

Council Meeting - 4 December 2025

PUBLISHED
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Agenda

Main meeting

Thursday 4 December 2025 - 11:10 – 14:35

Meeting

11:10 – 11:12 <i>2 mins</i>	M1	Chair's business
11:12 – 11:15 <i>3 mins</i>	M2	Minutes of the meeting on 1 October 2025
11:15 – 11:35 <i>20 mins</i>	M3	Chief Executive's report
11:35 – 12:00 <i>25 mins</i>	M4	Corporate Strategy 2026-30
12:00 – 12:25 <i>25 mins</i>	M5	2026 Budget and Business Plan (including financial update and outcome of triennial valuation)
12:25 – 12:45 <i>20 mins</i>	M6	Involving patients and the public in our work as a regulator
12:45 – 13:15 <i>30 mins</i>		Lunch
13:15 – 13:40 <i>25 mins</i>	M7	Fairer Employer Referrals
13:40 – 13:50 <i>10 mins</i>	M8	Quality Assurance, Monitoring and Improvement - PA Courses
13:50 – 14:05 <i>15 mins</i>	M9	Compliments and Complaints report
14:05 – 14:20 <i>15 mins</i>	M10	Report of the Audit and Risk Committee 2025
14:20 – 14:30 <i>10 mins</i>	M11	Report of the Remuneration Committee 2025
14:30 – 14:35	M12	Any other business

5 mins

Below-the-line items*

M13 Council forward work programme

M14 Fairer Training Cultures

M15 ED&I Annual Report

M16 Annual report of the GMC Pension Plan Management Board 2025

***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.**

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Draft as of: 3 October 2025

To approve

Minutes of the meeting on 1 October 2025

Members present

Carrie MacEwen, Chair

Alison Wright

Keith Lloyd

Douglas Millican

Jane Ramsey (virtual)

Jeeves Wijesuriya

Olamide Oguntimehin

Raj Patel

Suzanne Shale

Vanessa Davies

Wendy Williams

Others present

Charlie Massey, Chief Executive and Registrar

Shaun Gallagher, Director of Strategy and Policy

Una Lane, Director of Registration and Revalidation

Pushpinder Mangat, Medical Director and Director of Education and Standards

Anthony Omo, Director of Fitness to Practise and General Counsel

Paul Reynolds, Director Strategic Communications and Engagement

Neil Roberts, Director of Resources

Melanie Wilson, Head of Corporate Governance and Council Secretary

Agenda item 2

Minutes of the meeting on 1 October 2025

Chair's business (item M1)

- 1 The Chair welcomed members of Council, the Senior Management Team (SMT) and observers to the meeting.
- 2 Apologies had been received from Deepa Mann Kler.
- 3 It was noted that the following appointments had been made:
 - a Mike Jennings, external member of the Investment Committee had been reappointed for a four-year term.

Minutes of the meeting on 23 July 2025 (item M2)

- 4 Council approved the minutes of the meeting on 23 July 2025 as a true record.

Chief Executive's Report (item M3)

- 5 Council considered the Chief Executive's Report.
- 6 Council noted that:
 - a The Government has committed to regulatory reform and the GMC is busy working with the Department of Health and Social Care to refine the draft order prior to the Government consultation which is planned before the end of this year.
 - b The GMC is scrutinising recommendations from the Leng Review and consulting with all UK Governments. The GMC is hoping for consistency from all government responses and hopes to contribute to the implantation plan.
 - c The State of Medical Education and Practice (SOMEPE) experience report is due to be published soon which give valuable insights into how doctors are feeling. Initial indications are that the situation highlighted in previous reports has remained stable. The SOMEPE workforce report is due soon and will provide valuable data on areas such as the role of international medical graduates (IMGs), post graduate medical education, specialist training places and trends across the four countries.
- 7 During the discussion, Council noted that:
 - a The Contact Centre has missed its key performance indicator (KPI) of customer experience and satisfaction for the last few months. This appears to be focused around two teams and reflects an increase more generally in 'unhappy' callers. Due to the feedback system in use, it is hard to be more specific. The new system currently being integrated will enable an automatic request for feedback allowing more accurate

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Minutes of the meeting on 1 October 2025

identification of satisfaction rates, which is helpful in the context that the contact centre may be the only contact registrants and the public have with the GMC.

- b** It was noted that procedures have been put in place to address requirements of the Economic Crime and Corporate Transparency Act 2023, which came into effect on 1 September 2025.

Financial update (item M4)

8 Council noted an update on the GMC's latest financial position.

9 Council noted that:

- a** Finances are in a good position for the rest of 2025 with a surplus predicted of £4.7 million. Income remains healthy due to growth in the register being higher than budgeted and expenditure being lower than budgeted due to a higher level of vacancies than initially assumed, which decreases the staff cost forecast, and reduced expenditure linked to PLAB 2 examinations.
- b** The GMC's finances are sensitive to small variations in the budget assumptions so it is important to get these assumptions right when setting the 2026 budget.
- c** Due to market volatility, there are no returns expected from the investment portfolio but there has been higher than anticipated returns from funds under treasury management.
- d** As part of work by the Investment Committee to reduce risk in treasury management activities, the Committee has approved proposals to move funds which are not under management with CCLA, or working capital, to a common deposit fund with CCLA. This will produce the same level of returns while reducing the risk to funds in the event of a bank collapse. Associated changes to the Investment Policy have been recommended at item M11.

10 During the discussion, Council noted that:

- a** The Investment Committee have had a thorough discussion about common deposit funds before making the decision to use them as part of their work to reduce risk to GMC funds.
- b** Data from the SOMEPE report suggests falling numbers applying to sit the PLAB examinations may be due to international medical graduates finding it more challenging to find job opportunities, rather than the UK being less attractive to work.

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Regulatory Fairness Review – Implementation Update (item M5)

- 11** Council noted an update on the implementation of recommendations from the Regulatory Fairness Review since the last update to Council in October 2024.
- 12** Council noted that:
 - a** The 42 high impact decision points and decision-making principles have been published.
 - b** Bespoke learning has been rolled out across the organisation to regulatory decision makers.
 - c** Directorate implementation plans, detailing how decision-making principles are being put into practice, have been finalised. They also detail assurance and mitigation measures put in place and support learning for colleagues. Progress of the plans is being monitored with some expected to be completed this year, though it is acknowledged some will take longer to implement.
 - d** There is a programme of ongoing learning for colleagues which is being expanded to associates. Consideration is also being given to embedding, as business as usual, as the programme comes to an end.
 - e** Plans are in place to commission an external assessment which will include benchmarking against other organisations and reviewing literature.
 - f** An audit by BDO was presented to the Audit and Risk Committee. Themes from the report included a shortage of people resources, which is currently being resolved, and moving to business as usual and developing a closure process.
- 13** During the discussion, Council noted that:
 - a** Council praised the work that has been undertaken and the impact it has had.
 - b** Although work has been undertaken to publicise this work, there could be more that could be done to share this with stakeholders.
 - c** Council was assured the programme of work has been proportional. The review has undertaken some important work looking at patterns and understanding why differentials arise.
 - d** There are no concerns around completing the programme of work, though regulatory reform may pose some people resource issues and there continues to be a focus on the original recommendation to actively seek out bias in our processes.
 - e** Measures have been deliberately designed regarding anti-bias in general to ensure future proofing rather than specific to particular protected characteristics. A report will

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Minutes of the meeting on 1 October 2025

be provided to Council in 2026 measuring the benefits across the organisation of this programme of work.

Mid-year People and Gender Pay Report 2025 (item M6)

14 Council noted the Mid-year People and Gender Pay Report 2025.

15 Council noted that:

- a** Turnover of staff remains low and absence rates are below pre-pandemic levels with absences due to mental health continuing to fall.
- b** Overall representation of minority ethnic colleagues has improved, although there has not been the desired progress at manager level and above.
- c** Turnover of colleagues from ethnic minority backgrounds remains above our targets; as does promotion, which is positive.
- d** A working group will be established to look at ED&I targets for the workforce and what additional interventions can be put in place for recruitment. This was welcomed by Council and this will be reported in the 2026 People plan.
- e** There is a continuing downward trend in the gender pay gap which is positive. There is also no significant disparity in pay for ethnic minority colleagues.

16 During the discussion, Council noted that:

- a** It would be useful to understand if there is a gender difference in mental health absences and detail on the length of absences for occupational health referrals. **[Action]** The next People plan will have a renewed focus on mental health.
- b** A continued focus on converting applications to offers for ethnic minority colleagues was welcomed by Council.

Revised Risk Management Framework (item M7)

17 Council received the revised risk management framework for approval.

18 Council noted that:

- a** The framework has been updated to align with how risks are monitored and escalated, and to update the risk appetite statement and levels of risk appetite.
- b** There has been engagement with colleagues across the organisation as well as considering risk appetite statements from other regulators.

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- c The revised framework has been considered by the Audit and Risk Committee and will be used in developing the next corporate strategy, looking at it through a risk lens.
- d There will be engagement and support for colleagues and a phased approach to updating risk registers across the organisation.

19 During the discussion, Council noted that:

- a Setting risk appetite is Council's responsibility and Council would value further time to consider risk appetite and risk appetite descriptions before it approves them. **[Action]**
- b While much of the GMC's work may be at the lower end of risk appetite, the GMC does sometimes undertake work with a higher risk appetite and moving to five levels of risk appetite is appropriate.
- c There may be further work required on how the risk appetite statements are applied.

20 Council approved the risk management framework but further consideration of the risk appetite statement was required before that aspect is approved.

Significant Event Review Guidance Refresh (item M8)

21 Council received refreshed guidance on reporting a 'serious incident' to the Charity Commission, for approval.

22 Council noted that:

- a The guidance has been updated following engagement with the Charity Commission to align with their updated expectations.
- b The refreshed guidance takes into account feedback from the senior management team and Audit and Risk Committee.
- c Key changes are: a new step earlier in the process to consider if a referral needs to be made; delegating the decision on whether a referral should be made to the GMC Chair and Chair of the Audit and Risk Committee; and a review and update to reporting thresholds with a 'must report' category added.

23 During the discussion, Council noted that:

- a The Audit and Risk committee would consider whether there are any other specific areas that should be referred to the Charity Commission under the 'harm to people' category, such as where we are exercising our regulatory role in respect of registrants where there has been patient harm. **[Action]**
- b It would be worth exploring further Council's duty of care to registrants as charity trustees. The Chair of the Audit and Risk Committee offered to look into this.

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- 24** Council approved the revised guidance and approved proposed delegations to the Chair and Chair of Audit and Risk Committee.

Update to the Governance Handbook (item M9)

- 25** Council received a number of proposed updates to the Governance Handbook for approval.
- 26** Council noted that:
- a** The main changes were to: two delegated authorities under the Medical Act and two under the AAPA order; and one to allow the GMC Chair of Council and Chair of the Audit and Risk Committee to approve referrals to the Charity Commission between Council meetings.
 - b** Policy legal colleagues were engaged to ensure changes are legally sound.
- 27** Council approved the updates to the Governance Handbook.

Any other business: (item M10)

- 28** Council approved a below the line item:
- a** Investment Policy changes (item M11).
- 29** Council noted two below the line items:
- a** Council forward work programme (item M12).
 - b** Council members' register of interest (item M13)

Date of next meeting

- 30** Council noted that its next meeting is scheduled for 4 December 2025 in London.

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 continue our work around regulatory reform; consultation on the legislation is now expected early in 2026. ● We have recently published <i>The state of medical education and practice in the UK: Workforce report 2025</i>.
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	Katherine Ince, Head of OCCE Any enquiries to: GovernanceTeamMailbox@gmc-uk.org
Sponsoring director/ Senior Responsible Owner	Charlie Massey , Chief Executive

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Chief Executive's report

Regulatory reform

- 1 A current key focus for the programme is carrying out a detailed review of the draft GMC Order that has been developed by the Department for Health and Social Care (DHSC), ahead of their consultation on the legislation - now expected early in 2026. We are pleased to see that DHSC has largely taken on board feedback that we have provided on previous iterations of the Order, and is reflecting this in the updated drafting that is being sent to us. We will use our response to DHSC's consultation to raise any outstanding concerns we have in relation to the draft legislation alongside our ongoing engagement with officials.
- 2 The recent BDO audit spot check has concluded and the findings were shared and discussed with the Audit and Risk Committee (ARC) in November. This spot check focussed specifically on the effectiveness of the recent programme governance restructure and included a review of the approach we are taking to prepare for implementing the changes.
- 3 Following ongoing engagement from registrant representative bodies and the GMC, we are pleased that the DHSC has indicated that health will be added as a third ground for action in the draft GMC Order. We believe it is more compassionate and appropriate to not rely only on two grounds: inability to provide care to a sufficient standard, and misconduct.
- 4 We are continuing our planning work with colleagues across the organisation to develop an integrated plan that sets out the timetable for the implementation of the reforms.

PA/AA regulation, and the Leng review

- 5 In September 2025, the DHSC announced they intend to consult on proposals to amend the professional titles of physician associates and anaesthesia associates as part of their wider consultation on our proposed future regulatory framework.
- 6 Understanding how governments and stakeholders in the four countries of the UK are implementing the Leng report is important to inform our own response to the recommendations. We are inputting to, and working with, implementation groups and stakeholders to support their work and plan our actions.

The state of medical education and practice in the UK: Workforce report

- 7 On Friday 21 November, we published *The state of medical education and practice in the UK: Workforce report 2025*. Our messaging to the media highlighted the key findings from this year's report, with a particular focus about how the UK risks 'huge holes' in its health services if the trends for international qualified doctors leaving the workforce continue, and how this comes at the same time as there is a levelling off in those joining.

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Chief Executive's report

- 8 In this year's report, we also explored key issues across the workforce in all four countries of the UK, including patterns of employment, the movement and location of doctors at different career stages, and the number and success rate of post graduate training applications for international doctors and UK graduates. We highlighted shifting dynamics within the profession, including the history of female doctors and a significant change in the number of doctors declaring a disability.
- 9 We individually contacted health editors and correspondents at every national newspaper and broadcaster and spoke to trade press titles. As a result, we secured good coverage in The Guardian, Daily Mail, Independent, Daily Telegraph, Daily Star, and on the ITV news website, as well as in a number of regional daily newspapers. Charlie Massey was interviewed for independent radio stations, including LBC which prompted a follow-up phone-in on the issue in its flagship Nick Ferrari breakfast show. Trade press coverage included being the lead story in BMJ's print edition.
- 10 We saw press statements post-launch from [NHS providers](#), [NHS Employers](#), [The Royal College of Physicians](#) and [Royal College of General Practitioners](#).
- 11 On launch we also promoted the report on social media and via our e-newsletters and saw strong engagement with the data and findings.
- 12 We engaged with stakeholders across all four countries in the UK in advance of publication and we will work to extend the impact post-launch through briefings on our data and insight for organisations including Royal colleges and parliamentarians. We are also seeking opportunities, through meetings, speeches, forums and roundtable events, to highlight how system leaders and policy makers can use the findings to inform long term planning in England, Northern Ireland, Scotland and Wales.

Parliamentary and stakeholder updates

- 13 In October we wrote to European medical regulators to repeat our request that they proactively share details of fitness to practise action they take against registrants in their jurisdictions. This was in response to an investigation reported in The Times and other media outlets across Europe.
- 14 We have written to the Ministers of State in both the DHSC and the Department for Business and Trade to request that renewed access to the fitness to practise information tool hosted by the European Union's Internal Market Information system is included in the mandate for the UK renegotiation of its relationship with the EU.
- 15 We wrote to Penny Dash, Chair of NHS England, and Mike Richards, Chair of the Care Quality Commission, to request a position on the refreshed National Quality Board, and received a

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positive response. We look forward to representing the GMC and other key professional regulators with NHS-facing registrants.

- 16 We have held our bi-annual patient group roundtable with patient organisations from across the UK. We discussed our patient participation panel pilot, provided an update on regulatory reform and heard attendees' views on two pieces of our more detailed guidance, which we are currently consulting on.
- 17 The theme of our autumn UK advisory forums was 'supporting a workforce that is empowered to lead'. Discussions centred around the importance of clinical leaders role-modelling positive behaviours and creating workplace cultures focussed on patient safety.
- 18 We have had an introductory meeting with the new Wales Deputy Chief Medical Officer to discuss his priorities, and responded to Health Education and Improvement Wales' call for evidence to inform its national education strategy.
- 19 We met with the Northern Ireland Permanent Secretary and Chief Medical Officer in November. We discussed Department of Health (NI) priorities including the NI Health and Social Care Reset plan and opportunities to support the development of medical leadership.

GMC conference

- 20 At the time of writing, we are looking forward to our annual conference, which this year brings together healthcare professionals, policymakers, educators and sector leaders to explore how data, insights and research can drive progress across the UK's healthcare system.
- 21 In addition to three keynote speeches, there will be plenary sessions looking at workforce data and how it can inform future workforce planning; tackling differential outcomes in medical education; and how early engagement between responsible officers and GMC employer liaison advisers can support better local management of concerns about doctors.

People Survey 2025

- 22 We have just received the results of our 2025 People Survey. Our overall engagement score has improved by 1% to 73%. It is a strong score, especially when compared with analogous organisations. We also achieved an increase in our response rate to 89% for this year's survey, which is also a very positive outcome.
- 23 This year's survey was smaller and focused on our employee engagement and inclusivity indexes and the priority areas from the 2024 survey:
 - leadership and change
 - tackling bullying and harassment and raising concerns

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- development opportunities

- 24 We have seen improvements in scores for the majority of survey areas. We will now be analysing the survey data more closely to support our action planning over the next 12 months, and will return to Council in 2026 with more detailed analysis of the responses and how we propose to take actions forward in our People Strategy

The 10-Year Workforce Plan for England

- 25 In November we responded to a joint call for evidence issued by the DHSC and NHS England to support the development of the 10-Year Workforce Plan. Our response drew on our unique data and insights, including from the recently published *The state of medical education and practice in the UK: Workforce report 2025*, to set out what we think is needed to develop a workforce that is fit for the future. In our submission we have argued that:

- education and training must be diversified - and reform must be integrated within the workforce plan
- a clear commitment is needed in the workforce plan to better support - and increase the capacity of - educators and trainers of the medical workforce
- the consequences of plans for overseas doctors must be well understood - and the contribution these doctors already make properly recognised
- the staffing standards must become a reality and be embedded in how provider performance is measured and evaluated to support retention of healthcare staff
- greater clarity is needed on the role of PAs and AAs.

- 26 We also set out our vision for the future of medical education and career development and how our programme of work to revise and adapt education and training in the UK for medical students and doctors will support the ambitions set out in the 10 Year Health Plan.

Inquiries and reviews

- 27 We are currently engaging with the Ockenden review to disclose information to inform the work of the review. We continue to engage with affected families through various mechanisms, including holding surgeries in Nottingham.
- 28 The National Maternity and Neonatal Investigation has published its terms of reference which include: the role of regulatory bodies in the context of a wider focus on accountability; information sharing with families; and the extent to which education and training support staff to deliver good maternity care. The investigation will also undertake a thematic review of previous recommendations made by inquiries into maternity care to consider how many of them have been implemented and what impact they have had, as well as identifying why

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Chief Executive's report

certain recommendations have not been implemented. We have received a letter confirming that formal stakeholder interviews will begin as soon as possible but that interim findings may not be delivered until the new year. We have offered our assistance to the investigation and have shared a thematic maternity report outlining key GMC data and insights on maternity care and maternity failings, reflecting on past maternity inquiries.

Equality, diversity and inclusion (ED&I)

- 29 On 16 October, the UK government announced that Lord John Mann will lead [a review to tackle antisemitism and other racism in the NHS](#). The UK government is also reviewing the recommendations of the independent working group on Islamophobia.
- 30 We have written to Lord Mann to offer our support for the review and stand ready to engage with the inquiry. We welcome the review and its ambitions, which align with the core professional standards that apply to doctors, PAs and AAs who are registered with us.

Enhanced monitoring

- 31 There are currently 22 open cases, with conditions attached to GMC approval to deliver a programme of training at five sites.
- 32 Issues around foundation training in general surgery at Borders General Hospital (QA13844) were identified during a visit by NHS Education for Scotland. The concerns related to appropriate clinical supervision and systems for raising concerns. Due to these concerns, the case was escalated to enhanced monitoring. We will work closely with NHS Education for Scotland to monitor progress in this case.
- 33 We noted improvements in training in neurosurgery at Imperial College Healthcare NHS Trust (QA12767). This case has now been closed.

Enterprise resource planning system

- 34 Work to implement a new enterprise resource planning (ERP) system is progressing as planned. The finance system build phase has completed and we are currently testing the system. We are also making good progress on developing the system integrations.
- 35 The HR system is in the build phase, with testing starting in January 2026. Build has also started with our new payroll system.
- 36 Two programme audits were presented to ARC in November, covering HR implementation and data migration.

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Operational performance

- 37** The attached Performance Annex (Annex A) includes the status of our corporate priority projects and programmes. Associate worker status (AWS), future education and career development, regulatory fairness implementation (RFI) and regulatory reform all continue to report amber due to resourcing pressures. ERP continues to manage high demand on both project teams and business as usual but is making steady progress with planned programme activities. The AWS project is currently working at a reduced capacity due to unexpected resource challenges. Plans are underway to address this, including revised milestones and recruitment of additional resource. Both RFI and the future education programme have recently completed the recruitment process for a new programme manager.
- 38** Our contact centre technology project has moved to amber during this period to signal delays to their ongoing phase two work as they have pushed back their go live date by three weeks; however, the risk attached to delays is minimal. Work is already underway to plan the next phase of the project including key milestones for the remainder of the project.
- 39** In terms of our operational KPIs, there is very little change in September and October performance compared to our last report to Council. Although we remain slightly below our 80% target for customer satisfaction, we have seen a small improvement (September 77% and October 74%, compared with 71% in August). This is despite the continued increase in the volume of interactions with the contact centre, with the number of calls rising by 11% month on month. However, we are managing this well as our call KPI still remains within target, with 80% of calls being answered within 20 seconds in September, and 83% in October.
- 40** A short update on our KPI reporting for 2026 has been included in the separate business plan and budget paper also being discussed at the December 2025 Council meeting. This update summarises any changes we plan to make following our most recent annual review of performance measures.
- 41** The annexed Corporate Opportunities and Risks Register has had two key updates. The approach to managing the Welsh language standards Implementation threat (ID303) has been changed from centralised responsibility to dispersed responsibility across directorates, which has been reflected in the risk's description. We have slightly updated the pension deficit threat (ID207) description to reflect the current position.

Executive Board

- 42** The Executive Board met on 29 September and 27 October and considered the following:
- a** An update on performance and risk.
 - b** Annual update of the Equality, Diversity and Inclusion Steering Group.

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- c** Corporate Strategy 2026-30.
- d** Medical Licensing Assessment content map.
- e** Fairer Employer Referrals.
- f** GMC Pension Plan Management Board Statement of Purpose.

Annex A

Performance Annex

Data presented as at 20 November 2025 (unless otherwise stated)

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

Indicator		Sep	Oct	Commentary
Operations	Decision on 95% of all registration applications within 3 months	99%	98%	Customer Survey feedback: Our customer satisfaction survey, which measures a sample of our customer experiences, continues to record slightly lower levels of satisfaction than our 80% target. This period we are reporting satisfaction levels of 77% in September and 74% in October. Feedback suggests this is due to an increase in our response times; however, we continue to meet our SLA for answering calls within 20 seconds. We have experienced an 11% rise in demand month on month which has likely contributed to this. Additionally, we have noted some frustrations around the wider delays to processes that affect individuals' registration, such as Fitness to Practice, voluntary erasure, specialist applications and international applications processes.
	Decision on 95% of all revalidation recommendations within 5 working days	99%	99%	
	Respond to 90% of ethical/standards enquiries within 15 working days	97%	100%	
	Conclude 90% of fitness to practise cases within 12 months	94%	95%	Media sentiment: We received significant positive coverage across national and regional titles in September (30%), which significantly increased our performance, although this continued to be outweighed by a greater number of articles with a neutral tone. Comparatively the GMC received a lower volume of positive coverage in October (12%), contributing to a decrease in overall performance. While the proportion of negative media coverage for the organisation remained low in September (4%), the 'below 15%' target was just missed in October (18%). Two issues contributed to a spike in negative media coverage, namely: the global investigation into the effectiveness of registration checks carried out by regulators on international medical graduates, and handling of cases involving antisemitism.
	Conclude or refer 90% of cases at investigation stage within 6 months	97%	97%	
	Conclude or refer 95% of cases at the investigation stage within 12 months	98%	98%	
	Commence 100% of Investigation Committee hearings within 2 months of referral	100%	No Cases	Staff turnover: The rolling 12-month staff turnover remains below our 8-12% target range at 7.2% in October, with 5 colleagues leaving the organisation. This shows a slight increase following August (6.2%) and September (6.9%).
	Commence 100% of Interim Order Tribunal (IOT) hearings within 3 weeks of referral	100%	100%	
	Contact Centre sample survey - % of customers who rated their overall experience and satisfaction at 7 or above (out of 10) – target 80%	77%	74%	
	Contact Centre - Answer 80% of calls within 20 seconds	80%	83%	
	Positive media coverage of GMC (target 45% or above)	30%	20%	
	Negative media coverage of GMC (target 15% or below)	4%	18%	
	Satisfaction of users with GMC website (target: a Net Promoter Score of at least 40)	44	48	
Organisation	75% of doctors intend to change practice following Outreach learning session	79%	82%	
	2025 Income and expenditure [% variance +/- 4%]	3.5%	3.6%	
	Rolling twelve-month staff turnover within 8-12%	6.9%	7.2%	
	IS system availability (%) – target 99.89%	100%	100%	

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

		2025		2025									
Indicator		Nov	Dec	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct
Operations	Decision on 95% of all registration applications within 3 months	98%	97%	98%	97%	98%	99%	99%	99%	99%	98%	99%	98%
	Decision on 95% of all revalidation recommendations within 5 working days	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%
	Respond to 90% of ethical/standards enquiries within 15 working days	100%	98%	100%	97%	98%	97%	100%	100%	87%	100%	97%	100%
	Conclude 90% of fitness to practise cases within 12 months	95%	93%	95%	94%	96%	96%	92%	96%	94%	94%	94%	95%
	Conclude or refer 90% of cases at investigation stage within 6 months	97%	97%	96%	95%	97%	98%	97%	97%	97%	97%	97%	97%
	Conclude or refer 95% of cases at the investigation stage within 12 months	98%	97%	97%	98%	98%	98%	97%	98%	96%	97%	98%	98%
	Commence 100% of Investigation Committee hearings within 2 months of referral	No Cases	No Cases	No Cases	No Cases	No Cases	100%	50%	No Cases	100%	100%	100%	No Cases
	Commence 100% of Interim Order Tribunal hearings within 3 weeks of referral	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Contact Centre - % of customers who rated their overall experience and satisfaction at 7 or above out of 10 (target 80%)	81%	80%	83%	77%	81%	83%	76%	70%	72%	71%	77%	74%
	Contact Centre - Answer 80% of calls within 20 seconds	81%	84%	87%	88%	92%	90%	80%	83%	75%	82%	80%	83%
	Positive media coverage of GMC (target 45% or above)	25%	17%	6%	13%	33%	11%	11%	2%	24%	55%	30%	20%
	Negative media coverage of GMC (target 15% or below)	2%	4%	2%	6%	3%	4%	3%	5%	5%	4%	4%	18%
	Satisfaction of users with GMC website (target: a Net Promoter Score of at least 40)	42	41	48	43	48	39	48	43	47.4	54	44	48
	75% of doctors intend to change practice following Outreach learning session	79%	79%	77%	79%	81%	90%	79%	79%	80%	74%	79%	82%
Organisation	2025 Income and expenditure [% variance +/- 4%]	0.6%	2.6%	4.9%	3.8%	4%	4.1%	4.2%	4.3%	4.2%	3.6%	3.5%	3.6%
	Rolling twelve-month staff turnover within 8-12%	6.9%	6.7%	6.8%	7%	6.9%	6.6%	6.7%	6.9%	6.7%	6.2%	6.9%	7.2%
	IS system availability (%) – target 99.89%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Physician Associates and Anaesthesia Associates

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

PA and AA registrant numbers		
	Number on voluntary register at 16 December 2024	Number registered as at 20 November 2025*
Physician Associate (PA)	5,092	3,789
Anaesthesia Associate (AA)	178	182

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

PA and AA applications as at 20 November 2025	Physician Associates		Anaesthesia Associates	
	Applications Received	Applications Granted	Applications Received**	Applications Granted
Transition Voluntary Register	3,598	3,437	110	105
UK Qualification (Direct cohort UK Qual)	195	169	4	4
Newly qualified PAs/AAs (<i>UK Student</i>)	215	183	74	73
Non-standard UK qualification (Non-Standard UK Qual)	2	-	-	-
International (INT Reg Application)	-	-	-	-
Total	4,010	3,789	188	182

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

Physician Associates and Anaesthesia Associates

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

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

Total number of complaints regarding PA/AAs received (since December 2024)	
Practitioner Type	Number of complaints
Physician Associate related complaints	28
Anaesthesia Associate related complaints	1
Total complaints relating to PA/AAs	29

Complaint outcome	Number of complaints
Closed at triage	25
Promoted to Investigation – In Progress	4

Corporate Portfolio Overview

Priority Project	2026 project resource cost	2025		2026				2027			
		Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Regulatory Reform				DHSC Consultation on GMC order opens	DHSC Consultation on GMC order closes	GMC Order laid in legislatures	GMC Order made in legislatures	Gateway 1			
Enterprise Resource Planning				Build phase completed	Testing & training completed	Go-live completed	Early life support completed				
Associate Worker Status		Start holiday back payments	Periodic holiday and pension payments start		Periodic holiday and pension payments start		Routine ongoing payments alongside fees in the new system				
Future of Career Development & Education			Problem statement for assessment delivered	Written engagement survey		Engagement report				Consultation on changes to Standards	
								Update the standards and processes; implementation plans begin			
Regulatory Fairness Implementation			HIRD reporting pilots completed	First phase of directorate implementation activities completed			FTP, Legal and Corporate implementation plans completed				
Contact Centre Technology			- User Acceptance Testing - Launch Messaging & Instant Survey	Phase 2 Closure							
Fairer Employer Referrals		Phase 4 deliverables and go live	Exec Board sign off Phase 5 plan	Final research report due	Final Primary Care report due	FTP SMT review of annual Council paper	ED&I steering group	Annual presentation to Council			
Fairer Training Cultures		Contribution to 2025 annual EDI report	2025 deep dive to Council			Contribution to 2026 annual EDI report	2026 deep dive to Council			Contribution to 2027 annual EDI report	2027 deep dive to Council

£1.1m - £5m

£501k - £1m

£100k - £500k

<£100k

Cost of project resource

Last updated November 2025.



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

2025 Priority change activities		RAG	Status
Fairer Employer Referrals (FER)	Why? To eliminate differentials in employer fitness to practise referrals. When: by 2026 Who: Anthony Omo, Anna Rowland		A set of options for organisational consideration, along with the annual EDI deep dive paper, has been presented to the FTP SMT for review and formal sign-off, enabling progression to Council submission. The Phase 5 Plan, including progress updates and proposed options for the target date, has been presented to the Equality, Diversity & Inclusion (ED&I) Steering Group for feedback and alignment. This phase includes a variety of projects, from analysis and sharing of best practice case studies identified from the research underway in the current phase, to the development of a programme narrative that charts the journey of the FER programme, as well as our relationship with the system and the challenges and opportunities we've encountered. In addition to this, the Phase 5 Plan has been presented to and approved by the Executive Board, confirming organisational endorsement for implementation. Updated fairness questions have now been successfully embedded and made live within the Responsible Officer referral form, supporting improved data collection and continued commitment to fairness and transparency.
Fair Training Cultures (FTC)	Why? To deliver on our commitment to eliminate discrimination, disadvantage and unfairness for all index measures of fair medical education and training pathways. When: September 2031 Who: Pushpinder Mangat		We are progressing work to explore the data throughout specialities, regions and programmes that have successfully narrowed the attainment gap over the last 10-years. This information is being used to identify a potential research approach and develop case studies, key themes and lessons learned guidance. We continued to focus on delivering the action plan for 2025 including meeting with external stakeholders, working with key internal areas such as the FutureEd programme, and the new Specialty and Specialist and Locally Employed Doctors survey. In October we focused on writing the annual EDI deep dive paper, preparing for the November Programme Board and EDI steering group. Our focus over the next month will be looking into case studies for further analysis, as well as moving forward an analysis of all action plans from colleges/faculties and post-graduate training organisations – these will be looked at individually and overall, for any common themes.



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

2025 Priority change activities		RAG	Status
Future of education and career development (FutureEd)	Why? We have a statutory duty to regularly review our education framework, including our standards, outcomes, and guidance. We want to work with partners to ensure that our new framework has the greatest positive impact for the public and the profession. When: Q4 2029 Who: Pushpinder Mangat, Phil Martin, Nico Bridge		The programme continues to report amber while the outputs recommended by BDO auditors are actioned and the induction of the new programme manager, who will lead us through the to the next phase of the programme, is completed. The scope of the programme is likely to be updated with additional priority work, including the NHS 10-year plan and Leng review recommendations. The programme is on track to meet its current milestones. Recommendations to consider for the programme's review of the education framework include establishing a more inclusive definition of an “educator”, redefining the term ‘trainer recognition’, developing new standards to support educators, and adapting our quality assurance processes. Detailed planning has begun on work around Career Development such as the development of a knowledge, skills and experience framework for locally employed doctors via a short-life stakeholder working group. This took place on 5 November 2025, and another is provisionally scheduled for January 2026. As part of our review of the current Standards, which will identify areas that require further consideration, we are undertaking a mapping exercise to identify any emerging themes throughout the documentation. We also attended the Scottish Government’s Future of medical education engagement, as part of our engagement with key stakeholders throughout the UK for the education framework. A new public web presence for the programme has been created to direct public interest and will continue to be developed in the coming months.



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

2025 Priority change activities		RAG	Status
Regulatory Reform	Why? To improve the design and delivery of our functions so that we can be more responsive to the changing needs and expectations of patients, the health system, and the professions. When: Expected by Q4 2025 (dependent on when DHSC consult on the Medical Professions Order and lay this in parliament). Who: Shaun Gallagher; Tim Aldrich		We continue to have ongoing concerns that Department for Health and Social Care (DHSC)'s timetable remains ambitious and that short deadlines for responding to feedback increase the likelihood that a significant issue is missed or the implications not fully evaluated. Due to this, and the significant amount of operational change required as a result of regulatory reform, we are continuing to report amber. We're also aware of resource pressures impacting several areas of the programme at the moment and are working with colleagues to put plans in place to address this, including a Planning Gateway bid in Q1. A current key focus for the programme is carrying out a detailed review of the draft GMC Order that has been developed by the DHSC, ahead of their consultation on the legislation – now expected early in 2026. From our initial review, we are pleased to see that the DHSC has largely taken on board our feedback from their previous iterations. We will also use our response to DHSC's consultation, alongside our ongoing engagement with DHSC, to raise any outstanding concerns we have in relation to the draft legislation. The recent BDO audit spot check has concluded, and the findings are being shared and discussed with the Audit and Risk Committee in November. This spot check has focused specifically on the effectiveness of the recent programme governance restructure and has included a review of the approach we are taking to prepare for implementing the changes. We are continuing our planning work with colleagues across the organisation to develop an integrated plan that sets out the timetable we are working to for the implementation of the reforms and ensures safe delivery.
Regulatory Fairness Implementation	Why? We are focused on making fairness central to our work, and we are working on implementing all recommendations from the Regulatory Fairness Review published in February 2023. When: Q4 2025 Who: Shaun Gallagher, Claire Light		During this reporting period, we have continued to develop options and proposals for in-house refresher learning to embed and sustain the 'Fairness in Decisions for Regulatory Professionals' training for decision makers. This will be an area of focus for the RFI programme board in December. We have also continued to refine detailed plans, ownership and central support for directorate level reporting on High Impact Regulatory Decision (HIRD) outcomes by protected characteristics. We have progressed assessment of the requirements from directorates in terms of data monitoring and dashboards and will be completing pilot dashboards and sequencing of this element of the programme in the next period. As part of our external assurance activities, the literature review has been commissioned to review assurance measures supporting high impact regulatory decisions. The bids for this review have been received and are being reviewed, to be shortlisted in November. We provided an update to Council on 1 October, where the programme's progress was received positively. Council members highlighted the need to ensure that this work is duly publicised and to also be clear about our priorities moving forwards. We have drafted the RFI progress update in the ED&I Annual report that is due to be presented to Council in December. The programme team has now secured permanent project management resource and will look to build on this report in the coming weeks, as we develop detailed plans for transitioning to BAU.



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2025 Priority change activities		RAG	Status
Associate Worker Status	Why? To become legally compliant by introducing holiday pay and pension contributions for in scope payments for all of our eligible associates who hold worker status. When: Interim Solution expected by end of 2025, final solution implementation dependent on ERP programme Who: Neil Roberts, David Donnelly		The Programme continues to report amber due to recent resource challenges, resulting in the team currently working at reduced capacity. Plans are underway to address this, including revised milestones and recruitment of additional resource. We have completed recruitment for replacement resource, but the time needed for onboarding will slightly extend our timeline for commencing ongoing worker payments. We are on track to complete historic holiday payments by the end of November to all associates who want them, however periodic ongoing payments will not be until February 2026 (two months later than planned due to resource pressures). Associates will be notified of revised timelines before the end of November. New worker contracts came into force on 1 October. Over 96% of relevant associates have signed their contract, meaning there will be no service availability issues. We completed historic holiday payments to former associates in October and have started on payments for current associates - this is a time-consuming manual process that will continue throughout November. We've contracted with TPT Retirement Solutions, as our pension provider, to provide the GMC Associate Pension Plan and are now liaising with them to set up the scheme. We'll also let associates know the revised timeline for the ongoing periodic holiday and pension payments before the end of November.
Contact Centre Technology	Why? Our vision is to deliver an outstanding experience to our customers with every interaction. To help deliver this we will adopt efficient technology which allows us to understand and meet our customers' needs and report on their experience. When: by end of 2026 Who: Una Lane, Lindsey Westwood, Rachel Mooney		We are reporting amber for this period due to the replanned closure of the project from May 2026 until the end of 2026, and a slight delay to the go live of phase 2. While timelines have changed for the phase 2 delivery date, planning for phase 3 is underway. We are working through some key defects picked up during testing and further development work is required in order to resolve. As a result, we've pushed our go live date back by three weeks to enable us to conduct a second round of testing once the defects have been addressed. The launch is now expected to take place from the week commencing 24 November to week commencing 1 December 2025. This revised target go-live date for our second phase is still within the timeframe required for us to migrate our messaging channels from our current platform and complete decommissioning before contract renewal is due. We have completed training with Contact Centre advisors ready for phase 2 go live. We submitted an updated PID (Project Initiation Document) for consideration at the Q4 Gateway, providing an update on phase 2 and our approach to phase 3 planning, which includes a series of sub-phases within Phase 3.



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.

2025 Priority change activities		RAG	Status
Enterprise Resource Planning (ERP)	Why? To implement new HR/ Finance and Payroll solutions to replace the existing Agresso system which will withdraw its support at the end of 2026. When: Q3 2026 Who: Neil Roberts, Sunil Kapur, David Donnelly, Rachel Mooney		The overall programme is reporting amber as it reflects the high number of risks around the programme, demand on programme and BAU resources and tight delivery timeline. The Agresso team continue to absorb the ongoing support of the current system and requests to support IS operating system and security upcoming updates in parallel to the extensive work being undertaken to support the Finance implementation which is still in the build phase. The additional development and test team resources are now starting to gain traction with the integration work, and we have also secured additional time from the Inciper solution architect which is key to helping us align the process and solution at a faster pace. We are recruiting a solution architecture to support the HR project. We are also reviewing additional Payroll expertise. MS Dynamics 365 (D365) Finance implementation: The project continues in the build phase. We are due to complete the final sprint (sprint 8) at the end of November. Supplier CORE finance build and system acceptance testing (SAT) has been completed, and the remaining bug fixes are planned to be signed off. GMC Finance and System admin teams are focussing on test case preparation to support user acceptance testing (UAT) from 24 November to 19 December 2025. Data migration iteration 3 is progressing with dedicated focus on extract/transform of master and transactional data. Supplier Fees and billing D365 integration development is on track to complete by 14 November 2025. This will unblock our integration team to complete the outstanding Azure middleware integration work. GMC Integration testers are focussing on test case preparation to support system integration testing (SIT) from 24 November onwards this testing will be 'staggered' to complete as integrations are ready in order to maintain cadence to complete testing by end March 2026. We aim to complete the system by the end of Q1 2026 and go live in May. HR Workstream (Dynamics 365 HR): We have completed the Discovery phase and the Programme Board have endorsed the system development scope. The build phase has started, and we are currently in sprint 2. The HR team now have the opportunity to see parts of the new system as it is being built. We have planned for 4 build sprints and testing is due to start in the new year. The current assumption is that the HR system will go live at the same time as the Finance system. The project workshops with Zellis have started and we are currently configuring the new system. The Payroll system will go live after the Finance and HR systems are live.



RECRUITMENT – DIVERSITY TARGETS

Underlying measures and targets		Actual				Target		
		2024 (%)	2024 (Vol)	2025 ¹ (%)	2025 ¹ (Vol)	End of 2025	% points off 2025 target	2026
Increase the level of minority ethnic representation at Level 3 and above	Applications	42.1 %	430	43.9 %	868	29%	+ 6.0	30%
	Interviews	24.5 %	52	32.2 %	94	24%	+ 3.1	25%
	Offers	14.8 %	8	14.8 %	9	19%	- 5.4	20%
	Workforce	13.9 %	90	14.1 %	96	19%	- 4.9	20%
level of minority ethnic representation at Level 2+		12.6 %	27	13.6 %	29	18%	- 4.4	20%
level of minority ethnic representation at level 3		14.6 %	63	14.3 %	67	19%	- 4.7	20%
Increase the level of minority ethnic representation at all levels	Applications	45.3 %	2,370	49.1 %	3,017	39%	+ 10.1	40%
	Interviews	30.7 %	329	39.9 %	393	34%	+ 5.9	35%
	Offers	23.2 %	66	25.0 %	54	29%	- 4.0	30%
	Workforce	18.7 %	317	20.2 %	355	19%	+ 1.2	20%
Reduce differential turnover rates for minority ethnic staff compared to the average to improve retention and for rates to be within 1.5% of each other by end of 2024		4.6 %	-	Minority ethnic backgrounds (%)	White background (%)	1.5%	% points between groups	1.0%
				7.3 %	5.9 %		1.4	
Proportion of minority ethnic staff receiving promotion and grade progression is proportionate to our workforce at the relevant grade/level		1.1 %	-	Minority ethnic backgrounds (%)	White background (%)	2%	% points between groups	2%
				9.3 %	8.6 %		0.7	
Pay differentials within a confined band limited to 2% ² (table shows the proportion of bands that are inside of the +/-2% tolerance)		58.3%	7/12	41.7 %	5/12	12/12		12/12

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

² Specialist bands are not included

[^] Volumes fewer than 5 have been redacted to preserve anonymity

Litigation overview for Q3 2025

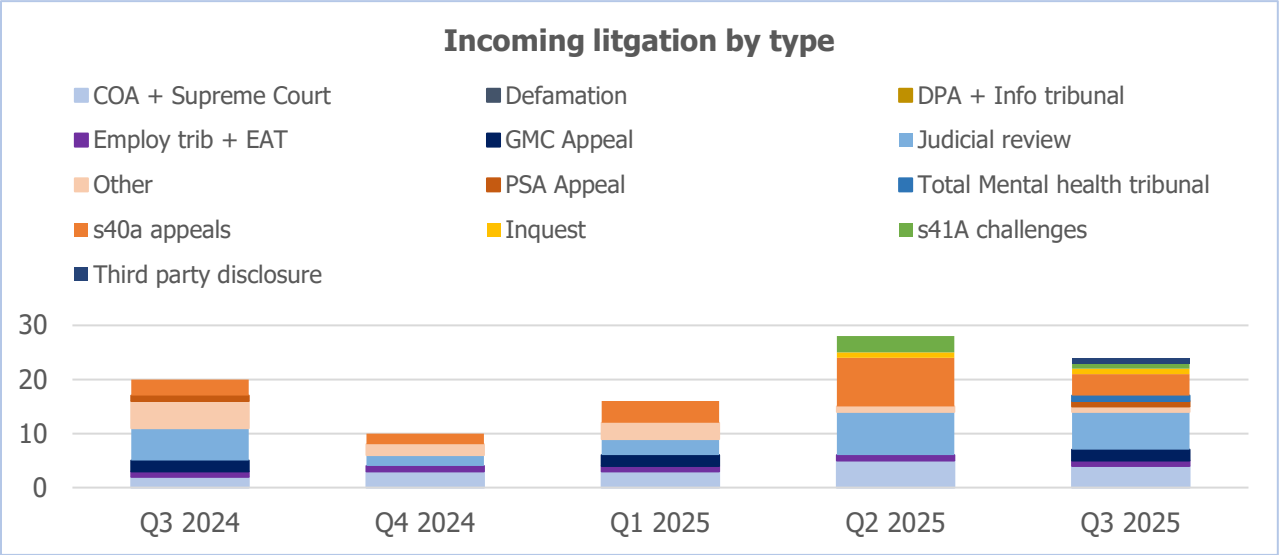
Notes – reporting criteria from Q3 2025

Data is pulled on the first working day of the quarter. For Q3 2025, this was 1 October 2025.

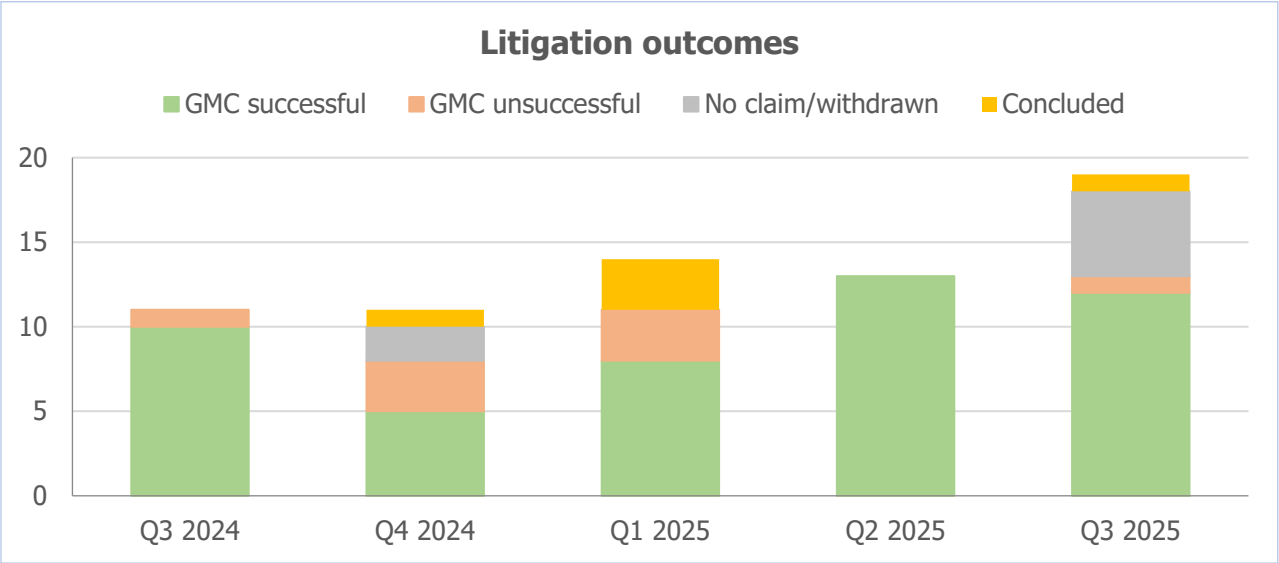
For the purpose of this report (from Q3 2025), we include types of litigation that represent a legal challenge to the GMC. We exclude costs matters, High Court Extensions, s35a enforcement and family court proceedings on the basis that they facilitate action by the GMC and pose a low risk.

As of 1 October 2025, we had 54 open litigation matters (after exclusions) – 24 of these were new incoming matters in Q3 2025.

