

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

Doctors on the register by gender



Total doctors on the GP Register*

79,685

Up **2.6%** from 2020 (**77,659**)

64,676 (81.2%) were residing in **England**.
2,204 (2.8%) were residing in **Northern Ireland**.
7,457 (9.4%) were residing in **Scotland**.
3,284 (4.1%) were residing in **Wales**.
2,064 (2.6%) either were located **outside the UK** or did not provide us with enough information to establish their location.

Total doctors on the Specialist Register*

107,009

Up **2.5%** from 2020 (**104,383**)

80,920 (75.6%) were residing in **England**.
2,577 (2.4%) were residing in **Northern Ireland**.
8,330 (7.8%) were residing in **Scotland**.
4,136 (3.9%) were residing in **Wales**.
11,046 (10.3%) either were located **outside the UK** or did not provide us with enough information to establish their location.

* Including doctors with temporary emergency registration (TER) – see pages 10 and 37 for more information.

Temporary emergency registration

As part of its response to the COVID-19 pandemic, in 2020 the UK Government asked us to give temporary emergency registration (TER) to doctors who had left the register in recent years. A number of these doctors played a valuable role in patient care and vaccine rollout during the pandemic. The UK Government has since asked regulators to close TER in September 2022.*

As of 31 December 2021,

22,718

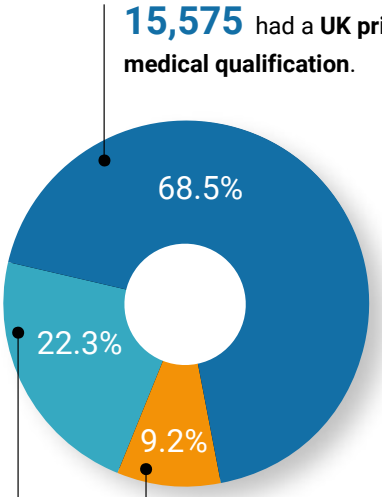
doctors on our register held **TER** with a licence to practise.

That is

10.2% ↓

fewer than at the same date in 2020.

TER doctors by where they graduated

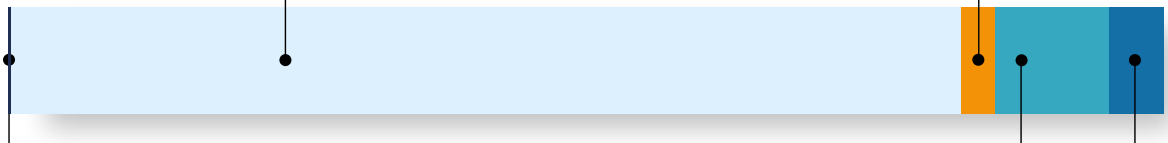


15,575 had a **UK primary medical qualification**.

2,082 had graduated in the **EEA** or in **Switzerland**.

5,061 had a qualification from the **rest of the world**.

TER doctors by location



18,642
(82%) were residing in **England**.

656
(2.9%) were residing in **Northern Ireland**.

201
(0.9%) were based **outside the UK** or did not provide us with enough information to establish their location.

2,194
(9.7%) were residing in **Scotland**.

1,025
(4.5%) were residing in **Wales**.

* For more information on temporary emergency registration, see page 37.

In 2021, we granted:

19,977

applications for first entry to the register.

That is up

13.7% ↑

from 2020 - (**17,234**).

7,377 (36.9%) were from doctors with a **UK PMQ**.

2,591 (13%) were from doctors who graduated in the **EEA** or in **Switzerland**.

10,009 (50.1%) were from doctors with a qualification from the **rest of the world**.

3,326

applications to join the GP Register.

That is up

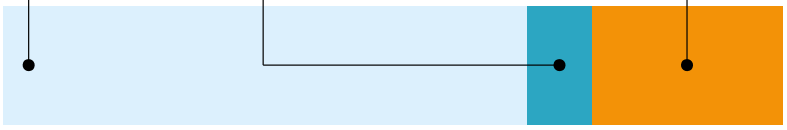
10.7% ↑

from 2020 (**2,970**).

2,299 (69.1%) were from doctors with a **UK PMQ**.

191 (5.8%) were from doctors who graduated in the **EEA** or in **Switzerland**.

836 (25.1%) were from doctors with a qualification from the **rest of the world**.



4,613

applications to join the Specialist Register.

That is down

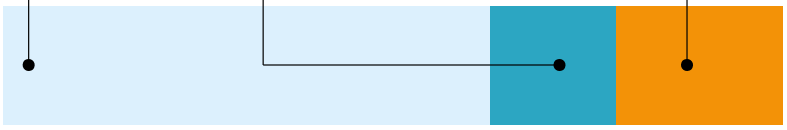
3.1% ↓

from 2020 (**4,755**).

2,959 (64.1%) were from doctors with a **UK PMQ**.

680 (14.8%) were from doctors who graduated in the **EEA** or in **Switzerland**.

974 (21.1%) were from doctors with a qualification from the **rest of the world**.



Professional and linguistic assessments board (PLAB)

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

PLAB 1

In 2020 and 2021 our capacity to deliver PLAB 1 tests around the world was severely impacted due to the rise in COVID-19 cases across the globe. In many cases we were forced to cancel testing due to local restrictions and in the interest of safety.

10,431

candidates took PLAB 1 in 2021, a very similar number to 2020 (10,601).

We appreciate that the challenges with the delivery of PLAB 1 have been frustrating for candidates. We have been working hard to increase the availability of PLAB 1 places, and hope that the vaccine rollout will allow us to welcome more doctors to UK practice soon.

PLAB 2

In 2021 we made significant investments to increase PLAB 2 examination capacity following the pandemic, including the creation of a second PLAB 2 circuit in Manchester.†

This resulted in

8,648

candidates taking PLAB 2 in 2021, a 136.7% increase on 2020 (3,654).

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

† See page 37 for more information.

Setting and maintaining standards

Revalidation

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

As part of our response to the pandemic, in 2020 and 2021 we postponed revalidation submission dates for around 60,000 doctors, helping healthcare settings cope with system pressures by making sure doctors could spend as much time as possible providing care.

In 2021 we received

65,893

recommendations for revalidation.

55,488 of the recommendations were submitted by designated bodies located in **England**.

2,100 were submitted by designated bodies located in **Northern Ireland**.

5,125 were submitted by designated bodies located in **Scotland**.

3,035 were submitted by designated bodies located in **Wales**.*

53,322

doctors were revalidated in 2021.†

44,778 were located in **England**.

1,580 were located in **Northern Ireland**.

4,152 were located in **Scotland**.

2,327 were located in **Wales**.

485 either were based **outside the UK** or did not provide us with enough information to establish their location.

We made decisions on

98.2%

of the total recommendations we received in 2021 **within 5 working days** from when we received them, **exceeding our target of 95%.**

11,041 We approved **deferral of revalidation submission dates** for 11,041 doctors.

398 We **withdrew the licences** of 398 doctors on our register.‡

* The remaining 145 are not associated to a specific location as they are the result of administrative processes necessary to consolidate data.

† Depending on where they work, single doctors can receive more than one recommendation.

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

Outreach

Our outreach teams delivered training on our standards to:

16,974 **doctors** in **527 sessions** and

That is up **73.6%** from 2020 (9,776).

8,218 **students** in **71 sessions** across the UK.

That is up **9.2%** from 2020 (7,529).*

93% of the doctors and **93%** of the students who attended one of our outreach workshops across the UK said **their knowledge of the GMC's role and standards improved**.

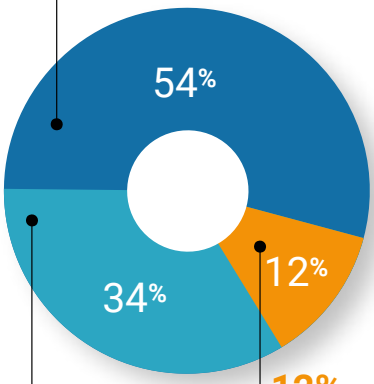
84% of the doctors and **87%** of the students who attended a session across the UK said **it had improved their impression of the GMC**.

Our standards enquiry team answered:

613 enquiries about our guidance.

That is down **18.9%** from 2020 (**756**).

Around **54%** of the enquiries were **from doctors** (2020: 65%)



34% from **members of the public** (2020: 22%)

12% **were from others,** including staff from professional organisations, students and the police (2020: 13%).

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

The team delivered **208 Welcome to UK Practice workshops** in 2021, involving **6,471 doctors** – up **72%** from 2020 (**3,762**).†

Our employer liaison advisers held **1,284** meetings with responsible officers.

They also provided fitness to practise advice in relation to **2,205** doctors.

* We have seen a smaller increase in student engagement due to the continued disruption in higher education caused by the ongoing pandemic.

† See page 31 for more information.

Overseeing medical education and training

Quality assurance

We regulate all stages of a doctor's undergraduate and postgraduate education and training in the UK. We set standards and expected outcomes, and we carry out quality assurance (QA) work to make sure standards are maintained.

Our undergraduate and postgraduate QA processes promote and encourage local management of concerns about the quality and safety of medical education and training.

At the onset of the pandemic in 2020, we had to suspend education QA visits temporarily for safety reasons. Later in the year, we were able to resume them virtually, and in 2021 we were able to significantly increase the number of visits.

In 2021 we carried out **208** education QA visits.

That is up **136%** from 2020 (**88**).

165 of the visits were in **England**.
6 of the visits were in **Northern Ireland**.
24 of the visits were in **Scotland**.
13 of the visits were in **Wales**.

154 of them were **QA visits to new medical schools, established medical schools, or clinical environments** where medical education and training take place.

54 of them were **enhanced monitoring visits**, aimed at promoting the resolution of concerns about the quality of postgraduate training locally.

From our QA visits, we found:

19 areas of **good practice or working well**.

21 areas where our **standards were met**, but where we **identified improvements** that could be made.

18 areas that **required improvement**.*

As a result of our enhanced monitoring visits:

9 cases relating to postgraduate education **were escalated to our enhanced monitoring process**.

10 **enhanced monitoring cases** escalated previously **were resolved**.

In order to make sure postgraduate training could continue even if affected by the pandemic, we worked with partners to apply some changes to curricula and exams.

By the end of 2021, we had **approved 80 derogations** to training curricula and temporary changes to **114 examination components**.

We also supported medical schools in **making decisions about graduating students** whose studies had been disrupted as a result of the pandemic.

* Not all QA visits lead to specific findings like those listed here – in some cases nothing of significance is found, as nothing has changed since the previous visit, or nothing has been found worthy of particular note (ie. education and training are working as expected).

Supporting the people we serve

In 2021 our Corporate review team received **1,884** **complaints** about our service.*

This is a **2.3%** decrease on 2020 (**1,928**).

It also logged **6,543** **compliments**.

This is a **100.9%** increase on 2020 (**3,257**).*

In 2021 our patient liaison service held 285 meetings with patients who had raised a concern with us.

88%	of those who attended one of our patient meetings were satisfied or very satisfied with the patient meeting experience.
96%	agreed or strongly agreed that patient liaison staff showed empathy for their situation.
92%	agreed or strongly agreed that they were satisfied that their concerns had been understood during the meeting.
95%	agreed or strongly agreed that the meetings helped them to understand what action the GMC could take.

Our contact centre answered **162,504** calls and **131,157** emails or letters.

77% of the calls and emails we received were from doctors, and **23%** from members of the public and others.

The contact centre also handled **65,178** webchat sessions.

* This significant increase is also partially due to efforts we made to make sure colleagues consistently capture and record the compliments we receive.

Investigating and acting on concerns

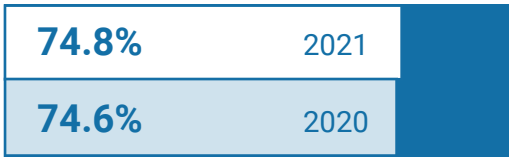
Concerns raised

9,074 **concerns were raised with us in 2021.**

This represents a **7.2%** increase on 2020 (8,468 concerns).

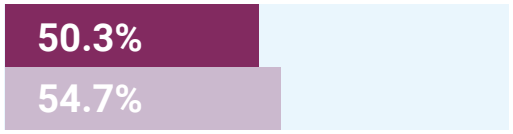
62.7%	**5,685** were raised in relation to incidents that happened **in England**. That is a similar percentage to 2020 (62%).
2.2%	**199** were raised in relation to incidents that happened **in Northern Ireland** – a slightly higher percentage than in 2020 (1.8%).
4.2%	**381** were raised in relation to incidents that happened **in Scotland** – a slightly lower percentage than in 2020 (4.9%).
2.8%	**253** were raised in relation to incidents that happened **in Wales** – around the same percentage as in 2020.
28.2%	For **2,556** of them either there was **no incident location specified, or they happened outside the UK** – a similar percentage to 2020 (28.5%).

Percentage of concerns raised by the public



Of the 9,074 concerns that were raised with us in 2021, 74.8% were raised by patients or members of the public. That is very similar to 2020 (74.6%).

The percentage of concerns relating to incidents that happened in **England** raised by the public was 72.2% (a slight increase from 70.7% in 2020).



In **Northern Ireland**, it was 50.3%, (a decrease from 54.7% in 2020).

In **Scotland**, it was 70.6%, (similar to 2020 - 70.2%).

In **Wales**, it was 60.9% (a decrease from 66.8% in 2020).

84.4% of the concerns we received with no location specified or having happened **outside the UK** were raised by the public (a slight decrease from 85.9% in 2020).

Investigations

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

925

(**10.2%**) of the concerns we received in 2021 met our **statutory threshold for investigation**.

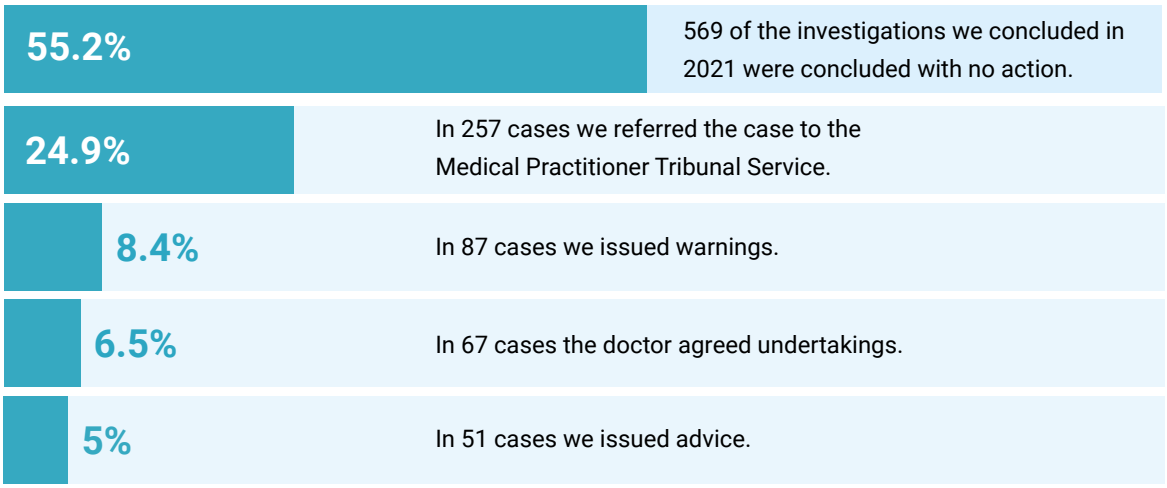
That is a lower percentage than in 2020 (**12.3%**).

214

(**23.1%**) referred to concerns raised by **members of the public**.

That is a lower percentage than in 2020 (**28.1%**).

Outcomes of investigations



Provisional enquiries

In certain cases, we make provisional enquiries, where we look at information at an early stage of a case, to provide swifter resolution for patients and doctors. If the evidence shows there is no future risk to patients, and regulatory action is not required, we will not move to a full investigation. For cases where we have concerns about patient safety, we will carry out a full investigation.

490

(**5.4%**) of the concerns we received in 2021 were **considered under provisional enquiry**.

↑

That is a higher percentage than in 2020 (**4.9%**).

382

of these (**78%**) referred to concerns raised by **members of the public.**

→

That is a similar percentage to 2020 (**77.3%**).

In

333

cases (**68%**) we closed the provisional enquiry with **no action**.

In

64

cases (**13%**) we **progressed the case to investigation**.

In

93

cases (**19%**) the provisional enquiry was **still open** as of 31 December 2021.

Outcomes of Medical Practitioners Tribunals Service tribunals

In 2021, the Medical Practitioners Tribunal Service held a total of 269 tribunals.

