

Council Meeting - 24 February 2022

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Council meeting – 24 February 2022

Agenda item M2

Minutes of the meeting on 9 December 2021

Draft at 17 December 2021

To approve

Minutes of the meeting held on 9 December 2021

Members present – via MS Teams

Carrie MacEwen, Acting Chair

Steve Burnett

Vanessa Davies

Anthony Harnden (from item 6)

Philip Hunt

Paul Knight

Deepa Mann-Kler

Raj Patel

Suzanne Shale

Alison Wright

Others present

Charlie Massey, Chief Executive and Registrar

Shaun Gallagher, Director of Strategy and Policy

Una Lane, Director of Registration and Revalidation

Colin Melville, Medical Director and Director of Education and Standards

Anthony Omo, Director of Fitness to Practise and General Counsel

Paul Reynolds, Director of Strategic Communications and Engagement

Neil Roberts, Director of Resources

Melanie Wilson, Head of Corporate Governance and Council Secretary

Chair's business (agenda item M1)

- 1 The Chair welcomed members, the Senior Management Team (SMT) and observers to the meeting.
- 2 Council noted that apologies had been received from Anthony Harnden for part of the meeting, as he was attending a meeting of the Joint Committee on Vaccination and Immunisation.
- 3 Council noted that since the last meeting members had approved on circulation the appointment of Michael Jennings as a co-opted member of the Investment Committee for an initial period of four years from 17 November 2021.

Minutes of the meeting on 3 November 2021 (agenda item M2)

- 4 Council approved the minutes of the meeting on 3 November 2021 as a true record, subject to the amendment of paragraph 10(a) to read as follows: 'Remote care has been highlighted as a new way of working; public attitudes and experience of it have ranged from positive to extremely negative.'

Chief Executive's Report (agenda item M3)

- 5 Council considered the Chief Executive's Report.
- 6 The Chief Executive and other members of SMT gave oral updates. Council noted that:
 - a Following the emergence of the Omicron variant of COVID-19 and changes to government advice, revised messaging about working from home was being put into place. The impact on operations, particularly the effect on Professional and Linguistic Assessments Board (PLAB) tests of restrictions on travel from particular countries was being assessed.
 - b Conversations with stakeholders at the recent UK Advisory Forum meetings in Scotland, Wales and Northern Ireland had focused on psychological safety and we have listened to concerns from the front line about the fear of making mistakes. This theme has been incorporated into the Acting Chair's message to the profession and the messaging around the State of Medical Education and Practice, due for publication the following week.
 - c The merging of Health Education England (HEE) into NHS England will bring workforce planning into one place, but might also not allow HEE to maintain the same degree of independence of action in relation to withdrawing trainees when there are safety issues. We would continue to make such

decisions where it is the right thing to do, even if we had to act without HEE support.

- d The meeting with the Minister of State for Health, Edward Argar MP, had been very positive, with the Minister emphasising the importance of maintaining international recruitment into the workforce and regulatory reform.
- e With the Chief Executive of the Nursing and Midwifery Council (NMC), we have met Sir Gordon Messenger, who is carrying out a leadership review in health and social care. We will write jointly with the NMC setting out some ideas for the review to consider. Sir Gordon Messenger's review covers similar ground to Sir Stuart Rose's NHS leadership review from 2015, with the potential to address issues for clinicians at the mid-career point moving across into management, such as in relation to pay and pensions.
- f The Department of Health in Northern Ireland has issued a consultation on mandatory COVID-19 and flu vaccination for new recruits to the health and social care workforce to which we will respond in similar terms to the consultation in relation to healthcare workers in England.
- g The Contact Centre had experienced another difficult month in October, with only 33% of calls answered within the 20 second key performance indicator (KPI) target, an average wait time of 3 minutes and 34% of calls being abandoned. A large volume of calls had resulted from doctors getting locked out of their GMC Connect accounts along with the release of 14,500 PLAB places, even when the release of those places had been staggered over the course of one week.
- h The number of calls handled by the Contact Centre in the first ten months of 2021 had been approximately 256,000, an increase of around 20,000 on the same period in 2020, with increases in emails and webchats also experienced.
- i Reaccreditation by the Institute of Customer Service and continuing high levels of customer satisfaction have provided some reassurance about the quality of service.

7 During the discussion Council noted that:

- a Metrics for the operational KPI for the Contact Centre would be reviewed and Council would be updated on the process for reviewing KPIs.

- b The percentage changes set out in the 'Investing in our people' slide of the performance annex would be updated to make it clearer where they refer to percentage point changes in future.

8 Council:

- a Noted the Chief Executive's report and oral updates.
- b Noted the Performance and Corporate Opportunities and Risk Register annexes.

Draft Business Plan and Budget 2022 (agenda item M4)

9 Council received a paper setting out the draft Business Plan and Budget for 2022.

10 Council noted that:

- a The budget includes a greater element of contingency to take into account uncertainty generally and risks around the pension scheme deficit and regulatory reform.
- b The increase in the Annual Retention Fee of 3.1% was based on the September 2021 Consumer Price Index, in accordance with a previous Council decision.
- c To ensure that the free reserves policy reflects changes in the size of the organisation, the paper proposes linking the target range directly to expenditure, expressed in percentage terms, setting a target range of free reserves between 20% and 35% of annual expenditure
- d In the earlier confidential session Council had received an oral update on the impact on the Staff Superannuation Scheme of salary inflation running slightly higher than expected rate. At the 2018 triennial valuation, lower salary growth assumptions were agreed with Trustees of the Scheme, with the GMC making a commitment to cover any additional projected shortfall on this element of the valuation. The Trustees of the Scheme had asked for a payment of £1 million in the current financial year to cover this agreement. The GMC's advisers have agreed that this amount is due, and the payment was being recommended for Council approval.

11 During the discussion Council noted that:

- a To reduce the costs of the annual retention fee for doctors who were not working, options included temporarily relinquishing the licence to practise or the 50% discount scheme if their gross taxable income falls below the threshold, currently £32,000.
- b Work on an equality impact assessment for the new fees framework that will be needed following regulatory reform was getting underway, and that fees framework will require Council approval.
- c The Business Plan and Budget does not receive a lot of external scrutiny, however wider communications will cover how we are focusing our work.
- d Although 'patient involvement and experience' was proposed for removal as a corporate priority after 2021, a task and finish group was in place to embed patient and public involvement into our work.

12 Council:

- a Approved the Business Plan and Budget for 2022.
- b Delegated authority to the Chair of Council to amend the GMC Registration Fees Regulations and GMC Certification Fees Regulations.
- c Updated the reserves policy to set the target range of free reserves between 20% and 35% of annual expenditure.
- d Approved the payment of £1 million to the Trustees of the GMC Staff Superannuation Scheme.

Equality, diversity and inclusion update (agenda item M5)

13 Council received its regular update on equality, diversity and inclusion (ED&I), with a particular focus on progress as an employer to support our ED&I ambitions.

14 Council noted that:

- a All recruitment measures were showing improved performance, including more diverse representation at all stages of the recruitment process.
- b The performance measure on progression showed that staff from underrepresented ethnic groups were now more likely than white staff to progress.

- c There has been some reaction from part of the workforce about the high pace of change and any colleagues who did not feel well informed have been engaged with. However, generally the profile of this work and engagement has been high across the organisation.

15 During the discussion Council noted that:

- a Advice and guidance had been provided to support some individual recruiting managers to ensure that positive action does not cause any concerns about positive discrimination.
- b The dedicated Resourcing Outreach role in the HR function referred to in the paper had not yet been recruited.
- c Issues of intersectionality of protected characteristics would be addressed in the next ED&I update, at Council in February 2022.
- d Work has started on removing the terms BAME and BME from usage to describe Black, Asian and other minority ethnic groups and our internal review will draw on the recent work of the NHS Health and Race Observatory.

16 Council noted progress against our ED&I ambitions.

Post-Brexit routes to registration (agenda item M6)

17 Council received a paper outlining the plans in place to ensure that our international routes to registration are updated and expanded in preparation for the expected end of the EU exit standstill period in December 2022.

18 Council noted that:

- a The programme of work on post-Brexit routes to registration is one of our top three priorities for the coming year, particularly in the wider context of workforce supply.
- b Doctors from the European Economic Area (EEA) have made up 12% of all applications to join the register during 2019 and 2020, and any changes to the trend will be closely monitored.
- c We do not anticipate that any individual EU country will seek a national-level mutual recognition agreement (MRA) for qualifications other than a cross-

border route to registration on the island of Ireland to facilitate ad hoc or emergency cross-border working.

- d Following our loss of access to the European Commission's database to exchange to information with EU regulators, we have continued to share information with overseas regulators but no longer receive information in return. We have alerted the government to the issue, which may have patient safety implications and continue to discuss potential access to data with individual regulators, although there are significant considerations relating to the General Data Protection Regulation.
- e We also make the point to government about the risks associated with being bound to MRAs which could be inconsistent across different countries and what that could mean for patient safety.

19 Council noted:

- a The programme of work for the coming 12 months.
- b The key external dependencies that may impact on delivery of the work.
- c The risks and the next steps in the programme.

Report of the MPTS Committee 2021 (agenda item M7)

20 Council received an update on the work of the Medical Practitioners Tribunal Service (MPTS) since the last report to Council in June 2021.

21 Council noted that:

- a Progress was being made with addressing the accumulation of cases resulting from the pandemic, with 51% more hearing days taking place in September 2021 compared to September 2019 and an increase in capacity in October to allow 17 cases to take place concurrently. Ten additional staff have also been recruited. The plan is to return to pre-pandemic hearing volume levels by the end of 2022.
- b Interim Orders Tribunals (IOT) have all been held virtually since the start of the pandemic. This arrangement has been almost universally well received by those involved and the intention is for IOTs to continue to take place virtually unless there are exceptional circumstances.

- c** Medical Practitioner Tribunal (MPT) hearings have been taking place in a mixture of in-person and virtual formats, with an emphasis on ensuring that no disadvantage results from whichever format is used. In-person MPT hearings have increased to around 60% by November 2021, although the situation is being kept under review.
- d** For virtual hearings, the support of the Doctor Contact Service has been expanded to help lessen the isolation and stress doctors might encounter when attending a hearing, particularly those attending hearings alone or without legal representation
- e** The MPTS have commissioned the GMC's Chief Statistician to analyse the outcomes of in-person and virtual hearings over the two-year period from March 2020 to March 2022.
- f** The MPTS was grateful to the GMC for the support received in addressing the backlog of cases, in terms of both advice and financially.
- g** A significant number of legally qualified chairs (LQC) had left their roles, mostly to take up salaried judicial roles, so an additional 50 LQCs were being recruited.

22 During the discussion Council noted that:

- a** Although most doctors were members of a medical defence organisation (MDO), reasons for doctors representing themselves include not agreeing with their MDO's advice or being ineligible to be represented. The MPTS gives advice to self-represented doctors about pro bono legal services and other free advice.
- b** As a result of the Professional Standards Authority's appeal against the MPT decision to grant voluntary erasure to Michael Watt, the MPTS would not be commenting on the case but will act on any learning points following the outcome.
- c** The MPTS Vision states that the service treats all tribunal service users with respect and fairness, so data in relation to that, including any the GMC collects in relation to the experience of patients and witnesses should be shared with Council.

23 Council noted the report of the MPTS Committee.

Report of the Audit and Risk Committee 2021 (agenda item M8)

- 24** Council received a report summarising the work of the Audit and Risk Committee since it last reported to Council in June 2021.
- 25** Council noted that:
- a** Since the last report to Council membership of the Committee had changed as a result of the sad death of Lara Fielden, the retirement of Liz Butler as a co-opted member and the appointment of Jon Hayes as a co-opted member.
 - b** The Committee was grateful to staff supporting the work of the Committee and for Council members and others who had contributed to the Committee's effectiveness survey.
 - c** Council should feel reassured about the strength of the system of risk management; and the absence of any red assurance ratings among the audit reviews indicate that the GMC is a well-run organisation. Any relevant issues would be signposted to Council when necessary.
 - d** There is an increasing risk of cybersecurity threats.
 - e** Council members are welcome to attend meetings of the Committee.
- 26** During the discussion Council noted that:
- a** Council members would like to see the internal audit programme ahead of being signed off by the Committee.
 - b** The internal audit function has been looked at and there is now a mix of one-off audits and an ongoing advisory approach where appropriate, such as in relation of regulatory reform.
 - c** Audit work has just started on two externally-focused ED&I targets, and risks around the dividing line between positive action and positive discrimination is being kept under review.
- 27** Council:
- a** Noted the report and the assurance provided by the work of the Committee.
 - b** Approved the changes to the Committee's Statement of Purpose.

Report of the Remuneration Committee 2021 (agenda item M9)

- 28** Council received a report summarising the work undertaken by the Remuneration Committee in 2021.
- 29** Council noted that the Committee's work during 2021 included:
- a** An emergency meeting to handle arrangements for Clare Marx stepping down as Chair of the GMC, interim arrangements and planning the appointment process for a new Chair.
 - b** The pay award for the Chief Executive, Directors and Chair of the MPTS.
 - c** Succession planning, including for the Chair of the MPTS, who stands down at the end of 2022.
 - d** The Committee is grateful to Carrie MacEwen for taking on the Acting Chair role and to the Chief Executive and Council Secretary for supporting the Acting Chair during this period.
- 30** Council:
- a** Noted the report.
 - b** Approved the changes to the Committee's Statement of Purpose.

Compliments and complaints report (agenda item M10)

- 31** Council received the twice-yearly report on customer complaints and compliments.
- 32** Council noted that:
- a** There had been 40% fewer complaints than in the previous six-month period.
 - b** Compliments received had been mostly in relation to how helpful the Contact Centre had been.
 - c** In relation to the 64 complaints which featured an element of ED&I or Equality Act issues, we were satisfied in each case that the complainant had been dealt with as their comparator would have been and there was no evidence of discrimination

33 During the discussion Council noted that:

- a** Council would be provided with the percentage split of doctors and patients at the three stages of complaint in future reports
- b** The Corporate Review Team would consider what they can learn from liaison with other regulators in relation to complaints.

34 Council noted the review of customer complaints and compliments.

Any other business (agenda item M11)

35 Council noted that members would next meet at the Regulatory Reform workshop on 11 and 12 January 2022 and the next Council meeting will be on 23 and 24 February 2022.

Council forward work programme 2022 (agenda item M12)

36 Council noted the 2022 work programme.

Report of the GMC Pension Plan Management Board 2021 (agenda item M13)

37 Council welcomed the report on the GMC's defined contribution pension plan as an important update for Council to receive each year.

38 Council noted the Report of the GMC Pension Plan Management Board.

Confirmed:

Carrie MacEwen, Acting Chair

24 February 2022

Action	To note
Purpose	<p>This report outlines developments in our external environment and progress on our strategy since Council last met. Key points to note:</p> <ul style="list-style-type: none"> ■ The increase in COVID-19 cases meant we took the decision to cancel PLAB 2 exams in January and February due to the need for examiners to prioritise their clinical commitments. We have offered places in February to 800 candidates who had already travelled to the UK at the time of cancellation, or who had a job offer or a place in training. ■ We have updated our COVID-19 guidance to decision makers to reassure the profession that we will take the prolonged nature of the pandemic into account if concerns are raised. ■ We submitted a response to the Health and Social Care Select Committee inquiry on workforce, highlighting the importance of compassionate, inclusive cultures and sharing data from <i>The state of medical education and practice</i>, which was published in December 2021.
Decision trail	Council receives this report at each full meeting.
Recommendations	<ul style="list-style-type: none"> a To consider the Chief Executive’s report. b To note the Performance Annex and the Corporate Opportunities and Risk Register.
Annexes	<p>Annex A: Performance Annex Annex B: Corporate Opportunities and Risk Register</p>
Author contacts	<p>Iona Twaddell, Head of the Office of the Chair and Chief Executive</p> <p>Any enquiries to: GovernanceTeamMailbox@gmc-uk.org</p>
Sponsoring director/ Senior Responsible Owner	Charlie Massey, Chief Executive

Pandemic response

PLAB

- 1 In response to the Omicron COVID wave leading to an increasing number of infections and limited availability of medical examiners who needed to prioritise clinical work, Executive Board took the difficult decision in December 2021 to cancel PLAB 2 tests scheduled for January and February 2022. This allowed us to prioritise places in February for candidates who had already travelled to the UK at the time of cancellation, or who had a job offer or a place in training, as we reopened our clinical assessment centre on a limited basis.
- 2 We were able to offer places in February to around 800 of the 2,600 candidates who had a test previously scheduled. We also offered places to around 350 candidates who are already UK residents for tests throughout March, April, May and June. Any candidates that did not meet our priority criteria had the opportunity to secure a place between July and October from the point we announced the cancellations.
- 3 We also worked with the Department of Health and Social Care and UK Visas and Immigration about what exceptional assurance could be provided to allow candidates whose visas were due to expire imminently to complete their test in February. We offered letters of support to those who wanted to apply for a visa extension and for those who are interested in applying for clinical placements while they wait for their test.
- 4 Having increased our PLAB 2 capacity by investing in new facilities and additional staffing last year, we registered over 12,000 doctors from outside of the UK in 2021 alone. We continue to register 250 international medical graduates each week and expect to offer around 15,000 PLAB 2 places this year which is a new record. We are determined to maintain the supply of doctors into the UK and hope to resume normal PLAB 2 capacity in March 2022, providing it is safe and practical to do so.

Supporting the medical profession

- 5 We know that the ongoing pandemic is putting enormous pressure on medical professionals. We are doing what we can to reassure the profession that the context in which they are working will be taken into account if any issues are raised to us.
- 6 On 18 January, we published [updated COVID-19 guidance](#) for our fitness to practise decision makers. We published the guidance earlier in the pandemic to

help ensure they fully take the context of the emergency into account when they are assessing complaints about doctors.

- 7 While the majority of the guidance remains unchanged, we have added new advice to reflect the sustained nature of the pandemic and the enhanced impact this can have on fatigue, the availability of resources and workforce shortages. We stress the importance of considering concerns fairly and proportionately to the circumstances, while protecting patient safety and maintaining standards.
- 8 On 8 December 2021, we also reiterated our [joint statement](#) with other healthcare professional regulators to highlight that we know that registrants will be making difficult decisions around care provision in very challenging circumstances, and that context is understood and will be considered by regulators.

Investigations

- 9 We have taken a flexible and proportionate approach to our investigations during the pandemic but have continued to act when necessary to protect patients or in the public interest. We continue to do all we can to progress our investigations, but we know that some employers and doctors will take longer to assist us (as witnesses or experts or by providing information), given the ongoing pressures on the NHS.
- 10 Pandemic-related delays to third party processes, such as investigations by the police or employers, and proceedings in the criminal or coroner's court, also impact our ability to progress investigations. That means some cases will progress more slowly for the time being and that the age profile of our investigations has increased. We are currently undertaking an external legal review of cases that are over two years old and have not reached a case examiner decision, to consider if they are impacted by an ongoing employer process and whether we should close our investigation until that process has concluded.

Education and training

- 11 We have worked collaboratively with education bodies, royal colleges and faculties through the pandemic to consider flexible changes to medical education and assessment. This approach has been underpinned by our established principles for education, which focus on patient safety and maintaining standards whilst being proportionate.

- 12 We understand that the impact of omicron has been largely felt in the cancellation of electives, and therefore the loss of training opportunities, rather than in active redeployment, but that this has had an effect particularly on top of previous missed training opportunities. The redeployments have been limited, and this raises the hope that some ground can be made up as the wave subsides. We are working with statutory education bodies to understand the scale of the issues and are looking to review derogations as well as considering the case for further changes.

Vaccination as a condition of deployment

- 13 The Government is consulting on revoking the regulations that make vaccination against COVID-19 a condition of deployment for health and social care workers in England, based on the latest emerging evidence. We have reviewed and updated our advice for doctors on vaccinations accordingly. The Secretary of State for Health and Social Care, Sajid Javid, wrote to professional regulators asking us to work with professional leaders in the United Kingdom and devolved governments to ensure that our current guidance on vaccination, and particularly vaccination for Covid, sends a clear message to registrants about their personal professional responsibilities in this regard.
- 14 Our position remains that doctors have a professional duty to protect patients from risks posed by their health, and to be immunised against common serious communicable diseases, unless contraindicated. We have released a joint statement with the Academy of Medical Royal Colleges to highlight this. We have also emphasised that being a good doctor means more than simply being a good clinician. Doctors can provide leadership to their colleagues and vision for the organisations in which they work and for the profession as a whole. Whether or not vaccination is required as a condition of deployment, it continues to be one of the most effective ways to protect patients, staff and the health service itself.

Offices

- 15 As of 27 January 2022, colleagues in our Manchester and London offices can return to working in the office on a voluntary basis. We have maintained our safety measures, so colleagues are asked to wear a face covering when not at their desk and to maintain social distancing of 1m+. Arrangements vary across the four countries of the UK, so we are working with our National Offices on arrangements for offices in Scotland, Wales and Northern Ireland. We are continuing to engage with colleagues on our longer-term approach, which we expect to implement after Easter.

Regulatory reform

- 16 We continue to liaise with DHSC on the drafting of the new legislation and are working through policy issues across a range of areas. We are hoping to see a full and settled draft this spring. The timetable remains under review and we will keep Council updated.

State of medical education and practice 2021

- 17 [*The state of medical education and practice 2021 report*](#) was published on 15 December 2021. The report looks at how the pandemic and the recovery of services are affecting doctors' working environments and medical practice. It explores the experiences of those undertaking and delivering postgraduate training and the factors influencing the shape of the medical workforce. The final chapter focuses on learnings that we hope the UK health services can use in their work to support doctors and patient care.
- 18 The report highlighted that the pandemic has had the effect of pressing 'fast-forward' on what was already a precarious situation for healthcare staff. Doctors have continued to perform with distinction, but the research paints a worrying picture of rising burnout and growing workloads. The report emphasised the importance of a renewed focus on ensuring workplaces in our health services are inclusive and compassionate, particularly during such a challenging time.

A sustainable medical workforce

- 19 In January, we submitted evidence to the Health and Social Care Select Committee inquiry on workforce. Our evidence highlighted the importance of making the health services a better place to work for all staff, culture and leadership and that retention for the workforce is a priority for employers. We also noted the importance of addressing the disparate experience of ethnic minority doctors and that employers will need to plan to make the best use of newly regulated professions such as physicians associates and anaesthesia associates.
- 20 In December 2021, we also submitted evidence to the Health and Social Care Select Committee's inquiry into the Future of General Practice. Our evidence highlighted the findings from *The state of medical education and practice*, which showed higher burnout levels for GPs. We also emphasised the importance of compassionate, inclusive working environments and leadership, as well as the importance of considering how best to incorporate physician associates into the GP workforce.

Legislation

- 21 The Health and Care Bill is now passing through the House of Lords. We provided medically qualified peers and those interested in our work with a briefing note ahead of the Second Reading, with a further detailed briefing on key amendments during the Committee Stage. We focussed on a probing amendment around the provisions on the new Secretary of State powers to remove a profession from regulation and abolish regulators, amendments proposing the creation of a separate register for cosmetic surgery and on proposals for the GMC to hold the conflict of interests register. The Minister, Lord Kamall, did not accept the amendments on a separate register and reaffirmed the government's commitment to regulatory reform and the importance of consultation before making changes to the regulatory landscape. In responding to the cosmetic surgery register amendment, the Minister acknowledged the work of the GMC in developing credentials in this area.
- 22 Following our engagement with Peers, the Minister and Home Office officials, we were successful in securing changes to the Police, Crime, Sentencing and Courts Bill. The Government acknowledged our concerns about the impact of the Serious Violence Duty provisions within the Bill on patient confidentiality and brought forward amendments to protect this.
- 23 The Professional Qualifications Bill continues through the House of Commons. We secured a series of amendments to the Bill in the Lords that reaffirm the autonomy of regulators over their registers and commit to consultation with regulators before any secondary legislation is proposed, and acknowledgement of the importance of engaging with regulators on the negotiation of trade agreements. We briefed MPs on the amended Bill and provided written evidence to the public bill committee in the Commons.

Inquiries and reviews

Maternity inquiries

- 24 We continue to engage with a number of inquiries into maternity care failings. These include the Independent Investigation into East Kent Maternity Services which we are giving evidence to in interview form this Spring. We have been engaging with the Ockenden review into maternity services at Shrewsbury and Telford Hospital NHS Trust, but due to issues with their information governance arrangements were unable to disclose the information we had compiled. We understand that the review intends to publish its report in the coming weeks without this information.

Inquiry publications

- 25 We await the publication of the Independent Neurology Inquiry in Northern Ireland. This has been reviewing the circumstances surrounding the Belfast Health and Social Care Trust's recall of neurology patients following concerns about the clinical practice of Michael Watt, with a focus on local clinical governance processes and complaints handling. We anticipate recommendations for the GMC and will brief Council about this inquiry and any recommendations for us in advance of publication.
- 26 The Independent review into West Suffolk Hospital NHS Foundation Trust published its report on 9 December 2021, which contained an advisory recommendation for the GMC.

Key implementation activity

- 27 We continue to support DHSC with the implementation of the Paterson Inquiry's recommendations following the recent publication of their full response.
- 28 We continue to engage with DHSC on the implementation of Recommendation 8 of The Independent Medicines and Medical Devices Safety Review on conflicts of interest and will shortly be joining two recently established DHSC working groups to discuss how an employer-led approach should be implemented and monitored across all four countries.

Operational performance

- 29 The report at annex A details performance against our KPIs and the rationalised set of priorities, agreed in the Business Plan approved by Council in December 2021. Uncertainty over legislative timeframes is the primary driver of exceptions in our change priorities. This year there have been no changes to our KPIs but going forward it is our intention to routinely review our performance measures at the same point Council approve the business plan.
- 30 Our missed service target for the Contact Centre in November and December last year was driven in part due to the decision to cancel PLAB 2 for January and February, which led to an increase in call volumes during a period of sickness absence and annual leave. Annex A now includes additional data on Contact Centre timeliness, including the average call wait time and abandonment rate. In addition, the Corporate Opportunities and Risk Register, at Annex B, includes a new risk (threat) on safeguarding as escalated to the January Audit and Risk Committee meeting.

Executive Board

- 31** The Executive Board met on 20 December 2021 and 31 January 2022 to consider items on:
- a** The regular Performance and Risk Report, providing a high-level report on performance, including finance and people, customer service and learning, and updates on the key risks to achieving our strategic aims.
 - b** A deep dive on risks relating the Medical Practitioners Tribunal Service (MPTS) to consider the extent to which individual board members are confident that the management of MPTS-level risks provide sufficient assurance to the Board collectively.
 - c** The cancellation of scheduled PLAB 2 tests in January and February 2022 in response to the impact of increasing numbers of cases of the Omicron variant of COVID-19, with UK-based candidates and those with jobs prioritised for the restart.
 - d** The approach for applying the 2022 pay award.
 - e** Progress on the review of *Good medical practice*, ahead of the update given to Council at this meeting.
 - f** The outcome of scoping work and next steps for the sex, gender and gender identity project, ahead of Council receiving an update, now scheduled for the June 2022 meeting.
 - g** The draft Executive Board report to Council, ahead of consideration by Council at this meeting.

