General Medical Council

Council Meeting - 23 July 2026

PUBLISHED
17 July 2026

General Medical Council

Council

Meeting room 2.64/2.65, Manchester

Agenda

Main meeting

Thursday 23 July 2026 – 11:30-14:55

Timing includes lunch and Seminar session two

		Main Meeting
11:30 – 11:33 *3 mins*	**M1**	**Chair's business**
11:33 – 11:35 *2 mins*	**M2**	**Minutes of the meeting on 10 June 2026**
11:35 – 11:50 *15 mins*	**M3**	**Chief Executive's report**
11:50 – 12:10 *20 mins*	**M4**	**Sustaining momentum post-delivery of the Fairer Employer Referrals programme**
12:10 – 12:30 *20 mins*	**M5**	**ED&I annual report**
12:30 – 12:45 *15 mins*	**M6**	**Safeguarding annual report**
12:45 – 12:50 *5 mins*	**M7**	**Any other business**
		Below-the-line items*
	M8	**Council forward work programme**
12:50 – 13:20 *30 mins*		Lunch

Seminar

13:20 – 14:05 *45 mins*	**S3**	**Engaging with medical students**
14:05 – 14:10 *5 mins*		Break
14:10 – 14:55 *45 mins*	**S4**	**Investment Committee – background and context**

*Members should notify the Chair a minimum of two days prior to the meeting should they wish to discuss any starred items.

Contents

General Medical Council

Draft as of: 10 June 2026

To approve

Minutes of the meeting on 10 June 2026

Members present

Carrie MacEwen, Chair

Vanessa Davies
Lucinda Etheridge
Keith Lloyd
Deepa Mann-Kler
Douglas Millican
Olamide Oguntimehin
Raj Patel
Jane Ramsey
Suzanne Shale
Wendy Williams
Jeeves Wijesuriya

Others present

Charlie Massey, Chief Executive and Registrar
Shaun Gallagher, Director of Strategy and Policy
Una Lane, Director of Registration and Revalidation
Pushpinder Mangat, Medical Director and Director of Education and Standards
Anthony Omo, Director of Fitness to Practise and General Counsel
Paul Reynolds, Director Strategic Communications and Engagement
Neil Roberts, Director of Resources
Daniel Darbyshire, Council Affiliate
Ella Jackson, Council Affiliate
Melanie Wilson, Head of Corporate Governance and Council Secretary

Agenda item 2
Minutes of the meeting on 10 June 2026

Chair's business (item M1)

1 The Chair welcomed members of Council, the Senior Management Team (SMT) and observers to the meeting.

2 The Chair welcomed two Council affiliates to their first Council meeting.

3 Council has approved on circulation the extension of Professor Paul Knight's appointment as Interim Chair of GMC Services International until 31 December 2026.

Minutes of the meeting on 23 April 2026 (item M2)

4 Council approved the minutes of the meeting on 23 April 2026 as a true record.

5 The action points from previous meetings were noted.

Chief Executive's Report (item M3)

6 Council received the Chief Executive's Report, outlining developments in our external environment and progress on our strategy since Council last met.

7 Council noted that:

a The Department of Health and Social Care (DHSC) launched the *Reforming the General Medical Council legislative framework* consultation on Tuesday 24 March 2026. The consultation will run for three months and close on Tuesday 23 June 2026.

b The Lord Mann Review into antisemitism and other forms of racism in the NHS has now been published. The GMC will consider the recommendations and take forward any actions relevant to its remit. A further discussion is scheduled for the July Council meeting.

c In relation to the Enterprise Resource Planning system, work is progressing as set out in the previous report, and testing of the finance system is nearing completion. Based on going live in October, the programme is expected to be approximately 30% over the original budget.

8 During the discussion, Council noted that:

a Members discussed the use of organisational turnover as a performance indicator, noting that turnover levels should be understood within an appropriate range, rather than as a metric to be actively driven upwards.

b The automated Genesys survey within the Contact Centre was discussed, and members were assured as to the reliability and accuracy of the data following testing. It was noted that response rates have increased significantly, providing a more robust evidence base

for understanding service user experience. Further analysis will be shared with Council in future reporting cycles.

c Members discussed recent website performance data, noting a sustained decline in key metrics. Further analysis will be undertaken to understand the drivers of this **[action]**.

9 Council noted the Chief Executive's report.

Finance update (item M4)

10 Council received an update on the organisation's financial position and performance on the investment portfolio.

11 Council noted that:

a There continues to be a significant reduction in Professional and Linguistic Assessment Board (PLAB) exam candidate volumes and new international medical graduate (IMG) applications compared with both budget assumptions and 2025 levels.

b Since the previous report in April, where a deficit of £0.8m was projected, the forecast has been revised to reflect a slower rate of growth in the medical register. This has resulted in a reduction of £1m in forecast annual retention fee (ARF) income.

c The level of projected operational income is now £167.3 million, which is a reduction of £4 million since budget setting.

d There have been relatively minor changes to the expenditure outlook, with an expected operational underspend of £2 million, primarily driven by variable cost reductions related to PLAB candidate volumes. Expenditure pressures continue, particularly given the significant year on year increase in FtP volumes and the need to adequately resource ongoing regulatory reform work.

e Current projections indicate that without corrective action, the GMC is likely to move into a deficit position in 2027 and 2028, reflecting sustained reductions in PLAB demand, lower IMG application volumes and increased rates of licence relinquishment.

12 During the discussion, Council noted that:

a Members supported the approach being taken to respond to the current financial position, recognising the importance of both achieving financial balance in the medium term and using this as an opportunity to consider longer-term organisational change.

b There is a need to develop a clear vision for the future shape of the organisation, supported by prioritisation and a coherent approach to resource allocation, particularly in the context of forthcoming regulatory reform.

c Financial planning should consider both areas where activity may be reduced or paused, and areas where investment is required to support future delivery, including changes to ways of working and organisational culture.

d While reductions in PLAB volumes had been anticipated, the pace of change has been accelerated by wider policy developments. Work is ongoing to strengthen forecasting and horizon scanning, including analysis of trends in other areas such as specialist applications.

e The Audit and Risk Committee is considering forecasting and horizon scanning more broadly and will report back later in the year. It was also noted that financial risks are reflected within the current risk reporting framework, with further developments planned as part of the refreshed approach to risk reporting.

13 Council noted the:

a financial position at the end of April 2026 and the forecast to the end of 2026;

b an update on financial risks and PLAB candidate volumes; and

c latest performance and valuation of our investment portfolio.

People Strategy (item M5)

14 Council received a report detailing the process to develop the People Strategy 2026 - 2030.

15 Council noted that:

a Following the publication of the Corporate Strategy (2026–2030), the People Strategy has been developed to support delivery of corporate priorities by ensuring the organisation has the necessary capacity, capability and culture in place.

16 During the discussion, Council noted that:

a The strategy had been shaped through extensive colleague engagement and includes a range of commitments, with learning and development remaining an ongoing focus for the People function.

b The Strategy has been approved by the Executive Board, however there may be merit in considering the role of Council in future governance processes, given the centrality of people and culture to organisational delivery.

c Although not explicitly included in the new Strategy, further information on the organisation's support to colleagues experiencing bereavement will be shared with members **[action]**.

d The importance of aligning the People Strategy with the organisation's financial context was highlighted, particularly in light of messaging relating to potential future deficits. It

was noted that these considerations will be reflected through leadership development and wider organisational communication.

e Feedback from trade union engagement on the strategy has been positive, particularly in relation to commitments on wellbeing and equality, diversity and inclusion.

f Members reflected on the approach to staff engagement, noting the breadth of activity undertaken, and discussed how the process had sought to capture a wide range of perspectives, including through the People Forum and staff networks.

17 Council noted the People Strategy 2026 - 2030.

Report of the Audit and Risk Committee (item M6)

18 Council received a report detailing the work of the Audit and Risk Committee from December 2025 to May 2026.

19 Council noted that the report provided a comprehensive update on the Audit and Risk Committee's (ARC) activities since it last reported to Council in December 2025, supplementing the summary notes provided to Council after the January and March meetings.

20 During the discussion, Council noted that:

a There had been three Significant Event Reviews reported during the period, related to data breaches. Members reflected on whether consideration had been given to these collectively to identify any underlying themes or learning. It was noted that such incidents are not uncommon in organisations of this scale, and further consideration could be given to thematic analysis of these events.

b The Head of Internal Audit's annual opinion, which highlighted a strong assurance position supported by a substantial evidence base. It was also noted that internal audit actions continue to be addressed comprehensively and in a timely manner, providing confidence in the control environment.

21 Council noted the work of the Audit and Risk Committee.

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Minutes of the meeting on 10 June 2026

Trustees' annual report and accounts (item M7)

22 Council received the draft Trustee's annual report and accounts.

23 Council noted that:

a The report and accounts incorporated feedback from colleagues and members as well as from the External Auditor.

b At the year end, free reserves were £56.7 million, compared with £48.9m at the end of 2024, and were towards the upper end of the target range of 20% to 35% of the following year's expenditure.

c Total income for the year was £171 million, an increase of £4m compared with 2024. This reflected continued growth in the size of the register and the impact of inflation on fee levels, partially offset by a £6 million reduction in PLAB income, resulting in lower overall growth than in previous years.

d Expenditure increased by £4 million to £160 million, primarily driven by inflationary pressures, contractual commitments and the annual pay award.

e That reductions in PLAB volumes also led to corresponding reductions in variable costs associated with administering PLAB examinations.

f As part of the finance system replacement programme, an over-release of Annual Retention Fee income of approximately £3.2 million was identified. This has been reflected in the 2024 comparative figures through a £2.9 million reduction in reserves brought forward and a £0.3 million reduction in 2024 income.

g In relation to the regulation of physician associates (PAs) and anaesthesia associates (AAs), £1.7 million of restricted income was recognised from DHSC to meet the net cost of regulation. This was supplemented by £1.4 million of income from PA and AA registration fees, with total costs fully covered by these funding streams in 2025.

h Investment performance remained positive, with gains of approximately £1 million during the year, alongside a strong cash position generating £2.3 million in interest income.

i The 2025 accounts include a legal provision of £5.5 million, to cover potential legal claims, and a dilapidations provision of £3.9m million.

24 Council approved the:

a Final draft of the 2025 Trustees' Annual Report;

b Final draft of the 2025 Accounts;

c Final draft of the Letter of Representation; and

d Noted the Back to Back Letter of Representation.

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Minutes of the meeting on 10 June 2026

Fitness to Practise Statistics Report (item M8)

25 Council received a statistical report summarising concerns about doctors' fitness to practise, and a report on doctors who have died while under investigation or during a period of monitoring.

26 Council noted that:

a Under the Medical Act 1983, the GMC is required to provide annual statistics and analysis on concerns about doctors' fitness to practise to the Privy Council.

b In previous years, this information has been published in a technical format without active promotion. This year, the report has been developed in a new format, including enhanced narrative to provide greater context to the data, and will be proactively promoted for the first time.

c This revised approach forms part of wider work to build trust and confidence in Fitness to Practise processes among professional audiences, and to improve public and patient understanding of the GMC's role.

d In line with commitments made under the Vulnerable Doctors Programme, the report also includes annual information on doctors who have died whilst subject to Fitness to Practise processes.

27 During the discussion, Council noted that:

a Further clarity in relation to appeals data could be helpful in light of the current external environment and increased scrutiny following recent reviews. It was noted that additional narrative has been included to explain the types of cases subject to appeal, and further refinement of language and presentation will be considered.

b The relationship between the GMC and the Medical Practitioners Tribunal Service (MPTS) was central, and clearly articulating how the interaction between Fitness to Practise and the tribunal works was not well understood outside the organisation. This will be reflected in both the report and the wider communications approach.

c Concerns raised by members of the public have increased significantly as opposed to those from other sources. It was recognised that this reflects wider trends across the regulatory landscape, and that further work will be undertaken to understand and communicate the drivers of these patterns where possible.

d The inclusion of narrative explanations within the report was welcomed. It was suggested that further clarity could be provided in certain areas, including clearer categorisation of concerns and greater contextualisation of the proportion of cases relative to the overall size of the register.

e The importance of ensuring that serious concerns, including sexual misconduct, are clearly reflected within the report to demonstrate the GMC's approach to these issues.

f The report is an important opportunity to strengthen engagement with registrants and the public, and noted that ongoing development of the report, including greater thematic analysis, will be taken forward over time.

28 Council approved, subject to changes to be made following the discussion:

a The annual Fitness to Practise Statistics Report; and

b The annual report on doctors who have died while under investigation or during a period of monitoring.

Report of the MPTS Committee (item M9)

29 Council received the report on the work of the Medical Practitioners Tribunal (MPTS) since the last report to Council in June 2025.

30 During the discussion:

a Members noted ongoing work to enhance training for Legally Qualified Chairs, including the incorporation of questions and scenarios raised by panel members to better reflect the complexity of cases encountered in practice. It was recognised that this is a sensitive area requiring a measured and consistent approach.

b In the context of the Lord Mann Review, members discussed how issues such as antisemitism and anti-Muslim hatred are reflected within MPTS processes and training. It was noted that tribunals draw on a broad range of definitions and evidence, with an approach that seeks to avoid narrowing interpretation while ensuring that all relevant evidence is considered.

c Members reflected on the consistency of sanctioning decisions, including the use of suspension and review hearings compared with erasure, and the extent to which learning from such cases is fed back to panel members. It was noted that mechanisms are being trialled to support more timely feedback to panels, alongside ongoing work to review sanction guidance and its interpretation.

d Members welcomed progress in developing appraisal processes for panel members and discussed how assurance will be obtained regarding the rigour and effectiveness of these arrangements, particularly given relatively low case volumes for individual panel members. It was noted that appraisal approaches are being developed with a focus on peer review and appropriate training, and that improvements in outcomes and application of the law will be key indicators of effectiveness over time.

e Members discussed the proportion of doctors who do not attend their hearings and sought to better understand the reasons for non-attendance. Work is ongoing to improve understanding of these patterns and to enhance communication and support for registrants, including those representing themselves.

31 Council welcomed the report of the MPTS Committee noting that recent discussions had been constructive and supported a strengthening relationship and noted the MPTS Report to Parliament.

Freedom to Speak Up Guardian Annual Report (item M10)

32 Council noted the Freedom to Speak Up Guardian Annual Report without discussion, highlighting the work of the Guardian and champions in 2025.

Annual QA update (item M11)

33 Council received a report on education and training quality assurance (QA) work in 2025.

34 Council noted that:

a The report encompasses proactive QA processes to engage with medical schools and postgraduate training bodies as well as reactive processes (including enhanced monitoring) to address challenged training locations.

b The report also covered the first year of delivery of the Medical Licensing Assessment (MLA) and the accreditation and ongoing quality assurance of education courses for physician and anaesthesia associates.

c An update was provided in the report on the assurance role of postgraduate training bodies, including developments in England following the integration of NHS England into the Department of Health and Social Care, and the potential implications of the GMC Order 2026 for future QA arrangements.

35 During the discussion:

a Members welcomed the breadth of QA activity and discussed how this work supports earlier identification of issues relating to professionalism and fitness to practise within medical education. The importance of understanding how equality, diversity and inclusion considerations are reflected within QA processes and data was highlighted, noting the potential for early indicators to inform future regulatory activity.

b The value of existing outreach and engagement with medical schools was commended, including guidance on professionalism and fitness to practise, and members expressed interest in further development of data and insight in this area.

c Members discussed plans for publication of MLA data and the extent to which this should include information at the level of individual medical schools. It was noted that this remains an area of ongoing discussion with the Medical Schools Council, with a preference to present data in a neutral and constructive manner to support understanding.

d Recent engagement with stakeholders has been constructive and that further work will be required to develop an approach to publication that balances transparency, context and public interest.

36 Council noted the annual QA update.

Recommendation of approval: Keele University PAA course (item M12)

37 Council received an overview of our quality assurance of the Physician Associate Apprenticeship (PAA) course at Keele University.

38 Council noted that:

a The AAPA Order requires Council to maintain and amend, as required, the list of courses entitled to deliver pre-qualification education for physician associates (PAs) and anaesthesia associates (AAs). In April 2025 Council approved the existing PA and AA courses that were meeting our criteria for approval as previously agreed by Council. The recommendation on approval for the University of Keele PAA course was deferred at the time as the course had not met the criterion of having graduated at least one cohort of students.

b The course provider has recently graduated the first cohort in May 2026 and is now meeting all our criteria for approval of existing courses. Standards of proficiency are set out in Standards for the delivery of PA and AA pre-qualification education (2024) and compliance with the standards is demonstrated through the Quality Assurance Framework, which includes annual returns from the course provider and at least one in-person quality activity as determined in our approach for the approval of existing PA and AA courses.

39 Council approved the PAA course at Keele University being added to the list of courses entitled to deliver pre-qualification education for physician associates (PAs) and anaesthesia associates (AAs).

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Any other business (item M13)

Date of next meeting

40 Council noted that its next meeting is scheduled for 23 July 2026 in Manchester.

41 Council noted the below the line items:

M14 – Council Forward Work Programme

M15 – People Survey workstreams update

General Medical Council

Chief Executive's report

Action	To note
Purpose	This report outlines developments in our external environment and progress on our strategy since Council last met. Key points to note: • The Department of Health and Social Care consultation on the GMC Order has been extended until 21 July 2026. • The Ockenden and Baroness Amos maternity reviews have been published, as well as the Lord Mann rapid review into antisemitism and other forms of racism.
Decision Trail	Council receives this report at each full meeting.
Recommendations	**a** To note the Chief Executive's report. **b** To note the Performance Annex and the Corporate Opportunities and Risk Register.
Annexes	Annex A: Performance Annex Annex B: Corporate Opportunities and Risk Register
Author contacts	**Katherine Ince**, Head of OCCE Any enquiries to: GovernanceTeamMailbox@gmc-uk.org
Sponsoring director/ Senior Responsible Owner	**Charlie Massey**, Chief Executive

Agenda item M3
Chief Executive's report

Regulatory reform

1 The deadline for the Department of Health and Social Care (DHSC) consultation on the GMC Order has been extended until 21 July 2026 to assist those who would like more time to respond to questions related to the Lord Mann review into antisemitism and other forms of racism.