33.8%	In 91 of them, the tribunal suspended the doctor who had been referred to the tribunal.
26.4%	In 71 cases the tribunal found no impairment.
21.6%	In 58 cases the doctor was removed from the register.
10.4%	In 28 cases, while the tribunal found no impairment, it issued a warning.
5.2%	In 14 cases the doctor had conditions put on their practice.
1.5%	In 4 cases doctors voluntarily removed themselves from the register.
0.7%	In 2 cases the doctor's practice was found to be impaired but no further action was taken.
0.4%	In 1 case the doctor agreed to undertakings.

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

In 2021 we made 10 appeals. That is 1 more than in 2020. 1 of the appeals we made was successful, while for 9 of them, as of 31 December 2021, we did not yet have a decision.

Delivering on our strategy

Delivering on our strategy

2021 marked the first 12 months of our 2021–2025 strategy. The strategy is underpinned by our 2030 vision to be an ever more effective, relevant, and compassionate regulator – for patients, for the public, for professionals, and as an employer.

Four main themes shape all our work:

In this section of the report, we describe how we worked to achieve these goals in 2021 through various initiatives, in close collaboration with our partners.

Responding to the pandemic

Throughout the year, COVID-19 significantly impacted on our operations. As in 2020, much of our work in 2021 focused on supporting doctors, students, and employers at a particularly difficult time. As part of this:

- we introduced temporary emergency registration in 2020 for doctors who left the register in recent years. Many of these doctors, a number of whom remained active in 2021, played a valuable role in delivering patient care. Others provided vital support for the vaccination programme.
- we opened a new temporary clinical assessment centre to allow Professional and Linguistic Assessments Board tests to continue at pre-pandemic capacity, allowing more doctors to join the profession.
- we approved a number of temporary changes to education curricula to support safe and flexible progression for doctors in training.
- we supported medical schools in making decisions about graduating students whose studies had been disrupted as a result of the pandemic.
- we rescheduled revalidation dates to ease pressure on doctors and their employers.
- we issued a joint statement with other professional regulators, assuring health and social care staff that we understood and would consider the contextual challenges caused by the pandemic when making decisions about fitness to practise or revalidation.
- we introduced new guidance for decision makers in fitness to practise, taking into account the circumstances and challenges brought about by the pandemic.

Equality, diversity, and inclusion

The pandemic also highlighted longstanding inequalities, including the impacts of racial discrimination and disadvantage.

We are fostering equality, diversity, and inclusion (ED&I) in everything we do as a regulator and employer. Tackling discrimination and inequality is the right and fair thing to do. It is also vital to helping retain doctors working in the UK and to supporting high-quality patient care. So, we have embedded ED&I into each aim of our strategy.

Reflecting this, in February 2021 we committed to achieving specific targets to tackle racial inequalities. We want to eliminate inequalities in fitness to practise referrals by 2026 and in student attainment based on race or other factors linked to ethnicity by 2031. We cannot achieve these targets alone as improvement relies on wider, systemic change. So during 2021, we worked with different partners across the UK's healthcare systems to start laying the base for these improvements.

Enabling professionals to provide safe care

Research shows that healthcare professionals who work in supportive environments where well-being is a priority are better able to give patients safe, high-quality care. We work with partners to improve working environments and cultures, making them supportive, inclusive, and fair for medical professionals. As a result, patients will benefit from safer and better care and the profession will keep and attract more professionals. We also continue to work with patients and medical professionals to make sure our guidance remains relevant and effective and that it represents patients' diverse needs. We addressed this aim in 2021 through a number of initiatives.

Updating our guidance

Reviewing *Good medical practice*

Good medical practice is the core guidance that all doctors working in the UK must follow. It shapes the way they care for patients by describing the values and behaviours they need to show.

We published the current version of *Good medical practice* in 2013. Since then, patients' expectations and the way healthcare is delivered have changed. We are also preparing to take on the regulation of physician associates (PAs) and anaesthesia associates (AAs). So we are reviewing the guidance to make sure it meets patients' needs and supports the medical professionals we regulate to provide safe, high-quality care. There are four main areas where we propose to update the guidance:

- patient-centred care, decision making, and communication with patients
- tackling bias and discrimination in the treatment of patients and professionals
- working effectively with colleagues
- leadership and organisational culture.

Since we started the review:

- we have invited doctors, patients, and other stakeholders to sign up to our community of interest. They will receive updates about the review and help to shape our work.
- we have undertaken scoping to develop an evidence base including: researching findings from recent reviews and public inquiries, gaining insights from PAs and AAs on the interim standards, and reviewing intelligence gathered from targeted engagements with stakeholders.
- we have commissioned research on how our guidance is currently used by doctors and other healthcare professionals.

To help with the review, we also set up an advisory forum. The forum acts as a sounding board for key decisions around the review and the changes we are planning to make. Its 12 members bring a wealth of expertise in areas such as medical ethics, patient care, multi-disciplinary working, and equality and diversity.

We expect to complete the review and publish a new version of *Good medical practice* in 2023. During 2022, we will consult with doctors, patients, employers, and other stakeholders in the UK's healthcare systems. We have also commissioned an external behavioural insight specialist to research and engage with over 200 patients with experience of the healthcare system. Inputs from these activities will help us decide what changes we need to make.

It is our ambition that the new edition of *Good medical practice* better reflect the needs and expectations of patients, service users, and carers and the context in which medical practitioners work. It will support professionals to work in partnership with the people they care for, and to navigate the challenges of delivering high-quality, person-centred care in a service under pressure. We will also strengthen duties around equality, diversity, and inclusion. We hope the changes will help make workplace culture safer and more responsive for patients, and our health services more inclusive, fair, civil, and compassionate for all.

Updates to our ethical hub*

Our ethical hub is a collection of online resources exploring how to apply our guidance in practice. It focuses on areas which doctors often ask about or find challenging. The resources include case studies, decision tools, flowcharts, and videos. They are all designed to support doctors with common ethical scenarios, such as adult safeguarding, trans healthcare, and caring for people with learning disabilities.

In 2021, we made several changes to the hub. In particular:

- we updated the style of our menus, which has resulted in increased engagement with our learning materials
- we published new content regarding identifying and tackling sexual misconduct
- we provided additional information on remote consultations
- we added more information about our upcoming regulation of PAs and AAs
- we improved our decision-making flowchart, complementing our updated guidance
- we updated our advice in relation to COVID-19, simplified the information available and added detailed information about vaccination.

In 2021, the hub pages maintained a high volume of visitors. Keeping the pages up to date has contributed to this retention rate.

* This section was updated 19/08/2022 because the original version contained information and statistics that were not part of work on the ethical hub.

Prescribing

In February 2021, we published our updated *Good practice in prescribing and managing medicines and devices* guidance. The new guidance came into effect on 5 April 2021. We updated it after a call for evidence on remote consultations and prescribing that launched in 2019. We wanted to understand if our guidance was keeping pace with changes in this area. The new guidance also responds to the surge in remote consultations we saw in recent years. This rise has only been increased by the onset of the pandemic.

We received 75 responses to our consultation from individuals and organisations with experience in this field. These responses helped us to shape the update.

The guidance provides updated advice on both face-to-face and remote prescribing. It is vital that the principles of good practice apply whether in a face-to-face or a remote setting. We also produced some common scenarios to support the guidance.

> The updated guidance was received very positively. Five days after it was launched it had already been downloaded almost 5,000 times.

The new guidance helps prescribers to understand their responsibilities. In turn, this helps them to prescribe in a safe, informed way. It supports doctors who are navigating what for many has become a new reality of remote medicine, helping them maintain good patient care amid challenging circumstances.

Working with partners to identify and address risks to patient safety

Maternity care

Maternity is a complex area of medicine that requires teamwork across disciplines. When things go wrong, the impact can be tragic. It is also an area that has markedly worse outcomes for women from ethnic minority backgrounds.

The issues and concerns in the UK's maternity services are well documented and go back at least two decades – with several high-profile cases, various reviews and inquiries, reports from other regulators, maternity services featuring regularly in both national and regional joint services oversight groups, and various maternity-specific efforts nationally and locally.

There is a significant amount of work going on across providers, regulators, and others to understand and improve maternity care. We have been working with partners to understand and act on concerns and to help improve the culture in maternity departments.

Sharing data and insights

Across UK healthcare, governments, providers, regulators, and others are committed to building, understanding, and acting on data and insights. We share that commitment and are taking an increasingly collaborative approach – including sharing our maternity data and insights to help identify risks early, increase cohesion between regulators, and address emerging issues. As part of this, we are currently working with the Nursing and Midwifery Council (NMC) and the Care Quality Commission (CQC) on a shared data platform to explore measures that might help identify struggling maternity departments.

Improving workplace cultures

Our outreach teams have been engaging with the National Health Service England/Improvement (NHSEI) Culture Working Group and regional perinatal oversight groups to shape and improve maternity culture. Our current focus is joint work with the NMC, Health Education England (HEE), and NHSEI to develop our guidance and deliver Professional Behaviour and Patient Safety (PBPS) sessions for targeted maternity units. The sessions can be delivered face to face or virtually, with content focusing on maternity care. We are now working with NMC and Regional Chief midwives to deliver PBPS sessions in all regions in England over 2022.

In collaboration with the NMC and Regional Chief Midwives, we have also been delivering joint regional events to maternity professionals, for example, on duty of candour.

Monitoring and addressing emerging risks

We continue to engage with the National and Regional Joint Strategic Oversight Group (JSOG) framework in England. The framework provides a forum for healthcare regulators, NHS England, and NHS Improvement to share and discuss intelligence on emerging risks to patient safety and to develop common approaches to address them. The other partners in the framework include the Care Quality Commission, Health Education England, and the Nursing and Midwifery Council.

In 2021, we contributed to discussions at a national level on the quality of training and on leadership. At a regional level, we continued to work with other regulators and stakeholders to share data and intelligence. We also continued to oversee and address areas of emerging risk.

Engaging with doctors, students, and other partners to promote safe care

> “Thank you both very much for such a fantastic workshop yesterday. The trainees were enthusiastic and learned a lot from the case scenarios and discussion.”
>
> - Training programme director

Our outreach teams and colleagues from our education quality assurance teams meet with doctors, students, employers, educators, and other partners in the UK’s healthcare systems to:

- improve understanding of our role and the support we offer
- promote and support excellence in medical education and practice
- identify and address risks to patients before harm occurs
- monitor the quality of medical education, working with partners to address challenges in training environments
- support employers in delivering revalidation, addressing and managing concerns about doctors, and strengthening training environments
- support the continuous development of local clinical governance systems to maintain and improve patient care.

In 2021, our regional and national liaison advisers held just under 600 interactive workshops, involving around 17,000 doctors and 8,200 students. The majority of the workshops were held online due to the ongoing pandemic. The ethical topics most frequently covered included decision making and consent, raising concerns, and confidentiality. Our employer liaison advisers also held over 1,200 meetings with responsible officers. In these meetings, they discussed our handbook for effective clinical governance for the medical profession and how it can help strengthen local systems. They also provided fitness to practise advice in relation to just over 2,200 doctors.

Our efforts in this area enable us to work with doctors and other partners to protect and promote patient safety in different ways. In the following pages are some examples of how our liaison advisers have responded to requests from our partners to contribute to their programmes of work.

In **England**, we have done significant work to support doctors at the start of their career.

- We collaborated with NHS England, NHS Improvement, and HEE to design and implement the Midlands Charter. The charter aims to support doctors in training.
- We contributed to the design of NHS England's standardised induction.
- We contributed to HEE's returners induction pilot.
- We participated in NHS Professionals' Doctors Gateway programme. The programme aims to help UK doctors who studied in the EU gain experience to develop a career in the UK.

> "Just the fact that you're reaching out to individual universities to hold sessions for students shows you really care."
> - Student attending an outreach session

> "Great reminder that everyone is responsible for patient safety and that the standard you walk past is the standard you accept."
> - Doctor attending an outreach session

In **Northern Ireland**, we provided educators and doctors in training with advice on ethical scenarios. We also provided information on our fitness to practise work. The work included:

- a session regarding student fitness to practise (FTP), attended by staff from both medical schools in Northern Ireland. The session helped academic staff understand how we make FTP decisions. It was a well-attended event and feedback was very positive.
- a session involving over 100 GPs in training. The session focused on raising and acting on concerns, and on appropriate use of social media. The training was well received, so we will continue to run it in 2022.

In **Scotland**, we engaged with partners to promote our work on equality, diversity, and inclusion.

- We piloted a half-day workshop around the findings from *Fair to refer?* and our commitment to eliminate differentials in FTP referrals and in attainment. The workshop was hosted by the NHS Grampian Health Board. As part of it, participants discussed local case studies and how implementing recommendations could help address issues.
- Following concerns expressed in NHS Scotland North about the expectations on fulfilling the requirements of the Recognition and Approval of Trainers scheme during the pandemic, we ran a session to reassure trainers about our expectations regarding the scheme and how the GMC has sought to support them and trainees during the pandemic.

In **Wales**, we engaged with doctors in training around different topics.

- We ran tailored interactive sessions with GP trainees in the Bridgend GP Training Scheme network. The sessions focused on decision making and consent, remote consultations, addressing unprofessional behaviour, and the use of social media during lockdown. They also sought to clarify some aspects of our FTP work.
- We developed a bespoke induction programme for IMG doctors at Aneurin Bevan University Health Board. The pilot was a great success and had 100% positive feedback. We covered an introduction to the GMC, key guidance topics, professionalism, and common misconceptions about our work. We plan to run two full-day induction workshops for IMG doctors every year.
- We began work to better support specialty and associate staff doctors wishing to apply for a Certificate of Eligibility for Specialist Registration. Work is well underway to embed a supportive framework for those who apply.

> “Thank you so much for an excellent session. The comments were all very good and I am sure the attendees went away feeling they had gained a lot. I sure did!”
>
> - Assistant Medical Director

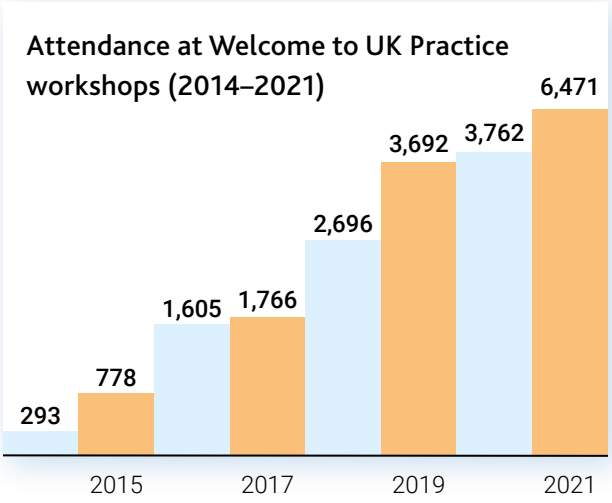
Welcome to UK Practice

In 2020, we began running online versions of our free Welcome to UK Practice (WtUKP) workshops. As the disruption caused by the pandemic continued into 2021, we expanded this approach.

The workshops are aimed at doctors new to working in the UK. They are designed to help doctors adjust to working in the UK's healthcare systems and are delivered by our regional liaison advisers, national office liaison advisers, and by GMC associates. They cover a range of possible ethical scenarios doctors might encounter. The sessions offer advice on how to tackle them and explain how to get support. They also provide insights into aspects of the different healthcare systems across the four countries of the UK and give participants a chance to meet other internationally qualified doctors starting their career in the UK.

The online workshops received consistently positive feedback and previous evaluations have confirmed they are effective in achieving their aims. Our long-term goal is to establish a hybrid model of engagement, combining digital engagement with traditional face-to-face engagement. We will also work with partners to make the workshops an integral part of induction programmes across the four countries of the UK.

> "I am extremely happy with this warm welcome organised by GMC for the new overseas trained doctors. I greatly applaud this initiative which significantly brings down the anxiety and doubts of 'fitting in' from the minds of these IMGs."
> - Doctor attending WtUKP workshop



> "I was a bit nervous before about joining the NHS; however, after today's workshop I feel at ease now that I know that there will always be help whenever I need it."
> - Doctor attending WtUKP workshop

Equality, diversity, and inclusion: fairer referrals

In February 2021, we committed to targets to tackle long-standing racial inequalities in the medical profession. One of these is to eliminate inequality in fitness to practise referrals based on race or place of primary medical qualification by 2026. So, we are promoting more supportive and inclusive environments to ensure fair treatment. Tackling discrimination and inequality is the right and fair thing to do. It is also vital to helping retain doctors working in the UK and to supporting high-quality patient care. Our research shows more inclusive environments have better patient satisfaction and outcomes.

We cannot achieve this target alone as it relies on wider cultural change. So, we are working closely with other organisations who share our aims. In particular, we are working with employers to make sure referral processes are fair and bias free. We will also work with regulators and partners across the UK's healthcare systems to bring about change.

