General Medical Council

Council Meeting - 29 September 2022

PUBLISHED
16 May 2023

Council

Meeting room: MS Teams

General Medical Council

Agenda

Main meeting

Thursday 29 September 2022 - 11:15 – 13:00

		Council meeting
11:15 – 11:18 *3 mins*	**M1**	Chair's business
11:18 – 11:20 *2 mins*	**M2**	Minutes of the meeting on 22 June 2022 and actions log
11:20 – 11:40 *20 mins*	**M3**	Chief Executive's report
11:40 -12:00 *20 mins*	**M4**	Safeguarding update
12:00 – 12:25 *25 mins*	**M5**	Fair training cultures
12:25 – 12:40 *15 mins*	**M6**	Amendments to the GMC regulations on specialist/GP registration
12:40 – 12:55 *15 mins*	**M7**	Biannual Section 40A appeals update
12:55 – 13:00 *5 mins*	**M8**	Any other business
		Below-the-line items*
	M9	Council members' Register of Interests
	M10	2022 Forward work plan

***Members should notify the Chair a minimum of two days prior to the meeting should they wish to discuss any below the line items. If not, then it is assumed that Council wishes to agree the recommendations without discussion.**

Contents

General Medical Council

Draft as of: 04 July 2022

To approve

Minutes of the meeting on 22 June 2022, via MS Teams

Members present

Carrie MacEwen, Chair

Steve Burnett
Vanessa Davies
Anthony Harnden
Philip Hunt
Paul Knight
Deepa Mann-Kler
Deepa Mann-Kler
Raj Patel
Suzanne Shale
Alison Wright

Others present

Charlie Massey, Chief Executive and Registrar
Shaun Gallagher, Director of Strategy and Policy
Anthony Omo, Director of Fitness to Practise and General Council
Neil Roberts, Director of Resources
Colin Melville, Medical Director and Director of Education and Standards
Paul Reynolds, Director Strategic Communications and Engagement
Melanie Wilson, Head of Corporate Governance and Council Secretary

Agenda item 2
Minutes of the meeting on 22 June 2022

Chair's business (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 Una Lane, Director of Registration and Revalidation.

Minutes of the meeting on 28 April 2022 and actions log (item M2)

3 Council approved the minutes of the meeting on 28 April 2022 as a true record.

Chief Executive's Report (item M3)

4 Council considered the Chief Executive's Report.

5 Council noted that:

a The Neurology inquiry report was published on the 21 June. GMC colleagues are currently analysing it for recommendations and lessons learnt.

b The first in-person UK Advisory Forum meetings since 2019 were well attended and generated positive conversations. Discussions focused on how we can work together to support the medical workforce in all countries.

c There has been good engagement with the review of GMP consultation which closes in four weeks.

d Places for PLAB 1 assessments are going live this weekend and there will be sufficient places available for all those needing one.

e Due to very high call volumes from the PLAB 1 issues and closing the temporary register, April was a challenging month for the Contact Centre. Additional resources are being put in place and customer satisfaction rates remain high.

f Financially, we expect to be in a slightly worse off position at the end of 2022 compared to budget. This is partly due to losses on our investments due to market volatility.

g Risks which could impact on the financial position of the organisation include: the potential for change in PLAB candidate volumes linked to pandemic restrictions; the performance of our investments; and the rise in inflation which will impact our 3rd party costs and drive labour market pressures.

h We will continue to monitor both risks and investments but are not concerned at this time.

6 During the discussion, Council noted that:

- **a** The Investment Committee would like to test Council's appetite for our current investment strategy.
- **b** There was praise from Council for both the recent UK Advisory Forum meetings and GMC conference.
- **c** Council would like the opportunity to join future Patient Roundtable meetings and receive more information such as the main themes arising.
- **d** Despite the recent challenges faced by the Contact Centre, team morale is high and they are positive about the quality of service being provided.

7 Council:

- **a** Noted the Chief Executive's report and the Performance and Corporate Opportunities and Risk Register.

Equality, diversity and inclusion update – regulatory fairness review interim update (item M4)

8 Council was provided with an interim update on the Regulatory fairness review.

9 Council noted that:

- **a** A learning needs analysis is nearly complete and a high stakes decision making group has been formulating its recommendations.
- **b** Several themes have emerged so far including: Identifying and managing the risk of bias needs to be an ongoing process; the need to develop GMC wide decision making principles; ensuring fairness in decision making should be an activity of all functions, not just the externally facing operations; staff wish to improve their learning on bias, feedback/challenging conversations, and cultural competency.
- **c** We already deliver a lot of fairness training but are identifying gaps.

10 During the discussion, Council noted that:

- **a** The high stakes decision making group have been looking at: Internal auditing of audit controls such as guidance, training and principles; looking at how decision making can be improved; and looking at processes through the lens of bias.
- **b** Training gaps include that some staff do not recognise training as such, when it is not delivered via a specific course. Improvements considered include: internal communications used to greater effect, community groups for decision makers; and quarterly conversations around fairness training for assistant registrars in FtP Triage.

c By having a broader scope there is a risk the original focus of the review is lost. However, many workstreams are still focused on Fitness to Practise. Howlett Brown, commissioned to carry out an expert review of our past approach to auditing fairness in our decision making, is focusing on decision making in Fitness to Practise and Registration and Revalidation.

d It would be useful for Council to receive further updates as the review progresses.

11 Council:

a Noted the regulatory fairness review interim report and progress update.

Sex, gender and gender identity consultation (item M5)

12 Council was updated on plans to develop a GMC policy and to launch a consultation into sex, gender and gender identity data on the Medical Register.

13 Council noted that:

a We receive criticism of the current Medical Register which has a mandatory male or female option.

b There are ethical considerations to think about and patient/doctor rights need to be balanced.

c Most other healthcare regulators offer a greater range of options for registrants to identify sex and gender but do not publish this information on their publicly available registers.

d We need to understand how and why this data is being used by those accessing the Medical Register.

14 During the discussion, Council noted that:

a Ethical considerations should be considered further before consultation through internal conversations with colleagues in Standards.

b Council supported the approach to a more open-ended consultation and felt further engagement work was required.

15 Council:

a Noted the outcome of scoping work and pre-consultation engagement activity for the sex, gender and gender identity project.

b Approved proposals to consult on expanding the data we collect from registrants to encompass the categories of sex, gender reassignment and gender identity, and reviewing the publication of registrants' 'gender' details on LRMP.

c Noted the proposed approach to a public consultation and plans for further discussion with Council once the agreed actions have been taken forward.

Report of the MPTS Committee (item M6)

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

17 Council noted that:

a Good progress is being made to clear the accumulation of cases as a result of the pandemic and are still on track for the end of 2022.

b All Interim Orders tribunals (IOT) are all held virtually, which is well received by participants, with a mix of virtual, in person and hybrid Medical Practitioners Tribunals (MPT). New video conferencing equipment has been installed to improve hearing efficiency, and fairness is still the priority to ensure participants of virtual hearings are not disadvantaged.

c Internal research has been commissioned to look at MPT outcomes comparing in person hearings and virtual hearings. It is hoped to have an update for the December 2022 report to Council.

d A team has been put in place to address delays in publishing some determinations and progress is being made.

e 50 new Legally qualified Chairs (LQC) have been appointed and have undergone induction. An equality analysis is being undertaken to compare to Bar Standards data and has shown there was no variation across all stages of the appointment process.

f There are plans to appoint a new pool of medical and lay tribunal members at the end of 2022 and efforts are being made to access as diverse a pool as possible.

g An MPTS Committee member has resigned and a process is in place to appoint a replacement.

h The MPTS is celebrating its 10th anniversary in 2022.

i The MPTS Chair, Dame Caroline Swift, is standing down at the end of 2022 and a process is underway to appoint a successor. There have been significant positive changes while she has been in office though there is still more to do.

18 During the discussion, Council noted that:

a Most MPT hearings are in public so there is little the MPTS can do to influence media reporting. The MTPS Communications team proactively follow up inaccurate reporting where possible.

b Learning points are circulated to all tribunal members by email and are followed up on an individual basis if appropriate. The impact of these emails is not assessed.

c An increase in erasures during 2020 was due to the type of case prioritised at that point during the pandemic.

d Both the GMC and MPTS discuss with doctors referred to a tribunal, the importance of getting representation and attending hearings. The importance of engaging with the process and getting representation is imparted at every opportunity with students and other stakeholders.

19 Council:

a Considered the report of the MTPS Committee.

b Noted the text of the MPTS Report to Parliament 2021.

c Thanked Dame Caroline and the MPTS for their hard work in reducing the backlog.

Freedom to speak up guardian annual report (item M7)

20 The annual report of the Freedom to speak up guardian was presented to Council.

21 Council noted that:

a The report has been circulated to all GMC staff and teams are encouraged to discuss the report.

b Additional questions have been added to the staff survey in an attempt to better understand what prevents colleagues from speaking up.

c The motivation and experiences of a Freedom to speak up champion were shared with Council.

22 During the discussion, Council noted that:

a It is difficult to benchmark against other organisations as there are different models available for investigation and reporting. However, the National Guardians' office do collate some data which shows bullying is the main issue raised. Speak up guardian networks also show a similar pattern of behaviours at most organisations.

b The report has been considered by the Audit and Risk Committee who were assured by the report.

23 Council:

a Noted the Freedom to Speak up guardian annual report 2021.

Report of the Audit and Risk Committee (item M8)

24 Council received the biannual update on the Audit and Risk Committee.

25 Council noted that:

a There is a wide-ranging audit programme giving a high level of assurance on key risk areas.

b The Committee could provide good assurance on work around regulatory reform.

c The Assistant Director, Audit and Risk Assurance has offered a positive view that the systems of governance, risk management and internal control in operation during 2021 were generally well designed and working effectively to ensure the achievement of the GMC's objectives.

d A review of the schedule of authority was commissioned by the Chief Executive.

e A procurement process is underway for internal audit partners.

f The Audit and Risk Committee have scrutinised the annual report and accounts and recommend them for approval.

26 During the discussion, Council noted that:

a The work of the Committee continues to be valuable and insightful for Council. It felt the frequency of reports and the level of detail was proportional.

b All key business areas are included in the annual audit schedule.

27 Council:

a Noted the report of the Audit and Risk Committee.

Trustees' annual report and accounts 2021 (item M9)

28 Council received an update on the draft 2021 Trustees annual report and accounts.

29 Council noted that:

a Our finances are in a strong position.

b During 2021 our income was higher due to the temporary medical register and additional PLAB assessments. However, our expenditure was also higher due to a greater number of tribunal hearings to clear the backlog caused by the pandemic.

c For 2021, the annual report includes additional information on Senior Management pay and benefits.

30 During the discussion, Council noted that:

a They endorsed the annual report and found the additional reports from the devolved countries insightful.

b The draft text had been reviewed by the Audit and Risk Committee and external auditor, who were happy to recommend the reports for approval by Council.

c It was felt the annual report could include a greater focus on the work of outreach teams in England.

31 Council:

a Approved the Trustees' annual report and accounts 2021.

b Approved the letter of representation.

c Approved the national reports for Northern Ireland, Scotland and Wales.

d Agreed to delegate authority to the Chair of Council to sign the annual report and accounts 2021 and the letter of representation on behalf of the Trustees.

Fitness to Practise statistics report 2021 (item M10)

32 Council reviewed the Fitness to Practise statistics report for 2021.

33 Council noted that:

a The statistics report does not include data on protected characteristics as this is included in the State of Medical Education and Practise report (SOMEP).

34 During the discussion, Council noted that:

a The report was challenging to interpret and might benefit from the addition of some context and explanation.

b Referrals which do not meet the threshold for investigation could be referred to the Responsible Officer for discussion at a doctor's appraisal meeting, and this is a recommendation from the Neurology review. However, a survey of ROs suggested many do not have the resources to process this information.

c The recent increase in doctors registering with the GMC are not yet reflected in the numbers of enquiries. There may also be a future impact from doctors who chose not to retire during the pandemic.

35 Council:

Agenda item 2
Minutes of the meeting on 22 June 2022

a Approved the Fitness to Practise annual statistics report 2021.

Any other business: (item M11)

36 Council noted that its next meeting is scheduled for 29 September 2022, venue to be confirmed.

Compliments and Complaints report (item M12)

37 Council noted the Compliments and Complaints report as a below-the-line item.

2022 Forward work plan (item M13)

38 Council noted the 2022 Forward work plan as a below-the-line item.

Confirmed:

Carrie MacEwen, Chair 29 September 2022

General Medical Council

Chief Executive's report

Action	*To note*
Purpose	This report outlines developments in our external environment and progress on our strategy since Council last met. Key points to note: • We are continuing to prepare for regulatory reform. We are currently reviewing the latest draft of the anaesthesia associate and physician associate (AA and PA) Order. This will form a template for the legislation for doctors and other regulated health and care professions. • The consultation on our updated *Good medical practice* guidance closed on 20 July 2022. We had a hugely positive response, with over 4,600 individuals taking part in either our main survey or our short surveys for healthcare professionals and patients. We are currently analysing consultation responses and will update Council on our findings in December. • We published the results of our national training survey on 19 July 2022. The results show that the standard of training remains high across the UK. However, the proportion of trainees and trainers at risk of burnout is at the highest level since we started measuring it in 2018.
Decision Trail	Council receives this report at each full meeting.
Recommendations	**a** To consider the Chief Executive's report. **b** To note the Performance Annex and the Corporate Opportunities and Risk Register.
Annexes	Annex A: Performance Annex Annex B: Corporate Opportunities and Risk Register
Author contacts	**Iona Twaddell**, Head of the Office of the Chair and Chief Executive Any enquiries to: GovernanceTeamMailbox@gmc-uk.org
Sponsoring director/ Senior Responsible Owner	**Charlie Massey**, Chief Executive and Registrar

Agenda item M3
Chief Executive's report

Regulatory reform

1 In July, the DHSC announced that to deliver the political priority of bringing physician associates (PAs) and anaesthesia associates (AAs) into regulation as soon as possible, the new legislation currently being drafted will refer only to the regulation of these professions, with the updated legislation for doctors to follow at a later date. The DHSC has told us it does not expect this change to create any delay in the implementation of legislation for doctors.

2 On 16 September we received the next draft of the anaesthesia associate and physician associate (AA and PA) Order. This will form a template for the subsequent legislation for doctors and other regulated health and care professions. DHSC is not inviting further comments on the draft legislation at this stage and are instead asking us to provide comments as part of our consultation response. We have assurances that DHSC will continue to prioritise the subsequent order that will bring in the reforms to doctors' regulation and our governance.

3 DHSC is still aiming to launch their consultation around the beginning of November. We are currently doing some internal planning to prepare for how we are going to review the draft when it arrives and coordinate our response to the DHSC's consultation. We are also developing comprehensive plans for how we will engage with MAPs and doctor stakeholders during this period.

4 We are pleased to hear that DHSC have revised their approach to some of the issues we were previously concerned about, although we will need to consider how some of these policy changes have been expressed in the latest draft of the legislation before we have confidence that these have been resolved.

5 We plan to provide Council with an update at the November meeting on how the drafting has moved on and what our likely response will be to the consultation.

6 We continue to work with colleagues across the programme to plan ahead on what implementation will look like for doctors and have scheduled another planning workshop for early November to bring colleagues together to discuss this in more detail.

7 Work continues apace to prepare for regulation of PAs and AAs, which is now expected to commence in the second half of 2024. At the end of September, we will publish our pre-qualification education framework, setting out the skills, knowledge and behaviours expected of newly-qualified PAs and AAs. At the same time, updated curricula for PAs and AAs will be published by the Faculty of Physician Associates and Royal College of Anaesthetists respectively. Separately, we have recently opened an engagement on our proposed approach to revalidation for PAs and AAs and this is drawing significant interest from stakeholders. In addition, work is underway to update our information systems to incorporate PAs and AAs, including registration application processes.

Agenda item M3
Chief Executive's report

Good medical practice

8 The consultation on our updated *Good medical practice* (GMP) guidance closed on 20 July 2022. We had a hugely positive response, with over 4,600 individuals taking part in either our main survey or our short surveys for healthcare professionals and patients. We also spoke to over 3,800 people at the virtual and in-person events delivered by our outreach team and national offices

9 We actively monitored the demographics of people responding to our surveys and participating in events during the consultation period and tailored our communication activities to encourage responses from under-represented groups. This resulted in responses that compare well with the make-up of the medical register and census data.

10 We are currently analysing the consultation responses. Early indications are that there has been a high level of support for the spirit of our changes, particularly the greater focus medical professionals' responsibility to address negative interpersonal behaviours such as bullying and harassment. But there are also calls to consider the cumulative impact of new duties and to make sure GMP reflects the reality of what doctors face and the cultures many are working in. We will reconvene the GMP advisory forum in October ahead of discussion at December Council.

National training survey

11 We published the results of our national training survey on 19 July 2022. The results show that the standard of training remains high across the UK. However, the proportion of trainees and trainers at risk of burnout is at the highest level since we started measuring it in 2018. Key findings include:

- two-thirds of trainees said they 'always' or 'often' felt worn out at the end of a working day, while 44% were regularly 'exhausted in the morning at the thought of another day at work'
- trainees in all medical specialties showed an increased risk of burnout compared to last year. The highest rate was in Emergency Medicine, with 32% of doctors in training at high risk of burnout, up from 21% in 2021
- despite this, nine out of 10 trainees rated their clinical supervision as good or very good and more than four fifths said they were confident they would be able to progress to the next stage of training
- nine out of ten trainers told us that they enjoyed their training role, and nearly three quarters said they had the resources they needed to train. However, less than half said

they were always able to use the time they had allocated for training; and over a fifth said they haven't had an education appraisal in the last 12 months.

12 We secured coverage for the results in more than 160 media titles across the UK, with articles featuring in The Independent, Mail Online and Express. Many of the pieces also included quotes from the healthcare departments in England, Scotland, Wales and Northern Ireland, which is testament to our stakeholder engagement in the run-up to the launch of the results.

13 We will now work with postgraduate deans, medical royal colleges and employers to explore what doctors have told them about training in their country, region, speciality, and site. And we will support them to address areas of risk and identify examples of good practice**.**

Parliamentary affairs

14 During the significant political changes over the course of the summer, we maintained our regular engagement with government officials. Having written to Rt Hon Steve Barclay MP and Maria Caulfield MP, who briefly held the Secretary of State and Minister of State posts from July, we have sent further letters of congratulations to the new post holders Rt Hon Thérèse Coffey MP and Robert Jenrick MP and hope to meet with them in due course, in particular to discuss our position on workforce. After the death of HRH Queen Elizabeth II and the pause in government and parliamentary business, junior ministers in Prime Minister Liz Truss' new government have now all been confirmed. Dr Caroline Johnson MP and Neil O'Brien MP have been appointed Parliamentary Under-Secretaries of State at DHSC. Dr Johnson is a consultant paediatrician, who occasionally practises at Northwest Anglia NHS Trust in Peterborough. Will Quince MP has been appointed Minister of State with responsibilities for social care.

15 The new Secretary of State brings with her, from her role in the DWP, a reputation for being very hard-working and for paying close attention to delivery and detail. In early media coverage of her appointment, she was quoted as having an 'ABCD' of priorities - Ambulances, Backlog, Care, Doctors and Dentists, matching the new Prime Minister's commitment to put the NHS on a 'firm footing'. It is expected the new SoS will prioritise patient's access to care, with a particular focus GP and dentist waiting lists. A ministerial statement expanding on these commitments is expected before parliament breaks for its conference recess.

16 During the parliamentary recess, the Health and Social Care Select Committee published reports from two of its inquiries on *Workforce: Recruitment, training and retention* and *The impact of body image on physical and mental health.* The reports made a number of recommendations, some directly for the GMC, on a range of issues including registration of international medical graduates, and medical education and training. We have written to the Committee in response.