2 We have submitted our response to the consultation and published it on our website.

3 In the lead up to the DHSC's consultation and whilst it has been open, we have engaged with a range of external stakeholders to discuss the GMC Order and explain our positions on the government's drafting. This included promoting the consultation at events over recent months such as our UK advisory forum (UKAF) meetings in Scotland, Wales and Northern Ireland, Strategic ED&I forum, and the patient group roundtable.

Leng review

4 Our priority areas of work for responding to Professor Leng's recommendations on Physician Associates (PAs) and Anaesthesia Associates (AAs) continue to focus on reviewing the presentation of *Good medical practice*, to identify opportunities for more clearly differentiating between the professions we regulate; and work to consider how we might implement the proposed change of title for PAs and AAs, should this be supported by the DHSC's consultation on the GMC Order.

5 We continue to attend government-based Leng implementation groups to support the work of other stakeholders where this impacts on our regulatory responsibilities in respect of PAs and AAs.

Parliamentary and stakeholder updates

6 In June, we chaired a meeting of the European Network of Medical Competent Authorities which brought together 41 participants from 21 medical regulators, including representatives from the European Commission. We discussed the recognition of overseas qualifications and the sharing of fitness to practise information across borders.

7 We hosted a visit from the Chinese University of Hong Kong who met with colleagues to discuss issues around education and regulatory policy.

8 On 30 June, we hosted our parliamentary and stakeholder reception in the House of Commons to highlight the importance of supporting the workforce. We provided MPs from across the UK with constituency-specific workforce data, and welcomed a number of members of the House of Lords with an interest in healthcare issues. We were delighted to

have the Health and Social Care Select Committee Chair, Layla Moran, as our keynote speaker and are grateful for the support of Lord Hunt in sponsoring the event.

9 Charlie spoke at Pulse Live in Cardiff on 2 July. The event is dedicated and designed exclusively for registered GPs and GP trainees and our session was titled: *In conversation with the GMC: the changing shape of the medical workforce in Wales*.

10 Charlie met with Wales Chief Medical Officer Isabel Oliver to discuss our UKAF and data roundtable.

11 We facilitated an informal briefing session for the Northern Ireland Assembly Health Committee to support members' understanding of our role. We responded to queries about our fitness to practise processes, our outreach activity, and workforce data.

12 There have been a number of new political appointments, and we are seeking introductory meetings:

a) In Wales, Mabon ap Gwynfor MS (Plaid Cymru) has been appointed Cabinet Minister for Health and Care, and Jayne Bryant MS has been elected as Chair of the Health and Social Care Committee.

b) In Scotland, Angela Constance MSP (SNP) has been appointed Cabinet Secretary for Health and Care, and Helen McDade MSP (Reform) has been elected Convenor of the Scottish Parliament's Health, Care and Sport Committee; she is also her party's health lead.

Inquiries and reviews

13 The report from the rapid review into antisemitism and other forms of racism led by Lord Mann was published on 4 June.

14 The Ockenden review of maternity services at the Nottingham University Hospitals NHS Trust was published on 24 June, and the final report of Baroness Amos's Independent National Maternity and Neonatal Investigation was published on 30 June.

15 The inquiry into Muckamore Abbey published its findings on 18 June. We will review the recommendations and take action where appropriate.

16 The inquiry into urology services at Southern Trust published its findings on 24 June. We will review any recommendations relevant to us.

Enhanced monitoring

17 There are currently 21 open cases, with conditions attached to GMC approval to deliver a programme of training at six sites. No new cases have been opened recently.

18 We have placed conditions on the approval of emergency medicine training at Prince Charles Hospital, Cwm Taf Morgannwg University Health Board. These conditions aim to strengthen culture and educational governance, provide clear routes for trainers to raise concerns, ensure protected time for educational duties, and maintain sufficient suitably qualified staff for safe supervision and effective training. We will continue to work with Health Education Improvement Wales to monitor progress.

19 We have removed the final condition on the approval of obstetrics and gynaecology training at University Hospitals Birmingham NHS Foundation Trust. While improvements mean the condition no longer meets our threshold, the enhanced monitoring case remains open, and we will continue to work with the NHS England West Midlands Workforce, Training and Education team to monitor the department.

20 We noted improvements in training in general internal medicine at The Grange University Hospital, Aneurin Bevan University Health Board. This case has now been de-escalated.

Enterprise Resource Planning (ERP) system

21 Core finance testing is complete, and we are performing final regression testing. We are in user acceptance testing phase 1 for HR.

22 Preparation is underway for the key data migration of finance and HR data. This work will help determine how long the migration will take on the go-live weekend.

23 Finance is due to go live in October; HR will go live in October if the testing and data migration are successful.

24 Based on going live in October, we expect the programme to be approximately 30% over the original budget.

Operational performance

25 The attached Performance Annex (**Annex A**) outlines our performance against KPIs and sets out the current status of our corporate priority projects and programmes.

26 We met our KPI targets for May, with the exception of staff turnover which remains below our target range due to high retention. Since the last report, we have updated our Contact Centre customer satisfaction measures to reflect the move to reporting through our new Contact Centre systems. This enables us to automate feedback surveys and reach a

significantly larger number of people who contact us, providing greater insight into their digital and telephone interactions. We will set a target for the new measures in due course.

27 Overall ratings are unchanged since the last reporting period. The regulatory reform programme and our programme to introduce a new ERP system continue to report amber, reflecting condensed timescales and ongoing resource pressures. The Leng implementation project is also reporting amber; resource has now been assigned, and we have begun scoping work with business areas.

28 There have been no notable updates to the annexed corporate opportunities and risk register (CORR) since the last meeting. The format and the content of the CORR is currently under review, and proposals are being developed and reviewed by SMT and Audit and Risk Committee.

Executive Board

29 The Executive Board met on 29 June 2026 and considered items on the following topics:

c) Quarter 2 Planning Gateway recommendations

d) Financial update

e) Equality, diversity and inclusion annual report

f) Business continuity annual report

g) People and Organisational Development policy update

General Medical Council

M3 – Annex A - Performance annex

Data presented as at 25 June 2026 (unless otherwise stated)

Operational Key Performance Indicators (KPIs) – since last report to Council

Indicators		Apr	May	Commentary
	Decision on 95% of all registration applications within 3 months	99%	99%	**Contact Centre Survey:** In May, we transitioned to reporting on customer satisfaction through an automated survey within our upgraded Contact Centre system. The two new measures look at experiences from both voice and digital interactions and will replace the previous measure going forward. Moving from a manual sample survey to an automated survey means we have more reach which has significantly increased the number of responses. It is important to note that surveys on voice interactions are presented at the end of every call, whilst surveys on messaging are emailed out three days following the digital interaction. This delay in sending our surveys for digital interactions is due to the system design and is not configurable. Overall, this means we are likely to have a lower response rate for the digital surveys which may impact the overall score. **GMC Website:** Our target Net Promoter score (NPS) of 40 was just missed in April (39) though recovered in May (44). The team have been exploring the general decline in performance over recent months, with results suggesting this may be due to declining interest in PLAB in some key countries. This is leading to lower traffic overall and therefore fewer survey responses. Further exploration of the data is ongoing to identify any other insights around PLAB and the GMC as a whole. **Staff Turnover:** The rolling 12-month staff turnover remains below our 8-12% target range (5.2% in May), with 5 colleagues leaving the organisation. Employee turnover has continued to fall in the last 12 months, (as shown in the following slide) with turnover last year in June having been higher at 7%.
	Decision on 95% of all revalidation recommendations within 5 working days	99%	99%	
	Respond to 90% of ethical/standards enquiries within 15 working days	100%	100%	
	Conclude 90% of fitness to practise cases within 12 months	92%	93%	
	Conclude or refer 90% of cases at investigation stage within 6 months	97%	97%	
	Conclude or refer 95% of cases at investigation stage within 12 months	97%	98%	
	Commence 100% of Investigation Committee hearings within 2 months of referral	100%	No Cases	
	Commence 100% of Interim Order Tribunal hearings within 3 weeks of referral	100%	100%	
	Contact Centre - Answer 80% of calls within 20 seconds	93%	86%	
	Contact Centre - % of customers who rated their overall experience and satisfaction at 7 or above out of 10 (target 80%)	81%	N/A	
	Contact Centre – Overall % of customers experience (telephone interactions)*	N/A	92%	
	Contact Centre – Overall % of customers experience (messaging interactions)*	N/A	85%	
	Media: combined positive, neutral and balanced media coverage of GMC (target: 90% or above)**	93%	96%	
	Satisfaction of users with GMC website (target: a Net Promoter Score of at least 40)	39	44	
	Finance - Income and expenditure % variance +/- 4%	1.3%	0.7%	
	HR - Rolling 12-month staff turnover within 8-12%	5.5%	5.2%	
	Information systems availability (target 99.89%)	100%	100%	
	GMC Outreach: Doctors intending to change practice following learning session (target: at least 75%)	81%	82%	
	GMC Outreach: Doctors attending a learning session improve their impression, or maintain a positive impression of the GMC (target: at least 65%)***	68%	66%	

*Introduced following upgraded technology within the Contact Centre. A target will be set once sufficient data has been collated to establish a baseline.

**The previous media sentiment measures on positive and negative coverage have been replaced with a singular measure, following the 2025 performance measures review. The 90% target means negative coverage must remain with 10%.

***A new Outreach measure has been added, following on from the 2025 annual performance measures review, to measure the quality of our sessions and better understand the impact on doctor's perceptions.

Operational Key Performance Indicators (KPIs) – 12-month summary

Indicator		2025							2026				
		June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
	Decision on 95% of all registration applications within 3 months	99%	99%	98%	99%	98%	98%	98%	99%	98%	98%	99%	99%
	Decision on 95% of all revalidation recommendations within 5 working days	99%	99%	99%	99%	99%	98%	99%	99%	99%	99%	99%	99%
	Respond to 90% of ethical/standards enquiries within 15 working days	100%	87%	100%	97%	100%	100%	100%	100%	100%	100%	100%	100%
	Conclude 90% of fitness to practise cases within 12 months	96%	94%	94%	94%	95%	95%	92%	94%	94%	92%	92%	93%
	Conclude or refer 90% of cases at investigation stage within 6 months	97%	97%	97%	97%	97%	98%	97%	98%	98%	96%	97%	97%
	Conclude or refer 95% of cases at investigation stage within 12 months	98%	96%	97%	98%	98%	98%	96%	97%	97%	98%	97%	98%
	Commence 100% of Investigation Committee hearings within 2 months of referral	No Cases	100%	100%	100%	No Cases	100%	100%	100%	No Cases	No Cases	100%	No Cases
	Commence 100% of Interim Order Tribunal hearings within 3 weeks of referral	100%	100%	100%	100%	100%	93%	100%	100%	100%	100%	100%	100%
	Contact Centre - Answer 80% of calls within 20 seconds	83%	75%	82%	80%	83%	88%	94%	97%	96%	93%	93%	86%
	Contact Centre - % of customers who rated their overall experience and satisfaction at 7 or above out of 10 (target 80%)	70%	72%	71%	77%	74%	76%	77%	77%	72%	71%	81%	
	Contact Centre – Overall % of customers experience (telephone interactions)*												92%
	Contact Centre – Overall % of customers experience (messaging interactions)*												85%
	Media: combined positive, neutral and balanced media coverage of GMC (target: 90% or above)**								93%	95%	95%	93%	96%
	Satisfaction of users with GMC website (target: a Net Promoter Score of at least 40)	43	47	54	44	48	53	40	33	22	24	39	44
	Finance - Income and expenditure % variance +/- 4%	4.3%	4.2%	3.6%	3.5%	3.6%	3.8%	2.3%	1.9%	2.3%	1.5%	1.3%	0.7%
	HR - Rolling 12-month staff turnover within 8-12%	6.9%	6.7%	6.2%	6.9%	7.2%	6.1%	6.1%	6.2%	5.7%	5.6%	5.5%	5.2%
	Information systems availability (target 99.89%)	100%	100%	100%	100%	100%	100%	100%	100%	99.4%	100%	100%	100%
	GMC Outreach: Doctors intending to change practice following learning session (target: at least 75%)	79%	80%	74%	79%	82%	80%	80%	77%	82%	95%	81%	82%
	GMC Outreach: Doctors attending a learning session improve their impression, or maintain a positive impression of the GMC (target: at least 65%)***								65%	71%	75%	68%	66%

*Introduced following upgraded technology within the Contact Centre. A target will be set once sufficient data has been collated to establish a baseline.

**The previous media sentiment measures on positive and negative coverage have been replaced with a singular measure, following the 2025 performance measures review. The 90% target means negative coverage must remain with 10%.

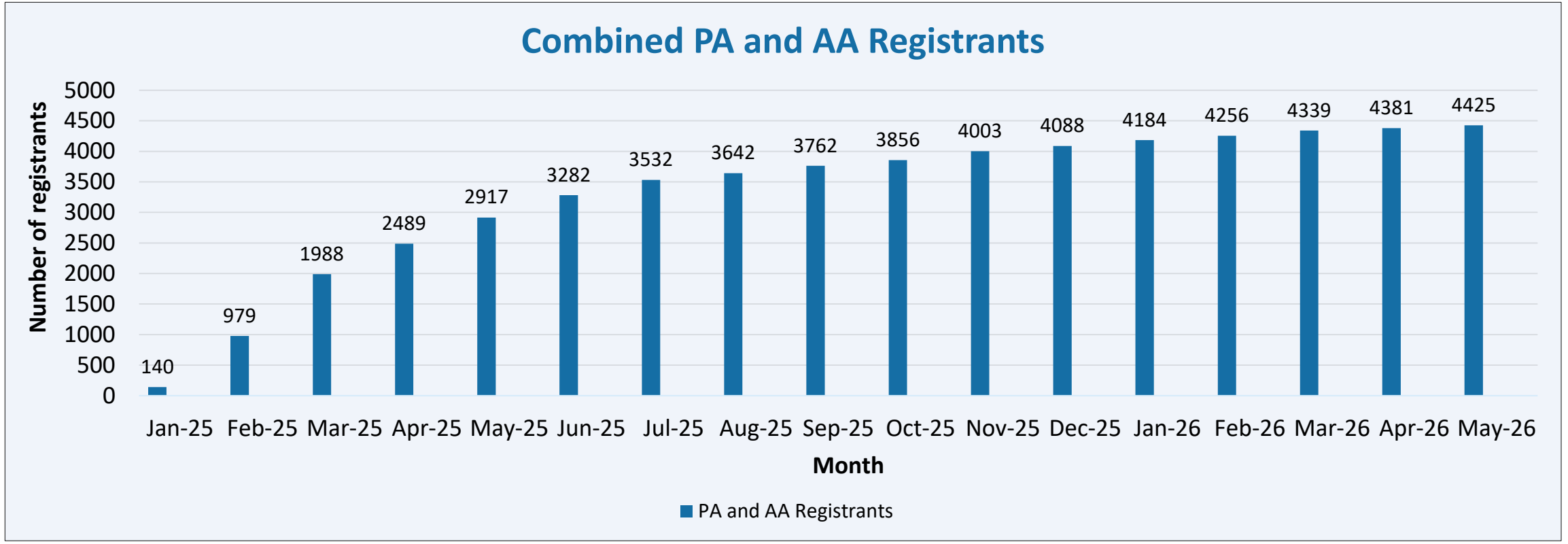
***A new Outreach measure has been added, following on from the 2025 annual performance measures review, to measure the quality of our sessions and better understand the impact on doctor's perceptions.

Physician Associates and Anaesthesia Associates

Registration – Between 16 December 2024 and 24 February 2025, we invited all those on the voluntary register to apply for registration with the GMC, and we continue to see a steady increase in applications during the transition period ahead of registration for PAs and AAs becoming a legal requirement at the end of 2026.

PA and AA registrant numbers	Number on voluntary register at 16 December 2024	Number registered as at 12 June 2026
Physician Associate (PA)	5,092	4,236
Anaesthesia Associate (AA)	178	213

**20 PAs registered with an International Registrable Qualification. All other PAs and AAs are UK qualified.*



Data last updated 19 May 2026

Physician Associates and Anaesthesia Associates

Registration continued.

	2025 Q1		2025 Q2		2025 Q3		2025 Q4		2026 Q1	
Physician Associate (PA)	**Received***	**Granted**	**Received**	**Granted**	**Received**	**Granted**	**Received**	**Granted**	**Received**	**Granted**
Direct Cohort UK Qual	78	31	53	68	37	55	23	26	24	23
International Reg Application	-	-	-	-	-	-	2	-	1	3
Non-Standard UK Qual	1	-	-	1	-	-	2	2	-	-
Transition Voluntary Register	2,580	1,834	642	1,092	242	378	173	187	158	171
UK Student	42	31	54	62	23	24	139	118	104	104
Total	**2,701**	**1,896**	**749**	**1,223**	**302**	**457**	**339**	**333**	**287**	**301**

	2025 Q1		2025 Q2		2025 Q3		2025 Q4		2026 Q1	
Anaesthesia Associate (AA)	**Received**	**Granted**	**Received**	**Granted**	**Received**	**Granted**	**Received**	**Granted**	**Received**	**Granted**
Direct Cohort UK Qual	1	-	3	1	-	3	-	-	1	1
Transition Voluntary Register	78	57	15	30	7	12	5	2	7	9
UK Student	35	20	31	40	5	11	4	4	14	10
Total	**114**	**77**	**49**	**71**	**12**	**26**	**9**	**6**	**22**	**20**

**Applications Received includes both applications that have been granted and applications in progress.*

***Data included for Q1 2026 is currently provisional. Complete figures will be updated following the end of the quarter.*

Data last updated 19 May 2026

Physician Associates and Anaesthesia Associates

Fitness to Practise – FTP summary statistics should be interpreted with caution, particularly while we are in the registration transition period and the full cohorts of PA/AAs have not been registered. Given the relative size in populations between doctors and PA/AAs caution should be applied when comparing fitness to practise rates between different groups.

