Council Meeting
Meeting Room 2.64/2.65/2.66
3 Hardman Street,
Manchester, M3 3AW

Agenda

Wednesday 12 June 2019

10:05 - 13:00

Meeting

10:05 – 10:10  M1  Chair’s business  5 mins

10:10- 10:10  M2  Minutes of the meeting on 30 April 2019  0 mins

10:10 – 10:20  M3  Chief Executive's Report  10 mins

10:20 – 10:35  M4  Chief Operating Officer’s Report  15 mins

10:35 – 10:50  M5  Medical Licensing Assessment: approach to designing the content map  15 mins

10:50 – 11:00  M6  Medical Licensing Assessment: approach to delivering the Applied Knowledge Test  10 mins

11:00 - 11:15  Break  15 mins

11:15 - 11:30  M7  Framework for GMC-regulated Credentials  15 mins

11:30 - 11:35  M8  Fitness to Practise annual statistics report 2018  5 mins
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To approve

Minutes of the meeting on 30 April 2019

Members present

Clare Marx, Chair

Steve Burnett  Deirdre Kelly
Shree Datta  Paul Knight
Christine Eames  Suzi Leather
Anthony Harnden  Denise Platt
Philip Hunt  Amerdeep Somal

Others present

Charlie Massey, Chief Executive and Registrar
Susan Goldsmith, Deputy Chief Executive and Chief Operating Officer
Paul Buckley, Director of Strategy and Policy
Una Lane, Director of Registration and Revalidation
Colin Melville, Medical Director and Director of Education and Standards
Anthony Omo, Director of Fitness to Practise and General Counsel
Neil Roberts, Director of Resources
Melanie Wilson, Council Secretary

Chair’s business (agenda item M1)

1  The Chair welcomed members, the Senior Management Team and observers to the meeting.

2  There were no apologies for absence. Michael Marsh, following his appointment as Regional Medical Director for the south west office of NHS England/Improvement, had demitted from Council with effect from 31 March 2019.
Minutes of the meeting on 27 February 2019 (agenda item M2)

3 Council approved the minutes of the meeting on 27 February 2019 as a true record.

Chief Executive’s report (agenda item M3)

4 Council considered the Chief Executive’s Report, noting that:

a The workforce implementation plan for England was likely to be published in May.

b The arrangements for regulation of physician associates were still being considered by the Department of Health and Social Care (England), so no decision had been made yet.

c On 1 May 2019 we are launching our first dedicated survey of speciality and associate specialist and locally employed doctors to tell us about their experiences in the workplace.

d The outcome of Dr Bawa-Garba’s hearing earlier in April had resulted in the doctor being allowed to return to practise with conditions on her registration for 24 months.

Chief Operating Officer’s report (agenda item M4)

5 Council considered the Chief Operating Officer’s Report.

6 Council noted the report, the Council portfolio at Annex A and the Corporate Opportunities and Risk Register at Annex B.

7 Council noted that:

a The Executive Board had agreed to exclude investment income from our financial key performance indicator, as investment performance is highly dependent on external market conditions.

b The reference to the Council seminar session on the Medical Licensing Assessment in paragraph 12 should have said it took place in February 2019 not April.

8 During discussion, Council noted that:

a The CCLA investment performance of 1.09% related to the end of February 2019 and performance was kept under review by the Investment Sub-Committee. The Investment Sub-Committee would consider reviewing whether the ethical framework has an impact on returns.

b There would be an update in June on progress with establishing the new arrangements for Field Forces/Outreach Teams.
2018 Human Resources Report and Gender Pay Reporting (agenda item M5)

Council considered an overview of the main HR monitoring data for 2018 including more detailed information on diversity and pay.

Council noted that:

a. The cause of the 17% gender pay gap in bonus pay was not clear, although additional payments for information systems staff could be a factor in distorting the figures.

b. Work to provide a supportive working environment for colleagues with mental health issues included mental health awareness training for managers, personal resilience training for staff and the establishment of a mental health network. In addition, there are plans to apply for the Investors in People Health and Wellbeing Award.

c. Recruitment of Black and Minority Ethnic (BME) candidates was continuing to increase, although higher turnover for BME staff was likely to be a result of higher turnover in the lower staff grades where the majority of recruitment occurred.

d. The workforce was fairly balanced in relation to other protected characteristics, such as sexual orientation, religious background and disability, although there was scope to do more to recruit disabled people.

During discussion, Council noted that:

a. An update would be circulated to Council on action being taken to support staff in relation to mental health, particularly those with acute needs.

b. Consideration should be given to how data on socio-economic background could be collected and analysed.

Review of flexibility in postgraduate training (agenda item M6)

Council noted an update on progress with the review of flexibility in postgraduate training.
13 Council noted that:

a The Academy of Medical Royal Colleges has produced draft principles to create a clearer process for transferability between specialties, which should be ready for roll-out in the autumn of 2019.

b There was concern in Northern Ireland and Scotland about unintended consequences of flexibility of doctors wanting to move around without enough safeguards in place.

c Further engagement with governments and education bodies in the four nations and other relevant stakeholders was planned to address the concerns.

d Discussions with Health Education England were planned to ensure that training programme directors were on board with the proposals.

14 During discussion, Council noted that:

a The progress to date was welcomed.

b The National Training Surveys would provide an opportunity to monitor the experience of trainees, but more could be done with the data we have.

Amending the list of bodies entitled to award a UK Primary Medical Qualification – University of Buckingham Medical School (agenda item M7)

15 Council received a paper on the proposal that the University of Buckingham be added to the GMC’s list of bodies that can award UK Primary Medical Qualifications.

16 Council noted that:

a Buckingham Medical School was the first and only privately funded medical school in the UK.

b Earlier concerns we had about physical space at the medical school and at Milton Keynes University Hospital have been addressed.

c There is a contingency arrangement with the University of Leicester to graduate the first cohort of students in the event that approval isn’t given in time for 2019 graduations.

d Final due diligence checks were required, so assurance would be provided to Council on circulation to avoid delaying approval until the next formal meeting.

17 Council agreed, subject to a positive outcome to the final due diligence checks, that the University of Buckingham be added to the GMC’s list of bodies that can award UK Primary Medical Qualifications.
Introducing a Framework for GMC-regulated Credentials (agenda item M8)

18 Council received a paper giving an update on engagement on a draft framework for introducing GMC-regulated credentials.

19 Council noted that:

a Analysis of consultation responses was ongoing and the final report would be brought to Council on 12 June 2019.

b A joint letter from the BMA Junior Doctors Committee and the Academy of Medical Royal Colleges Trainee Doctors’ Group, raising concerns about the introduction of credentials and the associated process we have undertaken to engage with doctors in training had been received and a response sent.

c We are setting a high threshold for consideration of whether a GMC-regulated credential is needed in any particular area: that is whether it is on patient safety grounds. There were likely therefore to be a small number of GMC-regulated credentials in total. The five areas that we have been working with to test the feasibility of the framework are:

i Cosmetic surgery

ii Liaison psychiatry

iii Mechanical thrombectomy

iv Rural and remote health

v Pain medicine.

d Council was asked to approve the process rather than the individual areas for introducing such credentials, approval for which would be the responsibility of the Curriculum Oversight Group and Curriculum Advisory Group.

20 Subject to review of the final engagement report in June, Council:

a Agreed to a phased introduction of GMC-regulated credentials, starting with a small number of early adopters, with a review point once they are developed.

b Noted the changes to the framework, particularly the clarification on entry requirements, based on patient safety.

c Noted that we will publish the engagement report, framework and supplementary documents in early summer.
Welcome to UK Practice Expansion (agenda item M9)

21 Council noted an update on progress with the corporate strategy target to increase attendance at Welcome to UK Practice (WtUKP) to 80% of new international medical graduates (IMGs)/EEA doctors by 2020.

22 Council noted our progress including an overview of: the evaluation, target forecasting, capacity modelling, risks and opportunities.

23 Council noted that:

a Attendees were generally more willing to access GMC guidance and the majority said they did change their practice as a result of attending a WtUKP session.

b There was a 53% increase in attendance numbers from 2017 to 2018, but the substantial increase in IMGs and EEA doctors meant that the percentage attending only represented 58%.

c Face-to-face training was regarded as the most effective way to deliver the material, which also offered those attending the opportunity to network and develop a community of practice.

d Regional Liaison Service associates were being recruited to deliver more of the sessions to ease the pressure on Regional Liaison Advisers and enable more evening and weekend sessions.

Proposed Amendments to the Governance Handbook (agenda item M10)

24 Council received a paper setting out proposals for amendments to the Governance Handbook, including the Schedule of Authority, to provide improved consistency in our procedures and delegation arrangements and to enable minor updates to be made and issued to Council.

25 Council:

a Approved the proposed amendments to the Governance Handbook, at Annex A.

b Delegated authority to the Chair of Council to approve updates to the statements of purpose of committees during 2019 to bring greater consistency to the content and formatting (noting that any substantive changes would still require Council approval).

26 During discussion, Council noted that:

a The proposed change of name of the Investment Sub-Committee to Investment Committee did not change the line of accountability to Council as it was intended to reflect the Committee’s status as a standalone committee of Council.
b Wording in the Members’ Code of Conduct on communication with the media about our work would be reviewed to ensure that the approach is proportionate.

Any Other Business (agenda item M11)

27 Council noted that the Council away day in 2020 was likely to be rescheduled to March 2020 to fit in with the timetable for drafting the next corporate strategy.

28 Council noted the date of its next seminar and meeting on 11 and 12 June 2019, in Manchester.

Confirmed:

Clare Marx, Chair 12 June 2019
Executive summary
This report outlines developments in our external environment and progress on our strategy since Council last met.

Key points to note:

- We are prepared for a ‘no deal’ Brexit, with legislation ready to be enacted which will allow us to register doctors who qualified in the European Economic Area (EEA) in a timely and streamlined way without compromising standards.

- The independent review into gross negligence manslaughter and culpable homicide, led by Dr Leslie Hamilton, has concluded. The final report and its recommendations were published on 6 June 2019.

- In May we published *Welcomed and valued*, our new advisory guidance for education organisations supporting disabled medical students and doctors. We believe this is an important step forward towards a more diverse and inclusive profession.

Recommendation
Council is asked to consider the Chief Executive’s report.
Developments in our external environment

Brexit

1 The Government intend to lay the EU Withdrawal Agreement Bill in Parliament in the week beginning 3 June. This Bill is the piece of legislation which would implement the Withdrawal Agreement into UK law. MPs have already voted three times to reject the Agreement. If the Bill is defeated, the Government has signalled that only two options would remain – a ‘no deal’ Brexit on 31 October or the revocation of Article 50.

2 The draft Medical Act amendments legislating for a ‘no deal’ Brexit were adopted in March and will be enacted should we have a ‘no deal’ Brexit. We worked closely with DHSC officials and lawyers to make sure that the amended Act allows us to register doctors who qualified in the European Economic Area (EEA) in a timely and streamlined way without compromising standards. DHSC officials have worked closely with officials in the devolved governments, and we have also engaged closely with these officials to ensure we are considering things appropriately from a four-country perspective.

3 We understand however that the arrangement to continue to recognise the majority of EEA qualifications will not be reciprocated by European medical regulators for UK qualifications. This loss of recognition of UK qualifications does have potential implications for undergraduate and postgraduate medical education in the UK bearing in mind that around five per cent and four per cent respectively of participants in those programmes are from the EEA – it remains to be seen whether UK medical education will continue to attract applications at this level when the qualifications conferred no longer benefit from automatic recognition throughout Europe.

Follow-up to Zholia Alemi case

4 The Registration Appeal Panel met on 29 April 2019 to consider an appeal from Zholia Alemi to our decision to erase her name from the register on the basis of fraud. The panel dismissed her appeal and her name has now been erased. She has 28 days from the date of the decision to exercise a further right of appeal to the County Court. At the time of writing, no such appeal had been submitted.

5 Separately, we have been verifying the primary medical qualifications of 3,117 doctors registered under the same Commonwealth route to registration who are currently licensed to practise in the UK. This exercise took slightly longer than anticipated as we were, for the most part, relying on the good will of medical schools to complete these checks and some had a significant number of qualifications that needed reviewing. We completed the exercise on 4 June 2019. All of these doctors were appropriately qualified. We are now considering whether any further checks of
other groups of international medical graduates should be undertaken and we will take a risk based approach to determining the extent of this further exercise.

_Inquiries and reviews_

6 We continue to support the work of a range of statutory and non-statutory inquiries and reviews:

**Infected blood inquiry**

7 We continue to work on the disclosure of materials to the infected blood inquiry. The inquiry has given us a target of mid-May to complete the disclosure and we are making excellent progress towards this, compiling all final items for disclosure. We also continue to complete urgent ad-hoc requests for information relating to individual doctors.

**Elizabeth Dixon investigation**

8 We have completed disclosure of 15,000 pages of documentation to the Dixon investigation and Dr Bill Kirkup’s team. We expect the report to be published in June 2019 and they have informed us we will receive a ‘salmon letter’ if any criticisms of the GMC are mentioned in the report. We have also been advised that they may send us further information relating to doctors criticised in the final report.

**Independent Inquiry into Child Sexual Abuse**

9 On 29 and 30 April 2019, the Independent Inquiry into Child Sexual Abuse (IICSA) held a seminar which examined the pros, cons and practical considerations of mandatory reporting of child sexual abuse. The discussions covered mandatory reporting in other jurisdictions; experiences of reporting child sexual abuse; and features of mandatory reporting models.

10 Sharon Burton, Head of Policy in the Standards and Ethics team, attended on behalf of the GMC. The seminar heard evidence in favour of mandatory reporting by both individuals and institutions, while others spoke about the barriers to good safeguarding practice presented by reductions in funding and the availability of training, specialist safeguarding staff, and local support services.

11 The IICSA informed participants that it will not reach a conclusion in relation to mandatory reporting until further evidence from the rest of the investigations is heard.
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The treatment of eating disorders

12 The Public Administration and Constitutional Affairs Committee is conducting an inquiry into the treatment of eating disorders in the NHS. This follows a report by the Parliamentary and Health Service Ombudsman (PHSO) in December 2017, which recommended that the GMC conduct a review of training for doctors in this area.

13 Professor Colin Melville, our Director of Education and Standards, gave oral evidence to the inquiry on 14 May 2019. As Colin set out, we believe that all doctors should have a relevant understanding of a wide range of conditions, including mental health, nutrition and eating disorders. However, our ability to conduct the review that the PHSO recommended is limited by scope of the powers we are afforded by the Medical Act (1983). The minister present at the evidence session recognised the GMC’s limited powers in this area.

14 Despite these limitations, we want to do everything we can to bring trainers and medical schools together to determine how to improve provision. We’ve worked with parliamentarians to convene a stakeholder meeting, and we have now formally written to every medical school to ask them to set out current provision for training. We are also exploring what scope there is for a common understanding among each medical school as to what the exact content of curricula on these conditions should be. We will be working with the Department for Health and Social Care to clarify our role to the Committee before they issue their report.

Progress on our strategy

Independent review into gross negligence manslaughter and culpable homicide

15 The independent review into gross negligence manslaughter and culpable homicide, led by Dr Leslie Hamilton, has concluded. The final report and its recommendations were published on 6 June 2019.

16 We will now consider the implications for the GMC and the programme of work necessary to take forward the recommendations, working closely with relevant stakeholders. We will also consider how the implementation of the recommendations is to be monitored and evaluated.

17 Views from a range of individuals, and organisations involved in medicine and the law, as well as those representing patients and families, from across the four countries of the UK were gathered, including over 850 pieces of written evidence.
Human factors

Our collaboration with the Oxford University’s Patient Safety Academy on human factors is progressing well. Training has now been delivered to our Case Examiners, our Employer Liaison Advisors as well as our triage team within Fitness to Practise. Further sessions are being arranged to ensure all relevant staff receive the training over the next few months.

Collaboration with other regulators

In May, we hosted an event bringing together Chairs and Chief Executives of the healthcare professional regulators. The discussion centred on three themes: what the group needed from the government, the Professional Standards Authority and each other in order to be more effective regulators. It provided an opportunity to identify shared interests among the group.

The group has now agreed to hold further discussions on workforce and fitness to practise, alongside the regular Chief Executive Steering Group meetings. The first of these discussions is expected in July and we will be provide support in organising it. The Nursing and Midwifery Council will take a lead on hosting a further event for Chairs and Chief Executives in the autumn.

As part of our involvement with the Health and Social Care Regulators Forum, which brings together system and professional regulators, we will be working in partnership to explore and develop a common, good practice framework for complaint handling.

These initiatives are all important parts of our objective of collaborating with others to improve patient safety and protection.

Education Quality Assurance pilots

In February 2019, Council considered a proposal of a new approach to the quality assurance of the management and delivery of medical education and training. Since then we have been working with medical schools and postgraduate organisations across Wales and West Midlands to pilot parts of the proposed process. All seven pilot organisations have now completed a newly developed self-assessment questionnaire which we are currently analysing, and we have now started holding follow-up meetings to discuss the quality activities we will test in the coming months.

Alongside this, we have been developing new data and intelligence dashboards that support the new approach, and some of these will be released to stakeholders this summer. We have also reviewed our quality assurance governance arrangements, including new plans for peer review and audit of our processes. Later this year we will develop the computer systems that support the new approach.
25 Following the conclusion of the pilots, a further report will be brought to Council. This is anticipated to be in early 2020.

Supporting disabled medical students and doctors
26 On Tuesday 14 May, we published *Welcomed and valued*, our new advisory guidance for education organisations supporting disabled medical students and doctors. This was the culmination of a two-year project where we worked with an expert steering group, a reference community of 300 people including disabled learners, and our core stakeholders.

27 We believe this is an important step towards a more diverse and inclusive profession, starting with more personalised conversations between organisations and learners about their needs.

Parliamentary roundtable on bullying and undermining in the NHS
28 We held a parliamentary roundtable in the House of Lords on 7 May 2019 to discuss measures to tackle bullying and undermining in the health service and the need to shift away from a bullying culture. The event was chaired by Dr Philippa Whitford MP (SNP) and Baroness Walmsley (Liberal Democrat). The roundtable was attended by a range of key senior stakeholders from across the UK, including many members of the Anti-Bullying Alliance. This was an opportunity to provide an update on the work that the GMC is taking forward, including the *Professional Behaviours and Patient Safety* training programme that we have developed with other stakeholders.

Patient feedback in revalidation
29 We have launched a public consultation on changes to our requirements for how doctors use patient feedback as part of their revalidation. The consultation runs until 23 July 2019.

30 It is vitally important that patients have the opportunity to give doctors feedback on the care they receive. We know doctors value feedback from their patients and find it one of the most helpful types of supporting information to reflect on at appraisal. This consultation does not ask whether doctors should be required to reflect on patient feedback as part of their revalidation but instead how they should do so.