M3 – Annex A Performance annex

Data presented as at 31 December 2021 (unless otherwise stated)

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

Indicator		Nov	Dec	Exception commentary
Operations	Decision on 95% of all registration applications within 3 months	96%	96%	<p>Finance The finance KPI is red as the cumulative variance between income and expenditure is 2.65%. Income is under budget due holding fewer PLAB 2 days than planned & also the cancellation of some PLAB 1 places in May. Expenditure is under budget as the variable costs linked to PLAB 2 days have been removed, we expect fewer hearing days and associated legal costs then budgeted, there is lower activity than planned in a number of areas, including staff expenses, as a result of additional lockdown restrictions and there is a higher level of vacancies now forecast than assumed in budget.</p> <p>Staff Turnover Staff turnover has been progressively increasing over the past 11 consecutive months. While it is in the bounds of what we would expect, continued increases may potentially create issues for us.</p>
	Decision on 95% of all revalidation recommendations within 5 working days	98%	98%	
	Respond to 90% of ethical/standards enquiries within 15 working days	100%	97.5%	
	Conclude 90% of fitness to practise cases within 12 months	93%	92%	
	Conclude or refer 90% of cases at investigation stage within 6 months	95%	96%	
	Conclude or refer 95% of cases at the investigation stage within 12 months	95%	95%	
	Commence 100% of Investigation Committee hearings within 2 months of referral	No cases	100%	
	Commence 100% of Interim Order Tribunal hearings within 3 weeks of referral	100%	100%	
Organisation	2019/20 Income and expenditure [% variance +/- 2%]	2.5%	2.65%	
	Rolling twelve month staff turnover within 8-15%	7.9%	8.2%	
	IS system availability (%) – target 98.8%	99.6%	100%	
	Monthly media score	162	115	

Performance Indicators – Making every interaction matter

2021

Indicator		Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
Contact centre operations	Answer 80% of calls within 20 seconds (KPI)	57%	83%	80%	89%	83%	78%	68%	71%	48%	33%	57%	60%
	Answer 90% of emails and letters (enquiries and updates) within 4 working days	82%	89%	96%	97%	92%	87%	80%	84%	59%	50%	53%	91%
	Average wait time (calls – seconds)	87	19	26	17	21	34	44	57	96	221	61	73
	Abandonment rate	14%	3%	5%	3%	3%	5%	6%	9%	15%	34%	9%	11%
<p>The KPI to answer 80% of calls within 20 seconds has now been missed since June 2021. In November and December we answered 57% and 60% of calls within 20 seconds. The miss in December was contributed to by our decision to cancel PLAB 2 for January and February, which led to an increase in call volumes. This had a particular impact given sickness absence (in part due to Covid-19) and because of planned annual leave over the Christmas period. On a positive note, we managed to meet our KPI for responding to emails and letters through a combination of overtime and colleagues in the CAC team handling the majority of PLAB 2 related correspondence. Abandonment rates fluctuated throughout the month, rising when volumes increased after PLAB communications went out, but averaged at a total of 11% in December.</p> <p>The performance challenges being experienced reflect a series of one-off events that drive significant contacts (systems upgrade, PLAB 1 release, PLAB 2 cancellations, temporary emergency registration communications) which compounds pressures from an underlying higher volume of activity across all channels.</p> <ul style="list-style-type: none"> • Calls <ul style="list-style-type: none"> • In 2021 we took c.184,000 calls compared to 161,000 in 2020 reflecting a 15% increase year on year. • For October-December we received 48,000 calls compared to 38,000 for the same period in 2020 (a 26% increase). • Correspondence <ul style="list-style-type: none"> • In 2021 we answered 131,000 emails and letters compared to 119,000 in 2020 reflecting a 10% increase year on year. • For October-December we processed 32,000 emails and letters compared to 23,000 in the same period of 2020 (a 39% increase) • Web messaging <ul style="list-style-type: none"> • In 2021 we dealt with 65,000 webchats, compared to 51,000 in 2020. For October-December webchat volumes decreased and are not comparable because we made the decision to turn this channel off for extended periods so we could focus on other channels. <p>The categorisation of queries show high volumes of contacts from International Medical Graduates, GMC Online based issues, and Fees queries, as well as questions about PLAB. In light of increasing volumes, a bid has been put forward to the February planning gateway for additional resource to give the team more resilience, and the capacity to engage in ongoing training and development.</p>													

Operational Key Performance Indicator (KPI) – 12 month performance summary 2021

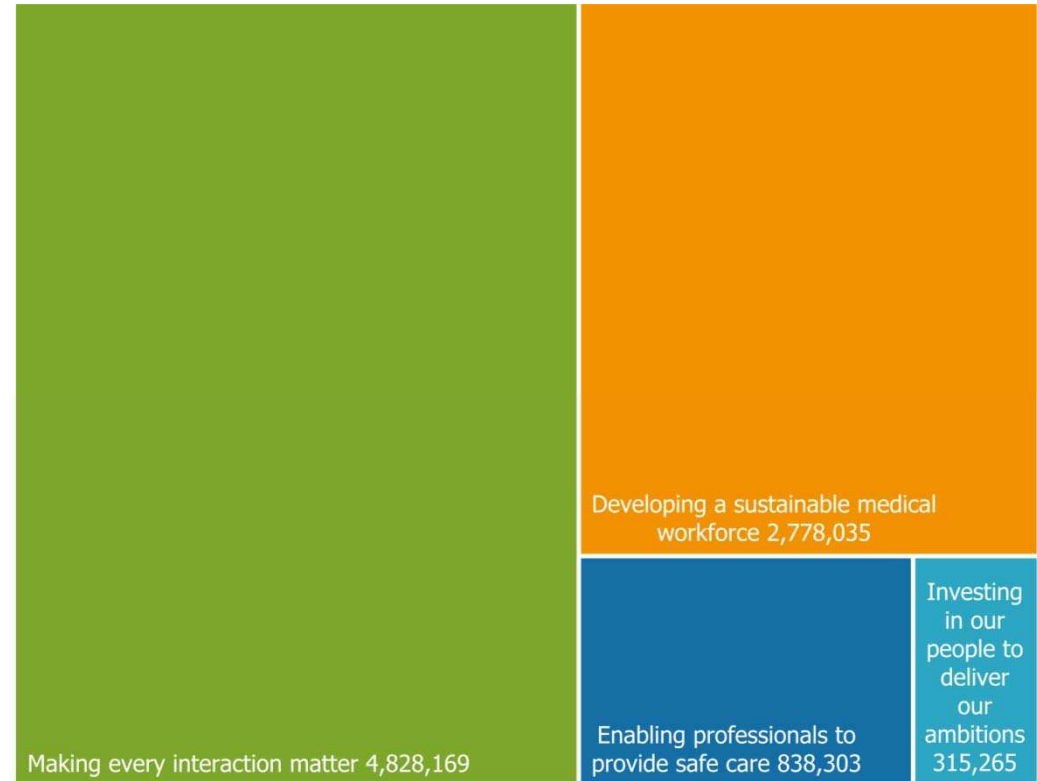
Indicator		Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
Operations	Decision on 95% of all registration applications within 3 months	97%	97%	92%	98%	99%	99%	98%	97%	97%	96%	96%	96%
	Decision on 95% of all revalidation recommendations within 5 working days	99%	100%	99%	98%	98%	97%	99%	98%	98%	98%	98%	98%
	Respond to 90% of ethical/standards enquiries within 15 working days	98.7%	98.3	96.5%	97.7%	100%	100%	96.1%	100%	94%	100%	100%	97.5%
	Conclude 90% of fitness to practise cases within 12 months	91%	89%	93%	89%	92%	93%	92%	90%	91%	95%	93%	92%
	Conclude or refer 90% of cases at investigation stage within 6 months	95%	94%	91%	95%	95%	96%	96%	95%	93%	95%	95%	96%
	Conclude or refer 95% of cases at the investigation stage within 12 months	95%	92%	96%	93%	95%	95%	94%	93%	95%	97%	95%	95%
	Commence 100% of Investigation Committee hearings within 2 months of referral	100%	No cases	No cases	No cases	100%	No cases	100%	No cases	100%	100%	No cases	100%
	Commence 100% of Interim Order Tribunal hearings within 3 weeks of referral	100%	100%	100%	100%	92%	100%	100%	100%	100%	100%	100%	100%
Organisation	2019/20 Income and expenditure [% variance +/- 2%]	4.81%	3.53%	4.40%	4.03%	3.16%	2.78%	2.63%	3.81%	2.76%	2.80%	2.5%	2.65%
	Rolling twelve month staff turnover within 8-15%	3.3%	3.6%	4%	4.5%	4.6%	5.2%	6.2%	6.8%	6.8%	7.5%	7.9%	8.2%
	IS system availability (%) – target 98.8%	99%	99.97%	99.99%	99.98%	100%	100%	99.97%	99.99%	99.91%	99.45%	99.6%	100%
	Monthly media score	217	282	1963	43	175	-152	757	182	544	1016	162	115
Answer 80% of calls within 20 seconds	57%	83%	80%	89%	83%	78%	68%	71%	48%	33%	57%	60%	

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

Our strategy



Business Plan Priorities



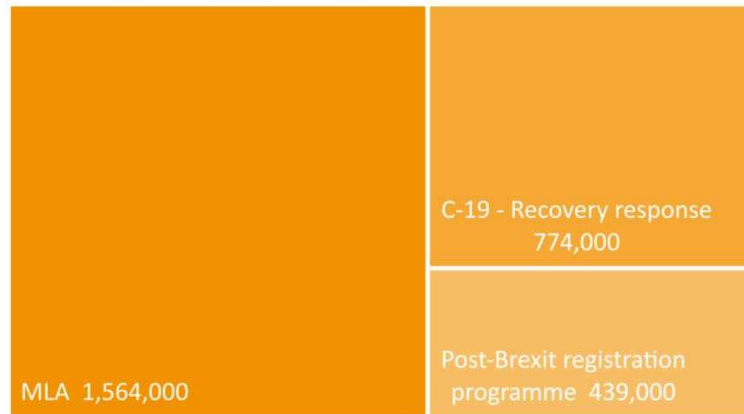
These estimates include the immediate-project team time cost to deliver against our key priorities. This helps us to better quantify the relative size of our commitments and inform prioritisation decisions against their expected impact.

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

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



Developing a Sustainable Workforce



Enabling professionals to provide safe care



Making every interaction matter



Investing in our people





Enabling professionals to provide safe care

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

2021-23 Priority activities		Status
Review of Good medical practice	<p>Why: Want to make sure our standards for professions we regulate reflect current patient and public expectations – and that our approach to embedding those with the profession maximises their relevance and application to care.</p> <p>When: Complete by Q3 2023 Who: Colin Melville; Mark Swindells</p>	<p>We are finalising a draft version of the guidance to submit to consultation, as well as finalising the consultation narrative and questions for the main survey. A separate Council agenda item refers.</p>
Fairer Employer referrals	<p>Why? To eliminate differentials in employer fitness to practise referrals</p> <p>When: by 2026 Who: Anthony Omo</p>	<p>RO referral form changes have now been implemented. Outreach met with approximately 90% of the designated bodies identified as having referral data indicating disproportionality. Work continues to develop feedback mechanisms with Responsible Officers on triage and Case Examiner decision outcomes.</p> <p>To support the delivery of the NHS England People Plan workstream titled 'Tackling the disciplinary gap', work underway with NHS Resolution to draft a shared narrative. Narrative reviewed by Comms colleagues in Jan 2022.</p> <p>Work to review how we deal with employer referrals and development of training to assist Assistant Registrars to counteract bias is underway. Training to be delivered Q1 2022.</p>
Fairer training cultures	<p>Why? To deliver on our commitment to eliminate discrimination, disadvantage and unfairness for all index measures of fair medical education and training pathways.</p> <p>When: September 2031 Who: Colin Melville</p>	<p>We have now published a breakdown of the trainer population by demographic characteristics within the SOMEPE data tables. This will assist Deaneries develop their Action Plans. Quantitative evaluation of the psychiatry exam interventions continues to indicate positive results for those attending, and suggests potential for reducing differential attainment. Funding has been agreed for three of these courses to run in 2022, to confirm findings and provide Edge Hill university with data for the qualitative analysis. We have agreed with the AoMRC to run a joint workshop for colleges in spring. Engagement meetings have been held with the Royal College of Surgeons England (Development of a college action plan to address attainment gap), Royal College of Psychiatry (Review of Curricula Programme of Assessment in the context of FTC), the HEE Y&H EDI Lead (Recruitment and Selection), and the UKFPO Directors Forum to present an overview of this work.</p>



Developing a sustainable medical workforce

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

2021-23 Priority activities		Status
Introducing the medical licensing assessment	<p>Why? Want to give patients greater confidence that they will receive a consistent level of core knowledge, skills and behaviours from any doctor practising in the UK. UK medical schools will deliver the Assessment embedded within final exams for a UK medical degree, overseen and regulated by us, and we will administer the assessment for IMG doctors.</p> <p>When: Q4 2025 Who: Colin Melville; Judith Chrystie</p>	<p>Discussions with medical schools and the Medical School Council (MSC) are ongoing, subject to directions, of a proposal for a university-led applied knowledge tests (AKT). Work has begun on monitoring Council’s directions, and regular meetings of the joint oversight group required by Council have started. Engagement is now moving into the details of the piloting stage, and how medical schools will demonstrate that they can meet the GMC’s requirements for compliant AKTs and clinical and professionals skills assessments (CPSAs).</p> <p>The programme is currently on track against agreed plans, but anticipates a resource gap over the next few months due to vacancies and recruitment lead times. The complex task of assuring that all AKTs and CPSAs meet the GMC’s standards and requirements has begun. Intensive and useful CPSA engagement sessions are underway, which begin the formal process for assessing schools’ CPSAs are compliant.</p>
Post-Brexit registration pathways	<p>Why? To ensure we have efficient and effective routes for skilled professionals to gain registration and maximise the number of skilled doctors available to the UK medical workforce. To start, we will expand our Clinical Assessment capacity for international medical graduates to respond to Covid and manage the UKs post-Brexit registration approach for EU professionals.</p> <p>When: Q4 2022 Who: Una Lane; Kirstyn Shaw</p>	<p>The overall status is amber.</p> <p>There remains a high degree of uncertainty about the timeframes for delivery and we remain in close dialogue with DHSC.</p> <p>DHSC have confirmed their plan that the PMET Order amendments will not be included in the end of standstill s60, and instead will be progressed as a standalone rules change. This means it won't be included in DHSC's Brexit consultation, and instead will require us to engage with stakeholders to feed into an explanatory memorandum. We are updating our engagement plans accordingly. They are also exploring whether the legislative changes needed for the EFTA trade deal and cross border solution on the island of Ireland will also be separated from the end of standstill s60, as well as what the review by the Secretary of State (currently specified in the Medical Act) may entail. The board agreed to pause the MRA framework project following the Professional Qualifications Bill progressing through the House of Lords. The wording of the Bill means that it is now unlikely that we will be given powers to develop MRAs in the short term.</p>



Making every interaction matter

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

2021-23 Priority activities	Status
<p>Regulatory Reform and MAPs</p> <p>Why? To improve the design and delivery of our functions so that we can be more responsive to the changing needs and expectations of patients, the health system, and the professions. To expand the medical workforce and the contribution by our professionals to quality patient care, while continuing to safeguard patients. We will deliver equivalent statutory functions across MAPs and doctors.</p> <p>When: Changes for MAPs to come into effect summer 2023, remaining changes to be implemented by Q4 2024.</p> <p>Who: Shaun Gallagher; Tim Aldrich for Regulatory Reform; Una Lane; Clare Barton For MAPs.</p>	<p>The overall status is amber.</p> <p>We continue to meet regularly with DHSC to review the timetable, but are yet to see a full and settled draft of the new legislation and have concerns that we will not see this by end of January (which is the deadline we are currently working to). There is also a risk that Covid 19 may affect the current timetable, either because staff are off unwell, or because DHSC prioritise their resource to support their pandemic response. We have a meeting with DHSC on 19 Jan to discuss unresolved policy issues and we will be holding a stock take meeting in February to review the feasibility of current milestones.</p> <p>MAPs is amber to reflect uncertainty over the timescale and the need for additional funding from DHSC. We have updated our programme plans for the revised delivery date of Summer 2023, but current progress with legislative drafting suggests this may be ambitious. We have submitted revised financial requirements to DHSC including a significant increase in the budget for 2022/23: in addition to incurring project costs for longer, we will receive no fee income in this year as had originally been forecast. We await a response from DHSC on this.</p>
<p>Regulatory Fairness</p> <p>Why? We are focussed on making fairness central to our work and we’re reviewing the fairness and transparency of high-stakes decision we make</p> <p>When: September 2022 Who: Shaun Gallagher</p>	<p>The overall status is amber.</p> <p>The procurement process for the expert review of our fairness audit approach (the assurance stocktake) did not attract any appointable suppliers. We are seeking feedback from prospective suppliers to understand why they did not tender for the work and based on that feedback will revisit our approach. Unlike other activity in the review, this has few consequent dependencies so the impact is primarily to timelines for end-delivery but this is a set-back in our preferred timeframes for learning and improving our approach.</p> <p>The remainder of the work is being delivered to schedule. The first Regulatory Fairness Review Board took place on 13 December. Both the cross-directorate high-stakes decision controls framework group and the data publication working group convened for the first time in December. We continue to deliver learning needs analysis workshops with the aim of completion in Q2 2022. The Review and ED&I team have agreed that there is a requirement for a service delivery equality policy and this is now in development with an aim to be reviewed by the Regulatory Fairness Review Board by Q2 2022.</p>



Investing in our people to deliver our ambitions

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

2021-23 Priority activities	Status
<p data-bbox="107 678 302 742">Investing in our People</p> <p data-bbox="389 518 1048 837">Why? To ensure our approach as an organisation to leadership, support and ongoing improvement attracts and retains the right people to meet our ambitions - we will strive for Gold accreditation from Investors in People. To treat our people fairly and model the commitment we ask of the health service – that diverse and inclusive environments support better outcomes for all - we will achieve maturity against the TIDE framework. When: Q2 2023 Who: Neil Roberts; Andrew Bratt.</p>	<p data-bbox="1086 462 2128 646">We have maintained the silver level of IIP accreditation overall, and also gained a silver IIP wellbeing accreditation for the first time. We have made significant progress towards Gold across all areas of the standard. In 2018 we had 2 themes at Bronze, 23 Silver and 2 Gold, whereas in 2021 we have 15 themes at Silver and 12 at Gold. Our focus for 2022-4 will be on continuing to embed our people management policies and procedures across the organisation to ensure further consistency.</p> <p data-bbox="1086 670 2128 853">We have now launched our new inclusion programmes for GMC colleagues. Approx. 430 GMC leaders will complete the Fostering Inclusion programme which consists of six modules that will be completed over 12 months. Our Professional Behaviours e-learning will be completed by all GMC colleagues. Our Developing Diverse Talent and Leadership programmes are available to all colleagues from ethnic groups underrepresented in our leadership roles.</p>

*All projects reporting green unless stated



Investing in our people to deliver our ambitions

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

Underlying measures and targets		Actual				Target		
		2020 (%)	2020 (Vol)	2021 (%)	2021 (Vol)	2023	% points off target	2026
Increase the level of BME representation at Level 3 and above	Applications	22.8%	170	32.1	253	27%	+5.1%	30%
	Interviews	15.2%	118	22.4	60	22%	+0.4%	25%
	Offers	14.6%	36	32.1	16	17%	+15.1%	20%
	Workforce	11.1%	64	13.3	77	16%	-2.7%	20%
level of BME representation at Level 2+		8%	18	10.8	23	14%	-3.2%	20%
level of BME representation at level 3		12%	46	14.3	54	16%	-1.7%	20%
Increase the level of BME representation at all levels	Applications	29.4%	663	40.0	1332	37%	+3%	40%
	Interviews	18.2%	118	27.4	260	32%	-4.6%	35%
	Offers	18.2%	36	30.2	88	27%	+3.2%	30%
	Workforce	14.3%	211	16.0	247	17%	-1%	20%
Reduce differential turnover rates for BME staff compared to the average to improve retention and for rates to be within 1-2% of each other by end of 2023**		0.8%	-	BME (%)	Non-BME (%)	1-2%	0.4%	1.0%
				8.2	7.8			
Proportion of BME staff receiving promotion and grade progression is proportionate to our workforce at the relevant grade/level*		-1%	-	BME (%)	Non-BME (%)	18%	3.4%	18%
				17.7	14.3			
Pay differentials within a confined band limited to 2% from 2023 ¹ (table shows the proportion of bands that are outside of the tolerance)		50.0%	6/12	41.7%	5/12	2.0%	N/A	2.0%

¹ specialist bands are not included

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

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

Data covers the period 1 Jan - 31 Dec 2021

Financial summary (December 2021)

Financial summary as at Dec 2021	Budget 2021	Forecast 2021	Actual 2021	Variance Budget to Actual	
	£000	£000	£000	£000	%
Operational expenditure	118,897	109,499	109,481	9,416	8%
New initiatives fund	1,056	0	0	1,056	0%
Pension top up payment	1,300	2,300	2,300	(1,000)	0%
Capital expenditure	8,438	8,563	7,684	754	9%
Total expenditure	129,691	120,362	119,465	10,226	8%
Operational income	126,102	119,582	119,460	(6,642)	(5)%
Operational surplus/(deficit)	(3,589)	(780)	(5)	3,584	

Financial summary as at Dec 2021`	Budget 2021	Forecast 2021	Actual 2021	Variance Budget to Actual	
	£000	£000	£000	£000	%
Investment income	2,282	4,080	4,879	2,597	114%
Total surplus/ (deficit)	(1,307)	3,300	4,874	6,181	

Financial detail (December 2021)

Expenditure as at Dec 2021	Budget 2021	Forecast 2021	Actual 2021	Variance budget to actual	
	£000	£000	£000	£000	%
Staff costs	73,880	72,850	72,765	1,115	2%
Staff support costs	3,489	2,468	2,378	1,111	32%
Office supplies	1,740	707	679	1,061	61%
IT & telecoms costs	4,531	4,501	4,533	(2)	(0)%
Accommodation costs	7,745	7,049	6,941	804	10%
Legal costs	4,344	4,226	4,278	66	2%
Professional fees	3,037	3,389	3,480	(443)	(15)%
Council & members costs	384	366	359	25	7%
Panel & assessment costs	18,465	13,197	13,225	5,240	28%
PSA Levy	858	843	843	15	2%
Under/over-achievement of efficiency savings	424	(97)	0	424	0%
Operational expenditure	118,897	109,499	109,481	9,416	8%
New initiatives fund	1,056	0	0	1,056	0%
Pension top up payment	1,300	2,300	2,300	(1,000)	0%
Capital expenditure	8,438	8,563	7,684	754	9%
Total expenditure	129,691	120,362	119,465	10,226	8%

Income as at Dec 2021	Budget 2021	Forecast 2021	Actual 2021	Variance budget to actual	
	£000	£000	£000	£000	%
Annual retention fees	99,258	99,383	99,316	58	0%
Registration fees	5,667	5,179	5,132	(535)	(9)%
PLAB fees	16,584	10,447	10,388	(6,196)	(37)%
Specialist application CCT fees	2,755	2,934	2,948	193	7%
Specialist application CESR/CEGPR fees	1,216	1,086	1,134	(82)	(7)%
Interest income	78	81	84	6	8%
Other income	544	472	458	(86)	(16)%
Total Operational Income	126,102	119,582	119,460	(6,642)	(5)%

GMCSI summary (December 2021)

GMCSI summary as at Dec 2021	Budget 2021	Forecast 2021	Actual 2021	Variance budget to actual	
	£000	£000	£000	£000	%
GMCSI income	388	230	239	(149)	(38)%
GMCSI expenditure	384	238	246	138	36%
Profit/(loss)	4	(8)	(7)	(11)	

Investment Committee Update

1) The Investment mandate, approved by Council, given to our Investment managers CCLA

- * Our objective is to protect against the erosion of capital by inflation
- * Our target annual return is CPI plus 2% measured over 5 year rolling periods.
- * Our benchmark for assessing performance is based on 25% Global Equities/65% Gilts/10% property
- * Ethical exclusions where companies are excluded if greater than 10% of Turnover for Tobacco/Alcohol/Gambling/Pornography/High Interest rate lending/Cluster munitions and landmines/Extraction of thermal coal

2) Holdings as at 31 December 2021

	£millions	%
Total Equities	21.9	35.5%
Fixed Interest	9.6	15.6%
Property	4.0	6.5%
Infrastructure	3.2	5.2%
Other Income	2.0	3.2%
Private Equity	1.1	1.8%
Cash	19.9	32.3%
Total	61.7	100.0%

2) History of portfolio valuation



3) Performance Overall

The following sets out the investment returns achieved by our chosen Investment managers compared to the target

As at 31 December	Performance Period		
	3 Months	12 Months	3 Years (p.a)
Our Actual Portfolio	3.55%	8.59%	7.86%
Target: CPI + 2%	2.90%	7.40%	4.43%
Actual minus Target Performance	0.65%	1.19%	3.43%

Conclusion: Our managers have exceed target by 1.19% over the last year and an average of 3.43% p.a over each of the last 3 years.

The latest valuation at 21 January 2022 is a total fund value of £60.0m

Legal summary (as at 17 January 2021)

The table below provides a summary of appeals and judicial reviews as at 17 January 2022:

	Open cases carried forward since last report	New cases	Concluded cases	Outstanding cases
s.40 (Practitioner) Appeals	17	2	5	14
s.40A (GMC) Appeals	1	10	0	11
PSA Appeals	0	1	0	1
Judicial Reviews	0	3	0	3
IOT Challenges	3	3	2	4

Explanation of concluded cases	s.40 (Practitioner) Appeals	<ul style="list-style-type: none"> a. 3 GMC successful – b. 3 appeals dismissed c. 1 GMC unsuccessful – appeal allowed by consent
	s.40A (GMC) Appeals	
	Judicial Reviews	
New referrals by PSA to the High Court under Section 29 since the last report with explanation, and any applications outstanding	PSA Appeals	There has been one new referral by PSA to the High Court under Section 29 since the last report, and zero concluded.
Any new applications in the High Court challenging the imposition of interim orders since the last report with explanation; and total number of applications outstanding	IOT challenges	There have been three new applications in the High Court challenging the imposition of interim orders since the last report, and two concluded (one claim was withdrawn and one where the order was terminated – GMC unsuccessful), therefore four challenges outstanding.
Any other litigation of particular note	We continue to deal with a range of other litigation, including cases before the Employment Tribunal, the Employment Appeals Tribunal and the Court of Appeal.	

