General Medical Council

Council Meeting - 5 December 2024

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Council

London

General Medical Council

Agenda

Council meeting

Thursday 5 December 2024 - 09:50 – 14:40

		Public session
09:50 – 09:52 *2 mins*	**M1**	**Chair's business**
09:52 – 09:55 *3 mins*	**M2**	**Minutes of the meeting on 2 October 2024**
09:55 – 10:15 *20 mins*	**M3**	**Chief Executive's report**
10:15 – 10:35 *20 mins*	**M4**	**2025 Budget and Business Plan**
10:35 – 11:05 *30 mins*	**M5**	**Patient and Public Involvement update**
11:05-11:20 *15 mins*		**Break**
11:20 – 11:50 *30 mins*	**M6**	**Regulation of PAs and AAs**
11:50 – 12:15 *25mins*	**M7**	**Fairer Employer Referrals**
12:15 – 12:40 *25 mins*	**M8**	**Fairer Training Cultures**
12:40 – 13:30 *50 mins*		**Lunch**
13:30 – 13:50 *20 mins*	**M9**	**Report of the MPTS Committee 2024**
13:50 – 14:05 *15 mins*	**M10**	**Report of the Audit and Risk Committee 2024**

14:05 – 14:20 *15 mins*	**M11**	**Report of the Remuneration Committee 2024**
14:20 – 14:35 *15 mins*	**M12**	**Compliments and Complaints report**
14:35 – 14:40 *5 mins*	**M13**	**Any other business**
		Below-the-line items*
	M14	**Council forward work programme**
	M15	**Annual report on Defined Contribution pension scheme**

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

Contents

General Medical Council

Draft as of: 2 October 2024

To approve

Minutes of the meeting on 2 October 2024

Members present

Carrie MacEwen, Chair

Alison Wright	Paul Knight
Anthony Harnden	Raj Patel
Deepa Mann-Kler	Steve Burnett
Douglas Millican	Suzanne Shale
Jeeves Wijesuriya	Vanessa Davies

Others present

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

Agenda item 2
Minutes of the meeting on 2 October 2024

Chair's business (item M1)

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

2 No apologies were noted.

Minutes of the meeting on 24 July 2024 (item M2)

3 Council approved the minutes of the meeting on 24 July as a true record.

Chief Executive's Report (item M3)

4 Council considered the Chief Executive's Report.

5 Council received an oral update and noted that:

a We are on track to begin regulation of physician associates (PAs) and anaesthesia associates (AAs) in December 2024, and that we are analysing the consultation responses.

b Engagement with the Department for Health and Social Care (DHSC) is ongoing in relation to regulatory reform. We understand that there is continued support for this work, and we are in discussions with officials about plans for development of the next GMC Order.

c We published *The state of medical education and practice in the UK Workplace experiences 2024* report in August. This was received positively by key stakeholders.

d We submitted key highlights from our data as evidence to Lord Darzi's independent investigation of the NHS in England, setting out staffing and workforce pressures as barriers to good patient care, the impacts of burnout and pressures on capacity and productivity, the need for a greater focus on workforce retention as well as education reforms, and the pressures on educators.

e On 3 September 2024, the initial engagement exercise on our review of the Medical Licensing Assessment (MLA) content map closed. The review will ensure the content map continues to reflect the core knowledge, skills and behaviours required for day-to-day medical practice in the UK and the diverse needs of the UK population.

f Work to implement a new enterprise resource planning (ERP) system is progressing as planned. We have selected the system to manage our finance processes; development and implementation is due to start with a third party in early 2025. We are currently evaluating system options for our people processes, with the aim of selecting our people system in early 2025.

Agenda item 2
Minutes of the meeting on 2 October 2024

6 Council received an oral update on finances and noted that:

a Operational expenditure is under budget, driven by lower utility charges, and lower variable costs associated with reduced PLAB demand. Operational activity levels are broadly in line with budget, noting we do not expect to use all the contingency funds or Gateway funds, with the net effect of an underspend of circa £3m.

b Operational income is lower due to reductions in demand for PLAB and fewer initial registrations. Combining the two gives and operational surplus of roughly £4m against a budget of £3m.

c The investment portfolio is currently valued at just over £63m which combined with the operating surplus gives a forecast total surplus of £5m against budget £3.5m

7 During the discussion, Council noted that:

a There has been a decline in the number of candidates sitting PLAB exams. If this is the start of a sustained trend it may impact income and expenditure in the Clinical Assessment Centre. This will be monitored and an update provided at the mid-year review.

b An update will be provided about the work undertaken on the Lampard Inquiry, noting the statutory nature of the Inquiry and the expectation that registrants would participate in such processes.

c In May, we participated in the Talent Inclusion and Diversity Evaluation (TIDE) benchmark. We have made significant progress since we last completed the benchmark in 2019. We have now been assessed as working at 'Embed' level. We plan to complete the benchmark again in 2027 to support the development of our 2030 corporate strategy. Procurement remains an area for improvement, with advice and guidance from organisations excelling in this area being sought to make improvements.

d The report highlighted staff turnover, particularly in senior roles, noting low turnover can hinder diversity within the workforce. Council expressed confidence in the recruitment processes and expects to generate a diverse pool of candidates. A future people survey will provide further analysis.

8 Council noted the Chief Executive's report, performance annex and Corporate Opportunities and Risk Register.

Agenda item 2
Minutes of the meeting on 2 October 2024

Regulatory Fairness Review – Implementation Update (item M4)

9 Council received an update on implementation progress on the Regulatory Fairness Review (RFR) recommendations, noting that the RFR final report was reported to Council in December 2022 and Council received its first annual update on progress in September 2023.

10 Council noted that:

a The Equality, Diversity, and Inclusion (ED&I) annual report, which included the last RFR update, was initially intended for publication in September 2024 but has been delayed due to the process of translating the report into Welsh. This is the first time the GMC has done so, and the complexity of translating charts and tables caused delays. The report will be published by mid-October.

b Key points to note in relation to our implementation of the Regulatory Fairness Review include:

- Of the RFR recommendations, ten remain ongoing and two are scheduled to begin in the next phase.
- The focus has shifted toward strengthening assurance measures and addressing fairness and anti-bias considerations. The GMC has reframed its approach to external assurance, now emphasising the prevention of bias within the system, as this is expected to drive further improvements.
- The learning programme related to the RFR will conclude in November 2024. Additional efforts are underway to integrate these learnings into business-as-usual practices and support decision-makers.

c We are now in the implementation phase:

- There is a slight delay in the submission of directorate implementation plans, now expected by early 2025, due to competing project resource demands.
- An implementation toolkit has been launched, and further progress will be made based on the availability of resources.

d We have established corporate co-ordination of some elements of the project, data and assurance, learning and culture change, and these workstreams will support directorate implementation.

11 During the discussion, Council noted that:

a We are actively sharing progress updates with the authors of reviews and implementing internal messaging across the organisation.

b Plans are being developed to enhance visibility for the Audit and Risk Committee regarding assurance mapping. Another audit is scheduled to focus on the implementation of these plans.

c The work is helping to define and reinforce GMC values. Training programs are being adapted to mainstream the ED&I learning, with elements incorporated into induction training.

d Evaluation of the impact of the training programme is being carried out, especially through interactive case studies, which help gauge staff perspectives and confidence levels. Positive feedback was received, although some employees reported initial discomfort in discussing bias, especially when challenging peers or seniors. A culture of confidence and open dialogue is being cultivated.

e There is a focus on ensuring that the work and implementation of the RFR extends into the devolved offices and to cover all colleagues across the organisation.

12 Council noted the progress in implementing the recommendations from the RFR.

PA/AA update (item M5)

13 Council received an update to note on completed work on the regulatory framework for physician associates (PAs) and anaesthesia associates (AAs), noting that the Anaesthesia Associates and Physician Associates Order (AAPAO) will come into force on Friday 13 December 2024.

14 Council noted that:

a Registration applications will open on Monday, 16 December 2024. There will be no automatic transition to the register for existing PAs and AAs, who will need to apply and demonstrate compliance with the set standards.

b Upon registration, PAs and AAs must follow Good Medical Practice, with updated guidance covering key areas like confidentiality and the professional duty of candour, which will be refreshed for the start of regulation.

c At the outset, the regulatory framework for PA and AA education will cover only teaching and learning that leads to the award of an initial PA or AA qualification. There are currently no formal post-qualification development pathways for PAs and AAs such as those that exist for doctors.

d Prior to registering any PA or AA we will assure ourselves they are fit to practise. The registration process requires a self-declaration, just as it does for doctors. In addition, if a PA/AA has previous UK practice, they will need to provide a reference from their most recent employer. We will also receive information from the Faculty of Physician

Associates about any PAs who have been subject to formal investigation during their voluntary registration.

e We will incorporate data relating to PAs and AAs into our business reporting. In the short term, data collection will focus on operational management information, including application numbers, concerns, and investigations.

f The fee announcement will now be made in November 2024 once we have received validation of our costings from external consultants.

15 During the discussion, Council noted that:

a There are approximately 5,000 PAs/AAs, with the vast majority being PAs. Most PAs are based in England, with smaller numbers in Scotland, Wales, and Northern Ireland. Around 2,000 PAs work in primary care. We will directly contact those on the voluntary registers, which is estimated to be around 90% of PAs and AAs currently practising in the UK, to invite them to apply for registration. Others will also be encouraged to register as soon as possible through employers, groups, and networks.

b Council discussed potential incentives for early registration, including employer encouragement. Registration is expected to be a requirement in employment contracts, as voluntary registration already is for many, strengthening workplace standards.

c There is ongoing discussion around whether Responsible Officers (ROs) will have a formal role in overseeing PAs/AAs. This isn't set out in legislation as it is for doctors, but employers may choose to ask ROs to take responsibility for PAs and AAs. Our Outreach team is actively engaging with ROs on this topic.

d Employers will continue to have an important role in handling complaints relating to PAs/AAs, although the GMC will take fitness to practice cases when the regulation comes into force.

e The GMC has no power with regards to the decision as to whether or when PAs/AAs might be granted prescribing rights. The potential extension of prescribing responsibilities to PAs/AAs is being led by DHSC, the MHRA and NHS England, with GMC involvement likely to focus on ensuring appropriate education and training for whatever prescribing mechanisms are decided. Legislative changes will be required, so this will take several years to implement.

Process for approving PA/AA courses (item M6)

16 Council discussed the process for approving PA and AA courses and the use of the quality assurance framework to gather information about PA and AA course providers during the pre-regulation period.

17 Council noted that:

a Regulation of PAs and AAs is an important step in assuring the public about these professionals, and it is critical that we are confident that the courses we approve meet our standards.

b The Anaesthesia Associates and Physician Associates Order (AAPAO) requires the GMC to accredit the education courses for these professions. We have undertaken quality assurance of PA and AA courses ahead of statutory regulation to provide evidence to support this accreditation. The quality assurance approach followed for PA and AA courses is the same as Council approved for the quality assurance of undergraduate and postgraduate medical education.

c In December 2023 the criteria were published that each course provider would need to meet to have the qualification they award approved for the purposes of registration.

d Once regulation begins, we will use our quality assurance processes to check the compliance of each course against our standards. The regulatory powers included in the legislation will enable us to approve at programme level for PA and AA courses.

18 During the discussion, Council noted that:

a Many PA/AA programmes are small, with around 20-30 students per cohort. Discussions on workforce planning have taken place, but it is not the GMC's role to suggest consolidating into fewer, larger courses.

b There are concerns about the job market for PAs, with some schools potentially suspending entry due to lack of demand. In contrast to medical schools, there have been discussions about some PA schools possibly closing until job prospects improve. Issues like bullying and harassment during placements have also been raised, affecting participation and progression in PA/AA programmes.

c A recent BMJ report indicated that over 50% of PAs applied for medicine. This contrasts with the USA, where becoming a PA is often a clear, standalone career choice.

19 Council noted the process followed to date, and the approach for approval of existing courses due to be considered in Spring 2025.

Amendments to GMC Medical Act Rules (item M7)

20 Council discussed the proposed amendments that would be achieved under the annexed draft Statutory Instrument (SI), following the AAPAO amendments to some definitions within the Medical Act.

21 Council noted that:

a The Anaesthesia Associates and Physician Associates Order (AAPAO) was approved in April 2024 and will commence in December 2024 for the regulation of PAs and AAs. The Medical Act continues to apply for the regulation of doctors and our governance.

b The AAPAO contained consequential amendments to the definitions of "registrant" and "lay" in the Medical Act, in two contexts:

- In relation to the constitution of Council and the constitution of the MPTS, "registrant" is amended to incorporate PAs and AAs and "lay" is amended to exclude those registered (or formerly registered) as PAs or AAs.
- In relation to the constitution of Medical Practitioners Tribunals and Interim Orders Tribunals, the amendments ensure that "registrant" member will include only those registered under the Act (doctors) and "lay" member will exclude all registered professions (doctors, PAs and AAs).

c Because these are amends to rules made under the Medical Act, both require the approval of Privy Council (PC), noting rule-making under the AAPAO and any subsequent GMC Order will not require PC approval.

22 Council approved the rules amendments ahead of submission to the Privy Council.

Any other business: (item M8)

23 Council noted below the line items:

a M9 - Council forward work programme

b M10 - Council members' Register of Interests

24 Council noted that its next meeting is scheduled for 5 December 2024 in London with a Seminar on the evening of 4 December 2024.

General Medical Council

Chief Executive's report

Action	To note
Purpose	This report outlines developments in our external environment and progress on our strategy since Council last met. Key points to note: • We continue to work towards the regulation of physician associates (PAs) and anaesthesia associates (AAs), and will report on this later this month. • Work to transition the Medical Licensing Assessment to business as usual is underway, with several functions operating within their new home teams. Formal programme closure activities will be carried out over the next few months, including a closure report which will be circulated to Council for information.
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

Agenda item M3
Chief Executive's report

Regulatory reform and regulation of PAs and AAs

1 We are on track to begin regulating physician associates (PAs) and anaesthesia associates (AAs) from 13 December 2024. We have now completed our analysis of the responses we received to the consultation we ran earlier this year. The consultation analysis report and associated standards, guidance and rules will be reviewed and approved by Council prior to regulation commencing.

2 We are keeping system leaders, employers, and all stakeholders up to date on key milestones. These updates are also published on our website and highlighted on other channels, including social media.

3 Anaesthetists United filed their judicial review claim on 11 October 2024 following the announcement that the BMA would be providing financial support for the claim.

4 We continue to receive a significant number of freedom of information requests regarding our work to bring these professions into regulation.

5 We continue to engage with the Department for Health and Social Care (DHSC) on its plan for regulatory reform. We understand that reform for the GMC is still a key priority and we have already started to meet with officials to work through areas of policy that require consideration as part of the next GMC order.

6 On 20 November, the DHSC announced an independent review to consider how PA and AA roles are deployed across the health system, in order to ensure that patients get the highest standards of care. Professor Gillian Leng CBE will lead the review and we will do all we can to support this work.

People survey headlines

7 We achieved a very high response to the survey again this year – 1,449 completions, which is a response rate of 87%.

8 Overall, we have seen a slight improvement in the survey results. The employee engagement score has increased to 72.14, from 70.88 in 2023; the inclusivity index score is unchanged from 2023 at 74%.

9 More analysis is needed to establish the main priorities for the GMC as the reports from our survey provider become available. More detailed insight into the results will be shared with the senior management team in due course.

10 Directorate and section reports have been shared and discussions on the survey and action planning have started.

Agenda item M3
Chief Executive's report

Corporate strategy development

11 Our work to develop the next corporate strategy (2026-2030) is on track. Engagement and testing will run until June 2025, with the final drafting taking place July-August 2025 before sign-off from September 2025 onwards.

12 We will continue to engage and update Council through this process.

Parliamentary and stakeholder updates

13 On 22 October 2024, we attended a reception hosted by the Secretary of State for Health and Social Care, Rt Hon Wes Streeting MP to hear about his priorities for health and social care. The wider Ministerial team, senior officials and NHS England's senior leadership team also attended.

14 We met Neil Gray MSP, the new Cabinet Secretary for NHS Recovery, Health and Social care on 6 November 2024 to discuss mutual priorities, workforce and regulatory reform.

15 We held our autumn UK advisory forum meetings in Northern Ireland, Scotland and Wales. The meetings focused on engaging forum members on our education work, identifying areas of mutual interest and opportunities for collaboration.

16 On 7 November 2024, we held our bi-annual patient group roundtable with stakeholders from across the four countries to seek views on the Medical Practitioners Tribunal Service's new sanctions banding, our next corporate strategy, and our work to bring PAs and AAs into regulation.

17 We responded to consultations from:

- **a** The Scottish Government on amendments to the Adults with Incapacity (Scotland) Act (2000). Our response focuses on how our guidance intersects with the legislation.
- **b** The Department of Health (Northern Ireland) on Safe and Effective Staffing Legislation in Northern Ireland and the Policy Proposals to inform the development of a new Public Health Bill for Northern Ireland.

Enterprise resource planning system

18 Work to implement a new enterprise resource planning (ERP) system is progressing as planned. We have selected the system to manage our finance processes. The finance system development and implementation is due to start in early 2025. We are currently evaluating whether our new system, with some development, could also support our HR processes. If it is assessed that it can support HR processes, we would expect to have the information required to make a decision by the end of December. If not, we would conduct a process to select an alternative supplier by early April.

19 Our programme team set-up is complete, with Neil Roberts sponsoring the work, and dedicated programme finance resources in place. Executive board will be monitoring progress of the programme and approving key decisions. We are keeping Audit and Risk Committee updated on this work, as well as updating Council regularly.

Enhanced monitoring

20 The case volume of enhanced monitoring has been steady. There are currently 28 open cases, with conditions attached to GMC approval to deliver a programme of training at five sites. Whilst we have escalated one case to enhanced monitoring over the past month, we also resolved one case in the same period.

21 Issues in clinical radiology training at Northwick Park Hospital, London North West University Healthcare NHS Trust (QA12876) were identified during an urgent risk review in August 2024. The case was escalated to enhanced monitoring in September 2024. We removed a condition from obstetrics and gynaecology training at University Hospitals Birmingham NHS Foundation Trust (QA11968) in October but continue to monitor the remaining condition at the trust.

22 We have attached conditions to our approval of medicine and surgery training at Norfolk and Norwich University Hospitals NHS Foundation Trust (QA12118). This follows longstanding concerns around rotas and clinical supervision, access to educational opportunities, and feedback from doctors in training about racist and misogynistic behaviours in the departments.

Inquiries and reviews

23 We recently finalised an information sharing agreement with an independent review of Nottingham maternity services and met with the chair, Donna Ockenden, to discuss engagement with the families.

24 The Eljamel and NHS Tayside Public Inquiry into the actions of neurosurgeon Sam Eljamel in Scotland (now practising in Libya) has begun holding public meetings. The work of the inquiry will include looking at the role of NHS Tayside in the process by which the doctor came to erase his own name from the medical register. We held an initial meeting with the inquiry team to discuss how we can support their work.

Equality, diversity and inclusion

25 On 17 October 2024 we published our annual equality diversity and inclusion progress update. We gave an exclusive interview to The Guardian, which was published online and in print. Further coverage from Pulse and GP online focused on the report's findings on our progress, followed by our system-wide call to action. Our approach to social media focused

on highlighting the specific work that has led to progress against our ED&I targets. The Chair also wrote to doctors across the UK, to reiterate our commitment to tackling inequalities in medicine, and we followed this up with an email bulletin providing more information about the report and its findings.

Operational performance

26 The update in our Performance Annex (Annex A) includes the status of our corporate projects. Regulation of PAs and AAs reports as green for September as it is on track to commence regulation by the end of the year. Regulatory reform remains amber because the timetable for wider reforms is still to be confirmed by the DHSC. Good progress has been made with the associate worker status (AWS) project and the enterprise resource planning (ERP) programme, but both are amber for this period. AWS will continue to report amber until an implementation timetable has been finalised, and on ERP, we are currently working with the people team to address a resourcing gap which they hope to fill by January 2025.

27 The contact centre KPI to answer 80% of calls within 20 seconds was missed in both August (55%) and September (52%), however customer satisfaction remains high over this period indicating that the slower response times are not having a significant impact on our customers. The main impact on the call KPI had been due to needing to prioritise the implementation and associated staff training for our new telephony system, which has been successfully delivered, eliminating the risks we faced around becoming imminently unsupported by our previous provider. The training roll out to staff is now complete, and with 12 new starters in the process of completing their induction, we expect to see our call KPI recover in the coming months.

28 Recently we switched to a new media monitoring provider to help us better evaluate our media performance and gain greater insight into perceptions externally. As a result, we will likely see fluctuations in our positive and negative media coverage measures in the early stages post-transition. During this reporting period, the majority of GMC mentions were neutral, bringing down the proportion of positive coverage below our 45% target to 5%. Our negative coverage also remains low, so for this measure we remain well with our target of being below 15% at 3%.

29 The annexed corporate opportunities and risk register (CORR) includes one key change since the last Council meeting - an updated description for the IT industry cloud risk. The update reflects potential licence cost implications if vendors adopt more aggressive tactics such as withdrawing support to force a move to cloud-hosted subscription-based licensed solutions on their timeframes. In the new year we will review the CORR to ensure terminology we use encompasses doctors, PAs and AAs where appropriate.

30 The contact centre has again received a distinction from the Institute of Customer Services in their service mark accreditation scheme. We are really proud of the service our colleagues provide across all channels.

Finance

31 Year to date our finances are in a strong position with our operational surplus exceeding budget by £1.4m. This is a result of:

- **a** Underspends on service charge at a number of sites, with the invoices received from landlords falling significantly below the level anticipated. There have also been some underspends on staffing, and a reduction in staff churn in some areas to below that included within the budget. We are also noting underspends on panel and assessment costs linked to lower PLAB volumes.
- **b** Being offset slightly by income year to date falling behind budget on registration fees, with current trends indicating that volumes are likely to be more in line with 2023, rather than grow at the rate included in the budget. PLAB fee income has fallen below anticipated levels with a reduction in PLAB 2 volumes, and some expenditure is in excess of the budget to complete the PLAB fourth circuit build.

32 At an operating surplus level, we are forecasting to be £0.9m ahead of budget by the end of 2024.

- **a** We expect capital expenditure overspends, largely on the PLAB fourth circuit. This should be offset by underspends on service charge as noted in our year to date position, but also through additional overheads being funded by the DHSC due to increased MAPs activity in 2024.
- **b** Additionally, there is a continued impact of demand changes in PLAB 2 volumes affecting circuit delivery in the second half of the year. We are forecasting both lower PLAB income and lower variable costs associated with PLAB delivery, most notably on the panel and assessment line.

33 At a total surplus level, we are seeing gains accrue on our investment portfolio up to the end of October. This is £0.5m ahead of budget, but worth noting the degree of volatility in this assumption, with our most recent investment report showing us having made gains of only £0.5m since the prior year, 50% of the budget for 2025.

34 The key medium-term risk is the impact of high levels of inflation, and we will see the impact of this throughout the next few years.

Executive Board

35 The Executive Board met on 30 September 2024 and 28 October 2024 considered the following:

36 An update on Performance and Risk.

- **a** An update on GMC Policy Development.
- **b** A note on the 2024 ED&I Steering Group activities and how the BDO audit of the group is being implemented.
- **c** An update on Net Zero.

General Medical Council

M3 – Annex A - Performance annex

Data presented as at 12 November 2024 (unless otherwise stated)

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

	Indicator	Aug	Sep	Commentary
Operations	Decision on 95% of all registration applications within 3 months	99%	98%	**Contact Centre**: Training for the new Genesys system was delivered in August following a successful implementation. In addition, 12 new advisers were inducted in September. This combination impacted performance against our call KPI. Scheduled development for operational needs, organised courses and check in chats were all also contributing factors. Support from other teams and overtime were utilised to try and clear email backlogs and increase staff availability. With induction training due to conclude soon, the new advisers will join frontline operations. Although the target was not met for August and September, calls were answered within two minutes and customer satisfaction remained high as indicated by our other Contact Centre measure. We should see an improvement in performance in the coming months. **Media coverage:** Initial fluctuation in the evaluation data we receive is expected as we begin working with a new media monitoring supplier, and we are currently working with them on quality assuring their evaluation of our media coverage. September saw a significant volume of media coverage that was neutral towards GMC, with either no opinion expressed, or with a balanced view, therefore driving down the proportion of positive mentions we achieved. Our negative media coverage remains low and within target. **Staff Turnover:** Our staff turnover remains the same at 7% for September as retention remains high.
	Decision on 95% of all revalidation recommendations within 5 working days	99%	99%	
	Respond to 90% of ethical/standards enquiries within 15 working days	96%	96%	
	Conclude 90% of fitness to practise cases within 12 months	95%	93%	
	Conclude or refer 90% of cases at investigation stage within 6 months	95%	96%	
	Conclude or refer 95% of cases at the investigation stage within 12 months	96%	96%	
	Commence 100% of Investigation Committee hearings within 2 months of referral	N0 Cases	N0 Cases	
	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%	81%	82%	
	Contact Centre - Answer 80% of calls within 20 seconds	55%	52%	
	Positive media coverage of GMC (target 45% or above)	5%	5%	
	Negative media coverage of GMC (target 15% or below)	3%	3%	
	Satisfaction of users with GMC website (target: a Net Promoter Score of at least 30)	45%	45%	
	75% of doctors intend to change practice following Outreach learning session	78%	78%	
Organisation	2024 Income and expenditure [% variance +/- 4%]	+0.96	+0.85	
	Rolling twelve-month staff turnover within 8-12%	7%	7%	
	IS system availability (%) – target 99.89%	100%	100%	

Operational Key Performance Indicators (KPIs) – 12month summary

		2023			2024								
Indicator		**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**
Operations	Decision on 95% of all registration applications within 3 months	97%	97%	98%	98%	98%	98%	99%	100%	99%	99%	99%	98%
	Decision on 95% of all revalidation recommendations within 5 working days	99%	99%	99%	99%	99%	99%	99%	99%	99%	100%	99%	99%
	Respond to 90% of ethical/standards enquiries within 15 working days	98%	100%	96%	100%	100%	92%	94%	98%	98%	98%	96%	96%
	Conclude 90% of fitness to practise cases within 12 months	96%	97%	95%	96%	96%	97%	95%	96%	95%	96%	95%	93%
	Conclude or refer 90% of cases at investigation stage within 6 months	97%	97%	97%	98%	97%	99%	98%	97%	96%	97%	95%	96%
	Conclude or refer 95% of cases at the investigation stage within 12 months	98%	98%	98%	98%	98%	98%	98%	98%	97%	98%	96%	96%
	Commence 100% of Investigation Committee hearings within 2 months of referral	No Cases	100%	No Cases	No Cases	No Cases	No Cases	No Cases	No Cases	100%	No Cases	No Cases	No Cases
	Commence 100% of Interim Order Tribunal hearings within 3 weeks of referral	100%	100%	100%	100%	100%	100%	100%	96%	100%	100%	100%	100%
	Contact Centre - % of customers who rated their overall experience and satisfaction at 7 or above out of 10 (target 80%)	83%	82%	78%	85%	84%	81%	85%	82%	80%	80%	81%	82%
	Contact Centre - Answer 80% of calls within 20 seconds	85%	78%	84%	84%	87%	83%	86%	83%	82%	44%	55%	52%
	Positive media coverage of GMC (target 45% or above)				36%	61%	48%	80%	38%	11%	47%	5%	5%
	Negative media coverage of GMC (target 15% or below)				17%	10%	5%	3%	6%	17%	3%	3%	3%
	Satisfaction of users with GMC website (target: a Net Promoter Score of at least 30)	50	40	39	40	41	43	35	35	35	37	45%	45%
	75% of doctors intend to change practice following Outreach learning session	79%	78%	81%	77%	77%	81%	80%	82%	78%	79%	78%	78%
Organisation	2024 Income and expenditure [% variance +/- 4%]	-0.53%	-0.64%	+1.02%	+1.83%	+0.44%	+0.66%	+1.27%	+0.34%	+0.71%	+0.5%	+0.96	+0.85
	Rolling twelve-month staff turnover within 8-12%	7.7%	7.1%	7.0%	7.9%	6.8%	7.1%	7.4%	7.3%	6.9%	6.7%	7%	7%
	IS system availability (%) – target 99.89%	99.93%	100%	100%	99.96%	99.94%	99.97%	100%	100%	100%	100%	100%	100%

Corporate Strategy Delivery: Priority activities forecast

October – December 2024 estimated investment (project team resource)

Our strategy 2021-25

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

Committed project resource for remainder of 2024 by Strategic Aim

Themes	Project resource costs to deliver corporate priorities
Making every interaction matter	1,996,000
Developing a sustainable medical workforce	541,700
Enabling professionals to provide safe care	57,900
Investing in our people	355,200
Total	2,950,800

Corporate Strategy Delivery: Priority activities forecast

October – December 2024 estimated investment (project team resource)

Cost for Regulatory Reform also includes estimated resource from enabling teams supporting the Project Management Office to deliver the programme
Regulation of AAs and PAs resource is funded by DHSC and nil cost to the GMC

Enabling professionals to provide safe care

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

2024 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		We will be presenting a paper on our phase 4 plan to Executive Board in November for approval. We have started drafting on the deep dive FER paper for December Council. This is currently being circulated to our subject matter experts for comments and we will be attending FtP SMT for initial sign off on the 16 October. Our dip sampling of Responsible Officer (RO) Allegation Of Impairment (AOI) data is complete, and recommendations from this finalised, although currently the data quantity is not yet sufficient to draw conclusions on trends. Our Liaison Advisors in Northern Ireland facilitated a pilot of the 'Fairer Feedback Conversations' workshop for 23 Belfast Trust trainers on 17 September and 100% of attendees noted they would change their practice as a result of attending the session. A National Office meeting is being held in December with the Medical Directors (MDs)/ROs and Deputy MDs from a number of Health Boards across South Wales to discuss working together to improve and enhance fairness and impartiality in local processes. Lastly, we have paused the Narrative workstream for three months due to resource pressure in FtP Policy as a result of our work to bring AAs and PAs into regulation. This will not impact on the overall timeline of the FER project as this piece of work is to support publication of our target in 2026.
Fair Training Cultures	**Why?** To deliver on our commitment to eliminate discrimination, disadvantage and unfairness for all index measures of fair medical education and training pathways. **When:** September 2031 **Who:** Colin Melville		September consisted largely of onboarding activities for the new project manager, and engagement activities with our working group, internal teams and other workstreams to formulate the second phase of our project. We presented our annual impact review to the programme board, along with an analysis of 2023 Royal College and Deanery annual action plans, which has overall aims to provide us assurance that there is awareness and momentum in issues regarding differential attainment. We have also agreed an outline for our forward response in our programme of work.

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

2024 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:** Colin Melville, Phil Martin, Nico Bridge		We continue to establish the structural elements of the programme. We held a quarterly programme board on 4 October, at which we heard a verbal summary from the recent internal audit of the programme (BDO report due 25 October) and presented the first draft of the Project Initiation Document (PID). Additionally, we have established three stages for the programme: Stage 1 (2024-2026) which includes the thematic consultation, stage 2 (2026-2027) which includes developing the draft framework and the technical consultation, and stage 3 (2027-2029) which includes publication of the new framework and implementation of new policies and processes. Our priority now is to prepare detailed plans for stage 1 for both the programme, and communications and engagement. Activities in this stage will primarily focus on engaging with new and existing stakeholders on our objectives, as well as research and working with stakeholders to test new approaches. These activities will help us better understand how our framework should be developed and build the rationale and evidence base to support the changes. Also, part of our engagement, we continue to work with communications colleagues to develop the GMC 2024 symposium in November.
Introducing the Medical Licensing Assessment (MLA)	**Why?** We want to give patients greater confidence that they will receive a consistent level of core knowledge, skills and behaviours from any doctor practising in the UK. UK medical schools will deliver the Assessment embedded within final exams for a UK medical degree, overseen and regulated by us, and we will administer the assessment for IMG doctors. **When:** Q2 2025 **Who:** Colin Melville, Nico Bridge		With work complete in regards to planning which teams would be assuming the functions of the MLA as a business-as-usual activity and identifying the skills needed to perform the tasks needed, we were able to move swiftly to accommodate the closing down of the MLA Assistant Director role sooner than anticipated (when the role holder moved to another position within the business.) MLA team members have been transferred and will remain in these team for the duration of the transition project until May 2025 and we will be reviewing post-transition positions ahead of this date. In light of the transfer of staff, the PMO has reviewed the approach to project and risk management and reviewed deliverables for each transition workstream and streamlined. Three transition workstreams (PLAB, Data and reporting and Evaluation) were closed at our Transition Oversight Group meeting on 9 October and, after this point, work will be carried out by receiving teams as BAU. There is also significant work underway across the other workstreams, with discussions between the Quality assurance and monitoring improvement team and Medical Schools Council (MSC) in relation to ongoing regulatory oversight, and the development of quality assurance processes to ensure the ongoing compliance of medical schools and the MSC. We will run a number of cross-team workshops over the coming weeks to agree protocols in the case of acute situations or change requests by medical schools or the MSC, and to agree an ongoing approach to collaborative work across our Education and Standards directorate. The PMO has also put together a proposal for an MLA steering group which will act as an information hub / expert advisory mechanism for the MLA during and after the closure of the transition project. Alongside the transition project, work continues on the thematic reports and on triaging responses to the content map review. The revised transitional arrangements (by which certain students, who meet the criteria in the arrangements, can graduate without a pass in the MLA if they passed their final exams before the launch of the MLA) were signed off at Executive Board on 30 September.

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

2024 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 report amber to reflect the large volume of activity that still needs to be completed to make necessary updates to rules, guidance, and standards following the PA/AA consultation ahead of 13 December when regulation is due to begin. Additionally, we are working on finalising the consultation analysis report. We are on track for this final package of materials to go to programme board, SMT and Council around early November 2024 for review. We also continue to engage with DHSC around the timings for updating the legislation that will replace the AAPAO and the Medical Act, however we do not yet have an agreed timetable for this work.
Regulation of Anaesthesia Associates (AAs) and Physician Associates (PAs)	**Why?** To expand the medical workforce and the contribution by our professionals to quality patient care, while continuing to safeguard patients. We will deliver equivalent statutory functions across MAPs and doctors. **When:** End of 2024 **Who:** Una Lane; Clare Barton		We are on track for Council to make rules for PA/AA regulation on 13 December, enabling registration to open on 16 December. Detailed planning for the go-live event is at an advanced stage and no significant concerns have been identified. In September we supported a webinar for Council members to discuss proposed changes to the PA/AA rules following consultation; Outreach held a two-day development day on PAs and AAs, featuring external speakers and members of the MAPs Programme team; Phase 2 system build was completed and handed over for business testing and finalised communications plans for the period up to regulation go-live. We remain sensitive to the external environment in our communication and engagement, maintaining a clear focus on the imminent introduction of regulation and the benefits this will bring.
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		We conducted a short review of the programme which was presented to the programme board on 15 October. The recommendations and changes have been implemented. The directorate roadmap and project roadmap for supporting project planning and implementation phases, has been created and will be reviewed. Highlight reports are being used for reporting and risk is now being reviewed regularly, through a new standard process. Directorates are working on planning changes with decision makers and creating directorate implementation plans. The rollout of the training for decision makers continues with positive feedback which we will keep monitoring. We are also considering how to embed the training and principles learned on a longer-term basis. We received positive feedback from Council on an update paper presented on 2 October about the progress we have made. The principles (as part of the ED&I Annual Report) were published to the GMC website on 17 October.
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 2026 **Who:** Una Lane, Lindsey Westwood, Rachel Mooney		We successfully launched the new Genesys call handling software in September with no notable issues of concern. We have now begun migration of investigations and complaints and remaining telephone lines into Genesys, decommissioning the legacy phone system (Maintel), and implementing Welsh Language interactive voice response (IVR). This is due to be completed by December 2024. We are also in the process of reviewing the project governance structure to ensure it is fit-for-purpose in supporting the delivery of future phases of work as well as prioritising the remaining deliverables and associated benefits listed in the business case. The immediate risk of being unsupported by CallMedia has now been mitigated.

Making every interaction matter

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- 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

2024 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		We are continuing to report as amber for the project as we currently do not have an agreed implementation date at this point. We have needed to delay the paper to Executive Board with recommendations around the retrospective holiday pay period for associates as we are awaiting some further legal advice. In this period, we held a workshop to explore the benefits and drawbacks of moving associates to payroll. Following this discussion, we drafted a paper with recommendations which we will be bringing to the project board for a decision in October. We have started to work with colleagues in Finance and MPTS to trial the use of Seibel reporting in providing authority to pay associate fees and expenses for tribunal members. This work is to address a challenge with the number of emails being received in the Associate fees and expenses team from MPTS, causing significant work from both teams to manage these and deal with queries when claim forms and invoices come in. This is part of the work required to 'clear the ground' for the introduction of worker status. We have collated the feedback received from operational areas around the associate rate card and supporting guidance documents and made relevant changes and updates. We will be reviewing this with the associate services and finance teams before publishing. We held a workshop with key stakeholders to agree decisions required at Executive Board around the retrospective holiday pay period for associates and our approach to retrospective holiday pay payments to former associates, as well as our approach to pension arrangements. This brought to light changes in the legal advice received by other regulators around retrospective holiday payments and we are seeking further clarity on the legal position as mentioned above.

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.

2024 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		We are reporting as amber status due to the programme not having dedicated back-fill resource across the People Team. The recruitment for People Team backfill is due to commence on 14 October, with all roles expected to be filled by January 2025. MS Dynamics 365 Finance implementation: We have the Project Initiation Document (PID) signed off and have agreed engagement principles for the Finance subject matter experts (SMEs) to deliver the business analysis outputs required to enable us to define the target configuration in Dynamics. The Fees and billing work continues at pace with the dedicated resource, SMEs and Head of Section support in place. We continue to engage the Finance Assistant Director to ensure that resource requirements for Finance are identified and planned in over the coming months to help us achieve our business analysis outputs. We have launched a 'pre-engagement' work package with Inciper to mobilise a team to help us deliver the pre-requisite work required between now and the end of December 2024. Executive Board have confirmed the contract can be prepared for a January 2025 start. Alongside this, the process for procuring Microsoft licences for Dynamics 365 has been defined. Finally, following an initial risk workshop, we held a follow up session to assign owners, review RAG statuses, and agree treatment and mitigations where required. Further sessions are planned. HR discovery: The team has started work on the Project Initiation Document (PID), with completion expected by the end of 2024. All current HR 'as-is' processes have been completed with ongoing work with the payroll, pensions, data analytics and other areas having begun, with expected sign-off scheduled for end of December 2024. The HCM Change Manager will meet with People Services for a Superuser workshop on 7 November to deep dive into the team roles and responsibilities and discuss lessons learned from the People Process Systems (PPS) project. We will update the programme structure once this work is complete and share it with the wider business. Proof of concept work is starting with Inciper and the People Services Team to determine whether Dynamics 365 (software) is fit for purpose, before exploring other HCM/Payroll solutions. Finally, we met with the HR and Finance key stakeholders to discuss aspirational 'Go-Live' dates for the HR & Payroll solution(s). Additional workshops are planned to conduct deeper dives alongside the Finance workstream. We have scheduled an in-person risk workshop for 2 December with relevant Heads of Section and Assistant Directors (ADs) to assess project risks, assign ownership, and agree on treatments and mitigations where needed.