Please note - the running total uses current figures as of the production of the report. This means that as complaints are progressed, and data cleansing activity takes place (e.g. identification of duplicate concerns) the figures here differ from historical totals.

Total number of complaints regarding PA/AAs received (since December 2024)`

Practitioner Type	2025 Q1	2025 Q2	2025 Q3	2025 Q4	2026 Q1
Physician Associate related complaints	23	9	7	10	21
Anaesthesia Associate related complaints	0	1	1	0	1
Total complaints relating to PA/AAs	23	10	8	10	22

Number of complaints regarding PA/AAs we could not progress because the practitioner was not registered with us* (since December 2024)

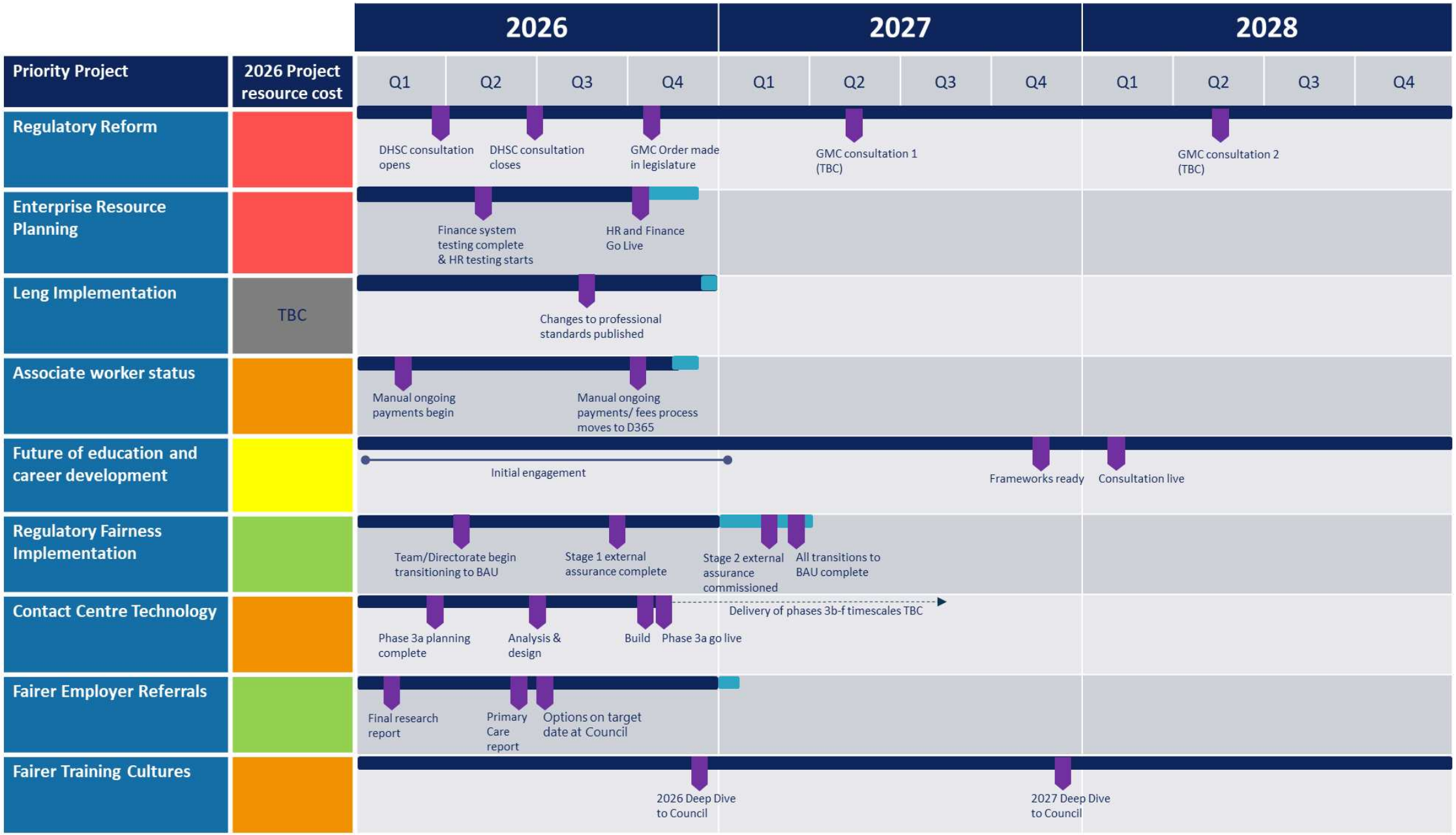
Practitioner Type	2025 Q1	2025 Q2	2025 Q3	2025 Q4	2026 Q1
Physician Associate complaints that could not progress	22	6	3	4	4
Anaesthesia Associate complaints that could not progress	0	0	0	0	0
Total PA/AA complaints that could not progress	22	6	3	4	4

**Unidentified practitioners are not included in these totals*

Complaint Outcome	Number of complaints
Closed at triage	60
Promoted to Investigation – In Progress	10
Concluded Assistant Registrar	3

Data last updated 19 May 2026

Corporate Portfolio Overview



Supporting good, safe patient care

We'll work with others to create healthcare environments that are inclusive, supportive and fair

2025 Priority change activities		RAG	Status
Fairer Employer Referrals (FER)	**Why?** To eliminate differentials in employer fitness to practise referrals. **When:** by 2026 **Who:** Anthony Omo, Anna Rowland		The first draft of the primary care report has been completed and is being reviewed by the project sponsor. Promotional communications plans for the Work Psychology Group research report have been developed, with additional engagement opportunities currently being explored. The Council paper relating to reconsideration of the 2026 target date has been updated and will be shared with FTP senior management for further feedback. Work is underway to finalise amendments to the employer referral form guidance, including the incorporation of the fairness questions currently used by Responsible Officers (ROs). In addition, a draft programme report has been produced, outlining the historical context of disproportionality and the research undertaken to better understand the issue. Further development of the report will include updates reflecting the systemic changes and improvements resulting from the FER programme.
Fair Training Cultures (FTC)	**Why?** To deliver on our commitment to eliminate discrimination, disadvantage and unfairness for all index measures of fair medical education and training pathways. **When:** September 2031 **Who:** Pushpinder Mangat		In May we have focussed on preparing for our FTC Programme Board in June, where the discussion will focus on the half-way point of the programme and the aims for the next 5 years. We will also discuss the thematic review of external action plans, as well as the analysis of the feedback from the Foundation 1 preparedness focus group, which looks to understand the gap identified through the National Training Survey between ethnic minority UK graduate doctors and their white counterparts. We have also significantly progressed work to mature the quality assurance model this month by running a second team action plan workshop with the quality assurance and improvement team. We also provided regional data ahead of annual quality assurance meetings with post-graduate Deans. We have been working on sharing information with required stakeholders, including presenting some data to Royal College Presidents meetings. These were primarily graphs showcasing 'change over time' data and also 'what works'.

Supporting good, safe patient care

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2025 Priority change activities		RAG	Status
Future of education and career development (FutureEd)	**Why?** We have a statutory duty to regularly review our education framework, including our standards, outcomes, and guidance. We want to work with partners to ensure that our new framework has the greatest positive impact for the public and the profession. **When:** Q4 2029 **Who:** Pushpinder Mangat, Phil Martin, Nico Bridge		We continue to remain on track, and at our Programme Board in May, we shared an updated programme risk log along with our slide pack for our upcoming Council Seminar in July. This slide pack was also tested at the Q2 Planning Gateway meeting in May to gain a steer on how we approach our Council session to outline our deliverables and intended outcomes. The update paper on our plans for the revised framework were well received at a recent Programme Board. The SAS and LE doctor survey has now closed with good response rate of around 12,000 responses. The responses will help us gain insight into how these groups are training and working, and we can compare this with the last survey we conducted in 2019 to see how experiences have evolved. These insights will help shape GMC policy and activities, while also supporting employers and organisations working with SAS and LE doctors. Planning for the approach to programme evaluation is underway with the pro-formas now with workstreams for completion. We have started work on the programme's equality impact assessment (EQIA) and will be consulting teams internally, including holding a programme wide workshop to identify gaps in our data and evidence collated so far. Our first external Content Development Group meeting was held on 15 May, and we have completed an initial review of our standards on *Promoting Excellence* and *Excellence by Design*. We will shortly commence our review of *Outcomes for Graduates* and the *Generic Professional Capabilities*. A workshop will be held on 15 June to plan the drafting process. Programme communications and engagement has continued. We delivered a presentation and facilitated table discussions at the Conference of Postgraduate Medical Deans (COPMED) meeting and attended both UK Advisory Forum meetings in April and May to provide updates on programme plans. We will continue to engage stakeholders across the programme, and we will shortly issue the first newsletter to those who have signed up to our Community of Interest (mailing list for updates and information about the programme). We will also start to roll out our internal Future Ed resources pack to support consistent messaging internally and externally.

Delivering better, fairer regulation

We'll modernise our processes to make them faster, fairer and better able to support good practice

2025 Priority change activities		RAG	Status
Regulatory Reform	**Why?** To improve the design and delivery of our functions so that we can be more responsive to the changing needs and expectations of patients, the health system, and the professions. **When:** Expected by Q4 2025 (dependent on when DHSC lay the Medical Professions Order in parliament)**.** **Who:** Shaun Gallagher; Tim Aldrich		We continue to report amber due to the inherent delivery risk associated with this large, complex, multi-year programme. We're currently on track but are mindful of potential capacity constraints across the programme, along with uncertainties within the external stakeholder environment that could affect progress. The Department of Health and Social Care (DHSC) launched the *Reforming the General Medical Council legislative framework* consultation on 24 March 2026. The consultation will run for three months and close on Tuesday 23 June 2026. We have engaged with a range of external stakeholders to discuss the GMC Order whilst the DHSC's consultation is open. In total, we have discussed regulatory reform at over 60 stakeholder meetings and events at a senior, strategic and policy level. Our own response to the consultation has now been approved by Programme Board and senior management and is being shared with Council on 10 June. We will aim to submit to DHSC after making any final revisions. We have also developed a set of process design principles to ensure our approach has greater across the programme. We also held a planning workshop to look at the key tasks that require completion ahead of the first GMC consultation. Lastly, we have been preparing for the upcoming audience involvement panels and continued scoping work with operational colleagues, to explore options relating to a single appeals function.
Leng Implementation Project	**Why?** Implementing new professional titles for physician associates and anaesthesia associates, in line with the forthcoming GMC Order. Reviewing and updating the presentation of our professional standards, and potentially other public-facing information, to achieve greater clarity regarding our three registrant groups **When:** Q2 2027 **Who:** Shaun Gallagher, Judith Chrystie		We are reporting as amber as the resource for delivering work relating to the change of role titles has not yet been secured. We anticipate that, funding for these posts, and related PA/AA work, will be provided by DHSC but this is still to be confirmed. Internally, the Planning Gateway has endorsed the establishment of the project and our governance structures. The project manager who will oversee the delivery of the work relating to the change in titles is now in post. They will shortly meet with Directorates to begin scoping delivery and the planning of milestones. These will inform the project initiation document, currently due to be drafted by the end of July. In mitigation, the GMC Order consultation is proposing a six-month extension of the transition period for introducing the new titles; assuming that these do change following consultation, this will move to June 2027 (after which it will be an offence to use these without GMC registration). Senior management have agreed that we will not introduce the new titles before this point, which will also provide additional time to complete the project. However, this extension is subject to the findings of the GMC Order consultation. Following feedback from the Post Leng Steering Group (PLSG), Standards and Strategic Communications and Engagement (SC&E) colleagues will provide a further update to the group on 9 June, on their proposed changes to our professional standards (recommendation 15) – which states that we should clearly differentiate between PA and AA professions for regulations and reaccreditation. This will inform a separate paper for senior management on 13 July on our overall response to recommendation 15.

Delivering better, fairer regulation

We'll modernise our processes to make them faster, fairer and better able to support good practice

2025 Priority change activities		RAG	Status
Regulatory Fairness Implementation	**Why?** We are focused on making fairness central to our work, and we are working on implementing all recommendations from the Regulatory Fairness Review published in February 2023. **When:** Q1 2027 **Who:** Shaun Gallagher, Claire Light		Registration & Revalidation (R&R) and Outreach have completed delivery of their directorate implementation plans, with fairness considerations embedded within teams and leadership, and ongoing assurance/audit plans in place. They will be going for sign off at Programme Board in June before transitioning to business as usual. They will continue to be involved in, and supported by, the programme as we develop centralised arrangements for ongoing Regulatory Fairness focuses. Decision-maker refresher training is being compiled by the EDI team, options for centralised data and monitoring are being developed, and we are collating information for internal and external narratives. We are also exploring dependencies with Regulatory Reform.

Making every interaction matter

We'll make our services accessible and treat everyone with kindness, respect and efficiency

2025 Priority change activities		RAG	Status
Contact Centre Technology	**Why?** Our vision is to deliver an outstanding experience to our customers with every interaction. To help deliver this we will adopt efficient technology which allows us to understand and meet our customers' needs and report on their experience. **When:** by end of 2026 **Who:** Una Lane, Lindsey Westwood, Rachel Mooney		During this period, we inducted a new project manager to oversee the programme. We continued defining the requirements for manual security checks through a series of workshops, focussing on Siebel integration, and concluded a user testing pilot for the automated security checks, which will influence further design changes in the automated process. We signed a contract with the third-party supplier and Enterprise systems team have begun the onboarding process. In advance of Q2 Planning Gateway, we have circulated the updated PID and benefits framework and are preparing responses to questions from Members. Finally, we've undertaken work on the Quality Management evaluations pilot, which tests to see if the quality-of-service process could be improved if systems are changed - this is due to conclude in June.

Being an inclusive and well-run organisation

We'll invest in our people and culture, and use resources responsibly, to maximise our impact

2025 Priority change activities		RAG	Status
Enterprise Resource Planning (ERP)	**Why?** To implement new HR/ Finance and Payroll solutions to replace the existing Agresso system which will withdraw its support at the end of 2026. **When:** Q4 2026 **Who:** Neil Roberts, Sunil Kapur, David Donnelly, Rachel Mooney		The overall programme is reporting amber as it reflects the high number of risks and demand on assigned resources. Delivery of go-live for both finance and HR systems has been moved to October 2026, with a high workload to be completed. **MS Dynamics 365 Finance implementation:** The project is in the testing phase. Core finance testing is almost complete, and Fees and Billing testing is in the early stages. We plan to complete all Finance system testing by the end of June. From July onwards we will focus on report writing, system training data migrations and go live preparation. We have completed data migration (DM) 7 and are preparing for an interim DM. **HR Workstream (Dynamics 365 HR):** We have been delivering familiarisation sessions in preparation for testing. The majority of the test scripts have been written, and testing starts on 17 June. We are preparing for the next DM and continue to cleanse data. Reporting development is underway and training preparation has started. **Payroll Workstream (Zellis HCM Air):** The payroll system is built and we have started testing. We are finalising the integrations with D365. These integrations will also be tested as part of the development. The payroll system will go live the same time as HR. We will parallel run the old and new payroll systems for 2 months before switching to D365 for payroll.
Associate Worker Status	**Why?** To become legally compliant by introducing holiday pay and pension contributions for in scope payments for all of our eligible associates who hold worker status. **When:** Q4 2026, final solution implementation dependent on ERP programme **Who:** Neil Roberts, David Donnelly		The programme remains green as progress against milestones are on track across the board. During May we made holiday payments and pension deductions covering fees paid in April 2026. We are up to date with ongoing worker payments and are successfully operating a monthly in arrears payment schedule. We enrolled a further 7 associates in the pension plan, taking the total to 385 - around 23% of all those eligible. We also issued historic holiday payments to the 256 associates who responded to our recent reminders for the offer of historic holiday pay made in Summer 2025. The overall position on historic holiday pay for workers associates is now 91.8% accepted, 1.7% declined and 6.5% no response. We reviewed the programme milestones and updated these for the remainder of the year to include new work on associate processes, plus clarity on BAU handover. Lastly, we attended the preliminary Employment Tribunal hearing and are now considering our next steps.