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



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



Concluded litigation Q3 2025:

- 13 = GMC Successful**
- X1 Employment Tribunal
 - X5 Judicial Review
 - X2 COA appeal
 - X1 Judicial Review – GMC
 - X3 s40 appeals
 - X1 RAP appeal
- 1 = GMC unsuccessful**
- X1 s40 appeal
- 5 = No claim/withdrawn**
- X2 s40 appeal
 - X1 Other
 - X1 Employment Tribunal
 - X1 Judicial Review - GMC

Annex B

Corporate Opportunities and Risk Register

Corporate Opportunities and Risk Register - November 2025

Risk Title	Date Raised	Category	Detail	Owner	Business Department	Impact - Financial	Business Department	Mitigation/Enhancement	Business Department	Financial Department	Council and/or Board Assurance	Assurance	Further Action Detail	Risk Appetite
Programme threats														
806	Regulatory Reform –DHSC approach to drafting the GMC Order 26/08/2025	Strategic / Policy	Due to DHSC's current drafting approach and timeline for the GMC Order – along with the volume and speed of shared drafts – there's a risk that errors or omissions may go unnoticed. If undetected, these could lead to an unworkable Order or one that fails to meet policy goals or benefits, resulting in operational, legal, or reputational risks. Additionally, the intense workload and uncertainty around the Order's viability are straining staff, risking burnout, demotivation, and potential attrition.	Shaun Gallagher	HIGHLY LIKELY	MAJOR	CRITICAL	Key Controls • Retain constructive and open communication lines with DHSC colleagues. • Seek to support colleagues who are working on regulatory reform as much as possible during this busy period. Eg by looking for opportunities to stop all other work that colleagues are leading/supporting so that time can be freed up to focus on reviewing the drafting. • Adopted an approach of providing feedback to DHSC on particular concerns within the drafting as early as possible to increase the likelihood that these can be flagged and addressed ahead of the DHSC consultation (rather than waiting until deadlines for feedback). Mitigations • Hold regular time on SMT meeting agendas to escalate specific drafting concerns. Ensure that SMT shares around risk ownership and support for a "good enough" approach are fed back to colleagues in an ongoing way. As well as ensuring SMT members are informed and equipped to engage directly with supporting colleagues in their directorates. • We escalated our concerns to senior officials on 10 Oct, setting out the minimum requirements we expect the draft legislation to meet and specifying the time we need to do a thorough review of the legislation before it goes through legal checks.	QUITE LIKELY	MAJOR	SMT SMT paper on 11 August 2025 on risks and approach.	• Identify the risks of the timetable and approach, whilst maintaining our efforts to meet the DHSC's plan. • Push for time with DHSC to talk through specific policy issues to aid understanding and prevent policy misalignment – several policy discussions have now been initiated. We will continue to push for further conversations with DHSC whilst we're collating our response to their consultation if required. • Seek assurances from DHSC that they will be open to incorporating additional feedback that we provide both during the consultation and after the consultation (before the Order is laid in legislatures). • Further escalation to senior officials and/or ministers if we are sufficiently concerned about specific issues in the drafting that remain unresolved.	Low	
544	GMC Finance and HR System 28/11/2023	Technical	Due to our Finance and HR system provider withdrawing support for our on-premise system we will need to move our Finance and HR system to the cloud by the end of 2026 necessitating business process changes. This will include significant change management work, and there is a risk that we will be unable to do the significant and complex work required for this migration in time, leaving us in an unsupported configuration and unable to receive product updates from 2027, such as new tax rules to apply to payroll.	Neil Roberts	HIGHLY LIKELY	MAJOR	CRITICAL	Key Controls • A programme is overseeing the move to new Finance and HR systems, including significant process change work, by the end of 2026. • Work to implement the new finance system is being planned, using an approach of setting milestones to enable us to deliver in advance of 2027 and resourcing the work as required to hit the milestones. • Project streams have been prioritised and resourced within IS, HR and Finance with funding for resources requested where required. • A new finance, HR and payroll system has been selected and work is underway with the vendor. Mitigations • Support has been secured for the current finance and HR system until the end of 2026.	HIGHLY LIKELY	MAJOR		Audit and Risk Committee • ERP Implementation: Data Migration (Advisory). • ERP Implementation – HR Workstream Programme Governance Report (October 2025, green/amber for control design and green for control effectiveness). • ERP Implementation progress (May 2025, green/amber for control design and green for control effectiveness). • AIC seminar held in May 2025. • ERP Implementation - Governance and programme arrangements review (September 2024).	Medium	
452	Regulatory reform - securing transitional and commencement arrangements for the next GMC Order 04/05/2023	Strategic / Policy	If DHSC do not engage with us sufficiently, or they do not understand the complexities we are faced with around commencement timings and transitional arrangements, they could create issues and delays in implementing the new Order, and/or an Order that is unworkable. This could lead to systems failure, puts GMC staff under unreasonable pressure, and could impede our ability to protect the public and deliver our functions to time and quality.	Shaun Gallagher	HIGHLY LIKELY	MAJOR	CRITICAL	Key Controls • Planning discussions with DHSC and regular review of plans and critical path to set realistic expectations on programme milestones • Proactive engagement with DHSC on planning for the next GMC Order to make sure that we have a realistic plan that we can have confidence in, and to plan the work effectively to minimise impact on busy teams. Mitigations • We will continue to consider where there may be opportunities to share GMC resources with DHSC, where we believe that this may help to assist the development of the next GMC Order.	QUITE LIKELY	MODERATE	Council This threat has been verbally discussed at various points over the past 12 months at Council meetings, making Council aware of the threat.	Significant	• Work with DHSC to make sure commencement sequencing is a workable approach for us. • Set up a regular planning discussion meeting with DHSC, and regular review of plans and critical path to set realistic expectations on programme milestones. • Developing a clear view on what transitional and commencement arrangements we need and setting out persuasively the risks associated with anything less.	Low
200	Regulatory Reform - not securing benefits 06/08/2020	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	Key Controls • 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." • 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.	QUITE LIKELY	MODERATE	Council • Provided an update on the key issues we intend to highlight in our response, and further detail on our approach to engaging key stakeholders during the consultation - 1 Mar 2023. • Council meeting to discuss final consultation response, ahead of this being signed off by the Chair on behalf of Council - 27 April 2023. • Delivered several Council webinars setting out our proposed approach to Education and Training, Registration and setting Fees for A&A and P&A, based on provisions in the updated AAPAO. Further sessions delivered on P&P, Revision and Appeals - November 2023. • Extraordinary Council meeting on 13 March 2024 to present the consultation package on rules, standards and principles for fitness to practise guidance. SMT • Provided SMT with an update on the re-drafted AAPAO (received from DHSC on 29 Sep 2023), including an overview of our key concerns and points that we wish to escalate – 9 Oct 2023. • Ongoing monthly updates as required by programme.	Internal Audit • BDO spot checks completed in August 2023, September 2024 and September 2025.	• Be prepared to continue to escalate concerns to senior DHSC officials as appropriate. • Programme board agreed to introduce a new approach to monitor and track benefits during the programme – we're in the process of rolling this out. Outputs of this work will be used to influence DHSC whilst they draft the next Order and to inform our Rules, to ensure that we remain focused on achieving intended outcomes and maximising benefits.	Medium
Operational Threats														
512	Uncertainty around our touchpoints and engagement with NHS England 31/07/2023	Operational	Because of NHS England's abolishment, there is an immediate uncertainty on the touchpoints the GMC has with them, this may impact on our effectiveness in some operational processes, as well as further requirements for resourcing to support our statutory functions.	Paul Reynolds	QUITE LIKELY	MAJOR	CRITICAL	Key Controls • Ongoing engagement with DHSC and NHS England officials to keep abreast of developments and to highlight implications of change for our regulatory work. • Relationships established with the new national co-medical directors at NHS England, who are part of the joint executive team that is leading the transition. • Ongoing monitoring of other external sources (such as the media) to keep track of developments and impact on the GMC. • Written to NHS England's Interim Chief Executive and DHSC's Director General of Secondary Care and Integration, highlighting key areas where the GMC currently interacts with NHS England. • Our Chief Executive met with Sir Jim Mackay, NHS England's Interim Chief Executive, in June 2023. • Outreach team considering specific implications which changes to NHS England may have on the architecture of patient safety systems in the regions of England, which we engage with to identify and triage risks to patient safety. • Secured membership of the National Quality Board on behalf of NHS-facing professional regulators (GMC, Nursing and Midwifery Council, and Health and Care Professions Council). Mitigations • Initial mapping exercise completed by directorates to identify potential regulatory implications of change. • Mapping presented to Policy Leadership Group who have agreed to own the work going forward on policy/operational contingencies for their areas. • Outreach England regions are addressing implications as they arise, working to mitigate harm.	QUITE LIKELY	MAJOR	SMT Paper on risks and opportunities from NHS England changes (31 March 2025)	CRITICAL	• Establish relationship with new DHSC Director General (People) once appointed and regular meetings with GMC Chief Executive. • Senior Corporate Engagement Plan to include regular CEO meetings with NHSE's interim CE and Director General (People).	Medium
207	Pension Deficit 21/08/2020	Financial	Due to economic instability, both asset and liability value of the pension scheme have reduced (causing a greater deficit). This scheme's funding position and any future volatility could lead to continued additional funding of the scheme from the employer.	Neil Roberts	HIGHLY LIKELY	MAJOR	CRITICAL	Key Controls • Trustees meet regularly and continue to take professional advice in relation to the existing deficit, which has improved as of the last valuation on 31 December 2024. • The funding position remains under review and Trustees will continue to liaise with the employer. Trustees are considering an alternative investment model and will keep the employer updated on any change to the investment strategy. • The employer factors annual payments into the budget to cover the agreed funding arrangements. • The employer and trustees work together to ensure suitable funding arrangements are in place to address the deficit. • Trustees monitor the funding position of the Scheme on a regular basis and are supported by professional advisors. • Trustees are required to meet all conditions relating to the running of the Scheme to ensure compliance with regulatory requirements specified by the Pension Regulator and Pension legislation.	QUITE LIKELY	MODERATE		Significant		Medium
303	Welsh Language Standards Implementation 28/02/2024	Legal	Since 6 December 2023 the GMC has been subject to the Welsh Language Standards (No.3) Regulations 2022 set by the Welsh Language Commissioner. We have now reached a point of maturity in our culture and processes as an organisation that has enabled us to mainstream compliance with the standards throughout the organisation. All directorates are now responsible for ensuring continued compliance with the standards, ensuring guidance is implemented, and monitor ongoing compliance, else we risk legal, reputational and financial damage.	Paul Reynolds	QUITE LIKELY	MODERATE	Significant	Key Controls • Relationship sponsor for the Welsh Language Standards Commissioner and relationship plan agreed; and will be updated in 2026. • The GMC's Senior Management Team has approved a plan to embed the guidance, learning and processes we have developed in BAU across the organisation. Central to that plan is the creation of a network of Welsh Language Champions to in each directorate to enable limited coordination of our approach to managing the WLS. • Any complaints or concerns raised about our compliance with the WLS will continue to be recorded and dealt with in line with the customer complaints process by the Corporate Review Team. • If the Welsh Language Commissioner launches an investigation into a complaint or concern about our compliance, an incident response team will need to be established to include the relevant team, the relationship coordinator and sponsor, and CRT. • Procurement process successfully concluded in Sept 2025 with agreement to again commission the services of Cymen for all of our Welsh language translation and interpretation needs. • Relationship Plan in place for the Welsh Language Commissioner supported by Director of SCALE as relationship sponsor and will be reviewed in 2026. Mitigations • Welsh Language Standards Manager (WLSM) role in place from 31 October 2023 until 31 October 2025.	QUITE LIKELY	MODERATE	SMT • Risk deep dive (March 2025) • Transition to business as usual (September 2025) Executive Board • Statutory annual report on our compliance with the standards 2024/25 (July 2025)	Internal Audit • Preparation for implementation (2023, green/amber control design, green/amber effectiveness). • Compliance readiness review (2024, green/amber). External compliance assessment • Amb conducted a compliance assessment of key activities between June and September 2024. They found an overall assurance level of amber. An action plan developed and implemented by WLSM and relevant teams.	• Welsh Language Champions Forum will be established to support ongoing compliance with representative and deputy from each directorate. • We will look to ensure ongoing compliance with the standards through exercises such as mystery shopping, internal audit to gain assurance the new way of managing compliance is working well.	Low

706	HLA - exam delivery 26/05/2024	Technical	If an incident occurs, that impacts on Medical Schools' ability to deliver, and students' ability to take a complete HLA assessment, this could risk invalidating the Primary Medical Qualification (PMQ) being awarded by those medical school(s). This may be of significance as we roll out the HLA compliance process for new schools for the first time.	Puipinder Hangat	OUTLINELY	MAJOR	CRITICAL	Key Controls - From our initial HLA compliance process, every school has a set of recommendations for future improvement or a request updated information. For the HSA A&T, these include areas regarding incident reporting and escalation, and exam security. - Issues will continue to be discussed at all levels between the GMC and Medical Schools Council (MSC), including the recent establishment of a regular discussion at Assistant Directorate/level of Section level. - We have regular contact with schools as part of routine assurance and oversight to check contingency planning. - Ensure the MSC understand the GMC approach to routine oversight and assurance through engagement, reinforced by Senior Oversight as required. Mitigations - Continue to learn from the live experience from the A&T and ensure that the MSC and individual medical schools communicate clearly with the GMC when things go wrong. Ensure that all schools have at least one additional sitting identified in case of failure, and reminding schools that passing the HLA is now a requirement for their students to be awarded a PMQ and to be added to the register.	UNLIKELY	MODERATE	Low	Internal Audit - HLA transition to BAU (2024, green/amber for control design, green/amber for control effectiveness). - HLA arrangements for delivery of the Applied Knowledge Test (May 2025, green/amber for control design and control effectiveness).	Low
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Strategic Themes

120	ED&I compliance 17/02/2020	Strategic / Policy	The measures in place to demonstrate compliance with the public sector equality duty are not robust enough and we are subject to legal challenge that weakens confidence in regulation.	Shaun Gallagher	OUTLINELY	MAJOR	CRITICAL	Key Controls - Skilled ED&I team provide strategic advice across the GMC. - Equality, Diversity and Inclusion (ED&I) objectives published within the corporate strategy and supported by focused targets based on evidence and routine monitoring and reporting of progress. - Supporting governance including the Strategic EDI Advisory Forum and Race Equality Forum (external) and ED&I Steering Group (internal) provides senior oversight and guidance to inform action and priorities. - Mandatory learning for all staff and associates – all learning needs are being delivered or is BAU activity, all suppliers are in place and delivering against requirements. - Mandatory training for all staff and associates. - Approach to a regulatory new Equal Opportunities Policy has been reviewed and published in April 2022 and updated in 2024. Mitigations - Regulatory fairness review now complete and implementation board established. Leads across the directorates appointed and first phase of corporate deliverables underway. Update on progress, including new decision making principles and the HREDS has been published in the ED&I Annual report in 2024.	UNLIKELY	MAJOR	MODERATE	Council - Reporting to Council on Fairer training cultures, Fairer referrals and the inclusion programme, deep dive reporting annual cycle in place. Regulatory fairness review included in annual reporting cycle. Executive Board - ED&I steering group has forward plan for reporting and will report to Executive Board annually on progress the Steering Group has made. Programme Board - ED&I steering review is now in implementation phase. A new regulatory fairness board has been established to govern the implementation of all of the recommendations.	Internal Audit - Efficacy of ED&I reporting (2023, green/amber for design, green for effectiveness). - Regulatory Fairness Programme Board arrangements and governance (2023, green/amber for design, green/amber for effectiveness). - ED&I steering group governance (2024, green/amber for design, green/amber for effectiveness). - Regulatory Fairness Implementation in Directorates (August 2025, amber for control design and green/amber for control effectiveness). Other assurances - Strategy and policy ED&I compliance and governance review - Campbell Ticked (2020). - Engagement, not personal characteristics, was associated with the seriousness of regulatory adjudication decisions about physicians: a cross-sectional study, Javier A Caballero, Steve P Brown, British Medical Journal (2019). - Fairness of decisions to refer doctors to the MPTS interim orders tribunal (2018). - Plymouth University Review of decision-making in the GMC's FTP procedures (2014).	• Assurance measures for new decision making principles finalised in directorate action plans in Q1 2025. Implementation plan progress will be reviewed in Q3 2025 – varied phasing to implementation, including piloting measures, and therefore their plans will iterate and be revised following pilots. Re-planning outcomes and milestones between now and closure has been completed and we will be aiming to incrementally work through workload stream closure. • Further findings for first phase of data assurance on the fairness of our processes are under development, and rapid evidence review will commence before the end of 2025. • Reg Fairness will form part of the ED&I annual report, and Council will also receive separate annual update on progress. • ED&I data review is seeking to deliver ED&I data improvements that will continue to mitigate the compliance risks - business case approved by Planning Gateway. Further work on the FID on hold pending resources becoming available.	Low
148	Delivery of statutory functions 31/03/2020	Operational	If we fail to deliver our core statutory functions, there is a potential impact on patient safety, public confidence, and the GMC's reputation as a leading regulator.	Charlie Nassey	QUITE UNLIKELY	MAJOR	CRITICAL	Key Controls - Monitoring and reporting against statutory duties for the professions we regulate, to Executive Board and Council. - Forecasting of operational demand is built into budget planning. - Active engagement with those we regulate about potential situations which may put patients at risk. - Outreach structure in place (ensures statutory process for responsible officers to contact effectively and enables engagement with employers with respect to PAs and A&Ts) to help identify and manage concerns (pre-identification). - Available staff with relevant training and skills. - Information exchange with competent authorities informs our processes. - Documented operational process and procedures, that are subject to regular review and continuous improvement by specialist staff. - Auditing our decisions on a regular basis. - Processes are in place to provide assurance on overseas applications for the professions we regulate.	QUITE UNLIKELY	MODERATE	MODERATE	Council - Review of performance metrics through the quarterly CEO report. Executive Board - Review of performance metrics through the bi-monthly Performance and Risk Report.	Internal Audit - Registration services (2023, green/amber control design, green/amber control effectiveness). - Hearing listings and cancellations (2023, green/amber control design, green/amber control effectiveness). - Expanding registration pathways (2023, green/amber control design, green/amber control effectiveness). - Fit to practise arrangements (2023, green control design, green control effectiveness). - Specialist Applications approved training route arrangements (2024, green control design, green control effectiveness). - Interim Report Case Examiners (2024, green/amber control effectiveness). - FTP Case Review team arrangements (2025, green/amber control design, green control effectiveness). - VERL (2025, amber control design, green/amber control effectiveness). Other assurances - The MPTS continues to meet our service level agreement to commence 100% of new interim referrals within 21 days. - The MPTS continues to hear reviews of all MPT sanctions and IOT orders within statutory deadlines. - Passed all PSA standards of good medical regulation in 2023.		Low
149	Availability of resources 31/03/2020	Resource	If we don't secure and retain an appropriately skilled and experienced workforce, a resilient and secure IT and facilities infrastructure, and maintain a sound financial position, it will threaten the delivery of our statutory functions, change and development programmes and capacity to deal with unplanned events.	Neil Roberts	HIGHLY UNLIKELY	MAJOR	CRITICAL	Key Controls - Our People practices and leadership strategy is aimed towards attracting and retaining a high calibre workforce. - We have processes in place to identify and manage key staff risks. - We consider recruitment market surveys and data to identify potential skills shortages. - Our Health and safety policies and procedures are robust in regards to our workforce. - Clear Financial management practice and controls and safeguards including annual investment (CSCS), fraud policies and pensions. - New activity, including Gateway Fund initiatives and ongoing project work routinely covered by Planning Gateway process to form a cross-organisational recommendation on the priority and deliverability of proposals for SMT to consider collectively. - Routine monitoring and reporting of operational performance and the volume and complexity of our work. - Process for regularly mapping workload pressures across teams to help focus resourcing and prioritisation decisions. - We work closely with the Pension Trustees to address the increased scheme liability arising from the Gov decision to align RPI and CPI and other factors affecting the valuation. - The Investment Committee oversees the investment portfolio, supported by professional advisers and fund managers. - We undertake financial stress testing to ensure we have the capacity to withstand financial shocks within our reserve levels. - We continually invest in our IT infrastructure and systems to ensure availability and protect against cyber-security threats and maintain ISO 27001 accreditation. - We have business continuity champions and robust business continuity plans in place that are tested regularly. - We provide mandatory e-learning for GMC colleagues and have support in place from business continuity consultants. - Annual training and exercise sessions are delivered for all incident responders. - We have health and safety policies and risk assessments in place to ensure review and maintenance of office facilities. - We have redundancy and backup systems in place for critical IT infrastructure. This includes resilient data centres, backup power supplies, backup and recovery plans, and failover mechanisms to ensure continuity of operations in case of failure. - Industry standard security benchmarks are used at development phase of projects ensuring our systems are secure by design and regular security assessments take place to validate our position.	QUITE UNLIKELY	MODERATE	SEVERE	Council - Review of annual budget and Annual Accounts. Executive Board - Executive Board regular review of finance, HR, project and operational performance and risks.	Internal Audit - Cyber testing (2023, amber). - Values and behaviours (2023, green/amber control design, green/amber control effectiveness). - Aligning culture with strategy and behaviours (2023, green/amber control design, green/amber control effectiveness). - Payroll review (2024, green control design, green control effectiveness). - Payroll review (2024, green/amber control design, green/amber control effectiveness). - Contract Management (2024, amber control design, green/amber control effectiveness). - Data Protection Review (2024, green/amber control design, green/amber control effectiveness). - Contact Centre transformation (2025, green control design, green/amber control effectiveness).		Medium
150	Ability to work with others 31/03/2020	Strategic/Policy	If we are unable to work collaboratively with our external partners, we may not be able to achieve the ambitions of the corporate strategy and to deliver parts of our core functions as efficiently, effectively and compassionately as we would like, reducing our potential impact on patient safety and those we regulate.	Paul Reynolds	QUITE UNLIKELY	MAJOR	CRITICAL	Key Controls - Proactive, senior-level engagement carefully planned through the Senior Corporate Engagement Plan - Engagement with other regulatory bodies to identify opportunities for collaboration and alignment (such as through the Chief Executive Officer Regulatory Body (CEO/RB) Group), cross-regulatory groups in Scotland, Wales and Northern Ireland and the professional regulator councils & engagement groups. - Proactive engagement on all major policies and issues, including active engagement with the four UK Governments over the future of our regulation, co-ordinated through use of Engage system by external affairs, policy and operational teams. - Development, management and review of stakeholder relationships of strategic importance at national and regional levels of the UK, supported by relationship plans delivered by our external affairs and engagement teams and sponsorship of key relationships by SMT. - Regular evaluation of relationships with key partners, using insights from our internal systems and periodic surveys of stakeholders' perceptions, to identify opportunities for improvement. - Annual relationship stipulations to SMT. - Mitigations - Results of our 2024 perceptions survey inform the work of the External Affairs and Engagement teams.	QUITE UNLIKELY	MODERATE	SEVERE	Council - Seminar: Scotland focus (September 2025). - Seminar: Our approach to managing stakeholder relationships (July 2025). - Communications and engagement priorities (June 2025). - Seminar: Findings of our 2024 perceptions survey (December 2024). - Communications and engagement priorities (June 2024). - Seminar: General election preparations and our strategic engagement approach (April 2024). Executive Board - Four Country Relationship stocktake, SMT (June 2025). - Paper on General Election considered by SMT in February 2024.	Other assurance Annual health assessments by our external relations teams of GMC's major relationships (next assessment (Q3 2025)).	• SMT Risk deep dive - Ability to work with others (November 2025). • We have commenced a public tender for our 2026 perceptions survey, which will seek the views of national-level stakeholders on the quality of our relationships.	Medium
152	Unplanned event 31/03/2020	Reputational	The impact of an event in the external or internal environment causes our systems to be compromised or our activities to be publicly challenged, potentially leaving us vulnerable to delivery of key functions central to patient safety and reputational damage.	Neil Roberts	QUITE UNLIKELY	MAJOR	CRITICAL	Key Controls - Crisis management policies (including crisis communications plan) & procedures; pandemic response plan. - Business continuity champions and emergency response plans in place with regular testing. - Mandatory e-learning for GMC staff and support from business continuity consultants. - Continuous proactive monitoring of external environment with processes and products in place to share and escalate emerging issues likely to affect our regulatory operations and external confidence in the organisation. - Arrangements in place between regulatory operations and communications teams to identify and plan for events which could negatively impact on our functions and external confidence in the organisation. - Analysis of range of qualitative and quantitative information about the external environment through the Patient Safety Intelligence Forum. - Regular engagement with the Professional Standards Authority to assure them on the exercise of our statutory powers – including emergency powers under 18A of the Medical Act 1983 (Covid-19). - Health and Safety (H&S) management system (ie framework of policies and guidance) in place outlining a coordinated and systematic approach to managing H&S risks. - Quality assurance of H&S management system provided through H&S audit process. - Safeguarding processes, policies and annual training embedded across the organisation.	QUITE UNLIKELY	MODERATE	SEVERE	Audit and Risk Committee - Seminar on Business Continuity and Disaster Recovery - November 2022 and September 2024. SMT - Deep Dive - October 2024.	Internal Audit - Business continuity and disaster recovery management review (2025, amber control design). - Cyber security (2023, amber).		Medium
151	Responding to a changing environment 31/03/2020	Strategic / Policy	Inability to respond effectively to changes in the external environment, including legislation, healthcare and wider social impact changes, could lessen our influence and relevance and reduce public, professional and political confidence in our role.	Paul Reynolds	QUITE UNLIKELY	MAJOR	CRITICAL	Key Controls - Proactive, senior-level engagement with stakeholders to understand their agendas. - Outreach teams structures in place, aligned to UK countries and regions of England, to help us understand and have influence within national and local systems. - Contribution to government and system initiatives across four nations. - Continuous monitoring of our external environment, including longer term horizon scanning and research (e.g. barometer and perception surveys with the medical profession). - Contributing to meetings and networks across the UK and Europe. - Internal governance in place to process, consider and make decisions on the intelligence we receive about the quality and safety of local practice and training environments (JWG and PSIF meetings). - Systems and products in place to share insights and intelligence from external environment with organisation's leadership community to aid them with planning and decision-making.	QUITE UNLIKELY	MODERATE	SEVERE	Council - Communications and engagement priorities (June 2025). - Seminar: Findings of our 2024 perceptions survey (December 2024). - Communications and engagement priorities (June 2024). - Seminar: General election preparations and our strategic engagement approach (April 2024). SMT - Paper on risks and opportunities from NHS England changes (31 March 2025)	Internal Audit Internal Audit Restructure Project Review (2024, green/amber control design, green/amber control effectiveness).	• Closely monitoring developments relating to the abolition of NHS England. • Council Seminar: Findings of our 2024 perceptions survey (December 2025) – in development.	Low
234	ED&I Strategic Ambition 02/05/2021	Strategic/Policy	The actions we take to influence change across the health and education system, and within the GMC, do not deliver progress at a pace to meet our strategic ED&I targets, sustaining known areas of inequality.	Shaun Gallagher	HIGHLY UNLIKELY	MAJOR	CRITICAL	Key Controls - Clear timebound targets to focus system-wide efforts. - Nominated Executive leads for each of our strategic commitments. - Skilled and resourced teams designing interventions to deliver against the targets. - Established plans of action to deliver against the targets both internally and externally. - Annual and bi-annual progress reporting. - Scrutiny and monitoring and reporting from the ED&I Steering Group, Executive and Council to allow refinement of plans in response to progress. - Established Outreach and engagement functions to understand and influence the system with broader calls for action and support to facilitate system-wide change. - Supporting and aligned commitments of others (ie reducing differentials in disciplinary processes). - Research and data assets including our surveys and insights to highlight relevant issues and support calls for action. - Annual reports published 2022, June 2023 and October 2024.	QUITE UNLIKELY	MODERATE	SEVERE	Council - Regular agenda item on ED&I and ED&I annual progress update reported to Council in April and published. Executive Board - Twice yearly review by Executive Board and performance against internal targets embedded in Performance and Risk Reporting.	Internal Audit - Regulatory Fairness Implementation in Directorates (2025, amber control design, green/amber control effectiveness). - ED&I internal living targets reporting (2023, green control design, green/amber control effectiveness). - ED&I external facing targets reporting (2023, green/amber control design, green/amber control effectiveness). - Regulatory Fairness governance arrangements, (2023, green control design, green/amber control effectiveness). Other assurances - Strategy and policy ED&I compliance and governance review - Campbell Ticked (2020).	• Council directed the need to extend our understanding of inequalities impacting on other projected groups, specific disaggregated groups and also intersectional groups. We will build on this through the regulatory fairness work. • From the 2023 Audit recommendations – consider the timing and approach to reviewing the ambitions and seek agreement from the GMC on the workstreams. Build this into the planning for 2025 & 2026 and consider the interdependency with corporate strategy development and incorporate this into a forward plan for the annual reports. • The next phase of work for Regulatory Fairness will be focused on supporting directorates to develop their implementation plans and to coordinate 3 corporate work packages. Planned BDO audit completed and reported to Reg Fairness Board in October 2025 and working on the implementation of the findings. • Drafting of the 2025 ED&I annual report and submission to SMT and Council in December 2025. • Considering future plans for reporting and approaching to reviewing existing measures that are nearing end point.	Medium

Opportunities															
27	Deriving more insight from our data capability 31/03/2020	Strategic / Policy	Developing, sharing and working with others using our insight capability provides an opportunity to shape public debate, influence the external environment and deliver more proactive regulation.	Shaun Gallagher	QUITE LIKELY	MAXX	GOLD	Key Controls • Use of our research and insight activity to highlight key issues facing the medical profession, suggesting courses of action which healthcare systems can take to tackle workforce and workplace issues that might directly or indirectly impact on patient safety. Take every opportunity for it to contribute to mailouts, briefings and other external engagement. • Leverage our communications channels (such as media and social media) and engagement opportunities to raise awareness of our research and insights and secure external support for the issues and recommendations we are highlighting. • Use new data and research insights as a 'push' for bringing together regulatory partners and key stakeholders together to drive positive changes in policy and practice. • Provide data support to the rest of the GMC to inform our response external developments such as the Lord Ara Darzi review. • Provide data to support the development of policy and process plans for AA and PA regulation, regulatory reform, and education reform.	HIGHLY LIKELY	MAXX	GOLD	Other assurances • A range of perception surveys with stakeholders undertaken each year. • An evaluation of State of medical education and practice in the UK reports' impact underway.	• Enhancing and providing substantial ED&I data for EQIAs and to identify inequalities in referrals to us; we are also commissioning as part of the research programme a sequence of independent audits on the fairness of our regulatory processes. • Development of a Power BI platform for our data that will allow more interactivity and self-service. • Larger reporting tools like Data Explorer will be reviewed and improved to encompass PA and AA reporting by early 2027. • Developing data, research and insight capacity in relation to PAs and AAs.	High	
59	Corporate Social Responsibility 30/11/2022	Reputational	There is a potential opportunity for the GMC to lead the health regulatory sector in identifying, delivering and sharing how to be a more responsible regulator and demonstrating the positive impact this can have on those we regulate, our colleagues, suppliers, communities and patients. This could have multiple benefits, including the GMC becoming an employer of choice; increased diversity in our recruitment campaigns; new organisational partnerships; a positive impact on the environment; an increased regulatory reputation; and increased engagement and satisfaction with those that we regulate.	Neil Roberts	QUITE LIKELY	MIDGATE	SILVER	Key Controls • Our Corporate Strategy 2021-26 includes clear commitments to be a more responsible organisation both socially and environmentally. Every GMC Annual Report includes a CSR round-up of the previous year. • We have improved external visibility of our CSR work on the GMC website and internally on the GMC Intranet. We have used blogs to promote our support for widening participation (in medical training) initiatives and consideration of the regulatory challenges posed by sustainable healthcare'. • The GMC established the Cross Regulator CSR Group early in 2022 after the proposal (by the GMC) was agreed by the CEOR8 group. This meets quarterly and from mid-2022 includes representatives from the Greener NHS Team. • External recruitment campaigns now include reference to our CSR initiatives with the intention that this will be a 'pull' factor for potential candidates. • The GMC is increasingly engaged with new stakeholders, such as KPMG, on regional and national CSR bodies. These are new relationships which are increasing the profile of the GMC beyond the regulatory, health and education sectors. • CSR project closed in June 2022; project closure report completed with most initiatives now embedded as BAU. • Net Zero Working Group, sponsored by director of Resources, established at end of 2022. Whilst this has a broader remit than the CSR project, it will also support achievement of this opportunity. • CSR Community of Interest established in August 2023 to help BAU teams identify dependencies and mutual interests. This will also assist in maintaining oversight of CSR related activities across GMC.	QUITE LIKELY	MAXX	GOLD	SMI • Opportunity deep dive completed in February 2024.		High	
28	Working with patients and public 31/03/2020	Operational	Understanding and improving the experiences which patients and the public have of our regulatory services and involving them effectively in our work (such as strategy and policy development) will help us gain their trust and confidence and make us a better regulator	Paul Reynolds	QUITE LIKELY	MIDGATE	SILVER	Key Controls • Champions for patients established at SMT level to ensure senior-level overview of our engagement and signal importance of this to organisation. • Strategic ambition to improve patient and public involvement and long-term outcomes agreed. • Clear information easily accessible for patients and public about how we work and can support them (such as on our website). • Involvement of patients and the public in our policy development activity in a variety of ways including public consultations and the commissioning of independent research, supported by information and guidance for policy and operational teams to aid their work in this area. • Regular assessment of patients and the public's perceptions of the GMC and experiences of our work through regular evaluation and research (such as our perceptions survey). • Regular engagement with patient leaders in all four countries of the UK (by our senior leadership team as well as our bi-annual roundtable, UKAF meetings in the devolved nations and other activities). • 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 its work.	QUITE LIKELY	MIDGATE	SILVER	Council • Annual update on patient and public involvement (December 2024). Audit and Risk Committee: • Update on FPI review recommendations (May 2025).	Other assurances • Annual perceptions survey showing the public's confidence in how doctors are regulated and feedback on our working relationships with patient and public bodies. Results from 2023 survey shared with Council in November 2023. • Insights and perspectives from patients and their organisations shared in weekly external update for GMC leadership community.	• Development of our next annual update for Council about our work with patients and the public has commenced and will be delivered to Council in December 2025. • We have received the key findings of our 2025 perceptions survey, which has involved patients and the public. We will share the findings with Council in our annual update they will receive in December 2025. • Our next roundtable with patient bodies will take place in November 2025. The agenda will include a discussion about our reviews of our professional guidance on 'Raising and acting on concerns about patient safety' and 'Leadership and management'. • Our Contact Centre has procured a new omni-channel system capable of delivering automated customer surveys and providing granular survey analysis to help us understand the experiences of different customers (including patients and the public). The Contact Centre team plans to deploy these surveys towards the end of 2024. • Our Fitness to Practise Directorate is delivering a pilot that will help them test ways of seeking feedback from users of its services. This pilot began in February 2025 and will conclude towards the end of the year. FPI will then conduct a full evaluation of the pilot and consider next steps. • Our Fitness to Practise Directorate has commissioned research that will help it to understand the public's views on where our thresholds should sit in public confidence cases. Research began in January 2025 and reported in the autumn of 2025. The key findings of this research will be shared with Council in December, leading to further public engagement activities in early 2026. • Our new corporate strategy is the final stages of development. The needs of patients and the public will be reflected within its strategic themes, both directly and indirectly. The new strategy is expected to include a commitment that we will review our customer service standards as an organisation.	Medium

Corporate Strategy 2026-30

Action	To approve
Purpose	This paper sets out the approach we took to developing the 2026-30 corporate strategy and gives an overview of launch and implementation plans. The strategy is presented for approval for publication in early 2026.
Decision Trail	● Council away day March 2024 ● Council away day March 2025 ● Council meeting July 2025 ● Council webinar October 2025
Recommendation(s)	Council is asked to: a Approve the corporate strategy for publication. b Note launch and implementation plans.
Annexes	Annex A: Corporate Strategy 2026-30 Annex B: Engagement report Annex C: Equality Impact Assessment (EqIA) Annex D: Plans for assessing progress
Author contacts	Fionnula Flannery, Head of Strategy Kuljit Dhillon, Assistant Director - Strategy, Planning & Inclusion Any enquiries to: GovernanceTeamMailbox@gmc-uk.org
Sponsoring director/ Senior Responsible Owner	Shaun Gallagher , Director of Strategy and Policy

Background

- 1 Work to develop the 2026-2030 GMC Corporate Strategy began in the summer of 2024 in anticipation of the current strategy ending in December this year. The intention is to publish the new strategy in January 2026.
- 2 This is the second of two strategies to deliver the [2030 vision](#). Initial scoping conversations with senior leaders (including Council members, SMT and a selection of assistant directors) suggested that this strategy would be an evolution of the current one. Early steers were that we should:
 - Retain the 2030 vision unchanged but be more specific about what the key words ‘relevant’, ‘effective’, and ‘compassionate’ mean in practice.
 - Keep the flexibility that has been a strength of the current strategy, while being more granular about what our strategic objectives are, how they relate to the success measures, and how the strategy will help us to make choices about where to focus our efforts.
 - Start the work from a position of confidence and pride in what has been achieved during the current strategy and strike a balance between ambition and realism in the next one given the extent of change already committed to in the next five years.
- 3 Over the past year we have carried out extensive evidence gathering, engagement and testing to arrive at the strategy that is before Council for approval today.

Evidence gathering and engagement activities

- 4 An early decision (given we are still working to the 2030 vision) was that we should not carry out a public consultation on this strategy, but it has still been important to understand perspectives of stakeholders in a way that minimises burdens on them.
- 5 We therefore drew upon the extensive evidence we already hold (for example from recent consultations, regular surveys and engagements) to identify doctor, PA, AA, patient and public, and other stakeholder perceptions of relevance to the future strategy. We also used our 2024 perceptions survey to ask our key audiences (over 3,500 respondents) where they thought we should be focusing our attention.
- 6 We have used existing engagement opportunities (such as the Patient Group Roundtable, Strategic Equality, Diversity & Inclusion Advisory Forum, and Responsible Officer Reference Group) to carry out targeted engagement. And we have used focus groups (with doctors and students) and bilateral conversations (eg with trade unions, and other regulators) to explore specific issues.

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Corporate Strategy 2026-30

- 7** Internally, we have carried out comprehensive engagement with GMC and MPTS colleagues. Methods included 1-2-1 meetings with senior leaders (including Council members); meetings with all leadership teams and with colleagues at all levels through directorate and team meetings. We also carried out an internal survey and ran a series of workshops and focus groups attended by colleagues from across all directorates. We have also engaged closely with around 40 colleagues from across the business to develop the specific objectives and success measures, through meetings and shared documents on Teams.

Key themes from engagement

- 8** There was a high degree of consensus from key audiences responding to our perceptions survey in terms of where we should be focusing more of our attention. The top responses were that we should be:
- Improving our fitness to practise processes, with a particular focus on mitigating perceived bias and reducing their length.
 - Using our influence to improve working environments for registrants.
 - Increasing our use of data and insights to improve patient safety, especially with employers.
- 9** Our direct engagements with key external audiences confirmed these priorities and added that we should:
- Focus on getting the basics right in terms of delivering our statutory responsibilities, and set out our intentions in terms of being a multiprofessional regulator.
 - Foreground patients' interests in the strategy, and help registrants, patients and the public to understand our purpose and role.
 - Tackle a broader range of ED&I issues beyond our current focus on race and ethnicity, including by developing our understanding of intersectionality.
- 10** Colleagues within the GMC shared these goals, and added that we should:
- Give greater attention to strategic change in the delivery of our statutory functions, with a better connection between our strategic goals and our operational work.
 - Maintain our ambitions in relation to influencing the environments in which doctors, PAs and AAs work, but with greater clarity about what we influence and what we control.
 - Communicate positively and with pride about the work we do, and about the value of regulation to patients and registrants.
 - Keep a focus on the quality of interactions with us, with the goals of enhancing our understanding of our customers and using insights to improve their experiences of us.

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- Maintain a focus on our people but widen the lens to include commitments around a culture of collaboration, reflection and curiosity, and compassion for staff. Colleagues also felt that affordability and efficiency are important and called for decisions to be based on evidence and risk.

11 A full engagement report is at Annex B.

What is similar and different to the current strategy?

- 12** Given the continuity from the current strategy, we have retained the four-theme structure as colleagues already have a high degree of familiarity with it. As now, there is a 'strategy on a page' section to aid easy digestion. And we have retained 'Making every interaction matter' as a strategic theme, given its salience across all directorates.
- 13** The most significant difference from the current strategy is the introduction of a new theme on regulatory change. This is in response both to the scale of change we expect over the next period (including the work to deliver regulatory reform) and to the feedback from colleagues that they wanted a clearer connection between our strategic goals and our operational work. We have also broadened our current theme 'Investing in our people to deliver' to include wider commitments about our culture, ways of working, and management of our resources.
- 14** We have also aimed for more specificity in the commitments we make, while still retaining flexibility in terms of how these are delivered. And we have sought to be clearer about what we control and what we influence.

Equality, diversity and inclusion, and 4 country regulation

- 15** We have carried out a full equality impact assessment (EQIA), which will be published alongside the strategy. This contains an action plan which has been agreed with action owners across the business. Progress will be monitored by the strategy team during the life of the strategy. The EQIA also records how we have paid attention to our Welsh language responsibilities. The draft EQIA is at Annex C.
- 16** We have also considered national variations, for example in terms of workforce strategies and operating contexts, and engaged with our national offices, to make sure that the objectives we set in the strategy are relevant in each of the countries we regulate in.

Testing the strategy

- 17** We have engaged with a small number of patient and registrant bodies to test how the strategy will land with them. The Patient Safety Commissioner's office saw a high degree of alignment with their patient safety principles, and representatives from the British Medical Association (BMA) and United Medical Associate Professionals (UMAPs) were positive overall

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about what it contained. We have also carried out targeted engagement with doctors (clinical fellow alumni) and PAs to test responses to the strategy before it is published, to help shape our communications approach.

- 18** We discussed the strategic objectives with Council members at a webinar on 7 October. The comments and suggestion that were made have been addressed in the attached draft and changes made will be summarised at the meeting.

Assessing progress against the strategy

- 19** Underpinning the strategy will be an assessment framework, which will capture all the measures we are using to assess progress against each objective. Some measures will be tracked as part of BAU and programmes and will be incorporated into the Performance and Risk Report which goes to Executive Board every other month. Others will be tracked annually or every two years, or captured more qualitatively, within the proposed assessment/reporting cycle. We expect the framework to be finalised in Q1 2026, but an outline of our approach is at Annex D.

Integrating the strategy into business planning and reporting

- 20** We are keen to use existing reporting mechanisms to provide more regular, routine and streamlined updates on delivering the strategy. In Q1 2026 the Business Planning and Reporting team will carry out a review of our reporting to Executive Board and Council, which will include a mapping exercise against the new strategy.
- 21** Alongside this, we are working up an analysis of risks to delivery of each of the strategic objectives. Owners will be assigned and risks documented on operational/project risk registers to be managed through the risk management framework (RMF). We are updating the strategic themes in the Corporate Opportunities and Risks Register (CORR) and propose to add a new column in the CORR that shows the link between risks and strategic objectives. This will give us a more holistic view of the risks against each objective, helping us to assess progress against the strategy through a risk lens.
- 22** We are also developing an approach to using risk appetite to help us define relative priorities within the strategy. For each strategic objective we propose to articulate our tolerance for delaying or not fully achieving each objective, and willingness to trade it off against other ambitions (whether strategic or other goals). That will enable us to give a priority ranking to each objective, which will be reflected in the prioritisation framework that is used to inform gateway decisions. It will also help inform local decisions within directorates.
- 23** We explored this approach with the Audit and Risk Committee at the November seminar. Members were supportive overall, seeing this as a helpful approach for having focused

conversations about resource allocation in a context of increased financial constraint. They also recognised the complexity and granularity of resource choices, the need for cross-organisational discussions and alignment, and the importance of describing what ‘good enough’ looks like across different areas of work, with colleagues encouraged to adapt and take calculated risks. They also said controls and assurance must be balanced against efficiency.

Launch and implementation

- 24** We expect to launch the strategy in early 2026, alongside the 2026 business plan. We are developing a strategic communications and engagement plan which will be divided into three phases taking us from pre-publication, to launch through to long term implementation. It will reflect the opportunity that a new strategy provides, to reset, renew and refocus and to tell a clear and impactful story about who we are, what we do and why we do it, that resonates with the professions we regulate and the patients we serve.
- 25** Our overarching approach, and each phase, will be underpinned by four guiding principles:
- Relationships – we will continue to engage our partners and stakeholders, with a focus on how we can work together over the life of the strategy to improve patient safety
 - Devo-competence – we will recognise the distinct political and policy environments in each of the four UK countries, and tailor our approach to reflect country specific priorities
 - Storytelling – we will use a compelling narrative, evidenced by data and insight to explain our contribution to the UK’s health system and our work to support registrants to deliver good, safe, patient care.
 - People – we will bring the value and purpose of regulation to life through our people. We will explain, and humanise, the work that they do every day with professionalism, expertise and compassion.
- 26** An internal communications plan has also been developed. We have already delivered two webinars and some sessions with directorates to feedback what we heard during our engagement to show how we have reflected colleagues’ views in the new strategy. As we move towards the launch date, we will be recapping on our achievements from the current strategy to provide some closure for staff and build momentum for the launch. There will also be a toolkit to help leaders and managers facilitate conversations about the strategy with their teams and how their work will contribute to it.
- 27** We are also working with the People team to consider how the strategy can be integrated into the development of SMART personal objectives from 2026. It is likely that the guidance for leaders will be reviewed and enhanced to facilitate this.

Annex A

Corporate Strategy 2026-30



Our strategy 2026–30

General
Medical
Council

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[This publication is available in Welsh on our website.](#)
[Mae'r cyhoeddiad hwn ar gael yn Gymraeg ar ein gwefan.](#)

Foreword

Five years ago, we set out a ten-year vision grounded in our role as an effective, relevant and compassionate regulator – one that works in partnership with others, guided by evidence and by our commitment to equality, diversity and inclusion. Since then, pressures across healthcare have intensified. The legacy of the pandemic endures, the realities of modern practice are ever more complex, and services continue to face sustained challenges in capacity and workforce.

Throughout this period, we've worked to ensure that how we regulate keeps pace with the world in which we live and our registrants work. We've updated our professional standards and invested in how we support the professionals we regulate to meet these. We have proactively made changes to ensure our fitness to practise processes are more proportionate, and support fair and timely outcomes for everyone involved. These achievements have laid the groundwork for the next phase of our vision – one focused on delivering reform and lasting improvement for both patients and registrants.

We're now approaching a once-in-a-generation opportunity: the most significant reform of professional regulation in decades. The changes ahead will give us greater flexibility – allowing us to act faster when patient safety is at stake and to encourage proportionate, local solutions that promote learning and improvement. They will help us build a modern framework for multiprofessional regulation that is fairer, simpler and more responsive, better serving patients across the UK.

As a professional regulator, we cannot solve every challenge the system faces. But we can stay focused on doing our work effectively, fairly and with compassion. That means listening to and learning from those who interact with us, and working with others to support our registrants to provide safe, high-quality patient care.



A black ink signature of Professor Dame Carrie MacEwen, written in a cursive, flowing style.

Professor Dame Carrie MacEwen
Chair

Our role

We are the UK's independent regulator of doctors, physician associates (PAs), and anaesthesia associates (AAs).^{*} Our mandate is set out in the Medical Act 1983 (as amended) and the Anaesthesia Associates and Physician Associates Order 2024.[†]

We work with doctors, PAs, AAs, patients, and other stakeholders to support good, safe patient care across the UK.

As part of this, we:

- set the standards of patient care and professional behaviours doctors, PAs and AAs need to meet
- make sure doctors, PAs and AAs get the education they need to deliver good, safe patient care
- check who is eligible to work as a doctor, PA or AA in the UK and work with them and their employers to confirm they're keeping up to date and meeting the professional standards we set
- give guidance and advice to help doctors, PAs and AAs understand what's expected of them
- investigate where there are concerns that patient safety, or the public's confidence in doctors, PAs or AAs may be at risk, and take action if needed.

The Medical Practitioners Tribunal Service (MPTS)

The MPTS runs hearings that make independent decisions about whether doctors, PAs and AAs are fit to practise in the UK.

Its tribunals can restrict a doctor's, PA's or AA's practice, or stop them from working in the UK.

It is accountable to the GMC's Council and the UK Parliament and operates separately from the GMC.

This strategy sets the direction of travel for both the GMC and the MPTS.

^{*} We are aware that changes to these titles have been proposed in the Leng Review and the UK government is considering implementation. In the meantime, to make sure our regulatory processes and documentation remain clear and consistent, we are continuing to use the titles for our registered professionals that are currently set out in law.

[†] The GMC is also registered as a charity with the Charity Commission in England and Wales and the Office of the Scottish Charity Regulator. The GMC's activities in Northern Ireland do not currently fall under the auspices of the Charity Commission for Northern Ireland. Our charitable purpose in England and Wales states that: "We are an independent organisation that helps to protect patients and improve the practice of medical practitioners, physician associates and anaesthesia associates across the UK." Our charitable objects, derived from the Medical Act, (as amended, including by the Anaesthesia Associates and Physician Associates Order) are those of our overarching objective. Our registration with the Office of the Scottish Charity Regulator states that: "The main objective of the General [Medical] Council in exercising their function is to protect promote and maintain the health and safety of the public".

Strategy on a page

This is the second of two strategies to deliver our ten-year vision. Over the next five years, four themes will shape all our work, helping us to achieve our goal of being an effective, relevant and compassionate regulator.

Our vision

Our vision is rooted in the people we work with and for. We will be an effective, relevant and compassionate regulator for patients, the public and professionals, and as an employer.

We will foster a culture of equality, diversity and inclusion in everything we do as a regulator and employer.

We will work to deliver wider health system goals by working in partnership with others. Evidence will drive our decisions.

We will be a multiprofessional regulator focusing on supporting professionals in the places they work. This requires unified action from us all – regulators, employers and educators.



Our values

• Integrity • Excellence • Collaboration • Fairness • Transparency

Supporting good, safe patient care

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



Why this is important

To better serve patients, UK's health systems must do more to create working environments that support safe, high-quality care

This requires compassionate leadership and collective action to create environments that empower doctors, PAs, and AAs to meet the professional standards we set. It also requires sustained collaborative efforts across the healthcare systems to tackle the structural problems that lead to persistent inequalities in the workforce.

Professionals need to be equipped to meet the changing needs of patients. And greater flexibility in training is needed to make a fulfilling career in UK practice a realistic prospect.

Many of these things are not within our direct control. But we have a part to play in working with others across England, Northern Ireland, Scotland, and Wales (along with the Crown dependencies and other territories we have agreements with) to achieve them.