Recruitment – Diversity Targets

Underlying measures and targets		Actual				Target		
		2023 (%)	2023 (Vol)	2024[1] (%)	2024[1] (Vol)	End of 2024	% points off 2024 target	2026
Increase the level of minority ethnic representation at Level 3 and above	Applications	34.9%	430	41.0%	452	28%	+ 13.0	30%
	Interviews	20.1%	52	21.1%	40	23%	- 1.9	25%
	Offers	14.8%	8	8.1%	^Redacted	18%	- 9.9	20%
	Workforce	13.9%	90	13.4%	89	17.5%	- 4.1	20%
level of minority ethnic representation at Level 2+		12.6%	27	12.0%	26	16%	- 4.0	20%
level of minority ethnic representation at level 3		14.6%	63	14.0%	63	17.5%	- 3.5	20%
Increase the level of minority ethnic representation at all levels	Applications	45.3%	2,370	51.6%	2,641	38%	+ 13.6	40%
	Interviews	30.7%	329	37.5%	336	33%	+ 4.5	35%
	Offers	23.2%	66	26.6%	55	28%	- 1.4	30%
	Workforce	18.7%	317	19.0%	327	18%	+ 1.0	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		2.2%	-	Minority ethnic backgrounds (%)	White background (%)	1.5%	% points between groups	1.0%
				11.0%	6.2%		4.8	
Proportion of minority ethnic staff receiving promotion and grade progression is proportionate to our workforce at the relevant grade/level		- 2.9%	-	Minority ethnic backgrounds (%)	White background (%)	2%	% points between groups	2%
				8.2%	9.9%		1.7	
Pay differentials within a confined band limited to 2%[2] *(table shows the proportion of bands that are inside of the +/-2% tolerance)*		83.3%	10/12	58.3%	7/12	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

Financial summary (October)

Financial summary as at October 2024	YTD Budget	YTD Actual	Variance		Budget 2024	Forecast 2024	Variance	
	£000	£000	£000	%	£000	£000	£000	%
Operational expenditure	(122,105)	(120,530)	(1,575)	1%	(149,745)	(145,257)	(4,488)	3%
Capital expenditure	(9,258)	(9,768)	510	(6)%	(12,160)	(12,719)	559	(5)%
Total expenditure	**(131,363)**	**(130,298)**	**(1,065)**	**1%**	**(161,905)**	**(157,976)**	**(3,929)**	**2%**
Operational income	136,025	135,694	(331)	(0)%	164,693	163,401	(1,292)	(1)%
Operational surplus/(deficit)	**4,662**	**5,396**	**734**		**2,788**	**5,425**	**2,637**	

Financial summary as at October 2024	YTD Budget	YTD Actual	Variance		Budget 2024	Forecast 2024	Variance	
	£000	£000	£000	%	£000	£000	£000	%
Investment income / (loss)	833	1,468	635	76%	1,000	1,468	468	47%
Investment management fees	(217)	(213)	(4)	2%	(290)	(288)	(2)	1%
Net investment return	**616**	**1,255**	**639**		**710**	**1,180**	**470**	
Total surplus/(deficit)	**5,278**	**6,651**	**1,373**		**3,498**	**6,605**	**3,107**	

Financial detail (October)

Expenditure as at October 2024	YTD Budget	YTD Actual	Variance		Budget 2024	Forecast 2024	Variance	
	£000	£000	£000	%	£000	£000	£000	%
Staff costs	75,137	74,862	275	0%	90,648	90,575	73	0%
Staff support costs	3,244	2,985	259	8%	3,991	3,904	87	2%
Office supplies	1,426	1,311	115	8%	1,307	880	427	33%
IT & telecoms costs	5,683	5,643	40	1%	7,008	7,027	(19)	(0)%
Accommodation costs	8,113	7,485	628	8%	9,830	9,156	674	7%
Legal costs	3,165	3,403	(238)	(8)%	3,704	3,974	(270)	(7)%
Professional fees	2,408	2,627	(219)	(9)%	3,193	3,379	(186)	(6)%
Council & members costs	402	338	64	16%	471	416	55	12%
Panel & assessment costs	17,398	16,742	656	4%	21,205	20,150	1,055	5%
Associate fee changes	850	850	0	0%	1,020	1,020	0	0%
PSA Levy	779	784	(5)	(1)%	938	944	(6)	(1)%
Contingency fund	0	0	0	0%	1,218	332	886	73%
Gateway fund	0	0	0	0%	1,712	0	1,712	0%
Pension top up payment	3,500	3,500	0	0%	3,500	3,500	0	0%
Total operational expenditure	**122,105**	**120,530**	**1,575**	**1%**	**149,745**	**145,257**	**4,488**	**3%**

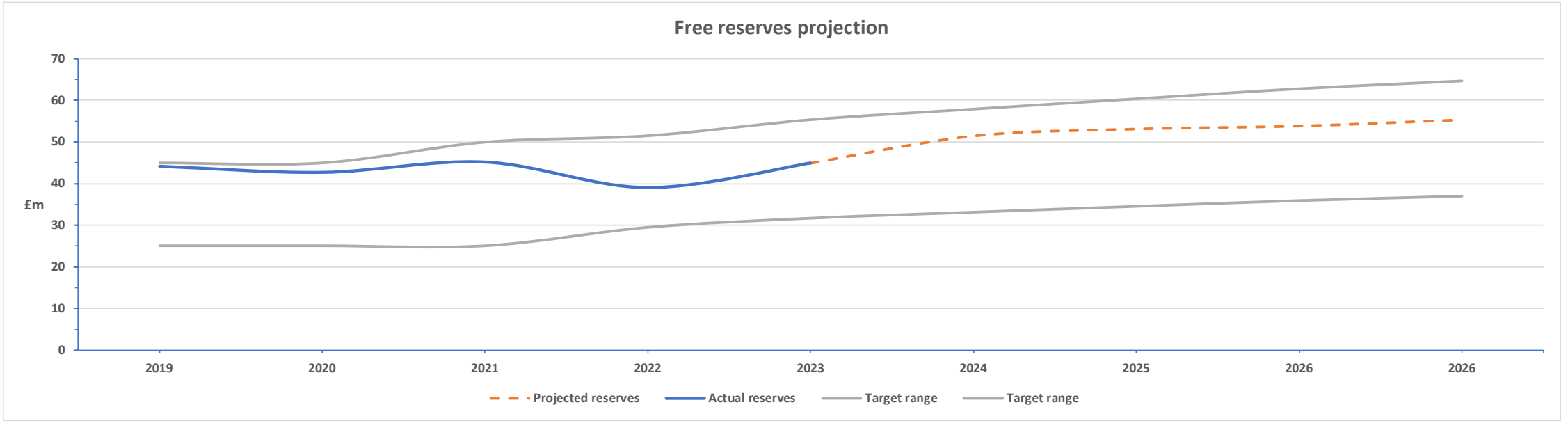
Income as at October 2024	YTD Budget	YTD Actual	Variance		Budget 2024	Forecast 2024	Variance	
	£000	£000	£000	%	£000	£000	£000	%
Annual retention fees	100,103	100,795	692	1%	121,155	121,846	691	1%
Registration fees	7,251	6,329	(922)	(13)%	8,594	7,466	(1,128)	(13)%
PLAB fees	21,695	21,015	(680)	(3)%	26,744	25,276	(1,468)	(5)%
Specialist application CCT fees	3,178	3,407	229	7%	3,608	3,837	229	6%
Specialist application CESR/CEGPR fees	1,730	1,714	(16)	(1)%	2,068	2,022	(46)	(2)%
Interest income	1,671	2,067	396	24%	2,030	2,490	460	23%
Other income	397	367	(30)	(8)%	494	464	(30)	(6)%
Total Operational Income	**136,025**	**135,694**	**(331)**	**(0)%**	**164,693**	**163,401**	**(1,292)**	**(1)%**

* The gateway budget was £2.5m, the amount allocated across directorates is £0.8m, therefore the remaining £1.7m is shown above, we are assuming that nothing further will be allocated this year.

Finance - GMCSI summary (October)

GMCSI summary as at October 2024	YTD Budget £000	YTD Actual £000	Variance £000	Variance %	Budget 2024 £000	Forecast 2024 £000	Variance £000	Variance %
GMCSI income	448	354	(94)	(21)%	477	391	(86)	(18)%
GMCSI expenditure	(361)	(299)	(62)	17%	(452)	(384)	(68)	15%
Profit/(loss)	**87**	**55**	**(32)**		**25**	**7**	**(18)**	

Finance – financial stability monitoring



Risk factor	Long term assumption	Current analysis	Individual trigger point	Multiple trigger point*
PLAB volumes	Stable volumes including utilisation of 4th circuit	Demand declining for PLAB 2, and softening of demand for PLAB 1 - impact uncertain	PLAB 1 or PLAB 2 volumes dropping by 30% or amendment to skilled worker VISA rules	PLAB 1 volumes dropping by 10% PLAB 2 volumes dropping by 10%
Register growth	4.5% per year	3.8%	Reduction to 1.5%	Reduction to 3.5%
Investments	£1m benefit per year	£1.5m gain to October 2024	Reduction of £9m	Reduction of £3m
3rd party cost increases	4.0% per year	CPI rate - September 2024 - 1.7%	10% per year	6% per year
Staff vacancy rate	4.3% per year - based on budget values	4.7%	Reduction to 2% per year	Reduction to 4% per year
Staff pay increases	Agreed at budget setting	Aligned to April Pay Award (within amounts budgeted)	In year increase of 3%	In year increase of 1%

* requires 1 threshold to be breached to trigger SMT discussions and potential remedial actions/contingency plans
* requires 3 thresholds to be breached to trigger SMT discussions and potential remedial actions/contingency plans

Finance – Investment Committee update

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

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

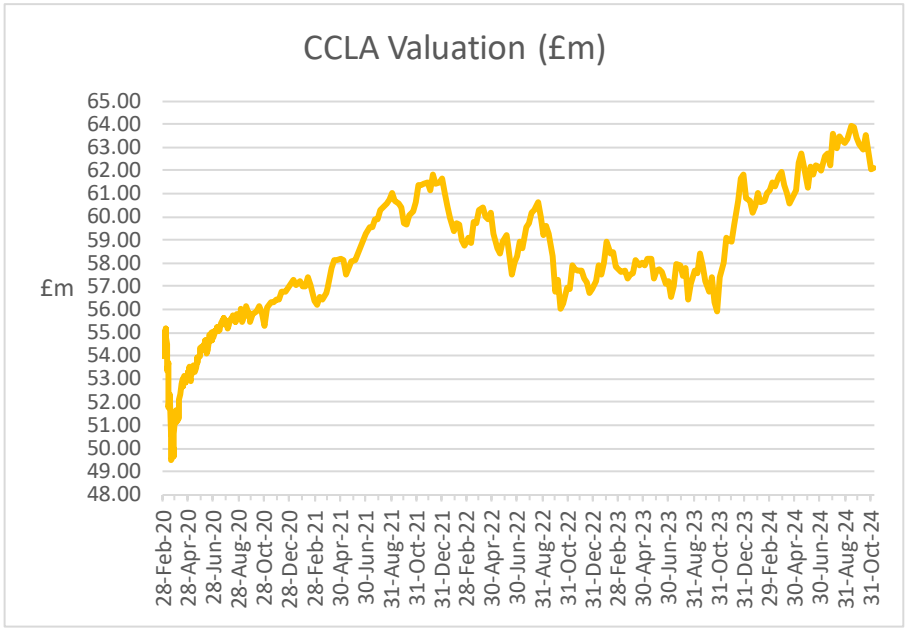
Holdings as at 8 November 2024 (reflected in the graph below)

	£millions	%
Alternatives	11.2	18.0%
Cash	3.3	5.3%
Equity	8.3	13.3%
Fixed Interest	39.3	63.3%
Total	62.1	100.0%

Performance Overall

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

	Performance Period			
As at 30 September 2024	3 Months	12 Months	3 Years (p.a)	5 Years (p.a)
Our Actual Portfolio	2.6%	11.5%	2.5%	3.7%
Target: CPI + 2%	0.6%	6.1%	8.1%	6.3%
Benchmark	1.6%	10.2%	(2.7)%	(0.5)%
Actual minus Target	2.0%	5.3%	(5.6)%	(2.7)%
Actual minus Benchmark	1.1%	1.3%	5.2%	4.2%



As the table shows over the 12 months to 30/09/2024 the portfolio has delivered a return of 11.5% and an average of 2.5% p.a. over the past 3 years, which is below target over the 3 years but above in a 12 month period. However, when compared to the benchmark performance, which we also monitor against, the outcome is a consistently positive one, with outperformance of 1.3% and 5.2% p.a over 12 months and 3 years respectively. The 5 year average, shows us once again falling below target by 2.7%, but once again exceeding our benchmark group by some 4.2% p.a.

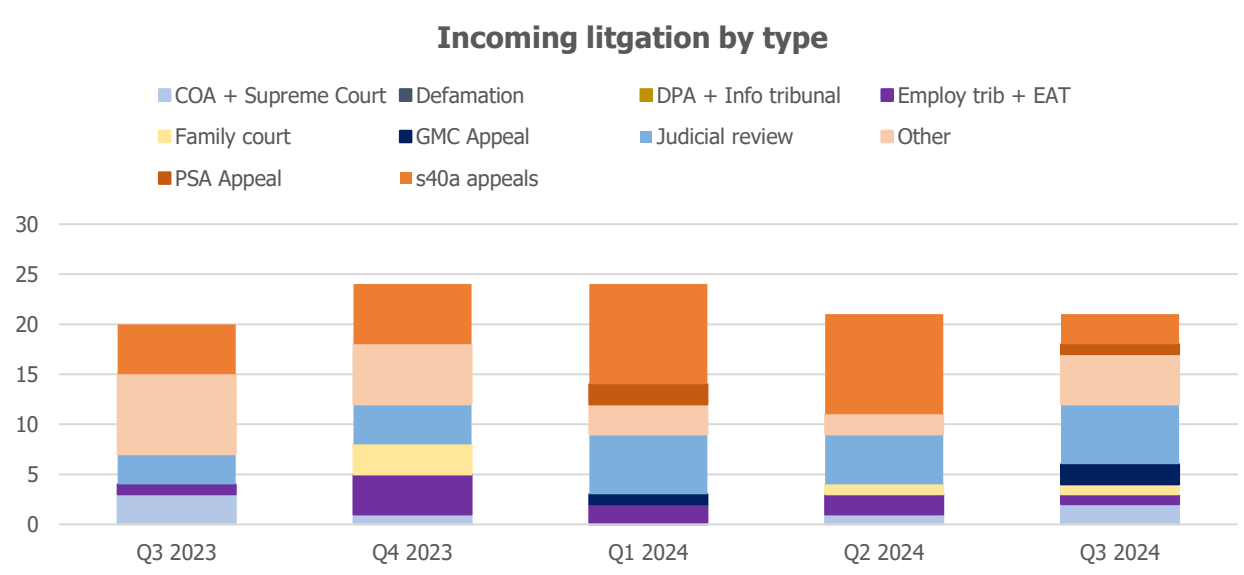
At this review date our investments were valued significantly above December 2023 at £63.2m. The most up to date valuation - November 8th - shows performance below October month end position but in excess of the 2023 year end position at £62.1m.

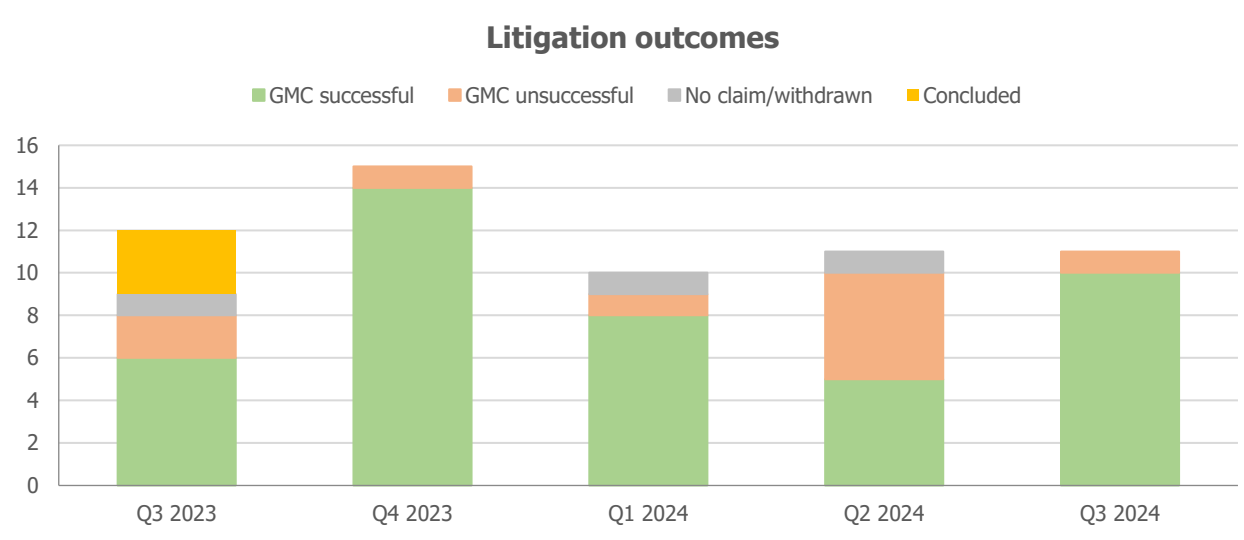
Litigation overview for Q3 2024

Data was pulled on the first working day of this quarter, for Q3 2024. This was 1 October 2024.

Total Open Litigation on 1 October 2024

We currently have 61 litigation matters open - 21 of which are new incoming matters in Q3. This figure excludes costs matters/High Court Extensions and s35a disclosure.





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

Concluded litigation: 11

10 = GMC Successful
- X3 = s40 (doctor) Appeals
- X3 = Judicial Reviews
- X2 = COA Appeal
- X1 = RAP Appeal
- X1 = Information Tribunal

1 = GMC unsuccessful
- X1 s40 (Doctor) Appeal

Corporate Opportunities and Risk Register - November 2024

Risk ID	Title Date Raised	Category	Detail	Owner	Likelihood - Inherent	Impact - Inherent	Rating - Inherent	Mitigation/Enhancement	Likelihood - Residual	Impact - Residual	Rating - Residual	Council and/or Board Assurance	Assurance	Further Action Detail	Risk Appetite
544	**IT Industry Cloud System Drive** 28/11/2023	Technical	Due to IT software vendors becoming more aggressive in their drive towards cloud hosted subscription licensed solutions, there is a risk that they will substantially increase license costs on an annual basis that we will have to pay due to the deeply embedded nature of the products and the critical functions that they perform. Furthermore, vendors whose products that we currently license on a perpetual basis may adopt an aggressive tactic of withdrawing support to force a move to cloud hosted subscription based licensed solutions on their timeframes. 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	• Support has been secured for the current finance and HR system until the end of 2026. • A cross-organisational programme board, reporting to Exec Board, is in place to oversee the significant process change and system replacement work. • A new finance system has been selected and work is underway with the vendor. • Work is underway to identify a suitable HR and payroll system. • Significant work has been undertaken to identify pitfalls with other organisations projects of this nature in a bid to learn lessons and avoid common pitfalls.	HIGHLY LIKELY	MAJOR	CRITICAL		Audit and Risk Committee • ERP Implementation - Governance and programme arrangements review - September 2024.	• Further programme audits planned for 2025. • We are planning our wider cloud migration strategy with KPMG support, factoring in the risk associated with vendors driving customers to the cloud.	Medium
538	**PA and AA regulation** 30/10/2023	Customer	Due to the wide range of views in the external environment on the roles of AAs and PAs in the workforce, our ability to contribute to enhancing protection of public and patient safety through working effectively with key stakeholders to embed the regulation of PAs and AAs, may be affected with potential operational, financial, legal, reputational and GMC colleague-related impacts.	Una Lane	HIGHLY LIKELY	MAJOR	CRITICAL	• Ongoing review of financial modelling and discussions with DHSC officials around funding arrangements. • Processes in place to ensure our work around the AAPAO consultation analysis, the consultation analysis report and fee-setting is robust and minimises the risk of legal challenge. • Pressing system partners to show collective leadership and challenge narratives around doctor substitution and impact on patient safety, in order to reduce the negative impacts on doctors, PAs and AAs. • Working with Royal Colleges on the development of their guidance around the safe utilisation of PAs and AAs in primary and secondary care, and encouraging system partners to ensure all guidance being produced is aligned so as not to cause confusion for employers. • Working with RCP to ensure a smooth transition for PAs from the managed voluntary register to the GMC register once regulation begins. • We have agreed an MoU with the RCP for the delivery of the PA Registration Exam over a four-year period from December 2024 with a 12-month break clause that either side can exercise unilaterally. • Process and resource in place to manage significant increase in FOI requests to us and system partners.	QUITE LIKELY	MAJOR	CRITICAL		• No indication from Government of intention to pause plans to bring PAs and AAs into regulation, and no legal mechanism to prevent regulation commencing from 13 December 2024 that is likely to succeed.	• Planned engagement with PAs, AAs, students and employers ahead of regulation commencing in December 2024.	Low
706	**MLA first live exams - contingency & scenario planning** 28/05/2024	Technical	If a significant incident occurs, such as connectivity or online security problems for the national MS AKT, this could affect the delivery of a complete MLA assessment for medical school students affected, which could risk invalidating the PMQ being awarded by those medical school(s).	Colin Melville	QUITE LIKELY	MAJOR	CRITICAL	• From our initial MLA compliance process, every school has a set of recommendations for future improvement or a request updated information. For the MS AKT, these include areas regarding incident reporting and escalation, and exam security. • We are communicating with the MSC to understand how their scenario, contingency and escalation plans should help ensure the security/robustness of the MS AKT. • Issues will continue to be discussed at all levels between the GMC and MSC, including at a senior level through our joint Senior Oversight Group (SOG), and in relation to future oversight.	UNLIKELY	MAJOR	SIGNIFICANT			• We collectively engaged with schools through engagement sessions in May/June 2024 and plan to have individual meetings with schools to check in on their contingency planning (we met with the nine schools who sat the MS AKT in June 2024 and plan to use pre-existing QAME meetings to meet schools who will sit the AKT during 2025). • Communicate the GMC's own position and plans to the MSC, by Q2 2025, outlining what we would do/not do in the event of an incident in AKT delivery and our expectations of MSC and schools for responding to an incident.	Low
512	**Uncertainty around our touchpoints and engagement with NHS England** 31/07/2023	Operational	NHS England's regional quality management workforce has continued to decline following the merger with Health Education England in 2023. This may impact the GMC's effectiveness in some operational processes that fulfil statutory functions in Education, and the impact may increase without NHSE commitments to support our functions.	Colin Melville	QUITE LIKELY	MAJOR	CRITICAL	• Ongoing engagement with NHSE stakeholders, including at senior leadership level. • We are monitoring our resource requirements to ensure our standards are being met, including the option to act independently in cases where trainees need to be removed from training environments. • We have enhanced our support offer to help NHSE teams meet our data provision requirements for our National Training Survey (NTS) and Annual Review of Competence Progression (ARCP) collections.	QUITE LIKELY	MODERATE	SIGNIFICANT			• Share soft intelligence on regional challenges with NHSE senior leaders in bilateral meetings and seek formal reassurance of support for GMC functions. • Work with Statutory Education Bodies in all four countries to develop a document clarifying GMC requirements of postgraduate deans.	Medium
207	**Pension Deficit** 21/08/2020	Financial	Due to economic instability, both asset and liability value of the pension scheme have reduced (assets to a greater extent). This could lead to continued funding of the deficit from the employer. The funding position remains under review and Trustees will continue to liase with the employer.	Neil Roberts	HIGHLY LIKELY	MAJOR	CRITICAL	• Trustees meet regularly and continue to take professional advice in relation to the existing deficit. • The employer and trustees work together to ensure suitable funding arrangements are in place to address the deficit. • The employer factors annual payments into the budget to cover the agreed funding arrangements.	QUITE LIKELY	MODERATE	SIGNIFICANT			• Strategy now set as part of triennial valuation – Trustees continue to receive updates on investment performance. The next triennial valuation date is 31/12/24.	Medium
452	**Regulatory reform - potential delays introducing reform for doctors** 04/05/2023	Strategic / Policy	There is a risk that external factors such as limited DHSC resources and the changes in the priorities of a new government will cause delays to the development of the next GMC order, which in turn will affect the timing for the implementation of reforms for doctors. This will lead to us needing to run two systems (one for doctors and one for PAs and AAs) and using workarounds for a longer period of time.	Shaun Gallagher	HIGHLY LIKELY	MAJOR	CRITICAL	• Continuing to reinforce the importance of DHSC prioritising the next GMC Order as soon as possible in our engagement with officials, politicians and their advisors, as well as maintaining an influencing strategy that keeps pressure up on this issue. • Two GMC lawyers have had their secondments extended to assist with consequential amendments, to help speed up the progress of the development of the next GMC order. • Proactive engagement with DHSC on planning for doctor reforms to minimise impact on busy teams. • GMC Chief Executive met with Health minister to set out case for Regulatory Reform.	QUITE LIKELY	MODERATE	SIGNIFICANT	Council This threat has been verbally discussed at various points over the past 12 months at Council meetings, making Council aware of the threat.			Low
120	**ED&I compliance** 17/02/2020	Strategic / Policy	The assurance we can evidence that our regulatory decision-making is fair, is not persuasive to key stakeholders and weakens confidence in regulation.	Shaun Gallagher	QUITE LIKELY	MAJOR	CRITICAL	• Equality, Diversity and Inclusion (ED&I) objectives published within the corporate strategy and supported by focused targets based on evidence and routine monitoring and reporting of progress. • Supporting governance including the Strategic EDI Advisory Forum (external) and ED&I Steering Group (internal) provides senior oversight and guidance to inform action and priorities. • Skilled ED&I team provide strategic advice across the GMC. • Mandatory training for all staff and associates. • Regulatory fairness review now complete and implementation board established. Leads across the directorates appointed and first phase of corporate deliverables underway. • Approach to a regulatory new Equal Opportunities Policy has been reviewed and published in April 2022 and being updated in 2024 - publication before the end of the year. • Staff learning and training needs is being delivered or is BAU, all suppliers are in place and delivering against requirements.	UNLIKELY	MAJOR	SIGNIFICANT	Council • Reporting to Council on Fairer training cultures, Fairer referrals and the inclusion programme, deep dive reporting annual cycle in place. Regulatory fairness now included in annual reporting cycle. Executive Board • ED&I steering group has forward plan for reporting and will report to Executive Board annually on progress the Steering Group has made. Programme Board • Regulatory fairness review is now in implementation phase. A new regulatory fairness board has been established to govern the implementation of all of the recommendations.	Internal Audit • Arrangements to operationalise delivery of external facing targets (2022, no rating). • 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) Other assurances • Strategy and policy ED&I compliance and governance review - Campbell Tickell (2020). • Engagement, not personal characteristics, was associated with the seriousness of regulatory adjudication decisions about physicians: a cross-sectional study, Javier A Caballero, Steve P Brown, British Medical Journal (2019). • Fairness of decisions to refer doctors to the MPTS interim orders tribunal (2018). • Plymouth University Review of decision-making in the GMC's FTP procedures (2014).	• Develop new decision making principles (published in Oct 2024) and consider key decision-points in our operations for process controls to mitigate the risk of bias or unfairness (such as separated decision making) and our quality assurance regime for decisions (this is already in progress as part of the regulatory fairness work). Decision principles complete, pending timescales for launch and publication. Assurance measures will be finalised in directorate action plans by Q2 2025. • Consider the adequacy of how we report the timeliness of our regulatory processes to better understand the characteristics of the individual in that process, and possible real-time interventions required to address risks of unfairness - this exercise has been completed for fitness to practice and has not identified differentials. • Consider the coverage and credibility of past independence assurance on the fairness of our processes in design and operation to identify gaps or required change in approach - this is integrated into the audit programme considerations and will be considered by the Regulatory Fairness board in 2024 following agreement on the final list of decisions in scope of this work - proposals are approved and will be published before the end of 2024. • Reviewing the impact of launching new templates and guidance on equality impact assessment and strengthen the tracking and oversight (through ED&I SG) throughout 2024 and managing phased introduction of the use of the new template. • Regulatory fairness implementation programme considering future assurance measures across specific high impact regulatory decisions. Future assurance measures will form part of directorate action plans and progress reported to council in 2025 update on RFR (Oct 25). • Reg Fairness will form part of the ED&I annual report, and Council will also receive separate annual update on progress.	Low
148	**Delivery of statutory functions** 31/03/2020	Operational	If we fail to deliver our core statutory functions, there is a potential impact on patient safety, public confidence, and the GMC's reputation as a leading regulator.	Charlie Massey	QUITE LIKELY	MAJOR	CRITICAL	• Monitoring and reporting against statutory delivery to Executive Board and Council. • Forecasting of operational demand is built into budget planning. • Active engagement with doctors about potential situations which may put patients at risk. • Outreach structure in place (ensures statutory process for responsible officers to continue effectively) to help identify and manage concerns (pre-investigation). • Available staff with relevant training and skills. • Information exchange with competent authorities informs our processes. • Documented operational process and procedures, that are subject to regular review and continuous improvement by specialist staff. • Auditing our decisions on a regular basis. • Fourth PLAB 2 circuit opened to help manage demand from International Medical Graduates seeking registration. • Digital ID checking in place to verify new registrants' identities accurately and efficiently. • Qualification Application Team are in place to assess international qualifications, to give us additional assurance on International Medical Graduate (IMG) applications and to streamline the process for IMG doctors.	QUITE LIKELY	MODERATE	SIGNIFICANT	Council • Review of performance metrics through the quarterly CEO report. Executive Board • Review of performance metrics through the bi-monthly Performance and Risk Report. • Risk deep dive (Nov 2020, Feb 2022, Nov 2022, March 2023, May 2023).	Internal Audit • Legal Services (May 2022, green-amber). • Clinical Assessment Centre, (2022, green/amber). • Post COVID renewal FTP and MPTS (2022, green/amber). • MPTS Continuous Improvement and learning (2022, green). • Good Medical Practice (2022, green/amber). • Safeguarding arrangements (2022, not rated). • 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) • FtP triage 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 design, green control effectiveness). Other assurances • Covid learning reviews (GMC Case Studies): How the regulator responded to emerging evidence of higher prevalence of Covid-19 infection in BAME people; Temporary registration implementation; The impact of the pandemic on the regulator's corporate strategy/the impact of the strategy on the regulator's response (December 2020). • The MPTS continues to meet our service level agreement to commence 100% of new interim referrals within 21 days. • The MPTS continues to hear reviews of all MPT sanctions and IOT orders within statutory deadlines. • 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 LIKELY	MAJOR	CRITICAL	• Our People practices and leadership strategy is aimed towards attracting and retaining a high calibre workforce. • We have processes in place to identify and manage key staff risks. • We consider recruitment market surveys and data to identify potential skills shortages. • Our Health and safety policies and procedures are robust in regards to our workforce. • Clear Financial management practice and controls and safeguards including around investment (GMCSI), fraud policies and pensions. • New activity, including Gateway Fund initiatives and existing project work routinely considered by Planning Gateway process to form a cross-organisational recommendation on the priority and deliverability of proposals for SMT to consider collectively. • Routine monitoring and reporting of operational performance and the volume and complexity of our work. • Process for regularly mapping workload pressures across teams to help focus resourcing and prioritisation decisions. • We work closely with the Pension Trustees to address the increased scheme liability arising from the Govt decision to align RPI and CPI and other factors affecting the valuation. • The Investment Committee oversees the investment portfolio, supported by professional advisers and fund managers. • We undertake financial stress testing to ensure we have the capacity to withstand financial shocks within our reserve levels. • We continually invest in our IT infrastructure and systems to ensure availability and protect against cyber-security threats and maintain ISO 27001 accreditation. • We have business continuity champions and robust business continuity plans in place that are tested regularly. • We provide mandatory e-learning for GMC colleagues and have support in place from business continuity consultants • Annual training and exercise sessions are delivered for all incident responders. • We have health and safety policies and risk assessments in place to ensure review and maintenance of office facilities. • We have redundancy and backup systems in place for critical IT infrastructure. This includes resilient data centres , backup power supplies, backup and recovery plans, and failover mechanisms to ensure continuity of operations in case of failure. • Industry standard security benchmarks are used at development phase of projects ensuring our systems are secure by design and regular Security assessments take place to validate our position.	QUITE LIKELY	MODERATE	SIGNIFICANT	Council • Review of annual budget and Annual Accounts. Executive Board • Executive Board regular review of finance, HR, project and operational performance and risks.	Internal Audit • Recruitment (2022, green/amber). • ED&I internal target progression (2022, green/amber control design, green/amber control effectiveness). • 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). • MPTS legal arrangements (2024, green/amber control design, green/amber control effectiveness). • Contract Management (2024, amber 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 change priorities, reducing our potential impact on patient safety and doctors' practice.	Paul Reynolds	QUITE LIKELY	MAJOR	CRITICAL	• Engagement with other regulatory bodies to identify opportunities for collaboration and alignment (such as through the Chief Executive Officer Regulatory Body (CEORB) Group). • Proactive engagement on all major policies and issues, including active engagement with the four UK Governments over the future of our legislation, co-ordinated through use of Engage system by external affairs, policy and operational teams. • Development and management of stakeholder relationships of strategic importance at national and regional levels of the UK, supported by relationship plans delivered by our external affairs teams and sponsorship of key relationships by SMT. • Regular evaluation of relationships with key partners, using insights from our internal systems and periodic surveys of stakeholders' perceptions, to identify opportunities for improvement. • Relationship stocktakes on annual basis with Chief Executive and directors. • Relationship plans with external stakeholders are mapped and refreshed annually.	QUITE LIKELY	MODERATE	SIGNIFICANT	Council • Seminar: Findings of our 2022 perceptions survey (December 2022). • Annual update on communications and engagement (including four country update) (June 2023). • Seminar: Findings of our interim perception survey (December 2023). • Seminar: General election preparations and our strategic engagement approach (April 2024). • Annual update on communications and engagement (including four country update) (June 2023) Audit and Risk Committee • Seminar: building the trust and confidence of our audiences and stakeholders (Jan 2022). SMT • Paper on General Election considered by SMT in February 2024.	Internal audit • Managing UK-wide stakeholder relationships (March 2022, Control design - Green; Control effectiveness - Green/Amber). • Review of progress in implementing Outreach (May 2021, Green-amber). Other assurance • Bi-annual health assessments by our external relations teams of GMC's major relationships, next assessment Q1 2024, results due 3 May 2024.	• Results of our 2024 perceptions survey with stakeholders and audiences are now available. Results for national stakeholders have been shared with external relations teams to inform their relationship evaluation and planning. We'll deliver a seminar to Council about the results in December 2024. • We will hold a seminar with Council about our approach to managing our relationships with stakeholders. This has been scheduled for July 2025.	Medium
152	**Unplanned event** 31/03/2020	Reputational	The impact of an event in the external or internal environment causes our systems to be compromised or our activities to be publicly challenged, potentially leaving us vulnerable to delivery of key functions central to patient safety and reputational damage.	Neil Roberts	QUITE LIKELY	MAJOR	CRITICAL	• Crisis management policies (including crisis communications plan) & procedures; pandemic response plan. • Business continuity champions and emergency response plans in place with regular testing. • Mandatory e-learning for GMC staff and support from business continuity consultants. • Continuous proactive monitoring of external environment with processes and products in place to share and escalate emerging issues likely to affect our regulatory operations and external confidence in the organisation. • Arrangements in place between regulatory operations and communications teams to identify and plan for events which could negatively impact on our functions and external confidence in the organisation. • Analysis of range of qualitative and quantitative information about the external environment through the Patient Safety Intelligence Forum. • Regular engagement with the Professional Standards Authority to assure them on the exercise of our statutory powers – including emergency powers under section 18A of the Medical Act 1983 (Covid-19). • Health and Safety (H&S) management system (ie framework of policies and guidance) in place outlining a coordinated and systematic approach to managing H&S risk. • Quality assurance of H&S management system provided through H&S audit process.	QUITE LIKELY	MODERATE	SIGNIFICANT	Audit and Risk Committee • Seminar on Business Continuity and Disaster Recovery - November 2023 and September 2024. SMT • Deep Dive - October 2024.	Internal Audit • Cyber security (July 2021, green-amber). • Cyber security (2023, amber).		Medium
200	**Regulatory Reform** 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	• 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	SIGNIFICANT	Council • Provided an update on progress and programme timelines, an overview of our initial feedback on draft AAPO Order and plans for responding to DHSC's consultation when this goes live - 3 Nov 2022. • Provided an overview of the legislation and our provisional view of the key themes we anticipate raising in our consultation response - 14 Dec 2022. • 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 AAs and PAs, based on provisions in the updated AAPAO. Further sessions delivered on FtP, 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 Sep 2022, June 2022, March 2022, Nov 2021, Aug 2023 and Sep 2024.	• Be prepared to continue to escalate concerns to senior DHSC officials as appropriate. • Paper that went to August 2024 Programme Board to discuss our approach to identifying internal benefits was approved and we're aiming for this work to begin early 2025. We will use the outputs of this work to influence DHSC whilst they draft the next Order and to inform our Rules, to make sure that we remain focused on achieving the intended outcomes and maximise the benefits we're seeking.	Medium
151	**Responding to a changing environment** 31/03/2020	Strategic / Policy	Inability to respond effectively to changes in the external environment, including legislation, healthcare and wider social impact changes, could lessen our influence and relevance and reduce public, profession and political confidence in our role.	Paul Reynolds	QUITE LIKELY	MAJOR	CRITICAL	• Proactive, senior-level engagement with stakeholders to understand their agendas. • Outreach teams structures in place, aligned to UK countries and regions of England, to help us understand and have influence within national and local systems. • Contribution to government and system initiatives across four nations. • Continuous monitoring of our external environment, including longer term horizon scanning and research (e.g. barometer and perception surveys with the medical profession). • Contributing to meetings and networks across the UK and Europe. • Internal governance in place to process, consider and make decisions on the intelligence we receive about the quality and safety of local practice and training environments (JWIG and PSIF meetings). • Systems and products in place to share insights and intelligence from external environment with organisation's leadership community to aid them with planning and decision-making.	QUITE LIKELY	MODERATE	SIGNIFICANT	Council: • Annual update on communications and engagement (incorporating extensive four country update) (April 2022). • Seminar: Findings of our 2022 perceptions survey (December 2022). • Seminar: Findings of our interim perception survey (December 2023). • Seminar: General election preparations and our strategic engagement approach (April 2024). • Communications and engagement priorities (June 2024). Audit and Risk Committee: • Seminar: building the trust and confidence of our audiences and stakeholders (January 2022). SMT: • Discussion about health service winter pressures and GMC response (January 2023).	Internal Audit • Managing UK-wide stakeholder relationships (2022, green control design, green/amber control effectiveness) • IA horizon scanning rated green for both control design and control effectiveness.	• Results of the perceptions survey 2024 with audiences and stakeholders are now available and we will deliver a seminar to Council about the results in December 2024. • Internal audit: review of Outreach is underway, report expected mid-November.	Low
234	**ED&I Strategic Ambition** 02/03/2021	Strategic/Policy	The actions we take to influence change across the health and education system, and within the GMC, do not deliver progress at a pace to meet our strategic ED&I targets, sustaining known areas of inequality.	Shaun Gallagher	HIGHLY LIKELY	MODERATE	CRITICAL	• Clear timebound targets to focus system-wide efforts. • Nominated Executive leads for each of our strategic commitments. • Skilled and resourced teams designing interventions to deliver against the targets. • Established plans of action to deliver against the targets both internally and externally. • Annual and bi-annual progress reporting. • Scrutiny and monitoring and reporting from the ED&I Steering Group, Executive and Council to allow refinement of plans in response to progress. • Established Outreach and engagement functions to understand and influence the system with broader calls for action and support to facilitate system-wide change. • Supporting and aligned commitments of others (ie reducing differentials in disciplinary processes). • Research and data assets including our surveys and insights to highlight relevant issues and support calls for action. • Annual reports published 2022, June 2023 and October 2024.	QUITE LIKELY	MODERATE	SIGNIFICANT	Council • Regular agenda item on ED&I and ED&I annual progress update reported to council in April and published. Executive Board • Twice yearly review by Executive Board and performance against internal targets embedded in Performance and Risk Reporting.	Internal Audit • ED&I internal facing targets reporting (2023, green control design, green/amber control effectiveness). • ED&I external facing targets reporting (2023, green/amber control design, green 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 Tickell (2020).	• Council directed the need to extend our understanding of inequalities impacting on other projected groups, specific disaggregated groups and also intersectional groups. The 2023 ED&I annual progress update (already published) contained some intersectional information and some evidence on the wider work we are doing for other protected group. We will build on this in the ED&I annual report for 2024 (reported to council in July 2024) and also through the regulatory fairness work. • Within the scope of the regulatory fairness work, we will be considering developing inclusive assurance measures at High Impact Regulatory Decision points, workshops have now been completed and we are in the process of consolidating the findings. We have finalised a list of decision points that were approved by SMT in May 2024, alongside the decision making principles. Now both have been approved, they are referenced in the 2024 ED&I Annual report and will be published alongside the report in Sept 2024. We have completed consolidation of the existing and potential assurance measures, and have also finalised an implementation plan framework for directorates, and an implementation toolkit that was issued to directorates in early August. The next phase of work will be focussed on supporting directorates to develop their implementation plans and to coordinate 3 corporate work packages focussed on data and assurance, people processes and support and communication. The next gateway milestone and the planned BDO audit will now both be in 2025. • Workstreams from Dec 2023 audit recommendations continue to report to Council and the ED&I Steering Group, and reports are planned for all workstreams in 2024. The ED&I annual report will include key RFR progress, alongside that, we will be publishing the decision making principles (published) and the high impact regulatory decisions (pending publication) due shortly.	Medium