Agenda item M3
Chief Executive's report

Workforce

17 Building on the position discussed at the Council away day, we are continuing to develop our position on developing a sustainable medical workforce. Our key priorities are to support retention of the doctors we have – for example with induction and support for international medical graduates and SAS doctors, expanding those who could work in primary care, ensuring training is protected and maximising the contribution of physician associates and anaesthesia associates.

18 We are working with partners across the system in all four countries to share our data and insight, and inform their thinking about the changes that need to be made to address the workforce challenges in each of the four countries. For example, Charlie Massey, together with Andrea Sutcliffe, Chief Executive of the NMC, is meeting with Amanda Pritchard, CEO of NHS England to share our priorities for supporting the medical workforce as NHS England updates its People Plan.

19 We are due to publish a *State of medical education and practice* workforce report with our key data on the medical workforce, in October.

Disability confident employer

20 We are committed to the employment and career development of disabled people and particularly welcome disabled people to apply for roles at the GMC. We will implement a new disability confident interview scheme, which is our commitment to offer an interview to all people with a disability who provide evidence of meeting all the essential criteria for the post. We trialled the new job description and person specification template with essential and desirable skills with a CV and cover letter process when recruiting 14 graduate roles in May 2022. This identified helpful learnings as we prepare to roll this out further for all roles across the organisation at the end of September.

Inquiries and reviews

21 The Independent Neurology Inquiry in Northern Ireland published its final report in June 2022. As anticipated, the report contained a number of criticisms of, and recommendations for, the GMC. These included our handling of complaints against Michael Watt (the doctor at the centre of the Inquiry); the relationship between appraisal, revalidation and clinical governance; the sharing of information with responsible officers; and the need for the GMC to hold to account doctors who fail to report concerns about colleagues. We are currently considering how best to take the recommendations forward. A number of them will require collaborative work with our partners, including the Northern Ireland Department of Health. We expect to publish a detailed response to the report in the autumn.

22 The Ockenden Review into maternity services at the Shrewsbury and Telford NHS Trust published its report on 30 March. The report focused on systemic concerns that exist within maternity services at the Trust. It has not yet generated any individual fitness to practise referrals to the GMC. In examining the report, we have identified a number of issues which may require investigation by us and we have sought further information about these. As previously reported to Council, in May we replied to a letter from the Secretary of State for Health setting out how we intended to respond to the systemic concerns relating to poor leadership, culture and multidisciplinary team working described in the report.

23 The Independent Investigation into East Kent Maternity services is expected to report in October. We have engaged with the Investigation throughout and earlier in the summer sent written observations to the Investigation Team as part of its pre-publication fact checking exercise.

24 The terms of reference for the UK Covid 19 Inquiry have now been confirmed and the Inquiry has begun its work. Substantive public hearings are expected to begin in Spring 2023. In the meantime, we will remain in touch with the Inquiry team and monitor developments with the expectation that we will engage more directly as the Inquiry progresses.

25 We continue to support the implementation of the Government's response to the IMMDS review (specifically recommendation 8 on Conflicts of Interest) through our attendance on the DHSC's Task and Finish Group. Discussions continue on how a locally led approach to the declaration and publication of Conflicts of Interest can be implemented across all four countries of the UK. DHSC are planning to publish a progress report on their implementation of the IMMDS review's recommendations in the autumn.

26 As this summary of individual inquiries illustrates, recent years have seen a constant stream of new inquiries and reviews being established. However, the way in which they are set up, organised, resourced and run varies considerably. This can pose challenges for organisations like the GMC, for example in the way we deal with disclosure of documents, data protection issues and the follow-up to recommendations once an inquiry has reported. We have therefore opened a dialogue with DHSC, NHSE and PSA about how greater consistency of approach can be introduced to the operation of inquiries as this will help us to better fulfil our duty to help them.

Operational performance

27 After the sad death of HRH Queen Elizabeth II, we implemented our business continuity plans. We published a statement on our website to express our condolences and paused proactive communications, but continued with the majority of our operational communications. The day of the Queen's funeral, 19 September 2022, was a Bank Holiday

and we closed our offices. We had no PLAB exams scheduled so did not need to cancel any candidates. MPTS had a few hearings scheduled which we were able to postpone.

28 The annexed report details performance against our KPIs and priorities agreed in the Business Plan signed off by Council in December 2021. Although MAPs have now received their revised timelines from DHSC, Regulatory Reform are still impacted by legislative delays.

29 The Contact Centre call timeliness KPI was at its lowest in June (9%) but we are now starting to see the benefit of the 17 new starters with the figure rising to 20% for July. This is despite it being the peak period for provisional registration, FY1 applications for full registration and processing Annual Retention Fees payments. The Contact Centre are also facing increased pressures due to the influx of calls from IMG doctors around PLAB and registration applications. Our current KPI on timeliness does not fully reflect the wider picture of the Contact Centre's performance and current challenges, so we are exploring more comprehensive measures to address this. The ambition is to report on areas such as customer satisfaction and 'First Contact Resolution' to draw greater insight. It should be noted that this will require significant system changes, and IS build development time and resource.

30 The CSR risk has been removed from the annexed Corporate Opportunities and Risk Register (CORR) and de-escalated to directorate level following Executive Board approval on 25 July. The threat was originally escalated to the CORR following BDO's audit earlier this year. This highlighted the lack of information publicly available around the CSR work which was later rectified when the team published new web pages in May.

Finance

31 The July financial update shows we expect to be £2.2m better off at the end of 2022 compared to budget. Our planned operational deficit is forecast to be £5.8m lower, leaving us in an improved position, however we currently expect to make a £1.7m loss on our investments, against a budgeted £1.9m gain. Our overall finances remain in good shape and we are confident our medium term financial forecasts are in line with previous projections and consistent with our reserves policy. As we expect to be in a better financial position at the end of 2022 we have the flexibility to make an in year one off payment to staff while remaining within the approved annual budget. Much of the reduction in expenditure in 2022 compared to budget is one off in nature, linked to the impact of the Omicron variant, therefore our longer-term financial planning takes this into consideration when determining our fee increase and pay budget assumptions.

32 Factors that affected our income and expenditure compared to budget this year include:

a. The cancellation of PLAB 2 exams in January and February reduced both income and expenditure. However, we are forecasting an additional 1,500 PLAB 1 places and 8

additional PLAB 2 circuits later in the year, which will increase income and expenditure compared to our expectation.

b. Expenditure was also reduced early in the year because of the Omicron variant reducing travel and other costs.

c. Our planned vacancy factor was 4% however it currently stands at over 5% which also reduces our expenditure compared to budget.

d. The Gateway Fund had £5m allocated to it, but we expect to utilise a maximum of £2.8m of that fund.

33 There continues to be several financial risks which could impact our current forecasts for 2022. These include the potential for change in PLAB candidate volumes linked to pandemic restrictions, the performance of our investments and the rise in inflation, which will increase our third party costs and drive labour market pressure without being able to raise our fee levels to match.

34 Additionally, further to recent discussions at the Audit and Risk Committee seminar we will develop a form of financial stress test, which will seek to periodically evaluate our capacity to deal with external financial shocks and risks and our potential actions and response. We expect the method and parameters to be approved and results considered by the Audit and Risk Committee.

35 We will continue to monitor our investment performance and the impact of inflation rises closely.

Executive Board

36 The Executive Board met on 27 June and 25 July 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 review of the KPIs the GMC uses and whether these remain fit for purpose. Once an organisational review of the KPIs has been considered, Council will be updated on next steps.

c) A deep dive on risks relating to the organisation's appetite for risk and a consideration of our Risk Registers.

d) The removal of reference data from fitness to practise performance assessment tests of competence. The Board approved the proposal which will increase the validity and fairness of assessments, as doctors under assessment will no longer be compared with

doctors of different grades and specialties. The removal of reference data is supported by the performance assessors and Tests of Competence Panel.

e) An update on the *Good medical practice* review which will be considered by Council in December.

General Medical Council

M3 – Annex A - Performance annex

Data presented as at 31 July 2022 (unless otherwise stated)

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

	Indicator	May	Jun	Jul	Exception commentary
Operations	Decision on 95% of all registration applications within 3 months	99%	99%	99%	
	Decision on 95% of all revalidation recommendations within 5 working days	96%	97%	98%	
	Respond to 90% of ethical/standards enquiries within 15 working days	100%	100%	100%	
	Conclude 90% of fitness to practise cases within 12 months	95%	93%	95%	
	Conclude or refer 90% of cases at investigation stage within 6 months	97%	96%	97%	
	Conclude or refer 95% of cases at the investigation stage within 12 months	98%	96%	97%	
	Commence 100% of Investigation Committee hearings within 2 months of referral	100%	No Cases	100%	
	Commence 100% of Interim Order Tribunal hearings within 3 weeks of referral	100%	100%	100%	
Organisation	2022 Income and expenditure [% variance +/- 2%]	+2.93%	+2.67%	+2.88%	**Finance** The KPI was missed between May and July (2.88% variance against the +/-2% target). All PLAB 2 tests were cancelled in January and a further proportion in February, which contributes to a £2m reduced income year-to-date. However in total, expenditure is under budget by £4m partly due to the variable costs linked to PLAB tests in Jan-Feb being unspent. Additionally, ongoing limited travel patterns and working from home reduces some of our operational costs, and the current vacancy rate is at 5.5% which is higher than the 4% assumed in the budget. MPTS hearing volumes are lower than budgeted for which reduces associate costs for tribunal members and legal costs in FTP.
	Rolling twelve month staff turnover within 8-15%	9.6%	9.5%	9%	
	IS system availability (%) – target 98.8%	99.9%	100%	100%	
	Monthly media score	164	-263	892	

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

		2021							2022				
	Indicator	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
Operations	Decision on 95% of all registration applications within 3 months	97%	97%	96%	96%	96%	98%	97%	97%	99%	99%	99%	99%
	Decision on 95% of all revalidation recommendations within 5 working days	98%	98%	98%	98%	98%	98%	96%	94%	95%	96%	97%	98%
	Respond to 90% of ethical/standards enquiries within 15 working days	100%	94%	100%	100%	97.5%	98.2%	95%	100%	94%	100%	100%	100%
	Conclude 90% of fitness to practise cases within 12 months	90%	91%	95%	93%	92%	94%	93%	93%	94%	95%	93%	95%
	Conclude or refer 90% of cases at investigation stage within 6 months	95%	93%	95%	95%	96%	96%	96%	96%	96%	97%	96%	97%
	Conclude or refer 95% of cases at the investigation stage within 12 months	93%	95%	97%	95%	95%	96%	96%	96%	97%	98%	96%	97%
	Commence 100% of Investigation Committee hearings within 2 months of referral	No Cases	100%	100%	No cases	100%	100%	No Cases	No Cases	No Cases	100%	No Cases	100%
	Commence 100% of Interim Order Tribunal hearings within 3 weeks of referral	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Organisation	2022 Income and expenditure [% variance +/- 2%]	+3.81%	+2.76%	+2.80%	+2.5%	+2.65%	+2.61%	+0.70%	+2.23%	+2.94%	+2.93%	+2.67%	+2.88%
	Rolling twelve month staff turnover within 8-15%	6.8%	6.8%	7.5%	7.9%	8.2%	8.4%	8.3%	8.7%	9%	9.6%	9.5%	9%
	IS system availability (%) – target 98.8%	99.99%	99.91%	99.45%	99.6%	100%	99.98%	99.99%	99.93%	99.96%	99.9%	100%	100%
	Monthly media score	182	544	1016	162	115	79	4	716	424	164	-263	892

Performance Indicators – Making every interaction matter

		2021					2022						
	Indicator	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**
Contact centre operations	**Answer 80% of calls within 20 seconds (KPI)**	71%	48%	33%	57%	60%	58%	78%	64%	43%	23%	9%	20%
	Answer 90% of emails and letters (enquiries and updates) within 4 working days	84%	59%	50%	53%	91%	96%	87%	83%	84%	44%	51%	35%
	Average wait time (calls – seconds)	57	96	221	61	73	63	26	50	121	242	559	459
	Abandonment rate	9%	15%	34%	9%	11%	10%	4%	9%	19%	32%	56%	45%

Contact Centre (CC) - July was incredibly challenging with continued high call volumes partly attributed to a 'peak' period that takes place yearly over the summer. During this period, the CC are managing all UK graduate applications for provisional registration and FY1 applications for full registration (around 15,000 in total). It has also been the peak time for Annual Retention Fee payments for those who don't pay by direct debit, and it's often the time that doctors are making choices about relinquishing or restoring their licences. Although this is traditionally a busy period for the CC, it has been made even more so due to the unprecedented surge in PLAB bookings and registration applications from IMGs.

The CC is currently experiencing significantly higher volumes than in 2021. There were 20,000 more calls received YTD by the end of Q2 this year than the same period last year. In June alone the number of calls received were nearly double what they were in June 2021, and around 8,000 higher in July 2022 than July 2021. This illustrates the extreme level of impact on the CC caused by a combination of both expected peaks and additional unplanned pressures. Despite this, the SLA has increased from June which is largely due to the 17 new starters now beginning in operations, and we hope the upward trend will continue for August.

We've been doing some work to explore a comprehensive suit of measures that will provide a more rounded picture of the pressures on the CC and its performance. This will give greater insight than simply reporting on the call answer time SLA, which is limited in telling us about the service provided by the team. In particular the ambition over the medium-long term is to move towards a sophisticated reporting that includes measures on other areas such as customer satisfaction and 'First Contact Resolution'. This improvement will require system changes and support from teams across the business to implement.

Corporate Strategy Delivery: Priority activities forecast

August - December 2022 investment (project team resource)

Our strategy 2021-25

This strategy has been developed with and for patients, medical professionals, partners and colleagues. Over the next five years, four themes will shape all our work, helping us to achieve our ten-year vision.

Committed project resource for remainder of 2022 by Strategic Aim

Themes	Project resource costs to deliver tier 1 priorities
Making every interaction matter	3,242,700
Developing a sustainable medical workforce	1,226,000
Enabling professionals to provide safe care	391,700
Investing in our people to deliver our ambitions	154,700
Total	5,015,100

Corporate Strategy Delivery: Priority activities forecast

August - December 2022 investment (project team resource)

*Cost for Regulatory reform includes resource from enabling teams to deliver programme
**MAPs resource is funded by DHSC and nil cost to the GMC

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		RAG	Status
Review of Good Medical Practice	**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. Our guidance will be publicly consulted on and we will have launched an updated GMP. **When:** Complete by Q3 2023 **Who:** Colin Melville; Mark Swindells		The consultation closed on 20 July, and received a great response across all three surveys with over 4,600 individuals taking part in our surveys for healthcare professionals and patients. We also spoke to over 3,800 people at the virtual and in-person events delivered by our outreach team and national offices. There was a significant increase on survey respondents from priority groups where we can see the engagement work made a difference. Responses from the consultation are being analysed and reports created which will form the basis for the redraft recommendations.
Fairer Employer Referrals	**Why?** To eliminate differentials in employer fitness to practise referrals **When:** by 2026 **Who:** Anthony Omo		Phase 2 action plan was discussed at the steering group and agreed. Six-month post-implementation review of changes to the RO referral form is underway and updated 'lines to take' have been drafted. Plans are underway to roll out anti-bias training in relation to employer referrals to our other decision makers, in line with the learning needs analysis taking place as part of the Regulatory Fairness Review. Development of Triage/RO feedback loop in progress.
Fairer Training Cultures	**Why?** To deliver on our commitment to eliminate discrimination, disadvantage and unfairness for all index measures of fair medical education and training pathways. **When:** September 2031 **Who:** Colin Melville		Final scoping workshop is complete. The results are being collated and a long-term work programme being drawn up. The programme board will consider these recommendations in October, supported by a working group meeting held in September. We've completed our Initial work with stakeholders which draws upon principles around exam support provision. We held two workshops with representatives to collect their views and created a first draft which the Academy Assessment Committee will continue to own and develop. The first draft of our placement allocation process ED&I review has been completed and will be presented to MDRS in mid-August. Our masterclass pilot with HEE/RCPsych has now secured enough research engagement to begin report writing which will be carried out by Edge Hill University. Enhanced-demographic progression reports are being published by us in this period. These are initially being released to stakeholders as part of earlier engagement in preparation for a public release later in the year. We're also starting to plan a narrative report to support the release scheduled for autumn.

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		RAG	Status
Introducing the Medical Licensing Assessment	**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. **When:** Q4 2025 **Who:** Colin Melville; Judith Chrystie		We've started the process of evaluating medical schools' individual and collective compliance with the GMC's MLA Requirements and setting up data management and evaluation processes. We've begun to undertake live reviews of medical school submissions against the CPSA requirements. As a high-profile change programme being delivered with, and in some aspects through, external delivery partners, the overall programme is likely to remain at amber for the foreseeable future.
Post-Brexit Registration Pathways	**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. **When:** Q3 2024 **Who:** Una Lane; Kirstyn Shaw		PIDs for the PGQ Expansion, Portfolio assessment pathways and Direct assessment pathways are being reviewed and updated for the August programme board. The Board will also consider comms materials and slides on the governance process. We've received indications that an emerging Swiss trade deal may mimic the EFTA deal, in which case we would consider if this falls in scope with EFTA trade deal project. The drafting of the PMET order has now been agreed along with an explanatory note. We've asked that the PMET is not laid until October and are expecting it to come into effect on 30 November 2023. The PGQ project has been working on a policy rationale for adding specialist/GP qualifications to the acceptable PGQ list whilst the EFTA project has begun planning workshops on the implementation of EFTA route applications. The DHSC confirmed their preferred option of a new route to registration, and our Cross border working project will proceed on this basis. The Portfolio assessment pathways project has continued engaging with Royal Colleges and Faculties as part of the CESR /CEGPR workstream, and has been finalising their equality impact assessment and data protection screening documents. The Direct assessment pathways project have agreed their proposal recognising qualifications in the new RSQ policy.

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		RAG	Status
Regulatory Reform and MAPs	**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. **When:** Changes for MAPs to come into effect summer 2023, remaining changes to be implemented by Q4 2024**. Who:** Shaun Gallagher; Tim Aldrich for Regulatory Reform; Una Lane; Clare Barton for MAPs.		The overall programme status is amber. We continue to engage with DHSC on key policy issues and our concerns with their plans to move forward with a s.60 that we have reason to expect still requires more work before it's ready for consultation. We're working with colleagues across the programme to be in a position to respond to DHSC and engage with stakeholders as soon as the next draft is received. Following a face to face planning workshop in June, we're looking ahead at planning for the implementation of doctor and Governance and Operating Framework reforms. We have a series of workshops taking place during August with thematic workstreams to explore what it will take to implement these reforms. We'll use the outputs of these workshops to liaise with the enabling workstreams. We plan to collate this feedback and use this, as well as the updated draft of the S.60 that we are waiting to receive from DHSC, as the starting point of the next planning workshop, scheduled for Q4 2022. MAPS programme rating has moved from 'red' to 'amber' this month to reflect increased clarity on delivery timeline following DHSC's confirmation of its revised legislative approach and milestones. Regulation of PAs and AAs is now scheduled to begin in the second half of 2024. Our processes and systems will comfortably be ready by that point, but concerns remain as to the completeness and workability of the current draft AA/PA Order. During July we: updated key milestones for legislation and consultation in our plan; finalised the PA and AA curricula and shared drafts with course providers to allow enhanced preparation time before formal publication at the end of September; we shared our proposed model for the AA registration assessment with the External Advisory Group and will now set up a development group to design a knowledge test (delivered by us) plus a schedule of workplace-based clinical assessments. We also held an introductory meeting with the incoming president of the Faculty of PAs and continued preparing for an external engagement exercise on the revalidation policy approach for PA/AAs that will open in August.
Regulatory Fairness	**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. **When:** September 2022 **Who:** Shaun Gallagher		The literature review and stakeholder engagement for our external review of our assurance audits has now been completed and an interim report outlining proposed content and areas for recommendation has been presented by Howlett Brown to the GMC project team. A plan has been approved to address the most urgent gaps in learning provision by January 2023. The development of a 3 year strategy and implementation plan upon which a gateway bid is to be founded continues. Preparation for handover of Learning Needs Analysis (LNA) work from LNA project board to BAU delivery is underway. Discussions are underway with another potential QA supplier for the Equality Impact Assessment for regulatory reform processes. Development of the final report has commenced. Both the High-stakes decision-making and FtP data analysis and publication have now been closed. Outputs have been signed off as presented by the Review Lead, and plans for further development of FtP EDI data analysis and reporting have been agreed.