31 By changing our guidance, we want the feedback to better support doctors’ learning and development and to make it easier for patients to take part.

32 The consultation seeks views on proposals developed in collaboration with an advisory group of doctors, their employers and patients. The proposals include
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allowing doctors to use their own tools to collect feedback (rather than the requirement to use a standard questionnaire).

Executive Board

33 The Executive Board met on 23 April 2019 to consider items on:

a Options for further work that could increase our assurance that licensed doctors have appropriate insurance and indemnity arrangements in place. This work follows on from the recent consultation by the Department of Health and Social Care (England) on appropriate clinical negligence cover, and the introduction of the new clinical negligence scheme for GPs in England and Wales. The Board agreed to revisit the topic once the outcomes of the Independent Inquiry set up following the conviction of surgeon Ian Paterson are known later in the year, in order to act on any recommendations that may arise.

b A process to enable us to make nominations for honours of GMC staff and members where exceptional individuals have gone above and beyond to help us achieve our patient safety goals, and to offer light touch support of nominations made by others in the system.

c Proposed changes to our publication and disclosure policy to provide for the publication of decisions taken by the new Executive Panel which makes decisions about whether or not we would take forward an appeal following a decision from a Medical Practitioners Tribunal. The Board approved the update to our Fitness to Practise publication and disclosure policy, which fulfils our commitment to the Health and Social Care Committee to publish such decisions.

d The draft Trustees’ Annual Report and Accounts, ahead of their consideration by Council at this meeting.

34 The Board also noted updates on:

a Brexit preparedness.

b The process for developing the next Corporate Strategy.

c Council away day planning.

d Work being undertaken on reward and recognition.

e Corporate complaints in Quarter 4 of 2018 and Quarter 1 of 2019.

f Annual fitness to practise statistics.

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Executive summary
This report provides an update on our operational performance, key projects and programmes, and other operational matters arising including:

- Financial summary and Quarter One forecast
- Operational volumes
- Transformation Programme update
- Welsh Language Standards update
- Updates to the Corporate Opportunities and Risk Register (CORR)
- 2018 Pension Scheme Triennial Valuation

Recommendation
Council is asked to consider the report, Annex A (Council portfolio), Annex B (Corporate Opportunities and Risk Register) and Annex C (Pension Scheme Valuation).
Issue

1. This report provides an update on our operational performance, strategic progress, and other operational matters arising. It is exception-based, highlighting the key issues that Council should be aware of in the delivery of our work programme for 2019.

Operational Key Performance Indicators (KPIs)

2. In March 2019 we missed our target to Commence 100% of Investigation Committee (IC) hearings within two months of referral, achieving 50% (i.e. one out of two cases). Although the IC hearing was listed within the two-month target, it had to be postponed due to a medical member of the panel needing to step down because of health issues. We were unable to empanel a replacement within the timeframe for the planned date. This was an isolated incident, and the target was met for April 2019.

Operational volumes and pressures

Trends in applications for registration and demand for the Professional and Linguistic Assessments Board (PLAB)

3. In my last report to you, I highlighted that volumes of applications for registration received from graduates from the European Economic Area (EEA) was beginning to increase. As at the end of April and as shown in Graph 2 at Annex A, we had received 56% more applications year to date than at the same point in 2018. This was partly due a surge in applications from EEA doctors in the run up to the original proposed exit date of 29 March 2019, with approximately two months’ usual volume of applications received in 19 days. Applications from doctors with a Primary Medical Qualification (PMQ) from the University of Malta accounted for 45% of these. Further investigation revealed that the Medical Association of Malta had advised prospective doctors on specialist training programmes to register with the GMC before the UK’s exit date. Volumes subsequently returned to more typical levels following the announcement on extension to Brexit, and we are confident that the plans we have in place will successfully navigate any new surges in applications in the run up to the October EU exit deadline.

4. Applications for registration from International Medical Graduates (IMGs) continue to increase. As at the end of April, as shown at Graph 1 at Annex A, we had received 34% more applications for registration from IMGs year to date than at the same point in 2018. For comparison, this is 166% higher than at the same point in 2013 and a 110% increase at the same point in 2016.
Consequently, demand for the PLAB 1 and PLAB 2 assessments continues to grow, as shown in Graph 3 at Annex A. Our new Clinical Assessment Centre in Manchester, which will significantly expand our capacity to run PLAB 2 assessments, is on track to launch on 6 August 2019. In the meantime, we ran a further PLAB assessment at an external venue in May. We are confident in our ability to ensure doctors wishing to take the assessment, which is a requirement for practising in the UK, will continue to be able to do so within reasonable timeframes.

**Fitness to Practise caseloads and MPTS hearings**

7 We are currently experiencing increased volumes of caseloads within Fitness to Practise. In line with this, the number of referrals to the Medical Practitioners Tribunal Service (MPTS) has also increased. For comparison, since September 2017 the monthly average number of referrals received by the MPTS has increased from 22 to 30 for March 2019.

8 These increases cannot be attributed to any single factor. Some indicators are that we are receiving increased numbers of serious cases. In addition, in September 2017 we made some changes to guidance for case examiners, which reduced their discretion about whether to refer cases about violence or dishonesty. We will continue to monitor caseloads closely, to seek to understand the drivers for increases.

9 In the meantime, we are taking measures around recruitment to ensure that routine staff turnover does not aggravate this further. We have also created some additional posts in both FtP and MPTS to deal with the higher workloads. The financial summary below gives more detail on changes to our original forecasts for hearing costs.

**Financial summary and Quarter one forecast**

1 As at end of April 2019, operational income to date was £633k higher than budgeted, boosted by increased demand for registration and PLAB tests, as outlined in the paragraphs above; and the numbers of doctors leaving the medical register was also slightly lower than budgeted. Investment income has remained strong in the first part of the year but can change quickly depending on market conditions. Expenditure as at the end of April 2019 was overall in line with budget.

2 Our latest forecast to the end of the year is that expenditure will be higher than budgeted, but this is likely to be more than offset by additional income. The main factors are:

- Staff costs expected to be approximately £900k higher, as we are experiencing a lower level of staff vacancies than assumed in our original budget.
- An increase in costs of approximately £320k due to a forecasted 246 additional hearing days. The increase in hearings drives up costs in associate fees and expenses in MPTS, and legal costs in FTP.

- Income higher than budget due to increased demand for PLAB tests, more new registrations and fewer doctors leaving the register.

3 Overall, we are forecasting a lower deficit than budgeted, which would increase our reserves by £684k.

Changes to our forecasting and New Initiatives Bid processes

4 From June, our financial forecasting will change from a quarterly to a monthly basis. This means our reported forecasts will reflect the latest available actual costs, and cost expectations for the remainder of the year. Having more up to date and accurate forecasting information will assist the Senior Management Team (SMT) in decision making on New Initiatives Fund, and other financial matters.

5 In May, the SMT considered bids to the New Initiatives Fund. Set at £3.5m for the year, the purpose of this fund is to ensure money can be allocated during the year, if needed; either as investment for new areas of work where there is a strong business case, or to deal with unexpected events. This year, the process for allocating the NIF has been revised so that the SMT make collective decisions on which bids to approve, at set intervals. This provides further scrutiny to ensure we are investing in initiatives that deliver real value to our customers. The updates to the NIF fund, and forecasting are examples of how we are ensuring our financial processes support more flexible and agile ways of working.

6 Successful bids from the first round, considered by SMT on 20 May, include enhancements to our cyber-crime security; a new system to support management of our stakeholder relationships, which will interface with Siebel; and support for changes to how our outreach teams work that will bring greater alignment to NHS regions from January 2020. £1.3m of this fund remains available as a contingency for the rest of 2019.

2018 Pension Scheme Triennial Valuation

7 The 2018 Pension Scheme Valuation is now underway and a summary of the latest position is provided at Annex C. A triennial valuation process is required to be undertaken by trustees of the GMC Defined Benefit (DB) scheme, using assumptions agreed with the GMC as employer. This differs from the accounting valuation which Financial Reporting Standard FRS 102 requires us to include in the 2018 Annual Report and Accounts. The accounting valuation is used purely to allow comparisons
across organisations on a consistent basis and is not used by pension trustees and Council when considering pension scheme funding requirements.

**Strategic delivery**

8 The strategic portfolio, at Annex A, shows the detail of our strategic delivery in 2019, by exception.

*Strategic aim 1: Supporting doctors in delivering good medical practice*

9 Medical Licensing Assessment (MLA) – the programme continues to be reported as red. Alternative approaches to the design and delivery of the Applied Knowledge Test (AKT) have been developed, with input from the MLA expert reference group. These are for discussion under Item M6, and overall timeframes for delivery will need to be revisited once Council have advised on the options proposed. In the meantime, development of other aspects of the MLA, such as the clinical and professional skills assessment (CPSA), continues to make good progress.

10 Supporting a profession under pressure – overall progress remains good, and a number of key independent reviews prepare to report shortly. We are working to co-ordinate across the whole programme to ensure that learnings from the reviews are maximised. The Chief Executive’s report at Item M3 gives further detail. Some exceptions in programme delivery are set out below, none of which put major milestones for publication at risk:

   a Fairness – The ‘Fair to Refer’ research report is in draft format and we are currently completing final revisions with the research team. Publication is planned to be on or before the 26th of June (Belfast ARM) and an extraordinary meeting of the BME forum is planned for the 4th of July.

   The protected characteristics fill rate campaign continues and will continue to run into July. The Strategic ED&I Forum has been delayed until after the summer to allow for time to undertake some preliminary engagement with new organisations and ensure we given enough notice for doctors attending. Date yet to be finalised.

   b Induction and returners – This project continues to be reported as amber whilst we consider how we can best work with others to enhance induction support, which links to our engagement on the NHS Longer Term Plan. The lead for this work has also changed due to an internal move.

11 Public interest concerns pilot – Reported as red, due to slippage on the timescales for the implementation of the evaluation report recommendations as a result of capacity pressures with other pilot work taking place. The pilot was started in 2016, to test safeguards for doctors who are whistleblowers. This was part of an action plan we
published in 2015 in response to the findings of an independent review that we had commissioned by Sir Anthony Hooper QC, about doctors who have raised concerns in the public interest. The pilot tested changes to the way that employers and contractors of doctors make referrals into our fitness to practise procedures, and the way that we provide safeguards for doctors that are whistleblowers. The FTP Senior Management Team will now consider the revised guidance for decision makers in July. The final paper to update on the totality of the Hooper recommendations will be considered in September.

Strategic aim 4: Meeting the change needs of the health services across the four countries of the UK

12 Brexit - Internal plans to prepare the business for Brexit are complete and we are ready for whatever scenario we will face on 31 October 2019 (or earlier if the Withdrawal Agreement is adopted). However, following the defeats in Parliament, our work to prepare continues to be reported as red as we are not able to put systems in place until we have certainty on the external political environment. As set out in paragraph 3, we saw a surge in applications from EEA graduates in the run up to 29 March 2019. This has now levelled off and we are confident that we have plans in place to successfully navigate any new surge in the run up to October 2019.

Progress with our Transformation Programme

13 In 2018, we moved to an annual staff survey as part of the Transformation Programme. This year’s staff survey, conducted on our behalf by our new survey provider, BMG Research, launched on 23 April. We will receive the top line report shortly, followed by more detailed reports. Key themes will be further explored through focus groups, facilitated by BMG. This will give us valuable feedback on staff views, and insight into themes central to transformation, such as supporting career development.

14 In the meantime, we continue to make good progress on delivery across the programme. Recent milestones include the recruitment of key staff for our new Strategic Relationship Unit, which will enhance the way we work with others in the political and healthcare environment. Planning for the implementation of our Outreach teams, which will better align with the NHS regions in England, continues.

15 We have also interviewed leaders at the GMC to explore what factors enhance transparency of decision making and contribute to successful change. Heads of Section will shortly be asked to help define criteria for what constitutes ‘good enough’ in their areas of operations. Understanding this will be key to making us a more flexible and responsive organisation and will allow us to develop further tools for staff to help manage workloads and prioritise effectively.
Welsh Language Standards update

16 On 29 April we met with Eluned Morgan, Minister for International Relations and the Welsh Language, along with colleagues from the General Dental Council, General Pharmaceutical Council, General Optical Council and Nursing and Midwifery Council. The Minister said her department is ready to proceed with standards for health regulators but hasn’t been able to confirm the timescale due to the uncertainty caused by Brexit.

17 The Minister will name the healthcare organisations in regulations via a vote in a plenary session of the Assembly. Organisations will receive a compliance notice and will have 6 months to implement each standard. During this period, the Welsh Language Commissioner will consult with us before issuing a final compliance notice.

18 Our Welsh Language Schemes remain in force whilst we work towards the introduction of the Standards.

19 We are currently developing an action plan and continuing to liaise with policy colleagues across GMC and other healthcare regulators.

Updates to the Corporate Opportunities and Risk Register (CORR)

20 Key changes to the corporate risk profile:

21 New opportunity (AOP3) added on the Supporting a Profession under Pressure programme. Overlapping themes across the major reviews within the programme, and interdependencies with work by external stakeholders such as the NHS Long Term Plan, given the opportunity to make a real impact to the environments in which doctors work. Effective co-ordination with stakeholders will be key to success and we are to identify opportunities for collaboration, in the run-up to publication of the reviews.

22 The residual rating for risk AT4, relating to credentialing, has been lowered to significant due to Council’s decision on next steps at meeting in April 2019.
M4 – Annex A – Council Portfolio

Council meeting
June 2019

Data presented as at 30 April 2019 (unless otherwise stated)
Commentary as at 15 May 2019

Working with doctors Working for patients
# Operational Key Performance Indicator (KPI) summary

<table>
<thead>
<tr>
<th>Core regulatory objective</th>
<th>Key Performance Indicator</th>
<th>Performance</th>
<th>Exception summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>We decide which doctors are qualified to work here and we oversee UK medical education and training.</td>
<td>Decision on 95% of all registration applications within 3 months</td>
<td>98%</td>
<td>On track</td>
</tr>
<tr>
<td></td>
<td></td>
<td>99%</td>
<td>On track</td>
</tr>
<tr>
<td></td>
<td>Answer 80% of calls within 20 seconds</td>
<td>87%</td>
<td>On track</td>
</tr>
<tr>
<td></td>
<td></td>
<td>90%</td>
<td>On track</td>
</tr>
<tr>
<td>We set the standards that doctors need to follow, and make sure that they continue to meet these standards throughout their careers.</td>
<td>Decision on 95% of all revalidation recommendations within 5 working days</td>
<td>98%</td>
<td>On track</td>
</tr>
<tr>
<td></td>
<td></td>
<td>98%</td>
<td>On track</td>
</tr>
<tr>
<td></td>
<td>Respond to 90% of ethical/standards enquiries within 15 working days</td>
<td>95%</td>
<td>On track</td>
</tr>
<tr>
<td></td>
<td></td>
<td>100%</td>
<td>On track</td>
</tr>
<tr>
<td>We take action to prevent a doctor from putting the safety of patients, or the public’s confidence in doctors, at risk.</td>
<td>Conclude 90% of fitness to practise cases within 12 months</td>
<td>91%</td>
<td>On track</td>
</tr>
<tr>
<td></td>
<td></td>
<td>93%</td>
<td>On track</td>
</tr>
<tr>
<td></td>
<td>Conclude or refer 90% of cases at investigation stage within 6 months</td>
<td>93%</td>
<td>On track</td>
</tr>
<tr>
<td></td>
<td></td>
<td>92%</td>
<td>On track</td>
</tr>
<tr>
<td></td>
<td>Conclude or refer 95% of cases at the investigation stage within 12 months</td>
<td>96%</td>
<td>On track</td>
</tr>
<tr>
<td></td>
<td></td>
<td>97%</td>
<td>On track</td>
</tr>
<tr>
<td></td>
<td>Commence 100% of Investigation Committee hearings within 2 months of referral</td>
<td>50%</td>
<td>No cases due</td>
</tr>
<tr>
<td></td>
<td></td>
<td>On track</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Commence 100% of Interim Order Tribunal hearings within 3 weeks of referral</td>
<td>100%</td>
<td>On track</td>
</tr>
<tr>
<td></td>
<td></td>
<td>100%</td>
<td>On track</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Business support area</th>
<th>Key Performance Indicator</th>
<th>Performance</th>
<th>Exception summary</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2017/18 Income and expenditure [% variance]</td>
<td>1.23%</td>
<td>On track</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.47%</td>
<td>On track</td>
</tr>
<tr>
<td></td>
<td>Rolling twelve month staff turnover within 8-15%</td>
<td>8.18%</td>
<td>On track</td>
</tr>
<tr>
<td></td>
<td></td>
<td>8.1%</td>
<td>On track</td>
</tr>
<tr>
<td></td>
<td>IS system availability (%)</td>
<td>100%</td>
<td>On track</td>
</tr>
<tr>
<td></td>
<td></td>
<td>99.99%</td>
<td>On track</td>
</tr>
<tr>
<td></td>
<td>Monthly media score</td>
<td>100</td>
<td>Strongest percentage of positive/neutral coverage in over two years, maintained above target by GMC Conference-related coverage</td>
</tr>
<tr>
<td></td>
<td></td>
<td>710</td>
<td></td>
</tr>
</tbody>
</table>

NB We are currently reviewing our operational KPIs with a view to introducing a revised suite of indicators during 2019.
Strategic delivery – overall view

The diagram below shows the key benefits of the 2018-2020 Corporate Strategy. The RAG ratings indicate our progress with delivery of the activities that will realise these benefits. More detail on exceptions is on Slides 4-7.

Corporate Strategy 2018-2020

1. Supporting doctors in delivering good medical practice
   - Doctors are supported to deliver high quality care
   - Doctors have a fulfilling/sustained career
   - Enhanced trust in our role
   - Increased confidence in the quality of training environments
   - Improved identification of risk

2. Strengthening collaboration with regulatory partners.
   - Smarter Regulation
   - Right response by the right organisation, at the right time
   - Enhanced perception of regulation

3. Strengthening our relationship with the public and the profession
   - Public confidence in GMC
   - Enhanced customer service
   - Contribute to public confidence in doctors

4. Meeting the change needs of the health services across the four countries of the UK
   - UK workforce needs better met
   - Maintenance of a coherent model of regulation across the UK
   - We are well prepared for and can influence legislative change

These RAGs are based on delivery of strategic benefits envisioned in the GMC Corporate Strategy. While they may be affected by external issues and challenges they will not, as a necessity, reflect in all cases external opinion at that point in time as they are future focused on benefit delivery and the GMC contribution to that delivery.
Strategic delivery (by exception)

Strategic aim 1: Supporting doctors in delivering good medical practice

Key benefit
Doctors are supported to deliver high quality care

Activities to deliver (by exception)
Medical Licensing Assessment

Lead indicators
Establish policy, and put in place operational infrastructure, resources and processes are place to deliver a live run of the MLA in 2022.