309	**Safeguarding at the GMC** 12/01/2022	Reputational	Failure to meet our safeguarding obligations by having insufficient policies and guidance in place, staff members who are unclear about their roles and responsibilities due to lack of training and awareness; and insufficient collation of information and data to provide assurance that appropriate steps are taken to protect and safeguard adults and children with whom we have contact. We must be alive to the risk to both the individual and to the reputation of the organisation if we encounter a safeguarding issue which results in harm to a vulnerable person.	Neil Roberts	QUITE LIKELY	MODERATE	SIGNIFICANT	• Safeguarding Working Group in place since 2019 chaired by Director of Resources. • Action plan in place – Project team assembled to take forward recommendations • Designated Safeguarding Manager in post and is providing safeguarding advice and support to staff. A new reporting system for staff to use to refer safeguarding to the Designated Safeguarding Manager. • Comms strategy in place • Pilot completed - 90 referrals made to the safeguarding manager. Analysis has taken place on results along with capacity modelling for gateway. • Gateway and SMT approved our bid for additional resources which includes one permanent Safeguarding Officer and the extension to the secondment of the Safeguarding Project Manager to Dec 2024. • Safeguarding Policy was approved at Exec Board on 30th May. A phased program of training has commenced starting with Resources Directorate. Information on our policy and processes is available for colleagues on our Intranet via a new Safeguarding Hub which helps to raise awareness and knowledge about safeguarding and roles and responsibilities. The risk will remain significant until the policy, process and training has been implemented across all directorates. • Guidance documents for staff and the DSM have been drafted, digital training materials went live in July 2023. • Digital training has been rolled out in Resources, Corporate, FTP, R&R and MPTS. A two day training course for colleagues in these directorates who deal with safeguarding on a regular basis is taking place. • Training delivered to SMT in February 2024 and Council in July 2024.	QUITE LIKELY	MODERATE	SIGNIFICANT	• Presentation given to SMT and Council (Feb 2022) on direction of project. • Policy and release plan signed off by Exec Board in May 2023. • Safeguarding annual report for 2023 was presented to Exec Board in March 2024 and will be presented to ARC in May 2024 and will be presented to Council in July.	Internal Audit • BDO audit - Safeguarding Learning Review (November 2022, Green with advisory recommendations). • BDO and Safeguarding Alliance audit - Safeguarding arrangements (2024, green control design, green effectiveness). Other assurances • Advisory Review conducted by BDO using a specialist social worker to review our practices and recommend action plan.	• Training in MPTS is complete, and has started in R&R. 3 of 4 workshops with ADs have taken place. The release plan is still on track for completion at the end of 2024. • Reporting thresholds will be changed to include colleagues reporting cases of suicide identification to the safeguarding team. This change will take place from January 2025.	Low
303	**Welsh Language Standards Implementation** 28/02/2024	Legal	Since 6 December 2023 the GMC has been subject to the Welsh Language Standards (No.8) Regulations 2022 set by the Welsh Language Commissioner. As we embed the standards in to BAU, it is important for all directorates to continue to engage 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	• Senior Sponsor in place. • Welsh Language Standards Manager role in place from 31 October 2023 until 31 October 2025. • Maintain, quality assure and continuously improve internal and external compliance guidance. • WLSM to manage relationships with external stakeholders including Ateb, Cymen ,Welsh Language Commissioner and Joint Regulators Forum. • The Welsh Language Standards Steering Group (Grŵp Llywio Safonau'r Gymraeg) was established in July 2024 and will be meeting quarterly going forwards. They will oversee ongoing governance of our work and obligations under the standards. The group includes representation from across the organisation and is chaired by the SMT Sponsor for Welsh Language, the Director of Strategic Communications and Engagement. • CRT to manage complaints with support from WLSM who will liaise with the Welsh Language Commissioner in the event of investigations and enforcement actions. • WLSM to handle internal questions and queries regarding compliance via dedicated WLS inbox. • WLSM to advise on Equality Screening Assessments (EQSAs) and Equality Impact Assessments (EQIAs) for projects and policies. • Regular Joint Regulatory Forum meetings in place to align and share information with other healthcare regulators. • Embedding organisational culture that welcomes and understands the Welsh language via internal comms, digital learning, Directorate drop-in sessions and potential Welsh Language Community for speakers and learners.	UNLIKELY	MODERATE	low	Project Board • Proposed recommendations from compliance readiness review were approved on 14th March 2024. • A plan to transition the project work into BAU was signed off by Project Board at their final meeting on 8 May.	Internal Audit • Preparation for implementation (2023, green/amber control design, green/amber effectiveness). • Compliance readiness review (2024, green/amber).		Low
27	**Deriving more insight from our data capability** 31/03/2020	Strategic / Policy	Developing, sharing and working with others using our insight capability provides an opportunity to shape public debate, influence the external environment and deliver more proactive regulation.	Shaun Gallagher	QUITE LIKELY	MAJOR	GOLD	• Use of our research and insight activity to highlight key issues facing the medical profession, suggesting courses of action which healthcare systems can take to tackle workforce and workplace issues that might directly or indirectly impact on patient safety. Take every opportunity for it to contribute to mailouts, briefings and other external engagement. • Leverage our communications channels (such as media and social media) and engagement opportunities to raise awareness of our research and insights and secure external support for the issues and recommendations we are highlighting. • Use new data and research insights as a 'peg' for bringing together regulatory partners and key stakeholders together to drive positive changes in policy and practice. • Provide data support to the rest of the GMC to inform our response external developments such as the Lord Ara Darzi review. • Provide data to support the development of policy and process plans for AA and PA regulation, regulatory reform, and education reform.	HIGHLY LIKELY	MAJOR	GOLD	Executive Board • Risk 'deep dive' (July 2023).	Internal Audit • Arrangements for assessing progress in the delivery of the Corporate Strategy (July 2021, green-amber). 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 new platform for our data that will allow more interactivity and self-service. As well as developing a GMC data hub bringing together all our data into a single entry point on the GMC web site, with further development through 2024. • Developing data, research and insight capacity in relation to PAs and AAs.	High
28	**Working with patients and public** 31/03/2020	Operational	Understanding and improving the experiences which patients and the public have of our regulatory services and involving them effectively in our work (such as strategy and policy development) will help us gain their trust and confidence and make us a better regulator.	Paul Reynolds	QUITE LIKELY	MODERATE	SILVER	• Champion for patients established at SMT level to ensure senior-level overview of our engagement and signal importance of this to organisation. • Strategic ambition to improve patient and public involvement and long-term outcomes agreed. • Clear information easily accessible for patients and public about how we work and can support them (such as on our website). • Involvement of patients and the public in our policy development activity in a variety of ways including public consultations and the commissioning of independent research, supported by information and guidance for policy and operational teams to aid their work in this area. • Regular assessment of patients and the public's perceptions of the GMC and experiences of our work through regular evaluation and research (such as our perceptions survey). • Regular engagement with patient leaders in all four countries of the UK (by our senior leadership team as well as our bi-annual roundtable, UKAF meetings in the devolved nations and other activities). • 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	MODERATE	SILVER	Council • Update on patient and public involvement (November 2022). • Update on communications and engagement (June 2023). • Update on patient and public involvement (November 2023). SMT/Executive Board • Deep dive(December 2023). Audit and Risk Committee • Review of arrangements for patient and public engagement (November 2022). • Update on how we involve patients and the public in our work (March 2023).	Internal Audit • Review of arrangements for patient and public engagement (November 2022, Control design: Amber; Control effectiveness: Amber). 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.	• Council will receive a comprehensive annual update in December 2024 about our work with patients and the public. • We surveyed patients and the public as part of our perceptions research in the summer of 2024. The results of the survey are being finalised. Results specific to patients and the public will be reported to Council in December 2024 as part of our annual update. • Our next roundtable with patient bodies is scheduled to take place on 7 November 2024. Agenda items will include the Medical Practitioners Tribunal Service's proposed changes to sanctions banding, our next corporate strategy and an update on our plans to bring PAs and AAs into professional regulation at the end of 2024. • Our Contact Centre has procured a new omni-channel system which is capable of delivering automated customer surveys and providing granular analysis of those survey results to help us understand the experiences of different customers (including patients and the public). The Contact Centre team plans to deploy these surveys in 2025. • Our Fitness to practise directorate is developing plans for a pilot in 2025 that will help them test ways of seeking feedback from users of its services. • Our Fitness to practise directorate has commissioned research that it will help it to understand the public's views on where our thresholds should sit in public confidence cases. The research is due to begin in January 2025 and report in the autumn of 2025. • We are currently exploring themes for our next corporate strategy including, among other things, how patient involvement and insights might inform our work as a regulator over the next five years.	Medium
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 medical professionals.	Jane Durkin	QUITE LIKELY	MODERATE	SILVER	• Our Corporate Strategy 2021-26 includes clear commitments to be a more responsible organisation both socially and environmentally. Every GMC Annual Report includes a CSR round-up of the previous year. • We have improved external visibility of our CSR work on the GMC website and internally on the GMC intranet. .We have used blogs to promote our support for widening participation (in medical training) initiatives and consideration of the regulatory challenges posed by 'sustainable healthcare'. • The GMC established the Cross Regulator CSR Group early in 2022 after the proposal (by the GMC) was agreed by the CEORB group. This meets quarterly and from mid-2023 includes representatives from the Greener NHS Team. • External recruitment campaigns now include reference to our CSR initiatives with the intention that this will be a 'pull' factor for potential candidates. • The GMC is increasingly engaged with new stakeholders, such as KPMG, on regional and national CSR bodies. These are new relationships which are increasing the profile of the GMC beyond the regulatory, health and education sectors. • CSR project closed in June 2023; project closure report completed with most initiatives now embedded as BAU. • Sustainability Working Group, sponsored by director of Resources, established at end of 2022. Whilst this has a broader remit than the CSR project, it will also support achievement of this opportunity. • CSR Community of Interest established in August 2023 to help BAU teams identify dependencies and mutual interests. This will also assist in maintaining oversight of CSR related activities across GMC.	QUITE LIKELY	MAJOR	GOLD	Council • Annual update on progress for Council given in March 2023. SMT • Opportunity deep dive completed in February 2024.	Internal Audit • Review of ESG, (March 2022, amber).	• GMC sustainability statement is currently being drafted, this will demonstrate a broad statement in time and frame our offering around sustainability - Q4 2024.	High

General Medical Council

2025 Budget and Business Plan

Action	To approve
Purpose	This paper sets out our 2025 priorities and associated budget required to deliver it.
Decision Trail	Council considered the approach to setting the fee increases and pay budget at its meeting in October. At its meeting on 25 November Executive Board reviewed the draft budget and has recommended the current version to Council for approval.
Recommendation(s)	**a** To approve the draft Business plan and Budget for 2025. **b** To approve and sign the Fees Regulations attached at Annex F. **c** To approve the proposed changes to performance measures reported to Council for 2025, at Annex H.
Annexes	Annex A: 2025 draft Business Plan Annex B: 2025 Budget and 2026-2027 Forecast Annex C: Income and expenditure movements Annex D: Reserve Scenarios Annex E: Reserves projections Annex F: Registration Fees Regulations 2025 **and** Specialist Fees Regulations 2025 Annex G: Contract and accommodation details Annex H: 2025 performance measures
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Sponsoring director/ Senior Responsible Owner	**Neil Roberts**, Director of Resources **Shaun Gallagher**, Director of Strategy and Policy

Agenda item M4
2025 Budget and Business Plan

Background

1 The Corporate Strategy sets out the strategic direction of the organisation and the Business Plan sets out the immediate priorities. Our priorities and the resources required to deliver them determine our budget.

2 This review also lends itself to the review of our corporate reporting measures. As such in considering our strategic direction, we have aimed to build on the changes made in the prior year to further enhance the monthly reporting to Council to ensure the most effective monitoring of these priorities.

3 At Council, in October we identified an increased financial pressure moving into 2025 principally owing to a requirement to invest in a replacement for our Enterprise Resource Planning (ERP) system, Agresso, coupled with a decline in demand for our PLAB services. Council encouraged us to continue to manage our free reserves position and target the mid-point of our free reserves thresholds (20%-35% of expenditure) in the medium term. This approach will offer financial resilience in response to economic 'shocks', and it was on this basis the Budget and two year forecast was developed.

4 As part of these discussions, Council approved setting the fee increase in line with September CPI, which will apply from April 2025.

5 To support those previously reported budgeting priorities, we have undertaken the business planning and budget process in broadly the same way as previous years including the use of budget scrutiny to effectively challenge budgetary inputs. We have sensitised the budget, with respect to key risks to ensure its robustness.

2025 – 2026 priorities

6 We continue to maintain an internally published list of cross-GMC priority change projects, namely the 'corporate portfolio'. This is reviewed quarterly by the Planning Gateway and Executive Board. Periodically, we also carry out a more in-depth analysis of this list. The most recent in-depth analysis was conducted in April/May this year and signed off by executive Board, at which point we also introduced a more robust prioritisation framework. The result is a more rationalised list of priorities. The new framework means we prioritise all projects against the same criteria and factors, which increases the consistency and transparency of our approach. We plan to undertake another holistic prioritisation exercise mid-2025.

7 As part of our development of the new corporate strategy – which will cover the period 2026-2031 - we will consider how to integrate the prioritisation framework and the revised corporate strategy.

8 The current list of cross-GMC projects has nine priorities, which are set out in the draft Business Plan at Annex A. The Plan is broadly the same as last year but key changes include:

- Updated terminology to reflect that we will be a multiprofessional regulator in 2025.
- Updated PA and AA programme narrative to reflect the fact they will be professions regulated by the GMC and that our focus will shift to registration of individual AAs and PAs.
- Updated narrative of work on the future of education and career development to reflect current thinking and work on this programme.
- Addition of our work to implement a modern multichannel system into the Contact Centre and also the new ERP system.
- Removal of the transition to Welsh Language Standards programme, Good Medical Practice project and work to expand our registration pathways, as these have transitioned to business as usual (BAU) and will not be a priority for 2025.

9 We expect these priorities to be significant commitments, most of which extend beyond 2025 and will therefore be highly relevant as we develop the next corporate strategy.

Performance measures

10 Alongside renewing our change priorities, we conducted our annual review of corporate performance measures to ensure these remain relevant and fit for purpose. We have proposed two changes. Firstly, updated diversity targets for 2025 to replace our 2024 targets. The approach taken is to incrementally increase percentages each year as we strive towards reaching our overall targets for the end of 2026. The second change is a proposed increase in the target Net Promoter Score (NPS) for our external website satisfaction measure. Having consistently met the current target (NPS 30) we propose increasing this to a NPS of 40. Annex H illustrates how the corporate performance measures will look with these two amendments. We ask that Council approve these proposed changes. If approved, these changes will be implemented for 2025 reporting.

11 We are also reviewing our initial approach for reporting on Physician Associates (PAs) and Anaesthesia Associates (AAs) during the first part of the two-year transition before registration becomes mandatory. Our focus in 2025 will be registering these professionals and closely monitoring volumes against relevant processes and observing any trends or nuances to help us identify whether any changes are needed to processes or resourcing during the transition period.

2025 budget – Financial context

12 We originally targeted a Budgetary out-turn of £3.5 million in 2024, with similar surpluses throughout 2025 and 2026 to build our reserves balances towards the mid-point of our

reserves target by the end of 2026. Significant returns on our investments in the final 5 weeks of 2023 reduced the pressure on future year surpluses to meet that target.

13 We are currently broadly achieving the mid-point of our reserves target, and we are forecasting a total surplus in the region of £6.6 million in 2024, some £3.2 million ahead of our planned position. Points of note:

- Lower utilisation of the Contingency and Gateway funds than anticipated, in total c. £2.1 million unlikely to be expended.
- Upside in our budgeting for accommodation with electricity costs being lower than those anticipated, and additional credits relating to a prior year being received (£0.6m). This is not fully replicated in the 2025 Budget.
- We prudently assumed investment income would generate returns of £1.0 million in 2024, given losses accruing for most of the 2023 financial year and historical volatility. At the end of October, we were around £0.5 million ahead of this budget but seeing significant fluctuations month to month.
- Higher than budgeted work to deliver AA/PA regulation in 2024, was agreed with the Department of Heath and Social Care in Q1 of 2024 as such we were able to recover more costs incurred in programme delivery, including overheads.
- Offsetting this is a reduction in PLAB demand, which sees us forecast £1.6 million lower income and c. 70% lower associated costs.

14 There continues to be uncertainty heading into 2025, which may impact the Financial out-turn:

- We have ongoing legal cases, which may result in both one off and ongoing costs. Notably remaining uncertainty around the financial impact of associates as workers, however subject to further legal advice this has the potential to increase reserves if we are able to release part of our provision.
- Work continues to deliver changes for our regulatory reform programme, and we anticipate it will be several years before the additional investment on this programme will end.
- Uncertainty around the demand for PLAB, and the ongoing levels of registration income derived from International Medical Graduates (IMGs), which in turn has an impact on the register growth rate. This has been a key driver in the scenario planning for 2025 and is addressed further from paragraph 20.
- Investment of £2-3 million per year until 2027 in implementing a new ERP system to replace our current system, Agresso.

- Our pension top-up payments revert to £1.5 million from 2026. The triennial valuation will complete in 2025 and will include a new recovery plan.

15 Our planning assumptions include a pay budget increase of 2% above the September CPI rate and this has been applied within the 2025 Budget and Forecast to 2027.

16 The Office for National Statistics released a CPI figure of 1.7% for September. We are therefore proposing a fee increase of 1.7% and a pay budget increase of 3.7% both with effect from 1 April 2025. These are the assumptions included in the budget presented in Annex B.

17 Overall, the surplus on the 2025 Budget is £1.3 million. While the levels at which they are held have been adjusted year on year, the expenditure lines include both a Gateway fund and a contingency to ensure continued targeted investment, and to recognise the wider risks present resulting from ongoing uncertainty in the current economic climate.

2025 budget – Fees & income

18 In 2025 we are proposing to increase the fee in line with CPI released in September. Applying that, a 1.7% increase to our schedule of fees results in the following key changes:

		2025 £	2024 £
Newly qualified doctors	Provisional Registration fees	25	25
	Full registration	177	174
	Annual retention fee (years 2-5)	177	174
Other doctors	Full registration	463	455
	Annual retention fee with a licence	463	455
	Annual retention fee without a licence	166	163
Other fees	PLAB test – part 1	273	268
	PLAB test – part 2	998	981
	Portfolio pathway to specialist & GP registration*	1,902	1,870
	Other pathways to specialist & GP registration^	497	489
	AA / PA Registration	320	325

19 The fees above, and that we charge to doctors are set out in the General Medical Council Registration Fees Regulations 2025 and General Medical Council Specialist Fees Regulations 2025, at annex F.

20 No additional changes to fee levels are proposed to take effect in 2025, however we propose to increase the income discount in line with the increase in fees, to £37,000 (2024: £36,000) from 1 April 2025. While this adjustment is relatively modest the income discount is funded predominantly by the ARF and therefore any increase to the discount threshold creates upward pressure on the ARF.

21 Council is asked to approve these regulations and for designated parties to sign and apply the official seal.

22 Based on the above fee increase and a modelling assumption of increased register growth rate of 3.5% in the period 2025 – 2027, the total operational income budget for 2025 of £164.2 million, of which fee income accounts for £163.8 million.

23 The most significant movement between 2024 and 2025 budget setting is linked to our assumptions around the demand for PLAB.

24 We had previously reported that a reduction in demand for PLAB places, depending on the extent, constitutes a significant financial risk for us. Although we would see a drop in associated variable cost of holding examination days, our financial stress testing analysis indicated the anticipated lag between income reducing and our ability to remove fixed costs from our cost base would create additional short-term pressures on our finances.

25 We advised Council in October that we were starting to see a behavioural shift from PLAB candidates with lower demand on both PLAB 1 and PLAB 2. It remains uncertain whether this is a merely a delay in uptake, for PLAB 1 to PLAB 2 conversion, or a prolonged decline.

26 We still understand, based on anecdotal evidence, that the primary factors in the shift in demand are the high degree of competition for entry level roles within the health service coupled with this are increased opportunities to work in other countries.

27 However, a survey was undertaken in October of candidates having recently passed PLAB 1. The survey had a 24% response rate and the respondents predominantly indicated plans to sit PLAB 2 but with a larger break between exams than historically seen. This has been factored into our assumptions for budget setting.

28 As a result, we have reduced PLAB 1 and PLAB 2 volumes within the budget by 17% and 32% respectively when compared to 2024 levels. We have assumed these reduced levels are held through to 2027 with no further decline.

29 In looking at PLAB we have also looked at other income streams linked to IMGs and noted a plateauing of registrations in this area so have reflected volumes at an equivalent level to 2024 actual applications in the 2025 budget.

30 For 2025 we have included a £1.5 million budget for income generated through our investment with CCLA, compared to a budget of £1.0 million included in 2024. The risk of investment volatility remains, however given a proposed target return of CPI plus 2%, and improved performance throughout 2024, we thought it sensible to reflect the returns in our budget.

31 We have also set our interest income budget at £1.5 million, reducing to £1.0 million by 2026. This reflects the current high interest rates being received but an expectation that the base rate will be cut in by the bank of England as we align with our inflation targets.

32 The draft 2025 income budget is £167.2 million. An analysis of the changes from 2024 to 2025 is at Annex C.

2025 budget – Expenditure & Surplus

33 We have used the 2024 forecast of actual expenditure as our starting point for the 2025 budget, adjusted to reflect:

- The full year effect of 2024 business plan decisions and in-year allocations from the Gateway fund.
- The removal of 2024 costs that are not required in future years – largely volume changes and one-off project costs.
- A pay budget increase of 3.7% from April 2025. The final structure of the award will reflect our priorities on recruitment and retention and our continued focus on reducing pay gaps, or keeping them narrow where this is already the case. This reverts to 4% in the remaining forecast period.
- A staff churn adjustment of 4.25% on average across the business. The level of churn is consistent with the prior year however, we have flexed the churn slightly across the directorates to align more closely with historic vacancy trends.
- Additional payments approved by Council in June 2023 to address the deficit on the defined benefit scheme. We will continue to pay £1.5 million per annum until 2030, with a further £1.0 million approved top-up in 2025 respectively.
- Investment in the ERP/HCM solution has been included in the budget based on Executive Board approvals on 30 September. We have included £3.5 million, £2.7 million and £1.2 million in 2025-2027 respectively. Only specifically approved costs have been allocated within the budget, with the remaining held in contingency amounting to £1.1 million, £1.2 million and £0.9 million in each respective years totals. This reflects the uncertainty around the HCM element of the implementation, and we have therefore included what we believe to be the maximum cost in each financial year.
- The Budget announcement of the 30 October which increased Employers NI by 1.2% to 15% and reduced the threshold over which Employers NI is payable. This increased our total staff cost by around £1.4 million in 2025 Budget and £1.9 million in 2026 and 2027.

34 While developing the 2025 expenditure budget we built upon the budget scrutiny process, feeding in learnings from the 2024 mid-year review to ensure we effectively deliver our strategic aims and constrain growth within the financial envelope provided by our income. The core aim of this was to identify targeted expenditure reductions.

35 It is important to note the quality of the first draft of the budget, underpinned by submissions from the directorates, which were all well considered and realistic. They all recognised the financial pressures and made efforts to recycle existing resources where possible.

36 We therefore used the scrutiny meetings to test budget submissions in key areas and determine the appropriate balance of constraint on Business-as-Usual Activity (BAU) through directorate budgets and future investment, via the Gateway. Areas considered were:

- Volume assumptions in operational areas.
- In non-operational areas asking directors to review call on Gateway pipeline and to consider further a greater degree of internal prioritisation.
- Contingency, which was factored in at £0.75 million. This was included to cover:
  - Potential roll-forward of Gateway funds due to delays, rather than separately coming to council to request the change in budget bottom-line.
  - Volume assumptions
  - Inflationary pressures not yet fully realised through renegotiated contracts and therefore not reflected within the directorate budgets.
- Gateway initially budgeted at £3.0 million plus any potential draw down approved through Q4 Gateway 2024 with a maximum impact of £1.1 million, £3.1 million and £3.0 million in each year 2025-2027.

37 In response to the material increase in National Insurance, we constricted the year 1 Gateway fund to £1.5 million in all of 2025-2027 which is more reflective of actual in year approvals through the Gateway, and reduced the contingency to £0.5 million in 2025. We believe the choices made will not seriously undermine our planned work to support the final year of the current corporate strategy.

38 The total 2025 expenditure budget is £165.9 million, with a surplus of £1.3 million. Budget details are at Annex B and an analysis of expenditure movements between 2024 forecast and 2025 budget is in Annex C.

2025 budget – reserves policy and forecast

39 We measure our financial health by the level of our free reserves. We hold reserves for the following reasons:

- To provide working capital to undertake ongoing business.
- To provide funds to deal with any risks that materialise, resulting in an unexpected increase in expenditure and/or a reduction in income.

- To provide funds to respond quickly to new initiatives, opportunities and challenges that may present themselves during the year.
- To cover the time-period before any changes to fee levels take full effect.

40 There is no set formula to calculate the appropriate level of free reserves. However, in line with Charity Commission guidance we set reserve parameters of 20%-35% of expenditure which allows the level of our reserves to reflect the growth in the organisation and the risks we face.

41 Council confirmed, in October 2024, that our medium-term aim should be to fall as close to the mid-point of our reserves targets as practicable to ensure continued resilience against shocks.

42 Our latest projections show that free reserves will be c. £51 million at the end of 2024, which falls around the mid-point of our reserves thresholds. The 2025 budget, plus 2 year forecast to 2026, would see free reserves sit at £54 million, slightly ahead of the mid-point of our reserves. Annex E shows our reserve projections through the medium term.

43 We as an institution are subject to a number of risks both internal and external, which could have a financial impact. We have completed some sensitivity modelling to test the risks on our reserve levels. Annex D sets out risks and their likely impact.

44 We acknowledge the uncertainty around income streams linked to IMGs. For this reason have aimed for our operational position net of the ERP investment to remain at least breakeven across the forecast period, with small surpluses being generated at a total surplus level despite the ongoing investment. This ensures that we position ourselves in the upper half of our reserves parameters and allows us greater financial resilience and time to modify spending plans should we see a further decline in these income streams from forecast levels.

45 We believe that by being surplus generative into the medium term and maintaining a healthy free reserves position that we appropriately balance any future financial risks and ensure appropriate resources to deliver our strategic ambition and withstand shocks in the short and medium term.

Financial regulations

46 Further to Council's prior discussions, we will be proposing revisions to financial regulations to provide greater clarity over the approval process for significant financial commitments as part of a paper in early 2025.

47 Annex G sets out the contracts of significant financial value we have in place in addition to the estate lease commitments.

General Medical Council

Annex A

2025 draft Business Plan

General Medical Council

Our 2025 priorities to support our corporate strategy

Our 2030 vision is to be an effective, relevant, and compassionate regulator for patients, the public, professionals and as an employer. Our core role is to deliver flexible and responsive regulation that protects patients, supports professionals to deliver quality care, and meets the needs of the UK health system. To do 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 and training 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 our doctors, PAs or AAs, may be at risk, and take action if needed. Given the unprecedented uncertainties and challenges facing the UK healthcare system, we'll continue to:
    - listen to the experiences and needs of patients, the public, and our registrants to inform our priorities
    - use evidence and data to maximise the part we play in responding to those challenges.

Our focus in 2025

We are now in the final year of our current five-year corporate strategy (2021–2025). Our focus in 2025 will be to build on the progress we've achieved so far, focus our efforts on our priority areas and progress work to develop our next corporate strategy. The next corporate strategy will run from 2026-2031 and will continue to support work to achieve our 2030 vision.

Our assessment of progress shows that we've started, and in some cases completed, much of the planned work relating to the current corporate strategy. We have introduced the Medical Licensing Assessment (MLA) and 2025 will mark our first year as a multiprofessional regulator as we start the regulation of PAs and AAs. Compassionate regulation will continue to be a priority. And we expect to see the projects and activities we started under the *Making every interaction matter* and *Developing a sustainable medical workforce* theme start to gain momentum.

However, many of the long-term outcomes and impact will only be fully realised once the current strategy has ended. This is the case for some of our large change projects and ambitions, such as:

- regulatory reform
- embedding the regulation PAs and AAs within GMC regulatory business
- our equality, diversity and inclusion (ED&I) targets.

We're now in a stronger position to consider the opportunities that lie ahead, such as those provided by regulatory reform, our future role as a multiprofessional regulator, and how we can collaborate with others to make us more effective. We will use our position to inform and influence the work being undertaken across the four countries of the UK in relation to workforce planning.

Delivering our statutory functions

In 2025, in relation to doctors, we expect to:

- process **c.43,000** revalidation recommendations
- support **c.27,000** first-time applicants to join the UK register
- review **c.11,200** concerns raised with us
- Take further action in response to concerns in the form of running approximately **300** Medical Practitioners Tribunal Service hearings
- visit **15** new medical schools or new medical programmes and use our proactive quality assurance process to review **14** postgraduate training organisations and **39** established medical schools
- review **106** postgraduate curricula and their programmes of assessment to make sure that they continue to meet our standards
- respond to **c.475** ethical enquires in relation to our professional standards
- host over **1,000** events, engaging with over **45,000** doctors and students
- host over **150** Welcome to UK Practice events and in doing so, support more than **11,250** international medical graduates new to UK practice
- approach **65,000** doctors in training and **55,000** trainers to understand their views on training, and on the quality of postgraduate medical education through our national training survey.

We will develop our PA and AA targets as we embed their regulation.

Making every interaction matter

Regulatory reform

We're moving into the next phase of our work with the Department of Health and Social Care (DHSC) to implement changes to our legislation to reform the way regulate. The primary focus for this year will be working alongside DHSC while they draft and consult on new legislation that will replace the Medical Act 1983. Our focus will then turn to developing the new legal framework, rules, policies, and processes that will sit across all our regulatory functions. The development of this framework and the introduction of these changes will continue into 2026 and beyond.

We will continue to engage with key stakeholders on what the legislative changes will mean for the way that we regulate, and where possible, to take a co-production approach to the design of some of our key processes.

Regulatory reform will change the way we regulate and give us more flexibility to set our own rules and change the way we work in the future when evidence suggests there are improvements that can be made. This will enable us to be more supportive, inclusive, and compassionate in the way that we regulate. It will also provide greater consistency between us, and other regulators.

Regulation of physician associates and anaesthesia associates

In 2025 our primary focus will be getting existing and newly qualified PAs and AAs onto our register. We'll also support improvements in PA and AA training through our education quality assurance and approval processes. Alongside this we will continue to embed our regulatory framework for these professionals, including developing policies for revalidation.

Continuing the transformation of our customer interactions

We will continue our work to implement a modern multichannel system into the Contact Centre, after the successful introduction of a new telephony system in 2024. In 2025, we will introduce features such as enhanced webchat and mobile messaging to increase and improve the ways our customers can contact us. These changes, alongside improvements to how the Contact Centre operates will ensure that we continue to deliver an exceptional experience to all our customers with every single interaction.

Associate worker status

We will develop our systems and processes to facilitate the implementation of worker status for eligible groups.

Developing a sustainable medical workforce

The Medical Licensing Assessment (MLA) population

We've embedded the new MLA in final exams for newly qualified doctors in the UK and are delivering it to international medical graduates. The assessment improves consistency in the levels of core knowledge, skills, and behaviours required of doctors practising in the UK.

We will introduce a monitoring system to check ongoing compliance of the assessment and in 2025 we will publish an updated version of the MLA content map, which was originally published in 2019, after further engagement with stakeholders.

The content map is a live document and we're committed to keeping it up to date with timely revisions to ensure it continues to set out the core knowledge, skills and behaviours that are essential for a newly qualified doctor to be ready for safe practice, manage uncertainty and deliver patient centred care when entering UK medical practice.

Engaging on the future of education and career development

We're continuing our work to review the education framework that sets out our expectations for the quality and outcomes of education to reflect the needs of a changing UK population.

In 2025, this will include extensive engagement across the UK with the organisations we work closely with, other partners in the sector, and the people who will benefit from the changes – doctors, PAs, AAs, patients, and the public.

We will work collaboratively to make sure our future regulation helps to drive much needed improvement and innovation in the sector while continuing to protect the public. In doing so, the sector needs to:

- improve support for a larger, more diverse pool of multiprofessional medical educators

- support changes in pre-qualification education by encouraging innovation and diversity in programmes that meet our standards
- make post-qualification career pathways more accessible for a changing workforce so that they are flexible and easier to navigate—this will involve considering the role of assessment, encouraging ‘generalism’ and improving quality and consistency in lifelong learning.

Investing in our people to deliver our ambitions

Continuing to attract and retain talent

We’ll continue to attract and retain diverse talent, including maintaining a competitive package for new recruits and existing staff, and building resilience for our future skills requirements. We’ll ensure that our employment practices on pay, performance, progression, and engagement are fair and consistent. We will also be investing in a new Enterprise Resource Planning (ERP) Product for our Human Resources, Finance, Payroll, Subscription Billing and Employee self-service processes.

Enabling professionals to provide safe care

Fairer regulatory outcomes

We continue to deliver against the aims in our corporate strategy 2021–2025 to foster a culture of equality, diversity and inclusion (ED&I) in everything we do and make sure ED&I is an integral part of our work both as a regulator and employer. This includes continuing to deliver our equality aspirations. And working with others across the system to address long-standing inequalities and the impact of racial discrimination and disadvantage.

We have four projects which will help us focus on delivering against our aspirations to address inequalities and make sure fairness remains central to our work. Our ambition is to make sure that our work on ED&I improves trust and confidence in the GMC as a fair organisation.

- We will continue to make fairness central to our work by eliminating differentials in employer fitness to practise referrals.

- We are progressing the programme of work to eliminate discrimination, disadvantage, and unfairness in education and training pathways by 2031.

- We will continue to implement the findings of the 2022 internal regulatory fairness review to further enhance the safeguards and controls we have in place for ensuring fairness and mitigating against bias in our high impact regulatory decisions.

- We will begin a project to enhance how we collect, use, and monitor diversity data across our regulatory activities. This will deliver improvements to the quality of our diversity data. And enable us to take action to reduce the potential for barriers or unfairness in our activities for groups who share protected characteristics.

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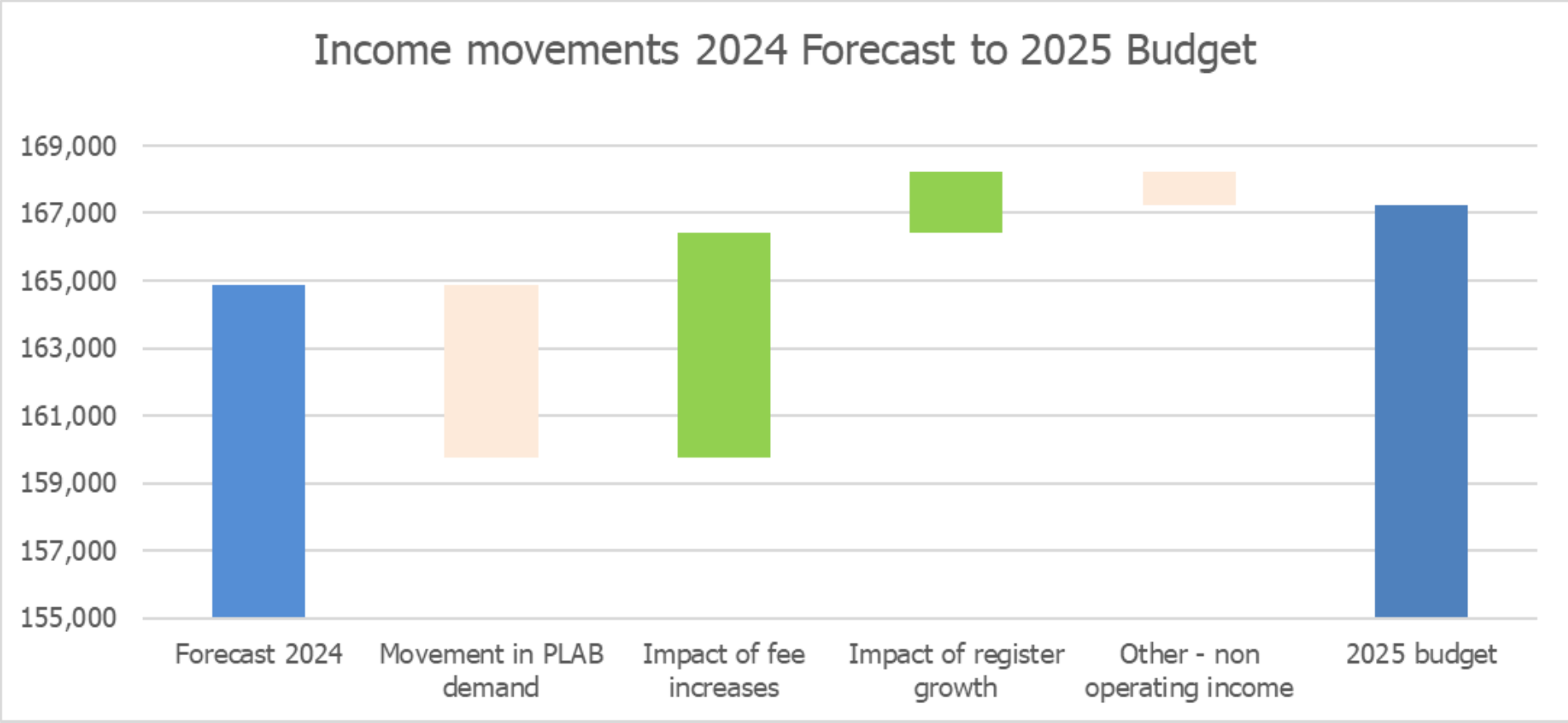
Annex B

2025 Budget and 2026-2027 Forecast

Financial summary	Budget 2024 £000	Budget 2025 £000	Forecast 2026 £000	Forecast 2027 £000
Operational income	**162,663**	**164,245**	**170,827**	**178,490**
Operational expenditure	143,135	146,706	152,321	158,479
Central costs	6,407	5,564	8,124	11,158
Capital Expenditure	12,583	10,167	9,959	9,172
ERP Expenditure		3,501	2,688	1,179
Total Expenditure	**162,125**	**165,938**	**173,092**	**179,988**
Operational surplus/(deficit)	**538**	**(1,693)**	**(2,265)**	**(1,498)**
Interest Income	2,030	1,509	1,019	1,019
Investment Income	1,000	1,500	1,500	1,500
Total surplus / (deficit)	**3,568**	**1,316**	**254**	**1,021**

Annex C

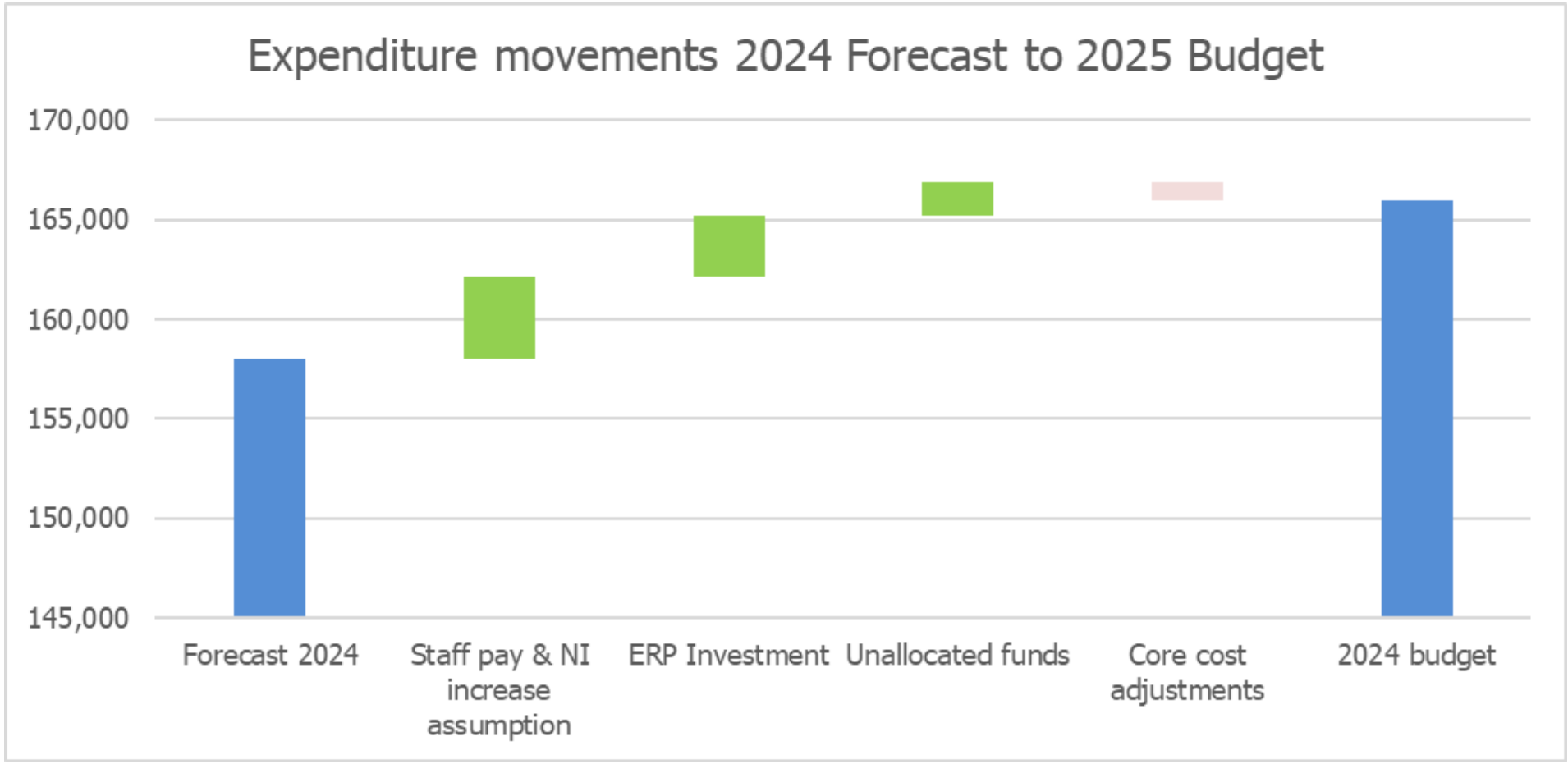
Income movements



Agenda item M4

Business Plan and Budget 2025

Expenditure movements



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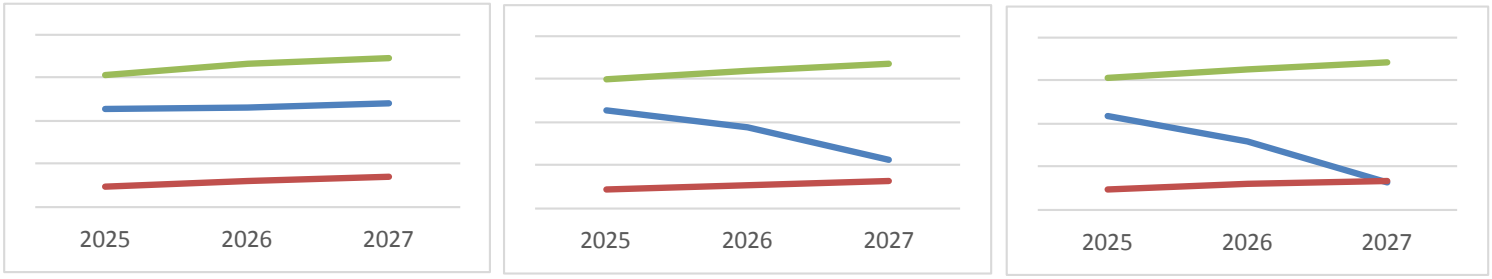
Annex D

Reserve Scenarios

	Base case	Scenario 1	Scenario 2
Surplus / (deficit)	*£'000*	*£'000*	*£'000*
2025	1,316	1,316	316
2026	254	(4,048)	(6,048)
2027	1,021	(7,504)	(9,504)
Reserves	*£'000*	*£'000*	*£'000*
		51,393	*51,393*
2025	52,709	52,709	51,709
2026	52,963	48,661	45,661
2027	53,984	41,158	36,158



Scenario 1: Assumes a further 20% decline on PLAB and IMG applicants in 2026 and then a further compounded 20% decline in 2027. Plus the resultant impact on register growth, reducing to 3% (assuming no other changes in growth rate).