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		RAG	Status
Investing In Our People	**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're expanding the diversity of our people and targeting the barriers some colleagues experience so we can become a more inclusive work environment. We're also working to achieve Gold accreditation under Investors in People (IiP). **When:** Q3 2023 (IiP), 2026 for wider diversity. **Who:** Neil Roberts; Andrew Bratt		Initial responses on our feedback for success pilot have been really positive. Feedback is being sought from reviewers and insights coaches so further improvements can be made. We'll be asking approx. 200 colleagues who joined the GMC prior to the 2020 Equality Act to complete an ED&I refresher, and making a curriculum available for all to meet our immediate needs. We are finalising plans for 2023 which will include an annual ED&I curriculum for all staff, with links to some of our existing training packages and additional elements for decision making roles. Our intern programme was highly successful, with positive feedback from interns and their managers. We're still on track for graduates and apprentices to join in Q4 2022. 11 graduates have been recruited to date, with 25% ethnic minority candidates. Three graduate roles still outstanding. Apprentice roles will be readvertised with a view to increasing the volume of applications. We're expecting to pilot new coaching courses from Q4 following appointment and induction of the new provider.

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		
		2021 (%)	2021 (Vol)	2022[1] (%)	2022[1] (Vol)	2023	% points off 2023 target	2026
Increase the level of BME representation at Level 3 and above	Applications	32.1%	301	34.9%	279	27%	+7.9%	30%
	Interviews	22.4%	38	24.0%	54	22%	+2.0%	25%
	Offers	32.1%	18	21.7%	10	17%	+4.7%	20%
	Workforce	13.3%	81	14.5%	89	16%	-1.5%	20%
level of BME representation at Level 2+		11.7%	25	12.3%	26	14%	-1.7%	20%
level of BME representation at level 3		14.3%	56	15.6%	63	16%	-0.4%	20%
Increase the level of BME representation at all levels	Applications	40.0%	1,517	47.7%	1,998	37%	+10.7%	40%
	Interviews	27.4%	306	27.0%	261	32%	-5.0%	35%
	Offers	30.2%	103	27.2%	87	27%	+0.2%	30%
	Workforce	16.0%	248	16.8%	267	17%	-0.2%	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**		0.6%	-	BME (%) 8.3%	Non-BME (%) 9.1%	1-2%	% points between groups 0.8%	1.0%
Proportion of BME staff receiving promotion and grade progression is proportionate to our workforce at the relevant grade/level **difference is not set against the 2023 figure, the target is that the proportion of staff will be equal across BME and Non-BME*		-3.4%	-	BME (%) 11.8%	Non-BME (%) 12.0%	18%	% points between groups 0.2%	18%
Pay differentials within a confined band limited to 2% from 2023[2] *(table shows the proportion of bands that are outside of the tolerance)*		41.7%	5/12	41.7%	5/12	2.0%	N/A	2.0%

1 Rolling 12 month period used to the end of the reporting month

2 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%.

Financial summary (July)

Financial summary as at Jul 2022	Budget Jul	Actual Jul	Variance		Budget 2022	Forecast 2022	Variance	
	£000	£000	£000	%	£000	£000	£000	%
Operational expenditure	73,739	69,742	3,997	5%	130,806	123,492	7,314	6%
Capital expenditure	3,372	3,362	10	0%	8,980	8,980	0	0%
Total expenditure	**77,111**	**73,104**	**4,007**	**5%**	**139,786**	**132,472**	**7,314**	**5%**
Operational income	76,035	74,018	(2,017)	(3)%	133,782	132,233	(1,549)	(1)%
Operational surplus/(deficit)	**(1,076)**	**914**	**1,990**		**(6,004)**	**(239)**	**5,765**	

Financial summary as at Jul 2022	Budget Jul	Actual Jul	Variance		Budget 2022	Forecast 2022	Variance	
	£000	£000	£000	%	£000	£000	£000	%
Investment income	1,116	(1,713)	(2,829)	(253)%	1,926	(1,713)	(3,639)	(189)%
Investment management fees	130	110	20	15%	262	202	60	23%
Net investment return	**986**	**(1,823)**	**(2,809)**		**1,664**	**(1,915)**	**(3,579)**	

Total surplus/(deficit)	**(90)**	**(909)**	**(819)**		**(4,340)**	**(2,154)**	**2,186**	

Financial detail (July)

Expenditure as at Jul 2022	Budget Jul £000	Actual Jul £000	Variance £000	Variance %	Budget 2022 £000	Forecast 2022 £000	Variance £000	Variance %
Staff costs	45,898	44,924	974	2%	79,818	78,487	1,331	2%
Staff support costs	2,110	1,657	453	21%	3,737	3,301	436	12%
Office supplies	827	672	155	19%	1,035	1,009	26	3%
IT & telecoms costs	2,916	2,771	145	5%	5,271	5,086	185	4%
Accommodation costs	4,628	4,359	269	6%	7,899	7,656	243	3%
Legal costs	2,749	2,633	116	4%	4,820	4,409	411	9%
Professional fees	1,337	1,471	(134)	(10)%	3,232	3,048	184	6%
Council & members costs	242	221	21	9%	440	398	42	10%
Panel & assessment costs	11,235	9,235	2,000	18%	19,505	17,241	2,264	12%
PSA Levy	497	499	(2)	(0)%	856	864	(8)	(1)%
Gateway fund	0	0	0	0%	2,893	693	2,200	0%
Pension top up payment	1,300	1,300	0	0%	1,300	1,300	0	0%
Total operational expenditure	**73,739**	**69,742**	**3,997**	**5%**	**130,806**	**123,492**	**7,314**	**6%**

Income as at Jul 2022	Budget Jul £000	Actual Jul £000	Variance £000	Variance %	Budget 2022 £000	Forecast 2022 £000	Variance £000	Variance %
Annual retention fees	59,710	59,823	113	0%	104,718	104,832	114	0%
Registration fees	3,440	2,285	(1,155)	(34)%	7,115	5,855	(1,260)	(18)%
PLAB fees	9,862	8,601	(1,261)	(13)%	17,155	16,319	(836)	(5)%
Specialist application CCT fees	1,975	2,037	62	3%	2,903	2,970	67	2%
Specialist application CESR/CEGPR fees	745	929	184	25%	1,293	1,340	47	4%
Interest income	23	72	49	213%	54	383	329	609%
Other income	280	271	(9)	(3)%	544	534	(10)	(2)%
Total Operational Income	**76,035**	**74,018**	**(2,017)**	**(3)%**	**133,782**	**132,233**	**(1,549)**	**(1)%**

Finance - GMCSI summary & investments (July)

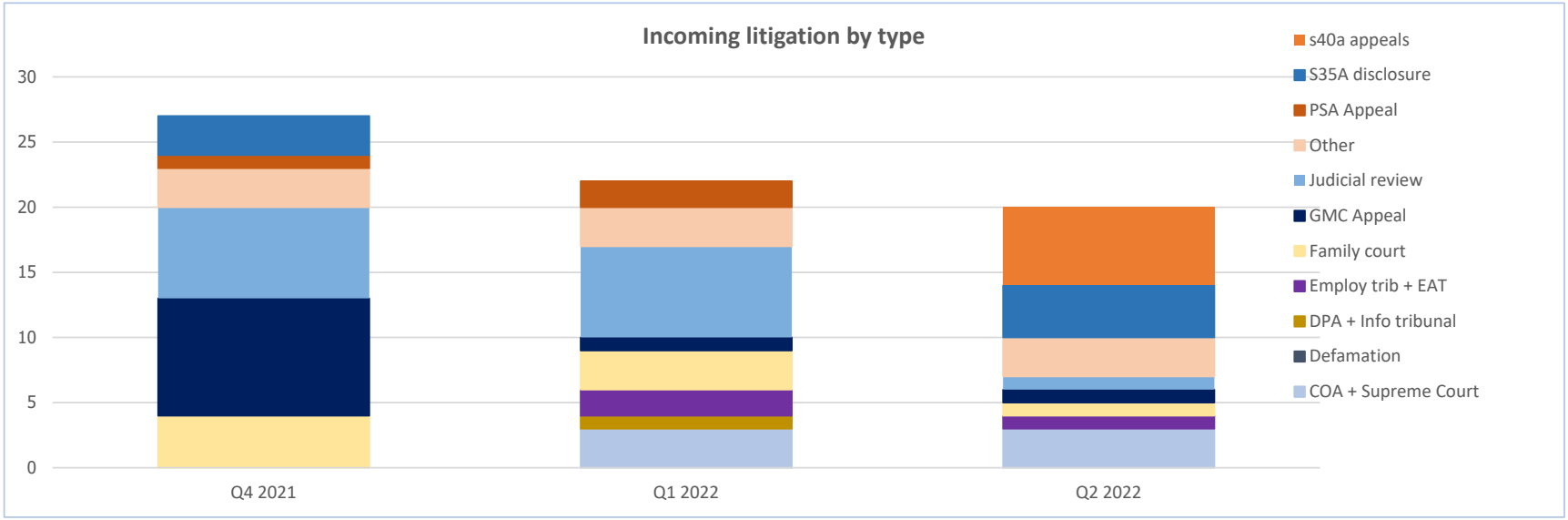
GMCSI summary as at Jul 2022	Budget Jul £000	Actual Jul £000	Variance £000	Variance %	Budget 2022 £000	Forecast 2022 £000	Variance £000	Variance %
GMCSI income	217	228	11	5%	323	328	5	2%
GMCSI expenditure	189	173	16	8%	323	323	0	0%
Profit/(loss)	**28**	**55**	**27**		**0**	**5**	**5**	

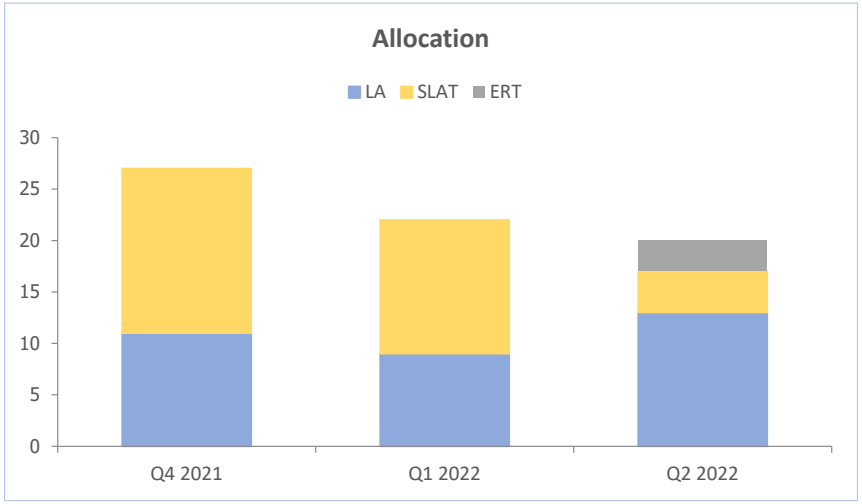
Litigation summary - Q2 2022

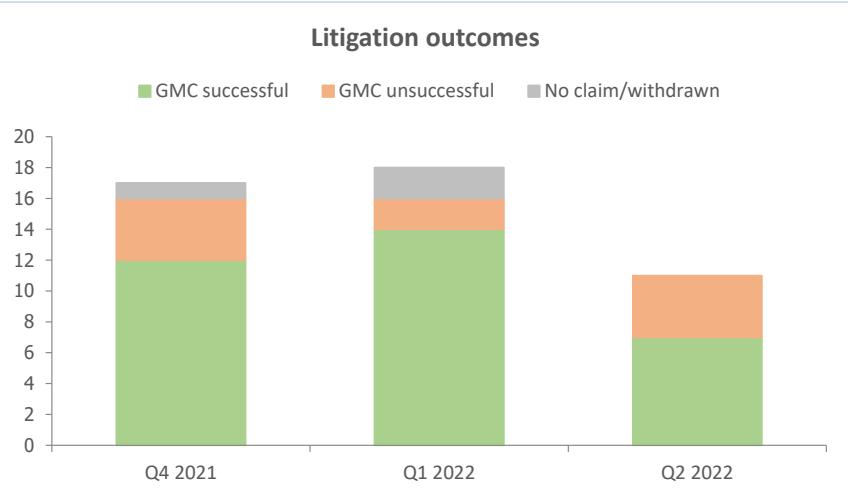
Data was pulled on the first working day of the next quarter, for Q2 2022 this was 1 July 2022.

7 = GMC Successful
- x5 = s40 (doctor) Appeals
- x1 = Judicial Review
- x1 Family Court

4 = GMC Unsuccessful
- x1 s41a –challenge against an interim order of suspension (revoked).
- x1 GMC Appeal
- x1 PSA Appeal
- x1 s40 (doctor) Appeal



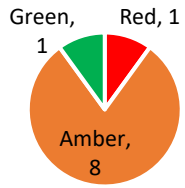




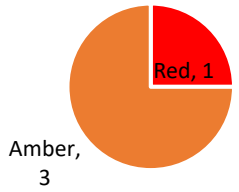
Key:
PSA – Professional Standards Authority
EAT – Employment Appeal Tribunal
DPA – Data Protection Act
COA – Court of Appeal
LA – Legal Adviser
SLAT – Senior Legal Adviser (Technical)
ERT – Expert Report Team

Corporate Risk Register (CORR) Overview

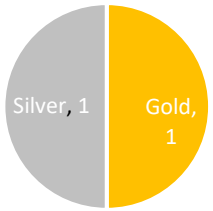
Threats - post-mitigation rating summary



Threats - Post-mitigation rating higher than appetite



Opportunities - Post-enhancement rating summary



Key Updates:

CSR Position threat deescalated to Directorate level. The threat was escalated to the CORR following BDO's audit earlier this year as the audit report highlighted a lack of any available web information about the GMC's activities in this area. This was rectified with publication on our web pages in May

Active Threats above risk appetite

315 - MAPs regulation delay – red (critical) after mitigation. If there are further delays to the timescale for commencing regulation of PAs and AAs, we could lose the confidence of stakeholders, and numbers of PA/AAs in education and employment may fail to increase as expected.

Active Threats above risk appetite

148 – Delivery of Statutory Functions - remains amber (significant) after mitigation. 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.

120 - ED&I compliance - remains amber (significant) after mitigation. The assurance we can evidence that our regulatory decision-making is fair - is not persuasive to key stakeholders and weakens confidence in regulation.

309 – Safeguarding at the GMC remains amber (significant) after mitigation. 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.

Opportunities

27 – Deriving more insight from our data capability –gold after enhancement. 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.

Opportunities

28 – Working with patients and public – silver after enhancement. 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.

Corporate Opportunities and Risk Register - August 2022

Risk ID	Title	Category	Detail	Owner	Likelihood - Inherent	Impact - Inherent	Rating - Inherent	Mitigation/Enhancement	Likelihood - Residual	Impact - Residual	Rating - Residual	Council and/or Board Assurance	Assurance	Further Action Detail	Risk Appetite
315	MAPs regulation delay	Reputational	If there are further delays to the timescale for commencing regulation of PAs and AAs, we could lose the confidence of stakeholders, and numbers of PA/AAs in education and employment may fail to increase as expected. As well as adversely affecting workforce objectives, this would reduce GMC fee income and further increase our funding requirement from DHSC, which is subject to approval annually. The workforce impact of delay is magnified by the fact that extension of prescribing responsibilities to PAs and AAs is subject to a separate legal process that cannot start until these professions are regulated.	Una Lane	HIGHLY LIKELY	MAJOR	CRITICAL	• Regular communication with key stakeholders, including promoting achievements from the programme so far and upcoming activity. • We will maintain some dedicated staffing resource on each workstream until regulation starts, in order to retain expertise and ensure readiness for implementation. • Programme cost projections updated quarterly and reported to DHSC/GMC Financial Accountability Group, providing advance notice of funding needs. • Principle clearly established that costs of MAPs regulation will not be met from doctor fees.	HIGHLY LIKELY	MODERATE	CRITICAL		In July 2022, DHSC announced a revised approach to legislation that will separate the introduction of PA/AA regulation from the wider reform of the Medical Act. Theoretically, this should reduce the risk of significant further delay to regulation, but it is difficult to judge until we see the draft legislation.	• Continue liaison with DHSC to ensure they understand our relationships with key PA/AA stakeholders and the importance of maintaining trust for our continuing progress on regulatory development. • Use our influence with Governments, SEBs and other stakeholders to press for actions that would help mitigate the workforce impact of continuing delay to regulation.	Low
120	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	• 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 impact assessment as a requirement of project and policy activity to consider fairness impacts of approach (being reviewed and revised) • Past research, fairness audits, Campbell Tickell Governance and Compliance review • Regulatory Fairness Review has commenced and is in progress.	UNLIKELY	MAJOR	SIGNIFICANT	• Reporting to Council on ED&I aspirations now set annually and deep dive reporting cycle in place. • Regulatory fairness review also reporting to Council at intervals throughout the duration of the review. • ED&I steering group has forward plan for reporting and will report to Executive Board on progress the SG has made.	• Howlett Brown project considering future approach to fairness assurance. Strategy and policy ED&I compliance and governance review - Campbell Tickell (2020). • Engagement, not personal characteristics, was associated with the seriousness of regulatory adjudication decisions about physicians: a cross-sectional study, Javier A Caballero, Steve P Brown, British Medical Journal (2019). • Fairness of decisions to refer doctors to the MPTS interim orders tribunal (2018). • Plymouth University Review of decision-making in the GMC's FTP procedures (2014).	• 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 (part of reg fairness) • 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 (part of reg fairness • 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 (new policy launched) • 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 • Launch new templates and guidance on equality impact assessment and strengthen the tracking and oversight (through ED&I SG)	Low
148	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	• 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 •Assessments teams running three PLAB 2 circuits concurrently through 2022 in order to accommodate as many candidates as possible. • Successful release of PLAB 1 places on 25 June 2022 mean that all eligible candidates have had an opportunity to book a place. • We are engaging a new supplier for digital identity checking software and have implemented an interim solution for managing ID checks in the intervening period.	QUITE LIKELY	MODERATE	SIGNIFICANT	Council • Review of performance metrics through the quarterly CEO report. Executive Board • Review of performance metrics through the bi-monthly Performance and Risk Report. • Risk deep dive (November 2020).	Internal Audit • Legal Services (May 2022, green-amber). • 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 2021, green-amber). Other Assurance: • 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). • 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.	• 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. •We'll consider and triage all new concerns, progressing those requiring investigation.	Low
149	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	• 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 (GMCSI), fraud policies and pensions. • New activity, including Gateway Fund initiatives and existing project work routinely considered by Planning Gateway process to form a cross-organisational recommendation on the priority and deliverability of proposals for SMT to consider collectively • Routine monitoring and reporting of operational performance and the volume and complexity of our work • Process for regularly mapping workload pressures across teams to help focus resourcing and prioritisation decisions • 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	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).	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). Other assurance • 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	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	• Engagement with other regulatory bodies to identify opportunities for collaboration and alignment (such as through the Chief Executive Officer Regulatory Body (CEORB) Group) • Proactive engagement on all major policies and issues, including active engagement with the four UK Governments over the future of our legislation • Development and management of stakeholder relationships of strategic importance at national and regional levels of the UK, supported by relationship plans delivered by our external affairs teams and sponsorship of key relationships by SMT. • Regular evaluation of our relationships with key partners, using insights from our Engage system and periodic surveys of our stakeholders' perceptions.	QUITE LIKELY	MODERATE	SIGNIFICANT	Council • Annual update on communications and engagement (including four country update) (April 2022) • Four country update (November 2021) Audit and Risk Committee • Seminar: building the trust and confidence of our audiences and stakeholders (Jan 2022) Executive Board • Four country public affairs update (March 2021)	Internal audit • Internal audit: Managing UK-wide stakeholder relationships (March 2022) (Control design - Green; Control effectiveness - Green/Amber). • Review of progress in implementing Outreach (May 2021) (Green-amber). Other assurance • Quarterly health assessments of our major relationships (external affairs teams currently completing assessments for Q3 2022)	• Fieldwork for 2022 perceptions survey with audiences and stakeholders is currently in progress. We will receive the full results late summer/early autumn. We have included new question in the survey to help us understand how well we are perceived to work with others.	Medium