To meet our target on referrals, we will engage in activities that will vary over time. This is because we need to take into account changes in the working world. Flexibility in how we reach our target means that we can adapt our approach over time. In 2021:

- we met with responsible officers (ROs)* to explore how they are implementing the recommendations from our *Fair to refer?* research and to understand any barriers they are experiencing.
- we updated our employer referral form to help ROs make sure referrals are fair and appropriate. We also engaged in conversations with ROs about the form and the new questions about referrals it asks them to consider. We will review the insights from this work to identify best practice and work to embed it more widely.
- we worked to develop and improve our feedback process for ROs about the cases they referred to us. As part of this, we ran a workshop with them to explore ways of developing, recording, and sharing feedback.
- we contributed data to the *Medical Workforce Race Equality Standard*, led by NHS England. Our support focused on three key areas: revalidation recommendations, postgraduate training, and fitness to practise concerns. We will continue to support this work in future. We will promote its findings as a powerful tool in measuring and driving fairness in medicine.
- we significantly expanded the number of Welcome to UK Practice workshops available, reaching more doctors. The workshops are a valuable way to help doctors new to the UK adapt to working in the UK's healthcare systems.

For more information about our work in this area and to see how it is progressing, see our *Equality, diversity, and inclusion: Targets, progress, and priorities for 2022* report.

* A responsible officer is the senior clinician in an organisation who ensures that doctors continue to practise safely and are properly supported and managed in maintaining professional standards.

Developing a sustainable workforce

Safe, effective, and responsive healthcare rests on the talent, commitment, and diversity of the people providing it. The long-standing shortage of healthcare professionals in the UK poses risks to patient care. It is also a threat to professionals' well-being and progression. Our position allows us to help shape medical education and training in ways that can better support the development of medical students and professionals. We also make sure that entry to the medical register and progression through training is fair and flexible, meeting the needs of both patients and professionals.

In 2019, we agreed with the UK's Department for Health and Social Care that we will also start to regulate physician associates and anaesthesia associates. We welcome this development and, while the legislation to allow this is being developed for approval by the UK's different legislatures, we made significant progress on this agenda in 2021.

Assuring the quality of medical education and training

As part of our role, we regulate all stages of a doctor's undergraduate and postgraduate education and training in the UK. We set standards and expected outcomes and we carry out quality assurance work to make sure standards are maintained.

New schools and programmes

If an institution plans to open a new medical school, or an existing school plans to establish a new programme, we conduct quality assurance to ensure they meet our standards and outcomes.

In 2021:

- we visited five medical schools that were created in England as a result of the 2017 undergraduate expansion programme who had admitted their first students (Anglia Ruskin, Aston, Edge Hill, Kent Medway, and Sunderland).
- in Northern Ireland, Ulster University admitted its first students in August 2021. We quality assure the university's programme in accordance with our new schools process and will continue to do so in the coming years.
- in Scotland, we are quality assuring ScotGem, a graduate entry programme delivered by the Universities of Dundee and St Andrews. The programme plans to graduate its first students in 2022.
- we also visited Brunel University, one of three new schools planning to admit students in 2022. We plan to visit Worcester (Three Counties) University and Chester University, who are expected to do the same.

Proactive quality assurance

Our undergraduate and postgraduate quality assurance processes promote and encourage the local management of concerns about the quality and safety of medical education and training.

In 2021, we completed the rollout of our new proactive quality assurance process. The process covers both undergraduate and postgraduate education and training and is part of our efforts to make our regulation as proportionate as possible. As part of it, every established medical school will need to declare that it meets, or is working to meet, our standards for education and training. Completing the rollout means that all the 35 UK medical schools, plus any future schools, will participate in the process.

Despite the disruption caused by the pandemic, we were also able to continue to monitor the quality of postgraduate training environments, identifying and addressing challenges to the safety of patients and doctors in training where necessary. As part of this, in one case we worked with Health Education England to temporarily suspend training in an A&E department and related acute medical specialties at Weston General Hospital. The University Hospitals Bristol and Weston Trust NHS Foundation Trust has since been taking remedial action to address the situation.

Supporting students and medical schools

We also continued to support medical schools in making decisions about graduating students whose studies had been disrupted as a result of the pandemic. We encouraged the development of enhanced induction for graduates who were also joining a service that faced many challenges in terms of backlogs and the ongoing pandemic. We are aware that the disruption to studies will affect students in later years and we will continue to work with medical schools to ensure that only those students who are safe to practise and who can meet GMC outcomes and standards can graduate as doctors.

Investing in medical education

Flexibility in training

Doctors have long told us that training opportunities were not flexible enough. For example, if a doctor wanted to switch specialties, they had to restart training from the beginning. This could be a frustrating experience. It was also not a constructive use of professional time. In some cases, doctors left the profession entirely rather than repeat years of training.

In 2021, after careful research, we introduced some changes to make training more flexible.

- Doctors who want to change specialty and become GPs can have some of their existing skills recognised so they do not have to repeat during training.
- We facilitated improved training options for doctors who work or train less than full time.
- We introduced further flexibility in curriculum development that we agreed with colleagues and the statutory education bodies to help support doctors' progression during the pandemic. The changes will be ongoing for as long as training continues to be disrupted.

These changes and others will allow doctors to progress and grow their skills more efficiently. Our work in this area will continue into the future as we support the development of a more sustainable workforce.

Credentialling

In 2021, our Council approved our updated credentials framework. Credentialling is a process through which we will recognise a doctor's expertise in a specific area of practice. GMC credentials will provide a proportionate and flexible training solution to address changing patient needs and safety issues. They will be approved where there is a demonstrable need for recognised standards in an area of expert practice not otherwise certified through postgraduate training. They will also provide additional regulation in areas where this can help reduce risks to patient safety. We started introducing credentials in 2019, testing how well our existing postgraduate curricula approval process worked with five early credential adopter areas. These are:

- rural and remote medicine
- liaison psychiatry
- interventional neuroradiology (acute stroke)
- pain medicine
- cosmetic surgery.

The early adopters continued to progress through our approval processes in 2021 and we are now working with them on preparing for full implementation. The updated framework reflects their feedback. It also reflects further policy development and engagement since we started working on the credentialling process. We aim to approve the first GMC credentials in 2022.

Equality, diversity, and inclusion: fairer education and training cultures

In February 2021, we committed to targets to tackle racial inequalities, including in medical education and training.

There is evidence that students from ethnic minorities face barriers in accessing important educational resources. This makes them more vulnerable to feeling less prepared and leads to poorer educational outcomes. These students, and doctors in training from ethnic minorities and/or with primary qualifications obtained outside the UK, also have different experiences of inclusivity than white students and doctors. Negative experiences in training and in the workplace affect well-being and performance and can ultimately affect patient safety. It is right and fair that students receive an equitable footing in their training experience, regardless of background or characteristic. So we want to end differentials in medical education and training based on ethnicity and primary qualification by 2031.

Achieving change in this complex area requires significant collaboration with multiple organisations and partners. There is recognition across the board of the collective need to act throughout healthcare if progress is to be made and, in line with this, we have adapted our ask of training institutions.

Educators must have stronger governance and plans in place for providing inclusive, supportive environments while assuring themselves they are making improvements. Change is needed to policy and process throughout the whole system from entry into medical education, to access to support and learning opportunities, to the design of assessments. This is a challenge reflected in broader education and society and it will require close ongoing attention.

To pursue these objectives in 2021, we provided guidance to medical royal colleges and faculties and required them to submit evidence of work to make sure assessments reflect the diversity of the trainee and patient population and that appropriate support is provided to candidates to both prepare for or recover from a high-stakes examination fail. We also supported medical schools in their work to:

- review curricula and assessment materials to better represent patients' and doctors' diversity
- engage with students on their experiences of racism
- develop reporting tools for concerns relating to inequalities in the education journey
- make sure recruitment and selection processes are fair and represent diversity.

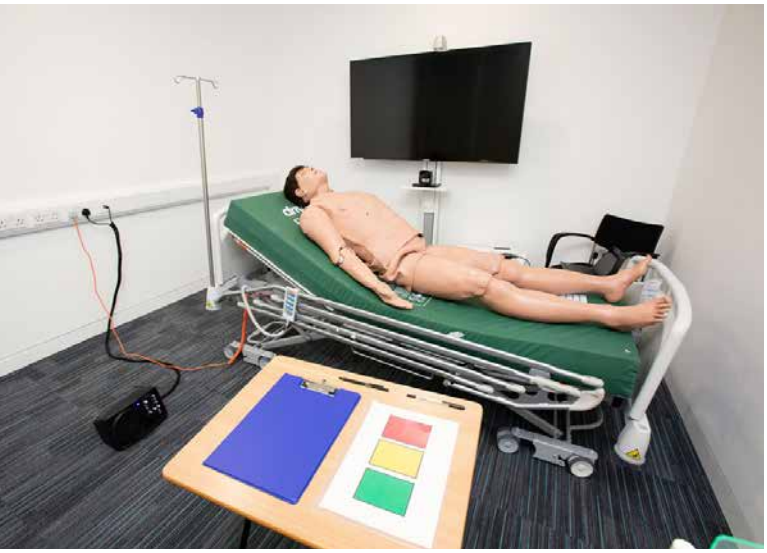
Medical schools provided us with examination outcomes data that will feed into our proactive quality assurance process (see page 34). We also shared updated data with postgraduate training organisations and supported them in analysing it. Training organisations are now required to submit annual action plans demonstrating how they are addressing the attainment gaps in their regions and meeting our standards.

We are committed to building evidence on the interventions that make a real-world difference to trainee outcomes. As part of this, we partnered with Health Education England and the Royal College of Psychiatrists to pilot an examination preparation training course and to formally evaluate its impact on examination outcomes for ethnic minority trainees. This initiative will continue through 2022, with 170 trainees taking part, and will provide essential evidence on which further initiatives can be built.

Systemic changes in medical education and training are complex and require adaptability. We will continue to capture learning from this work and the work of our partners on this agenda. We will also continuously review our approach based on that learning.

Managing entry to the medical register

Our new clinical assessment centre



Around half of all doctors from outside the UK who want to practise medicine in the UK's healthcare systems need to take our Professional and Linguistic Assessments Board (PLAB) test. The test is in two parts, a multi-choice examination (PLAB 1), and a clinical assessment (PLAB 2).

PLAB 2 is taken at a clinical assessment centre (CAC), located in Manchester. The examination allows us to test doctors' clinical competence through a series of scenarios. The practical scenarios reflect real-life situations that doctors may encounter during their work in the UK.

In 2020, our testing capacity for PLAB 2 was severely impacted by the social distancing measures required to combat the pandemic. To overcome this, we developed an additional, temporary assessment centre at our Manchester headquarters. We opened the new temporary CAC in June 2021. The new centre brings our total assessment capacity back to pre-COVID levels. This means we have been able to welcome more doctors from all over the world to sit their exam. In 2021, we examined 8,648 candidates across both our assessment centres. 3,283 of these attended the temporary centre. Overall, 6,043 candidates were successful and have since progressed to apply to join the register. These new doctors come at a time when the medical profession and our healthcare systems need as much support as possible.

Granting temporary emergency registration as part of the response to the pandemic

As part of the national response to the pandemic, in 2020 the UK Government asked us to give temporary emergency registration (TER) to doctors who left the register in recent years. Over 35,000 doctors who had stopped practising were given TER. As of the end of 2021, around 22,000 of them still held their temporary registration. Many of these doctors played a valuable role in delivering patient care. Others were of vital support for the vaccination programme. In 2021, we remained in regular contact with this group to make sure they understood they had been re-registered, and what this meant. Their registration was intended to last for the duration of the emergency, and the UK Government has asked regulators to close it in September 2022.

However, more than 1,100 doctors have since decided to return from TER to full registration. This means they will remain available for work in the future. There is great value in bringing back the talents and contribution of experienced professionals both in regard to patient safety and in terms of the wider healthcare community.

Medical Licensing Assessment

We are pleased to be working in collaboration with medical schools and other partners to introduce a new assessment – the Medical Licensing Assessment (MLA). It is set to launch in 2024.

The assessment will test the core knowledge, skills, and behaviours of doctors wishing to practise in the UK. It will help make sure that the standards we set match patients' needs and that doctors new to the register are well prepared to provide safe care. This will give patients, employers, and fellow doctors greater confidence in doctors new to practice, wherever they trained. It will also provide for better consistency and fairness between candidates. Finally, it will allow us to better monitor and approve the standard for entry to the profession over time.

All medical students who graduate from UK universities from the 2024–25 academic year will be required to pass the new assessment as part of their degree. Doctors from overseas who currently need to take our PLAB test to practise in the UK will also take the MLA instead once it has been introduced.

In 2021, we made significant progress towards the introduction of the new assessment.

- In March, we published *Assuring readiness for practice: a framework for the MLA*. The framework covers the content of the MLA and the requirements for its components.
- In June, our Council approved a proposal by all medical schools and the Medical Schools Council (MSC) for the Applied Knowledge Test (AKT) to be set centrally, overseen by the GMC, and delivered by each school locally to their students.
- We have since been working with schools and the MSC to oversee the design and development of the national AKT for medical schools.
- We have continued to engage extensively with staff in medical schools to help them prepare for the introduction of the MLA.
- We have continued our work to make the MLA a fair, robust, and high-quality assessment and to engage widely to inform our work, including with postgraduate training bodies and students.

> "a landmark moment in the history of medical education in the UK"
>
> - Professor Malcolm Reed, Lead Co-Chair of the Medical Schools Council, commenting on Council's approval of the proposal made by medical schools and the MSC

Post-Brexit registration routes

The Brexit transition period ended on 31 December 2020. As part of this, agreements between the UK and the EU on the mutual recognition of professional qualifications ended. This meant that graduates with EEA nationality wishing to practise as a doctor in the UK would no longer be entitled to automatic recognition of their qualifications in the UK.

To make sure doctors from EEA countries could continue to join the UK medical workforce, the UK Government introduced new legislation on 1 January 2021. This meant we needed to prepare and implement new registration routes based on assessing the qualifications doctors have rather than on routes to registration resting on nationality.

Through an extensive programme of work, we updated our systems, policies, and processes to prepare these for 1 January 2021. We launched communications in advance to give as much notice as possible and developed extensive guidance on how doctors can apply under the new arrangements. This has helped us assure continuity in the intake of new doctors from overseas at a time when our healthcare systems are under significant pressure.

Sharing insights about trends in the medical profession

As part of our role, we collect and share a significant amount of data to help improve patient safety and aid planning. We also carry out or commission analysis and research. This work helps to improve medical training, patient care, and workforce development.

In 2021:

- we released findings from our commissioned research into how employer induction can affect medical practice and patient care. The research revealed a huge difference in the quality of inductions.
- we published research into the impact and value of feedback for trainee doctors. The report highlighted the important link between feedback and well-being.
- we also published findings from research into how working in an FiY1 role affected new doctors' practice. Different from Foundation Year 1 (FY1), interim Foundation Year 1 (FiY1) roles were created to allow final year medical students to be fast-tracked onto the frontline to help respond to the COVID-19 pandemic. The research concluded that FiY1 was a largely valuable experience that eased the transition into practice.
- we shared findings from commissioned research into how service changes impact doctors' training. The findings illustrated how involving trainees in decisions about service changes can lead to better patient care.

If you would like to receive regular updates on our research work, sign up to our Research e-newsletter.

The state of medical education and practice in the UK

In December, we published the 11th edition of our annual report into the state of medical education and practice in the UK. The report uses data and insights from the medical register, surveys, and other sources to provide a comprehensive picture of doctors' experiences, as well as trends in the medical workforce and in medical education.

The 2021 report looked in particular at how the COVID-19 pandemic and the recovery affected doctors' work and training. One of its conclusions was that despite the current pressures on the UK's healthcare systems, now is the time to retain and embed positive changes to ways of working that were a key part of the initial response to COVID-19. Otherwise, the report warns, exhaustion and disillusionment will grow even more rapidly, blunting the effects of initiatives to boost recruitment.

In particular:

- 23% of doctors said they were planning to leave the profession, up from 19% in 2020. 7% of all doctors also said they had taken hard steps towards leaving the profession, up from 4% in 2020.
- over a third of doctors (35%) said they were considering reducing their contracted hours. Some doctors also felt it was not realistic to reduce their hours in the current climate, though they may have wanted to.

The report also made for stark reading in relation to equality, diversity, and inclusion. For example, it outlined that:

- disabled doctors were almost twice as likely as non-disabled doctors to be dissatisfied, at a high risk of burnout, struggling with workload, and taking hard steps towards leaving the profession.
- doctors from ethnic minority backgrounds, particularly Asian/Asian-British doctors, were less likely to agree that they are supported by their immediate colleagues or are part of a supportive team.