Scenario 2: As per scenario 1, plus the impact of pension top up payments being increased to £3.5 million per annum (in budget at £2.5 million (2025), £1.5 million (2026/2027))

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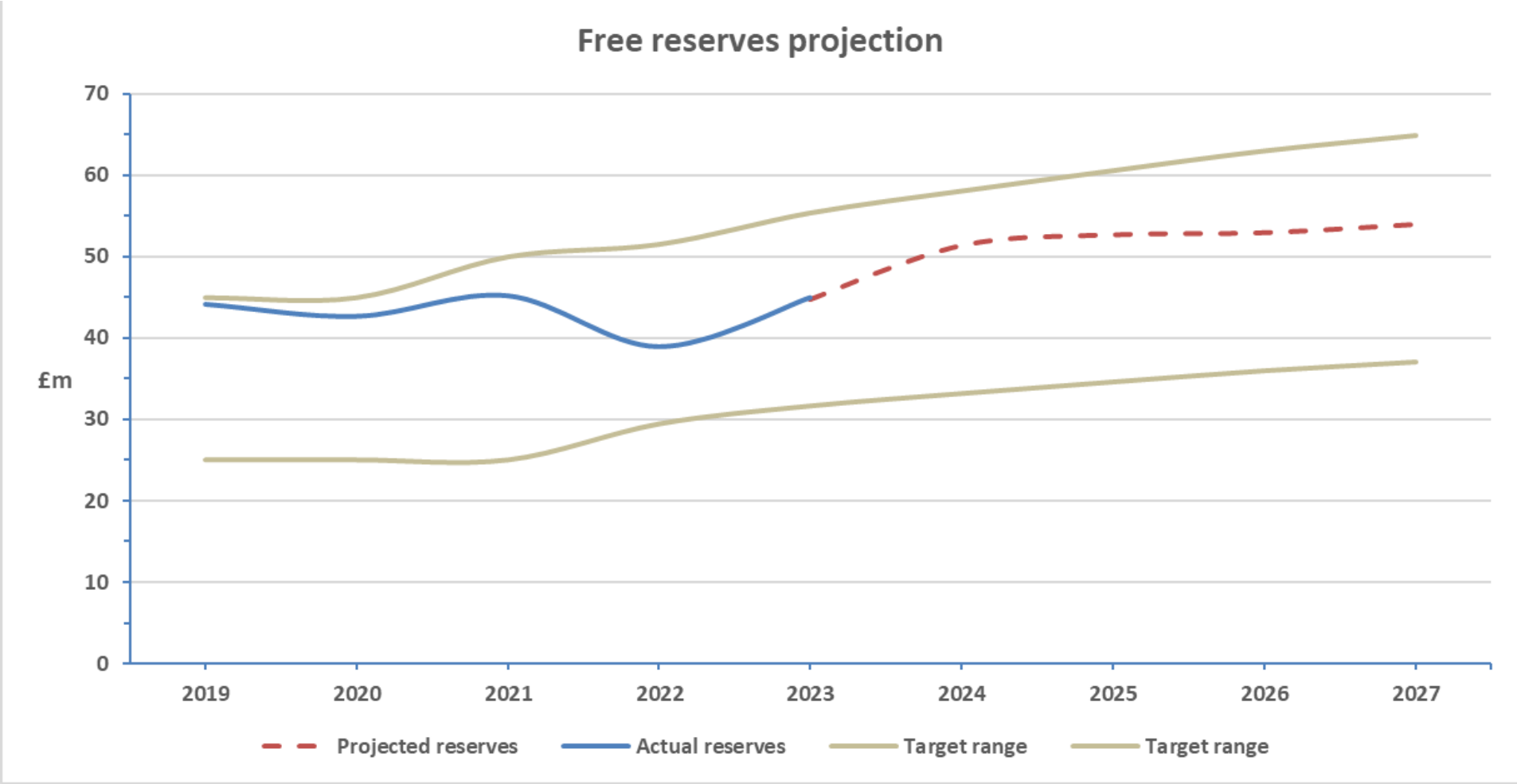
Annex E

Reserve Forecasts



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Annex F

Registration Fees 2025 and Specialist Fees Regulations 2025

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.

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Annex G

Contract and accommodation details

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.

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Annex H

2025 performance measures

After reviewing our targets we have proposed one change for 2025 highlighted below.

		2023			2024								
Indicator		**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**
Operations	Decision on 95% of all registration applications within 3 months	97%	97%	98%	98%	98%	98%	99%	100%	99%	99%	99%	98%
	Decision on 95% of all revalidation recommendations within 5 working days	99%	99%	99%	99%	99%	99%	99%	99%	99%	100%	99%	99%
	Respond to 90% of ethical/standards enquiries within 15 working days	98%	100%	96%	100%	100%	92%	94%	98%	98%	98%	96%	96%
	Conclude 90% of fitness to practise cases within 12 months	96%	97%	95%	96%	96%	97%	95%	96%	95%	96%	95%	93%
	Conclude or refer 90% of cases at investigation stage within 6 months	97%	97%	97%	98%	97%	99%	98%	97%	96%	97%	95%	96%
	Conclude or refer 95% of cases at the investigation stage within 12 months	98%	98%	98%	98%	98%	98%	98%	98%	97%	98%	96%	96%
	Commence 100% of Investigation Committee hearings within 2 months of referral	No Cases	100%	No Cases	No Cases	No Cases	No Cases	No Cases	No Cases	100%	No Cases	No Cases	No Cases
	Commence 100% of Interim Order Tribunal hearings within 3 weeks of referral	100%	100%	100%	100%	100%	100%	100%	96%	100%	100%	100%	100%
	Contact Centre - % of customers who rated their overall experience and satisfaction at 7 or above out of 10 (target 80%)	83%	82%	78%	85%	84%	81%	85%	82%	80%	80%	81%	82%
	Contact Centre - Answer 80% of calls within 20 seconds	85%	78%	84%	84%	87%	83%	86%	83%	82%	44%	55%	52%
	Positive media coverage of GMC (target 45% or above)				36%	61%	48%	80%	38%	11%	47%	5%	5%
	Negative media coverage of GMC (target 15% or below)				17%	10%	5%	3%	6%	17%	3%	3%	3%
	Satisfaction of users with GMC website (target: a Net Promoter Score of at least 30) – Target to increase to at least 40	50	40	39	40	41	43	35	35	35	37	45%	45%
	75% of doctors intend to change practice following Outreach learning session	79%	78%	81%	77%	77%	81%	80%	82%	78%	79%	78%	78%
Organisation	2024 Income and expenditure [% variance +/- 4%]	-0.53%	-0.64%	+1.02%	+1.83%	+0.44%	+0.66%	+1.27%	+0.34%	+0.71%	+0.5%	+0.96	+0.85
	Rolling twelve-month staff turnover within 8-12%	7.7%	7.1%	7.0%	7.9%	6.8%	7.1%	7.4%	7.3%	6.9%	6.7%	7%	7%
	IS system availability (%) – target 99.89%	99.93%	100%	100%	99.96%	99.94%	99.97%	100%	100%	100%	100%	100%	100%

Recruitment – Diversity Targets

In addition to reviewing our KPI targets, we have also reviewed our targets for increasing the diversity of our workforce. Please see our proposed 2025 targets highlighted below.

Underlying measures and targets		Actual				Target			
		2023 (%)	2023 (Vol)	2024[1] (%)	2024[1] (Vol)	~~End of 2024~~	End of 2025	% points off ~~2024~~ 2025 target	2026
Increase the level of minority ethnic representation at Level 3 and above	Applications	34.9%	430	35.7%	327	~~28%~~	29%	+ 5.7	30%
	Interviews	20.1%	52	16.5%	30	~~23%~~	24%	- 7.5	25%
	Offers	14.8%	8	10.5%	^Redacted	~~18%~~	19%	- 8.5	20%
	Workforce	13.9%	90	13.7%	90	~~17.5%~~	19%	- 6.3	20%
level of minority ethnic representation at Level 2+		12.6%	27	12.0%	26	~~16%~~	18%	- 6.0	20%
level of minority ethnic representation at level 3		14.6%	63	14.6%	64	~~17.5%~~	19%	- 4.4	20%
Increase the level of minority ethnic representation at all levels	Applications	45.3%	2,370	48.4%	2,311	~~38%~~	39%	+ 9.4	40%
	Interviews	30.7%	329	34.9%	325	~~33%~~	34%	+ 0.9	35%
	Offers	23.2%	66	24.1%	55	~~28%~~	29%	- 4.9	30%
	Workforce	18.7%	317	18.7%	318	~~18%~~	19%	-0.3	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		2.2%	-	Minority ethnic backgrounds (%)	White background (%)	~~1.5%~~	1.0%	% points between groups	1.0%
				9.5%	6.5%			3.0	
Proportion of minority ethnic staff receiving promotion and grade progression is proportionate to our workforce at the relevant grade/level		- 2.9%	-	Minority ethnic backgrounds (%)	White background (%)	~~2%~~	2%	% points between groups	2%
				8.3%	10.2%			1.9	
Pay differentials within a confined band limited to 2%[2] *(table shows the proportion of bands that are inside of the +/-2% tolerance)*		83.3%	10/12	66.7%	8/12	~~12/12~~	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

General Medical Council

Patient and Public Involvement update

Action	To note
Purpose	To provide Council with an update on the progress we have made with our engagement with patients, the public and their representatives and with the embedding of their views in our work as a regulator.
Decision Trail	Council received our last update about our work with patients and the public in November 2023.
Recommendation	To note the efforts being made across the organisation to continuously improve and strengthen the way that we involve patients and the public in our work as a regulator.
Annexes	Annex A: Additional case studies Annex B: Feedback from patients about their experiences of fitness to practise Annex C: Our engagement with patient and public organisations in the Devolved Nations
Author contacts	**Judith Chrystie**, Assistant Director - Strategy, Planning & Inclusion **Joanna Farrell**, Assistant Director - Investigation Operations **Robert Khan**, Assistant Director of Public Affairs and National Offices Any enquiries to: GovernanceTeamMailbox@gmc-uk.org
Sponsoring director/ Senior Responsible Owner	**Paul Reynolds**, Director of Strategic Communications and Engagement

Agenda item M5
Patient and Public Involvement update

Background

1 Our Corporate strategy says 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 aspects of our work as a public 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 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
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. Further improvements are required.
When raising a concern about a doctor or needing our help in some other way, we can demonstrate (through the	Evidence demonstrates we are partially meeting this

feedback that we collect) that patients are able to access our support easily and have a compassionate experience throughout their engagement with us.	outcome. Further improvements are required.
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. Further improvements are required.

4 This update to Council provides evidence of how we are making progress towards meeting the outcomes set out above.

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 public regulator.

6 We commissioned a perceptions survey in 2024 with our audiences and stakeholders, which included a survey of 2,038 adults from across the UK. Seventy-nine per cent of patients and the public said they were confident in the way that doctors were regulated. Our researchers confirm this was a statistically significant increase compared to 2022 when 74% said they were confident. In addition, 79% of patients and the public said they trusted the GMC to deal with a concern about a doctor fairly and appropriately. When asked what would improve their confidence in how doctors are regulated, patients and the public were more likely to mention their experiences of wider service issues (such as waiting times and appointment availability) over any action the GMC could take.

7 In addition to having a high level of confidence, patients and the public were more likely to agree that the GMC was an effective regulator (74%) and relevant regulator (77%). They were less likely to agree the GMC was a compassionate regulator (54%).

8 The survey results show that the public's awareness of the GMC has remained stable over the past two years, with 58% in 2024 and 54% in 2022 reporting some familiarity with our work. When asked what they thought the GMC's role as a regulator involved, the most common responses (from patients and the public who expressed some familiarity with the GMC) were that we were responsible for setting and maintaining professional standards and the general regulation of doctors, followed by the investigation of complaints.

9 Familiarity with the GMC had a slight influence on confidence in regulation. Patients and the public who said they were familiar with the GMC were more likely to be confident in the way that doctors are regulated (84%). For those unfamiliar with the GMC, their confidence in doctors' regulation was lower yet still high (73%).

10 We also saw a higher level of confidence among 'patients' – those who had received care and treatment from a doctor in the last 12 months – compared to 'members of the public' (those who had not received any care from a doctor recently). Eighty-six per cent of 'patients' were confident in the regulation of doctors compared to 73% of 'the public'.

11 Analysis of the survey results shows there were no significant differences in confidence levels by patients' sex, age, ethnicity, location in the UK or occupation type. Analysis also tells us that the most important driver of patient and public confidence in the regulation of doctors is their confidence in doctors themselves as health professionals.

12 Patients and the public did express less familiarity with the Medical Practitioners Tribunal Service as a body compared to the GMC. Only 24% said they knew something about the MPTS (either a lot, a fair amount or a little) while a further 22% said they had heard of the MPTS but did not know anything about it. Of those patients and the public who knew something about the MPTS, 81% were confident that it would make fair, appropriate and independent decisions.

Involving patients and the public in our policy development

13 Our ambition is to firmly embed patient and public involvement in the way that we develop our policies as an organisation. This involves:

- 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 which can be applied to our work in the future.

14 In April 2023 we published internal guidance for our policy profession on how to involve patients and the public effectively in their work. We have followed this by producing a suite of case studies, which draw on the experiences we have acquired through involving patients in several major programmes (such as updating *Good medical practice* where we have run training for patient organisations about the new professional standards – see **Annex A** for more details of this work). 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.

15 We published the case studies in June 2024, as part of an update to our internal framework for policy development and, during our internal promotion, we delivered an internal learning event for over 80 members of our policy profession. We received positive feedback about the session, which delivered increased awareness of how we consider patients in our policy

development process. We will 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

16 Regulatory reform will allow us greater flexibility and responsiveness in how we regulate the professions that we oversee. 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.

17 Over the last year we have commissioned two significant pieces of work which have helped us to listen to and understand the views of these groups as we prepare for these important changes to regulation.

18 We are working with Community Research, a company that specialises in research, engagement and consultation within the public, private and charitable sectors, to facilitate an engagement panel of 30 participants – a mix of patients, doctors, PAs and AAs – that is helping us with the development of new processes, guidance and communications through the use of co-production methods where possible.

19 Co-production is a relatively new way for the GMC to engage with its audiences and we are still learning how to use it effectively and meaningfully. Therefore, we are capturing learning points from our engagement with the panel and will evaluate the impact of this approach in due course. This evaluation will help us to understand how co-production methods compare to the traditional way we involve patients and the public in our work, enabling our teams to make informed decisions when approaching similar initiatives in the future.

20 Half of the engagement panel's participants are professionals (doctors, PAs and AAs) while the other half are members of the public. We have representatives from a range of healthcare settings, protected characteristics and locations across the UK.

21 The engagement panel has now met several times to discuss two different topics, both about our future fitness to practise processes. The first round of engagement took place in April and May and focused on accepted outcomes. Participants gave feedback on what we could do to help them have trust and confidence in this new process, and how they'd like to be kept up to date if they were a complainant or registrant experiencing fitness to practise proceedings.

22 The second round of engagement was in July. This time the panel discussed how decisions in FTP can be challenged through the revision process and what we might do to improve this process in future. The participants used an online forum to watch a briefing video on the process and then shared their initial feedback on a series of hypothetical case studies.

Community Research then facilitated an online workshop where the group discussed their reflections in more detail.

23 From both rounds of engagement, we have found the panel to be remarkably engaged in the activities and workshops, which have been held both face-to-face and online. The findings have provided a rich source of feedback to the policy teams involved. It's also been positive to see panel members find common ground and show empathy for one another's perspectives.

24 Two further rounds of engagement are planned with the panel towards the end of 2024 and early 2025. We plan to show the panel a range of letters we currently send to registrants and complainants in fitness to practise cases and seek their views on how we can make them as clear and compassionate as possible. We are also in the early stages of developing a session with the panel on how we describe the work we do to quality assure the education received by doctors, PAs and AAs. We plan to run this round of engagement in early 2025 and use the findings to improve the information we share on our website about our work in this area.

Involving patients in the development of our regulations for PAs and AAs

25 To support our consultation on the proposed rules, standards and guidance that we'll need to begin regulating PAs and AAs from the end of 2024, we commissioned research to help us seek views from a broadly representative sample of members of the public about the changes to our regulations and what the reforms might mean for doctors in the future.

26 We anticipated that patients and the public would be less likely to respond to our formal consultation, which was highly technical in nature in comparison with other public consultations we have run previously (such as those about our professional standards and guidance) – a point of concern raised with us by some patient organisations, which is important that we reflect on as we consider future public consultation exercises on highly technical, regulatory matters.

27 For information, our consultation on our proposed rules for PAs and AAs received responses from over 400 patients, carers and advocates, and members of the public; whereas our consultation on *Good medical practice* in 2022 received the views of over 1,000 patients, carers and relatives.

28 The research that we commissioned (by Shift Insight) involved a series of focus groups and 1:1 interviews with 58 members of the public which ran alongside our public consultation. We asked the researchers to adapt their approach to the needs of groups, to make sure we heard from people with a range of health conditions or those who were less likely to engage with us.

29 The research found there was broad support for our proposed approach to regulating PAs and AAs, and our proposed changes to the regulation of doctors, which (to the participants)

felt clear, logical and fair. The majority felt that the processes and procedures described had improved, appearing more efficient and less bureaucratic. While few participants had heard of PAs and AAs, there was support for them to be regulated and there was a consensus that GMC regulation was appropriate and necessary, and that these roles should be regulated in a similar way to doctors. However, the research also highlighted a lack of trust in public bodies like the GMC and little awareness in our role as a regulator (which stands in contrast to the findings of our 2024 perceptions survey which are summarised earlier in this paper).

30 We have incorporated the findings from the research into our analysis of the consultation and will publish them later in 2024. We have also used the findings to inform our future planning for the next phase of regulatory reform.

Communicating our new role as a multi-professional regulator

31 In December 2024, we will assume responsibility for the regulation of PAs and AAs. This is a major change to our role as a regulator, one that we will communicate widely with patients and the public so they are aware of how they can access information about registered PAs and AAs and raise concerns should they experience any issues with their care and treatment.

32 We are working closely with patient representative bodies and other stakeholders across the UK to raise awareness about our role as the regulator of PAs and AAs. Our goal is to ensure consistent and accurate messaging which highlights the benefits that regulation brings to patient safety.

33 Although we will be the professional regulator of PAs and AAs, we are not the only organisation that has a responsibility to inform patients of this change. Therefore, we'll continue to work with our partners across the four countries of the UK that lead on issues that sit outside of the remit of GMC regulation.

34 To prepare for this change, in October we began our 'get ready for regulation' campaign, which is aimed at educating patients, the public and our key stakeholders about the value and purpose of PA and AA regulation for patient safety. The campaign runs in parallel with a programme of tailored communications for PAs and AAs, which welcomes these professionals to regulation, clarifies what it means to be a regulated professional and outlines the requirements they must meet.

35 The plan for the campaign has three phases:

- 'Prepare': In the lead-up to regulation commencing, we have continued to engage with patient representative bodies to emphasise the importance of regulation for patient safety. We're explaining how regulation will strengthen the quality of care patients can expect from PAs and AAs. We're also seeking their support in disseminating clear, accessible information through their channels.

- 'Regulate': As regulation and registration commences, we will deliver updates through various public-facing channels and platforms, including our website, social media and mainstream media.
- 'Multiprofessional regulation': In early 2025, as PAs and AAs begin to join the register, we'll promote content that highlights key aspects of the regulatory framework. This will include our role in education and upholding professional standards, how the register works and its role in distinguishing between the professions we regulate for patient safety, as well as fitness to practise processes and revalidation.

36 Our medical register will be a key source of information used by patients and the public to check the details of PAs and AAs when regulation begins. In early 2024 we engaged with patients, doctors, PAs and AAs to test how the new medical register would look. More information about this work can be found in **Annex A**.

Involving patients in our review of public confidence thresholds

37 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 doctor's behaviour undermines, or is capable of undermining, the trust and confidence that a fully informed member of the public places in doctors as a whole.

38 However, our thresholds in public confidence cases are linked to society's expectations of acceptable behaviour for professionals such as doctors and teachers. These expectations can vary significantly among different social, cultural and economic groups. They may also shift over time.

39 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 divisive political and social issues. Particular challenges also arise from cases where a doctor has been acquitted after a full trial of a serious criminal offence in their personal life, where no additional issues of professional misconduct arise.

40 This increased scrutiny makes it 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 wider public confidence in the professions that we regulate.

41 We have therefore commissioned some research to better understand the public's views on where our thresholds should sit in public confidence cases. We believe the research, which is due to commence in January 2025, will be a valuable opportunity for patients and the public to help shape our thresholds following regulatory reform and further into the future. A variety of methods will be used to gather views from a representative sample of the public, ensuring that different protected characteristics, socio-economic groups and geographic

locations are fairly represented. We expect to receive a final report about this research in the autumn of 2025.

42 We are also scoping options for holding a public consultation on this issue. This will ensure we hear from a wide range of voices, including patients and the public, and take different perspectives into account before making any changes. Although we originally planned to include threshold questions in the second regulatory reform consultation to accompany the new rules for doctors, this may no longer be the most appropriate option as there could be a delay until 2026. We are therefore considering the risks and benefits of a stand-alone consultation exercise on thresholds in 2025.

Other opportunities for involving patients in the development of our policies

43 Our programme looking at the future of career development and education involves us working with a wide range of partners to ensure that our new framework supports positive change for both the public and the professions that we regulate. The views of patients and the public are fundamental to helping us develop our approach and we are committed to involving them in key conversations and at key stages. Our symposium in November, for example, will start from a consideration of what patients need from doctors, PAs and AAs, and how these needs might be addressed through education and life-long learning.

44 Council will be aware that we have started work to develop our next corporate strategy (for 2026-30). We are currently exploring themes for our next strategy including, among other things, how patient involvement and insights might inform our work as a regulator over the next five years. We will engage with patients as we develop the new strategy as we believe they will be an important voice in helping us to determine:

- how we can make further progress towards our ten-year vision to be an effective, relevant and compassionate regulator, from a patient's perspective
- the challenges and opportunities we face in our regulatory work, especially in relation to patients' experiences
- how our future strategic priorities should take account of and improve the patient journey with the GMC
- and how we should communicate our aims on patient safety with the public.

Improving patients' experience of our services

45 Our current corporate strategy says we will make sure that members of the public and healthcare professionals are 'met with empathy, fairness and professionalism by all our colleagues' and that we will 'listen to, learn from and act on their feedback about our services.'

46 We know that we need to improve how we gather, analyse and report on the feedback that we receive from patients and members of the public about our services as a regulator. By doing so, we will gain a better understanding of their experiences. This will also help us find ways to make our services more accessible and helpful to them.

47 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 only form a small proportion of the service's customer base (between 5%-10% per year). Our interaction with patients also varies in nature from service to service.

48 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, as well as our work to implement new standards for the Welsh language.

Contact Centre

49 In early 2024, our Contact Centre began its reaccreditation process with the Institute of Customer Service (ICS). It has held accreditation with 'distinction' since November 2021 and has been working to improve its offer to customers (including patients and the public) even further via action plans developed with the Institute.

50 In the first quarter of 2024, the ICS carried out independent customer surveys to benchmark our Contact Centre against the services of other, similar organisations. The results show our Contact Centre customers continue to have a high level of satisfaction with the service compared to other public services in the UK. In recognition of this, the ICS has awarded the Contact Centre with 'distinction' again.

51 The Contact Centre reports customer satisfaction data (using Net Promoter Score methodology) internally on a monthly basis. So far during 2024, satisfaction levels have consistently sat at an NPS score of between 79 – 85, which is considered excellent. At present, however, this data is gathered and reported on manually and satisfaction levels for specific customer groups (such as patients) cannot be identified.

52 In September, we successfully launched the telephony element of our new omni-channel system, Genesys. The new system will automate the running of customer surveys by our Contact Centre and significantly expand the volume of interactions they seek feedback about. The Contact Centre is currently scoping the development of automated surveys and plans to roll them out in the first half of 2025.

53 The only interaction that many customers and stakeholders will ever have with the GMC comes via the Contact Centre, which makes the service key to the reputation of the

organisation as well as the delivery of our statutory functions. The team is therefore developing a new customer experience vision for the Contact Centre. One of the key components of that vision is ensuring we have a clear and documented analysis of our key customer segments, with an evidence-based understanding of their needs, priorities and preferences. This will be used to inform training, resourcing and scheduling to ensure sufficient resource is available to meet customer expectations. The Contact Centre is currently mapping its customer segments, including patients and members of the public, with support from a consulting firm called Gartner.

Fitness to Practise: developing a 'feedback loop' for our processes

54 Our Fitness to Practise (FtP) directorate continues to develop its approach to seeking feedback from those who come into contact with its processes (including patients and the public) and they are currently developing plans for a pilot that will allow them to test options for holding feedback surveys. 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.

55 From this engagement, they have learned how other, similar organisations seek and monitor feedback in their areas equivalent to our FtP process, the typical response rates they achieve and the resource required, the key themes of feedback, and the risks and issues faced when implementing a feedback process. FtP is now developing a plan for its feedback pilot, which it aims to begin by the end of Q1 2025.

Fitness to Practise: feedback forum

56 Our FtP directorate has established an internal forum to help it consider, learn and act on feedback from those who experience our investigation processes. The forum has met twice during 2024 and has involved teams from across FtP, the Contact Centre and our Corporate Complaints team.

57 The following examples demonstrate a series of processes which have been improved or corrected in response to feedback from patients and the public:

- a member of the public complained as they had tried to make a telephone complaint but had incurred costs as the number was a premium rate number. We identified the customer had used an historic number on our website. We apologised to the customer as the telephone number should not have been used anymore. We also refunded the costs they had incurred and made sure the number was no longer visible on our website**.**
- we made updates to the FtP online complaint form following feedback from a member of public that the form didn't reflect what capacity they were raising concerns in.

- our patient liaison service received feedback from a patient saying they would have liked more detailed written information about the provisional enquiry process and the limits of what can be done at this stage in our investigation process. This feedback led us to amend relevant leaflets and letter templates, develop new intranet pages for our teams, and ensure patient liaison team members clarify this as part of the meeting structure as well as in the outcome letter.

Fitness to practise: patient liaison service

58 Our FtP directorate continues to provide a dedicated service to patients who have raised a concern about a doctor. We offer meetings with 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.

59 Between January and June 2024, we held 184 meetings with patients to discuss the concerns they had raised about doctors (32% more than during the same period in 2023). Patients are invited to give their feedback about their experience of each meeting they have. The team's data for the first half of 2024, which is based on completed survey responses from 41 patients, tells us that:

- 95% of patients said they were either satisfied or very satisfied with their experience of meeting us (compared to 92% in 2023).
- 98% agreed that team members showed empathy for their situation (compared to 83% in 2023) while 96% agreed they felt listened to.
    - 91% agreed they were satisfied that their concerns had been understood during the liaison meeting (compared to 81% in 2023).
    - 93% agreed that the meetings helped them to understand what action the GMC could take (compared to 83% in 2023).

60 Some examples of the qualitative feedback that we have received from patients about our patient liaison meetings and other FtP services can be found in **Annex B.**

Fitness to practise: telephone complaints service

61 The quickest and easiest way for most people to raise a concern about a doctor with the GMC is by using our online form. However, for those with a disability or those who need assistance with raising their concern we can offer support via our telephone complaints service.

62 So far in 2024 we have supported 131 complainants with raising their complaints over the telephone. This work continues to be an area of growth for the team with this figure

representing a 10% increase on the number of telephone complaint requests supported in the first half of 2023.

Fitness to practise: advocacy Support

63 Between January and June 2024, we referred 14 members of the public to a charity called POhWER for funded advocacy support. This is a free, independent and confidential service that can be offered to support complainants who are struggling to access or engage with fitness to practise processes. Feedback for this service has been very positive, helping us to remove barriers faced by customers trying to engage with our services.

Implementing Welsh language standards for patients

64 Since December 2023 our work has been subject to the Welsh Language Standards (No.8) Regulations 2022 for healthcare regulators. The standards are derived from the Welsh Language (Wales) Measure 2011 which makes Welsh an official language in Wales and gives individuals the right to receive certain services in the medium of Welsh.

65 In December 2023, we launched our compliance plan and announced our commitment to enhance our Welsh language provision in line with the standards. We promoted this via social media channels, a news story on our website and bilingual communications to our key stakeholders in Wales (including Llais, which is the citizen voice body for health and social care in the country).

66 With the help of processes and guidance that we have developed to support compliance with the standards, patients are now able to correspond with us via email, raise a concern about a registrant and access key information on our website – all in Welsh.

67 One year on, we have commissioned an external assessment to check our compliance with the standards, focusing on those areas where patients are most likely to interact with us in Welsh. This included 'mystery shopper' exercises in the summer of 2024. We expect to receive the compliance report by late 2024 and it will inform our ongoing work to ensure we are meeting the requirements of the standards.

Improving our relationships and engagement with patient groups

68 We continue to engage with patient organisations, seeking their input into our priority programmes (such as bringing PAs and AAs into regulation, our broader programme of regulatory reform and our work looking at the future of career development and education) and providing them with platforms where they can communicate their work to others.

69 Our Chair, Chief Executive and Directors meet with the leaders of patient advocacy organisations (such as Healthwatch England, the Patient and Client Council, The Patients

Association, the Patient Safety Commissioner and National Voices) to discuss our respective priorities. These meetings are supplemented by regular engagement between patient bodies and our respective external relations teams in the four UK nations – see **Annex C**.

70 We invite patient advocacy organisations to take part in our regular, independently-run research to help us understand the views of our audiences and stakeholders. Four patient bodies – two from England, one from Wales and one from Northern Ireland – participated in our 2024 survey and gave their consent to be identified to the GMC. All four described their overall working relationship with the GMC as good.

Our roundtable with patient groups

71 Twice a year we bring together patient organisations from around the UK, through our patient group roundtable, to discuss our emerging thinking about our policies and services and to help shape the GMC's development of policies. The meetings provide us with a valuable opportunity to share our thinking and seek the views of patients (who, by participating, are helping us to be a more effective and relevant regulator). The meetings are chaired by our Director of Strategic Communications and Engagement.

72 Since the pandemic, we have held these meetings virtually to make them more accessible to organisations and to increase participation by groups across the four countries. We seek feedback from attendees after each meeting to ensure the topics we bring to the roundtables remain relevant and valuable to attendees.

73 We have held two roundtable meetings in 2024. At our meeting in April, we held sessions on the contribution of professional capabilities to patient care, the GMC's approach to dealing with misconduct in a doctor's private life, and information for patients about PAs and AAs. At our meeting in November, we sought views on the Medical Practitioners Tribunal Service's proposed changes to sanctions banding and our next corporate strategy. We also provided an update on our work to bring PAs and AAs into professional regulation at the end of 2024.

Conclusion

74 We continue to make positive progress in the way that we involve patients and the public in our work as a regulator:

- We can demonstrate significant and meaningful engagement with patients in the development of our policies and processes – for our programme of regulatory reform and the work we have begun to review our thresholds in fitness to practise for maintaining public confidence. Culturally, the evidence shows we are considering patients more in our work than we ever have done before.

- As we prepare to assume responsibility for the regulation of PAs and AAs, we are working closely with patient representative bodies and other stakeholders across the UK to raise awareness of our new role and highlight the benefits that professional regulation will bring. When regulation commences, we will deliver updates to patients using various public-facing channels and platforms (such as our website, social media and mainstream media).
- We have successfully deployed the first element of a modern, omni-channel system that will support the work of our Contact Centre, which will give them the ability to automate, expand and analyse in more detail the interactions they have with patients, doctors and others. Meanwhile, our Fitness to Practise directorate continues to strengthen its approach to seeking feedback from those who experience its processes. Its patient liaison team has also managed to maintain high levels of satisfaction from patients with the support it offers.

75 It's also positive and reassuring to see that the public's confidence and familiarity with the work of the GMC remains high and that the majority of those who participated in our 2024 perceptions survey believe us to be an effective regulator.

76 That said, an assessment we have made of our progress towards the high-level outcomes for this work shows that we still have some way to go before we fully achieve our aspiration to be a more open and inclusive organisation for patients and the public. Some of this will be addressed by work that is due to take place in 2025, by our Contact Centre and Fitness to Practise teams, to enhance the way we capture and learn from the experiences which patients and others have of our services.

77 Council will remember that we conducted an external review of other organisations' approaches to patient and public involvement during 2023. This found that we were, at the time, broadly in the same place as the organisations that we heard from in our survey. However, we will repeat this review during 2025 to understand whether our position has changed and whether there is any good practice in this field that we can learn from to improve our ways of working.

78 While we make these improvements, we will maintain the progress we have achieved to date (in areas such as policy development). We'll be aided by our next corporate strategy, which will play a key role in recognising the value of patients' insights to inform our work as well as the importance of ensuring that patients, and others who interact with us, have a constructive and compassionate experience of us as an organisation.

General Medical Council

Annex A

Additional case studies

Embedding *Good medical practice* 2024

As part of our implementation of *Good medical practice*, which we launched in January 2024, our Standards team developed a patient guide about our new professional standards for our website. There are multiple versions of the guide – in English, Welsh, easy read in English and easy read in Welsh. Patients can also request the guide in other formats and languages. The page about the guide on our website has been viewed nearly 500 times between 31 January and 30 September, while the English and Welsh versions of the document have been downloaded 100 times in that period.

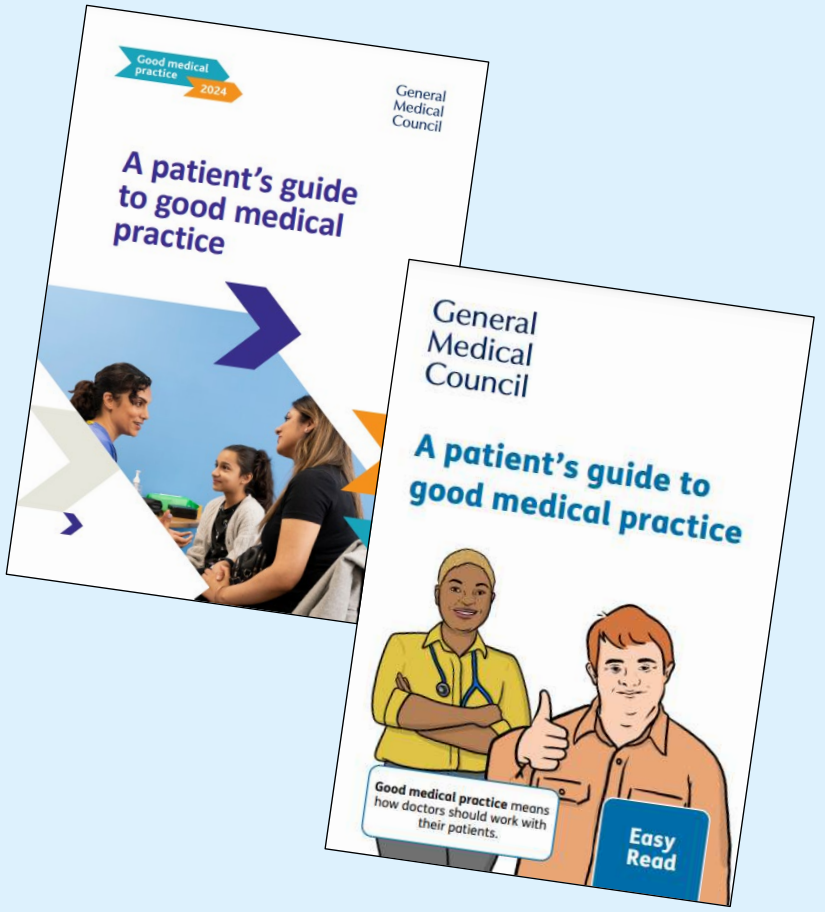
Following the publication of the patient guide on our website, our Standards team asked patient organisations to share information about any issues they had while accessing and using it. They collected this information using a survey and made minor updates to how the guide was presented.

We know that patient organisations are viewed by patients as a trusted source of information about healthcare issues and that they would be key users of the patient guide. Our Standards team therefore developed a training package for staff and volunteers in patient organisations to help them give advice to patients about the professional standards they can expect from doctors, PAs and AAs.

The format and timing of the session was developed with patients and organisations that attended our patient group roundtable meeting in November 2023.

Then, in late April 2024, we held the training session with several organisations including The Patients Association, the Royal National Institute of Blind People, Prostate Cancer UK, Action against Medical Accidents and the Northern Ireland Public Services Ombudsman.

We will evaluate the impact of this training to identify lessons for similar work in the future.