Lag indicators
a. Perception Question (Drs) - %

Exception commentary
At present, the project continues to be reported as red, whilst council determine the design and delivery of the Applied Knowledge Test (AKT) is pending.

Public Interest Concerns

Work with partners in the health services in England, Scotland, Wales and Northern Ireland to make sure doctors at all career stages feel supported to raise and act on concerns.

a. NTS workload indicator - (%)

We have reworked the timescales for the implementation of the evaluation report recommendations. We will now take decision maker guidance for approval to the FTP SMT meeting on 15 July. The final paper to update on all the recommendations will be taken to FTP SMT on 11 September.
Strategic delivery (by exception)

Strategic aim 1: Supporting doctors in delivering good medical practice

Key benefit | Activities to deliver (by exception) | Lead indicators | Lag indicators | Exception commentary
--- | --- | --- | --- | ---
Doctors are supported to deliver high quality care | Fairness (Supporting a Profession Under Pressure) | Determine how the GMC can use insight, understanding and regulatory levers and other methods of influence to provide supportive interventions for different groups of doctors | 1. Perception Question (Drs) - % Drs feel supported 2. NTS Supportive Environment 3. NTS Workload Indicator | The ‘Fair to Refer’ research report is in draft format and we are currently completing final revisions with the research team. Publication is planned to be on or before the 26th of June (Belfast ARM) and an extraordinary meeting of the BME forum is planned for the 4th of July. The protected characteristics fill rate campaign continues and will continue to run into July. The Strategic ED&I Forum has been delayed until after the summer to allow for time to undertake some preliminary engagement with new organisations and ensure we given enough notice for doctors attending. Date yet to be finalised.

Doctors have a fulfilling / sustained career | Induction and Returners (Supporting a Profession Under Pressure) | TBC | a. Perception Question (Drs) - % Drs found career fulfilling | This project is reported as amber whilst we consider how we can best work with others to enhance induction support, which links to our engagement on the NHS Longer Term Plan. Leadership change within the project team.
Strategic aim 4: Meeting the change needs of the health services across the four countries of the UK

Key benefit

We are well prepared for and can influence legislative change

Activities to deliver (by exception)

Preparing for Brexit

Lead indicators

More certainty on likelihood of scenarios

Lag indicators

Perceptions question - % stakeholders felt that they knew at least a fair amount about ‘why the GMC is calling for legislative reform and the effects that such reform could have on the medical workforce on how well prepared for an can influence legislative change’

Exception commentary

We saw a surge in applications from EEA doctors in the run up to 29 March 2019 but this has now levelled off. We are confident that we have plans in place to successfully navigate any new surge in the run up to October 2019.

Additional detail regarding this is contained within the main body of the report.
### Financial summary

#### Finance - Summary

<table>
<thead>
<tr>
<th>Financial summary as at April 2019</th>
<th>Budget to April</th>
<th>Actual to April</th>
<th>Variance</th>
<th>Budget Jan - Dec</th>
<th>Forecast Jan - Dec</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Operational expenditure</td>
<td>33,530</td>
<td>33,669</td>
<td>-139</td>
<td>0%</td>
<td>105,641</td>
<td>106,740</td>
</tr>
<tr>
<td>New initiatives fund</td>
<td>71</td>
<td>74</td>
<td>-3</td>
<td>0%</td>
<td>3,500</td>
<td>3,500</td>
</tr>
<tr>
<td>Capital expenditure</td>
<td>1,685</td>
<td>1,712</td>
<td>-27</td>
<td>2%</td>
<td>6,480</td>
<td>6,303</td>
</tr>
<tr>
<td>Clinical Assessment Centre expansion</td>
<td>1,227</td>
<td>1,227</td>
<td>0</td>
<td>0%</td>
<td>4,570</td>
<td>4,313</td>
</tr>
<tr>
<td>Pension top up payment</td>
<td>1,900</td>
<td>1,900</td>
<td>0</td>
<td>0%</td>
<td>1,900</td>
<td>1,900</td>
</tr>
<tr>
<td><strong>Total expenditure</strong></td>
<td>38,413</td>
<td>38,582</td>
<td>-169</td>
<td>0%</td>
<td>122,091</td>
<td>122,756</td>
</tr>
<tr>
<td>Operational income</td>
<td>33,671</td>
<td>34,304</td>
<td>633</td>
<td>2%</td>
<td>107,237</td>
<td>108,586</td>
</tr>
<tr>
<td>Investment income</td>
<td>520</td>
<td>1,497</td>
<td>977</td>
<td>188%</td>
<td>1,919</td>
<td>1,919</td>
</tr>
<tr>
<td><strong>Total income</strong></td>
<td>34,191</td>
<td>35,801</td>
<td>1,610</td>
<td>5%</td>
<td>109,156</td>
<td>110,505</td>
</tr>
<tr>
<td><strong>Surplus/ (deficit)</strong></td>
<td>-4,222</td>
<td>-2,781</td>
<td>1,441</td>
<td></td>
<td>-12,935</td>
<td>-12,251</td>
</tr>
</tbody>
</table>

#### Key drivers of expenditure - To date

<table>
<thead>
<tr>
<th>Key drivers of expenditure - To date</th>
<th>£000</th>
<th>Key changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headcount changes</td>
<td>-205</td>
<td>The churn cut incorporated into the budget was 75 roles. To date headcount levels have been slightly over budget after adjusting for churn therefore there is an equivalent overspend. The churn assumption in the forecast has been reduced in line with experience to date.</td>
</tr>
<tr>
<td>Volume variance</td>
<td>28</td>
<td>There have been cost reductions in travel and other discretionary spend to date. These savings are offset by additional costs related to the increase in PLAB 1 candidate volumes in March.</td>
</tr>
<tr>
<td>Unit cost decreases/ efficiency savings</td>
<td>-75</td>
<td>Although efficiencies have been committed to achieve targets in 2019 the banked efficiencies to date lag behind the budget profile target. This is offset by small cost reductions which are non volume related.</td>
</tr>
<tr>
<td>New activities not in plan</td>
<td>-79</td>
<td>The GNM review in Strategy &amp; Policy, external consultancy review of team working in Strategic Communications &amp; Engagement and a number of unplanned recruitment costs create the overspend to date.</td>
</tr>
<tr>
<td>Planned activities dropped/delayed</td>
<td>192</td>
<td>A number of areas have rescheduled activity compared to budget however the forecast assumes many of these will take place later in the year. Significant areas are ad hoc maintenance for accommodation, travel and other staff related costs, fund manager investment fees and undertaking fewer Education visits.</td>
</tr>
<tr>
<td>Total</td>
<td>-139</td>
<td></td>
</tr>
</tbody>
</table>
Financial summary

<table>
<thead>
<tr>
<th>Key drivers of expenditure - Forecast</th>
<th>£000</th>
<th>Key changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headcount changes</td>
<td>-903</td>
<td>The churn assumption built into the forecast is now 62 roles based on the data to date. The vacancy rate in 2019 is significantly lower than in 2017 and 2018 and there are further additional roles for long term absence cover.</td>
</tr>
<tr>
<td>Volume variance</td>
<td>-319</td>
<td>The increase in cost is mainly due to the additional 246 hearing days forecast in MPTS due to an increase in the referral rate from FTP. The increase in hearing days impacts associate fees and expenses in MPTS and legal costs in FTP.</td>
</tr>
<tr>
<td>Unit cost increases</td>
<td>-32</td>
<td>PSA fees have increased on renewal.</td>
</tr>
<tr>
<td>Unit cost decreases/efficiency savings</td>
<td>131</td>
<td>Efficiency savings are committed to over achieve created a £42k benefit. The remaining benefit is created by prior year service charge reconciliation providing a refund at Hardman Street.</td>
</tr>
<tr>
<td>New activities not in plan</td>
<td>-111</td>
<td>The additional work undertaken to date plus further unplanned recruitment costs create the anticipated overspend at the end of 2019.</td>
</tr>
<tr>
<td>Planned activities dropped/delayed</td>
<td>135</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>-1,099</td>
<td></td>
</tr>
</tbody>
</table>
### Expenditure as at April 2019

<table>
<thead>
<tr>
<th>Category</th>
<th>Budget to April</th>
<th>Actual to April</th>
<th>Variance</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Staff costs</strong></td>
<td>£20,556</td>
<td>£20,761</td>
<td>-205</td>
<td>1%</td>
</tr>
<tr>
<td><strong>Staff support costs</strong></td>
<td>£1,242</td>
<td>£1,190</td>
<td>52</td>
<td>4%</td>
</tr>
<tr>
<td><strong>Office supplies</strong></td>
<td>£601</td>
<td>£610</td>
<td>-9</td>
<td>1%</td>
</tr>
<tr>
<td><strong>IT &amp; telecoms costs</strong></td>
<td>£1,214</td>
<td>£1,165</td>
<td>49</td>
<td>4%</td>
</tr>
<tr>
<td><strong>Accommodation costs</strong></td>
<td>£2,311</td>
<td>£2,200</td>
<td>111</td>
<td>5%</td>
</tr>
<tr>
<td><strong>Legal costs</strong></td>
<td>£1,455</td>
<td>£1,457</td>
<td>-2</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Professional fees</strong></td>
<td>£754</td>
<td>£782</td>
<td>-28</td>
<td>4%</td>
</tr>
<tr>
<td><strong>Council &amp; members costs</strong></td>
<td>£136</td>
<td>£135</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td><strong>Panel &amp; assessment costs</strong></td>
<td>£5,167</td>
<td>£5,120</td>
<td>47</td>
<td>1%</td>
</tr>
<tr>
<td><strong>Under-achievement of efficiency savings</strong></td>
<td>(153)</td>
<td>0</td>
<td>-153</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Operational expenditure</strong></td>
<td>£33,530</td>
<td>£33,669</td>
<td>-139</td>
<td>0%</td>
</tr>
<tr>
<td><strong>New initiatives fund</strong></td>
<td>£71</td>
<td>£74</td>
<td>-3</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Capital expenditure</strong></td>
<td>£1,685</td>
<td>£1,712</td>
<td>-27</td>
<td>2%</td>
</tr>
<tr>
<td><strong>Clinical Assessment Centre expansion</strong></td>
<td>£1,227</td>
<td>£1,227</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Pension top up payment</strong></td>
<td>£1,900</td>
<td>£1,900</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Total expenditure</strong></td>
<td>£38,413</td>
<td>£38,582</td>
<td>-169</td>
<td>0%</td>
</tr>
</tbody>
</table>

### Income as at April 2019

<table>
<thead>
<tr>
<th>Category</th>
<th>Budget to April</th>
<th>Actual to April</th>
<th>Variance</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual retention fees</strong></td>
<td>£28,661</td>
<td>£28,824</td>
<td>163</td>
<td>1%</td>
</tr>
<tr>
<td><strong>Registration fees</strong></td>
<td>£860</td>
<td>£953</td>
<td>93</td>
<td>11%</td>
</tr>
<tr>
<td><strong>PLAB fees</strong></td>
<td>£2,844</td>
<td>£3,056</td>
<td>212</td>
<td>7%</td>
</tr>
<tr>
<td><strong>Specialist application CCT fees</strong></td>
<td>£617</td>
<td>£672</td>
<td>55</td>
<td>9%</td>
</tr>
<tr>
<td><strong>Specialist application CESR/CEGPR fees</strong></td>
<td>£312</td>
<td>£380</td>
<td>68</td>
<td>22%</td>
</tr>
<tr>
<td><strong>Interest income</strong></td>
<td>£166</td>
<td>£189</td>
<td>23</td>
<td>14%</td>
</tr>
<tr>
<td><strong>Other income</strong></td>
<td>£211</td>
<td>£230</td>
<td>19</td>
<td>9%</td>
</tr>
<tr>
<td><strong>Total Operational Income</strong></td>
<td>£33,671</td>
<td>£34,304</td>
<td>633</td>
<td>2%</td>
</tr>
<tr>
<td><strong>Investment income</strong></td>
<td>£520</td>
<td>£1,497</td>
<td>977</td>
<td>188%</td>
</tr>
<tr>
<td><strong>Total income</strong></td>
<td>£34,191</td>
<td>£35,801</td>
<td>1,610</td>
<td>5%</td>
</tr>
<tr>
<td><strong>Surplus / (deficit)</strong></td>
<td>-4,222</td>
<td>-2,781</td>
<td>1,441</td>
<td></td>
</tr>
</tbody>
</table>
## GMCSI summary and investments summary

### Finance - GMCSI summary

<table>
<thead>
<tr>
<th></th>
<th>Budget YTD £000</th>
<th>Actual YTD £000</th>
<th>Variance £000</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>GMCSI income</td>
<td>170</td>
<td>99</td>
<td>-71</td>
<td>42%</td>
</tr>
<tr>
<td>GMCSI expenditure</td>
<td>184</td>
<td>151</td>
<td>33</td>
<td>18%</td>
</tr>
<tr>
<td><strong>Profit/ (loss)</strong></td>
<td><strong>-14</strong></td>
<td><strong>-52</strong></td>
<td><strong>-38</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Budget Jan - Dec £000</th>
<th>Forecast Jan - Dec £000</th>
<th>Variance £000</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>GMCSI income</td>
<td>707</td>
<td>629</td>
<td>-78</td>
<td>11%</td>
</tr>
<tr>
<td>GMCSI expenditure</td>
<td>602</td>
<td>549</td>
<td>53</td>
<td>9%</td>
</tr>
<tr>
<td><strong>Profit/ (loss)</strong></td>
<td><strong>105</strong></td>
<td><strong>80</strong></td>
<td><strong>-25</strong></td>
<td></td>
</tr>
</tbody>
</table>

### Investment summary 2019 to date

<table>
<thead>
<tr>
<th></th>
<th>Value as at Dec 2018 £000</th>
<th>Current value £000</th>
<th>Increase in investment £000</th>
<th>2019 returns £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCLA managed funds</td>
<td>£20,578</td>
<td>£42,075</td>
<td>£20,000</td>
<td>£1,497</td>
</tr>
</tbody>
</table>

### Investments summary as at 31st March 2019 (figures are updated quarterly)

#### Asset Allocation

<table>
<thead>
<tr>
<th></th>
<th>GMC thresholds</th>
<th>Current allocation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equities</td>
<td>20% - 45%</td>
<td>15.7%</td>
</tr>
<tr>
<td>Fixed interest</td>
<td>0% - 100%</td>
<td>14.9%</td>
</tr>
<tr>
<td>Cash and near-cash</td>
<td>0% - 15%</td>
<td>36.7%</td>
</tr>
<tr>
<td>Infrastructure and operating assets</td>
<td>0% - 10%</td>
<td>4.4%</td>
</tr>
<tr>
<td>Property</td>
<td>0% - 10%</td>
<td>7.4%</td>
</tr>
<tr>
<td>Other</td>
<td>0% - 20%</td>
<td>20.9%</td>
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</tbody>
</table>

#### Investment returns

<table>
<thead>
<tr>
<th></th>
<th>1 year rolling</th>
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</thead>
<tbody>
<tr>
<td>Target (CPI + 2%)</td>
<td>3.94%</td>
</tr>
<tr>
<td>CCLA performance</td>
<td>6.34%</td>
</tr>
</tbody>
</table>
Legal summary (as at 30 April 2019)

The table below provides a summary of appeals and judicial reviews as at 30 April 2019:

<table>
<thead>
<tr>
<th>Open cases carried forward since last report</th>
<th>New cases</th>
<th>Concluded cases</th>
<th>Outstanding cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>s.40 (Practitioner) Appeals</td>
<td>18</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>s.40A (GMC) Appeals</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>PSA Appeals</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Judicial Reviews</td>
<td>2</td>
<td>2</td>
<td>0</td>
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<tr>
<td>IOT Challenges</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Explanation of concluded cases

- s.40 (Practitioner) Appeals: 4 dismissed
- s.40A (GMC) Appeals: N/A
- Judicial Reviews: N/A

New referrals by PSA to the High Court under Section 29 since the last report with explanation, and any applications outstanding

- PSA Appeals: There have been no new referrals by PSA to the High Court under Section 29 since the last report; and therefore a total of 2 outstanding.

Any new applications in the High Court challenging the imposition of interim orders since the last report with explanation; and total number of applications outstanding

- IOT challenges: There has been no new application in the High Court challenging the imposition of interim orders since the last report; and therefore a total of 1 application outstanding.

Any other litigation of particular note

- We continue to deal with a range of other litigation, including cases before the Employment Tribunal, the Employment Appeals Tribunal and the Court of Appeal.
Trends in registration applications

**Graph 1:** Applications received for first registration from International Medical Graduates

(End of year 2013 - 2019)

**Graph 2:** Applications received for first registration from European Economic Area Graduates

(End of year 2013 - 2019)
Graph 3: PLAB 1 & 2 assessments taken 2012-2019
(Showing volume each year, 1 May to 30 April, percentage figures show year on year change)

Graph 4: Number of Doctors on the register with a License to Practise
(End of year 2013 - 2018 to April 2019)
Corporate Opportunities and Risk register
OST1 – If we don’t keep abreast of the changing political landscape, the UK health environment and UK and EU legislative change, we may find our regulatory effectiveness, credibility and reputation erodes over time.

OST2 – We may find that our data functions are not equipped to support the capacity and complexity of the programme of work we seek to undertake, meaning we are unable to use data to highlight emerging risks.

T2.1 – In cases where there are high profile patient safety issues and potentially unsafe environments for doctors and doctors in training, there are challenges in working effectively and collaboratively with other regulatory partners causing an adverse reputational impact for the GMC.

New opportunity
AOP3 – New opportunity added on the Supporting a Profession under Pressure programme. Overlapping themes across the major reviews within the programme, and interdependencies with work by external stakeholders such as the NHS Long Term Plan, give the opportunity to make a real impact to the environments in which doctors work. Effective co-ordination will be key to success and we are working closely with key stakeholders to identify opportunities for collaboration, in the run-up to publication of the reviews.

Key updates
IT2 – The further action reflects the work being completed as a result of the Zholia Alemi issue to review the PMQ’s of the 3117 commonwealth doctors currently registered and licensed to practice who bypassed PLAB before December 2018. From a search of Siebel records we have identified 27,173 non PLAB and S19 IMG doctors on the register and licenced to practice who have been subject to some form of fitness to practise investigation. We will use this analysis to determine where there should be further focus on PMQ checks.

IT3 – We revalidate an individual who is not fit to practise with an impact on patient safety and our reputation. The further action detail has been updated to highlight the two of the projects prompted by the Alemi issue have been added to the business plan for R&R this year, designed to mitigate the threat of revalidating a doctor who is not fit to practise/does not have the required PMQ’s, they are:
1. Explore possible triggers to prompt review of registration documentation
2. Risk mitigation activities arising from legal advice in Alemi case.
A number of other workstreams are also underway.