We shared the report on our website and through the media, and the web pages containing the report were viewed around 7,000 times in the first fortnight after release. Many of our partners released statements acknowledging the findings and the importance of the report in providing key insights into medical education and practice trends.

Completing the picture: why doctors leave the profession

As part of our research programme, we worked with Health Education England, the Department of Health (Northern Ireland), NHS Education for Scotland, and Health Education and Improvement Wales to understand the reasons why doctors leave the profession and what might encourage them to return. Over 13,000 doctors completed an online survey on this topic. All of them had practised in the UK within the last 15 years but were not practising at the time they responded to the survey.

Key findings from the survey, available in our *Completing the picture* report, include:

- many doctors stopped practising in the UK for personal reasons, such as retirement. However, others left due to negative pressures such as burnout.
- a higher proportion of disabled doctors stopped practising in the UK than those who did not consider themselves as disabled.
- disabled doctors are more likely to report bullying as an important factor in leaving, and LGBTQ+ doctors more commonly indicated mental health issues as key.
- 35% of the respondents wanted to return to practice in the UK, but only 23% thought it likely they would. However, the majority (59%) said they were both unlikely and unwilling to return.
- GPs showed higher levels of burnout and were reported as being less likely to return than other doctors.
- a small pool of countries account for a very large proportion of doctors moving abroad (eg Australia and New Zealand).
- improvements in areas like induction and providing up to date information on how to return could make a big difference in encouraging more doctors to return.

These findings suggest that well-led, supportive, and compassionate workplaces are vital in encouraging doctors and other healthcare professionals to stay in the profession.

> "This has been a useful barometer in our education reform work and will allow us to understand how we help support doctors who wish to return, as well as giving those thinking of leaving the profession the support to stay..."
> - Professor Sheona MacLeod, Deputy Medical Director, Education Reform, HEE

National training survey

Our national training survey helps us to monitor and report on the quality of postgraduate medical education and training. It is the largest annual survey of doctors' training in the UK. In the 2021 survey, we asked some questions about the continued impact of the COVID-19 pandemic on training. Over 63,000 doctors completed the survey. 76% of all trainees in the UK responded, and 32% of trainers. This is higher than in 2020, but still lower than our usual response rates. We believe this was due at least in part to the pressures and the disruption caused by the pandemic.

The survey helps us improve our quality assurance work in relation to education. It also improves the support we provide to trainers, trainees, and training environments across the UK.

For more information and to read the survey findings in detail, see the National Training Survey pages on our website.

Regulating physician associates and anaesthesia associates

In 2019, we agreed with the UK's Department for Health and Social Care (DHSC) that we will also start to regulate physician associates (PAs) and anaesthesia associates (AAs).

PAs and AAs are two of the medical associate professions (MAPs) working in UK healthcare. We are pleased to support the development of these valuable professionals, recognising the important role they play in the medical workforce. Regulation will help to increase the contribution PAs and AAs can make to UK healthcare, while keeping patients safe.

While the legislation that will enable us to bring these two professions under our regulation is being developed, we have made significant progress on several aspects of regulatory design.

Registration

We designed the processes that will bring the following groups of PAs/AAs onto the register:

- existing UK-based practitioners
- future PA/AA qualifiers from UK universities.

We published information about these processes on our website, so that future registrants can familiarise themselves with our expectations ahead of time. We will contact them nearer the start of regulation to let them know what we need from them to support their registration.

We have also begun work on how PAs and AAs will revalidate and are developing registration criteria for overseas-qualified practitioners.

Education

We have established a quality assurance (QA) process for UK PA and AA courses. All 37 current course providers have:

- engaged voluntarily in a baseline QA exercise
- completed a self-assessment against our published standards
- received initial feedback on strengths and areas for improvement.

We also developed high-level education outcomes for these professions. We worked with the Royal College of Physicians, Royal College of Anaesthetists, and others to create PA and AA curricula that are outcome-focused and meet our standards.

Professional standards

In October 2021, we published interim standards for the two associate professions. *Good medical practice for PAs and AAs* provides a framework for decision making to keep patients safe. We also produced accompanying case studies to set the standards in context. These standards will apply from when we begin regulating PAs and AAs until we publish new ethical guidance for all registrants, as part of our overall review of *Good medical practice*.

Fitness to practise

We expect PAs and AAs to be subject to revised fitness to practise processes eventually resulting from broader regulatory reforms that are currently underway. In the meantime, we have been liaising with the Faculty of Physician Associates and the Royal College of Physicians on handling concerns about the conduct of PAs on the voluntary register. We have met with counterparts to understand their approach and the nature of concerns raised and will offer our expertise in the year ahead.

Supporting the case for prescribing

The DHSC has begun work to extend appropriate prescribing responsibilities to PAs and AAs after our regulation begins. We are supportive of this step as it will maximise the contribution these professionals can make to patient care. We therefore contributed to discussions on the subject with relevant partners and offered our support to those working on defining the practical aspects of this important move.

To learn more about our work around PAs and AAs, join our community of interest, which is open to members of the public and those working in healthcare, or visit our online information hub.

Making every interaction matter

Healthcare professionals and members of the public often come to us at a challenging time. We want to make sure they are met with empathy, fairness, and professionalism by all our colleagues. We are also committed to listening to, learning from, and acting on their feedback about our services, and to learning more about the challenges experienced by the profession through research. Below are some examples of our work towards these objectives in 2021.

Supporting patients and others who raise a concern with us

When a patient raises a concern with us, we review the information to see if we need to investigate. If we decide to investigate a concern, our patient liaison team contacts the patient to talk through what is going to happen and to answer any questions. Once we have finished our investigation, we offer another meeting to explain the outcome and any next steps.

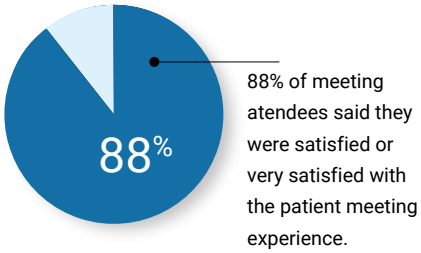
> "I was given time to voice any concerns and questions. I felt listened to and understood. I was given a full, clear explanation regarding the process that would take place."
>
> - Patient attending a patient liaison meeting

Prior to the pandemic, our patient liaison meetings were generally held in our offices in Belfast, Cardiff, Edinburgh, London, and Manchester.

In 2021, the majority of the meetings were held by telephone due to the pandemic. At the end of the year, we also started offering online meetings, which were very positively received.

We held liaison meetings with 285 patients over the course of 2021. Feedback was very positive: 88% of meeting attendees said they were satisfied or very satisfied with the patient meeting experience.

We also improved the information available on our website for patients considering whether to raise a concern with us. Often, concerns are best raised locally first, and we have provided updated guidance on how to do this. We also provided more information on the types of concern we typically investigate and those we do not. We explain that we only investigate when we believe a doctor poses a serious risk to patients or has significantly or repeatedly failed to meet our standards. Since the new web pages were launched in May 2021, they have been viewed over 40,000 times.



Regulatory reform

Regulation exists to protect the public. However, the legislation that currently regulates our work has not kept up with changes to the UK's healthcare system and society. In particular, it prevents us from adapting our processes as quickly as we would like in order to better support those we regulate to deliver great care.

The UK Government has proposed changes to the way that we and other healthcare regulators work. The changes will affect all areas of our work and processes. We welcome the opportunities the legislation will bring. Regulatory reform will help us respond more quickly and effectively. This means:

- dealing with complaints faster and more flexibly, reducing stress for all involved
- implementing more streamlined registration processes which will help the development of a more sustainable workforce
- exercising additional powers over monitoring education and training, allowing us to better support medical professionals through their studies and career.

These reforms will be key in enabling us to achieve the aims of our corporate strategy. We formally established a programme of work to support the changes in January 2021. From March to June last year, the Department of Health and Social Care consulted on high-level changes to healthcare regulators. Further Government consultation will need to take place once the drafting of this complex legislation is complete. Following that, the new legislation will be laid before the UK Parliament. If and when that is approved, we will consult to seek views on the way to put changes in place. We will then begin to introduce these changes. We expect some to happen quickly, while others will need to be phased over several years.

Communication and engagement continue to be a vital part of our work on regulatory reform. We have regularly updated and engaged with our key audiences on this agenda, and we will continue to do so while this programme of change develops.

Fairer regulation

We want to make sure fairness is at the core of our approach. We also want to set an example of the behaviours we expect from others. So, we have committed to reviewing our processes to make sure they are free from bias and as transparent as possible.

In 2021, an employment tribunal ruled that a number of factors led to us making a decision that was racially discriminatory against a doctor, with reference to a case dating back to 2018. We have applied to appeal this ruling, and at the time of going to print with this report the appeal has not yet been held.

In any case, we are determined to make sure that every registrant is treated fairly, both by ourselves and by others.

So, following previous research on the subject, we commissioned a fairness audit from the University of Edinburgh and Fieldfisher. The audit focused on how we make decisions regarding fitness to practise. The auditors found no evidence of bias in the way our decision makers interpreted our guidance. However, we are aware that further work is needed. The targets we set in relation to equality, diversity, and inclusion reflect this acknowledgement.

As part of our ongoing commitments, we are:

- future proofing our approach through regulatory reform: as we reform how we work as a regulator, we want to make sure fairness is central to all the changes we plan to introduce. We are doing this by engaging all our teams in understanding how to meet our equality goals and assessing how new regulatory processes could impact on equality and diversity. We will publish our equality analyses to be transparent with our stakeholders.
- improving our processes: we are systematically reviewing the decision points in our procedures to see if we can strengthen fairness controls. For example, through more or different training of our people, anonymisation of data, group decision making, and other quality assurance arrangements.
- investing in independent assurance: following the fairness audit mentioned above, we have commissioned an external review of how doctors experience our processes and of best practice in auditing for bias. We plan to use the review's findings to develop and put in place routine fairness audits as part of our processes.

Four-country regulation

The Northern Ireland, Scotland, and Wales healthcare systems each have different and specific characteristics and needs to the healthcare system in England. In order to understand and address these needs and better serve patients and doctors in these contexts, we regularly engage with our partners and key interest groups in each of the UK's devolved nations through our UK Advisory Forums.

Forum members include representatives from the relevant Departments of Health, medical leaders, medical education bodies, system and professional regulators, and patient representative organisations.

At twice-yearly meetings in each country, members have the opportunity to raise issues directly with our Chair and Chief Executive. The meetings allow us to discuss our priorities and seek views on policy development in collaboration with members in each country.

In 2021, discussions focused on our equality, diversity, and inclusion targets and on pressures on the medical profession. Members shared their insights on issues and initiatives to support doctors from ethnic minority backgrounds in each country. They also shared their reflections on the impact of the pandemic on the medical profession, highlighting aggression from the public towards healthcare staff and high levels of burnout, and what we can do collectively to support doctors' psychological safety.

Improving the user experience on our online portals

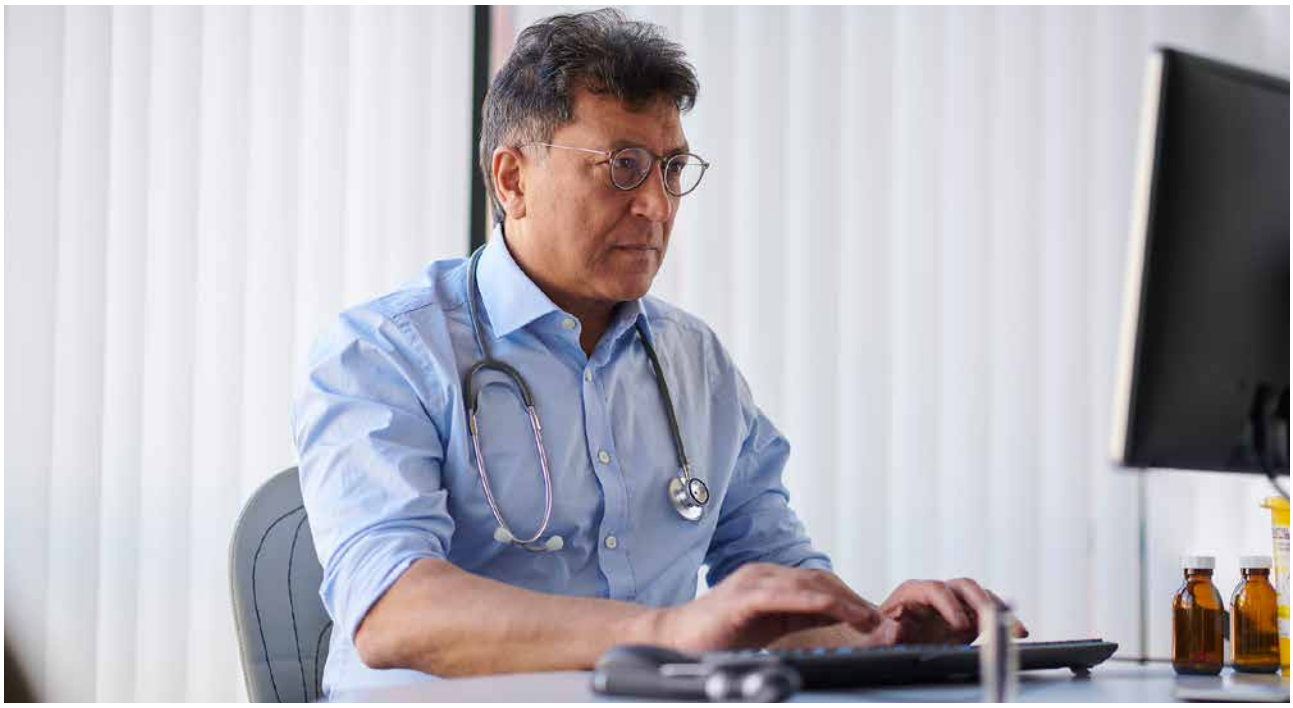
In August 2021, we introduced significant improvements to our secure online portals – GMC Online and GMC Connect.

GMC Online is our portal for doctors. They can use it to manage registration, carry out revalidation, pay fees, apply to take a Professional and Linguistic Assessments Board test, complete our national training surveys, and more.

GMC Connect is the system used to transfer data securely, both into and out of the organisation. The groups we share with include responsible officers, education organisations, legal organisations, and more. The improvements we made to the systems include:

- a better experience accessing GMC Online on a phone or tablet
- a simpler login process
- easier password recovery
- the ability to link accounts for GMC Online and Connect, which means users need only one login for both platforms
- an updated design which is more consistent with the rest of our website.

The changes significantly improve the user experience for doctors and others with accounts and are part of continuing work we are doing to keep up with external developments and increasing demand for our services.



Investing in our people

The majority of our colleagues tell us they find the GMC a great place to work. But we know that not everyone has the same experience. In 2021, our annual people survey showed that the percentage of colleagues who experience or witness bullying, harassment, or discrimination increased. We have zero tolerance for these behaviours and recognise we have more to do to ensure all colleagues are treated with respect and feel safe at work.

Equality, diversity, and inclusion programmes

We want to build a more diverse and inclusive organisation and a broader, more inclusive and diverse workforce where everyone can fulfil their potential through dedicated personal support. In line with this commitment, alongside our other equality, diversity, and inclusion (ED&I) targets, we have set ourselves targets in relation to improving staff representation and career progression for underrepresented ethnic groups in our workforce. By 2026, we want to reduce ethnicity-related differentials in relation to:

- recruitment and selection
- representation across staffing levels
- retention and progression
- employee engagement and inclusivity perceptions
- pay gaps.

To achieve these goals in 2021, we:

- briefed staff responsible for recruitment and selection on the targets we have set and how to achieve them
- embedded inclusivity into the core behaviours expected of all staff and integrated it into everyone's objectives
- expanded our leadership development programmes to cover colleagues of all levels, including those who do not (yet) have direct reports
- launched a talent development programme aimed at colleagues from ethnic groups that are under-represented in our leadership roles
- launched a bespoke training programme focusing on fostering inclusion with around 430 colleagues in leadership positions expected to take the training in 2022
- developed new training on professional behaviours (see page 49), to be completed by all staff by the end of 2022
- launched a new anti-racist allyship programme. As part of the first phase, 50 colleagues across the organisation have taken the training, including our senior management team.

We will review and report on progress against our goals in this area regularly based on human resource data, focus groups, and the results of our annual people survey.

Investors in people

We use Investors in People (IiP)'s We Invest in People framework to assess our processes and policies relating to our people. We have a talented and committed workforce and the IiP standard allows us to look at how we can best engage and inspire our people to achieve our strategy and deliver our business plan.