152	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	• 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 1983 (Covid-19).	QUITE LIKELY	MODERATE	SIGNIFICANT	• 'Deep Dive' Executive Board (June 2021). • Paper: People planning across the United Kingdom (November 2019).	Internal audit • Cyber security (July 2021, green-amber). • Cyber security (November 2020, green-amber). Audit and Risk Committee • Significant Event Review: Fraudulent registration application, Teodora Crisovan (March 2021). • Report on Significant Event Review follow-ups (March 2021). • Significant Event Review: Fraudulent doctor Zhola Alemi (November 2019). • Significant Event Review: Fraudulent registration application, Teodora Crisovan (March 2021). Other assurance • 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).	• Response to a range of public Inquiries and Reviews underway including Paterson (now reported), Infected Blood Inquiry, Hyponatraemia, and Historical Public Abuse.	Medium
200	Regulatory Reform	Strategic / Policy	There is a risk that we do not secure and deliver the full range of benefits that the reforms present.	Shaun Gallagher	HIGHLY LIKELY	MAJOR	CRITICAL	• 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 • Routes for escalation identified (and have been used) for raising concerns with senior officials at DHSC, where required. • 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 opportunities are maximised. and changes can be operationalised as soon as policy agreed	QUITE LIKELY	MODERATE	SIGNIFICANT	Council seminar (21 June 2022) to provide an update on our engagement with DHSC and proposed changes to commencement of the reforms and to share our approach to engaging with Council on regulatory reform Council away day (4 July 2022) to update Council on progress of policy development and seek views on proposed approach to policy engagement ahead of the DHSC s.60 consultation this autumn.	Most recent spot check concluded in August 2022 and report due to go to Audit and Risk Committee in Sep 2022. Previous spot checks completed in June 2021, March 2021 and Nov 2021.	• 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 check in meetings with DHSC) • 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 continue to escalate concerns to senior DHSC officials as appropriate.	Medium
234	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	• 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 (i.e. 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	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' embedded throughout the year.	• Strategy and policy ED&I compliance and governance review - Campbell Tickell (2020).	• Annual report has been published in 2021 and further annual report due in 2022. • Council directed the need to extend our understanding of inequalities impacting on other projected groups, specific dis aggregated groups and also intersectional groups - starting in Autumn 2022.	Medium
309	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	•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 specialist consultants •Presentation given to SMT and Council (Feb 2022) on direction of project • Workshops taking place with staff across directorates to work through detailed process design • Designated Safeguarding Manager in post.	QUITE LIKELY	MODERATE	SIGNIFICANT			•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 work started on developing a new reporting system pilot of new policy, processes and training in a small number of teams to start November 2022	Low
151	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, profession and political confidence in our role.	Paul Reynolds	QUITE LIKELY	MAJOR	CRITICAL	• 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 government and system initiatives across four nations • Continuous monitoring of our external environment, including longer term horizon scanning and research (e.g. barometer and perception surveys with the medical profession) • Contributing to meetings and networks across the UK and Europe • Internal governance in place to process, consider and make decisions on the intelligence we receive about the quality and safety of local practice and training environments (JWIG and PSIF meetings) • Intelligence from external environment shared routinely with organisation's leadership.	UNLIKELY	MODERATE	LOW	Council: • Annual update on communications and engagement (which included four country update) (April 2022) • Four country update (November 2022) Audit and Risk Committee: • Seminar: building the trust and confidence of our audiences and stakeholders (Jan 2022) Executive Board: • Deep dive on Devolution (September 2021)	• Internal audit: Managing UK-wide stakeholder relationships (March 2022) (Outcome: Control design - Green; Control effectiveness - Green/Amber) • Review of progress in implementing Outreach (May 2021) (Outcome: Green-Amber) • IA horizon scanning rated green for both control design and control effectiveness		Low
27	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	QUITE LIKELY	MAJOR	GOLD	• 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.	HIGHLY LIKELY	MAJOR	GOLD	• Paper: Review of UK Advisory Forum meetings (December 2019). Executive Board • Risk 'deep dive' (March 2021).	Internal audit • Arrangements for assessing progress in the delivery of the Corporate Strategy (July 2021, green-amber). Other assurance • Corporate strategy and stakeholder perceptions baseline survey (published March 2019). • Tracking survey, undertaken every two years, currently underway and due to report findings in Q4 2022.		High
28	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	QUITE LIKELY	MODERATE	SILVER	• Champion for patients established at SMT level to ensure senior-level overview of our engagement • Strategic ambition to improve patient and public involvement agreed by Executive Board (in November 2020) • 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 perceptions survey) • Regular engagement with patient leaders in all four countries of the UK (such as through our bi-annual roundtable, our UKAF meetings and other activities) • 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)	QUITE LIKELY	MODERATE	SILVER	Council • Annual update on communications and engagement (April 2022). Executive Board: • Opportunity deep dive (February 2021). • Paper: Strategic approach to patient and public involvement (November 2020).	• 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 and their organisations shared in weekly external update for GMC leadership community.	• An internal audit of our work with patients is in progress. Audit and Risk Committee will receive report in Sept 2022. • Fieldwork for our 2022 audience perceptions survey is progressing. We have added new questions to the survey for patients about their experiences of care. We should receive full results of survey in late summer/early autumn. • Next roundtable with patients planned for 23 November 2022. Agenda is in development. • Extensive engagement with patients is progressing in support of our consultation on Good medical practice. As part of our 2022 research programme, the Standards team have appointed a research provider to support engagement with communities of patients that we struggle to engage with. • Regulatory Reform Programme Board has agreed principles for user-centred design which policy and operational teams will embed in their redesign of our regulatory services.	Medium

General Medical Council

Safeguarding update

Action	*To note*
Purpose	The purpose of this report is to update council members on the development and piloting of our new safeguarding policy and processes.
Decision Trail	Audit and Risk Committee: January 2021 - presentation on BDO Learning Review Presentation to SMT: November 2021 Council: February 2022 Safeguarding report (closed session)
Recommendations	**a** To note the update report **b** To note the proposed pilot
Annexes	Annex A: Summary of consultation findings
Author contacts	**Claire Gardner**: Head of Quality Development and Assurance Any enquiries to: GovernanceTeamMailbox@gmc-uk.org
Sponsoring director/ Senior Responsible Owner	**Neil Roberts:** Director, Resources

Agenda item M4
Safeguarding update

Background

1 In 2020, BDO were commissioned to undertake a learning review of GMC's safeguarding policy and processes and subsequently a project team was set up to implement BDO's recommendations.

2 In February 2022, Council approved a paper which outlined our plans to develop a new safeguarding policy and process. It was agreed that we would adopt a proactive approach to sharing relevant safeguarding information with external statutory safeguarding organisations while ensuring we protect the rights of data subjects and that disclosures are necessary and proportionate.

3 This report provides an update on work undertaken to develop our policy and process and our plan to pilot the approach.

Policy and process

4 Working with consultants from the Social Care Institute of Excellence (SCIE) we have drafted our corporate safeguarding policy and supporting guidance documents.

5 Our policy sets out how we will safeguard children and adults at risk of abuse and harm. Its purpose is to ensure that everybody working for and with us understands what is required of them in respect of safeguarding - how to recognise, respond to, report, and record concerns and allegations. It includes details on:

- how we will manage safeguarding concerns and allegations of abuse, including information we receive from external partners and stakeholders
- roles and responsibilities of all staff: the Designated Safeguarding Manager (DSM), Senior Leadership teams, and Council
- definitions and categories of abuse and harm
- our approach across the four UK countries
- GDPR and information sharing requirements.

6 Key messages in our policy include:

- safeguarding is everyone's responsibility – all staff need to know how to identify a possible safeguarding concern and how to report it to the DSM
- details of the DSM's role
- details of how we will safeguard GMC staff and those who work with us. The People Team will continue to be the primary contact for safeguarding concerns relating to staff, with the DSM offering advice and guidance.

7 We have drafted a series of guidance documents for staff and the DSM. Our DSM guidance includes information about our decision-making principles, which will be reviewed by policy lawyers and the information governance team.

Designated Safeguarding Manager

8 In July 2022 we appointed an experienced DSM. The job description and role requirement of the DSM were produced with support from SCIE and the role is pivotal to our proposed policy and process. The DSM will be responsible for:

- determining if information should be shared with statutory safeguarding organisations and making any subsequent referrals in line with our policy and thresholds
- liaising and communicating with operational teams regarding any referrals
- providing training, advice, and ongoing support to staff

9 When assessing information, the DSM will always aim to act in what we believe to be the best interests of the individual at risk. The DSM will record their actions and decisions in our safeguarding reporting system.

10 The DSM has already developed strong relationships with key managers, and we have observed high levels of engagement with the DSM, who has already provided advice on our proposed policy and process as well as support to staff and managers on a range of safeguarding issues.

Reporting and data collection

11 The project team is working with colleagues in IS to develop a new safeguarding reporting system. The system will be built in Siebel and will allow for the safe transfer of information between staff and the DSM. It will also serve as the case management system for the DSM, who will use the system to record their actions and decisions, along with details of any information shared externally. The reporting system will be available in November and will be used during our pilot.

12 The system will enable us to collate information on the volumes and types of safeguarding concerns we see at the GMC. It will also allow us to provide regular performance and audit reports to Council and the Executive Board.

Pilot Preparation

Consultation and change management

13 We have shared our draft policy and processes with representatives from all directorates and workshopped our proposed approach with key operational teams. This has enabled us to gain information on:

- where safeguarding concerns are likely to be raised
- the impact our policy and process might have on our regulatory business as usual (BAU) activities
- the impact the process might have on staff workloads
- the training and welfare support requirements of staff.

14 A summary of consultation findings can be found at Annex A. There was significant support for our proposed approach and the recruitment of a DSM, however, there are also a number of change management issues that need further consideration. These include:

- ensuring we consult with managers prior to making any external safeguarding referral; so that any impact on BAU, stakeholder engagement or external communications can be addressed
- the impact on workload. This could be significant in teams where safeguarding concerns are more likely to occur, for example in Triage or the Contact Centre
- ensuring all staff feel empowered and confident in reporting concerns. There is a risk that some staff do not adhere to the process of reporting concerns to the DSM as set out in training and guidance.

15 Until the policy and process has been rolled out and embedded, it is difficult to identify all the implications it may have on our BAU functions. However, to help understand these issues further we plan to pilot our process.

Pilot

16 Starting in November, we aim to pilot our new safeguarding process with staff in the Contact Centre and Triage, for a period of three months. This will enable us to gain further information on the volumes, DSM workload, our approach to provide resilience and cover for the DSM role and suitability of the reporting system, as well as identify any issues with the process.

17 There are high levels of engagement from the organisation in the preparation and delivery of the pilot along with support for the appointment of an experienced DSM.

Implementation plan

18 Following an evaluation of the pilot we will make the necessary changes to our policy and present it to the Executive Board for sign off.

19 The implementation of the agreed policy and process across the GMC will be via a phased release. This will enable us to monitor volumes and workload, and to support the rollout of training to all staff. Further details on the release plan will be presented to the Executive Board for sign off in Q1 2023.

Training

20 Our training strategy involves a tiered approach, where all GMC staff will be expected to complete mandatory digital learning on safeguarding. Teams and specialist roles where safeguarding is more prevalent will be supported with additional training.

Other considerations

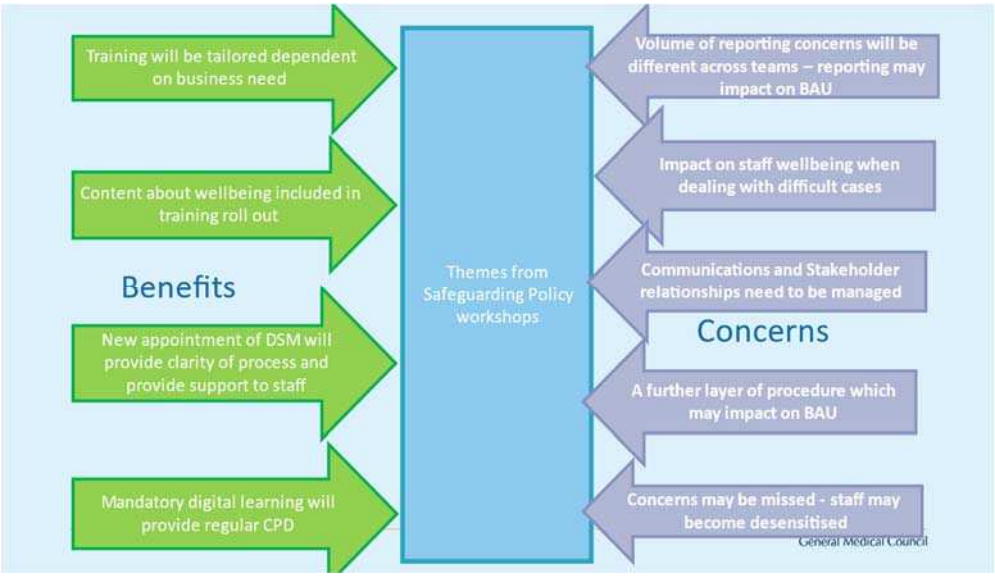
21 We are currently working with Internal Communications to produce a Communication Strategy for safeguarding. This will include developing awareness and lines to take in the event of public or media enquiries. In addition, information and training documents will be available on our intranet pages.

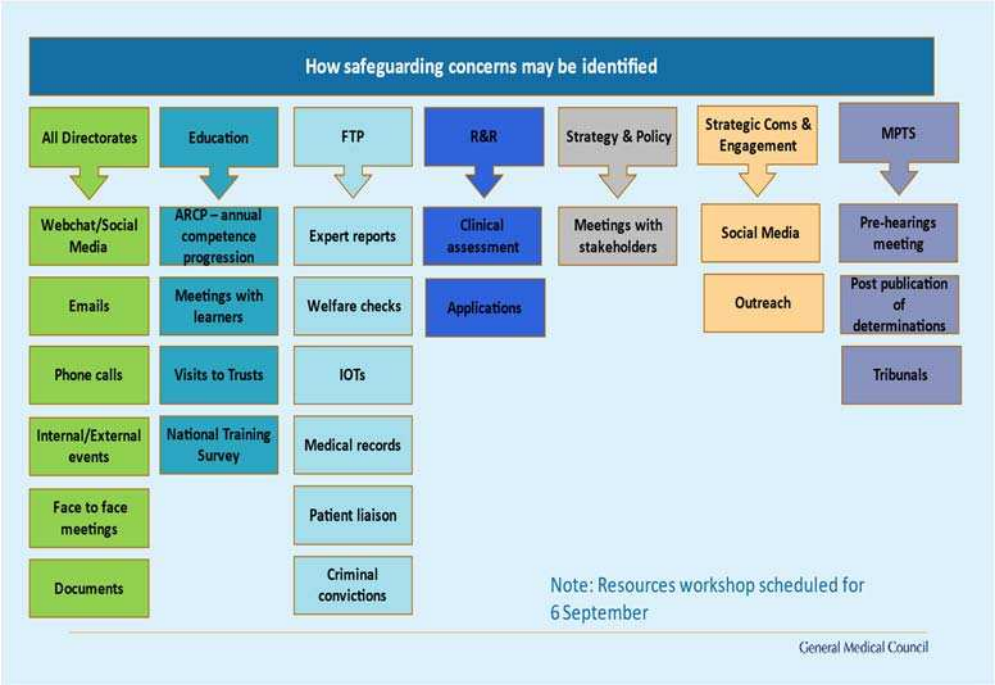
22 Our policy and guidance include information and legislation which relates to safeguarding across the four UK countries, and the DSM is aware that reporting requirements will be different across the UK.

23 Initial ED&I and GDPR impact assessments have been undertaken and the project team continue to work with ED&I, Information Policy, and Policy Lawyers in the design of our policy, processes, and decision-making criteria and thresholds.

24 BDO along with a consultant from the Safeguarding Alliance will be undertaking an internal audit of our proposed safeguarding policy and processes. The scope is currently being finalised but the audit is expected to focus on actions taken to date to address the recommendations from the 2020 BDO Learning Review, the mitigation of risks and our implementation plan. The audit findings will be reported to the Audit and Risk Committee in November 2022.

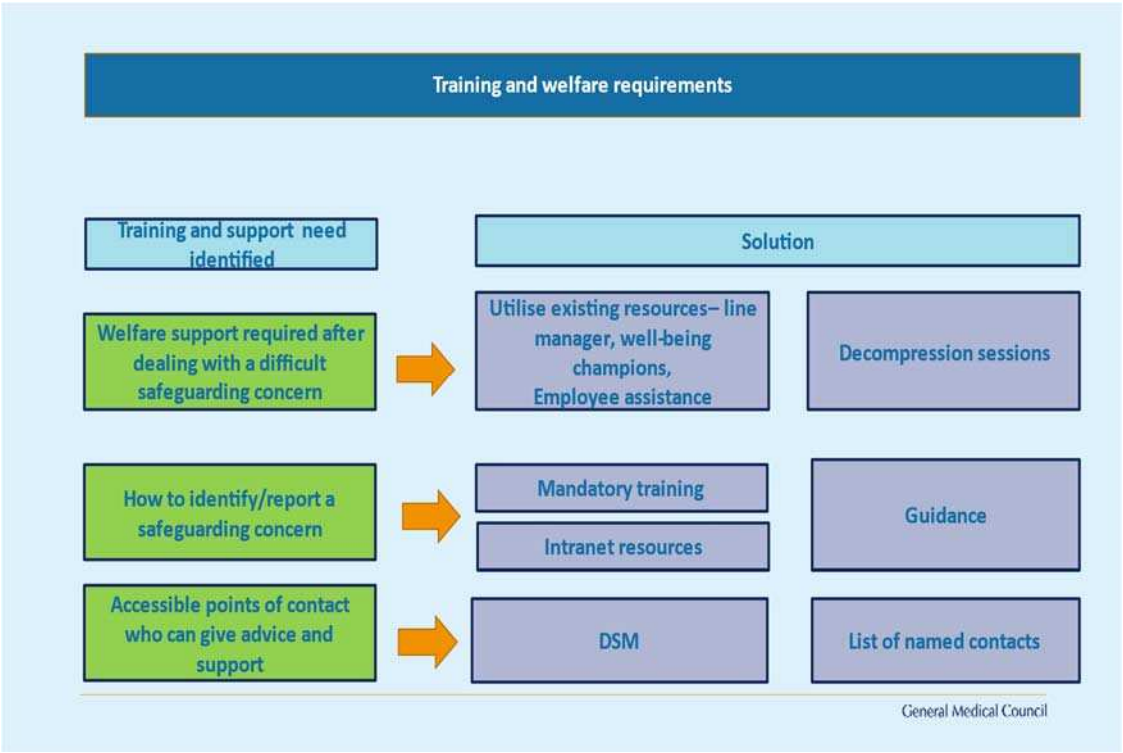
Annex A – Summary of consultation findings





Agenda item M4

Safeguarding update



General Medical Council

Fair training cultures

Action	*To discuss*
Purpose	To update Council on progress against our commitment to eliminate discrimination, disadvantage, and unfairness for all index measures of fair medical education and training pathways by 2031.
Decision Trail	Council approved our ED&I priorities in February 2021 and considered an annual report on progress in February 2022.
Recommendation(s)	To consider performance against our commitment, and our priorities and asks of others in response.
Annexes	Annex A: Index Measures for Fairer Training Cultures Annex B: Developing increasingly meaningful progress insights Annex C: Action plan phases Annex D: Key engagements this period Annex E: National Offices ED&I engagement Annex F: Tracking progress to goal (Redacted)
Author contacts	**Jane Cannon**, Programme lead **Mark Willison**, Project manager Any enquiries to: GovernanceTeamMailbox@gmc-uk.org
Sponsoring director/ Senior Responsible Owner	**Colin Melville,** Medical Director and Director, Education and Standards **Nico Kirkpatrick**, Assistant Director, Education Operations

Agenda item M5
Fair training cultures

Executive Summary

1 Our corporate strategy commits to fostering a culture of equality, diversity and inclusion in everything we do as a regulator and employer. Since February 2021, this commitment has been embodied in a priority area of work to eliminate discrimination, disadvantage, and unfairness for all index measures of fair medical education and training pathways by 2031.