Recruitment – Diversity Targets

Underlying measures and targets		Actual				Target		
		2025 (%)	2025 (Vol)	2026[1] (%)	2026[1] (Vol)	End of 2026	% points off 2026 target	2026
Increase the level of minority ethnic representation at Level 3 and above	Applications	38.0 %	848	32.3 %	545	30%	+ 2.3	30%
	Interviews	27.7 %	85	21.9 %	67	25%	- 3.1	25%
	Offers	14.3 %	10	16.7 %	9	20%	- 3.3	20%
	Workforce	14.1 %	97	14.0 %	97	20%	- 6.0	20%
level of minority ethnic representation at Level 2+		13.4 %	29	14.0 %	31	20%	- 6.0	20%
level of minority ethnic representation at level 3		14.5 %	68	14.0 %	66	20%	- 6.0	20%
Increase the level of minority ethnic representation at all levels	Applications	44.2 %	2,651	42.5 %	2,176	40%	+ 2.5	40%
	Interviews	38.0 %	377	34.3 %	318	35%	-0.7	35%
	Offers	25.8 %	60	27.6 %	54	30%	- 2.4	30%
	Workforce	20.6 %	366	20.5 %	366	20%	+ 0.5	20%
Reduce differential turnover rates for minority ethnic staff compared to the average to improve retention and for rates to be within 1.5% of each other by end of 2026		1.3%	-	Minority ethnic backgrounds (%)	White background (%)	1.0%	% points between groups	1.0%
				5.8%	5.0%		0.8	
Proportion of minority ethnic staff receiving promotion and grade progression is proportionate to our workforce at the relevant grade/level		2.3 %	-	Minority ethnic backgrounds (%)	White background (%)	2%	% points between groups	2%
				12.3%	8.9%		3.4	
Pay differentials within a confined band limited to 2%[2] *(table shows the proportion of bands that are inside of the +/-2% tolerance)*		58.3%	7/12	66.7%	8/12	12/12		12/12

Rolling 12-month period used to the end of the reporting month
Specialist bands are not included in the pay differentials
^ Volumes fewer than 5 are redacted to preserve anonymity

Litigation overview for Q1 2026

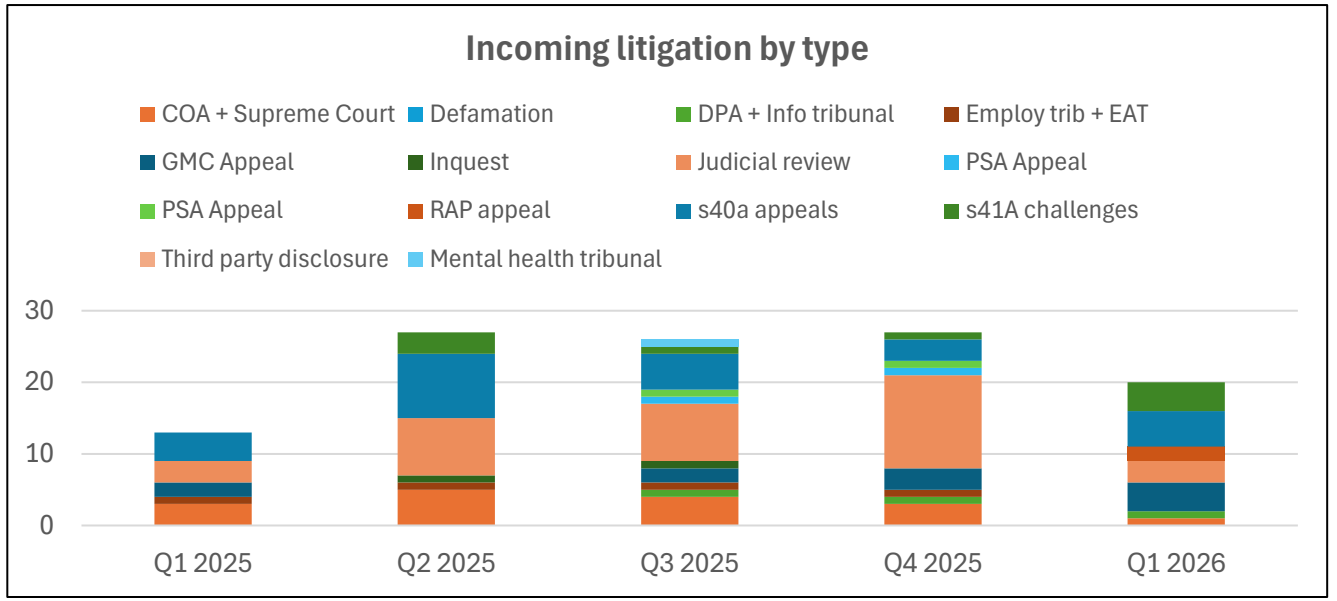
Notes – reporting criteria from Q1 2026

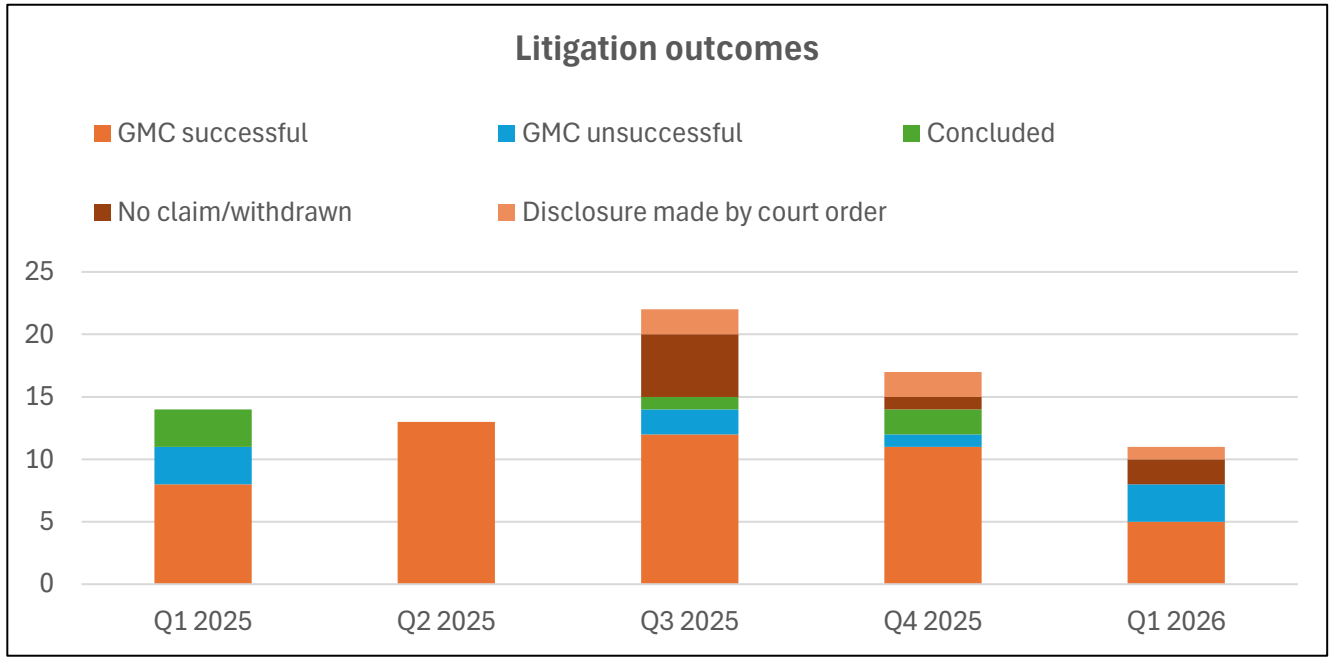
Data is pulled on the first working day of the quarter. For Q1 2026, this was 1 April 2026.

For the purpose of this report (from Q1 2026), we include types of litigation that represent a legal challenge to the GMC. We exclude costs matters, High Court Extensions, s35a enforcement and family court proceedings on the basis that they facilitate action by the GMC and pose a low risk.

As of 1 April 2026, we had 68 open litigation matters (after exclusions) – 21 of these were new incoming matters in Q1 2026.

The 'other' incoming litigation category contains litigation types that are infrequent/low in number so are not captured by a specific reporting category.





Key:
PSA – Professional Standards Authority
EAT – Employment Appeal Tribunal
DPA – Data Protection Act
COA – Court of Appeal

Concluded litigation Q1 2026:

5 = GMC Successful
- X1 Employment Tribunal
- X1 COA appeal
- X2 s40 appeals
- X1 Other

3 = GMC unsuccessful
- X1 s40 appeal
- X1 S.41A – 10 IOT challenge
- X1 COA appeal

2 = No claim/withdrawn
- X1 s40 appeal
- X1 DPA

1 = Disclosure made by Court Order
- X1 Mental Health Tribunal

Data Dictionary

Data dictionary – Key performance indicators (published)

KPI	Definition
Answer 80% of calls within 20 seconds	% of calls answered, by the Contact Centre, within 20 seconds (excludes lost calls).
Contact Centre – Overall % of customers experience (telephone and messaging interactions)	Customers who provided feedback on their overall experience and satisfaction of the service provided by the Contact Centre. A rating of 7 or above (out of 10) indicates a good experience. Voice surveys on telephone interactions are presented at the end of every call, whilst surveys on messaging, and the way our systems are designed, mean that surveys on messaging interactions are emailed out three days after the interaction.
Decision on 95% of all registration applications within 3 months	Registration applications for doctors in R&R counted from *received* to *approved* date (Portfolio pathway looks at evaluation date) - includes applications for initial registration, provisional registration to full registration, giving up or restoring licence, voluntary erasure or restoration to the register and specialist registration. Counted in calendar days and included from the month registration was approved.
Decision on 95% of all revalidation recommendations within 5 working days	The % of recommendations completed (both approved and rejected), within 5 working days, counting from received application to decision completion date. Decisions included are counted in the month they are completed.
Respond to 90% of ethical/standards enquiries within 15 working days	All enquiries received to the Standards team are answered within 15 working days of receipt, counting from date of initial contact with the GMC.
Conclude 90% of fitness to practise cases within 12 months	% of the triages created in the same month of the previous year that have had a hearing, CE Decision, or were closed at triage.
Conclude or refer 90% of cases at investigation stage within 6 months	% of triages that have had a final CE Decision or been closed within 6 months of being created.
Conclude or refer 95% of cases at the investigation stage within 12 months	% of the triages that have had a final CE decision within 12 months of being created.
Commence 100% of Investigation Committee hearings within 2 months of referral	% of Investigation Committee (IC) hearings that have commenced within 8 weeks of the referral being made.
Commence 100% of Interim Order Tribunal hearings within 3 weeks of referral	% of Interim Order Tribunal (IOT) hearings that have commenced, within 3 weeks of the referral being made.
Finance - Income and expenditure % variance +/- 4%	The combined variance of actual income and expenditure is to be within +/- 4% of the approved budget. Any variance exceeding this threshold shall be classified as out of tolerance.
HR - Rolling 12-month staff turnover within 8-12%	% of employed staff (permanent and agency) leaving the organisation across the 12-month period.
Information systems availability (target 99.89%)	Key IS systems are counted by the minute if they go down or are unavailable. The KPI reflects the % of time systems are available to the business. If availability drops below 99.89% then the target is unmet.
Media: combined positive, neutral and balanced media coverage of GMC (target: 90% or above)	Combined % of media coverage mentioning the GMC, which is positive, neutral or balanced in tone (either explicit or implied). If the proportions of these sentiments combined is less than 90%, it will be due to a spike in the proportion of media coverage with a negative sentiment. This measure will help us monitor whether we are content with the overall sentiment of our media coverage.
GMC website satisfaction (NPS score: target at least 40)	Users of the GMC's website, engaging with non-transactional areas, rate their experience in a survey which asks them to give a score between 0 and 10. Responses are used to calculate a Net Promoter Score (NPS). Within the marketing industry, a score of 20 and above is considered good. Our KPI is set at a more stretching score of 40.
GMC Outreach: Doctors intending to change practice following learning session (target: at least 75%)	% of doctors who told us their practice will change as a result of attending a learning session on ethics and professionalism, delivered by our Outreach Advisors. This is collected through evaluation surveys completed after the session.
GMC Outreach: Doctors attending a learning session improve their impression, or maintain a positive impression of the GMC (target: at least 65%)	% of doctors who told us that their impression of the GMC remained positive or improved as a result of attending a learning session on ethics and professionalism, delivered by our Outreach Advisors. This is collected through evaluation surveys completed after the session.