We have been accredited against this standard since 2018 at Silver level and we are working to achieve Gold accreditation. In 2021, following a survey and targeted interviews with staff, IiP found that we made significant strides towards Gold across all areas of the standard. Out of the 27 themes assessed, 12 met the Gold standard and 15 achieved the Silver standard. IiP also acknowledged that we improved on all the indicators in the framework since 2018.

Our focus for the next few years will be on continuing to embed our people management policies and procedures across the organisation.

> "There have been improvements in the responses to all indicators compared to the results in 2018, with many themes within each indicator increasing to Advanced (Gold) level...it is clear, from a strategic perspective, that the organisation is operating at Advanced (Gold) level."
> - IiP 2021 report

Professional Behaviours: Championing respect and inclusion

The majority of our colleagues tell us they find the GMC a great place to work. But we know that not everyone has the same experience.

During 2021, we developed mandatory training, Professional Behaviours: championing respect and inclusion. The training underpins our strategy and our equality, diversity, and inclusion objectives. It combines online learning with team discussions and follow-up events and encourages staff to consider their behaviour, the impact they have on others, and our individual responsibility for creating an inclusive and professional environment. It also focuses on what colleagues can do if they feel someone is not behaving appropriately and how to raise a concern. Those who completed the first phase of the training provided very positive feedback:

- 88% agreed or strongly agreed they had reflected critically on their behaviour past and present
- 83% agreed or strongly agreed they are now more likely to change their behaviour where it may be negatively affecting another person
- 72% agreed or strongly agreed they feel more confident to challenge or report unprofessional behaviour in the future.

We expect the training to be completed by all staff by the end of 2022.

Freedom to speak up

The *Freedom to speak up* (FTSU) initiative started in 2016 with the appointment of Freedom to Speak Up Guardians across the NHS. The scheme encourages and supports workers to speak up about events or behaviours that impact negatively on patients or on staff.

At the GMC, we have had a FTSU Guardian since March 2019. We recognised the value of enhancing our existing arrangements for colleagues internally to raise any issue they felt was negatively affecting our work and our culture.

The initiative has proved a valuable addition to our existing arrangements. Between March 2019 and December 2021, 279 issues were raised through this channel. These covered a range of matters, with the main themes including:

- behaviours (how we treat one another)
- consistent application of GMC policies
- perceived fairness of recruitment exercises.

Evidence from the programme shows that an increasing number of colleagues have felt able to take follow-up action themselves after a conversation with the Guardian or one of our supporting FTSU champions. It takes courage for colleagues to speak up and we actively encourage them to do so. We recognise the valuable learning from their experiences, which we can use to continuously improve our policies, management training, and communication.

Corporate social responsibility

Corporate social responsibility

We strive to be a socially responsible organisation. We want to embed sustainability, social impact, and ethics into everything we do. From standalone initiatives to everyday activities, we try to carry out our work in a way that benefits the environment and society.

In 2021, we made progress with this agenda in several ways.

Supporting social mobility and widening participation in medical education

- We designed and implemented a legal apprenticeship scheme with support from the Social Mobility Foundation. We launched the scheme in August 2021, receiving a positive response. The scheme allowed us to recruit four talented law students from the Greater Manchester area who will study towards their degree while they work in our legal team.
- We also took part in a number of events organised by the Social Mobility Foundation. The events were aimed at young people who want to go to medical school. Three of our clinical fellows presented at summer school events for these students, sharing their experiences of applying for medical school and their experiences of training.
- We joined the National Medical Schools Widening Participation Forum and worked with the Medical Schools Council on plans to develop resources to help widen participation in medical education.

Protecting the environment

- We launched the GMC's net zero carbon project. The project is designed to enable us to measure our environmental impact and develop options to become a net-zero-carbon organisation.
- We grew our internal network of GMC environment champions.
- We attended the International Association of Medical Regulatory Authorities conference. As part of this, we gave a joint presentation with Greener NHS.
- We published a blog in support of COP26.

Benchmarking and working with partners to promote CSR

- We strengthened our relationship with Business in the Community (BITC). As part of this, we started using their Responsible Business Tracker to benchmark our CSR work. The tracker allows us to measure our progress compared to other organisations.
- We represented the GMC on the BITC North West Leadership Board. The Board provides guidance and support for responsible business work across the region.

Creating opportunities and developing our CSR programme further

- We began a pilot programme of internships focusing specifically on CSR. Our first CSR intern joined us in May 2021 for 12 weeks. The intern helped us with research into widening participation schemes at UK medical schools.
- We launched our first corporate volunteering pilots. As part of this, some of our staff took part in a virtual reading scheme with a north London academy. They have been reading with Year 9 and 10 pupils from the academy with English as a second or third language for 30 minutes twice a week. We also worked with an academy trust in Manchester on their plans for Special Educational Needs schools in the area.

> “The reading scheme will provide huge benefits, as literacy is so important. For me, being able to contribute to it will be a positive highlight of my work at the GMC. It also reflects well on the organisation, showing it wants to contribute to local communities and society in this way.”
>
> - GMC colleague taking part in our corporate volunteering scheme

The steps we have taken so far in relation to our CSR agenda will help us identify where we can do even more in future.

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 4 countries of the UK, 6 of whom are medical members and 6 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 Professional Standards Authority's guidance for making appointments to healthcare professional regulatory bodies.

The trustees between 1 January 2021 and 31 December 2021 were:

- Mr Steve Burnett
- Dr Vanessa Davies
- Ms Lara Fielden (until August 2021)
- Professor Anthony Harnden
- The Rt Hon Lord Hunt of Kings Heath PC
- Professor Paul Knight
- Professor Dame Carrie MacEwen
- Professor Deepa Mann-Kler
- Dame Clare Marx (until July 2021)
- Professor Suzanne Shale
- Dr Raj Patel
- Miss Alison Wright.

Dame Clare Marx was appointed by the Privy Council as the Chair of the General Medical Council in January 2019, but sadly due to ill health decided to step down at the end of July 2021. Dame Carrie MacEwen took on the role of acting Chair after Dame Clare Marx stepped down and chaired Council from then on.

In August 2021, we were shocked and extremely saddened by the untimely death of Lara Fielden, an outstanding member of Council who joined us in January 2021. Her contribution will be greatly missed.

Council therefore had two vacancies. Recruitment for a permanent Chair commenced in November 2021 and concluded in May 2022, with the appointment of Dame Carrie MacEwen as Chair.

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

All Council members also participated in appraisal reviews in 2021, 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.

As a charity, we take into account the seven principles set out in the Charity Governance Code (2020) and can demonstrate how we use these principles to guide our 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 deputy or vice-chair. However, provisions are made in the *Governance handbook*

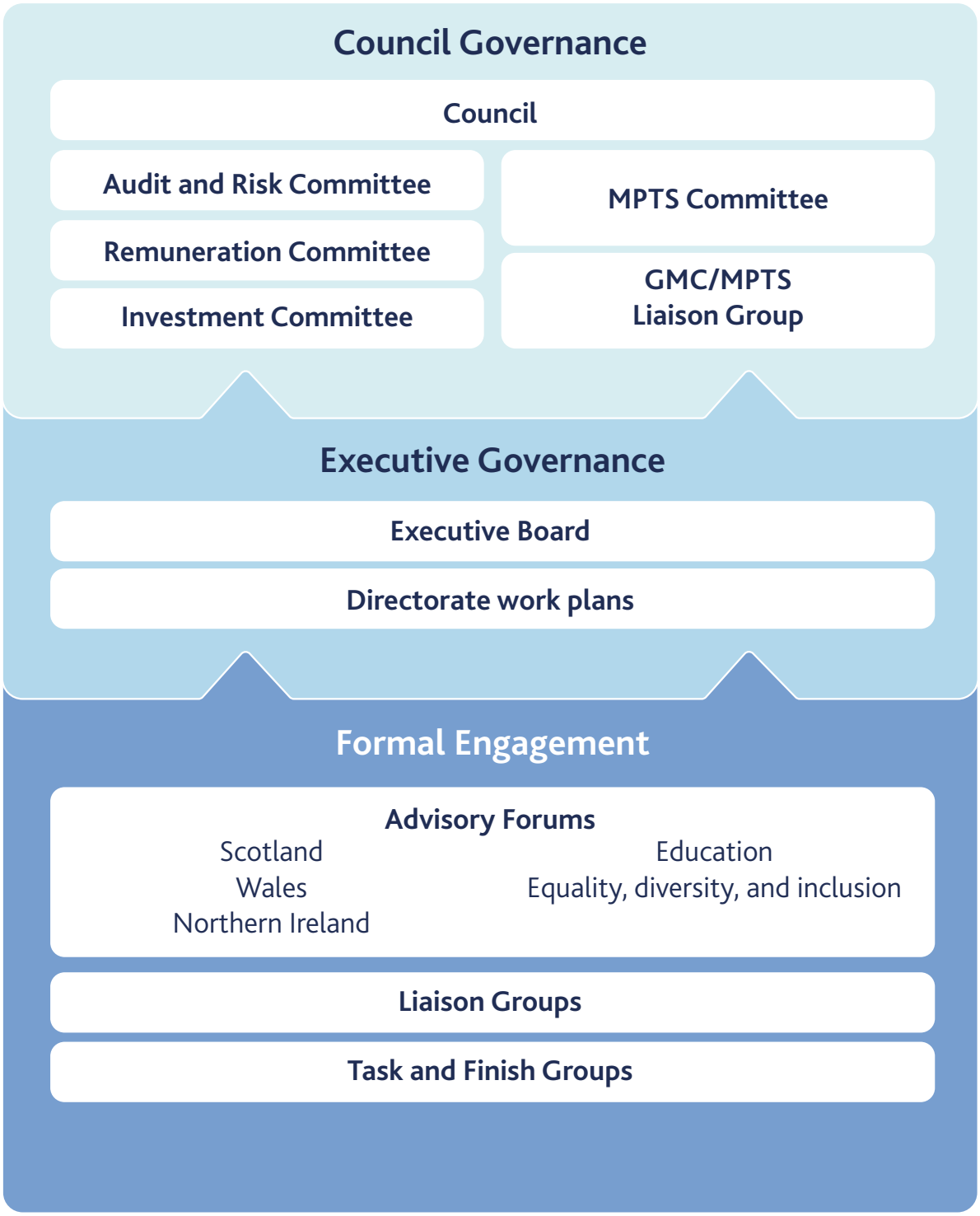
for chairs to nominate a deputy to assist during periods of absence, which was enacted this year. Secondly, as our appointments process is well established and thorough and is overseen by the Professional Standards Authority, a nominations committee is not considered necessary.

The *Governance handbook* is the governing document of the organisation. It was reviewed in 2019 to further incorporate the Charity Governance Code and minor updates are made with Council's approval on an ongoing basis, for example, to the membership of committees.

Our 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 undertake to review their effectiveness in delivering its statement of purpose, which is reviewed annually.

The diagram on the next page 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.


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
Equality, diversity, and inclusion
Liaison Groups
Task and Finish Groups

Audit and Risk Committee

Paul Knight chaired the Audit and Risk Committee during 2021. Its external co-opted members were Elizabeth Butler (until July 2021), Jon Hayes (from July 2021), and Kenneth Gill.

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

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

The Committee met five times in 2021 and reports to Council twice a year. You can find out more about its role and its work in the Audit and Risk Committee Report section (see page 71) of this report.

Remuneration Committee

Anthony Harnden chaired the Remuneration Committee in 2021. The Committee advises Council on the remuneration, the terms of service, and the expenses policy for Council members, including the Chair. It oversees the recruitment process of the Chair and Council members before their appointment by the Privy Council. It determines the appointment process for the Chief Executive and the Medical Practitioners Tribunal Service (MPTS) Chair and the remuneration, benefits, and terms of service for the Chief Executive, directors, MPTS Chair, and MPTS Committee members. 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 and met three times in 2021.

Investment Committee

Steve Burnett chaired the Investment Committee in 2021. Its external co-opted members during 2021 were Tim Scholefield (until May 2021), David Stewart (until June 2021), Keith MacKay, and Mike Jennings (from November).

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.

It also has responsibility for overseeing the GMC's investment in GMC Services International Limited (GMCSI), including ensuring compliance with the GMC's Investment Policy, scrutinising GMCSI's business plan, and 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. It met five times in 2021.

GMC Services International

GMC Services International Limited (GMCSI) was established by Council in 2016 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.

Robust and effective governance arrangements are in place to ensure that our interests are protected and that our relationship with GMCSI is managed effectively.

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.

Andrew McCulloch chaired the GMCSI Board during 2021. The Board comprised (in addition to the Chair) Paul Reynolds, Anthony Harnden, Alison Wright, and Colin Melville.

Board of Pension Trustees

The GMC's defined benefit staff superannuation scheme is managed and administered by a board of trustees in accordance with the scheme's trust deed and rules. The trust makes sure the pension scheme's assets are kept separate from those of the employer.

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

Deirdre Kelly chaired the Board during 2021. Deirdre, Steve Burnett, Raj Patel, and Vanessa Davies are employer-nominated trustees. Danny Dubois, John Foley, Paula Robblee, and Martin Hart 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. It is overseen by Dame Caroline Swift as Chair and by Gavin Brown as Executive Manager.

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

Dame Caroline Swift chairs the MPTS Committee. The Committee 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

The Executive Board is the senior decision-making and oversight forum established to provide strategic direction, scrutiny, and reporting to Council by the GMC's senior management team on significant policy, strategy, finance, performance, operational delivery, and resource management issues. It ensures that the GMC is a high-performing and agile regulator that understands its registrants, the healthcare systems in which it operates, and the views of its key stakeholders.

The Board meets monthly (except for August) and reports to every meeting of Council through the Chief Executive's report and via a separate annual report.

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. The invited membership differs from country to country and reflects the diverse range of those who have an interest and expertise in the areas under our regulation across the UK. The forums report on their work to the Executive Board twice a year.

Education Advisory Forum

The Education Advisory Forum, which replaced the Education and Training Advisory Board (ETAB) and the Assessment Advisory Board (AAB), 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 work of the forum is reported to the Chief Executive and to Council through the Chief Executive's report.

Equality, Diversity and Inclusion Forum

Our Strategic Equality, Diversity and Inclusion Forum helps us make sure that our activities respond to the needs of diverse groups of doctors. The forum comprises organisations representing doctors with shared protected characteristics, and helps us meet our ED&I objectives by providing feedback and advice on our policies and strategies, raising issues and concerns requiring our attention, and generally acting as a sounding board in relation to ED&I issues. In 2021, discussions with the forum covered our new ED&I targets, fairness and transparency, bullying, harassment, and discrimination, our review of *Good medical practice*, and the redesign of our processes as part of our regulatory reform programme.

Member attendance at Council, boards, and committees in 2021*

Member and trustee	Number of meetings attended
Steve Burnett	
Council	8/8
Investment Committee	4/4
Board of Trustees of the GMC's Superannuation Scheme	5/5
UK Advisory Forums – Wales	2/2
Vanessa Davies	
Council	8/8
Remuneration Committee	3/3
Board of Trustees of the GMC's Superannuation Scheme	5/5
Lara Fielden (until August 2021)	
Council	3/4
Investment Committee	2/2
Anthony Harnden	
Council	8/8
Remuneration Committee	3/3
Investment Committee	1/1
GMCSI	3/3
Philip Hunt	
Council	8/8
Audit and Risk Committee	5/5
Remuneration Committee	3/3

* Includes seven 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. Attendance data reflects the total number of meetings where attendance was possible.

Member and trustee	Number of meetings attended
Paul Knight	
Council	8/8
Audit and Risk Committee	5/5
GMC Services International	1/1
UK Advisory Forums – Scotland	2/2
Carrie MacEwen	
Council	8/8
Investment Committee	4/4
GMC/MPTS Liaison Group	1/1
UK Advisory Forums – Northern Ireland	1/1
UK Advisory Forums – Scotland	1/1
UK Advisory Forums – Wales	1/1
Deepa Mann-Kler	
Council	8/8
Investment Committee	4/4
Remuneration Committee	3/3
UK Advisory Forums – Northern Ireland	2/2
Clare Marx (until July 2021)	
Council	4/4
GMC/MPTS Liaison Group	1/1
UK Advisory Forums – Northern Ireland	1/1
UK Advisory Forums – Scotland	1/1
UK Advisory Forums – Wales	1/1
Raj Patel	
Council	8/8
Audit and Risk Committee	5/5
Board of Trustees of the GMC's Superannuation Scheme	5/5
Suzanne Shale	
Council	8/8
Audit and Risk Committee	5/5

External co-opted members

External co-opted members sit on the Investment Committee and Audit and Risk Committee respectively.