2 This paper has been produced to support a deep-dive discussion on Fair training cultures and complements our annual progress report on all priority areas. It outlines our progress towards the targets, key achievements, engagement of stakeholders with the work, challenges and planned next steps.

3 Our aim is to provide assurance to Council that we are effectively driving the systemic and cultural changes necessary to achieve our EDI targets.

4 Shifting the dial:

- The percentage point gap across all postgraduate (PG) exams has decreased by 2.5% for UK ethnic minority trainees and is now 9.8%. The gap for international medical graduate (IMG) trainees has decreased by 4.1% and is now 25.2%.
- In a small-scale Core Psychiatry 'enhanced exam preparation' pilot, we have reduced the attainment gap from 11.8% to 1% for UK ethnic minority trainees, and from 59.8% to 21.1% for IMG ethnic minority trainees.

5 Strong progress has been made delivering Phase 1 of our work programme. We have focused on testing interventions particularly around personalised, targeted support for learners, developing fair recruitment and selection processes, and enhancements to our data.

6 Key achievements:

- We delivered three pilots, with evaluations due by early 2023. Our pilots tested the impact of enhanced trainee exam preparation, improved cultural competence and feedback techniques for trainers, and peer support and mentoring for students.
- Our '*enhanced exam preparation*' pilot has delivered strong results which are already creating behaviour and policy changes across the system.
- Evidence that training for trainers is changing behaviours and attitudes.
- Colleges are committed to developing new ED&I action plans, submitting these to us in September. In addition, Colleges are supporting the development of new *Principles for Exam preparation, guidance and feedback,* in response to our enhanced exam prep pilot.
- Our deep-dive analysis of outcomes for each stage and impact of selection criteria has led to the creation of a working group to develop and deliver solutions.
- We have begun to collect and analyse medical school assessment data for the first time.

Agenda item M5
Fair training cultures

Managing uncertainty to deliver real-world change

7 We are tracking our progress at two levels. Six high-level Index Measures (**Annex A**) report the outcomes of doctors at different stages on the training journey. Our progress towards shifting the dial on these is measured through evidence of the removal of inequalities within the systems and cultures, which we know drives the attainment gaps these metrics capture.

8 We have identified which systems and cultures require change based on the causal factors and protective processes which doctors from an ethnic minority background have told us are important, and have made a significant difference to their experience and outcomes. Phase 1 of the project will test the impact of key initiatives before moving to wider implementation.

9 The impact of our proposed interventions remains largely untested, however, and so the project carries an inherent, residual uncertainty which we must accept and work to mitigate. To address this, our second level of tracking estimates the impact we *expect* to have. We have embedded this within our project management and governance processes, and this is described in **Annex B**.

Progress against Index Measures

10 In broad terms, the Index Measures show the continued persistent and consistent attainment and experience gaps year on year which we have observed since 2015. This is to be expected; Although significant progress has been achieved, we have not yet implemented the wide-scale system changes needed.*

11 However, two events have generated significant, observable improvement to PG exam differentials in the Index Measures: The covid-19 pandemic and a targeted exam preparation course.

12 The last reporting period covers the pandemic, and all groups of trainees saw improved PG exam pass rates. The biggest improvement was seen in ethnic minority and overseas graduates. Pass rates rose by 4.7%, 6.6% and 9% for UK white, UK ethnic minority and IMG trainees respectively. This resulted in a decrease in the percentage point gap compared to 2019 by 2.5% (to 9.8%) and 4.1% (to 25.2%) for UK ethnic minority and IMG trainees (**Annex A**).

13 We are undertaking work to understand which of the pandemic-related changes led to this shift – such as moving exams online, moving some assessments to the workplace, or allowing exams to be completed later than usual – and if they have benefits that can be retained.

*Note: There is some natural fluctuation in the data which is not indicative of a material improvement or deterioration.

14 In addition to this system-wide shift, we are testing the impact and feasibility of promising interventions on a small scale with a view to upscaling in future.

15 Interim findings from the Core Psychiatry enhanced exam preparation pilot (described further below) show the attainment gap for UK ethnic minority trainees reduced from 11.8% to 1%, and for IMG ethnic minority trainees from 59.8% to 21.1%. If this can be scaled up sustainably across specialties, we believe the impact would be significant.

Progress in delivering Phase 1 of our work programme

16 The Fair training cultures work programme will be delivered in phases. Details of the prioritisations within each stage can be found at **Annex C**.

17 Phase 1 focusses on the areas we believe will achieve change at pace and scale. It focuses on building evidence about the impact of interventions at a small-scale, for wider delivery in future phases. Our current work focuses on two key areas:

- *Personalised, targeted support for learners*
- A fairer *Recruitment and selection system.*

Personalised, targeted support for learners

Intervention 1 – Enhanced exam preparation for RCPsych clinical exam

18 Together with Health Education England (HEE), we commissioned the Royal College of Psychiatrists (RCPsych) to pilot a 2-day clinical exam preparation course. We targeted trainees from postgraduate training organisations with exam pass rates below the national average. For places on the course, we prioritised trainees with previous failed exam attempts and those from ethnic minority and IMG backgrounds.

19 We have asked Edge Hill University to formally evaluate why the course is impactful. This is important because there is a wide range of exam prep support already provided by colleges, trust/boards, Deans and through peer-support and we are looking to evaluate why this model seems to have particular impact:

- Are our target groups struggling to access other support?
- Is the content or experience of the pilot particularly beneficial to marginalised groups?
- Is it that courses designed by Colleges, and using college examiners, give more focused and relevant feedback? Does this highlight a knowledge gap to be addressed?

- Is it that a course designed and run by examiners from an IMG background has been better able to support IMG candidates? Perhaps by alleviating anxiety, increasing self-belief and created a sense of being welcomed and valued?

20 Reflections from the examiners running the pilot suggest it's a combination of these factors. Understanding this will help trust/boards, postgraduate training organisations and colleges design and deliver courses which meet the needs of ethnic minority and IMG learners.

21 We hope that lessons learned will be applicable across all clinical exams, potentially to knowledge tests and also to other systems which rely on high-stakes assessment such as Recruitment and Selection.

Results and next steps

22 The pilot cohort as a whole achieved an average pass rate above the national average. The attainment gap between UK ethnic minority and IMG trainees has been **substantially reduced from 11.8% to 1%, and from 59.8% to 21.1% respectively.**

23 Final results for the whole pilot cohort will be available in early 2023.

24 Statutory bodies, Colleges and trust/boards are already reflecting and acting on interim findings to consider what this means for exam support offered by different organisations in the future.

25 The GMC's funding is due to end with the final pilot cohort in November 2022, and we should have draft findings from the qualitative evaluation at the end of the year. This will create an opportunity for a discussion with PG Deans and the RCPsych about the future of this programme, to consider how we can keep momentum in Core Psychiatry into 2023 within the pilot regions, and how to scale up access to trainees across the UK.

26 We are working with Colleges to develop new guidance on support and feedback for all clinical exams. As a priority, any future pilots should look to test interventions in the four largest clinical exams in early specialty training: MRCP (PACES), MRCGP (CSA), MRCS part B OSCE, Primary FRCA OSCE.

Challenges and opportunities in scaling up

27 We have seen an improvement in exam outcomes over a fairly short timeframe (2-3 months after attending the course), but creating the courses requires resources and time to develop.

28 The course costs around £1,000 per delegate to run. A future funding model and whether costs should be borne by individuals, statutory bodies or employers will need to be considered.

29 Improved pass rates will lead to knock-on cost savings for Statutory bodies from fewer training extensions, as well as and longer-term workforce benefits from an increase in the rate of doctors becoming consultants.

30 Examiner availability to run additional training is likely to be a challenge. The RCPsych is looking at delivery models with less demand on examiners time.

31 Transferability and scalability. This model applies to clinical assessment only. Different preparation training is likely to be relevant to different types of assessment.

32 GMC standards require organisations to help prepare trainees for exams but allow significant flexibility in practice. Organisations with resources may choose to adopt a similar model however those with limited resources may find this a challenge.

Communication of findings

33 We have presented interim findings to College presidents and senior stakeholders, PG Deans and Academy of Medical Royal Colleges (AoMRC) Assessment Committee members as well as DEMEC and Ottawa conferences (*Aspiring to excellence in Assessment and evaluation*).

Impact and next steps

34 We have set up a short-life working group with the AoMRC and representation from across colleges to develop a new set of principles for "exam support and feedback" to ensure that the exam preparation colleges provide to all candidates are inclusive and meet the needs of all candidates.

35 We are asking all colleges to report in their Action Plans on initiatives that support candidates preparing for their exams.

36 We are developing a comprehensive communication strategy for publication in 2023 and considering the implications for GMC policy and standards.

Intervention 2 – Encouraging courageous, compassionate conversations with trainers

37 A 'Train the Trainer' programme to improve confidence and skills to deliver high-quality feedback across cultural barriers, delivered by the Psychiatry Teaching Unit and Centre of Experiential Learning at Derbyshire Healthcare NHS Foundation trust.

38 Delivered to trainers within Core psychiatry, Internal Medicine and Core Surgery across a number of postgraduate training organisations.

39 Evaluation of impact carried out by Edge Hill University and final results are expected in December 2022.

Results

40 Interim results show increased awareness of the barriers faced by ethnic minority and overseas qualified trainees, and motivation to have conversations and provide feedback to improve trainees performance. In follow-up interviews after 6-months, trainers reported continued changes in their attitudes and behaviours and cascading their training through their organisations.

Challenges / opportunities

41 By changing trainers' beliefs and behaviour this intervention can potentially impact a wide number of learners.

42 Our aim is to share findings and encourage cultural awareness and humility to be embedded into the 'Educational Supervisor / Train-the-trainers' courses run widely across the system.

43 It may be that more motivated trainers choose to attend this training. We are looking at opportunities to strengthen standards and quality assurance (QA) for all trainers in phase 2.

Next Steps

44 We are working with our Outreach team on a training programme for Educators, to increase awareness of barriers faced by disadvantaged groups and develop skills for giving feedback.

45 Together with Fitness to Practise and Strategic Communications & Engagement directorates, we have recruited a Clinical Fellow to work on improving the quality and culture around feedback and to deliver the recommendations of *Good Conversations, Fairer Feedback*.

Recruitment and selection

Intervention 3 – Equality assessment of specialty recruitment and selection

Background and approach

46 Our research highlights the long-term impact recruitment decisions have on trainees' experience of training. Lower recruitment scores for ethnic minority and IMG graduates result in lower likelihood of receiving an offer in competitive specialties, and less choice where they train. This affects access to support networks and resources.

47 Recruitment scores are affected by doctors' ability to access further degrees, wider work experience, publish research or attend international conferences.

48 We presented a deep-dive data analysis and equality impact assessment of the person specification and scoring criteria to the Medical and Dental Recruitment and Selection (MDRS) and asked them to develop an action plan to address the inequality of outcomes.

49 They have asked us to co-chair a new ED&I focused working group to tackle these issues.

Findings

50 Our analysis shows a significant attainment gap in the recruitment process for both UK ethnic minority learners and overseas graduates. For example, the gap in offer rates for IMG ethnic minority applicants and UK white ranged between -27% and -45% across different specialties.

51 We found significant variation in the demographic profile of trainees in regions and specialties. This may have implications for the local workforce, demand for resources and for patient health inequalities. In London, for example, only 5.7% of trainees are from an IMG ethnic minority background, compared to over 25% in the North-West and West Midlands. In Core Anaesthetics, 1.9% of the training population is from an IMG ethnic minority background, while in General Practice they make up over 32%.

Challenges and opportunities

52 Creating fair and equitable systems which select the best doctors, but are able to account for earlier privileges or disadvantages, is inherently challenging. It will require buy-in from many stakeholders.

53 There may be resistance from those who benefit from the current system. We will need to consider the impact and timeline for changes on those who have worked for years towards improving their selection chances.

54 Potential cost to the system and scale of widescale change are key barriers. These can only be worked through and explored in constructive discussion. Changes will not be enacted by us, but by the MDRS and postgraduate training organisations.

55 Being sure of the efficacy of change. We know the current system compounds disadvantage, but we do not yet know what practical improvements could be made to remove or reduce it.

56 Time to implement any change will be lengthy (minimum 2-3 years). While implemented change will be felt instantly and across large numbers of people, it would take another 2-3 years for the impact to show up in our Index Measures such as Annual review of competency progression (ARCP) measures and exam results.

Next steps

57 We will establish a working group with MDRS and key stakeholders, including doctors in training and the BMA, to develop an action plan.

Other work in progress in phase 1

58 **Understanding the landscape of specific deprivation forms on medical training progression.** The director of Education & Standards is leading a UKMED analysis on GP training exploring the role of deprivation on progression. When available, this will provide insights into how ethnic minority trainees experience the system, and help highlight areas to address.

59 **Mentoring and peer support.** New data shows a significantly higher attainment gap for UK black trainees compared to UK white (-18%). In response, we are working with Melanin Medics to evaluate the impact of their Enrichment Programme* which provides targeted peer support and mentoring to medical students of Black African or Caribbean heritage.

60 **Quality assurance of medical schools.** We are introducing annual ED&I action plans for medical schools from the academic year 2023/24. In advance of this we are sharing undergraduate assessment data with medical schools to show the presence and scale of the attainment gap for the first time and gathering examples of their initiatives to support EDI, and we are asking schools to tell us how they are implementing the MSC EDI guidance *Active inclusion: challenging exclusions in medical education*†, which we endorsed, and the EDI guidance in our recently published *Guidance on undergraduate clinical placements*‡.

61 **Royal college action plans.** In Sept 2022, Royal Colleges and Faculties will submit ED&I action plans for the first time. This is a major milestone in our engagement with them, and provides assurance that this is fully on the agenda in each and every organisation.

In these action plans, colleges have been asked to report to us on the diversity of their examiner population, initiatives to improve the quality of exam support and of feedback following an exam fail.

In May we co-hosted a workshop *"Eliminating inequality in medical education – the role of Royal Colleges"* attended by 60 senior College staff to discuss interventions and share good practice. The leadership shown by the AoMRC, and the wide participation by colleges, reflects their level of commitment to the issue. Colleges share responsibility to support

* https://www.melaninmedics.com/enrichment-programme
† https://bit.ly/MedicalSchoolsSupportInclusion
‡ https://www.gmc-uk.org/education/standards-guidance-and-curricula/guidance/undergraduate-clinical-placements/guidance-on-undergraduate-clinical-placements

trainees prepare for exams with PG Deans and a collaborative approach between these organisations is likely to lead to greater impact.

62 **Enhanced progression reports.** In August, we released Enhanced Progression reports to Colleges and Deans. These allow more refined analysis of educational outcomes by different groups including intersectional analysis. We have added new characteristics including religion and sexual orientation and disaggregated large categories such as 'BME' to show variation between smaller cohorts.

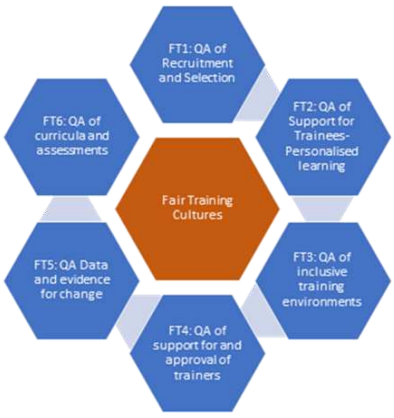
We plan to release this data to the public before the end of the year.

63 **Ethical hub on witnessing racist abuse or other discrimination at work.** Later this year, we will be launching a new ethical hub page titled, *Racism in the workplace*. The page is designed for doctors and is focused on providing support and advice on tackling racism at work. The page aims to set out relevant principles from our guidance, signpost to resources from other organisations, and provide real-life case studies from doctors.

64 **Building diversity and inclusion into Physician and Anaesthesia Associates training.** The draft pre-qualification education framework, including a curriculum for each profession, will be published in September. The development of the framework was informed by our ED&I targets and policy and research around Fair training cultures.

Planning for phase 2: Six workstreams to leverage our regulatory powers

65 Planning for Phase 2 of our work programme is well underway. We have evaluated opportunities to drive system wide change utilising our powers to set standards and policy and quality assure medical education and training. We have created a work programme covering six workstreams which reflect our regulatory framework. This will be presented to our programme board this year for work to progress in 2023.



Overview of the work our stakeholders are undertaking

66 **Our engagements so far have assured us** that:

- We and the system as a whole are moving in the same direction
- We are joined up with our stakeholders, and positioned in the conversation appropriately, and
- There is widespread commitment to eliminate inequality from medical education and recognition of the wider system benefits, including for workforce and staff retention.

67 **Minimum standards for IMG inductions.** In June, NHS England & NHS Improvement and the Workforce Race Equality Standards team launched new minimum standards for IMG Induction, and intend to pilot this in select sites. This was supported by our Outreach team.

68 **HEE pilot new initiatives to address the attainment gap*.** The first annual report from HEE Deans ED&I Committee reports £4.5 million allocated to provide targeted support for IMG GP trainees and evaluate its impact on the attainment gap. Mentoring, early screening for neurodiverse conditions and access to Reasonable Adjustments are all considered.

69 **Royal College of Surgeons England independent diversity review†.** The RCSEng report from March 2021 includes a recommendation to *Deliver a study on differential attainment in surgical exams*. They are developing an action plan to address the attainment gap.

70 **Anti-racist Wales Action Plan‡.** In June, the Welsh Government published the *Anti-racist Wales Action Plan*. This includes a commitment to address differential attainment in medical education in Wales.

Four country perspective

71 There is a statistically significant attainment gap for ethnic minority and overseas qualified learners in spite of variation in the demographic profile of different parts of the UK.

72 PG Deans across England, Northern Ireland, Wales and Scotland submit an Action Plan describing the work underway in their region every year to our Education Quality Assurance teams, and there is regularly engagement with our National Offices outlined in **Annex E**.