What we are building on

- In 2023 we launched an updated version of *Good medical practice*, the professional standards for doctors, PAs and AAs. The revised standards have a stronger focus on patient-centred care. They also include new duties for the professionals we regulate to contribute to respectful, fair, supportive, and compassionate workplace cultures. Our outreach teams have delivered training on the standards to thousands of doctors and medical students across the UK.
- We've continued to use and share our data to influence the medical workforce by identifying key trends, risks, and inequalities. Through reports like *The state of medical education and practice in the UK* and our national training surveys, we've informed workforce planning and highlighted pressure points such as training capacity, supervision gaps, and burnout.
- We've also contributed to wider work to tackle persistent inequalities faced by doctors working in the UK healthcare system. In 2021, we set ambitious targets for our work as a regulator.* We've worked with healthcare organisations across the UK to identify and promote interventions that work to address inequalities, and we've seen encouraging progress against our targets. But there's still further to go. Achieving them will need sustained collaborative efforts across the healthcare systems to tackle the structural problems that stand in the way of equity.

What our stakeholders want

In our engagement on this strategy, we have sought to hear and understand the views of patients, the professionals we regulate, students, stakeholders and the people who work for us.

Patient representatives said it was important that the standards we set reflect what 'good' looks like to patients and the public. They also said we should support doctors, PAs, and AAs to meet those standards.

The professionals we regulate told us they lack confidence that we really understand the context in which they work. They also want our standards and guidance to keep pace with changes in practice and new technologies.

All stakeholders generally agreed that we should continue to work with others to address inequalities and to improve working and training environments. But we should be clearer about what is in our direct control, and what we can only work with others to achieve.

Our commitments

We have set five strategic objectives to achieve our goal of supporting good, safe patient care.

Promote good practice

Our goal is to support doctors, PAs, AAs and students in a way that is **relevant** to the challenges they face and helps them understand and apply the professional standards in their work.

We will:

- promote good practice, positive leadership, and professional behaviours
- update our guidance in line with legal, digital, and other changes

* These targets are to eliminate disproportionality in employer referrals relating to a doctor's ethnicity and place of qualification by 2026, and eliminate discrimination, disadvantage, and unfairness in undergraduate and postgraduate education and training by 2031. [\[link\]](#)

- continue to strengthen our role in supporting early intervention to prevent problems before they happen.

We will have succeeded if we maintain positive perceptions of the clarity, relevance and helpfulness of our standards, advice, and outreach support. More of the professionals we regulate will also agree in response to our surveys that we support them to provide good, safe care.

Work with others to improve workplace cultures and tackle workforce inequalities

Our goal is to work with others so that together we are **effective** in improving workplace cultures, developing clinical leadership, and tackling persistent inequalities in the workforce.

We will:

- continue to work with responsible officers, educators and employers. We will support and challenge them to embed positive cultures, promote compassionate leadership, and tackle the structural barriers that stand in the way of equity
- develop our understanding of the drivers of – and effective responses to – persistent inequalities in the workforce. This includes understanding the compounding effects of overlapping barriers (also known as intersectionality)
- share evidence on what works to change behaviour and improve outcomes.

We will have succeeded if we can demonstrate tangible impacts of our work to tackle discrimination and unprofessional behaviour. We will also have achieved our current targets in relation to disproportionate employer referrals and will be making good progress towards eliminating discrimination, disadvantage, and unfairness in education and training.

Encourage career development and lifelong learning

Our goal is for there to be greater flexibility and innovation in education and training, and a greater focus on lifelong learning.

This is so all the professionals we regulate, whether they are in formal training or not, are better supported to develop the clinical and professional skills that are **relevant** to the needs of patients and the public across a range of settings and sectors. It will also enable them to have fulfilling careers, which will aid retention of talented professionals in the UK workforce.

We also want to be **effective** in our work with others to develop more, better supported and more diverse educators, trainers, and supervisors. This is vital to maintain the pipeline of future clinical and leadership skills we will need.

We will:

- work with employers, education organisations, and other regulators to encourage a greater focus on education, career development, and lifelong learning
- continue to make the case for an education and training infrastructure – including trainer capacity – that matches workforce growth.

We will have succeeded if doctors in training continue to rate the quality of their training highly, as measured through our national training survey. We will also see evidence of improved access to learning and development opportunities for registrants who are not in formal training programmes.

Share our data and insights to drive change

Our goal is to use and share **relevant** data, research and insights to support the development of local and national healthcare policies and plans across the UK.

We will:

- share our data, research, and insights with the UK's governments, education and training organisations, employers, other regulators, our registrants, and the public in ways that are useful and accessible to different audiences
- highlight trends and risks we see relating to workforce development and retention, quality of education and training, and patient safety, and collaborate with partners to identify risks and trends jointly
- identify actions where we think change is needed.

We will have succeeded if our stakeholders continue to say that our data, research, and insights help them with their work. We will also see increased agreement that we are focusing on the right issues as a regulator.

Work collaboratively with healthcare partners

As a four-country regulator, we engage with partners across the UK to understand the contexts in which they operate and build understanding of our work. We also work collaboratively with partners to make sure the standards we set are met, and patient safety is maintained.

Our goal is to be **effective** in how we work with others to deliver our regulatory processes. We also want to better understand the environments in which our registrants practise and train, and make sure our priorities remain **relevant**.

We will:

- continue to build strong relationships with partners at national and local levels across England, Northern Ireland, Scotland and Wales
- listen and use stakeholder views to shape our work
- work collaboratively with employers, education and training providers, other regulators, improvement bodies, international partners, and other organisations at a local level to support quality improvement and promote effective clinical governance arrangements.

We will have succeeded if stakeholders continue to say that we work well with them and others to keep patients and registrants safe. We will also see improved stakeholder perceptions of us as a listening organisation.

Delivering better, fairer regulation

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



Why this is important

Our central purpose is to support good, safe patient care across the UK. It is crucial for patient safety, and for the public's confidence in the people we regulate, that we carry out our core responsibilities as well as we can.

The way we work is also changing. In December 2024, we started regulating PAs and AAs alongside doctors. As a multiprofessional regulator, we recognise and regulate doctors, PAs, and AAs as

three distinct professions, and we will evolve our approach in a way that is proportionate for each profession.

During the life of this strategy, the UK government will reform the way we and other healthcare professional regulators work. We welcome this opportunity to develop a more modern and responsive legislative framework, which will help us with our ambitions to become a more effective, relevant, and compassionate regulator.

What we are building on

- We've made significant improvements to how we deliver our regulatory functions over the past few years. For example, we've improved the timeliness of fitness to practise cases* – reaching key decision points faster and reducing the number of open old cases. Effective management of the timeliness of our fitness to practise processes helps reduce the stress for everyone involved in them.
- We've also carried out and published a review of regulatory fairness and reviewed decision points in our processes to strengthen fairness controls. As part of this work, we've developed decision-making principles to promote consistency across our decisions. We've also introduced tailored training to help our decision makers recognise bias, ask questions, and challenge assumptions in their work.
- In 2024 we introduced the Medical Licensing Assessment (MLA). Its purpose is to improve consistency in the levels of core knowledge, skills and behaviours required of doctors working in the UK. UK graduates take the MLA as part of final exams, and we deliver the assessment for international medical graduate doctors.

What our stakeholders want

During our engagement on this strategy, patient representative groups emphasised the importance of putting patient interests at the heart of what we do.

The professionals we regulate told us that they wanted to see a visible commitment to continuous improvement of our processes – with a particular focus on the timeliness of our fitness to practise

procedures. They also wanted us to do more to monitor and mitigate bias within our processes.

Colleagues within the GMC supported these areas of focus and wanted the organisation to simplify our processes.

And, among all audiences, fairness and transparency in how we carry out our role were seen as essential to building trust and confidence in how we regulate.

Our commitments

We have set four strategic objectives to achieve our goal of delivering better, fairer regulation.

Improve and sustain fairness in our decision making

Our goal is to make sure that the decisions we make are **compassionate**, fair, and robust.

We will:

- monitor, assure, and develop the way we make regulatory decisions
- actively consider the risk of bias, encourage more professional curiosity and cultural humility in how we make decisions, and respond to changing contexts and societal shifts
- improve the transparency of our decisions through publication of equality, diversity and inclusion (ED&I) data and equality impact assessments.

We will have succeeded if we can demonstrate compliance against the anti-bias measures we have introduced. We will also have confidence that our decision makers are displaying the behaviours we want to see. And we will be transparent about how we assure the fairness of our decision making.

* These are cases where a concern has been raised with us about a doctor's, physician associate's or anaesthesia associate's behaviour, health or performance.

Deliver regulatory reform

Our goal is to secure a more modern, flexible, and **effective** legislative framework that will allow us to make our processes faster and simpler, as well as more **compassionate**, for the people involved in them.

We will:

- work closely with the UK government's Department of Health and Social Care as it delivers a new legislative framework
- put in place implementation plans to make our regulatory processes more flexible, accessible, consistent, and accountable, and the resolution of complaints faster and less adversarial for registrants, complainants, and witnesses.

We will have succeeded if the new legislative framework provides us with the legal basis to carry out our functions effectively and we can show how it will enable us to realise the benefits of regulatory reform.

Develop our education framework to meet the UK's changing and diverse health needs

Our goal is to make sure that the framework we set for the education and training of doctors, PAs, and AAs is relevant to the changing needs and expectations of patients, the changing structure of the healthcare workforce, and a changing health service.

This includes that the professionals we regulate will have the capabilities needed to care effectively for diverse patients and communities and address healthcare inequalities. They will also be equipped to deliver care innovatively and safely, using new technologies such as artificial intelligence (AI).

We will:

- develop an education framework that makes sure training effectively meets the UK's changing and diverse health needs
- apply the framework to a wider range of learning settings and require better organisational support for learners and educators.

We will have succeeded if we can show how the revised education framework responds to the changing needs of patients. We will also be able to show how it will help our registrants gain the knowledge and skills they need.

Continue to develop and improve our regulatory processes

Our goal is to maintain and develop our approach to being an **effective** regulator of doctors, PAs, and AAs. This means continuing to be robust in how we carry out our responsibilities, while being fair, flexible, proportionate, and **compassionate** in how we treat the people who are involved in our processes.

We will:

- continue to improve our processes
- develop our rules, standards, and guidance, to make sure they are timely, transparent, evidence-based, consistent, and appropriate for each of the three professions we regulate.

We will have succeeded if we can demonstrate successful delivery of programmes of work to develop and improve our regulatory processes. We will also continue to perform strongly against our key performance indicators and meet all PSA standards.

Making every interaction matter

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



Why this is important

How we treat people goes to the heart of what we do. It's part of how we earn trust, which we need to be able to regulate effectively.

People interact with us for a wide range of reasons. For patients and complainants, engaging with a regulator – especially after a distressing or traumatic experience – can be confusing or emotionally difficult.

Doctors, PAs, and AAs often want brief, practical guidance from us, or they want to manage their registration quickly and easily. And, for the small minority of registrants this applies to, being

under investigation can be deeply stressful and isolating. It's important that every person who interacts with us is met with compassion, openness, and efficiency.

Listening to, and understanding, the diverse range of people affected by our work is also vital. It enables us to shape policies, services and processes that are practical, relevant, and responsive to the lived experiences of professionals, patients, and members of the public. It also helps us make sure our policies and processes are accessible and don't impose barriers or disadvantage people with protected characteristics.*

* These are the characteristics protected by legislation – age, disability, gender reassignment, race, marriage and civil partnership, pregnancy and maternity, religion or belief, sex and sexual orientation.

What we are building on

- Since 2021, we've improved how we deliver our services. For example, we've updated our contact centre technology so that people can interact with us in ways that best meet their needs. We've implemented the Welsh language standards, to make it easier for Welsh speakers to interact with us in their preferred language. And we've introduced virtual tribunal hearings, where appropriate, to improve accessibility and efficiency for those involved in them.
- We continue to achieve high levels of satisfaction on a range of customer service measures. Our contact centre customers report a high level of satisfaction with the service they receive. And the Institute of Customer Service re-accredited our contact centre with 'distinction' in 2024.
- We've strengthened the involvement of registrants, patients, and the public in our work, so their voices help shape the ongoing development of our services and policies. For example, we engaged with thousands of professionals, patients, and members of the public during the development of *Good medical practice*. And we've explored more collaborative engagement methods as part of our programme of regulatory reform.

What our stakeholders want

During our engagement on this strategy, patient representatives, the professionals we regulate, and GMC colleagues said we should do more to seek, listen to and act on feedback. This is so we can help to make our processes and interactions more accessible and tailored to individuals' needs. Patient groups also said we should signpost effectively to help patients navigate a complex complaints system.

Those we regulate told us that we don't listen enough to their voices. They also said we need to do more to help them understand the reasons for our decisions and to address fear of our fitness to practise processes.

All our stakeholders said we should explain our role more proactively and be clearer about what we can and can't do. This includes explaining the differences between the role of the GMC and the role of the MPTS. GMC colleagues shared this view and said we should all speak positively and with confidence about the value of the work we do.

Our commitments

We have set four strategic objectives to achieve our goal of making every interaction matter.

Improve our customer service

Our goal is to make sure that everyone, regardless of disability, background, or circumstance, can understand and use our services. This includes making it easier for everyone to engage with us. And we want to make sure they have clear, **compassionate**, and consistent experiences when they do.

We will:

- review our customer service standards
- improve how we gather, analyse, and act on the feedback that we receive about our services as a regulator
- make effective use of digital tools in our work.

We will have succeeded if we maintain existing high levels of customer satisfaction. We will also be able to demonstrate that we routinely seek and act on feedback to improve experiences of our services.

Understand the people who interact with us

Our goal is to understand better the diverse characteristics of the people who interact with us. This is so we can make sure our policy, services, and processes are **effective** and accessible.

We will:

- develop the data and insight we need to understand the diverse characteristics of the people who interact with us
- use these insights to make sure our policies and processes are designed inclusively.

We will have succeeded if the quality of our data on those who interact with us improves. We will also be using this deeper understanding of those with diverse backgrounds to improve experiences and shape our services.

Involve people in our work

Our goal is to continue to strengthen our engagement with people who are affected by our work. This is so that we develop **relevant**, evidence-based, inclusive, and proportionate policy, services, and processes.

We will:

- involve diverse groups of patients and carers, the public, and the professionals we regulate meaningfully in our work
- use the insights this give us in the development of our policies, services and processes.

We will have succeeded if we can show how the experiences, expectations, and needs of patients and carers, the public, and the professionals we regulate have helped shape our work.

Making it easier to understand what we do and why

Our goal is to communicate clearly about our role, reduce fear of our fitness to practise processes, and build trust and confidence that we regulate in a way that is **effective, relevant, and compassionate**.

We will:

- communicate proactively and clearly about the positive value of regulation to professionals, students, patients and the public
- explain our decisions as simply and clearly as possible
- join up with other organisations that deal with concerns about healthcare to help make regulation more accessible and easier to navigate.

We will have succeeded if we maintain positive perceptions of the quality of our communications. We will also continue to see increased confidence in how we regulate.

Being an inclusive and well-run organisation

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



Why this is important

Our culture – as an organisation, and as an employer – strongly influences our effectiveness as a regulator. It shapes how our people behave, make decisions, and uphold standards, all of which are fundamental to regulation.

A healthy culture encourages openness, challenge, and accountability. It allows colleagues to raise concerns, question assumptions, and make sound,

evidence-based decisions. It is also compassionate. A culture that values wellbeing helps prevent burnout, builds resilience, and helps make sure that our people stay motivated and productive.

Our people need to reflect the diverse communities we serve so we remain credible, fair, and relevant. And inclusive leadership enables diverse perspectives to be heard, which leads to better decision-making and reduces the risk of bias.

We also need to work as efficiently as possible, using our resources responsibly. This is so we can remain effective in a complex and fast-changing healthcare environment. A well-run organisation has a clear purpose, strong leadership and governance, good planning, and the right people in the right roles. It uses its money wisely, makes decisions based on evidence and evaluation, weighs up risks and benefits, looks for better ways to do things, and keeps up with digital advancements.

What we are building on

- In 2024, we were awarded gold status by Investors in People against their *We Invest in People* framework – an increase from our previous silver award. This reflects our work to lead, support, and build capability in our people. We were also awarded silver status for *We Invest in Wellbeing* – maintaining our previous award but making positive moves towards the gold accreditation. In 2024 we also achieved Level 2 Disability Confident Employer status.
- In 2021 we set a range of ED&I targets for ourselves as an employer. These were to:
 - achieve a more ethnically diverse workforce with 20% ethnic minority colleagues and a management profile that reflects this
 - close pay gaps and maintain alignment on pay where it exists
 - create a more consistent workplace experience across all our workforce, measured via our engagement and inclusion index.

We're on track to meet our overall workforce target, and to meet our targets on engagement and pay gaps. But progress in other areas remains challenging, and there is more we can do to address structural inequalities for other groups, such as disabled people.

- We've improved our systems to support our workers better. Our staff can now work effectively as they move between office, remote, and home-based settings. We've also made things simpler for doctors, PAs, and AAs, for example by creating a single login for our online services.

What our stakeholders want

During our engagement on the strategy, registrants and patient groups made the link between our culture as an organisation and employer and our performance as a regulator. Those we regulate also said it's important that we make visible commitments to environmental sustainability, given the impacts of the climate crisis on public health.

Colleagues within the GMC found it important to keep improving how we work. They highlighted the need for more collaboration across teams, and a culture that encourages reflection and curiosity. Another clear message was to put more compassion into how we work, especially by supporting the wellbeing of staff who handle difficult and sensitive cases.

Colleagues also felt that affordability and efficiency are important and called for decisions to be based on evidence and risk. They were also keen to make better use of technology and digital tools, including AI, to reduce administrative burden and streamline our work.

Our commitments

We have set five strategic objectives to achieve our goal of being an inclusive and well-run organisation.

Strengthen our leadership

Our goal is to develop confident, inclusive leaders who promote equity and effectively manage change. This is to foster a fair, inclusive, **compassionate**, and productive workplace where people feel supported, feel able to ask questions and challenge assumptions in their work, and thrive.

We will:

- review our existing workforce targets to assess their effectiveness, relevance and achievability, and consider extending them to other underrepresented protected characteristics
- support our leaders to build inclusive, supportive teams where our people feel safe and valued
- encourage reflection and professional curiosity
- help our leaders manage change with compassion.

We will have succeeded if we have met our ED&I representation targets, strengthened our leadership and change management capabilities, and seen improvements in inclusivity scores.

Invest in our people to deliver

Our goal is to keep building an open and supportive culture that prioritises wellbeing and helps people grow. Our aim is to create a stronger, more adaptable workforce with the **relevant** skills we need to shape the organisation's future.

We will:

- redesign our pay, performance, and career development frameworks
- address structural inequalities for ethnic minority and disabled colleagues
- offer more support for learning and wellbeing
- use our data and systems to manage people better.

We will have succeeded if we maintain high staff engagement scores and can show how we have addressed structural inequalities in pay, promotions, and turnover for ethnic minority and disabled colleagues.

Enhance our digital capabilities

Our goal is to deliver an effective digital technology programme that strengthens our cyber security, boosts productivity, and improves the digital experience for our people, and the people we serve. We also want to support future innovation and change, while managing costs and risks.

We will:

- keep our information systems secure
- complete our migration to cloud-based services
- make more use of automation and AI
- continue to improve our digitally-enabled services based on user experience and feedback.

We will have succeeded if we have maintained information security, improved existing technology, and implemented new digital tools to improve productivity and user experience.

Work efficiently and effectively

Our goal is to work as efficiently as possible so that we can be **effective** in a constantly changing environment, using evidence and evaluation to inform our decision making.

We will:

- carefully manage our resources, weighing up risks and benefits
- continue to look for better ways to do things
- modernise our governance by introducing a unitary board
- work together flexibly and collaboratively to maximise our impact as a regulator.

We will have succeeded if we are able to show how our assessments of risks and benefits help us to manage our resources effectively, and we can demonstrate improved efficiency in how we work.

Demonstrate social responsibility and environmental sustainability

Our goal is for our environmental sustainability work to be **relevant** and to demonstrate tangible impacts. We also want to be a socially responsible organisation.

We will:

- actively push forward our environmental sustainability work, setting clear goals and using data to track progress. Our aim is to become a fully net zero organisation by 2040
- carry out our work in a way that is ethical and benefits society.

We will have succeeded if we are on track to meet our net zero goal and can assess our impact and value as a more sustainable organisation.

Delivering this strategy

Thanks to the input of patient representatives, doctors, PAs, AAs, students, partners, and colleagues, we have a clear picture of where we want to be.

Alongside this strategy, our annual business plan will set out our priority projects and programmes. These will be reassessed on a quarterly basis. We will also use our risk management framework to identify risks to delivery of the strategy and help define our priorities.

Promoting equality, diversity and inclusion

Equality, diversity and inclusion (ED&I) are an integral part of our work as a regulator, and as an employer. This is why we've integrated our ED&I commitments into this strategy. We have also published an equality impact assessment, which sets out how we have assessed the potential impacts of this strategy on different groups of people who share protected characteristics.

Tracking and reporting progress

Throughout the life of this strategy, we will assess progress and publish updates in our annual reports. This assessment will largely focus on existing performance measures. It will be complemented by available analysis and stakeholder feedback to help us understand progress and context for each strategic theme.

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Mae croeso i chi gysylltu â ni yn Gymraeg. Byddwn yn ymateb yn Gymraeg, heb i hyn achosi oedi ychwanegol.

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Annex B

Engagement on the corporate strategy

Engagement with patients, registrants and other key audiences

Overview

The work to develop the 2026 – 2030 GMC Corporate Strategy has included proportionate engagement with a range of external stakeholders at every stage of the development process. In 2024 and 2025, the strategy team engaged with:

- patient group representatives
- strategy colleagues from other healthcare regulators and organisations
- representatives from non-healthcare regulators and organisations
- doctors
- registrant representative groups

We made use of existing connections and networks, for example, by engaging with the GMC clinical fellow network. We also reached out to the strategy teams of organisations or stakeholders we thought it would be valuable to engage with. In some cases, we met with individuals, in others (particularly when engaging with clinicians) we ran workshops or focus groups.

When meeting with stakeholder organisations, rather than just providing feedback on our strategy, organisations explained their approach to strategy development, including outlining challenges and successes, providing us with advice on how to approach our own development.

This report summarises the feedback we received from external stakeholders at the different stages of the development of the strategy. We responded to the feedback received as part of this external engagement on an ongoing basis. Later drafts and edits of the strategy have taken account of the views provided and are reflected in the final version of the 2026 – 2030 strategy as much as possible.

Top line summary

What stakeholders wanted to see:

- Increased clarity of the GMC's role and remit [patient groups; registrant groups; medical students]

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- Improved communication, including innovative communication [patient groups; registrant groups; medical students]
- Better use of the GMC's influencing role in the sector, including role in 'upstream regulation' to reduce referrals to the regulator [registrant groups]
- GMC doing more to promote positive workplace environments, including improved doctor-PA relationships [registrant groups]
- Work with other regulators/organisations in the sector to influence change [stakeholder organisations]
- Work to increase trust and confidence in the GMC amongst registrants (and reduce fear) [registrant groups]
- Improved timeliness, clarity, and transparency of GMC processes [registrant groups]
- A commitment to supporting responsible workforce planning [registrant groups; stakeholder organisations]
- A strategy that helps registrant feel supported [registrant groups]
- Better management of expectations before entering GMC processes [patient groups].
- A balance of registrant vs patient interests [stakeholder organisation]

Feedback on the draft strategic themes

- Approval on the focus on 'our interactions' [patient groups]
- Approval of patients being at the heart of the strategy [patient groups; registrant groups]
- Concern about the lack of focus on multi-professional regulation [patients; registrant groups; stakeholder organisation]
- Desires to see more emphasis on intersectionality [registrant groups]
- An ask for clarity on vision words [registrant groups]
- An ask for more focus on education about the GMC's role and remit and processes [registrant groups]
- Concern about a blind spot in the strategy about the importance of clinical leadership [registrant groups]

Engagement with patients and the public

Patient roundtable

The strategy team attended two Patient Group Roundtable (PGR) sessions to invite views on what patients and the public expect from a healthcare regulator, and what the GMC should do to achieve its vision. We attended these roundtables in November 2024 and June 2025.

In the November session, the strategy team asked the PGR to discuss patients' needs and expectations of a healthcare regulator, and opinions on the GMC's vision words and how they relate to patients. Key points highlighted included:

- the importance of two-way **communication with patients and the public**, with better, more robust engagement with patients (including opportunities for patients to feed back to the GMC about their experiences)
- the need to **clarify the role and remit of the regulator** (including its limitations)
- increased **clarity of processes** for patients
- **compassion** to be built throughout a patient's journey with the GMC, not just at key touch points
- the importance of the GMC **influencing** the environments in which professionals work, to enable good practice.

In the June session, the Strategy team tested the proposed strategic objectives with the PGR. PGR members were **positive about the focus on interactions** ('Making every interaction matter') and said they were pleased to see that patients were at the heart of the strategy work. Other points included:

- it's important that patients feel empowered and can understand the GMC processes they are involved in
- we could expand the strategic principles to include a point about informing the public what good looks like
- the GMC could do more to inform the public about the professionals they are less familiar with (i.e., PAs)
- the GMC could do more to prevent feelings of intimidation being a barrier to patients coming to the GMC with concerns.

Audience testing

The strategy team also carried out some targeted audience testing of the draft strategy with two PGR members – the office of the Patient Safety Commission (PSC) and Llais. This is to hear their views on the public/patient facing aspects of the strategy and whether it contains the sorts of commitments they'd expect.

The PSC found strong alignment with their published [patient safety principles](#). They particularly commended the focus on communication; transparency and accountability; ease of engagement and accessibility; use of data and feedback to improve services; use of patient experience to shape policy; and promotion of the positive value of regulation.

Llais said the strategy is clear and well balanced, and said they thought we should focus in particular on public awareness and understanding of the GMC; strengthening patient/carers involvement in our work; and continuing to demonstrate how regulation protects people.

Clinical voice

SEDIAF

The strategy team met with the Strategic Education, Diversity, and Inclusion Advisory Forum (SEDIAF) in September 2024 and in May 2025. SEDIAF members are responsible for advising on the development, delivery, and progress of the GMC's ED&I commitments and legal obligations as an employer and regulator. Members of SEDIAF include doctor, physician associate, and anaesthesia associate representatives from black, Asian and ethnic minority groups, ethnic minority faith groups, and registrants who obtained their primary medical qualification from overseas who are from an ethnic minority.

The strategy team first met with SEDIAF in September 2024, prior to any initial drafts. SEDIAF members were asked how the next strategy could reflect the needs of and engage with registrants with protected characteristics. Attendees highlighted the importance of the GMC's **influencing role**. They wanted to see more being done to address harassment, discrimination and sexism in the workplace as well as better support for LGBT registrants, stating that the GMC had both hard and soft levers it could use to influence improvements in these areas (upstream regulation). They also stated that the GMC has a responsibility to **reduce referrals** to the regulator, to encourage conflict management, and to help create inclusive cultures in workplaces.

In May 2025, the strategy team returned to SEDIAF and presented the emerging story of the strategy, the four draft strategic themes, and an overview of the equality impact assessment (EqIA) for the strategy. SEDIAF members were asked for their thoughts and reflections on

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- the EqIA
- actions that the strategy team should take to incorporate the needs of those with protected characteristics into the strategy
- and specific groups that should be prioritised in the strategy.

Group members said they would like to see a **focus on intersectionality** and highlighted the importance of a nuanced and tailored approach when identifying and supporting different cohorts of doctors. They also wanted a better understanding of high rates of referrals for SAS and BME doctors.

Responsible Officers

The strategy team engaged with responsible officers (ROs) to

- understand about the aspects of our regulatory work that affect them
- what we could do better
- and what they think we should be focusing on to support them and the working environment for all registrants.

In November 2024, at the RO events, the strategy team gave ROs an overview of the GMC vision and the early thoughts and structure of the 2026 – 2030 strategy. ROs were asked what the GMC is already doing well as a regulator that should be retained, what is valuable in their work, and what the GMC could do to more proactively support ROs over the next five years.

Building trust and confidence in the GMC

ROs highlighted the importance of **confidence in the GMC** being at the forefront of the strategy, in order to address fear of the GMC amongst registrants. ROs showed strong support for regional liaison advisors and employer liaison advisors, with whom they had high levels of engagement with.

In terms of fitness to practice, ROs highlighted concerns about the **timeliness and transparency** of the process involved and said that it was not easy to understand outcomes or inconsistencies. They said that registrants found it difficult to navigate FtP processes, and it wasn't always clear who they were dealing with when. However, there was acknowledgement that the work done on FTP processes and fairness has been a good start.

GMP was seen as having **levers to implement and support positive workplace behaviours**, and ROs said the recent GMP updates has made the guidance more relevant. However, there is a gap around guidance for doctors working with PAs and AAs respectfully and effectively. ROs called for stronger messaging in support of AAs and PAs, and a clamp down on negativity.

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Improved communication

In terms of communication, ROs called for **better strategic listening and feedback** from the GMC (eg., ‘you said, we did’), and for the GMC to provide clearer explanations about regulation to enhance registrant understanding. Podcasts were suggested as an alternative form of communication to provide information about things such as the ethical hub and Welcome to UK Practice.

ROs said the GMC needed a strong basis of transparency and fairness and needed to **get the basics** right internally before seeking to influence others.

RO feedback on draft strategy

In July 2025, the strategy team engaged with ROs again, this time to share the draft strategic themes and to test with the ROs whether the draft themes were focussing on the right issues, and what success would look like.

Overall, there was **support for the four themes**, with a recognition of the importance of the different elements covered and some constructive suggestions for things that could be added, such as points around the NHS 10 Year plan. ROs stated that patients should continue to be our number one priority and focus.

Transparency and respect

Transparency around FtP processes was a key theme touched on by most groups. There was a general feeling that we needed to provide more information about what we mean by ‘regulating effectively’. ROs also felt to increase confidence in us as a regulator we need to build **greater awareness and understanding of our processes**. They felt this was an important theme which needed more fleshing out.

ROs stated that the GMC should do more to counter-misinformation about us but also stated that we should move away from wanting doctors to ‘like’ us and a move towards **building respect** towards us amongst doctors and patients.

Success factors

Success factors highlighted by ROs included proportionality, trust and confidence, clarity of role (GMC vs MPTS), efficient and timely processes, reducing inappropriate referrals, working with others, better signposting, more registrants following GMC guidelines, and working collaboratively with the BMA.

Clinical Fellows (current and alumni)

The strategy team met with the current Clinical Fellows in March, and a small number of Clinical Fellow Alumni in April 2025. The Fellows were shown the emerging story of the strategy and the draft strategic objectives. They provided the following feedback:

- Fellows were positive about a shift to being more open and **prouder of the FtP** arm of the organisation. However, **timeliness of processes and FtP being less adversarial** were also highlighted as being important.
- The importance of **compassion** was highlighted, but there was some feedback that the Fellows were struggling to see which strategic themes related to compassion.
- Fellows were keen for there still to be some commitment to working to maintain/support a 'sustainable workforce': i.e., something around '**responsible workforce planning**'.
- A couple of the Fellows felt strongly about the importance for some commitment around the GMC's influence on **environmental sustainability**.
- The Fellows highlighted a **disconnect** between the GMC's internal environment (which is very positive) and the environment that doctors are working in (which is negative) and stated that this is one of the reasons that trust in the GMC is far off for doctors.
- There is more the GMC could do in terms of **influencing**.
- There could be better **communication to the profession about the GMC's role and remit**: the Fellows were clear that it's the GMC responsibility to get these messages across. Overall, there was a fair bit of discussion about ways to improve the relationship the GMC has with the profession.

Case examiners

The strategy team attended the case examiners away day in March 2025, where the emerging story of the strategy and the draft strategic themes were presented. Case examiners were asked their thoughts on the emerging story and themes, if the focus was right, how the GMC could better engage and communicate with registrants and the public, and what success would look like in five years' time.

Case examiners reflected on the current strategy (2020 – 2025) and stated that the general areas of the strategy should be retained, but with some evolution the **reflects changes in the external environment**, for example, responding to changes with AI. In their view, the focus of the GMC's work should be **regulation and ensuring that FtP is fit for purpose**.

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Communication came through strongly, with case examiners saying we should focus on how we, and our processes, are perceived and understood. Case examiners also thought it was important to:

- **build trust** among doctors (and not focus on being 'liked')
- **engage with doctors early** in their careers and/or when they are medical students
- use our **data** about investigations more effectively
- improve our language, making it more **user friendly and accessible**, especially in FtP
- **put out positive messages** about our work to the public.

GMC associates

The strategy team ran a focus group with five GMC associates in April 2025. The strategy team presented the same slides and asked the same questions that case examiners were asked in March.

GMC associates highlighted **doctors' fear of the GMC**, especially amongst trainees, which they were concerned about. They stated that this is exacerbated by the GMC focussing on individual errors rather than considering the impact of systems and the context in which doctors are working. Associates felt that **the strategy should work to help registrants feel supported**.

It was noted that **multiprofessional regulation** wasn't coming through from the four draft themes; there wasn't any mention of PAs or AAs. Associates stated that the GMC was not seen as having handled PA/AA registration well so far. They said that the new strategy could be a good opportunity to re-brand as a multiprofessional regulator.

In terms of the standards doctors are held to, some of the GMC associates believed that holding doctors to high standards in their personal life (as opposed to just in their professional life) was outdated.

Finally, associates felt that better **communication** about GMC processes was needed.

Medical Students

A focus group was held with four medical students in June 2025. They were asked their thoughts of the draft strategic themes, ways of communication and engagement, and finally what success would look like.

The group were positive about commitments to increase understanding of the GMC amongst registrants. In their experience, first year medical students don't know what the GMC does.

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Understanding of the GMC's role is poor throughout medical school: many students think the GMC's main role is discipline. It is important to **better communicate what the GMC's role is**, and to be more **transparent** as a regulator.

Suggestions as to how to communicate with students included:

- Use **new forms of communication**, for example, Instagram to connect with younger people
- Stands at freshers' fairs, which may be more effective than lectures (which are less memorable)
- GMC reps at medical schools (similar to BMA reps).

Audience testing

A near-final version of the strategy was shared with some Clinical Fellow alumni and some PA and AA representatives to understand how the strategy might land with registrants. All audiences responded positively overall. For doctors, a significant indicator of success would be that more doctors think the GMC understands the context in which they are working and that this is properly taken into account in fitness to practise investigations. They felt our communications were key to this. The PAs we spoke were mostly interested in how we would communicate our goals concisely to registrants and keep registrants updated on how we were implementing them.

Other organisations

The strategy team met with strategy colleagues from a range of organisations, including other regulators, in both the healthcare sector and non-healthcare organisations.

Healthcare

- Care Quality Commission (CQC)
- Health Care Practitioners Council (HCPC)
- General Dental Council (GDC)
- Patient Safety Commissioner
- British Medical Association (BMA)
- United Medical Associate Professionals (UMAPs)

Non-healthcare

- Ofsted

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- Professional Standards Agency (PSA)

Strategy colleagues also attended a webinar about the development of the National Trust's next strategy.

Top line summary

- Placing patients/service users first and organisations working together to influence and make improvements for common good
- Being part of the solution and not just pointing out problems. Addressing fear and mistrust of regulation.
- Being ever mindful of the tricky balance between the core remit of protecting patients and the public and minimising the negative impact of regulatory processes.
- Balancing ambition with resources and being realistic about what's possible re. perceptions
- Strong focus on narratives, communication, listening, storytelling and managing expectations.

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Our internal engagement approach

The work to develop the 2026-2030 GMC Corporate Strategy has included comprehensive engagement with GMC colleagues at all levels and directorates. The first phase of engagement ran from September 2024 to March 2025 and incorporated:

- One-to-one meetings with SMT and an away day (7)
- One-to-ones with Council members (12)
- Meetings with leadership teams from all directorates (120)
- Session at GMC wide leadership day (90)
- Meetings with staff at all levels at directorate stand-ups or away days (390)
- Team meetings in areas of specific interest / change projects (73)
- A GMC wide staff survey (161 responses)
- A series of workshops and focus groups, attended by colleagues from across all directorates (102)

Over 900 people participated in the range of meetings and interactions undertaken (however please note we interacted with many individuals on multiple occasions at different events).

This report summarises the comments, thoughts, and feedback we've heard from phase one of engagement, highlighting the key themes and messages. There are two sections: the first section summarises the key themes that emerged **by group**, while the second section brings together the main findings **by selected key themes**.

Overview of key findings by group

GMC Leaders: SMT Away days and 121s

We engaged with all members of SMT at two away days and via 1-2-1s and attended the GMC-wide leadership day to consult with assistant directors and heads of section.

Senior leaders consider the next strategy should focus on how we communicate, our relationships and influencing work, our education reform work and our internal processes.

Communications, relationships, and our influence

- **Our influencing role:** we shouldn't be afraid to be ambitious. We should be responsive to, supportive of, contributing to, and enabling for the sector at large as well as our stakeholders

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and partners. The role of data is important, but our data has gaps (especially the NTS which only looks at trainers and trainees, while other surveys only have small sample sizes) therefore we need a level of caution with what we say using our data.

- **Patient and public interactions:** Proportionality and focus is necessary to ensure we use our resources and insights helpfully and effectively. Understanding and improving customer experience would be a key route into being an effective and compassionate regulator.
- **Building trust and confidence:** This should be a particular area of focus around fitness to practice processes.

Education

- **Clarity:** Being clear about what we own and what we can influence in training and education. This should be a fundamental driver of the next strategy, and the new strategy could be used to help us do things differently. However, we need to understand there will be challenges around the career development and curricular reviews of PAs and AAs.
- **Focus on doctors' needs:** Supporting more varied participation in medical education, focusing on ways to get the medical workforce to the areas (geographical and specialty wise) where they are most needed, and ensure there is an equitable focus between those in training and those not.

GMC as an organisation

- **Technology:** Better use of technology to improve productivity, efficiency, customer experience, and employee satisfaction, all while balancing funding constraints and cyber security. For registrants, enhance the web-based experience for registrants. Though, there is a risk of the unknown around the future of technology and AI means it could be difficult to be explicit about this in the corporate strategy.

The strategy

- **Measurability:** the corporate strategy should be ambitious and realistic, with specificity and SMART objectives that can be developed at team level that align to the corporate strategy. The new strategy must be enabling as we're aiming for evolution, not revolution.
- **Remit:** It must reflect four country regulation and fully reflect our remit of patient safety.
- **Employer of choice:** It should drive conversations about how we can be an employer of choice with bespoke and relevant commitments.
- **Relatability:** Everyone should have a coherent view of our values and behaviours, while recognising the benefits of diversity and difference. Everyone should be able to see their place in the strategy, and how their role relates to the themes.

Council 121s

We spoke to twelve council members in total covering registrant and lay members. We engaged with them via 1-1 conversations.

Council members identified that the GMC need to be agile in the context of a changing external environment, consider risk, communicate our role clearly, collaborate with stakeholders and address misconceptions, and consider ED&I challenges. The strategy needs to be memorable and identify what we can control and influence.

GMC as an organisation

- **The GMC needs to be more agile, strategic, and responsive:** This is particularly important regarding factors in the external environment that the GMC needs to better consider, such as social values and systemic factors that affect or have the potential to affect our ability to regulate. Some examples given were the ageing population, social and economic deprivation (often linking to higher referral rates), the systemic forces on doctors' working environments, and climate change.
- **More of an organisational and strategic focus on risk:** particularly for the themes of effectiveness and relevance. Specifically, risk management, appetite, how we can learn from it, and how we communicate our consideration of risk.

GMC regulatory role

- **Important link between our performance in FtP and the perceptions and trust of the GMC amongst registrants:** Registrant trust is of paramount importance – around which everything else is linked.
- **A focus on workforce, education and training:** Regarding workforce, the GMC could support doctors more and have a global focus. Regarding education and training, reform is a priority, and the GMC can control more elements of this over the working environment. To be effective, education and training can support with health inequalities and population needs.
- **Readiness to be a multi-professional regulator:** Questions around whether we are ready to be a multi-professional regulator (speaking from before 13 December 2024). Also need to mention MAPS more and consider the news of regulating managers.
- **Consideration for patients:** This includes whether the GMC should switch from language of patient safety to patient care, and whether to prioritise based on patient safety. The GMC can also use insights to better understand patient profiles, needs, and who brings complaints.
- **Technology:** a useful tool to enhance regulatory activities and support staff.

Communications and relationships

- **Clearly communicate the GMC's role, remit and function with registrants:** including via better outreach, communication (to address misunderstandings of FtP in particular) and improved transparency to build trust and provide clarity. Regarding PAs and AAs, the GMC's communications and strategy should steer clear of too much mention of this as it could further diminish support from doctors.
- **Identify and collaborate with stakeholders:** to be effective and build relationships on the ground, particularly with MPTS.

ED&I considerations

- **ED&I considerations are consistently important:** including identifying equity and intersectionality within the workforce. Data will be useful for this.

The strategy

- **Communicate meaning and be memorable:** The strategy should be particular about the meaning of each word of the vision and be memorable. Compassion is notably lacking a definition and will be important for framing regulatory activities (FtP in particular), and the perceptions survey will be useful for addressing gaps. The themes and vision can also be more clearly aligned.
- **Make clear what the GMC can control versus what it can influence:** This could also be better explained to staff, to help them understand the rationale for our activities and how they can make a difference.
- **Prioritise:** A useful exercise might be to consider what we could do if we only had half of our budget.

Directorate leadership teams

We met with individual leadership teams from across the GMC, attending their management and leadership meetings.

Directorate leadership teams consider that the new strategy overall needs to be ambitious, realistic, affordable, relevant to all, short and clear.

- **Need to take account of scale and impacts of committed change:** This will include a focus on consolidation/simplification and connecting strategic goals with operational work. We should consider risk appetite – including increasing our risk appetite – and affordability, while balancing the importance of efficiency and effectiveness. Overall, we should define what success looks like and measure it throughout.

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- **Foreground patients and set broader ambitions on EDI:** There should be a dedicated resource for patient engagement, and we should understand barriers for complainants using better data and insight. There should be overarching strategic ambitions on ED&I which broaden our reach across different protected characteristics.
- **Greater clarity on goals of ‘upstream’ regulation:** This will include defining influencing goals and direct/indirect levers more clearly, being more selective about our work, and seeing our core functions as part of upstream regulation. We should have clearer and stronger positions on specific issues and better articulate the relational aspects of regulation. Engaging and collaborating with others will be key.
- **Use the strategy to support ‘story telling’:** We should increase the internal visibility of the strategy and the progress we're making. There should be clearer link to team plans and more visibility of operational successes – e.g. ftp timeliness trends. We should use a confident and positive tone in communications and include short-term milestones to maintain momentum on multi-year programmes.
- **Maintain focus on internal culture and ways of working:** There should be more cross-organisation collaboration, proactivity, flexibility and reflection and professional curiosity across the organisation. There should be a greater emphasis on learning lessons/continuous improvement and sharing good practice and increased support for all staff including managers and those working on FtP cases. Affordability, efficiency, and effectiveness should be strong components in the strategy, and there should be an emphasis on consistency across functions, including alignment on decision making.
- **Engage externally:** with registrants, other regulators, and stakeholders across the sector. We need strong communication of our strategy and our vision and to clearly lay out how we are being relevant etc; setting objectives on knowledge sharing and supporting vulnerable doctors and witnesses; better communication of FtP processes and statistics to reassure doctors and employers; importance of timeliness and empathy in our comms; multi-professional regulation, ensure PAs and AAs are central in everything we do, alongside doctors.
- **Good and effective use of technology:** We should revisit the systems we use and explore the use of AI. There needs to be more clarity and permission on when and where to use AI and the strategy team should work closely with IS, ensuring there is an underpinning IS strategy that supports the corporate strategy.

Directorate / team days / other meetings with specific teams

We met with individuals at a team level from across the organisation where feasible through whole directorate sessions and/or teams responsible for our change projects. We met with the

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ED&I steering group, the MLA team, and the standards team. We engaged at a directorate level with SC&E, S&P, resources, E&S, and the corporate directorate.

Overall, teams want to see a focus on ED&I, better engagement and communication with our audiences, and improved internal ways of working.

Teams want to see:

- **ED&I:** A more strategic ambition for ED&I externally and internally. Our overarching aims should filter through to teams and individuals with accountability. More understanding of all protected characteristics and intersectionality.
- **Engagement and communication (patients):** There needs to be a greater focus on understanding our audiences. Including patient needs generally, understanding the patient voice and what they expect - and using this to shape our work. Also need to understand the motivations for complaints from patients and barriers to complaining. Are complaints more likely from certain groups / people who are more able?
- **Engagement and communications (registrants):** Need to demonstrate understanding of the context doctors are working in and conveying to doctors we take this into account. Build a stronger relationship with registrants and supporting a positive relationship between our different groups of registrants. Building relationship with medical students earlier on to educate about regulation, what this means and our statutory role.
- **Engagement and communications (general):** Overall, we need improved awareness of the range of work the GMC does, more focus on real-life in person interactions with registrants and medical students, more focus on engagement with other stakeholders, and the GMC taking a stronger influencing role.
- **The Vision:** A greater focus on being compassionate (effective and relevant broadly doing ok). Clearer definition of what it means for our organisation given the perceived tension between being compassionate and work of regulation.
- **Internal working cultures:** Continuous improvement, evaluation, sharing good practice, promoting a learning culture and being more evidence-based. Learning from previous large programmes of work.
- **Technology:** More up-to-date technology, improved systems (sense we are behind other similar organisations), and better external facing websites. Finding ways of using AI to make some work processes easier and quicker.
- **Upstream regulation:** A shift towards more upstream regulation - using our education and training responsibilities to do this. Moving more towards understanding the system as a whole.

How can we achieve this?

- **Education and standards:** Promote and implement the standards through education channels. Ensure that our professional standards can be applied in the context in which people are working and consider the pressures they are facing.
- **Our communications:** Stronger articulation and clarification of our influencing role; a shift from reactive to proactive communications; move away from firefighting / defensive mode; being more confident; better use of our data in our comms; acting on the link between perceptions and FtP cases - telling our story more effectively and clearly; and be better at listening and reflecting with registrants. This could include producing more advice and resources in areas where there are challenges and there's evidence that providing more support would be useful.
- **FtP processes:** Providing better support for doctors and promoting what is available more openly to help them have a less stressful experience.
- **Internal working cultures:** We should have more effective / quicker sign-off processes, more inclusion in meetings, and a greater sense of belonging. Also, an improved understanding and awareness of what each team and directorate does and how work interlinks, reduced silos that can hinder our work, and develop better knowledge sharing/updates of team activities.

Staff survey

We conducted a staff survey at the end of 2024. 161 staff members from across the GMC (at all levels and from all directorates) responded to the survey.

There were four main areas of concern for staff that the next strategy should reflect:

1. communication and engagement
 2. how we function as a regulator
 3. our internal working culture, and
 4. integrating ED&I into our internal and external work.
- **How we communicate and engage with external stakeholders:** make this clearer, confident, more proactive, manage perceptions, and address fear. Staff would also particularly like us to focus on using our influence to improve working environments for registrants and increasing our use of data and insights to improve patient safety, especially with employers.
 - **How we function as a regulator:** improve our processes, tools and systems, FtP (fairness and proportionality), our transparency, as well as learning and development for GMC staff. Staff would like us to focus on improving our fitness to practise processes (mitigating bias and reducing their length) in particular.

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- **Improve our internal working culture:** Compassion comes from within first. Staff would also like us to focus on using learning internally to increase consistency across the GMC directorates.
- **ED&I:** Weaving throughout all our work both internally and externally.
- **The next strategy:** Staff highlighted the next strategy should reflect a greater focus on patients, improving our relationship with registrants, reaffirming and embedding our regulatory role and understanding the relationship between perceptions of us and our FtP processes.

Focus groups

A total of 57 members of staff took part in a series of focus groups on a self-selected basis. The focus groups related to the following three areas:

- **Our focus:** what should our goals and priorities be for the next five years?
- **Our approach:** what should we do to achieve our aims and remain relevant?
- **Our interactions:** how should we work with one another and with our partners?

Below we summarise key themes and suggestions that emerged from these discussions. The full report on the focus groups is available [here](#).

- **Being proactive and telling a more positive story about what we do.** Examples of what this could look like included fostering a greater understanding of our role and remit as a regulator, dispelling myths and mistruths about the organisation, and publishing an FtP case studies hub.
- **Engaging registrants at an early stage of their career.** Early engagement with registrants was seen as important to help them better understand our processes, and to build a more positive relationship with them. Engagement with universities could play a role in this.
- **Focusing on our core functions versus influencing activity.** There was a tension between where our focus should be as a regulator.
- **Bolstering outreach.** This was suggested as a way of making us a more compassionate regulator and have a powerful impact on perceptions of the GMC.
- **Use of more personalised communications.** Communications could be targeted and personalised. Registrants could have a specific case worker to contact if they are in our processes. People involved in FtP investigations could have a way of checking in with the status of their case.
- **Breaking down siloed working.** Discussions showed a clear lack of understanding about the work that is done across the GMC. There could be more sharing of internal insights and

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updates, and better collaboration within the GMC. Ways of knowledge sharing could also be via videos and other interactive content.