OST1 – If we don’t keep abreast of the changing political landscape, the UK health environment and UK and EU legislative change, we may find our regulatory effectiveness, credibility and reputation erodes over time.

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T2.1 – In cases where there are high profile patient safety issues and potentially unsafe environments for doctors and doctors in training, there are challenges in working effectively and collaboratively with other regulatory partners causing an adverse reputational impact for the GMC.

Increased rating*

De-escalated/closed

Post-mitigation rating higher than risk appetite

Post-mitigation rating summary

Corporate Risk Register (CORR) Overview

Business Risks - Active threat above risk appetite
T4.3 – Medical Licensing Assessment (MLA) - because of challenges to the proposed MLA Applied Knowledge Test (AKT) model from specific key stakeholders, and the submission of an alternative proposal for its design and delivery, there may be a lack of support from some stakeholders for delivering the MLA.

Business Risks – Active threats

VT4 – The residual rating for risk AT4, relating to credentialing, has been lowered to significant due to Council’s decision on next steps at meeting in April 2019.

AT1 – Recruitment and transfer activity remains high and could challenge teams ability to deliver their functions effectively and impact on other key initiatives such as development of the policy profession.

AT2 – Stretched external resources in the system, potentially create environment for increased patient safety incidents, which then impacts on our role as regulator – creating pressure on fitness to practise operations.

IT9 – Difficulties in the recruitment and retention of staff and associates with the required skills and experience may challenge our ability to deliver our functions effectively.

New opportunity
AOP3 – New opportunity added on the Supporting a Profession under Pressure programme. Overlapping themes across the major reviews within the programme, and interdependencies with work by external stakeholders such as the NHS Long Term Plan, give the opportunity to make a real impact to the environments in which doctors work. Effective co-ordination will be key to success and we are working closely with key stakeholders to identify opportunities for collaboration, in the run-up to publication of the reviews.

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1. Explore possible triggers to prompt review of registration documentation
2. Risk mitigation activities arising from legal advice in Alemi case.
A number of other workstreams are also underway.
### Strategic risks and how we manage them

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>OSOP1 Opportunity</strong></td>
<td>P. Buckley</td>
<td>If we clearly articulate our new strategic direction to partners and the profession, we have an opportunity to build a platform from which to start moving 'upstream' in our work and be seen to actively support doctors at all stages of their careers.</td>
<td></td>
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</tr>
<tr>
<td></td>
<td><strong>OSOP2 Opportunity</strong></td>
<td>P. Reynolds</td>
<td>We use our reputation for operational excellence to further enhance collaboration with our stakeholders, so that we identify new opportunities to deliver our statutory functions and contribute to patient safety in the wider healthcare system.</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**Overarching opportunities and risks in delivering the Corporate Strategy**

- New Strategic Communication and Engagement Directorate
- Regional Liaison Service (RLS) and Employer Liaison Service (ELS) – contact with multiple stakeholders including Responsible Officers (ROs), NHS Trusts, doctor groups etc.
- Our review of the outcomes will ensure that our expectations of what newly qualified doctors from UK medical schools must know and be able to do when they start work for the first time are up to date and fit for purpose.
- Visits and Monitoring teams in regular contact with students, trainees and educators during QA visits. Opportunity to share messages.
- Pre-registration PSV - value for our partners in knowing we've checked new registrant's qualifications.
- Collaboration with medical schools in relation to student Fitness to Practise and the graduation process.

Operational excellence tracked through:

- Monitoring and reporting on the performance of our core functions to Council, Executive Board, Audit and Risk Committee (ARC) etc.
- Professional Standards Authority (PSA) Performance Review
- Annual Report – provides overview of how we have deployed our resources to achieve our objectives and deliver our core functions.
- RLS/ELS colleagues – provide regular advice in relation to our core functional areas (P&P, Registration & Revalidation, Standards and Guidance etc.)
- Internal audit activities in relation to our core functions.
- MLA - addressing core function at entry to register with a licence to practise.
- Taking Revalidation Forward (TRF) Workstream 1 - Making revalidation more accessible to patients and the public.
- UPRKSELLA report - evaluation of revalidation, published May 2018. The evaluation provides us with a way to independently demonstrate to the profession and the public that revalidation is meeting its regulatory objectives. The findings of the evaluation will help us to identify improvements to revalidation we can make.
- Our response to the Department of Health and Social Care consultation around regulatory reform - opportunity to shape the future of medical regulation and legislation.

- Transformation Programme exception-based update at alternative Executive Board meetings.
- Scoping options for ‘Collective Effect’ work considered at Executive Board 29 Oct 2018.
- Council/Regional Board on 23 Apr 2019.
- Field Forces (now renamed as ‘Outreach’) Implementation (February 2019).

**Council and/or Board Review**

- Transformation Programme 'Engage workstream' (for example, Senior Management Team (SMT) engagement on the front line).
- Executive Board in December 2018 approved funding to establish a new Strategic Relationships Unit in 2019, enabling us to begin strengthening our strategic relationships in UK/England.
- Medical Licensing Assessment (MLA) - will assess new practitioners against a common threshold of safe practice.
- Next Corporate Strategy - the Exec Board considered at their meeting on 23 Apr 2019 an update on our initial thinking about the new strategy, and our plans to engage internally and externally.

**Residual risk with controls in place**

- Work to expand our outreach teams (initial options considered by the SMT on 22 Oct 2018).
- Understanding of strategic direction with our key partners tested in 2018 tracking survey.
- Focus on ‘local’ first principles.
- Patient and Public Engagement Plan, including a live engagement strategy, with our outreach teams and Directorates linking up to ensure the work we are doing within the business is promoted to external partners and stakeholders.
- Transformation Programme ‘Engage workstream’ (for example, Senior Management Team (SMT) engagement on the front line).
- Executive Board in December 2018 approved funding to establish a new Strategic Relationships Unit in 2019, enabling us to begin strengthening our strategic relationships in UK/England.
- Medical Licensing Assessment (MLA) - will assess new practitioners against a common threshold of safe practice.
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- Executive Board in December 2018 approved funding to establish a new Strategic Relationships Unit in 2019, enabling us to begin strengthening of our strategic relationships in UK/England.
- Engagement and provision of further evidence as requested by the PSA as part of the 2017/18 Performance Review, which began in September 2018. We received an initial assessment of our performance in April 2019, and for the final report to be published in June 2019.

- Executive Board in December 2018 approved funding to establish a new Strategic Relationships Unit in 2019, enabling us to begin strengthening of our strategic relationships in UK/England.
- Engagement and provision of further evidence as requested by the PSA as part of the 2017/18 Performance Review, which began in September 2018. We received an initial assessment of our performance in April 2019, and for the final report to be published in June 2019.
|----|----------------------|------------------------|-------|------------|--------|------------|--------------------------|---------------------------------|---------------------------|-----------|---------------------|---------------------|
| O3OP3 | Opportunity | Through enhancing our engagement across all of our activities, we empower and develop members of staff to build strong and mutually beneficial relationships with stakeholders, and develop understanding of the impact of GMC decisions/interventions, so that we achieve the full impact of our ambition to be collaborative | P.Reynolds | LOW | • Identification, prioritisation and coordination of engagement activities by the new Strategic Communication Directorate  
• Empowering and Developing Our People – Transformation Programme  
• Impact Assessments  
• The MLA programme is being implemented by work strands drawing on experience and expertise from across the GMC, and in collaboration with medical schools and other key stakeholders  
• Corporate strategy commitments at team level to increase level of ownership and engagement from staff  
• L&OD functions - delivering support and training to staff members in managing relationships with stakeholders | | | | | | Yes | • Follow through on GMC One Voice  
• Options and costs for developing new IT system to enhance our management and co-ordination of external relationships by staff at national and local levels to be prepared and considered further by SMT in May 2019. In the meantime, recruitment for the new Strategic Relationships Unit is underway |

**OSOP3 Opportunity**

Overlapping themes across the major reviews within the SPuP programme, and interdependencies with work by external stakeholders such as the NHS Long Term Plan, give the opportunity to make a real impact to the environments in which doctors work. Effective co-ordination with stakeholders will be key to success and we are working to identify opportunities for collaboration, in the run-up to publication of the reviews.

**AOP3 Opportunity**

Anthony Oms

- Coordination Group set up in March 2019
- Coordination group identified potential opportunities to align recommendations with other emerging priorities, including the NHS Long Term Plan, HEE mental wellbeing report, PSA research on public confidence, Kark review, SOMEP and workforce reports, new SAS doctor survey
- Main overlaps between recommendations mapped out and presented to SMT 15 April

- Transformation Programme exception-based update at alternative Executive Board meetings
- Council
- Communications & Engagement Strategy (June 2018)
<table>
<thead>
<tr>
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<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>OST1</strong> Threat</td>
<td></td>
<td></td>
<td>Paul Buckley</td>
<td>High</td>
<td>Likely</td>
<td>Council and/or Board Review</td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Paul Reynolds</td>
<td>Moderate</td>
<td>Moderate</td>
<td>Assurance</td>
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</tr>
<tr>
<td></td>
<td>The GMC’s regulatory effectiveness, credibility and reputation may erode over time if we don’t keep abreast of widening political agendas, UK and European legislative change as well as changes in the UK health environment in both the devolved nations and in England, which may restrict our ability to understand how these impact on individual doctor’s practice in order to deliver functions to full efficiency or develop as a regulator</td>
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<td></td>
<td>Domestic legislation - active engagement with DHSC including over the use of s.60 orders to amend the Medical Act and NICE/NHS on the long term health plan to explore if it can be altered</td>
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<td></td>
<td>European legislation - Skilled and resourced team to monitor and represent our interests at the European level and advise the organisation about any new EU developments. We also convene the Alliance of UK Health Regulators on Europe and jointly coordinate the European Network of Medical Regulators on Europe to develop common positions when new European policy and legislative initiatives emerge and jointly engage with decision-makers, if required.</td>
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<tr>
<td></td>
<td>UK Advisory Forums held twice a year</td>
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<tr>
<td></td>
<td>Patient Safety Intelligence Forum (PSIF)</td>
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<tr>
<td></td>
<td>Engagement teams – our field forces bring insight back into the business which assists us in developing our understanding of the healthcare system.</td>
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<tr>
<td></td>
<td>Better sharing of information and intelligence between engagement teams and business and using information effectively</td>
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<td></td>
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<tr>
<td></td>
<td>Training/Trainee surveys – State of Medical Education and Practice in the UK (SOMEP)</td>
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<tr>
<td></td>
<td>New Strategic Policy Directorate and Policy Leadership Group (PLG)</td>
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<td></td>
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<tr>
<td></td>
<td>GMC Senior Leadership Team engagement within the external environment - with insight gained shared with the rest of the business</td>
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<tr>
<td></td>
<td>Engagement with Medical Defence Organisations (MDOs)</td>
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<td></td>
<td>Implementation of strategic relationships operating model from 2019 onwards and deployment of new Stakeholder Relationship Management (SRM) system (subject to resource requirements being agreed) will deliver new stream of intelligence into the organisation about changes in external environment</td>
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<td>HLA - assessment blueprint to be framed in context of changes to the wider environment</td>
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<td>TRF Programme - Reducing burdens and improving the appraisal experience for doctors (Workstream 2)</td>
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<tr>
<td></td>
<td>Strategy and Policy Directorate – Regulatory Policy Teams &amp; Policy Leadership Group – more evidence led policy</td>
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<td>HR/Learning and Development/Talent teams – more resource in these teams to identify/develop talent within the business and attract external talent into the business in data – related roles</td>
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<td>Centralised data team established within the Strategy and Policy Directorate</td>
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<td>Development of data profession</td>
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<td>New Strategy function beginning rapid review on collective effect to be followed by review on maximising the impact of our field forces</td>
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<td>Business planning &amp; budget setting process</td>
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<td>Trained and skilled staff in project management</td>
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<td>PPM methodology and reporting: update on risks and project delivery every month via highlight reports with daily availability of progress for all including Portfolio Lead, Sponsor, Project Manager, PhD and COO</td>
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<td>Revised process for New Initiative Fund bids and in-year projects requiring new resource/budget approved by SMT in February 2019</td>
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<td>MS Project Online implemented to enable reporting within full portfolio approach (January 2019)</td>
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<td>Regular review of the business plan and re-assessment of priorities by SMT</td>
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<td>• Chief Executive’s report - Legislative reform update</td>
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<td>• Chief Operating Officer’s Report</td>
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<td>• Session on legislative reform (Feb 2016) • Council seminar on Brexit (Feb 2018) • Council seminar on Brexit (Nov 2018)</td>
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<td>• Regular updates to Council via the Chief Executive’s Report to Council</td>
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<td>• Council - Members Circular</td>
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<td>• Update on prospects of legislative reform (June 2017) • Council circular on conscientious objection (March 2018)</td>
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<td>• Council circular on appointment of new SoS, Matt Hancock (July 2018)</td>
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<td>• Council circular on appointment of new Minister, Stephen Hammond (November 2018)</td>
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<td>• We responded to the consultation on the shape of healthcare regulation in January 2018 and are awaiting the government’s response to the consultation</td>
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<td>• In the absence of primary legislation, we will work closely with officials to identify priorities for opportunities presented by one or more the proposed Section 60 Orders in the areas of FTP and governance.</td>
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<td>• Meeting held with DHSC &amp; other regulators to discuss legislative reform on 15 Feb 2019. The following were discussed: workforce, unitary boards, duty to co-operate, regulators’ power to make and amend rules/regulations without DHSC or Privy Council involvement. We submitted our written responses to two sets of policy instructions on 1 March 2019. The proposed changes to our governance structure could fundamentally change the structure of our council and how it is run</td>
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<td>• We are currently exploring the following: Potential new Health Bill, Making the case for a section to include legislative reform, Queen’s Speech 2019</td>
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<td>• Department of Health and Social Care (DHSC) response to consultation on the regulation of Medical Associate Professions published February 2019 announcing the introduction of statutory regulation for Physician Associates and Physician (anaesthesia). We are awaiting a decision on which organisation will regulate them. DHSC are developing a ‘matrix of factors’ to help ministers decide on which regulator, which may need to contribute towards in future</td>
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<td>P Buckley</td>
<td>Low</td>
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<td>The volume and complexity of the programme of work we seek to undertake may exceed our capacity to successfully deliver</td>
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<td>Paul Buckley</td>
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<td>Paul Reynolds</td>
<td>Moderate</td>
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<td>• Delivery progress update as part of CDO report at each meeting</td>
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<td>• 2019 business plan and budget approved by Executive Board (Nov 2018) and Council (Dec 2018)</td>
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<td>• Exceptions to corporate project delivery reported at every other meeting</td>
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<td>Internal Audit</td>
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<td>Risk Management in Projects (June 2017, amber)</td>
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<td>Review of Change Programme Benefits Realisation (June 2017, green/amber)</td>
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<td>Review of 2019 business planning (February 2019, rating TBC)</td>
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<td>OST3</td>
<td>Threat</td>
<td>P. Reynolds</td>
<td>Quick/Likely</td>
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<td>• Work to align our communications activity to avoid overburdening our stakeholders or creating engagement fatigue</td>
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<td>• SMT engagement and influencing activities with external organisations</td>
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<td>• Joint working frameworks (eg - CQC/NHSX/GMC)</td>
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<td>• Launch of our 2019-2020 Corporate Strategy and communications around this</td>
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<td>• MLA - building links with external partners through joint work on design and delivery</td>
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<td>• Education to work with Health Education England (HEE) and deaneries to ensure our Quality Assurance (QA) is proportionate. We also need to be assured their quality management is effective. Part of review of QA</td>
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<td>• Taking Revalidation Forward (TRF) Programme implemented</td>
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<td>• ELS engagement activities - building relationships with external partners and explaining what we are aiming to achieve: liaison teams in place</td>
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<td>• Implementation of strategic relationships operating model from 2019 onwards (subject to resource requirements being agreed) will deliver closer collaborative working with our regulatory partners</td>
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<td>• The MLA will establish a minimum threshold clearly linked to our regulatory function and the need to ensure patient safety: demonstrating that an individual is capable of functioning safely on the first day of clinical practice in the UK. If stakeholders accept that, we will be in a better position to drive consistent future improvement</td>
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<td>• Our quality assurance role involves us ensuring our standards are met. Our review of QA allows us to look at how we hold quality management organisations to account and ensure high standards. This involves looking at how good or notable practice is identified, shared and maintained</td>
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<td>• Regular communications and engagement between GMC senior leadership and the Department of Health and Social Care, and system regulators across the four countries</td>
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<td>• Engagement on NHS Longer Term Plan</td>
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<td>STRATEGIC AIM 1 - Supporting doctors in maintaining good practice</td>
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<td>Council</td>
<td>April 2019 paper on Welcome to the UK Practice</td>
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**Oppotunity**

- We use our contact with the large cohort of international and European medical graduates who join the Register each year, to make sure they understand our role and the ways in which we can support them, enhancing their ability to achieve and maintain good practice and their perception of us as their regulator

**Threat**

- If we do not take full account of the systemic pressures and wider culture within which doctors operate, the impact of our interventions to support doctors in maintaining good practice may be limited, and we may not focus our resources in the most effective way

### Risk pre-controls

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<td>T1.2 Threat</td>
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### Mitigation (for threats)