PA and AA regulation: testing changes to our online information

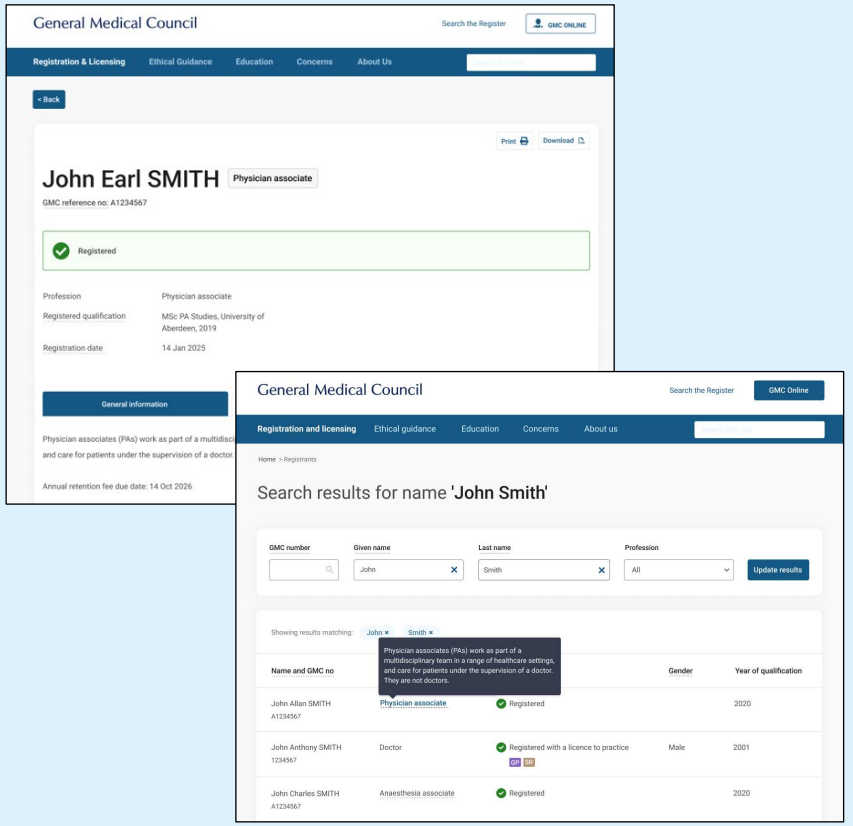
When the regulation of physician associates (PAs) and anaesthesia associates (AAs) commences in December 2024, we'll launch a register for PAs and AAs on our website that will allow patients and the public and others to see information about their registration and any fitness to practise history. This register will sit alongside our medical register for doctors. Similarly, the website for the Medical Practitioners Tribunal Service will be updated to display information about PAs and AAs who are the subject of hearings.

To prepare for this change, in early 2024 we conducted moderated user tests with doctors, PAs, AAs and members of the public. Our goal was to ensure that all users could easily navigate and comprehend our registers and tribunal listings.

These tests focused on evaluating the comprehension and ease of use of the online registers and hearings, particularly when users were trying to identify individuals among doctors, PAs and AAs when displayed together in searches.

The moderated user tests were conducted as 30–60 minute in-person (either remote or face-to-face) sessions. This format allowed moderators to interact directly with participants, observe their behaviour and understanding in real-time, and address any questions or challenges they encountered. Participants were asked to complete tasks such as identifying professionals and differentiating between profession types, helping us assess both functionality and user interface effectiveness.

The testing validated the design proposal for a consistent user experience across both the GMC online registers and MPTS tribunal hearings, particularly in the presentation and explanation of PAs and AAs. Participants all agreed that the inclusion of 'explainers' would clarify the distinction between PAs, AAs and doctors, improving overall clarity— especially for members of the public who may be unfamiliar with these roles.



General Medical Council

Annex B

Feedback from patients about their experiences of fitness to practise

Patient liaison service

‘When reliving a traumatic time in your life, it brings back the emotions. I was so lucky to have [Liaison Officer], who supported me, listened and heard me, which took away the fear.’

‘The process was explained to us in detail with language that was easy to understand.’

‘…full of information and compassion.’

‘I am dyslexic so apprehensive of a Teams call. However [Liaison Officer] was fantastic. She explained that she would be emailing me with a link and described exactly what key to press on my computer. We did a dummy run, which I was so grateful of, and to my surprise we had no hitches. Without [Liaison Officer] I wouldn't have been able to have the Teams call’.

Telephone complaints service

‘You’ve been refreshing to speak to, very to the point. You are excellent in representing the GMC – 101%’.

‘Thank you for your time and for really listening.’

‘Your ability to capture the story is excellent, it went way beyond my expectations.’

Advocacy support

‘I would like to thank you for your support towards me on this difficult time I am facing right now in my life’.

‘No one's listened to me like you have, thank you.’

General Medical Council

Annex C

Our engagement with patient and public organisations in the Devolved Nations

Northern Ireland

The Patient and Client Council is Northern Ireland's statutory patient organisation. One of its functions is to facilitate patient and public engagement with serious adverse incidents and the Neurology Independent Inquiry. The engagement platform for the Neurology Independent Inquiry is made up of former patients of Dr Michael Watt and their relatives.

In March 2024, our Director of Registration and Revalidation and our Director of Fitness to Practise, supported by our Northern Ireland team, attended a virtual meeting of the Neurology Engagement Platform. This was an opportunity to address outstanding questions following the case of Dr Michael Watt about our regulatory role and processes, and to provide clarification about the role of the MPTS. At the close of the meeting, the attendees thanked the GMC for its candour and compassion.

The Patient and Client Council is a member of our Northern Ireland UK Advisory Forum. They provide our Northern Ireland team with advice on securing patient input at Forum meetings. At the Northern Ireland UK Advisory Forum meeting in April 2024, members noted the value of raising awareness amongst patients and the public about the importance of the international health care workforce. Our Northern team is exploring how this can be facilitated via the Patient and Client Council and the Northern Ireland Confederation of Health and Social Care.

Scotland

Our team in Scotland has focused its engagement on continuing to re-strengthen ties with patient organisations in the country. We have been pleased to see increased representation from Scottish organisations at our patient group roundtable meetings as a result of this work.

A key priority has been strengthening our relationship with the Health and Social Care Alliance, an umbrella organisation for many of Scotland's patient and condition-specific organisations.

Our team in Scotland has met with the Alliance several times to discuss areas of mutual interest including the PA & AA Order and ED&I (exploring the links between patients' and doctors' experiences of discrimination). They have offered valuable contributions to our UK Advisory Forum meetings on topics including wellbeing and interprofessional alignment, ensuring patient experience is part of the conversation.

The team has also renewed its relationship with Healthcare Improvement Scotland Community Engagement and has had helpful conversations with them about our plans for regulatory reform, our new version of *Good medical practice* and our future of education programme.

Wales

Llais is the national independent body set up by the Welsh Government to ensure the views and experiences of people in Wales are used by decision-makers to plan and deliver better health and social care services. As such, Llais is an important relationship for the GMC and one which our team in Wales is actively building. Their Chief Executive has a standing invitation to attend our UK Advisory Forum meetings.

In July, the Head of Wales and Assistant Director for our MAPs programme met with the Chief Executive of Llais. They discussed regulatory reform and PAs and AAs and our future of education programme (covering what patients will want from doctors in the future and what this will mean for their education and training).

A representative from Llais attended our patient group roundtable on 7 November. A representative from the patient group Fair Treatment for the Women of Wales was also in attendance.

We regularly attend and contribute to discussions at the Welsh NHS Confederation's Health and Wellbeing Alliance meetings, which bring together a diverse group of stakeholders including Llais, condition-specific charities, and other patient representatives. At the meeting in September, training the future workforce was suggested as a potential future agenda item. We will explore how we can engage with the Alliance to ensure that the patient and public voice in Wales is brought into our future of education programme and other strategic priorities.

General Medical Council

Regulation of PAs and AAs

Action	To approve and to note
Purpose	As required by the Anaesthesia Associates and Physician Associates Order 2024 (AAPAO), the GMC has consulted on rules, standards and guidance for physician associates (PAs) and anaesthesia associates (AAs). Consultation responses have been analysed and changes made to the documents in response to feedback from stakeholders. We are now bringing final documents to Council to note/approve ahead of the commencement of PA and AA regulation on 13 December 2024.
Decision Trail	Previous versions of these documents have been reviewed by workstream local governance, the joint MAPs and regulatory reform programme board, SMT and Council.
Recommendation(s)	**a** To approve the Consultation analysis report. **b** To note the other documents included in this package, prior to approval of these on 13 December 2024: • The Rules • Course and curricula standards • three sets of Principles to inform fitness to practise guidance • Schedule of fees for PAs and AAs • updated Governance handbook
Annexes	Annexes are withheld, and will be published following the meeting
Author contacts	**Jennifer Agbanoma**, Programme Manager - Regulatory Reform **Tim Aldrich**, Assistant Director - Regulatory Reform Any enquiries to: GovernanceTeamMailbox@gmc-uk.org
Sponsoring director/ Senior Responsible Owner	**Shaun Gallagher**, Director of Strategy and Policy **Una Lane**, Director of Registration and Revalidation

Agenda item M6
Regulation of PAs and AAs

Background

1 In 2019 the UK government, with the support of the devolved governments, asked us to be the regulator of physician associates (PAs) and anaesthesia associates (AAs). Since then, we have been working hard to prepare for regulation.

2 We are now in the final stages of our preparations for beginning regulation of PAs and AAs and look forward to welcoming these two new professions into regulation from 13 December 2024 onwards.

3 This package includes the final version of the Consultation analysis report, plus several other documents that will need to be approved by Council before regulation can begin. Council members will be familiar with the documents in this package as they have been discussed previously in various Council meetings, however we ask that you take time to review the whole bundle as there will have been further amendments made to incorporate feedback that we have received from you (plus other colleagues across the organisation).

4 Where possible, if you can indicate in advance of the meeting where you may have questions or comments on the documents included, this better enables colleagues to respond.

What is included in this bundle

5 The documents contained within this bundle:

- **Consultation analysis report**: This report sets out in detail the results of the consultation, showing where respondents agreed with our proposals and where they disagreed. It describes how we have adjusted our proposals in the light of the feedback, as well as our reasoning where we have not done so. It contains a wealth of data and analysis, and makes reference to the findings from the external research with members of the public coordinated by Shift Insight.
- We have made some revisions to this document since it was last reviewed by Council to take on board the useful feedback that we received from members. You will notice that since it was last shared, the Consultation analysis report has now had a front cover added and it has also been through a tone of voice review to check that the structure and content of the report is as clear and as easy to read as possible. The report is currently being translated into Welsh and is going through final accessibility checks ahead of it being published on our website.
- **Rules**: This package includes the rules that will be required for us to regulate PAs and AAs (seven sets in total). All the rules have been reviewed externally by a lawyer specialising in legislation and the legislative process, and we have made final amends in response to the feedback that came out of this review.

- **Course and curricula standards**: we have included our two sets of education standards: Standards for the delivery of physician associate and anaesthesia associate pre-qualification education and Standards for physician associate and anaesthesia associate curricula. The standards have been revised slightly since the last time that they were shared with you – a brief introduction has been added, clarifying who these standards are for. A front cover has also been added. As a reminder, these are based largely on existing doctor standards, but are interim standards and will be reviewed in coming years.
- **Principles to inform fitness to practise guidance**: we consulted on principles to inform three pieces of core guidance on how we make decisions as part of our fitness to practise proceedings. The resulting new guidance for PAs and AAs will take effect from 13 December. Updated guidance for doctors will be published in April 2025 following a transition period.
- **Schedule of fees**: following Council agreement on the indicative registration and annual fee for PAs and AAs, this paper sets out the full Schedule of fees. The draft Schedule of fees has previously been shared with Council in November.
- **Governance handbook**: The focus for the draft revisions set out in this paper and shown in tracked changes (updated from the version approved by Council in February 2024) has been to ensure that our procedures and delegation arrangements are consistent with multiprofessional regulation from 13 December 2024. The most significant change is the inclusion of a second Schedule of Authority, under the AAPAO and associated rules. In addition to those changes, other amendments to the Handbook proposed at this time are intended to provide improved consistency and clarity in our procedures.

Next steps

6 Our planned next steps are as follows:

- **5 December:** We plan to publish the final version of the consultation analysis report after it has been approved by Council, alongside draft versions of the rules, Education standards, tracked changes Governance Handbook and FtP principles.
- **13 December:** Extraordinary meeting of Council formally to make the Rules (as it will only have the power from that date as per the AAPAO 2024) and to approve the final versions of the accompanying Education standards, FtP principles, Schedule of fees and Governance Handbook.
- **16 December:** With extensive updates to our website taking place over the weekend of 14-15 December, we will publish the approved rules, Education standards, FtP principles,

Schedule of Fees and Governance Handbook and all other materials required for the commencement of regulation of PAs and AAs on 16 December.

Communications and engagement approach

7 Once approved on 5 December, we will share the Consultation analysis report with key stakeholders across the four countries of the UK, issue a press release to trade and national media, and explore other media interview opportunities around this time. This will be followed by further communications through our newsletters and social media channels.

8 On 16 December, we will send out stakeholder communications to confirm that registration for PAs and AAs is open. We will promote this milestone across our channels, provide reminders about key actions for PAs, AAs, and others and use it as a hook for media opportunities.

9 We are delivering targeted communications to PAs and AAs to welcome them to regulation and provide practical information on what they need to do, or be aware of, to prepare. We are also working closely with employers and educators to ensure they are fully prepared to support this change.

Recommendation

10 We are asking Council to approve the Consultation analysis report and to note the other documents contained in this package, ahead of us seeking formal approval of these on 13 December 2024.

General Medical Council

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 and July 2024. Council considered an annual report on progress in December 2023.
Recommendation(s)	To consider performance against our commitments, our priorities and asks of others.
Annexes	Annex A: Report by the Fairer Employer Referrals programme
Author contacts	**Anna Rowland**, Assistant Director - Policy and Business Transformation **Rachael Elliott**, Project Manager **Fern Malley**, Project Manager Any enquiries to: GovernanceTeamMailbox@gmc-uk.org
Sponsoring director/ Senior Responsible Owner	**Elizabeth Jenkins**, Director of Fitness to Practice and General Counsel

Agenda item M7
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.

2 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.

Data

3 We have two performance measures, or key process indicators (KPIs) for the FER programme.

- **KPI1:** the percentage of active Designated Body's (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.

4 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.

5 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

6 Data: Our 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.

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 The table below shows an overview of our work completed to date. We are currently wrapping up Phase 3 and initiating Phase 4. Phase 4 has 13 deliverables, three of which have started and focus on:

- Ensuring our interface with employers supports proportionate referrals including improving our referral form, staff training about employer referrals and improving feedback to ROs about their referrals; and
- Influencing others to support inclusive local procedures including promoting formal mentoring programmes and improving the sharing of evidence-based good practice.

Table 2: FER deliverables status

	Deliverables	In progress	Completed
Phase 1	6	0	6
Phase 2	12	0	12
Phase 3	17	3	14
Phase 4	13	3	0

Key learning

9 As we have progressed through the FER programme, we have continuously reviewed our learning from the previous phases to inform our priorities in future work. Further detail on our approach can be found at Annex A.

10 We know the current data set will only begin to show the full impact of the project after project closure, therefore when measuring progress, we have focussed on the activities undertaken, as well as data.

11 We have compiled a detailed benefits analysis to understand the impacts of the work we have delivered. We are using the findings of this to develop a detailed narrative to capture our learning journey.

General Medical Council

Annex A

Report by the Fairer Employer Referrals programme

1 This is the third annual report provided by the Fairer Employer Referrals (FER) programme. We are now over halfway through the programme and embarking on our penultimate work plan.

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 three phases and have commenced a fourth. 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 process 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.
- **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 referrals from DBs based on ethnicity and PMQ by 2026					
		2016-2020	**2017-2021**	**2018-2022**	**2019-2023**
KPI1: % of DBs with evidence of disproportionality, for ethnicity or PMQ	**Ethnicity or PMQ**		**5.3%**	**4.4%**	**3.24%**
KPI2a: Difference in rates of referral between ethnic minority and white doctors	**Ethnicity**	**0.28%**	**0.24%**	**0.19%**	**0.13%**
KPI2b: Difference in rates of referral between UK and non-UK doctors	**PMQ**	**0.42%**	**0.34%**	**0.27%**	**0.16%**

7 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.

Agenda item M7

Fairer Employer Referrals

Forecast performance

8 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.

Chart 1: KP1 forecast

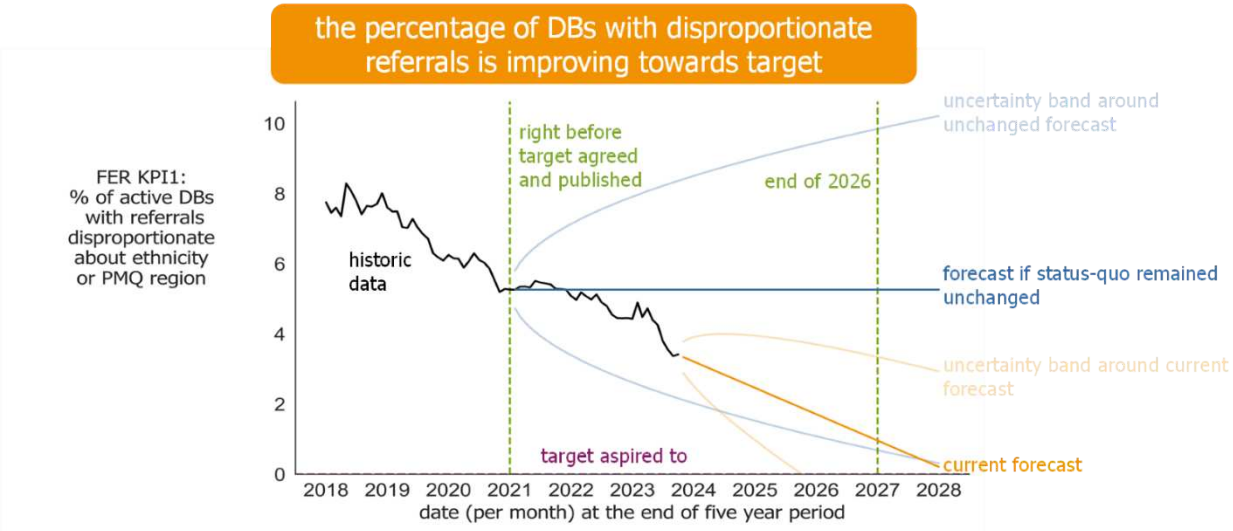


Chart 2: KPI2a forecast

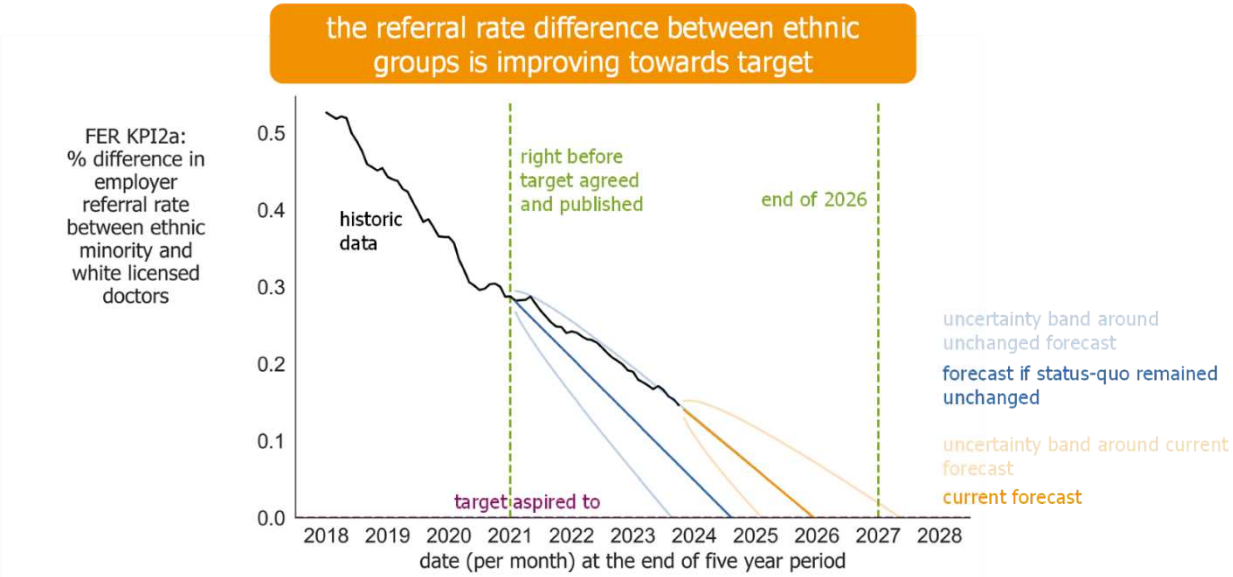
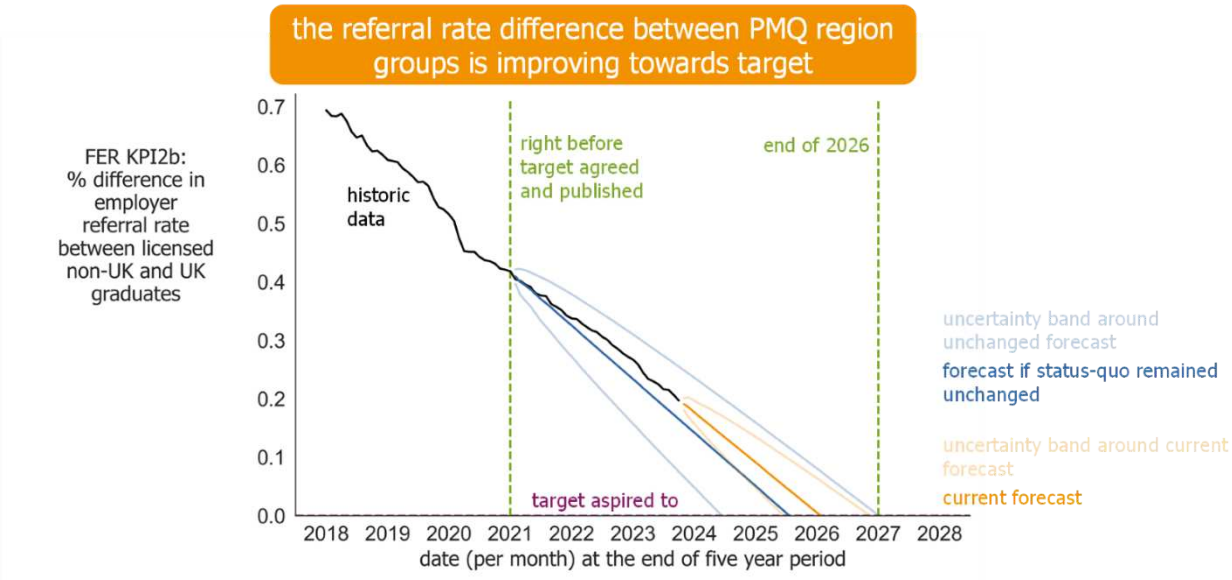


Chart 3: KPI2b forecast



9 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

10 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. For this reason, measuring progress will need to focus on activities as well as data.

Primary care

11 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 usually not the employer of the doctor and Primary Care covers many small independent organisations. 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 find this a challenging space to work in. 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 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. Again, controlling for other characteristics of doctors and their practice.
- 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 is can also be harder for doctors working in primary care to access supervision, coaching and mentoring, all of which are known to improve a doctor's feeling of 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 give the wide range, and number, of working environments. This is why we have chosen to focus our activity to date on engaging with the NHSE regional teams.

FER Activity

Deliverables

12 The table below shows an overview of our work completed to date. We are currently wrapping up Phase 3 and initiating Phase 4. Phase four has a total of 13 deliverables, thus far we have initiated 3 of these streams of work.

Table 2: FER deliverables status

	Deliverables	In progress	Completed
Phase 1	6	0	6
Phase 2	12	0	12
Phase 3	17	3	14
Phase 4	13	3	0

Completed activity in 2024

Phase 3

GMC action

13 **Deliver actions arising from our staff audit and workshop to identify any GMC levers to support fair workplace cultures that are not currently being deployed to maximum impact:** This action arose from our reflection at the end of Phase 1 where we identified that there was a heavy focus on Fitness to Practise in the project work and we want to ensure we utilise all GMC levers across directorates to best effect. We have used the evaluation of the audit to explore ideas. For example, exploring our revalidation processes for mechanisms to embed FER.

14 **Further roll out of anti-bias training to all FTP decision makers to mitigate the risk of bias in dealing with employer referrals:** Following training of Triage, ELAs and CEs in earlier phases, we have rolled out anti bias in employer referrals training to the Investigation Committee and are due to hold a follow up reflection session with Triage ARs. We have also been developing a training strategy to help move this process to BAU which we will focus on in Phase 4.

15 **To review our mechanisms for using contextual information to support decision making, following changes to the RO referral form to collect that information about employer referrals:** The *Fair to refer?* report identified a perception that context is more frequently

taken into account when assessing failings involving those in ingroups when compared to outgroups. In Phase 1 we included a question for ROs in the RO Referral form to ensure they consistently consider and share with us any relevant context about a referral to address that disparity. Follow up work is now being carried out to ensure that we have robust mechanisms for consistently recording, sharing, and taking that contextual information into account in fitness to practise decisions. There are key interdependencies with broader work on relevant context as part of the regulatory reform programme.

16 **A post implementation review of the feedback mechanism introduced in Phase 2 between Triage and ROs:** A six-month review identified four instances where this loop had been utilised. Operational feedback indicated that there was some uncertainty about what type of feedback should be raised and we are circulating some supplementary guidance on what should be fed back through this mechanism.

17 **Review our systems to record information referred to us about doctors already in our procedures (AOI):** Since December 2020 ROs have been asked to speak to an ELA before referring additional information that may reach our threshold for investigation to support consistency. A post implementation review of these changes highlighted that we are currently unable to systematically identify AOI provided by an RO. A manual review has not identified disproportionate trends but by categorising the source of AOI in our system we will be able to monitor more robust data over time and apply targeted interventions through Outreach to establish why these concerns were not raised in the initial referral.

18 **Scope the introduction of a referral form for referrals from employers that currently don't come via RO and ensure they're directed via the RO and ELA:** We have identified opportunities to update our web form to ensure that the *Fair to refer?* questions are included and to encourage referrers from workplace settings to discuss a referral with the doctor's RO prior to referral where possible to do so. An interdependency with the MAPs programme was also identified, as PAs and AAs do not have ROs, and this work will be taken forward in alignment.

19 **Prioritise implementation of recommendations from the Singh Forde review and the Regulatory Fairness review that support the delivery of the FER target:** We identified several interdependencies within the Singh Forde and the Regulatory Fairness reviews which we have prioritised and are supporting through the FER project workstream:

- Review of referrals from employers that currently don't come via RO.
- Anti-bias training.
- Outreach framework to identify, classify and store good practice about effective feedback in local complaint handling.

Influencing others

20 **Commission research to compare Designated Bodies who are proportionate and disproportionate to identify evidence-based good practice:** We are in the process of going out to tender for this research. We have formed an advisory group with a small number of organisations in the system, to endorse and receive updates about this piece of research. This will heighten the impact and influence the research will have at publication point.

21 **Pilot mechanisms to share good practice with the system following work completed in Phase 2 to develop a framework to identify and classify good practice:** We are taking forward development and testing of the framework, and we aim to complete this by the end of the year.

22 **Engage with NHSE's Professional Standards Working Groups to identify how to support fairness in Primary Care, both in decision making and in wider ED&I related activities:** We have worked with the NHSE's Professional Standards Working Group and, in January of this year, we hosted a good practice sharing workshop for the regional NHSE teams which feedback has confirmed had identified changes participants would make to their local processes. One region has created a "fair checklist" for their Initial Case Assessment process, which we contributed to and have shared with other regions. Since then, this working group has been stood down by NHSE due to resourcing issues, but we have identified an opportunity to further this work and collaborate with NHS Resolution (NHSR) to develop a fair and proportionate check list for DBs which is being piloted in two primary care regions of England. We will be carrying this collaboration forward into Phase 4.

23 **Increase RO understanding of the impartial checks they should carry out prior to referral to the GMC, to enhance their effectiveness in supporting fair referrals:** Outreach have been undertaking work to encourage ROs to think about impartiality earlier in their processes before referrals come to the GMC. Following an evaluation undertaken by Outreach and our own evaluation this year we know that the impartial checks question on the referral form is being completed but that there is still great variance in the quality of content being provided. An interactive session was held at the July RO reference event about impartiality. This explored how our RO Referral guidance and the Fitness to Practise referral form might be improved, to encourage all RO referrals to use the referral form, rather than email, and to ensure that the impartiality checks are carried out. The reviews and engagement with ROs and Outreach highlighted that there are a number of areas we can improve on to better support the quality of impartial checks carried out to support a GMC referral, for example clarifying the definition of an impartial check in our guidance. Outreach have been continuing their 'Fairness in Concerns' conversations to encourage ROs to consider fairness earlier on in their discussions. They have also been using their conversations with ROs to clarify what constitutes an impartial check to further their understanding. Content around fairness and referrals is included in the existing RO training, owned by NHSR and Outreach are currently helping them develop this content for a 2nd day of training. We have set a 6-

month review point following the implementation of potential form/guidance changes and will look to re-evaluate this process then.

24 **Scope further work to support the SAS workforce:** We have fed into work being delivered by NHSE to support SAS doctors as part of the long-term workforce plan. NHSE plan to create a simple dashboard with measures that are currently under discussion. Employers will then complete this dashboard to achieve a bronze/silver/gold award. The plans were launched in Q3 of 2024.

25 **Present to the PSA research conference on 14th of November**: We were selected to deliver a presentation on FER to stakeholders from across the health system at the PSA research conference in November 2023. We took this opportunity to inform them about our programme, goals, advances, and also encouraged them to partner with us in making referrals fairer.

Collaboration

26 **Discuss with NMC opportunities to support fair workplace cultures through joint work to improve multidisciplinary team working.** Currently we are collaborating through Outreach conversations, sharing approaches on use of data to identify disproportionality.

27 **Continue to collaborate closely with NHSR including piloting joint conversations in London with senior leaders on their disciplinary data, sharing learning from their compassionate conversations programme and our PBPS programme and continuing to support their 'Being Fair' initiative.** We have been in conversations with NHSR to collaborate on the joint conversations pilot. This involves sharing of our respective data about DBs to see if there are any learnings we can encourage DBs to reflect on. The work is scheduled for piloting under Phase 4 of the plan, and we plan to test it with three trusts in London. Following this pilot and depending on the success of this we will look to how this might be rolled out further.

Building our understanding of changes to the local landscape

28 **Work with Outreach to develop a narrative on key changes to the external environment to better understand what local changes may underpin improvements in disproportionality data and to enable us to assess and support sustainability:** We have reviewed the CQC's new framework to assess the inclusivity of local environments. A cross-mapping exercise showed that the quality statements from the CQC's well-led assessments category linked most closely to the FER programme and that there were only minor variations between their principles and content provided by the GMC for doctors in our guidance and policies. Many of the dissimilarities were due to the difference in the role of the CQC and the GMC.

29 Work is underway on a comprehensive report about disproportionality in GMC procedures to improve transparency and to support the wide range and volume of queries that are received across the business on fairness in our fitness to practise procedures.

30 **Continue to work with the National Offices to understand local landscapes across the four countries:** Through continuing to focus on our National Offices we are looking to ensure that our progress is sustained throughout the UK.

31 **In Scotland**: We held a discussion at our Spring UK Advisory Forum focused on creating supportive and compassionate working cultures and included a discussion of themes relevant to the FER agenda, including professionalism, discrimination and speaking up. We've also been invited to sit on the NES (NHS Education for Scotland) Advancing Equity in Medical Education Group, which discusses all the ED&I work ongoing at NES. Actions so far have included:

a Linking up NES with the Fairer Working Cultures Group re: work on anti-racism resources; and

b Facilitating a conversation between NES and DRIH colleagues about what data we can offer to help them evaluate the impact of the various ED&I initiatives going on in Scotland.

32 **In Wales:** Sessions were held with Swansea Bay and Aneurin Bevan clinical leaders on local management of concerns with a focus on fairness. We've also held a session with Southeast Wales ROs on fairness in local processes.

33 In south Wales we also recently brought together Medical Directors (MDs)/ROs and Deputy MDs from a number of Health Boards to discuss working together to improve and enhance fairness and impartiality in local processes. Feedback following the session was very positive and attendees are keen to progress a number of agreed actions, notably including developing a forum in which to benchmark or calibrate referrals to ensure consistency across HBs; and to sense check and share learning on an individual (anonymised) level with peers.

34 **In Northern Ireland**: The Outreach Equality, Diversity & Inclusion (ED&I) module developed by NI Clinical Fellow and Liaison Advisers has been delivered to all FY2s for this academic year. We've also held UKAF discussions, sharing data and insights about the poor experiences of International Medical Graduate (IMG) doctors and black and minority ethnic (BAME) medical students with stakeholders. Outreach advisers have also been contributing to enhanced induction programmes across Northern Ireland.

35 GMC Northern Ireland Liaison Advisers have also contributed to local Health and Social Care Trust Enhanced induction programmes for doctors new to Northern Ireland. Liaison Advisors facilitated a pilot of the 'Fairer Feedback Conversations' workshop for 23 Belfast Trust

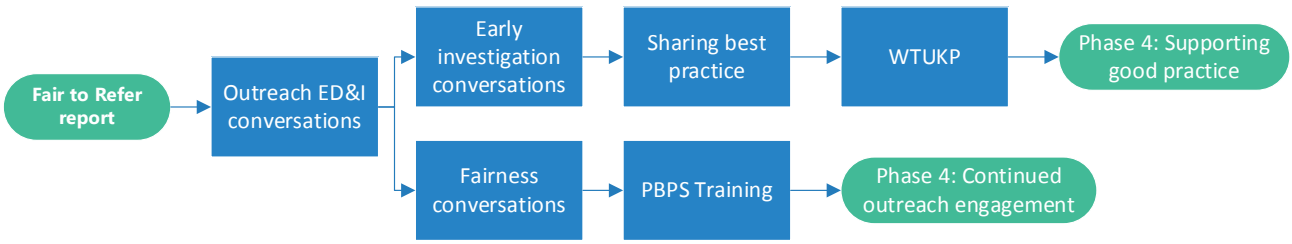
trainers in September. 100% of attendees noted they would change their practice as a result of attending the session.

Key learning

36 As we have progressed through the FER programme, we have continuously reviewed our learning from the previous phases to inform our priorities in future work.

37 In Phase 1, our early ED&I conversations with ROs and changes to our RO referral form provided us with an immediate opportunity to make an impact.

38 Our Outreach teams held conversations with ROs to emphasise their duty to provide supportive and inclusive working environments and to explore how they were implementing the findings of the *Fair to refer?* research. Outreach developed this approach with further discussions about the early investigation process and by supporting ROs to consider the doctor's protected characteristics within the wider context of the issue being raised. These early conversations also provided opportunities to share good practice.

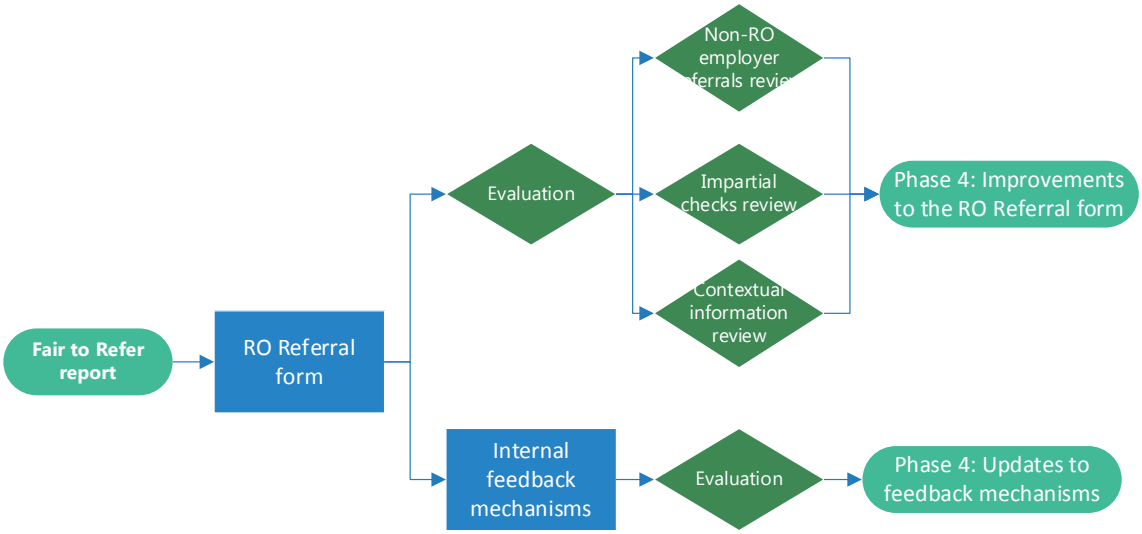


39 We piloted changes to our RO referral form following recommendations in *Fair to refer?* to include additional questions about how ROs considered systemic and environmental issues in their local processes, the support they've provided locally, and the impartial checks they've undertaken to ensure the referral is fair. This further supported the early conversations held with our Outreach teams.

40 As part of our second phase, we undertook a review of the changes made to the RO referral form. This revealed some ROs misunderstood what constitutes an impartial check and led to a further piece of work in Phase 3 of our programme to address the inconsistencies in impartial checks.

Agenda item M7

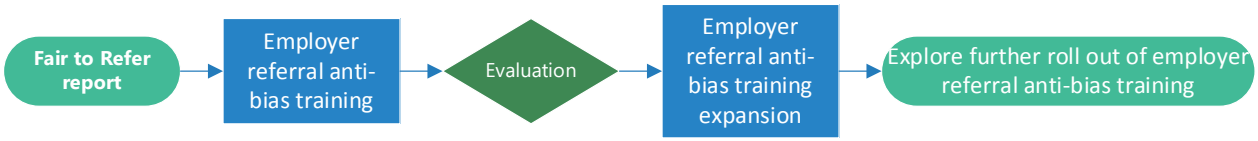
Fairer Employer Referrals



41 Following the introduction of the additional question about how ROs considered systematic issues, we have received queries from them about what we do with that information. This has highlighted the need for a piece of work on context, to enable us to be much clearer when explaining how the GMC's fitness to practise process stores, shares internally and uses contextual information in decision making.

42 As part of our learning from the changes made to the RO referral form, we recognised that it would be appropriate to also consider employer referrals that do not go via the RO. We are picking this up in Phase 4 of our programme.

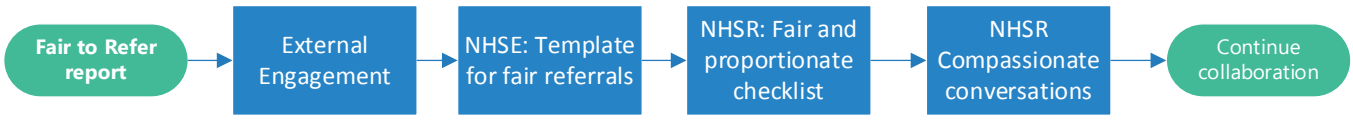
43 In Phase 1 we delivered training for our Triage Assistant Registrars, via an interactive programme of reflective learning about bias, specifically about counteracting authority bias when dealing with employer referrals. The feedback following the sessions was very positive and as a result we decided to roll this out to other decision makers.



44 System pressures are ever present. The merger between HEE and NHSE presented challenges while organisational adjustments and personnel changes were underway as this temporarily affected clarity around leadership for ED&I activities within NHSE.

45 We did however work with NHSE through the professional standards working group which focussed on supporting a range of EDI activity across Primary Care in England. One output of this group was creating a template for fair referrals in the Midlands - this has been shared

more broadly and has fed into the pilot for a "Fair and Proportionate checklist" that NHSR have developed. We are part of their pilot group for this activity and are ensuring that our focus areas are also included.



46 We have also worked closely with NHSR on a range of other activities, including collaborating on Being Fair 2, their guidance for employers on how they can create fair local investigation systems.

47 We further worked with NHSR to support local systems by supporting their 'Compassionate Conversations' training, designed to help all involved in local concerns to address matters with compassion. We also delivered via our Regional Liaison Advisers on the Professional Behaviours Patient Safety training programme (PBPS), which aims to empower doctors to challenge unprofessional behaviour in colleagues early, and hopefully avoid escalation through formal routes where it is appropriate to do so.