- **Allowing more time for reflection and continuous improvement.** There is a lack of time to allow this across the organisation, despite people wanting to do it. Reflection could be better embedded into structured processes, such as audits and workshops. There are existing tools that could help with this.
- **Embedding a culture of learning.** Existing learning opportunities are not well tailored to peoples' needs and can be difficult to access. Some were frustrated on the reliance on online learning. There is room for more training on practical skills, in particular related to technology and management.
- **Becoming bolder and less risk averse.** We could have more confident positions and be proactive about social issues (such as climate protests) rather than just being reactive to social change.
- **Communicating reasons for decisions.** There were incidences of inconsistent management approaches, for example related to flexi-working decisions. There could be better policies and communications about decision making processes, and training to avoid bias in decision making.
- **Becoming a more diverse organisation.** Staff could be recruited from more diverse backgrounds, with less of a focus on those with university degrees. SMT and decision makers should reflect the groups we regulate and the diversity of staff in the GMC. There could be more varied representation of staff at all levels externally.
- **Empowering staff and improving collaboration.** Clarity in roles and responsibilities was highlighted as being key. There could be better understanding of our aims and outcomes when we engage externally.
- **Engaging patients.** Patients and their needs should be a priority. We could use internal resources, as many staff are patients too.
- **Making better use of our data.** Data could be more user friendly and accessible. Our data could support better proactivity in sharing positive messages. Region specific data could be useful to external stakeholders.
- **Connecting to the professions we regulate.** We rely heavily on formal mechanisms for intelligence and we could spend more time with registrants asking what they want/need from us. This could help improve perceptions and relationships with registrants also.

Scenario workshops

A total of 45 self-selecting staff were involved in our scenario workshops for the corporate strategy. Four workshops were held with staff from across the GMC to consider three different

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fictional scenarios concerning the GMC and our operating environment in 2035. Scenarios were discussed within each workshop and staff were asked to consider these questions following exposure to the scenario:

- What priorities and goals might we need to be to ensure that we are effective?
- What ways of working might we need to adopt to stay relevant?
- Who would we need to work with and how?

The full write-up of the workshops is available [here](#).

Scenario 1: Represents a future characterised by ample resource and growth in the workforce, and a regulatory approach that is more tailored to individual needs and circumstances.

Participants generally felt that this was a positive, albeit unrealistic, scenario.

- **Effective multi-disciplinary working:** closer working between clinical teams, other regulators and insurance of effective multi-disciplinary working, which will be achieved through actively listening to doctors' concerns and addressing public concerns.
- **Expanding the workforce:** need to consider pressures on foundation places and training, as well as how to meet the need of IMGs. Patients may be frustrated with seeing medical associate roles and not doctors. Also, increasing workforce may mean increasing managers so collaboration about regulation of managers is important.
- **Digitally connected patient records:** improved transparency and accountability but potentially an issue for privacy and our relationship with patients.
- **Patients having access to information about registrants:** would be consequences to this and lead to unfairness. May also result in too much demand for some doctors.
- **The delivery of care closer to people's homes:** would need to increase engagement with local providers and more ROs covering smaller areas.
- **GMC regulation of doctors based overseas and treating people in the UK:** raises questions about registration in the UK, cultural differences, and relationships and information sharing with international regulators.
- **The opening of new GMC offices in different parts of the UK:** understand different contexts and the reasoning for locations, develop the four nations lens, and be more technologically minded and up to date on these tools.
- **Demographic change:** more collaboration with patient representative groups – especially ageing populations.

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Scenario 2: is characterised by resource pressures, reduced access to care, and poor morale in the workforce. GMC priorities have been scaled back and the organisation's influencing power has been diminished. Participants tended to feel that this was a bleak, albeit plausible, scenario.

- **Unrelenting resource and financial pressures:** would need emergency guidance as well as an understanding of what's happening on the ground. More strategic use of multiple professions to share load but could increase workplace tensions. Likely rising healthcare inequalities.
- **A global shortage of healthcare workers:** using data would need to identify the positions the NHS needs filled, shorten medical degrees to plug gaps, focus on retention, attract overseas doctors and support them, and adapt our comms and standards to the environment.
- **GMC financial constraints:** focus on core functions, scaling back work, and doing the basics well. Strong leadership required and less risk adverse as an organisation. Essential we collaborate with other regulators to tackle cross cutting issues, we would face external pressure from stakeholders (e.g. Government) and would need to enhance our understanding of the experiences of registrants through them. We would need to focus on staff retention, as well as strategic and evidenced-based business planning and decision making. In workforce, we would need to help build resilience and trust, while recognising this may have limits in an environment with these pressures.
- **FtP referrals and pressure from the Government to take a firm stance to help maintain public confidence in the health service:** likely to see rising complaints so may have to adapt FtP to this environment and divert internal resource to the team. Will need to maintain performance but acknowledge the context doctors are working in.

Scenario 3: represents a future in which the NHS has been split into three parts and in which there is a much greater role for influential private providers. The GMC has taken on responsibility for regulating additional professions and, in response to resource pressures, is sharing services with other organisations and has delegated some regulatory powers. Participants generally felt that this represented a complex and challenging future.

- **The NHS has been deemed financially unsustainable and split into three parts:** a tiered healthcare system could further health inequalities. We would need to adapt to a rapidly changing environment and new stakeholders, and use outreach, decision making, and information sharing effectively.
- **An increased role for independent sector providers and major companies:** concerning for their motivations to be in the healthcare space and would need to understand their influence on the GMC. Harder to influence and engage with these groups so may need a firmer stance on issues and to adjust the GMC internal environment to move in step with the private sector (e.g. having more powerful leadership against the private sector, different funding models). Would also need to learn from other country models and ensure training quality does not entrench health inequality if the private sector is involved.

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- **Climate change:** A rise in heat-related deaths and shortages of medicines because of climate related disruption to global supply chains. It's likely that climate change will also affect the nations differently, requiring different responses.
- **GMC responsibility for regulating dentists and pharmacists:** may allow streamlining of processes, resource pooling, and patient benefits but would need to be strategic, proportionate (to account for varying groups) and will change the internal make-up of the GMC.
- **Shared services, including a joint Register with the details of regulated professionals from different sectors:** would require management, oversight, shared standards, and flexible options for staff to attract talent.
- **Regulatory powers delegated to third parties:** may delay investigations but could also allow for complaint resolution at local level.
- **'Pop-up' offices can be rapidly established in locations where there is a greater risk of FtP complaints:** would enable agility and may better illuminate the patient side of things but should be balanced with risk and a need to be a more flexible organisation, that predicts and attends sites of risk.
- **The use of AI to help anticipate and mitigate risks:** could enhance case transparency and undertake checks, but human interaction with stakeholders and in communications is important.

Key findings by theme

In this section, we've brought together all the findings from our interactions and discussions under some key headings to support the development of the strategic themes. These are:

- Defining the vision
- Our influencing role
- Communications and interactions
- Internal structure and culture
- Strategy 'look and feel'
- Measuring success.

Defining the vision

This section summarises the findings that can be drawn from all our engagement regarding the key words of the 2030 vision: relevant, effective, and compassionate. The table below brings together all views on what each of these words mean for our work.

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● Relevant	● Keeping pace with the external environment, particularly the specific political, societal and technological changes which have an impact on our regulatory role and internal processes. ● Seeking to influence in key areas where we have the data / evidence and can lever our relationships to do so. ● Engaging and clearly listening to external stakeholders and customers to understand their challenges and priorities, including registrants and patients. ● Being a responsible and socially conscious employer with ambitious ED&I commitments, seeking to continually improve and embedding a learning and evidenced-based culture across the organisation.
● Effective	● Moving upstream, being curious and flexible, building a trusted and respected relationship with registrants, and acting to address patient safety issues. ● Ensuring that our regulatory processes are fair, that we and others learn from our mistakes, and that we harness the opportunities of technology. ● Being proactive in identifying risk, mitigating risk, and assessing risk appetite ● Be a flexible, collaborative, and reflective employer. Ensure staff feel listened to, can interpret their work's effectiveness, and feel supported with what they need to do their jobs well and progress beyond their current roles.
● Compassionate	● Important to define and communicate this clearly and recognising its differing application to a range of needs – including ED&I considerations. ● Understanding the experiences and context of registrants, focus on the human and tailored nature of our processes, explaining our decisions. ● Staff feel empowered to speak up to raise concerns with our processes. ● A transparent and thoughtful approach to communication. ● Being accountable and showing humility: learning from our mistakes and apologising where appropriate. ● Understanding that compassion starts from within. Assist staff with compassionate skills development, prepare staff for future regulatory changes, ensure consistent application of our policies and behaviours, and support staff who deal with challenging areas of work. Use evidence

	to continuously learn from successful projects where compassion was a key element or driver.
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Our influencing role

The new corporate strategy should emphasise our commitment to influence, especially as influencing feeds into our statutory purpose.

- As part of this, it is necessary to **identify and define the boundaries of what we want to control or influence** and understand the difference between what we can control and what we can influence.
- We will need to articulate **our ambitions and goals around influencing**, and the value added through our influencing activity. Influencing comes hand in hand with collaboration, partnership, and sharing i.e. working with other stakeholders for mutual benefit.
- There was some scepticism around the value/impact of influencing. Influencing is a huge investment, need to **be sure about the value brought**. Furthermore, we need to **be cautious** when using our data to influence, being mindful of gaps in the data and sample sizes.

Communications and interactions

- **GMC Values:** Good communication plays a role in being an effective regulator in terms of the types of things we choose to communicate. Furthermore, we can demonstrate compassion through the way we communicate. Communications must also be accessible.
- **Trust and confidence:** Our communications strategy can be key to increasing trust and confidence in the GMC. We can do this through clear, tailored and co-produced communications with registrants (considering tone and voice and what people need).
- **Transparency:** Better communication of FtP statistics could reassure doctors. Sharing other data and insights we hold could also be beneficial. Ensure we are telling the whole story in our communications.
- **Proactivity:** Our approach to communications could be more proactive about addressing misconceptions and misinformation about the GMC and our role and remit. We could also do more to communicate the positives of our role and remit.
- **Stakeholder engagement:** Some lines of communication are a bit one way: what can we do to optimise these relationships?
- **Internal communications:** Calls for better internal communications and interactions to improve working cultures. This could also help counter siloed working.

Internal structure and culture

- **Cross directorate working:** There is a clear opportunity for the corporate strategy to encourage better cross-directorate working and understanding of different functions to reduce silos. There could be more collaboration between directorates. For example, when a new project is started, making sure the right people from a range of directorates are made aware and included. Where siloes exist, these should be recognised: there should be a defined way of identifying internal issues.
- **Flexible and supportive working cultures:** Supportive cultures could be improved. In particular, supporting the emotional wellbeing of those who work on FtP cases or have negative experience when interacting with people external to the GMC. Flexibility is key, and there could be a less hierarchal structure, and more autonomy for staff members.
- **Consistency:** There should be consistency across functions, including a consistent decision-making approach across the organisation but particularly in FtP and R&R. Alignment on how decisions are made and who makes those decisions.
- **GMC structure:** There is opportunity to think carefully about roles and structure of teams. For example, if someone leaves, take it as an opportunity to see if a replacement is necessary (catalyst for change).
- **ED&I:** There is a lack of corporate investment in this area and variations across teams/directorates. Need more engagement and workshops/training rather than passive mandatory training. There should be better cultural awareness of colleagues, and the new corporate strategy should communicate an aim to increase GMC diversity and be bolder recognising ED&I challenges.
- **Continuous learning:** There should be a clear focus on continuous learning for all staff members, and managers should role model positive internal behaviours around this.

Strategy ‘look and feel’

This section provides an overview of the key aspects of the look and feel of the strategy that we have gleaned from our internal engagement.

Influence	● Focus on areas within our control and demonstrate limitations. Identify our levers (both hard and soft levers) and where we can stretch these (e.g. upstream regulation). ● Define our ambitions, outcomes, impacts, and success while being aware of our limits and being realistic. Don’t overplay what a strategy can do. ● Provide clear objectives, measurable deliverables, and the granularity that will be needed in certain areas e.g. EDI.
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GMC corporate strategy 2026-30

	● Establish timelines and ways to measure progress (e.g. is a 5-year corporate strategy realistic?). ● Demonstrate our agility to the external environment and how the organisation has changed. ● Push what we have been doing/pushing for already but in a different way. ● Commitment to engage with other regulators.
Relatability	● Keep relatability so that staff feel like their work is reflected in the strategy. Ensure there is a people hook within the new strategy for staff. Maintain the human element. ● Reflect the four nations. ● Better embed the patient safety role. ● Reframe our interactions and consider trust and confidence as themes within their own right. ● Be consistent, articulate and particular with new themes. The themes must connect our activities to the strategic themes. They must be meaningful but with sufficient detail to be achievable. ● 'Every interaction matters' has been successful in its relatability but, could be more specific to people's daily work and what we do. ● 'Enabling professionals to provide safe care' doesn't truly reflect what we do or how we need to understand the working environment and climate for healthcare professionals. ● 'Developing a sustainable medical workforce' generally less effective as a theme and the language is confusing.
Language and tone	● Reframe our ED&I focus, a particular focus on equity. ● Importance of accessibility and inclusion, as well as consideration of the Welsh Language. ● 'Sustainable workforce' not so effective. ● Reflect the 'customer' element. ● Clear, succinct and easy to understand. Define key words and concepts. ● Make it memorable and the tone uniquely ours – the current strategy could be for any organisation. ● Importance of storytelling and a narrative.

The emerging story of the strategy

- **The vision:** The corporate strategy needs to focus on achieving the vision. As part of this, there need to be clear definitions of what it means for the GMC to be 'relevant', 'effective', and 'compassionate'.
- **Who and where we regulate:** The new corporate strategy should be ambitious but realistic given the scale of change already committed. It will need to balance consistency and adaptability as a 4-country regulator, and as a multi-professional regulator. Becoming a multi-professional regulator allows us to re-focus on the importance of good, safe patient care.
- **ED&I:** ED&I will remain embedded within the strategy: we show risk-based commitment across the ED&I agenda, fairness for patients, complainants, and professionals. However, ED&I will be broadened out to encompass more protected characteristics.
- **Engagement and influence:** Meaningful engagement with professionals, students, patients and the public, and stakeholders is essential to delivering our statutory purpose. However, there is opportunity for greater specificity of our influencing goals, including defining who we want to influence, on what, and why. We recognise that our unique data and insights represent a very valuable offer to our stakeholders.
- **Change programmes:** In the next corporate strategy, there may be more focus on the change to how we regulate that we are seeking through committed major change programmes, and which will absorb a lot of our change capacity. We aim to maximise the benefits of that

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GMC corporate strategy 2026-30

change: part of this will include the need to anticipate future changes and the impacts on the shape of the organisation or the skills required.

- **Trustworthiness:** While we can't make registrants trust us, there is more we can do to demonstrate and control whether we are worthy of trust. Fairness, transparency, timeliness, and being seen to listen and respond will be key in this. We need to communicate proactively, compassionately, and with confidence.
- **Technology:** We need to define what we want to enable through the effective use of technology: i.e. productivity, customer experience, employee satisfaction etc, and keep pace with the implications of technology in healthcare.
- **GMC as an employer:** As an organisation, the GMC needs to maintain a focus on people and our internal cultures. We need to have a strong employment offer and widen our lens to include our wider responsibilities such as CSR, good stewardship, and our approach to decision making. Overall, we need to improve our story telling.
- **GMC processes:** On GMC processes, there should be better links with business planning, more risk- and evidence-based decision making and more focus on cost-effectiveness. We will continue to measure and hold ourselves to account against the corporate strategy. There will be operational transformation, with a focus fairness; transparency and timeliness; listening and responding.

Measuring success

There should be some level of granularity about how the strategy will be delivered included in the strategy. There should be outcome indicators to track high level ambitions and influence.

- The strategy will include high-level strategic objectives. These will be implemented at team level via SMART measures which should be developed with local delivery plans that connect to the broader strategic aims and objectives.
- When it comes to the vision, the GMC will have achieved the vision (being effective, relevant and compassionate) if we can demonstrate that we are confidently delivering our statutory obligations and are trusted and respected in doing so. As part of this, we will need to stay up to date on the external environment and not only follow but lead changes and respond well to change externally.
- Our stakeholders (including the public) will understand our role and see our value. Positive feedback will be indicative of success.

Practical examples/suggestions:

Throughout the engagement, there were suggestions from individuals of practical steps that could be taken that relate to the themes emerging in the strategy.

- We used to publish a newsletter (hard copy) with a case study on the back (anonymised) so doctors could read it and see 'that's not me' - and therefore understand that most cases are extreme and its obvious why they were investigated. Doctors liked this and would often comment anecdotally.
- Increased visibility of the strategy around the office, for example, posters or screen savers.
- Working to improve positive perceptions amongst medical students.
- Celebrate 5 years of being a multi-professional regulator at the end of 2029, as it is an important milestone we should be proud of.
- Could we use the voices of the clinical fellows more to 'sell' ourselves as an organisation?
- Importance of accessibility to those who are neurodiverse.
- Specific weight and focus to business as usual (BAU).

Annex C

Equality Impact Assessment (EqIA)

**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.

Annex D

Plans for assessing progress

What is the purpose of this work?

Two **primary** purposes of Assessing Progress:

1. Inform ongoing planning and prioritisation discussions
2. Contribute to overall assurance, both internally and externally, that the corporate strategy is being successfully implemented and delivering the anticipated outcomes

Secondary purposes include:

- An opportunity to celebrate successes across the organisation
- A means of maintaining momentum throughout the five years and keeping it in people's minds.

Lessons learned from current strategy:

- that we need to take account of the primary purposes to better inform the **frequency, content, audience and methods of reporting & communication.**
- getting the insights gained from our assessment to the most relevant audiences to drive ongoing planning and prioritisation discussions.

Underlying principles for assessing progress

Initial

Develop the strategy and assessment approach together: they inform each other

Create pre-defined list of measures for objectivity with flexibility to use new/emerging data for additional insights

Define the content of our approach as early as possible to ensure clarity with colleagues

Method

Strike a balance between reporting on BAU, activities, outcome and impact

Use existing sources of data and evidence

Prioritise using data sources that provide greatest insight for least amount of effort (proportionate)

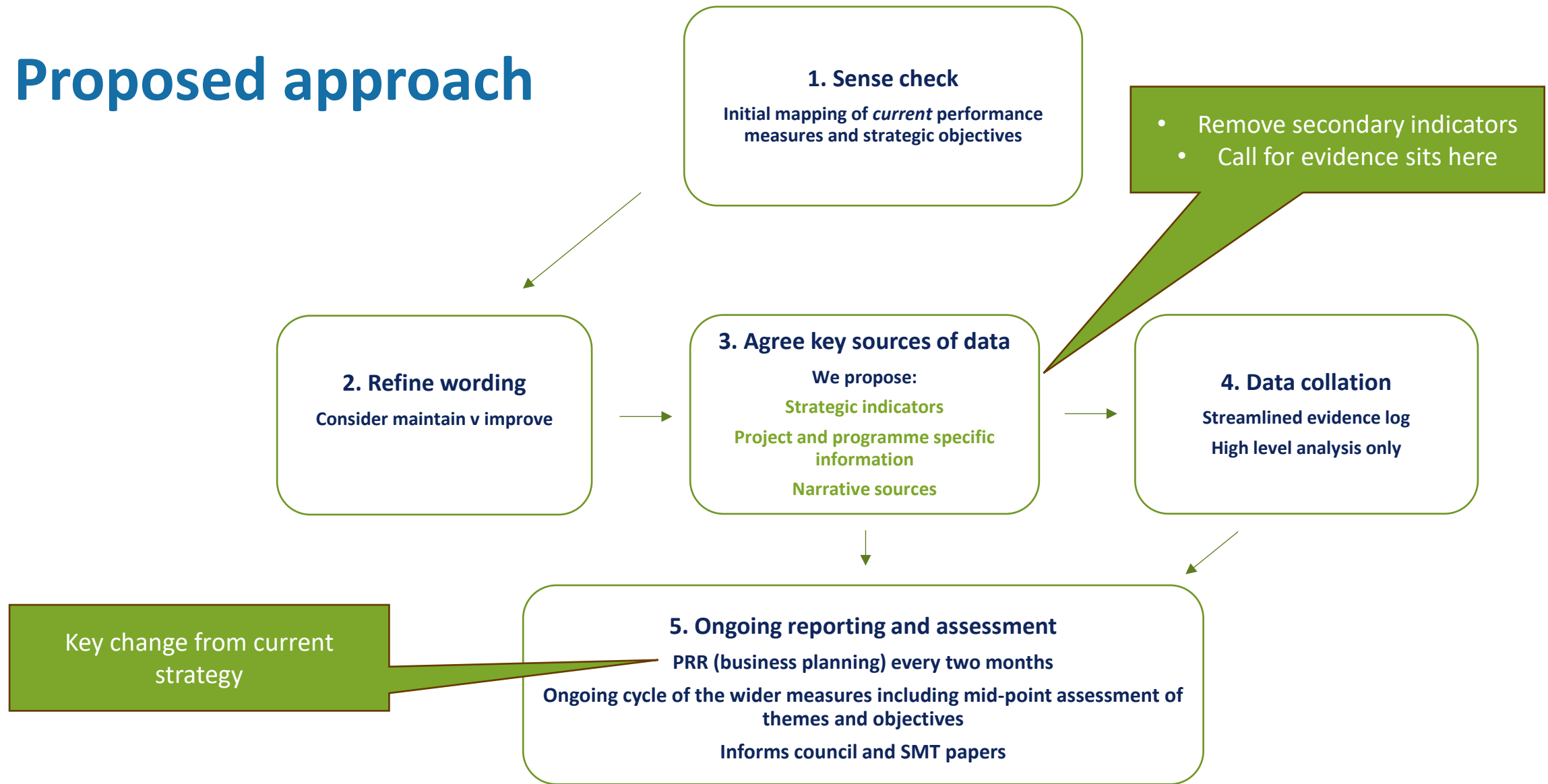
Roles

DRIH & BPR teams collate and summarise the existing data

DRIH lead analysis of the data

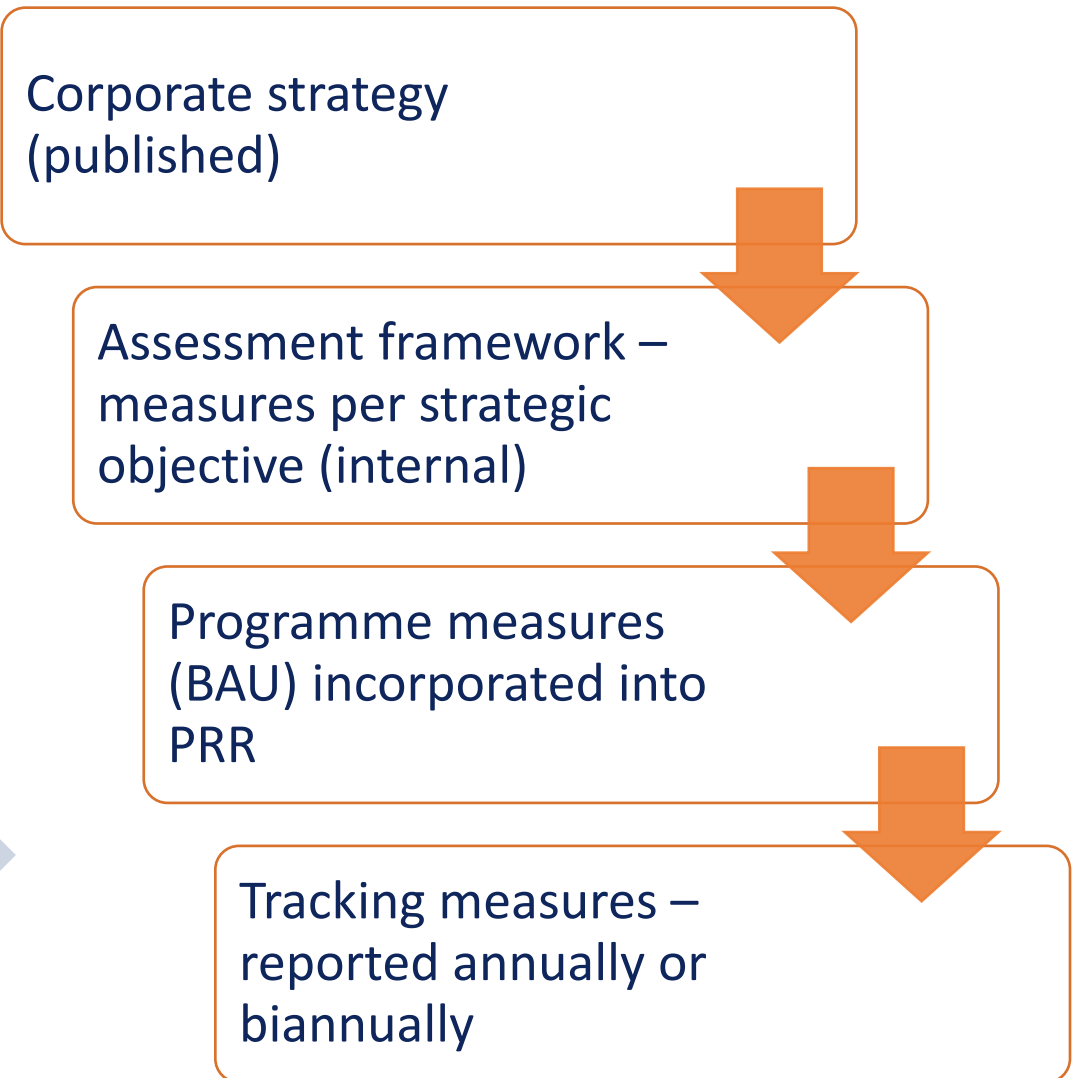
Strategy team triangulate and make assessment of whether progress is good or not (with support from DRIH and BPR)

Proposed approach



How will we report against the strategy?

- Beneath the strategy will sit an assessment framework with measures for each strategic objective
- Some measures will be tracked as part of BAU and programmes and can be incorporated into PRR and reported every other month
- Others will be tracked annually or every two years, or captured more qualitatively, with the proposed assessment/reporting cycle:



Evidence sources

Strategic

Performance indicators and ED&I target data

Surveys - perceptions tracking, barometer, people, NTS

Other team specific, none performance indicator, e.g. CO2 emissions, complaints, internal turnover

Project / programme specific

BP data - milestones updates, risk updates, closure reports

Evaluations (internal/external)

Audits

Narrative

Free text comments in key surveys e.g. tracking, Barometer

Anecdotal feedback

Cross-cutting

PRR

Annual report, ED&I, comms, GMC, freedom to speak up, PPI rpts

Call for evidence

Outreach data

Less useful (do not intend to use for this strategy)

NHS staff survey

Intelligence module

Horizon reporting

Example: Delivering better, fairer regulation

Strategic objective	Success will look like..	Evidence sources
Improve and sustain fairness in our decision making Our goal is to make sure that the decisions we make are compassionate, fair, and robust. We will: • monitor, assure, and develop the way we make regulatory decisions • actively consider the risk of bias, encourage more professional curiosity and cultural humility in how we make decisions, and respond to changing contexts and societal shifts • improve the transparency of our decisions through publication of equality, diversity and inclusion (ED&I) data and equality impact assessments.	<i>We will have succeeded if we can demonstrate compliance against the anti-bias measures we have introduced. We will also have confidence that our decision makers are displaying the behaviours we want to see. And we will be transparent about how we assure the fairness of our decision making.</i> Indicators • Greater assurance in the fairness of our decision making and stronger capabilities to mitigate bias • Greater transparency, understanding and confidence in how we ensure fairness in regulatory decision making • Colleagues understand their role in identifying and minimising the risk of bias in their work, and how this approach supports the creation of a fair culture. • We can evidence that FtP colleagues demonstrate professional curiosity (critical thinking, challenging assumptions, considering changing circumstances etc). • Publication of revised guidance - cross directorate decision making guidance.	Strategic - Performance indicators: yes - Surveys - perceptions tracking, barometer, people, NTS: yes - ED&I target data: yes (for FER) - Other team specific, none performance indicator: yes some (e.g. FtP tracking data on cancellations & no impairment judgements) Project/ programme specific - BP data: milestones updates, risk updates, closure reports: yes some - Evaluations - internal/external: yes though likely to be later - Audits: yes (internal and poss external - RFR) Narrative - Survey open ends, anecdotal, external reports: yes some Cross cutting - Internal reporting: PRR, ED&I, comms, GMC, freedom to speak up, PPI, outreach: possibly - Call for evidence: yes (outreach, FtP and R&R colleagues in particular)

Example: Delivering better, fairer regulation

Strategic objective	Success will look like..	Measures
Continue to develop and improve our regulatory processes Our goal is to maintain and develop our approach to being an effective regulator of doctors, PAs, and AAs. This means continuing to be robust in how we carry out our responsibilities, while being fair, flexible, proportionate, and compassionate in how we treat the professionals we regulate, complainants and witnesses. We will: continue to improve our processes, and develop our rules, standards, and guidance, to make sure they are timely, transparent, evidence-based, consistent, and appropriate for each of the three professions we regulate.	<i>We will have succeeded if can demonstrate successful delivery of programmes of work to develop and improve our regulatory processes. We will also continue to perform strongly against our key performance indicators and meet all PSA standards.</i> Indicators • We maintain our effectiveness as a successful regulator • We maintain our strong relationships with key, close stakeholders and we've established productive relationships with new stakeholders • We can evidence that we are continuously seeking and acting on feedback, take opportunities to respond to legislative changes quickly and appropriately and can demonstrate we are keeping pace with emerging areas of risk. Evidence of development of rules / standards / guidance. • We have produced and delivery of a roadmap for development of the processes for PAs and AAs. The order will have completed.	Strategic - Performance indicators: yes and PSA standards - Surveys - perceptions tracking, barometer, people, NTS: yes - ED&I target data: N/A - Other team specific, none performance indicator - possibly Project/ programme specific - BP data - milestones updates, risk updates, closure reports: yes likely - Evaluations (internal/external) & audits: some (possibly) Narrative - Survey open ends, anecdotal, external reports: unlikely Cross cutting - Internal reporting: PRR, ED&I, comms, GMC, freedom to speak up, PPI, outreach – yes some e.g: relationship assessments - Call for evidence: yes, very likely from FtP and reg reform

2026 Budget and Business Plan (including financial update and outcome of triennial valuation)

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.

Involving patients and the public in our work as a regulator

Action	To note
Purpose	To provide Council with an update on our work to engage and involve patients, the public and their representatives in our activities as a regulator as we approach the end of our current corporate strategy.
Decision Trail	Council received our last annual update about our work with patients and the public in December 2024. In July 2025, Council received a report reflecting on our use of an engagement panel to support our work on regulatory reform. In May 2025, Audit and Risk Committee received an update on our work to implement the recommendations of a review (carried out in 2022) which looked at the GMC's approach to patient and public engagement.
Recommendation	To note the efforts which continue to be made across the organisation to improve and strengthen the way that we involve patients and the public in our work as a regulator.
Annexes	Annex A: Feedback received by patient service (FTP) Annex B: Our engagement with patient and public organisations in the Devolved Nations
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Sponsoring director/ Senior Responsible Owner	Paul Reynolds , Director of Strategic Communications and Engagement

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Background

- 1 Our current corporate strategy says that we want every person, including patients and members of the public, to have a compassionate, fair and professional experience when they interact with us. It adds that we will ‘work with diverse groups of patients and members of the public to shape our work, so we can continuously improve our interactions and processes.’ Framing this is our vision to be an ‘effective, relevant and compassionate regulator for patients, the public and professionals, and as an employer’ by 2030.
- 2 We are committed to strengthening our involvement of patients and the public in three dimensions of our work as a regulator: policy development, the experiences which patients have of our services and processes, and our engagement with patients through the organisations and networks that represent their needs and interests.
- 3 Building on the commitment we make in our current corporate strategy, we aim to achieve the following outcomes through this work over time. Some outcomes are contingent on the delivery of large-scale programmes (such as regulatory reform) and the full deployment of new approaches and technology (such as that used by our Contact Centre) for measuring the experiences of patients and others:

Outcome	Current assessment (end of 2025)
We see an increase in the overall engagement we have with patients and the public with the development of our key policies and changes to our regulatory services.	Evidence demonstrates we are meeting this outcome and must now sustain our progress.
We can demonstrate clearly how patients and the public have shaped and influenced the ongoing development of our services and policies.	Evidence demonstrates we are meeting this outcome and must now sustain our progress.
Our policy, operational and engagement teams value the involvement of patients in shaping their work. We can see an increased awareness and consideration of patients and their perspectives throughout our policy development process.	Evidence demonstrates we are meeting this outcome and must now sustain our progress.
We see an improvement in the quality of our relationships with organisations representing patients and the public. Bodies representing patients and the public believe we listen, respect and respond to their views.	Evidence demonstrates we are partially meeting this outcome. Our external relations teams in all four UK nations continue to strengthen our relationships with existing patient and public bodies. However, because of

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	the rapidly changing landscape (particularly in England), this will remain work in progress. Our perceptions survey in 2026 will give us the opportunity to assess our relationships with patient and public organisations and plan further improvements (see paras 67-73 and Annex B for further information).
When raising a concern about a doctor or needing our help in some other way, we can demonstrate (through the feedback that we collect) that patients are able to access our support easily and have a compassionate experience throughout their engagement with us.	Evidence (from our Contact Centre and patient liaison team in FTP, in particular) demonstrates we are partially meeting this outcome. However, further improvements are required and are in train. Towards the end of 2025, our Contact Centre will deploy its new automated feedback surveys (see paras 21-22) while our Fitness to Practise directorate will conclude and evaluate the feedback pilot it has been running during 2025 and consider its next steps (see paras 24-30 for further information).
We can demonstrate a broad range of patients and the public, who share protected characteristics, can engage with us effectively and have informed our policies and services.	Evidence demonstrates we are partially meeting this outcome. A project to identify an organisational position on the collection, analysis, report and use of diversity data to inform our work was added to the GMC's list of corporate priority activities in March 2025. We aim to develop a full Project Initiation Document (PID) for this work for consideration by the GMC's Planning Gateway in the first quarter of 2026 (see paras 36-40 for further information).

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Involving patients and the public in our work as a regulator

- 4 This update to Council provides evidence of how we are making progress towards meeting the long-term outcomes set out above, which will continue to inform our work as we begin the organisation's new corporate strategy in early 2026.

The public's perception of the GMC

- 5 One way we listen to patients and the public is by commissioning regular, independent research to understand their perceptions of us as a regulator. It is important to us that patients and the public have confidence in our role and work.
- 6 We commissioned perceptions research in 2025, which included a survey of over 2,000 adults from across the UK. Fieldwork for the survey was conducted between 24 June and 28 July 2025 and included several new questions about our increased responsibilities as a multiprofessional regulator. We found:
 - 83% of patients and the public were confident in the way that doctors are regulated (compared to 79% in 2024).
 - 73% of patients and the public who said they were familiar with the GMC agreed that the GMC is an effective regulator (compared to 74% in 2024).
 - 46% of patients and the public said they were familiar with the roles of physician associates (PAs) and anaesthesia associates (AAs), of which 64% said they were aware that the roles are now regulated. Of those patients and the public who said they were aware that PAs and AAs are regulated, 85% stated they were confident in their regulation.
- 7 We will survey patients and the public again in 2026, as part of our biennial perceptions research that year.

Our new corporate strategy

- 8 To support the development of our organisation's next corporate strategy (for 2026-2030), our Strategy team has explored the views of patients and the public to ensure their needs and interests are woven into our ambitions for the future.
- 9 This exploration has included mining existing data and insights to understand the needs and interests of patients, including equality impact assessments carried out by the GMC, the findings of the GMC's 2024 perceptions survey with patients and other audiences, the results of recent consultations by the GMC, as well as research that was commissioned to support our review of *Good medical practice* (which told us much about patients' expectations of and experiences with healthcare services).

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- 10 Our Strategy team has attended two meetings of the Patient Group Roundtable (PRG) – in November 2024 and June 2025 – to understand what patients and the public expect from a healthcare regulator and to test our proposed strategic objectives. In these conversations, they heard PRG members express the need for the GMC to:
- have better two-way communication with patients and the public and more robust engagement with them
 - clarify its role and remit as a regulator (including the limitations of our role)
 - be much clearer with patients about how our processes work
 - build compassion into the entirety of a patient’s experience with the GMC, not just at key touch points
 - influence the environments in which professionals work so they are conducive to providing good, safe care to patients.
- 11 Our new corporate strategy is in the final stages of development and will be published in January 2026. The needs of patients and the public are reflected within its strategic themes, both directly and indirectly:
- *Delivering better, fairer regulation:* This strategic theme is focused on strategic regulatory change and continuous improvement of our processes. While the ultimate beneficiaries of this theme are patients and the public, the most direct impact on them is through the exercise of our responsibilities in relation to education and training. We commit to developing a new education framework to ensure that the education for doctors, PAs and AAs continues to be relevant for the changing and diverse needs of patients and the public.
 - *Supporting good, safe patient care:* This strategic theme is about our role in helping shape environments in which our registrants can provide good, safe care. The objectives under this theme are focused on ensuring better outcomes for patients through ensuring that doctors, PAs and AAs work and learn in environments that are inclusive, supportive and fair.
 - *Making every interaction matter:* This theme has the greatest direct relevance to the experiences of patients and the public. Listening to, and understanding, the diverse range of people affected by our work enables us to be responsive to the lived experiences of professionals, patients, and the public. It also helps us make sure our policies and processes are fair and accessible. Our commitments within this theme are to involve diverse groups of people in our work, understand the people who interact with us, and explain what we do and why.
- 12 Our new strategy will also include a commitment that we will review our customer service standards as an organisation. These standards will provide an opportunity to build on the

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[charter of commitments](#) that we produced for patients and their families in late 2019 as well as service-specific outcomes that are in place across the organisation.

Improving patients' experience of our services

- 13 We have regular interactions with patients and the public across several of our services, although the amount of interaction that we have with them is significantly less than what we have with registrants and applicants for registration (i.e. medical students and international medical graduates). For example, our Contact Centre is used by patients and the public, although they form only a small proportion of the service's customer base. Our interaction with patients also varies in nature from service to service.
- 14 Our Contact Centre and Fitness to Practise directorate are two key areas of the organisation which patients and the public access for support. Here, we give an overview of how these areas are developing their services for patients and their understanding of their experiences.

Contact Centre

- 15 The Contact Centre concluded 2024 by undergoing a reaccreditation reassessment with the Institute of Customer Service (ICS). The ICS assess a wide range of criteria, including whether 'processes are designed from a customer's viewpoint and are consistently delivered'. The Contact Centre received accreditation with 'distinction' (a level of accreditation held by fewer than 20 organisations). The assessor commented that 'employees interviewed were passionate about delivering service excellence and aligned to the organisation's mission. Individuals were clear on the benefits of delivering world class service and the role they play in achieving this'.
- 16 In 2025, the Contact Centre has undertaken a 'mid-cycle survey' as part of their ICS accreditation. For the first time, this survey (which assesses staff commitment and engagement to customer service) has included teams beyond the Contact Centre – specifically, our Liaison team in FTP and our Clinical Assessment Centre.
- 17 We received the results of this survey, based on completed responses by over 100 colleagues across the three teams, in late October and received an overall score of 82% (against a benchmark of 65% for government departments). We will now reflect on the results of the survey and consider what actions we can take to improve our scores.
- 18 Contact Centre leaders are increasingly communicating with other organisations to share knowledge and best practice, through opportunities such as the newly created Customer Experience Regulators Forum. Many of the organisations involved in this Forum have more significant contact with members of the public as part of their work. Participating in this group therefore allows us to hear and benefit from their experiences.

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- 19** As we have previously reported, the Contact Centre is engaged in a large-scale programme of work to upgrade the technology which supports its operations and services. The work is focused on harnessing technology to transform customer and colleague experience. Importantly, the programme is underpinned by the Contact Centre's 'customer experience vision' which aims to understand their customers, priorities and preferences and enable customers to interact with the Contact Centre in the way that best suits their needs. Around 6% of interactions into the Contact Centre come from patients and members of the public. Council received an overview of this programme, which will provide an integrated omnichannel system, at their away day in March 2025. In May 2025, Audit and Risk Committee reviewed the results of an external audit of the programme.
- 20** The first phase of this technology transformation programme has focused on the introduction of a new telephony system. This was successfully delivered in September 2024. Throughout 2025, the team has been focused on scoping and developing the second phase of the programme, which will (in November 2025) deliver enhancement of our messaging channels and virtual agents, meaning that customers can receive answers to queries on a 24/7 basis. This will also deliver more effective compliance with Welsh language standards, with automated translation introduced on messaging channels.
- 21** Currently, the Contact Centre reports customer satisfaction data (using Net Promoter Score methodology) internally every month. However, this data is gathered and reported via manual surveys. The volume of data captured is therefore small and less statistically reliable. Nevertheless, most of the feedback received via this current method is positive, with over 70% of customers consistently rating the Contact Centre's services as good. Phase two of the transformation programme will however implement automated surveys for all messaging and voice interactions. This will allow the Contact Centre to gather feedback after every interaction.
- 22** The questions for the new automated surveys have been designed (in collaboration with the GMC's communications and ED&I teams) to focus on gathering customers' views on the speed, friendliness and accuracy of the Contact Centre's service. Once the surveys are bedded in, the team will use the data to inform the development of more holistic SLAs for business reporting.
- 23** The Contact Centre is alive to the risk of digital exclusion and has made commitments that it will continue to offer existing channels, including voice and email, that are valued by many of its customers.

Fitness to Practise

- 24** Our Fitness to Practise directorate continues to develop its approach to seeking feedback from those who experience its processes (including patients and the public) and they are

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currently delivering a pilot to test options for holding feedback surveys in the future. To inform their approach, the directorate has engaged with a range of other organisations, including the Institute of Customer Service, the Information Commissioner's Office and the Financial Ombudsman Service.

- 25** The directorate's feedback pilot went live on 24 February 2025 and is designed to:
- test whether feedback can be effectively gathered about our fitness to practise processes
 - identify the resource that would be required to deliver a full-scale solution
 - explore whether survey format or delivery impacts on response quality or volume.
- 26** Feedback in the pilot is gathered via an online survey, which is sent to all doctors and patients/members of the public at the point at which a case is closed (this includes closures at triage, closures following a provisional enquiry, and closures following a full investigation). The questions in the survey focus exclusively on participants' experience of their communication and interaction with us, rather than the decisions or outcomes we have reached about their cases.
- 27** The pilot began with a single survey for everyone, regardless of the stage at which their case closed. However, this proved less effective for cases closed at triage stage where individuals often have limited engagement with us. Many respondents in these cases struggled to answer questions that assumed greater interaction, leading to a high proportion of partial responses.
- 28** To address this, FTP has developed two different surveys which it began to pilot in early June: the first is for those whose cases have progressed to provisional enquiry or investigation stage, while the second is designed specifically for triage closures. Early results have been encouraging. Before the change, the proportion of partially completed responses was 24%. Since introducing the separate surveys, there have been no partial responses.
- 29** FTP reviews the feedback from these surveys every month to identify trends, action points and areas for improvement. One recurring theme from the feedback received from surveys completed at triage closure is a perceived lack of 'human' interaction. In response, FTP is engaging with other healthcare regulators that handle large volumes of complaints to understand how they approach engagement at equivalent early stages. They have also started to update the letter templates which they use to communicate the closure of cases and will evaluate the impact of these changes through the collection of further feedback.
- 30** Our Fitness to Practise directorate will conclude their feedback pilot later in 2025 and will then conduct a full evaluation and consider next steps.
- 31** Separate from this pilot (which is focused on the experiences of investigations), FTP also gathers feedback from those who have acted as a witness for the GMC in cases which result

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in referral to a Medical Practitioners Tribunal (MPT). Historically, this has been in the form of a single survey sent to witnesses who gave evidence at a hearing. However, in June of this year, they reviewed this feedback mechanism. In addition to refining the questions asked, the survey was split in two: one survey is now sent to all witnesses who give a statement as part of an investigation, asking them specifically about that stage of the process (including in cases which do not result in a referral to MPT); the second survey is sent to all witnesses who are asked to be available to give evidence at a hearing (whether or not they were in fact called). The updated surveys went live on 14 July 2025 and FTP has seen good engagement with them so far.

- 32 FTP is also in the process of reviewing the reporting arrangements for witness survey data and producing a protocol for this. Starting at the end of 2025, they intend to report (on a quarterly basis) against key metrics relating to overall witness satisfaction, use of/satisfaction with the Independent Support Service, and witness care. They will also look at the lowest scoring questions and the narrative feedback received each quarter to identify common themes and potential for improvements. Finally, the protocol will define when and how they should go about contacting respondents to arrange live witness focus groups to gain richer insights.
- 33 Our Legal team, which is responsible for the preparation and support of witnesses in tribunal cases, has also reviewed the recommendations from Professor Louise Wallace's research 'Witness to harm, holding to account' and has some planned work relating to these.
- 34 Fitness to Practise continues to provide a dedicated service to patients who have raised a concern about a doctor. As part of this service, meetings are offered to complainants to help them understand the way that we work and, at the end of the investigation process, the decision that we have made about their concern.
- 35 Between January and June 2025, this service held 167 meetings with patients to discuss the concerns they had raised about doctors. Patients are invited to give their feedback about their experience of each meeting they have. The team's data for the first half of 2025 tells us that:
 - 95% of patients said they were either satisfied or very satisfied with their experience of meeting us.
 - 92% agreed that they felt listened to and that team members showed empathy for their situation.
 - 92% agreed they were satisfied that their concerns had been understood during the liaison meeting.
 - 92% agreed that the meetings helped them to understand what action the GMC could take.

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Please see **Annex A** for some examples of the feedback which this service has received from patients.

Improving our diversity data

- 36** A project to identify an organisational position on the collection, analysis, report and use of diversity data to inform our work was added to the organisation's list of corporate priority activities in March 2025. This followed consideration of a business case by the Planning Gateway and approval by the Executive Board.
- 37** The project recognises that we rely on having strong equality, diversity and inclusion (ED&I) data to inform how we develop, design and deliver the policies, processes and procedures which underpin our regulatory functions. If this data is not reliable or sufficiently detailed, the evidence we use to inform our decisions, such as in equality impact assessments, will be limited and potentially unbalanced. This risks us being unfair and not meeting the needs of those with whom and for whom we work.
- 38** The project aims to be comprehensive in scope to (among other things):
- address the gap in the data we have for complainants and patients in comparison to the data we have for registrants
 - ensure that the diversity monitoring categories for characteristics – as well as the terminology and language we use – is current and inclusive
 - deliver the remaining element of the previous Sex, Gender, and Gender Identity (SGGI) Information Policy project.
- 39** Initial work on this project began in early 2023 and was paused during 2024 to enable our ED&I team to focus its expertise on implementing the organisation's Regulatory Fairness Programme (which was designated a corporate priority).
- 40** In our last update to Council, we said that work on this project would restart in 2025. However, this project remains paused due to ongoing resourcing challenges. We aim to develop a full Project Initiation Document (PID) for submission to the Planning Gateway in the first quarter of 2026. This should allow us to take into account important developments since the business case was approved (such as the anticipated guidance following the Supreme Court Ruling on the definition of sex under the Equality Act).

Raising awareness of our role

- 41** The review of maternity care at Nottingham University Hospitals NHS Trust has highlighted the need for us, as well as other professional regulators (such as the Nursing and Midwifery Council (NMC)), to help patients who have concerns about their care to understand the roles and remits that we have as organisations.

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- 42 Building on the engagement which our Chief Executive and others have had with families who have concerns about the care they received at Nottingham University Hospitals, we have established a programme of work, within our Outreach team, to build our relationships with key national maternity charities and local organisations that work with patients and families who have experienced baby loss or other adverse outcomes during their maternity care. These organisations include Sands, Tommy's and Baby Lifeline.
- 43 Our first step has been to understand how these organisations support patients and families and the level of information they already have about the GMC. We have tested a draft patient information resource with them and the parent group linked to Sands to make sure this resource is clear, accurate, accessible and sensitive. The intention is for this resource to be used by these organisations to inform and signpost patients who may wish to raise concerns about professionals who have treated them. We are also delivering training for staff of these organisations (through our Outreach advisers) on our role and remit so they can better advise patients and families.
- 44 In addition to this, we have engaged with several patient organisations, including Sands and Tommy's, to develop (in collaboration with the NMC) new online resources to help our registrants apply our professional standards in maternity care environments. In our engagement with Sands and Tommy's, for example, we heard about the challenges faced by those who have direct experiences of the difficulties in maternity care. We used these insights from patients to shape our online resources and to emphasise, in particular, the importance of honest, open and compassionate communication with bereaved parents. We published these new resources, in the [ethical hub section](#) of our website, in October 2025.

Involving patients and the public in our policy development

- 45 We continue to ensure patient and public involvement is firmly embedded in the way that we develop our policies as an organisation. We do this by:
- having guidance, tools and materials which assist our policy profession in considering the needs and interests of patients at every stage of the policy development process
 - policy leaders championing the value of involving patients with their teams
 - commissioning research activity to enhance our involvement of patients
 - and evaluating our experiences of involving patients in policy development, to identify lessons we can apply to our work in the future.
- 46 In recent years we have developed internal guidance for our policy profession on how to involve patients and the public effectively in their work and developed a suite of case studies as a way of sharing the experiences we have acquired through involving patients in several

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major programmes (such as our work to update *Good medical practice*). They explain the different methodologies selected by teams, the outcomes that were achieved as well as the key learning points. They also include advice about engaging with patients and the public who have protected characteristics.

- 47 We continue to encourage policy teams to share their experiences of involving patients through the production of further case studies that will build our knowledge, skill and evidence in this area.