**Enhancement (for opportunities)**

- Non-training grade doctors is an increasing cohort of the doctor population and has an increasing impact on training. We have identified these impacts in our QA visits. This can be positive, as they fill rota gaps, or negative, as they compete for training opportunities with trainees. Any training of this doctor cohort is heterogeneous and currently outside of the oversight and regulation of ourselves, Health Education England (HEE) and deaneries. We do not set standards or survey this cohort about their training. We do sometimes speak to these doctors on QA visits however
- Where an IMG or EEA doctor is in an official training post, we do regulate their training. We have also analysed their National Training Survey (NTS) responses separately to UK qualified doctors
- We have analysed progression through training of different trainee doctors in our differential attainment project. Later in 2018 we will liaise with postgraduate deans to find out what they are doing to remove any unfair barriers to progression
- Registration ID checks for all first time registrants, meeting with a member of GMC staff (opportunity)
- International Association of Medical Regulatory Authorities (IAMRA) - potential to work (opportunity)
- Strategy and Policy Directorate – Regulatory Policy Teams & the Policy Leadership Group
- We have analysed progression through training of different trainee doctors in our differential attainment project. Later in 2018 we will liaise with postgraduate deans to find out what they are doing to remove any unfair barriers to progression
- Registration ID checks for all first time registrants, meeting with a member of GMC staff (opportunity)
- International Association of Medical Regulatory Authorities (IAMRA) - potential to work (opportunity)
- Patient Information Department (PID) - will be able to personalise updates to Council on pressures in the external environment in his report and verbal briefings
- Director of Compliance & Professionalism (DCP) – increased emphasis on MDTs. In the development process we are talking with clinical practitioners and assessors so could share any insight from those conversations. Views of the Medical Schools Council (MSC) being taken into account in development of the applied Knowledge Test
- Increased collaboration with other regulators through various forums e.g Inter-regulator Groups and Special Measures and Challenge Provider Oversight Group
- We attend quality management visits that are increasingly multidisciplinary. Health Education England (HEE) and deaneries have a remit for non-medical learners also. Our oversight and regulation of ourselves, Health Education England (HEE) and deaneries has a remit for non-medical learners also. Our evidence on training environments focuses on the whole environment, and we also collect evidence on team working. Often solutions to issues in training are multidisciplinary, such as nurse practitioners, physician associates
- In our QA visits, we interrogate our standards, which includes how training environments enable trainee doctors to fulfil the duty of candour
- Digital Transformation 2020 programme - changes to the information on our website, making it easier to navigate and personalise
- The MLA will be a touchpoint for all International Medical Graduates (IMGs) (and potentially EEA), with an assessment blueprint covering ethics and professionalism. Information packs or Welcome to UK Practice sessions forIMGs could potentially be linked to MLA stages (e.g. first application, passing AKT, passing CPSA)
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| T2.1 | Threat | In cases where there are high profile patient safety issues and potentially unsafe environments for doctors and doctors in training, there are challenges in working effectively and collaboratively with other regulatory partners causing an adverse reputational impact for the GMC | Susan Goldsmith | Quite Likely | Major | CRITICAL | • Information sharing agreement in place with Care Quality Commission (CQC)  
• Working closely with the Health and Social Care Regulators Forum to improve collaboration  
• Education enhanced monitoring process in place  
• Internal processes to manage communications  
• We help ensure available and appropriately trained staff through our mandatory training on Information Security/Data Protection and training courses such as Influencing & Stakeholder engagement training  
• Escalating concerns protocol has been developed | Council  
• Acting Chief Executive's Report (June 2015), North Middlesex Audit and Risk Committee  
• CEO/COO update at each meeting  
• CE gave evidence to the Health Select Committee about the impact of Brexit on medical regulation (February 2017) | Quite Likely | Positive | Yes | • Working towards information sharing agreements in other regulators including devolved nations  
• We are currently undertaking a lessons learned exercise, including whether there are ways to improve our joint working with other regulators  
• Health and Social Care Regulators Forum have agreed actions and work streams to improve collaboration across the system  
• Influence existing structures and fora to support information sharing  
• Agree a process for defining and communicating roles and responsibilities  
• Improve the use of data and insight - GMC to set up working group and feedback on analysis of current practice  
• Develop a culture of proactively sharing information and briefings | Low | STRATEGIC AIM 2 - Strengthening collaboration with our regulatory partners across the health services |
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<td>STRATEGIC AIM 3 - Strengthening our relationship with the public and the profession</td>
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**OP3.1 Opportunity**

If we clarify how we want to strengthen relationships with members of the public, we will target our efforts appropriately and be able to demonstrate the impact our work is having which will impact on our reputation as an effective and transparent regulator in the eyes of the public and the profession.

- Patient and Public Working Group established
- Patient and Public engagement workstream reported through Engage Board as part of Transformation Portfolio
- Annual tracking survey results to understand perceptions of patients and the public (September/October)
- Better signposting workstream led by Fitness to Practise - we are looking at how to engage with members of the public who want to complain
  - COO met patient representatives at GMC Conference (March) and spoke at Patient Safety Conference (May)

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| Discussion at Council Away day (July 2018) about Patient and Public engagement and plans for meeting objectives set out in the Corporate Strategy
| Council considered Corporate Strategy success measures baseline report results at its meeting in November 2018
| Full range of strategic lead and lag indicators, updated for 2019, included as part of COO Report to Council February 2019
| Discussion at Council Away day (July 2019) planned on Patient and Public engagement

| Yes |

**OP3.2 Opportunity**

We have the opportunity to be a more proactive regulator and demonstrate our understanding of the environment in which the profession is working as well as showing a willingness to speak up about issues facing the profession, allowing us to provide further support to doctors.

- Being more vocal about the pressures in our narratives to external world
- Holding other stakeholders to account
- Bringing stakeholders together through various forums to deliver their part in addressing system pressures
- Using campaigns to speak up and raise concerns based on solid evidence and insight, such as publication of NTS results (July)

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| Roundtable with patient organisations held in October 2018. We have committed to holding two roundtables in 2019, with the first in late June focusing on Fitness To Practise’s ‘signposting’ review
| Creation of Strategic Relationship Unit in Q2 2019 onwards will begin to support increase in our strategic engagement with patient organisations in UK/England
| Research carried out in the summer of 2018 to baseline perceptions for our Corporate Strategy 2018-2020 shows confidence in the profession and in regulation among patients and the public remains high. Majority of patient organisations surveyed for the exercise agreed that we listen to them and use their views to shape our work
| Regional Liaison Service to maintain relationships with local patient organisations in England during 2019
| GMC conference (Mar 2019)
| Plans underway for an event with focus on FTP signposting (June 2019)

| Yes |

**Risk appetite**

- Low
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<tbody>
<tr>
<td>T4.1</td>
<td>Threat</td>
<td>Uncertainty around the outcome of the UK Government's Brexit negotiations may result in disruption to the NHS workforce and, may have a significant impact in policy, operational and resource terms on the GMC.</td>
<td>Paul Buckley</td>
<td>High</td>
<td>Likely</td>
<td>Major</td>
<td>High</td>
<td>Establish a cross-Directorate Brexit working group led by the UK, European and International Affairs team to scope challenges and opportunities for the GMC; to define legislative priorities; and to review the potential impact on the legislation affecting our work (monthly meetings)</td>
<td>Active engagement with key influencers to influence post Brexit proposals for healthcare regulation and accountability; Liaison with UK and European regulators to ensure influence and leadership of key networks is maintained; Annual publication of analyses of licensed doctors with an EEA PHQ and of doctors with EEA nationality</td>
<td>Council</td>
<td>Further action required?</td>
<td>Yes</td>
<td>Further action detail</td>
</tr>
<tr>
<td>T4.2</td>
<td>Threat</td>
<td>There is an increase in non-training posts and training pathways which include training that is not GMC approved; there is a reputational risk that the profession believe the GMC are responsible for the unregulated training.</td>
<td>Colin Mahlely</td>
<td>High</td>
<td>Likely</td>
<td>High</td>
<td>Low</td>
<td>We have been working on the Flexibility project, some of the outcomes of this review will help mitigate the issues arising from training pathways; We are reviewing the CESR/CPS route that will enable doctors joining an approved training programme pathway through to gain a CCT which is important for worldwide recognition</td>
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<tr>
<td>T4.3</td>
<td>Threat</td>
<td>Because of challenges to the proposed MLA Applied Knowledge Test (AKT) model by specific key stakeholders and the submission of an alternative proposal for the design and delivery of the applied knowledge test (AKT), there may be a lack of support from some stakeholders for delivering the AKT in the way agreed by Council. This may lead to a less robust assessment, damage to the credibility of the MLA, increasing costs and delays to the proposed timetable; or strained stakeholder relationships which could also impact on wider GMC activities.</td>
<td>Colin Melville</td>
<td>Highly Likely</td>
<td>Major</td>
<td>CRITICAL</td>
<td>• The programme team is exploring with expert advisers the key changes to the AKT model that would be required by the recent stakeholder proposals and the potential impact to the project. • Communications and exploration with a wide range of medical school and other stakeholders</td>
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<td>Yes</td>
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</table>
## Business risks and how we manage them

<table>
<thead>
<tr>
<th>ID</th>
<th>Threat / Opportunity</th>
<th>Risk detail</th>
<th>Owner</th>
<th>Likelihood</th>
<th>Impact</th>
<th>Assessment</th>
<th>Council and / or Board Review</th>
<th>Assurance</th>
<th>Further Action Required?</th>
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<tbody>
<tr>
<td></td>
<td>ACTIVE OPERATIONAL RISKS</td>
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<td>Recruitment and transfer activity remains high and could challenge teams ability to deliver their functions effectively and impact on other key initiatives such as development of the policy profession</td>
<td>Continued stretched resources and finances in the health environment create the potential for increased patient safety incidents which could strategically impact the GMC's role as the regulator of the profession, as a guide for supporting disabled doctors and students (May)</td>
<td>Neil Roberts</td>
<td>Quite Likely</td>
<td>Major</td>
<td>Moderate</td>
<td>Unlikely</td>
<td>Yes</td>
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<tr>
<td></td>
<td>Recruitment of additional HR staff</td>
<td></td>
<td>Susan Goldsmith</td>
<td>Quite Likely</td>
<td>Major</td>
<td>Moderate</td>
<td>Unlikely</td>
<td>No</td>
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<td></td>
<td>Recruitment planner/tracking system and weekly update to SMT</td>
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<td>Headcount forecasts produced by Finance are reviewed monthly</td>
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<td></td>
<td>Regular monitoring of staff turnover, which remains stable and low</td>
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<td></td>
<td>Arrangements in place to quickly source temporary workers when needed</td>
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<td></td>
<td>Monitoring and forecasting of Fitness to Practise case loads</td>
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<td>Monitoring of Centre for Workforce Information re NHS staff shortages and skills gaps, and other external sources of quantitative and qualitative data, through horizon scanning (Data, Research and Intelligence team)</td>
<td>Ongoing engagement with Department of Health and Social Care (DHSC), Health Education England (HEE), and other stakeholders</td>
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<tr>
<td></td>
<td>Monitoring external environment</td>
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<td></td>
<td>Active engagement with doctors about potential situations which may put patients at risk</td>
<td>Enhanced monitoring process in place</td>
<td>Chair's annual letter to the profession</td>
<td>E&amp;D related activities in directorate business plans and further work underway to complete full benefits mapping to inform 2019/2020 plans</td>
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<td>We do not comply with our statutory obligations on Data Protection, Human Rights and/or Equality and Diversity, leading to legal challenge, financial loss and/or unfair outcomes, all of which could lead to reputational damage.</td>
<td>Scoping of research opportunities with Roger Kline in relation to key requirements for further insight in relation to representation patterns</td>
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<tr>
<td>AT4</td>
<td>Threat</td>
<td>As we are moving towards the implementation of GMC regulated credentials in 2019, stakeholders may not react positively to it potentially causing challenges with its introduction</td>
<td>Colin Melville</td>
<td>Highly Likely</td>
<td>Moderate</td>
<td>CRITICAL</td>
<td>Exception based reporting to Executive Board and Council through corporate updates</td>
<td>Council updated in June 2018 and November 2018, and planned for April 2019</td>
<td>Yes</td>
<td>We are working with UKMERG to co-brand the frequently asked questions document</td>
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<tr>
<td>AT6</td>
<td>Risk</td>
<td>Following the announcement that Health Education England (HEE) &amp; NHS Improvement (NHISI) will work jointly with NHISI, there is a risk that the change in leadership and the reporting structure, could result in the Education agenda not being pushed and potentially training opportunities reduced as a result of shared budgets</td>
<td>Colin Melville</td>
<td>Quite Likely</td>
<td>Moderate</td>
<td>CRITICAL</td>
<td>Exception based reporting to Executive Board and Council through corporate updates</td>
<td>The Executive Board considered a paper detailing the potential impact of the new arrangements, including risks and opportunities, in December 2018</td>
<td>No</td>
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</table>

**Mitigation (for threats)**
- During September 2018 – January 2019 we engaged on the proposals and draft framework. Engagement mainly took the form of presentations to groups, circulating the draft to key stakeholders for comment, and a mechanism for stakeholders (both individual and organisations) to respond on our website.
- We also engaged with trainees, via workshops and meetings including at the GMCs Doctors in training roundtable, and a bespoke credentialling doctors in training workshop
- Continue to work closely with a number of teams internally, including our curriculum approvals team, colleagues in communications, the devolved offices, and registration and revalidation
- During the policy development, we have been working with colleges, departments and other stakeholders to explore the range and type of credentials needed to deliver the requirements of Shape, Flexibility and Excellence by Design
- Multiple pilots have been run in 2018 to test out different scenarios and different ‘types’ of potential credentials. The pilots have informed the policy development work and allowed us to gain a wide view of how the framework may run in practice
- A formal internal project board has been set up with cross directorate representation, to fully consider the potential operational impact
- Ongoing internal work with comms colleagues to agree narratives for launch including a comms workshop and regular catch up meetings.
- A frequently asked questions document has been developed and will be available for launch in 2019
- Council considered the framework and supporting documentation at their meeting in April 2019, and approved, in principle, to the introduction of GMC regulated credentials. They will make their final decision in June 2019

**Enhancement (for opportunities)**
- Engage with Health Education England (HEE) & NHS Improvement (NHISI) through various forums to promote the training and education agenda and influence at an early stage
- Be proactive in developing and sharing actions

**Residual risk with controls in place**
- Council and/or Board Review
- Assurance

**Risk appetite**
- Medium
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<th>Mitigation (for threats)</th>
<th>Enhancement (for opportunities)</th>
<th>Risk appetite</th>
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</thead>
<tbody>
<tr>
<td>AOP1 Opportunity</td>
<td>Credentialing would provide some opportunities for doctors to move more quickly to areas of practice where there is greatest need to better meet patient and service need. This flexibility will allow doctors to have a clear way to develop, plan or re-focus their careers to ensure they use their skills and experience to the greatest effect. Credentialing will also give employers a mechanism to train/develop their medical workforce relatively quickly in areas where there are local service gaps that won’t be met by training alone.</td>
<td>Colin Melville</td>
<td>Working closely with the UK Medical Education Reference Group (UKMERG) in developing the framework and an agreed four-country consensus on the direction of travel.</td>
<td>• Formal engagement with external stakeholders on the framework ran from September 2018 until end of January 2019 and will provide an opportunity to promote the benefits of credentialing.</td>
<td>• A phased implementation is planned that will initially address key safety concerns, whilst enabling us the opportunity to develop further over time (for example bringing in other groups such as SAS doctors).</td>
<td>• Executive Board considered an update on credentialing in February 2019. • Council updated in June 2018 and November 2018, and planned for April 2019. • Interim decision made by Council in April 2019 to the introduction of GMC regulated credentials.</td>
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<td>AOP2 Opportunity</td>
<td>Following the announcement that Health Education England (HEE) will work jointly with NHS Improvement (NHSI), there could be an opportunity to develop longer term planning and promote training to be more central to workforce planning.</td>
<td>Colin Melville</td>
<td>• Engage with HEE &amp; NHSI through various forums to promote the training and education agenda.</td>
<td>• Exception based reporting to Executive Board and Council through corporate updates.</td>
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<th>ID</th>
<th>Threat / Opportunity</th>
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<th>Likelihood</th>
<th>Impact</th>
<th>Residual risk with controls in place</th>
<th>Council and/or Board Review</th>
<th>Assurance</th>
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<tr>
<td>IT1 Threat</td>
<td>Application of key controls and processes lead us to reach the wrong conclusion in investigating a doctor's fitness to practise with an impact on patient safety, registrants, witnesses and/or the reputation of the GMC</td>
<td>Anthony Omo</td>
<td>Quite Likely</td>
<td>Major</td>
<td>Low</td>
<td>CRITICAL</td>
<td>Council</td>
<td>Internal Audit</td>
<td>No</td>
<td>Integration of Human Factors training into investigation processes (Throughout 2019)</td>
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<tr>
<td>IT2 Threat</td>
<td>We register an individual who is not properly qualified and/or fit to practise with an impact on patient safety and our reputation</td>
<td>Una Lane</td>
<td>Quite Likely</td>
<td>Major</td>
<td>Low</td>
<td>CRITICAL</td>
<td>Council</td>
<td>Internal Audit</td>
<td>No</td>
<td>Review completed on all but 3 of the 3,117 Primary Source Verification; explore possible triggers to prompt review of registration documentation; risk mitigation activities arising from legal advice on the Zholia Alemi case; embedding the clinical governance handbook</td>
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### INHERENT OPERATIONAL RISKS

- **Council**
  - Operational KPIs reported each meeting
  - Executive Board

- **Executive Board**
  - Activity volumes and service target performance reviewed each meeting
  - Changes to our guidance for decision makers at the end of the investigation stage
  - Changes to guidance for decision makers at the end of the investigation stage (September 2017)
  - Publication and disclosure - revised written policy (January 2018)

- **Internal Audit**
  - Review of Legal Services (June 2017, green-amber)
  - Review of the use of independent expert witnesses in FTP activity (June 2017, green)
  - Provisional enquiries (April 2017, green-amber)

### Further Action detail

- Review of outreach teams in 2019. The mitigation for this risk (in regards to ELS/ROs and the GMC/RO relationship) will be monitored in regards to the outcome of this review, changes to ELS could reduce or enhance our mitigations against this threat

- The issue around Zholia Alemi's fraudulent registration to practise within the UK has prompted activity which supports further mitigation against the threat of registering an individual who is not properly qualified.