48 Following the success of the changes to the RO referral form, we wanted to consider any other potential levers the GMC may have. We carried out a review with members of staff across the organisation to assess if we are using our levers to maximum effect to deliver the target. We considered reviewing whether deferrals in revalidation may be consistent with FTP referral data and if that might provide any additional opportunities. Following that scoping work no additional areas were identified, and we have not pursued it further.

49 We also carried out a review to understand if there were any potential opportunities when we receive additional allegations for registrants already in our FTP process. Our headline data did not show any benefit to pursuing that, however we did pick up that we could improve the quality of our data and have handed that action point across to the relevant teams directly.

50 In our second phase, we carried out a horizon scan to understand if other organisations also experience referral disparities. Our review found a lack of reliable data by which to make a comparison, preventing us from exploring this any further.

51 The Outreach team have developed their expertise in talking to doctors and employers about the issues raised by *Fair to refer?* As part of their upstream engagement, they have trained 46,391 doctors on how they can influence their working environment to be more inclusive and how to challenge unprofessional behaviour in others. They have also delivered induction training to 27,567 doctors through the Welcome to UK Practice training programme.

52 We have aimed to ensure our programme remained aligned to other concerns being raised in the system and have monitored interdependencies in other programmes of work, for example the Singh/Forde review.

53 From our early conversations with ROs, we learned that it was important to have good practice examples to share with the profession and that those examples need to be evidence based and specific. We identified a challenge in analysing, recording, storing and sharing information and therefore we developed two areas of work:

- We collaborated with a clinical fellow to design a framework for how to describe evidence based good practice and we're now looking at testing that framework in the field.
- We are further commissioning a piece of research to capture effective interventions used by proportionate DBs to share across the system.

54 We are conscious of utilising opportunities for engagement with the NMC on this work given the close working between doctors and nurses in multidisciplinary teams. We are currently sharing our approaches on use of data to identify disproportionality and have agreed to share the outputs of our evidence based good practice research.

55 To support the delivery of the FER programme, we are about to start developing a narrative document to capture our detailed learning journey. This will paint a comprehensive picture of our journey from the delivery of the *Fair to refer?* report, capturing the challenges and opportunities of running such a programme when there are many other competing initiatives and stakeholders.

56 Our national offices have successfully delivered context specific content for their areas. We are due to hold a learning session in early 2025 to assess what has worked well that may be useful to develop further. Our continued engagement with them ensures colleagues have access to information they need in their ambitions to deliver the target.

Upcoming activity

57 Phase 4 is in the process of final approval and will be delivered between December 2024 and September 2025. In developing Phase 4, we have utilised our knowledge and understanding gained throughout previous phases and given careful thought to whether we are maximising our internal levers and external influence. We have looked to identify activities that will be the most impactful at continuing to support the positive trajectory seen so far in our data on disproportionality in employer referrals.

Phase 4 plan

58 The Phase 4 action plan has been split into the four themes utilised last year:

- **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

59 **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 and we are using this in conjunction with ELA fairness conversations to successfully encourage RO reflection on fairness in local processes. We know from *Fair to refer?* that complaints from employers are far more likely to be investigated than complaints from members of the public (84% compared with 16%) and to subsequently lead to sanction. Therefore, we want to ensure that the employer referral process is fair and impartial and to encourage fairness at a local level long before complaints are sent to the GMC.

60 We carried out a review of the use of the fairness questions in the RO Referral Form in early 2023, our data highlighted the form is being completed but there were variances in the quality of content being provided.

Table 3: RO % of fully completed RO referral forms

Year	Percentage of RO referral forms with all 3 fairness questions completed
2022	71%
2023	93%
2024 (to August)	91%

61 Our reviews along with engagement with ROs and Outreach highlighted that there are a number of areas we can improve on to better support the completion of the fairness questions which are designed to ensure that fairness is considered at a local level. This was highlighted when we took the RO referral form to an RO Network event and feedback from this centred on:

- A need to revise the language used to describe the information that the GMC requires.
- Clarity about the term impartial check, how it applies across different designated bodies (including non-employing ROs) and its relationship to existing local checks.
- Queries as to whether looking at the first five years of an IMG's practice was sufficient and whether the questions that we were asking were the right ones.
- Examples required to help guide completion. Some guidance integrated into the form was requested.
- More clarity about how the GMC uses the information to improve equality.

62 Improving RO understanding of the fairness questions also improves the quality of the information we are collecting, which will give a more rounded picture of a referral for our operational teams and decision makers and better support our FER objectives. New guidance produced in the regulatory reform programme has detailed content on taking context collected in the referral form into account when making GMC decisions. In 2024 we examined data from 2021-2023 on referrals from employers that currently don't come via an RO, and 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:

63 Across the four nations we will:

- Continue to consult with ROs on how they use the referral form and make changes to reflect their feedback.
- Consider changes to the three EDI fairness questions and supporting guidance to better reflect our FER objectives.
- Consider 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.
- Support ROs who are making referrals through training and other engagement activities.
- Consider how to reduce the number of employer referrals about doctors that don't 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

64 **Rationale:** Feedback from our employer referral anti-bias sessions have 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.

65 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 our decisions. Several of the Singh/Forde recommendations cross over into this area of work as well. 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.

66 **Activities:** Phase 4 will explore extending this training, building on the Regulatory Fairness Programme HIRDS training and if taken forward, will include the development of a training strategy for handover to BAU. This would build on the success of our employer referral anti-bias training for Assistant Registrars, Employer Liaison Advisers and Case Examiners, Legal and the Investigation Committee in Phases 1, 2 and 3.

Implementation of recommendations to improve the CE to RO feedback mechanism

67 **Rationale:** The Case Examiner Team developed a process in 2022 to provide feedback to ROs via our Outreach team about the outcome of cases referred to the GMC where potential for learning had been identified. In 2023 we evaluated the RO CE feedback mechanism. Through reviewing our data and conversations with CEs and Outreach, recommendations were developed to improve the process.

68 **Activities:** In light of the recommendations, implement, changes to improve the process centred on:

- Guidance
- Siebel
- Learning
- Reporting
- Induction.

69 We will review these changes following implementation to ensure they are having the desired impact. This will also help us to identify further learning points from the feedback mechanism and if there are any additional process changes needed to help this process run as efficiently as possible ahead of this moving to BAU.

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

70 **Rationale:** In our 6-month evaluation of the Triage to RO feedback mechanism, we identified that there was still confusion around 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.

71 **Activity:** We will update operational guidance to ensure feedback requirements are clearer and are being discussed, recorded, and escalated using the appropriate method. We will review these changes following implementation to ensure they are having the desired impact and help us to identify learning points. This will identify if there are any additional changes needed to help this process run as efficiently as possible ahead of moving to BAU.

Influencing others

Work to raise awareness with both employers and doctors about the value of mentoring programmes as a key intervention to support outgroups who, according to the findings of *Fair to refer?*, miss out on everyday mentoring, which contributes to differential referrals

72 **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 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.

73 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.

74 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. Premotion 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. There is also evidence to show these groups enthusiastically engage with formal mentoring schemes when made available.

75 **Activity:** Collaborate with the Fairer Training Cultures (FTC) project team to maximise GMC influence to promote mentoring across the system and the four nations. Utilise the mentoring tool kit produced by FTC to provide a strong lever for the GMC to promote formal mentoring programmes in NHS trusts and other providers.

Support good practice

76 **Rationale:** *Fair to refer?* clarified that the disadvantages that lead to disproportionate referral arise long before the events leading to the referral and Recommendation four in *Fair to refer?* states that '*The GMC should collaborate with system partners to collate, support them to evaluate, and promote examples of 'what works' to reduce risks of disproportionate referrals, and pilot approaches to resolve concerns locally'.* From our conversations with ROs and Outreach we know that generic good practice feedback is ineffective and for interventions to work feedback must be relevant and specific to a DB.

77 **Activities:**

- Work with comms colleagues to identify effective ways to share evidence based good practice identified from our research to compare DBs who appear to be statistically proportionate/disproportionate: We expect this research to produce usable outputs from around six months after it has been commissioned. We plan to utilise this information as a lever to influence local processes across the four nations.
- Developing and piloting an approach to analysing, storing, and sharing examples of good practice shared with Outreach in the course of their work with employers: This will build on the work done in Phase 3 to develop and test a framework to identify and classify good practice across the four nations. Development and testing are underway on this piece of work, and we aim to pilot this with live information in late 2024/early 2025.

Focus on primary care

78 **Rationale:** In our data on disproportionality, Primary Care tended to have disproportionate referrals more often than other types of DBs. This can be seen in table 5 below, as of Q2 2023. The DB types shown separately are the main contributors to the values taken by KPI1.

Table 5: Active DBs with disproportionate referrals by DB type

Disproportionate DBs by DB type

Interpretation:

- The DB types shown separately were the main contributors to the values taken by KPI1 (seen in the low percentage for the "rest of DB types")

	No. active DBs	No. DBs disproportionate	% DBs disproportionate
NHS Acute or Non-Acute Trust	202	8	4.0
NHS Primary Care	19	7	36.8
NHS/HSC	59	13	22.0
LETB/Deanery	20	3	15.0
Locum agency	122	4	3.3
rest of DB types	938	7	0.7
all together (KPI1 as above)	**1360**	**42**	**3.1**

79 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.

80 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 in that report on primary care. 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. In England, we are mindful that NHSE are involved in work targeting inequality in primary care and we are engaging with them on this work. We have focussed our work for Phase 4 on interventions that are specifically targeted at addressing these findings.

81 Activities:

82 Across the four nations we will:

- Review our data to assess the influence of primary care trends on our updated overall disproportionality trends.
- Assess further interventions based on the *Fair to refer?* evidence from primary care.
- Continue to work with NHS Resolution and NHSE on piloting the Fair and Proportionate Checklists for local investigations.

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

83 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.

84 Activity: We will update operational guidance to ensure feedback requirements are clearer and are being discussed, recorded, and escalated using the appropriate method. We will review these changes following implementation to ensure they are having the desired impact and help us to identify learning points. This will identify if there are any additional changes needed to help this process run as efficiently as possible ahead of moving to BAU.

Collaboration

Continue to collaborate closely with NHSR

85 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.

86 Activities:

- Evaluating the pilot of joint conversations in London with senior leaders on their disciplinary data: The joint conversations pilot will be tested with three trusts in London. We will be evaluating this pilot to analyse its success and dependant on this we will look at how this might be rolled out further.

- Collaborating to develop a fair and proportionate check list with DBs for local investigations: This is being piloted in two primary care regions of England. We are part of the pilot group and will look to contribute and feed into this.
- Continuing to support their Being Fair programme and meeting to discuss any other areas for collaboration on respective wider fairness programmes.

Continue to collaborate with NHSR and other stakeholders on meeting the ambitions of NHSE's First Five report. The report lays out five areas around which organisations will focus their energies to drive forward fairness in the health system.

87 **Rationale**: We committed to collaborate with a range of stakeholders on activities to address some of the disparities highlighted by the findings of the Medical Workforce Race Equality Standard. Stakeholders include NHSE, the BMA, NHS Resolution, the Academy of Medical Royal Colleges and NHS Employers. The First Five document laid out a range of work that the various organisations would take forward.

88 **Activity**: Our activities focus on two areas; driving forward induction for new International Medical Graduates and activity to reduce disproportionate referral. We will shortly be reporting the activity we have done against these two domains to NHSE, and working with stakeholders to consider what work we can collaborate on moving forward.

We will monitor and assess opportunities to engage with the NMC.

89 **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.

90 **Activity:** Continue to share and discuss with the NMC our approaches on use of data to identify disproportionality and share the outputs of our evidence based good practice research.

Building our understanding of changes to the local landscape

Continue work with Outreach across our four nations to develop a narrative on key changes to the external environment to better understand what local changes may underpin improvements in disproportionality data and to enable us to assess and support sustainability

91 **Rationale:** We know that there are many factors influencing our data trends on disproportionate referrals. By understanding changes in the wider environment, we are hoping to build a picture of the external and internal work that has impacted on our targets in preparation for our go live date in 2026 and how to sustain improvements over the longer term. This will also include exploring what impact the revised Good Medical Practice standards might be having on referrals.

92 **Activity:** Create a narrative of activities across both the GMC and the external environment that are impacting on the FER target.

Continue to work with the National Offices to understand local landscapes across the four countries

93 **Rationale:** Through continued focus on our national offices, we are looking to ensure that our progress is sustained throughout the UK.

94 **Activities:**

95 As well as participation in the Outreach actions identified above, our National Office teams are committed to ensuring progress is sustained throughout the four UK countries. Some specific examples include:

- GMC Wales will be running 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 Northen Ireland are working with the Northern Ireland Confederation of Health and Social Care (NICON) to facilitate a workshop at their conference, in October 2024, showcasing positive interventions that employers can make to support healthcare professionals from diverse backgrounds.
- GMC Scotland are continuing to work with ROs in Scotland to refocus the RO Network to provide opportunities for FtP case studies to be discussed to enable a consistent and fair approach and to use this 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.

General Medical Council

Fairer Training Cultures

Action	To discuss
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.
Recommendation(s)	To consider performance against our commitments, our priorities, and asks of others in response.
Annexes	Annex A: Index Measures Annex B: FTC activity across National Offices & Outreach England Annex C: Annual impact review summary Annex D: 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	**Colin Melville**, Medical Director and Director, Education and Standards

Agenda item M8
Fairer Training Cultures

Background

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 Our 10-year strategy focuses on the removal of systemic and cultural barriers which drive inequitable outcomes as well as championing initiatives designed to improve outcomes for marginalised groups.

3 We proactively drive change by requiring educational organisations to show how they are tackling the causes of inequality, and by helping establish an evidence base for 'what works'.

4 We use our influence at meetings and events to maintain attention on this issue and to shape the narrative. We are building the case for change by presenting evidence that improving outcomes is possible and that removing barriers to career progression contributes to NHS strategic priorities, workforce and patient care.

5 The 10-year programme is split into three phases. Phase 1 will be complete at the end of 2024 during which time we have:

- Built an evidence base of 'What Works' through small scale pilots and used these to successfully shift the narrative and create more openness to change.
- Embedded our target into Education and Standards quality assurance teams, influenced GMP standards and collaborated with National Offices and Outreach colleagues to pilot GMC led training. This maximises our impact and will create a sustained focus on equality for the long-term.
- Collaborated with educational organisations to deliver systemic change, co-creating new policies and practices.

6 In Phase 2 our priority is to work with *The Future of Education and Career Development* programme to embed Fair Training Cultures (FTC) firmly into our new educational standards and policies.

Strategic plan

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 (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?' (2019).

- To ensure the target is embedded into GMC standards, policies, and quality assurance activity. Our action plan is developed through six workstreams to ensure we are driving change across the entire system.

- To demonstrate the value of tackling inequality to NHS strategic priorities, workforce planning and patient care.

8 The 10-year programme is broken into three phases:

Phase 1 – 2021-2024: *Laying the groundwork*

- Build evidence base of 'What Works' through small scale pilots to show that change is realistic and achievable; driving a culture change within organisations.
- Embed targets into 'Business as usual' work of Quality Assurance teams to maximise impact and to drive change throughout the entire system.
- **Measuring success in phase 1**:
  - demonstrable shift in index measures at pilot/local level
  - evidence of educational organisations beginning to invest in / pilot the priority initiatives expected to lead to better outcomes.

Phase 2 – 2025-2028: *Scale up*

- Widespread adoption of priority initiatives nationwide.
- Continued evaluation and evidence building for initiatives with longer timeframes.
- Embed 'Fairer Training' into FutureEd and the next generation of educational standards and policies.
- **Measuring success in phase 2**:
  - Narrowing of the gap for all Index measures at a national level.
  - Evidence of widescale adoption of initiatives and policy / systemic change.

- Better reliable forecasting models based on data from pilots & evidence of real-world change.

Phase 3 – 2029-2031: T*he new normal*

- Implementation of new standards and requirements founded on principles of fairness.
- **Measuring success in phase 3**:
  - Evidence that systems & policies underpinning education and training are demonstrably fair.
  - Evidence that changes are being sustained.
  - Closing of the gap across all Index Measures.

Barriers to success

9 Whilst there is good evidence of widescale commitment from stakeholders to improving outcomes for marginalised doctors, we must recognise that there are many barriers to change. These include a resource-stretched system with many competing priorities and time pressures on educators and learners which reduce individual commitment to new initiatives.

10 There is a general lack of good quality evidence about which initiatives are effective which can make the cases for change less compelling. At the same time there are financial and time barriers to undertaking good quality evaluations of the work which is already happening.

11 A work programme deliberately targeting specific groups is at risk of push back from some who feel that they are being disadvantaged by changes, and from those we are seeking to support who may perceive the work as stigmatising. It is important that we can clearly articulate the problems with the status quo, and that we invest time in communication and engagement so that we take people with us.

12 There is no silver bullet, and a change is needed throughout the system. The GMC has direct influence on the fundamental principles of Education through our standards and how these are assured. New standards will take time to feed through to educational outcomes. We do not have direct control of many of the identified barriers and we need to work with and through others to change these. Some factors are beyond the influence of the GMC and educational organisations and their effect may remain in spite of this work.

Evidence of progress at the end of Phase 1

13 We evaluate our progress each year to ensure not only that we are delivering on actions but to look for signals that the work is having the hoped-for impact on learning experiences and outcomes.

14 Evidence of progress at the end of Phase 1:

a Publication of evaluations of our priority interventions:

- Educator training and support
- Peer support and mentoring
- Enhanced exam preparation and support

b These give us clear evidence that outcomes for non-UK graduates can be improved by targeted support such as exam preparation.

c Our evidence shows that mentoring and peer support is highly valued by black UK graduates and leads to improved confidence and preparedness. This supports our expectation that mentoring will lead to a positive impact on career outcomes and progression.

d Analysis of action plans shows that organisations are responding positively to our evaluation evidence. We are seeing increasing investment and focus on these key initiatives across regions, countries and specialties.

- Most postgraduate training organisations report having in place or having a plan to pilot a mentoring / buddying scheme.
- Many colleges are developing the guidance to help prepare for exams and the Academy of Medical Royal Colleges (AoMRC) have published additional guidance for colleges and faculties.

National level Index Measures

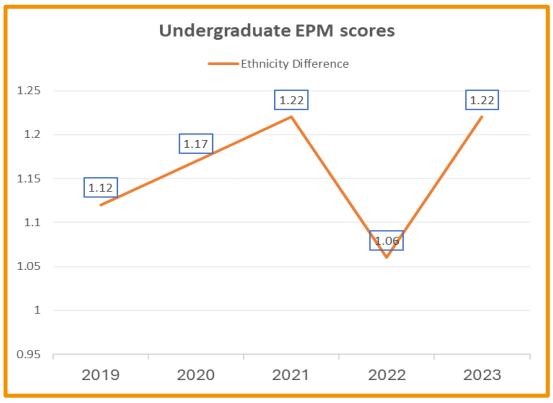
15 At a national level a significant attainment gap remains across all the index measures and remains at levels that warrant continued system wide action.

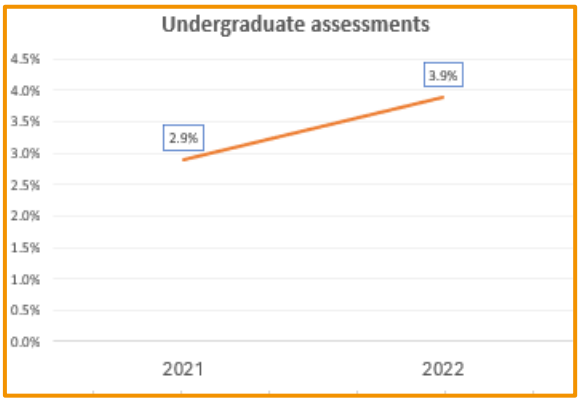
16 Charts below show the difference between UK Graduate (UKG) White and UKG ethnic minority learners (orange line) and UK and non-UK graduate learners (blue line) across our index measures. (See **Annex A** for detailed Index Measure tables).

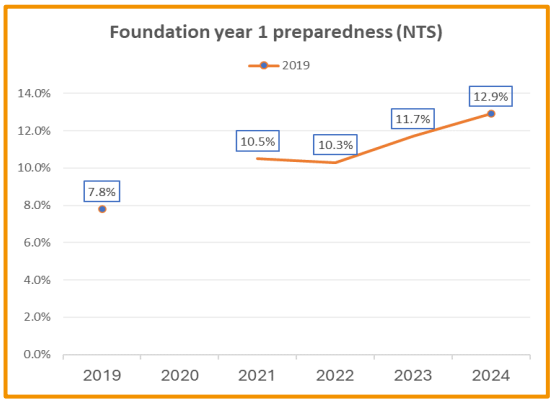
17 Note: For Undergraduate: Education Performance Measure (EPM) will be replaced by undergraduate assessment from 2024.

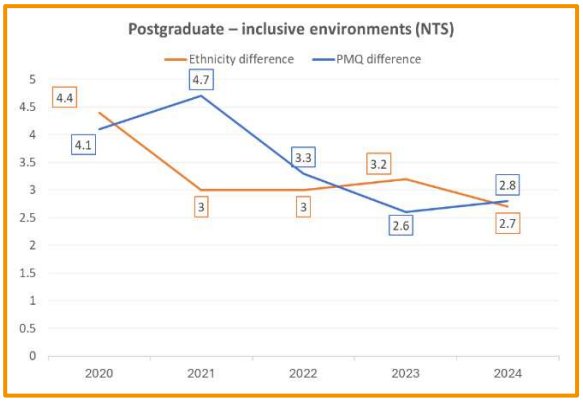
Agenda item M8

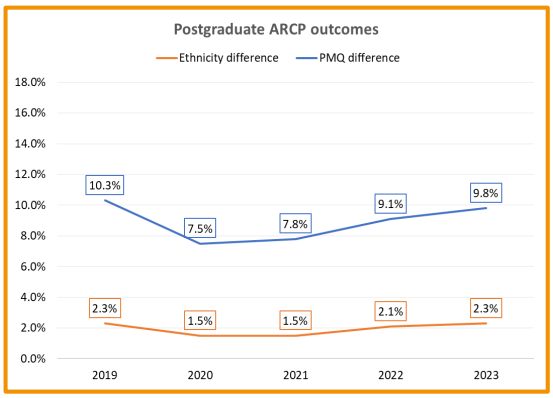
Fairer Training Cultures

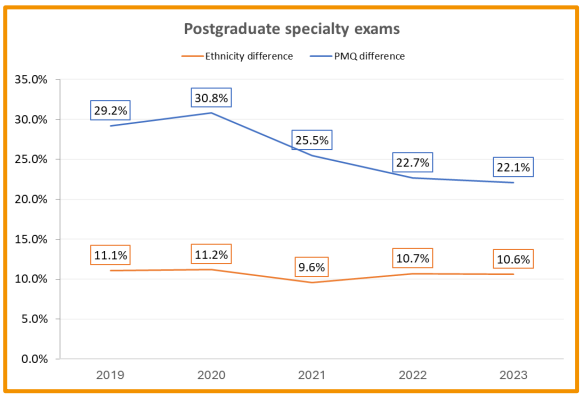












Specialty Training index measures

18 We can observe the first signs that the attainment gap is narrowing in specialty training. All three index measures (inclusive environment, Annual Review of Competency Progression (ARCP) and exams) have edged in a positive direction. Improvement is more pronounced for non-UK graduates than UK Black and ethnic minority specialty trainees.

19 The biggest movement can be seen in Post Graduate (PG) exams where the pass rate differential between UK and non-UK graduates has narrowed by seven percentage points.

20 This may reflect the greater number of initiatives we can observe in organisation action plans targeting non-UK graduates, or that some of the risks faced by this group are more amenable

to change and respond more quickly to initiatives such as targeted training to address knowledge and experience gaps.

21 A range of organisations offer support to prepare for exams, educator training and mentoring schemes as part of their core business and it's important that they reflect on how existing offers can be improved or any gaps plugged. This including PG Training Organisations, Professional Support and Wellbeing Units, Local Employers, Medical Royal Colleges and Faculties, and Medical Schools.

22 It is noted that some improvements to ARCP and exam outcomes during the pandemic have reversed and this may indicate that the derogations in place, such as giving trainees longer to complete high-stakes exams, disproportionately benefitted disadvantaged groups. In Phase 2 we will explore this further to see if there is a case for revisiting these temporary changes.

Undergraduate and Foundation Training index measures

23 Disappointingly, the two Index Measures targeting earlier stages of training do not yet show improvement. Education Performance Measure (EPM) scores show no change and Foundation Year 1 preparedness has deteriorated in both absolute and relative terms.

24 Our data and research have centred on postgraduate training to date however, this will shift in 2025 with the publication of Medical School assessments data for the first time in Q1 2025.

25 Organisations are taking action and it is expected that the impact will be measurable over time.

- Medical Schools reported on their work to address attainment gaps for the first time in 2023, and this will become an annual requirement.
- A new recruitment system was introduced by the UK Foundation Programme (UKFPO) in 2024 which aims to remove barriers to marginalised Foundation Year 1 (F1) entrants accessing their preferred placements. This affects new starters from Aug 2024. We will be monitoring the impact of this change on widening access and doctors reported preparedness in the 2025 National Training Survey (NTS).
- We have published the final evaluation of Melanin Medics 'Enrichment Programme'. It is designed to improve preparedness for new Foundation Doctors. There is strong evidence that mentoring, peer support and career advice are highly valued by learners and that confidence, career readiness and access to networks are improved which we would expect to lead to improved outcomes over time.

Trajectory

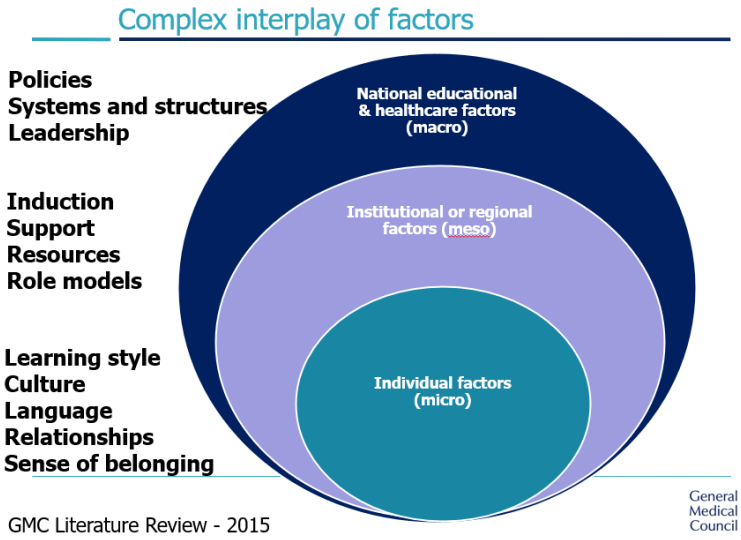
26 There are many barriers and uncertainties with such an ambitious and large-scale programme. It is important that we regularly review whether we are achieving the necessary impact. The GMC directly controls only a small number of the wide range of factors which need to change. External risks may affect progress including NHS resource constraints and competing strategic priorities.

27 Each year we carry out a peer-reviewed impact review to check whether we are on track to achievement of the targets by 2031. A summary of our 2024 review is enclosed as **Annex C.** it is clear that our work is helping to increase and focus activity to address the attainment gap, particularly for non-UK graduates.

28 In addition we have a forecast model for each index measure (**Annex D**) which compares annual changes in the data alongside a reference forecast of what would be expected if there were no change. The forecasting models are based on the very small number of data points available and are unable to reliably detect change or provide reliable information about whether we are on track to achieve the targets.

Programme activities

29 The work programme is designed to tackle the multiple root cause factors identified in our research. These are spread throughout the educational experience and sit at different levels.



Priority 1: Fair recruitment and selection

Recruitment into foundation training

30 The UK Foundation Programme Office this year implemented a new preference informed allocation process which aims to be a fairer method for allocating placements to applicants. The previous system ranked applicants using EPM and other criteria giving the highest performers first choice of location. UK graduate white applicants consistently achieved a higher rank than UK graduate ethnic minority applicants. The new system allocates a computer-generated ranking giving all applicants an equal chance of being able to select their preferred placement. 75% of all applicants received their first preference, versus 71% under the previous system*.

31 This system change is expected to improve outcomes for marginalised learners because lack of choice in training environment is a key factor in the attainment gap. It affects sense of belonging, feeling of preparedness, confidence, and access to support networks inside and outside of the working environment.

Specialty recruitment and selection

32 We continue to work with the Medical and Dental Recruitment and Selection (MDRS) committee co-chairing an EDI working group to remove unfair barriers in specialty recruitment.

33 This group:

- Produced new ED&I principles to guide Medical Royal Colleges and Faculties develop fairer Person Specifications and scoring criteria; and
- Is supporting Medical and Dental Recruitment and Selection (MDRS) review recommendations following a fairness audit of the Multi-Speciality Recruitment Assessment (MSRA).

34 Revised person specifications will be used for recruitment into new CT1/ST1 posts from August 2025, and into ST3+ posts from August 2026.

Priority 2: Supporting educational organisations to prioritise activity

Enhanced exam support

35 Our final data analysis of participants in the exam preparation pilot known as the "Royal College of Psychiatrists (RCPsych) Clinical Assessment (CASC) masterclass" shows that this is

* 2024 Foundation Programme Allocation - UK Foundation Programme

an effective initiative. When compared to exam candidates from the same demographic group those who had attended the masterclass had pass rates:

- 12% points higher (non-UK PMQ); or
- 15% points higher (Black and ethnic minority non-UK PMQ).

36 It is less clear whether the initiative had a beneficial effect for UK black and ethnic minority participants. This group made up only a small number of participants, and an unexpected increase in the exam pass rate for this group irrespective of attendance at the masterclass occurred at the same time. We will work with the RCPsych to understand what lessons can be learned and shared.

37 Qualitative interviews by Edge Hill University looked specifically at *why* such initiatives are effective so that they can be replicated by others. It found:

- The CASC masterclass helped candidates know what to expect and allowed them to hone exam technique in a low-stakes, supportive environment. Once commented "Until now, I've been doing it completely blind. It was like playing a game and what was never really explained was the rules."
- The highly personalised feedback was especially valued by attendees.
- Some participants commented on the reassurance of meeting examiners from a non-UK background.

38 Following this pilot, the AoMRC developed Principles for exam support to address the awarding gap. This sets a clear direction for all Medical Royal Colleges and Faculties to ensure they are taking appropriate action to eradicate systemic inequalities which contribute to the attainment gap. We encourage colleges and faculties to act on these principles.

39 The AoMRC are also developing new principles on Exam Feedback which we expect to be published before the year end.

40 ***Next steps***:

- We are widely sharing the findings of the evaluation and encourage PTOs, Professional Support Units, Colleges and Faculties and employers to reflect on the existing exam support they offer, and how well this meets the needs of different learners.
- We will work with AoMRC to monitor the implementation of the Principles for exam support and exam feedback.

Inclusive learning environments

41 Ensuring learning environments are welcoming and inclusive is a key ambition for the programme. To support our Quality Assurance (QA) teams and Post Graduate Training Organisations (PTOs) to address issues on the ground we have developed new NTS questions on discriminatory behaviours to a provide a deeper insight into training locations.

42 The 2024 NTS report found that the majority of trainees continue to say that they work in supportive workplaces. However, the demographic breakdown of questions about discriminatory behaviours provide new insight into unprofessional behaviours in some healthcare environments. The analysis shows that gender, ethnicity, religion, sexual orientation, and disability status affect a trainee's experience.

Table 4: Trainees – Discriminatory behaviours questions

In your current post how often, if at all:	Daily / Weekly	Monthly	Less than once a month	Never
do you hear insults, stereotyping or jokes in your presence on the grounds of a person's protected characteristics?*	4% (as 2023)	6% (as 2023)	16% (↓1pp)	74% (↑2pp)
do you experience micro-aggressions, negative comments, or oppressive body language from colleagues?	7% (↑1pp)	7% (↑1pp)	16% (↑1pp)	71% (↓2pp)
are you not given the same training opportunities as your peers at the same stage of training? (such as the opportunity to observe an unusual case)	7% (↑2pp)	4% (as 2023)	8% (as 2023)	81% (↓3pp)
are you ignored or excluded from conversations, groups, or meetings?	3% (as 2023)	3% (↑1pp)	10% (↑2pp)	84% (↓3pp)
are you intentionally humiliated in front of others?	1% (as 2023)	2% (as 2023)	9% (↑1pp)	88% (as 2023)
do you experience unwelcome sexual comments or advances causing you embarrassment, distress, or offence?	1% (↑1pp)	1% (as 2023)	5% (as 2023)	93% (↓1pp)

43 ***Next steps***:

- We are exploring opportunities to use the new NTS data within or QA of learning environments and possibly within the Patient Safety Intelligence Forum alongside intelligence from Outreach.

Updated EDI guidance

44 Our QA teams, Quality Assurance - Monitoring and Improvement (QAMI) and Medical Education Development (MED), are refreshing the EDI guidance that support *Promoting Excellence* and *Excellence by Design* standards in collaboration with the ED&I team. This aims

to improve the quality of EDI Impact assessments for curricula changes and provide more current case studies based on new pilots and research.

45 ***Next steps***:

- Draft guidance expected to be published in 2025.

Priority 3: Supporting learners and educators

Mentoring

46 We recently published the final evaluation of a 2-year study with Melanin Medics into the impact of their Enrichment Programme aimed at improving career readiness for Black African or Caribbean heritage doctors as the transition into F1. This has shown a positive impact on the preparedness of new F1 doctors: one of our key index measures.

47 The study found over 90% of participants would recommend the programme to their peers, and around **80% stating they felt ready or very ready to become an F1 doctor at the end of the programme**. The most significant impact arose from:

- Receiving mentoring support / Visibility of role models.
- Networking / professional contacts.

48 To compliment the pilot, we also commissioned a clinical fellow to undertake a literature review into Mentoring. The review looked for evidence of the value of mentoring across different sectors and assessed the current availability of mentoring within the NHS.

49 Following stakeholder engagement and focus groups, a Mentoring toolkit was created and published with advice from individuals and organisations that have established schemes. This toolkit is aimed at helping organisations tackle any barriers to setting up a mentoring scheme. It has been promoted including via a Blog for National Mentoring Day.

50 ***Next steps***:

- We are calling on organisations to establish formal mentoring schemes targeting or promoted to marginalised groups to maximise uptake. We are monitoring the extent of action via Organisational Action Plans.
- We're promoting the toolkit at educational events, and Outreach are supporting us to promote it with employers.
- We are looking at opportunities to continue to work with *Melanin Medic's Enrichment Programme* on a longitudinal study to measure the long-term impact of mentoring on career progression.

Supporting educators

51 We published an evaluation of a pilot training programme for supervisors of non-UK graduates. It showed improved awareness of the barriers non-UK learners face and improved confidence in how to provide effective support and feedback on performance.

52 Following this, the Outreach team developed an in-house GMC delivered training programme entitled *Supporting IMGs for supervisors* which is in pilot phase.

53 ***Next steps***:

54 We encourage organisations to develop support for educators supporting learners from different cultural backgrounds and building skills for more effective feedback conversations.

- We will engage with the *FutureEd Valuing medical educators* workstream to ensure future standards for educators reflect the skills needed to support a diverse learner population.

Improving formative feedback

55 A lack of informal, formative feedback has been highlighted as a factor contributing to the attainment gap. We have explored the different experiences of giving and receiving feedback for UK white, UK ethnic minority and non-UK graduate trainees and published findings in *Improving feedback in the context of differential attainment*.

56 As a result, the Outreach team developed an in-house training programme entitled *Fairer feedback for supervisors* which is in pilot phase.

57 The AoMRC is developing new guidance for colleges to improve feedback to candidates who fail an exam to help them identify where improvements need to be made. This was reviewed as part of our 'Sharing Good Practice' event in July.

58 ***Next steps***:

59 We will continue to ask organisations to focus on supporting educators and learners to have open and honest feedback conversations. This is likely to require training for educators, examiners and assessors and potentially trainees themselves in the giving and receiving of feedback and the context of cultural difference:

- We are hoping to test a new NTS question on the quality of exam feedback in 2025.

Deepening our understanding of inequality affecting all protected groups

60 We have worked with researchers to undertake an in-depth multivariate analysis of all postgraduate exams. This evaluated the independent predictive validity of a range of factors, including protected characteristics, measures of socio-economic status and educational privilege and intersectional impacts. It will help identify groups at greatest risk of inequality and help to prioritise resources in future.

61 The research finds that ethnicity and PMQ are the strongest predictors of specialty exam pass rates for both UK graduates and non-UK graduates, even when all other factors are accounted for. This includes prior attainment, socio-economic status and other protected characteristics.

62 Research papers are being currently being submitted to journals for publication.

Engagement and communications

63 We work with comms teams to promote new publications and at key times, such as national mentoring day.

64 We are regularly approached by organisations to discuss their work to address the attainment gap or to present on the GMC's work at conferences or events.

65 In June we co-hosted the 3rd annual 'Sharing Good Practice' event with the Academy of Medical Royal Colleges, Conference of Post Graduate Medical Deans, and Medical Schools Council.

66 The event is intended to help address the lack of good evidence by encouraging organisations to evaluate their interventions and share their findings with others. It is an opportunity to spotlight promising interventions and share emerging evidence that are driving real-world change to encourage others and promote cross-system learning. This year we had speakers from Queens University Belfast, Southampton Medical School and Imperial College London as well as NHSE and GMC Clinical Fellows.

Four country perspective

67 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.

68 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,

69 National Offices and Outreach England provide valuable support to achieving the Fair Training targets as outlined in **Annex B**.

Forward Look - Phase 2 priorities

70 Phase 2 will focus on scaling up priority initiatives at a national level:

- Mentoring;
- Support for Educators;
- Enhanced induction for non-UK graduates; and
- Targeted support for marginalised learners approaching high stakes recruitment, exams or career transition points.

71 We will:

- Formalise our expectations and requirements through new GMC policy and monitor implementation through our QA.
- Review the Organisational Action Plan process and identify opportunities to strengthen our key asks to speed up change.
- Focus on UK graduate ethnic minority learners by:
  - Continuing to build evidence of 'what works' to improve outcomes for UK graduate ethnic minority learners.
  - Focusing on earlier interventions at Medical School and Foundation training.
- Work closely with the *FutureEd* team to ensure new standards and guidance are founded on the evidence for *Fair Training Cultures.*

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'. 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.

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Fairer Training Cultures

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.

General Medical Council

Annex A - Index Measures

Index measure	DATE (Year or academic year ending)	2019	2020	2021	2022	2023	2024
Undergraduate EPM scores Difference between mean Educational Performance Measure (EPM) decile scores.	White Ethnic Minority **Difference in mean decile score**	6.05 4.93 **1.12**	6.09 4.92 **1.17**	6.16 4.94 **1.22**	6.17 5.11 **1.06**	6.24 5.02 **1.22***	Measure discontinued – replaced with UG assessment measure
Undergraduate assessments Difference between mean medical school assessment pass rates.	White Ethnic Minority **Difference**	DATA NOT AVAILABLE		96.1% 93.2% **2.9pp**	93.9% 90.0% **3.9pp**	DATA AVAILABLE FOR 2022/2023 academic yr expected in 2025	Not yet available
Foundation year 1 preparedness (NTS) Difference in self-reported preparedness for first F1 post.	UK White UK Ethnic Minority **Difference**	70.2% 62.4% **7.8pp**	QUESTION NOT INCLUDED IN 2020 NTS	76.3% 65.8% **10.5pp**	68.5% 58.2% **10.3pp**	61.6% 49.9% **11.7pp**	68.0% 55.1% **12.9pp**
Postgraduate – inclusive environments (NTS) Difference in perceived inclusivity of training environment. Score out of 100.	UK White UK Ethnic Minority **Difference** All UK All IMG **Difference**	QUESTION NOT INCLUDED IN 2019 NTS	81.6% 77.2% **4.4pp** 80.1% 76.0% **4.1pp**	83.0% 80.0% **3.0pp** 82.0% 77.3% **4.7pp**	82.1% 79.1% **3.0pp** 81.0% 77.7% **3.3pp**	82.7% 79.5% **3.2pp** 81.6% 79.0% **2.6pp**	83.1% 80.4% **2.7pp** 81.9% 79.1% **2.9pp**
Postgraduate ARCP outcomes Difference in proportion of unsatisfactory ARCP outcomes for foundation and specialty trainee.	UK White UK Ethnic Minority **Difference** All UK All IMG **Difference**	5.2% 7.5% **2.3pp** 6.0% 16.3% **10.3pp**	3.3% 4.8% **1.5pp** 3.9% 11.4% **7.5pp**	3.1% 4.6% **1.5pp** 3.7% 11.5% **7.8pp**	4.5% 6.6% **2.1pp** 5.4% 14.5% **9.1pp**	4.8% 7.1% **2.3pp** 5.7% 15.5% **9.8pp**	Not yet available
Postgraduate specialty exams Difference in mean exam pass rates for specialty trainees.	UK White UK Ethnic Minority **Difference** All UK All IMG **Difference**	80.2% 69.1% **11.1pp** 76.3% 47.1% **29.2pp**	81.2% 70.0% **11.2pp** 77.2% 46.4% **30.8pp**	83.1% 73.5% **9.6pp** 79.5% 54.0% **25.5pp**	81.3% 70.6% **10.7pp** 77.2% 54.5% **22.7pp**	82.2% 71.6% **10.6pp** 78.1% 56.0% **22.1pp**	Not yet available

Agenda item M8
Fairer Training Cultures

Index Measure – Understanding the data

EPM scores

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

2 This data is discontinued from 2023. And will be replaced by UG assessments as an Index Measure for undergraduate education.