Involving patients in our programme of regulatory reform

- 48 The UK Government is reforming the way that we and other healthcare professional regulators work by creating a modern and flexible legislative framework that will enable us to better protect patients and support the professionals we regulate. As we prepare for these changes, we are committed to involving everyone impacted by our work – patients, doctors, physician associates (PAs) and anaesthesia associates (AAs) – in the shaping of our future policies and processes.
- 49 One strand of our engagement has been to commission a panel of patients, doctors, PAs and AAs to help us co-produce new processes, guidance and communications. This panel, which was set up and managed by an external research agency (called Community Research), ran over an 18-month period (between November 2023 and April 2025). They recruited a diverse group of 30 patients, doctors, PAs, and AAs to ensure there was four-country representation within the panel as well as a range of ages, genders, ethnicities and (in the case of doctors) professional backgrounds. Across the 18-month period we conducted a series of engagements – on the support which would be needed by registrants and patients in the proposed new process for agreeing accepted outcomes in fitness to practice cases, our communications in fitness to practise cases, and our role in quality assuring education and training.
- 50 This was the first time that we have pursued a co-productive approach with the development of our work as a regulator. We have therefore evaluated this project internally to understand what went well and what we could apply in future, similar engagement approaches.
- 51 Our evaluation suggests that the engagement panel was broadly successful at achieving its primary aim of meaningfully embedding participants' voices in our work. As we heard from one patient:

'We were made to feel that we made a meaningful contribution to the process and our collective opinions were valuable and would be considered. The group were put at ease at the first face to face session which enabled a healthy discussion and the opportunity to ask questions of both the facilitators and registrants.'

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- 52 The panel also proved that it is possible for us to explore topics with patients and professionals together. However, we also found that co-production is not always the best solution. Some subjects and activities, for example, were harder for members of the public to engage with. We also learned several practical lessons on how we can deliver engagement panels more effectively in future. These lessons include how to better procure such services and manage their delivery (as they take substantial resource to manage well).
- 53 On the basis of our experience, we are in the process of commissioning another engagement panel to run alongside the new few years of our regulatory reform programme. It is likely that we will look to increase the number of panel members and run the panel for slightly longer (closer to two years this time). The tender process for this engagement panel has commenced and we aim to have a supplier in place and panel members recruited in early 2026. From helping us to develop policy positions to designing operational processes and new standards for customer experience, there will be various aspects of our work where we believe the engagement panel will be of invaluable help.

Involving patients in our review of public confidence thresholds

- 54 Regulatory reform should provide us with increased discretion over the types of concern we investigate and the regulatory action we take. In broad terms, we are required to investigate and consider whether we need to take action where a professional's behaviour undermines, or is capable of undermining, the trust and confidence that a fully informed member of the public places in their profession as a whole.
- 55 However, our thresholds in public confidence cases are linked to society's expectations of acceptable behaviour for professionals. These expectations can vary significantly among different social, cultural and economic groups. They may also shift over time.
- 56 Recently, there has been increased scrutiny of how we fulfil our duty to maintain public confidence in cases where doctors have broken the law when protesting about climate change and in others where doctors have made comments on social media platforms about political and social issues.
- 57 To inform a wider review of our thresholds, it is important that we build an evidence base around the public's attitude towards misconduct outside of professional practice and when this will – and will not – undermine their confidence in the professions that we regulate. This evidence base will then support us to take a proportionate approach so we only investigate, and take action, where there is a genuine risk to public confidence.
- 58 To ensure patients and the public are closely involved in the shaping of our thresholds, we commissioned research on common types of public confidence concern. Research participants were carefully selected to ensure a diverse range of views and that different protected characteristics, socio-economic groups and geographic locations were fairly represented.

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- 59 We have received the final report of this research and the findings are the subject of a separate discussion by Council in December. In the short term, we will use the research as reliable evidence of the public's views and review whether our current approach to behaviour outside the workplace is in broad alignment with its findings, or whether any changes may be needed. Future updates to our guidance for decision makers and tribunals will also be informed by the research outcomes and the range of public views expressed.
- 60 Going forward, a more substantive review of our thresholds would further build our evidence base ahead of regulatory reform. This could include undertaking a listening and engagement exercise to proactively seek the views of a wide cross section of the public on a range of questions around public confidence (including areas highlighted in the research such as the use of warnings and conditions).

Involving patients in our reviews of professional guidance

- 61 Patients can offer us important perspectives which help to shape the development of our professional standards and guidance and, consequently, the care and treatment they receive from our registrants. Following the publication and implementation of the new version of *Good medical practice* in early 2024, our Standards team is progressing reviews of five pieces of professional guidance:
- *Leadership and management* and *Raising and acting on concerns about patient safety*. We launched a public consultation on these two, related, pieces of guidance in late October 2025. The consultation, which will close in late January 2026, asks questions about a series of themes which have emerged during six weeks of scoping and stakeholder engagement (which has included discussions with organisations such as the National Guardian's Office, the Patient Safety Commissioner for England, the Independent National Whistleblowing Officer and Scottish Public Services Ombudsman (SPSO), and Civility saves lives). To encourage patients to share their views, we are seeking opportunities to co-create content with patient organisations.
 - *Personal beliefs and medical practice*. We plan to hold a 12-week public consultation on a revised version of this guidance in early 2026. During the consultation, we will also hold a series of roundtable discussions on particular issues, such as non-therapeutic male circumcision (an area of longstanding debate).
 - *0-18 years* and *Protecting children and young people*. We plan to hold a 12-week public consultation on these two pieces of guidance later in 2026. Recognising the strength of our capabilities in this area, we are also considering commissioning a specialist research agency to help us make sure we are understanding and including the views of children and young people (in particular lesser-heard groups, such as care-leavers).

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- 62 These reviews are being overseen by an internal governance board and our Standards team are in the process of supplementing this by establishing an external advisory forum. This advisory forum will include a member with specific expertise in patient and public engagement to ensure this is considered in all aspects of guidance development. The forum will meet regularly from the end of 2025 to provide the reviews with expert oversight and constructive challenge.

Future of Education and Career Development

- 63 The *Future of Education and Career Development* is one of our corporate priorities, as part of which we want to create an updated framework that ensures the education and training of the professionals we regulate can meet the changing needs and expectations of patients. This includes making sure that professionals have the skills and abilities to care effectively for diverse patients and communities and to address healthcare inequalities.
- 64 We are working closely with a wide range of stakeholders – including patients and the public – to develop this framework, to ensure it delivers real benefits for everyone who will be impacted. Over the past year, we have created opportunities for patients and the public to share their views and shape our thinking. For example, at our Patient Group Roundtable in the spring, we explored the role of educators and discussed how our framework can better support the needs of the UK population.
- 65 In June, we ran two workshops in association with Manchester University’s Doubleday Centre for Patient Experience. These workshops (which were attended by clinicians, educators, and patient and public involvement leads from universities) focused on understanding the expectations of patients and how students can be supported to meet them. We also explored how the involvement of patients can be enhanced across curriculum design, assessment and quality assurance. In these workshops we heard about the importance of inclusive engagement, integrating the lived experience of patients throughout education and training, and the need for clearer guidance from regulators on involving patients in education.
- 66 These conversations are helping us to build an updated education framework that is grounded in real experiences and inclusive of diverse voices. We are committed to continuing this approach as we move forwards with the programme, incorporating further engagement with patients and the public to ensure their input is reflected in the outcomes we deliver.

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Improving our relationships and engagement with patient groups

- 67** We continue to engage with patient organisations, seeking their input into our priority programmes (such as regulatory reform and shaping the future of medical education) and providing them with platforms where they can communicate their work to others.
- 68** Our Chair, Chief Executive and Directors meet regularly with their counterparts at patient organisations including the Patient Safety Commissioner's office, The Patients Association, Healthwatch England and Action against Medical Accidents and National Voices, to discuss respective priorities. These meetings are supplemented by regular, working-level engagement between our external relations teams and patient organisations across the four countries (see **Annex B** for further information).
- 69** Council will be aware that the landscape of patient organisations within England is undergoing significant change. In July 2025, Dr Penny Dash published a report, as part of her review of patient safety across the health and care landscape, which concluded that England's patient safety regulatory environment has become fragmented and bureaucratic. The review recommended that the Patient Safety Commissioner for England should be hosted by the Medicines and Healthcare products Regulatory Agency (MHRA). Additionally, the report recommended that local Healthwatch organisations be brought together with the engagement functions of integrated care boards, while national strategic functions should move into the Department of Health and Social Care. While we wait for these recommendations to be enacted, we are maintaining our current approach to engagement with both the Patient Safety Commissioner and Healthwatch.
- 70** It's important to us that we have strong relationships with organisations that represent the interests of patients and the public. To help us assess the strength of these relationships and plan further improvements with them, we will invite a number of patient and public organisations to take part in our perceptions survey in 2026 where they will be able to share their views on the quality of their relationship with the GMC.

Patient Group Roundtable

- 71** Twice a year we bring together patient organisations from across the UK, through our Patient Group Roundtable (PGR), to discuss our emerging thinking about our policies and services as an organisation. These meetings offer a valuable opportunity for open dialogue and consultation with patient representatives, helping ensure our work remains relevant, effective and aligned with patients' needs. The roundtables are chaired by our Director of Strategic Communications and Engagement and include reflections and a Q&A with our Chair.

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- 72 These meetings are held virtually to make them as accessible as possible across the four countries, thereby increasing participation. We have held two roundtable meetings in 2025. Our spring roundtable featured discussions about our new corporate strategy and our programme shaping the future of medical education. Our roundtable in the autumn looked at our reviews of our professional guidance on *Raising and acting on concerns about patient safety* and *Leadership and management*.
- 73 To ensure roundtables remain relevant and valuable to attendees, we gather feedback after each meeting. In 2025, we introduced real-time polling to collect immediate feedback, which resulted in the highest level of feedback we have received to date and clear insight into what participants value from the roundtables. We will use these responses to inform the planning of future roundtables.

Conclusion

- 74 This is the last annual update about our patient and public involvement work as an organisation which Council will receive during the lifetime of our current corporate strategy.
- 75 During 2025, we have continued to make improvements to the way that we involve patients and the public in our work as a regulator and can point to several activities and developments over the course of the year which have brought us closer to achieving the long-term outcomes we have set. Those activities and developments have built on the progress, previously recognised by Council, that we have made in previous years.
- 76 Our position at the end of 2025, therefore, is fundamentally different to how it was in 2022 (our starting point for strengthening our work in this area).
- 77 That said – and despite this progress – we recognise (as an organisation whose primary purpose is to protect the public) that there is still more work for us to do, across all aspects of our role as a regulator, to engage and involve patients significantly and meaningfully in the development of our policies and services. Patient and public involvement will, therefore, continue to be an important priority for us as an organisation as we begin our new corporate strategy.

Annex A

Feedback received by patient service (FTP)

‘Just to know that **finally I was being heard** for what has happened to our family was a relief.’

‘**To be kept in the loop as a family is invaluable. Even when there is no ‘news’** as such. To understand time frames and possible outcomes is also helpful.’

‘The [Liaison Officer] was so **lovely and compassionate**. She explained everything thoroughly and answered any questions I had. I wasn’t rushed and the LO listened to me and recognised how upset I was. She **made me feel at ease even though I was upset and crying.**’

‘Please help the NMC and CQC to be anywhere as good as you are.’

‘I really valued the opportunity to discuss the procedure with the [Liaison Officer]. She was able to allay my concerns and **I really feel I understand what might happen much better now.** Thank you.’

‘**I felt listened to** and understood during the meeting and was able to discuss my concerns openly and they were met with respect. The process was explained to me clearly and **I could understand now what was happening with my complaint.**’

‘The meeting **helped me understand the process the GMC follows and the types of actions they can take.** I appreciated the way the [Liaison Officer] explained things to me, she was clear, patient, and respectful.’

‘The [Liaison Officer] **reassured me that my report has been taken very seriously** and also clearly explained processes and **explained why there may be period where I don't hear a lot which is very helpful.** She signposted me to GMC supportive services should I need to use them too. I now **better understand how a GMC investigation is carried out and how that fits with/around any police investigations** which may be simultaneously ongoing or have been made into the same issue.’

‘The [Liaison Officer] was **very supportive during a difficult conversation.** She remained calm and understanding and talked me through next steps.’

Annex B

Our engagement with patient and public organisations in the Devolved Nations

Northern Ireland

Northern Ireland's Patient and Client Council (PCC) continues to be a key relationship for our National Office team in the country. It is a valued member of our UK Advisory Forum, for example, contributing positively to the discussions we hold with stakeholders. In 2026, our Northern Ireland team will seek to strengthen their ties with the PCC (and with its Chief Executive, in particular) and work with other regulators in Northern Ireland to involve it in the work of the country's shared intelligence network where appropriate.

During 2025, the team has continued to find ways to amplify the voice of patients in their work and the organisation's more broadly. At its Spring UKAF meeting, for example, the session included a short video featuring the family member of a deceased patient of Dr Michael Watt. They spoke about the

importance, to patients and their families, of supportive cultures and accountability.

In January 2025, the team met with a family to discuss their feedback about the GMC's duty of candour guidance. The team shared their views with our Standards team and have established links with the family to secure their involvement in a future review of the guidance. As a result of this engagement, the team's Outreach advisers ensure that learning taken from the patient and family experience regarding openness and honesty is shared with doctors during their interactive workshops.



Scotland

Our National Office team in Scotland continues to ensure we have quality engagement and ties with patient organisations in the country. Among other things, this ensures continued high engagement from Scottish stakeholders with our Patient Group Roundtable meetings.

A key priority in 2025 has been to ensure that the patient voice is heard in the ongoing discussions about the renewal of the NHS in Scotland. The team welcomed the contributions of both the Health and Social Care Alliance and Healthcare Improvement Scotland Community Engagement at our Spring UK Advisory Forum. The Forum considered the question of how health stakeholders ensure that patient safety and experience is front and centre of this national conversation, particularly as patient representative organisations hold a wealth of data and insight.

The team continues to improve its relationship with the Patient Advice & Support Service Scotland (PASS), an independent service delivered by the Citizens Advice network in Scotland. For example, it hosted an online Outreach session for PASS in October 2025 to explain the GMC's fitness to practise processes, having hosted a session explaining our professional standards and role in March.

The team is also looking forward to engaging with Scotland's first ever Patient Safety Commissioner, Karen Titchener, following her official start in September 2025.



Wales

Our National Office team in Wales has prioritised the development of relationships with two organisations in the country during 2025 – Llais (the independent statutory body set up by the Welsh Government to give the people of Wales more say in the planning and delivery of their health and social care services) and the Public Services Ombudsman for Wales.

The Chief Executive of Llais, Alyson Thomas, is routinely invited to attend our UK Advisory Forum meetings and the Head of our team in Wales has met with her twice during 2025 to discuss the best way for these meetings to include and consider the views and needs of patients.

The team has also worked with Llais to explore opportunities for working together to improve the information available to patients and families who have concerns about maternity and neonatal care. This followed the publication in May of Llais's report (*Listening*

to parents) on maternity experiences at Swansea Bay University Health Board. The team will continue to work with Llais and partners on this important issue in 2026.

Our team in Wales is keen to further develop its relationship with Llais in 2026. For example, our Outreach advisers in Wales are exploring opportunities to engage more routinely with Llais's regional teams, including running workshops to improve understanding of the GMC's key roles and functions.

Our team in Wales has also taken steps to strengthen its working relationship with the Public Service Ombudsman for Wales, finalising a Memorandum of Understanding with the body in March that will facilitate the sharing of information between our two organisations where there are concerns.



Fairer Employer Referrals

Action	To discuss
Purpose	To update Council on progress against our commitment to eliminate disproportionate employer referral of ethnic minority doctors and non-UK graduates by 2026.
Decision Trail	Council approved our ED&I priorities in February 2021 Council considered annual ED&I reports on progress in February 2022, April 2023, July 2024 and December 2025. Council considered an annual report on progress in December 2023 and December 2024.
Recommendation(s)	To consider performance against our commitments, our priorities and asks of others. To consider the programme recommendation for the 2026 target date.
Annexes	Annex A: Full report by the Fairer Employer Referrals programme Annex B: Sustaining momentum of the programme post target
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Sponsoring director/ Senior Responsible Owner	Anthony Omo , Director of Fitness to Practice and General Counsel

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Fairer Employer Referrals

Background

- 1 In 2021, we set a target to eliminate disproportionate referrals from employers in relation to ethnicity or origin of Primary Medical Qualification (PMQ) by 2026. We committed to deliver the programme in phases, allowing us to learn as we progressed and to take account of wider changes in the healthcare environment.

Data

- 2 We have two performance measures, or key process indicators (KPIs) for the FER programme.
 - **KPI1:** the percentage of active DBs with evidence of disproportionality in their referrals, for either ethnicity or origin of PMQ.
 - **KPI2:** the difference in rates of employer referral between groups of licensed doctors, in two ways:
 - **KPI2a:** Difference between ethnic minority and white doctors.
 - **KPI2b:** Difference between UK and non-UK doctors.
- 3 All KPIs improved since last year. From our initial benchmark (2016-2020), the percentage of DBs with disproportionality in their referrals (KPI1) dropped 2.4 percentual points. This represents a drop of 43 %. Similarly, KPI2 metrics have dropped 0.15 (KPI2a) and 0.26 (KPI2b) percentual points, respectively, in relation to our initial benchmark. This means that the referral rate difference between either ethnic minority and white doctors or UK and non-UK graduated ones, has dropped 54% (KPI2a) and 62% (KPI2b) respectively.
- 4 The forecasted trajectories of FER KPIs are very similar to those from last year. We expect both KPIs to be close to meeting the target by the end of 2026. More detail on our data can be found at Annex A.

Challenges

- 5 **Data:** Statistical forecasting suggests a high likelihood of nearing our aspirational targets by the end of 2026. However, it is reasonable to expect that some measures may not reach zero, as one referral can change the profile of an organisation's referral patterns. As with any forecast, the exact values cannot be precisely predicted but are expected to fall within the reported uncertainty bands.
- 6 **Impact:** It is not possible to directly attribute the improvements in trends to the Fairer Employer Referrals programme alone, as our KPIs reflect the combined effect of numerous interactions and influences across both the healthcare system and the GMC.

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- 7 Primary Care: The structure of the disciplinary and referral process for primary care brings specific challenges to considering where change can be focussed to have the best impact.

Deliverables

- 8 We are currently wrapping up Phase 4 and initiating Phase 5. Phase 5 has eight deliverables, three of which have started and focus on:
 - Producing a communications calendar and plan, outlining the communications activities we intend to undertake, including the audience and key messages in the lead up to the target date
 - Continuing our work to use our influence to promote the value of mentoring, utilising any tangible evidence for how to support effective mentoring programmes where available.
 - Developing our work in Primary Care to further embed fairer local procedures and promote inclusive practices.

Approaching the target date

- 9 The programme team has considered options, which are set out in Annex B, for what if any next steps we should take once we reach the December 2026 target and recommends a “pause and take stock” approach. This would allow the GMC to review progress, assess the impact of the interventions carried out during the programme, and determine if any further work should be carried out, including any future focus that may be required, for example in primary care.
- 10 A short pause would enable the team to complete remaining deliverables, capture lessons learned and produce a report about the programme to support consistent ongoing communication about the work we have carried out to address disproportionality. Responsibility would then transition to business-as-usual teams, who would continue publishing and monitoring diversity data and using insights to support engagement. This option provides a structured point for reflection before agreeing any future direction.
- 11 During Phase 5 in advance of the target date, the programme will develop a dual-track communication plan to ensure a clear and consistent response once performance against the target is confirmed. If the target is met, communications will highlight progress and achievements, recognising the range of work carried out with stakeholders and the importance of sustaining improvements made. If the target is not met, messaging will be transparent about both the progress made and the extent of any shortfall, emphasising lessons learned and next steps while managing reputational risk. In both scenarios, communications will be supported by targeted stakeholder engagement, internal briefings,

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and risk management to ensure Council, partners, and the wider public receive clear, consistent messaging.

Annex A

Report by the Fairer Employer Referrals programme

- 1 This is the fourth annual report provided by the Fairer Employer Referrals (FER) programme. We are now embarking on our final phase.
- 2 In 2021, we set a target to eliminate disproportionate referrals from employers in relation to ethnicity or origin of Primary Medical Qualification (PMQ) by 2026. We committed to deliver the programme in phases, allowing us to learn as we progressed and to take account of wider changes in the healthcare environment.
- 3 To date, we have completed four phases and have commenced a fifth. We continue to develop each phase considering the initial [Fair to refer?](#) report, which is our most reliable qualitative evidence base on the causes of disproportionality, along with any additional evidence and learning we have identified as we have progressed through the phases. We have also continued to use our in-house-generated quantitative evidence base.
- 4 We are seeing signs of improvement in our disproportionality data year on year; although we continue to remain cautious about drawing conclusions as we know that continued and persistent efforts are needed across the whole system. We are mindful that there is no quick solution to cultural change and therefore the activities that we are pursuing in this programme are not just about reaching our target but also aimed at shifting perspectives and generating engagement.
- 5 We are working towards eliminating differentials in employer referrals by the end of 2026, and we are closely monitoring any factors or developments that emerge during this period which might impact our ability to do so.

Overall progress - our data

- 6 We have two performance measures, or key performance indicators (KPIs) for the FER programme. These reflect the nature of the challenge which requires attention by employer designated bodies (DBs) to assure themselves that their systems produce proportionate referrals (KPI1), and that this needs attention by all employers (not all are DBs), across regulators, and system partners to affect change (KPI2):
 - **KPI1:** the percentage of active DBs with evidence of disproportionality in their referrals, for either ethnicity or origin of PMQ.

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- **KPI2:** the difference in rates of employer referral between groups of licensed doctors, in two ways:
- **KPI2a:** Difference between ethnic minority and white doctors.
- **KPI2b:** Difference between UK and non-UK doctors.

Table 1: Fairer employer referrals measures

Target: Eliminate disproportionality in fitness to practise (FTP) referrals from DBs based on ethnicity and PMQ by 2026						
		2016 – 2020	2017–2021	2018–2022	2019–2023	2020-2024
KPI1: % of DBs with evidence of disproportionality, for ethnicity or PMQ	Ethnicity or PMQ	5.6%	5.3%	4.4%	3.2%	2.94%
KPI2a: Difference in rates of referral between ethnic minority and white doctors	Ethnicity	0.28% ethnic minority 0.58% white	0.24% ethnic minority 0.50% white	0.19% ethnic minority 0.41% white	0.13% ethnic minority 0.31% white	0.11% ethnic minority 0.26% white
KPI2b: Difference in rates of referral between UK and non-UK doctors	PMQ	0.42% UK 0.70% non-UK (made up of 0.73% IMG and 0.63 % EEA)	0.34% UK 0.58% non-UK (made up of 0.59% IMG and 0.56% EEA)	0.27% UK 0.48% non-UK (made up of 0.48% IMG and 0.45% EEA)	0.16% UK 0.34% non-UK (made up of 0.34% IMG and 0.31% EEA)	0.13% UK 0.28% non-UK (made up of 0.28% IMG and 0.27% EEA)

- 7 To draw more robust conclusions out of the small number of referrals we get from each DB, we run our analysis on a five-year rolling period. However, this also means that improvements in disproportionality can take a while to be reflected in our KPIs.
- 8 Each FER KPI has continued to improve substantially since last year, and at a rate close to what is desirable to reach their aspired target within the FER programme lifespan (2021-2026). Compared to our initial benchmark period (2016-2020), KPI1 decreased 2.7 percentage points towards our aspired target at 0% (from 5.6 to 2.9%). This means KPI1 improved 48 % toward the target as we were 67 % of the way through the lifespan of the FER programme. Similarly, from our initial benchmark, KPI2a and KPI2b decreased 0.17 and 0.29 percentage points respectively, towards the aspired targets at 0% (from 0.28 to 0.11%, and from 0.42 to 0.13%). This means that

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KPI2a, b improved 61 and 69%, respectively, towards their target. The improvement of FER KPIs cannot be solely attributed to our activities in the FER programme. Instead, it is the net result of such activities in the context of many interactions across the health system.

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Forecast performance

- 9 For each FER KPI, we produced a fresh forecast of the current direction of travel and contrasted it with the forecast of what we would have expected from 2021 onwards as a reference. See charts below.

Chart 1: KP1 forecast

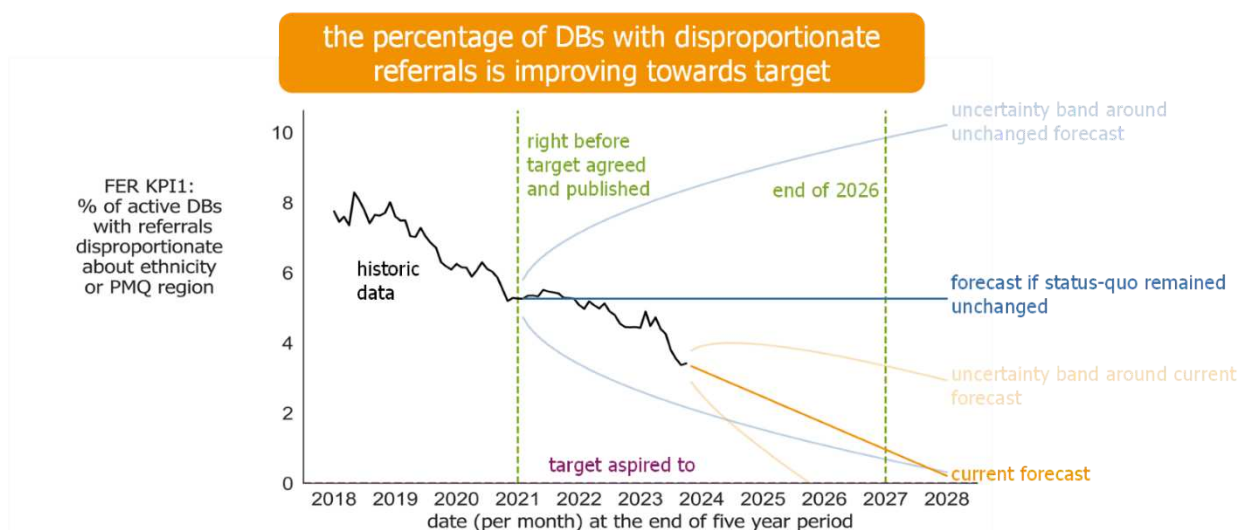
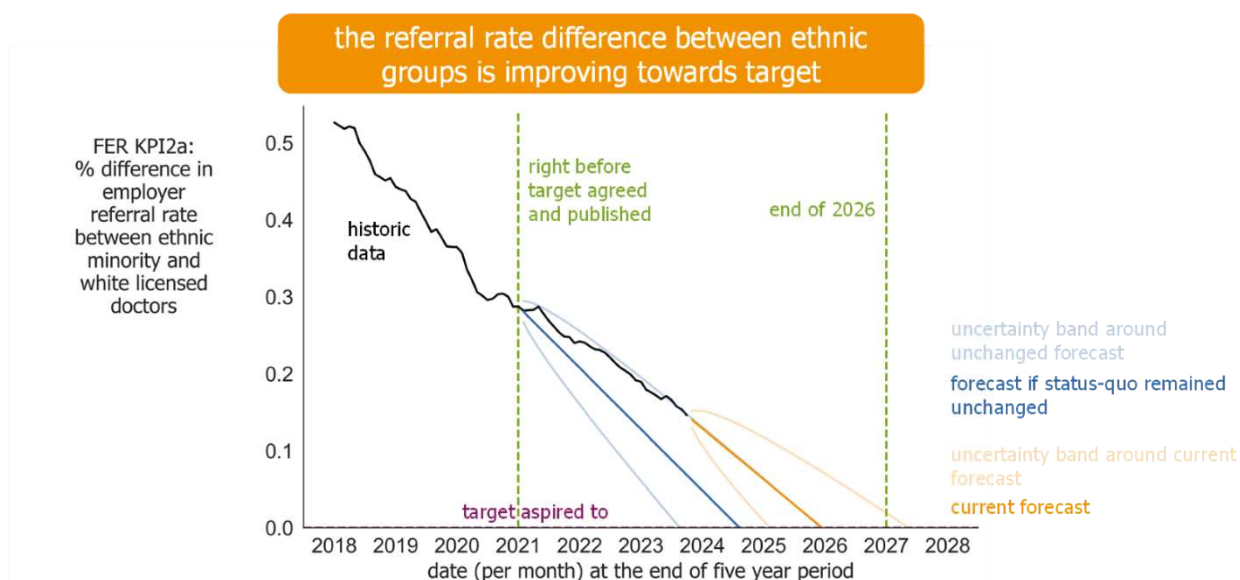


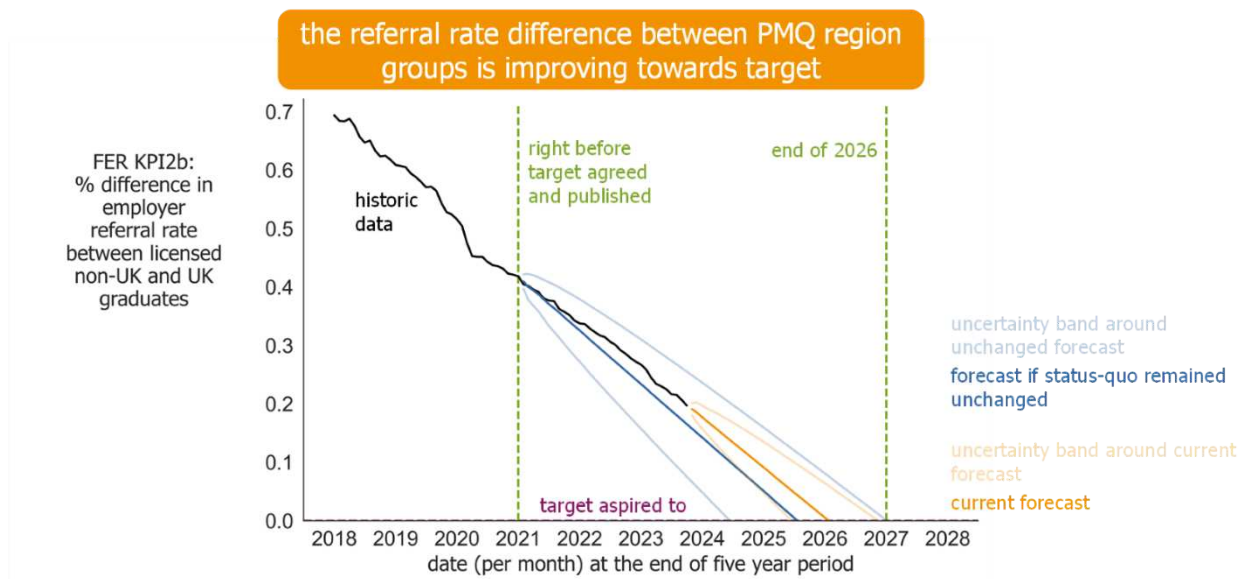
Chart 2: KPI2a forecast



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Chart 3: KPI2b forecast



- 10 The forecasted trajectories of FER KPIs are very similar to those from last year. The percentage of DBs with disproportionate referrals (KPI1) is expected to continue improving towards target and get close to it by the end of 2026. The referral rate difference between both ethnic minority and white licensed doctors (KPI2a) and between non-UK and UK graduated ones (KPI2b) are also becoming smaller and are both expected to get very close to the target by the end of 2026.

Challenges

Data

- 11 As highlighted in our previous papers to Council, the KPIs are calculated quarterly, using a five-year rolling period for robust analysis due to small volumes. Given the time lag, it is likely that we will not know with certainty in 2026 if we have achieved the target. But we will have a good indication on the direction of travel and our forecast model suggests a good likelihood of getting close to our targets by the end of 2026. The time lag also means our quantitative metrics are not immediately useful for judging the impact, or lack of impact, of on-going or recently completed activity. The current data set will only begin to show the full impact of the project after project closure.

Impact

- 12 It is not possible to directly attribute the improvements in trends to the Fairer Employer Referrals programme alone, as our KPIs reflect the combined effect of numerous interactions and influences across both the healthcare system and the GMC.

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Primary care

13 As previously highlighted to Council, the structure of the disciplinary and referral process for primary care brings specific challenges to considering where change can be focussed to have the best impact. These include:

- The referring DB is often not the employer of the doctor and Primary Care covers many small independent employers. This span and distance make reporting, consistency, and messaging difficult and may lead to issues being addressed inconsistently.
- GP practices serve very different and diverse communities and will experience different and nuanced challenges. *Fair to refer?* found that ethnic minority doctors or overseas doctors by PMQ are disproportionately found in smaller practices, in more challenging and deprived areas and are more likely to experience professional isolation and work longer hours. Additional challenges can include cost of living impacts across the four countries, the impacts of the pandemic still being felt within Primary Care, recruitment, and the diversity of the patient group. These are not always sufficiently recognised in funding which can add to pressure.
- We are not the only regulator to highlight these challenges. The Care Quality Commission (CQC) has previously reported on the layers of difficulty that providers led by GPs who are from an ethnic minority background experience. Published in 2022, *Ethnic minority-led GP practices: impact and experience of CQC regulation* found that there are distinct, multi layered challenges that can affect how poorly a practice operates, and whether the GPs are able to offer safe care.
- Our pilot multivariate (i.e. controlling for other characteristics) statistical models of employer referrals confirm that being a GP is separately related to being referred more often, compared to not being a GP.
- It is harder for new international medical graduates (IMGs) to become embedded into UK culture if they are working relatively remotely as a GP. Lack of demographic data within the DBs makes it hard for them to measure activity. It can also be harder for doctors working in primary care to access supervision, coaching and mentoring, all of which are known to improve performance and inclusion.
- From our perspective, it can be difficult to engage with GPs as they do not come together for training as often as colleagues in secondary care may do. It can also be harder to understand where influence can be best applied to improve local investigation given the wide range, and number, of working environments. This is why, to date, we have focused our primary care activity on engaging with NHSE regional teams in England; with NES, health boards and individual practices in Scotland; with Health Education and Improvement Wales (HEIW) and health boards in Wales; and in Northern

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Ireland, with GP Federations, GP trainers and appraisers (in relation to our standards and guidance, including *Fairer Feedback*), as well as Medical Advisers regarding local investigation processes. In addition, we have prioritised engaging with doctors in primary care when rolling out the new Good Medical Practice guidance, which focuses on the importance of working in an inclusive and supportive environment.

Communications activity

14 We have continued to proactively use our communications channels to raise awareness of the programme. Over the past year, activities have included:

- The Professional Standards Authority's (PSA) [Good practice guide – lessons from meeting our EDI Standard for regulators \(July 2025\)](#) recognising the GMC's FER and FTC programmes as examples of good practice. To promote their recognition, the GMC also shared the report via its LinkedIn social media channel.
- Collaboration between the FER and FTC programme to promote the benefits of mentoring. We have utilised E-newsletters, social media and blog content: [The importance of mentoring in doctors' career development – Supporting good, safe patient care across the UK](#).
- Presenting the aims and benefits of the FER programme at the IAMRA conference in Dublin.
- Publishing a blog focussing on the contributions of our ELAs in the programme: [Fairer referrals – how our employer liaison advisers are making a difference – Supporting good, safe patient care across the UK](#).
- Presenting to the BMA retired doctors forum about the evidence of the benefits of mentoring and to explore what BMA members could do to build a culture of professional mentoring in medicine, normalise mentoring as a basic professional activity, and promote formal mentoring programmes in all training and working environments.

FER Activity in phase 4

15 The Phase 4 action plan was developed utilising the following themes:



- **GMC action:** Actions we can take internally through GMC processes to meet our targets including training and evaluation of the effectiveness of such actions.
- **Influencing others:** Influencing the wider healthcare setting to create a fairer working environment at a local level.
- **Collaboration:** Collaborating with employers, regulators, and other stakeholders across the UK to share learning and deliver impactful work.
- **Understanding local change:** Collating information to ensure that we have a broad understanding of the current landscape, recent changes and the influence and pressures that they are exerting on our targets.

GMC action

Improving the RO Referral process

- 16 **Rationale:** The RO referral form is one of our most direct levers not just to influence referrals from responsible officers but also to influence their behaviours within their own local procedures upstream of our own referral process. We use this in conjunction with ELA fairness conversations to encourage RO reflection on fairness in local processes.
- 17 In 2023 and 2024, we carried out reviews of the use of the three fairness questions. Our evaluations of the data along with engagement with ROs and Outreach highlighted that there were areas we could improve to better support clarity and the forms completion.

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- 18** Improving RO understanding of the fairness questions also improves the quality of the information we are collecting, which gives a more rounded picture of a referral for our operational teams and decision makers to better support our FER objectives. A new suite of fitness to practise decision maker guidance produced in the regulatory reform programme contained detailed content on taking context collected in the referral form into account when making GMC decisions.
- 19** In 2024 we examined data from 2021-2023 on referrals from employers that currently do not come via an RO. We want to reduce the percentage of employer referrals that come via email because they bypass the fairness questions in the RO referral form.

Activities:

- 20** Across the four nations we have:
- Consulted with ROs on how they use the referral form and made changes to reflect their feedback.
 - Made changes to the three EDI fairness questions and supporting guidance to better reflect our FER objectives.
 - Considered how we use the responses to the three EDI fairness questions, in particular on context (systems/working environments/personal emergencies) in our procedures to support fair decisions.
 - Supported ROs who are making referrals through training and other engagement activities.
 - Considered how to reduce the number of employer referrals about doctors that do not come via the RO and/or address the fairness questions.

Explore further roll out of employer referral anti-bias training in FTP focussed on mitigating the risk of bias in dealing with employer referrals

- 21 Rationale:** Feedback from our internal employer referral anti-bias training sessions in earlier phases indicated that it was helpful to discuss the potential biases in employer referrals specific to GMC decision making and advice. We reflected on this feedback and adapted our training to create more time for this and to also include aspects of cultural competence.
- 22** The Singh/Forde review into the case of Dr Arora was published in November 2022, and it included a series of recommendations which were accepted in full. Recommendation 13 and 15 talk about *eliminating bias in fitness to practise decision making* and *considering how the GMC assures itself that its decision making is fair and unbiased*. In February 2023 we also published our Regulatory Fairness Review which considered how we ensure the fairness of

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our decisions. Several of the Singh/Forde recommendations cross over into this area of work. Recommendations 4 and 12 talk about *assessing the level of risk of bias that the inclusion of judgements/assessments by external experts in regulatory decision making represents and develop a proportionate approach to the identification and management of 3rd party bias, and mitigation of the risk of authority bias*. Our employer referral anti-bias training supports these recommendations.

- 23 Activities:** During phase 4 we have developed a training strategy to combine the Fairer Employer Referrals and Regulatory Fairness Review training programmes to create a robust, consistent and ongoing approach to training for all GMC staff with additional support for Fitness to Practise.

Updates to operational guidance to improve the Triage to RO feedback mechanism

- 24 Rationale:** In our 6-month evaluation of the Triage to RO feedback mechanism, which gives feedback to ROs in cases where we have identified learning about referral, we identified that there was still confusion about what the feedback loop should be used for. To assist with this, we engaged with operational teams to develop comms to strengthen understanding of when to use the feedback mechanism in relation to:

- Overall quality of referral.
- Timing of referral.
- Appropriateness of the referral.

- 25 Activity:** We have updated operational guidance to ensure feedback requirements are clearer and are being discussed, recorded, and escalated using the appropriate method.

Influencing others

Work to raise awareness with both employers and doctors about the value of mentoring programmes as a key intervention to address differential referrals

- 26 Rationale:** *Fair to refer?* identified the impact of ingroup and outgroup dynamics as having a significant impact on disproportionate referral. In particular the report suggests that informal mentoring is pervasive within healthcare for those who are part of ingroups and that there are barriers to such mentoring that persists for those in outgroups who often work in isolation. The report says *'In addition to the above risk factors increasing the chance of outsiders being reported to the GMC, are protective factors that decrease the chance of insiders being reported. Examples of how this happens include insiders comprising strong cohesive and non-diverse working teams and supporting and coaching each other through*

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difficulties. Thus, participants described “tribes” formed where colleagues (particularly but not only white doctors) have attended UK medical schools with each other, trained together, lived together, and dated or married each other. This leads to strong in-group identification, as demonstrated by relative homogeneity within the group, long period of identification, and the development of norms which are opaque to outsiders.’ Having more formal mentoring programmes that are equally accessible to all can enable outgroups to access those protective factors that have traditionally been available only to ingroups. Mentoring, particularly formalised schemes, appear to be more widely utilised in other professions than in Medicine.

27 Mentoring offers well documented benefits (both objective and subjectively measured) for mentees, mentors, organisations, and patients. For mentees and mentors this includes positive attitudes to work, better interpersonal work relationships, career progression, a sense of belonging. For organisations, investment in mentoring schemes offers a positive return in the form of:

- Improved staff retention.
- Reduced rates of sickness.
- Being a more attractive employer.
- Employees with mentors are more resilient to stressful environments and burn out.
- Improved induction for new starters who pick up on organisation’s nuances and practices more quickly, and so get up to speed quicker and more safely.
- Increased knowledge creation and sharing amongst colleagues.
- There may also be benefits in the early identification of problems, allowing prompt and targeted intervention and preventing escalation to fitness to practise concerns.

28 In discussion about the FER programme at a recent BMA Equality Committee meeting, mentoring was raised as a critical protective factor for doctors who are at risk of being in outgroups. Promotion and adoption of mentoring in the workplace has the potential to be effective in both primary care and secondary care. Formal mentoring schemes are frequently cited as being key to overcoming systemic inequalities and improving outcomes for minority groups.

29 Activity: We have developed a strategic approach to promoting mentoring across the system and the four nations, in collaboration with the Fairer Training Cultures (FTC) project team to maximise GMC influence. Activities include:

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- Outreach have conducted a smart survey with a selection of trusts and boards to identify examples of best practice in mentoring. The results are being analysed and findings will be shared with the system as part of our phase 5 activities.
- Presenting to the BMA retired doctors forum to look at the evidence behind the benefits of mentoring and to explore what BMA members could do to build a culture of professional mentoring in medicine, normalise mentoring as a basic professional activity, and promote formal mentoring programmes in all training and working environments.
- The FTC workstream developed a resource that includes a mentoring toolkit to aid the establishment of mentoring schemes and sets out the value of mentoring along with links to our website. Outreach have shared this resource with their contacts during regular engagement and gathered insights on the challenges some organisations face when implementing mentoring schemes. These insights will be used to develop our understanding of how good practice can be shared in an impactful way.
- Key messages to promote the value of mentoring have been shared for inclusion in senior colleagues regular external meetings. These have also been shared with the heads of the national offices for use in meetings as appropriate across the devolved nations.
- Several blogs and posts on social media have been published to highlight the benefits of mentoring.

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Focus on primary care

- 30 Rationale:** In our data on disproportionality, Primary Care tends to have disproportionate referrals more often than other types of DBs. This can be seen in the table below, as of Q2 2025. The DB types shown separately are the main contributors to the values taken by KPI1.

Active DBs with disproportionate referrals by DB type

Designated Body type	No. active DBs	No. DBs disproportionate	% DBs disproportionate
NHS Acute or Non-Acute Trust	196	10	5.1
NHS Primary Care	23	7	30.4
NHS/HSC	61	10	16.4
LETB/Deanery	20	4	20.0
Locum agency	119	3	2.5
rest of DB types	1022	6	0.6
	1441	40	2.8

- 31** In interpreting the table above, we should remain mindful that the percentages at the rightmost column are computed out of the often-small numbers in the left columns.
- 32** This suggests that improvements to date have primarily arisen in secondary care. We have returned to the findings of the *Fair to refer?* Research and carried out a detailed review of the findings on primary care in that report. That research suggests that as for secondary care, the causes of disproportionality are complex and multi-layered. As GP practices are often run as partnerships, GPs may go into partnership with those who are part of their close peer group. The *Fair to refer?* research identified that BME and IMG doctors can find it difficult to join larger well-funded GP practices in more affluent areas and often end up opening sole or two-partner small practices in deprived areas. The research suggested that they have higher patient lists and funding is often not adequate to reflect the more demanding healthcare needs of patients in those areas, involving multiple and complex co-morbidities. GPs in these practices work longer hours and find it difficult to get cover to attend continuing professional training. When something goes wrong, the report suggests that the standards against which such GPs are judged do not take into account the nature of the environments in which they are working, and they are assessed against standards that are more appropriate for better-funded practices with less complex patient needs.
- 33 Activities:**
- 34** Across the four nations we have:
- Delivered impartiality and bias training to RO networks to include covering Primary Care contextual considerations in referrals.

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- RLAs have continued to focus efforts on building and improving relations with Primary Care.
- Updated our RO referral guidance on the context in which fitness to practise concerns arise to include reference to different types of practice environments including Primary Care.
- Continued to support the work of NHS Resolution and NHSE on piloting the Fair and Proportionate framework for local investigations.
- Shared key messages to highlight the challenges in primary care along with activities the GMC are pursuing to promote fairness, for inclusion in Charlie and Carrie's regular meetings. These have also been shared with the heads of the national offices for use in meetings as appropriate across the four countries.
- Researched the Deep End projects, which are a network of initiatives focused on improving health outcomes and reducing inequalities in areas facing high levels of socio-economic deprivation. These projects, like the Scottish Deep End Project and the Deep End Wales Project, engage general practitioners (GPs) in tackling health challenges in these areas by listening to their experiences, sharing best practices, and advocating for increased resources, which may also improve the experience of those GPs themselves.
- Connected with a Deep End GP in Scotland to explore opportunities to collaborate and share learning.
- In Northern Ireland we have seen an increase in the number of IMG GP trainees, and we have been working with NIMDTA to support doctors new to Northern Ireland working in primary care to support retention.
- We have prioritised engaging with doctors in primary care when rolling out the new Good Medical Practice guidance, which focuses on the importance of working in an inclusive and supportive environment.
- Recruited a clinical fellow, with a view to further reviewing and developing a detailed report on the challenges within primary care. The paper will draw on evidence from the *Fair to Refer?* report and the GMC's wider research, including the findings from the best practice research by Work Psychology Group, to examine what more can be done to support fairness in primary care.

It will outline the GMC's current work to address disproportionality, through the FER and FTC programmes and BAU activities, and will consider how the GMC might support the embedding of the NHS Resolution fairness framework within primary care. It will set out the key challenges in improving fairness across diverse primary care contexts, providing clear recommendations.

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The paper will also explore how the GMC can maintain and build strong relationships across primary care, while responding to the challenges posed by an evolving environment.

Continue to ensure Outreach engagement reflects ambitions set out in the FER priorities

- 35 Rationale:** Outreach have a fundamental role in working with GMC stakeholders across the UK. They engage with employers and medical professionals to deliver teaching and advice on improvement interventions and therefore are well placed to promote and support FER ambitions and priorities.
- 36 Activity:** As well as the targeted activities described elsewhere in this paper, Outreach have engaged in a number of BAU activities designed to support the aim of the FER target. This includes running training sessions on inclusive working environments and wider EDI topics to RO's and thousands of doctors across the UK. In addition, the team have engaged with a wide range of representative organisations such as British Association of physicians of Indian Origin (BAPIO), British International Doctors Association (BIDA) and the Medical Association of Nigerians across Great Britain (MANSAG) to share the work we are doing and engage them in our plans.

Collaboration

Continue to collaborate closely with NHSR

- 37 Rationale:** From our extensive external engagement work we have identified that collaboration with NHSR has been an effective interface to further FER targets. They have a core role in ensuring that local investigation processes are fair through their MHPS process. They also have a strong interest in embedding fairness. Much of their data supports ours in specifying that local, early addressing of issues is key. Their [Being Fair 2](#) guidance offers advice for employers on embedding fairness in local decision making.
- 38 Activities:**
- Supported the development and roll out of the Fairness and Proportionality Principles and Framework to help organisations ensure their local investigation process is fair and proportionate.
 - Continued to support their Being Fair programme and meeting to discuss any other areas for collaboration on respective wider fairness programmes.

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We will monitor and assess opportunities to engage with the NMC

- 39 Rationale:** The [Caring for Doctors Caring for Patients research](#) by Prof. Michael West and Dame Denise Coia pointed to the importance of multi-disciplinary teams in creating supportive, compassionate, inclusive environments. In reflecting on those findings, we are mindful that doctors and nurses often play key leadership roles in multi-disciplinary healthcare teams and we are keen to try to align our FER work with any work the NMC may be doing to support fair, inclusive working environments among nurses.
- 40 Activity:** We have shared and discussed our approaches to using data to identify disproportionality with the NMC. We have also met with the NMC's Head of ED&I to outline our overall approach to the FER programme, including our key areas of focus and priorities.

Continue our four-country approach

- 41 Rationale:** Through continued focus on our national offices, we are looking to ensure that our progress is sustained throughout the UK.
- 42 Activities:** As well as participation in the Outreach actions identified above, our National Office teams are committed to ensuring progress is sustained throughout the four U.K countries. Some specific examples include:
- GMC Wales ran a series of fairness and impartiality of concerns management workshops in Wales with ROs. They plan to support change programmes and pilots that arise from these workshops and consider extending the workshops to other groups.
 - GMC Northern Ireland delivered a workshop at the Northern Ireland RO forum in January 2025, with a specific focus on fairness in local concerns processes.
 - GMC Scotland continues to work with ROs in Scotland to refocus the RO Network to provide opportunities for strategic learning. This includes discussion of case studies to enable a consistent and fair approach. This can be used as a catalyst (where needed) for bespoke sessions led by Outreach on our FtP thresholds generally and/or fairness aspirations across health board leadership teams.

Upcoming activity

- 43 Below is our plan for Phase five, which is to be the final phase of the Fairer Employer Referrals programme before target date in December 2026. Phase five has been created factoring in our previous learning, while considering the requirements for the completion of the programme.