Corporate Opportunities and Risk Register - June 2026

Risk ID	Title Date Raised	Category	Detail	Owner	Likelihood - Inherent	Impact - Inherent	Rating - Inherent	Mitigation/Enhancement	Likelihood - Residual	Impact - Residual	Rating - Residual	Council and/or Board Assurance	Assurance	Further Action Detail	Risk Appetite
Programme threats															
843	**Regulatory Reform – Safe and timely delivery of the reforms** 02/03/2026	Strategic / Policy	If planning, programme oversight, and delivery monitoring are insufficiently robust—and commencement and transitional complexities are not fully understood—internal readiness, timelines, and change impacts may be underestimated. This could result in the GMC Order being implemented in an unworkable or misaligned form, with statutory functions not delivered safely or to the required standard, creating patient safety risks, operational disruption, and backlogs.	Shaun Gallagher	HIGHLY LIKELY	MAJOR	CRITICAL	**Key Controls** •Maintain open, constructive communication channels with DHSC, use these mechanisms to influence drafting quality, and ensure alignment between policy intent and operational deliverability and transitional arrangements. • Maintain and review a joint plan with DHSC to set realistic expectations validate assumptions, test feasibility, and update timelines in response to emerging risks or policy changes. • Maintain defined escalation routes to senior officials at DHSC, with clear criteria for when issues should be escalated. • Use joint workshops, readiness assessments, and scenario planning to ensure operational impacts are understood early and that changes can be implemented safely and at pace. • Reinforce a "one GMC" approach through shared ownership of risks, decisions, and delivery milestones. • Maintain clear and actively managed programme governance. • Use regular assurance reviews and milestone checkpoints to identify drafting-related risks early and ensure delivery plans remain realistic and controlled. • Operate a structured influencing plan to secure timely external support for key policy and drafting decisions. • Monitor stakeholder positions and adapt engagement tactics proactively to address emerging risks. • Allocate standing agenda time at SMT to review drafting risks, resolve ownership questions, and provide direction. • Ensure SMT decisions and expectations are communicated consistently to teams, and that SMT members are equipped to engage directly with colleagues. • Delivery schedule for programme in place and will continue to be reviewed and amended.	QUITE LIKELY	MAJOR	CRITICAL	SMT • Planning discussion at SMT stocktake meeting on 15 Dec 2025. Programme Board • Updated programme plan shared with Programme Board on 26 Feb 2026. • Programme plan approved by SMT at meeting on 23 March 2026.		• A baseline plan for the next 18 months to be proposed at Programme Board - Q3 2026. • Prioritisation of deliverables currently in development - ongoing. • Explore how the programme utilises governance routes to enhance risk management practicies - Q3 2026	Low
544	**GMC Finance and HR System** 28/11/2023	Technical	Due to our Finance and HR system provider withdrawing support for our on-premise system we will need to move our Finance and HR system to the cloud by the end of 2026 necessitating business process changes. This will include significant change management work, and there is a risk that we will be unable to do the significant and complex work required for this migration in time, leaving us in an unsupported configuration and unable to receive product updates from 2027, such as new tax rules to apply to payroll.	Neil Roberts	HIGHLY LIKELY	MAJOR	CRITICAL	**Key Controls** • A programme is overseeing the move to new Finance and HR systems, including significant process change work, by the end of 2026. • Work to implement the new finance system is being planned, using an approach of setting milestones to enable us to deliver in advance of 2027 and resourcing the work as required to hit the milestones. • Project streams have been prioritised and resourced within IS, HR and Finance with funding for resources requested where required. • A new finance, HR and payroll system has been selected and work is underway with the vendor. • Build phase for all parts of the ERP system, Finance, HR and Payroll completed. **Mitigations** • Support has been secured for the current finance and HR system until the end of 2026. • Finance build phase completed.	HIGHLY LIKELY	MAJOR	CRITICAL		Audit and Risk Committee • ERP pre-Go Live Advisory Review (March 2026). • ERP Implementation: Data Migration Advisory Review (November 2025) • ERP Implementation – HR Workstream Programme Governance Report (October 2025, green/amber for control design and green for control effectiveness). • ERP Implementation progress (May 2025, green/amber for control design and green for control effectiveness). • ARC seminar held in May 2025. • ERP Implementation - Governance and programme arrangements review (September 2024).	• Working through integrations with Seibel and other GMC systems. • Internal audit planning pre go live.	Medium
844	**Regulatory Reform – organisational capacity, prioritisation and workforce resilience** 02/03/2026	Resource	If organisational capacity, prioritisation and planning processes are insufficient for the scale and pace of reforms, critical support, expertise, and decision-making may become limited, and key skills or knowledge may be lost. This could lead to reduced programme resilience and delivery capacity, increasing delivery risks, delays, or compromises in achieving safe and effective implementation.	Shaun Gallagher	HIGHLY LIKELY	MAJOR	CRITICAL	**Key Controls** • Work with Business Planning and others to implement a clear, senior-led prioritisation process to pause or de-scope other activity • Assess workstream capacity and workload pressures quarterly. • Provide targeted support (eg temporary resource, specialist input, or reallocation of tasks) to teams experiencing acute pressure. • Explore joint recruitment campaigns and the development of a shared pool of staff who can be deployed flexibly. • Coordinate gateway bids to ensure reg reform work is presented coherently and efficiently. • Use established governance and communication channels to provide consistent, timely updates on reform progress, expectations, and upcoming workload peaks. • Reinforce key messages about priorities, wellbeing, and available support, ensuring leaders actively model these behaviours. • Create structured opportunities for staff feedback and concerns to be surfaced early.	QUITE LIKELY	MODERATE	SIGNIFICANT	• Re-deployment policy approved by People Development Board on 30 March 2026.		• Gateway bid to secure additional capacity and extension of funding for existing colleagues - Q3 2026.	Low
845	**Regulatory Reform – Effective communications** 02/03/2026	Customer	If DHSC or GMC communications are drafted in language that is unclear, overly technical, or insufficiently tailored to stakeholder needs, there is a risk that stakeholders do not fully understand the purpose or implications of the consultation, resulting in low engagement, misinterpretation of proposals, reduced quality of feedback, and potential reputational or decision-making impacts for the organisation.	Shaun Gallagher	QUITE LIKELY	MAJOR	CRITICAL	**Key Controls** • Established a comms and engagement workstream responsible for detailed comms and engagement plans. • Incorporated effective consultation/discussion with patient groups and ROs into the consultation(s) on regulatory reform. • Created a comms and engagement plan to keep all relevant groups and stakeholders informed about the timelines and practicalities of implementation and transition. • Planned for proactive engagement at senior levels with key stakeholders. • Considered and planned for potential risks through the regulatory reform comms and engagement steering group. • Commission a research company to set up a series of engagement panels to facilitate panels with our key audiences on complex or uncertain areas. • Provide feedback to DHSC on their draft consultation document.	QUITE LIKELY	MODERATE	SIGNIFICANT	• Briefing that we are planning to send to external stakeholers whilst DHSC consultation is open was shared with SMT and Council during w/c 20 April.		• Internal comms products in development to provide colleagues with updates and key lines if asked about Reg Reform consultations. • GMC response to DHSC consultation to be reviewed/approved at Programme Board on 27 May 2026. • GMC response to DHSC consultation to be reviewed/approved at SMT on 1 June 2026 and Council on 10 June 2026.	Medium
Operational Threats															
512	**Uncertainty around our touchpoints and engagement with NHS England** 31/07/2023	Operational	Because of NHS England's merger with DHSC, there is an immediate uncertainty on the touchpoints the GMC has with them, this may impact on our effectiveness in some operational processes, as well as further requirements for resourcing to support our statutory functions.	Paul Reynolds	QUITE LIKELY	MAJOR	CRITICAL	**Key Controls** • Ongoing engagement with DHSC and NHS England officials to keep abreast of developments and to highlight implications of change for our regulatory work. • Relationships established with the new national co-medical directors at NHS England, who are part of the joint executive team that is leading the transition. • Ongoing monitoring of other external sources (such as the media) to keep track of developments and impact on the GMC. • Written to NHS England's Interim Chief Executive and DHSC's Director General of Secondary Care and Integration, highlighting key areas where the GMC currently interacts with NHS England. • Existing relationship with newly appointed DHSC Director General (People). • Our Chief Executive met with Sir Jim Mackey, NHS England's Interim Chief Executive, in June 2025. • Outreach team considering specific implications which changes to NHS England may have on the architecture of patient safety systems in the regions of England, which we engage with to identify and triage risks to patient safety. • Secured membership of the National Quality Board on behalf of NHS-facing professional regulators (GMC, Nursing and Midwifery Council, and Health and Care Professions Council). • Senior Corporate Engagement Plan now includes regular CEO meetings with NHSE's interim CE and Director General (People). **Mitigations** • Initial mapping exercise completed by directorates to identify potential regulatory implications of change. • Mapping presented to Policy Leadership Group who have agreed to own the work going forward on policy/operational contingencies for their areas. • Outreach England regions are addressing implications as they arise, working to mitigate harm.	QUITE LIKELY	MAJOR	CRITICAL	SMT • Paper on risks and opportunities from NHS England changes (31 March 2025)			Medium
207	**Pension Deficit** 21/08/2020	Financial	Due to economic instability, both asset and liability value of the pension scheme have reduced (assets to a greater extent). This scheme's funding position and any future volatility could lead to continued additional funding of the scheme from the employer.	Neil Roberts	HIGHLY LIKELY	MAJOR	CRITICAL	**Key Controls** • Trustees meet regularly and continue to take professional advice in relation to the existing deficit, which has improved as of the last valuation on 31 December 2024. • The funding position remains under review and Trustees will continue to liaise with the employer. Trustees have agreed to move to an advisory investment model and investment adviser and will keep the employer updated on any change to the investment strategy. • The employer factors annual payments into the budget to cover the agreed funding arrangements. • The employer and trustees work together to ensure suitable funding arrangements are in place to address the deficit. • Trustees monitor the funding position of the Scheme on a regular basis and are supported by professional advisers. • Trustees are required to meet all conditions relating to the running of the Scheme to ensure compliance with regulatory requirements specified by the Pension Regulator and Pension legislation. • We work closely with the Pension Trustees to address the increased scheme liability arising from the Govt decision to align RPI and CPI and other factors affecting the valuation. • The GMC reserves policy was approved and updated in December 2025 to record that the pension scheme will be financially supported if a value at risk event occurs.	QUITE LIKELY	MODERATE	SIGNIFICANT				Medium
303	**Welsh Language Standards Implementation** 28/02/2024	Legal	Since 6 December 2023 the GMC has been subject to the Welsh Language Standards (No.8) Regulations 2022 set by the Welsh Language Commissioner. We have now reached a point of maturity in our culture and processes as an organisation that has enabled us to mainstream compliance with the standards throughout the organisation. All directorates are now responsible for ensuring continued compliance with the standards, ensuring guidance is implemented, and monitor ongoing compliance, else we risk legal, reputational and financial damage.	Paul Reynolds	QUITE LIKELY	MODERATE	SIGNIFICANT	**Key controls** • Relationship sponsor for the Welsh Language Standards Commissioner and relationship plan agreed; and will be updated in 2026. • The GMC's Senior Management Team has approved a plan to embed the guidance, learning and processes we have developed in BAU across the organisation. Central to that plan is the creation of a network of Welsh Language Champions to in each directorate to enable limited coordination of our approach to managing the WLS. • Any complaints or concerns raised about our compliance with the WLS will continue to be recorded and dealt with in line with the customer complaints process by the Corporate Review Team. • If the Welsh Language Commissioner launches an investigation into a complaint or concern about our compliance, an incident response team will need to be established to include the relevant team, the relationship coordinator and sponsor, and CRT. • Procurement process successfully concluded in Sept 2025 with agreement to again commission the services of Cymen for all of our Welsh language translation and interpretation needs. • Relationship Plan in place for the Welsh Language Commissioner supported by Director of SC&E as relationship sponsor and will be reviewed in 2026.	QUITE LIKELY	MODERATE	SIGNIFICANT	SMT • Risk deep dive (March 2025) • Transition to business as usual (September 2025) Executive Board • Statutory annual report on our compliance with the standards 2024/25 (July 2025)	Internal Audit • Preparation for implementation (2023, green/amber control design, green/amber effectiveness). • Compliance readiness review (2024, green/amber). External compliance assessment • Ateb conducted a compliance assessment of key activities between June and September 2024. They found an overall assurance level of amber. An action plan developed and implemented by WLSM and relevant teams.	• Welsh Language Champions Forum has been established and members identified to support ongoing compliance with representative and deputy from each directorate. The first meeting of the Forum is expected before summer 2026. • We will look to ensure ongoing compliance with the standards through exercises such as mystery shopping, internal audit to gain assurance the new way of managing compliance is working well	Low
706	**MLA - exam delivery** 28/05/2024	Technical	If an incident occurs, that impacts on Medical Schools' ability to deliver, and students' ability to take a complete MLA assessment, this could risk invalidating the Primary Medical Qualification (PMQ) being awarded by those medical school(s). This may be of significance as we roll out the MLA compliance process for new schools for the first time.	Pushpinder Mangat	QUITE LIKELY	MAJOR	CRITICAL	**Key Controls** • MLA compliance is now embedded into our new schools process. This helps to ensure that new schools are suitably prepared to deliver both parts of the MLA, and are suitably briefed on processes around connectivity, incident reporting and escalation, and exam security (particularly for the AKT). • We have regular contact with all schools and check contingency planning as part of routine assurance and oversight. Recommendations for improvement from our original compliance process are now embedded into our BAU QA, monitoring and improvement activities. • Issues, including those relating to regulatory oversight and assurance, continue to be discussed at regular meetings between the GMC and Medical Schools Council (MSC) at Assistant Director/Head of Section level. • Remind new schools that passing the MLA is now a requirement for their students to be awarded a PMQ and to be added to the register. **Mitigations** • Ensure that new schools have a contingency school in case of issues with their preparations for MLA delivery. • Ensure that all schools have at least one additional sitting identified in case of failure. • Continue to learn from the live experience from the AKT and ensure that the MSC and individual medical schools communicate with the GMC when things go wrong.	UNLIKELY	MODERATE	Low		Internal Audit • MLA transition to BAU (2024, green-amber for control design, green-amber for control effectiveness). • MLA arrangements for delivery of the Applied Knowledge Test (May 2025, green/amber for control design and control effectiveness).		Low

Strategic Themes																		
120	**ED&I compliance** 17/02/2020	Strategic / Policy	The measures in place to demonstrate compliance with the public sector equality duty are not robust enough and we are subject to legal challenge that weakens confidence in regulation.	Shaun Gallagher	QUITE LIKELY	MAJOR	CRITICAL	**Key Controls** • Skilled ED&I team provide strategic advice across the GMC. • Equality, Diversity and Inclusion (ED&I) objectives published within the corporate strategy and supported by focused targets based on evidence and routine monitoring and reporting of progress. • Supporting governance including the Strategic EDI Advisory Forum and Race Equality Forum (external) and ED&I Steering Group (internal) provides senior oversight and guidance to inform action and priorities. • Mandatory learning for all staff and associates – all learning needs are being delivered or is BAU activity, all suppliers are in place and delivering against requirements. • Mandatory training for all staff and associates. • Approach to a regulatory new Equal Opportunities Policy has been reviewed and published in April 2022 and updated in 2024. **Mitigations** • Regulatory fairness review now complete and implementation board established. Leads across the directorates appointed and first phase of corporate deliverables underway. Update on progress, including new decision making principles and the HIRDs has been published in the ED&I Annual report in 2024.	UNLIKELY	MAJOR	SIGNIFICANT	Council • Reporting to Council on Fairer training cultures, Fairer referrals and the inclusion programme, deep dive reporting annual cycle in place. Regulatory fairness now included in annual reporting cycle. Executive Board • ED&I steering group has forward plan for reporting and will report to Executive Board annually on progress the Steering Group has made. Programme Board • Regulatory fairness review is now in implementation phase. A new regulatory fairness board has been established to govern the implementation of all of the recommendations.	Internal Audit • ED&I steering group governance (2024, green-amber for design, green-amber for effectiveness). • Regulatory Fairness Implementation in Directorates (August 2025, amber for control design and green/amber for control effectiveness). Other assurances • Strategy and policy ED&I compliance and governance review - Campbell Tickell (2020). • Engagement, not personal characteristics, was associated with the seriousness of regulatory adjudication decisions about physicians: a cross-sectional study, Javier A Caballero, Steve P Brown, British Medical Journal (2019). • Fairness of decisions to refer doctors to the MPTS interim orders tribunal (2018). • Plymouth University Review of decision-making in the GMC's FTP procedures (2014).	• Assurance measures for new decision-making principles were finalised in directorate action plans in Q1 2025. Implementation will vary by workstream (including pilots), with plans iterating as pilots conclude. Progress will be reviewed in 2026, with a closure process and roadmap now in place to support phased workstream completion. • A tender for the first phase of external assurance on process fairness is in development. A rapid evidence review has been tendered and a supplier appointed, with the report due in September 2026. • Regulatory Fairness will be reported through the ED&I annual report, alongside a separate annual progress update to Council. • The ED&I data review aims to improve data quality and mitigate compliance risks. The business case has been approved by Gateway; further PID work is paused pending resource availability.	Low
148	**Delivery of statutory functions** 31/03/2020	Operational	If we fail to deliver our core statutory functions, there is a potential impact on patient safety, public confidence, and the GMC's reputation as a leading regulator.	Charlie Massey	QUITE LIKELY	MAJOR	CRITICAL	**Key Controls** • Monitoring and reporting against statutory delivery for the professions we regulate, to Executive Board and Council. • Forecasting of operational demand is built into budget planning. • Active engagement with those we regulate about potential situations which may put patients at risk. • Outreach structure in place (ensures statutory process for responsible officers to continue effectively and enables engagement with employers with respect to PAs and AAs)) to help identify and manage concerns (pre-investigation). • Available staff with relevant training and skills. • Information exchange with competent authorities informs our processes. • Documented operational process and procedures, that are subject to regular review and continuous improvement by specialist staff. • Auditing our decisions on a regular basis. • Processes are in place to provide assurance on overseas applications for the professions we regulate.	QUITE LIKELY	MODERATE	SIGNIFICANT	Council • Review of performance metrics through the quarterly CEO report. Executive Board • Review of performance metrics through the bi-monthly Performance and Risk Report. SMT • Risk deep dive - Postgraduate Exam QA (February 2026).	Internal Audit • PA & AA Registration Applications (2026, green control design, green/amber control effectiveness). • Specialist Applications approved training route arrangements (2024, green control design, green control effectiveness). • Interim Report Case Examiners (2024, green/amber control design, green control effectiveness). • FTP Case Review team arrangements (2025, green/amber control design, green control effectiveness). • VERL (2025, amber control design, green/amber control effectiveness). Other assurances • The MPTS continues to meet our service level agreement to commence 100% of new interim referrals within 21 days. • The MPTS continues to hear reviews of all MPT sanctions and IOT orders within statutory deadlines. • Passed all PSA standards of good medical regulation in 2025.		Low
149	**Availability of resources** 31/03/2020	Resource	If we don't secure and retain: a workforce that is flexible, adaptable, appropriately skilled and experienced to meet our complex and reactive requirements; a resilient and secure IT and facilities infrastructure, and maintain a sound financial position, it will threaten the delivery of our statutory functions, change and development programmes and capacity to deal with reactive and unplanned events.	Neil Roberts	HIGHLY LIKELY	MAJOR	CRITICAL	**Key Controls** • Our People practices and leadership strategy is aimed towards attracting and retaining a high calibre workforce. • We have processes in place to identify and manage key staff risks. • We consider recruitment market surveys and data to identify potential skills shortages. • Our Health and safety policies and procedures are robust in regards to our workforce. • Clear Financial management practice and controls and safeguards including around investment (GMCSI), fraud policies and pensions. • New activity, including Gateway Fund initiatives and existing project work routinely considered by Planning Gateway process to form a cross organisational recommendation on the priority and deliverability of proposals for SMT to consider collectively. • Routine monitoring and reporting of operational performance and the volume and complexity of our work. • Process for regularly mapping workload pressures across teams to help focus resourcing and prioritisation decisions. • We work closely with the Pension Trustees to address the increased scheme liability arising from the Govt decision to align RPI and CPI and other factors affecting the valuation. • The Investment Committee oversees the investment portfolio, supported by professional advisers and fund managers. • We undertake financial stress testing to ensure we have the capacity to withstand financial shocks within our reserve levels. • We continually invest in our IT infrastructure and systems to ensure availability and protect against cyber-security threats and maintain ISO 27001 accreditation. • We have business continuity champions and robust business continuity plans in place that are tested regularly. • We provide mandatory e-learning for GMC colleagues and have support in place from business continuity consultants • Annual training and exercise sessions are delivered for all incident responders. • We have health and safety policies and risk assessments in place to ensure review and maintenance of office facilities. • We have redundancy and backup systems in place for critical IT infrastructure. This includes resilient data centres , backup power supplies, backup and recovery plans, and failover mechanisms to ensure continuity of operations in case of failure. • Industry standard security benchmarks are used at development phase of projects ensuring our systems are secure by design and regular Security assessments take place to validate our position.	QUITE LIKELY	MODERATE	SIGNIFICANT	Council • Review of annual budget and Annual Accounts. Executive Board • Executive Board regular review of finance, HR, project and operational performance and risks. SMT People Deep dive - April 2026.	Internal Audit • Procurement Act (2026, green/amber control design, green/amber control effectiveness). • Payroll review (2024, green control design, green control effectiveness). • MPTS legal arrangements (2024, green/amber control design, green/amber control effectiveness). • Contract Management (2024, amber control design, green/amber control effectiveness). • Data Protection Review (2024, green/amber control design, green/amber control effectiveness). • Contact Centre transformation (2025, green control design, green/amber control effectiveness). • Review of Associate Worker Status (2025, green control design, green control effectiveness).		Medium
150	**Ability to work with others** 31/03/2020	Strategic/Policy	If we are unable to work collaboratively with our external partners, we may not be able to achieve the ambitions of the corporate strategy and to deliver parts of our core functions as efficiently, effectively and compassionately as we would like, reducing our potential impact on patient safety and those we regulate.	Paul Reynolds	QUITE LIKELY	MAJOR	CRITICAL	**Key Controls** • Senior Chair and CE stakeholder engagement carefully planned through the Senior Corporate Engagement Plan • Engagement with other regulatory bodies to identify opportunities for collaboration and alignment (such as through the Chief Executive Officer Regulatory Body (CEORB) Group), cross-regulatory groups in Scotland, Wales and Northern Ireland and the professional regulator comms & engagement group. • Proactive engagement on all major policies and issues, including active engagement with the four UK Governments over the future of our legislation, co-ordinated through use of Engage system by external affairs, policy and operational teams. • Development, management and review of stakeholder relationships of strategic importance at national and regional levels of the UK, supported by relationship plans delivered by our external affairs and engagement teams and sponsorship of key relationships by SMT. • Regular evaluation of relationships with key partners, using insights from our internal systems and periodic surveys of stakeholders' perceptions, to identify opportunities for improvement. • Annual relationship stocktakes to SMT. • Results of our 2024 perceptions survey inform the work of the External Affairs and Engagement teams.	QUITE LIKELY	MODERATE	SIGNIFICANT	Council • Seminar: Findings of our 2025 perceptions survey with stakeholders (December 2025). • Seminar: Scotland focus (September 2025). • Seminar: Our approach to managing stakeholder relationships (July 2025). • Communications and engagement priorities (June 2025). • Seminar: Findings of our 2024 perceptions survey (December 2024). • Communications and engagement priorities (June 2024). • Seminar: General election preparations and our strategic engagement approach (April 2024). Executive Board • Seminar: Relationship stakeholder SMT (June 2025)	Other assurance • Bi-annual health assessments by our external relations teams of GMC's major relationships (next assessment (Q3 2025). SMT • Risk deep dive - Ability to work with others (November 2025).	• We have appointed a research provider for our 2026 perceptions survey. The research will include a survey with national-level stakeholders in each of the four UK nations. Fieldwork will commence in early June and the results will be reported to Council at the end of 2026. • We are bringing an Election outcomes update to SMT in May 2026, as well as the Four-country strategic relationships stocktake.	Medium
152	**Unplanned event** 31/03/2020	Reputational	The impact of an event in the external or internal environment causes our systems to be compromised or our activities to be publicly challenged, potentially leaving us vulnerable to delivery of key functions central to patient safety and reputational damage.	Neil Roberts	QUITE LIKELY	MAJOR	CRITICAL	**Key Controls** • Crisis management policies (including crisis communications plan) & procedures; pandemic response plan. • Business continuity champions and emergency response plans in place with regular testing. • Mandatory e-learning for GMC staff and support from business continuity consultants. • Continuous proactive monitoring of external environment with processes and products in place to share and escalate emerging issues likely to affect our regulatory operations and external confidence in the organisation. • Arrangements in place between regulatory operations and communications teams to identify and plan for events which could negatively impact on our functions and external confidence in the organisation. • Analysis of range of qualitative and quantitative information about the external environment through the Patient Safety Intelligence Forum. • Regular engagement with the Professional Standards Authority to assure them on the exercise of our statutory powers – including emergency powers under section 18A of the Medical Act 1983 (Covid-19). • Health and Safety (H&S) management system (ie framework of policies and guidance) in place outlining a coordinated and systematic approach to managing H&S risk. • Quality assurance of H&S management system provided through H&S audit process. • Safeguarding processes, policies and annual training embedded across the organisation.	QUITE LIKELY	MODERATE	SIGNIFICANT	Audit and Risk Committee • Seminar on Business Continuity and Disaster Recovery - November 2023 and September 2024. SMT • Deep Dive - October 2024.	Internal Audit • Business continuity and disaster recovery management review (2025, amber control design).	• Currently reviewing our national power restrictions guidance documents.	Medium
151	**Responding to a changing environment** 31/03/2020	Strategic / Policy	Inability to respond effectively to changes in the external environment, including legislation, healthcare and wider social impact changes, could lessen our influence and relevance and reduce public, profession and political confidence in our role.	Paul Reynolds	QUITE LIKELY	MAJOR	CRITICAL	**Key Controls** • Proactive, senior-level engagement with stakeholders to understand their agendas. • Outreach teams structures in place, aligned to UK countries and regions of England, to help us understand and have influence within national and local systems. • Contribution to government and system initiatives across four nations. • Continuous monitoring of our external environment, including longer term horizon scanning and research (e.g. barometer and perception surveys with the medical profession). • Contributing to meetings and networks across the UK and Europe. • Internal governance in place to process, consider and make decisions on the intelligence we receive about the quality and safety of local practice and training environments (JWIG and PSIF meetings). • Systems and products in place to share insights and intelligence from external environment with organisation's leadership community to aid them with planning and decision-making.	QUITE LIKELY	MODERATE	SIGNIFICANT	Council • Seminar: Patient safety intelligence (March 2026). • Seminar: Findings of our 2025 perceptions survey (December 2025). • Communications and engagement priorities (June 2025). • Seminar: Findings of our 2024 perceptions survey (December 2024). • Communications and engagement priorities (June 2024). • Seminar: General election preparations and our strategic engagement approach (April 2024). SMT • Paper on risks and opportunities from NHS England changes (31 March 2025)	Internal Audit • Outreach Restructure Project Review (2024, green/amber control design, green/amber control effectiveness).	• Closely monitoring developments relating to the abolition of NHS England.	Low
234	**ED&I Strategic Ambition** 02/03/2021	Strategic/Policy	The actions we take to influence change across the health and education system, and within the GMC, do not deliver progress at a pace to meet our strategic ED&I targets, sustaining known areas of inequality.	Shaun Gallagher	HIGHLY LIKELY	MODERATE	CRITICAL	**Key Controls** • Clear timebound targets to focus system-wide efforts. • Nominated Executive leads for each of our strategic commitments. • Skilled and resourced teams designing interventions to deliver against the targets. • Established plans of action to deliver against the targets both internally and externally. • Annual and bi-annual progress reporting. • Scrutiny and monitoring and reporting from the ED&I Steering Group, Executive and Council to allow refinement of plans in response to progress. • Established Outreach and engagement functions to understand and influence the system with broader calls for action and support to facilitate system-wide change. • Supporting and aligned commitments of others (ie reducing differentials in disciplinary processes). • Research and data assets including our surveys and insights to highlight relevant issues and support calls for action. • Annual reports published 2022, June 2023 and October 2024.	QUITE LIKELY	MODERATE	SIGNIFICANT	Council • Regular agenda item on ED&I and ED&I annual progress update reported to council in April and published. Executive Board • Twice yearly review by Executive Board and performance against internal targets embedded in Performance and Risk Reporting.	Internal Audit • Regulatory Fairness Implementation in Directorates (2025, amber control design, green/amber control effectiveness). Other assurances • Strategy and policy ED&I compliance and governance review - Campbell Tickell (2020).	• In response to the 2023 Audit, the timing and approach to reviewing ambitions will be agreed with workstreams and built into planning for the 2025–26 ED&I annual reports, aligned with corporate strategy development. • The next phase of Regulatory Fairness will support directorates with implementation plans and coordinate three corporate work packages; the BDO audit was completed in October 2025 and recommendations are being progressed. • The 2025 ED&I annual report was submitted to SMT and Council in December 2025 and was published in January 2026; the next report is planned for the July 2026 Council meeting. • Future reporting arrangements and the review of measures nearing completion are under consideration.	Medium
Opportunities																		
27	**Deriving more insight from our data capability** 31/03/2020	Strategic / Policy	Developing, sharing and working with others using our insight capability provides an opportunity to shape public debate, influence the external environment and deliver more proactive regulation.	Shaun Gallagher	QUITE LIKELY	MAJOR	GOLD	**Key Controls** • Use of our research and insight activity to highlight key issues facing the medical profession, suggesting courses of action which healthcare systems can take to tackle workforce and workplace issues that might directly or indirectly impact on patient safety. Take every opportunity for it to contribute to mailouts, briefings and other external engagement. • Leverage our communications channels (such as media and social media) and engagement opportunities to raise awareness of our research and insights and secure external support for the issues and recommendations we are highlighting. • Use new data and research insights as a 'peg' for bringing together regulatory partners and key stakeholders together to drive positive changes in policy and practice. • Provide data support to the rest of the GMC to inform our response external developments such as the Lord Ara Darzi review. • Provide data to support the development of policy and process plans for AA and PA regulation, regulatory reform, and education reform.	HIGHLY LIKELY	MAJOR	GOLD		Other assurances • A range of perception surveys with stakeholders undertaken each year. • An evaluation of State of medical education and practice in the UK reports' impact underway.	• Enhancing and providing substantial ED&I data for EQIAs and to identify inequalities in referrals to us; we are also commissioning as part of the research programme a sequence of independent audits on the fairness of our regulatory processes. • Development of a Power BI platform for our data that will allow more interactivity and self-service. • Larger reporting tools like Data Explorer will be reviewed and improved to encompass PA and AA reporting, by early 2027. • Developing data, research and insight capacity in relation to PAs and AAs.	High
59	**Corporate Social Responsibility** 30/11/2022	Reputational	There is a potential opportunity for the GMC to lead the health regulatory sector in identifying, delivering and sharing how to be a more responsible regulator and demonstrating the positive impact this can have on those we regulate, our colleagues, suppliers, communities and patients. This could have multiple benefits, including the GMC becoming an employer of choice; increased diversity in our recruitment campaigns; new organisational partnerships; a positive impact on the environment; an increased regulatory reputation; and increased engagement and satisfaction with those that we regulate.	Neil Roberts	QUITE LIKELY	MODERATE	SILVER	**Key Controls** • Our Corporate Strategy 2021-26 includes clear commitments to be a more responsible organisation both socially and environmentally. Every GMC Annual Report includes a CSR round-up of the previous year. • We have improved external visibility of our CSR work on the GMC website and internally on the GMC intranet. .We have used blogs to promote our support for widening participation (in medical training) initiatives and consideration of the regulatory challenges posed by 'sustainable healthcare'. • The GMC established the Cross Regulator CSR Group early in 2022 after the proposal (by the GMC) was agreed by the CEORB group. This meets quarterly and from mid-2023 includes representatives from the Greener NHS Team. • External recruitment campaigns now include reference to our CSR initiatives with the intention that this will be a 'pull' factor for potential candidates. • The GMC is increasingly engaged with new stakeholders, such as KPMG, on regional and national CSR bodies. These are new relationships which are increasing the profile of the GMC beyond the regulatory, health and education sectors. • CSR project closed in June 2023; project closure report completed with most initiatives now embedded as BAU. • Net Zero Working Group, sponsored by director of Resources, established at end of 2022. Whilst this has a broader remit than the CSR project, it will also support achievement of this opportunity. • CSR Community of Interest established in August 2023 to help BAU teams identify dependencies and mutual interests. This will also assist in maintaining oversight of CSR related activities across GMC	QUITE LIKELY	MAJOR	GOLD	SMT • Opportunity deep dive completed in February 2024.			High