3 **Note**: In the 2024 report historical EMP data has been revised to reflect new demographic data being obtained from trainees.

Undergraduate assessments

4 Reporting starts for year 20/21 and includes only first and final year assessments. From 21/22 onwards assessments from all years of study are included.

5 Due to a delay in receiving data from HESA, year 22/23 is not complete and not included. The rest of 22/23 is expected to be included in the 23/24 collection which is currently underway

6 Reporting years are based on the date of assessment - a year runs from 1 August - 31 July as per https://www.hesa.ac.uk/collection/c23055/introduction. Only assessments that were passed or failed have been included, assessments marked as nullified/deferred or any other result have been excluded. Pass rate has been calculated using first attempts only. Assessments categorised as "Other - not reported" or Uncategorised are excluded.

Foundation – F1 preparedness

7 Data at March NTS census date. We asked foundation year 1 doctors the question ‘I was adequately prepared for my first foundation post’. The measure shows the proportion of respondents that agreed or strongly agreed with the statement.

Postgraduate education – inclusive environments

8 Data at March NTS census date. The responses to the survey question ‘my department/unit/practice provided a supportive environment for everyone regardless of

background, beliefs or identity' were converted into a score out of 100, with higher scores indicating higher levels of support.

Postgraduate education - ARCP

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

Postgraduate education – specialty exam

10 Data is for previous full academic year. Difference in specialty examination pass rates, across all UK specialties and training levels, and for all attempts for candidates within a relevant specialty training programme. Candidates not in training or in Foundation training at the time of the exam attempt have been excluded from the results. Data provided by royal colleges and faculties.

11 Progress reports prior to 2023 show post-graduate exams data for all those who took Royal College exams including those not in relevant training programmes. From 2023 we are reporting only on those in a relevant training programme at the time of examination and updated the figures retrospectively.

General Medical Council

Annex B

FTC activity across National Offices & Outreach England

1 The FTC work is promoted and supported across the four nations by GMC National Offices, Outreach Development and Support Unit, and Outreach colleagues across England.

England

2 We have supported the efforts to improve formative feedback with the creation of *Fairer feedback for supervisors* – a training programme dedicated to supporting supervisor to have high quality feedback discussions with their trainees. We are now piloting this across the UK.

3 We are also supporting the take-up of the *Mentoring toolkit* developed by the Fair training cultures team, and we are promoting it with stakeholders.

4 We have continued to work with NHS England to embed induction for new IMGs, and working at national, regional and local level for the adoption of the Welcoming and Valuing IMG programme guidance*.

5 We have piloted the Supporting IMG Supervisors – cross cultural communication session in London and Scotland, with strongly positive feedback.

Northern Ireland

6 ED&I was the main focus of discussion at the NI UK Advisory Forum meeting in April. There was consensus on the value in raising awareness of GMC data and insights with HSC Trust boards, and raising awareness amongst patients and the public of the importance of the international health care workforce.

7 The Northern Ireland team also exhibited at the Institute of Government and Public Policy's conference on EDI in the workplace in Belfast, and contributed to a session at NICON 2024 titled "Supporting our diverse workforce- Stepping up". During this session the role of NICON

* https://www.e-lfh.org.uk/programmes/nhs-induction-programme-for-international-medical-graduates/

members in tackling discrimination and inequality was explored, including what we can do to retain healthcare staff working in Northern Ireland and to support high quality patient care.

8 An ED&I module has been integrated into the FLIGHT sessions attended by all F2s in NI. This explores what EDI really means and encourages self-reflection on individuals bias, privilege and the importance of raising concerns within the workplace when doctors see or experience unfair behaviours. Our clinical fellow will continue the roll-out of this.

9 The NI liaison advisers recently piloted 'Fairer feedback conversations' workshop to 23 trainers at the BHSCT 100% of attendees said they would change their behaviour as a result of attending the course.

10 The Northern Ireland team are supporting enhanced induction in all HSC Trusts for IMGs.

Scotland

11 In Scotland, *Supporting IMGs for supervisors* training is being carried out by associates. This outreach developed training is designed to help supervisors understand and overcome often unseen cultural barriers that may act as barriers between them and their trainees.

12 Outreach are also contributing to NES' Welcoming IMGs New to Scotland (WINS) events in Glasgow, Edinburgh and Aberdeen. These events will include trainers who support IMGs, as well as the trainees themselves.

13 They also trialled in-person Welcome to UK Practice sessions holding them in centralised locations. They took place in Perth, Edinburgh, Aberdeen and Glasgow to enable doctors to meet other colleagues new to medicine in Scotland in person. An online session was also held for those doctors unable to attend any of the face to face sessions. These GMC sessions complemented the NES WINS events (Welcoming IMGs New to Scotland).

14 The team have also been collaborating on the Scottish government's Fairer Working Cultures Group, on relevant areas including IMG support and anti-racism resources. Ways we've collaborated include:

- **a** Outreach colleagues speaking at the Ethnic Minority Forum with a view to myth busting and highlighting the work we're doing to promote fairness.
- **b** Linking up with patient organisation the Health and Social Care Alliance to understand their experience of engagement in respect to patients with experience of discrimination.

15 We've been invited to sit on NES' Advancing Equity in Medical Education Group which discusses all the ED&I work ongoing at NES. We have updated on Fair training cultures work at this group.

Wales

16 NHS Wales Shared Services Partnership attended our Fairness in Local Processes workshop in late September. Although the focus is on Health Board investigations there was read across to trainees.

17 We presented on the 'impact of positive working cultures on training' at South Wales' annual educators development day.

18 Our ELA also ran a workshop with Betsi Cadwaladr which focused on fairness and included discussion of trainees.

19 Inductions and supporting IMGs to contribute to good training cultures:

- **a** Since October 2023, our Outreach team in Wales have hosted 7 enhanced induction events in all health boards across South and West Wales, reaching 114 international medical graduates. These workshops are designed specifically to support newly recruited international doctors to the ethical and professional standards expected of them in NHS Wales and feedback is positive across all sites. All boards in South Wales are now committed to providing annual or biannual induction events to ensure these doctors are properly supported during their transition to NHS Wales. In North Wales, we have delivered three Welcome to UK Practice sessions in the Betsi Cadwaladr University Health Board area.
- **b** Our outreach team also presented at HEIW Sharing Training Excellence in Multiprofessional Education conference in March on the importance of supporting internationally qualified trainees and doctors, as well as the changes to Good Medical Practice.

20 Developing Positive Cultures:

- **a** Our outreach team have worked closely with two Health Boards in South Wales to create a programme designed to promote positive cultures in specific departments, using the updated Good Medical Practice as the lever to tackle unprofessional behaviours. We have trained the workforce team in one board to deliver this programme to all workforce and development staff and have been asked to roll this out to further departments.
- **b** We have also delivered a joint professionalism workshop with HEIW and a bespoke Leadership and Management workshop for senior clinicians in Betsi Cadwaladr University Health Board with a focus on professionalism, including new case study material around identifying and challenging unacceptable behaviour and racism.

21 Bridging training cultures at undergraduate and postgraduate level:

a Our outreach team have engaged with medical education faculty leads and deans in South Wales to discuss a rise in unprofessional behaviours witnessed across the UK in foundation cohorts. We have now established a routine curriculum engagement for first and final year students which covers the importance of professionalism and Achieving Good Medical Practice.

b In March 2024, the RLA ran a workshop for GP tutors across North Wales who work with placement students from Bangor University. The focus was on Good Medical Practice and how that is contextualised within day-to-day clinics to better support positive training cultures and enhance the experiences during placements.

c It was also agreed with the Medical School programme director to approximately double the number of face-to-face sessions at Bangor University for 2024/25 following it gaining accreditation as an independent medical school. This expanded programme consists of nine subject matter sessions which commenced in early Sept, with a focus on AGMP and professionalism.

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Annex C

Annual impact review summary

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

General Medical Council

Annex D

Current statistical KPI forecasts

1 We show the historic data on the five Index Measures for fair training cultures (FTC) alongside statistical forecasts, and possible future trajectories.

2 Crucially, though we used best-established cutting-edge methods of forecasting, these are unlikely to be the reality that materialises. There are many limitations to forecasts. However, they represent our best ability to statistically model the future given available data.

3 For each Index Measure 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 our 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.

4 Summary suggestions from forecasts:

- It remains highly premature for forecasts of current direction of travel to be reliably informative.
- Such forecasts must not be taken as a suggestion that nothing is currently changing or that nothing will change in the future.
- We currently 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 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 is no evidence for change in any of the KPIs.

- In addition, it remains very challenging to forecast reliably so far into the future. The drivers for FTC are very complex, systemic change will take time to have an impact, and attaining targets is expected to take up to 10 years.
- Despite this, for two FTC metrics, forecasting models have started to detect trends. Both the difference in postgraduate ARCP outcomes between ethnic groups and the difference in postgraduate exam pass rates between UK graduates and IMGs, appear to be turning towards their aspired targets.

Interpretational notes

5 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.
- Also, the actual data may be naturally bounded. For instance, percentages cannot go below 0% or above 100%. Models currently cannot reliably incorporate the effect of getting close to those bounds; this is seen in some expected forecasts and uncertainty bands crossing such bounds, rather than being limited by them. The drivers underlying real data often change when data gets close to such bounds. And it is very difficult to anticipate how so. Therefore, making hard (and most of the time unnecessary in practice) to make models to incorporate the effect of such bounds.

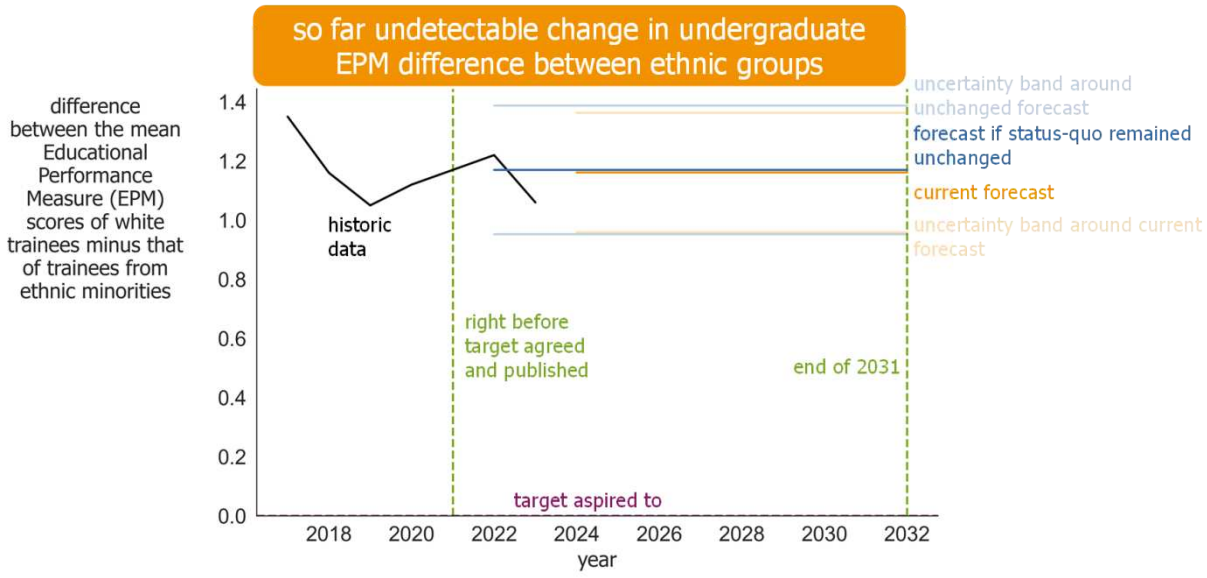
6 The farther we forecast into the future, the more uncertain a forecast tends to become, as shown by uncertainty bands (95% prediction intervals) surrounding each expected forecast. Regardless, the forecasts here represent our best evidence base, given existing data, and are useful to guide our decisions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

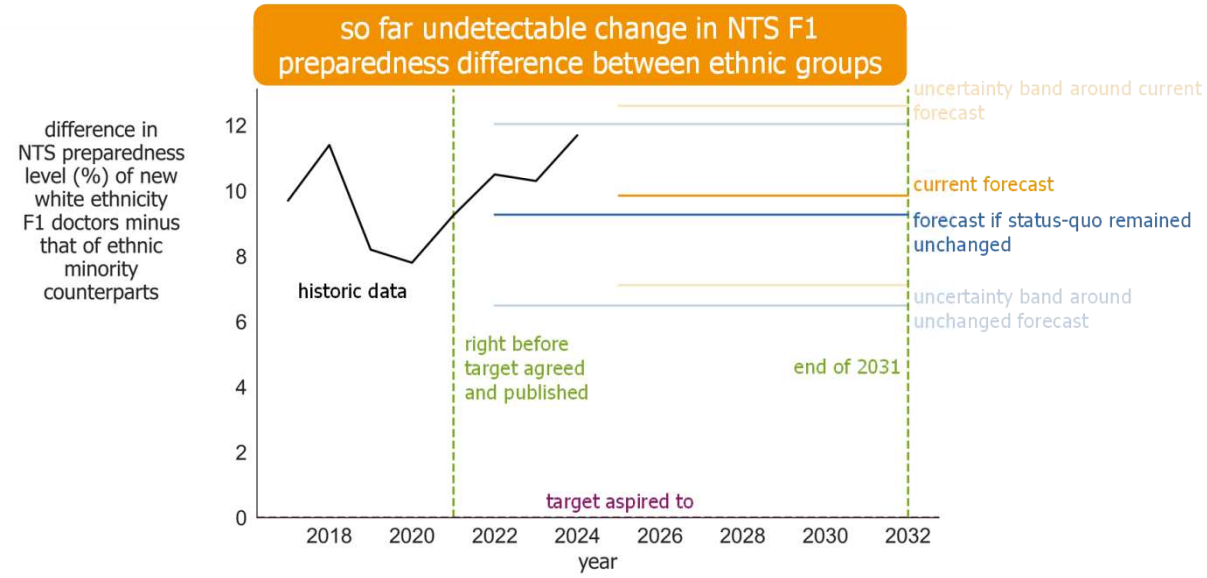
7 For FTC:

- 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.
- FTC data takes a long time to be generated and verified, so the most recent currently available is from 2022, except for NTS metrics that were available for 2023. Therefore, we forecast from 2023 and 2024 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.

Fair training cultures' forecasts





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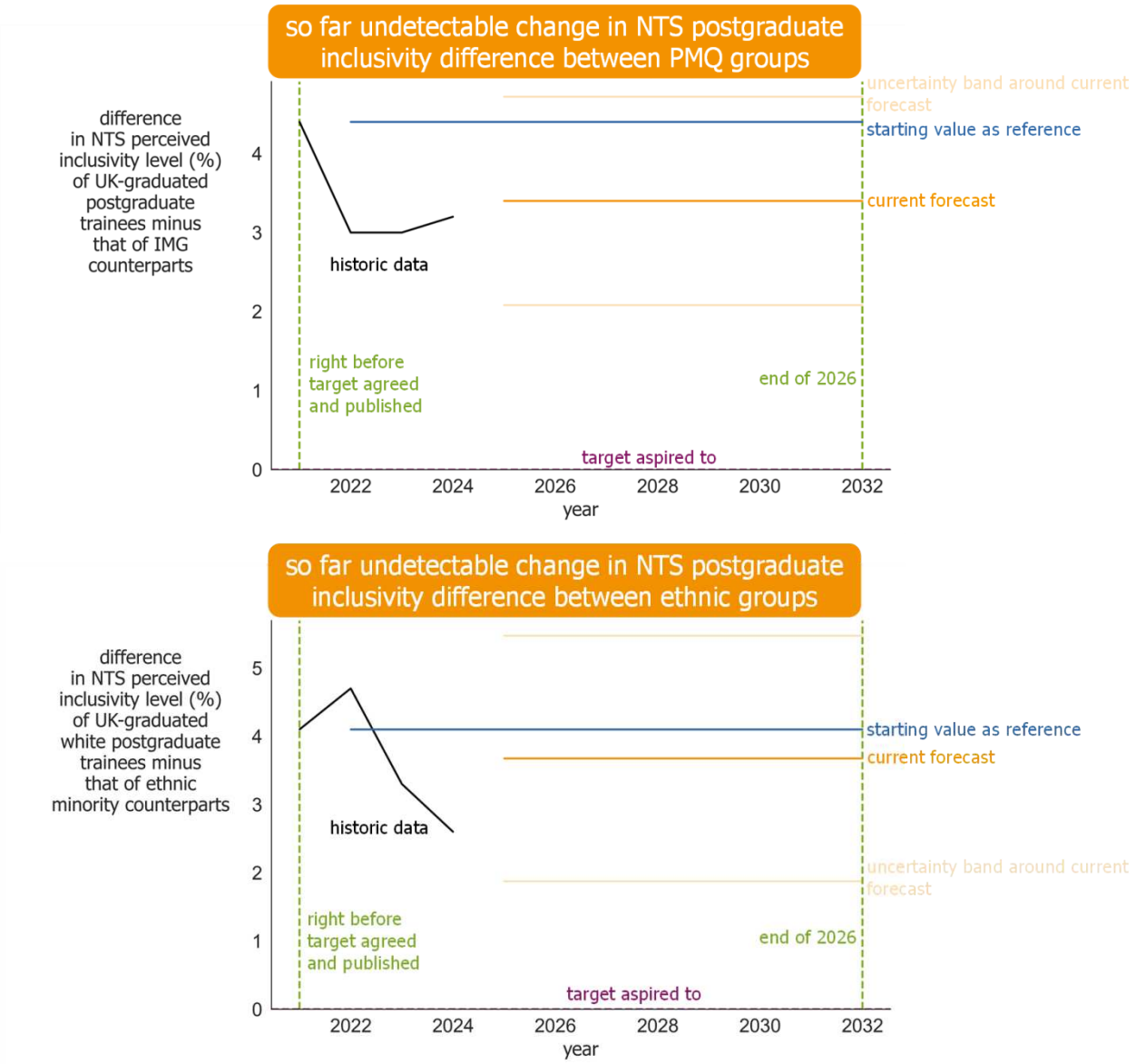
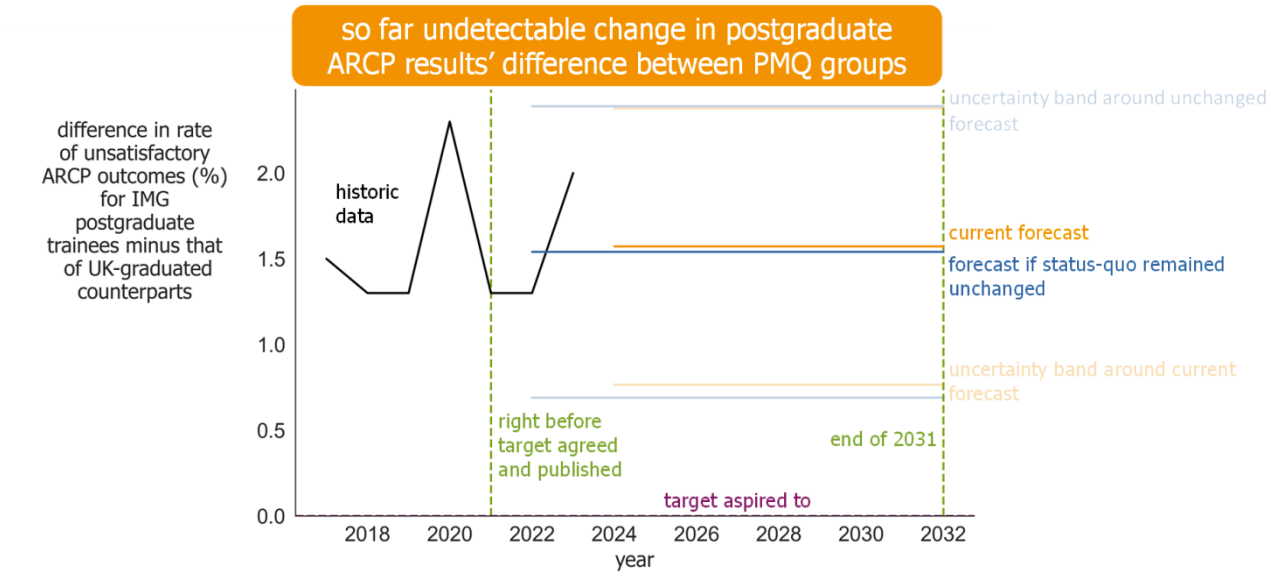
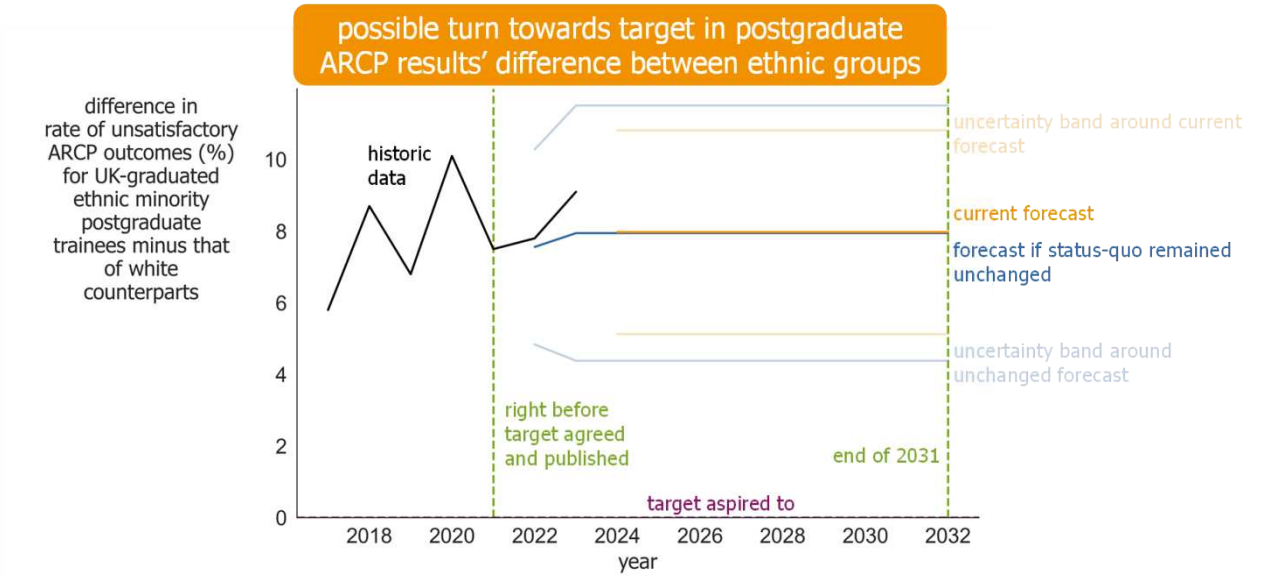
Fairer Training Cultures



Agenda item M8

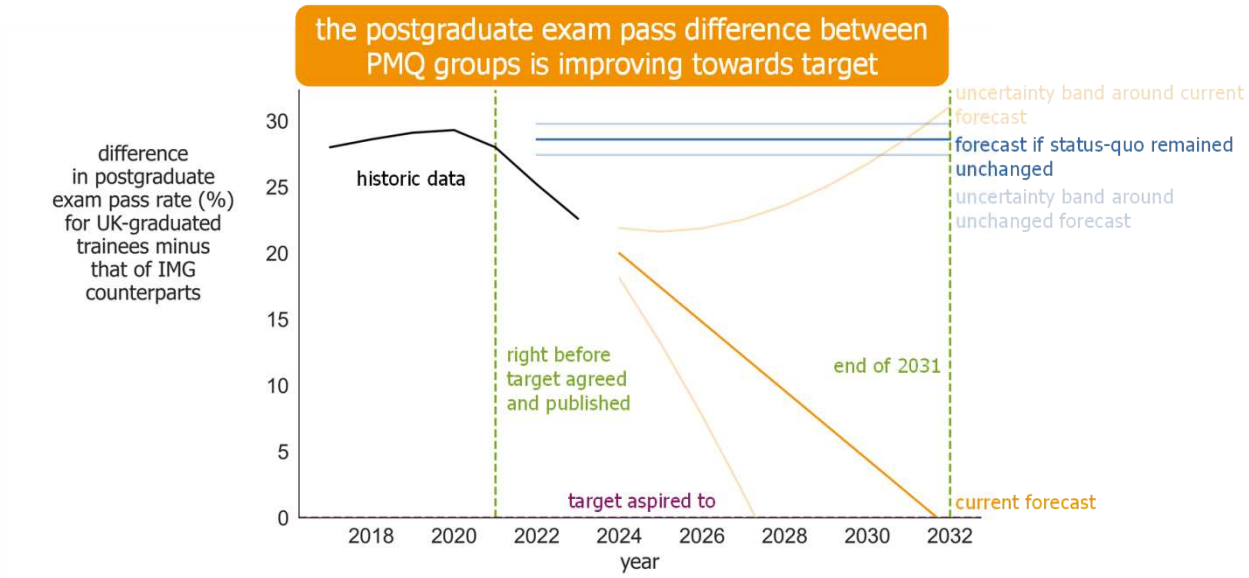
Fairer Training Cultures

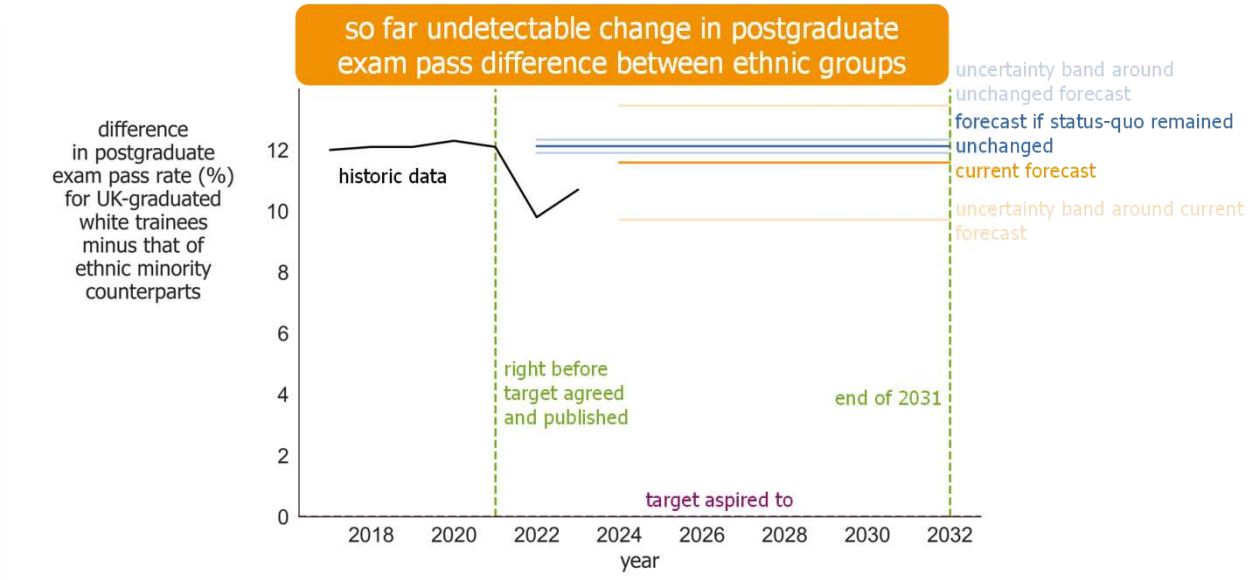




Agenda item M8

Fairer Training Cultures





MPTS Medical Practitioners Tribunal Service

Agenda item:	**M9**
Report title:	**Report of the MPTS Committee 2024**
Report by:	**Her Honour Deborah Taylor, Chair of the MPTS, MPTSChair@mpts-uk.org**
Considered by:	**MPTS Committee, GMC/MPTS Liaison Group**
Action:	**To consider**

Executive summary

This report gives an update on the work of the Medical Practitioners Tribunal Service (MPTS) since the last report to Council in June 2024.

Key points to note:

- As planned for, the MPTS has delivered 20% fewer hearing days, taking account of our recovery from the pandemic and a reduction in cases referred to us. We are on track to spend over £1m less than in 2023.
- The MPTS is prepared for the regulation of Physicians Associates and Anaesthesia Associates from 13 December 2024.
- The MPTS Chair has been engaging with key stakeholders on a proposed new *Methodology Flowchart* and *Sanctions Bandings* guidance, which we hope to introduce in summer 2025.

Recommendation

- Council is asked to consider the report of the MPTS Committee.

Governance

1. The Medical Practitioners Tribunal Service (MPTS) reports twice a year to Council on how we are fulfilling the statutory duties for which we are accountable to the UK Parliament. This paper is the MPTS Committee's second report of 2024.

2. The MPTS annual report was laid before the UK Parliament on 18 July.

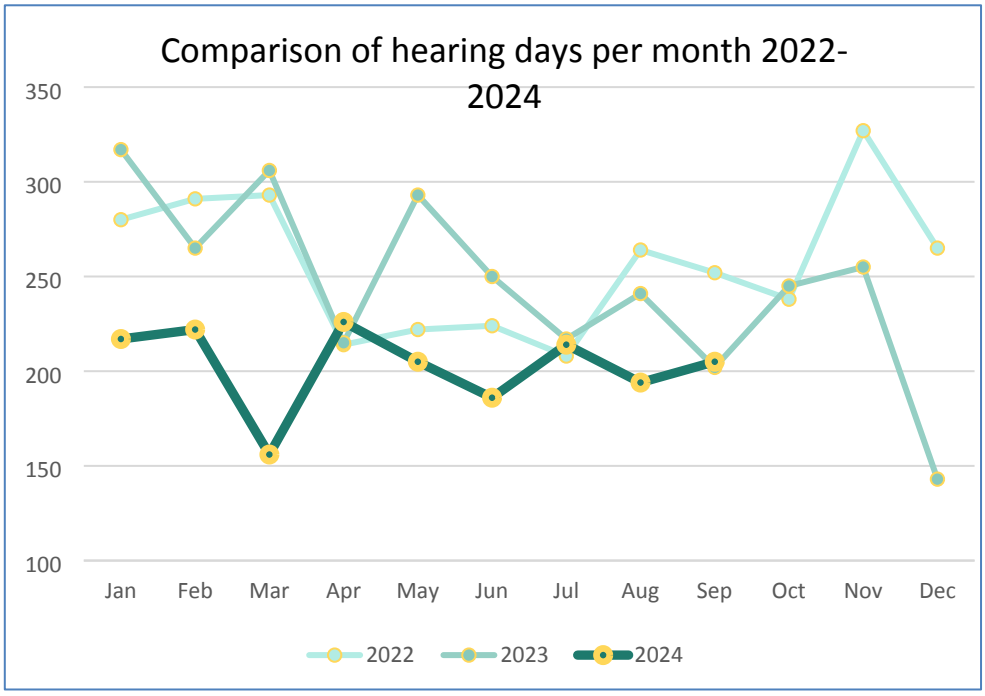
3. The MPTS Committee met on 11 September on when it received updates on our performance, appeals, quality assurance and adjournments.

4. The Committee also met on 13 November 2024, when it reviewed this report, expenditure in 2024 and the draft budget for 2025 and received a project update.

Operational update

5. All new referrals from the GMC are being listed within our 9-month service target.

6. The number of hearing days held so far this year has reduced by 20.8% and 18.8% when compared to 2023 and 2022 respectively.



7. At the beginning of October 2024 the MPTS's total hearing workload was 171 cases, including all cases currently in progress, awaiting listing or on hold for exceptional reasons. This is a 28.1% decrease on our live hearing caseload at this time last year.

8. By the end of 2024 we expect to have concluded around 200 new medical practitioners tribunal hearings. Before the pandemic, we would usually conclude around 250 cases a year.

9. Our GMC Fitness to Practise Directorate colleagues expect that referrals to us will continue at this slightly lower rate. The reduction has been weighted towards simpler, shorter cases which leaves the more complicated and time-consuming cases. This is being factored into our operational and budget planning for 2025 and beyond.

10. We have proposed a budget broadly in line with 2024, despite increased annualised staffing costs and the costs of inducting our newly appointed Legally Qualified Chairs and medical tribunal members.

Regulatory reform

11. The MPTS has worked closely with GMC colleagues to prepare for the regulation of Physicians Associates (PAs) and Anaesthesia Associates (AAs) from 13 December 2024.

12. New processes and guidance have been created to ensure the MPTS is ready to run any Interim Measures Tribunal (IMT) hearing that may be necessary from 13 December onwards. This work will continue into 2025, preparing the MPTS for any future Associate Tribunal (AT) hearings.

13. Tribunal members and MPTS staff have already received initial training on these new hearing types and more detailed training will take place in 2025.

14. New guidance documents and updated information will be available on the MPTS website from Monday 16 December onwards.

Decision-making methodology and sanctions bandings

15. Our MPTS Chair, Deborah Taylor, has been leading on engagement with various key stakeholders on our proposed new *Methodology Flowchart* and *Sanctions Bandings* guidance. It is our intention to introduce these for use in our hearings from summer 2025.

16. These documents aim to encourage consistency and transparency in our decision-making. They build on best practice in other regulatory tribunals and will complement the *Principles to inform guidance* on fitness to practise matters which were consulted on by the GMC earlier this year.

17. The *Methodology Flowchart* will provide tribunals with a clear route map and framework for decision-making at all three stages of the tribunal process. It will help all concerned in the process, including the public, understand how our tribunals' decisions are reached.

18. The *Sanctions Bandings* will complement existing guidance. The bandings will assist tribunals in reaching consistent and well-reasoned decisions, reduce anomalies, and also provide all concerned in the process, including the public, with clarity on the range of outcomes which can be expected in any case.

19. We will reflect on feedback from our various stakeholders before presenting a final version of both documents for approval by Council at a future meeting.

Refurbishment of SJB

20. The GMC signed a new lease on our Manchester hearing centre at the end of 2023. As part of the agreement, our landlord is currently undertaking work to provide us with nine refurbished hearing rooms, with two further rooms that can be converted at short notice, and office accommodation by April 2025.

21. This is a reduction from our previous fifteen hearing rooms, reflecting both the reduction in the number of hearings that we are holding and that a significant proportion of our hearings are now held virtually. We are also reducing the size of our office space, to reflect modern hybrid working patterns.

Tribunal members

22. As of November 2024 we had a tribunal member pool of 296: 114 medical members, 79 lay members and 103 Legally Qualified Chairs.

23. We are currently conducting an appointment campaign in which we expect to appoint around 90 new tribunal members. This will include medical members and LQCs.

24. These new members will undergo their induction training in early 2025.

Hearing outcomes

25. In the first three quarters of 2024, tribunals made decisions in 147 new MPT hearings and 235 new IOT hearings.

26. Details of the outcomes of those hearings, and others, are included at Annex A.

MPTS Medical Practitioners Tribunal Service

Agenda item: **M9**

Report title: **Report of the MPTS Committee 2024**

Annex A

Hearing outcomes 2022 to Q3 2024

Concluded hearings

New IOT hearing outcomes	2022		2023		Q1-3 2024	
	Cases	%	Cases	%	Cases	%
Suspension	34	12.5%	29	12.1%	38	16.2%
Conditions	184	67.6%	173	72.4%	151	64.2%
No order	54	19.9%	37	15.5%	46	19.6%
Total	**272**	**100%**	**239**	**100%**	**235**	**100%**

New MPT hearing outcomes	2022		2023		Q1-3 2024	
	Cases	%	Cases	%	Cases	%
Impaired: Erasure	68	24.9%	60	24.0%	54	36.7%
Impaired: Suspension	101	37.0%	109	43.6%	64	43.5%
Impaired: Conditions	18	6.6%	13	5.2%	5	3.4%
Impaired: No action	4	1.5%	2	0.8%	1	0.7%
Not impaired: Warning	21	7.7%	15	6.0%	3	2.0%
Not impaired	58	21.2%	49	19.6%	19	12.9%
Voluntary erasure	2	0.7%	2	0.8%	1	0.7%
Undertakings	1	0.4%	0	0.0%	0	0.0%
Total	**273**	**100%**	**250**	**100%**	**147**	**100%**

Non-compliance outcomes	2022	2023	Q1-3 2024
Suspension	3	8	4
Conditions	1	1	1
Non-compliance not found	0	1	2
Total	**4**	**10**	**7**

Restoration outcomes	2022	2023	Q1-3 2024
Application granted	6	3	4
Application refused	17	13	12
Application withdrawn	0	0	1
Total	**23**	**16**	**17**

Review hearings concluded

Review hearing types	2022	2023	Q1-3 2024
Medical practitioners tribunal review hearings	94	118	86
Medical practitioners tribunal reviews on the papers	16	24	13
Non-compliance review hearings	13	14	15
Non-compliance reviews on the papers	0	0	0
Interim orders tribunal review hearings	397	347	238
Interim orders tribunal reviews on the papers	819	673	452

Total hearings concluded

All hearings concluded	2022	2023	Q1-3 2024
Total	**1911**	**1691**	**1210**

General Medical Council

Report of the Audit and Risk Committee 2024

Action	To note
Purpose	To report the work of the Audit and Risk Committee June – November 2024
Decision Trail	This report is based on the Committee's activities and scrutiny of papers discussed on 10/11 September and 12/13 November 2024
Recommendation	To note the work of the Committee
Annexes	Annex A: Internal audit reports completed since June Annex B: Internal Audit Plan 2025
Author contacts	**Lindsey Mallors**, Assistant Director Audit and Risk Assurance Any enquiries to: GovernanceTeamMailbox@gmc-uk.org
Sponsoring director/ Senior Responsible Owner	**Paul Knight**, Chair Audit and Risk Committee

Background

1 The Audit and Risk Committee'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 audit services.

2 This is achieved primarily by seeking the information it requires through regular risk dialogue with the Chief Executive and Director Resources, overseeing an annual programme of internal and external audit activity, seeking assurance on implementation of audit recommendations, scrutiny of significant events and learning opportunities and calling on other members of the Executive for further information as required.

3 This report provides a comprehensive update of the Committee's activities since May, supplementing the summary notes provided to Council after each seminar and meeting. We have not considered any significant event reviews in this period and therefore, there are no issues which we consider require reporting to the Charity Commission.

Key activities

Seminars

4 Since its June report, the Committee has met twice – 10/11 September and 12/13 November. On 10 September it held two half day seminars in Manchester, ahead of the meeting the following day. The first session covered a comprehensive run through of the GMC's business continuity and disaster recovery arrangements. The second focused on MPTS. A summary of the insight and assurance we gained is shown in the following table.

Business continuity and disaster recovery arrangements	MPTS
Understanding the approach to continuous cyber intelligence gathering and how this informs an integrated cyber security strategy and arrangements The GMC's arrangements for preparedness, response and recovery stages in the event of a cyber attack The priority focus on information security when an incident occurs How risk is assessed to inform a data breach response and communications (internal and external, including the Information Commissioner) How an exercise in 2021 focusing on loss of GMC systems for a month had informed and shaped the current business continuity plans, response plans and recovery processes	A walk through the MPTS approach to listing hearings Key features and recent improvements of hearing case management The support available to registrants Circulation of case law updates through quarterly circulars to tribunal members to support continuous improvement Mandatory annual training for tribunal members, including sessions on legal matters Proposals on a new methodology framework to support sanctions decision-making

5 In November the seminar had two sessions. The first provided an opportunity for further understanding of the programme of work to implement a new enterprise resource system (ERP). The Team, led by the Programme Manager, shared the progress to date including how the finance system has been selected and proposals for how the HR and payroll systems will be chosen. The Committee will continue to be updated on progress at each meeting and look forward to a further seminar next year.