Council meeting – 24 February 2022

Agenda item M3

Chief Executive's Report

Corporate Opportunities and Risk Register

**General
Medical
Council**

Annex B

Corporate Opportunities & Risk Register - January 2022

id	Threat / Opportunity	Title	Category	Detail	Owner	Without - Inherent Impact - Inherent Rating - Inherent	Mitigation/ Enhancement	With - Residual Impact - Residual Rating - Residual	Council and/ or Board Assurance	Further Assurance	Further Action Detail	Risk Appetite
148	Operational Threat	Delivery of statutory functions	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	<ul style="list-style-type: none"> Monitoring and reporting against statutory delivery to Executive Board and Council Forecasting of operational demand is built into budget planning Active engagement with doctors about potential situations which may put patients at risk Outreach structure in place (ensures statutory process for responsible officers to continue effectively) to help identify and manage concerns (pre-investigation) Available staff with relevant training and skills Information exchange with competent authorities informs our processes Documented operational process and procedures, that are subject to regular review and continuous improvement by specialist staff Auditing our decisions on a regular basis GMC SMT oversight of pandemic response and recovery planning Following the cancellation of PLAB 2 exams in January and February 2022 we have worked with affected candidates and their representative organisations to secure them new places. Over 1,000 candidates have already rebooked their places for later in the year, and we have prioritised candidates already in the UK or with job offers for the limited PLAB 2 sittings now scheduled for February 	QUITE LIKELY MODERATE SIGNIFICANT	<ul style="list-style-type: none"> Council Review of performance metrics through the quarterly CEO report Executive Board Review of performance metrics through the bi-monthly Performance and Risk Report Risk deep dive (November 2020) 	<ul style="list-style-type: none"> Internal Audit Recovery and renewal (November 2021, green-amber) FTP Covid-19 Response (Aug 2021, green-amber) Quality Control Audit CE IOT decisions (Aug 2021) Quality Control Audit CE Rule 8 decisions (July 2021) Review of progress in implementing Outreach (May 2021, green-amber) Quality Control Audit Triage decisions (April 2021) Education Quality Assurance (February 2021, green) Curricula approvals (January 2021, green-amber) Virtual hearings (September 2020, green) Temporary registration (September 2020, green) Interim Order Tribunals (January 2020, green-amber) Standards and Ethics (September 021, green-amber)2019, green-amber) Interim Order Review on Papers (May 2019, green-amber) Voluntary and admin erasure (May 2019, green-amber) <p>Other assurance</p> <ul style="list-style-type: none"> Annual PSA Performance review (2020/21) Covid learning reviews (GMC Case Studies): How the regulator responded to emerging evidence of higher prevalence of Covid-19 infection in BAME people; Temporary registration implementation: The impact of the pandemic on the regulator's corporate strategy/the impact of the strategy on the regulator's response (December 2020) 	<ul style="list-style-type: none"> Continue to engage with the Professional Standards Authority and other regulatory partners, coordinating the Covid-19 response and reviewing our approach as the situation evolves Well consider and triage all new concerns, progressing those requiring investigation The MPTS continues to meet our service level agreement to commence 100% of new interim referrals within 21 days The MPTS continues to hear reviews of all MPT sanctions and IOT orders within statutory deadlines Continuing to work closely with our supplier on implementing digital ID checks for doctors Despite the cancellation of PLAB 2 exams in January and February, we still plan to make 15,000 PLAB 2 places available in 2022 using all three of our assessment circuits and examining regularly at weekends 	Low
120	Operational Threat	ED&I compliance	Strategic / Policy	The assurance we can evidence that our regulatory decision-making is fair is not persuasive to key stakeholders and weakens confidence in regulation	Shaun Gallagher	QUITE LIKELY MAJOR CRITICAL	<ul style="list-style-type: none"> Equality, Diversity and Inclusion (ED&I) objectives published within the corporate strategy and supported by focused targets based on evidence and routine monitoring and reporting of progress Supporting governance including the Strategic EDI Advisory Forum (external) and ED&I Steering Group (internal) provides senior oversight and guidance to inform action and priorities Skilled ED&I team to provide strategic advice across the GMC Mandatory training for all staff and associates Guidance and tools for equality analysis as a requirement of project and policy activity to consider fairness impacts of approach Past research, fairness audits, Campbell Tickell Governance and Compliance review 	UNLIKELY MAJOR SIGNIFICANT	<ul style="list-style-type: none"> Executive Board and Council consideration of Campbell Tickell compliance report (Feb and April 2021) 	<ul style="list-style-type: none"> Strategy and policy ED&I compliance and governance review - Campbell Tickell (2020) Engagement, not personal characteristics, was associated with the seriousness of regulatory adjudication decisions about physicians: a cross-sectional study, Javier A Caballero, Steve P Brown, British Medical Journal (2019) Fairness of decisions to refer doctors to the MPTS interim orders tribunal (2019) Plymouth University Review of decision-making in the GMC's FTP procedures (2014) 	<ul style="list-style-type: none"> Consider key decision-points in our operations for process controls to mitigate the risk of bias or unfairness (such as separated decision making) and our quality assurance regime for decisions Assess staff learning and training needs from first principles through a Learning Needs Analysis (LNA) and the most current evidence base on learning approaches with the greatest impact Consider the adequacy of how we report the timeliness of our regulatory processes to better understand the characteristics of the individual in that process and possible real-time interventions required to address risks of unfairness Review our approach to a regulatory Equal Opportunities Policy Consider the coverage and credibility of past independence assurance on the fairness of our processes in design and operation to identify gaps or required change in approach 	Low
234	Operational Threat	ED&I Strategic Ambition	Strategic / Policy	The actions we take to influence change across the health and education system, and within the GMC, do not deliver progress at a pace to meet our strategic ED&I targets, sustaining known areas of inequality	Shaun Gallagher	HIGHLY LIKELY MODERATE CRITICAL	<ul style="list-style-type: none"> Clear timebound targets to focus system-wide efforts Nominated Executive leads for each of our strategic commitments Skilled and resourced teams designing interventions to deliver against the targets Established plans of action to deliver against the targets both internally and externally Annual and bi-annual progress reporting Scrutiny and monitoring and reporting from the ED&I Steering Group, Executive and Council to allow refinement of plans in response to progress Established Outreach and engagement functions to understand and influence the system with broader calls for action and support to facilitate system-wide change Supporting and aligned commitments of others (ie reducing differentials in disciplinary processes) Research and data assets including our surveys and insights to highlight relevant issues and support calls for action 	QUITE LIKELY MODERATE SIGNIFICANT	<ul style="list-style-type: none"> Council Regular agenda item on ED&I Executive Board Twice yearly review by Executive Board and performance against internal targets embedded in Performance and Risk Reporting Risk 'deep dive' (July 2021) 	<ul style="list-style-type: none"> Strategy and policy ED&I compliance and governance review - Campbell Tickell (2020) 		Medium
149	Operational Threat	Availability of resources	Resource	If we don't secure and retain: an appropriately skilled and experienced workforce; a resilient and secure IT and facilities infrastructure; or maintain a sound financial position, we threaten delivery of our statutory functions and strategic aims.	Neil Roberts	HIGHLY LIKELY MAJOR CRITICAL	<ul style="list-style-type: none"> Our HR practices and leadership strategy is aimed towards attracting and retaining a high calibre workforce We have processes in place to identify and manage key staff risks We consider recruitment market surveys and data to identify potential skills shortages. Our Health and safety policies and procedures are robust in regards to our workforce Clear Financial management practice and controls and safeguards including around investment (GMCs), fraud policies and pensions. New activity, including New initiatives and initiatives and existing project work routinely considered by Planning Gateway process to form a cross-organisational recommendation on the priority and deliverability of proposals for SMT to consider collectively Routine monitoring and reporting of operational performance and the volume and complexity of our work Process for regularly mapping workload pressures across teams to help focus resourcing and prioritisation decisions Reactivated Recovery and Renewal Taskforce to coordinate our transition to resuming paused activities and use of office space We are working closely with the Pension Trustees to address the increased scheme liability arising from the Govt decision to align RPI and CPI Financial reserves and management provide financial resilience to risks that are realised and effective business continuity processes manage and minimise the impact of such risk We continually invest in our IT infrastructure and systems to ensure availability and protect against cyber-security threats and maintain ISO 27001 accreditation 	QUITE LIKELY MODERATE SIGNIFICANT	<ul style="list-style-type: none"> Council Review of annual budget and Annual Accounts Executive Board Executive Board regular review of finance, HR, project and operational performance and risks Risk deep dive (June 2020) 	<ul style="list-style-type: none"> Internal Audit Social engineering: Nov 2021 green/amber Recovery and renewal: Nov 2021 green/amber Payroll (May 2021, green-amber) Procurement (March 2021, green-amber) Fraud arrangements (March 2021, green) Raising concerns arrangements (March 2021, green) Risk Management (October 2020, green) Covid learning review (August, 2020) Assurance Spot-check - Business Planning & Budgeting changes (May 2020 green-amber) Recruitment (September 2019, green-amber) Managing change (August 2019, amber) Transformation Programme (July 2019, amber) Risk Management (June 2019, green-amber) <p>Other assurance</p> <ul style="list-style-type: none"> Covid learning reviews (GMC Case Studies): The impact of the pandemic on the regulator's corporate strategy/the impact of the strategy on the regulator's response (December 2020) 		Medium

150	Operational Threat	Ability to work with others	Strategic / Policy	If we are unable to work collaboratively with our external partners, we may not be able to achieve the ambitions of the corporate strategy, reducing our potential impact on patient safety and doctors' practice	Paul Reynolds	QUITE LIKELY MAJOR CRITICAL	<ul style="list-style-type: none"> Being transparent and managing stakeholders at SMT level Engagement with other regulatory bodies to identify opportunities for collaboration and alignment (such as through the Chief Executive Officer Regulatory Body (CEO RB) Group) Proactive engagement on all major policies and issues Development and management of stakeholder relationships of strategic importance at national and regional levels of the UK, supported by annual relationship plans delivered by our external affairs and outreach teams Regular evaluation of our relationships with key partners, through analysis of insights captured in our new Engage system and periodic surveys of our stakeholders' perceptions Active engagement with the four UK Governments over the future of our legislation Contribute to joint work through CEO RB group 	QUITE LIKELY MODERATE SIGNIFICANT	<p>Council</p> <ul style="list-style-type: none"> Paper: Perceptions Survey 2020 (which included key results from stakeholders) (December 2020) Paper: Four countries update (November 2020) Paper: Annual update on communications and engagement (July 2020) Paper: Four countries update (April 2020) <p>Executive Board</p> <ul style="list-style-type: none"> Four country public affairs update (March 2021) Risk 'deep dive' (July 2020) Public affairs strategy (June 2020) 	<p>Internal audit</p> <ul style="list-style-type: none"> Review of progress in implementing Outreach (May 2021, green-amber) <p>Other assurance</p> <ul style="list-style-type: none"> Quarterly health assessments of our major relationships (last assessments carried out by external affairs teams in July 2021) Corporate strategy and perceptions survey 2020 (published December 2020) Corporate strategy and stakeholder perceptions baseline survey (published March 2019) 	<ul style="list-style-type: none"> Initial adoption programme for Engage system is now complete and system now managed on BAU basis using quality framework Continue to strengthen our collaboration on patient safety issues with our regulatory partners (such as CQC and NMC) following Paterson inquiry report on issues such as maternity care and treatment in the independent sector 	Medium
151	Operational Threat	Responding to a changing environment	Strategic / Policy	Inability to respond effectively to changes in the external environment, including legislation and wider social impact changes, could lessen our influence and reduce public, professional and political confidence in our role	Paul Reynolds	QUITE LIKELY MAJOR CRITICAL	<ul style="list-style-type: none"> Proactive, senior-level engagement with stakeholders to understand their agendas Outreach teams structures in place, aligned to UK countries and regions of England, to help us understand and influence national and local systems Contribution to NHS People Plan (England) and Government initiatives across the UK Continuous monitoring of our external environment, including longer term horizon scanning and research (e.g. barometer and perception surveys with the medical profession) Contributing to meetings and networks across the UK and Europe Internal governance in place to process, consider and make decisions on the intelligence we receive about the quality and safety of local practice and training environments (JWIG and PSF meetings) Intelligence from our external environment is shared on a weekly basis with Senior Leadership team and Council members 	UNLIKELY MODERATE LOW	<p>Council:</p> <ul style="list-style-type: none"> Four countries update (November 2020) Update on Outreach implementation (October 2020) Seminar: Four countries update (September 2019) <p>Executive Board:</p> <ul style="list-style-type: none"> Deep dive on Devolution (September 2021) Four country public affairs update (March 2021) Future scenarios for GMC Outreach (December 2020) New public affairs strategy (December 2019) 	<p>Review of progress in implementing Outreach (May 2021, green-amber)</p> <ul style="list-style-type: none"> Regulatory Reform - Spot Check (June 2021, March 2021) Horizon scanning arrangements (June 2020, amber) 	<ul style="list-style-type: none"> Initial adoption programme for Engage system is now complete and system is now managed on BAU basis using quality framework and our engagement and policy teams continue to capture intelligence from our engagement with stakeholders Internal programme established by Strategy and Policy to improve our approach and capabilities for capturing, coordinating, recording and using intelligence from our external environment Media Relations team exploring how new monitoring platform can be exploited to improve content of daily media summary, to make it more relevant to work of teams across GMC 	Low
152	Operational Threat	Unplanned event	Reputational	The impact of an event in the external or internal environment causes our systems to be compromised or our activities to be publicly challenged, potentially leaving us vulnerable to delivery of key functions central to patient safety and reputational damage	Neil Roberts	QUITE LIKELY MAJOR CRITICAL	<ul style="list-style-type: none"> Crisis management policies & procedures; pandemic response plan Business continuity champions and emergency response plans in place with regular testing Mandatory e-learning for GMC staff and support from business continuity consultants Responding to public inquiries and reviews, and proactive horizon scanning Analysis of range of qualitative and quantitative information about the external environment through the Patient Safety Intelligence Forum Regular engagement with the Professional Standards Authority to assure them on the exercise of our statutory powers – including emergency powers under section 18A of the Medical Act 1993 (Covid-19) 	QUITE LIKELY MODERATE SIGNIFICANT	<ul style="list-style-type: none"> 'Deep Dive' Executive Board (June 2021) Paper: People planning across the United Kingdom (November 2019) 	<p>Internal audit</p> <ul style="list-style-type: none"> Cyber security (July 2021, green-amber) Cyber security (November 2020, green-amber) Cyber security (July 2019, green) <p>Audit and Risk Committee</p> <ul style="list-style-type: none"> Significant Event Review: Fraudulent registration application, Teodora Crisovan (March 2021) Report on Significant Event Review follow-ups (March 2021) Significant Event Review: Fraudulent doctor Zholia Alemi (November 2019) Significant Event Review: Fraudulent registration application, Teodora Crisovan (March 2021) Report on Significant Event Review follow-ups (March 2021) <p>Other assurance</p> <ul style="list-style-type: none"> Covid learning reviews (GMC Case Studies): How the regulator responded to emerging evidence of higher prevalence of Covid-19 infection in BAME people; Temporary registration implementation; The impact of the pandemic on the regulator's corporate strategy/the impact of the strategy on the regulator's response; Approach to producing Covid specific guidance (December 2020) 	<ul style="list-style-type: none"> Response to a range of public Inquiries and Reviews underway including Paterson (now reported), Infected Blood Inquiry, Hyponatraemia, and Historical Public Abuse Continue to engage with the Professional Standards Authority regularly, to assure them of how we use our emergency powers in response to the Covid-19 pandemic arising from section 18A of the Medical Act 1993 	Medium
200	Operational Threat	Regulatory Reform	Strategic / Policy	The DHSC's approach to reform, including the scale and complexity of the changes we are seeking, the pressure to deliver change quickly, and the potential for different levels of support from stakeholders, could result in us not delivering the reforms to the appropriate quality, or failing to maximise the full range of opportunities that the reforms present. In addition to this, the pressures created by the pandemic and the Omicron variant may risk DHSC resource being diverted to support other work which could cause further delays to the programme.	Shaun Gallagher	HIGHLY LIKELY MAJOR CRITICAL	<ul style="list-style-type: none"> Governance and controls in place for the programme, including: agreed objectives, defined scope, benefits identified, appropriate risk management and robust plans for delivery Stakeholder influencing plan developed to ensure we secure external support for changes Ongoing engagement with DHSC to maintain good working relationships, enabling us to collaborate effectively and influence their work and manage potential implementation risks associated with drafting of the legislation Cross-directorate working built into programme approach, to ensure that policy is developed in conjunction with operational teams, encouraging a 'one GMC' approach and making sure that changes can be operationalised as soon as policy agreed 	QUITE LIKELY MODERATE SIGNIFICANT	<p>Executive Board</p> <ul style="list-style-type: none"> Risk deep dive (March) 	<p>Most recent spot check took place in Nov 2021. This report is going to the Audit and Risk Committee on 27 Jan. Previous spot checks completed in June 2021 and March 2021</p>	<ul style="list-style-type: none"> Combined programme plan developed (in conjunction with DHSC) setting out critical path and clear caveats and assumptions that underpin our planning (Plan being reviewed at regular stocktake meetings with DHSC - next meeting scheduled for 2 Feb) Use existing structures/communication channels internally as a way of reinforcing messaging and maintain momentum and morale Continue to use internal audit assurance to provide ongoing scrutiny and give assurance that the programme is being run appropriately Be prepared to escalate concerns to senior DHSC stakeholders as appropriate - a meeting is scheduled to take place to review several policy issues that require escalation on 19 Feb 	Medium
309	Operational Threat	Safeguarding at the GMC	Reputational	If there isn't sufficient corporate understanding and visibility of our safeguarding activities, we may not meet our safeguarding obligations as a regulator and as an employer.	Neil Roberts	QUITE LIKELY MODERATE SIGNIFICANT	<ul style="list-style-type: none"> Safeguarding Working Group in place since 2019 and Neil Roberts chairs. Advisory Review conducted by BDO using a specialist social worker to review our practices and recommend Action plan Action plan in place – Project team assembled to take forward recommendations SCIE appointed as specialised consultants Presentation given to SMT on direction of project 	QUITE LIKELY MODERATE SIGNIFICANT			<ul style="list-style-type: none"> Developing our policy and process to ensure we have corporate approach and consistency in decision making Development of training package – level one for all staff to be delivered by e-learning and level two for specialist colleagues Reporting arrangements to be finalised for both workstreams Recruitment to commence for Designated Safeguarding Manager 	Low

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

Action	To discuss
Purpose	This item provides the annual update on progress against our equality, diversity and inclusion (ED&I) ambitions as both a regulator and as an employer.
Decision trail	ED&I has been a standing agenda item since September 2020. Council agreed to establish ED&I measures and targets in February 2021 and this report is the first of an annual update on progress.
Recommendations	<p>a To consider progress against our ED&I ambitions, the extent of our asks of the system going forward, and levels of assurance in our future plans.</p> <p>b To agree proposals for future ED&I reporting to Council post-February 2022.</p>
Annexes	<p>Annex A: Annual ED&I progress report</p> <p>Annex B: Performance projections</p>
Author contacts	<p>Claire Light, Head of ED&I – Strategy and Policy</p> <p>Robert Scanlon, Assistant Director, Business Planning & ED&I</p> <p>Any enquiries to: GovernanceTeamMailbox@gmc-uk.org</p>
Sponsoring director/ Senior Responsible Owner	<p>Shaun Gallagher, Director of Strategy & Policy</p> <p>Anthony Omo, General Counsel and Director of Fitness to Practise</p> <p>Colin Melville, Medical Director and Director of Education and Standards</p> <p>Neil Roberts, Director of Resources</p>

Background

- 1 In February 2021 Council agreed to a step-change in our ED&I ambitions, aiming to provide stronger leadership and more focus to ED&I, with an immediate focus on racial inequalities within the health service and our own organisation.
- 2 Council agreed targets to:
 - Reduce year on year the disproportionality in fitness to practise referrals from designated bodies based on ethnicity and place of primary medical qualification (PMQ) - with an overall target to eliminate disproportionality by 2026.
 - Eliminate discrimination, disadvantage, and unfairness for all index measures of fair medical education and training pathways by 2031.
 - Eliminate differentials within our own staffing performance, in ethnic minority recruitment, representation across staffing levels, retention, progression, pay and employee engagement by 2026.
- 3 We knew these targets were ambitious and we committed to demonstrating leadership across the system, using our levers and our regulatory powers, to increase the pace of change. We intended for the targets to generate collective and collaborative efforts, and our annual reporting of progress would be an opportunity for us to continually shine a light on progress and inform our calls for action.
- 4 In July 2021, an Employment Tribunal judgement upheld a claim that we had racially discriminated against Mr Karim in our fitness to practise processes. We instigated a broader review of how we assure ourselves that our regulatory processes are not only free of discrimination, but more actively seek out and challenge bias. This workstream forms the fourth pillar of work under our accelerating ED&I programme and is characterised by the same level of commitment to achieving positive change at pace. This is an important demonstration that we are prepared to hold the mirror up to ourselves, at the same time as highlighting changes the wider system needs to make and is covered in the report.
- 5 The first annual ED&I progress report is attached at Annex A for Councils consideration.

Summary of progress

- 6 This cover paper does not seek to replicate the content of the annual report in detail, but instead reflect on some of the experience of setting and implementing the targets.
- 7 The overarching conclusion we have made is that the key actions put in place to pursue the targets reflects a solid foundation for a first year of activity. However, it is too soon to draw a meaningful conclusion on progress in the metrics themselves. Given the longstanding nature of these issues, we would need to see sustained and meaningful progress over a longer timeframe. The first year of data suggests positive improvements in employer referrals, and a static picture on education and training when statistical significance is accounted for.

Embedding action plans

- 8 All workstreams have made progress against the actions set out in our initial plans in February 2021. The pace of delivery has undoubtedly been faster than we would normally achieve. We continue to reflect on the need to balance pace with the importance of maintaining the quality of our approach and ensuring we build in time to secure buy-in from all relevant stakeholders.
- 9 Each of the initial three workstreams are characterised by plans that need to 'test, implement, take-stock, recalibrate'. These are contained within the report in Annex A. This iterative approach will be the reality of how we must work to understand what has an impact, and to vigilantly reassess our interventions and work with others in a more agile way. This highlights the need and value for the annual reflection on progress and recalibration of plans and asks of others.

Embedding performance measures

- 10 We are working to develop performance projections on the measures and targets. We need to undertake more work to assure ourselves on the validity of the approach and ensure that each workstream is working to the same consistent method. These will become more important in the longer term as we have more data points to report on. What we can say from our early work on assessing past and current performance trends, is that it seems that the gap in referral rates appears to have been reducing for some time. Conversely, some of the measures in education appear to have remained static for some time. But we need to be sure that these conclusions are valid and consider how these trends need to inform our future approach before we publish these projections. We intend to publish performance projections for all measures available later this year.

Influencing the system

- 11 We said from the outset that we are not alone in having aspirations to 'shift the dial' on addressing inequalities, and this remains true. Many of our partners have active and wide-ranging agendas targeted on addressing inequalities and we know that a small number are showing positive progress. But the challenge remains for us all – to ensure that this activity is delivering real change and improvement and on that we have a long way to go.
- 12 When we launched our ED&I aspirations, we were cognisant that we did so during a pandemic. Despite this we received universal support for the areas we focused on, and for setting targets, albeit with some scepticism from some stakeholders of the sincerity of our commitment. A number of stakeholders told us that they felt it was an important signal from the regulator to the system. Although the pressures of the pandemic remain, we have not sensed or seen any diminished commitment to tackling these issues. Instead, stakeholders have remained sharply focussed on the need to deliver real change, but inevitably there will be challenging and ongoing demands for scarce resources across the health service for the foreseeable future.
- 13 We have sought to make it clear in the progress report where we think other stakeholders must play a role. We recognised that we need to improve our clarity of ask of our partners and stakeholders across the health system and be very clear where we intend to use our regulatory levers to good effect in the future.

Internal and external communications approach

- 14 We will use a series of communications and engagement opportunities throughout 2022 to regularly update our internal and external audiences on progress with our ED&I programme. This will draw on key information, asks, and reflection of progress in the 2022 progress report.
- 15 Making the health services a better place to work for all staff is top of the [NHS's operational planning priorities for 2022-23](#) and will continue to be central to workforce plans across Wales, Scotland and Northern Ireland. Our ED&I targets and work to support and influence inclusive and compassionate training and working environments will therefore remain relevant over the coming months.
- 16 We will regularly review our approach and messages to consider wider ED&I issues and external developments. This includes the outcome of our appeal of the Employment Tribunal, which may affect how our external and internal audiences respond to our ED&I messages.

- 17 Across all our communications, we will show how our ED&I priorities contribute to national programmes of work and ongoing internal projects such as regulatory reform and our review of *Good medical practice*.

Future reporting to Council

- 18 The last year of activity has affirmed the importance of our role in helping to drive change on ED&I across the system. The system wide view the GMC has brings a unique and co-ordinated insight alongside significant opportunities to leverage change. The existence of the measures has opened up opportunities for conversations on ED&I that we would not otherwise be having.
- 19 Maintaining this annual progress report provides a central moment of reflection on progress and what needs to happen next. As such, we are keen to embed a stronger routine and focus to the nature of Council's engagement on the agenda.
- 20 We are proposing to move away from the routine standing agenda item on ED&I at each Council meeting, where the update has tended to reflect an opportunistic presentation of what we have achieved. Instead, we recommend using a more considered and scheduled model - an overarching ED&I annual progress update in February each year, supported by four deep-dive updates across the course of the year. These deep-dive updates would focus on our strategic commitments around our three targets and the regulatory fairness work. The timing of these would be agreed with leads for each workstream to maximise the quality and richness of the conversation. For instance, there are some benefits in reconsidering when the focussed paper on the internal inclusivity agenda would best align with other reporting on our people survey and pay gaps. Likewise, there are some gaps in the reporting of data on education and training within the report, and a later designated reporting month would ensure complete data can be reported to Council.

Annual ED&I progress report

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Executive summary

- 1 In 2021, we set targets for us as a regulator and an employer, to tackle persistent areas of inequality.
- 2 Addressing these inequalities is beyond the control of the GMC alone. In setting these targets, we have aspired to create sustained focus across the health system on these critical areas. If we are successful in achieving these targets, we will fundamentally improve the quality of education, training, and practice environments –and ultimately, the quality of care for patients.
- 3 This report reflects on progress so far to meet these targets, as well as future actions for us and our partners to create sustained improvements. It will play a regular part in how we hold ourselves and others to account for progress and we hope it will be an ongoing catalyst for engagement and collaboration across the health service.
- 4 2021 has represented a strong start. Workstreams have been established to lead and deliver the commitments supported by longer term plans. We have engaged with 90% of the designated bodies with referral data indicating disproportionality to highlight what inclusive and fair environments look like. We have changed our referral process to better understand what local efforts have

been put in place to ensure referrals to us are fair. And on fairness in education and training, we have engaged with postgraduate training organisations, medical schools, and medical royal colleges to ensure they have ED&I action plans in place to support these targets. We have implemented our own ED&I action plan to improve our own inclusivity. More detail on our work is set out further in the report.

- 5 Early indications of performance on our regulatory measures shows mixed results. We are cautious in drawing conclusions from this given the longstanding and persistent nature of these challenges.
- 6 Our data shows that employer referrals have moved in a positive direction, with the gap in referral rates reducing across both measures and the proportion of Designated Bodies (DBs) that are disproportionate slightly declining.
- 7 Measures of medical education and training remain essentially unchanged when you factor in statistical significance of any variation in the measures. This is not unexpected given the education and training outcomes reflect a complex interplay of inequalities over a 10–15-year period in which a doctor is training. But we know there is a huge amount of work going on across the healthcare system, prompted by a collective recognition of the need to act. This incremental change may take time to work through into the target measures, which are lag indicators of change.
- 8 Performance against our employment targets shows consistent and significant improvement in the first year - contributing to improvements in ethnic minority workforce representation at all levels. Our overall workforce representation is likely to be in line with, or above, our 2023 target. Our staff turnover and progression rates for ethnic minority staff are also improving and are already in line with our 2023 targets.
- 9 We have worked closely with partners across the health service to support our shared ambitions and will continue to do so. We highlight a range of examples of this within this report. But there is more we and our partners across the system need to do and our asks are detailed in the report. They include:
 - national, systems, and local bodies, having a stronger focus on addressing the underlying factors driving inequalities across all four countries of the UK.
 - employers, educators, trusts and boards having stronger governance and plans on providing inclusive and supportive environments and assuring themselves they are making improvements.

- employers and educators to contribute to building the evidence on 'what works' by evaluating pilot initiatives and sharing their findings with others across the system.
 - all health system stakeholders recognise and support the power of data and implement measures to gain insight into the impacts of inequalities in medicine in their jurisdictions.
- 10 In addition to the targets we have set, in 2021 we committed to reviewing our own regulatory decision-making processes and approach to assure ourselves we are doing everything we can to be as fair and transparent as we aspire to be. This report also explains more about our work to provide greater assurance of fairness in our processes.

Our ambition and targets

- 11 Our [corporate strategy for 2021-2025](#) renewed our commitment to foster a culture of equality, diversity and inclusion in everything we do as a regulator and employer. The pandemic continues to highlight the need for meaningful action to address longstanding inequalities, and the impacts of racial discrimination and disadvantage.
- 12 The culture and leadership in workplaces is the most critical factor in enabling doctors to thrive and provide good care. We and our partners across the health service have a shared goal of making the health service a better, inclusive and supportive place to work for all staff. This is rightly top of the NHS's operational planning priorities for 2022-23 and will continue to be central to workforce plans across Wales, Scotland and Northern Ireland.
- 13 Taking firm steps to address the disparate experience of ethnic minority doctors is an urgent priority. It's the right thing to do and it will also make sure that the skills and experience of ethnic minority doctors can be fully utilised and deployed.
- 14 Racial disadvantage is not a minority issue. In 2020 38% of all licensed doctors in the UK were from an ethnic minority background and this proportion is growing. These doctors do not have a fair and equitable experience in their medical education and training, and they are significantly more likely to be referred into our fitness to practise process by their employer.
- 15 In February 2021 we committed to eliminating:

- disproportionality in fitness to practise referrals from designated bodies based on ethnicity and place of primary medical qualification (PMQ) by 2026.
 - differences in key index measures of fairness in medical education and training by 2031.
- 16** Eliminating these differentials will create more inclusive, supportive and fairer local environments. And inclusive environments lead to better patient outcomes and satisfaction.
- 17** There is also more we can do to assure ourselves that we are a fair and transparent organisation. This includes modelling the behaviours we are expecting of others to create more inclusive local environments.
- 18** We also want to test that existing systems, controls and approaches on mitigating bias, monitoring differentials and promoting fairness across our regulatory functions are as robust as possible, both for now and the longer-term. We have committed among other things to:
- review our own processes to provide more positive assurance that we actively challenge bias and are transparent about how we work.
 - improve our own inclusivity as an employer, eliminating differentials in recruitment, representation, retention, progression, pay and employee engagement by 2026.

2021 progress

- 19** 2021 shows a mixed picture of overall performance. We are cautious in drawing conclusions from this given the longstanding and persistent nature of these challenges. Annual movements in figures over a longer time period will give us clearer trends. Our threshold for success will only be seeing sustained improvements over several years and improvements that are statistically significant.
- 20** In that context, our data shows that employer referrals have moved in a positive direction, with the gap in referral rates reducing across both measures and the proportion of DBs that are disproportionate slightly declining.
- 21** Measures of medical education and training remain essentially unchanged when we factor in statistical significance of any variation in the measures. This is not unexpected given the education and training outcomes reflect a complex

interplay of inequalities over a 10–15-year period in which a doctor is training. Change is needed to policy and process throughout the whole system from entry into medical education, access to support and learning opportunities and the design of assessments. This is a challenge reflected in broader education and society and will require close ongoing attention. Owing to when data is available, we also do not have a complete set of updated metrics to inform our overall assessment at this time.

- 22 We have made significant progress on our ambitions to become a more inclusive employer. We have established a 'Fostering Inclusion' learning programme for all managers and implemented two talent programmes to support ethnic minority staff to develop and progress. We have revised our recruitment processes to ensure we attract more diverse talent and generated beneficial insight on inclusivity within our staff survey.
- 23 Performance against our employment targets shows consistent and significant improvement in the first year. Our recruitment metrics are on target and this performance is contributing to improvements in ethnic minority workforce representation at all levels. Our overall workforce representation is likely to be in line with, or above, our 2023 target. Our staff turnover and progression rates for ethnic minority staff are also improving and are already line with our 2023 targets. However, we are not complacent and recognise we need to sustain or exceed this performance to be able to meet the overall targets in the long term.
- 24 It is too soon to say what the concrete solutions are to the challenge of driving further improvement across all our measures. Our response will need to continue to be iterative over time, understanding the impact of interventions and making a coordinated effort to focus attention on a sustained basis.
- 25 This iterative approach will be the reality of how we must work to understand what has an impact. This highlights the need and value for the annual reflection on progress and recalibration of plans and asks of others. We will vigilantly reassess our interventions and work with others in a more agile way.
- 26 We will undertake more work to assure ourselves on the validity of our performance approach in the longer term as we have more data points to report on. We need to be sure that our measures remain valid and inform our future projected activity.
- 27 Many organisations are working towards the same goals and we have been able to collaborate on many initiatives. This report reflects on some of their key initiatives as much as our own. It also reflects our calls to action for others.