* https://www.hee.nhs.uk/sites/default/files/HEEDS annual report Jan 2022 FINAL for upload.pdf

† https://www.rcseng.ac.uk/about-the-rcs/about-our-mission/diversity-review-2021/

‡ https://gov.wales/sites/default/files/publications/2022-06/anti%E2%80%91racist-wales-action-plan.pdf

Wider understanding of inequalities

73 Our analysis shows that race and primary medical qualification (PMQ) are the strongest predictors of educational outcomes. However, other characteristics also play an important role, including socio-economic status.

74 We are publishing new enhanced progression reports to provide deeper insights into different groups and to strengthen our understanding and ability to create inclusive systems and cultures which support all doctors.

75 We are considering the benefit and impact for all groups, in addition to addressing racial inequality, when developing initiatives to achieve our targets.

Communications and engagement

76 We have embarked on a wide programme of engagement this year, to build commitment to the new GMC targets, introduce new quality assurance requirements, and promote key findings from our pilot activity. This work will continue throughout the programme.

77 Please see **Annex D** for details of key engagements we have carried out this year.

Projected performance

78 Significant uncertainties and a lack of evidence around the scale and timing of impact of key interventions creates a challenge in forecasting accurately. Phase 1 aims to build up some data and evidence of impact to improve our accuracy over time.

79 **Annex E** shows our "aspiration" charts which have been developed based on:

- the limited evidence we have available on the impact of initiatives
- historical data showing the attainment gap, which we expect to persist if we "do nothing".

Calls to action

80 Progress against the five calls to action that we set out to Council in February 2022:

Call to action	Progress so far
1. We ask all educational organisations to contribute to building the evidence on 'what works' by evaluating pilot initiatives and sharing their findings with others across the system.	• We are running pilots on cultural competence and feedback, Exam preparation and mentoring and monitoring interventions led by others • Early findings have been shared and are leading to system changes • A communications strategy is in development for the publication of final results
2. We require medical royal colleges, postgraduate deans (PG Training Organisations) 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.	• PG training organisation action plans were submitted in January, Royal colleges will submit their first plans in September 2022 and Medical schools are expected to submit their plans from 2023/24 • We hold regular events for organisations to share lessons learned
3. We ask all medical royal colleges to improve the diversity and inclusion of high-stakes exams. This includes broadening the diversity of examiners and question-writers and improving support for candidates to prepare for exams and recover from an exam fail	• We have set up a short-life working group to develop new principles with AoMRC. • The enhanced exam preparation pilot will enable others to understand 'what worked' so that lessons can be applied across the system. • Colleges have been asked to report on progress against these in asks their September 2022 Action Plans
4. We ask statutory education bodies, colleges, and the UK Foundation Programme Office to review the systems and policies around recruitment of learners and to deliver on recommended improvements.	• We have presented our Equality assessment findings to the MDRS • A new working group will the set up to develop and test solutions
5. We ask medical schools to provide exam data which will be used to monitor and improve fairness in undergraduate education.	• We have completed our first collection of undergraduate assessment data and will report on the outcomes in 2023.

General Medical Council

Annex A

Index Measures for Fairer Training Cultures

2020/21 caution note: ARCP and Exam results for 2020 and 2021 are likely to be affected by COVID: ARCPs included new COVID outcomes, and many exams were postponed or cancelled. Caution should be applied when interpreting those year's results, in particular any perceived closing of the attainment gap in our measures.

Index measure	2019	2020	2021
Undergraduate EPM scores 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 YET AVAILABLE PLEASE SEE OVERLEAF FOR FURTHER DETAILS*		
Undergraduate – F1 preparedness (NTS) - Difference in preparedness levels of new F1 doctors	White: 70.2% Ethnic Minority: 62.4% **Gap: 7.8%**	NOT INCLUDED IN COVID-ERA SURVEY	White: 76.3% Ethnic Minority: 65.8% **Gap: 10.5%**
Postgraduate– inclusivity (NTS)- Difference in perceived inclusivity levels	QUESTION FIRST INCLUDED IN 2020	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 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%**	UK White: 3.2% UK Ethnic Minority: 4.5% **Gap: 1.3%** ALL UK: 3.9% ALL IMG: 11.4% **Gap: 7.5%**	UK White: 3.2% UK Ethnic Minority: 4.6% **Gap: 1.3%** ALL UK: 3.7% ALL IMG: 11.5% **Gap: 7.8%**
Postgraduate education – exams Difference in exam pass rates	UK white: 77.7%, UK Ethnic Minority: 65.4% **Gap: 12.3%** ALL UK: 73.2% ALL IMG: 43.9% **Gap: 29.3%**	UK white: 78.4%, UK Ethnic Minority: 66.3% **Gap: 12.1%** ALL UK: 73.9% ALL IMG: 45.9% **Gap: 28%**	UK white: 81.8%, UK Ethnic Minority: 72.0% **Gap: 9.8%** ALL UK: 78.1% ALL IMG: 52.9% **Gap: 25.2%**

See overleaf for notes, and for detailed explanation of what each index measures.

Agenda item M5
Fair training cultures

*Undergraduate exams

During autumn 2021/spring this year the Surveys and Reporting team carried out the first collection of undergraduate assessment data from medical schools.

The first year of collection comprised data from the academic year 2020/21, and included only first and final year assessments (more years' data are proposed in future).

Following a period of data cleaning and matching with wider GMC and UKMED data, the team has trialled a method of analysis to explore the extent of UK-wide differential attainment in undergraduate assessment.

Unlike with postgraduate exams, each undergraduate institution currently carries out its own method of assessment, which makes comparability across medical schools more challenging. For this reason, it was agreed with the MSC Assessment Board that the best way to obtain a valid measure of difference in attainment across schools would be to use Z scores and Cohen's D.

The first set of reports showing this data have been developed, and were sent out for consultation to medical schools in August for them to evaluate the reporting methodology and initial findings form the data.

Early analysis of the data suggests there is a UK-wide difference between white and ethnical minority attainment with undergraduate assessment, and that the gap is present to varying degrees across all schools.

For the purposes of this work programme, we propose to report the findings of these reports to Council in more detail at our next update in February 2023. This is to ensure we've given medical schools time to respond to the initial reports, and to conclude a full discussion on the most valid approach to reporting attainment differences across all medical schools.

COVID-19

ARCP and Exam results are likely to be affected by Covid, since ARCP outcomes include new Covid outcomes and the suspension of many PG Exams.

Caution will need to be applied when viewing measures for 2020, 2021 and 2022.

Explanation of the measures used in Annex A

EPM scores

The Educational Performance Measure (EPM) is a measure of clinical and nonclinical skills, knowledge and performance up to the point of application to postgraduate education. It is used in applications to foundation training. Score is out of 10, with 1 the lowest and 10 the highest and best performing decile.

Undergraduate education – F1 preparedness

We asked foundation year 1 doctors the question 'I was adequately prepared for my first foundation post'. The measure shows the proportion of respondents that agreed or strongly agreed with the statement.

Postgraduate education - inclusivity

Difference in perceived inclusivity levels, as measured in the NTS.

The responses to the survey question 'my department/unit/practice provided a supportive environment for everyone regardless of background, beliefs or identity' were converted into a score out of 100, with higher scores indicating higher levels of support.

Postgraduate education - ARCP

Difference in rates of unsatisfactory outcomes for annual review of competency progression (ACRPs), across all specialties and training levels. Data provided by postgraduate deans.

Postgraduate education - exam

Difference in specialty examination pass rates, across all UK specialties and training levels. Data provided by royal colleges and faculties.

General Medical Council

Annex B

Developing increasingly meaningful progress insights

Due to a time lag effect, providing meaningful quantitative progress updates on the elimination of differential attainment is difficult in 2022.

This annex will detail some of these factors at high level, and provide details of our approach to mitigate this risk over time.

Understanding the origin causes of the time lag

Due to the practical constraints of the medical education landscape, we will see considerable time-lags from action to measurable effect in terms of Index Measures, and underscores the need for our targets to be set long-term. Some of the constraints include:

a) The complexity of securing system changes as well as changes to our Education QA processes and the time that takes to produce on the ground effect
b) The length of time, negotiations and other dependencies necessary for our partners and stakeholders to scale up and deploy initiatives which are proved to be successful
c) The basic timescales for change/ improvements to show up in exams and assessment data, given the education and training outcomes are based over a 10–15-year period in which a doctor is training.

We also cannot accurately forecast, due to an absence of available historical data across the sector regarding what works.

The time lag and inability to forecast means our quantitative metrics are not immediately useful for judging the impact, or lack of impact, of on-going or recently completed initiatives or pilots.

Our considerations

Eventually, we do want to be able to use our Index Measures as micro and macro-performance measures for the project.

In the interim, we recognise this lack of “live” metrics as a risk.

1 We are seeking to mitigate this through the addition of qualitative indicators of progress.

2 This is as a supplement to a plan to use increasing amounts of data gained over the course of this project to try to bring meaning to both retrospective views of performance and, importantly, forecasts using the quantitative data.

Agenda item M5
Fair training cultures

The qualitative scale

Rating	Standard
Very strong	We have evidence that our work will result in direct and wide-scale reduction of disadvantage.
Strong	We have evidence that our work will result in practical improvements and direct reduction of disadvantage.
Good	We expect our work will result in positive changes working towards the reduction of disadvantage. We have a clear plan or understanding of how that improvement will be directly felt, and how we will monitor that.
Fair	Although some positive outcomes have been achieved, we cannot be confident our current work is having or will have the real-world impact we want. We have plans agreed to address this, either by delivering this confidence or by pivoting our activities.
Weak/Neutral	We cannot be confident our work is having or will have a real-world impact. We do not yet know how we will address this, or we have not secured the resources we need to address this.

Our process for judging our place on the scale

The determination of qualitative performance will be a subjective decision, subject to scrutiny.

1 The project lead and project manager will initially hold a review discussion, and examine the work underway:

- How successful has work been, and how do we know?
- What sort of impact do we expect it to have? How sure are we that it will have that impact, and why?

The provisional overall rating will be the highest rating given to any one piece of work or intervention.

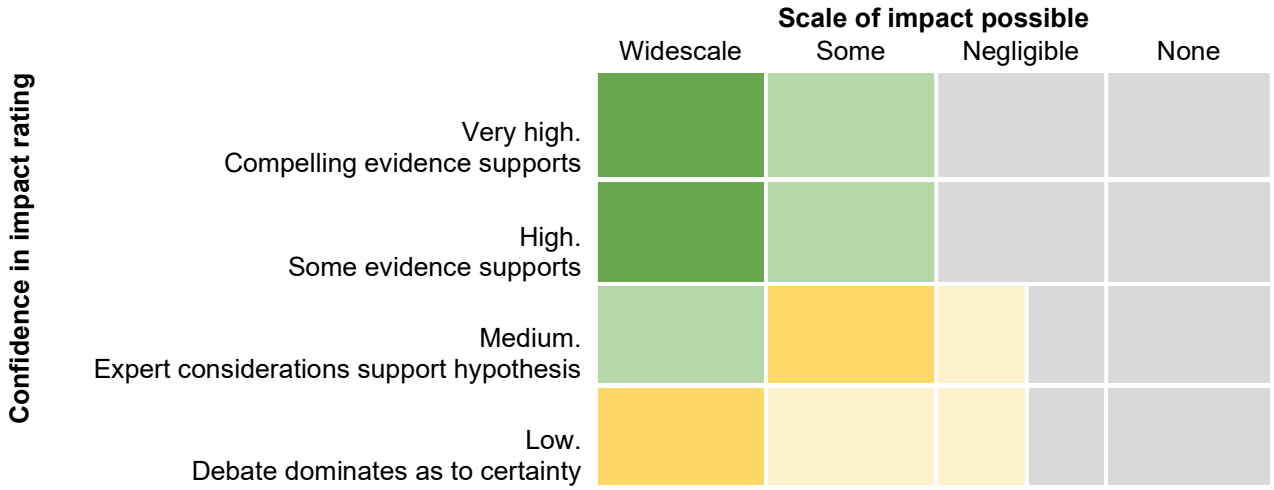
2 Provisional views will be put to the internal Fair training cultures working group for further debate, ratification or the proposal of alternative ratings.

3 The outputs from this discussion will form an initial evidence base which will be presented to the project sponsor, who will question the evidence and agree upon a rating.

4 This will be provided to the Fair training cultures programme board for further scrutiny and challenge.

Our qualitative assessment matrix

In arriving at one of the ratings above, we consider the scale of impact possible versus the weight of evidence that supports that impact being likely.



Summary key of impact ratings

- Very strong. Evidence will have direct and widescale effect
- Strong. Some evidence will have practical effect
- Good. Expectation of work having practical effect
- Fair. Not confident of impact, but have a plan to improve
- Weak. Not confident of impact, no plan in place to change this

Developing increasingly meaningful quantitative data

In the immediate, short term (to 2024): We will predominantly rely on the qualitative data, and emerging data from pilots to assess whether we believe we are achieving success, and why.

We will head these with clear indicators, so that the evidence around them can be considered by our programme board and Council and the fairness / reliability of that self-rating can be scrutinised.

In the medium term (from 2025): We will perform a combined qualitative/quantitative analysis for monitoring on our key activities, and use this information to make recommendations.

We will also start to highlight those activities on the Index Measures in terms of when we expect them to have an impact, and clarity of historical performance will steadily grow as each year's data is added.

In the medium to long term (from 2027): historical data will help provide more certain guarantee of travel direction and pace, including guiding on what if anything more we might need to do to reach goal by target date.

General Medical Council

Annex C

Action plan phases

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
Operational stages and activities ***Stage 1*** / ***Stage 2*** / ***Stage 3*** / ***Stage 4*** **Scoping** / **Planning for phase 2** / **Execution of work plans. Ongoing evaluation** / **Closure** **Immediate work, groundwork** **External engagement with partners**		
Phase action plans		
Phase 1: **FTC1**: Initiate EDI impact assessment of Recruitment & Selection processes against GMC standards **FTC2:** 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 **FTC3**: Modelling to identify concerning learning environments & build evidence on interventions which improve inclusive local cultures **FTC4**: 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 **FTC6**: Define QA requirements for curricula and assessments – college and medical school ED&I action plans established	**Phase 2:** 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 **FTC1**: potential to create new Standards for Recruitment and selection **FTC2:** Consider new Standards on personalised learning and recommended interventions for learners at higher risk (e.g. New to UK) **FTC3**: – 6: Embed and expand QA of QAMI, data and research, Trainers and Curricula and Assessments	**Phase 3:** 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

Agenda item M5
Fair training cultures

Selection of Phase 1 early start work areas:

We have designed our immediate work programme (Phase 1) over two stages.

Stage 1 from 2021 to 2023:

- Immediate work in selected priority areas, and running pilot programmes
- Data gaps analysis and closing those gaps
- Stakeholder relationship building for stage 2
- Stage 2 planning

Stage 2 from 2023, and extending into Phase 2:

- Our full structured, impact assessed work programme running across all six workstream themes comprising a mix of policy, Quality Assurance and support work.

Two workstream theme areas have been prioritised for early work within Stage 1:

Recruitment and selection: This is a challenging area to secure improvement within, and will involve lengthy discussions with a wide range of stakeholders. As an area central to workforce and the supply of doctors there are a large number of sensitivities, and any change will need to be made with the utmost care. Our focus is on supporting our partners in grappling with these issues.

For this reason, we have started our engagement in this area immediately.

Personalised learning: Our own research has suggested that the quality of feedback trainees receive prior to assessments is variable.

- Research uncovered fear of giving honest feedback, as well as reticence to hear it, and
- We are aware of a gap between workplace-based assessments and exam outcomes, where trainees passing assessments go on to fail exams.

These provided early insight that improving feedback may improve exam outcomes, by more accurately directing trainees to where they need to improve.

An early opportunity arose to co-fund with HEE a trio of interventions that tackle this issue:

- An exam preparation course, with qualitative evaluation to find out what helped trainees
- A train the trainer course designed to skill up trainers to tackle issues around access to opportunity and unseen learning needs, and
- An early-learning needs analysis tool to help identify trainees who may need enhanced support (funded solely by HEE).

Results from these pilots may provide evidence to support the hypothesis around feedback, and it will offer insight into direct ways to improve outcomes.

We have therefore prioritised this workstream theme in order to take full advantage of this opportunity.

General Medical Council

Annex D

Key engagements this period

Table. Key stakeholder engagements this year

Who	Topics
MDRS	Developing principles around exam support provision. The equity of the recruitment and selection processes.
UKFPO	The equity of the recruitment and selection processes.
AoMRC	Eliminating inequality in medical education: The role of Royal Colleges.
Medical Schools Council	Support for the MSC's "Active inclusion" framework.
Royal Colleges (all)	Eliminating inequality in medical education: The role of Royal Colleges.
HEE North West	Pilots: • Support for trainees taking high stakes exams • Support for trainers delivering feedback • Timely learning-needs analysis
Royal College of Psychiatrists	Pilots: • Support for trainees taking high stakes exams • Support for trainers delivering feedback
Federation of the Royal Colleges of Physicians of the UK	ED&I action plans.

Table. Major conferences we've attended this year

What	Description of role
BME Network Race Equality Panel	Engagement and sharing of activities

Agenda item M5
Fair training cultures

College Presidents Meetings	Engagement and sharing of activities. Discussion of College Action plans
Trainee round table	Engagement and sharing of activities
NES: Eliminating inequality in medical education and training.	Guest speaker. Topic: Our understanding of inequalities and our programme of work to address it.
Eliminating inequality in medical education: The role of Royal Colleges	Designed and hosted in partnership with the AoMRC. A 60 strong engagement and empowerment day with senior members of Royal colleges.
COPMeD	Guest speaker. Topic: Our understanding of inequalities and our programme of work to address it.
DEMEC	Guest speaker. Topic: Our understanding of inequalities and our programme of work to address it.
OTTAWA	Guest speaker. Topic: Our understanding of inequalities and our programme of work to address it.

General Medical Council

Annex E

National Offices ED&I engagement

Scotland

1 GMC staff recently met with ED&I leads at the Scottish Government and discussed the need for collaboration between stakeholders to deliver improvements. We've been invited to join their equalities workstream where we'll share our data, input and advice on policy.

2 We've engaged with NHS Greater Glasgow and Clyde around the development of Civility Peer roles, and we're continuing to engage with ROs on the tailored sessions we can provide eg. Professional Behaviour and Patient Safety.

Northern Ireland

3 Northern Ireland Medical and Dental Training Agency (NIMDTA) ran a survey of doctors who considered themselves 'New to Northern Ireland' which will be published in Sept 2022.

4 Welcome to UK Practice sessions are now mandatory for IMGs entering the Health & Social Care (HSC) workforce.

5 We are continuing to raise awareness of ED&I issues with HSC employers and support the development of solutions in collaboration with the NI Joint Regulators Forum, NICON, the universities and NIMDTA.

6 In April 2022, the Chair met with a group of BAME medical students from Queen's University Belfast, including representatives of their BAME medical student forum.

Wales

7 GMC staff have worked with HEIW to form an expert advisory group to strengthen, coordinate and align support for IMGs.

8 Welcome to UK Practice is being embedded into the HEIW web-based welcome as well as into standard induction

9 GMC staff have developed a pilot induction programme with Aneurin Bevan University Health Board. This has been very well received and will now be run twice a year. Other health boards wish to replicate this.

Agenda item M5
Fair training cultures

10 A GMC clinical fellow has completed a research project interviewing SAS doctors to identify lessons and improvements. This includes for training opportunities and progression. The findings will be shared internally and externally over.