Investment Committee	
Mr Keith MacKay	5/5
Mr Tim Scholefield	1/2
Mr David Stewart	1/2
Mike Jennings	1/1

Audit and Risk Committee	
Ms Elizabeth Butler	3/3
Mr Kenneth Gill	4/5
Jon Hayes	2/2

GMCSI	
Dr Andrew McCulloch	4/4

Management

At the beginning of 2021, our staff were under the direction of Chief Executive Charlie Massey. He is supported by a team of directors, who, as at 31 December 2021 were:

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

Key management personnel – remuneration policy

The Remuneration Committee is responsible for determining the remuneration, benefits, and terms of service for the Chief Executive, Chair of 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, it ensures that:

- 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.

2021 financial review

The accounts for the year ended 31 December 2021 have been prepared in accordance with the Charities Statement of Recommended Practice (FRS 102).

Our total income and expenditure in 2021

The coronavirus (COVID-19) pandemic continued to have a significant impact on our activities throughout 2021, but we were able to start to work through the backlogs created by the early pandemic lockdowns and we continued to deliver many of our core services to support doctors and patients.

In 2021, we generated unrestricted income of £119.7 million, which was £11.4 million higher than 2020. This was due to the increase in the size of the register and the impact of running more Professional and Linguistic Assessments Board (PLAB) tests in 2021 than 2020, plus the subsequent increase in new applications to the register.

We were able to run additional PLAB tests by investing £1 million in a new temporary clinical assessment centre designed specifically for socially distanced exams, which allowed us to return to pre-pandemic capacity from June.

In addition, the Department of Health and Social Care of the UK Government provided £2.6 million of funding in 2021 to continue implementation work to bring physician associates and anaesthesia associates into regulation by the General Medical Council. This funding is restricted in nature, and so is shown separately in the accounts. It was fully spent in 2021, with £0.9 million used to develop IT systems, which are capital in nature, creating a restricted asset on the balance sheet.

We also generated £4.9 million of gains on our investments in 2021. This was higher than 2020 due to the impact of the early stages of the pandemic on financial markets in 2020.

Our unrestricted charitable expenditure in 2021 was £117.9 million, which was an increase of £11.3 million compared with 2020. In 2020 tribunals and PLAB 2 tests were temporarily postponed and restarted in the second half of the year. Throughout 2021 we were able to run tribunals on a hybrid basis, with some being face to face and some being virtual. We continued to deliver PLAB 2 tests under social distancing measures and successfully ran PLAB 2 tests on a non-socially distanced basis towards the end of 2021. We increased capacity for both tribunals and PLAB tests in 2021, which allowed us to process some of the work delayed during the temporary closures, which increased costs.

We increased our dilapidations provision by £1.9 million to ensure our obligations under our building leases can be met. Our 2021 accounts also include a further £0.1 million provision to meet potential costs arising from legal claims.

Our other core activities continued throughout 2021 with the impact of the pandemic generally influencing our ability to travel, return to the office with new working patterns, and host and attend events.

We set an efficiency target to generate savings of £1.5 million, which we felt was a realistic target considering the challenges the pandemic has brought to our operating environment. We managed to deliver cost savings of £1.9 million by realising savings through implementing virtual tribunals and deferring recruitment to vacant posts.

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

Reserves policy and going concern

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

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

We hold free reserves:

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

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

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

There is no standard formula that can be used to calculate the ideal level of free reserves. We follow the Charity Commission's guidance and set a target range based on our cash flow requirements and an assessment of the risks facing the organisation. We aim to hold free reserves at a level that is not excessive but does not put our solvency at risk.

Based on our analysis of cash flows and the risks facing the organisation, our policy has been to maintain free reserves in the range of £25 million to £45 million. However, in 2021 we re-assessed the risks we face, and Council approved increasing our upper threshold to £50 million.

For future years, to ensure that the free reserves policy continues to reflect changes in the size of the organisation, we will link the target range directly to expenditure, expressed in percentage terms, therefore our target range of free reserves will be between 20% and 35% of annual expenditure.

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

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 2021 were £99.8 million, made up of free reserves of £45.2 million, plus £18 million of reserves represented by fixed assets, and a pension reserve of £36.6 million.

The spread of the coronavirus (COVID-19) had a significant impact on our activities throughout 2020 and 2021, and in overall terms our net costs were lower than planned. We are planning for our expenditure to be higher than our income in 2022 as we continue our recovery plans. We estimate that our free reserves will reduce to around £40.9 million at the end of 2022, which is consistent with our reserves policy.

Most of our income comes from registration fees paid by doctors. All doctors must be registered with us to practise medicine in the UK, and so our income is relatively certain. Despite the impact of the pandemic, 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. It has delegated responsibility for implementing the investment policy, appointing and managing fund managers, and monitoring performance to the Investment Committee, which regularly reports to Council.

Our 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.

We originally invested £50 million under management in June 2019. Our target rate of return on funds invested under management is inflation (CPI) plus 2% over a rolling five-year period. This reflects our relatively low risk appetite. 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 regarding 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 credentials. When appointing fund managers, we take into consideration how they incorporate an assessment of a company's performance on environmental, social, and governance issues in their stock selection.

Our funds under management were valued at £61.6 million at the end of 2021, compared with £57 million at the start of the year. We generated a return of 8.59% in 2021, compared with a target of 7.4%.

We invested £0.6 million as share capital in GMC Services International Limited, a trading subsidiary of the GMC, at the end of 2016. Our investment at the end of 2021 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 £0.08 million on our cash balances, equivalent to an average annual rate of return of 0.20%. Cash held as working capital, and any residual cash, is shown on our balance sheet within current assets.

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 GMC Services International Limited (GMCSI). In its early years of operation GMCSI generated net losses but has been able to recently generate modest profits. In 2021, GMCSI generated a net loss of £7,410 and ended the year with net assets of £230,445, so no profits have been gift-aided back to the GMC. GMCSI is projected to generate profits over the medium term.

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

Trustees' responsibilities for the financial statements

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 Statement of Recommended Practice
- make judgements and estimates that are reasonable and prudent
- state whether applicable accounting standards have been followed, subject to any material departures being disclosed and explained in the financial statements
- prepare the financial statements on the going concern basis unless it is inappropriate to presume that the charity will continue in business.

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

Related party transactions

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

In 2021, all disclosures were made and there were no issues of concern.

Audit and risk committee report

Our Council's Audit and Risk Committee plays a key role 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.

It also monitors our anti-fraud policies and any risks relating to the *General Data Protection Regulations* and reviews arrangements for raising concerns.

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

At the beginning of 2021, there were seven members on the committee – five Council members and two co-opted members. The committee welcomed a new co-opted member in July and unfortunately lost one of our Council members in September due to their untimely passing, resulting in four Council members and two co-opted members on the committee at the end of 2021. Co-opted or independent, members enhance the work of the committee by bringing valuable additional skills and experience to the independent scrutiny of finance, risk, and governance. All members of the committee participate in an annual appraisal process.

In 2021, the committee met five 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 five seminar sessions.

The committee bases its annual work programme on risk and our Corporate Opportunities and Risk Register reflects the key strategic risks we manage. The committee's oversight and scrutiny play a valuable role in assuring that risks are being managed and opportunities are enhanced through effective systems of governance, internal control, and risk management arrangements.

Key activities during 2021

In 2020, the committee paused its planned programme of audit work to respond to the emerging risks of the pandemic and focus instead on a series of learning reviews and audit activity to provide assurance over new activities and risks. In 2021, the committee was able to pursue its planned internal audit programme. This has continued to focus on activities which have been adapted to respond to the pandemic, checking progress on our plans for backlog recovery, and completing regular spot checks to assess progress in our work to support the Government's regulatory reform programme.

At each of its meetings, the committee:

- discussed a wide range of strategic risks to provide an important backdrop to its understanding of the challenges and opportunities the GMC was facing
- considered the assurance it had with respect to how the organisation was responding to emerging threats and opportunities
- challenged our Corporate Opportunities and Risk Register
- continued support for risk maturity evolution in line with the principles of effective risk management set out in the ISO 31000:2009 international guidance standard
- scrutinised audit and learning review findings to satisfy itself that the actions being taken were appropriate
- monitored the implementation of recommendations made in previous audit reports to make sure they were being managed effectively by senior management
- reviewed any findings and lessons learnt from work undertaken in relation to significant adverse events.

Other key activities in the year included:

- approving the external audit letter of engagement and scrutinising the Annual report and accounts for 2020
- reviewing the *Head of Internal Audit's annual report and opinion*
- commissioning an independent test of our cyber security control arrangements
- reviewing concerns raised to our Freedom to Speak Up (FTSU) Guardian, as reported in the FTSU 2020 annual report
- holding a seminar to understand how we are addressing the committee's corporate social responsibility agenda
- considering risk and assurance through the lens of organisations that experienced a major event or failing of governance and internal controls.

The committee also commissioned an independent review of our arrangements for compliance with BS 10008 standard on the evidential weight and legal admissibility of electronically stored information (ESI), to which the GMC became fully accredited in 2016. The independent reviewer was again complimentary about our work and the ongoing maintenance of high standards despite the continued disruption caused by the pandemic. The review concluded that our information management system is effective in ensuring the trustworthiness of electronic information.

Risk management in 2021

During 2021, the wider context has continued to be dominated by the pandemic. Our priority has continued to be protecting patients, supporting the medical workforce, and the health and well-being of our colleagues. The organisation has continued to adapt to external circumstances and risks. For example, reflecting COVID-19 contexts in fitness to practise decision making, continuing MPTS hearings remotely, developing interim circuits for PLAB 2 clinical assessments, and continually updating plans to ensure a safe return to offices.

This ability to handle a diverse range of risks, continually scanning the wider external horizon for emerging threats and opportunities, and work with others across the health landscape illustrates the maturity of our risk arrangements and their resilience.

High-level strategic risk discussions at both Council and Audit and Risk committee provide an important backdrop to understanding the context of the GMC's activities and the potential to achieve positive impacts for patients and doctors. As well as reflecting on the potential implications of the ongoing nature of the pandemic and thinking about the opportunities for future plans and recovery activities, some of the key areas of risk and opportunity focus in 2021 have been:

- considering the opportunities to re-shape and improve delivery of our statutory responsibilities through the Government's programme of regulatory reform
- managing preparations for the impact of Brexit
- preparing for the introduction of the Medical Licensing Assessment in 2024
- responding to a range of important public investigations and inquiries, including the Independent Neurology Inquiry in Northern Ireland, the Independent review into West Suffolk Hospital NHS Foundation Trust, and the review into safety of maternity services in England
- developing our approaches to regulatory fairness to eliminate the disproportionate pattern of fitness to practise concerns we receive from employers based on doctors' ethnicity and place of qualification, and eliminating discrimination, disadvantage, and unfairness in undergraduate and postgraduate medical education and training
- maintaining staff safety and welfare in responding to Government guidance for home working and for return to offices.

Risk thinking is inherent in discussions and operations at all levels of the business. We have a mature set of risk management arrangements embedded in day-to-day activities and risk registers are used as a tool for identifying, articulating, monitoring, and managing operational and project risks which help us identify opportunities to improve how the business is managed and our working environment. Our Corporate Opportunities and Risk Register is published regularly on the website through the Chief Executive's report to Council.

Learning from events and issues

Fundamental to good risk management and developing resilience is the ability to appraise situations openly and honestly when something unexpected arises. We have a robust approach to undertaking significant event and learning reviews to identify opportunities to improve.

We carried out a number of these in 2021, including:

- a learning review following an incident when sensitive information was inadvertently shared in response to a Freedom of Information request. In this instance the Information Commissioner was notified in line with the statutory GDPR notification process, but they decided not to investigate or take action and subsequently closed the matter.
- a review following the judgment from an employment tribunal in a case where a doctor brought a claim of race and religious discrimination against the GMC, in relation to the handling of a concern regarding their fitness to practise. The tribunal found that the complaint of direct race discrimination was well founded and succeeded. The complaint of discrimination on the grounds of religion and belief was deemed to be not well founded and was dismissed. As part of the review, we undertook an initial exercise to consider immediate learnings to help improve how we respond to future employment tribunal claims and other non-standard litigation. Separately, recognising the potential for racial inequality to affect our activities, we have established a programme of work focused on making sure that existing systems, controls, and approaches on mitigating bias, monitoring differentials, and promoting fairness across our regulatory functions are effective both for now and the longer term (see page 45). The outcomes from this work will become a blueprint for how we embed stronger fairness control mechanisms in our processes as part of the UK Government's regulatory reform agenda.

Beyond 2021

As we begin to recover from the effects of the pandemic operationally, the external environment will remain uncertain as the wider health system begins to address the mounting backlog of elective activity and we enter a challenging economic period. This will present us with further opportunities and threats. Our ambitious Corporate strategy 2021-2025 and the public commitments we have made require us to remain focused but cognisant of the pressures on partners externally and colleagues internally. Active risk management will continue to be key to aiding us in balancing our work and priorities so that we continue to support doctors and patients.

Key opportunities in 2022

Externally, we have the opportunity to:

- continue working on a legislative reform agenda that transforms us (and other regulators) into a progressive, modern, and flexible regulator
- use our influence, data, and insight to generate pace in our partners' understanding and support to address inequalities and unfairness in the medical education and wider health system.

Internally we will build momentum to:

- refresh and evolve ways of working to enhance business recovery, building on learning and progress in responding to the pandemic
- advance ways of working that support a culture of inclusivity and innovation, including delivery of our diverse talent and leadership programmes.

Key challenges in 2022

There will also be challenges for us to navigate as a regulator and employer, including:

- delivering the policy and operational changes for regulatory reform in line with the timeframes set by the UK Government
- maintaining effective collaboration with key partners whose capacity and organisational efforts are focused on responding to the after effects of the pandemic
- balancing the continued pressures and potential impact on the well-being of our colleagues.

We are not underestimating the scale of these challenges. We know that we cannot achieve the positive impacts patients and doctors deserve if we do not continue to listen to them, to medical leaders, and to patient organisations so that we learn about their experiences and expectations for the future. We have to work with compassion and understanding in a time when society's expectations are shifting. We must be sensitive and flexible so that we continue to keep patients safe, support doctors, and earn respect for being an effective, relevant, and compassionate regulator and employer.

Approved by the trustees on 22 June 2022 and signed on their behalf by:

Dame Carrie MacEwen

Independent auditors' report to the trustees of the GMC

Opinion

We have audited the financial statements of the General Medical Council ('the charitable company') and its subsidiary ('the group') for the year ended 31 December 2021 which comprise the Consolidated Statement of Financial Activities, Consolidated Balance Sheet, Consolidated Statement of Cash Flows and notes to the financial statements, including significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and United Kingdom Accounting Standards, including Financial Reporting Standard 102 The Financial Reporting Standard applicable in the UK and Republic of Ireland (United Kingdom Generally Accepted Accounting Practice).

In our opinion the financial statements:

- give a true and fair view of the state of the group's and the charitable company's affairs as at 31 December 2021 and of the group's 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* and 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 charitable company in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

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

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

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

Other information

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

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

We have nothing to report in this regard.

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 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 69, 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 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.

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

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

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

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

We obtained an understanding of the legal and regulatory frameworks within which the charitable company and group operate, focusing on those laws and regulations that have a direct effect on the determination of material amounts and disclosures in the financial statements. The laws and regulations we considered in this context were the *Companies Act 2006, Medical Act 1983* and the *Charities and Trustee Investment (Scotland) Act 2005* together with the Charities SORP (FRS102). We assessed the required compliance with these laws and regulations as part of our audit procedures on the related financial statement items.

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

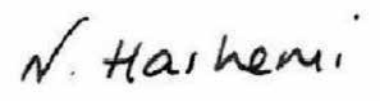
Auditing standards limit the required audit procedures to identify non-compliance with these laws and regulations to enquiry of the trustees and other management and inspection of regulatory and legal correspondence, if any.

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

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations (irregularities) is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it. In addition, as with any audit, there remained a higher risk of non-detection of irregularities, as these may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. We are not responsible for preventing non-compliance and cannot be expected to detect non-compliance with all laws and regulations.