2022 calls to action

28 In 2022 we will:

- request Responsible Officers (ROs) advise us how they have assured themselves any fitness to practise referral to us is fair. They will also need to identify what support they have provided to the individual as part of that referral.
- review the quality and insights from these referrals and their local checks and controls to identify best practice to promote and embed more widely.
- target conversations with ROs on best practice on maintaining fair and inclusive environments and identify and share this across the system.
- continue to deliver Welcome to UK Practice (WtUKP) and work with stakeholders to make sure it will be (or remain) a mandatory part of a broader coordinated and appropriate induction for those international medical graduates (IMGs) that are new to practice in the UK.
- ask that all educational organisations contribute to building the evidence on 'what works' by evaluating pilot initiatives. We ask that they share their findings with others across the system so that initiatives can be scaled up and applied in different environments more quickly.
- require medical royal colleges, postgraduate deans and medical schools to submit organisational action plans describing how they will improve outcomes for IMG and ethnic minority learners in their region, country or specialty.
- ask medical royal colleges to improve the diversity and inclusion of high-stakes exams. This includes broadening the diversity of examiners and question-writers. It also includes developing targeted support and feedback for candidates unfamiliar with UK assessment methods, with fewer educational resources to help prepare effectively and coping with the additional anxiety of perceived bias within the assessment.
- ask statutory education bodies, colleges and the UK Foundation Programme Office to review the ED&I impact of the systems and policies around recruitment of learners and to deliver on recommended improvements.
- ask medical schools to provide exam data which will be used to monitor and improve fairness in undergraduate education.

- continue to use our regulatory levers to drive a stronger focus on eliminating ethnicity differentials in education and training providers.
- continue to push for action on ethnicity and race. Some stakeholders have viewed this focus as us shying away from the disadvantage of others. We have a responsibility to tackle inequality for all, however the focus on race is overdue and proportionate based on our data and the scale of the issue. Ultimately, the solution to addressing ethnicity-related differentials – understanding the needs of the individual and providing tailored support – is an approach with universal benefits for all.
- ask national and systems bodies to embed the conclusions of [Fair to refer?](#)¹ into their understanding and definitions of what good looks like. This will help us build a consensus on the scale of the challenges of bias and discrimination in local environments and acceptance of the need for us all to play a role in actively tackling these challenges.
- ask national, systems, and local bodies, for a stronger focus on closing local disciplinary gaps across all four countries of the UK. Tackling the disciplinary gap is a critical intervention that will drive better focus on ensuring tailored understanding of individual needs and support.
- ask that all health system stakeholders recognise and support the power of data. We will continue our close support of the work and ambitions of the NHS England/Improvement's (NHSEI) Medical Workforce Race Equality Standard (MWRES) as a powerful tool to measure and drive progress in England. We will also consider how we can offer regionalised data to support regional activities across the whole of the UK. We ask that relevant stakeholders in other countries of the UK consider an equivalent measure to gain insight into the impacts of inequalities in the health service in their jurisdictions.
- ask employers, trusts and boards to consider how they assure themselves that they have inclusive and supportive environments in place. This includes their race equality action plans, equality training, inclusive performance objectives for leaders, and networks of coaches and mentors for all staff.
- ask employers who lead on good practice in these areas to openly and proactively share this for others across the system to learn from. We ask

¹ [Fair to refer?](#) is research we commissioned to understand why disparity exists in patterns of employer referrals based on ethnicity

those who recognise they need to do more to proactively seek evidence on the approaches that might help them to improve.

- ask anyone defining action plans, pilot interventions, targets and measures, to align them wherever possible to the timeframes of our targets to promote stronger coordination. We also ask for them to design their interventions with a focus on understanding the needs of the individual in a broader sense, so that improvement may have universal benefit across all protected characteristics.
- ask that interventions are supported by investment in evaluating the impact and to share those outcomes. Understanding what works will be key to understanding what initiatives should be scaled up once proven to be effective.

Fairer employer referrals

29 We set two performance measures to underpin this target. They reflect the nature of the challenge which requires attention by employers to assure themselves that their processes are fair and free from bias (KPI1), and it needs national attention across regulators and system partners to affect change (KPI2):

- KPI1 - percentage of DBs with evidence of disproportionality, for either ethnicity or PMQ region in their referral.
- KPI2 - difference in rates of referral between ethnic minority and white doctors and between 'UK PMQ' vs 'non-UK PMQ' at a national level.

30 At the DB level the number of referrals is very small. Our first-year experience of monitoring this has shown that a single referral can move a DB into or outside of the group of DBs with disproportionate referrals. However, this group is relatively recurrent. Of every 10 DBs in this group in any quarter of 2021, 9 were in such group in the previous quarter too. We have used this grouping to target our conversations with employers, and our analysis has highlighted some areas that may benefit from further analysis and consideration.

31 Because of the small number of referrals, a five-year rolling period is used to generate and monitor referral trends. As a result, the benefits from local improvements in environments will take some time to be realised and the visibility of change will be very gradual over time.

- 32 We are working towards eliminating these differentials in the timeframes set, but we recognise that there may be factors or developments that emerge over the next 5 or 10 years which might affect these reducing to exactly zero. Regular monitoring will allow us all to keep close scrutiny of this. Once we reach the end of our timeframes, we will use regular review mechanisms to check that all the changes continue in the right direction.

Table 1 – Fairer Referrals Measures

TARGET: Eliminate disproportionality in fitness to practise referrals from designated bodies (DBs) based on ethnicity and PMQ by 2026*			
		2016-2020 (pooled data)	2017-2021 (pooled data)
KPI1: % of DBs with evidence of disproportionality, for ethnicity or PMQ	Ethnicity or PMQ	5.6%	5.3%
KPI2a: Difference in rates of referral between ethnic minority and white doctors	Ethnicity	0.28% 0.58% ethnic minority 0.30% white	0.24% 0.50% ethnic minority 0.26% white
KPI2b: Difference in rates of referral between UK and non-UK doctors	PMQ	0.42% 0.28% UK 0.70% non-UK (made up of 0.73% IMG and 0.63 % EEA)	0.34% 0.25% UK 0.58% non-UK (made up of 0.59% IMG and 0.56% EEA)

*N.B. We have enhanced the accuracy of all KPIs, including the initial benchmarks. The enhanced accuracy of the data for these indicators has been achieved following a data improvement exercise. Since the last reporting time in February 2021, there has been a slight decrease in the proportion of DBs showing disproportionality (KPI1) and in overall employer referral disproportionality (KPI2), which is our key target for differences based on both ethnicity and PMQ

- 33 From our initial benchmark, KPI1 improved by about 5 % and KPI2 metrics dropped by about 16 and 19 % respectively. But we will continue to measure the efficacy of these performance metrics over time and formally review progress against the measures at the mid-way point.
- 34 After the first year of monitoring, our view is that, though these KPIs can in principle be reduced towards zero, in practise it is unlikely that they will become exactly zero. The 5-year rolling period is necessary for robust analysis but means that if disproportionality improves in the first year, it will take time to

show in the overall measure. If the improvement was small, it could take up to 5 years to be fully seen in the overall measure.

- 35** For example, for KPI1, if a DB with disproportionality starts referring proportionately, the assessment of its proportionality will be based on data that is partly disproportionate and partly a proportionate period of referral for the next 4 years it will have older data in its pooled 5-year sample. This may not be enough for the DB to become statistically proportionate in the 5-year rolling period. Also, an unusual referral pattern may result in a DB to newly join the group of DBs with disproportionate referrals, increasing KPI1 off zero for a short period. For KPI2, the rates of referral may become more similar, but may not become equal to make KPI2 exactly zero.
- 36** The ongoing pressure on the system from responding to the pandemic is impacting our ability to have some conversations both nationally and locally. However, the pandemic itself continues to expose the need to tackle these and other areas of inequality affecting minority ethnic members of the health service and the public.

2021 action

Fairness conversations

- 37** We have met with approximately 90% of the DBs identified as having referral data indicating disproportionality. These conversations will continue on an ongoing basis.
- 38** The focus of these meetings is to understand what local action is linked to the key findings in *Fair to refer?* (FTR). The conversations so far indicate that all ROs recognise it is important to take forward the recommendations of FTR in the form of more supportive and inclusive working environments, and there is work underway across the system. However, there is variance in the levels of expertise to address the key findings, and the resource and commitment to do so. Some positive examples of work we have heard about from DB's are:
- race equality action plans and race equality training.
 - inclusion as part of objectives for leaders.
 - networks of coaches and mentors for all staff.
 - IMG fellowship scheme for non-training grades (formalised recruitment, shadowing, induction period).

39 Some examples of areas that need more work are:

- mixed levels of ability and confidence across their organisation in giving feedback to colleagues.
- few DBs are aware of staff support networks, but some considering links for future work.
- a single DB told us they do not have inductions that support the transition of doctors into UK culture but are looking at how they welcome doctors from overseas.

40 From our detailed look at many of the trusts and boards in the dataset, it is clear the context of referrals might be significant and, if understood, could influence the appropriate engagement with a DB. We have taken the approach of engaging with ROs across the system to understand how they are progressing activity to embed the recommendations from FTR and mitigate risk of bias. As part of this work, we are inviting ROs to identify what they believe is good practice that we can then share with others and identify areas where we can provide support through activities such as providing additional data.

Referral form changes

41 We updated our employer referral form to require ROs to confirm the steps they have taken to ensure a referral is fair and appropriate before it is submitted to us. This includes questions about:

- any systems issues related to the events.
- for doctors new to UK practice, any induction about what is expected when things go wrong.
- support provided since the concerns were identified about any improvement needed.
- impartial checks undertaken of whether a GMC referral is appropriate at that time.

42 This followed a three-month pilot where ROs were supportive of these changes, although some felt that they were already giving system factors due consideration. Where we did receive a referral with questions answered, this detailed a series of attempts to support the doctor and in-depth checking of the fairness of the referral.

Feedback mechanisms

- 43** We are refining our process to provide feedback to ROs about the outcome of cases referred to us. A workshop explored mechanisms for developing, recording, and sharing feedback. This includes premature referrals that do not meet our threshold for investigation and where more local support is appropriate.

Future action plan and 2022 focus areas

- 44** As successful delivery of this target relies on substantial cultural change in external organisations, we are using an iterative approach to taking forward actions. This will enable us to monitor and take account of changes in the external environment and to reflect learning from that in our approach.
- 45** Our action plan is front-loaded with activity. We will undertake annual reviews and use that to inform the next phase of actions. During the review points, we will also consider engaging the system to collate feedback and develop our future phases.

Table 2: Fairer Referrals Action Plan

2021 launch	2022 Phase one	2023 Phase 2	2024 Phase 3	2025 Phase 4	2026 Phase 5
Action Plan: Shared narrative on the disciplinary gap Review of AoI AR training on handling employer referrals Amend RO referral form Enhance feedback to ROs on triage and investigation outcomes	Action plan: Collaborate with system partners on the disciplinary gap Analysis of RO referrals and outcomes Ongoing review of our approach to referrals <u>Cycle evaluation:</u> Progress against agreed activities Learning & feedback (internal/external) to inform next cycle	Action plan: Evaluation and monitoring of impact on referrals and our handling Other activities TBC <u>Cycle evaluation:</u> Progress against agreed activities Learning & feedback (internal/external) to inform next cycle	Action plan: Board engagement Support with fairness/inclusivity Further activity TBC dependant on outcome of trajectory review <u>Cycle evaluation:</u> Progress against agreed activities Learning & feedback (internal/external) to inform next cycle	Action plan: Board engagement Support with fairness/inclusivity Further activity TBC, dependant on outcome of trajectory review <u>Cycle evaluation:</u> Progress against agreed activities Learning & feedback (internal/external) to inform next cycle	Action plan: Further activity TBC, dependant on outcome of trajectory review <u>Cycle evaluation:</u> Progress against agreed activities Learning & feedback (internal/external) to inform next cycle
Ongoing RO conversations and Board engagement					

- 46 At the core of these interventions will be our continued commitment to embedding the key recommendations and learnings from FTR into the understanding and definitions of what 'good looks like'. We will continue to ask national stakeholders to make sure their work is predicated using FTR as a source of common and good practice and using data sources similar to the NNHSEI MWRES data as measures of success.
- 47 We cannot deliver this target alone. We continue to collaborate with national and regional stakeholders who have similar aspirations to tackle inequalities. In particular, the WRES team is currently planning their priorities for 2022 with an increased focus on the work to address the NHS England People Plan workstream entitled 'tackling the disciplinary gap' in spring 2022.
- 48 Linked to this, we are currently agreeing a shared understanding with NHS Resolution (NHSR) on the importance of this work, what our pooled data

shows, effective interventions and why healthcare organisations should prioritise it. We have approached NHSEI, the Care Quality Commission and the Nursing and Midwifery Council to join the work to help draw a more complete and common understanding of the challenge and potential solutions.

49 Given the pressure on the system across the four countries of the UK, there has been a common concern about progressing this work and the need for reasonable expectations about the pace of change. There are varied views on what good looks like and some organisations to continue to question the validity of our role in this area. Some of the challenges we have heard about across the system are centred around lack of expertise, resource, and capacity, such as:

- a lack of time to focus on this given other support needs, such as wellbeing support through the pandemic.
- lack of time and money to release doctors for learning.
- a lack of expertise in what works in specific settings – it cannot be a ‘one size fits all’ approach.
- releasing support staff for managing projects and evaluating what works.
- buying and embedding new systems that might make a difference such as a feedback system for all doctors.

Fairer education and training cultures

50 Council approved an index of six measures and since the initial benchmarking in February 2021, there have been updates to educational performance measure (EPM) scores and the national training survey measures. The Annual review of competency progression (ARCP), exam and undergraduate assessment analysis will be available in May 2022. The full update to the index measures is in Table 3 below.

Table 3 – Index Measures for Fairer Training Cultures

Index measure	Baseline	2020	2021
Undergraduate EPM scores- 2019 Difference between mean Educational Performance Measure (EPM) scores	White: 6.05 Ethnic Minority: 4.93 Gap: 1.12*	White: 6.09 Ethnic Minority: 4.92 Gap: 1.17*	White: 6.16 Ethnic Minority: 4.94 Gap: 1.22*
Undergraduate exams - Differences in medical school exam pass rates Data not available to baseline until May 2022			
Undergraduate – F1 preparedness (NTS) - Difference in preparedness levels of new F1 doctors		White: 70.2% Ethnic Minority: 62.4% Gap: 7.8%*	White: 76.3% Ethnic Minority: 65.8% Gap: 10.5% *
Postgraduate – inclusivity (NTS) - Difference in perceived inclusivity levels		UK White: 81.6% UK Ethnic Minority: 77.2% Gap: 4.4* ALL UK: 80.1% ALL IMG: 76.0% Gap: 4.1*	UK White: 83.0% UK Ethnic Minority: 80.0% Gap: 3.0* ALL UK: 82.0% ALL IMG: 77.3% Gap: 4.7*
Postgraduate – ARCP outcomes - 2018/19 - Difference in rates of unsatisfactory outcomes	UK White: 4.8% UK Ethnic Minority: 7.1% Gap: 2.3%* ALL UK: 5.6% ALL IMG: 15.7% Gap: 10.1%*	Data not available until May 2022	
Postgraduate education – exams 2018/19 - Difference in exam pass rates	UK white: 77.7%, UK Ethnic Minority: 65.4% Gap: 12.3%* ALL UK: 73.2% ALL IMG: 43.8% Gap: 29.4%*	Data not available until May 2022	

*N.B. Not statistically significant difference

The differentials in the key measures remain persistent and consistent with the trend observed since 2015. The small annual fluctuations do not represent meaningful worsening or improvements in outcomes.

2021 action

Postgraduate training organisations

- 51 Annual engagement meetings with all the postgraduate training organisations have taken place with a strong focus on differential attainment. This is the third year these conversations have taken place. We ask that postgraduate training organisations document their action plan to record what they are doing to address the attainment gaps in each region.
- 52 Differential attainment data have been refreshed and provided to organisations to allow them to track progress and update their action plans which are due to be resubmitted in January 2022.
- 53 We held an annual quality leads meeting with postgraduate training leads across the UK to bring organisations together to share ideas and practice. Improving fairness is high on the agenda. Health Education England, for example, have established an ED&I strategy group to coordinate change across England and invested a significant budget in developing interventions within General Practice. The number of projects running simultaneously could affect the momentum of work because there will evidently be a lot of change and reform.

Medical schools

- 54 The annual quality leads meeting focused on our ED&I targets and our proactive quality assurance process to oversee medical school action plans.
- 55 The first set of medical school assessment data has been received and will inform our proactive quality assurance process in 2022.
- 56 The Medical Schools Council established an ED&I Alliance. In December 2021, they [published a framework](#) for supporting medical schools to make their environments and processes more inclusive.
- 57 Medical schools are undertaking a significant amount of work such as:
 - revising curriculum and assessment material to represent a diverse patient population.
 - student engagement on their experiences of racism.
 - development of reporting tools for concerns relating to ED&I issues.
 - adopting the British Medical Association's racial harassment charter.

- broadening support packages for different groups of students.
- ensuring recruitment panels are fair and have recruited staff that is representative.

Medical royal colleges and faculties

58 In November 2021, we launched a new ED&I action plan for Medical royal colleges and faculties. This requires colleges and faculties to submit evidence of the work they are doing to tackle the attainment gap in 2022. We held a quality leads meeting to introduce the action plan with representation from every college and faculty and received a positive response. They have been asked to report on specific areas which will inform the future development of fair assessment and curricula, which are:

- diversity of examiners and exam boards.
- support for Educational Supervisors.
- support for learners and developing inclusive programmes of learning and assessment.

59 Building up evidence about which interventions are most effective is critical to achievement of our targets. We have partnered with Health Education England and the Royal College of Psychiatrists to fund a pilot to support exam preparation training. The first cohort achieved a very promising 70% pass rate. Although we need to be cautious of drawing conclusions from a single cohort, this compares favourably to the 33% pass rate for IMG candidates nationally. This initiative will continue through 2022 with 170 trainees taking part in total and is being evaluated by Edge Hill University through qualitative and quantitative evidence.

60 A new grant has also been issued to [Melanin Medics](#) to fund an enrichment programme focused on peer-support and mentorship for final year medical students of black African and Caribbean heritage and to evaluate its impact.

61 We know there is a huge amount of work that is going on across the system. For example [Health Education England](#) (HEE) have just published a report after the first 12 months of their ED&I programme. We know similar work is going on within the UK Foundation Programme Office, Medical Schools Council, Medical Royal Colleges, Health Education and Improvement Wales, NHS Education for Scotland and the Northern Ireland Medical & Dental Training Agency.

Future action plan and 2022 focus areas

- 62 This is a complex programme, with many causal factors. There is no single solution and system-wide change is necessary. To deliver our targets we will need to work in collaboration with statutory education bodies, local education providers, medical royal colleges, and medical schools across the UK.
- 63 Evidence of effective solutions is limited. We will take an iterative approach to testing, evaluating, scaling up interventions and identifying new work.
- 64 There is a genuine appetite to address our targets for the good of all trainees and students. Many organisations are trying to find the right initiatives that works for them and their learners. This means there may be a lot of initiatives happening simultaneously and trialling different approaches in the early years of this programme of work.
- 65 Connected with this, there is a likely gap in investment in evaluating the impact of the changes that are made because of time and resource constraints. We will continue to push for appropriate evaluation so that we understand, and support, business cases to scale up initiatives once proven to be effective.
- 66 Our action plan focuses on the deliverables for phase one of the 10-year work programme. Impact of individual deliverables will be tracked during phase one and the impact of all work collectively evaluated at the of this phase. The phases will overlap as different workstreams progress at different rates.
- 67 Systematic change is required at multiple points across the system. That is reflected in the six workstreams we are developing to leverage our regulatory power to set standards for medical education and training. Our focus will be:
- ***Quality assurance of recruitment and selection*** – evaluating the EDI impact of the current system including opportunity for ethnic minority and IMG learners to access their preferred specialty and training location.
 - ***Personalised support for learners and early intervention*** - setting new expectations of support for learners and developing reliable mechanisms to identify an individual’s learning needs earlier in training.
 - ***Quality assurance of inclusive learning environments*** - refining how we quality assurance training environments including a review of the quality of the evidence we gather.

- ***Quality assurance of approved trainers and support for trainers*** – refining our QA of trainers to ensure they have the skills to support a diverse group of learners and are supported by postgraduate deans.
- ***Building our data and evidence on what works*** – enhancing reports which meet the needs of our QA functions and empower stakeholders to take action and monitor impact. In 2022 we will publish more granular demographic groupings to enable more targeted interventions. We will continue partnering with others to build evidence on which interventions make a difference.
- ***Fair assessments and curricula*** – enhancing our requirements and QA to ensure that learners are supported to understand and meet the standards outlined in curricula and assessments, particularly those less familiar with UK training.

Table 4: Fairer Training Cultures Action Plan

2021 – 2024 Phase 1 Scope, external engagement and initiate transformation of QA processes and testing interventions	2024 – 2028 Phase 2 Scale up, embed new standards or guidance, reassess scope of phase 2 in response to learning and evidence of impact	2028 – 2031 Phase 3 Iterative monitoring, evaluation of impact and refinement of scope
<p>Action plan: WS1: Initiate EDI impact assessment of Recruitment & Selection processes against GMC standards WS2: good practice guidance on supporting 'higher risk' learners, QA 'deep-dive' into action plans in priority regions, development of early needs analysis tools and testing interventions to build 'what works' evidence WS3: Modelling to identify concerning learning environments & build evidence on interventions which improve inclusive local cultures WS4: Develop QA of and support for Trainers (linked with Outreach, GMP and Leg reform) WS5: Publish expanded EDI data & improve visibility and links with MWRES WS6: Define QA requirements for curricula and assessments – college and medical school ED&I action plans established</p>	<p>Action plan: Evaluate evidence from Phase 1 and impact on KPIs within pilot regions – scale up effective interventions and identify gaps to be addressed in phase 2 & 3 through new workstreams WS1: potential to create new Standards for Recruitment and selection WS2: Consider new Standards on personalised learning and recommended interventions for learners at higher risk (e.g. New to UK) WS3: – 6: Embed and expand QA of QAMI, data and research, Trainers and Curricula and Assessments</p>	<p>Action plan: Impact on KPIs – identify any further gaps to be addressed in phase 3 through new workstreams Monitor impact of establishment of new standards, systems and monitoring</p>
External engagement with partners		

Assuring Fairness of the GMC

- 68** The most recent audit of our fitness to practise decisions was completed in May 2021 by law firm FieldFisher, in partnership with the University of Edinburgh. The auditors considered 119 fitness to practise cases and found no evidence of bias in the way our decision makers interpreted the guidance. This complements past, similar research where we have sought to assure ourselves, we are not contributory to discriminatory outcomes.
- 69** While we were assured by the audits, we know that bias and disadvantage is a significant issue in the health system and broader society. If we are to learn and improve, our fairness audits need to be designed and delivered in a way

that seeks out and finds the instances of bias so that we, and others, can learn from them.

- 70 In June 2021 an Employment Tribunal upheld a claim that we had racially discriminated against a doctor in our fitness to practise processes. We understand stakeholders' disappointment with that outcome, and our decision to appeal. In response we began a broader review of how we assure ourselves that our regulatory processes clearly demonstrate fairness in decision making, and proactively demonstrate where potential fairness concerns may exist. We will complete this programme of work later this year, under the following focus areas.

Future proofing through regulatory reform

- 71 The UK Government's proposed reforms to how we regulate brings many benefits and opportunities. This is a unique chance to redesign our processes and embed fairness across everything we do. It has the potential to fundamentally change what concerns we investigate and how. We want to ensure that fairness is central to how we design these processes and to be transparent with our stakeholders about how we have taken account of the equality dimension of our proposals. We also want to support our people to do this to the best of our ability. In response we:

- delivered supplementary training during October to our teams working on our regulatory reform programme on our approach to equality impact assessment and targeted training on human rights
- will publish our equality impact assessments that underpin our proposals when we publicly consult
- will externally and independently quality assure our final equality impact assessments. These will reflect the feedback of stakeholders during our consultation. And we will publish them to demonstrate our confidence in the approach we adopt and our openness to scrutiny of the fairness of our proposals.

Improving our current processes

- 72 From November 2021 through to March 2022 we are delivering workshops across all our functions to understand the equality, inclusion, and fairness learning needs of our people, targeted to their role. This builds on our existing ED&I mandatory staff training, to provide more targeted learning support. We are using this output to complete a refreshed learning needs analysis that is

clear on how we can skill and support our people to not just be fair and inclusive, but to proactively challenge bias and discrimination.

73 We have created two working groups to:

- systematically review high-stakes decision points in our processes and identify if we can strengthen the controls for fairness in the short term. This includes single vs. group decision-making, quality assurance arrangements, and the adequacy of guidance
- review how we use protected characteristics data in our process performance reporting. We want to be transparent about how our processes operate and the individuals within them. We have challenges meeting the wide range and specificity of requests from stakeholders and they often result in numbers so low that they hit our suppression rules. This can contribute to perceptions of a lack of transparency. This work will develop an approach to standardised reporting on a regular and routine basis of how our processes work from a fairness perspective.

Independent assurance

74 In January 2022, we commissioned an external, expert review of our past research on the fairness of our processes to identify and apply any learnings from this. This includes listening to doctors that have been through our processes to understand their perceptions of bias in our approach, so that future audits can test these elements.

75 We will use the output of this review to implement a rolling programme of routine fairness audits of our processes and publish the results and learnings of where bias exists in ours, and others, processes.

Inclusivity within the GMC

76 Our aim is to build an organisation that is diverse at all levels and that the employment and workplace experience of all colleagues is inclusive, positive and provides fair access to opportunities for all. To do this, we are committed to eliminating differentials by protected characteristic in recruitment, representation across staffing levels, retention, progression, pay and engagement. These are currently most marked when we look at ethnicity.