6 The second item was a discussion on the outcome from this year's Committee effectiveness review. Our view that the Committee works well as a group was supported by the Institute of Internal Auditors assessor's External Quality Assessment report, which noted that ARC performs an effective audit committee function.

Meetings

7 Once again, we have had the opportunity through our agenda business to welcome a range of colleagues to meetings in addition to regular attendance of the Chief Executive, Director Resources and other directors as pertinent to business matters. This continues to reassure the Committee of the strength and depth of professionalism across the organisation beyond the Executive and assistant directors, which is important for business resilience and confidence in potential for succession management.

8 We have met individually with the internal auditors (BDO and the Assistant Director Audit and Risk Assurance, and the external auditor, Crowe), without management present. Again, this reassured us as to the independence of both audit parties.

9 At the end of December, the Chair of the Committee demits office as a member of Council, and November was their last Audit and Risk Committee meeting. Transition arrangements have been in place for a couple of months to ensure a smooth handover to the new Chair, Vanessa Davies. The January meeting is being planned carefully, to welcome the change in Chair and arrival of new members.

Risk and issue management and oversight

10 In each meeting we have continued to hold an open discussion with the CEO on hot topics in the external environment which impact GMC activities. and scrutinised the Risk and Issues Report by the Director Resources and Corporate Opportunities and Risk Register (CORR). The Committee find these invaluable in providing a lens on risk management and the key matters and priorities SMT is focused on. From these conversations and the areas explored through our various agenda items, we are confident in assuring Council that risk management arrangements are in place and operating effectively.

11 Of particular note have been more detailed discussion on assurance with respect to the risks in relation to external scrutiny of the government's proposals to bring physician associates and anaesthesia associates into regulation. The Committee shares the Executive's confidence that the arrangements for regulation are well designed and ready to implement in line with the legislation from 13 December. It recognises that a number of the current challenges are outside the GMC's control but are assured that these continue to be monitored carefully.

12 We have commented on proposals for a refresh to the CORR, which will take place next year, including how clarity between risk and issues might be more visible. The Committee was keen to understand how the Register is used for managing the business by the Senior Management Team and the wider business. We are planning to focus further on understanding how risk management operates in practice and risk appetite in the Committee's March seminar day in Manchester. The Committee is also proposing to incorporate risk deep dive discussions into its annual work programme (the Senior Management Team routinely holds risk deep dives throughout the year).

13 The Committee's other main activities are outlined below.

Key activities

- Received and scrutinised 11 internal audit reports
- Received the internal audit management memo on the review of the programme and governance arrangements for implementing the new Enterprise Resource Planning system
- Reviewed the revised proposals and supporting arrangements for publishing the GMC's Gifts and Hospitality Register
- Received the report of the External Quality Assessment by the Institute of Internal Auditors assessor, Rachel Bowden
- Scrutinised the Business Assurance Framework
- Approved the Internal Audit Plan for 2025
- Approved the external auditor's terms of engagement, plan and audit scope for the 2024 external audit and approved the fee
- Reviewed our Statement of Purpose
- Reviewed and re-signed the refreshed Internal Auditor Charter to reflect the incoming Global Audit Standards from January 2025
- Undertaken our annual effectiveness review

Key observations

Business assurance framework

14 The Business Assurance Framework provides a structured overview mapping the main sources of assurance for each directorate and business area in the organisation. It follows a common 'three lines of defence' assurance model:

15 Each year the Framework is updated and draws attention to where assurance activities need strengthening, helping to inform corporate internal quality assurance activity and internal audit planning. The Framework has built up over a number of years and the 2024 refresh is the most comprehensive yet strengthening understanding and confidence of the assurance activities in place.

16 The Framework gave the Committee a very clear view of the assurance levels across all teams/functions at the GMC and we noted how it is used to inform activities by the Quality Development, Quality Assurance and internal audit teams.

Delivery of 2024 internal audit programme

17 The internal audit reports completed since June are shown in Annex A. Of particular note is that the GMC's internal Quality Assurance Team and BDO used the case examiner arrangements review to pilot a joint assurance review. We were pleased to hear the efforts being made to increase efficiency of these assurance activities and the importance of their contribution to the Business Assurance Framework.

18 With the exception of the work on the Enterprise Resource Planning system, which is discussed in para 25, there are no particular areas of concern from the audit findings. We would particularly like to acknowledge the work of the teams which received green audit ratings this year – payroll, implementation readiness for PAs and AAs, safeguarding and specialist applications.

19 The high priority recommendations in relation to regulatory reform, MLA transitioning to BAU, and the Outreach restructure have all been addressed.

20 There are two pieces of audit work remaining in the programme for this year and one which has been deferred into next year's programme. The fieldwork for a review of social media arrangements is in progress and evaluating the new digital ID system introduced in Registration, will be conducted in December. A review of the arrangements being put in place for teams responsible for high impact regulatory decisions in relation to the Regulatory Fairness programme was delayed and has been included in the audit programme for 2025. This will follow completion of the roll out of the toolkit developed by ED&I to support local teams.

21 At each meeting we have also received progress updates on the implementation of previous audit recommendations and appreciate the continued Executive focus on this. At the time of writing, there was one recommendation due which was part complete. This was in relation to considering how to provide greater clarity of responsibilities and proportionate scrutiny of projects through the different project/programme governance groups, including Gateway.

Internal audit plan 2025

22 In November the Committee considered and approved the proposed internal audit plan 2025, noting the comprehensive analysis and rationale for inclusion. As always, the plan remains fully flexible to adapt to emerging risks and the Committee will have the opportunity to consider this at each meeting. The budget to deliver the programme remains at the 2024 level £235,740. For information, the outline plan is in Annex B.

External Quality Assessment of the internal audit function

23 Following completion of the External Quality Assessment of the GMC's internal audit function by the Institute of Internal Auditors, the Committee is pleased to report that the Team has maintained the highest assessment rating first awarded in 2019 and notes the maturity of the GMC's audit function. The assessment was conducted against the internal audit standards 2017 but from January the 2024 standards will take effect globalinternalauditstandards_2024january9_printable.pdf (iia.org.uk). There are helpful suggestions to help the Team focus on continuous improvement in preparation for the new Standards which articulate the keys to effective internal auditing through five domains:

24 The assessor was commissioned to identify any areas for improvement to ensure the function will be compliant with the new standards. We will be wrapping these into the next Quality Assessment and Improvement Plan which is due to the Committee in January. The January seminar will be a presentation from BDO on the new standards with a focus on the role and requirements of audit committees.

Enterprise Resource Planning system implementation

25 The Committee has continued its focus on assurance in relation to implementation of the new ERP system, which was unexpectedly prompted by the provider of the Agresso system announcing their withdrawal of on-premises system support from the end of 2026. This carries significant risks as well as unplanned financial pressures and we have been keen to understand the robustness of the framework and governance arrangements which are supporting decision-making.

26 The Internal Audit Management Memo in July confirmed the Team's approach and outlined a number of areas where focus was required in the short term to ensure the programme arrangements and governance were more fully developed. In September the Team provided an update on progress and in November, as noted above, the seminar session allowed further exploration of the programme to provide assurance on the reasonableness and robustness of the underpinning decision-making framework and broad timelines. The Director Resources

has also produced an assurance timeline showing when internal audit assurance activity will be shared with the Committee.

Committee annual effectiveness review

27 As highlighted above, in November the Committee considered its effectiveness review. In line with our culture of continuous improvement, over the next 12 months the Committee plans to bring more external perspectives into its deliberations. It also would like to suggest that Council includes a discussion on risk appetite in the context of developing the next corporate strategy, and that it considers and confirms whether or not it is satisfied with the current level of financial scrutiny.

28 In welcoming two new members to the Committee in January, the incoming Chair will be keen to bring their views to discussions about how to best focus our seminar time to ensure there is maximum value from these more informal and discursive sessions.

Closing remarks

29 Over the last 12 months the Committee has continued to develop its understanding of the business and has welcomed the ever increasing number of GMC colleagues providing input to seminars and responses to audit reports. We continue to bring our collective experience to Committee business, reflecting wider knowledge in the discussions and scrutiny brought to each agenda item.

30 The Chair continues to have regular meetings with Crowe, BDO the Chair of Council and the Chief Executive and ongoing dialogue with the Assistant Director Audit and Risk Assurance. This allows the agendas to be carefully planned, reflecting the key areas of business where assurance or deeper understanding of the issues is valuable to wider Council conversations. We observed that in the September Council meeting, there were six specific references to the Committee's work contributing to the various discussions. We believe this demonstrates the Committee carrying out our assurance role efficiently and effectively and adding value to the GMC's overall work.

31 To support our activities in 2025, Committee members would welcome feedback from Council members on areas of assurance or activities to include in their work programme which have not been outlined in this report.

32 In demitting office as Chair and a member of Council, I would like to take this opportunity to record my thanks to all members of Council and the Executive, past and present, who have supported me and the Committee over the last eight years.

General Medical Council

Annex A

Internal audit reports completed since June

1 The assurance ratings can range from red to green with red/amber, amber and green/amber in between. The ratings incorporate two categories:

- control design – there is a sound system of internal control designed to achieve system objectives.
- control effectiveness – the controls in place are being consistently applied.

Audit review	Assurance ratings		Number of recommendations (high priority)
MPTS legal arrangements	Green	amber	3
	Green	amber	
Case examiner arrangements	Green	amber	5
	Green	amber	
Contract management arrangements	Amber		8
	Green	amber	
ERP governance arrangements – management memo	Not rated		Number of next steps suggested
Payroll arrangements	Green		2
	Green		
Regulatory reform management	Green	amber	10 (3)
	Green	amber	
Safeguarding arrangements	Green		0
	Green		

Audit review	**Assurance ratings**		**Number of recommendations (high priority)**
People Plan review	Green	amber	7
	Green		
MLA transition to BAU	Green	amber	8 (1)
	Green	amber	
Outreach change arrangements	Green	amber	9 (2)
	Green	amber	
Cyber security	Green	amber	4
Future of Career Development and Education programme arrangements	Green	amber	7
	Green	amber	
Data compliance arrangements	Green	amber	6
	Green	amber	
Total			**69 (6)**

Rating definitions

	Control design	Control effectiveness
Green	There is a sound system of internal control designed to achieve system objectives.	The controls that are in place are being consistently applied.
Green-Amber	Generally, a sound system of internal control designed to achieve system objectives with some minor exceptions.	Evidence of minor non-compliance with some controls, of a housekeeping nature, which are unlikely to put system objectives at risk.
Amber	Some weaknesses in the system of internal control exist with some system objectives potentially at risk of not being achieved.	More significant non-compliance with some controls that may put some of the system objectives at risk.
Amber-Red	System of internal controls is weakened with the majority of system objectives at risk of not being achieved.	Non-compliance with key procedures and controls places the system objectives at risk.
Red	Poor system of internal control.	Non-compliance and/or compliance with inadequate controls.

If only one rating is given, it is for control design.

Risk and significance categories for actions and recommendations

High	There is potential for financial loss, damage to reputation or loss of information. This may have implications for the achievement of business objectives and recommendation should be actioned immediately.
Medium	There is a need to strengthen internal control or enhance business efficiency.
Low	Internal control should be strengthened, but there is little risk of material loss.

General Medical Council

Annex B

Internal Audit Plan 2025

Area for review	CORR risk Directorate risk	2025 proposed coverage (director sponsor and assistant director lead)	Resource days
Voluntary erasure and licence restoration	148 Delivery of statutory functions	Arrangements for voluntary erasure from the register and requests for licence restoration (Una Lane, Blake Dobson)	5
Case review (monitoring doctors under restriction)	148 Delivery of statutory functions	Arrangements for managing and reviewing doctors placed under working restrictions (Anthony Omo/Liz Jenkins, Joanna Farrell)	5
Cyber security	152 Unplanned event **Resources: Cyber incident affecting infrastructure and security systems - critical**	Testing of GMC system defences (Neil Roberts, Rachel Mooney)	5
ERP implementation	544 IT cloud system drive 149 Availability of resources **Resources: IT Industry Cloud System Drive**	Three reviews across the year - continued focus on general programme arrangements, and progress with specific focus on implementation and HR arrangements for the finance system (Neil Roberts, Sunil Kapur)	25
Future of education and career development	151 Responding to a changing environment 150 Ability to work with others **E&S: Approved postgraduate medical training programmes are becoming less attractive to doctors, reducing our regulatory control - critical**	Programme management arrangements follow up and programme progress (Colin Melville, Phil Martin)	5

	E&S: Regulation will become more difficult as partner organisations reduce the resources they commit to supporting our regulatory activities - critical		
Area for review	**CORR risk** **Directorate risk**	**2025 proposed coverage** **(director sponsor and assistant director lead)**	**Resource days**
Contact Centre transformation	151 Responding to a changing environment	Phase 2 programme arrangements review including focus on development of measures for success (Una Lane, Lindsey Westwood)	5
Regulatory fairness	234 ED&I strategic ambition	Review of individual directorate arrangements for implementing regulatory fairness toolkit (Shaun Gallagher, Judith Chrystie)	10
MLA	206 MLA live, contingency and scenario planning	Establishment and embedding of BAU arrangements, including role of new oversight Steering Group (Colin Melville, Nico Bridge)	5
Associate worker status	149 Availability of resources Resources: Procurement of Associates	Arrangements for introduction of new associate worker requirements (Neil Roberts, Sunil Kapur)	5
Regulatory reform	452 Potential delays 200 Not securing the benefits reform presents **E&S: Regulatory reform may weaken our mandate to co-ordinate and promote all stages of education - critical**	Programme progress review including focus on workstreams in directorates (Shaun Gallagher, Tim Aldrich)	10
Liaison		Covers BDO management – liaison and contract meetings, quality assurance, contribution to planning, ARC attendance	15
Additional reporting		Key output is the Business Assurance Framework	5
Contingency		Note additional resources can be requested if needed at any point during the year	15
Total			**115**

NB: All audit scopes will be discussed with the relevant auditee team and signed off by the director sponsor.

General Medical Council

Report of the Remuneration Committee 2024

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 2024. 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)	Council is asked to note the report.
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	**Anthony Harnden**, Council Member and Chair of Remuneration Committee

Agenda item M11
Report of the Remuneration Committee 2024

Background

1 The Committee has met twice in 2024. It has the scope to consider issues on email circulation where action was required to be taken between meetings. This has taken place once this year in relation to the appointment of Liz Jenkins as Interim Director of Fitness to Practise, where the Committee approved the terms and conditions for the role. The Committee is satisfied that in undertaking its work programme for 2024 it has fulfilled its responsibilities under its terms of reference. The Remuneration Committee's Statement of Purpose is at Annex A.

2 For reference, Council members can access the Remuneration Policy on the 'Useful documents' shelf in Board Intelligence.

Recruitment to Council

3 The process to recruit new GMC council members commenced in June 2024 and will finally conclude when the Privy Council writes to our four recommended candidates to appoint them to the roles of registrant and lay members of Council.

4 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 on -line 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.

5 The calibre was incredibly high. In the lay cohort, there were 101 applicants, with 13 reaching the long list and 5 reaching the final interview. There were 156 registrant applicants in total, of whom 12 made it to the first stage interview and 5 reached the final stages.

6 The selection process consisted of:

- A competency-based application form
- An initial interview with GatenbySanderson
- A final interview

7 The interview panel was chaired by Carrie MacEwen and consisted of Anthony Harnden, Vanessa Davies and Cindy Butts (independent). Between them, this diverse group of panel members brought registrant, lay and four nations perspectives to the decision making.

2024 Pay award

8 The Committee considered the annual pay award for the Chief Executive, directors and Chair of the Medical Practitioners Tribunal Service.

9 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.

10 The Committee agreed that the base pay award for roles within its remit would be 5%, slightly below the approach taken for the wider staff group.

11 The committee decided to use the variable pay element for 2024 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 0.6 % variable pay.
- Outstanding – base pay plus 1.2% variable pay.

Talent and succession planning and market review

12 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.

13 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. The absence of the Director of Strategic Communications and Engagement had demonstrated that plans are robust.

14 The Committee noted in March that the Director of Education and Standards/Medical Director had indicated his likely retirement in 2025.

15 The Committee noted in March that the process for recruitment to a key AD role had received significant interest. Similarly, arrangements for two other key AD positions were discussed in the October meeting.

2025 Work programme

16 The Committee reviewed and agreed the proposed work programme for 2025.

Review of Statement of Purpose

17 The Committee is required to review its Statement of Purpose at least once a year and suggest any amendments considered necessary to Council.

18 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.

19 The Committee is satisfied that in undertaking its work programme for 2024 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 2024

20 The Chair of the Committee in 2025 will be Alison Wright. The Committee extended its grateful thanks to Anthony Harnden for all he has done over the past four years in his role as Committee Chair, not least in chairing the Appointment Panel for a new Chair of the General Medical Council.

General Medical Council

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.
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.

General Medical Council

Compliments and Complaints report

Action	To note
Purpose	To provide Council with an update on our handling of complaints from October 2023 – September 2024, 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.
Decision Trail	As previously agreed, Council now receive an annual update on complaints and compliments. This is the first annual update, covering data from October 2023 – September 2024. This report was considered by the Executive Board on 25 November 2024.
Recommendations	**a** To note the review of 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
Author contacts	**Jennifer Broadley**, Head of Corporate Review Team Any enquiries to: GovernanceTeamMailbox@gmc-uk.org
Sponsoring director/ Senior Responsible Owner	**Sophie Brookes**, Assistant Director Corporate Directorate

Agenda item M12
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 The Corporate Review Team are responsible for managing and maintaining our complaints process. Since achieving ISO 10002 accreditation in 2017, we have been audited annually on our complaints handling. The last audit in November 2023 was successful and no non-compliances or opportunities for improvement were identified. The auditor will consider our processes again on 28 November 2024 and we will share the outcome of the audit with Council.

3 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 2023 – September 2024 complaints data and trends

4 We received 1,412 complaints between October 2023 and September 2024, a 7% decrease on the 1,512 complaints received between October 2022 – September 2023 (see Annex B). We saw a notable spike in complaints received in March 2024, following the coverage of a high-profile case at the MPTS relating to climate change activism. We received 47 complaints on this topic. We are continuing to see general correspondence about our views on climate change.

5 We responded to 1,347 complaints, 22% fewer than the 1,652 complaints responded to between October 2022 – September 2023 (see Annex B). We responded to more complaints in 2022-2023 following spikes in complaints about our position on qualifications from the Dnipro institute, how we record gender on the register and the extension to the temporary emergency registration process. These increased volumes increased the number of responses the complaints teams managed in the previous reporting period. The decrease in complaint volumes during the period this paper relates to led to us responding to fewer complaints.

6 For the current reporting period, we replied to 85% (1,141) of complaints with an explanation or as part of a broader campaign response. This is similar to the previous 12 months, where between October 2022 and September 2023, we resolved 87% (1,435) of complaints with an additional explanation or a campaign response.

7 Campaign complaints tend to be about the GMC's general position, 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. Examples of campaign complaints in this reporting period included our regulation of PAs and AAs and our decisions relating to doctors involved in climate change activism.

8 We concluded 9% (126) of complaints by apologising for a service failure, a slight increase on the 7% (129) of apologies issued between October 2022 and September 2023. We have seen 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 complainants experiencing delays.

9 We generally issue apologies in around 10% of the complaints received, so it is positive to see that overall volumes remained below 10% for this reporting period despite the high-profile complaints we have received about our regulatory functions. Examples of a service failure include significant delays to our handling or administrative errors such as communicating by email when an individual has requested all correspondence by post.

10 We closed a further 6% of complaints either without sending a response, because we had previously terminated correspondence on the specific issue(s) in the complaint, or because the complaint process was inappropriate so we signposted the complainant to other areas of the business, such as an appeal process, a review under Rule 12 or an information access request.

11 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, 16% of complaints needed further signposting or were closed without a response.

12 Our complaints policy allows for three stages of escalation. Previous external audits have confirmed that it is important to manage a complainant'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.

13 As well as terminating correspondence under the three-stage escalation process, we may also restrict or terminate contact under our behaviour policies. We have policies relating to vexatious complaints, persistent complaints, and unreasonable behaviour. Annex A gives some examples of the application of these policies.

14 Of the 1,347 complaints responded to, we considered 56 under stage 3 of our processes. Generally, the Corporate Review Team consider 15 – 20 escalated complaints each quarter so it is positive to see the reduction in this area and we can be reassured that our initial responses are addressing complaints thoroughly, with less need for a further investigation. In 53 of those complaints, we received no further correspondence. Three complainants reiterated their complaints, but we did not send any further responses.

15 We met the 10-working day service level agreement ('SLA') in 83% of complaints. Most directorates work towards an SLA of 90% but we are conscious that Registration and Revalidation work to a 95% target. Whilst we have not met the 90% SLA in this period, we have continued to see an improvement on previous reports, where the SLA was between 75%-80%. We will continue to monitor this and consider whether there are any trends beyond unplanned absences that may indicate we need to consider the level and allocation of resources. We are forecast to meet the SLA in 93% of complaints received in October 2024.

16 Of the 194 complaints responded to outside of the 10-working day SLA, 94 were complex complaints and we responded within 15-working days. In 87 of those complaints, we responded on day 11. We responded to the remaining 13 complaints within 20 working days. In each of these complaints, we kept the complainant up to date and advised when they could expect our response.

17 The only notable trend in this period related to our decisions to suspend a doctor following their involvement in climate activism.

18 Of the 1,347 complaints we responded to, we resolved 81% (1,085) at the first stage of our processes. We resolved a further 11% (147) at the second stage and escalated just 8% (56) to the Corporate Review Team for an intended final response. It is positive to see that most complaints continue to be resolved at the earliest possible point in our complainants handling process and by way of an additional explanation to help to address the complaints raised.

19 We have continued to log complaints which feature an element of equality, diversity, and inclusion/Equality Act issues. During this period, 8% (106) of complaints we received included references to equality, diversity and inclusion issues. This was almost identical to the 105 complaints highlighting equality, diversity and inclusion between October 2022 and September 2023. 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.

20 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.

21 In the reported period, FTP recorded 26 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 more referrals this year than in previous years, with a predicted number of 10,600 new fitness to practise concerns being raised in 2024 compared with 10,031 in 2023. It is positive to see we continued to record complaints in fewer than 1% of interactions given the often-contentious nature of fitness to practise cases.

22 The Corporate Review Team recorded 56 complaints, all of which were escalated from other areas of the business. In the same period, the Corporate Review Team made 481 decisions not to commence a review of an FTP decision.

Business improvements and assurance

23 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.

24 Since the last report, we have carried out four further improvements;

a We have improved the way cross-directorate requests are accessed in our case management system. Cross-directorate requests are used when an individual has contacted us but their query needs to be referred to another area of the organisation. For example, the contact centre might need to raise a cross-directorate request if they have taken the details of a fitness to practise concern over the telephone and the concern needs to be considered by a fitness to practise decision maker. Previously, visibility of these requests was limited, and it meant that some teams did not have access to outstanding correspondence.

b Following a complaint from a doctor who was unaware that they needed a current licence to practise to continue as a Responsible Officer, we updated our website to make it clear that this was the case.

c A doctor complained because they had experienced a delay following their request for an Article 24 letter. An Article 24 letter confirms the details of the basic medical training a doctor has completed. The doctor in this complaint needed to submit the letter as evidence of their qualifications to the Swiss authorities. We have updated our internal guidance for colleagues handling Article 24 letters so that doctors are routinely updated if there is likely to be a delay in us responding to them because we have had to recall paper files from our external storage.

d We have updated our guidance for doctors who have only taken an overseas internship so that the advice about converting from provisional to full registration is clearer.

25 As a result of feedback from complaints, we have identified a further 41 potential improvements, some of which are set out in Annex A. The complaints teams will routinely identify improvements in their handling of complaints, and the Customer Complaints Review Group ('CCRG') is a network of complaints advisers from across the organisation. As part of our regular 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

26 At the time of writing, we had recorded 2,421 compliments across the directorates.

27 The majority (2,157) of the 2,421 compliments recorded were received by Registration and Revalidation. As well as general emails expressing thanks, there were positive comments about processes and the manner in which we corresponded, for example:

a 'I really appreciate your kindness and patience in dealing with this issue. You've made me feel a lot better. Thank you so much. You've been very helpful Thank you for your time yesterday and your patience, your understanding was greatly appreciated. I can only apologise if it was not fully constructive, I am still very much struggling with it all.'

b 'Once again thank you. Thank you so much for giving me such a wonderful news. it was well awaited.'

c 'Thank you and to all the colleagues who contributed and helped me to sail through this journey of Cesr . It wouldn't have been possible without your support and help.'

d 'You all have been marvellous and prompt in response to any email I have sent throughout the process. Thank you once again, please convey my regards to the team involved.'

e 'Thank you so much. This is the best news I have ever received. I am actually crying. I am so thankful for your help and guidance.'

f 'Thank you so much for having humanity and for giving me your time the other day.'

g 'First of all I would like to thank you and the GMC team with whom I had contact during the investigation period.'

h 'I applaud you for your decision to use inclusive language. I think it would be very helpful if medical bodies made public statements to this effect. Particularly in the

current political climate in which the Tories are seeking to demonise transgender people.'

General Medical Council

Annex A

Business improvements and case studies

1 A member of the public requested a review under Rule 12. By the time they had made the request, the doctors involved had taken voluntary erasure. In the complaint, the member of the public explained that they had invested a considerable amount of time in putting the request together and they were not aware that a doctor had to have current registration for us to consider a review request. We recognised the impact our processes had had on this individual, particularly because the circumstances surrounding their complaint were very painful for them. Following this complaint, we have started to work on updating our guidance information for the public so it is clear that a doctor needs to be registered with us.

2 Following a complaint from a doctor who felt we should be able to accept QR codes from other regulators to verify their Certificate of Good Standing, we are considering whether this is something we can consider in future.

3 A doctor complained to us about the requirement for a supervisor to fill in employer statements as part of a voluntary erasure application. The doctor felt the process was overly bureaucratic and was unhappy that they had to continue paying their registration fee whilst the matter was resolved. We are considering whether part of the Voluntary Erasure application should be updated to reflect when we might consider waiving the fee.

4 We received a complaint from a member of the public who had told us they had an advocate when they initially contacted us. They had not, however, told us that they wanted us to communicate solely with their advocate rather than including them in correspondence. We recognised that our approach might have caused further distress to the individual, who was vulnerable. We are now updating our guidance about approved contacts in the fitness to practise process, so that it is clear if a member of the public has an advocate and to capture preferred contact methods if that is the case.

5 We are considering whether to refer to country specific internship guidance so that it is clearer for doctors whether they will be eligible for full registration, or whether they will need to apply for provisional registration first.

6 We are improving our guidance for members of the public to access our secure file transfer system. The system is used to upload larger documents which cannot be emailed, and as part of a complaint response, we identified that the instructions were not always clear when looking at how to upload documents and how to check the upload had been successful.

Application of complaints policies

7 A member of the public had requested a review of a fitness to practise decision. A decision maker concluded the original decision must stand and there were no grounds for us to commence a review. On receipt of the decision, the member of the public sent repeated emails outlining their refusal to accept the decision. The member of the public also called the contact centre multiple times each week. We responded to the member of the public under the Persistent Complaints Policy to confirm that their correspondence had become excessive and that because they continued to refuse to accept our explanations or decisions, we had been left with no option other than to restrict contact under the Persistent Complaints Policy. We have not received any further correspondence since this decision was made.

8 A doctor wrote to us several times to ask us to intervene in an investigation process at the school his wife worked at. The doctor felt the school's investigation was an indication that he was being investigated by government bodies, and this was preventing him from applying to restore his registration. We had previously exhausted our complaints process to respond to the doctor. Because of the repeat nature of the correspondence, and the fact the doctor was including various organisations in the correspondence, we terminated contact with the doctor under the Persistent Complaints Policy. We have not had any further contact from the doctor, but they have been informed of the appropriate way to apply for restoration and we have explained our statutory remit at length.

General Medical Council

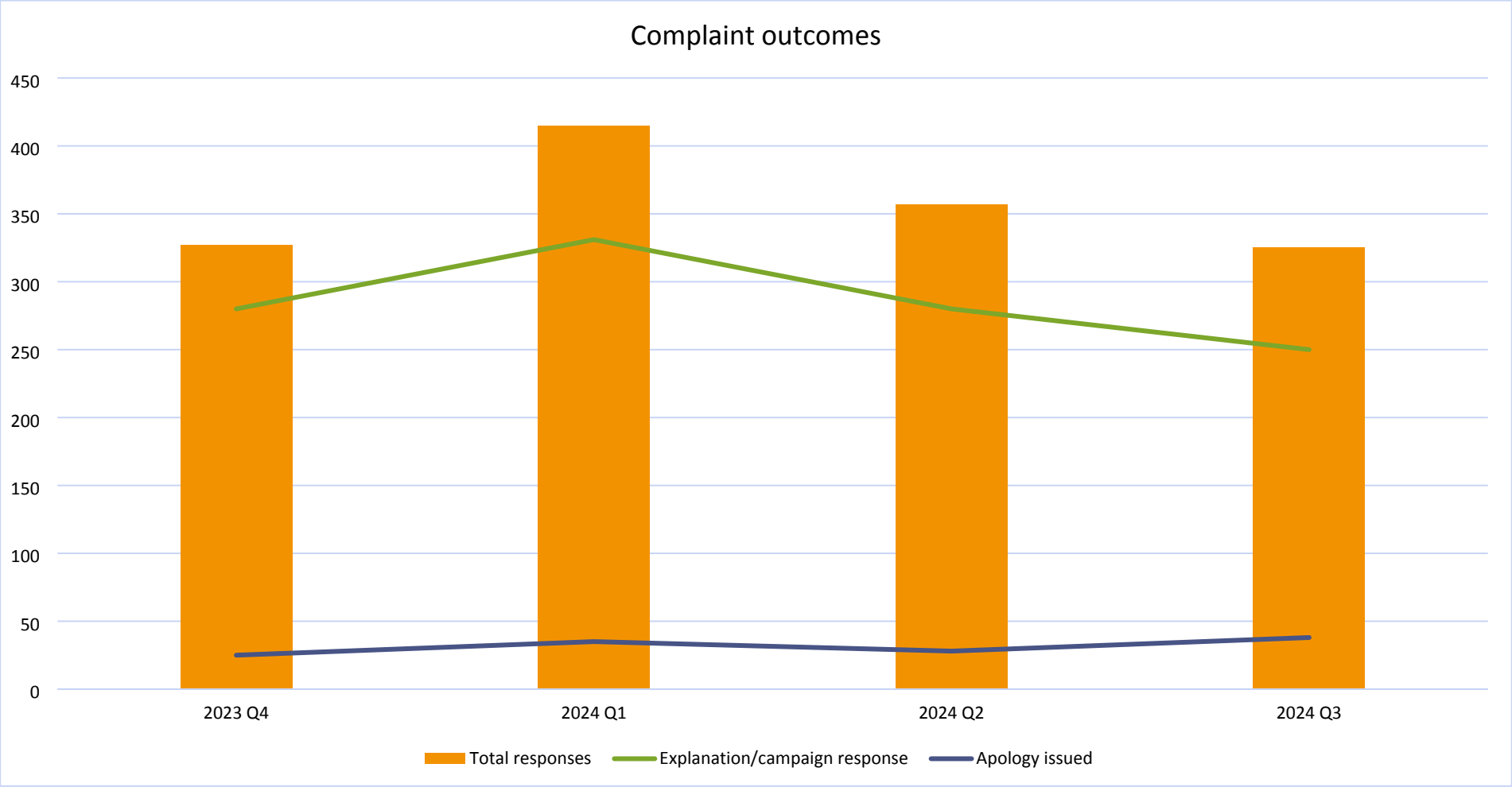
Annex B

Complaint volumes and outcomes

Agenda item M12

Compliments and Complaints report

Complaint outcomes



General Medical Council

Council forward work programme

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.

13 December 2024 – Extraordinary Council meeting – Virtual

Item	Sponsor
• AA/PA Order: Making the Rules and approval of underpinning documents.	

11/12 February 2025 – London

	Item	Sponsor
Seminar	• Social media	Paul Reynolds
	• FTP voices - MDO/RO	Liz Jenkins
Confidential session	• Annual Review of Governance Framework: GMC/GMCSI	Sophie Brookes
Public session	• Chief Executive's report	Charlie Massey
	• Report of the Investment Committee	Neil Roberts
	• Annual update of Governance Handbook	Sophie Brookes
	• PSA Annual report	Shaun Gallagher
	• Changing the form and content of the register regulations	Una Lane
	• Regulatory reform update [placeholder]	
	• New guidance update	Deborah Taylor/Liz Jenkins

Agenda item M14
Council forward work programme

	• Approving PA/AA Courses	Colin Melville
	• Amending the list of bodies entitled to award a UK primary medical qualification	Colin Melville
	• People Survey report	Neil Roberts
	• 2026 Council meeting schedule	Sophie Brookes
Below the line	• Council forward work programme	Carrie MacEwen
	• Report of the Executive Board	Charlie Massey
Seminar	• ED&I Training	Shaun Gallagher

4/5 March 2025 Away Day – Manchester

Item	**Sponsor**
• Corporate Strategy	Shaun Gallagher
• Regulatory reform update	Shaun Gallagher

8/9 April 2025 – Manchester

	Item	**Sponsor**
Seminar	• SoMEP Workplace & Experiences report – key findings/messages	Shaun Gallagher
	• External speaker [placeholder]	
Confidential session	• Report from GMCSI	Paul Reynolds
	• Risk appetite statement	Neil Roberts
Public session	• Chief Executive's report	Charlie Massey
	• People Report (including Inclusion workstream)	Neil Roberts
	• 2023 national reports	Paul Reynolds
	• Annual QA update	Colin Melville
	• Biannual section 40a report	Charlie Massey

Agenda item M14
Council forward work programme

	• Regulatory reform update [placeholder]	
	• 6 Monthly SC&E Impact report	Paul Reynolds
	• Amending the list of bodies entitled to award a UK primary medical qualification	Colin Melville
Below the line	• Council forward work programme	Carrie MacEwen
	• Council members' register of interest	Carrie MacEwen

3/4 June 2025 – London

	Item	**Sponsor**
Seminar	• External speaker [placeholder]	
	• To be confirmed	
Confidential session	• Communications and engagement update	Paul Reynolds
Public session	• Chief Executive's report	Charlie Massey
	• Report of the MPTS Committee	Deborah Taylor
	• Trustees' Annual report and accounts	Paul Reynolds / Neil Roberts
	• Fitness to practise statistics report	Liz Jenkins
	• Freedom to Speak Up Guardian annual report	Neil Roberts
	• Regulatory reform update [placeholder]	
Below the line	• Council forward work programme	Carrie MacEwen

22/23 July 2025 – Manchester

	Item	**Sponsor**
Seminar	• External speaker [placeholder]	
	• To be confirmed	
Confidential session	• To be confirmed	
Public session	• Chief Executive's report	Charlie Massey

Agenda item M14
Council forward work programme

	• Report of the Audit and Risk committee	Paul Knight/ Neil Roberts
	• 2025 Financial update	Neil Roberts
	• ED&I Annual report	Shaun Gallagher
	• Safeguarding annual report	Neil Roberts
	• Regulatory reform update [placeholder]	
Below the line	• Council forward work programme	Carrie MacEwen

30 September/1 October 2025 – Edinburgh

	Item	**Sponsor**
Seminar	• External speaker [placeholder]	
	• To be confirmed	
Confidential session	• Report from GMC Services International Ltd	Paul Reynolds
	• SC&E Impact report	Paul Reynolds
	• 2026 Budget Assumptions and Approach	Neil Roberts / Shaun Gallagher
Public session	• Chief Executive's report	Charlie Massey
	• Regulatory reform update [placeholder]	
	• Regulatory Fairness Review	Shaun Gallagher
	• People Report	Neil Roberts
	• SoMEP workforce report	Shaun Gallagher
Below the line	• Council forward work programme	Carrie MacEwen
	• Council members' register of interest	Carrie MacEwen

3 December/4 December 2025 – London

	Item	**Sponsor**
Seminar	• External speaker [placeholder]	

Agenda item M14
Council forward work programme

	• DB pension scheme triennial valuation sign-off	Neil Roberts
Confidential session	• To be confirmed	
Public session	• Chief Executive's report	Charlie Massey
	• Fairer Employer Referrals and Fairer Training Cultures	Liz Jenkins / Colin Melville
	• 2026 Budget and Business Plan	Neil Roberts / Shaun Gallagher
	• Corporate Strategy	Shaun Gallagher
Below the line	• Council forward work programme	Carrie MacEwen
	• Council members' register of interest	Carrie MacEwen

General Medical Council

Annual report on Defined Contribution pension scheme

Action	To note
Purpose	This paper updates Council on the activities of the Pension Plan Management Board in 2024.
Decision Trail	This report was approved by the GMC Pension Plan Management Board and the Executive Board.
Recommendation	To note the annual report of the GMC Pension Plan Management Board.
Annexes	None
Author contacts	**Niall Kelly**, Corporate Governance Officer Any enquiries to: GovernanceTeamMailbox@gmc-uk.org
Senior Responsible Owner	**Neil Roberts**, Chair of Pension Plan Management Board

Agenda item M15
Annual report on Defined Contribution pension scheme

Background

1 The GMC Pension Plan Management Board is an advisory forum which monitors and reviews the operation of the GMC's Pension Plan, with a focus on performance of the default investment option, other funds available to the membership by the GMC, member engagement and the provider's level 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 the member and the contract is between them and the provider. The choice of investment funds is a decision made between the member and provider, in this case Aviva. This is the Board's tenth annual report to Council.

3 The Board met four times during 2024 – 16 January, 24 April, 4 July and 5 November. At each meeting the Board received advice from the GMC's pension advisers, Aon and were provided with an update on performance and investment from the scheme's managers, Aviva. The Board also receive an update and support from the internal pension team.

4 The Board comprises of four employer nominated members and three Scheme member nominated members; and is chaired by the Director of Resources. This year, we held elections to find successors for three of our Member Nominated representatives, as the terms of two representatives had ended and one representative resigned from their position. The nomination and selection process for this involved providing all members of our pension plan with the opportunity to vote for their preferred candidates and the successful candidates were approved and appointed by the Chair. This brought the number of Member Nominated representatives back to four.

Monitoring the investment performance and administration of the GMC Pension Plan

5 Investments 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 has been within expectations, albeit at the lower end of the performance measures.

7 As of the 5 November 2024 meeting, the triennial investment review of the default investment fund is now complete, and the Board has agreed to recommend to Executive Board that the GMC should adopt the proposed changes outlined by the Scheme's advisers, Aon. With the approval of the Executive Board, the Board will prepare a comprehensive implementation plan and begin to roll out communications of the changes to the membership in 2025.

8 The new Default Investment Option (DIO) strategy incorporates twelve investment funds including Environmental, Social and Governance (ESG) funds, providing colleagues with ethical alternatives to the existing DIO. The current Socially Responsible fund will remain open to members as an alternative investment option.

9 The investment market has been volatile this year due to a number of factors, including the fallout following the spring budget, persisting high interest rates, invasion of Ukraine, the heightened situation in the Middle East, global uncertainty, the cost-of-living crisis and recession. The Board has been reassured that Aviva is managing the funds within the set risk parameters and on all ethical grounds.

10 As measured on 31 August 2024, the number of active members of the DC scheme was 1,723 and the total value of scheme members' assets under management was £82,287,190.

Communications and Member Engagement

11 Whilst we are evidencing a healthy improvement in member interest, member engagement continues to remain a focus for the Board. A communications schedule for 2024 was agreed by the Board which included educational seminars covering various relevant topics, newsletters, a number of promotional projects, a member survey and drop-in sessions. Work to support the implementation of Pension Dashboards is on-going.

12 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.

13 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.

14 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.

15 As of 1 October 2024, 99% of employees are members of the GMC's pension scheme.

16 As of 31 August 2024, 30.6% of members have nominated a beneficiary of their pension pot in the event of an untimely death – an increase from 28.5% in the previous Aviva report. 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

17 The Board has its own Risk Register which is reviewed regularly. 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 Board.

Board Governance

18 The Board reviewed its governance arrangements at the July 2023 meeting. Aon confirmed that all the principles of good governance were met, as determined by The Pension's Regulator.

19 During this review the Board approved minor updates to its Statement of Purpose, which were then approved by the Executive Board in October 2023.

20 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.

21 A further effectiveness review of the Board has been scheduled for 2025.

22 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.