Use of our report

This report is made solely to the 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 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 and 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
Crowe U.K. LLP
Statutory Auditor
55 Ludgate Hill
London
EC4M 7JW

1 July 2022

Consolidated statement of financial activities for the year ended 31 December 2021

	Note	Unrestricted funds £'000	Restricted funds £'000	**Total 2021 £'000**	Total 2020 £'000
Income					
From charitable activities					
Registration	2	114,545	-	**114,545**	103,042
Specialist and GP registration	2	4,047	-	**4,047**	4,052
Revalidation	2	107	-	**107**	54
Other trading activities	3	337	-	**337**	193
Commercial trading operations	3	239	-	**239**	316
Investments	3	154	-	**154**	388
Department of Health funding - MAPS*	3	-	2,605	**2,605**	1,577
Other	3	308	-	**308**	242
Total incoming resources		119,737	2,605	**122,342**	109,864
Expenditure					
Raising funds					
Commercial trading operations	4	246	-	**246**	302
Investment management costs	4	249	-	**249**	221
		495	-	**495**	523
Charitable activities					
Fitness to practise	4	46,882	-	**46,882**	42,936
Registration and revalidation	4	29,803	-	**29,803**	25,394
External relationships	4	15,319	-	**15,319**	15,140
Medical Practitioners Tribunal Service	4	14,012	-	**14,012**	11,297
Education	4	9,941	-	**9,941**	10,025
Standards	4	1,920	-	**1,920**	1,760
Department of Health funding - MAPS	4	-	1,749	**1,749**	1,577
		117,877	1,749	**119,626**	108,129
Other expenditure					
Legal provision	11	144	-	**144**	3,744
Dilapidations provision	11	1,882	-	**1,882**	973
		2,026	-	**2,026**	4,717
Total expenditure	4	120,398	1,749	**122,147**	113,369
Operating surplus/(deficit)		(661)	856	**195**	(3,505)
Net gains/(losses) on investments	8	4,879	-	**4,879**	2,476
Net income/(Net loss)		4,218	856	**5,074**	(1,029)
Other recognised gains and losses					
Actuarial (loss)/gain on defined benefit pension scheme	16	30,143	-	**30,143**	(6,971)
Net movement in funds		34,361	856	**35,217**	(8,000)
Total funds brought forward		64,581	-	**64,581**	72,581
Total funds carried forward		98,942	856	**99,798**	64,581

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 £35,217,000.

* The Department for Health and Social Care (DHSC) provided funding in 2021 to continue implementation work to bring physician associates and anaesthesia associates under regulation with the General Medical Council. Funding was restricted in nature, and was fully spent in the year. A proportion of the funds paid for IT System Development which has created an asset on the balance sheet. The net impact on GMC reserves is £856,000. The balance of the reserves will reduce when the asset is amortised in future periods.

Balance sheet

	Note	2021 Group £'000	2021 Charity £'000	2020 Group £'000	2020 Charity £'000
Fixed assets					
Intangible fixed assets	6	11,702	11,702	10,361	10,361
Tangible fixed assets	7	6,305	6,305	7,519	7,519
Investments	8	61,649	61,879	57,020	57,257
		79,656	**79,886**	74,900	75,137
Current assets					
Debtors and prepayments	9	24,041	24,096	23,349	23,303
Cash and bank balances		46,821	46,502	38,128	37,882
		70,862	**70,598**	61,477	61,185
Liabilities					
Creditors: amounts falling due within one year	10	(80,538)	(80,504)	(71,067)	(71,012)
Net current liabilities		(9,676)	(9,906)	(9,590)	(9,827)
Total assets less current liabilities		**69,980**	**69,980**	65,310	65,310
Provisions for liabilities and charges	11	(6,743)	(6,743)	(4,717)	(4,717)
Net assets excluding pension scheme asset		**63,237**	**63,237**	60,593	60,593
Defined benefit pension scheme asset	16	36,561	36,561	3,988	3,988
Total net assets		**99,798**	**99,798**	64,581	64,581
Unrestricted income funds		62,381	62,381	60,593	60,593
Restricted income funds		856	856	-	-
Pension reserve		36,561	36,561	3,988	3,988
Total funds	12, 13	**99,798**	**99,798**	64,581	64,581

The financial statements were approved by the trustees and authorised for issue on 22 June 2022.
They were signed on behalf of trustees by:

Dame Carrie MacEwen
Chair of Council

Consolidated cash flow statement

	2021		2020	
	£'000	**£'000**	£'000	£'000
Cash flows from operating activities:				
Net cash provided by/(used in) operating activities (note i below)		16,902		14,064
Cash flows from investing activities:				
Dividends, interest and rents from investments	84		180	
Purchase of property, plant, equipment and intangibles	(8,293)		(6,783)	
Net cash used in investing activities		**(8,209)**		(6,603)
Change in cash and cash equivalents (note ii below)		**8,693**		7,461

Note (i)

Cash flow from operating activities	
Net incoming/(outgoing) resources	5,074
Investment income and interest	(154)
Net investment movement	(4,629)
Non-cash items - depreciation and amortisation	8,165
Non-cash items - assets written off	1
Pension scheme contribution	(2,360)
(Increase)/decrease in debtors	(692)
Increase/(decrease) in creditors and provisions	11,497
Net cash provided by/(used in) operating activities	**16,902**

Note (ii)	**Short-term deposits**	**Cash at bank and in hand**	**Total**
Cash and equivalents	**£'000**	**£'000**	**£'000**
Balances at 1 January 2021	-	38,128	**38,128**
Net increase in cash and cash equivalents	-	8,693	**8,693**
Balances at 31 December 2021	-	46,821	**46,821**

Notes to the accounts

General information

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

1. Principal accounting policies

(i) Accounting convention

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

Our financial statements have been prepared on a going concern basis and in accordance with the Charities Statement of Recommended Practice (FRS 102) - effective 1 October 2019, applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland, the Charities Act 2011, the Charities and Trustee Investment (Scotland) Act 2005, the Charities Accounts (Scotland) Regulations 2006 and UK Generally Accepted Practice as it applies from 1 October 2019. The GMC meets the definition of a public benefit entity under FRS 102.

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

(iii) The principal accounting policies adopted in the preparation of the financial statements, which have been applied consistently, are:

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 made for all leased buildings. They are assessed on a case-by-case basis reflecting the different configurations of leased buildings and the cost to revert to their original state.
- 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.

The estimated useful lives are as follows:

- Leasehold buildings and leasehold improvements - the lesser of five years or the remaining term of the lease.
- Furniture, fixtures, and office fittings - the lesser of five years or the remaining term of the lease.
- Information Technology (IT) equipment - three years.
- Intangible assets: (IT software) - three years.
- Other office equipment - three years for IT-related items and five years for all other items

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

Licensed IT software

Development costs for implementing new IT systems are capitalised and depreciated over the lesser of 3 years or the useful life of the asset. The first year license costs are capitalised as they are necessary to bring the asset into use, subsequent year license costs are treated as operating expenditure.

Operating leases

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

Financial instruments

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

Investments

Our investment policy separates our funds into four categories: those which are required as working capital for the normal day to day operation of the business; those which we invest under management; those which we may decide to invest in a trading subsidiary; and the remaining cash balance which fluctuates during the year.

Funds held as cash for the normal day to day operation of the business are shown on the GMC's balance sheet within current assets, while funds held for the longer term are shown as investments.

Pensions

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

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

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

Termination payments

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

2. Income from charitable activities

	Unrestricted funds	**Total 2021 £'000**	Unrestricted funds	Total 2020 £'000
Registration				
Annual retention fees	99,025	**99,025**	93,428	93,428
Registration fees	4,630	**4,630**	3,916	3,916
Provisional registration fees	416	**416**	25	25
PLAB fees	10,388	**10,388**	5,576	5,576
Other fees	86	**86**	97	97
	114,545	**114,545**	103,042	103,042
Specialist and GP registration				
Certificates of Completion of Training fees	2,949	**2,949**	2,790	2,790
Certificate of Eligibility for Specialist Registration/ Certificate of Eligibility for General Practitioner Registration fees	1,072	**1,072**	1,220	1,220
Other fees	26	**26**	42	42
	4,047	**4,047**	4,052	4,052
Revalidation				
Revalidation annual return	98	**98**	48	48
Revalidation assessment	9	**9**	6	6
	107	**107**	54	54

3. Income from raising funds

	Unrestricted funds	Restricted funds	**Total 2021**	Unrestricted funds	Restricted funds	Total 2020
			£'000			£'000
Activities for raising funds						
Other trading activities*	337	-	**337**	193	-	193
Commercial trading operations†	239	-	**239**	316	-	316
Other‡	308	-	**308**	242	-	242
	884	-	**884**	751	-	751
Investment income						
Other finance income - pension scheme (note 16)	70	-	**70**	208	-	208
Bank interest	84	-	**84**	180	-	180
	154	-	**154**	388	-	388
Department of Health funding						
Funding to cover expenditure on Medical Associate Professionals regulation¶	-	2,605	**2,605**	-	1,577	1,577

* Other trading activities include 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.

‡ Other income includes reimbursement of legal fees from appeals and transaction fees generated through registration status changes.

¶ The Department of Health and Social Care have provided funding for the General Medical Council to start implementation work to bring physician associates and anaesthesia associates under regulation with the General Medical Council. The work is ongoing and legislation is expected to be in place for regulation to start no sooner than 2023.

4. Total expenditure

Charitable activity and support cost allocation

	Direct staffing costs £'000	Direct costs £'000	Allocated costs £'000	Total 2021 £'000	Direct staffing costs £'000	Direct costs £'000	Allocated costs £'000	Total 2020 £'000
Expenditure on:								
Commercial trading operations	216	30	-	**246**	266	36	-	302
Investment management costs	-	249	-	**249**	-	221	-	221
Total expenditure on raising funds	216	279	-	**495**	266	257	-	523
Fitness to practise	21,354	6,774	18,754	**46,882**	20,168	4,597	18,171	42,936
Registration and revalidation	12,077	5,915	11,811	**29,803**	10,491	4,403	10,500	25,394
External relationships*	8,948	602	5,769	**15,319**	8,992	506	5,642	15,140
Medical Practitioners Tribunal Service	4,782	4,972	4,258	**14,012**	4,295	3,054	3,948	11,297
Education	5,841	345	3,755	**9,941**	6,048	151	3,826	10,025
Standards	1,109	13	798	**1,920**	1,002	2	756	1,760
Department of Health funding - MAPS	1,196	553	-	**1,749**	1,185	392	-	1,577
Total charitable expenditure	55,307	19,174	45,145	**119,626**	52,181	13,105	42,843	108,129
Other expenditure - legal provision	-	144	-	**144**	-	3,744	-	3,744
Other expenditure - dilapidation provision	-	1,882	-	**1,882**	-	973	-	973
Total group expenditure	55,523	21,479	45,145	**122,147**	52,447	18,079	42,843	113,369

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

Support costs allocated to charitable activities

	Management £'000	IT £'000	Human resources £'000	Finance £'000	Procurement £'000	Facilities £'000	Governance £'000	Total 2021 £'000	Management £'000	IT £'000	Human resources £'000	Finance £'000	Procurement £'000	Facilities £'000	Governance £'000	Total 2020 £'000
Fitness to practise	3,249	6,066	2,367	875	161	4,678	1,358	**18,754**	3,237	5,817	2,082	756	154	4,744	1,381	18,171
Registration and revalidation	2,046	3,820	1,490	551	102	2,946	856	**11,811**	1,871	3,361	1,203	437	89	2,741	798	10,500
External relationships*	999	1,866	728	269	50	1,439	418	**5,769**	1,005	1,806	646	235	48	1,473	429	5,642
Medical Practitioners Tribunal Service	738	1,377	537	199	37	1,062	308	**4,258**	703	1,264	452	164	34	1,031	300	3,948
Education	650	1,215	474	175	32	937	272	**3,755**	682	1,225	438	159	32	999	291	3,826
Standards	138	258	101	37	7	199	58	**798**	135	242	87	31	6	198	57	756
Total charitable expenditure	7,820	14,602	5,697	2,106	389	11,261	3,270	**45,145**	7,633	13,715	4,908	1,782	363	11,186	3,256	42,843

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

Support cost recharges have been made to both the trading subsidiary, GMCSI, and the MAPS project throughout the year on a direct basis therefore are treated separately to the year end allocation.

Group expenditure by type

	Charitable activities 2021	**Expenditure on raising funds 2021**	**Department of Health funding - MAPS 2021**	**Other expenditure 2021**	**Total 2021**	Charitable activities 2020	Expenditure on raising funds 2020	Department of Health funding - MAPS 2020	Other expenditure 2020	Total 2020
	£'000	**£'000**	**£'000**	**£'000**	**£'000**	£'000	£'000	£'000	£'000	£'000
Staffing costs	74,880	216	1,196	-	**76,292**	71,692	266	1,185	-	73,143
Office costs	1,412	24	530	-	**1,966**	1,558	29	392	-	1,979
Council and committee costs	359	-	-	-	**359**	435	1	-	-	436
Panel and assessment costs	13,220	-	-	-	**13,220**	9,296	-	-	-	9,296
Legal costs	4,408	-	-	144	**4,552**	2,627	-	-	3,744	6,371
Accommodation costs	7,016	-	-	1,882	**8,898**	5,876	-	-	973	6,849
Financial, actuarial and professional costs	4,115	255	23	-	**4,393**	3,371	228	-	-	3,599
Purchase of assets - charged to revenue	4,301	-	-	-	**4,301**	3,795	-	-	-	3,795
Assets written off	1	-	-	-	**1**	47	-	-	-	47
Depreciation	3,163	-	-	-	**3,163**	3,070	-	-	-	3,070
Amortisation	5,002	-	-	-	**5,002**	4,784	-	-	-	4,784
	117,877	495	1,749	2,026	**122,147**	106,551	524	1,577	4,717	113,369

Total resources expended includes:

	2021	2020
Operating lease costs: leasehold property and equipment	3,639	3,505
Audit fees	43	43

5. Staff

	2021	2020
	£'000	£'000
Total costs of all staff		
Salaries	**59,022**	56,922
Social security costs	**6,189**	5,874
Superannuation costs - defined contribution scheme	**8,487**	7,928
Redundancy costs	**202**	-
Other staffing costs	**2,392**	2,419
	76,292	73,143

During the year the General Medical Council made termination payments of £40,000 (2020: £0), a further £162,000 was paid after year-end relating to decisions within 2021, giving a total expense for the year of £202,000 (2020: £0).

	2021	2020
Average staff numbers in the year by category		
Fitness to practise	**478**	460
Registration and revalidation	**301**	266
External relationships	**147**	143
Medical Practitioners Tribunal Service	**109**	100
Education	**96**	97
Standards	**20**	19
Governance and Management	**154**	145
Resources	**217**	211
	1,522	1,441
GMC Services International Ltd	**1**	1
	1,523	1,442

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

	2021	2020
GMC		
£60,000–£70,000	52	59
£70,001–£80,000	57	42
£80,001–£90,000	28	29
£90,001–£100,000	14	12
£100,001–£110,000	7	7
£110,001–£120,000	11	11
£120,001–£130,000	9	7
£130,001–£140,000	3	5
£140,001–£150,000	4	3
£150,001–£160,000	1	-
£160,001–£170,000	-	-
£170,001–£180,000	-	-
£180,001–£190,000	-	-
£190,001–£200,000	-	1
£200,001–£210,000	6	4
£210.001–£220,000	-	-
£220,001–£230,000	-	1
£230,001–£240,000	-	-
£240,001–£250,000	-	-
£250,001–£260,000	1	1
	193	182
MPTS		
£60,000–£70,000	2	2
£70,001–£80,000	1	1
£80,001–£90,000	2	2
£90,001–£100,000	1	1
£100,001–£110,000	-	1
£110,001–£120,000	1	-
	7	7
Total	200	189

	2021	2020
Number of staff included above for whom retirement benefits are accruing		
GMC defined contribution pension scheme	197	186
NHS defined benefit pension scheme	1	1
Not in scheme	2	2
	200	189

The senior management team includes the Chief Executive and six permanent directors in 2021. The total employee benefits (including employer pension contributions) of the senior management team was £1,705,118 in 2021. The equivalent figure for 2020 was £1,739,919.

Senior management team remuneration

	Basic salary 2021 (bands of £5,000)
	£'000
Charlie Massey	245–250
Paul Reynolds	200–205
Anthony Omo	200–205
Shaun Gallagher	200–205
Una Lane	200–205
Neil Roberts	200–205
Colin Melville	200–205

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

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

The Chief Executive's salary is 7.67 times the median salary.

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

6. Intangible fixed assets

Group and charity

	Computer software and systems development £'000
Cost	
Balance at 1 January 2021	28,410
Additions	6,343
Disposals	(3,804)
Balance at 31 December 2021	**30,949**
Amortisation	
Balance at 1 January 2021	18,049
Amortisation charge for year	5,002
Disposals	(3,804)
Balance at 31 December 2021	**19,247**
Balance at 1 January 2021	10,361
Net book value at 31 December 2021	**11,702**

Intangible assets incorporates 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.