77 Our performance targets and performance for 2021 are set out in Table 5 below:

Table 5: Inclusivity in Employment Measures

		Actual				Target		
		2020 (%)	2020 (Vol)	2021 (%)	2021 (Vol)	2023	2021 percentage points from 2023 target	2026
Increase the level of ethnic minority representation at Level 3 and above	Applications	22.8%	170	32.1%↑	253	27%	+5.1%	30%
	Interviews	15.2%	118	22.4%↑	60	22%	+0.4%	25%
	Offers	14.6%	36	32.1%↑	16	17%	+15.1%	20%
	Workforce	11.1%	64	13.3%↑	77	16%	-2.7%	20%
Level of ethnic minority representation at Level 2+		8%	18	10.8%↑	23	14%	-3.2%	20%
Level of ethnic minority representation at level 3		12%	46	14.3%↑	54	16%	-1.7%	20%
Increase the level of ethnic minority representation at all levels	Applications	29.4%	663	40.0%↑	1332	37%	+3.0%	40%
	Interviews	18.2%	118	27.4%↑	260	32%	-4.6%	35%
	Offers	18.2%	36	30.2%↑	88	27%	+3.2%	30%
	Workforce	14.3%	211	16.0%↑	247	17%	-1.0%	20%
Reduce differential turnover rates for ethnic minority staff		0.8%	-	Ethnic Minority (%) 8.2%↑	White (%) 7.8%	1-2%	0.4%	1.0%
Proportion of ethnic minority staff receiving promotion and grade progression is proportionate to our workforce at the relevant grade/level <small>*difference is not set against the 2023 figure, the target is that the proportion of staff will be equal across BME and Non-BME</small>		-1%	-	Ethnic Minority (%) 17.7↑	White (%) 14.3	18%	3.4%	18%
Pay differentials within a confined band limited to 2% from 2023 ¹ <small>(table shows the proportion of bands that are outside of the tolerance)</small>		50.0%	6/12	41.7%	5/12	2.0%	N/A	2.0%

N.B. - ↑ identifies improving measures

2021 action

Workforce profile and career development

- We have made solid early progress and our workforce trends are on track:
 - turnover and progression are in line with our 2023 targets
 - our recruitment metrics are on target, albeit with a fall off from application to interview
 - our overall staffing make up is likely to be in line, or above, our 2023 target.
- 78** Our latest projections suggest that current turnover and appointment trends will take us to, or close to our targets.
- 79** Sustaining these trends will be helped by further planned activities targeted at graduates and apprentices, and we expect our in-house training to support improved internal progression. We will also expand our recruitment outreach work to better identify, support and attract a pipeline of diverse talent.
- 80** Increased external recruitment has had a positive impact on these results. We need to balance this against ensuring our investment in existing staff from under-represented groups translates into career progression for them also.
- 81** While we are happy with our progress, the recruitment market is volatile, and turnover is higher at our lower levels. We will need to work hard to retain staff and maintain this level of performance. Our planned programmes for graduate and apprentice programmes (starting this year) are expected to have an additional positive impact on our workforce profile (and management roles in 4 to 5 years).
- 82** We have seen a solid, but more limited level of progress in our more senior roles compared with than we have at other levels. Our 2026 targets are ambitious and progress towards them is sensitive to turnover. Our current projections are that we would, in terms of headcount and current, be 8 below our target in 2026, 3 below in 2027. Forward planning and supporting early retirements may help. While our recruitment experience is generally positive, we will ensure we take every opportunity over the coming years to progress further on senior hires We expect that our internal development programmes and an increasing diverse workforce will see us close this projected shortfall.
- 83** Alongside this work on our workforce projections, we have also started to look at the wider impact of changes to our turnover, recruitment and promotion patterns. This at an early stage, but this will inform our ongoing work, especially around recruitment where we can potentially identify groups where

we are less successful on attracting or progressing candidates, while consolidating good practice where we are making progress

- 84** Our work on the relationships between different protected characteristics is at an early stage, but there are some clear patterns from our 2021 data. Over the last four years we have seen a small average increase in the percentage of our staff who are women (62% to 63.1%). We know female applicants are increasingly well represented as our recruitment process progresses. This is slightly more marked for ethnic minority candidates. In 2021 ethnic minority candidates were 60.2% female and 39.8 % male, but the appointment ratio was 69.2% female and 30.4% male, so a potential area for further review.
- 85** The other area we have considered is age. Ethnic minority colleagues are younger on average, and this became more marked in 2021. In 2018 ethnic minority colleagues were 2.1 years younger on average, in 2021 it was 3.7 years. Ethnic minority applicants are on average 29.6 years old compared to 33.4 years for other candidates.
- 86** This highlights the potential value of our internal development programmes, the importance of career ladders and retention in meeting our longer term aims.
- 87** It also provides some reassurance that further recruitment via graduate and apprenticeship schemes. Is likely to support our aims.
- 88** While our current focus on more external recruitment has proved successful, we can see the longer-term benefits of supporting the progression of an increasingly diverse internal workforce. It also highlights the potential challenge in diversifying our senior leadership in the short and medium term where younger candidates face extra challenges.
- 89** We have a programme of learning and development initiatives to support achieving our aspirations. This includes two programmes delivered by an external training provider. These supplement our existing leadership offering for all staff, to make sure colleagues from ethnic minority groups currently underrepresented at a senior level are supported to reach their potential:
- Developing Diverse Leadership - for colleagues at levels 2, 3 and 4
 - Developing Diverse Talent - for colleagues at levels 5 and 6.

Workplace experience

- 90 As an important foundation for our inclusion aspirations, we embedded inclusivity into our OneGMC behaviours at the start of 2021. This included making sure inclusivity considered and integrated into staff objectives and promoting our internal and external aspirations widely across the organisation. This will become a more integral part of our approach to 360° feedback.
- 91 In October 2021 we launched our *Fostering inclusion* programme, designed to help managers build more inclusive teams. Leaders and managers are starting their learning journey with initial self-evaluation and self-led learning modules. The programme will be rolled out in cohorts, each one including managers from a mix of levels and directorates. All people managers will take the course over the next 18 months.
- 92 We completed the first phase of an anti-racist allyship programme, training five separate cohorts for a total of 50 allies across all directorates and levels (three all staff cohorts, one Head of section/Assistant director cohort and one for our Senior management team).
- 93 It is harder to assess the trends on workplace experience for colleagues. We have seen black colleagues move closer (on average) to our GMC average engagement score with a four-point improvement against generally falling scores. Conversely, colleagues who identify as Indian and colleagues who identify as 'other' ethnic minority groups are just outside our 5% target.
- 94 The inclusion index, which has a more focused set of questions, illustrates the progress we need to make. Analysis of our survey results suggests that some specific groups of ethnic minority staff are well below the GMC average (75%). Our other staff surveys that occur at various times of the year, covering specific issues show similar patterns on ethnicity. Another related indicator (turnover) is more positive.

Action plan for future activity and 2022 focus areas

- 95 We have developed activity plans for the duration of the measures in three domains, our projected activities are shown below in Tables 6 - 8.
- 96 Most of our planned interventions are at an early stage, so it is too early to assess progress through our people survey in July, but we will continue to monitor on a monthly basis performance against the delivery of these plans and how these are impacting on our performance measures. Our targets are challenging and the output from the 2022 survey will be crucial in assessing any initial impact and next steps.

- 97** For 2023/24, assuming we continue to make progress against our targets we would expect to focus on a sustainable model that consolidates our progress and meet our wider organisational needs.
- 98** Our approach from 2024 will be governed by our experience in the previous years and any changing skills requirements as a result of regulatory reform and broader changes. We will also need to make sure that we keep pace with changing candidate expectations and new processes. For example, increasingly virtual/remote recruitment and its equality implications.
- 99** Our longer-term approach will include:
- diverse intake options, such as graduates and apprentices, continuing
 - a shift towards career pathways - graduates, fast-track, professions maps – should result in management roles filled from a diverse internal pool
 - an increasing focus on specific under-represented groups
- 100** Our internal development support for colleagues will be reviewed and updated for 2024. This is a typical pattern for leadership programmes. We expect to maintain a commitment to support all staff and continue to address the barriers some groups of colleagues' face. Our initial thinking is that our next generation of programmes will do both, with core elements for all colleagues and options that allow an individual to build a personalised programme that addresses their individual needs.

Table 6 – Action Plan for Recruitment and Workplace Diversity

2021 launch	2022 phase one	2023 phase one	2024 phase two	2025 phase two	2026 phase two
Recruitment and Workplace Diversity					
<p>Completed:</p> <p>Briefing sessions for all recruiting managers and toolkit.</p> <p>Level 3 + vacancies advertised externally.</p> <p>Diverse candidate list implemented.</p> <p>Briefings to recruitment agencies on targets & monitoring.</p>	<p>Action plan:</p> <p>Develop outreach recruitment processes</p> <p>Approved apprentice, interns, and graduate programmes</p> <p>Deliver People Manager Essentials – Recruiting managers training</p> <p>Develop a structured process for diverse shortlist and interview panels</p> <p>Disability Confident Employer – Level 1 - launch a guaranteed interview scheme in line with Disability Confident</p>	<p>Action plan:</p> <p>Next phase of outreach recruitment function delivered</p> <p>Deliver the approved apprentice and interns’ programme.</p> <p>Recruitment agency tender & apply targets to the contract.</p> <p>Review People Manager Essentials & recruiting managers training</p> <p>Expand publication of monitoring data to cover all characteristics</p>	<p>Action plan:</p> <p>Deliver the approved apprentice, intern and graduate programme</p> <p>Start new People Manager Essentials – Recruiting manager’s programme</p> <p>Develop new career pathways model (consider trainee/fast track routes)</p> <p>Achieve Disability Confident Level 2 - Disability Confident Employer</p>	<p>Action plan:</p> <p>Continue to deliver the approved apprentice, intern and graduate programme</p> <p>New fast-track/trainee route to be considered</p> <p>Achieve Disability Confident Level 3: Disability Confident Leader</p>	<p>Action plan:</p> <p>Recruitment agency tender & apply targets to the contract.</p> <p>Continue to deliver the approved apprentice, intern and graduate programme</p>

Table 7: Action Plan for Learning and Development

2021 launch	2022 phase one	2023 phase one	2024 phase two	2025 phase two	2026 phase two
Learning and Development					
<p>Completed: New competency framework - Embed inclusion into OneGMC behaviours & PDPs. Allyship programme and network of Allies.</p> <p>Delivery of People Manager Essentials – Absence and Health.</p> <p>Launch Fostering Inclusion Programme for all Leaders</p> <p>Increase diversity of coaching & mentoring pools.</p> <p>Ensure all leaders have access to leadership development programme, Leading at the GMC.</p>	<p>Action plan Roll out of Professional Behaviours module Embed OneGMC Behaviours into performance cycle Update of 360 & all colleagues to have 360 feedback Access to coaching for all colleagues. Talent programmes for ethnic minority staff CPD / support to Allies, coaches, and mentors. Launch Leadership Everywhere programme Refreshed Treating People Fairly e-learning</p>	<p>Action plan: Deliver our Leadership Everywhere programme. Deliver our Inclusion Programme for all People Leaders. 360 feedback for remaining staff Deliver our talent programmes for ethnic minority colleagues Assess impact of talent programmes to inform next round in 2024. Assess the impact of our Fostering Inclusion and Professional Behaviours Maintain skilled coaching/ mentoring pool.</p>	<p>Action plan: Phase 2 of talent programmes. Phase 2 of inclusion programmes - all staff and leaders Development of training on bullying, harassment, and discrimination. Phase 2 leadership development - focus on organisational change & regulatory reform. Review suite of development programmes and digital content Review and update behaviours/competence framework Maintain a skilled coaching/ mentoring pool.</p>	<p>Action plan: Phase 3 of talent programmes – new integrated model Phase 3 of inclusion programmes - all staff and leaders Next phase of leadership development, with a focus on supporting organisational change arising from regulatory reform. Maintain a comprehensive suite of development programmes and digital content Updated 360 process based on 2024 behaviours review</p>	<p>Action plan: Phase 4 of talent programmes – new integrated model Phase 4 of inclusion programmes - all staff and leaders Next phase of leadership development, with a focus on supporting organisational change arising from regulatory reform. Maintain a comprehensive suite of development programmes and digital content</p>

Table 8: Action Plan for Staff Engagement and Workplace Inclusivity

2021 launch	2022 phase one	2023 phase one	2024 phase two	2025 phase two	2026 phase two
Staff Engagement and Workplace Inclusivity					
Completed: Developing future working arrangements including flexibility guidance. Providing HR support to networks. Tracking progress through our people survey and EDI elements of pulse surveys.	Action plan: Updating our job evaluation framework Review our benefits offering to ensure suitability and value for money Introduce a new EAP service Ensure all managers access to mental health training Maintain our wellbeing champions and mental health first aid networks Assess impact on new Valued award process. Introduce expanded retirement/late career guidance support	Action plan: Take further steps to reduce the gender and ethnicity pay gaps within pay bands to under 2% by 2023. Occupational Health service contact review Ongoing programme of policy review and development of associated EQIAs Expand support on pensions & financial planning through total reward statements, staff seminars Maintain our wellbeing champions and mental health first aid networks	Action plan: New preparation for retirement programme Review our progress against IIP gold standard/Wellbeing standards Ensure all managers have continued access to mental health training Maintain our wellbeing champions and mental health first aid networks EAP contract review 2024 staff survey	Action plan: Programme of policy review and development of associated EQIAs Ensure all managers have continued access to mental health training and complete people manager essentials on absence Maintain our wellbeing champions and mental health first aid networks Review our progress across IIP gold standard 2025 staff survey	Action plan: Programme of policy review and development of associated EQIAs Ensure all managers have continued access to mental health training and complete people manager essentials on absence Maintain our wellbeing champions and mental health first aid networks Review our progress across IIP gold standard 2026 staff survey

Working with others – four country context

England

- 101** We continued to facilitate group engagement at RO Networks across England. We have developed specific case studies to help share good practice and to drive forward the thinking of some in the network, such as: :
- providing feedback to locum doctors to help identify future career options
 - better flow of information around the system to make sure locums are properly regulated and supported
 - equip management teams with skills and mindset to tackle low level issues appropriately.
- 102** We engage with the WRES team on a bi-monthly basis to support the commitment in the NHSE People Plan to address the ethnicity gap. We are also exploring opportunities to align messaging with NHS Resolution’s professional performance advisory service and the safety and learning directorate.
- 103** Within London we are working collaboratively with NHSE&I and HEE counterparts to help providers develop a three-to-five-year change programme to address the disparities in the MWRES data and support doctors locally.
- 104** Across the North of England, we have collaborated with partners across the system including NHSE&I, the BMA and providers to raise the issues from FTR at a number of local and regional events. We have also worked with an NHSE&I IMG induction pilot task and finish group which secured funding for two induction pilots in the Northeast which we will support with local WtUKP.
- 105** In the Midlands, we have partnered with HEE and NHSE&I to support the development and promotion of the [Midlands Charter for training and wellbeing](#) guide which received the 2021 British Medical Journal’s Wellbeing award.
- 106** In the South of England, we have shared the findings from FTR with the regional NHSE&I Human Resource director network, an ED&I leads network and the NHSE&I regional ED&I working group. We are currently helping to pilot a regional RO/Medical Director (MD) ED&I working group with NHSE&I to consider how best to work together to support ROs/MDs around the NHS disciplinary gap and the disproportionality within referrals. We are also engaging with a trust Director of Organisational Development to support their

work to improve organisational culture, with a focus on fairness and professionalism.

Northern Ireland

107 Northern Ireland has a comparatively low proportion of IMG and minority ethnic doctors. Gender and sexual orientation are generally higher on the ED&I agenda and stakeholders cite Northern Ireland's different equality legislation. We have collaborated with NHS Confederation and Health and Social Care (HSC) Trusts to deliver an ED&I seminar at the Northern Ireland Confederation for Health and Social Care annual conference. At this event, we secured a commitment that ED&I issues would be raised at the HSC Leadership Council.

108 Although we see many issues in Northern Ireland take greater priority, there have been positive outcomes for ED&I:

- WtUKP is now a mandatory requirement for all doctors new to Northern Ireland, to be completed within their first three months.
- 25% of Queen's University medical students are from ethnic minorities. This is not reflective of the Northern Ireland population. They have an established programme of interventions to support ethnic minority students but have been unable to secure support for changes to dress codes in HSC trusts, such as disposable sleeves.

109 Since the re-establishment of the Northern Ireland Joint Regulators Forum in spring 2021, there is a platform to share information, novel approaches, and ideas about improving the impact and effectiveness of regulation. ED&I issues are regulatory discussed by the Forum.

Scotland

110 We have discussed our targets with stakeholders in Scotland, including at our UK Advisory Forum. We have heard about positive work happening across Scotland, but also that some organisations need to review their own practices, including leadership. Sessions and interactions with medical education managers and supervisors has produced positive feedback, with a common comment on the need to broaden our remit to include women, disabled doctors, and consider intersectionality. Across all interactions there has been a common concern about the challenge of progressing this work amidst current pressures.

111 We are aware of several changes and improvements taking place across Scotland at the moment, including:

- a group looking into creating a system similar to the MWRES for Scotland
- a new system of ED&I leads and champions across the health boards
- the provision of unconscious bias and active bystander training in undergraduate and postgraduate training.

Wales

112 We have been working closely with a specific Health Board and plans are in place to embed WtUKP in sessions in 2022. And we are making progress with Health Education Improvement Wales to get WtUKP included in their week-long induction programme for IMGs.

113 We are part of the new Specialty and associate specialists (SAS)/IMG Expert Advisory Group that is looking specifically at our differential attainment data and the wider environments that lead to unfair referrals. This group includes Health Education Wales and Health Board Medical Directors and was set up on the back of our presentation on our ED&I targets to the Wales Medical Directors in September.

114 Most stakeholders in Wales have placed ED&I as a top priority. IMGs and ethnic minority healthcare workers make up a large proportion of the workforce in Wales. Work underway includes:

- Welsh Government's race equality action plan for public services, which covers several areas and includes our own ED&I targets.
- NHS Wales' SAS charter and NHS's respect and resolution policy. These are important policies to create positive work cultures but still need to be fully embedded.
- British Association of Physicians of Indian Origin (BAPIO) Wales's memorandum of understanding with Health Boards. This focuses on early intervention and early resolution, taking a local first approach.

Conclusion

- 115** In setting these aspirations and targets, we knew these were ambitious. We committed to using our levers and our regulatory powers to increase the pace of change. We intended for the targets to generate collective and collaborative efforts, and this annual progress report is an opportunity for us to continually share progress and our calls for action.
- 116** We have made significant progress in delivering the key actions we intended to put in place to pursue the targets and we believe this demonstrates a solid foundation for a first year of activity. However, it is too soon to draw a meaningful conclusion on progress against the metrics themselves. Given the longstanding nature of these issues, we would need to see sustained and meaningful progress over a longer timeframe.
- 117** The pace of delivery in year one has undoubtedly been fast. We continue to reflect on the need to balance pace with the importance of maintaining the quality of our approach and ensuring we build in time to secure buy-in from all relevant stakeholders.
- 118** We have recognised that we need to maintain an iterative approach to make sure we understand what has an impact, and to vigilantly reassess our interventions and work with others in a more agile way.
- 119** We are working to develop an estimated picture of long-term change on the measures and targets. We need to undertake more work to assure ourselves on the validity of the approach.
- 120** We said from the outset that we're not alone in aspiring to shift the dial on addressing inequalities, and this remains true. Many of our partners have active and wide-ranging agendas to address inequalities and we know that some are showing positive progress. But the challenge remains for us all to make sure this activity is delivering real improvement and on that, we have a long way to go.
- 121** When we launched our ED&I aspirations, we were cognisant that we did so during a pandemic. Despite this, we received universal support for the areas we focused on, and for setting targets. A number of stakeholders told us that they felt it was an important signal from the regulator to the system. Although the pressures of the pandemic remain, we have not sensed or seen any diminished commitment to tackling these issues. Instead, stakeholders have remained sharply focussed on delivering change, but inevitably there will be challenging

and ongoing demands for scarce resources across the health service for the foreseeable future.

- 122** We have sought to make it clear in this progress report where we think other stakeholders must play a role. We recognised that we need to be clearer with our ask of partners and stakeholders across the health system and how we intend to use our regulatory levers to good effect in the future.

<p>Paper withheld from publication</p>	<p>Please note that this annex is withheld from publication until late 2022.</p> <p>For further information, please contact the Corporate Governance team via email, GovernanceTeamMailbox@gmc-uk.org.</p>
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Action	To note
Purpose	<p>This report updates Council on the regulation of physician associates (PAs) and anaesthesia associates (AAs). Although legislation is progressing more slowly than hoped, we are well advanced in delivering core programme outputs. We have designed routes to registration, established an education quality framework and published interim professional standards. Engagement with stakeholders remains extremely positive and our communications to PAs and AAs continue to be well received.</p> <p>Becoming a multi-professional regulator presents new challenges, especially as the number and role of PAs and AAs in the workforce continues to develop. Upcoming work will address some complex issues around local governance and supervision for PAs and AAs, and the extension of prescribing responsibilities.</p>
Decision trail	Council has received regular updates on MAPs since the programme began, most recently at the June 2021 meeting.
Recommendations	<p>a To note the progress made on the core regulatory framework</p> <p>b To note the emerging issues outlined and offer any reflections</p>
Annexes	None
Author contacts	<p>Clare Barton, Assistant Director, MAPs</p> <p>Helen Arrowsmith, Programme Manager, MAPs</p> <p>Any enquiries to: GovernanceTeamMailbox@gmc-uk.org</p>
Sponsoring director/ Senior Responsible Owner	Una Lane , Director of Registration and Revalidation

Background

- 1 In July 2019, the Department of Health and Social Care (DHSC), with the support of the four UK governments, asked us to regulate PAs and AAs, two of the four medical associate professions (MAPs). We have now completed many aspects of regulatory design, and work continues as we await the legislation needed to bring our new responsibilities into effect.
- 2 All MAPs programme costs are being met by DHSC under a formal agreement which prevents any cross-subsidisation from fees paid by existing registrants. The agreement includes set-up costs plus transitional funding for running costs until these are fully covered by fees paid by PA and AA registrants.
- 3 This report has three sections and updates Council on:
 - Legislation and the revised timeline for starting regulation
 - Our progress on regulatory design: what's either done or underway
 - Emerging issues to consider, including workforce development

Legislative development and timeline

- 4 DHSC intend to bring PAs and AAs into regulation at the same time as making wider reforms to the GMC's powers and duties.¹ The decision to couple the legislative changes in this way means PA/AA regulation is not now expected to begin until summer 2023 at the earliest.
- 5 There have been two significant delays to the regulatory timeline since we began our programme. Whilst this is disappointing for stakeholders, our work continues uninterrupted and additional funding has been requested from DHSC to cover increased costs incurred due to the delay. We have kept in close contact with key stakeholders across the four nations throughout and this has helped to maintain positive relationships and confidence in the GMC.
- 6 The draft legislation identifies three groups that will be regulated by the GMC:
 - a Medical practitioners (ie, doctors)
 - b Physician associates
 - c Anaesthesia associates

¹ As set out in the March 2021 consultation, [Regulating healthcare professionals, protecting the public](#)

With the exception of some transitional provisions, we understand that the powers and duties laid out in our revised legislation will apply equally to all three professions; any differences in application across professions will be specified in GMC rules or policy.

Work completed or underway

Registration and assessment

- 7 We have completed processes for our two priority PA/AA registration groups: the transitional cohort of existing practitioners and future qualifiers from UK universities. Attention is now focused on:
 - a Designing a registration route for overseas-qualified PAs and AAs. This is not straightforward because, unlike doctors, there is no internationally accepted title or scope of practice for PA or AA roles, and these professionals aren't regulated in many countries outside North America.
 - b Developing a registration assessment for AAs to match the one that already exists for PAs. A pass in our designated assessment will be a requirement for entry to the GMC register, for both UK and overseas professionals.
- 8 PAs and AAs will be separately identified on our register. We'll be exploring how best to present the three registrant groups on the public-facing register to allow users to search either across the whole register or just within one profession.

Education

- 9 Our priorities for PA and AA education are to update the existing curriculum for each profession and establish a quality assurance (QA) process for UK courses. We've made strong progress in both these areas. All 37 course providers (35 for PAs and two for AAs) have engaged voluntarily in a baseline QA exercise, completed a self-assessment against our published standards, and received initial feedback on strengths and areas for improvement. We'll continue to support current and future providers in the run up to regulation.
- 10 We've developed high-level education outcomes for MAPs and worked with the colleges and others to create PA and AA curricula that are outcome-focused and can meet our standards. Over 100 organisations and individuals responded to our recent engagement on the draft curricula, offering high levels of support. We'll support the respective colleges/faculties to make further revisions prior to formal approval by the GMC and will ask course providers to implement the new curricula from September 2023.

Professional standards

- 11** We published *Good medical practice (GMP) for PAs and AAs* in October 2021 together with accompanying case studies. These standards will operate from the start of regulation until we publish new ethical guidance for all registrants emerging from the wider GMP review. Publishing interim standards gives PAs and AAs, students, and educators, time to prepare for our expectations, and we know from feedback that this has been appreciated. We're currently considering how our Outreach teams can support future/new registrants, both before and after regulation.

Fitness to practise

- 12** We expect PAs and AAs will be subject to the revised fitness to practise processes enabled by reformed legislation, although details are still to be confirmed. These same processes are expected to apply to doctors, subject to the outcome of consultation and appropriate transitional provisions.
- 13** In the meantime, we are supporting the Faculty of PAs/Royal College of Physicians in handling concerns about the conduct of PAs on the managed voluntary register.² Although we don't yet have any regulatory remit, we have a shared interest with colleges and employers in maintaining high standards of professional conduct and ensuring a smooth transition to regulation.

Communication and engagement

- 14** We continue to engage widely with PAs, AAs, doctors, patients, and other stakeholders. Our External Advisory Group meets quarterly; we've created an [information hub on the GMC website](#); and over 1,500 individuals have signed up to receive regular news or contribute views via our 'Community of Interest'. The programme team regularly speak at stakeholder events, including the recent PA and AA national conferences where we reached over 700 people.
- 15** Our communication and engagement strategy is regularly updated to respond to changes and emerging risks in the external environment, as well as the needs of different audience groups. Activity over the coming months will target PA/AA students, employers and doctors. Later, we'll explore what information would be helpful for the wider healthcare team. In addition, our upcoming GMP consultation (which covers all three registrant groups) provides an opportunity to engage patients and increase their understanding of these new professions.

² There is an AA voluntary register held by the Royal College of Anaesthetists, but no code of conduct or fitness to practise process, so concerns about AA conduct can only be raised with employers.

- 16 We remain mindful of the impact of the pandemic and system pressures. The current situation reinforces the value of developing PAs and AAs as regulated professionals who can contribute to a sustainable NHS workforce. But our engagement activity needs to be proportionate and targeted at this time.

Emerging issues and longer-term regulatory development

Prescribing

- 17 The DHSC has begun work with PA and AA professional bodies, NHS England and the devolved administrations to extend prescribing responsibilities to PAs and AAs after regulation. We support this important step in increasing the utility of these professions and are contributing to discussions. The decision on prescribing will be made by the Commission on Human Medicines and requires a separate public consultation and legislative process.³
- 18 We don't yet know how prescribing will operate for these professions but access to prescribing is likely to involve a period of supervised clinical practice and learning/assessment *after* qualification. The GMC would be responsible for quality assuring that learning. We might also develop a view on the best training mechanism for different cohorts, bearing in mind that existing PA/AAs already have experience of recommending medications and, in future, we will oversee the pharmacology/prescribing content of approved PA and AA courses.

Post-qualification education, training, and development

- 19 Future implementation of prescribing sharpens the focus on governance and lifelong learning arrangements for PAs and AAs. There is currently no structured post-qualification education and training for PA/AAs such as exists for doctors with foundation and specialty training. Instead, PAs and AAs develop within local governance structures and non-statutory guidance.⁴ Whilst that isn't necessarily a problem, it limits our ability as regulator to influence how PAs and AAs develop their knowledge, skills and scope of practice after entry to the register. For example, should we wish to require minimum levels of supervision for newly qualified PA/AAs, we have no obvious mechanism to do so.

³ Alongside prescribing, PAs and AAs are currently prevented by law from ordering X-rays and ionising radiation. However, once they are regulated, this will be possible without further legislation, provided the PA/AA has been approved by their employer and undergone the appropriate training.

⁴ Health Education England, with input invited from all four countries, are working on a core capabilities framework covering the four MAPs professions. We have been closely involved in this project, which will provide a valuable structure for PA/AA career development, but it doesn't include profession-specific training and isn't a regulatory or quality assurance mechanism.

- 20 At the programme scoping stage we decided to defer consideration of the post-qualification arena until after we had established the essential, core regulatory framework. Delays to the regulatory timescale offer a potential opportunity for us to develop thinking in this area, although we remain mindful of the principle of proportionality and financial constraints whilst the number of practising PAs and AAs is comparatively small.
- 21 Questions have also arisen as to whether there will be pathways to move between the PA/AA and doctor professions without the need to re-qualify from scratch. We need to consider how we would respond to the emergence of a 'fast-track' conversion qualification and how best to display on our register those who are qualified in more than one profession.

Governance and revalidation

- 22 As with doctors, the GMC isn't responsible for deployment decisions or local clinical governance arrangements for PAs and AAs. However, we can influence these including through our revalidation policy. We have begun considering revalidation for PAs and AAs and we're revising our existing clinical governance handbook so that it applies to all GMC-registered professionals.
- 23 There won't be a revalidation requirement for PAs and AAs immediately upon registration, but employers are keen to understand our expectations to inform local workforce planning and governance arrangements. For example, we are often asked whether appraisal practices for doctors should now also be applied to PA/AAs, and if we intend to maintain the exam-based re-certification process that currently operates for PAs on the voluntary register. We therefore intend to engage stakeholders on revalidation options during the first half of this year.

Multi-disciplinary team working

- 24 PAs and AAs are still relatively small and new professions. At the time writing, there are around 2,800 PAs and 160 AAs practising in the UK. It's likely they will grow in both number and scope of practice in the coming years, and this may occur differently in different sectors or parts of the UK. Such development presents a significant opportunity for the NHS workforce, but it may also create challenges if integration of PAs and AAs into teams isn't well managed. We know doctors and other healthcare professionals sometimes have concerns about the potential adverse impact of changing workforce composition on role boundaries (including patient understanding of these), line management responsibilities, pay and professional development opportunities.

- 25** We're already engaging with the professions, employers, and educators to make sure the future PA/AA regulatory framework supports workforce needs and is capable of keeping pace with changing circumstances. We'll keep listening, as well as sharing progress, as regulation of PAs and AAs moves closer.
- 26** We welcome reflections from Council on the emerging issues presented here.