Analysis and sharing of research outputs

- **Rationale:** In phase 4, we commissioned Work Psychology Group (WPG) to create an evidence base of programmes and interventions in different types of designated bodies (DBs) that may contribute to more proportionate referrals to us. This research built on our previous *'Fair to Refer?'* work and aimed to contribute to our target of reducing disproportionate referrals of international medical graduates and Black and minority ethnic doctors into our fitness to practise processes.
- **Activity:** Following the completion of the research, we will undertake a review of the findings to identify any potential levers during phase 5 and proposals to support sustainability beyond the target.
We will also produce a plan to proactively share the best practice outputs with the system as well as other relevant stakeholders such as the NMC. We further plan to link this with our communications activity to raise the profile of the research outputs.

Sustainability plan

- **Rationale:** The Fairer Employer Referrals programme of work is due to conclude at the end of 2026. From the outset of the programme in 2021 to date, we have seen continued progress in our data towards achieving our target. While we cannot directly say this is because of the programme, we have actively monitored the trends in the data, learned from the activity we, and the system, have undertaken and have planned activity to strive to reach the target to eliminate disproportionality in referrals. When the programme concludes, it will be important to have a strategy to maintain oversight of the data and ensure the successes realised in the data are maintained.
- **Activity:** The programme team will prepare a plan which outlines the BAU activity that will support sustaining the successes in the data post the target date. The plan will also include an action to engage with corporate governance to consider the appetite and mechanism for the GMC to maintain oversight of the data following the programme closure. We will also link in with our contacts at NHSR to establish any further areas for future collaboration, building on a very fruitful relationship throughout the programme.

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Referral form changes – post implementation review

- **Rationale:** In phase 4, we reviewed and updated the three fairness questions and our supporting guidance following feedback from ROs and Outreach which highlighted ways we can better support the completion of the fairness questions. We also introduced the fairness questions for referrals from non-RO employers and now ask employers to ensure they have discussed the concerns with the doctor's RO prior to making the referral.
- **Activity:** We will complete a post implementation review at 12 months to assess the impact of the changes to the RO and employer referral forms. We will also undertake training for ROs to support their understanding of impartial checks we ask them to carry out prior to making a GMC referral. We will continue our work supporting ROs around good local investigations, with particular focus on where ROs may change.

Communications plan

- **Rationale:** As meeting the FER target requires lasting change by employers, a strong communications and engagement approach - combining operational, outreach and strategic communications and engagement activity - is critical to support awareness raising and influence. The programme deliverables and data present a positive story, which will enable ongoing work to build understanding of, and confidence in, our fitness to practise processes. We will also collaborate with colleagues from the Fairer Training Cultures programme, where appropriate, to align communications and engagement strategies.
- **Activity:** The programme will produce a calendar and plan outlining intended activities, audiences, and key messages. This will cover operational, outreach, and strategic communications and engagement to ensure alignment across all channels. We will collaborate with various teams to develop options in the lead-up to and following the target date. The programme will also produce a report of the FER programme and the GMC's commitment to embedding lasting improvements, to inform ongoing work to build understanding of and confidence in fitness to practise processes, and to continue promoting the aims of FER post-programme completion.

Primary Care

- **Rationale:** Our multivariate statistical models of employer referrals confirm that being a GP is separately related to being referred more often, compared to not being a GP. The structure of the disciplinary and referral process for primary care brings specific challenges to considering where change can be focussed to have the best impact. Our

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data show the increasing presence of primary care as improvements take effect in secondary care.

- **Activity:** The programme team have successfully engaged a clinical fellow to consider options for how we can support the embedding of the NHSR fairness framework in primary care, as well as identifying how we might best maintain relationships and address any gaps given the changing environment. The clinical fellow will produce a report highlighting what we have found as well as tracking our efforts across primary care, exploring the challenges, setting out what can be done, what cannot be done and why.

Continuing our four-country approach

- **Rationale:** Through continued focus on a four-country approach, we are looking to ensure that our progress is sustained throughout the UK.
- **Activity:** Our teams are committed to ensuring progress is sustained throughout the four UK countries. The programme will also produce a report summarising the work across the four countries over the duration of the programme.
- Outreach business plans will continue to support a focus on discussing and embedding fairness and inclusivity within healthcare environments. This includes focussing on topics such as Cultural Competence, Delivering Fairer Feedback and embedding Good Medical Practice.
- Outreach will also continue to engage with RO's around the fairness of local processes, encouraging local action that is both fair, proportionate and timely.

Mentoring

- **Rationale:** *Fair to refer?* identified the impact of ingroup and outgroup dynamics as having a significant impact on disproportionate referral. In particular the report suggests that informal mentoring is pervasive within healthcare for those who are part of ingroups and that there are barriers to such mentoring that persists for those in outgroups who often work in isolation.
- **Activity:** The programme will continue its work to use our influence to promote the value of mentoring, utilising any tangible evidence for how to support effective mentoring programmes where available e.g. outputs of the FER research findings. We will also produce a report on mentoring which will include a stakeholder map outlining who we should continue to engage with including recommendations for future activity. The report will further cover the details of how FER has worked to embed mentoring in the system.

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Programme Narrative

- **Rationale:** The Fairer Employer Referrals programme has embarked on a significant journey from the delivery of the *Fair to refer?* report, driving calls to action across the system to influence positive changes in local complaints handling procedures.
- **Activity:** The programme will develop a narrative on FER which will document the journey of our relationship with the system, drawing out the challenges and opportunities of the programme.

Annex B

Sustaining momentum of the programme post target

Purpose

This paper sets out options for maintaining momentum following the delivery of the Fairer Employer Referrals programme. It outlines key actions required to sustain long-term cultural change within the healthcare system and seeks Council endorsement of a post-target date strategy.

Background

The Fairer Employer Referrals programme is a strategic priority for the GMC, aimed at addressing persistent concerns around the fairness and disproportionality of employer referrals, particularly affecting ethnic minority doctors.

Over the life of the programme, we've observed a consistent reduction in the gap in referral rates across all three of our key performance indicator (KPI) measures, see Annex.

Statistical forecasting suggests a high likelihood of nearing our aspirational targets by the end of 2026. However, it is reasonable to expect that some measures may not reach zero, as one referral can change the profile of an organisation's referral patterns. As with any forecast, the exact values cannot be precisely predicted but are expected to fall within the reported uncertainty bands.

It's not possible to directly attribute the improvements in trends to the Fairer Employer Referrals programme alone, as our KPIs reflect the combined effect of numerous interactions and influences across the healthcare system.

Interpreting disproportionality data in context

Since the programme's inception, we have drawn on our disproportionality data, in conjunction with the findings from the 2019 [Fair to Refer?](#) report to develop our approach. The data provides an important lens on how different groups of doctors' experience referrals and regulatory processes. It allows us to track patterns over time, identify disparities, and consider whether initiatives such as our Fairer Employer Referrals programme are having an impact.

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However, we recognise that the data alone does not provide a complete picture of proportionality on the ground. Disproportionality metrics show outcomes but cannot, on their own, explain the complex drivers behind those outcomes. Factors such as workplace culture, local HR practices, the availability of informal resolution routes and the lived experiences of doctors all play a significant role in shaping whether and how referrals occur.

Our metrics, KPI1 and KPI2, capture different aspects of fairness, and should be interpreted with consideration to certain caveats:

- KPI1 focuses on whether a designated body (DB) shows statistical disproportionality in referrals, but this can be influenced by the size of the DB. Smaller DBs, with fewer referrals (one or two in a five-year period), may appear disproportionate due to statistical volatility, despite the referrals being justified based on individual circumstances. Conversely, larger DBs may appear proportionate overall and therefore not feature in KPI1 but could be contributing to KPI2 if differences in referral rates emerge at scale.
- Improvements in headline disproportionality figures do not automatically mean that all doctors are experiencing a fair or supportive process.
- Our data measures referrals from Responsible Officers (ROs). We are confident that these referrals are appropriate, as they have usually been discussed with an Employer Liaison Adviser (ELA) and go on to be investigated by Fitness to Practise. *Fair to Refer?* clarified that referral trends reflect complex patterns of disadvantage that accumulate over time for groups with disproportionate trends.
- The overall rate of referrals remains very low and continues to decrease, which may impact our metrics.
- Our metrics cover doctors connected to a DB. This excludes groups such as resident doctors (connected through NHS education bodies) and locums (connected through agencies). Referrals made by ROs may also concern doctors outside their own DB, making it difficult to draw firm conclusions about fairness within individual workplaces.

These caveats illustrate the challenges the programme has faced and reinforce the approach we have taken to seek systemwide, sustained attention to deliver lasting change.

Our approach and impact

The Fairer Employer Referrals programme has taken a system-wide approach across all four UK countries, recognising the diverse structures, policies, and regulatory contexts within England, Scotland, Wales, and Northern Ireland. The GMC has worked collaboratively with designated bodies, NHS organisations, and others, to support fairness in local processes.

By focusing on inclusive and supportive workplace cultures, providing targeted training and guidance, and sharing best practice across the system, the programme has sought to embed

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fairer frameworks, while acknowledging the challenges and opportunities within each country's healthcare system.

We are seeing encouraging signs that these initiatives and others are embedded locally across the system. For example, strengthened local investigation policies to support more proportionate, locally resolved concerns, and structured induction processes for internationally trained doctors are becoming more common. These developments align with national efforts such as NHS Resolution's Fair and Proportionate Referral Framework, reflecting a growing, shared commitment to fairer referral practices and early support. However, challenges remain in primary care, where smaller organisational structures, workforce pressures and limited HR support can make it harder to apply consistent processes and ensure equitable handling of concerns.

There has been a reported shift in emphasis in ED&I activity in organisations, moving from a primary focus on supporting international medical graduates to a broader focus that includes supporting UK graduates. This change is reflected in feedback from NHS colleagues, though its longer-term impact is not yet clear. Some organisations have reported challenges in providing effective induction programmes for international medical graduates, highlighting ongoing areas where targeted support may be required.

Recommendation

Sustained system-wide commitment to fairness remains a strategic priority. While substantial progress has been made toward our target, we remain firmly committed to eliminating disproportionality.

The programme team recommends adopting **option two** from those outlined below, to pause and take stock. This will allow time to review progress and provide space to consider a potential future focus on primary care, where persistent challenges and distinct system pressures may require tailored approaches. The outcome of the stocktake and any proposed future work will be brought back to Council for consideration should the recommendation be approved.

Option 1 – Formal programme closure and transition to business as usual (BAU)

This option proposes the formal closure of the GMC's Fairer Employer Referrals programme at the target date.

Formal closure of the Fairer Employer Referrals programme reflects the progress achieved to address trends of disproportionate referrals for some groups. The GMC will maintain its focus on fairness by continuing to monitor, influence, and lead through its core regulatory activities. This

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will be supported by the Building Trust and Confidence programme and aligning with the Fairer Training Cultures programme, reinforcing our strategic commitment to regulation that is inclusive, proportionate, and compassionate.

Rationale

- **System progress:** Prior to, and since, the programme's launch, significant system wide changes have been made to improve fairness which we are seeing signs of embedding into local procedures. The conditions are in place for fairness to be maintained and developed as part of routine regulatory practice, not reliant on a standalone programme.
- **Strategic alignment:** The Fairer Training Cultures programme addresses parallel issues of bias and inclusion in postgraduate training environments.
- **Avoiding duplication:** As the aim is for fairness to be embedded, continuing the programme in its original form risks duplicating work that is now owned and driven by the system.

1. Establish a programme closure stage

Retain the programme team for 3 months to:

- Complete all final deliverables.
- Document lessons learned, delivery outcomes and any final data narratives.
- Produce a final programme report, including:
 - Summary of changes implemented
 - Data snapshot of impact (e.g. referral trends)
 - Outstanding risks or actions.

2. Transition to BAU Ownership

The programme team proposes:

- The organisation continues to publish diversity data on referrals and outcomes to maintain transparency and accountability.
- Highlight and escalate any trends and areas for concern with recommended actions.
- Continue to use the data as a conversation starter not just for reporting, but to continue to influence change through our outreach and engagement channels.

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3. Continued Stakeholder Engagement

- Integrate referral fairness conversations into wider GMC engagement activity (e.g. RO forums, regulatory updates, NHS partner events).
- Publish closure statement and next steps, reinforcing the GMC's commitment.

Recommendation: Not recommended

Closing the programme at this stage may potentially inhibit consolidation of learning to secure lasting change. It also limits the opportunities to embed links with initiatives such as the Fairer Training Cultures programme.

Option 2: Pause and Take Stock at the December 2026 Target Date

This option proposes that at the December 2026 target date, the GMC pause to take stock of progress made under the programme. This will provide an opportunity to review outcomes, assess the impact of interventions, and consider opportunities before determining next steps.

Rationale:

A review point provides space to assess progress in both secondary and primary care and identify any potential further work we think may be appropriate. The review will also provide an opportunity to consider a future focus on primary care, reflecting its distinct referral patterns and workforce profile. Any proposed future direction will be brought back to Council for decision.

During this review period, the GMC will:

- Continue to publish diversity data on referrals and outcomes to maintain transparency and accountability.
- Evaluate progress against the programme's objectives, including any changes in referral patterns and experiences of doctors from different backgrounds.
- Engage with key stakeholders, including employers, professional bodies, and equality networks, to understand the effectiveness of support and guidance provided.

1. Establish a programme pause stage

Retain the programme team for 3 months to:

- Complete all final deliverables.

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- Document lessons learned, delivery outcomes and any final data narratives.
- Produce a final programme report, including:
 - Summary of changes implemented
 - Data snapshot of impact (e.g. referral trends)
 - Outstanding risks or actions
 - Capture any future opportunities i.e. within primary care.

2. Transition to BAU Ownership

The programme team proposes:

- The organisation continues to publish diversity data on referrals and outcomes to maintain transparency and accountability.
- Highlight and escalate any trends and areas for concern with recommended actions.
- Continue to use the data as a conversation starter not just for reporting, but to continue to influence change through our outreach and engagement channels.

3. Continued Stakeholder Engagement

- Integrate referral fairness conversations into wider GMC engagement activity (e.g. RO forums, regulatory updates, NHS partner events).
- Consider external messaging as appropriate.

Recommendation: Recommended

This option allows for reflection on outcomes, stakeholder feedback, and data trends before determining the most effective next steps.

Option 3 – Short term extension of the programme

This option proposes that the GMC keeps the Fairer Employer Referrals programme open for a short, defined period (e.g. 9 - 12 months) following the target date. This transitional phase would enable the GMC to consolidate learning, support final handover to BAU, and maintain visible leadership on fairness in referrals while embedding links with other key priorities particularly the Fairer Training Cultures and Building Trusts and Confidence programmes.

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Rationale

- **System progress:** Significant strides have been made by employers and system partners in embedding fairer local processes. The conditions are now in place for fairness to be maintained and developed as part of routine regulatory practice, not reliant on a standalone programme.
- **Managing the transition responsibly:** A short extension would provide space to ensure all GMC teams and external partners are fully prepared for the shift from a time-bound programme to sustained BAU ownership. It also allows the GMC to close the programme from a position of confidence and stability.
- **Strategic alignment:** Extending the programme helps to coordinate messaging, resources, and shared learning around fairness across the medical education and practice pipeline with the Fairer Training Cultures programme.
- **Visible commitment to fairness:** Retaining the programme in the short term allows the GMC to signal publicly the importance of embedding the changes for the future.

1. Establish a formal post-implementation phase

- Treat the target date as the start of a new phase, not the end.
- Set a clear post-implementation roadmap (e.g. 9 - 12 months) with follow-up activities.
- Keep a named programme lead or team in place during this phase to coordinate any final activity and engagement.
- Embed links with the Fairer Training Cultures and Building Trust and Confidence programmes.

2. Continue to monitor, publish and act on data

- The organisation should continue to publish diversity data on referrals and outcomes to maintain transparency and accountability.
- Highlight and escalate any trends and areas for concern with recommended actions.
- Continue to use the data and FER programme as a conversation starter not just for reporting, but to continue to influence change through our outreach and engagement channels.

3. Maintain active stakeholder engagement

- Continue to engage with Responsible Officers, medical leaders, and ED&I leads.
- Encourage employers to share their own improvement efforts, creating a community of learning and accountability.
- Partner with system organisations (e.g. NHSR, Royal Colleges etc) to keep fair referrals on the agenda at external events and policy discussions.

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4. Capture and share learning

- Conduct a reflections exercise 6 - 12 months after the target date, including both qualitative and quantitative insights.
- Share findings in an accessible format: what worked, what changed, and what still needs attention.
- Publish case studies and stories of improvement from both the GMC and employers.
- Produce a final programme report, including:
 - Summary of changes implemented
 - Data snapshot of impact (e.g. referral trends)
 - Outstanding risks or actions.

Recommendation: Not recommended

A brief continuation period risks duplicating existing activity without allowing sufficient time to embed learning, assess outcomes, or plan strategically for the next phase. Instead, a more deliberate pause and review will enable the GMC to make informed decisions on future direction, ensuring resources are targeted effectively and the programme remains impactful and sustainable.

Quality Assurance, Monitoring and Improvement - PA Courses

Action	To approve
Purpose	To provide a summary on progress of our quality assurance of the PA courses at Aston University and University of East London, and to summarise progress made with action plans to remove conditions on approval for Bradford University, Queen Mary University of London, and Sheffield Hallam University.
Recommendation(s)	a To approve the PA course at Aston University. b To approve, with conditions, the PA course at the University East London. c To remove the conditions on approval for Bradford University, Queen Mary University of London and Sheffield Hallam University.
Annexes	None
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Sponsoring director/ Senior Responsible Owner	Pushpinder Mangat , Medical Director and Director of Education and Standards

To approve the physician assistant course at Aston University

Background

- 1 The AAPA Order requires Council to maintain and amend, as required, the list of courses entitled to deliver pre-qualification education for physician associates (PAs) and anaesthesia associates (AAs). In April 2025 Council approved the existing PA and AA courses that were meeting our criteria for approval as previously agreed by Council. The recommendation on approval for the University of Aston PA course was deferred at the time as the course had not met the criterion of having graduated at least one cohort of students.
- 2 The course provider has recently graduated the first cohort in September 2025 and is now meeting all our criteria for approval of existing courses. Standards of proficiency are set out in *Standards for the delivery of PA and AA pre-qualification education (2024)* and compliance with the standards is demonstrated through the Quality Assurance Framework, which includes annual returns from the course provider and at least one in-person quality activity as determined in our approach for the approval of existing PA and AA courses.

About Aston University Physician Assistant course

- 3 The PA course at Aston University is a two-year postgraduate programme combining academic teaching at university with a substantive clinical component. The course started in September 2023 and is part of the Aston Medical School within the College of Health and Life Sciences.
- 4 Following the publication of the Leng review the course provider has changed the name of its course to MSc in Physician Assistant Practice. Legal instruction that we have received on name changes advises that course name changes do not impact directly on our approval processes as approval of a course is based on how the course delivery and curriculum meets our standards.
- 5 During our pre-regulation quality assurance with the Aston University PA course we have not identified any significant concerns linked to any areas of our standards. The course provider has to date submitted two self-assessment questionnaires, engaged well with our quality activities and submitted a mapping of their course syllabus to the draft PA national curriculum.
- 6 During our quality assurance of the course, we have had support from a team of education associates on areas such as curriculum review or the visit. We have identified areas working well and recommendations as listed below. We will continue to monitor and check progress

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with the open recommendations through our routine quality assurance cycles with the course provider.

Recommendation

7 We recommend the PA course delivered by Aston University for approval.

Open recommendations

	Theme	Standard/ Requirement	Recommendation
1	Theme 2: Educational governance and leadership	R1.19	The course provider should consider the level of information shared with clinical placement providers ahead of students starting their placements.
2	Theme 4: Supporting educators	R3.9	The course provider should explore further opportunities for clinical educators to liaise with each other.

Open recommendations linked to the course provider curriculum mapping

	Theme of PA and AA generic and shared learning outcomes	Category	Outcome
1	Theme 4 – Safety and quality	31. Patient safety and quality improvement	The provider should demonstrate how it assesses the following outcome: 31h. describe the value of national surveys and audits for measuring the quality of care.

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	Theme of PA and AA generic and shared learning outcomes	Category	Outcome
2	Theme 4 – Safety and quality	33. Healthcare resource management	The provider should demonstrate how it assesses the following outcomes: 33c. the processes of commissioning and funding, and that all healthcare professionals have a responsibility for stewardship of healthcare resources. 33f. cost implications of common treatments in terms of money, equipment and human resources (e.g. generic prescribing, intravenous v oral antibiotics).
3	Theme 4 – Safety and quality	34. Teaching and learning	The provider should demonstrate how it assesses the following outcomes: 34a. participate in the effective teaching, mentoring and training of other healthcare professionals, adapting to an individual's diverse background and experience, including for colleagues who are new to UK practice and those who don't have easy access to sources of support. 34c. engage in effective feedback dialogue with learners, identify development needs, suggest appropriate action plans and support them to address these. 34g. supervise less experienced colleagues in their clinical assessment and management of patients and in carrying out practical procedures (within their scope of practice).

To approve with conditions the physician associate course at University of East London

Background

- 8 The AAPA Order requires Council to maintain and amend, as required, the list of courses entitled to deliver pre-qualification education for physician associates (PAs) and anaesthesia associates (AAs). In April 2025 Council approved the existing PA and AA courses that were meeting our criteria for approval as previously agreed by Council. The University of East London was not recommended for approval as our standards were not being met in a number of areas.
- 9 We now have assurance that the University of East London is meeting our standards to a satisfactory level and we recommend approving the course with conditions attached. Standards of proficiency are set out in *Standards for the delivery of PA and AA pre-qualification education* (2024) and compliance with the standards is demonstrated through the Quality Assurance Framework, which includes annual returns from the course provider and at least one in-person quality activity as determined in our approach for the approval of existing PA and AA courses.

About University of East London PA course

- 10 The PA course at the University of East London (UEL) is a two-year postgraduate programme combining academic teaching at university with a substantive clinical component. The course commenced in 2022 and has capacity for 30 students per cohort, with a January intake. The course is based within the School of Health, Sport and Bioscience.
- 11 During our baselining exercise we identified serious concerns which directly informed our recommendation to not approve this course. The main concerns were:
 - Learners' ability to meet the shared learning outcomes for PAs across the whole programme.
 - The length and breadth of clinical placements.
 - The provision of pastoral and academic support for learners.
 - Systems for quality management of the course delivery and clinical placements.
 - Processes for the management of fitness to practise and progression issues.
 - Mapping of learning outcomes to GMC standards and guidance.

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- 12** There are three cohorts of students that are impacted by our decision to not approve the course:
- Cohort one - two students who commenced their studies in January 2022 but due to personal circumstances did not complete the course until February 2025.
 - Cohort two - 17 students who commenced their studies in January 2023 and have completed the course.
 - Cohort three - students who commenced their studies in January 2024 and are expected to complete the course in December 2025.
 - For cohorts one and two graduation has been withdrawn by the university due to the fact that they will be unable to register with the GMC until the course has been approved (there is no provision in the AAPA Order or in our rules and related policies for individuals who complete their course post December 2024 to register with us if they graduate from an unapproved course).
- 13** The course provider paused student recruitment in 2025 and was subject to an enhanced programme of quality assurance regarding their current cohorts and future course delivery.

Enhanced quality assurance

- 14** We have continued to work closely with the PA course team at UEL, with the support of a team of three education associates. This work has included:
- Regular meetings with the course team, and the team of education associates.
 - Submission of an additional self-assessment questionnaire (SAQ).
 - Extensive document submission.
 - Virtual quality activity where we provided feedback on our desk-based review of submitted documents.
 - Review of the mapping of the course syllabus against the draft PA National Curriculum.

Addressing concerns

- 15** Following the Council decision in April 2025 to not approve the course we have been engaging with the University of East London on a regular basis. There is a new executive lead for the PA programme and new members of the faculty who have engaged with us in an open and constructive manner.
- 16** We provided clear details of our concerns and linked them to Standards for the delivery of physician associate and anaesthesia associate pre-qualification education, and also Promoting excellence, the standards that we measured against prior to regulation.

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- 17 Following this we undertook the following targeted quality activities:
- In May 2025 we asked the course provider to submit a further self-assessment questionnaire and an extensive list of documents.
 - Requested a new mapping of the course syllabus to the draft PA national curriculum and our PA and AA generic and shared learning outcomes.
 - In June 2025 we met with our team of education associates to discuss the evidence submitted by the course provider.
- 18 In July 2025 we met with the programme team at the course provider to discuss our findings based on their evidence submission and to explore in more detail some areas of their course delivery and curriculum. We found that UEL had made significant progress in addressing the concerns we had identified. The meeting focussed on the main areas of concern for the course delivery:
- Placements (mapping of each placement to the course syllabus and national curriculum).
 - Assessments (level of assessment and standard setting).
 - Curriculum (implementation of the new curriculum).
- 19 We were not assured that the course provider fully met our *Standards for the delivery of PA and AA pre-qualification education*. As a result, UEL was asked to provide additional information and documentation to support further assurance. We received the further evidence in September 2025.
- 20 We have scrutinised the latest submission with support from our team of education associates and met with them in October 2025.
- 21 The course provider has made significant progress regarding the different areas of their course delivery, particularly on their teaching, student support, and alignment of their syllabus to the national curriculum. Some concerns remain in terms of the course delivery. These concerns are linked to placement provision and the rigorousness of the assessments included in the course. These concerns can be resolved by putting in place targeted action plans to address the conditions and recommendations attached to the course approval as detailed.

Recommendation

- 22 The course provider has been responsive and engaged well with our quality assurance processes so far and we have confidence that they are committed to making the improvements required to close the open conditions and recommendations. We are working closely with the programme team to put in place detailed action plans that will enable us to monitor progress with any of the conditions through targeted QA processes.

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Quality Assurance, Monitoring and Improvement - PA Courses

We therefore recommend the PA course delivered by the University of East London is approved with conditions.

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Quality Assurance, Monitoring and Improvement - PA Courses

Open Conditions

Course Delivery

	Theme	Standard/ Requirement	Recommendation
1	Theme 5: Developing and implementing curricula and assessment	R5.1	1 The provider must review clinical placements to ensure they cover a breadth of disciplines and settings in order to ensure that students are able to meet the GMC's generic shared learning outcomes. The provider must consider more placement time for students in secondary care in areas such as acute medicine, general medicine (including care of the elderly), cardiology and respiratory medicine.
2	Theme 5: Developing and implementing curricula and assessment	R5.3; R5.4	2 The provider must continue to develop their programme of assessment including the following elements: • the assessment strategy • the assessment blueprint, which evidences that all of the generic shared learning outcomes are assessed robustly for each individual student • standard setting • responding to feedback from their external examiner • psychometric analysis • faculty development in assessment

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	Theme	Standard/ Requirement	Condition
	Theme 5: Developing and implementing curricula and assessment	R5.3; R5.4	3 At its own cost, the course provider must ensure that before students from cohorts one and two are graduated pass a final assessment at another PA programme agreed by the GMC. Or 4 At the course provider's cost, students from cohorts one and two must re-sit their second year of the programme and pass the assessment of the UEL PA course.

Open recommendations

	Theme	Standard/ Requirement	Recommendation
	Theme 5: Developing and implementing curricula and assessment	R5.3; R5.4	5 The provider should appoint an appropriately trained and supported assessment lead for the programme.
	Theme 5: Developing and implementing curricula and assessment	R5.1; R5.3; R5.4	6 The provider should address the outstanding areas in their syllabus mapping to the national curriculum*.

* The outstanding recommendations from the curriculum mapping review have been shared with the course provider and will be monitored through targeted quality activities.

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Quality Assurance, Monitoring and Improvement - PA Courses

List of documents reviewed during enhanced QA

1. Summary document for additional information May 2025
2. More details about the disruptions
3. Student Mapping - Placement Overview
4. Clinical Placement Handbook - Students and Supervisors
5. Clinical Logbook
6. Gap analysis
7. UEL PA Bridging Course 2025
8. Personalised learning plans
9. Cohort 2 Year 1 Term 1 Timetable
10. Cohort 2 Year 1 Term 2 Timetable
11. Cohort 2 Year 1 Term 3 Timetable 2023
12. Cohort 2 Year 2 Term 1 Jan-May timetable
13. Cohort 2 Year 2 - Term 3 Timetable
14. Cohort 2 & 3 Year 2 full placement timetable
15. PA Course Assessment Schedule
16. Summary Assessment document for cohort 2
17. KBA Cohort 2 Year 1 Term 1 SAQ
18. KBA Cohort 2 Year 1 Term 1 EMQ
19. KBA Cohort 2 Year 1 Term 2 SBA
20. KBA Cohort 2 Year 2 Term 3 Formative SBA
21. OSCE Cohort 2 Year 1 Term 2
22. OSCE Cohort 2 Year 1 Term 1
23. PA EE (2022-23) Report & Response
24. PA EE (2023-24) Report & Response
25. PA EE (Action Plan) revision 16.4.25
26. Cohort 3 Year 1 Term 1 Timetable
27. Cohort 3 Year 1 Term 2 Timetable
28. Cohort 3 Year1 Term 3 Timetable
29. Cohort 3 Year 2 Course Plan 2025 Timetable
30. Cohort 3 summary assessment document
31. Clinical logbook
32. Clinical placement guide – Students and Supervisors
33. Mapping of activities on PA course to GMC learning outcomes
34. PA External Examiner (2024-25 Report) school response
35. Response to next steps from meeting 8th July 2025
36. Student Mapping - Cohort 3 (2025)
37. Student Mapping - Cohort 19 Placement Hours

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38. UEL May 2025 MAP curriculum mapping feedback

39. UEL PA Student A& E Clinical LogBook

Removing conditions from the Physician Associate courses at Bradford University, Queen Mary University London and Sheffield Hallam University

Background

- 23 The AAPA Order requires Council to maintain and amend, as required, the list of courses entitled to deliver pre-qualification education for physician associates (PAs) and anaesthesia associates (AAs). In April 2025 Council approved the existing PA and AA courses that were meeting our criteria for approval as previously agreed by Council.
- 24 Four courses were approved with conditions where we felt that certain elements of our standards were not fully met at that time. All conditions related to how each provider's programme mapped to the *Physician associate and anaesthesia associate generic and shared learning outcomes* and were identified through our curriculum mapping exercise with all course providers. Each course provider submitted the mapping of their syllabus against the PA and AA generic shared learning outcomes which are in turn mapped to the PA national curriculum. The submissions were reviewed by a panel of at least three GMC education associates who are also assessment and curriculum experts. The curriculum mapping exercise started in December 2023 and the panel consolidated their decisions in December 2024.
- 25 This paper sets out our recommendations in relation to the evidence we have received for the conditions in place for the PA courses at three providers:
 - University of Bradford (UoB).
 - Queen Mary University London (QMUL).
 - Sheffield Hallam University (SHU).

Quality assurance process

- 26 Since approval all courses have been subject to our routine quality assurance processes. For those with conditions, we have implemented a targeted approach for receiving updates, within a timeline of six months post condition setting.
- 27 UOB, QMUL and SHU all provided updates on the conditions for their respective courses within this timeframe. These updates were scrutinised by the regional quality assurance

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team responsible for the organisation and two associates who took part in the original curriculum mapping exercise.

Recommendation

- 28** The updates provided by UoB, QMUL and SHU are outlined in more detail. We believe the course providers have provided sufficient evidence against their conditions to assure us that the related outcomes are now being met. As such we recommend these conditions be removed from their approval.

UoB condition

Condition	Update
<i>The provider must demonstrate how it assesses the following outcome: 'to prepare safe and legal prescriptions for a prescriber, tailored to the specific needs of individual patients, using either paper or electronic systems and using decision support tools where necessary' (29h vi).</i>	Following the implementation of the condition and course approval, the course provided an update detailing how they currently assess students' ability to prepare safe and legal prescriptions, including multiple teaching sessions and an OSCE station. The course provider also outlined further plans for incorporation of this element within future teaching sessions and assessments. These updates were shared with associates for review, upon which it was decided there is sufficient evidence to reduce the condition to a recommendation. This will be monitored in the future via our reactive QA processes. An update on the implementation of the new teaching sessions will be requested and reviewed prior to recommendation closure.

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QMUL condition

Condition	Update
The provider must demonstrate how it teaches and assesses the following outcome: <i>‘to prepare safe and legal prescriptions for a prescriber, tailored to the specific needs of individual patients, using either paper or electronic systems and using decision support tools where necessary’ (29h vi).</i>	Following the implementation of the condition and course approval, QMUL provided a further update detailing how they currently teach and assess students’ ability to prepare safe and legal prescriptions. Teaching appears to spiral throughout the curriculum and there are multiple forms of assessment, including OSCE stations. SCRIPT ensures students are required to interact and engage with the learning. These updates were shared with GMC associates for review, following which it was decided there is sufficient evidence this condition has now been met. This will be monitored in future via our proactive QA processes.

SHU conditions

Condition	Update
<i>The provider must demonstrate how it plans to assess the knowledge of anatomy, physiology and pathology: ‘Explain how normal human structure and function and physiological processes applies, including at the extremes of age, in children and young people, during pregnancy and childbirth and variation in different groups (25a.)</i>	Following the implementation of the condition and course approval, the course provided an update detailing the changes they have made to assessments, including a move to MCQ, and how all specialties are covered. These updates were shared with associates for review, upon which it was decided there is sufficient evidence to close the condition. The curriculum of the PA programme will be monitored in the future via our proactive QA processes.

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The provider must demonstrate how it plans to assess the knowledge of anatomy, physiology and pathology: Understand the relevant scientific processes underlying common and important disease processes, (25b).

Following the implementation of the condition and course approval, the course provided an update detailing the changes they have made to assessments, including a move to MCQ, and how all specialties are covered. These updates were shared with associates for review, upon which it was decided there is sufficient evidence to close the condition. The curriculum of the PA programme will be monitored in the future via our proactive QA processes.

The provider must implement their plans to demonstrate how it assesses the following outcomes: 'Calculate safe and appropriate medication doses and record the outcome accurately, seeking support and advice from the supervising doctor or healthcare professional, pharmacist or other colleagues when necessary, (29h v.)'

Following the implementation of the condition and course approval, the course provided an update detailing how the changes they have made to assessments, including the formative and summative assessments they now have in place to assess this requirement. These updates were shared with associates for review, upon which it was decided there is sufficient evidence to close the condition. The curriculum of the PA programme will be monitored in the future via our proactive QA processes.

The provider must implement their plans to demonstrate how it assesses the following outcomes: 'Prepare safe and legal prescriptions for a prescriber, tailored to the specific needs of individual patients, using either paper or electronic systems and using decision support tools where necessary, (29h vi.)'

Following the implementation of the condition and course approval, the course provided an update detailing how the changes they have made to assessments, including the formative and summative assessments they now have in place to assess this requirement. These updates were shared with associates for review, upon which it was decided there is sufficient evidence to close the condition. The curriculum of the PA programme will be monitored in the future via our proactive QA processes.

The provider must implement their plans to demonstrate how it assesses the following

Following the implementation of the condition and course approval, the course

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Quality Assurance, Monitoring and Improvement - PA Courses

outcomes: detect and report adverse medication reactions and therapeutic interactions and react appropriately by recommending the stopping or changing of medication to a prescriber, (29h x.)

provided an update detailing how the changes they have made to assessments, including the formative and summative assessments they now have in place to assess this requirement. These updates were shared with associates for review, upon which it was decided there is sufficient evidence to close the condition. The curriculum of the PA programme will be monitored in the future via our proactive QA processes.

Compliments and Complaints report

Action	To note
Purpose	To provide Council with an update on our handling of customer complaints from October 2024 – September 2025, identifying key trends and summarising how we have used learning from complaints across the organisation to help us identify business improvements. The paper also notes the compliments we have received in relation to the service we provide, and the learning we have taken from them.
Decision Trail	As previously agreed, Council now receive an annual update on customer complaints and compliments from across the organisation. This update covers data from October 2024 – September 2025. This report was considered by the Executive Board on 24 November 2025.
Recommendations	To note the review of customer complaints and compliments and discuss any issues arising from the trends identified.
Annexes	Annex A: Business improvements and case studies Annex B: Complaint volumes and outcomes
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Sponsoring director/ Senior Responsible Owner	Sophie Brookes , Assistant Director Corporate Directorate

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Compliments and Complaints report

Background

- 1 Complaints about the service we provide are considered under our Customer Complaints Policy, which applies to the GMC and MPTS. There are nominated complaints advisers in each directorate who are responsible for looking into the complaint, drafting and sending responses at the first and second stage of our complaints process. At the third stage of escalation, the Corporate Review Team consider previous responses and whether we have addressed all of the outstanding complaints. Each stage of the complaints process gives us an opportunity to consider whether we can improve our services.
- 2 Our complaints policy allows for three stages of escalation. Previous external audits have confirmed that it is important to manage a customer's expectations and not to unfairly raise their expectations by engaging in lengthy, repetitive correspondence. Taking this into account, the Corporate Review Team send the intended final response and explain that we have exhausted all of the mechanisms available to us to address the complaint. Our letters are clear that, without new information, we will not be responding further on the issues related to that specific complaint.
- 3 As well as terminating correspondence under the three-stage escalation process, we may also restrict or terminate contact with an external customer under our behaviour policies. We have policies relating to vexatious complaints, persistent complaints, and unreasonable behaviour. Annex A gives some recent examples of the application of these policies.
- 4 As part of our compliance with the ISO 10002 standard on complaints handling (referred to below), we operate a Customer Complaints Review Group ('CCRG'). CCRG is a network of complaints advisers from across the organisation, which meets eight times a year to discuss potential complaints drivers, business improvements arising out of complaints and training needs across the complaints teams.

BSI Audit 2025

- 5 The Corporate Review Team are responsible for managing and maintaining our customer complaints process and lead on the preparation for the BSI audit – briefing teams and liaising with the auditor. Since achieving ISO 10002 accreditation in 2017, we have been audited annually on our complaints handling. The most recent audit in October 2025 was successful and no non-compliances or opportunities for improvement were identified. The auditor will consider our processes again in October 2026.
- 6 The auditor was exceptionally positive about our processes and the engagement level of staff, as well as the level of preparation and quality of materials provided. In addition to giving positive feedback about the work of each directorate, the auditor also commented that:

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- a The Customer Complaints Review Group is a brilliant tool, and knowledge is shared well across teams;
 - b It is impressive to see our attendance at the Healthcare Regulators Forum, which shows we are not complacent and we are happy to work with similar organisations to give consistency to customers;
 - c It is excellent to see we use a separate, internal team, to carry out audits of our complaints work so we can be confident there is always independent oversight, and we are committed to improving;
 - d ED&I is clearly a significant focus for the organisation, and it really comes through in all of our complaint documentation. We are clearly alive to the vulnerabilities of our customers and action those well.
- 7 We will continue to provide information to the PSA at their request, in line with their standard. This formalises actions we already take and provides an additional layer of external oversight of our complaints handling.

October 2024 – September 2025 complaints data and trends

- 8 We received 1,370 complaints between October 2024 and September 2025, a 3% decrease on the 1,412 complaints received between October 2023 and September 2024 (see Annex B). R&R have seen an increase in complaints about the portfolio pathway to specialist registration. The key driver has been delays in processing and evaluating applications as a result of a 20% increase in applications compared to the same period in 2024 and most of the medical Royal Colleges struggling to identify sufficient numbers of assessors to complete the evaluations within a reasonable time. Since October 2024, we have received 188 complaints about this. We have been working with the Royal Colleges to try to address the issue, have recruited our own assessors to support the evaluation of portfolios in house, have increased the resources in our specialist applications team and we have also changed our approach to managing these applications to make the process more efficient.
- 9 We continue to see correspondence about the conflict in the Middle East, and our regulatory processes for registrants who comment frequently on social media in relation to this issue.
- 10 We responded to 1,245 complaints, 7% fewer than the 1,347 complaints responded to between October 2024 – September 2025 (see Annex B), an understandable decrease given the slightly lower volume of complaints received.
- 11 For the current reporting period, we replied to 80% (966) of complaints with an explanation or as part of a broader campaign response. This is a slight decrease on the 85% (1,141) of complaints resolved by way of a further explanation between October 2023 – September 2024. In the previous year, we saw a spike in complaints about our decision to remove

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primary medical qualifications from the Dnipro Institute from our list of accepted qualifications, which we responded to with a further explanation of our position.

- 12 We use the phrase 'campaign complaints' in relation to complaints about the GMC's position or perceived position on certain topics or specific cases, rather than a specific service the GMC has provided to an individual. For example, when a case has received significant media coverage, or we have made a change to a process.
- 13 We concluded 11% (151) of complaints by apologising for a service failure, a slight increase on the 9% (126) of apologies issued between October 2023 and September 2024. We have continued to see a slight increase in the proportion of complaints resolved by way of an apology because of increased workloads across the organisation, which resulted in some customers experiencing delays.
- 14 We generally issue apologies because of a service failure in around 10% of the complaints received. Examples of a service failure include significant delays to our handling or administrative errors such as communicating by email when a customer has requested all correspondence by post.
- 15 We closed a further 4% (58) of complaints without sending a response, because we had previously terminated correspondence on the specific issue(s) in the complaint. We closed a further 5% (61) of complaints by advising of an alternative way forward, such as an appeal process, a review under Rule 12 or an information access request.
- 16 Generally, we close around 8% of complaints without a further response, and direct 5% to other areas of the business. It is positive to see that the majority of complaints have been appropriately dealt with by the complaints process, rather than needing further signposting to other areas of the business. In the last report, 7% of complaints needed further signposting or were closed without a response.
- 17 Of the complaints responded to, we considered 79 under stage three of our processes. Generally, the Corporate Review Team consider 60 – 80 complaints a year, so although we have seen an increase on the 56 escalated complaints reported on in the previous year, it is positive to see that volumes are continuing as we expect them to. In 68 of those complaints, we received no further correspondence. 11 customers reiterated their complaints, and we sent further responses to three of them. In line with our complaints policies and previous replies to the customers, we did not send any further responses to the other repeat complainants.
- 18 We met the 10-working day service level agreement ('SLA') in 82% of complaints. Most directorates work towards a target of responding to 90% of complaints within SLA, but we are conscious that Registration and Revalidation work to a 95% target. Whilst we have not met the 90% target in this period, we have achieved the SLA in 80% of cases for the previous two years. Prior to that, the rate of adherence to the SLA was around 75%. We will continue

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to monitor this and consider whether there are any trends. We have discussed with other regulators at the Healthcare Regulators Forum, and it appears that service complaints are becoming more complex and voluminous in nature which is contributing to the additional length of time it is taking for us to respond. We have seen an increase this year in mass complaints, which appear to be generated by AI. We are considering how best to manage these by working with teams in IS and Strategic Communications and Engagement to identify these complaints as early as possible, and to produce some general guidance to support staff with handling.

- 19 Of the 224 complaints responded to outside of the 10-working day SLA, 122 were complex complaints and we responded within 15-working days. In 64 complaints, we responded on day 11. We responded to the remaining 38 complaints within 20 working days, some of which were complex and required legal advice, or were particularly high profile and needed input from various teams across the organisation. In each of these complaints, we kept the customer up to date and advised when they could expect our response.
- 20 Of the 1,245 complaints we responded to, we resolved 85% (1,058) at the first stage of our processes. We resolved a further 9% (108) at the second stage of our processes and escalated only 6% (79) to the Corporate Review Team for an intended final response. It is positive to see that we continue to resolve most complaints at the earliest possible point in our complainants handling process and by way of an additional explanation to help to address the complaints raised.
- 21 We have continued to log complaints which feature an element of equality, diversity, and inclusion/Equality Act issues. In these complaints, the main area of dissatisfaction tends to be a policy or process, such as the handling of a fitness to practise investigation or the criteria for specific types of registration, but they include a suggestion that we have worked differently because of a protected characteristic. During this period, 7% (101) of the complaints we received included reference to equality, diversity and inclusion. This is a very slight decrease on the 8% (106) of complaints highlighting equality, diversity and inclusion between October 2023 and September 2024. In each of these complaints, we were satisfied that the interactions with us had been in line with our processes and there was nothing to suggest any evidence of discrimination.
- 22 As with the previous paper, R&R recorded the most complaints. This is in the context of the directorate having by far the most interactions with doctors and the public, handling doctors coming on and off the register, revalidation, the contact centre and PLAB.
- 23 In the reported period, FTP recorded 88 complaints, the majority of which related to general dissatisfaction with decision making in and handling of Fitness to Practise cases. This figure should also be read within the context of FTP receiving increased volumes on fitness to practise concerns year on year since 2022. Between October 2024 – September 2025, there have been 12,913 concerns received by triage. It is positive to see we continued to record

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complaints in fewer than 1% of interactions given the often-contentious nature of fitness to practise cases.

- 24** The Corporate Review Team recorded 101 complaints, 79 of which were escalated from other areas of the business.

Business improvements and assurance

- 25** When we respond to complaints, we take the opportunity to consider whether there are any areas of our service which could be improved. We do this at each stage of escalation, and the three-stage process gives us the chance to review our actions to date, all of our previous responses, and feedback to teams if we think there are improvements or if responses have not fully addressed the complaints.

- 26** Since the last report, we have carried out 29 further improvements, including:

- a** Registrations and Revalidation have implemented a new business improvement tracker, to improve accessibility and visibility of business improvements, as well as being able to check on the progress of their suggestions with the relevant team. Since implementing the tracker, 60 ideas have been put forward, compared with around 10 in the previous year. We will look to roll this out across other complaints teams in 2026.
- b** As part of our regulatory fairness review work, the Corporate Review Team have produced guidance to demonstrate fairness in complaint investigations. This work should also provide reassurance to the PSA around complaints involving allegations of discrimination. Previously, we have not been able to demonstrate comparator data because some complaints are from members of the public, and we do not routinely capture protected characteristic data because we have no justifiable reason for doing so. The new guidance and templates mean we can clearly demonstrate how the process complained about should have worked, and whether there are any gaps between what should have happened, and what did happen. By doing this, we can be confident our processes are being applied fairly.
- c** We have updated our list of countries where English is a first or native language to include Malta and updated our online guidance to reflect the change.
- d** Ensuring complaint references are always included in outbound correspondence to make it easier for customers to speak to the appropriate team.
- e** Updating the Customer Complaints intranet pages to provide clearer information about the escalation process, and the information required to escalate a response so we can work more efficiently on escalated complaints.

- 27** As a result of feedback from complaints, we have identified a further 44 potential improvements, some of which are set out in Annex A. The complaints teams and CCRG will routinely identify improvements in their handling of complaints. As part of CCRG's regular

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meetings, we are working towards a cross-organisation peer review process to ensure complaints are handled consistently and so that learning can be shared. We are also reviewing the general complaints guidance to give a clearer focus on equality, diversity and inclusion and to better support staff with handling challenging interactions in the complaints process.

Compliments summary

- 28** In the same way as we use complaints to learn from, we use compliments to inform wider organisational best practice and staff development. When teams receive substantive compliments, as opposed to general expressions of gratitude, they are discussed in team meetings to promote learning at directorate level. Where explanations of our processes have been particularly helpful, the wording is shared with teams to ensure we can continue to provide consistent, helpful responses to our external customers.
- 29** At the time of writing, we had recorded 2,859 compliments across the directorates.
- 30** The majority (2,612) of the 2,859 compliments recorded were received by R&R. As well as general emails expressing thanks, there were positive comments about processes and the manner in which we engaged with customers, for example:
- a** 'I just wanted to say in writing how immensely grateful I am to...the brilliant GMC advisor I spoke to today. [They] were so kind and understanding, and went that extra mile to help resolve my difficulty paying fees during a period of ill health/not working. It really does make a huge difference to have someone so kind at the end of the phone. Please can you kindly feed this back to [them] with my thanks again for [their] exceptional service, help and kindness.'
 - b** 'Having previously dealt with the police, the speed and understanding from both [Investigation Officers] were such a reassuring breath of fresh air. Both really took on board just how distressing this situation is and showed compassion.'
 - c** 'You did something very good. You really made a difference to my life.'
 - d** 'I wanted to take a moment to commend one of your staff members for their exceptional handling of my GMC complaint recently. Their approach has made a significant difference. They have not only been incredibly responsive to all of my queries and concerns, but also consistently caring and empathetic throughout the entire process. What stood out to me was how efficiently and professionally they managed the situation...Their efforts have truly helped reduce the stress and anxiety associated with the process, and I feel both supported and confident that the matter was handled appropriately.'
 - e** 'Thank you for your thoughtful message and for keeping me updated. It truly means a lot to have your support during such an incredibly challenging period in my life. Your

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kindness, understanding and consistent support have been a beacon of light through this darkness. Knowing that you are there, guiding and assisting me through the complexities of this process brings a sense of reassurance that I deeply appreciate. Your efforts have not gone unnoticed, and I am sincerely grateful for your dedication and empathy.'

- f** 'Thank you very much for your kind email and for taking the time to explain the process clearly. It was a pleasure speaking with you as well. I am grateful for your support.'