28	**Working with patients and public** 31/03/2020	Operational	Understanding and improving the experiences which patients and the public have of our regulatory services and involving them effectively in our work (such as strategy and policy development) will help us gain their trust and confidence and make us a better regulator.	Paul Reynolds	QUITE LIKELY	MODERATE	SILVER	**Key Controls** • Champion for patients established at SMT level to ensure senior-level overview of our engagement and signal importance of this to organisation. • Strategic ambition to improve patient and public involvement and long-term outcomes agreed. • Clear information easily accessible for patients and public about how we work and can support them (such as on our website). • Involvement of patients and the public in our policy development activity in a variety of ways including public consultations and the commissioning of independent research, supported by information and guidance for policy and operational teams to aid their work in this area. • Regular assessment of patients and the public's perceptions of the GMC and experiences of our work through regular evaluation and research (such as our perceptions survey). • Regular engagement with patient leaders in all four countries of the UK (by our senior leadership team as well as our bi-annual roundtable, UKAF meetings in the devolved nations and other activities). • Assessing stakeholder network to learn how other organisations engage meaningfully and well with patients and public	QUITE LIKELY	MODERATE	SILVER	Council • Annual update on patient and public involvement (Dec 2025). • Annual update on patient and public involvement (Dec 2024). Audit and Risk Committee: • Update on PPI review recommendations (Jan 2026). • Update on PPI review recommendations (May 2025).	Other assurances • Annual perceptions survey showing the public's confidence in how doctors are regulated and feedback on our working relationships with patient and public bodies. Results from 2023 survey shared with Council in November 2023.	• Next Patient Group Roundtable to be held on 19 May 2026. • Contact Centre to bed in new automated surveys for patients and other users of its services, following deployment in late 2025. • Fitness to Practise to evaluate results of feedback pilot in 2025 and agree next steps. • Perceptions of patients and the public to be researched in next perceptions survey (summer 2026) • Internal discussions taking place about prioritising strategic commitments, which will determine timetable and resources for progressing PPI-related activities (such as ED&I data and reviewing our customer service standards).	Medium

General Medical Council

Sustaining momentum post-delivery of the Fairer Employer Referrals programme

Paper withheld from publication	This paper is being withheld from publication. For further information, please contact the Corporate Governance team via email, GovernanceTeamMailbox@gmc-uk.org.

General Medical Council

ED&I Annual Report

Paper withheld from publication	This paper is being withheld from publication. For further information, please contact the Corporate Governance team via email, GovernanceTeamMailbox@gmc-uk.org.

General Medical Council

Safeguarding Annual Report

Action	Council is asked to approve the content of the Safeguarding Annual Report 2025
Purpose	The Charity Commission requires charities to produce an annual safeguarding report. This is our third safeguarding annual report. It details safeguarding initiatives and data for 2025.
Recommendation(s)	To approve the content of the Safeguarding Annual Report 2025
Annexes	Annex A: Safeguarding Annual Report for 2025 Annex B: Directorate safeguarding activity Annex C: Data Annex D: Safeguarding costs
Author contacts	**Helen Majerski**, Designated Safeguarding Manager **Claire Gardner**, Head of Quality and Safeguarding Any enquiries to: GovernanceTeamMailbox@gmc-uk.org
Sponsoring director/ Senior Responsible Owner	Neil Roberts, Director of Resources

Agenda item M6
Safeguarding Annual Report

Background

1 The GMC has a responsibility under the Charity Commission's guidance to have robust arrangements in place to safeguard and promote the welfare of children and adults at risk and to take reasonable steps to protect those who we come into contact with from harm.

2 This is our third safeguarding annual report and covers safeguarding activity for 2025.

Safeguarding Annual Report for 2025

3 The Safeguarding Annual Report is at **Annex A**. The report has been reviewed by:

- Executive Board on 27 April 2026
- Audit and Risk Committee (ARC) on 14 May 2026

Continuous improvement of our safeguarding processes

4 In 2025 we completed the implementation phase of our safeguarding project and safeguarding work moved to business as usual (BAU) activity. A project closure report was approved by Gateway and Executive Board in March 2025.

5 We refreshed our Corporate Safeguarding Policy to reflect changes in our processes. These changes include amendments to reporting thresholds, and colleagues are now required to report cases where an individual expresses suicidal ideation or self-harm. Colleagues are still required to deal with any immediate risk to life or provide appropriate signposting to support organisations prior to reporting the incident to the Safeguarding Team.

6 This change to our thresholds enables us not only to ensure that colleagues have been supported appropriately but to collate comprehensive data on suicidal ideation and self-harm disclosures. It allows us to identify patterns, understand pressures faced by those we come into contact with, and better tailor our support offer.

7 Other changes to our policy include:

- safeguarding cases referred to Triage directly from statutory safeguarding organisations (eg Police, Local Authority or NSPCC) are reviewed by the Safeguarding Team. Again, this is to ensure we have a full data set, and that any safeguarding support and advice is provided to colleagues if required.
- changes to our safeguarding decision template so we can record more information on our decision rationale. This improvement was a recommendation following a compliance review of safeguarding decisions by the Quality Assurance (QA) Team.

8 In 2025 there was a safeguarding related data breach which resulted in a significant event review (SER). The breach was reported to the Information Commissioner's Office (ICO) and the Charity Commission, who confirmed receipt and no further action was taken. The SER was reviewed by the Audit and Risk Committee, along with recommendations for process improvements.

Conclusion

9 Considerable progress to embed safeguarding across the GMC has taken place during 2025. We have completed the implementation phase of our safeguarding project and safeguarding is now business as usual activity, with continuous improvements made to processes and guidance.

10 The corporate Safeguarding Team continue to support directorates and colleagues in developing safeguarding awareness and implementing safeguarding into local processes. This is evidenced through the completion of objectives in our three-year plan and a significant increase in requests from colleagues for safeguarding advice.

11 The number of internal safeguarding reports has increased during 2025, again an indicator of increased awareness amongst colleagues but also a result of changes to our reporting thresholds. Whilst the number of external referrals to statutory safeguarding organisations remains similar to 2025 (7 compared with 5 in 2024) the benefits the work of the Safeguarding Team brings include:

- reviewing relevant information to ensure any vulnerable adult or child is protected
- ensuring the GMC meets our Charity Commission requirements, including the management and development of our corporate policies, processes, and training
- consistency in decision making
- providing advice, support, and reassurance to colleagues that all appropriate support and actions have been completed
- enabling the organisation to understand our safeguarding cases and data across all directorates
- continuing to raise awareness of current and developing safeguarding practice.

General Medical Council

Annex A

Safeguarding Annual Report 2025

Authors:

Claire Gardner, Head of Quality, Assurance and Safeguarding

Helen Majerski, Designated Safeguarding Manager

April 2026

Agenda item M6

Safeguarding annual report

Background

1. The GMC has a responsibility under the Charity Commission's guidance to have robust arrangements in place to safeguard and promote the welfare of children and adults at risk and to take reasonable steps to protect those who we come into contact with from harm. This responsibility lies with everyone who works at the GMC or is working on behalf of the GMC including our colleagues, those contracted to work with us, and council members.
2. There is also a Charity Commission expectation that an annual report on safeguarding is produced. This is our third annual safeguarding report. It provides Council with:
   - assurance that we are meeting our safeguarding obligations in relation to the Charity Commission guidance and our GMC values.
   - an overview of GMC's safeguarding practice and activity.
   - information on the types of safeguarding concerns we see at the GMC.
   - an overview of our plans for 2026 and our commitment to continuously improve and develop our safeguarding culture.

Safeguarding structure and governance

3. The Director of Resources is the Senior Management Team (SMT) lead for Safeguarding. Our corporate Safeguarding Team is located in the Quality, Continuous Improvement and Safeguarding Section, Resources Directorate. The team consists of a Designated Safeguarding Manager (DSM) who was appointed in July 2022 and a Safeguarding Officer (SO) who was appointed in November 2023. Both members of the team have received Level 5 safeguarding training which is refreshed every three years. The corporate Safeguarding Team support safeguarding issues identified as part of our regulatory activity. Safeguarding concerns relating to colleagues are managed by the People Team, with support from the DSM.
4. Our safeguarding work is supported on an ad hoc basis by other professionals across the GMC, including colleagues in our Outreach and Legal and Information Governance teams who provide advice and support on complex cases and in the sharing of information. Three colleagues from the Quality Assurance Team, have received additional safeguarding training (Level 3) and provide ad hoc support and resilience to the corporate Safeguarding Team during peaks in workload.
5. While not a statutory safeguarding organisation, our approach to safeguarding incorporates good practice and learning from frameworks and national safeguarding guidance, taking account of safeguarding requirements and legislation to protect adults and children across the four countries. Governance in safeguarding relies on strong leadership, structures, policies, development of a safeguarding culture and oversight systems to ensure people are protected from harm. It is the responsibility of trustees and senior leaders to make sure safeguarding is embedded, monitored, and there is accountability across the organisation.

6. We are committed to developing a strong safeguarding culture across the GMC, where safeguarding is a key element in what we do. A Safeguarding Working Group (SWG), chaired by the Director of Resources, is attended by representatives from all our directorates and the MPTS. The group provides advice, challenge, support, and direction on safeguarding issues.
7. Our safeguarding risks are managed via our corporate and directorate risk registers and within the corporate Safeguarding Team.

Safeguarding policies and processes

8. Our corporate safeguarding policy was refreshed in 2025 and approved by the SMT in November 2025.
9. In addition to our corporate safeguarding policy, the GMC have a suite of policies, procedures, and processes in place that support our approach to safeguarding. These include:
   - Health and Safety, including our threatening & abusive behaviour policy.
   - a range of people policies, including unexplained absences, sickness absence, and disciplinary policy, processes and procedures.
   - Raising Concerns policy.
   - Independent Support Services for victims and doctors.
   - Supporting Vulnerable People Toolkit.
   - Domestic Abuse policy.
   - Recruitment policy.