Action	To note progress on the review of <i>Good medical practice</i> and approve plans to move to public consultation on a revised draft.
Purpose	This paper summarises progress on the review of GMP and seeks approval to consult on the revised text in Annex A. It gives an overview of: our intelligence gathering and engagement activity; equality analysis; key changes to be tested in consultation; consultation plans and implementation strategy.
Decision trail	<p>We updated Council on plans to review <i>Good medical practice</i> at the Council meeting on 25 February 2021.</p> <p>SMT approved the Planning Gateway recommendation to progress the review to delivery stage in May 2021.</p> <p>The review was discussed at the Council away day in September 2021 and progress was summarised in Council circular 27/21.</p>
Recommendations	To approve plans to move to public consultation on a revised draft of <i>Good medical practice</i> .
Annexes	<p>Withheld From Publication:-</p> <p>Annex A: An annotated working draft of revised <i>Good medical practice</i></p> <p>Annex B: A detailed summary of changes to the document</p> <p>Annex C: The intelligence and research underpinning the review</p> <p>Annex D: Engagement and consultation</p> <p>Annex E: Planning for implementation</p> <p>Annex F: Explanatory guidance in scope</p>
Author contacts	<p>Mark Swindells, Assistant Director, Standards and Guidance</p> <p>Fionnula Flannery, Head of Strategy and Planning, Standards</p> <p>Any enquiries to: GovernanceTeamMailbox@gmc-uk.org</p>
Sponsoring director/ Senior Responsible Owner	Colin Melville , Medical Director and Director of Education and Standards

Background to the review

- 1** In May 2021, SMT agreed to progress to delivery stage the review of *Good medical practice* (GMP) and ten pieces of associated explanatory guidance. SMT agreed that the review supports our corporate strategy ambitions and is a timely opportunity to:
 - prepare for our regulation of physician associates (PAs) and anaesthesia associates (AAs)
 - capture the changes in healthcare and wider society since the previous update eight years ago
 - fit with upcoming regulatory reform which will give us new rules, systems and processes for fitness to practise (FtP), registration and education. Refreshed professional standards will support that change: new system, new standards.
- 2** In September 2021, we updated Council on the key insights emerging from our intelligence gathering to date, and sought Council’s input into the future model, style, tone and scope of the future professional standards. We also provided a background reading pack on the history of GMP, which is available on Board Intelligence. Council members may find it helpful to refresh their memories of that ahead of this meeting.
- 3** Key steers from the away day discussion included that we should:
 - publish shared professional standards for all our registrants, and future proof for other groups we may be asked to regulate
 - retain the succinctness and four domain structure of GMP, and resist calls to turn it into a narrative, virtue signalling document
 - enhance the content on communication
 - engage meaningfully with patients as well as professionals in the development of the revised standards.
- 4** This paper summarises progress on the review since then and seeks agreement to publish a revised draft of GMP for consultation.

Intelligence gathering and research

- 5** We carried out a range of pre-consultation activities to develop the evidence base for the review. These included:
 - desk research, with support from our intelligence, data and research teams, to identify relevant findings from recent reviews and public inquiries; external reports and research; and insights from internal data sources

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- a three-part research project which looked at: guidance models used by other regulators; how our guidance is used internally by different parts of the organisation; how external audiences use our guidance and materials
- a targeted four country stakeholder survey.

6 More detail on this activity and the evidence base we developed is at **Annex C**.

External advisory forum and pre-consultation engagement

- 7** In September, we held the first meeting of the [GMP Advisory Forum](#), chaired by Professor Emma Cave, Professor of Healthcare Law at the University of Durham. The twelve members bring together experience and perspectives from across the four countries of the UK, ranging from clinical leaders, practising clinicians (doctor, PA and AA) and patient advocates, to experts on medical ethics and equality, diversity and inclusion. The group met four times in 2021 and we expect it to meet on a further three occasions following the consultation analysis in the autumn of 2022.
- 8** Given the extremely challenging environment across the UK's health services, we have mostly used existing forums and mechanisms to test emerging insights and ideas with key stakeholder audiences. We have sought views at meetings including our patient roundtable, doctors in training roundtable, strategic Equality Diversity and Inclusion (ED&I) forum, responsible officers' reference group, legal counsel forum, and the Black and Minority Ethnic (BME) doctors' forum.
- 9** We have also carried out targeted engagement with the British Medical Association, defence bodies and other regulators to keep them informed about progress on the review, and identified opportunities to promote the review at senior level meetings and events, including with written updates at the UK advisory forums.

Internal oversight and engagement

- 10** The project has been overseen by an internal project board, made up of workstream leads and representatives of the teams across the GMC that are delivery partners to the review. A senior oversight group made up of assistant directors across the GMC has been kept informed through update emails and direct engagement from the project sponsor.
- 11** Alignment with the regulatory reform programme has been maintained through the project sponsor attending the regulatory reform programme board, and through quarterly meetings between the project management teams. We are also engaging directly with the Department of Health and Social Care (DHSC) and colleagues on the regulatory reform programme to make sure there are no unintended consequences of regulatory changes to our standards model. These discussions are ongoing.

- 12** Internal engagement has been through bespoke workshop sessions with colleagues across the GMC; sessions at existing meetings; and three cross-GMC workshops on our implementation strategy. We also brought together an equality, diversity and inclusion (EDI) working group, and a drafting steering group, made up of colleagues with policy, drafting, clinical, ftp decision making and communications expertise, which met four times to advise on the style, tone and content of the revised guidance.

Equality, diversity and inclusion

- 13** ED&I has been at the heart of our scoping, engagement, drafting, and consultation and implementation planning activity. A key objective of the intelligence and evidence gathering phase was to identify ways in which the professional standards or their implementation may have adverse impacts on registrants or patients/members of the public who share protected characteristics, and to identify opportunities to advance equality.
- 14** In addition to the recognised protected characteristics, we identified in early scoping that country of primary medical qualification and socio-economic status are also drivers of inequalities in healthcare, both for patients and for registrants. We have therefore been looking into how that might affect their interaction with GMP or any issues which are particularly prevalent to these groups.
- 15** We have tested and explored the impacts of these insights in a series of workshops with the external advisory forum as well as groups such as the strategic ED&I forum. These activities have been central to redrafting of the guidance. We have also completed the initial draft of the equality impact analysis (EqIA), which will be reviewed and updated as our work continues and issues emerge.

Key changes to the guidance

- 16** We started with a good, highly regarded product, so our approach has been 'evolution, not revolution'. Our overarching ambition for redrafting GMP has been to shift the tone of the guidance to be more empathic, to recognise the context medical professionals are working in, and to position the guidance as empowering and supporting medical professionals to practise well in the interests of patients.
- 17** Our scoping and engagement activity found that there was strong support for the style and level of detail in current GMP. Stakeholders were keen for us to keep the four domain structure, but saw value in moving content around to give greater prominence to certain themes (such as communication and team working) and to make navigation more intuitive. There was appreciation for the succinctness of GMP, but also appetite to further contextualise duties and to acknowledge the environments that medical professionals are practising in. There was general support

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for the proposal to create shared professional standards for doctors, physician associates, and anaesthesia associates.

18 Stakeholders generally wanted us to retain the terms ‘you must’ and ‘you should’ to express duties, but there was interest in exploring some form of ‘I will’ statements, which we are exploring by reformulating the existing ‘duties of a doctor’ in the front of GMP. There were also calls to make clearer the interaction between the professional standards and fitness to practise/local processes.

19 The thematic priorities we identified for new or amended professional duties were:

- tackling bias and discrimination in healthcare
- patient centred care, decision making and communication
- team working (including working in multi-disciplinary teams)
- leadership and interprofessional behaviours (including civility and sexual misconduct between colleagues).

20 Taking all this into account, the key changes we propose to test in consultation are:

- a new introductory section, which shifts the focus from what is expected of registrants to an account of what the professional standards are for and who they benefit. We have also given a fuller account of how our professional standards are used in fitness to practise decision making
- reworked four domains, with content organised more thematically than in the current version of GMP and a new ‘narrative arc’ that more clearly draws the connection between healthcare cultures and outcomes for patients. Each domain now opens with a preamble intended to frame the duties in positive language, improve the overall tone and more clearly describe how the document coheres as a whole

Domain	2013 GMP	Redrafted GMP
1.	Knowledge, skills and performance	Working with colleagues
2.	Safety and Quality	Working with patients
3.	Communication, partnership and teamwork	Professional capabilities
4.	Maintaining trust	Maintaining trust

- new or revised duties in relation to all the themes identified in paragraph 18 above. In particular, we have drawn several key principles from our *Leadership and management* and *Decision making and consent* guidance into GMP. We have also added expanded duties in relation to conflicts of interest and communicating as a professional (including on social media) and are exploring how the new draft can address sexual harassment, remote consultations, use of artificial intelligence and new technologies, and issues to do with sustainability and global health.
- 21** A revised, annotated working draft of revised GMP is at **Annex A**, and a more narrative account of what has changed is at **Annex B**. We propose that the draft should be finalised following the Council discussion, and following tone of voice review, with final approval of the consultation text delegated to the Director of Education and Standards.
- 22** There has been a high level of support for these changes when we have tested them internally and externally, but we can still expect significant scrutiny and challenge during consultation. We anticipate the most likely areas of controversy will be in relation to:
- the overall burden of the new professional duties, given the ongoing impact of the pandemic and workforce pressures
 - our decision to consult on shared professional standards for doctors, physician associates, and anaesthesia associates
 - new duties that attempt to influence how registrants behave towards each other, particularly in relation to civility, promotion of positive and inclusive cultures, self-awareness and reflection, and personal/sexual relationships between colleagues
 - the extent to which the revised professional standards respond to live debates in healthcare and wider society about discrimination, equality and inclusion.
- 23** We have identified mitigations, which will inform our engagement and communication plans.

Plans for public consultation

- 24** We propose to consult on the draft guidance for 12 weeks, starting in late April/early May.
- 25** We will use consultation methods including questionnaires, meetings and events. During the consultation, outreach colleagues and liaison advisors based in the national offices will promote the consultation to a range of audiences, and will ask

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polling questions linked to the consultation in their sessions with frontline practitioners. They will deliver this via a mix of bespoke sessions and add-ons to existing sessions.

- 26** We have also commissioned an external behavioural insight specialist (ICE Creates) to conduct research and engagement with over 200 patients with lived experience of the healthcare system. This research is targeted at groups who are unlikely to participate in a written consultation and who we think we would find it difficult to reach ourselves. During the public consultation they will run dedicated online focus groups for people living in English regions, Wales, Northern Ireland and Scotland to act as a sounding board for policy ideas.
- 27** Further detail on our approach to communication and engagement planning and stakeholder mapping is at **Annex D**.

Post consultation actions and timings

- 28** We expect to analyse the consultation responses between late July and September 2022 and reconvene the GMP Advisory Forum from September to advise on post-consultation drafting. We expect the revised version of GMP to be approved by Executive Board and Council in early 2023. Our intention is that the guidance will be ready for publication in 2023, but timings will be agreed nearer the time, taking account of the key delivery dates for regulatory reform.
- 29** Ten pieces of explanatory guidance are also in scope for review (these are listed at **Annex F**). These are not part of the consultation on GMP but will be reviewed post-consultation, drawing on feedback we receive on the core guidance. Given that the explanatory guidance expands upon principles that we will consult on in the GMP consultation, we are currently planning to develop these pieces of guidance through targeted engagement with key stakeholders, rather than through further public consultation. We will however review this decision when we begin to draft the guidance, taking account of our existing policy and forthcoming duty to consult in the new legislation.

Planning for implementation and publication

- 30** In parallel to the guidance development, the implementation workstream has been working with colleagues across the GMC to develop a framework for how we support and enable registrants to put professional standards into practice.
- 31** A detailed account of the work to date, evidence gathered, and working hypotheses is at **Annex E**.

Action	To note
Purpose	<p>In February 2020, Council approved a revised approach to proactive quality assurance (QA) of undergraduate and postgraduate medical education and training. We have continued to implement this despite the pandemic and, although we and the system have faced challenges, continue to provide oversight of the quality of medical education and training.</p> <p>This paper summarises the main developments in our QA in 2021, including the development of new medical schools, our ongoing oversight of postgraduate training (including enhanced monitoring) and our early work to engage with MAPs providers.</p>
Decision trail	Council approved a revised approach to quality assurance in February 2020 (paper M5).
Recommendation	To note the Education quality assurance update.
Annexes	<p>Annex A: QA process diagrams</p> <p>Annex B: Enhanced monitoring activity</p>
Author contacts	<p>Martin Hart, Assistant Director, Education and Standards</p> <p>Any enquiries to: GovernanceTeamMailbox@gmc-uk.org</p>
Sponsoring director/ Senior Responsible Owner	Colin Melville , Medical Director and Director of Education and Standards

Background

- 1 Diagram 1 in Annex A reminds members of our high-level approach to assurance. In brief:
 - a The Medical Act¹ requires us to secure our standards². We do this by first approving medical schools, postgraduate programmes and training locations, and postgraduate curricula.
 - b We then check that organisations continue to meet our standards through our proactive quality assurance (PQA) processes. This includes checking that the education bodies have mechanisms for checking the standards are met by the organisations they commission to deliver training.
 - c Our reactive quality assurance processes, including monitoring, enhanced monitoring and setting conditions, enable us to respond to any concerns arising from anywhere in the medical education system. Diagram 2 in Annex A shows how our proactive and reactive processes are aligned, and the responsibilities of the various organisations involved in the processes.
 - d Our approach is underpinned by our intelligence, data and evidence, including the national training surveys. These inform and enhance all parts of our assurance processes.
- 2 Following extensive piloting and feedback, Council agreed to roll out the model illustrated in diagram 3 in Annex A.
- 3 In essence, the model is as follows:
 - a Medical schools and postgraduate training organisations (PTOs)³ sign a declaration every four years that signifies their intention to meet the standards. This is a confirmatory process for organisations, similar to our revalidation model for individual doctors.
 - b Every year (with a staggered initial roll out to manage GMC capacity and the fact that some institutions will have had greater recent scrutiny by the GMC) they complete a self-assessment that asks them to demonstrate how they

¹ As set out in sections 5(1) and 34H(1)(b) of the Medical Act 1983

² *Promoting Excellence* (2015) sets out our standards for the management and delivery of medical education and training. *Excellence by Design* (2017) sets out our standards for curricula and assessment systems.

³ Postgraduate training organisations are Health Education England and its local offices, NHS Education for Scotland, Health Education and Improvement Wales and the Northern Ireland Medical and Dental Training Agency.

meet the standards of *Promoting Excellence* through the outcomes of their day-to-day activities, policies and processes.

- c We scrutinize their submission along with the data and evidence we hold and identify areas where either a) we are not assured or b) there is potential good practice. We meet each organisation to discuss their submission and agree activities that we will undertake to gain the assurance that we need.
 - d We undertake a range of activities including document requests, observing their various quality management activities, and potentially full-scale GMC visits. Some of these activities will involve GMC associates.
 - e We gather structured feedback directly from students, trainees and trainers on a regular basis to ensure that these groups have opportunities to report directly to the regulator about their training provider. We also gather structured feedback directly from local education providers about their relationships with medical schools and PTOs. The GMC's outreach teams will also be engaged with this work.
 - f If we are not assured, we may set requirements and recommendations which we will then monitor until we have the requisite assurance. If we identify notable or good practice (this could be areas working well or innovation and excellence), we will seek to promote this to other organisations who may be able to benefit from this.
 - g We have now reached the point where we are now starting to produce the annual summaries for each organisation which includes information about the self-assessment, activities we have undertaken and any requirements, recommendations, good or notable practice we have identified.
- 4 We plan to evaluate the process when all organisations have completed two self-assessments and when we have completed a full cycle. (see diagram 4, Annex A)
 - 5 We have also embarked on a further phase of QA review to consider our education relationship with the medical royal colleges. This year we have done a useful pilot exercise with the Royal College of General Practitioners (RCGP) to understand how we can work better together, share intelligence and make use of the college's expertise.
 - 6 The remainder of this paper is devoted to short updates on our activities since February 2021 covering:

- a The Proactive Quality Assurance (PQA) process.
 - b The ongoing impact of the pandemic, including the results of our survey of existing medical schools and the research undertaken into the experience of interim F1 doctors.
 - c The growth in the number of universities seeking to establish medical schools (including private medical schools) and the expansion of medical student numbers (both planned and unplanned as a result of changes to A levels in 2020 and 2021).
 - d Our work with postgraduate training bodies and our work with locations that have particular training challenges (enhanced monitoring).
 - e Our work with medical associate professionals (MAPs) course providers to baseline our understanding of the courses and to satisfy ourselves that they meet our standards ahead of statutory regulation in 2023.
 - f The audit report that went to the ARC in March 2021.
- 7 As last year, the pandemic has had an impact on the delivery of our statutory education functions, and we note the successes and challenge we have faced over the last twelve months.

GMC's approach

- 8 As we noted last year, the GMC's approach to the regulation of education and training during the pandemic has been the maintenance of standards and outcomes. Across undergraduate and postgraduate, we have sought to embed the following principles in our approach:
- Patient safety
 - Maintaining standards
 - Meeting outcomes
 - Competence
 - Proportionate approaches
 - Supporting diverse patient and doctor populations

Proactive QA process

- 9 In December 2021, we completed the roll out of the new proactive quality assurance process to all UK medical schools (35) and postgraduate training organisations (16).
- 10 We have analysed 53 self-assessment questionnaires (SAQ) and we have completed over 100 quality activities. These are designed to allow organisations to demonstrate how they quality manage their education and training and include observation of key committee meetings, attending quality management visits, document requests and reviews and meeting students and trainees.
- 11 We have drafted 19 Annual Quality Assurance Summaries (AQAS) which note the self-assessment, quality activities and summarises our engagement with the organisation over the year. For postgraduate organisations, this includes a summary of enhanced monitoring activity and differential attainment. We list any areas of notable practice, areas working well, requirements and recommendations. We also detail the areas of focus and next steps in the process. These AQAS reports will be published on our website in 2022.

Impact of the pandemic

- 12 The pandemic continued to have an impact on our quality assurance with the vast majority of activities remaining virtual. We were able to make a number of in person visits to medical schools and for enhanced monitoring and were reminded of the added value of these activities⁴. During the latest Omicron wave, and with government recommendations to work from home in place until January 2021, our activities again moved on-line and were scheduled sensitively recognising the pressures on the NHS.

Undergraduate survey

- 13 In June 2021 we wrote to undergraduate quality leads to ask them about the continuing impact of Covid-19 on their ability to deliver their planned schedule of curricula and assessments. This included a link to an eight-question survey in which we asked a series of questions about changes made to final assessments and graduation arrangements for the 2020/2021 student cohort. We also asked questions on how each school has evaluated the changes made for the previous year's graduating cohort and whether schools intended to make any permanent changes to their curricula or assessments because of the pandemic.

⁴ In person visits to Brunel, Chester and Lancaster medical schools, in person enhanced monitoring visits to Lincoln and Wales

- 14 All established schools had been able to deliver final assessments for their graduating cohort. Most schools made adaptations to their planned delivery of written and clinical assessments. A number of schools undertook written assessments online with remote proctoring or invigilation whereas others could hold written assessments in person with appropriate social distancing.
- 15 All schools were able to deliver an assessment of clinical skills for their graduating cohorts. Most schools delivered formal clinical examinations (such as Objective Structured Clinical Examinations [OSCEs]) in person, although adaptations were made to meet the restrictions of the pandemic. For example, reducing the number of stations and/or replacing real patients with simulated patients.
- 16 For schools that did not hold a formal final year OSCE, other methods were used to assure schools of students' clinical competence including programmatic assessment or a suite of workplace-based assessments.
- 17 All schools indicated that they were able to return to delivery more in keeping with a 'normal' final year for 2020-21. However, some accommodations were needed to deal with the disruption caused by the pandemic including making up for lost placement time and changes to electives. Decisions as to graduate were largely guided by university's processes and procedures but did involve consultation with a variety of bodies, including the GMC.

Interim F1 research

- 18 We commissioned research from Gill Vance and colleagues into the work and wellbeing of interim F1 doctors during the pandemic: [2020 Medical Graduates: The work and wellbeing of interim Foundation Year 1 doctors during COVID-19](#)
- 19 In brief, the researchers concluded that FiY1 was a largely valuable experience which eased the transition to practice. Medical students were attracted to the FiY1 role for their own learning, to contribute to the NHS in a time of need, or through a sense of obligation. FiY1s' work was similar to the work of F1s and those who had worked as FiY1s felt more prepared for starting F1 than those who had not been working since April 2020 or those who had worked in non-FiY1 clinical roles.
- 20 The FiY1 experience had limited impact on participants' wellbeing and although participants faced challenging experiences during their FiY1 posts, these were not necessarily negative if accompanied by support from colleagues.

Merger of Health Education England (HEE) with NHS England

- 21 In postgraduate training, a significant development has been the proposal to merge Health Education England (HEE) into NHS England. Although this merger is expected to create a stronger organisation that aligns workforce, financial and service planning with education and training, we will want to ensure that concerns about training and trainee experience remain a priority for the merged organisation. As members know, we sometimes make difficult decisions with HEE to withdraw trainees (eg Weston, East Kent, North Middlesex). The merger may make it harder for HEE to make such decisions with significant operational implications for NHSE/I, and therefore we need to be ready for the possibility of standing more alone in making those tough judgements.

New medical schools and expansion of medical student numbers

- 22 The five 'new' medical schools in England that were created in the 2017 expansion have now all admitted their first students (Aston, Anglia Ruskin, Sunderland, Kent Medway and Edge Hill). These institutions had been visited by the GMC as part of our new schools process and 'virtual' visits have been arranged since the start of the pandemic.
- 23 There are now three further schools that are planning to admit students from 2022 on a private basis (i.e. outside the Office for Student's (OfS) intake controls). Due to OfS rules, they will be largely restricted to taking students from overseas only. These are at Brunel University, Worcester University (Three Counties) and Chester University. As the Medical Act requires us to consider accreditation of all undergraduate medical education in the UK (irrespective of whether or not it is publicly funded) we have engaged with these schools as part of our new schools' process. We managed to visit Brunel and Chester in person in 2021 and will visit Three Counties in February 2022.
- 24 We continue to monitor carefully the effect of this expansion, in particularly focusing QA attention on the schools with the largest increases in numbers and areas of the country where clinical placement capacity is most challenged.
- 25 In Northern Ireland, the University of Ulster admitted its first students in 2021.
- 26 In Wales, plans are developing for a third medical school at the University of Bangor. We have had meetings with Cardiff University (the contingency school), the Welsh Government and Health Education Improvement Wales.

- 27 We continue to engage with two innovative programmes in Scotland the ScotGEM programme (a graduate entry programme delivered by the University of Dundee and the University of St Andrews) and the Edinburgh HCP (Health Care Professions) programme (a programme designed to enable existing healthcare staff to become doctors).
- 28 Also in Scotland, the government is making a commitment to a significant increase in the number of medical students. It has not yet committed to a new medical school although this remains under discussion in Scotland.
- 29 There is increased lobbying for a more systematic increase in the number of medical school places. The Royal College of Physicians launched a campaign (Double or Quits) to increase the number of places by 7,500 and the Medical Schools Council has also recently suggested that the UK needs a further 5,000 medical school places.
- 30 We continue to have responsibility for the oversight of a number of programmes delivered by UK universities overseas. This year has seen the development of a new programme from Kings University in conjunction with Sustech University in Shenzhen, China. We also continue to oversee the Queen Mary's programme in Malta.

Postgraduate training and enhanced monitoring

- 31 We use enhanced monitoring to promote and encourage local management of concerns about the quality and safety of medical education and training.
- 32 We require more frequent progress updates from those responsible for managing these concerns. We can provide representation on a locally led visit to investigate a concern or check on progress. We publish information on enhanced monitoring cases on our website. We share information with other healthcare regulators where appropriate.
- 33 Issues that require enhanced monitoring are those that could affect patient safety or training progression or quality. Issues are usually referred to us if there are concerns that the standards in Promoting Excellence are not being met and they meet the following criteria:
 - Persistent and serious patient safety concerns
 - Doctors in training's safety is at risk

- 34** Annex B provides a visual summary of enhanced monitoring activity in 2021. The overall number of cases has remained reasonable static with six cases having GMC imposed conditions in place (two in Scotland and four in England).
- 35** Among the notable cases in England, the long-term challenges at University Hospitals Bristol NHS Foundation Trust (Weston site) have remained a key area of focus. 2021 has seen some progress with greater engagement from the Trust to secure long-term solutions (and the ultimate return of a number of trainees who have been withdrawn from the Trust by Health Education England).
- 36** Full details of all our enhanced monitoring cases are published on our website (with the exception of those cases that could identify individuals or are not yet in the public domain).
- 37** We are taking the opportunity in 2022 to reflect on our enhanced monitoring process and consider whether any changes are appropriate. We have good support from postgraduate training organisations and many of them value the input the GMC brings to often very challenged training providers. Our ability to impose conditions and ultimately the threat of withdrawing training recognition often helps focus attention of local education providers on finding sustainable solutions to problems that ultimately undermine training and patient experience.
- 38** However, we are aware that some departments remain in enhanced monitoring for lengthy periods and that progress in resolving issues, even with GMC intervention, can be very slow. We are considering whether there are operational improvements we can make to our processes and practices to ensure GMC interventions lead to long term solutions and drive-up training standards.
- 39** We intend to have a series of internal workshops with Education and Standards colleagues and with other GMC colleagues who work with us on enhanced monitoring (notably outreach and communications). We will also talk to postgraduate deans (probably via COPMED – the Council of Postgraduate Medical Education Deans). We hope to complete this review within six months and will of course report back to Council on any improvements we make.
- 40** We conducted our annual engagement meetings with postgraduate training organisations where we discussed differential attainment and outlined our ask of them to develop action plans detailing what they are doing to address the attainment gaps in their regions. These action plans are currently being

submitted and will be considered as part of the wider GMC work to eliminate discrimination, disadvantage and unfairness in undergraduate and postgraduate medical education.

Our work with MAPs course providers

- 41 Ahead of statutory regulation, we have begun a programme of engagement with those higher education institutions that deliver Physician Associate or Anaesthesia Associate courses.
- 42 Mirroring our process for medical schools, we have developed a self-assessment questionnaire (SAQ), mapped to *Promoting Excellence*. We are using the results of this to 'baseline' our understanding of MAPs courses and we have met (virtually) all 36 course providers at a series of quality seminars.
- 43 Early indications are that course providers have good systems for supporting students, identifying and managing concerns and complying with university and national regulations on teaching and curriculum.
- 44 The most frequent areas where we have identified a need for improvement are quality management of placements, internal educational governance systems and managing risk.
- 45 We have identified regional differences with some regions benefiting from regional approaches and collaboration which is reflected in the quality of teaching and governance systems.
- 46 We will prepare an overarching report in the next few months on the early indications of the quality of MAPs education and are now developing tailored QA approaches for each institution (including some in person visits) and will continue to support course providers ahead of statutory regulation.
- 47 We have also run a recruitment campaign for MAPs education associates and student associates. We received 149 associate applications and 41 student applications and recruited 12 education associates and 6 students to help us with our quality assurance work.

Audit

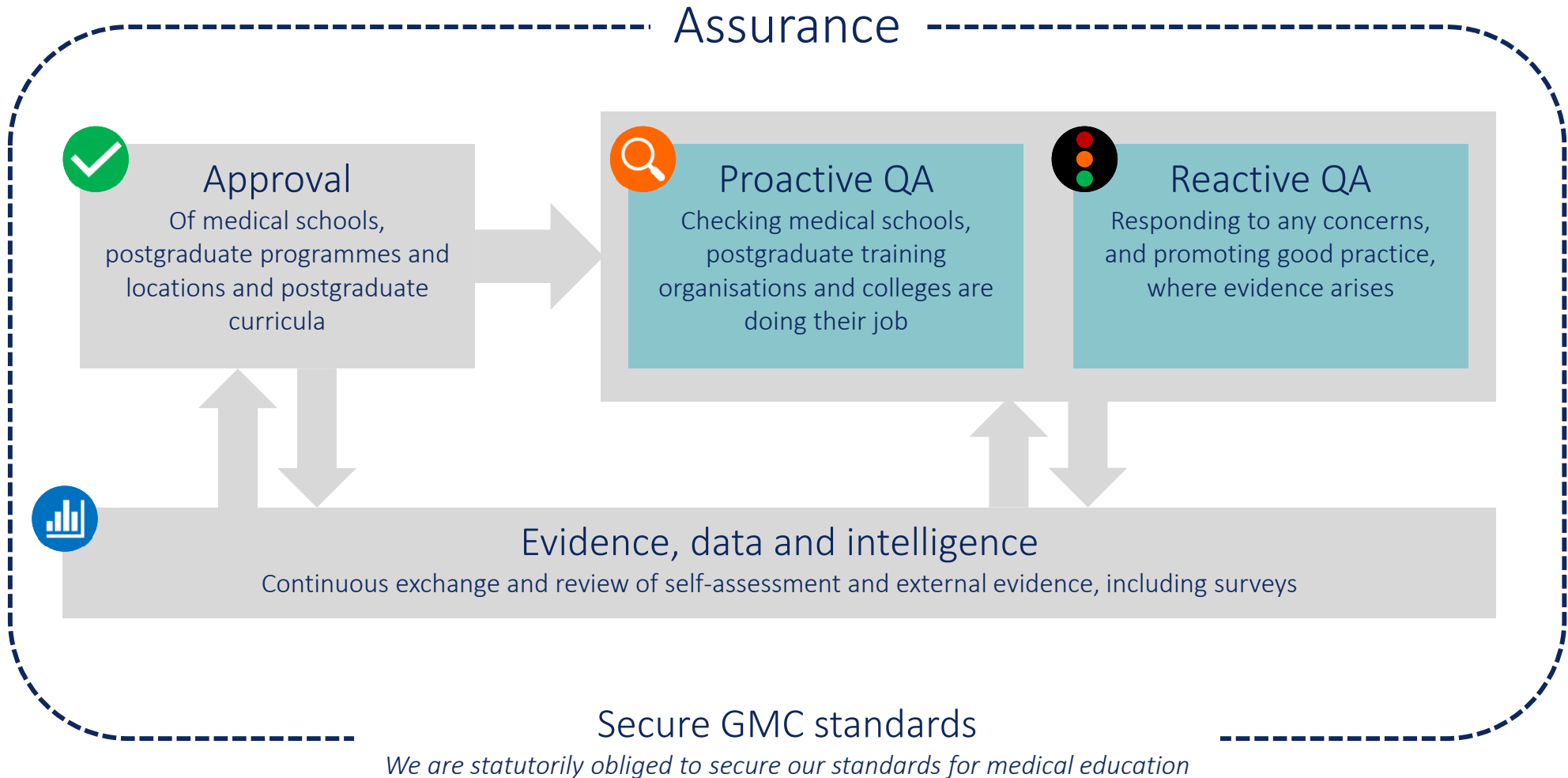
- 48 An audit was undertaken of our approach to QA during the pandemic in early 2021. The purpose of this review was to assess how the GMC fulfilled its statutory function in relation to the quality of medical education, including enhanced monitoring arrangements in response to COVID-19, to provide

assurance that the quality of medical education has been maintained throughout the pandemic.