- Review completed on all but 3 of the 3,117 Primary Source Verification; explore possible triggers to prompt review of registration documentation; risk mitigation activities arising from legal advice on the Zholia Alemi case; embedding the clinical governance handbook
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<th>Enhancement (opportunities)</th>
<th>Mitigation (for threats)</th>
<th>Residual risk with controls in place</th>
<th>Council and/or Board Review</th>
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<th>Further action detail</th>
<th>Risk appetite</th>
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<tbody>
<tr>
<td>IT3</td>
<td>Threat</td>
<td>We revalidate an individual who is not fit to practise with an impact on patient safety and our reputation</td>
<td>Una Lane</td>
<td>Quite Likely</td>
<td>Moderate</td>
<td>Documented process and procedures • Regular performance monitoring and reporting • Trained and available staff • Local clinical governance systems identify and address performance concerns • Local quality assurance processes review the set up and operation of appraisals and revalidation recommendations • Daily downloads of the register are sent to primary and secondary healthcare organisations • Support and guidance for Responsible Officers making recommendations through the Employer Liaison Service • Majority of &quot;Taking Revalidation Forward (TRF) programme completed</td>
<td>Council</td>
<td>Operational KPIs reported each meeting • Activity volumes and service target performance reviewed each meeting • Update on the evaluation of Revalidation (December 2017) • Revised guidance on supporting information for appraisal and revalidation (December 2017) • Updating our revalidation guide for doctors (December 2017)</td>
<td>Assurance</td>
<td>Other assurance • UMBRELLA Report - commitment to ongoing study (final report published Q1 2018)</td>
<td>Yes</td>
<td>No</td>
<td>• Finalisation of Taking Revalidation Forward - consulting on changes to our patient feedback requirements for revalidation • Two of the projects prompted by the Zholia Alemi issue have been added to the 2019 business plan for Registration &amp; Revalidation, designed to mitigate the threat of revalidating a doctor who is not qualified or fit to practise in the UK, they are: 1. Explore possible triggers to prompt review of registration documentation 2. Risk mitigation activities arising from legal advice in Alemi case</td>
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<tr>
<td>IT4</td>
<td>Threat</td>
<td>Our quality assurance processes fail to identify a lack of compliance with standards for education, training and curricula with a potential impact on patients and below expectation educational outcomes for doctors</td>
<td>Colin Melville</td>
<td>Quite Likely</td>
<td>Moderate</td>
<td>Documented process and procedures • Checks and thematic quality assurance enable short focussed visits to explore specific issues • Trained and available staff and Associates • Enhanced Monitoring Information Published on our website quarterly • Sharing of information across the organisation PSIF and RLS, Employer Liaison Service (ELS) via Joint Working Intelligence Group</td>
<td>Council</td>
<td>Operational Key Performance Indicators (KPIs) reported each meeting • Consideration of proposals for Phase 2 of education QA strategy (Feb 2019)</td>
<td>Patient Safety Intelligence Forum</td>
<td>• Considers patient risk dimension at each meeting</td>
<td>Moderate</td>
<td>No</td>
<td>• November 2018 audit on enhanced monitoring indicated general assurance, with an amber/green rating • QA review offers a more continuous and risk based assurance process, with emphasis on available data; this is due for audit in late 2019</td>
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<tr>
<td>IT5</td>
<td>Threat</td>
<td>Low awareness and use of our ethical guidance by doctors limits the impact on raising standards of medical practice with a consequent impact on patient care</td>
<td>Colin Melville</td>
<td>Quite Likely</td>
<td>Moderate</td>
<td>Internal standards and ethics oversight group • Established, documented procedures • Public consultation used to develop and validate guidance • Trained and available staff • Extensive outreach and engagement activities to promote ethical guidance • Proactive communications strategy and website improvements • Transformation of our online digital offer - through Digital Transformation 2020</td>
<td>Council</td>
<td>Approved decisions to go to consultation on draft guidance and decisions to publish new/revised guidance. Seminars held with Council Sept 2018 and April 2019 on guidance and implementation</td>
<td>Executive Board</td>
<td>• Regular updates during guidance development (ongoing)</td>
<td>Low</td>
<td>No</td>
<td>Further tracking survey planned in 2019 Guidance developed in line with the policy framework. Major consultation are audited by independent auditors with expertise in consultation practice</td>
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<tr>
<td>IT6</td>
<td>Threat</td>
<td>Patient safety is impacted and/or reputational damage is caused by not providing an effective and timely adjudication process</td>
<td>Gavin Brown</td>
<td>Quite Likely</td>
<td>Major</td>
<td>Documented process and procedures (Adjudication Manual) • Regular performance monitoring and reporting • Trained and available staff (including MPTS induction) • Tribunal members training and assessment (including Induction programme) • 560 changes implemented to bring further assurance to MPTS process including binding case management decisions</td>
<td>Council</td>
<td>MPTS formal report to Council (6-monthly) • Interim Order Panel service targets reported to each meeting</td>
<td>MPTS Advisory Committee</td>
<td>• Quarterly reports to MPTS Advisory Committee</td>
<td>Low</td>
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| IT7 | Threat               | Doctors under conditions or undertakings do not comply with their sanctions and patients are harmed as a consequence | Anthony Omo | Unlikely | Major   | SIGNIFICANT | • Case Review Team - documented processes and skilled resources  
• Sanctions are listed on the List of Registered Medical Practitioners  
• Notification of overseas regulators (if required)  
• Publication of public hearing minutes  
• Daily downloads of the register are sent to primary and secondary healthcare organisations  
• Continuing development of GMC/RO relationships | Low | Executive Board | • Publication and disclosure of immediate/interim orders and warnings (June 2017)  
• Warnings - publication and disclosure (September 2017)  
• Publication and disclosure - revised written policy (January 2018) | No | Review of outreach teams in 2019. The mitigation for this risk (in regards to ELA / ROs and the GMC/RO relationship) will be monitored in regards to the outcome of this review; changes to ELS could reduce or enhance our mitigations against this threat | Low |
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<td>IT8</td>
<td>Threat</td>
<td>Our anti fraud procedures and process may not prevent internal or external parties from committing fraud against the GMC resulting in monetary loss</td>
<td>Neil Roberts</td>
<td>Quite Likely</td>
<td>Moderate</td>
<td>Low</td>
<td>Council</td>
<td>No</td>
<td>Transformation Portfolio set up June 2017 to oversee delivery of enhancing our organisational capabilities, Programmes of work are designed around embedding a clearer sense of purpose and impact; empowering and developing our people; injecting more pace, agility and cross-organisational working, and enhancing our engagement with the healthcare system</td>
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<tr>
<td>IT9</td>
<td>Threat</td>
<td>Difficulties in the recruitment and retention of staff and associates with the required skills and experience may challenge our ability to deliver our functions effectively</td>
<td>Neil Roberts</td>
<td>Quite Likely</td>
<td>Major</td>
<td>Low</td>
<td>Council</td>
<td>Yes</td>
<td>Business Continuity Working Group - (2 monthly)</td>
<td></td>
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<tr>
<td>IT10</td>
<td>Threat</td>
<td>An external incident, including a cyber attack, which affects our infrastructure, security systems and/or staffing levels may prevent us from delivering our key functions</td>
<td>Neil Roberts</td>
<td>Quite Likely</td>
<td>Major</td>
<td>Low</td>
<td>Business Continuity Working Group - (2 monthly)</td>
<td>No</td>
<td>Business continuity arrangements (May 2018, green-amber)</td>
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<td>IT11</td>
<td>Threat</td>
<td>Adverse economic events create a significant deficit in the Defined Benefit (DB) scheme which the employer needs to cover, and/or a fall in the value of the GMC's investments</td>
<td>Neil Roberts</td>
<td>Quite Likely</td>
<td>Major</td>
<td>Low</td>
<td>Council</td>
<td>No</td>
<td>Trustees and Council will continue to liaise on reducing risk as part of the internal valuation cycle</td>
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**INHERENT OPERATIONAL RISKS**

- **IT1 Threat**: Reduced cashflow and/or a fall in levels may prevent us from delivering our functions as required. It is quite likely that funds may need to be reallocated to meet cashflow requirements and may be required to increase our external profile as an employer. Our anti-fraud procedures and process may not prevent internal or external parties from committing fraud against the GMC resulting in monetary loss.

- **IT2 Threat**: Scheme which the employer needs to cover, and/or a fall in the value of the GMC's investments.

- **IT3 Threat**: Financial performance reported as part of CDO report each meeting. Internal Audit Review of annual accounts (May 2017, green-amber).

- **IT4 Threat**: Annual review of succession planning. Internal Audit HR conducting annual review of succession planning.


- **IT6 Threat**: Business planning & budget setting process to ensure funds are allocated appropriately. Monthly management reporting and review. Financial Regulations and financial controls including delegated authorities by the Executive Board.

- **IT7 Threat**: Scheme which the employer needs to cover, and/or a fall in levels may prevent us from delivering our functions as required. Internal Audit Review of annual accounts (May 2017).

- **IT8 Threat**: Our anti fraud procedures and process may not prevent internal or external parties from committing fraud against the GMC resulting in monetary loss. It is quite likely that funds may need to be reallocated to meet cashflow requirements and may be required to increase our external profile as an employer. Our anti-fraud procedures and process may not prevent internal or external parties from committing fraud against the GMC resulting in monetary loss.

- **IT9 Threat**: Difficulties in the recruitment and retention of staff and associates with the required skills and experience may challenge our ability to deliver our functions effectively. It is quite likely that funds may need to be reallocated to meet cashflow requirements and may be required to increase our external profile as an employer. Our anti-fraud procedures and process may not prevent internal or external parties from committing fraud against the GMC resulting in monetary loss.

- **IT10 Threat**: Adverse economic events create a significant deficit in the Defined Benefit (DB) scheme which the employer needs to cover, and/or a fall in the value of the GMC's investments. It is quite likely that funds may need to be reallocated to meet cashflow requirements and may be required to increase our external profile as an employer. Our anti-fraud procedures and process may not prevent internal or external parties from committing fraud against the GMC resulting in monetary loss.

- **IT11 Threat**: Reduced cashflow and/or a fall in levels may prevent us from delivering our functions as required. It is quite likely that funds may need to be reallocated to meet cashflow requirements and may be required to increase our external profile as an employer. Our anti-fraud procedures and process may not prevent internal or external parties from committing fraud against the GMC resulting in monetary loss.
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<tr>
<td>IT12</td>
<td>Threat</td>
<td>Due to operating a global trading subsidiary, there is a risk GMCSI activities create reputational harm which may impact on our charitable mission and our ability to effectively deliver some aspects of core regulatory services</td>
<td>Charlie Massey</td>
<td>Quite Likely</td>
<td>Major</td>
<td>CRITICAL</td>
<td>Governance framework in place</td>
<td>Governance arrangements April 2017</td>
<td>No</td>
<td>Quarterly Report Sept 2017</td>
<td>Council</td>
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<td></td>
<td></td>
<td>GMC/GMCSI Forum now meeting monthly with GMC Directors given early sight of opportunities</td>
<td>Executive Board on 18 September 2017</td>
<td>Moderate</td>
<td>Residual risk with controls in place</td>
<td>Executive Board</td>
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<td>GMC Services International Ltd Operating Agreement (June 2017)</td>
<td>A set of commercial principles covering UK activity was approved by the GMC Executive Board on 18 September 2017</td>
<td>LOW</td>
<td>Assurance</td>
<td>Commercial principles September 2017</td>
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<td>A set of commercial principles covering UK activity was approved by the GMC Executive Board on 18 September 2017</td>
<td>The ethical guidelines and ‘what ifs’ developed and agreed with the GMCSI Chair and Board were presented to the GMC Council as part of an ethics session in December 2017</td>
<td>LOW</td>
<td></td>
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Risk appetite: Low
M4 – Chief Operating Officer’s Report

2018 Pension Scheme Valuation

Background

1. Trustees of the GMC Defined benefit (DB) scheme are required to undertake a triennial valuation process. This process determines the scheme liabilities. Trustees do this by agreeing a series of assumptions that help determine the assets that need to be held to meet the cost of the pension commitments the employer has made. The assumptions used in the process need to be agreed by the employer.

2. Where the liabilities (technical provisions) are greater than the value of the assets and there is a deficit then a recovery plan needs to be agreed and signed off by both parties. This plan aims to close any deficit and is a legal requirement.

3. As well as the recovery plan the Pensions regulator is increasingly emphasising the importance of long term funding plans. In the case of the GMC Scheme Trustees are aiming to reach a point over ten years known as self-sufficiency. At this point no further employer contributions are expected to be needed and the risk faced by the GMC as scheme sponsor is significantly reduced.

4. The timing and level of financial support is something that we would expect negotiate with Trustees and produce a recommendation for Council to consider in September.

Initial Valuation Results

5. The initial valuation results show scheme liabilities at £248m and assets at £230.2m as of 31 December 2018.

6. There have been two significant changes since the last valuation. Life expectancy improvements have slowed and this has a positive impact on the scheme’s funding position.
The very latest life expectancy tables, for 2018 are only just available, if used then these would have a positive impact of £1-2m on the scheme’s funding and we are discussing this with Trustees.

The other major change since the 2015 process has been a very significant shift away from scheme members taking pension options that include a tax free cash lump sum. The ‘all pension’ option is more expensive to the scheme, and we believe it is sensible to take account of this trend.

We have also agreed with Trustees to adjust the salary growth assumptions, reflecting scheme member scope for salary progression in our new pay system. Our new pay system prioritises lower paid staff, and these tend not to be scheme members. This would reduce the deficit by around £5m.

There are two further assumptions we are working with Trustees on. The first is the gap between the Retail Price Index (RPI) and the Consumer Price Index (CPI) which we expect to finalise at 0.6%. The second is the long term discount rate. This calculates what we believe we need to hold in assets to meet our pension obligations. It is important to emphasise that final outcome of the valuation depends on the agreement of all parties to the assumptions. Some of these can have a significant impact on the outcome when subject to very small adjustments.

We have believe that there is good progress on this work but the next stage is potentially more complex as we consider Trustee proposals for a recovery plan and long term funding targets.

Our aim is to seek an agreed position with Scheme Trustees for Council to consider at its September meeting.
Executive summary
The Medical Licensing Assessment (MLA) content map defines the knowledge, skills and behaviours that will be tested in the MLA. It is the cornerstone of the MLA, illustrating the areas through which we can set a common threshold for safe practice.

Over the past ten months, we have worked with a group of external experts to design a first draft of the content map. This process has involved two rounds of engagement with a wide range of stakeholders, iterative drafting and review, with expert advice and oversight.

We are currently midway through an extensive engagement exercise on the draft content map; early responses are positive and we will provide further detail at the Council meeting.

The final version of the content map will be an interactive dashboard accessed via the GMC website. Subject to Council’s views on, and approval of, the approach to developing the content map, we intend to finalise the MLA content map over the next two months and publish it by late summer 2019.

Recommendations
Council is asked to:

a  Note and endorse our approach to designing the MLA content map, including obtaining expert advice and undertaking wide stakeholder engagement.

b  Agree that MLA Programme Board can sign off the final version of the content map prior to publication in August/September 2019.
Background

1 The MLA’s core aim is to create a demonstration that those who obtain registration with a licence to practise medicine in the UK can meet a common threshold for safe practice. The MLA content map will define the knowledge, skills and behaviours that will be tested in the MLA and, therefore, the areas that the GMC deems pertinent to the common threshold for safe practice.

Development overseen by a group of appointed experts

2 The development of the content map has been led by the content map subgroup (subgroup) of the MLA Expert Reference Group (ERG) – a group of GMC Associates providing advice and recommendations on the development of the MLA. The subgroup is chaired by Emeritus Professor Jean Ker and includes six members with assessment and blueprinting expertise from their experience within the: Academy of Medical Royal Colleges (AoMRC) Academy Assessment Committee, UK Foundation Programme Office (UKFPO), Medical Schools Council (MSC) Assessment Alliance and GMC Professional and Linguistic Assessments Board (PLAB) panels.

3 The subgroup has taken an iterative approach to the work, meeting in person six times since August 2018, with extensive homeworking activities between meetings to review and comment on draft content. In addition, the main ERG acted as a ‘critical friend’ throughout the process.

Development of the content map with stakeholder engagement

4 The development of the content map has involved a number of defined stages.

a **Audit of other examples.** We reviewed exam blueprints from medical schools, PLAB and international medical regulators. This highlighted the complexity of the task and, therefore, the importance of wide stakeholder engagement.

b **Mapping of source documents.** The expert group reviewed the GMC’s Outcomes for graduates (2018) and Generic professional capabilities framework (2017); the Foundation Programme curriculum; and the PLAB blueprint in order to identify knowledge and capabilities of relevance to the MLA.

c **Agreement of themes, domains and draft content.** The subgroup agreed three overarching themes for the content map – readiness for safe practice, patient-centred care and managing uncertainty. They then drafted content under six domain headings.

d **Initial engagement on patient presentations and medical conditions.** In November 2018, we invited all medical schools, as well as PLAB panellists and the UKFPO (directors, supervisors and trainees), to comment on detailed lists of
medical conditions and presentations drawn from the question banks used by PLAB and medical schools. This exercise generated some negative feedback from schools (primarily related to the scale and format of the task) but proved valuable in demonstrating transparency and raising awareness.

e **Refinement of content and narrative.** Supported by GMC staff and informed by the data and feedback from the initial engagement, the subgroup refined content and prepared a narrative explaining the context, purpose and structure of the content map.

f **Engagement on full draft content map.** During April and May 2019 we shared a first full draft of the content map with UK medical schools, PLAB panel members, UKFPO representatives, Royal Colleges and Faculties, MSC, the BMA Medical Students Committee and the British Pharmacological Society (who set the national prescribing safety assessment). We invited comments on the clarity of the materials together with suggestions for addition or removal of content.

**Next steps: final refinements, online version, publication and review**

5 At the time of writing the paper the engagement exercise identified at 4(f) above is still open. A verbal summary of responses will be provided at the Council meeting. Early comments, including those from medical schools, have been almost wholly constructive. Suggestions include greater emphasis on areas seen by newly qualified doctors (eg, clinical radiology) and less on ‘niche’ topics rarely encountered in Foundation training (eg, porphyria); and specific suggestions for refining the lists of patient presentations and conditions. There is general agreement that we have provided a clear explanation of the purpose and scope of the content map.

6 We are working on a searchable, online version of the content map and will test it with medical students and International Medical Graduates (IMGs) in early summer. We will also hold an event with special interest/patient groups to present the draft MLA content map, explain what it will cover (and what it will not) and offer an opportunity for questions.

7 Subject to Council’s endorsement of the approach to developing the content map, comments from the ERG on the final version of the MLA content map and final approval by MLA Programme Board, we intend to publish the MLA content map in late summer 2019.

8 We expect to review the MLA content map on a regular basis to ensure that it reflects current practice and is in line with the source documents that underpin it.
Executive summary
As discussed in detail in earlier sessions with Council, we have been engaging with the Medical Schools Council (MSC) and other stakeholders about the current delivery model for the MLA applied knowledge test (AKT). We now have more understanding of the practical implications for medical schools of delivering the assessment as part of their degree and have been exploring how we can address legitimate practical issues and concerns while maintaining the integrity of the MLA.

Based on considerable analysis and discussion, this paper recommends a proposed way forward, based on a set of key principles that should provide a sound framework for future development.

Recommendations
Council is asked to:

a. Note the key principles for the design and delivery of the AKT which have been developed with the medical school representatives, and endorse them as a basis for further development (paragraphs 6-9 and Annex A).

b. Agree to re-designate the first year of the MLA in 2022/23 as a further pilot year.

c. Apply the requirement for UK students to pass the MLA as part of their degree programme’s requirements for the award of a UK PMQ from 2024 (paragraphs 10-12).
Background

1 In December 2017, following public consultation, Council approved the introduction of a Medical Licensing Assessment (MLA) to demonstrate that those who gain registration with a licence to practise medicine in the UK can meet a common threshold for safe practice.

2 The current design of the MLA has two parts:

- All UK medical students and international medical graduates (IMGs) will sit a common onscreen **applied knowledge test (AKT)**. The GMC will determine the content of the AKT, set the standard, and deliver the test to IMGs. Medical schools will deliver it to UK candidates.