General Medical Council

Annex F

Tracking progress to goal

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

General Medical Council

Amendments to the GMC regulations on specialist/GP registration

Action	*To approve*
Purpose	We are making consequential amendments to our Applications for General Practice and Specialist Registration Regulations 2010 to align them with some amendments the Department of Health and Social Care (DHSC) will be making to The Eligibility and Registration of General Practitioners and Specialist Medical Practitioners (Amendment) Order of Council 2022. The legislation will be amended to remove reference to Certificate of Completion of Training (CCT) equivalence and replace it with the standard that we use for general registration.
Decision Trail	The Post-Brexit registration programme board have agreed the recommendation. It has also been shared with the EU exit group.
Recommendation(s)	**a** To approve and make the amended General Medical Council (Applications for General Practice and Specialist Registration) (Amendment) Regulations 2022 **b** To authorise the Chair of Council and the Chief Executive to apply the Corporate Seal to the 2022 Regulations
Annexes	Annex A: The General Medical Council (Applications for General Practice and Specialist Registration) Regulations Order of Council 2010 (marked up with changes) Annex B: General Medical Council (Applications for General Practice and Specialist Registration) (Amendment) Regulations 2022
Author contacts	**Kirstyn Shaw**, Assistant Director Policy, Information and Change Any enquiries to: GovernanceTeamMailbox@gmc-uk.org
Sponsoring director/ Senior Responsible Owner	**Una Lane**, Director of Registration and Revalidation

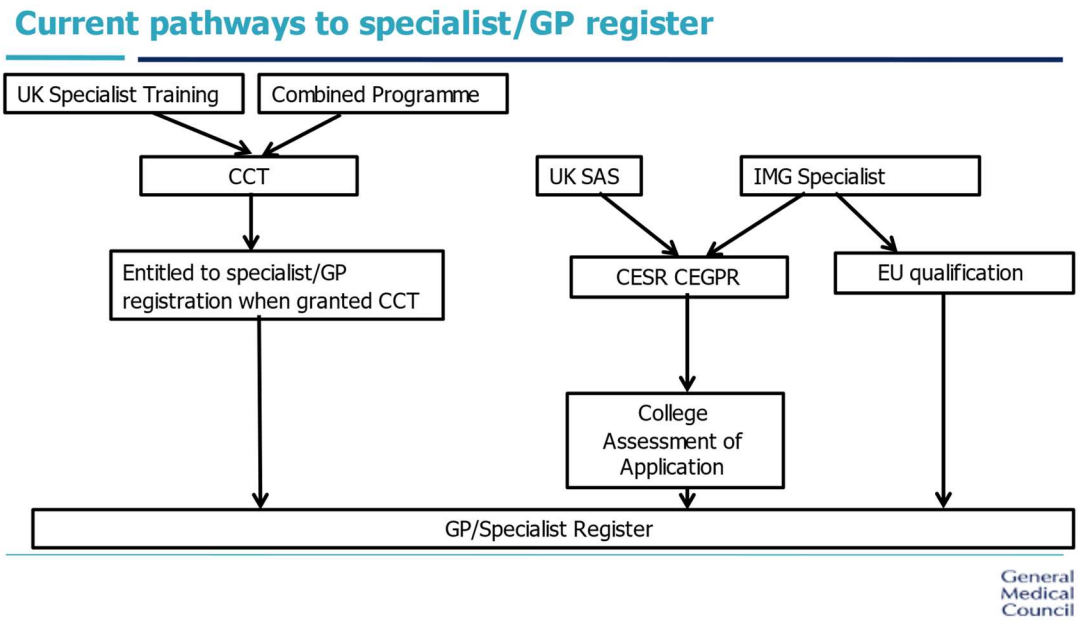
Agenda item M6

Amendments to the GMC regulations on specialist/GP registration

Background

1 Requirements for entry onto the Specialist and General Practice registers are set out in the Eligibility and Registration of General Practitioners and Specialist Medical Practitioners (Amendment) Order of Council 2010 (the Order) and the General Medical Council (Applications for General Practice and Specialist Registration) (Amendment) Regulations 2010 (the Regulations). Both the Order and Regulations sit beneath the Medical Act 1983.

2 The specialist register and GP register are subsets of the GMC's general register. Doctors must be on the specialist register to be appointed as a substantive consultant in non-foundation NHS Trusts in England and health boards in the devolved countries. Doctors must be on the GP register before they can be entered on to the medical performers list and work as a GP in the NHS in all four countries of the UK.



3 The 2010 Order and 2010 Regulations require non-UK trained applicants for specialist or GP registration to demonstrate that their specialist knowledge or training, or both when taken together are 'equivalent to a CCT' in the relevant specialty or general practice. Currently, the only pathway to specialist or GP registration for this group of doctors is through The Certificate of Eligibility for Specialist Registration (CESR) or Certificate of Eligibility for GP Registration (CEGPR) routes.

4 The current legislative requirements for these doctors to demonstrate 'equivalence to a CCT' is problematic because it:

- leads to disproportionate and overly prescriptive evidential requirements
- does not allow doctors to use the full range of evidence from their existing practice to demonstrate eligibility

- is very difficult for highly qualified doctors from overseas to meet regardless of how senior or expert they might be
- is inflexible and misaligned with our standard and approach to general registration.

5 The prescriptive and inflexible nature of the legislation means that the CESR and CEGPR process is overly bureaucratic, complex to navigate, burdensome and does not recognise the often extensive experience doctors have gained outside the UK or outside formal training posts. On average, it takes an applicant 12 months to collate the evidence required (circa 1000 pages) and a further 9 months for the application to be assessed.

6 In addition, the 2010 Order and 2010 Regulations are inconsistent on the evidential threshold applied for international specialist applicants. Applicants qualified in non-CCT specialities are required to demonstrate that they have knowledge and skills consistent with practice as a consultant in the UK, rather than demonstrating equivalence to UK standards. Thus, the standard of assessment is different for these types of applications as they are not assessed against the outcomes of a UK specialty curriculum, as CESR applicants are.

Amendments to the legislation

7 We welcome DHSC's intention to amend the 2010 Order to remove the requirement for general practitioners and specialist doctors seeking to join the GMC's GP and specialist registers to demonstrate 'equivalence' to a UK certificate of completion of training. The requirement will be replaced with a requirement for applicants to demonstrate the 'knowledge, skills and experience' required for GP or specialist practice in the UK. The amendments will be laid before parliament in the Autumn.

8 As a consequence of the amendment to the 2010 Order, the GMC must also amend the 2010 Regulations to align the standard across the legislation. The Regulations have been amended to replace equivalence to a UK certificate of completion of training with a requirement to demonstrate knowledge, skills and experience required for practising as an eligible specialist or GP in the UK. We are asking Council to make the amended 2022 Regulations as set out at Annex B.

Benefits of the amended legislation

9 In 2021, 929 doctors were granted specialist or GP registration via the CESR and CEGPR routes. This is the only route to specialist or GP registration available to internationally qualified specialists and GPs as well as UK SAS doctors. It will also be the only route to specialist or GP registration for EEA qualified specialists if the current post Brexit standstill

arrangements come to and end in late 2023 as planned. We cannot develop new pathways to specialist or GP registration without these changes to our legislation.

10 We have been seeking amendment to the 2010 Order for many years as part of our work to develop a more flexible and accessible registration framework. Our 2019 survey showed that 20% of UK SAS doctors have ambitions to apply for specialist/GP registration but are discouraged by the procedural and evidential barriers of the existing process. The majority of these doctors have more than 10 years' experience working as specialty doctors within the NHS. Approximately 60% of SAS/Locally Employed doctors are IMGs and around 76% of CESR/CEGPR applicants come from a minority ethnic background. Greater flexibility in routes to specialist and GP registration, including recognising relevant experience and qualifications gained overseas and in practices, will facilitate an increase in applications and doctors, including those from BME backgrounds, holding specialist and GP registration.

11 Amending the legislation will also enable us to streamline the existing CESR CEGPR routes and develop additional pathways to the GP and specialist registers. We will also be able to implement a more equitable and inclusive approach to demonstrating the standard has been met as doctors will be able to use the full range of evidence from their existing practice to demonstrate eligibility.

12 We undertook a programme of engagement activity between March and May 2022 with a number of organisations including Statutory education bodies (representing the four UK countries), 19 UK Royal Colleges and Faculties, the British Medical Association, NHS England/Improvement and NHS Trusts/Employers. Stakeholders were supportive of the additional flexibility that the amended Order and Regulations would provide for applicants and assessors.

13 All stakeholders were supportive of streamlining CESR/CEGPR and the exploration of the development of new pathways. Many confirmed that these changes to introduce more flexibility and accessibility for specialist/GP registration would help address workforce issues. The engagement activity provided an opportunity to explore the GMC's initial thinking on potential new pathways following the amendment of the Order. We committed to further engagement with stakeholders and completed a second round of engagement workshops with the royal colleges and faculties in August. A new advisory board has been established with the Academy of Medical Royal Colleges to provide ongoing engagement and input from stakeholders as our work to implement the standard develops.

Next Steps

14 Once Council has agreed and made the amended Regulations, the Chair of Council and Chief Executive will apply the Corporate Seal. The 2022 Regulations will then be submitted to Privy Council alongside the amended 2022 Order for approval and then laid before Parliament.

The commencement date for the 2022 Order and 2022 Regulations will be 30 November 2023.

General Medical Council

Annex A

2010 No. 475

HEALTH CARE AND ASSOCIATED PROFESSIONS

The General Medical Council (Applications for General Practice and Specialist Registration) Regulations Order of Council 2010

Made	*24th February 2010*
Laid before Parliament	*1st March 2010*
Coming into force	*1st April 2010*

At the Council Chamber, Whitehall, the 24th day of February 2010

By the Lords of Her Majesty's Most Honourable Privy Council

The General Medical Council have made the General Medical Council (Applications for General Practice and Specialist Registration) Regulations 2010, which are set out in the Schedule to this Order, in exercise of the powers conferred by section 34E(1) and (3) of the Medical Act 1983[1].

By virtue of section 34E(6) of that Act, such Regulations shall not come into force until approved by Order of the Privy Council

Their Lordships, having taken these Regulations into consideration, are pleased to and do approve them.

Notes

[1] Section 34E is inserted by S.I.2010/ 234.

This Order may be cited as the General Medical Council (Applications for General Practice and Specialist Registration) Regulations Order of Council 2010 and comes into force on 1st April 2010.

Judith Simpson
Clerk of the Privy Council

SCHEDULE

The General Medical Council (Applications for General Practice and Specialist Registration) Regulations 2010

The General Medical Council make the following Regulations in exercise of powers conferred by section 34E(1) and (3) of the Medical Act 1983.

1. Citation and commencement

These Regulations may be cited as the General Medical Council (Applications for General Practice and Specialist Registration) Regulations 2010 and come into force on 1st April 2010.

2.— Interpretation

(1) In these Regulations—

"the 2010 Order" means the Postgraduate Medical Education and Training Order of Council 2010;

"the Act" means the Medical Act 1983;

"application" means an application for inclusion in the General Practitioner Register under section 34C of the Act or the Specialist Register under section 34D of the Act, and the term "applicant" shall be construed accordingly;

"Fees provisions" means rules made under article 24(5) of the General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003[1] or regulations made under section 34O(1) of the Act[2];

"previous legislation" means—

(a) the European Specialist Medical Qualifications Order 1995[3]; and

(b) the General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003;

"primary medical qualification" means—

(c) a primary United Kingdom qualification as defined in section 4(3) of the Act[4];

(d) a primary European qualification as defined in section 17 of the Act[5]; or

(e) an acceptable overseas qualification as defined in section 21B(2) of the Act[6];

"provider" means any hospital, general practitioner, or other body or person in the United Kingdom or elsewhere by whom, or under whose direction or management, any postgraduate education or training, or sub-specialty training, has been given, non-training posts have been undertaken or other experience has been provided;

"statement of eligibility" means a statement issued by the Registrar under regulation 7.

(2) In these Regulations, "relevant authority" means—

(a) in relation to medical education and training conducted in the United Kingdom, a Medical Royal College, Faculty, Postgraduate Deanery, or other body, or any committee, council or grouping of such bodies, which administer or implement a curriculum approved by the **[** General Council **]** [7];

(b) in relation to medical education and training conducted in a relevant European State **[…]**[8], the competent authority or authorities of that State under Article 56 of the Directive; and

(c) in relation to medical education and training conducted in any other country, any body, institution or authority in that country responsible for the supervision, accreditation, certification or approval of courses, programmes, training posts, examinations, assessments or other tests of competence in postgraduate medical education and training.

(3) The reference to a competent authority in paragraph (2)(a) is a reference to an authority which was a competent authority at the time the approval was given.

(4) The reference to a competent authority in paragraph (2)(b) includes references to authorities which are no longer competent authorities of that European State but which were a competent authority of that State at the time the medical education and training was conducted.

3.— Form and content of applications

(1) An application must be made in writing to the Registrar in accordance with the following paragraphs of this regulation.

(2) An application must include the following—

(a) the applicant's name, date of birth and, where applicable, General Council reference number;

(b) the applicant's registered address or, where applicable, any postal or electronic mail address to which the Registrar is able to send to the applicant written communication relating to the application;

(c) information regarding whether the application is for inclusion in the General Practitioner Register or the Specialist Register;

(d) if the application is for inclusion in the Specialist Register, information regarding whether the applicant wishes the Registrar to indicate in that register the name, or a description of, a field within the relevant specialty in accordance with section 34D(9)(b) of the Act[9]; and

(e) any evidence required to be submitted in accordance with regulation 5.

(3) An application must be accompanied by any fee payable under the Fees provisions.

4. Acknowledgment of applications

The Registrar must, as soon as reasonably practicable, and in any event within one month of receipt of an application—

(a) acknowledge receipt of the application; and

(b) inform the applicant of any missing document which is required for the purposes of the application.

5.— Evidence

(1) The applicant must submit the following evidence, in support of an application, of their eligibility for inclusion in the General Practitioner Register or the Specialist Register, including, as applicable—

(a) evidence verifying the identity of the applicant;

(b) evidence, where relevant, that the applicant is a national of a relevant European State or is, by virtue of an enforceable **[** EU **]** [10] right, entitled to be treated, for the purposes of access to the medical profession, no less favourably than a national of a relevant European State;

(c) evidence that the applicant is, or will be at the time the application is determined (if

granted), a registered medical practitioner;

(d) a copy of any CCT awarded under section 34L of the Act[11] or of any CCT or equivalent qualification awarded under the corresponding provisions of previous legislation;

(e) a copy of any certificate of acquired rights issued in accordance with section 34G(2) of the Act or in accordance with previous legislation;

(f) a copy of any certificate of equivalent experience or certificate of prescribed experience issued under previous legislation by the Postgraduate Medical Education and Training Board or by the Joint Committee on Postgraduate Training for General Practice;

(g) evidence that the applicant fulfils the criteria set out in any scheme published under section 34D(6) of the Act;

[(h) a statement of eligibility, or a statement of eligibility for registration issued in accordance with article 11(7) or 14(11) of the General and Specialist Practice (Education, Training and Qualifications) Order 2003[13] ; **]** [12]

(i) **[…]**[14]

[(j) evidence that the applicant's training ~~is~~, or qualifications ~~are~~, or both when considered together ~~are~~, gives the applicant the knowledge, skills and experience required for practising as a general practitioner~~equivalent to a CCT~~[16] ~~in general practice~~ for the purposes of article 4(4) of the 2010 Order (general practitioners eligible for entry in the General Practitioner Register);

(k) evidence that the applicant's specialist training ~~is~~, or specialist qualifications in a recognised specialty ~~are~~, or both when considered together ~~are~~, gives the applicant the knowledge, skills and experience required for practising as an eligible specialist~~equivalent to a CCT in the relevant specialty~~ for the purposes of article 8(2) of the 2010 Order (specialists eligible for entry in the specialist register);

(l) evidence that the applicant's level of knowledge and skill is consistent with practice as a consultant in any of the UK health services for the purposes of article 8(3) of the 2010 Order. **]** [15]

(2)-(3) **[…]**[17]

6.— Collection of information, evidence and advice

(1) **[[** The **]** [19] Registrar may **]** [18], at any time whilst considering the application—

(a) request the applicant to produce such further information, documents or reports;

(b) obtain from any person other than the applicant, provider, relevant authority, or other body, such information, documents or reports, including advice from one or more medical or lay advisers as to whether the applicant is eligible for inclusion in the General Practitioner Register or the Specialist Register;

(c) make such further investigations, and obtain such information, documents or reports; or

(d) refer any question or matter arising to a Registration Panel for advice,

as in the Registrar's opinion is appropriate to the determination of the application.

(2) In paragraph (1)(b)—

"lay" means a person who—

(a) is not, and never has been, provisionally registered or fully registered;

(b) was at no time registered with limited registration; and

(c) does not hold qualifications which would entitle an application to be made by that person for provisional or full registration,

under the Act;

"medical" means a registered medical practitioner.

(3) **[…]**[20]

7.— […][21]

8.— Determination of applications

(1) The Registrar must, subject to paragraph (2), grant or refuse an application and, in considering their decision, must take into account—

(a) where appropriate, any standards and requirements established by the General Council under section 34H(1)(a) of the Act **[…]**[22] ; and

(b) any failure by the applicant to provide any evidence, information, document or report required under regulation 5 or 6.

(2) **[…]**[23]

(3) As soon as reasonably practicable after having determined an application, the Registrar must notify the applicant of the determination in accordance with paragraphs 3(1) and 6 of Schedule 3A to the Act **[…]**[24] .

9. Correction of errors

Where it comes to the attention of the Registrar that there is an error in any of the information contained in a statement of eligibility, the Registrar must—

(a) request the original statement from the applicant;

(b) provide a corrected statement to the applicant; and

(c) notify such other persons or bodies as the Registrar considers appropriate, that the statement has been corrected, including details of the correction.

Given under the official seal of the General Medical Council this 11th day of February 2010

Peter Rubin
Chair

Niall Dickson
Chief Executive and Registrar

Notes

[1] S.I. 2003/1250. That instrument is revoked by S.I.2010/234, article 7 and Part 3 of Schedule 3 but rules under article 24(5) remain in force by virtue of paragraph 8 of Schedule 2 to S.I.2010/234.

[2] Section 34O is inserted by S.I.2010/234.

[3] S.I. 1995/3208. This instrument is revoked by S.I.2003/1250.

[4] Section 4(3) is amended by the Medical Qualifications (Amendment) Act 1991 (c.38), section 1.

[5] Section 17 is substituted by S.I.1996/1591 and amended by S.I.2004/1947 and 2007/3101.

[6] Section 21B is inserted by S.I.2006/1914 and amended by S.I.2007/3101.

[7] Words substituted in reg.2(2)(a) by Sch.1 para.50(a) by European Qualifications (Health and Social Care Professions) (Amendment etc.) (EU Exit) Regulations 2019/593 Sch.1(1) para.50(a) (December 31, 2020: shall come into force on IP completion day not exit day as specified in 2020 c.1 s.39(1) and Sch.5 para.1(1))

[8] Words revoked in reg.2(2)(b) by Sch.1 para.50(b) by European Qualifications (Health and Social Care Professions) (Amendment etc.) (EU Exit) Regulations 2019/593 Sch.1(1) para.50(b) (December 31, 2020: shall come into force on IP completion day not exit day as specified in 2020 c.1 s.39(1) and Sch.5 para.1(1))

[9] Section 34D is inserted by S.I.2010/234.

[10] Word substituted in reg.5 by Treaty of Lisbon (Changes in Terminology) Order 2011/1043 Pt 2 art.6(1)(f) (April 22, 2011)

[11] Section 34L is inserted by S.I.2010/234.