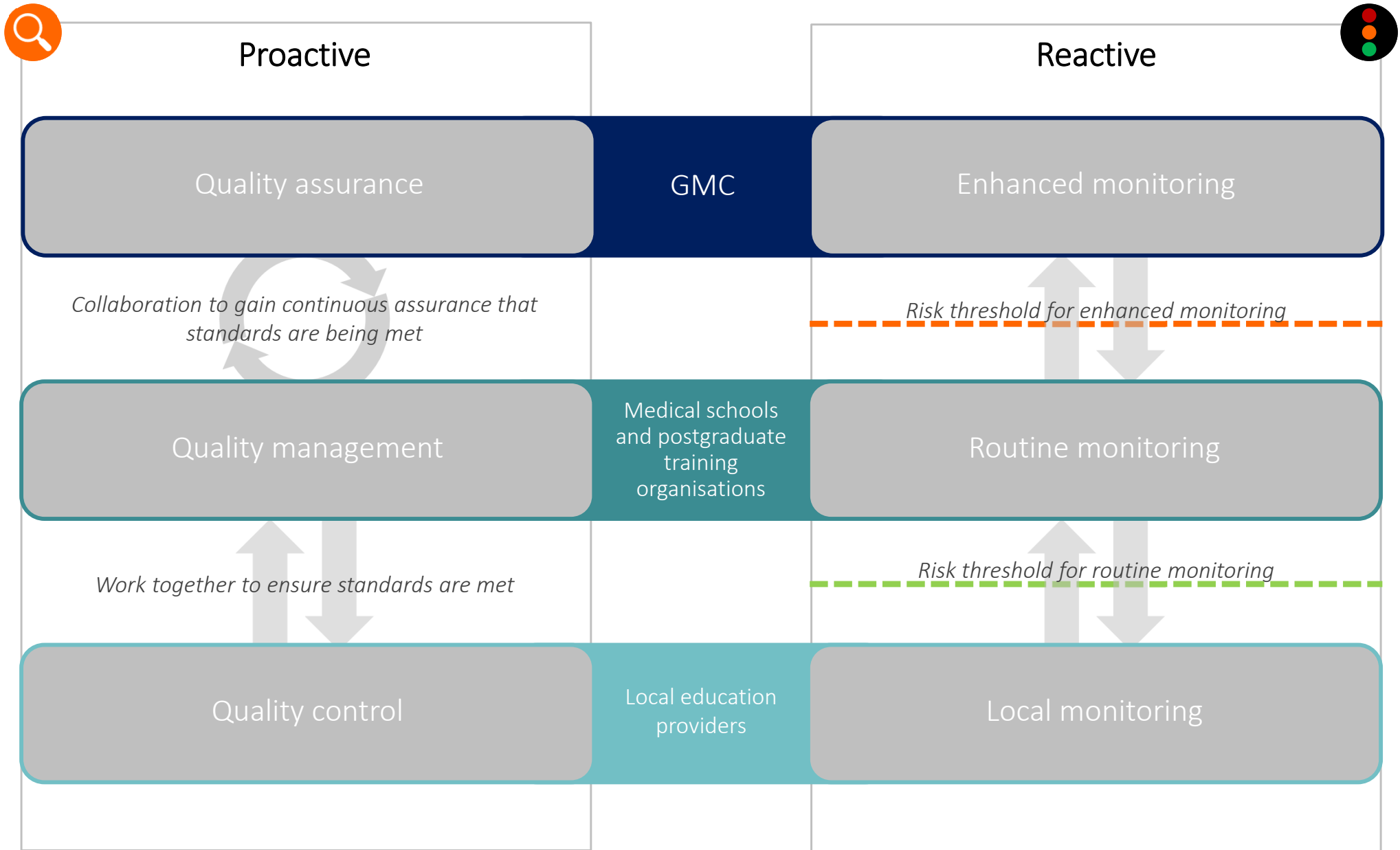
- 49** We were pleased that the audit confirmed that we had a sound system of internal controls in place to achieve our objectives and that the controls were being consistently applied. The review concluded that the QAMI Team reacted swiftly and decisively to deal with the challenges of assuring the quality of education provision in the face of the coronavirus pandemic. This ensured that the GMC continued to fulfil its statutory duties with respect to quality assuring the provision of medical education.

M7 – Annex A
QA process diagrams

Assurance is achieved through a variety of activities



Proactive and reactive QA



Quality assurance cycle

4-yearly

Declaration: organisations will re-declare that they meet the standards of Promoting Excellence. If we have serious concerns about an organisation’s ability to meet the standards, we may defer their re-declaration.

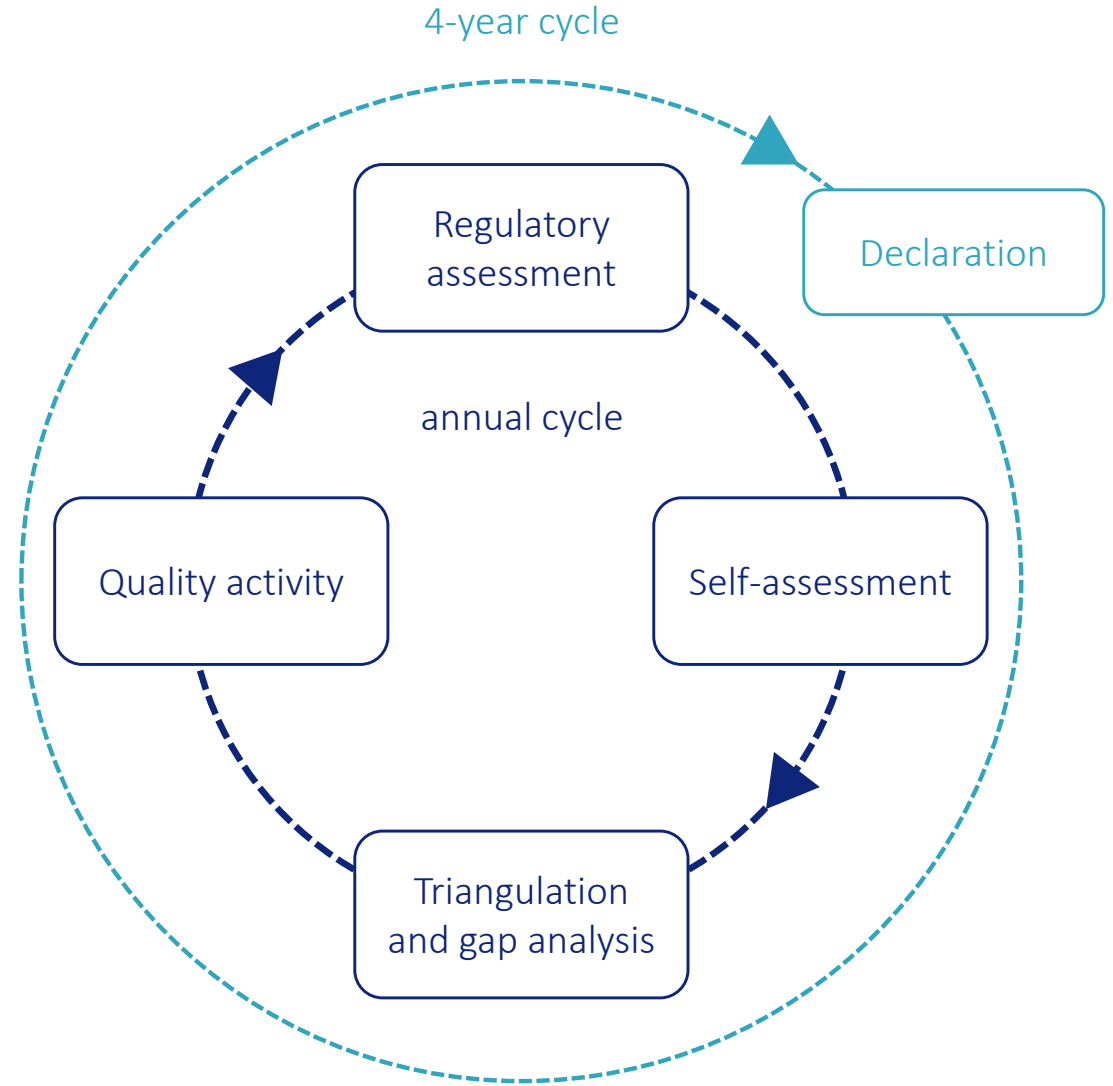
annual

Self-assessment: organisations will review their data and intelligence, as well as any we hold, and complete a self-assessment questionnaire.

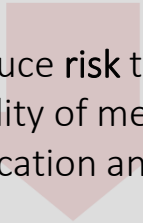
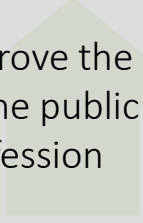
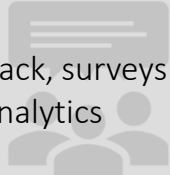
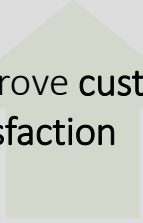
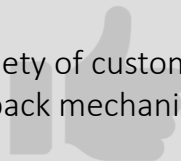
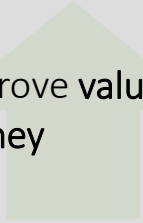
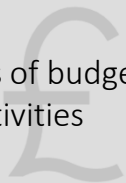
Triangulation and gap analysis: we will review organisations’ completed self-assessment questionnaires alongside our data and intelligence. We will meet with every organisation to discuss what quality activity is required.

Quality activity: we will undertake proportionate regulatory activity to seek assurance or to confirm evidence of excellence, innovation or notable practice. Activities may include document requests, meetings, shadowing, observations, visits and document reviews.

Regulatory assessment: if we are not assured we will undertake further activity and ask the organisation to provide a response in their annual self-assessment. If we are assured we will say so in our annual quality summary.



Post-roll-out evaluation plan

Objective	Aims	Test
 <p>Reduce risk to the quality of medical education and training</p>	<p>We will be more likely to know about something going wrong, and we'll know about it sooner. Achieved through more frequent checks, broader knowledge of QM activities, better use of more evidence.</p>	<p>Key indicator metrics, such as enhanced monitoring, national training survey and other data.</p>
 <p>Improve the assurance of the public and the profession</p>	<p>We will clearly demonstrate how we gain assurance, that our processes have improved, and by make information about our regulation more accessible and easier to use.</p>	 <p>Feedback, surveys and web analytics</p>
 <p>Improve customer satisfaction</p>	<p>We will reduce burden, cost and duplication, and regulate more collaboratively and flexibly, for medical schools and postgraduate organisations.</p>	 <p>A variety of customer feedback mechanisms</p>
 <p>Improve value for money</p>	<p>We will increase the proportion of time staff and associates spend on activities that add direct value to our assurance. We will reduce the use of associates in general. We will absorb the QA of the MLA with minimal increase in headcount.</p>	 <p>Analysis of budgets and staff activities</p>

Evaluation 1: after 2 years (all orgs have completed 2 self-assessments)

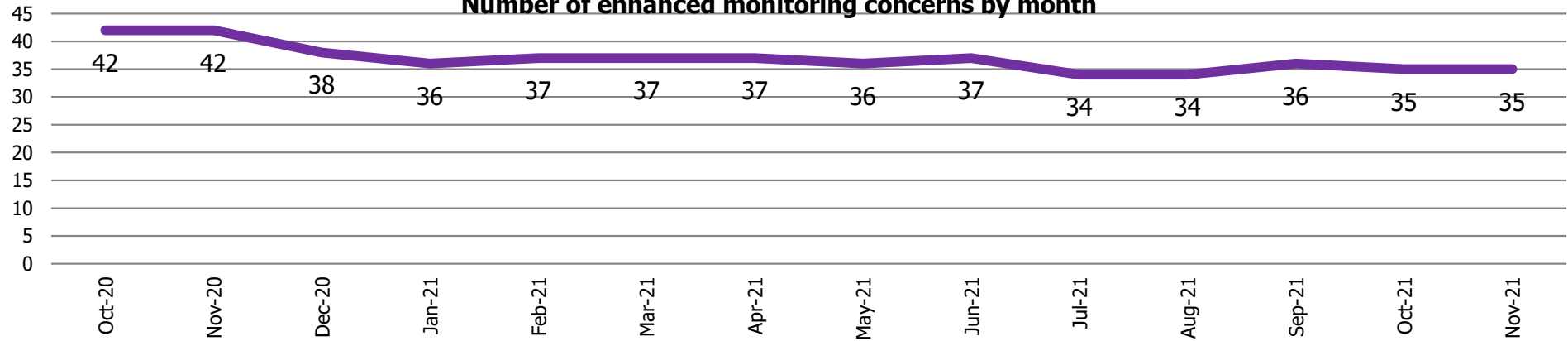
Evaluation 2: after 5 years (all orgs have completed a full cycle)

M7 – Annex B
Enhanced monitoring activity

Working with doctors Working for patients

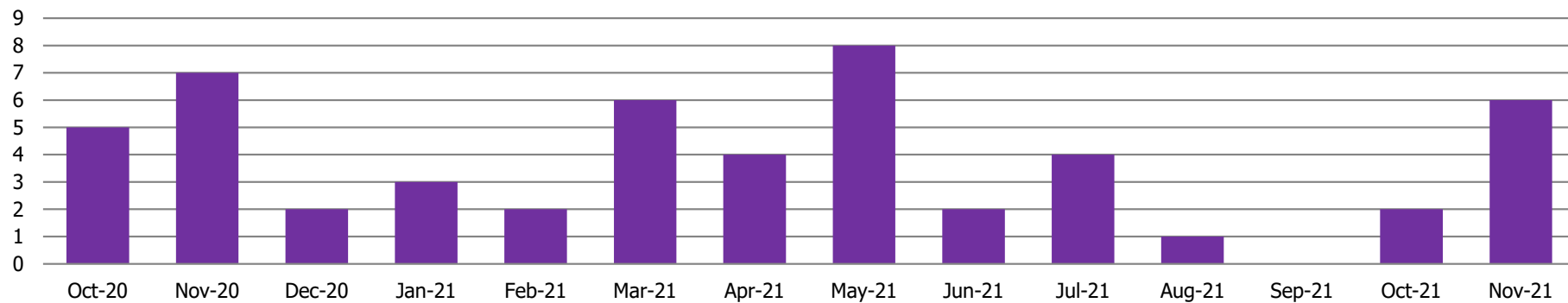
12 month summary

Number of enhanced monitoring concerns by month



Reporting status/Month	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21
Publishable	42	42	38	36	37	37	37	36	37	34	34	36	35	35

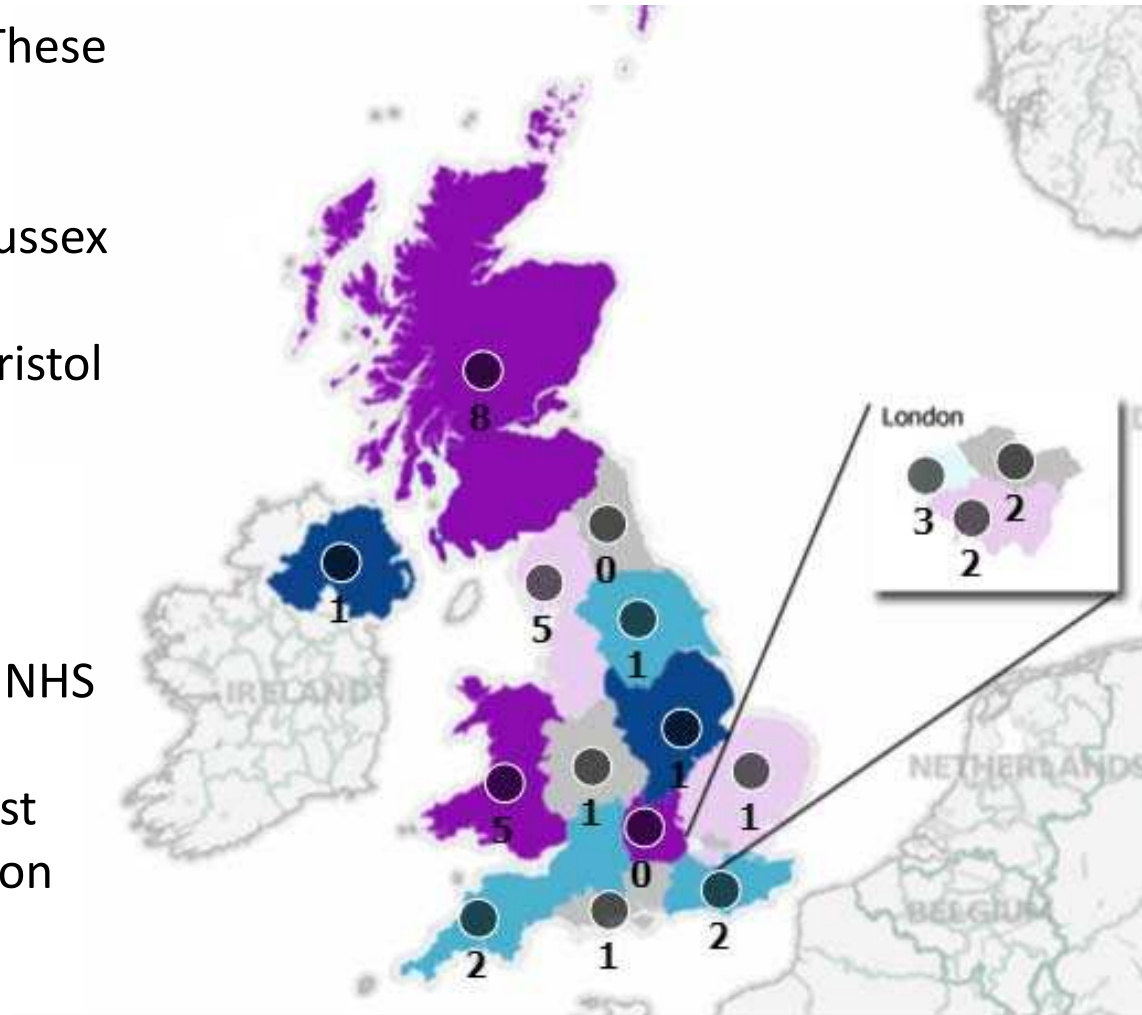
Enhanced monitoring activities by month



Location of EM cases

6 cases have conditions. These are:

1. University Hospitals Sussex NHS Foundation Trust
2. University Hospitals Bristol and Weston NHS Foundation Trust
3. Ayrshire & Arran
4. London North West University Healthcare NHS Trust
5. Central and North West London NHS Foundation Trust
6. NHS Tayside



Number of enhanced monitoring cases by organisation

Postgraduate training organisation	Number of enhanced monitoring cases ever
Health Education North West**	22
Health Education North East	5
Health Education West Midlands	8
Health Education East Midlands	10
Health Education Thames Valley	5
Health Education London*	40
Health Education KSS	6
Health Education Wessex	2
Health Education South West	2
Health Education East of England	22
Health Education Yorkshire and the Humber	10
Northern Ireland Medical and Dental Training Agency	7
NHS Education for Scotland	23
Health Education and Improvement Wales	10
*comprises of South London, NW London and North Central and East London	
**including a case under 'Northern Deanery'	

EM descriptors

- **Level 1 – assurance** that issues can be managed locally, with a **potential serious risk** to patients and/or safety/well-being of trainees.
- **Level 2 - some assurance** that issues can be managed locally, with a **potential serious risk** to patients and/or safety/well-being of trainees.
- **Level 3 - limited assurance** that issues can be dealt with locally, with a **potential or current risk** to patient and/or safety/well-being of trainees.
- **Level 4 – no assurance** that issues can be improved, with a **current risk** to patient safety and safety/well-being of trainees. Plans to remove trainees are being/have been put in place.
- **Level 5 – trainees have been removed**, although the key issues within the healthcare environment may not have been resolved.

General
Medical
Council

Conditions

Working with doctors Working for patients

Summary of current conditions cases

QA Code	Trust/Health Board	Site	Programmes	Conditions
QA5176	Weston Area Health NHS Trust	Weston General Hospital	Acute Care Common Stem Severn; Core Anaesthetics Training Severn; Core Medical Training Severn; Emergency medicine; Foundation; General Surgery	<ol style="list-style-type: none"> 1. A senior clinical decision maker, who has been assessed and deemed competent to provide supervision to doctors more junior, must be physically present and available to provide timely and appropriate supervision and direct clinical input to patient care in the emergency department at all times (when a Foundation doctor or GP trainee is working in this area). 2. The Trust must ensure that there is an adequate staffing level in the emergency department to ensure patient safety, with clear lines of responsibility for clinical supervision and published guidelines for escalation. 3. Consultant review must be made available on site for urology patients over weekends and a clear policy must be implemented for urological review of new patients over the weekend so that an F2 does not have to provide ongoing care without a clear treatment plan and direct on site supervision.
QA5462	Brighton and Sussex University Hospitals NHS Trust	Royal Sussex County Hospital	Foundation - South Thames	<ol style="list-style-type: none"> 1. The Trust must ensure that Foundation doctors working on the general surgery wards have on-site access to support from a competent, more senior colleague who must be suitably qualified to guide and teach the Foundation doctors and deal with problems as they arise. The senior colleague must be primarily based on the wards during the daytime (seven days a week) and immediately accessible at all times. 2. The Trust must ensure that there are enough staff members so that Foundation doctors have appropriate working patterns and workload. 3. Foundation doctors must be released to attend their dedicated teaching sessions and given access to other educational opportunities, such as the Emergency Department and theatre. 4. The Trust must work towards meeting all mandatory requirements and standards for Foundation doctors working in general surgery as set out by Health Education England Kent Surrey Sussex (HEE KSS).
QA8595	Ayrshire & Arran	University Hospital Ayr	Acute internal medicine - West; Core Medical Training - West WOS435; Foundation; General (internal) medicine	<ol style="list-style-type: none"> 1. NHS Ayrshire & Arran must ensure that core medical trainees are provided with appropriate learning opportunities and feedback.

Summary of current conditions cases

QA Code	Trust/Health Board	Site	Programmes	Conditions
QA10194	London North West University Healthcare NHS Trust	Northwick Park Hospital	Haematology	<p>1. The Trust must ensure measures are put in place within the haematology department to promote a culture that both seeks and responds to feedback from learners and educators on compliance with standards of patient safety and care, and on education and training.</p> <p>2. Haematology trainees must have an appropriate level of clinical supervision at all times by an experienced and competent supervisor, who can advise or attend as needed, on the wards and in the laboratory. The level of supervision must meet the individual learner's competence, confidence and experience; and provide educational opportunities with feedback given to the learner. The support and clinical supervision must be clearly outlined to the learner and the supervisor.</p> <p>3. There must be a clear system in place for handover of haematology patients to the acute medical take at night, as well as a system in place for learners to be aware of which haematology patients have come in overnight. Handover of care must be organised and scheduled to provide continuity of care for patients and maximise the learning opportunities for doctors in training in clinical practice.</p> <p>4. Haematology trainees must not be subjected to, or subject others to, behaviour that undermines their professional confidence, performance or self-esteem. The learning environment and culture within the haematology department must value and support education and training so that learners are able to demonstrate what is expected in Good medical practice and to achieve the learning outcomes required by their curriculum.</p>
QA11130	Central and North West London NHS Foundation Trust	Hillingdon Hospital; Park Royal Centre for Mental Health; St Charles Hospital; The Gordon Hospital	Core Psychiatry Training, General psychiatry	<p>1. No doctor in training will review an acute inpatient without an appropriately qualified member of staff accompanying them. Concerns affecting the safety of patients or trainees must be addressed by the Trust immediately and effectively.</p>
QA10483	NHS Tayside	Trust-wide	General Psychiatry	<p>1. NHS Tayside must ensure learning is facilitated through effective reporting mechanisms, feedback and local clinical governance activities.</p> <p>2. NHS Tayside must ensure that learners have access to an appropriate level of supervision at all times, including out of hours.</p>

Action	To discuss
Purpose	The Investment Committee is required by its Statement of Purpose to report annually to Council on its activities. This report outlines the Investment Committee’s work since its last report to Council in December 2020.
Decision trail	This report has been considered by the Investment Committee at its meeting in November 2021.
Recommendations	<p>a To discuss the annual report of the Investment Committee.</p> <p>b To discuss and approve the updated Statement of Purpose.</p>
Annexes	Annex A: Statement of Purpose of the Investment Committee Annex B: Investment Policy
Author contacts	<p>Samuel Curtis, Corporate Governance Manager</p> <p>Any enquiries to: GovernanceTeamMailbox@gmc-uk.org</p>
Sponsoring director/ Senior Responsible Owner	Neil Roberts , Director of Resources

Background

- 1 The Investment Committee is required by its Statement of Purpose to report annually to Council on its activities. Since its last report to Council on 10 December 2020, the Committee has met four times in 2021- February, May, September and November.
- 2 Steve Burnett was appointed as Chair of the Committee from 2021, along with Carrie MacEwen, Deepa Mann-Kler and Lara Fielden. During 2021 we sadly lost Lara and, due to an illness, and the Chair of Council, Clare Marx, stepped down from the position. Carrie was appointed as acting Chair of Council until a substantive appointment is made. In order to meet the quoracy requirements set out in the Committee's Statement of Purpose, Carrie will continue her membership on this Committee.
- 3 Due to conflicts of interest and workloads, two of the Committee's three co-opted members stepped down during the year: David Stewart and Tim Scholefield. A recruitment exercise was conducted in September 2021 and Council approved the appointment of Michael Jennings as a co-opted member. Michael attended his first meeting in November 2021. The Committee is content to operate with two co-opted members for the time being.

Investment Policy

- 4 The current investment policy includes a number of ethical restrictions on our investments. The Investment Committee has started work to develop a more comprehensive approach to ethical, social and governance issues. To this end the Committee is undertaking a project with our independent investment adviser (ARC) and our external fund manager (CCLA) to generate more comprehensive ethical data on the aggregate portfolio. This may lead us to revise the Investment Policy. We will update Council in due course.

Statement of Purpose

- 5 There has been one change to the Committee's Statement of Purpose, which is a point of clarification, to add the quoracy details of the Committee. This information is usually stored centrally in the Governance handbook, however the Committee recommended it be highlighted in the SoP too. Council is asked to review it and consider if it is still meeting Committee's needs.

GMC funds under management

- 6 The GMC originally placed £50 million under investment through its external fund manager CCLA. Returns varied throughout 2021 due to the ongoing

impact on financial markets of the COVID pandemic, and the portfolio ended the year with a value of £61.6 million. The value of the portfolio at the latest valuation on 31 January 2022 is £59.97 million.

- 7 Our fund manager CCLA performed well over the year 2021 and exceeded the CPI+2% target of 7.40% set by GMC with a return of 8.59%. Over the last 3 years CCLA have achieved an average of 7.86% per annum versus a target of 4.43% per annum. This outcome has been achieved whilst operating within the mandated risk constraints given to CCLA.
- 8 The portfolio comprises around 48% bonds and cash, 35% equities and 16% property and alternatives.
- 9 CCLA's performance is reviewed by the Committee on a quarterly basis and has been in the top quartile of their peer group comparators over the year.
- 10 The funds have all been managed within the agreed ethical criteria set out in our investment policy.

GMC Services International

- 11 The Committee have been updated on GMCSI's activities throughout the year. However due to the pandemic many GMCSI projects in the pipeline have been delayed. The Committee will continue to monitor the activities of GMCSI in 2022.