- Both cohorts will also sit a **clinical professional skills assessment (CPSA)**. Council agreed that medical schools and the GMC will continue to set and run their own CPSAs—for UK students and IMGs respectively—but with robust quality assurance of CPSAs against a published set of requirements. This was a change to the original proposal of a common GMC CPSA for all candidates. It was prompted mainly by medical schools’ responses to the public consultation in 2017, which set out specific concerns about the disruption which would be caused by moving from the current variety of practical assessments to a common CPSA.

3 UK students will need to pass the MLA before completing their degree programme. If they do, the GMC will accept their degree as meeting our determination of the knowledge and skills required, and prescribed standards needed, for recognition as a UK primary medical qualification (PMQ). A PMQ entitles an UK student to registration with a licence to practise (subject to their fitness to practise). IMGs will take both parts of the MLA (the AKT and a GMC-set CPSA) before they can apply for registration.

Alternative proposal for AKT

4 Since December 2017, we have been engaging with a range of stakeholders who have an interest in the MLA and its outcomes. Medical schools are key partners in successfully delivering the MLA, and much of our engagement has focused on school staff and students, through representative organisations and at in-depth meetings in individual schools. These meetings have indicated widespread discomfort in schools about the introduction of the MLA, but staff have also raised specific and practical difficulties with the current AKT model. In this context, the Medical School Council (MSC) proposed in January 2019 an alternative approach to delivering the AKT, designed to avoid or lessen schools’ concerns.

5 This led us to review both the MSC proposal and the current AKT model, to identify how to balance political, strategic and relationship issues with the requirement for a
Council meeting, 12 June 2019

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delivery model that is methodologically robust, credible in the eyes of assessment experts, operationally feasible and does not expose the GMC to excessive risk.

Recommended way forward

6 Discussions with MSC and medical schools have continued and, as we’ve explored the practical detail of the AKT, we gained a greater understanding of the particular logistical challenges presented by our proposal for four fixed dates per year, in terms of access to facilities and fit with existing assessment timetables.

7 As well this engagement with the undergraduate sector, we have sought technical, expert advice and a range of stakeholder views on potential changes to the AKT model. This feedback and advice, together with internal policy and operational discussions, has informed a proposed further evolution of our approach to delivering the AKT.

8 This is based on a set of principles (attached at Annex A) which have emerged from discussions between the GMC and medical school representatives. These principles would form a framework for future work on practical design and delivery. In summary, they allow medical schools a free choice of dates while retaining GMC control over question choice, paper-setting, delivery format, standard-setting, governance and other key aspects of the exam process. The GMC would continue to deliver both parts of the MLA for international candidates.

9 Following this framework should deliver an AKT that responds to practical and operational challenges while maintaining the integrity of the MLA as described at paragraph 2 above and reflecting previous steers by Council. In particular, we’re satisfied that an AKT built on these principles can:

- deliver a credible, reliable, valid, secure and defensible assessment;
- ensure that the GMC selects, and sets the standard for, all items used in the AKT, to ensure a common threshold across all candidates;
- enable the GMC to control essential AKT governance processes;
- be affordable and operationally manageable for the GMC and medical schools.

We recommend that GMC Council agrees these principles as a foundation for further development.

Implementation timetable and opportunities arising

10 The MSC proposal provided an opportunity to enhance the AKT model to reflect our delivery partners’ legitimate practical concerns. But we have lost significant
development time in exploring alternative solutions, and the amended approach encapsulated in Annex A will require additional question bank development, pre-testing of AKT items, and piloting. As a result, we have reviewed our existing plans for developing and implementing the programme.

11 We therefore propose to extend the implementation of the MLA. This would, as before, begin in 2022: we will maintain existing plans for the publication of the MLA content map and developing the CPSA requirements, and these will be developed and available on the original timetable. However, the first year of the MLA in 2022 would be re-designated as a further pilot year for all candidates; we would aim to replace the current PLAB exam with the MLA in 2023; and to apply the requirement for UK students to pass the MLA as part of their degree programme’s requirements for the award of a UK PMQ to those graduating from 2024.

12 This staged timetable would provide broader opportunities to engage with a wider range of stakeholders and to explain the rationale for a further evolution of our original model for the MLA. It would also give more time to build familiarity with the MLA content and the nature of the AKT, and gives universities more time to amend regulations, if necessary. In the meantime, we will engage with medical schools about their current approach to final knowledge tests, using an approach similar to that being used in formative discussions with schools about the CPSA.
Key principles for the design and delivery of the MLA applied knowledge test (AKT)

These principles confirm the proposed features of the applied knowledge test (AKT) in the context of the MLA. They are intended to be read as a whole, as some are interdependent with others. They aren’t intended to be exhaustive, but to guide future collaborative work on detailed practical design and delivery. Subject to planning, modelling and piloting, the GMC is satisfied that an AKT built on these principles will deliver:

- a credible and valid assessment that supports the intended purpose of the MLA in relation to UK and international candidates;
- reliable and defensible outcomes across UK and international candidates;
- wider stakeholder confidence in the security of the AKT item bank and tests; and
- processes that are robust and operationally deliverable and manageable for both the GMC and medical schools.

These principles reflect the outcomes of constructive, progressive and on-going discussions between the GMC and MSC executive.

Overall governance

- The GMC will appoint an exam board/panel (‘exam board’) of individuals who will undertake all the relevant processes connected with MLA (including question selection, standard-setting and decision-making for the AKT).
- The exam board will include relevant experience and expertise from medical schools, those involved in the GMC’s assessment of international candidates, and the postgraduate training community.
- All processes will follow internationally recognised assessment methodology.

**Dates**

- Medical schools will be able to choose the specific date on which they wish to deliver the AKT, without restriction.
- The GMC will choose the dates for international candidates.

**Item approval and selection**

- The AKT will draw on content from the MSCAA item bank, PLAB item bank, and supplementary content commissioned by the GMC to refresh or fill gaps.
- To ensure consistency, quality, relevance and an appropriate level of challenge, all items included in for the AKT will be subject to a rigorous and ongoing expert review process.
- Each cycle, medical schools will be able to view and comment upon the pool of items from which the GMC will construct AKT papers for that period.

**Paper construction**

- The GMC will construct an AKT paper for each school and for its own assessment of international candidates, derived from the item pool.
- To support each school’s wider assessment plans, schools will be offered advance sight of the AKT paper for their students.
- As a check on standards and the quality of content, some items will be common across a number of papers.

**Standard setting**

- The GMC will aim to ensure that AKT items are of appropriate standard, and content is of equivalent difficulty across papers. The GMC will plan a programme of trialling and piloting to support this.
- A standard-setting group will include relevant experience and expertise from medical schools, those involved in the GMC’s assessment of international candidates, and the postgraduate training community.

**Delivery**

- To ensure a comparable experience for all UK and international candidates, the AKT will be delivered to all candidates onscreen via a software platform.
Council meeting, 12 June 2019

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- The GMC will engage with medical schools in planning the timing and methodology for implementing this platform.

Results
- The GMC will process all AKT results, which will be ratified by the exam board.
- The exam board will meet regularly at peak assessment times.
- The GMC will return results to each school within an agreed time period after the date on which it delivered the AKT.

Other matters
- Subject to a decision on the particular design and delivery model for the AKT, discussions will continue with medical schools and other stakeholders about the approach to take to issues such as number of attempts/resits, determination of reasonable adjustments, consideration of appeals and other related matters.
Agenda item: M7

Report title: Framework for GMC-regulated credentials

Report by: Phil Martin, Assistant Director, Education Policy phil.martin@gmc-uk.org, 020 7189 5113

Rose Ward, Policy Analyst, Education and Standards rose.ward@gmc-uk.org, 020 7189 5136

Paula Robblee, Policy Manager, Education and Standards paula.robblee@gmc-uk.org, 020 7189 5207

Action: To consider

Executive summary
We finished engagement on a draft framework for introducing GMC-regulated credentials in February 2019, hearing from stakeholders across the UK at approximately 50 meetings, and in 175 written submissions.

In April, Council considered an interim report of findings from engagement, along with a revised framework based on patient safety. Council agreed, subject to review of the final engagement report in June, to a phased introduction of GMC-regulated credentials, starting with a small number of early adopters, with a review point once they are developed.

We have completed a final report of engagement on the draft credentialing framework. This confirms and presents further details of the findings of the summary report which Council considered in April.

Recommendations
Council is asked to:

a) Consider the final report of engagement on the draft credentialing framework.
b) Confirm the interim decision by Council on 30 April 2019 to begin a phased introduction of GMC-regulated credentials.
c) Note plans to launch the framework and supporting documents including funding statement supported by the UK Medical Education Reference Group.
Background

1 A detailed discussion was held in Council closed session on 30 April 2019 where a full set of papers was reviewed. These included a revised framework for approving and assuring GMC-regulated credentials in discrete practice areas, our plans for a phased implementation, and an interim summary engagement report.

2 Council agreed to a phased introduction of GMC-regulated credentials, subject to review of the final engagement report.

3 We have now completed the final engagement report, which refines and expands on the findings in the interim report presented in April.

Final engagement report

4 As indicated at Council in April, the final engagement report is not substantially different to the interim report. It confirms the findings in the interim report, with the addition of some further details.

a It includes a key findings section upfront, summarising the main issues raised throughout engagement, and setting out our response to feedback.

b It contains a more refined analysis of themes in the written responses, particularly around why credentials are needed. This includes further exploration of differences among stakeholder groups and where appropriate, more details around aspects of our proposals which received more or less support.

c We have added appendices including details of who we met with during engagement, as well as a summary of findings of our earlier consultation in 2015, which reflected similar concerns to those raised in our recent engagement.

Clarity on funding

5 We have written to the UK Medical Education Reference Group (UKMERG) asking for support and endorsement of our plans, including a co-branded frequently asked questions (FAQ) document, and a statement about supporting and funding credentials which help meet NHS service and patient needs. The UKMERG are the forum for discussion and approval of matters relating to medical education and training with representation from the four UK health departments and the four statutory postgraduate medical education bodies.

Plans for launch

6 We plan to publish the credentialing framework, with supporting documents including a FAQs paper and further details around implementation.
7 We have worked with our communications teams to develop a comprehensive communications and engagement strategy, tailored to the different needs of stakeholders in each of the four countries of the UK.

8 We are continuing to build on our implementation plans, including working with organisations who are putting forward the first few credentials in priority areas. We have begun discussions to set out timelines for these early adopters to enter our approvals processes and have reserved space at the Curriculum Oversight Group meetings from September 2019.

9 We are also setting up a task and finish group to allow further stakeholder input as these first few early adopter credentials are considered for approval.

10 We continue to work with other parts of the GMC and the leadership team, to consider implications for our work programme and resources, as we develop more detailed plans for the next phase of implementation.

11 We have completed an equality analysis for this project, and will continue to engage with key groups that represent doctors with protected characteristics, including SAS (specialty and associate specialist) doctors and locally employed doctors (LEDs).
M7 – Framework for GMC-regulated credentials

M7 – Annex A

Final report of engagement on draft framework for GMC-regulated credentials
Executive summary

From September 2018 to February 2019 we listened to feedback from stakeholders across the UK on our draft credentialing framework. We heard from doctors, organisations and individuals involved in medical training, and patient representatives, at around 50 meetings and events. And we received written feedback from 175 respondents.

Many stakeholders, including governments, statutory education bodies, deans, colleges and faculties, welcomed the introduction of credentialing. And many doctors who shared their views supported the principles of the draft framework as a way to improve patient safety where needed. There was general consensus that credentialing would enable necessary changes to improve patient safety and help meet service needs, while facilitating career flexibility and lifelong learning for doctors. A number of organisations, in particular colleges, faculties and specialty associations, told us of areas of practice where they are keen to introduce credentials.

We also heard a lot of concerns about our proposals from organisations representing doctors, colleges, doctors in training, and others. Many thought our definitions and implementation plans were open to interpretation, and lacked detail about how credentials would work in practice.

A strong voice of opposition was led by doctors in training. They communicated fears that credentialing could diminish postgraduate training. We have listened carefully to these concerns, and this has helped us refine our proposals.

The quality and depth of feedback has helped us to produce a stronger framework and more detailed implementation plans addressing the concerns raised. The experience and expertise stakeholders have shared with us has been invaluable in informing our understanding. These contributions will help us make sure credentialing can work for the benefit of patients, the health services, and the profession.
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Key findings and overview

Main themes in feedback

Broad support for principles

1. Most bodies representing doctors and specialties, colleges and faculties, and organisations involved in medical education and training, as well as many individual doctors, particularly SAS doctors and consultants, broadly welcomed the introduction of a process to approve credentials where they are needed to improve patient safety.

2. These stakeholders supported the principle of credentials and were also supportive of the use of credentials to facilitate career flexibility and lifelong learning for doctors.

3. Patient representatives supported the introduction of credentials, especially in areas where there are significant risks to patients, as well as areas where there are not enough doctors trained to meet service demands. They welcomed a transparent way for the public to confirm that doctors have credentials on the List of Registered Medical Practitioners (LRMP).

4. Many of the respondents, across all categories, recognised that credentials can be used to develop doctors to respond to the changing expectations and needs of patients and the service that cares for them.

Potential risks to postgraduate training

5. However, many respondents, especially the bodies representing doctors, bodies representing doctors in training, and some of the colleges and faculties, caveated that credentials should not undermine or negatively impact on the quality or standards of postgraduate training necessary to be recognised on the Specialist or GP registers.

6. While they recognised concerns about patient safety and service needs in some areas, they expressed fears that credentialing could diminish the quality of postgraduate training and the Certificate of Completion of Training (CCT). Some remained unconvinced that credentialing was the right solution, suggesting that current training arrangements already ensured patient safety and addressed service needs appropriately.

More details needed

7. We also heard a lot of concerns across all stakeholder groups that the proposed framework was high level and lacked clarity on the details, especially around how we had defined credentials, and how credentials would work in practice.
Funding and resourcing concerns

8 Many stakeholders were concerned about funding, especially that individual doctors might have to pay for their training. We also heard concerns about resources, both in terms of the bodies managing credentials, as well as competition among doctors for training needs in the workplace.

Views of stakeholder groups

Governments and statutory education bodies

9 The four UK Health Ministers, when the Shape of Training implementation report was published in 2017, stated that credentials were needed to bring in necessary changes to develop the medical workforce to respond to changing patient and service needs. The four country statement indicated that credentials should be introduced as soon as it is reasonable to do so. They have continued to urge us to work with others to bring in credentialing.

10 The Scottish Government and Health Education England are keen to see credentials approved in priority areas as soon as possible. Government and medical education leads in Northern Ireland want credentials to help respond to workforce need, and key stakeholders in Wales would like to see credentials provide opportunities for the development of SAS doctors.

11 The UK Medical Education Reference Group (UKMERG) oversees medical education and training across the four countries, with representation from the four UK health departments and the four statutory postgraduate medical education bodies. They will have a role working with us to ensure a strategic approach in identifying credentials based on service needs, and want to ensure consistent standards across the UK and UK-wide recognition of expertise. They have been working with us as representatives on our Curriculum Oversight Group (COG), to develop the framework and are keen to see credentialing proceed.

Colleges and faculties

12 In general, colleges and faculties were very supportive of the benefits of credentialing in supporting flexibility, developing learning in new areas, and bringing regulatory rigour where needed to improve patient safety.

13 Many colleges and specialty organisations were already developing or planning credentials, or saw an opportunity to train more doctors where needed.

14 Some college bodies expressed concerns about the impact of credentialing on postgraduate training, and resourcing challenges. The Scottish Academy were concerned about an over-proliferation of credentials and potential harm to training, and said we must be clear that credentials are not a first line solution.
Other organisations

15 In general, specialty associations, training bodies, and employers saw credentialing as an opportunity to provide additional training where it was needed, although some specialty associations expressed strong views that it was not appropriate for certain areas, where full training to CCT level was essential for patient safety.

16 Postgraduate deans were keen to know how credentials will work in practice, and how they will be funded.

17 Some bodies representing wider healthcare teams were keen to explore options for shared credentials, or improved opportunities for multiprofessional learning.

The profession

18 There was broad support from consultants, SAS doctors, and many doctors in training for flexibility to improve patient safety, respond to changes in medicine and technology, support individual career development, and meet service needs. However, strong concerns were raised over a number of elements of credentialing, particularly around funding and the effects on postgraduate training leading towards a CCT.

19 We were challenged by the BMA, who represent doctors and the medical schools in the UK, to ensure that postgraduate training is not diminished in any way.

Doctors in training

20 The views of doctors in training varied. Whilst representative organisations expressed concerns, several individual doctors in training from a variety of specialties were supportive.

21 A number of groups representing doctors in training, including the BMA Junior Doctors Committee (BMA JDC), the Association of Surgeons in Training (ASIT), British Orthopaedic Trainees’ Association (BOTA) and other similar organisations made it clear that they saw credentialing as a threat to the quality and value of postgraduate training. This was the biggest concern raised by doctors in training, alongside concerns about how credentials would be funded.

SAS doctors

22 SAS doctors viewed credentialing as a way of enabling learning opportunities and recognition, and would like to see credentials being available to them in the future.

Consultants

23 Consultant feedback was mixed but many were positive about how credentialing could support career development, career change and lifelong learning. They supported credentialing as a way to update skills to meet advances in medicine and service needs, and saw the potential for credentialing to support other hospital doctors.
Our response to feedback

24 We have made a number of changes to the draft framework, and to our plans for a phased implementation, to address the concerns we heard during engagement.

A revised framework

25 We have refined the framework to clearly state the principles that will apply to the development of credentials. And to make it clearer, we have identified some of the types of credentials that might be developed. These areas were identified and tested through our five pilots. We have agreed to use the term ‘GMC-regulated credentials’ to clearly distinguish these from any other uses of the word.

26 To ensure credentials complement current training, the framework clarifies that entry requirements will be needed for each credential. These will be based on the level of expertise needed to ensure the risk to patients is minimised as doctors develop and practise in a discrete areas. The organisation proposing the credential will have to determine the appropriate entry level to ensure patient safety. In many cases, credentials may be limited to doctors who are on the Specialist and GP register in a relevant area. We will consider a limited number of early adopters with wider eligibility to look at how SAS doctors may access credentials. We will discuss with stakeholders after our work with the early adopters about making further GMC-regulated credentials accessible to doctors who are not on the Specialist and GP registers. We will consider this only where evidence demonstrates patient safety requirements will not be diminished.

27 We have also described with more clarity the role of the UK Medical Education Reference Group (UKMERG) in prioritising areas for potential credentials and our curriculum oversight group (COG) in advising whether proposals have met the patient safety and service need factors. We have made it clear that the GMC decides what proposals have met the criteria for credentials and should be approved. They will be directly regulated by us.

28 We have also set out more details about the expected standards and processes for approval and quality assurance of GMC-regulated credentials.