Charity Commission requirements

10. We have made considerable progress in implementing our policies and processes and embedding safeguarding into our business as usual (BAU) activity. Key achievements to note for 2025 include:
    - the implementation of our three-year safeguarding plan. Examples of how safeguarding has been embedded across directorates are presented at Annex A.
    - the delivery of a refreshed digital training for colleagues.
    - the delivery of face-to-face safeguarding training to new colleagues.

Safeguarding systems

11. We continue to have various systems in place to enable us to capture safeguarding reports, information, and data.

- There is a Siebel based reporting form and an email inbox for colleagues to report safeguarding concerns, which they see through the course of their work. These safeguarding concerns relate to doctors, physician associates (PAs) and anaesthesia associates (AAs), members of the public, witnesses, and complainants. These reports are reviewed and actioned by the Safeguarding Team.
- Concerns that relate to colleagues or people who work with us (such as Associates) are reported via email to the People Team.
- Facilities capture and report separately on Health and Safety data, including information relating to threatening and abusive behaviour towards colleagues, doctors, PAs and AAs*.
- Safeguarding issues may also be raised with Mental Health First Aiders and Freedom to Speak Up Champions.

Key safeguarding activities and statistics

Safeguarding concerns reported to the corporate Safeguarding Team

12. The Safeguarding Team review concerns identified during the course of our work which relate to doctors, PAs and AAs, witnesses, complainants and members of the public.
13. A total of 639 safeguarding referrals were reported to the team in 2025: averaging 53 reports a month. This compares with 413 safeguarding referrals in 2024: averaging 34 reported concerns a month. This is an increase of 55% in total annual numbers reported in 2025. This can be explained in some part by the changes made to our reporting criteria at the start of 2025 which now requires colleagues to report concerns relating to suicide ideation.
14. A total of 58 reported concerns were closed as they were not safeguarding cases (9%). This is a lower proportion than the previous year (13%), suggesting that colleagues have improved awareness of which concerns meet the safeguarding categories.
15. A total of 506 reported referrals required a decision, and 668 decisions were made in total. The decisions figure is higher than the number of reported concerns as some reports included numerous people and a separate decision was made for each person.
16. Further data on the reported concerns and decisions can be found in Annex C. Key points to note:
    - the majority of safeguarding concerns reported to the Safeguarding Team related to adults, either solely or as one aspect of a decision. 8% of decisions related only to children, a reduction from 2024 when it was 14%
    - 49.8% of safeguarding concerns involved a doctor, PA or AA

* Only the threatening and abusive behaviour data has been included in this report.

- 57.4% of referrals came from Fitness to Practise and 33.5% from Registration and Revalidation. An 8.6% increase for Registration and Revalidation and a decrease for Fitness to Practise (8.9%) compared to 2024
- the most common safeguarding themes reported to the corporate Safeguarding Team were about adult mental health, suicide ideation, self-harm and domestic abuse. In relation to children, it was neglect and domestic abuse.

Decision outcomes

17. A safeguarding decision is made on each individual involved in a reported concern where it meets the definition of safeguarding and the reporting threshold. In relation to decision outcomes:
    - in 23% of safeguarding decisions signposting was recommended and no further action was required by the Safeguarding Team
    - in 33% of decisions the Safeguarding Team were able to establish through the case review process that a statutory safeguarding agency was already aware of the concern(s) and therefore no further action was required.
    - in seven concerns reported, relating to nine individuals, the matters were serious enough to warrant disclosure of information to an external statutory safeguarding organisation. One concern was reported to a GMC internal team for them to make a process change to support a vulnerable person.
    - four concerns were reported to the relevant local authority and three to the Police. These concerns related to:
        - a child sharing videos of domestic abuse at home. This concern was reported to the police
        - a complainant expressing suicidal thoughts and disclosing previous suicide attempts shared information relating to self-neglect and financial hardship. This concern was reported to the local authority
        - a member of the public expressed thoughts of suicide ideation where a child was also present and distressed. The police were contacted
        - a doctor was accused of raping a patient. This concern was reported to the police
        - a concern was raised that a doctor was suffering from self-neglect and was failing to care for her young child by not engaging with support. This concern was reported to the local authority
        - allegations were received of historic abuse by a doctor who conducted inappropriate examinations on children in a sports setting between 2007 and 2009. This was reported to the police

- a concern was received that a doctor was over prescribing controlled drugs to a patient. The concern was reported to the local authority.

Safeguarding reported to the People Team

18. The People Team recorded a total of 15 safeguarding concerns relating to GMC colleagues in 2025 compared to 32 concerns recorded in 2024. Most concerns (13) related to safeguarding adults.

19. Of the 15 reports:

- three related to domestic abuse
- seven to potential self-harm or neglect
- five related to suicide ideation
- two relating to children involved one concern of neglect and one relating to domestic abuse.

Learning and Organisational Development and employee benefits

20. A number of safeguarding activities have taken place to embed safeguarding and to provide support across the GMCs learning and development activities. These include:

- seven new coaches were onboarded to The International Coaching Federation cohort in December 2025 and informed of our safeguarding policy and additional guidance for coaches
- the digital mandatory safeguarding training module was refreshed and rolled out in February 2026.
- a total of 11 qualified decompression facilitators delivered approximately 50 hours of decompression sessions to individual and groups of colleagues across the organisation
- from January to October 2025 the Employee Assistance Programme (EAP) was contacted by 84 individuals of which 73% were female and 27% male. There were 142 calls in total of which 53 resulted in structured therapy, with a total of 266 therapy sessions delivered. The three main reasons for colleagues using EAP related to anxiety, bereavement and requesting legal advice.

Safer recruitment

21. We continue to thread safeguarding through our recruitment processes with reference to safeguarding within all job descriptions. The Resourcing Team continue to collaborate with recruiting managers during the campaign planning and selection stages, to ensure that appropriate skills, experience and knowledge are emphasised in job packs and tested where appropriate, providing appropriate support and advanced notice to candidates when sensitive topics are explored.

Threatening and abusive behaviour

22. A total of 20 threatening and abusive behaviour incidents were reported to the Compliance Team in 2025, similar to the 2024 figure of 24. Of these incidents:
    - 10 were reported to the police
    - 8 threats were made to colleagues
    - 6 threats were made to doctors or third parties
    - some incidents involved threats to both colleagues, doctors or third parties
    - the threats were made in a number of ways including three face to face, eight in writing and nine verbal threats.

Independent support to victims

23. The Legal Team manage our Independent Support Service with Victim Support. This service is for complainants, patients, witnesses, and their families involved in a fitness to practise case. The service provides emotional support to individuals who access it and includes signposting to specialist support agencies and where necessary, referrals to statutory safeguarding agencies.

24. During 2025:
    - a total 167 of referrals were made to Victim Support of which 74 were self-referrals by telephone and 92 were submitted by GMC colleagues via email on behalf of the person needing support. The use of the service is similar to 2024 where a total of 171 referrals were made to Victim Support.
    - there were 322 attempted calls made to Victim Support, of which 80% of calls were answered.
    - no safeguarding referrals were made as a result of a call with the service during 2025.
    - external signposting or information about other support services were documented by Victim Support 215 times.

Doctor Support Service

25. The Doctor Support Service offers emotional support to doctors under investigation or restrictions, facing a hearing or in the licence to withdrawal or restoration process. The service is free and is managed independently from the GMC. During 2025, 104 doctors contacted the service and were provided with support. This figure relates to doctors new to the service during 2025 compared with 95 doctors in this category contacting the service in 2024.

26. In 2025:
    - 19% of the doctors contacting the service were seeking restoration to the register or were in the licence withdrawal process

- 32% said they had contacted the service because they had been encouraged to by a GMC officer or other person
- 42% cited the impact of GMC activities/decisions or correspondence as their reason for seeking support
- 1% said a lengthy investigation.

27. A support service is also in place for AAs and PAs, which was set up at the start of 2025. The number of cases is currently less than 10 and none of them have used the support service yet.

Safeguarding advice

28. Through our communication and awareness strategy, colleagues are reminded that safeguarding is everyone's responsibility, and we expect colleagues to remain vigilant, follow safeguarding policies and report any concerns about the safety and wellbeing of children or adults at risk. Ongoing guidance and training support is provided to colleagues to help recognise potential risks and respond appropriately.
29. During 2024 the corporate Safeguarding Team received 142 requests for advice from colleagues. In 2025 this number increased to 510 requests, an increase of 259%.
30. The nature of these requests varies but examples include:
    - supporting fitness to practise colleagues with requests from Local Authority Designated Officers (LADO's)
    - supporting colleagues in our Social Media comms team when considering safeguarding concerns raised on various online platforms
    - advice to our Legal colleagues on supporting a witness with suicidal ideation or
    - advice on domestic abuse support in relation to colleagues
    - advice following on from Health Assessors report indicating risk of self-harm
    - information request from external agencies such as the Police, Practitioner Health or other organisations
    - advice to our QA Education team on supporting medical students.

Significant event

31. No matter how well we manage and control our activities, sometimes things go wrong, or we don't meet stakeholders' expectations. When this happens, it provides us with the opportunity for lessons to be learned and improvements to be made in the way we work.
32. In line with Charity Commission guidance a significant event review (SER) took place in 2025 in relation to the sharing of information that could have potentially put a vulnerable person at risk of harm.

33. The SER identified a number of system improvements were required to mitigate the risk of future events including sending automated emails which contain details of how the GMC will use data, increasing awareness of reporting to the GMC via the Online form and ensuring that safeguarding is considered and documented in investigation case plans.

34. The incident was reported to both the Information Commissioners Office and the Charity Commission who acknowledged the SER and determined no further action was required on their part.

Communication and awareness

35. Our Safeguarding Hub which went live on the GMC intranet in 2023 continues to be updated with the latest safeguarding information including policies and processes, roles and responsibilities, guidance documents, information on how to report concerns, and where colleagues can go to access support for themselves or where to signpost others.

36. In January 2025 an Inside Info article was published to communication changes to our safeguarding training. We use the feedback from both training and communication events to make changes to processes and ensure colleagues know their roles and responsibilities.

37. Our reporting exceptions criteria was updated in September 2025. This was in response to feedback from colleagues, an internal audit and as part of our commitment to continuously improve our processes.

38. We have over 45 Directorate Safeguarding Representatives (Reps) across the GMC and MPTS who continue to play a vital role in supporting and strengthening our safeguarding activity. The Reps are actively contributing to the embedding of a positive safeguarding culture within their directorates, helping to raise awareness, promote best practice, and ensure safeguarding remains a key consideration in day-to-day work.

39. Through their engagement, Reps have been key in driving forward local process and identifying areas for improvement. They have also shared updates on their progress and learning at the Safeguarding Working Group, providing valuable insights into how safeguarding is being implemented across different areas of the organisation and supporting a more consistent, joined-up approach.

40. The DSM and SO regularly attend team meetings across the organisation to further strengthen and embed safeguarding processes. This provides teams with direct access to expert advice and guidance, supports increased confidence in managing safeguarding concerns, and reinforces the importance of safeguarding.

External engagement

41. During 2025, we have significantly expanded our network and increased our collaboration with a range of fellow regulators and health professional organisations, with a particular focus on those working in the areas of domestic and sexual abuse.

42. We were also invited to join the Doctors, Nurses and Domestic Abuse Working Group, which recognised that, alongside the vital emphasis on supporting victims and survivors,

there is a need to address the issue of healthcare professionals, specifically doctors and nurses, who are perpetrators of domestic abuse.

43. These strengthened partnerships enable greater knowledge sharing, alignment of best practice, and a more coordinated response to complex safeguarding issues. By engaging more closely with other organisations, we can continue to enhance our understanding of the risks faced by vulnerable individuals and improve our safeguarding process. This collaborative approach reinforces our commitment to safeguarding and ensures that our policies and practices continue to evolve in line with emerging evidence and sector expertise.
44. We also engaged with an external consultancy specialist to support the HOS and DSM in strengthening our understanding and application of safeguarding processes. This collaboration is helping to ensure that we are fully aligned with other organisations and confident in our approach, ensuring we are equipped to identify and respond to safeguarding concerns effectively. The consultancy input also provided targeted guidance on risk identification and mitigation, supporting a more proactive and consistent approach to managing safeguarding risks across the organisation.

Training

45. The aim of our training is to create a culture where safeguarding is recognised, recorded, and reported, and where colleagues raising or impacted by a concern are supported. We have a duty to provide safeguarding training to our colleagues and those who work with us, which is commensurate with their role. All colleagues receive mandatory digital training to ensure they recognise safeguarding concerns, ensure that concerns and allegations are managed sensitively, and know how to report information to our DSM or People Team.
46. During 2025, digital mandatory training was completed by a total of 1860 colleagues across all directorates.
47. We also worked with the Associates Appraisal and Training team to deliver workshops to Health Assessors at their four annual training days.
48. Face to face training continues to be available for all colleagues, via Aspire, and a total of seven sessions to 69 colleagues were delivered. One of these sessions was delivered in our London office to ensure accessibility.
49. The feedback from colleagues relating to both the digital and face to face sessions has been positive:
    - 100% of colleagues who provided feedback on completion of the face-to-face training said it met their expectations and rated it good or excellent.
    - 100% of colleagues who provided feedback on completion of the face-to-face training said the course was well organised, met the described aims and engaged them as delegates, this figure has increased since 2024 which was 91%.

- 89% of colleagues who provided feedback on completion of the digital training said it met their expectations and that the course was very good or excellent. This is the same rating as 2024, and a similar rating to 2023 where 88% of colleagues found the course very good or excellent.
- 92% of colleagues who provided feedback on the digital training said it contained relevant information, a slight increase of 1% on 2024.

50. Training and continuous professional development is also in place for our HOS, DSM and SO.
    - DSM and the SO have continued to have external supervision regularly with Safeguarding Alliance.
    - HOS, SO and QA colleagues attended Safeguarding Adults level 3 course (1 day Feb 25).

Progress on 2025 priorities

51. We have made considerable progress on our priorities.
    - We completed a comprehensive review and update of our digital safeguarding training programme to ensure alignment with current organisational requirements and best practice. The revised content now includes GMC-specific case studies and scenarios, providing colleagues with more relevant, practical learning opportunities. It also reflects updated internal reporting processes, ensuring staff are equipped with clear guidance on how to recognise, report and record safeguarding concerns. The updated training was successfully rolled out to all colleagues in February 2026.
    - We supported directorates in completing their local safeguarding actions as recorded in the three-year plan. Significant progress has been made across multiple workstreams, demonstrating strong organisational commitment to safeguarding. Key achievements and examples of completed work are detailed in Annex B.
    - We delivered safeguarding training to new colleagues or colleagues who want to refresh their safeguarding knowledge. There were also five sessions delivered to 120 Health Assessors on their annual training days, ensuring this key group remains up to date with safeguarding expectations and practice.
    - We continued to actively monitor external developments in safeguarding policy, legislation, and best practice to ensure the organisation remains aligned with national standards. As part of this work, we strengthened our external engagement and established valuable networks with key organisations, including Local Authority Designated Officers (LADOs), the Royal College of General Practitioners (RCGP), the General Dental Council (GDC), and the Doctors' Association UK. These relationships support shared learning, benchmarking, and continuous improvement.
    - We progressed the delivery of our safeguarding communication and awareness strategy, aimed at embedding a strong safeguarding culture across the organisation.

This has included regular internal communications and the promotion of key safeguarding messages through multiple channels. Efforts have focused on increasing visibility of safeguarding responsibilities, reinforcing reporting processes, and ensuring colleagues feel confident in recognising and responding to concerns. Feedback indicates improved awareness and engagement across teams, with safeguarding increasingly recognised as a shared organisational priority.

Costs

52. A summary of the costs to provide support services and the resource costs for the Safeguarding Team is at Annex D. The total cost for all services was £269,061. This includes staffing costs for the Safeguarding team and the running costs of EAP, Doctor Support Scheme and Victim Support's Independent Support Service.

Priorities for 2026

53. Below are our priorities for 2026.

- Strengthening collaborative relationships with key partners across the regulatory and healthcare landscape to support information sharing, alignment of safeguarding standards and recording of low-level risks.
- Producing targeted briefings on specific safeguarding topics for colleagues and developing clear and accessible materials on key safeguarding issues (emerging risks, legislative changes and thematic trends). Content will be tailored to different internal teams to ensure relevance and support colleagues to consistently apply the safeguarding principles in their roles.
- Reviewing and updating training requirements including options for a refresh of our face-to-face training. We will ensure all safeguarding-related policies, procedures, and guidance are current, clear, and aligned with best practice and statutory requirements; and incorporate learning from case reviews, audits, and stakeholder feedback.
- To continue to monitor external developments in safeguarding and consider their implication for the GMC. Seeking input from colleagues, other regulators, and relevant organisations we will ensure safeguarding approaches are informed by external developments, including changes in legislation, government policy, and emerging best practice guidance.
- Strengthening a proactive safeguarding culture across the organisation by continuing to embed safeguarding as a shared organisational responsibility by promoting awareness, confidence, and accountability at all levels. This will include targeted communications, leadership engagement, and the use of real case examples to reinforce learning and expected standards of practice.
- Continuing to learn from feedback and lessons learnt and ensure there are clear, actionable improvements. This includes clarifying expectations, reinforcing

professional curiosity, and ensuring staff feel empowered to escalate concerns appropriately.

- Enhancing decision-making consistency in safeguarding assessments, refine decision-making frameworks, guidance, and peer review processes to reduce the risk of mistakes and support more consistent safeguarding decisions across the organisation.
- Resourcing and Learning and Organisational Development teams will be refreshing recruiting manager training, of which safeguarding will be included.