Treasury management

- 12 The Committee consider a report on the GMC's in-house management of its cash balances at each meeting.
- 13 The value of our investments, plus any cash balances we hold, are typically higher than the level of our free reserves, largely because many doctors pay their annual fees in advance.
- 14 The GMC's cash holdings at the end of 2021 were £46.5 million with a blended interest rate of 0.25%.

Investment Risk Register

- 15 The Committee reviewed and updated the Investment Risk Register at each of its meetings. This included consideration of the potential investment risks relating to the UK's withdrawal from the EU and the pandemic.

- 16 The Committee's external adviser, Asset Risk Consultants Ltd (ARC), provide an external perspective on the risk register and have advised that it adequately addressed the risks and mitigations relating to its investments.

Committee effectiveness review

- 17 In November 2020, the Committee held an effectiveness review. Due to the changes of the Committee, focus has been on induction and ensuring the Committee have a solid foundation and support network for financial process.
- 18 The Committee still has Governance support in the form of a committee secretary and training support in the form of CCLA and ARC providing sessions on specific financial topics.

Independent investment advice

- 19 ARC advised the Committee on all elements within the Committee's remit (excluding GMCSI). In addition to this, a review session is led by ARC during each meeting examining the fund manager's quarterly report providing expertise on the technical elements of the report.
- 20 The current contract for independent investment advice expires in May 2022 and the Committee is currently running a retendering exercise.

Investment Objective and ESG

- 21 The Committee is working with ARC and CCLA to invest in a conservative and well diversified portfolio. The focus is around long-term responsible investment. The investment portfolio will therefore be constructed in a sustainable manner and given due consideration to ethical, environmental, social and governance issues.
- 22 A benchmarking exercise will be developed in 2022 and Council will be updated once this has been implemented.

Statement of purpose of the Investment Committee

Purpose

- 1 The purpose of the Investment Committee is to provide a forum for implementing and reviewing Council's Investment Policy.
- 2 Council is ultimately responsible for determining and reviewing the overall Investment Policy, objectives, risk appetite and target returns. Operational decision-making and implementation of the policy is delegated to the Investment Committee.

Duties and activities

- 3 The Investment Committee:
 - a Ensures the management of the assets, including the assets of any trading subsidiary of the GMC in which the GMC has made an investment, is consistent with the Investment Policy set by Council.
 - b Monitors the Investment Policy to ensure it remains appropriate, and to recommend changes to Council as appropriate.
 - c Implements changes to the Investment Policy as appropriate.
 - d Establishes and monitors the investment management structure to ensure that it is appropriate to meet the agreed Investment Policy. This includes decisions about the appointment of fund managers, the number of fund managers used, the proportion of assets managed by each manager, and their mandates.
 - e Agrees the terms of appointment of the investment fund managers, including their fee scales.
 - f Implements changes to the investment management structure as appropriate.
 - g Sets asset allocation parameters, based on advice from fund managers and/or external advisers, and monitors the actual asset allocations chosen

by the fund manager, to ensure consistency with the policy. Where more than one fund manager is appointed, the Committee will also monitor the aggregate asset allocation to ensure it provides sufficient diversification to reduce the risk of capital and/or revenue loss.

- h** Monitors the performance of each fund manager against agreed objectives by means of regular review of the investment results and other information.
- i** Monitors the corporate governance activities, policies and exercising of voting rights of the investment fund managers.
- j** Meets with the investment fund managers at least biannually to discuss their performance, actions and future strategy.
- k** Considers and approves any investment by the GMC in a trading subsidiary.
- l** Monitors and has oversight of any investment by the GMC in a trading subsidiary –on a financial, programme-related or mixed motive investment basis to ensure the expected return is delivered, reporting to Council at least annually on this. This would include meeting with representatives of the trading subsidiary at least biannually.
- m** Monitors and reacts to legislative, financial and economic changes affecting, or potentially affecting, the Investment Policy.
- n** Reviews, and makes recommendations to Council on, the Investment Policy so that it remains consistent with, and supportive to, Council’s overall business plan, budget and reserves policy.

Working arrangements

- 4** The Investment Committee meets quarterly. Additional meetings may be scheduled if necessary.
- 5** Draft minutes should be cleared by the Chair and circulated to members for comment within two weeks of the meeting. The Committee approves the minutes at its next meeting.
- 6** Membership of the Investment Committee comprises:
 - a** Four members of Council, one of whom will be appointed as Chair of the Committee.

- b** Up to three external, co-opted members, with extensive investment experience.
 - c** The Director of Resources and the Assistant Director of finance.
- 7** The role of the external co-opted members is to bring their experience and knowledge of investments to the work of the Committee. Co-opted members are not appointed as advisers to the Committee. They are expected to act as full members of the Committee, while recognising that they are not trustees or members of Council.
- 8** Quoracy for Committee meetings will be three as outlined in line with B2 of the Governance Handbook.
- 9** In the event that a vote needs to be taken, only Council members will be entitled to vote, in line with Annex B1 of the Governance Handbook.
- 10** The Committee may engage professional external advisers to undertake a periodic review/health check of the investment arrangements, and to provide professional advice. External advisers will attend Committee meetings as necessary.
- 11** Fund managers who are appointed to manage investment funds on behalf of the GMC will be expected to attend Committee meetings at least biannually.
- 12** The Chair and/or directors of trading subsidiaries will attend Committee meetings at least biannually.
- 13** Other staff may attend Investment Committee meetings as necessary.
- 14** A summary of the performance of funds invested under management and funds invested through a trading subsidiary will be reported to Council as part of the normal reporting of financial performance within the Chief Executive's report. In addition, the Committee will report annually to Council on its activities.

[This version of the Investment Committee's Statement of purpose was approved by Council on 24 February 2022]

Investment Policy

Introduction

- 1 As a matter of prudent financial management we must hold sufficient reserves to:
 - a Provide working capital to undertake our day to day business
 - b provide funds to deal with any risks that materialise
 - c provide funds to respond to new initiatives, opportunities and challenges that present themselves
 - d cover the time period before any changes to fee levels takes full effect
- 2 This ensures that our regulatory independence is underpinned by a strong and stable financial base.
- 3 In addition to our reserves we typically hold significant cash sums during the year because our expenditure is broadly linear while our fee income is concentrated in the summer months.
- 4 This policy sets out the approach we will take with all of the funds that we hold. It supports our charitable aims and our statutory purpose as set out in the Medical Act 1983 and is in line with Charity Commission guidance on investments.
- 5 Our funds can be separated into four categories: those which are required as working capital for the normal day to day operation of the business; those which we may invest under management; those which we may invest in a trading subsidiary; and any residual cash balance.

Working capital

- 6 The Investment Committee will ensure that we hold sufficient working capital for normal cash-flow purposes. The Committee will determine an appropriate amount from time to time which provides sufficient flexibility to avoid temporary borrowing and/or the need to liquidate investments to deal with short term variations in operational income-and expenditure. Any changes to the actual

amount of working capital held will be notified to Council through the report of the Chief Executive Officer to the Council.

- 7 Working capital will be held as cash in instant access interest-bearing accounts in UK banks which are subject to regulation by the Financial Conduct Authority.
- 8 As a minimum, the bank must hold at least two out of three of the following short term credit ratings:
 - Moody's P-2
 - Fitch F1
 - Standard and Poor's A-2
- 9 Working capital will be managed by the Director of Resources who will seek to secure the most advantageous interest rates available, within the constraints of the policy. Funds may be moved between banks during the year to achieve this, but the primary requirements for working capital funds are security and liquidity.

Funds invested under management

- 10 After taking account of our working capital requirement we have determined that we will invest up to £50 million under management. This amount is reviewed annually by Council.

Attitude to risk

- 11 We have a low risk appetite. We wish to protect against volatility, capital loss and the erosion of asset value by inflation.

Objectives

- 12 When investing funds under management our objectives are: to provide protection against inflation; to generate a modest level of return; and to diversify our funds to reduce the risk of capital and/or revenue loss.
- 13 Our target rate of return on funds invested under management is inflation (CPI) plus 2% over a rolling five year period.
- 14 Funds under management will be invested in a broad range of quoted investments, bonds and other debt securities issued by public and corporate bodies, third party regulated funds, regulated and unregulated in-house funds, money market instruments, foreign exchange, private equity and cash (including deposits in pooled cash funds).

- 15 Asset allocation parameters will be determined by the Investment Committee, based on advice from fund managers and/or external advisers, to ensure that funds are diversified to reduce the risk of capital and/or revenue loss. The Investment Committee will monitor compliance with those parameters. The parameters will be reviewed periodically to ensure that they remain consistent with our low risk appetite. If more than one fund manager is used, the Investment Committee will monitor the aggregate asset allocation to ensure it provides sufficient diversification.

Ethical considerations

- 16 We have adopted a comprehensive ethical investment approach. We believe that investing in certain companies or sectors would conflict with our charitable aims, or may create reputational damage. We do not wish to profit directly from, or provide capital to, activities that are materially inconsistent with our charitable aims and so we specifically exclude investment in companies whose principal purpose involves: tobacco; alcohol; gambling; pornography; high-interest rate lending; cluster munitions and landmines; and the extraction of thermal coal or oil sands. We recognise that many large companies are involved in a broad range of business activities. Given this we do not invest in companies that derive more than 10% of their revenue from an excluded area. This allows us to invest in, for example, the retail sector while excluding tobacco companies.
- 17 We do not invest in companies that are under investigation for, or been found guilty of, tax evasion or money laundering in the last three years.
- 18 We recognise that when fund managers invest through a third party or pooled funds, we cannot directly influence the selection of individual investments. In these circumstances we require the fund managers to ensure that the proportion of excluded investments in the pooled fund is less than 10%.
- 19 We may invest in companies whose activities are consistent with, or supportive of, our charitable aims. We expect companies in which we invest to demonstrate responsible employment and corporate governance practices, to be conscientious with regard to environmental and social issues, and to deal fairly with customers and the communities in which they operate. We may also use our position as an investor to actively engage with and influence the corporate behaviour of those companies we invest in.
- 20 We will invest only through fund managers who demonstrate the strongest environmental, social and governance (ESG) credentials. When appointing fund managers we will take into consideration how they incorporate an assessment of companies performance on ESG issues into their stock selection.

Funds invested through a trading subsidiary

- 21 Where we have the power to do so we may invest funds in a trading subsidiary of the GMC.
- 22 Investments in a trading subsidiary may take the form of loan capital and/or share capital.
- 23 Any funding provided to a trading subsidiary must be justifiable as an appropriate investment of the GMC's resources, e.g. by means of specific investment advice and may take the form of:
 - a A financial investment to generate a financial return to be used to further our charitable objectives (requiring advice).
 - b A straightforward grant of money or a programme-related investment, to directly deliver one or more of our charitable objectives (not normally requiring advice).
 - c A mixed-motive investment, combining elements of both financial and programme-related investments (requiring advice as far as appropriate).
- 24 Any investment in a trading subsidiary will be subject to the same ethical considerations as funds invested under management.
- 25 Any investment in a trading subsidiary will require specific approval by the Investment Committee and must comply with HMRC's requirements for qualifying investments.

Residual cash balance

- 26 Any residual cash not held as working capital or invested will be held in medium term deposits and/or interest-bearing accounts.
- 27 Medium term deposits and interest-bearing accounts will be held in UK banks which are subject to regulation by the Financial Conduct Authority. As a minimum, the bank must hold at least two out of three of the following short term credit ratings:

■	Moody's	P-2
■	Fitch	F1
■	Standard and Poor's	A-2
- 28 No single deposit should exceed £5 million, with a maximum exposure of £40 million per bank (including any funds held as working capital in instant access interest-bearing accounts). Term deposits should be spread on a rolling

maturity basis, and maturity dates for deposits should be no longer than 18 months.

- 29 Funds will be managed by the Director of Resources who will seek to secure the most advantageous interest rates available, within the constraints of the policy.

Management, reporting and monitoring

- 30 Council is responsible for determining and reviewing the overall investment policy, objectives, risk appetite and target returns.
- 31 Council has delegated to the Investment Committee responsibility for implementing the investment policy, appointing and managing fund managers, monitoring performance and reporting to Council. Full responsibilities are set out in the Investment Committee's statement of purpose.
- 32 Day to day investment decisions are delegated to investment fund managers in line with this policy and are accountable to the Investment Committee for performance. The Investment Committee may determine benchmarks against which to measure performance.
- 33 Investment fund managers are required to provide quarterly valuation and performance data.

Approval and review

- 34 The Investment Policy will be reviewed by Council annually, on the advice of the Investment Committee. This will reflect the Council's overall financial position, its budgetary requirements, and any changes to the reserves policy.

[This version was approved by Council on the 24 February 2022]

Action	To note
Purpose	This report summarises the work undertaken by the Executive Board during 2021, setting out the decisions taken, policies and guidance agreed, and reports noted across a range of strategic issues.
Decision trail	Council receives a report on the work of the Executive Board annually, in addition to the updates included in the Chief Executive’s report at each meeting. This paper has been agreed by the Executive Board.
Recommendation	To note the report of the Executive Board 2021.
Annexes	None
Author contacts	Dale Langford , Corporate Governance Manager Any enquiries to: GovernanceTeamMailbox@gmc-uk.org
Sponsoring director/ Senior Responsible Owner	Charlie Massey , Chief Executive

Background

- 1 The Executive Board was established in 2017 as a decision-making forum and to promote collective executive decision-making by the senior management team (SMT). The Board is required by its statement of purpose to submit an annual report to Council, as well as regularly reporting to Council via the Chief Executive's report.
- 2 The Board met 11 times during 2021, on the following dates:

1 February 2021	26 July 2021
1 March 2021	27 September 2021
29 March 2021	25 October 2021
26 April 2021	29 November 2021
1 June 2021	20 December 2021
28 June 2021	

Key matters considered by the Executive Board in 2021

Operational performance and risk

- 3 In alternate months, the Board considered the Performance and Risk Report, providing high level reports on performance, including finance and people, customer service and learning, and updates on the key risks to achieving our strategic aims.
- 4 In the same meetings as the Performance and Risk Report, the board conducted a series of risk deep dives. The aim of these discussions is to focus on a single corporate risk and consider the extent to which individual board members are confident that the directorate level risks that underpin it provide sufficient assurance to the Board collectively that the corporate risk is being managed. A similar approach applies to deep dives relating to opportunities.
- 5 Risk deep dives during 2021 covered the following risks and opportunities: *Working with patients and the public* (1 February 2021), *Deriving insight from our data capability* (29 March 2021), *Unplanned event* (1 June 2021), *ED&I strategic delivery and ED&I compliance* (26 July 2021), *Responding to changes in external environment* (27 September 2021). The final such discussion of the year, on 29 November 2021, examined the Corporate Opportunities and Risk Register more broadly to provide assurance it still covers the right strategic risks.

Pandemic response and recovery

- 6 The Board discussed pandemic response and recovery throughout the year, including:
 - a Establishing a Recovery and Renewal Taskforce and approving the resumption of all paused investigations (29 March 2021).
 - b Agreeing plans for a phased return to the office when social distancing ends, in a way that supports the effective delivery of our functions (26 April 2021).
 - c Approving the reconfiguration of office space at 3 Hardman Street in Manchester to rebalance the office space between desks and collaborative areas for the return to the office. (28 June 2021).
 - d Agreeing to [cancel scheduled PLAB 2 tests](#) in January and February 2022 in response to the impact of increasing numbers of cases of the Omicron variant, with UK-based candidates and those with jobs prioritised for the restart (20 December 2021).

Business Plan and Budget

- 7 At its meetings on 27 September and 29 November 2021, the Board considered the draft Business Plan and Budget, ahead of consideration by Council on 9 December 2021.

Equality, diversity and inclusion

- 8 The Board discussed the Governance and Compliance Review on equality, diversity and inclusion (ED&I), as reported to Council on 29 April 2021 (26 April 2021).
- 9 ED&I targets for recruitment are included in the Board's regular Performance and Risk Report and, as referred to in paragraph 5, the Board also conducted a risk deep dive on *ED&I strategic delivery and ED&I compliance*.

Policy

- 10 The Board approved [changes to how we consider allegations of violence and dishonesty](#) (1 March 2021). These included [updated guidance for decision makers](#) so that further action may not be needed where a doctor's behaviour outside their professional practice does not pose a risk to patients or to public

confidence in the profession because it is at the lower end of the spectrum of seriousness.

- 11 The Board agreed to publish annually, from December 2021, data on [Doctors who have died whilst in FTP proceedings](#) for a three-year rolling period, with the cause of death data broken down into broad categories (1 March 2021).
- 12 The Board agreed to discontinue an exercise to verify the primary medical qualifications of a group of licensed doctors who had previously joined the Register via a route other than the PLAB test (26 July 2021).
- 13 The Board agreed a [Policy for granting temporary emergency registration](#) (27 September 2021), reflecting on the approach we are taking to granting temporary emergency registration as part of our response to the pandemic. The new policy provides a framework for developing an approach to support the response required for a particular emergency rather than detailing the approach itself.

Other regular reports

- 14 The Board received the following reports:
 - a The draft Executive Board report to Council (1 February 2021), ahead of consideration by Council on 25 February 2021.
 - b [The annual research report for 2020](#), providing an overview of the research programme managed within the Data, Research and Insight Hub during 2020, highlighting key findings, and how we make sure the quality of research is to a high standard and makes an impact (1 March 2021).
 - c [Plans for the staff survey](#) (1 March 2021) and results of the survey (25 October 2021) were reviewed by the Board, as reported to Council on 3 November 2021.
 - d Updates on the progress of regulatory reform (29 March, 1 June, 28 June, 26 July, 27 September, 29 November 2021).
 - e The [annual report of the Data Protection Officer](#), providing an overview of our information governance activities in 2020 (29 March 2021).
 - f Updates on GMC Services International Ltd (1 June and 29 November 2021).

- g** The work of the Medical Advisory Board (MAB) that will provide advice to the Executive Board on how the organisation engages with vulnerable doctors in GMC processes (1 June 2021).
- h** The draft 2020 Trustees' Annual report and accounts and the annual fitness to practise statistics, for submission to Council (26 April 2021). Council agreed the [Trustees' Annual report and accounts](#) for 2020 at its meeting on 9 June 2021.
- i** Update on corporate complaints received, ahead of Council's consideration of the complaints reports (26 April and 25 October 2021).
- j** The annual business continuity report, summarising the work undertaken by the Business Continuity Working Group and Compliance Team during 2020/21 (26 July 2021).
- k** [The annual health and safety report](#), providing an overview of health and safety activities and accident/incident information for 2020 (27 September 2021).
- l** The annual report of the GMC Group Personal Pension Plan Management Board (29 November 2021), on which Council also received an update on 9 December 2021.
- m** The draft Annual Responsible Officer Board Report and Statement of Compliance for submission to NHS England (25 October 2021).
- n** The approach for applying the 2022 pay award (20 December 2021).

Action	To approve
Purpose	This paper sets out the proposed dates of Council and Board/Committee meetings in 2023.
Decision trail	<p>Council notes the dates for the following year’s meetings in February each year. Each committee chair has been consulted on the proposed dates for their committee.</p> <p>Council’s work programme for 2023 will be considered by Council at the meeting in December 2022.</p>
Recommendation	To agree the 2023 schedule of meetings.
Annexes	Annex A: 2023 Council and committee dates
Author contacts	<p>Melanie Wilson, Head of Corporate Governance and Council Secretary</p> <p>Any enquiries to: GovernanceTeamMailbox@gmc-uk.org</p>
Sponsoring director/ Senior Responsible Owner	Sophie Brookes , Assistant Director Corporate Directorate

Background

- 1 In preparing this schedule, the Corporate Governance team has taken into account dates of school holiday periods, as far as is possible at this early stage, and major religious festivals. We avoided scheduling meetings in early January, late July, August, and late December. However, due to the number of meetings required and the fact that half terms and summer holidays vary between schools and different regions, and in each of the four countries, it is not always possible to completely avoid these periods.
- 2 We have also considered the reporting arrangements required and have sought to achieve a schedule that links with the production of performance and financial information to allow for Council's review of appropriate and timely data.
- 3 The full meeting schedule will also be uploaded and available for members to view via the Board Intelligence app and will be kept updated should any changes be made.
- 4 Arrangements set out in this paper will be subject to review in the light of regulatory reform and the possibility that we will move to a unitary board arrangement before the end of 2023.
- 5 Additional briefings or meetings may be held as required. The Corporate Governance Team will endeavour to arrange these at a convenient time for all.

Council

- 6 The draft schedule of Council meetings for 2023 is at Annex A. Council meets six times each year to meet the needs of the work programme, and has an away day/night, usually in July. Council seminars take place the evening before Council meetings, between 16:30 to 19:00.
- 7 Of the six meetings, one will be held in Manchester, one in one of the national offices, one 'virtual', and the remaining three in London.

Committees and other groups

- 8 The draft schedule at Annex A also contains the proposed dates of other meetings involving Council members, including the Audit and Risk Committee, Remuneration Committee, Investment Committee, GMCSI Board and the Board of Pension Trustees. The frequency of these meetings has been determined in accordance with the working arrangements set out in their statements of purpose.

- 9 As usual, it will be open to Chairs, in consultation with other members, to decide as the work programmes develop, whether there is a need to hold all of the proposed meetings scheduled, or indeed if additional meetings are required.

Council meeting – 24 February 2022

Agenda item M11

2023 Council and Committee planning

2023 Council and Committee dates

The proposed meeting schedule for Council is as follows:

Tuesday 28 February 2023, 16:30-19:00 (Evening seminar)

Wednesday 1 March 2023, 09:00-13:00 – **London**

Wednesday 26 April 2023, 16:30-19:00 (Evening seminar)

Thursday 27 April 2023, 09:00-13:00 – **Manchester**

Tuesday 20 June 2023, 16:30-19:00 (Evening seminar)

Wednesday 21 June 2023, 09:00-13:00 – **London**

Tuesday 11 and Wednesday 12 July 2023, Council away day – Residential/overnight

Wednesday 27 September 2023, 16:30-19:00 (Evening seminar)

Thursday 28 September 2023, 09:00-13:00 – **Virtual**

Wednesday 1 November 2023, 16:30-19:00 (Evening seminar)

Thursday 2 November 2023, 09:00-13:00 – **Devolved nation tbc**

Tuesday 12 December 2023, 16:30-19:00 (Evening seminar)

Wednesday 13 December 2023, 09:00-13:00 – **London**

2023 Committee and other group meetings

Audit and Risk Committee

Thursday 26 January 2023

Wednesday 29 March 2023

Thursday 25 May 2023

Tuesday 12 September 2023

Thursday 16 November 2023

Investment Committee

Tuesday 14 February 2023

Wednesday 10 May 2023

Thursday 21 September 2023

Tuesday 21 November 2023

Remuneration Committee

Tuesday 21 March 2023

Tuesday 10 October 2023

Board of Pension Trustees

Wednesday 8 March 2023

Tuesday 16 May 2023

Wednesday 19 July 2023

Wednesday 20 September 2023

Tuesday 14 November 2023

Council meeting – 24 February 2022

Agenda item M11 – 2023 Council and Committee planning

GMC/MPTS Liaison Group

Wednesday 7 June 2023

Wednesday 29 November 2023

GMCSI Board

Thursday 16 March 2023

Thursday 29 June 2023

Tuesday 26 September 2023

Thursday 30 November 2023

Council meeting – 24 February 2022

Agenda item M12

Council 2022 forward work programme

Council 2022 forward work programme

Draft as of: 15 February 2022

Date and time:	Meeting:
Wednesday 23 February (evening seminar) and Thursday 24 February 2022 (Meeting) 09.00 – 13.00 – London	Council
Evening seminar 16:00-17:30 <ul style="list-style-type: none">Learning from Inquiries and Reviews Pensions updatePensions update	
Confidential items <ul style="list-style-type: none">Safeguarding updateUpdate on regulatory reform- unitary boardsAnnual Review of Governance Framework: GMC and GMCSI (Below the line)	
Meeting <ul style="list-style-type: none">Chief Executive's reportEquality, diversity and inclusion – Annual progress reportProgress on MAPsQuality Assurance updateUpdate on GMPReport of the Investment Committee 2021	
Below the line <ul style="list-style-type: none">Report of Executive Board2023 meeting schedule2022 Council forward work programme	

Date and time:	Meeting:
Wednesday 27 April (evening seminar) and Thursday 28 April 2022 (Meeting) 09.00 – 13.00 London	Council
Evening seminar (tbc) Corporate social responsibility	
Confidential items <ul style="list-style-type: none">	

<p>Meeting</p> <ul style="list-style-type: none"> ▪ Chief Executive’s report ▪ Equality, diversity and inclusion impact report ▪ PSA annual review of our performance ▪ Human Resources report 2021 ▪ Biannual s40a appeals update ▪ Communications and Engagement update ▪ Update on regulatory reform ▪ Freedom to speak up guardian annual report ▪ Approval of awarding bodies: [tbc]
<p>Below the line</p> <ul style="list-style-type: none"> ▪ Council members’ register of interest ▪ 2022 Council forward work programme

Date and time:	Meeting:
<p>Tuesday 21 June (evening seminar) and Wednesday 22 June 2022 (Meeting) 09.00 – 13.00 Manchester</p>	<p>Council</p>
<p>Evening seminar tbc GMCSI</p>	
<p>Confidential items</p> <ul style="list-style-type: none"> ▪ GMCSI [Andrew McCulloch/Paul Reynolds] 	
<p>Meeting</p> <ul style="list-style-type: none"> ▪ Chief Executive’s report ▪ Equality, diversity and inclusion [tbc] ▪ Report of the MPTS Committee ▪ Trustees’ Annual Report and Accounts 2021 ▪ Fitness to Practise Statistics Report 2021 ▪ Report of the Audit and Risk Committee ▪ Compliments and Complaints report ▪ Update on regulatory reform ▪ Update on credentials (tbc?) ▪ Update on Brexit standstill ▪ Sex, gender and gender identity consultation 	
<p>Below the line</p> <ul style="list-style-type: none"> ▪ 2022 Council forward work programme 	

Date and time:	Meeting:
Tuesday 12/Wednesday 13 July 2022 Council Away Day	Council
Update on the Corporate Strategy Regulatory reform	

Date and time:	Meeting:
Wednesday 28 September (evening seminar) and Thursday 29 September 2022 (meeting) 09:00 – 13:00 virtual	Council
Seminar <ul style="list-style-type: none"> ▪ Perceptions audit ▪ tbc 	
Confidential items <ul style="list-style-type: none"> ▪ Outline draft Business Plan and Budget 2023 ▪ SoMEP report – early messages (tbc)] 	
Meeting <ul style="list-style-type: none"> ▪ Chief Executive’s report ▪ Equality, diversity and inclusion update ▪ Biannual s40a Appeals Update ▪ <i>Adapting to the future</i> report ▪ Update on Education reform ▪ Pensions update – re triennial valuation (<i>tbc: here or November</i>) 	
Below the line <ul style="list-style-type: none"> ▪ Council members’ register of interest ▪ 2022 Council forward work programme 	

Date and time:	Meeting:
Wednesday 2 November (evening seminar) and Thursday 03 November 2022 (Meeting) 09.00 – 13.00 Edinburgh	Council
Evening seminar <ul style="list-style-type: none"> ▪ Scotland focus plus stakeholder dinner 	
Confidential items	

<ul style="list-style-type: none"> ▪ Update on the staff survey
<p>Meeting</p> <ul style="list-style-type: none"> ▪ Chief Executive’s report ▪ Equality, diversity and inclusion update ▪ SOMEP report – final draft (tbc) ▪ Compliments and Complaints report ▪ Update on <i>Good medical practice</i> consultation ▪ Update on regulatory reform ▪ PPI update ▪ Pensions update – re triennial valuation ▪ Update on the staff survey
<p>Below the line</p> <ul style="list-style-type: none"> ▪ 2022 Council forward work programme

Date and time:	Meeting:
Wednesday 13 December (evening seminar) and Thursday 14 December 2022 (Meeting) 09.00 – 13.00 - London	Council
<p style="color: #0070c0;">Evening seminar 17:00 – 19:00 to be followed by dinner</p> <ul style="list-style-type: none"> ▪ Tbc 	
<p style="color: #0070c0;">Confidential items</p> <ul style="list-style-type: none"> ▪ Draft Business Plan and Budget 2023 ▪ GMCSI 	
<p>Meeting</p> <ul style="list-style-type: none"> ▪ Chief Executive’s report ▪ 2023 Business Plan and Budget ▪ Three-year business plan (activities, monitoring/reporting, evaluating) ▪ Report of the Medical Practitioners Tribunal Service Committee 2022 ▪ Report of the Audit and Risk Committee 2022 ▪ Report of the Remuneration Committee 2022 ▪ Update on regulatory reform ▪ MLA – update on MSC pilots (tbc) 	
<p>Below the line</p> <ul style="list-style-type: none"> ▪ Council forward work programme 2023 ▪ Committee membership 2023 ▪ Annual report on DC pension scheme ▪ 2022 Council forward work programme 	