Annex A

Business improvements and case studies

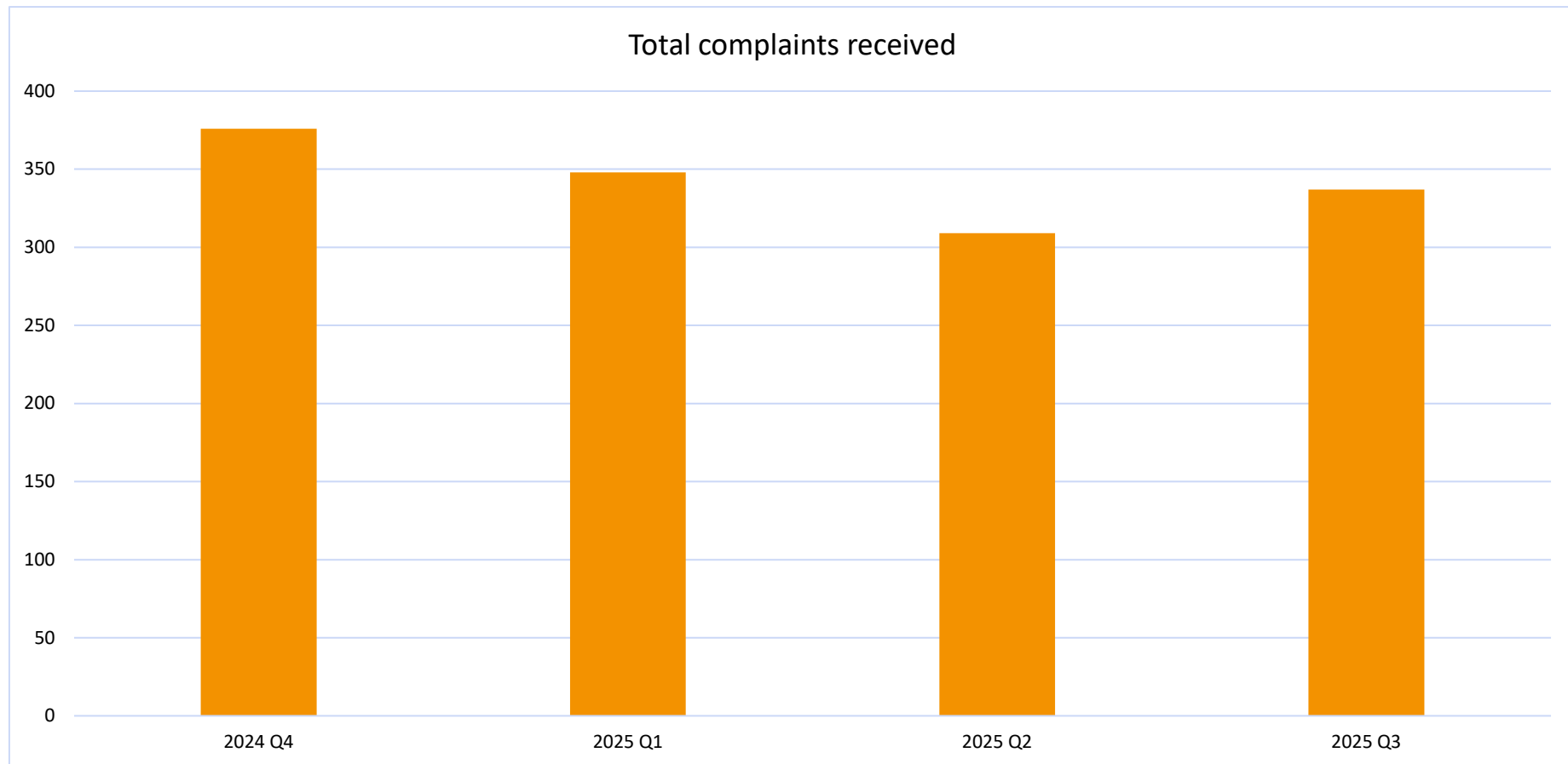
- 1 A medical student contacted us about our application process, specifically in relation to the list of countries where English is considered as a first language. We identified that the UK government now recognises Malta as having English as its first or native language and therefore updated our list of countries where this was the case.
- 2 A complainant in the FTP process had been through gender reassignment surgery. In the decision they received from FTP, a quote was included from a clinic letter where the complainant had been misgendered. The complainant therefore felt that we had misgendered them as well. Although we did not uphold the complaint, instead explaining that we were quoting from a clinic letter rather than describing the complainant's gender identity ourselves, we identified that we should continue training staff to understand the importance of pronouns.
- 3 The legal team considered a complaint from a doctor who is currently in prison. The complaint was that the doctor receiving documents relating to their investigation whilst already detained was causing further distress, particularly because some of the documents referred to a costs order following the doctor's unsuccessful litigation. We identified that we might need to consider the use of bespoke communications plans for doctors under investigation who are also imprisoned.
- 4 A doctor complained that the application for Voluntary Erasure was unnecessarily complicated as it required doctors to manually complete all employment information, rather than giving the option to tick a 'not applicable' box. This feedback was shared with the relevant team for consideration of whether we could add an auto fill or tick box to the form to make it less cumbersome.
- 5 A doctor complained that their Primary Medical Qualification was added to our not acceptable list without prior notice or explanation. The doctor had already booked their PLAB1 assessment and had incurred the cost of this assessment. Although we are clear that the responsibility is with doctors to check their qualification is on the acceptable list, and that there is a possibility that qualifications can be removed, we accepted that our communication could be improved once a decision has been made to remove a qualification from the acceptable list. We confirmed we would use the doctor's feedback to help us improve our communication and issued a goodwill refund of the PLAB1 fee.

Application of complaints policies

- 6** A doctor made repeated applications for registration, dating back to 2015, all of which have been unsuccessful. In their most recent interactions with us, the doctor indicated they did not think the process was accessible and that we had failed to offer reasonable adjustments. When we responded to their complaints at the first two stages of the complaints process, we explained that we had offered reasonable adjustments by taking regular telephone calls from the doctor but that these were often not constructive because we could not give any further updates until their application had been assessed. We escalated the doctor's complaints to the Corporate Review Team, and during correspondence with the team the doctor was derogatory towards staff and made a large volume of calls over a sustained period despite our explanations that we could not provide any further information until we had investigated the background to the complaints. Because of the derogatory comments directed at staff, we issued a warning under the unreasonable behaviour policy.
- 7** A doctor with an open fitness to practise investigation made repeated calls to the contact centre reiterating questions about the process and refusing to accept our explanations about the statutory framework under which the investigation had been opened. The doctor's contact exceeded 40 calls and emails a day over the period of a week, all reiterating the same questions. A warning was issued under the persistent complaints policy, and an agreed communication plan was implemented, where we would contact the doctor every fortnight even if there were no substantive updates in their investigation. This approach helped us to manage the doctor's expectations but also reduced unnecessary pressure on staff who had been dealing with the correspondence.

Annex B

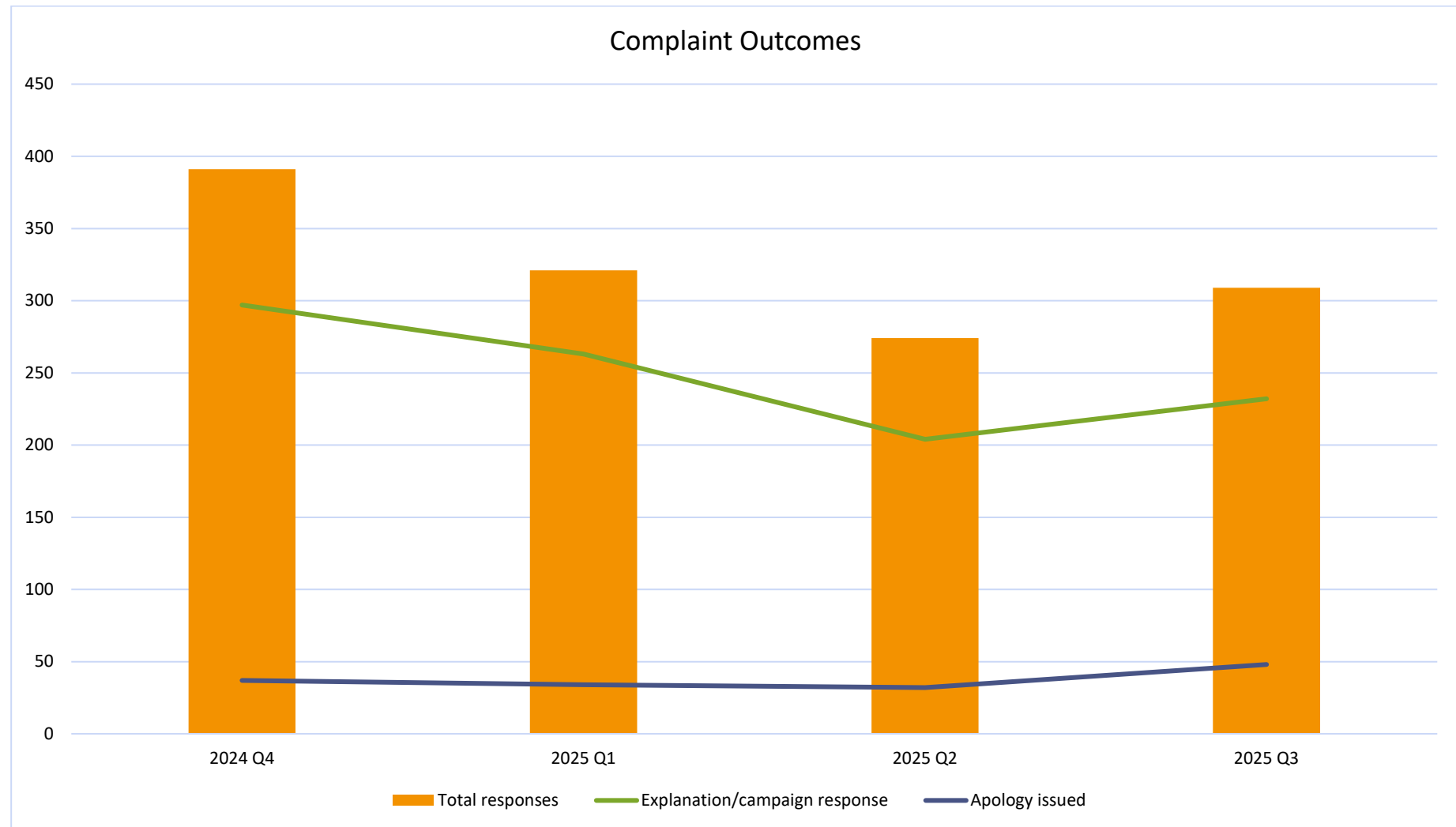
Complaint volumes and outcomes



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Complaint outcomes



Report of the Audit and Risk Committee 2025

Action	To note
Purpose	To report the work of the Audit and Risk Committee from June to November 2025.
Decision Trail	This report is based on the Committee's activities and scrutiny of papers discussed on 9/10 September and 11/12 November.
Recommendation	To note the work of the Committee
Annexes	N/A
Author contacts	Nicola McGowan , Assistant Director Audit and Risk Assurance Any enquiries to: GovernanceTeamMailbox@gmc-uk.org
Senior Responsible Owner	Vanessa Davies , Chair, Audit and Risk Committee

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Report of the Audit and Risk Committee 2025

Background

- 1** This report provides a comprehensive update on the Audit and Risk Committee's (ARC) activities since it last reported to Council in June 2025, supplementing the summary notes provided to Council after each seminar and meeting.
- 2** The ARC's purpose is to provide Council with independent assurance on the effectiveness of arrangements established by the Executive to ensure the:
 - Integrity of the financial statements.
 - Effectiveness of the systems of internal control, governance and risk management.
 - Adequacy of both the internal and external assurance services.
- 3** This assurance is achieved primarily through:
 - Regular risk dialogue with the Chief Executive and Director of Resources.
 - Overseeing the annual programme of internal and external audit activity.
 - Scrutiny of significant events and learning opportunities.
 - Seeking assurance on the implementation of recommendations arising from audit activities and in response to significant event reviews.
 - Calling on other members of the Executive for further information, as required.

Summary of the ARC work programme

September seminar

- 4** The virtual seminar was delivered by the leaders of the Future of Education and Career Development programme, which is fourth on the corporate priority list. The session covered:
 - The drivers for the evolution of medical education, with the aim for a new educational framework by 2030.
 - Stakeholder engagement within the programme.
 - An update on resources in the programme team and key governance mechanisms.
- 5** An overview of relevant stakeholder groups and examples of recent engagement demonstrated good progress to date, but the team recognise there is more to do to ensure that all stakeholders are engaged, including a wide range of seldom heard groups. The Committee were assured that there are plans in place to continue and extend engagement, including a planned consultation in 2027.
- 6** A rich risk discussion followed in breakout discussion groups focused on how the programme can navigate changes to the political environment, and align with the many external

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Report of the Audit and Risk Committee 2025

developments, such as the 10-Year Plan and Medical Training review, whilst keeping focus on our role as regulator.

- 7** The Committee will consider how it wishes to have oversight of programme progress and risk management as the programme moves forward to finalise its scope and milestones. As a first step, Internal Audit will assess whether the arrangements in place, including risk management, create the conditions for a successful programme.

November seminar

- 8** The most recent seminar was focused on risk and assurance matters through the lens of the new Corporate Strategy. It considered:
 - The risk framework already in place to help manage risk associated with the strategy
 - Work in progress to align strategic activity, decisions and trade-offs with risk appetite
 - Plans to move to a more integrated assurance model across the Internal Audit, Quality Development and Quality Assurance teams
 - Assurance work plans for 2026 and proposed coverage of strategic themes and objectives.
- 9** The Committee was assured that the developments being undertaken to the risk framework will support both the understanding and application of risk management and risk appetite in the delivery of the new strategy and the prioritisation of key objectives.
- 10** The ability to identify emerging risks was a theme in the wider discussion and there was support for reviewing the ARC's role to support management in relation to horizon scanning and the assessment of emergent risks. Opportunities to enhance risk reporting, such as identifying key indicators of new or increasing risks were also discussed. Financial considerations were explored as a further dimension to risk assessment and members encouraged increased focus on financial risks and impacts in the CORR.
- 11** There was broad support for plans to move to a more integrated assurance model. Members discussed the opportunity through this model to review the layers of assurance in place for key risks and activities and to 'right size' this in line with risk appetite, which may present opportunities to simplify.
- 12** The Committee will receive a formal internal audit plan proposal at the January meeting and had an opportunity to contribute ideas. Given a challenging and fast-moving external environment, members were supportive of developing a 12-month plan but with flexibility to change reviews, with appropriate ARC scrutiny, to address new or significantly changed risks, as these arise.

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Report of the Audit and Risk Committee 2025

ARC meetings

- 13** We continue to welcome a wide range of colleagues to meetings to support delivery of the agenda, in addition to the standing attendance of the Chief Executive and Director of Resources. This engagement with colleagues across the organisation continues to assure the Committee of the strength and depth of knowledge and capabilities, both at executive and assistant director level, and beyond. In turn, this supports our confidence in the organisational resilience and succession management.
- 14** In June we welcomed the new Assistant Director, Audit and Risk Assurance to the GMC and the Chair has supported her induction.
- 15** In addition to regular contact with the Assistant Director, Audit and Risk Assurance, the Chair has met both the internal and external auditors privately. The Committee has also met with both BDO and Crowe without management present. These meetings provide an open channel for communication on risks and issues and support the Committee's assessment of the ongoing independence of both audit firms.

Risk and issue management and oversight

- 16** We maintain a clear risk focus in our work programme and continue the practice at the start of each meeting to hold an unscripted risk discussion to consider current risks and issues facing the GMC and emerging threats in the wider external environment. We also consider the mitigations and other actions taken to manage these threats.
- 17** Scrutinising the Current Risks and Issues report from the Director of Resources, alongside the Corporate Opportunities and Risk Register (CORR), remains a feature of each meeting. We are prompted through the IA progress report to consider whether any emerging matters discussed should be reviewed by internal audit and, if so, how this fits with the agreed internal audit plan for the year.
- 18** The discussions at the last two Committee meetings have covered a wide range of risks and noted a complex and dynamic external environment that is adding to the organisational risk picture. We have heard from the directors managing the risks and issues, which include updates on doctors with overseas sanctions (addressing allegations in the recent The Times article), managing the GMC's response to maternity reviews, the Leng Review and the ongoing rapid review by Lord Mann into antisemitism and all forms of racism in the NHS. We have also considered the significant increases in triage volumes, mirrored in the experience of other professional healthcare regulators, and the action taken to manage the operational challenges that this presents. In meeting with the directors, we have the opportunity to explore the mitigations in place, and planned changes, which reassures the Committee that risks are being actively managed in a changing environment.

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- 19** The Committee has received updates for the Associate Worker Status, ERP and Regulatory Reform programmes, all of which have been subject to internal audit this year.
- 20** We reviewed the refreshed Risk Management framework at the September meeting. Comments from the Committee were addressed before submission to Council. The Committee will review any proposed changes in the light of feedback from the last Council meeting and the planned Council seminar on risk appetite in February 2026.
- 21** From these reports and associated discussions, along with our consideration of risk in the context of other agenda items, we are confident in assuring Council that risk management arrangements are in place and operating effectively. We think there is further scope to develop and better embed the concept of “risk appetite” across the GMC, especially in connection with the adoption and implementation of the new corporate Strategy, and are encouraged by the work in progress to articulate risk appetite for each strategic objective. The Committee is reflective as to the need to identify emerging risks and will consider its role in risk horizon scanning. Emphasis will also be placed on the articulation of financial risks and impacts in the CORR, which is a dimension to risk that can be further developed.

Other activities

- 22** In summary, the other main ARC activities in the last six months are shown below:

Topic	Activity
External Audit	- Approved the 2025 audit terms of engagement, plan, scope and fee - Considered a change in accounting treatment for deferred income as a result of the ERP change, and a proposed prior year adjustment - Reviewed auditor performance, objectivity, and independence
Internal Audit	- Reviewed seven internal audit reports - Assessed the progress in delivering the 2025 plan and all overdue actions - Considered the proposed approach to internal audit planning for 2026 - Received an update on the revised IT disaster recovery plan implementation
Other Assurance	- Assessed the Business Assurance Framework - Scrutinised a significant event review and the associated referrals to the Information Commissioner and the Charity Commission - Reviewed the refreshed guidance for undertaking significant event reviews - Discussed the biannual Quality Development and Quality Assurance report - Received external accreditation reports
Compliance	- Received the annual report of the Data Protection Officer - Reviewed the progress in implementing the requirements of the new Economic Crime and Corporate Transparency Act

Key matters to highlight

Significant Event Reviews (SERs)

- 23** A SER report was discussed in September, commissioned following the sharing of documents that had the potential to put a vulnerable person at risk of harm. The GMC self-reported to the Information Commissioner, who has taken no action to date. The matter was also referred to the Charity Commission, followed by an update on the steps taken to address the root causes of the issue, which is particularly linked to the different routes by which FtP referrals can be received and a difference in the way we inform referrers how the information will be used. No further correspondence has been received from the Charity Commission to date. ARC members were reassured that the complaint is being treated with care and compassion and that impacted colleagues have been engaged in the context of learning from this issue.
- 24** We also reviewed refreshed guidance for the completion of a SER in September and, following minor updates, this was recommended to Council for approval. At Council's direction, ARC will oversee further engagement with the Charity Commission to assess whether fitness to practise matters require referral where there has been harm to the public, before the guidance is finalised and communicated.

Responding to the Economic Crime and Corporate Transparency Act 2023 (ECCTA)

- 25** In September we received an update on the approach taken to comply with the new requirements of the ECCTA, which came into effect on 1 September 2025. Central to the act is the introduction of a new corporate offence of 'failure to prevent fraud'. The GMC would be liable for a potentially unlimited fine if we fail to put in place reasonable procedures to prevent the fraud occurring. The Committee reviewed the actions taken to date to establish reasonable procedures, in line with Home Office guidance, and the plans for management to assess the risks and related controls on an ongoing basis. The Committee was reassured that steps have been taken across the organisation to assess this risk and will consider when to seek independent assurance that these steps are effective and embedded.

Business Assurance Framework (BAF)

- 26** The BAF is a comprehensive annual exercise to map and assess the main sources of risk and assurance for each team in the organisation, collated by directorate. The BAF helps the Committee in its understanding and confirmation of where assurance is in place and where this may need strengthening, and informs the work plans for Internal Audit and the Quality Development and Assurance teams.

- 27** The BAF is based on an established 'three lines' model which splits assurance activity between local activity controls for the teams that own and manage the activities and risks (first line), oversight controls from functions which oversee the management of risk and assess compliance (second line), and functions which provide independent assurance, such as internal audit.



- 28** Now in its ninth year, the BAF is well embedded across the GMC and the Committee saw evidence of a mature and still improving picture of assurance year-on-year.
- 29** The Committee is supportive of plans to review the BAF process and cadence and will consider a proposal at the March meeting.

Delivery of the 2025 Internal Audit Plan

- 30** The seven reports presented to the Committee in the last six months have not raised any major concerns.
- 31** We took the opportunity, following an audit of Business Continuity and Disaster Recovery arrangements, to invite management back in November to provide an update on an IS-commissioned third-party assessment of the IT disaster recovery plan, which was in progress at the time of the audit. We were pleased to see the third-party report that confirmed the plan was fit for purpose and management's commitment to address the minor recommendations for further improvement, which we will track to completion.
- 32** The Committee maintains a focus on the ERP programme and received two audit reports at the November meeting, confirming robust governance on the HR workstream and delivering a forward-looking plan of action for data migration in the Finance workstream. We have commissioned a further seminar on the ERP programme in January, for both an update on progress and to determine the assurance needed ahead of 'Go Live'.
- 33** Twelve of the thirteen audits planned for delivery in 2025 are now complete. The timing of the final review, in relation to the Future of Education programme, is being reassessed. This may be deferred to the first half of 2026, to enable the recently appointed programme manager to complete updates to key programme documents and to align the timing of the assurance with the programme moving out of the planning stage, with a focus on assessing whether arrangements are in place to create the conditions for a successful programme.

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Report of the Audit and Risk Committee

- 34** There has been good progress this year in addressing agreed audit actions and, at the latest, meeting, only three related actions were overdue with a plan to address by the end of 2025.

Other assurance reports

- 35** In November the Committee was pleased to receive four reports with no non-conformities in relation to:
- a** **ISO 27001** – Information security management systems: two surveillance assessment reports covering the GMC’s London and Cardiff offices
 - b** **BS 10008** – Evidential weight and legal admissibility of electronically stored information: recertification report assessing the GMC’s scanning process and management of digitised documents
 - c** **ISO 10002**: Quality management: customer satisfaction – annual recertification relating to complaints handling across the GMC.
- 36** In all cases the assessors recommended that the GMC continues to be certified to the relevant standard, and we acknowledged the work of the teams that maintain this high level of conformance.

Closing remarks

- 37** Across the course of this year the Committee has continued to develop its understanding of the organisation and the complex and changing risk environment in which the GMC operates. The breadth of experience on the Committee brings different perspectives to the discussions and scrutiny of each agenda item.
- 38** The results of internal audits and other assurance activities, such as the BAF, paint a generally mature picture of control and assurance with management’s commitment to address weaker areas. Whilst there have been no major concerns to address in the period, we remain focused on the closure of agreed actions at every level of risk. With the marked reduction in overdue actions, we are assured that management are actively addressing risk and control matters.
- 39** We remain keen to ensure that the Committee’s activities fully align with Council’s assurance requirements, particularly during a period of significant planned change for the GMC and against the backdrop of a more volatile external environment, which may change, accelerate or introduce risks for the organisation.

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Report of the Audit and Risk Committee

- 40** We welcome any observations or comments from members on our activities, and in particular on how the Committee can adapt its oversight to ensure that emerging risks are identified and incorporated into the risk management framework, and increase focus on financial risks and impacts.

Report of the Remuneration Committee 2025

Action	To note
Purpose	The Remuneration Committee is required to report to Council on its activities at least annually. The report summarises the work undertaken in 2025. The Committee is also required to review its Statement of Purpose, included at Annex A. It has done so and does not propose any changes at this time, but noted the potential implications of legislative reforms for this committee
Decision Trail	N/A
Recommendation(s)	To note the report of the Remuneration Committee for 2025.
Annexes	Annex A: Remuneration Committee Statement of Purpose
Author contacts	Melanie Wilson, Head of Corporate Governance and Council Secretary Any enquiries to: GovernanceTeamMailbox@gmc-uk.org
Sponsoring director/ Senior Responsible Owner	Alison Wright , Council Member and Chair of Remuneration Committee

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Report of the Remuneration Committee 2025

Background

- 1 The Committee has met twice in 2025 under the leadership of Alison Wright, who took over the Chair when Anthony Harnden demitted from Council at the end of the 2024.
- 2 It has the scope to consider issues on email circulation where action was required to be taken between meetings, and following the March meeting a paper to provide further detail was approved on circulation (see item on Pay award below).
- 3 The Committee is satisfied that in undertaking its work programme for 2025 it has fulfilled its responsibilities under its terms of reference. It noted that the work to review the terms and conditions of Council members would be undertaken in 2026 (see paragraph 24). The Remuneration Committee's Statement of Purpose is at Annex A.
- 4 For reference, Council members can access the Remuneration Policy on the 'Useful documents' shelf in Board Intelligence.

Recruitment to MPTS Chair

- 5 The process to recruit a new chair of MPTS June 2025 following the appointment of Her Honour Judge Deborah Taylor to chair the Valdo Calocane Inquiry.
- 6 GatenbySanderson hold the contract for executive search for member recruitment and were the search agency for this process. The post was advertised in a wide range of online locations to access as diverse a pool of applicants as possible. This process was supplemented with a 'search', again focused on seeking a diverse pool of candidates.
- 7 The calibre was incredibly high. There were 19 applicants, with six reaching the long list and four reaching the final interview.
- 8 The selection process consisted of:
 - A competency-based application form
 - An initial interview with GatenbySanderson
 - A final interview
 - A media test, consisting of a mock broadcast interview with a journalist.
- 9 The interview panel was chaired by Carrie MacEwen and consisted of Raj Patel and Cindy Butts (independent).
- 10 Judge Fiona Monk has been appointed and takes up her post on 5 January 2025.

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Report of the Remuneration Committee 2025

Update on Council recruitment 2025

- 11 The Committee noted an update on the work to recruit a new Council member, to replace Alison Wright who demits in December, having been elected President of the Royal College of Obstetricians and Gynaecologists.
- 12 It was noted that it is relatively soon since the last round of recruitment and whilst we sometimes hold a 'reserve' list of candidates to draw on up to twelve months after the process has concluded, this had not been possible in this most recent round.
- 13 The process will largely be unchanged from the last round, with final interviews scheduled for 13 January 2026.

2025 Pay award

- 14 The Committee considered the annual pay award for the Chief Executive, directors and Chair of the Medical Practitioners Tribunal Service.
- 15 The Committee considered the available options, which included making no annual base award, applying the base award as agreed for all other GMC staff, and recognising performance by applying a variable non-consolidated element.
- 16 The Committee agreed that the base pay award for roles within its remit would be 2.7%, in line with the typical award received for the wider staff group.
- 17 Following a question at the March meeting, further detail was provided on circulation about the way the variable pay element applies to staff across the GMC. It noted that colleagues who are at the 'target rate' for their grade (mid-point of the pay band) received a maximum of 1% as variable pay. Given that SMT roles are at the target rate agreed by the Committee, it was decided to use the variable pay element for 2025 as follows, which is in line with the approach taken for the wider GMC staff:
 - Successful – base pay award and no variable pay.
 - Highly accomplished – base pay award plus 0.5 % variable pay.
 - Outstanding – base pay plus 1% variable pay.

Talent and succession planning and market review

- 18 The Committee considered talent and succession planning for roles within its remit, including capacity and potential at Assistant Director level to cover the roles within the Committee's remit. The Committee considered a half year interim review in March, with the annual review being reported to the Committee in October.

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Report of the Remuneration Committee 2025

- 19** The overall position remains stable at a senior level, and the Committee noted that the position on contingency and cover for senior roles remained positive overall.
- 20** The Committee noted that the Medical Director and Director of Education and Standards planned to retire in the summer and that we had successfully recruited a replacement, Professor Pushpinder Mangat.
- 21** The Committee noted that there had been a number of changes at AD level since the October 2024 report with increased turnover and staff movements. Although we have lost some corporate memory, on the whole the Committee considered that the new appointments and the use of internal cross-cover has increased our capacity at AD level, and consequently in our ability to cover SMT roles if required.

Review of Statement of Purpose

- 22** The Committee is required to review its Statement of Purpose at least once a year and suggest any amendments considered necessary to Council.
- 23** The committee did not identify any changes required but noted that regulatory reform may have implications for this committee as part of wider governance changes in due course.
- 24** The Committee agreed that it would institute a process in the coming year by which the remuneration and terms and conditions of council members will be reviewed. It was noted that this has been looked at periodically over the past few years to benchmark with other similar organisations, which had to date concluded that the GMC was in the lead in terms of remuneration, and therefore no change was needed. Regardless of this, committee members expressed a view that a review would be useful, especially given that there has been no change to the rate of remuneration since 2015.
- 25** With this exception, the Committee is satisfied that in undertaking its work programme for 2025 it has fulfilled its responsibilities under its terms of reference. Council is asked to note the report on the work of the Remuneration Committee in 2025
- 26** The Chair of the Committee in 2026 will be Raj Patel. The Committee extended its grateful thanks to Alison Wright for all she has done over the past six years in her role as Committee member and latterly, as Committee Chair.

2026 Work programme

- 27** The Committee reviewed and agreed the proposed work programme for 2026.

Annex A

Remuneration Committee Statement of Purpose

Governance Handbook Annex B4b: Statement of purpose of the Remuneration Committee

Purpose

1. The Remuneration Committee advises Council on remuneration, terms of service, and the expenses policy for Council members including the Chair.
2. The Remuneration Committee will agree and oversee the process for the recruitment or re-appointment of the Chair and Council members in accordance with Professional Standards Authority (PSA) guidance and the requirements of the Privy Council.
3. The Remuneration Committee will determine:
 - a. The appointment process for the Chief Executive.
 - b. The remuneration policy and underlying principles for remuneration of the senior management roles within its remit.
 - c. Remuneration, benefits, and terms of service for permanent and interim appointments to the role of Chief Executive and directors.
 - d. The appointment and suspension/removal process for the Chair of the Medical Practitioners Tribunal Service (MPTS) and members of the MPTS Committee.
 - e. Remuneration, benefits and terms of service for the Chair of the MPTS and members of the MPTS Committee.

Duties and activities

4. The Committee is responsible for reviewing and advising Council on the remuneration arrangements and levels (including expenses policy) for Council members, including the Chair.
5. The Committee sets all aspects of salary or honoraria, the provision of any other benefits, and any other arrangements or contractual terms, unless these are required by employment law or are routine changes to GMC staff policies.
6. The Committee will consider all proposed changes which will have a material impact on agreed terms and conditions, such as an extended leave of absence, sabbatical arrangements and relocation support, and offers advice in respect of the following roles:
 - a. The Chief Executive.
 - b. Directors.
 - c. The Chair of the MPTS and members of the MPTS Committee.
 - d. Any other such staff and posts as may be required.
7. In respect of the appointments of the Chief Executive and the Chair of the MPTS and members of the MPTS Committee, the Committee is responsible for designing the recruitment/appointment processes in accordance with Council's agreed delegation.
8. The Committee will:
 - a. Ensure that the assessment and measurement of performance takes place within an appropriate framework for the senior management roles within its remit.
 - b. Ensure that the assessment of talent management and succession planning issues takes place within an appropriate framework for the senior management roles within its remit.

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Annual review of the Committee's statement of purpose

9. The Committee will ensure that equality and diversity principles are embedded in the issues relevant to its remit.

Working Arrangements

10. The Committee may commission appropriate external advice where required.
11. Meetings are held twice a year. At the discretion of the Chair of the Committee, additional meetings can be convened.
12. The Committee should review its statement of purpose at least once a year and suggest any necessary amendments to Council.
13. Papers for each meeting will be sent electronically to Committee members at least seven days in advance of meetings.
14. Draft minutes, recording conclusions of the issues discussed, should be cleared by the chair and circulated to members for comment within two weeks of the meeting. The Committee approves minutes at its next meeting.
15. The Chair of the Committee presents a report on its activities to Council at least annually.

Council forward work programme

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

Agenda item M13**Council forward work programme**

Background

- 1 This paper sets out the planned items for future meetings of Council. The content of agendas is liable to change.
- 2 Items marked as 'below the line' are included on an agenda where no discussion is required, although members may request a discussion at the meeting.

10/11 February 2026 – London

	Item	Sponsor
Seminar	• Risk appetite	Shaun Gallagher / Neil Roberts
	• TBC	
Confidential session	• Annual Review of Governance Framework: GMC/GMCSI	Sophie Brookes
	• Associate/worker status update	Neil Roberts
Public session	• Chief Executive's report	Charlie Massey
	• Finance update	Neil Roberts
	• Annual update of Governance Handbook	Sophie Brookes
	• PSA Annual review of our performance	Shaun Gallagher
	• Regulatory reform update [placeholder]	Shaun Gallagher
	• People Survey report	Neil Roberts
	• Report of the MPTS committee	MPTS Chair
	• 2027 Council meeting schedule	Carrie MacEwen
Below the line	• Council forward work programme	Carrie MacEwen
	• Report of the Executive Board	Charlie Massey

4/5 March 2026 Away Day – Nantwich, Cheshire

	Item	Sponsor

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Council forward work programme

22/23 April 2026 – Manchester

	Item	Sponsor
Seminar	• SoMEP Workplace & Experiences report – key findings/messages	Shaun Gallagher
	• TBC	
Confidential session	• Report from GMCSI	Paul Reynolds
	• PA/AA revalidation rules - sign-off	Una Lane
Public session	• Chief Executive's report	Charlie Massey
	• Finance update	Neil Roberts
	• People Report (including Inclusion workstream)	Neil Roberts
	• 2025 national reports	Paul Reynolds
	• Annual QA update	Push Mangat
	• Annual section 40a report	Charlie Massey
	• Regulatory reform update [placeholder]	Shaun Gallagher
	• 6 monthly SC&E Impact report	Paul Reynolds
	• Amending the list of bodies entitled to award a UK primary medical qualification	Push Mangat
	• Investment committee annual report	Douglas Millican/Neil Roberts
Below the line	• Council forward work programme	Carrie MacEwen
	• Council members' register of interest	Carrie MacEwen

9/10 June 2026 – London

	Item	Sponsor
Seminar	• Engaging with Medical students	Paul Reynolds
	• TBC	
Confidential session	• Communications and engagement update	Paul Reynolds

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Council forward work programme

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

22/23 July 2026 - Manchester

	Item	Sponsor
Seminar	• Hearing from the Marx Fellows	
	• TBC	
Confidential session	•	
Public session	• Chief Executive's report	Charlie Massey
	• Report of the Audit and Risk committee	Vanessa Davies / Neil Roberts
	• Financial update including mid-year review	Neil Roberts
	• ED&I Annual report	Shaun Gallagher
	• Safeguarding annual report	Neil Roberts
	• Regulatory reform update [placeholder]	Shaun Gallacher
	• Corporate Strategy update	Shaun Gallagher
	• Strategic Communications and engagement update – strategic priorities	Paul Reynolds

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Council forward work programme

Below the line	Council forward work programme	Carrie MacEwen
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1 October 2026 – Northern Ireland

	Item	Sponsor
Seminar	Northern Ireland focus	
Confidential session	Report from GMC Services International Ltd	Paul Reynolds
	SC&E Impact report	Paul Reynolds
	2027 Budget Assumptions and Approach	Neil Roberts/Judith Chrystie
	SoMEP Workforce Report	Shaun Gallagher
Public session	Chief Executive's report	Charlie Massey
	Finance update	Neil Roberts
	Regulatory reform update	Shaun Gallagher
	Regulatory Fairness Review update	Shaun Gallagher
	People Report	Neil Roberts
Below the line	Council forward work programme	Carrie MacEwen
	Council members' register of interest	Carrie MacEwen

9 December 2026 - London

	Item	Sponsor
Seminar	Perceptions survey report	Paul Reynolds
	TBC	
Confidential session		
Public session	Chief Executive's report	Charlie Massey
	Financial update	Neil Roberts

Agenda item M13**Council forward work programme**

	• Fairer Employer Referrals – where next?	Anthony Omo / Push Mangat
	• Fairer Training Cultures	Push Mangat
	• 2026 Budget and Business Plan	Neil Roberts/Kuljit Dhillon
	• Report of the MPTS committee	MPTS Chair
	• Report of the Audit and Risk Committee	Vanessa Davies
	• Report of the Remuneration Committee	Raj Patel
	• PPI update	
	• Reg Reform update	Shaun Gallagher
	• Compliments and Complaints report	Sophie Brookes
Below the line	• Council forward work programme	Carrie MacEwen
	• Annual report on the DC pension scheme	Neil Roberts

Fairer Training Cultures

Action	To note
Purpose	To update Council on progress against our commitment to eliminate discrimination, disadvantage, and unfairness in undergraduate and postgraduate medical education and training by 2031.
Decision Trail	Council: ● Approved our ED&I priorities in February 2021; ● Considered an annual report on progress in February 2022; ● Considered a detailed project progress report in September 2022; ● Considered an annual report on progress in April 2023; considered a detailed project progress report in November 2023; and ● Considered an annual report on progress in July 2024, and a detailed progress report in December 2024.
Recommendation(s)	To consider performance against our commitments, our priorities, and asks of others in response.
Annexes	Annex A: Calls to action Annex B: Index Measures - 2019 to 2025 data tables Annex C: Current statistical KPI forecasts
Author contacts	Jane Cannon, Programme Manager Tracey Hooper, Project Manager Any enquiries to: GovernanceTeamMailbox@gmc-uk.org
Sponsoring director/ Senior Responsible Owner	Pushpinder Mangat , Medical Director and Director of Education and Standards

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Fairer Training Cultures

Executive summary

- 1 In 2021 we set a target to tackle persistent areas of inequality within medical education and training which impede doctors' progression through their career and from achieving their potential.
- 2 We committed to *eliminate discrimination, disadvantage, and unfairness in medical education and training by 2031*
- 3 Our 10-year strategy focuses on the removal of systemic and cultural barriers and championing initiatives shown to improve outcomes for marginalised groups.
- 4 This report summarises the progress made since 2021, and a deeper overview of 2025 activity:
 - **Phase 1** from mid-2021 to end-2024 focused on:
 - Building evidence of 'What Works' through small scale pilots to demonstrate change is possible
 - Embedding FTC activity into all Education and Standards quality assurance teams
Business as usual
 - Embedding FTC Action Plans into external educational organisations as well as collaborating to co-create new policy and guidance.
 - 2025 marks the first year of **Phase 2** which will run from Jan-2025 to Dec-2028. This phase will focus on
 - Scaling up evidence-based interventions
 - Embedding FTC into planned new Educational Standards for 2029
 - Driving inclusive learning environments
 - Shifting the dial for UK ethnic minority graduates, with emphasis on early intervention at medical school and F1
 - Widening the EDI lens
- 5 Our three index measures for early training show a widening of the gap between white and ethnic minority medical students and F1 doctors since 2019.
- 6 In contrast, in specialty training all six measures show a narrowing of the differentials between UK and overseas graduates, and white and ethnic minority UKG doctors.

Strategic approach

7 In 2021, we set a target to tackle persistent areas of inequality within medical education and training by 2031. Our strategy for achieving this target is:

- To remove or mitigate the systemic and cultural barriers highlighted in [Fair Training Pathways research](#) (2016).
- To champion initiatives shown to improve the **experience** and learning outcomes for ethnic minority learners and non-UK graduates as identified in '[What supported your success in training?](#)' research (2019).
- To embed the target into GMC standards, **policies**, and quality assurance activity and drive change across the entire system via the six FTC workstreams (Fig 1).

Figure 1: Six FTC workstreams



Measuring progress:

8 Our target is *to eliminate discrimination, disadvantage, and unfairness in medical education and training by 2031*

9 We measure progress in different ways:

- Evidence of real-world changes and initiatives reasonably expected to improve the fairness of systems, processes, attitudes and behaviours.
- Changes in the five index measures which aim to measure change at different stages of the training pathway
- Changes to wider 'lead indicators' such as recruitment outcomes, which we believe impact on the five index measures

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10 We expect it will take several years and require multiple initiatives before a significant impact is visible at a national level for all five index measures. There is no silver bullet.

11 At a national level a significant attainment gap remains across all the index measures and remains at levels that warrant continued system wide action

12 Since 2019 we can observe the following changes in the Index Measures:

Index Measure	Demographic group comparators	Year of last data point	Percentage point change since 2019	Percentage change since 2019
UG assessment*	White/ethnic minority students	2022	↑ 1.2% point increase	44% increase
F1 preparedness	UKG white/ethnic minority doctors	2025	↑ 4.5% point increase	56% increase
Unsatisfactory ARCP outcomes	UK/IMG doctors	2024	↓ 1.3% point reduction	12% decrease
	UKG white/ethnic minority doctors		↓ 0.2% point reduction	8% decrease
PG specialty exams	UK/IMG doctors	2024	↓ 5.3% point reduction	18% decrease
	UKG white/ethnic minority doctors		↓ 1.2% point reduction	10.8% decrease
Inclusive environments	UK/IMG doctors	2025	↓ 1.9% point reduction	46% decrease
	UKG white/ethnic minority doctors		↓ 1.8% point reduction	40% decrease

* UG assessment data for 2023 and 2024 delayed due to changes in transfer process between HESA and GMC. Data has now been received by GMC and is being processed

Note: The UG EPM measure has been removed as it stopped being used in 2023 and can no longer be tracked. Between 2019 – 2023 there was a 0.11%-point increase in the gap between white and BME students EPM scores. gmc-uk.org

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Fairer Training Cultures

Undergraduate and Foundation Training measures:

- 13 We are working closely with GMCs data teams to report on the 2023, 2024 and 2025 UG assessment outcomes as soon as possible so that we can see if the deteriorating trend between 2021 and 2022 continues. Without this data it is difficult to draw any firm conclusions.
- 14 For F1 preparedness there is clear evidence of a year-on-year worsening of the 'preparedness gap' which has increased by 4.5% points since 2019.
- 15 The programme of work to address undergraduate differentials began seven years after the postgraduate work and may be one reason why there appears to be a difference in progress between the different stages of training.
- 16 Phase 2 will strengthen our data and understanding of these earlier stages of training and we are developing targeted actions to address any deterioration, and shift the dial in a positive direction alongside the postgraduate work:
 - We will publish UG data for the first time early next year. This will provide us with a much larger data set to see national level trends and to see performance by individual medical school. We intend to use this data to develop a more targeted plan for shifting the dial.
 - Alongside publishing the data our QAMI team will be strengthening how they QA the actions each medical school is taking to address the attainment gaps in their institution, asking for a more in-depth action plan than is currently required. This will allow us to see what action organisations are taking and target further QA activity as necessary.
 - We have recruited a Clinical Fellow to examine the reasons why new doctors from marginalised groups feel unprepared, why this is widening and how the system can better support and ensure resources available are meeting needs and being utilised. This will look at the roles of both Medical School and Foundation School.
 - In January we met with the UK Foundation Programme Office (UKFPO) Foundation Programme Directors and a representative from the Medical Schools Council to highlight this concerning trend, present more detailed data analysis including new NTS data which looks at the potential causes. We will identify further opportunities to discuss these trends with UG and Foundation School leaders throughout 2026.
 - In 2024, UKFPO introduced a new recruitment which has significantly improved the 'access gap' to first choice placements – narrowing the differential between UK white and UK ethnic minority F1's by 15.5% points in 2024 compared to 2023. Research suggests that location plays a big role in feelings of preparedness and so this change may lead to improved results over time and is something we will monitor.

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Specialty Training index measures:

- 17 We continue to observe signs that the attainment gap is beginning to narrow in specialty training. All index measures for all groups have edged in a positive direction since 2019, although less markedly for UK ethnic minority doctors.
- 18 The gap in perceived inclusiveness of learning environment for IMGs and UKG ethnic minority trainees **has narrowed by over 40%**.
- 19 Postgraduate specialty exams **narrowed the differentials by 18% and 10.8% for IMG and UK ethnic minority learners respectively**. This is a very positive outcomes as exams often present one of the biggest barriers to career progression. We've noted a slight decrease in the improvement compared to the last year's results.
- 20 In Phase 2 we will focus on embedding the positive work in progress to support non-UK graduates and on increasing the scale initiatives targeting UK graduates.
- 21 **Forecast:** We have produced a forecast for each index measure (**Annex C**) which compares annual changes in the data alongside a reference forecast of what would be expected from 2021 on, if there was no change in the trend drivers since then. The forecasts are based on the very small number of data points available. As a result, most current direction forecasting models are unable to reliably detect a trend. This does not mean that the models are predicting that there will be no change. Most forecasts cannot yet provide reliable information about whether we are on track to achieve the targets or not.
- 22 There are three emerging exceptions to this undetected-trend pattern. First, the difference in postgraduate ARCP outcomes between UK and non-UK graduated doctors appears to be turning towards our aspired target. Also, the differences in postgraduate specialty exam pass rates, between either UK and non-UK graduated doctors, or between white and ethnic minority doctors, appear to be moving towards our aspired targets. It's premature to use these results to suggest whether we will meet our aspired target by the end of 2031. The reasons are that:
 - models have only started suggesting a trend for these index measures
 - that forecasts become less reliable further into the future
 - we are currently forecasting a very long period of seven years.

Four country perspective

- 23 We provide data to educational organisations on the attainment gap split by the four nations, region and specialty. There is a statistically significant attainment gap for ethnic minority and overseas qualified learners in all four nations of the UK.

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Fairer Training Cultures

- 24** PTOs 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.
- 25** National Offices and Outreach England provide invaluable support to achieving the Fair Training targets as outlined throughout this report.

Barriers to success

- 26** The GMC has limited control over the factors which need to change. And whilst there is good evidence of commitment from educational organisations to improving outcomes for marginalised doctors, we must recognise that there are still many barriers to change. These organisations exist in a resource-stretched system with many competing and changing priorities.
- 27** Although improving, the lack of evidence as to what works remains a barrier to change. Small scale pilots or scenarios where multiple initiatives are being delivered at the same time make evaluation challenging. In addition to financial and time barriers. However, good quality evidence is often the key to creating business case and securing investment.
- 28** Concerns from organisations and learners about the risk that targeted initiatives may increase stigma or create tension with those who are excluded can derail initiatives. And further evidence is needed to address these concerns and demonstrate how we can ensure fairness for all.
- 29** Systemic and cultural changes take a long time to feed into measurable outcomes, sometimes two-to-three years to redesign systems and processes.
- 30** Some factors are beyond the influence of organisations involved in medical education and their effect may remain in spite of this work.

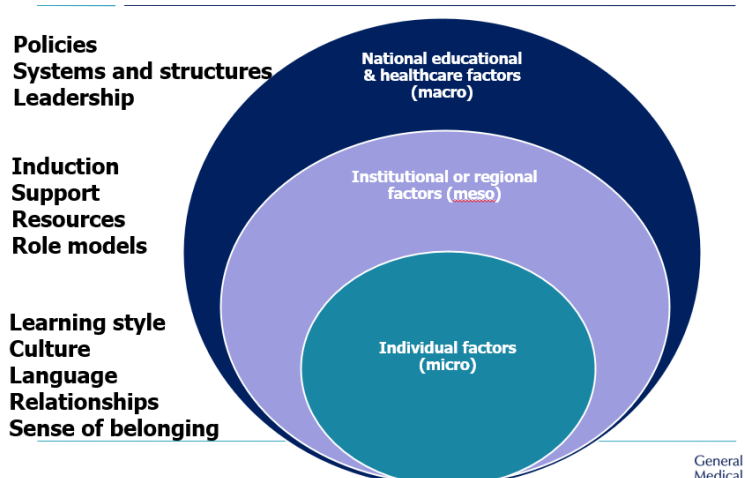
FTC action Plan

- 31** The FTC Action Plan is designed to tackle the root cause factors identified in research which collectively create differential experiences and outcomes (Fig 2).

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Figure 2: The complex interplay of factors



32 Achieving this scale and complexity of change relies on action from many other stakeholders. Including GMC Quality Assurance teams, Policy and Outreach teams, as well as many different types of external organisations.

33 We have broken this work into three phases each with specific goals and priorities.

2021 – 2024 Phase 1 <u>What works?</u>	2025 – 2028 Phase 2 <u>Scale up</u>	2029 – 2031 Phase 3 <u>Embed</u>
Building evidence of impact for promising interventions: Educator Training, Mentoring, Exam Prep training Build FTC into BAU for internal GMC teams: - GMC team action plans Maximise QA of current standards & guidance: embed external Action Plans & Recruitment EDI working group	Scale-up effective interventions Influence new standards Drive inclusive environments Intervene earlier and shift dial for UKG ethnic minorities: focus on Medical School and Foundation training Widen EDI lens while prioritising target groups	Implement new standards: higher expectations Ensure QA targets delivery of new standards Continue to monitor impact

Phase 1 – Key deliverables & achievements:

Phase 1 was completed at the end of 2024. Here is a summary of progress made:

34 **Building and promoting evidence base:** Building and promoting evidence base:

- Published and promoted evaluations of pilot interventions demonstrates clearly that outcomes for non-UK graduates can be improved with targeted interventions. And

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attitudes, beliefs and behaviours of educators and learners changed through raising awareness, a compassionate approach to supervision and mentorship:

- [Educator training and support](#)
- [Peer support and mentoring](#)
- [Enhanced exam preparation and support](#)
- Published [Tackling disadvantage in medical education](#) to provide deeper insights from our data and highlighting promising interventions.
- Published and promoted [Mentoring toolkit](#).
- We have encouraged organisations to evaluate the impact of their initiatives and to share their findings. Here is one example [An overview and evaluation of the differential attainment champion role in the North West of England GP school](#).