General Medical Council

Annex B

Directorate safeguarding activity

Directorate/theme	Activity
Fitness to Practise	
Updates to local guidance documents	Policy and Business Change teams reviewed guidance documents to reflect the new safeguarding policy and process including making changes to fields and tabs in Siebel.
Raising awareness of the role of the Local Authority Designated Officer (LADO)	Working with the corporate Safeguarding Team new information and guidance on the role of the LADO, their powers and the sharing of information is being drafted.
Urgent referrals	The Policy Team are drafting new guidance and a toolkit on reporting immediate concerns to the Police.
Legal	Support with how to deliver difficult news to suicidal witnesses.
Investigation processes	Updates have been made to case management documents and meeting agendas to ensure safeguarding is considered in case planning.
Revalidation and Registration	
Registrations	Introduction on specific guidance regarding safeguarding information sharing for registration teams.
UK applications	A new process for managing safeguarding concerns has been put in place.
Contact Centre	All new starters have been encouraged to book on face-to-face training session. Colleagues are aware of the

	Safeguarding Hub and signposted to use this to support their understanding of safeguarding and their role within the process. The Rep role continues to support Contact Centre colleagues with strengthening our approach to safeguarding and ensuring key messages continue to be shared across the teams.
Resources	
Business Continuity	Safeguarding is considered in Business Continuity Plans including obtaining access to relevant information and systems.
Information sharing	Information has been included in our revised privacy statement about safeguarding disclosures. The statement has been approved and is now live on the GMC website.
Sustainability and Social Responsibility	Safeguarding requirements relating to volunteers are considered as part of our corporate social responsibility work. The DSM attends working group meetings.
Associate Recruitment	Information for applicants has been updated with details of our safeguarding commitments. Guidance on safeguarding for Associates has been drafted and is available on Cornerstone. Safeguarding Team delivered safeguarding training sessions to Associates.
Procurement – modern slavery	Supported the annual refresh of the Modern Slavery policy.
Recruitment	Supported with preparing appropriate questions for candidates to understand the sensitive material they may be expected to work with.
IS	Supported the roll out of the vulnerable persons toolkit to all laptops.
L&OD	Supporting the strengthening of safeguarding within mentoring.
People Team	Supporting a new process for safeguarding data capture as part of ERP.

Education and Standards	
Education	The directorate has incorporated a standard decompression session after each quality visit to discuss any issues of concern and to make sure colleagues and Associates feel supported. A new process has been developed for the live monitoring of National Training Survey (NTS) comments, to enable us to share any potential immediate safeguarding concerns with the relevant postgraduate training organisation and internally with the GMC's Safeguarding Team where appropriate.
MPTS	
Case Management	All newly appointed hearing-based staff, who represent our most front-facing roles, now receive additional training focused on local safeguarding procedures within the hearing centre, ensuring they are well equipped to identify and respond to concerns effectively.
Case Management	Established regular decompression sessions, held twice weekly on a drop-in basis and led by a manager, to support staff wellbeing and reflective practice.
Case Management	MPTS has undertaken a comprehensive review of all external correspondence to ensure that safeguarding information and avenues for support are clearly communicated, while internal processes have been strengthened to provide clear guidance on managing safeguarding concerns raised through written or electronic communication
Strategic Communications and Engagement	
Outreach	Safeguarding is now embedded in Outreach induction. All new starters complete the mandatory safeguarding training on Aspire, but we also include a session in local Outreach induction to explore safeguarding in the context of specific roles.
Communications	Updated local guidance to reflect safeguarding that we see via online platforms and in wider comms work.
Strategy and Policy	

Risk	Safeguarding Deep Dive completed with the Senior Management Team in June 2026
Staff Networks	
Mental Health Network	An article of suicide prevention referenced the Corporate Safeguarding policy.

General Medical Council

Annex C

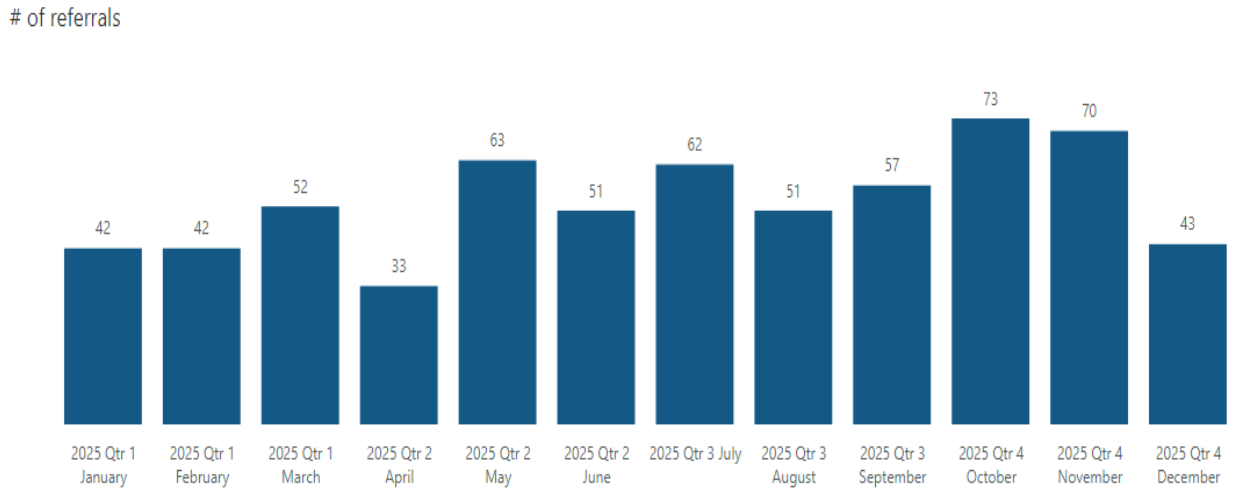
Safeguarding data held by the Corporate Safeguarding Team

Safeguarding referrals

639 referrals were made in 2025, which is an average of 53 per month. This is a 55% increase from the previous year's figure of 413. Of the 639 referrals, a total of 506 required a formal safeguarding decision to be made (79%).

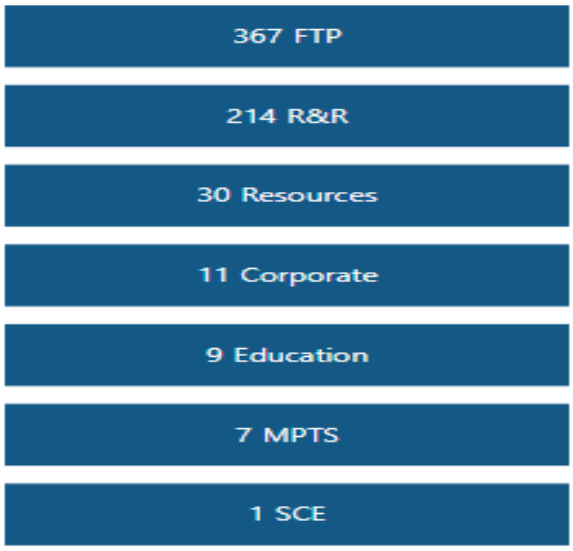
Reasons why some referrals did not require a decision?

- Of these 58 referrals were closed as not safeguarding (9%). This is a lower proportion than the previous year (13%).
- 41 concerns were closed as not meeting the reporting threshold, as per our safeguarding guidance the Safeguarding Team were able to establish through the case review process that a statutory safeguarding agency was already aware of the concern(s) and therefore no further action was required and/or weren't able to identify any of the data subjects.
- 34 concerns were closed without requiring a decision. Mostly commonly this is when they were repeat / duplicate concerns, most often relating to subjects with mental health conditions, or suicidal ideation, who had already been signposted to support organisations, and the further referral did not include any new information.



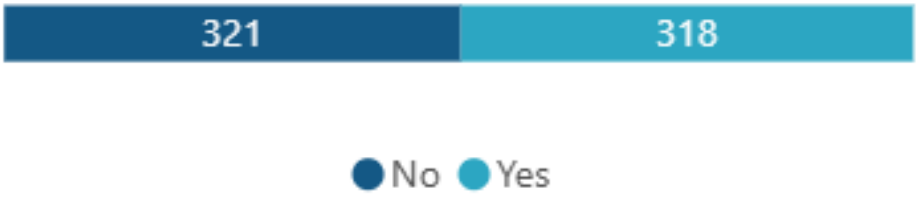
Reports by directorate

Most safeguarding referrals are reported by the Fitness to Practise (FTP) Directorate but there has been a slight change since last 2024 with a greater proportion of referrals coming from the Registration and Revalidation (R &R) Directorate. Together FTP and R&R Directorates account for over 90% of referrals in 2025.



Reports involving a doctor, physician associate (PA) or anaesthesia associate (AA)

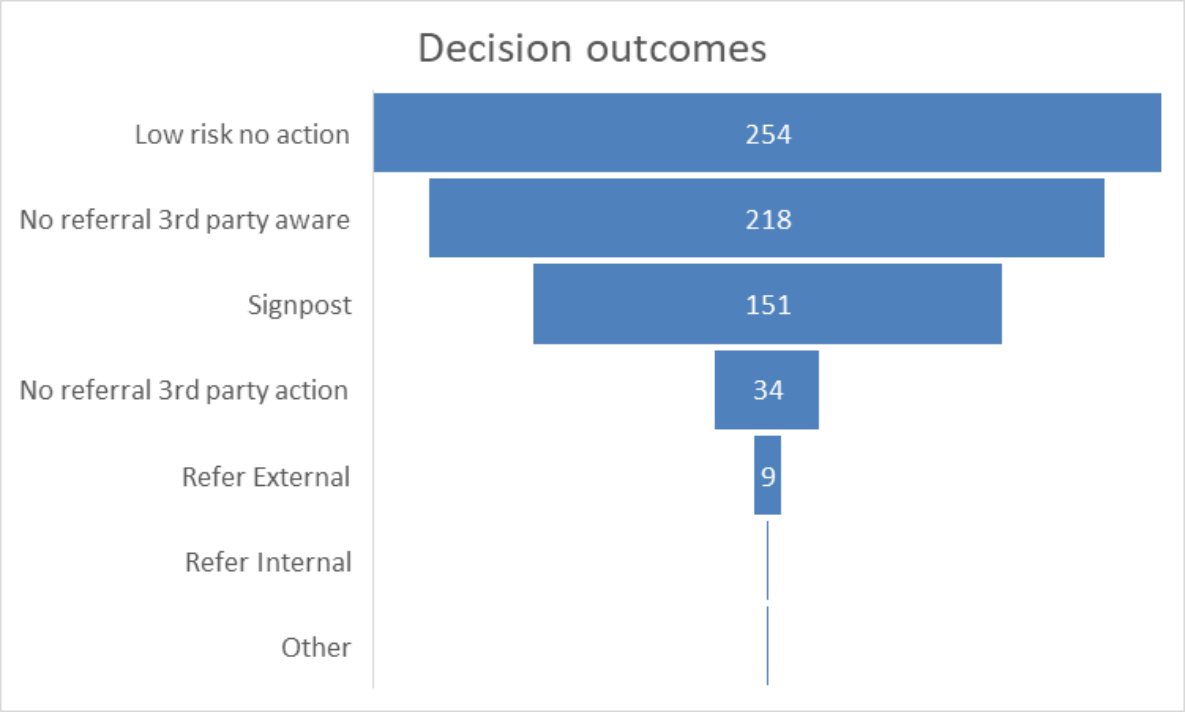
Was the referral about a doctor, PA or AA?



Of the 639 referrals the proportion that involved a doctor, PA or AA was 318 (49.8%). This is slightly more even split compared to 2024 when 62% of concerns involved a doctor, PA or AA.

Safeguarding decisions

A total of 668 safeguarding decisions were made by either the Designated Safeguarding Manager or Safeguarding Officer. The number of decisions made is higher than the number of referrals received, as referrals often involved more than one data subject and a separate decision is made for each person.



When compared with 2024 data there has been a decrease in the proportion of referrals that were closed as being low risk, and an increase in the number that were closed as signposting had already been provided by the relevant operational team, demonstrating an increased awareness at local level.

27% of all decisions related to either Adult Mental Health or Self-Harm /Suicide, making it the most common theme referred to the Safeguarding Team. Adult domestic abuse was the second most commonly occurring theme accounting for 16% of the total.

Referring safeguarding concerns to statutory safeguarding organisations

In 2025 the corporate Safeguarding Team referred seven concerns to external statutory safeguarding organisations. One case was reported to an internal GMC team for them to make a process change to protect an individual.

Of these eight cases:

- four were reported to the Police
- three were reported to the relevant Local Authority

- three cases were solely about an adult
- five involved an adult and a child(children)

In terms of potential safeguarding activity:

- two involved adult domestic abuse
- two involved adult self-harm/suicide ideation
- two involved adult sexual abuse
- two involved child neglect

General Medical Council

Annex D

2025 safeguarding costs

Activity	Cost (£)
Safeguarding Team with staff and training oncosts	108,738
Doctor Support Scheme	61,130
Independent Support Service – Victim Support	83,566
Employee Assistance Programme	15,627
Total	**269,061**

General Medical Council

Council forward work programme

Action	To note
Purpose	This paper sets out the planned items for future meetings of Council. The content of agendas is liable to change.
Recommendation	To note the Council forward work programme
Annexes	None
Author contacts	**Melanie Wilson**, Head of Corporate Governance and Council Secretary Any enquiries to: GovernanceTeamMailbox@gmc-uk.org
Sponsoring director/ Senior Responsible Owner	**Carrie MacEwen**, Chair of the GMC

Agenda item M8
Council forward work programme

Background

1 This paper sets out the planned items for future meetings of Council. The content of agendas is liable to change.

2 Items marked as 'below the line' are included on an agenda where no discussion is required, although members may request a discussion at the meeting.

1 October 2026 – Northern Ireland

	Item	Sponsor
	• Visit to Queen's University Medical School SIM centre	
Seminar	• Northern Ireland focus	Paul Reynolds
	• (tbc) Investment approach	Neil Roberts
Confidential session	• Report from GMC Services International Ltd	Paul Reynolds
	• SC&E impact report	Paul Reynolds
	• 2027 budget assumptions and approach	Neil Roberts / Kuljit Dhillon
	• SoMEP workforce report	Shaun Gallagher
Public session	• Chief Executive's report	Charlie Massey
	• Finance update	Neil Roberts
	• Regulatory reform update	Shaun Gallagher
	• Regulatory Fairness Review update	Shaun Gallagher
	• People report	Neil Roberts
Below the line	• Council forward work programme	Carrie MacEwen
	• Council members' register of interests	Carrie MacEwen

Agenda item M8
Council forward work programme

9 December 2026 – London

	Item	Sponsor
Seminar	• Perceptions survey report	Paul Reynolds
	• External speaker – Alison Wright – reflections on a year as RCOG president	Carrie MacEwen
	• (TBC) AI – external environment	TBC
Confidential session	• PA/AA revalidation rules	Una Lane
Public session	• Chief Executive's report	Charlie Massey
	• Financial update	Neil Roberts
	• Fairer Employer Referrals annual report	Anthony Omo
	• Fairer Employer Referrals – where next?	Anthony Omo / Push Mangat
	• Fairer Training Cultures	Push Mangat
	• 2026 budget and business plan	Neil Roberts / Shaun Gallagher
	• Report of the MPTS committee	MPTS Chair
	• Report of the Audit and Risk Committee	Vanessa Davies / Neil Roberts
	• Report of the Remuneration Committee	Raj Patel / Charlie Massey
	• Patient and public involvement update	Paul Reynolds
	• Reg Reform update	Shaun Gallagher
	• Compliments and complaints report	Charlie Massey
Below the line	• Council forward work programme	Carrie MacEwen
	• Annual report on the DC pension scheme	Neil Roberts

Agenda item M8
Council forward work programme

February 2027 – London

	Item	Sponsor
Seminar	• (TBC) FtP voices – a registrant's experience of going through our process	TBC
Confidential session	• SC&E priorities for the year ahead (based on perceptions survey results)	Paul Reynolds
Public session	• Chief Executive's report	Charlie Massey
	• Annual update of Governance Handbook	Charlie Massey
	• Finance update	Neil Roberts
	• PSA annual review of our performance	Shaun Gallagher
	• Regulatory reform update [placeholder]	Shaun Gallagher
	• People Survey report	Neil Roberts
	• 2028 Council meeting schedule	Sophie Brookes
	• Report of the MPTS Committee 2026	MPTS Chair
Below the line	• Council forward work programme	Carrie MacEwen
	• Report of the Executive Board	Charlie Massey

April 2027 – Manchester

	Item	Sponsor
Seminar	• TBC	
Confidential session	• Annual review of Governance Framework: GMC / GMCSI	Paul Reynolds
	• 6 monthly SC&E impact report	Paul Reynolds
Public session	• Chief Executive's report	Charlie Massey
	• Financial update	Neil Roberts
	• 2026 national reports	Paul Reynolds
	• Annual QA update	Push Mangat

	• Annual section 40A report	Charlie Massey
	• Regulatory reform update [placeholder]	
	• Investment Committee annual report	Douglas Millican / Neil Roberts
Below the line	• Council forward work programme	Carrie MacEwen
	• Council members' register of interests	Carrie MacEwen

June 2027 – London

	Item	Sponsor
Seminar	• TBC	
Confidential session	• Annual report of GMCSI	Paul Reynolds
Public session	• Chief Executive's report	Charlie Massey
	• Finance update	Neil Roberts
	• Report of the MPTS Committee	MPTS Chair
	• Trustees' annual report and accounts	Paul Reynolds / Neil Roberts
	• Fitness to practise statistics report	Anthony Omo
	• Freedom to Speak Up Guardian annual report	Neil Roberts
	• Regulatory reform update [placeholder]	Shaun Gallagher
	• Audit and Risk Committee annual report	Vanessa Davies / Neil Roberts
	• Annual QA update	Push Mangat
Below the line	• Council forward work programme	Carrie MacEwen

Agenda item M8
Council forward work programme

July 2027 – Manchester

	Item	Sponsor
Seminar	• TBC	
Confidential session	• TBC	
Public session	• Chief Executive's report	Charlie Massey
	• Finance update	Neil Roberts
	• Safeguarding annual report	MPTS Chair
	• Report of the Audit and Risk Committee	Vanessa Davies
	• ED&I annual report	Shaun Gallagher
Below the line	• Council forward work programme	Carrie MacEwen