[12] Reg.5(1)(h) substituted by reg.2(2)(a) (as set out in SI 2011/1248 Sch.1) by General Medical Council (Applications for General Practice and Specialist Registration) (Amendment) Regulations Order of Council 2011/1248 Sch.1 para.1 (June 8, 2011)

[13] SI 2003/1250; revoked by SI 2010/234 (seearticle 7(3) and Part 3 of Schedule 3)

[14] Reg.5(1)(i) revoked by Sch.1 para.51 by European Qualifications (Health and Social Care Professions) (Amendment etc.) (EU Exit) Regulations 2019/593 Sch.1(1) para.51 (December 31, 2020: shall come into force on IP completion day not exit day as specified in 2020 c.1 s.39(1) and Sch.5 para.1(1))

[15] Reg.5(1)(j)-(l) inserted by reg.2(2)(b) (as set out in SI 2011/1248 Sch.1) by General Medical Council (Applications for General Practice and Specialist Registration) (Amendment) Regulations Order of Council 2011/1248 Sch.1 para.1 (June 8, 2011)

[16] Section 55(1) of the Medical Act 1983 defines "CCT" as a certificate of completion of training awarded under section 34L(1) of that Act. Section 34L was inserted by SI 2010/234. Paragraph (2) of that section provides that a CCT may only be awarded in general practice or in a recognised specialty.

[17] Reg.5(2) and (3) revoked by reg.2(2)(c) (as set out in SI 2011/1248 Sch.1) by General Medical Council (Applications for General Practice and Specialist Registration) (Amendment) Regulations Order of Council 2011/1248 Sch.1 para.1 (June 8, 2011)

[18] Words substituted in reg.6(1) by reg.2(3)(a) (as set out in SI 2011/1248 Sch.1) by General Medical Council (Applications for General Practice and Specialist Registration) (Amendment) Regulations Order of Council 2011/1248 Sch.1 para.1 (June 8, 2011)

[19] Words substituted in reg.6(1) by Sch.1 para.52(2) by European Qualifications (Health and Social Care Professions) (Amendment etc.) (EU Exit) Regulations 2019/593 Sch.1(1) para.52(2) (December 31, 2020: shall come into force on IP completion day not exit day as specified in 2020 c.1 s.39(1) and Sch.5 para.1(1))

[20] Reg.6(3) revoked by Sch.1 para.52(3) by European Qualifications (Health and Social Care Professions) (Amendment etc.) (EU Exit) Regulations 2019/593 Sch.1(1) para.52(3) (December 31, 2020: shall come into force on IP completion day not exit day as specified in 2020 c.1 s.39(1) and Sch.5 para.1(1))

[21] Reg.7 revoked by Sch.1 para.53 by European Qualifications (Health and Social Care Professions) (Amendment etc.) (EU Exit) Regulations 2019/593 Sch.1(1) para.53 (December 31, 2020: shall come into force on IP completion day not exit day as specified in 2020 c.1 s.39(1) and Sch.5 para.1(1))

[22] Words substituted in reg.8(1)(a) by Sch.1 para.54(2) by European Qualifications (Health and Social Care Professions) (Amendment etc.) (EU Exit) Regulations 2019/593 Sch.1(1) para.54(2) (December 31, 2020: shall come into force on IP completion day not exit day as specified in 2020 c.1 s.39(1) and Sch.5 para.1(1))

[23] Reg.8(2) revoked by Sch.1 para.54(3) by European Qualifications (Health and Social Care Professions) (Amendment etc.) (EU Exit) Regulations 2019/593 Sch.1(1) para.54(3) (December 31, 2020: shall come into force on IP completion day not exit day as specified in 2020 c.1 s.39(1) and Sch.5 para.1(1))

[24] Words revoked in reg.8(3) by Sch.1 para.54(4) by European Qualifications (Health and Social Care Professions) (Amendment etc.) (EU Exit) Regulations 2019/593 Sch.1(1) para.54(4) (December 31, 2020: shall come into force on IP completion day not exit day as specified in 2020 c.1 s.39(1) and Sch.5 para.1(1))

General Medical Council

Annex B

General Medical Council (Applications for General Practice and Specialist Registration) (Amendment) Regulations 2022

The General Medical Council make the following Regulations in exercise of the power conferred by section 34E(1) and (2) of the Medical Act 1983(**a**).

1. The General Medical Council (Applications for General Practice and Specialist Registration) Regulations 2010(**b**) are amended as follows.

2. For regulation 5(1)(j)(**c**) substitute—

"(j) evidence that the applicant's training, or qualifications, or both when considered together, gives the applicant the knowledge, skills and experience required for practising as a general practitioner for the purposes of article 4(4) of the 2010 Order (general practitioners eligible for entry in the General Practitioner Register);"

3. For regulation 5(1)(k)(**d**) substitute—

"(k) evidence that the applicant's specialist training, or specialist qualifications in a recognised specialty, or both when considered together, gives the applicant the knowledge, skills and experience required for practising as an eligible specialist for the purposes of article 8(2) of the 2010 Order (specialists eligible for entry in the specialist register);"

Given under the official seal of the General Medical Council on this [day] of [month] 2022.

L.S.

Name
Chair

Name
Chief Executive and Registrar

(**a**) 1983 c.54. Sections 34C to 34O were inserted by S.I.2010/234, article 4 and Schedule 1, paragraph 10.
(**b**) The General Medical Council (Applications for General Practice and Specialist Registration) Regulations 2010 have been amended numerous times, most recently by the European Qualifications (Health and Social Care Professions) (Amendment etc.) (EU Exit) Regulations 2019/593.
(**c**) Reg.5(1)(j) was inserted by the General Medical Council (Applications for General Practice and Specialist Registration) (Amendment) Regulations Order of Council 2011/1248, Sch.1, para.2(2)(b).
(**d**) Reg.5(1)(k) was inserted by the General Medical Council (Applications for General Practice and Specialist Registration) (Amendment) Regulations Order of Council 2011/1248, Sch.1, para.2(2)(b).

Section 40A update – for the purposes of data protection, the update for Council has since been removed from this pack.

General Medical Council

Council members' Register of Interests

Action	*To note*
Purpose	In accordance with best practice, members of Council (and indeed the Senior Management Team) are asked to update their Register of Interests biannually, and whenever a material change is required. This register is published on the GMC's website. In order to enhance this practice and to maintain awareness of each other's interests and areas of expertise, the Register of Council Members' Interests is included below. This will continue to be presented to Council to note on an annual basis. SMT interests continue to be published on the website, but Council members, as the Charity's trustees, will also have their register noted by Council.
Recommendations	Council is asked to note the Register of Members' Interests.
Annexes	None.
Author contacts	**Melanie Wilson**, Head of Corporate Governance and Council Secretary Melanie.Wilson@gmc-uk.org, 0161 240 8331
Sponsoring director/ Senior Responsible Owner	**Charlie Massey,** Chief Executive and Registrar

Agenda item M9
Council members' Register of Interests

Background

1 In accordance with best practice, members of Council (and indeed the Senior Management Team) are asked to update their Register of Interests biannually, and whenever a material change is required. This register is published on the GMC's website.

2 In order to enhance this practice and to maintain awareness of each other's interests and areas of expertise, the Register of Council Members' Interests is included below. This will continue to be presented to Council to note on an annual basis. SMT interests continue to be published on the website, but Council members, as the Charity's trustees, will also have their register noted by Council.

3 The Corporate Governance team is available for advice and support on any matter in relation to the register of interests. There may be rare occasions where a declared interest is not published on the website, but this is managed on a case by case basis depending on assessed risk and the potential for a conflict to arise, by the Corporate Governance team.

The Register of Interests

4 The Register of Interests is published on the GMC website at the following address: https://www.gmc-uk.org/about/how-we-work/governance/council/council-member-register-of-interests

5 The current Register of Interests is published as follows for each Council member:

Professor Dame Carrie MacEwen (GMC Ref No: 2553610)

Organisation	Position
NHS Tayside	Consultant Ophthalmologist
University of Dundee	Honorary Professor
Royal College of Ophthalmologists	Fellow (Past President)
Royal College of Surgeons (Edinburgh)	Fellow
Royal College Surgeons and Physicians of Glasgow	Honorary Fellow
Royal College of General Practitioners	Honorary Fellow
Royal College of Pathologists	Honorary Fellow

Agenda item M9
Council members' Register of Interests

Faculty of Sport and Exercise Medicine	Honorary Fellow
College of Optometrists	Honorary Fellow
British and Irish Orthoptic Society	Honorary Fellow
Faculty of Medical Leadership and Management	Senior Fellow
Moorfields Eye Charity	Trustee
Healthcare Quality Improvement Partnership (HQIP)	Chair
Oxford Ophthalmological Congress	Member of Council
The Worshipful Company of Barbers of London	Honorary Freeman
Eye (Nature group)	Associate Editor
MDDUS	Member
BMA	Member
Academy of Medical Royal Colleges	Past Chair
Faculty of Public Health	Honorary Fellow

Mr Steven Burnett

Organisation	**Position**
GMC Pension scheme	Trustee

Dr Vanessa Davies

Organisation	**Position**
Quality Assurance Agency for Higher Education UK	Non-exec Board member; Chair of its Advisory Committee on Degree Awarding Powers
House of Lords Conduct Committee	Lay member
Law for Life	Trustee

Agenda item M9
Council members' Register of Interests

Crown Office and Procurator Fiscal	Non exec Director, member of Audit and Risk Committee
Honourable Society of the Inner Temple	Governing Bencher
GMC Pension Scheme	Trustee
Scottish Government	Decision Maker for complaints about Ministers or former Ministers
Occasional consultancy for professional regulators and for the Good Law Project.	
Family connections to King's College London, Newcastle University and University of Liverpool.	

Professor Anthony Harnden (GMC Ref No: 2807869)

Organisation	**Position**
Morland House Surgery, Wheatley, Oxfordshire	Partner
University of Oxford	Professor of Primary Care
St Hugh's College, University of Oxford	Governing Body fellow
Royal College of General Practitioners	Fellow
Medical Defence Union	Member
Joint Committee on Vaccination and Immunisation	Deputy Chairman
British Medical Association	Member
Morland House Healthcare Ltd	Director
GMC Services International Ltd	Board member
Daughter is a doctor on the Yorkshire Rheumatology training programme.	

Lord Hunt of Kings Heath

Organisation	**Position**

Agenda item M9
Council members' Register of Interests

House of Lords	Labour Member
Privy Council	Counsellor
British Fluoridation Society	President
Health Care Supply Association	President
Hospital Caterers Association	President
National Water Fluoridation Alliance	Patron
Foundation for Liver Research	Trustee
Royal College of Physicians	Honorary Fellow
Royal College of GPs	Honorary Fellow
Faculty of Public Health	Honorary Fellow
Faculty of Dental Surgery, Royal College of Surgeons	Honorary Fellow
GS1 UK	President
Philip Hunt Consultancy	Self-employed consultant
Eden & Partners	Consultant and trainer
SweatCo Ltd	Advisory Board Member
Philip was Advisory Board Chair at Octopus TenXHealth until February 2022, when the board ceased to exist.	
Brother-in-law owns Happy Computers, which also trades as Happy ltd, and has undertaken training for some GMC staff up to 2015.	
Step daughter-in-law undertakes market research/business intelligence for market research agencies on behalf of pharmaceutical companies.	
Philip Hunt was appointed a non-executive director of the Heart of England NHS Trust in October 2010 and subsequently became Chairman in April 2011 serving until July 2014. [Surgeon Mr Ian Paterson was excluded from practice at the trust in May 2011. The Independent Review led by Sir Ian Kennedy was commissioned and reported under his Chairmanship].	

Philip was Health Minister from 1999-2003 and in 2007 which involved some responsibilities in relation to the matters reviewed by the Gosport Independent Panel and also in relation to the matters being reviewed by the Infected Blood Inquiry.

Professor Paul Knight OBE (GMC Ref No: 2343239)

Organisation	Position
Social Security Scotland	Chief Officer (Health and Social Care Operations)
Glasgow University Medical School	Honorary Professor
Royal College of Physicians Edinburgh	Fellow
Royal College of Physicians and Surgeons of Glasgow	Fellow
Royal College of Physicians in Ireland	Fellow
Royal College of Physicians in London	Fellow
British Geriatrics Society	Past President / Member
European Union Geriatric Medicine Society	Past President
Glasgow City Health and Social Care Partnership	Consultant Geriatrician and older people's adviser
Swedish Research Council review panel for Clinical Therapy Research	Member
Chief Medical Officer for Scotland's Professional Advisory Group	Member

Professor Deepa Mann-Kler

Organisation	Position
Equality Commission NI	Commissioner
Public Health Agency NI	Non-Executive Director

Agenda item M9
Council members' Register of Interests

Neon*	Chief Executive
Ulster University	Visiting Professor in Immersive Futures
Pharmaceutical Society of Ireland	Member of the Professional Conduct Committee
DHSC Public Appointments Unit	Independent Panel Member

* Neon creates virtual and augmented reality apps and experiences, often focussing on health and wellbeing, by facilitating and working directly with consumers and patients.

Dr Raj Patel MBE (GMC Ref No: 3103487)

Organisation	**Position**
NHS England and NHS Improvement	Interim Medical Director for Primary Care
Royal College of General Practitioners	Fellow
British Medical Association	Member
Medical Defence Union	Member
GMC Pension Scheme	Trustee
Raj is listed as a director in his partner's retail company. The business has no links with healthcare.	

Professor Suzanne Shale

Organisation	**Position**
Oxleas NHS Foundation Trust	Non-Executive Director
The Ethicist Ltd	Director
Suzanne was previously a GMC Education Associate, prior to being appointed as a Council member.	
Suzanne was Chair of the charity Action against Medical Accidents from 2015-2020.	

Agenda item M9

Council members' Register of Interests

Miss Alison Wright (GMC Ref No: 3498288)

Organisation	Position
NHS England and NHS Improvement	National Speciality Adviser for personalised care in Obstetrics
HCA Hospitals	Vice Chair, Medical Advisory Committee, Portland Hospital
Royal Free London NHS Foundation Trust	Consultant Obstetrician and Gynaecologist
GMC Services International Ltd	Board member

General Medical Council

28/29 September 2022 – Virtual		
Session	**Item**	**Sponsor**
Seminar	• SoMEP Workforce report	Shaun Gallagher
	• FtP backlogs	Anthony Omo
Confidential Session	• Outline draft budget	Neil Roberts
	• Pensions update – re triennial valuation	Neil Roberts
	• Dr Arora case review	Anthony Omo
	• Unitary Board	Charlie Massey
Public session	• Chief Executive's report	Charlie Massey/ Iona Twaddell
	• Equality, diversity and inclusion update	Colin Melville
	• Safeguarding update	Neil Roberts
	• Biannual s40a Appeals Update	Charlie Massey/ Sophie Brookes
	• Amendments to the GMC regulations on specialist/GP registration	Una Lane
Below the line	• Council members' register of interest	Carrie MacEwen
	• 2022 Council forward work programme	Carrie MacEwen

2/3 November 2022 – Edinburgh		
Session	**Item**	**Sponsor**
Seminar	• Scotland focus (with stakeholder dinner)	Paul Reynolds
Confidential Session	• Pensions update – triennial valuation	Neil Roberts
Public session	• Chief Executive's report	Charlie Massey
	• Equality, diversity and inclusion update : Employer measures	Shaun Gallagher

Agenda item M10
2022 Forward work plan

	• Regulatory fairness review final report	Shaun Gallagher
	• Update on Regulatory Reform	Shaun Gallagher
	• PPI update	Paul Reynolds
	• Update on the people survey	Neil Roberts
	• Review of the Governance Handbook	Charlie Massey
Below the line	• 2022/23 Council forward work programme	Carrie MacEwen

13/14 December 2022 - London		
Session	**Item**	**Sponsor**
Seminar	• Perceptions survey	Paul Reynolds
	• GMP review	Colin Melville
Confidential Session	• Draft Business Plan and Budget 2023	Neil Roberts
Public session	• GMCSI	Andrew McCulloch
	• Chief Executive's report	Charlie Massey
	• Equality, diversity and inclusion update	Shaun Gallagher
	• Three-year business plan (Planning, evaluating)	Shaun Gallagher
	• Report of the MPTS Committee 2022	Caroline Swift
	• Report of the Audit and Risk Committee 2022	Paul Knight
	• Report of the Remuneration Committee 2022	Anthony Harnden
	• Update on Regulatory Reform	Shaun Gallagher
	• MLA – Update on MSC pilots	Colin Melville
	• Sex, Gender & Gender Identity	Shaun Gallagher
	• Compliments and Complaints report	Charlie Massey
Below the Line	• 2022/23 Council forward work programme	Carrie MacEwen
	• Committee membership 2023	Carrie MacEwen

Agenda item M10
2022 Forward work plan

	• Annual report on DC pension scheme	Neil Roberts

28 February/1 March 2023 - London		
Session	**Item**	**Sponsor**
Seminar	• Update on the Investment Committee	Neil Roberts
Confidential Session	• Annual Review of Governance Framework: GMC/GMCSI	Sophie Brookes
Public session	• Chief Executive's report	Charlie Massey
	• Report of the Investment Committee	Neil Roberts
	• ED&I Annual report on progress	Shaun Gallagher
	• Update on Regulatory Reform	Shaun Gallagher
	• PSA annual performance review 2021/22	Shaun Gallagher
Below the line	• 2023 Council forward work programme	Carrie MacEwen
	• Report of the Executive Board	Charlie Massey

26/27 April 2023 - Manchester		
Session	**Item**	**Sponsor**
Seminar	• Development of new medical schools (tbc)	Colin Melville
	• Update on the Investment Committee	Neil Roberts
Confidential session	•	
Public session	• Chief Executive's report	Charlie Massey
	• Approval of Aston and Anglia Ruskin to award PMQ	Colin Melville
	• Annual Quality Assurance update	Colin Melville
	• Annual Communications and engagement update	Paul Reynolds
	• People report 2022	Neil Roberts
	• ED&I – employer measures (data/recruitment/pay)	

Agenda item M10
2022 Forward work plan

	• Freedom to speak up guardian annual report	Neil Roberts
	• Biannual section 40a report	Charlie Massey
	• Update on Regulatory Reform	Shaun Gallagher
Below the line	• 2023 Council forward work programme	Carrie MacEwen
	• Council members' register of interest	Carrie MacEwen

14/15 June 2023 – London		
Session	**Item**	**Sponsor**
Seminar	•	
Confidential session	• GMCSI report	Paul Reynolds/Andrew McCulloch
Public Session	• Chief Executive's report	Charlie Massey
	• Report of the MPTS Committee	MPTS Chair
	• Trustees' Annual report and accounts	Paul Reynolds / Neil Roberts
	• Fitness to practise statistics report	Anthony Omo
	• Report of the Audit and Risk committee	Paul Knight/Neil Roberts
	• Compliments and complaints report	Charlie Massey
	• Credentialing post pilot/implementation update	Colin Melville
	• Education derogations	Colin Melville
	• Equality, diversity and improvement update	Shaun Gallagher
	• Update on Regulatory Reform	Shaun Gallagher
Below the Line	• 2023 Council forward work programme	Carrie MacEwen/ Mel Wilson

Away day Tuesday 11/Wednesday 12 July		
	• TBC	

Agenda item M10
2022 Forward work plan

27/28 September 2023 - Virtual		
Session	**Item**	**Sponsor**
Seminar	•	
Confidential Session	• Draft business plan/budget	Neil Roberts
Public session	• Chief Executive's report	Charlie Massey
	• Biannual section 40a appeals update	Charlie Massey
	• Equality, diversity and inclusion update	Shaun Gallagher
	• Update on Regulatory Reform	Shaun Gallagher
Below the line	• 2023/24 Council forward work programme	Carrie MacEwen
	• Council members' register of interest	Carrie MacEwen