35 Embedding FTC into GMC teams BAU and maximising current QA opportunities

- The FTC team have co-created team-level action plans to record and track deliverables led by cross-GMC teams contributing to the FTC target. We have regular meetings to discuss progress, identify new initiatives and share information.
- There are currently 38 actions (as at Oct 2025) shared across
 - Education & [Standards](#) teams:
 - Quality Assurance – Monitoring and Improvement (QAMI)
 - Medical Education Development (MED)
 - National Training Survey (NTS) / Data team
 - Outreach & National Offices
- GMC teams have identified opportunities to strengthen QA processes & asks of educational organisations required to meet our standards
 - Refreshed [EDI impact assessment published](#) guidance for Colleges & Faculties
 - Refreshed EDI guidance for PG Deans due for publication Q1 2026
 - Co-chaired EDI recruitment group to improve fairness of recruitment to specialty training

Measuring success in Phase 2

36 Success of phase two will be measured via:

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- Evidence of widespread adoption of priority initiatives nationwide.
- Evidence of a substantial increase in activity targeting the UKG ethnic minority learners.
- On-going development of evidence about what works, particularly to reduce the UK white/ethnic minority attainment gap, and impact of earlier intervention.
- Evidence of 'Fair Training' 'asks' being embedding into the next generation of educational standards and policies.
- Narrowing of the gap for all Index measures at a national level for both IMG and UKG ethnic minority learners.

Programme activities 2025

37 We're coming to the end of 2025, year one of Phase 2. This year we've been:

- **Evaluating the impact of key Phase 1 initiatives:** Evaluation of what works and changes to recruitment systems.
- **Kicking off the Phase 2 priorities:**
 - Scaling up evidence-based initiatives across more specialties and regions.
 - Influencing the development of new Standards for Education & Training.
 - Driving inclusive learning environments.
 - Intervening earlier to shift the dial for UKG ethnic minority learners: a focus on medical school and Foundation training.
 - Widening our EDI lens.

Evaluating impact of key Phase 1 initiatives

Evidence that external organisations are responding to growing evaluation of what works

38 Analysis of Action Plans submitted by postgraduate training organisations and medical royal colleges & faculties in 2022 and 2023 show that many are directing resources into the key initiatives that we have been promoting. A more detailed analysis of 2024 and 2025 submissions will be undertaken alongside work to develop case studies.

- Of 17 Postgraduate Training Organisation Action Plans:
 - 12 are working on targeted educator training

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- Six on enhanced IMG induction e.g. NHSE published [Welcoming & Valuing International Medical Graduates](#)
- Six on improved exam preparation & support
- 10 on mentoring schemes

- Of 23 Royal College & Faculty Action Plans
 - 14 are developing targeted training for educators/examiners
 - Two are working on enhanced IMG induction
 - 12 on improving exam preparation & support
 - Nine on mentoring

39 Education & Standards QA teams are strengthening how they QA the Action Plans. The MED team have been holding individual meetings with colleges to discuss the detail and progress of their plans. In 2026 we will add an ask for colleges to tell us how they are implementing AoMRC guidance aimed at reducing the attainment gap.

- [Principles for exam preparation to address awarding -gap 0923.pdf](#)
- [Feedback candidates following summative exam 0125.pdf](#)

40 QAMI are refreshing their operational EDI guidance to include enhanced case studies drawing from our published evaluations.

Have changes to recruitment and selection processes made a difference?

Recruitment into foundation training

41 The UK Foundation Programme Office, on behalf of the four statutory bodies, implemented a [new preference informed allocation process](#) in 2024 which aims to be a fairer method for allocating placements to F1 doctors.

42 Research into the attainment gap showed lack of choice in training environment to be a key factor influencing learners experience and access to support from family and friends.

43 Our analysis of F1 recruitment outcomes show a 71% reduction in the differentials from 2023 to 2024:

- **2023:** 64% of UK ethnic minority F1s secured their first-choice placement compared to 86.6% of UK white F1s (a 22.6% point difference)

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- **2024:** 73% of UK ethnic minority F1's secured their first-choice placement compared to 79.5% of UK white F1s (a 6.5% point difference.)

Specialty recruitment and selection

- 44** Revised person specifications went live for new CT1/ST1 posts from August 2025 and will go live for ST3+ recruitment from August 2026.
- 45** In 2026 we will be able to analyse the recruitment outcomes for August 2025 entrants to see whether the change has had any effect on the outcomes for different groups.

Phase 2 priorities:

Scaling up 'what works' across specialties and regions

Identification of Case Studies

- 46** We are bringing together our Action Plan analysis and diving beneath the national level Index Measures to see which specialties or regions are achieving measurable change. Most activity is occurring at a specialty or regional level and impact is observable at this level before it appears in the national index measures.
- 47** This work is at an early stage, but we wanted to share some examples of the specialties and regions substantially reducing the differentials from **2019 to 2024**. In 2026 we will be investigating how the improvements have been achieved and developing case studies to share.

For IMGs

- **Psychiatry, Core Surgery and General Practice** have decreased the attainment gap by **48%, 55% and 20%** respectively.
- **HEIW and NHSE-East of England** have decreased the attainment gap by **35% and 30%** respectively.

For UK ethnic minority learners

- **NHS Scotland, NHSE – East Midlands and NHSE North-West** and have reduced the attainment gap by 56%, 45% and 32%

Promotion of interventions

- 48** We've actively promoted our priority initiatives across the four nations through multiple channels. The priority initiatives are:
- Mentoring
 - Support for Educators

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- Enhanced induction for non-UK graduates
- Targeted support to prepare for high stakes assessments

49 Teams across Education and Standards are promoting these initiatives at conferences and events, in routine discussions training organisations on their Action Plans and via EDI guidance to be published early in 2026.

50 We have:

- Published a [Blog promoting the evaluation research from Phase 1](#) promoted to over 400,000 doctors via GMC News.
- Presented on mentorship to the BMA retired doctors forum and will be [promoting the Mentoring Toolkit again on National Mentoring Day](#).
- Designed Action Plan templates and guidance to direct organisations to priority areas and we analyse the plans to look at take up, and to feed into QA conversations.

51 Outreach and national offices are promoting key interventions and delivering training sessions:

- **Supporting a multicultural workforce: a workshop for supervisors:** supporting educators offer better support for IMGs and develop cross cultural communication skills. Pilot training developed and tested in 2025 with 17 sessions already run.
- **Fairer feedback for Educators** was developed and rolled out in 2025: by October over 40 training sessions had been completed across the four nations with more planned.
- **Promotion of mentoring:** RLAs and ELAs supported to engage stakeholders on value of mentoring and to capture examples of good practice.
- **Promotion of enhanced IMG induction:** working with trusts and boards to deliver targeted induction for IMGs, in addition to the GMC's Welcome to UK Practice and Thriving in UK Practice.

Influencing the development of new standards for education and training

52 Throughout 2025 we have been actively engaging with the new Future of Education and career development (FutureEd) programme to ensure FTC is embedded from the beginning:

- Achieving Fair Training has been adopted as a key design principle for the FutureEd programme.
- We meet regularly with project and workstream leads to discuss key 'asks' and to ensure the wider research and Phase 1 evaluations feed into the evidence gathering phase.

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53 In 2025, we solely focussed the **annual FTC ‘Sharing Good Practice’** event to what fair training would look – drawing on the expertise of nearly 50 EDI, operational and educational experts from Medical Schools, postgraduate training organisations, medical royal colleges & faculties and employers. Ideas have been analysed and collated into key themes relating to different parts of our standards and fed back into the FutureEd team.

Driving inclusive learning environments

54 In Phase 1 we introduced new NTS questions on discriminatory behaviours in the workplace. This [analysis](#) provided new insight into unprofessional behaviours in some healthcare environments and show that gender, ethnicity, religion, sexual orientation, and disability status affect a trainee’s experience.

55 In 2025 we began work with our QA and data teams to develop a new prioritisation tool using the discriminatory behaviours findings to flag and target the poorest performing locations.

56 An Education & Standards Clinical Fellow has completed a review of Medical Students ability to raise concerns if any arise while on clinical placement, and the underpinning policies and processes. The review highlights barriers relating to students’ employment status and the short time for each placement. A series of recommendations and next steps are in development.

57 QAMI are working with postgraduate training organisations to improve guidance on the diversity of ARCP panel membership when making high stakes recommendations. The GMC has submitted a proposal to update COPMED Gold Guide in 2026.

58 Outreach and National Offices deliver a range of training intended to improve workplace cultures including promoting key initiatives such as mentoring and enhanced IMG induction. They have a programme of work dedicated to **Tackling discrimination in working and learning environments** which is delivered across the four nations.

59 Actions include:

- presenting at 22 national conferences reaching almost 3000 delegates,
- delivering a variety of sessions on positive cultures, sex discrimination and supporting learners to over 1300 educators in addition to doctors in training.
- Collaboration with Scottish Government and others to develop a Fairer Working Cultures Action Plan for Scotland

Intervening earlier to shift the dial for UK qualified ethnic minority learners: a focus on Medical School and Foundation Training

60 F1 preparedness: We recruited a Clinical Fellow in August 2025 to begin a deep dive into understanding the differential in feeling prepared for F1 between UK Black and ethnic minority and white doctors, and why this gap is widening.

61 In 2023 we introduced a new NTS question asking respondents who report feeling unprepared, to select all relevant reasons from a pick list. This found

- 41% selected '*limited knowledge of the day-to-day reality of working as a foundation doctor*'.
- 30% selected '*working in a different type of hospital or health system*'.
- 18-25% selected a range of other factors including geographical relocation, moving away from support networks and inadequate training on IT systems and paperwork/documentation needed as an F1.

62 UG action plans and data: In 2026, our data team will publish UG data by protected characteristics and the QAMI team will strengthen the ask of Medical Schools, replacing the current mechanism for reporting EDI initiatives with a full Action Plan.

Taking a wider EDI lens

63 Multivariate analysis: We've now published the results of the 2024 Multivariate analysis by Dr Ricky Ellis, in two papers. These look at the relationship between a wide range of sociodemographic differences and performance. (Paper 1: [BMC Medicine](#), Paper 2: [Taylor & Francis Online](#)).

- **Focusing on** UK graduates only, the study showed evidence of poorer outcomes associated with all protected characteristics. The strongest and most persistent predictors are **ethnicity** and **disability**.

64 Looking at all doctors, having **qualified outside the UK** is the strongest predictor of poorer outcomes. Followed by **ethnicity** and **disability**.

65 The findings reinforce existing data and add yet more stark evidence of the scale of the issue:

- UK-qualified black or black British candidates are 56% and 58% less likely to pass written and clinical exams respectively compared to UK-qualified white candidates
- those with registered disabilities were 47% and 35% less likely to pass written and clinical examinations respectively than peers without disabilities

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- doctors who qualified outside the UK were 65% less likely to pass a written exam and 75% less likely to pass a clinical exam compared to UK graduates.
- 66** The new study creates a strong imperative for increased focus on disabled students and doctors and this will become a priority for phase 2 - especially the F1 preparedness project and FutureEd.
- 67** We'll continue to work with colleges and faculties to improve the data we hold on Reasonable Adjustments for specialty exams.
- 68** The data we have, suggests 7% of UK graduates have a reasonable adjustment compared to only 1% of IMGs.
- 69** Our data only covers roughly 20% of exams and it's important that we expand access to this information, and to understand what actions may be necessary to improve equity of access.

Annex A

Calls to action

1	We require Medical Royal Colleges & Faculties (RCFs), PG Training Organisations (PTOs) and Medical schools to tell us each year what action they are taking to improve outcomes for non-UK graduate and ethnic minority learners in their region, country, or specialty.
2	We ask educational organisations to evaluate the impact of their pilot initiatives and to share their findings with others across the system.
3	For educational organisations to put into practice learning and recommendations from our evaluations and research - the CASC Masterclass Evaluation, - Embedding Compassionate Courageous Cross-cultural Conversations into Training, - Formative feedback research - Melanin Medics – Enrichment Programme - Mentoring toolkit and case studies
4	We encourage RCFs to implement the AoMRC principles for exam preparation, feedback and support for candidates to address the awarding gap and ensure that all exam candidates are signposted to effective resources We ask RCFs to monitor and improve the diversity of examiners and question-writers
5	We urge Medical and Dental Recruitment Service (MDRS) , RCFs , and the UKFPO to review recruitment and selection policy and process to identify and remove sources of inequity On MDRS to implement the recommendations of the joint EDI working group for specialty recruitment
6	We ask educational organisations to share data to help track and improve fairness in undergraduate and postgraduate education.
7	For Local Education Providers (LEPs) to define the training and appraisal of Educators in the medical roles recognised by the GMC to ensure that ED&I training specifically covers 'Differential attainment'.

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	Raising awareness of the existence of an attainment gap across many protected characteristics and the barriers which lead to poorer outcomes for marginalised learners and Supporting educators to have compassionate and courageous conversations with learners about barriers they may face and working together to identify ways to overcome these.
8	For PTOs to develop improved support for New to UK learners based on the increasing evidence of positive impact such as Enhanced induction, exam preparation support, mentoring.
9	For LEP and PTOs to ensure learning environments are welcoming and inclusive; and to use data such as NTS Inclusive Environment and Discrimination questions, to identify areas for change
10	For the NHS across the UK (and Health and Social Care in Northern Ireland) to ensure that resources are available to Professional Support and Wellbeing Units and that they have a mandate to consider support for doctors in training from marginalised backgrounds which help remove barriers to progression.
11	For educational organisations to communicate and collaborate with each other on ED&I activity to ensure our priorities are aligned and we are amplifying each other's efforts.

Annex B

Index Measures – 2019 to 2025 data tables

- 1 The charts below show the year-on-year gap between cohorts across the 5 Index measures.
- 2 Notes:
 - In 2024 Undergraduate: Education Performance Measure (EPM) will be replaced by undergraduate assessment.
 - UG assessment data for 2023 and 2024 has been delayed due to changes in transfer process between HESA and GMC. It has now been received by GMC and is being processed.
 - The 2020 – 2022 ARCP and exam outcomes may be affected by changes introduced during the pandemic. These included allowing doctors in training longer to complete high-stakes exams, potentially disproportionately benefitted disadvantaged groups.

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Undergraduate EPM scores Difference between mean Educational Performance Measure (EPM) scores	Difference	Comparison group	2019	2020	2021	2022	2023	2024	2025
	UKG Ethnicity	UK Ethnic minority	4.92	4.93	4.93	5.06	5.01		
		UK White	6.06	6.08	6.18	6.19	6.26		
		Difference	1.13	1.15	1.25	1.13	1.24		
Undergraduate exams Differences in medical school exam pass rates	Difference	Comparison group	2019	2020	2021	2022	2023	2024	2025
	UKG Ethnicity	UK Ethnic minority			93.4%	90.0%			
		UK White			96.1%	93.9%			
		Difference (pp)			2.7	3.9			
Undergraduate - F1 preparedness (NTS) Difference in preparedness levels of new F1 doctors. Not included in COVID-era survey	Difference	Comparison group	2019	2020	2021	2022	2023	2024	2025
	UKG Ethnicity	UK Ethnic minority	62.4%		65.7%	60.1%	52.4%	55.1%	54.6%
		UK White	70.4%		76.3%	69.7%	62.9%	68.0%	67.1%
		Difference (pp)	8.0		10.6	9.6	10.5	12.9	12.5
Postgraduate – inclusivity (NTS) Difference in perceived inclusivity levels. Question first included in 2020 survey	Difference	Comparison group	2019	2020	2021	2022	2023	2024	2025
	PMQ	IMG		76.0%	77.1%	77.7%	79.0%	79.1%	80.0%
		UK		80.1%	81.9%	81.0%	81.6%	81.9%	82.2%
		Difference (pp)		4.1	4.8	3.2	2.6	2.9	2.2
	UKG Ethnicity	UK Ethnic minority		77.2%	79.9%	79.1%	79.8%	80.4%	80.7%
		UK White		81.6%	83.0%	82.1%	82.7%	83.1%	83.4%
		Difference (pp)		4.4	3.1	3.0	2.9	2.7	2.6
Postgraduate – ARCP outcomes Difference in rates of unsatisfactory outcomes	Difference	Comparison group	2019	2020	2021	2022	2023	2024	2025
	PMQ	IMG	16.3%	11.4%	11.5%	14.5%	15.5%	15.1%	
		UK	6.0%	3.9%	3.7%	5.4%	5.7%	6.0%	
		Difference (pp)	10.3	7.4	7.8	9.1	9.8	9.0	
	UKG Ethnicity	UK Ethnic minority	7.5%	4.8%	4.7%	6.6%	7.1%	7.2%	
		UK White	5.2%	3.3%	3.1%	4.5%	4.8%	5.1%	
		Difference (pp)	2.3	1.5	1.5	2.1	2.4	2.1	
Postgraduate – Specialty exams Difference in exam pass rates	Difference	Comparison group	2019	2020	2021	2022	2023	2024	2025
	PMQ	IMG	47.2%	46.4%	54.1%	54.5%	56.1%	56.3%	
		UK	76.4%	77.2%	79.6%	77.3%	78.3%	80.1%	
		Difference (pp)	29.2	30.8	25.5	22.7	22.2	23.9	
	UKG Ethnicity	UK Ethnic minority	69.2%	70.0%	73.4%	70.6%	71.6%	74.1%	
		UK White	80.3%	81.2%	83.2%	81.3%	82.4%	84.0%	
		Difference (pp)	11.1	11.2	9.7	10.6	10.7	9.9	

Annex C

Current statistical KPI forecasts

Here we show the historic data on FTC KPIs, alongside statistical forecasts of them, suggesting possible future trajectories. Crucially, though we used the best-established cutting-edge methods of forecasting, we should keep in mind that forecasts are unlikely to be the reality that materialises. Still, they represent our best expectation of the future given data so far, which, among many other drivers, likely reflects any fully embedded past interventions.

For each KPI, we have:

- included a one-sentence headline interpretation of the forecasts, on the title of each chart
- crafted a forecast on the current possible direction of travel given recent historic data (shown in orange on the charts below and labelled 'current forecast')
- crafted another forecast (whenever data allowed) on the status-quo remaining unchanged, starting with 2021 (shown in blue on the charts below), right before FTC targets were agreed and published. This serves as a reference. An encouraging sign would be that historic KPI data observed from 2021, as well as the forecast of its current direction of travel, separate from the forecast of the status quo remaining unchanged, in a direction closer to our targets. If so, it could be argued that the drivers of the KPIs have positively changed since January 2021. We would expect that to be partly due to our own actions to improve the value of the KPIs.

Summary suggestions from forecasts

It remains highly premature for forecasts of the current direction of travel to be reliably informative. Therefore, such forecasts must not be taken as a suggestion that nothing is currently changing or that nothing will change in the future. We still have very few FTC data points available for forecasting models to be trained on. The values taken by those data points are also currently insufficient for most models to reliably detect that there is a trend change – e.g. trends are not yet stronger than the ups and downs. Therefore, most models have automatically remained at their default detection that there's no evidence for a trend in such KPIs.

In addition, there remains the challenge of forecasting reliably so far into the future. The drivers for FTC are very complex, systemic change will take time to have an impact, and attaining aspirational targets is expected to take up to 10 years. Despite this, for a few FTC metrics, forecasting models have started to detect trends.

Interpretational notes

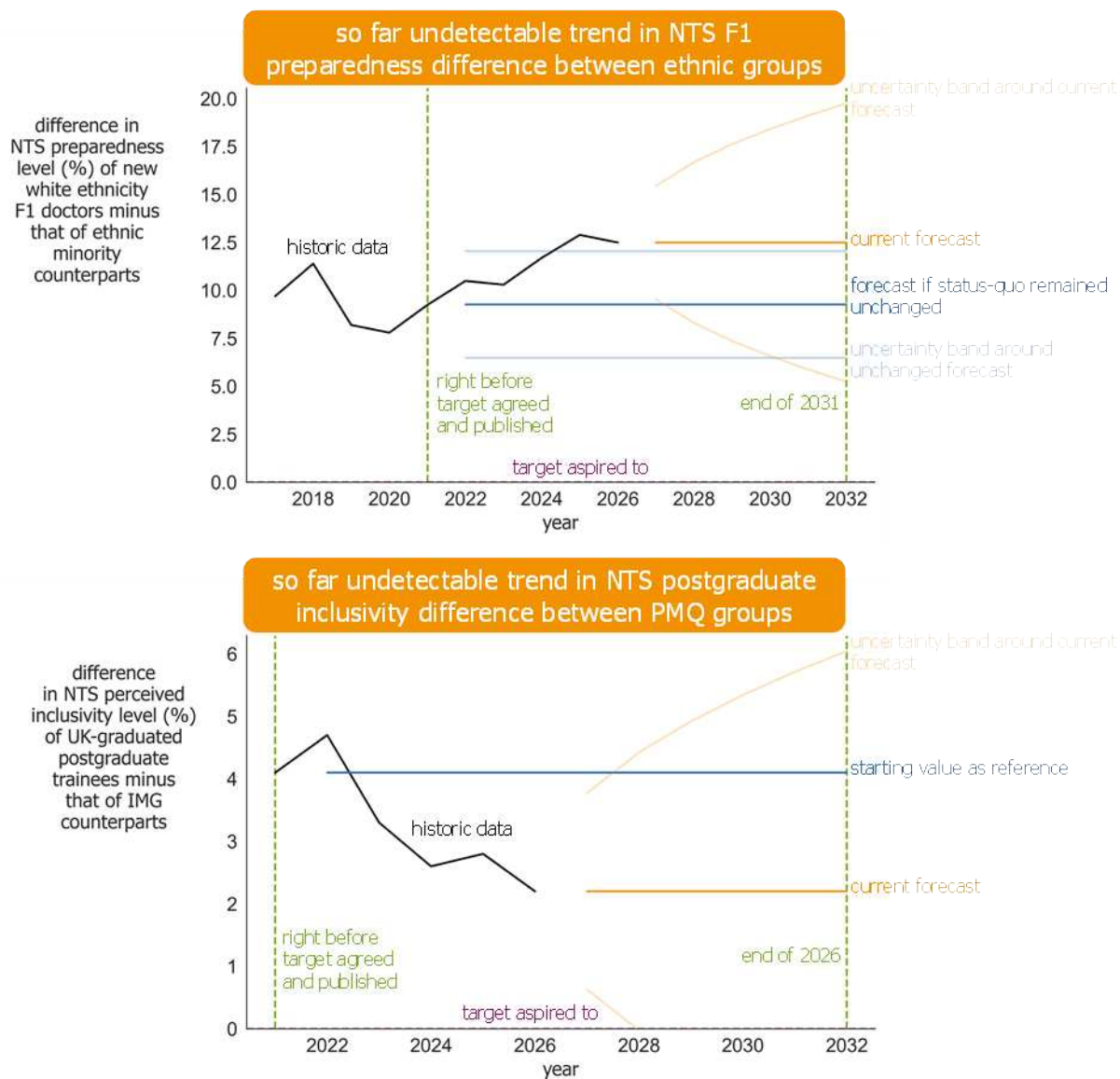
Forecasts are interpreted as the best expectations of the future given the data observed so far. All forecasts assume that the drivers behind the data (historic data) remain unchanged. This is critical to keep in mind, given that our aspiration is to contribute to modify such drivers via intervention where they relate to disproportionality.

The farther we forecast into the future, the more uncertain a forecast tends to become, as shown by uncertainty bands (95% prediction intervals) surrounding each expected forecast. Regardless, the forecasts here represent our best evidence base, given existing data, and are useful to guide our decisions ahead.

Important to note:

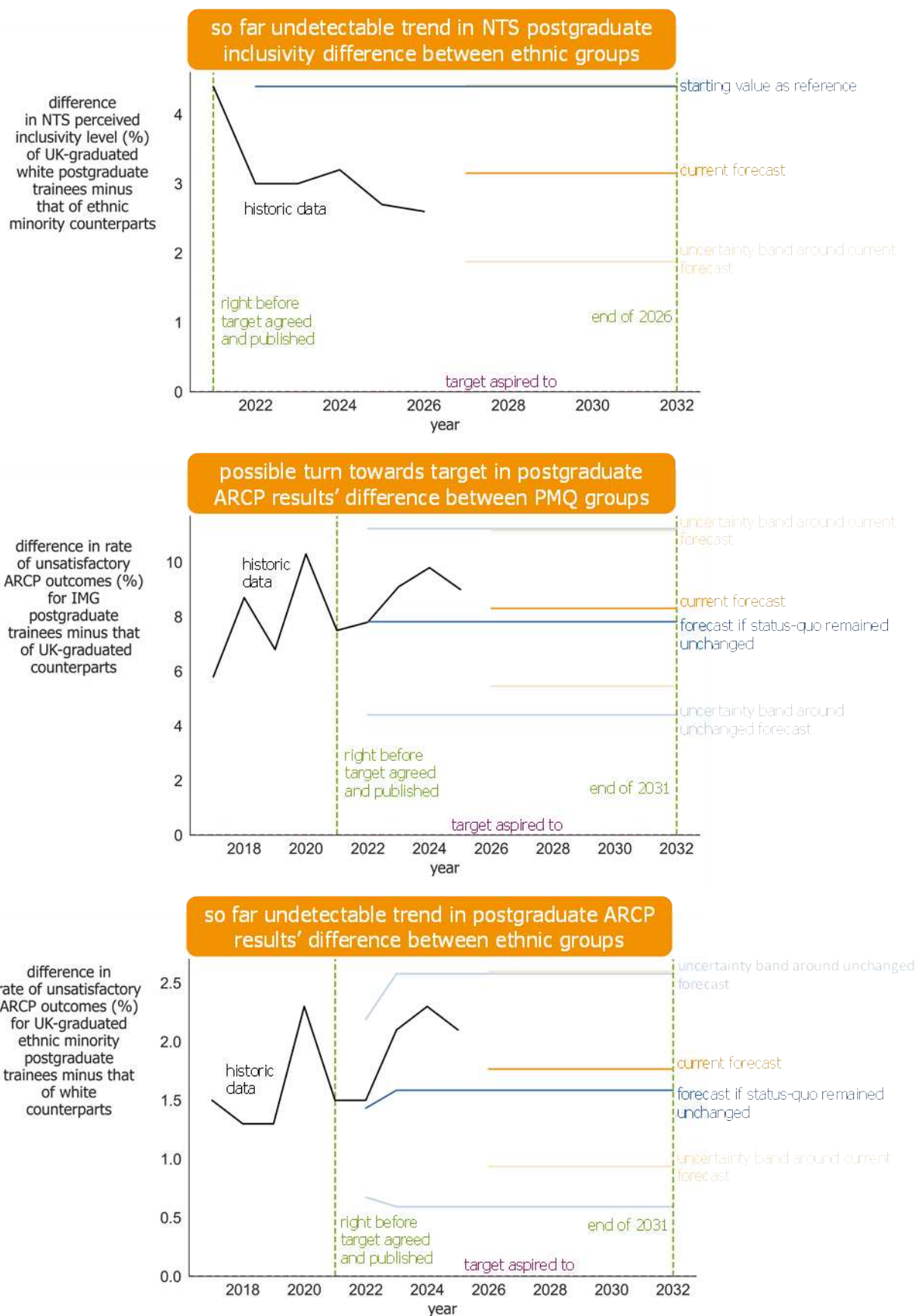
- Differentials about undergraduate EPMs are not forecasted because this metric is being retired
- Differentials about undergraduate exams are not yet forecasted because the data is still being collected
- Data are annual and taken as of the 31 of December of each year. This causes that, for instance, a point on 31 of December 2016 may appear to correspond to 2017 in the charts.
- FTC data take a long time to be generated and verified, so the most recent currently available is from 2024, except for NTS metrics that were available for 2025. Therefore, we forecast from 2025 and 2026 onwards, respectively.
- We are using data from as far back as we consistently have it. For most metrics, the first point in charts is shown on the 31 December 2016. For some of the metrics, this means that these data points are from the 2015 / 2016 academic cycle, so they encompass 2015 data.
- For two metrics, there was no data before 2020. For these, we project this starting value as a reference, rather than showing a reference forecast.

Forecast charts



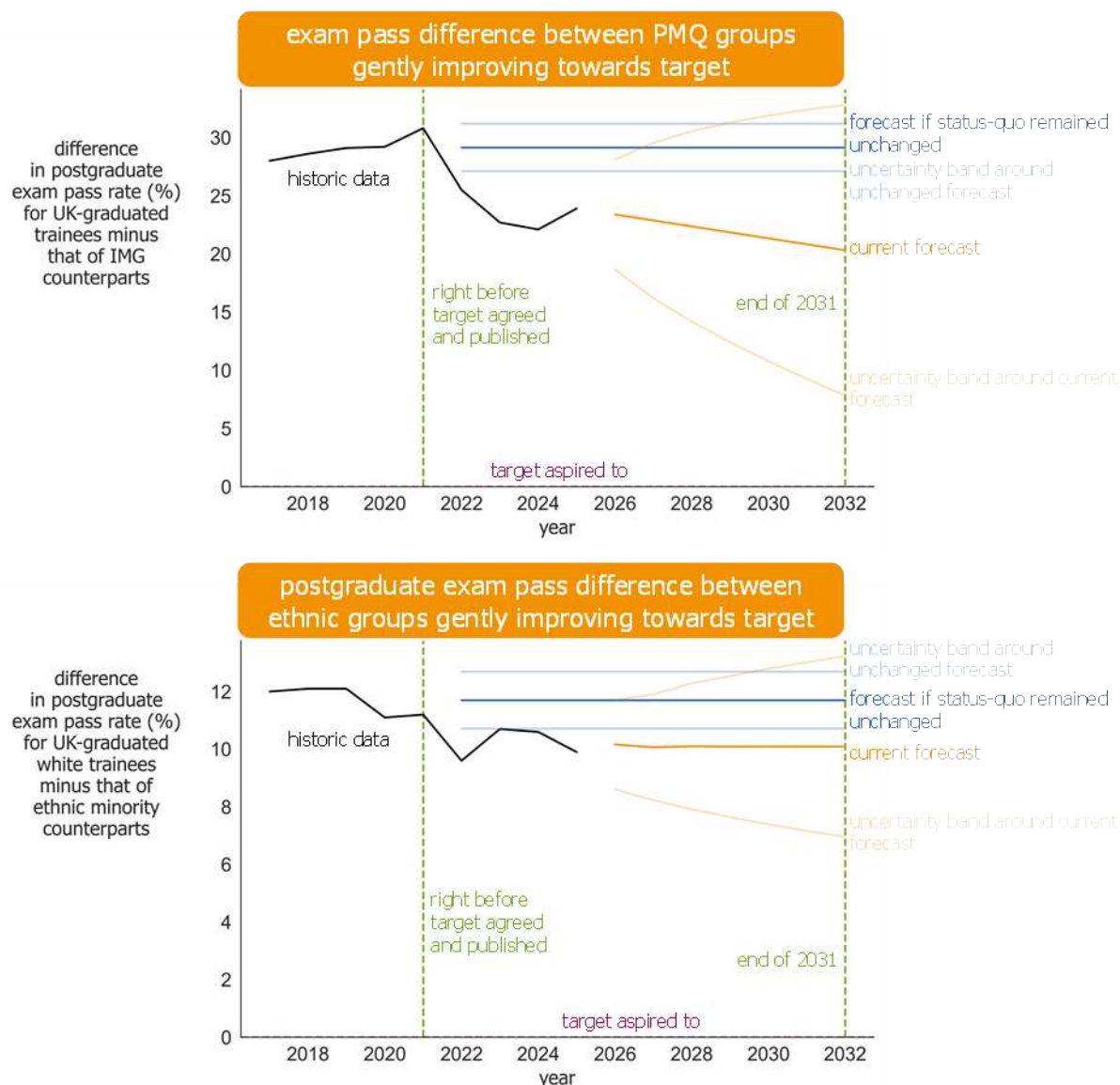
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Fairer Training Cultures



ED&I Annual Report

Action	To approve
Purpose	The purpose of this paper is to present the annual ED&I progress update for 2025.
Decision Trail	ED&I has been a standing agenda item since September 2020. Council agreed to establish ED&I measures and targets in February 2021 and this report is the fourth annual update on progress.
Recommendation(s)	a To consider progress against our ED&I ambitions, the extent of our asks of the system going forward and levels of assurance in our future plans. b To note the content of the full report at Annex A, and the communications plans at paragraphs 29-32. c To approve the ED&I Annual report for publication.
Annexes	Annex A: Draft Annual ED&I Progress Report 2025
Author contacts	Claire Light, Head of Equality, Diversity & Inclusion Kuljit Dhillon, Assistant Director - Strategy, Planning & Inclusion Any enquiries to: GovernanceTeamMailbox@gmc-uk.org
Sponsoring director/ Senior Responsible Owner	Shaun Gallagher, Director of Strategy and Policy Anthony Omo, Director of Fitness to Practise and General Counsel Pushpinder Mangat, Medical Director and Director of Education and Standards Neil Roberts, Director of Resources

Background

- 1 In 2021, we set long term ED&I targets for us as a regulator and an employer, to tackle persistent areas of inequality.
- 2 We also committed to publishing an annual report on progress against our aspirations, the first of which we reported to council in February 2022, the second in April 2023 and the third in July 2024. This will be the fourth annual report covering progress in 2024.
- 3 At the end of 2024, we are past the halfway point for our 2026 targets and aspirations, such as the Fairer Employer Referrals (FER) programme of work. For the other aspirations like the Fairer Training Cultures programme (FTC), we set a longer timeframe, up to 2031.
- 4 When setting the targets, we recognised they were ambitious though we have always been aware of the challenge involved in setting targets around inequalities with complex causes. However, we have also seen tangible evidence that the engagement from leadership in this space has been the catalyst for action. We remain committed for the duration of our aspirations to shining a light on progress made and identifying actions for others within the system, whilst making clear the commitments we are making ourselves. This is an important part of motivating further commitment to achieving progress on tackling these inequalities.
- 5 Our annual update on progress against our ED&I aspirations provides a detailed assessment of the progress achieved on the programmes in place and on the measures set with potential trajectory of progress. We aim for our annual reflection on progress update to be clear on what has changed, and our asks and expectations on ourselves and others. And to take a considered approach to reflecting on the progress made during 2024, whilst also demonstrating the planned priority activities we aimed to focus on in 2025.

Summary of Progress

- 6 Our performance has varied across the measures, but overall, the progress evidenced in 2024 and 2025 is positive, with some sustained improvements, some signs of change and some measures that we have been disappointed by given the lack of progress. We have seen:
 - **Continued progress on all fairer employer referrals indicators** and forecasts indicate that we should be close to achieving our targets and getting to a point where there's no significant disproportionality in referrals.
 - **At national level a significant attainment gap remains across all the index measures** at levels that warrant continued system wide action.
 - **First signs that the attainment gap is narrowing in specialty training.** We have published evaluations of our priority interventions that shows that outcomes can be improved by targeted support.

- **Measures for earlier stages of training do not show improvement.** For the first time we have included data in the report on average mean **medical school assessment pass rates which shows a difference between white and ethnic minority medical students.** This data is for those graduating in 2021, more recent data is not yet available for publication.
- **Sustained progress in relation to most GMC employer measures** - while progress in a one area remains challenging. We expect to meet our overall workforce target in 2026, but achieving representation aspiration at management level will be challenging.
- **The regulatory fairness programme made significant progress in 2024** to develop and publish the decision-making principles, define the high impact decision points, deliver learning to a large cohort of regulatory decision makers. And transitioned into implementation phase, with all directorates developing implementation plans to strengthen anti-bias and fairness assurance measures.

7 The more detailed findings from each of the workstreams is below:

Workstream	Key findings
Fairer employer referrals (FER)	● Forecasts for FER key performance indicators (KPIs) show that we expect to be close to achieving our targets by the end of 2026. We calculate the KPIs quarterly, using a five-year rolling period for robust analysis due to small volumes. Given the time lag, it's likely that we will not know with certainty in 2026 if we've achieved the target. But we will have a good indication of where we are heading. The proportion of designated bodies (DBs) with disproportionate referrals continued to decrease in 2024. And the gap in referral rates between ethnicity and primary medical qualification (PMQ) groups also reduced. ● There's significant activity going on across the health system to address disproportionality¹ in disciplinary proceedings at employer level. And we have research ongoing to identify what changes within designated bodies are effective.
Fair training cultures (FTC)	● Across the UK a significant attainment gap² remains across the five key measures and remains at levels that need continued system wide action. ● There are signs of improvement in specialty training with all three measures. These are: a inclusive environment indicator from National Training Survey b Annual Review of Competency Progression (ARCP) outcomes c specialty exam pass rates ● They all have edged in a positive direction.

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	● Improvement is more pronounced for non-UK graduates with the biggest shift observed in postgraduate exams where the difference between UK and non-UK graduates pass rates narrowed by seven percentage points. ● Measures focused on medical school and the first year of foundation training do not show any improvement. Education Performance Measure (EPM) scores show no change and Foundation Year 1 preparedness has worsened. ● For the first time, we can report on medical school assessment pass rates which show a 3.9 percentage points difference between white and ethnic minority medical students for 2021. ● Analysis of action plans show that organisations are responding positively to the growing evidence of what works. ● And we've published three new evaluations of the most promising interventions over the last few years looking at educator training and support, peer support and mentoring, and enhanced exam preparation and support.
GMC Inclusivity as an employer	● Our aim, by 2026, is for 20% of our workforce to be from an ethnic minority background and for our management profile to reflect this. We are on track to meet our overall workforce target by 2026 but are not on track to meet this target at management level, if we maintain the workforce trends of the last two years. ● To maintain our high attraction levels, we've expanded our outreach work and support for candidates. We attended various job fairs, quality assured job descriptions, and trained our decision makers. These actions supported the attraction rates³ for ethnic minority candidates for all our roles to remain high (53.1%). ● Our management profile is 14% and currently 3.5 percentage points behind our interim 2024 target. And without higher staff turnover and improved conversion rates for ethnic minority candidates we are unlikely to meet our 2026 target. ● Turnover rates show a difference by 4.6 percentage points. Turnover for ethnic minority colleagues in 2024 was 10.6% compared with 6% for other colleagues. Our target for 2026 is to have no more than 1.5 percentage points difference. ● Promotion and grade progression rates show a difference of 1.1 percentage points. For ethnic minority colleagues, it's 7.8% compared with 8.9% for other colleagues. This is within our target range of no more than 2% difference.

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	● Our inclusion index score fell by 0.2% to 74.3%. Engagement scores for ethnic minority (71.42%) and other colleagues (72.14%) continue to show a differential in engagement scores, but the gap is closing. Our aim was to make sure that we closed the gap in engagement scores, and we are currently well within our target.
Assuring fairness in GMC regulatory decision-making	● We identified and published our 42 high impact regulatory decision points (HIRDs), which form the focus of our activities to strengthen fairness assurance. We also published a set of decision-making principles to be applied across the HIRDs to promote consistency across all our different functions. ● We completed the rollout of bespoke learning covering over 330 decision makers – <i>fairness in decisions for regulatory professionals</i>. This learning focused on how to address bias in scenarios that HIRD decision makers might face. ● Each directorate⁴ worked towards developing an implementation plan. Each plan was focused on embedding the decision making principles and strengthening assurance measures for fairness and bias. The plans also focused on support and development for decision makers and supporting culture change through leadership.

Conclusions and key messages from the report

- 8 Since we launched these ED&I aspirations and targets in 2021, we've continued to closely monitor our progress and report at regular points to Council and our ED&I steering group. This year for the first time, we included data for medical school final exams in the measures.
- 9 We are always cautious about commenting on any signs of improvement, but there's consistent evidence of progress in some of the measures, such as the referral measures. There are first signs that other measures are beginning to show some sustained improvements, such as the attainment gap in specialty training. Other measures remain challenging, and we know now that we are not likely to meet the target set in the timescale planned, such as our own leadership representation.
- 10 The programmes of work that we, and other system stakeholders, have established that have achieved an evolving understanding of what works to address inequalities. We are continuing to see significant activity across the system in response to the building evidence about what interventions make a difference. And this is shaping future priorities and activities.
- 11 Overall, progress in 2024 is a positive picture, but we need to continue to measure progress and continue to shine a light on where we aren't seeing the progress we had hoped to see.

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The challenge remains, for all these ambitions, that the inequalities we are seeking to address are longstanding and complex causes.

Refining action plans

- 12** A great deal of progress is detailed in the annual report that demonstrates delivering against the planned changes to support our aspirations. The workstreams continue to generate ongoing learning that informs our planned activity for 2024 and beyond. We have refined all our plans to set new deliverables for the remainder of 2025 and into 2026.
- 13** We have also implemented some of the recommendations from the regulatory fairness review and have established a substantive work programme to manage the implementation of all these recommendations. Implementation plans have been developed by directorates to embed the decision-making principles, and we have developed tools to support the implementation within directorates. This will support them to further strengthen how they address fairness and bias in decision making activities.

Our calls to action

- 14** This year, some of our calls to action remain the same as previous years, whilst some are more nuanced or reflect the learning and progress from activities delivered so far.
- 15** We have included within the report calls to action for those responsible for local working environments such as system leaders, designated bodies/local education providers and leaders across medical education and training. These calls to action are focussed on the quality of local processes, sharing good practice with peers, raising awareness of how inequalities manifest in working and training environments, supporting compassionate cultures and identifying and addressing barriers faced by groups within the medical workforce.
- 16** There are six separate calls to action that we believe are important for UK and national level stakeholders. We have advocated for some of these previously and some progress has been made, but these we believe continue to be particularly important.
- 17** For system leaders to prioritise ED&I activity through pro-active organisational change and workforce plans, as it is central to ensuring a well-supported workforce.
- 18** For system regulators and healthcare bodies to consider how they are developing frameworks for assessing workplace fairness and understanding the impact of these.
- 19** Mandate externally led induction for new international medical graduates (IMGs) that includes the Welcome to UK Practice (WtUKP) induction programme.

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- 20** We have made a couple of new and notable calls to action in the UK and with national stakeholders:
- For integrated care boards (ICBs), integration joint boards (IJBs), integrated care system (ICS), and other system leaders to make sure they monitor and measure the overall impact of ED&I activity and interventions – with a clear focus on outcomes.
 - For the NHS across England, Scotland and Wales, and Health and Social Care in Northern Ireland, to develop and deliver anti-racism resources in partnership with the ethnic minority workforce.
- 21** The calls to action for stakeholders within medical education and training broadly relate to acting on the evidence base (that continues to develop) on the benefits of interventions, such as improved support on enhanced induction, exam preparation support mentoring. Where stakeholders are piloting interventions, that they evaluate the impact of pilot initiatives and to share their lessons learned with others across the system.

Internal and external communications approach

- 22** We will use the publication of the report to highlight the progress we have made towards our targets and celebrate positive change. Our messaging will demonstrate our commitment to tackling discrimination and inequality across the system, building on the ED&I communications activity we have shared throughout the year.
- 23** We will use a mix of communications tactics, creating channel-specific and people-centred content to engage our audiences. Our focus will be on telling a clear story, using evidence and examples from our work across the fairer employer referrals and fairer training cultures programmes to illustrate tangible progress in each of the four countries of the UK. We will also take account of developments across the wider system, such as the NHS 10 Year Health Plan and forthcoming Workforce Plan in England, to ensure our approach and messaging aligns with the broader context.
- 24** Ahead of publication, we will engage with stakeholders to inform them of publication, and highlight why it is vital that we, and those with a role in tackling inequalities, maintain our focus and commitment to this work. We'll share our progress and commitment to supporting further change with staff, media outlets, via our newsletters, and on social media.
- 25** Beyond publication, we will identify opportunities to reshare our key messages at appropriate moments, including through other communications and engagement activities and milestones at a regional and national level.

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Recommendations and next steps

- 26** The ED&I annual progress update is due to be published in both English and Welsh as soon as possible following the council meeting, likely to be week commencing the 8 December 2025.
- 27** We are seeking councils' approval to proceed to publication of the report.

ED&I Annual Report

**Paper withheld from
publication**

The draft ED&I Annual Report was originally withheld prior to publication. This has now been published on the GMC Website, and can be viewed below:

[Deep-rooted inequalities distort opportunities and weaken healthcare culture - GMC](#)

For further information, please contact the Corporate Governance team via email, GovernanceTeamMailbox@gmc-uk.org.

Annual report of the GMC Pension Plan Management Board 2025

Action	To note
Purpose	This paper updates Council on the activities of the Pension Plan Management Board in 2025.
Decision Trail	This report was approved by the GMC Pension Plan Management Board on 21 October 2025 and noted by Executive Board at the November meeting.
Recommendation	To note the annual report of the GMC Pension Plan Management Board.
Annexes	N/A
Author contacts	Niall Kelly , Corporate Governance Officer Christine Firth , Head of Pensions & Employee Benefits Any enquiries to: GovernanceTeamMailbox@gmc-uk.org
Senior Responsible Owner	Neil Roberts , Chair of Pension Plan Management Board

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Annual report of the GMC Pension Plan Management Board 2025

Background

- 1** The GMC Pension Plan Management Board is an advisory forum which monitors and reviews the operation of the GMC Pension Plan, with a focus on performance of the default investment option, other funds made available to the membership by the GMC, member engagement and the provider's level of customer service. There are a number of investment fund options made available to members by both the employer and the provider.
- 2** The pension plan is owned by our members and the contract is between them and the provider. The choice of investment funds is a decision made between the member and provider, which is currently Aviva. This is the Board's eleventh annual report.
- 3** The Board met three times in 2025 – 26 March, 3 July and 21 October. At each meeting the Board received advice from the GMC's pension professional advisers, Aon and were also provided with an update on performance of investment funds, service levels and member engagement from the scheme's managers, Aviva. The Board also received regular updates and support from the internal pension team.
- 4** The Board comprises of four employer nominated members and four Scheme member nominated members; and is chaired by the Director of Resources. This year, Ben Browne joined as Assistant Director – People and attended his first meeting in October 2025. The membership of the Board has remained consistent otherwise.

Monitoring the investment performance and administration of the GMC Pension Plan

- 5** Investments of pension contributions are actively managed by Aviva and monitored by Aon who provide the Board with assurance that they fall in line with standard performance and ethical measures.
- 6** The Board receives regular updates on Aviva's investment performance and administration provision including advice from Aon on its assessment of Aviva's performance. Investment performance continues to be within expectations, at the lower end of the performance measures.
- 7** The GMC Pension has a bespoke default investment strategy, designed by our advisers Aon, that is used within the Plan.
- 8** Following a number of meetings, reports, membership modelling and discussions the Board agreed to recommend the proposals made by their advisers to move to a new default strategy. The changes were presented to both Executive Board and Senior Management Team in June and August 2025, and their approval to proceed with the changes was obtained
- 9** During 2025, the Board oversaw a transfer of existing funds to a new default investment strategy on the recommendation of the Plans advisers, Aon. This new default investment

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option was aimed at improving the outcomes for members, providing better downside against market volatility for members especially those approaching retirement age and also to increase investment in assets designed to have a positive social and environmental impact.

- 10** The changes will result in an increased charge for members especially those who are in the de-risking phase. Aon believes the increased charge is justified due to the expected enhancements to the new strategy. The objectives of the change are to offer increased diversification, provide greater protection against downside risks caused by poor market performance and future market volatility, especially for those nearing retirement age, as well as investing more heavily in companies with a positive social and environmental impact
- 11** During the transition period members have corresponded with on a regular basis, kept informed of progress and invited to attend a webinar or have a 1-2-1 discussion. Member queries mainly focused on clarification on a personal level and it generated queries on members pension provision with other employers. There was no negative feedback.
- 12** Members were also informed of the increase in fund management charges. For members in the growth stage the charge increase is 0.249% to 0.315% and for members in the de-risking stage the charge increase is 0.259% to 0.420%
- 13** The assets of the existing default investment funds were transferred to the new strategy on a negative affirmation basis in October 2025.
- 14** The new Default Investment Option (DIO) strategy incorporates three blended funds.
- 15** The current Socially Responsible fund, and the two GMC alternative funds will remain open to members as an alternative investment option.
- 16** As measured on 31 August 2025, the number of active members of the DC scheme was 1,756 and 97.1% of the membership are invested in the default investment option.
- 17** At 31 August 2025 the total value of scheme members' assets under management was £104,429,154.

Communications and Member Engagement

- 18** The Board agreed a member engagement and communications schedule for 2025 which included educational seminars, newsletters and a number of other projects.
- 19** Work to support the implementation of Pension Dashboards has been undertaken by the GMC Pensions team and connection to the infrastructure has progressed and Aviva have confirmed that they met the statutory date for connection to the Dashboard infrastructure. Confirmation of a go live date for members will be advised by the Pension Regulator but likely to be during 2027.

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- 20** The level of engagement from members has continued to improve, evidenced by attendance numbers at the educational webinars, number of queries and requests for information and contribution rate changes received by the internal pension team.
- 21** The Pensions team has continued to work with Aviva and Aon to find ways to improve engagement with members. A member engagement objectives framework was created in 2021 and is regularly reviewed to understand what the membership needs and to monitor the current engagement methods to ensure that they are effective. This work will continue during 2026.
- 22** An induction programme continues to be provided to new members of staff and feedback has been that it gives a comprehensive overview of the pension scheme.
- 23** As of October 2025, 99% of employees are members of the GMC's pension scheme.
- 24** As of 31 August 2025, 39.7% of members have nominated a beneficiary of their pension pot in the event of an untimely death, something we are seeing a steady increase on. This is a continued area of focus for the Board and work is currently in progress to increase this percentage through regular engagement with the membership.

Risk Register

- 25** The Board has its own Risk Register which is reviewed annually. The register provides an overview of the risks associated with running the GMC Pension Plan and the mitigation measures in place or required to reduce risk. The Risk Register will continue to be developed, updated accordingly and regularly monitored by the Risk sub-group and the Board.

Board Governance

- 26** The Board approved minor updates to its Statement of Purpose, which are to be approved by the Executive Board in October 2025.
- 27** The Board continues to undertake training sessions at each meeting to ensure the Board member's skills and knowledge are up to date and a training log is maintained.
- 28** The Board is scheduled to carry out an effectiveness review in 2026.
- 29** The Board also receives updates at each meeting from Aon on legislative changes affecting defined contribution (DC) pension schemes, which the Board need to consider and act upon.