7. Tangible fixed assets

Group and charity

	Buildings	Fixtures, furniture and equipment	IT equipment	Total
	£'000	£'000	£'000	£'000
Cost				
Balance at 1 January 2021	2,188	13,353	9,344	**24,885**
Additions	-	1,180	770	**1,950**
Disposals	-	(1)	(2,042)	**(2,043)**
Balance at 31 December 2021	2,188	14,532	8,072	**24,792**
Depreciation				
Balance at 1 January 2021	1,918	8,157	7,291	**17,366**
Depreciation charge for year	82	1,913	1,168	**3,163**
Disposals	-	-	(2,042)	**(2,042)**
Balance at 31 December 2021	2,000	10,070	6,417	**18,487**
Net book value at 1 January 2021	270	5,196	2,053	**7,519**
Net book value at 31 December 2021	188	4,462	1,655	**6,305**

8. Investments

Managed funds

	Group			Charity			
	Cash & cash equivalents	Listed Investments	Total	Cash & cash equivalents	Listed Investments	Equity Investment in Group Undertakings	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
The valuation at the end of the year consisted of:							
As at 1 January 2021	-	57,020	**57,020**	**-**	57,020	237	**57,257**
Additions	-	11,252	**11,252**	**-**	11,252	-	**11,252**
Disposals	-	(11,502)	**(11,502)**	**-**	(11,502)	-	**(11,502)**
Gain on investments	-	4,879	**4,879**	**-**	4,879	-	**4,879**
(Impairment)/reversal of impairment*	-	-	**-**	**-**	-	(7)	**(7)**
Balance at 31 December 2021	**-**	**61,649**	**61,649**	**-**	**61,649**	**230**	**61,879**

* The General Medical Council incorporated a wholly owned trading subsidiary on 16 December 2016. Having previously been impaired by £363k due to trading losses incurred, an additional £7k impairment at the end of 2021 has been recognised as a result of the loss generated by the company reducing its net assets.

Listed investments are managed by CCLA Investment Management Ltd. Investment management fees of £249,422 were incurred (2020 £221,160).

9. Debtors

	2021		2020	
	Group	**Charity**	Group	Charity
	£'000	**£'000**	£'000	£'000
Amounts falling due within one year				
Registration debtors	**18,810**	**18,810**	17,539	17,539
Prepayments and accrued income	**5,054**	**5,121**	5,325	5,416
Other debtors	**177**	**165**	485	348
	24,041	**24,096**	23,349	23,303

10. Creditors

	2021		2020	
	Group	**Charity**	Group	Charity
	£'000	**£'000**	£'000	£'000
Amounts falling due within one year				
Trade creditors	**877**	**872**	1,129	1,120
Tax and social security	**1,829**	**1,825**	1,774	1,771
Holiday pay	**1,106**	**1,106**	1,763	1,763
Accruals	**9,050**	**9,025**	8,378	8,335
Deferred income	**67,676**	**67,676**	58,023	58,023
	80,538	**80,504**	71,067	71,012

Charity deferred income

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

	Annual retention fees	**PLAB fees**	**Specialist and GP registration fees**	**Revalidation assessment fees**	**Total**
	£'000	**£'000**	**£'000**	**£'000**	**£'000**
Deferred income at 1 January 2021	54,927	3,075	21	-	**58,023**
Resources deferred during the year	57,356	10,222	57	41	**67,676**
Amounts released from previous years	(54,927)	(3,075)	(21)	-	**(58,023)**
Deferred income at 31 December 2021	**57,356**	**10,222**	**57**	**41**	**67,676**

11. Provisions

Group and charity

	2021	2020
	£'000	£'000
Dilapidations	**2,855**	973
Legal claims	**3,888**	3,744
	6,743	4,717

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. In 2020 we increased the provision to reflect potential additional costs that may arise following the outcome of an employment tribunal. The outcome is still outstanding, but may have implications for a wider group of individuals. Further details in relation to the ongoing case cannot be provided in order to avoid prejudicing proceedings.

	Dilapidations	Legal claims	Total
	£'000	**£'000**	**£'000**
Provisions at 1 January 2021	973	3,744	**4,717**
Provisions created during the year	2,855	3,888	**6,743**
Amounts released from previous years	(973)	(3,744)	**(4,717)**
Provisions at 31 December 2021	**2,855**	**3,888**	**6,743**

12. Group fund movements in the year

Group and charity

	Unrestricted funds	Restricted funds	Pension fund	2021 Total
	£'000	£'000	£'000	£'000
At 1 January 2021	60,593	-	3,988	64,581
Net incoming/(outgoing) resources	1,788	856	32,573	35,217
At 31 December 2021	**62,381**	**856**	**36,561**	**99,798**

	Unrestricted funds	Restricted funds	Pension fund	2020 Total
	£'000	£'000	£'000	£'000
At 1 January 2020	63,190	-	9,391	72,581
Net incoming/(outgoing) resources	(2,597)	-	(5,403)	(8,000)
At 31 December 2020	60,593		3,988	64,581

13. Net assets by fund

Group and charity

Fund balances at 31 December 2021 are represented by

	Unrestricted funds	Restricted fixed asset funds	Pension reserve	2021 Total funds
	£'000	£'000	£'000	£'000
Intangible fixed assets	10,846	856	-	11,702
Tangible fixed assets	6,305	-	-	6,305
Investments	61,649	-	-	61,649
Current assets	70,862	-	-	70,862
Current liabilities	(80,538)	-	-	(80,538)
Provisions for liabilities and charges	(6,743)	-	-	(6,743)
Pension scheme asset	-	-	36,561	36,561
Total net assets	**62,381**	**856**	**36,561**	**99,798**

	Unrestricted funds	Restricted fixed asset funds	Pension reserve	2020 Total funds
	£'000	£'000	£'000	£'000
Intangible fixed assets	10,361	-	-	10,361
Tangible fixed assets	7,519	-	-	7,519
Investments	57,020	-	-	57,020
Current assets	61,477	-	-	61,477
Current liabilities	(71,067)	-	-	(71,067)
Provisions for liabilities and charges	(4,717)	-	-	(4,717)
Pension scheme asset	-	-	3,988	3,988
Total net assets	**60,593**	**-**	**3,988**	**64,581**

14. Capital commitments

Capital expenditure contracted but unspent at 31 December 2021 amounted to £63,936. The equivalent figure for 2020 was £93,288.

15. Operating lease commitments

	Land and buildings		Equipment	
	2021	2020	**2021**	2020
Expiry date	**£'000**	£'000	**£'000**	£'000
Within one year	**4,359**	3,649	**97**	145
In years two to five	**7,723**	11,119	**48**	48
After more than five years	**1,974**	2,876	**-**	-
	14,056	17,644	**145**	193

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

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 2021 there were 1,536 members of staff contributing to this scheme. It meets the government's requirements following the introduction of automatic enrolment. Individuals can choose to make additional contributions by deduction from salary to the scheme. Under the terms of FRS102, contributions are accounted for as a defined contribution scheme based on actual contributions paid through the year.

NHS Multi-Employer Scheme

We have 1 member of staff who contribute to the NHS multi-employer scheme, which is a defined benefit scheme. The staff member 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 FRS102, 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. There is an ongoing full assessment of the pension liabilities which is set to conclude late 2022. The output of this will form the basis of the 2022 FRS102 valuation.

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 two top-up payments to the scheme of £2.3m in total during 2021 and will contribute a top up payment to the scheme of £1.3m each year between 2022 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 FRS102 are set out below.

Main financial assumptions

	31 December 2021	31 December 2020
	%pa	%pa
Retail Prices Index inflation	3.1	2.7
Consumer Price Index inflation	2.7	2.3
Rate of general long-term increase in salaries	3.7	3.3
Pension increases (excess over guaranteed minimum pension)	2.7	2.3
Discount rate for scheme liabilities	1.9	1.4

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 22.7 years (2020 22.6 years) if they are male and for a further 24.5 years if they are female (2020 24.4).

For a member who retires in 2041 at age 65 the assumptions are that they will live on average for a further 23.3 years after retirement if they are male and for a further 25.4 years after retirement if they are female.

Scheme asset allocation

	31 December 2021		31 December 2020	
	£'000	**%**	£'000	%
Delegated consulting services	**327,665**	**99%**	305,166	99%
Other	**1,891**	**1%**	1,103	1%
Total	**329,556**	**100%**	306,269	100%

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

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

Reconciliation of funded status to balance sheet

	31 December 2021	31 December 2020
	£'000	£'000
Fair value of assets	**329,556**	306,269
Present value of funded defined benefit obligations	**(291,864)**	(301,086)
Funded status	**37,692**	5,183
Present value of unfunded defined benefit obligation	**(1,131)**	(1,195)
Asset/(liability) recognised on the balance sheet	**36,561**	3,988

Amounts recognised in income statement

	31 December 2021	31 December 2020
	£'000	£'000
Financing cost:		
Interest on net defined benefit liability/(asset)	**(70)**	(208)
Pension expense recognised in profit and loss	**(70)**	(208)

Amounts recognised in Other Comprehensive Income (OCI)

	31 December 2021	31 December 2020
	£'000	£'000
Asset gains/(losses) arising during the year	**19,325**	43,589
Liability gains/(losses) arising during the year	**10,818**	(50,560)
Actuarial gain/(loss) on defined benefit pension Scheme	**30,143**	(6,971)

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

	31 December 2021	31 December 2020
	£'000	£'000
Opening defined benefit obligation (DBO)	**302,281**	248,752
Interest expense on DBO	**4,213**	4,955
Actuarial (gains)/losses on liabilities	**(10,818)**	50,560
Net benefits paid out	**(2,681)**	(1,986)
Past service cost	-	-
Closing defined benefit obligation	**292,995**	302,281

Changes to the fair value of Scheme assets during the year

	31 December 2021	31 December 2020
	£'000	£'000
Opening fair value of Scheme assets	**306,269**	258,143
Interest income on Scheme assets	**4,283**	5,163
Gain/(loss) on Scheme assets	**19,325**	43,589
Contributions made by the company	**2,360**	1,360
Net benefits paid out	**(2,681)**	(1,986)
Closing fair value of Scheme assets	**329,556**	306,269

Actual return on Scheme assets

	31 December 2021	31 December 2020
	£'000	£'000
Interest income on Scheme assets	**4,283**	5,163
Gain/(loss) on Scheme assets	**19,325**	43,589
Actual return on Scheme assets	**23,608**	48,752

17. Honoraria

	2021	2020
Trustees		
Dame Clare Marx (Chair)*	64,167	110,000
Professor Dame Carrie MacEwen (Acting Chair)†	41,055	-
Mr Steve Burnett	18,000	18,000
Dr Vanessa Davies‡	18,000	-
Lady Christine Eames¶	-	18,000
Professor Anthony Harnden	18,000	18,000
Lord Philip Hunt	18,000	18,000
Professor Deirdre Kelly¶	-	18,000
Professor Paul Knight	18,000	18,000
Ms Lara Fielden§	12,000	-
Dame Suzi Leather¶	-	18,000
Professor Deepa Mann-Kler‡	18,000	-
Dr Rajesh Patel‖	18,000	16,500
Dame Denise Platt¶	-	18,000
Dr Suzanne Shale‡	18,000	-
Miss Amerdeep Somal¶	-	13,500
Miss Alison Wright‖	18,000	16,500

* Demitted as Council Member and Chair 31 July 2021.

† Appointed as Council Member in January 2021 and Acting Chair from 1 August 2021.

‡ Appointed as a Council Member in 2021.

¶ Demitted as a Council Member in 2020.

§ Appointed as a Council Member January 2021, deceased August 2021.

‖ Appointed as a Council Member in 2020.

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

Medical Practitioners Tribunal Service Committee members	2021	2020
Dame Caroline Swift	93,286	92,937
Mrs Joy Hamilton	3,720	3,720
Professor Jacky Hayden	7,440	7,440
Gill Edelman (Gillian Gordon)*	564	-
Dr Tushar Vince*	564	-
Dr Patricia Moultrie†	3,156	3,720
Mrs Judith Worthington†	3,156	3,720

* Appointed as MPTS Committee member 2021.

† Demitted as MPTS Committee member 2021.

Audit and Risk Committee co-opted members	2021	2020
Ms Elizabeth Butler*	1,473	1,550
Jon Hayes†	930	-
Mr Kenneth Gill	2,945	2,170

* Demitted as ARC co-opted member 2021.

† Appointed as ARC co-opted member 2021.

Investment Committee co-opted members	2021	2020
Mr Keith Mackay	2,170	2,170
Mr Tim Scholefield*	620	1,860
Mr David Stewart*	-	-
Michael Jennings†	620	-

* Demitted as IC co-opted member 2021.

† Appointed as IC co-opted member 2021.

GMC Services International Ltd	2021	2020
Dr Andrew McCulloch	-	155

18. Travel and subsistence expenses claimed in 2021

	2021	2020
Trustees		
Dame Clare Marx (Chair)*	**-**	445
Professor Dame Carrie MacEwen (Acting Chair)†	**236**	-
Mr Steve Burnett	**732**	489
Dr Vanessa Davies‡	**706**	-
Lady Christine Eames¶	**-**	1,704
Professor Anthony Harnden	**184**	84
Lord Philip Hunt	**-**	50
Professor Deirdre Kelly¶	**-**	420
Professor Paul Knight	**1,689**	659
Ms Lara Fielden§	**-**	-
Dame Suzi Leather¶	**-**	425
Professor Deepa Mann-Kler‡ **	**2,878**	-
Dr Rajesh Patel‖	**942**	175
Dame Denise Platt¶	**-**	113
Dr Suzanne Shale‡	**-**	-
Miss Amerdeep Somal¶	**-**	1,380
Miss Alison Wright ‖	**-**	194

* Demitted as Council Member and Chair 31 July 2021.

† Appointed as Council Member in January 2021 and Acting Chair from 1 August 2021.

‡ Appointed as a Council Member in 2021.

¶ Demitted as a Council Member in 2020.

§ Appointed as a Council Member January 2021, deceased August 2021.

‖ Appointed as a Council Member in 2020.

** Professor Mann-Kler is our Council representative based in Northern Ireland and as such incurs higher travel and subsistence expenses to carry out her responsibilities as a Council Member.

Medical Practitioners Tribunal Service Committee members	**2021**	2020
Dame Caroline Swift	**463**	30
Mrs Joy Hamilton	**-**	217
Professor Jacky Hayden	**302**	316
Gill Edelman (Gillian Gordon)*	**167**	-
Dr Tushar Vince*	**-**	-
Dr Patricia Moultrie†	**-**	250
Mrs Judith Worthington†	**-**	207

* Appointed as MPTS Committee member 2021.

† Demitted as MPTS Committee member 2021.

Audit and Risk Committee co-opted members	**2021**	2020
Ms Elizabeth Butler*	-	21
Jon Hayes†	241	-
Mr Kenneth Gill	-	101

* Demitted as ARC co-opted member 2021.

† Appointed as ARC co-opted member 2021.

Investment Committee co-opted members	**2021**	2020
Mr Keith Mackay	74	-
Mr Tim Scholefield*	-	-
Mr David Stewart*	-	-
Michael Jennings†	26	-

* Demitted as IC co-opted member 2021.

† Appointed as IC co-opted member 2021.

GMC Services International Ltd	**2021**	2020
Dr Andrew McCulloch	-	-

	2021	2020
Senior management team		
Charlie Massey (Chief Executive)	**1,118**	1,071
Paul Buckley – Director of Strategy and Policy*	**-**	1,196
Shaun Gallagher – Director of Strategy and Policy†	**1,355**	-
Una Lane – Director of Registration and Revalidation	**971**	1,088
Colin Melville – Director of Education and Standards	**392**	3,314
Anthony Omo – Director of Fitness to Practise	**-**	3,579
Paul Reynolds – Director of Strategic Communications and Engagement	**156**	2,313
Neil Roberts – Director of Resources and Quality Assurance	**2,164**	5,071

* Paul Buckley left his role as Director of Strategy and Policy on 31 December 2020.

† Shaun Gallagher was appointed as Director of Strategy and Policy on 01 December 2020.

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.

Reference and administrative information

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

Information requests

In 2021, we received 402 subject access requests under the General Data Protection Regulation (GDPR). This was a decrease of 15% from 2020. The number of information requests we received under the Freedom of Information Act 2000 (FOI) in 2021 was 841. This was a 32.6% increase from 2020.

We achieved 77.2% against our target of responding to 80% of subject access requests within the statutory timeframe. We achieved 83.1% against our target of responding to 90% of FOI requests within 20 working days.

Paying for goods and services

We paid 98% 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	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 2nd Floor, 55 Ludgate Hill London EC4M 7JW
Actuary and pension scheme adviser	Aon Parkside House, Ashley Road Epsom Surrey KT18 5BS

Email: gmc@gmc-uk.org

Website: gmc-uk.org

Telephone: 0161 923 6602

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

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