Clarifying details

29 We have produced a frequently asked questions (FAQ) document aimed at doctors, with significant input from doctors in training. We have asked the UKMERG to co-brand the FAQs in recognition that many of the issues relate to their responsibilities.

30 We are discussing with the four UK governments, through their statutory education bodies, the need for a clear statement about funding. Feedback was clear that this commitment is vital for the development and delivery of credentials. We expect the four UK countries to reassure us, before we introduce GMC-regulated credentials, that
they are firmly committed to ensuring there are equitable and proportionate funding arrangements underpinning credentials where they have been commissioned or funded to develop and secure the NHS medical workforce.

**Phased implementation with further review**

**31** We will publish the framework, FAQs and other documents in June 2019. Subject to Council approval, we are planning a phased implementation for credentials, working with a small number of early adopters in 2019. We will continue to learn and refine our processes. Once these initial credentials have been approved, we will have a review period to identify any issues or changes required.

**32** We are setting up task and finish groups for the early adopter credentials, to give a greater degree of assurance of these initial credentials. We recognise the strength of the views we’ve heard, and want to make sure we provide a forum for stakeholders to have input into the process for approving the first few credentials. The groups will have representatives from the four UK countries and will include consultants, doctors in training, SAS doctors, patient representatives, employers and specialty experts in relevant areas.
Our approach to engagement

33 We worked with partners while developing the draft framework in 2018, and followed this with a period of extensive engagement from September 2018 to January 2019. We wanted to develop a framework for credentialing with consensus from stakeholders across the four countries of the UK.

34 This was an engagement exercise, with the purpose of making sure any final credentialing framework was developed with the input of stakeholders. A summary of previous consultation on credentialing is at the end of this report.

35 We published a draft framework and an annex with supplementary information on our website, and approached key stakeholders inviting them to submit comments in writing via an online form, as well as offering the opportunity to meet with us to discuss the framework. We contacted colleges and faculties, groups involved in medical training, bodies representing doctors, patients and the public, and other organisations with an interest in credentialing.

36 We gave regular updates at our UK Advisory Forums in Northern Ireland, Scotland, and Wales. Our teams in Scotland, Northern Ireland and Wales, and regional teams in England were briefed so that local stakeholders could be kept up to date.

37 In the response form we asked for feedback on the framework in relation to several aspects of our proposals, with opportunities to comment under seven headings:

   a Why credentials are needed
   b Defining a credential
   c Criteria and threshold for credentials
   d The regulatory process
   e A phased approach to implementation
   f Supporting flexibility in training in other ways
   g Any other comments.

38 We sought open feedback on the draft framework, without any yes/no questions, as our aim was to make sure we heard and understood the range of stakeholder views on our latest proposals, rather than repeat the previous consultation exercise.

39 Discussions and feedback from our engagement activity has influenced development of the final framework and implementation plans.

www.gmc-uk.org
Who we heard from

Meetings with stakeholders

Developing the draft framework

40 In 2018 while developing the draft framework, we tested our thinking with members of the UK Medical Education Reference Group (UKMERG) who represent governments and education statutory bodies from the four countries. The UKMERG is currently the forum for the discussion and approval of matters relating to medical education and training.

41 The UKMERG is represented on our Curriculum Oversight Group (COG) and working together, we started meeting with colleges and faculties from late 2017, to review all postgraduate curricula. Throughout 2018 we met with all of the medical colleges and faculties to discuss how each curriculum would meet the standards and requirements in Excellence by design and principles in the Shape of Training implementation report, including looking at potential areas for credentials. These conversations fed into the development of the draft framework, helping us to understand the range of areas of practice that might be suitable for credentials.

42 During this phase we also shared progress and sought feedback on our plans through regular updates to the Conference of Postgraduate Medical Deans of the UK (COPMeD) which includes representatives of doctors in training and SAS doctors.

43 We also discussed our developing proposals with representatives from the BMA Junior Doctors Committee, and spoke with the Joint Academy Training Forum (JATF), the Northern Ireland Medical Education Policy Group (NI MEPG), Postgraduate Quality Leads, Shape of Training implementation groups and leads in Scotland and Wales, and a number of college and specialty organisations interested in developing credentials.

Engagement on the draft framework

44 We discussed the draft framework with stakeholders at around 50 meetings and events between September 2018 and January 2019.

45 We met with groups and individuals in various settings where we presented our proposals, held open discussions, answered questions, and listened to feedback.

46 We heard from medical colleges and faculties, postgraduate deans, specialty associations and others involved in medical training, as well as employers and a range of doctors including doctors in training, SAS and trust grade doctors, and consultants. We also spoke with patient and public representatives, cosmetic surgery organisations, and other organisations with an interest in credentialing.
47 We approached key stakeholder groups offering to come to meetings of their boards and groups, and to attend or host individual or small group meetings. We met with stakeholders through a number of forums.

a We held roundtable meetings in Northern Ireland, Wales and Scotland, which included representatives from deaneries, HEE local teams, trusts, boards, governments, and doctor groups.

b We presented to stakeholder groups such as the Joint Academy Training Forum, and groups representing doctors in training, SAS doctors, and patients and public.

c We presented to our doctors in training roundtable, a regular forum for dialogue.

d We held a dedicated credentialing workshop with doctors in training, and met with individual doctors in training representing different specialties.

e We met with representatives of organisations interested in developing credentials.

f We met with other groups with an interest in the impact of credentialing, such as indemnity organisations, cosmetic practice groups and others.

48 A full list of engagement events and groups we met with is at Appendix 1.

Written feedback on the draft framework

49 We received written feedback from a total of 175 stakeholders, made up of 108 individuals and 67 organisations.

50 We received 154 responses via our online form, and 21 were sent by email.

Written responses from individuals

51 There were 108 individuals who gave written feedback on our draft framework, and 105 of these were doctors.

52 The table below shows numbers of doctors in each main category.

<table>
<thead>
<tr>
<th>Individual category</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor</td>
<td>105</td>
</tr>
<tr>
<td>Doctor in training</td>
<td>23</td>
</tr>
<tr>
<td>Consultant</td>
<td>65</td>
</tr>
<tr>
<td>General practitioner</td>
<td>2</td>
</tr>
<tr>
<td>Staff and Associate grade Staff (SAS) doctor</td>
<td>12</td>
</tr>
<tr>
<td>Other doctor</td>
<td>3</td>
</tr>
<tr>
<td>Other individual</td>
<td>83</td>
</tr>
</tbody>
</table>
53 Many of the doctors who responded also identified in additional categories. This included one who was a sessional or locum doctor, four who were medical directors, and three who identified as other medical managers.

54 There were also 26 doctors who identified as medical educators. These were mainly consultants, with one who was an SAS doctor.

55 The numbers of individual respondents by country of residence are shown below. While four country representation was limited, written feedback was supported by meetings with a range of individuals in each of the devolved countries.

<table>
<thead>
<tr>
<th>Country of residence of individual respondents</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>87</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>3</td>
</tr>
<tr>
<td>Scotland</td>
<td>13</td>
</tr>
<tr>
<td>Wales</td>
<td>3</td>
</tr>
<tr>
<td>Not stated</td>
<td>2</td>
</tr>
</tbody>
</table>

Written responses from organisations

56 The 67 organisations who submitted written feedback are shown below by category.

<table>
<thead>
<tr>
<th>Organisation category</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Body representing doctors</td>
<td>15</td>
</tr>
<tr>
<td>Body representing doctors in training</td>
<td>12</td>
</tr>
<tr>
<td>Body representing patients</td>
<td>1</td>
</tr>
<tr>
<td>College or faculty</td>
<td>21</td>
</tr>
<tr>
<td>Government department</td>
<td>2</td>
</tr>
<tr>
<td>Independent healthcare provider</td>
<td>1</td>
</tr>
<tr>
<td>NHS/HSC organisation</td>
<td>2</td>
</tr>
<tr>
<td>Other (largely bodies representing healthcare professionals)</td>
<td>7</td>
</tr>
<tr>
<td>Postgraduate medical institution</td>
<td>6</td>
</tr>
</tbody>
</table>

57 The bodies representing doctors in training included a high number of groups representing doctors training in surgical specialties, as well as major bodies representing all specialties or all doctors in training.

58 Groups representing surgical specialties were also well represented among the bodies representing doctors.
Several organisations indicated that their responses represented a diverse range of stakeholders, such as colleges who had compiled views from various members including SAS doctors, trainees, and educationalists.

The numbers of organisation respondents based in each country is shown below. While four country representation was limited, written feedback was supported by meetings with a range of organisations in each of the devolved countries.

<table>
<thead>
<tr>
<th>Country organisation is based in</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>UK-wide</td>
<td>50</td>
</tr>
<tr>
<td>England</td>
<td>5</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>1</td>
</tr>
<tr>
<td>Scotland</td>
<td>6</td>
</tr>
<tr>
<td>Wales</td>
<td>0</td>
</tr>
<tr>
<td>Other (combinations of UK countries and Ireland)</td>
<td>5</td>
</tr>
</tbody>
</table>

A full list of organisations who gave written feedback is at Appendix 2.
What we heard

62 We asked stakeholders for written comments under seven headings, aligned with how we had set out our proposals in the draft framework and supplementary information.

63 Discussions at meetings were led by stakeholder questions or concerns, but in the written feedback form we gave prompts suggesting questions respondents might want to address. We have set out these prompts under each section below.

64 We were seeking views to help us get the framework right through open-ended questions and we did not ask yes/no questions. However, in some sections, responses tended to indicate support for our proposals, or not. In these cases we have reported the approximate proportion of comments which were supportive or against our proposals, as well as the proportion that were mixed or unsure. These were where stakeholders either directly expressed they were unsure, or where it couldn’t be clearly discerned, or where they had presented a mix of views, both supportive and against.

65 In general, we have presented the issues raised in the written responses grouped around main themes, discussing the themes or issues raised the most times under each section first.

66 At meetings we noted areas where stakeholders indicated there was broad support, and areas of concern, and we have reported this feedback under the same headings below, alongside the written comments.

Why credentials are needed

67 In the draft framework we outlined the reasons credentials were needed, along with some background and an overview of wider issues around credentialing. In the response form we asked for comments on ‘A case for change’ in the framework, and ‘Why we’re introducing credentials’ and ‘Impact and issues’ in the annex. We said we’re interested in views on:

- whether credentials will enable flexibility
- support necessary change
- opportunities for doctors
- any other thoughts on these sections.

68 We received 162 written responses in this section.

The case for change

69 Over half of respondents who gave written feedback under this section were clear that there is a need for credentials, or that they supported the proposals in the framework, or were eager to see credentialing introduced.
This included comments where the respondent had stated directly or made it clear in the overall tone that they supported the introduction of credentials, while also raising issues which need to be considered.

Just under a third of written responses indicated mixed views, or stated that they were unsure. These responses expressed some support mixed with some degree of concern, with the overall tone indicating caution, or uncertainty. Many responses were lengthy and noted a number of benefits, as well as areas of concern. Some indicated support for the principles of credentialing, or acknowledged that credentials were needed in some areas, but with caveats about the numerous or serious issues still to be addressed. Some accepted a need for credentials in general, but expressed some concern around certain aspects of our proposals. For example, they were concerned that credentials could create a barrier for some doctors to practise in the area.

A small but resolute minority of written responses were firmly against the introduction of credentials. Some of these responses were specifically concerned with the possibility of changes to training in a particular specialty.

At meetings and events, we found that in general stakeholders were supportive of taking credentialing forward, with many keen to see progress after several years of expectation. An exception to this was doctors in training, with some representatives very concerned about the potential for credentialing to negatively impact on training.

Different stakeholder views on the need for credentials

Among the 65 organisations who gave written feedback on this section, there were different levels of support from different types of organisations.

Bodies representing doctors

A large majority of respondents in this category indicated some general support for the principles of credentialing, though about one third of them noted caveats. These were largely based on what was unknown about how credentialing would work in practice. However, some were more strongly against credentials, seeing them as unnecessary, with potential negative effects, such as creating a ‘junior consultant’ grade. Many of those who were supportive of the introduction of credentialing were keen to propose areas suitable for credentialing, though some noted broader benefits.

While recognising the potential benefits of credentials in areas ‘where doctors develop expertise outside of an approved training programme and a consistent standard is absent’, the British Medical Association (BMA) reiterated its position.

‘We therefore must restate our opposition to the development of any credential that impairs, undermines or supplants any existing specialist or GP registration or training certification in the area covered by a specific credential or more generally’. (BMA)
Organisations representing surgeons were well represented in the written responses, making up more than a third of the bodies representing doctors. These expressed strong but mixed views on a credential in cosmetic surgery.

**Bodies representing doctors in training**

Of the 12 bodies representing doctors in training who responded in writing, none expressed unequivocal support for our proposals.

While a large majority of the bodies representing doctors in training saw some potential for credentialing to provide reassurances around protecting patient safety, two were clear that they didn’t think it would achieve this. These were based on concerns about a dilution of training, and that credentials wouldn’t be mandatory.

On the whole, bodies representing doctors in training made up the strongest voice of caution against the introduction of credentialing, with many acknowledging the need to regulate cosmetic surgery, but citing the lack of detail in the draft framework, the limited benefits of non-compulsory credentials, and suggesting that other potential solutions may be better than credentialing.

While most of these bodies presented mixed views, with recognition of some potential benefits, many expressed concerns about potential risks, and about using credentials to address service gaps.

‘No argument can be had when the case for change is based upon perceived patient safety issues. However, significant care needs to be taken when equating this with workforce gaps or service needs.’ (The Dukes’ Club)

Some noted risks around uneven access to credentials, and the challenges of having doctors trained in different ways to do the same job.

‘Credentials... risk of creating a climate of deprofessionalisation which may be detrimental to patient care rather than improve it ... existing skills could be limited by the availability of a credential: clinicians who do not hold a credential in an area may feel reluctant to instigate certain therapies ... previously ... considered standard practice’. (a joint response from the Royal College of Physicians of Edinburgh Trainees and Members Committee; Royal College of Physicians of London Trainees Committee; Royal College of Physicians and Surgeons of Glasgow Trainees' Committee)

Surgical groups were also well represented in this category, making up nine of the 12. Many of these acknowledged a need for regulation around cosmetic surgery, but were firm that there were no other areas of surgery suitable for credentials.

‘There is significant uncertainty regarding the synergy of credentialing with the current training and revalidation process. The principle concern for surgical trainees
and surgical trainee associations is that credentialing will result in the removal of content from existing postgraduate training and devalue the Certificate of Completion of Training (CCT).’ (Association of Surgeons in Training)

**Bodies representing patients**

84 Only one patient representative group gave written feedback on the draft framework, and they were fully supportive of the introduction of credentialing. This view was reflected by an individual patient representative.

‘The benefits for patients are clear, protection, safety and the knowledge that the highest medical regulatory body in the UK is validating such presentation of additional medical training.’ (Body representing patients)

‘Any initiatives offering flexibility to cover gaps in services, whilst still being quality assured, and also help to improve patient safety are welcomed.’ (patient representative)

85 We also heard from patient representatives at mixed meetings, who were positive about the potential for credentialing to bring improvements to patient safety. This included the Joint Committee of Surgical Training (JCST) Fellowships Reference Group, who were supportive of using the credentialing approach to fellowships as a model for safety and quality while not going through the GMC approval processes.

86 Feedback shared, for example from the Royal College of Surgeons on their accreditation scheme for cosmetic surgery, has been clear on patient expectations that there will be a mechanism to ensure that doctors are focused on patient safety.

87 While direct feedback from patient groups has been limited, it should be noted that broadly all stakeholder groups reflected that patient safety and patient needs should be the primary driver for credentials. We will continue to engage with patient representatives as we develop credentials.

**Colleges and faculties**

88 Colleges and faculties were generally keen to see credentialing introduced, with a large majority of written responses expressing positive views about the draft framework. These noted the benefits of encouraging compliance with professional standards in a doctor’s whole practice; providing opportunities for career flexibility and lifelong learning, with subsequent benefits to health and wellbeing; broadening specialist skills; developing new ‘combined’ specialisms; helping to meet urgent workforce needs; ensuring a standard level of practice in unregulated areas currently outside training programmes; recognising competence; and improving patient safety and competence.

89 About a quarter of responses in this category were more mixed, supporting the principles but with questions or concerns about how credentials will work in practice.
Some of these acknowledged potential benefits but there were varying levels of caution expressed about taking credentialing forward.

‘Credentials may improve a few specific areas of clinical practice in terms of standardisation and allowing some transferrable competencies irrespective of the parent speciality. However, as proposed, the draft credentialing framework poorly details how such issues would be resolved satisfactorily nor how potential unintended adverse impacts would be monitored and avoided.’ (Academy of Medical Royal Colleges and Faculties in Scotland)

Many were eager to put forward credentials in areas where there were service gaps.

**Government departments**

91 The four UK governments have pushed hard for the introduction of credentialing, and are keen to work with us to take this forward at pace. Government representatives on the UK Medical Education Reference Group helped us develop the framework, made specific drafting proposals, and are fully supportive of our proposals.

92 Two government departments submitted written feedback on the draft framework, which also supported our proposals. One noted this was an opportunity to provide additional training post-CCT.

93 Health Education England emphasised the key principle of ensuring the system allows them to deliver what is needed in response to patient, service and workforce need.

**Independent healthcare practitioners**

94 One independent healthcare organisation submitted written feedback which was fully supportive of credentialing as a way to formalise the pathway for doctors seeking to expand their scope of practice, and to offer recognition.

**NHS/HSC organisations**

95 NHS Employers (England) held several engagement exercises with employers, including hosting a presentation from the GMC on early proposals.

96 NHS Employers provided the following feedback:

‘Many employer representatives feel that credentialing, provided it is introduced under a robust framework, is adequately resourced (in terms of time, funding and supervision), and is responsive to local service and workforce needs, could support flexibility and transferability within specialties. Most agreed that credentials could provide valued development opportunities for SAS doctors and consultants, and could help to address skills gaps and improve patient care. Employers look forward to further engagement as credentialing plans develop.’
Other healthcare professionals

97 Of the seven ‘other healthcare profession’ organisations who commented on the draft framework, almost all were supportive, citing transparency for patients considering their options; enabling flexibility; supporting change; enabling responsiveness to patient and service needs; flexibility for doctors leading to improvements to wellbeing; bringing oversight to non-regulated practice; meeting workforce needs; opening up new opportunities to doctors; and raising standards in new and changing areas.

98 One organisation said they support the aim of regulating areas of unregulated practice, but expressed concerns about the potential for content to be removed from current postgraduate curricula, diminishing the value of the CCT.

Postgraduate medical institutions

99 Most of the six postgraduate medical institutions who commented saw benefits in credentialing, such as assuring quality control and regulation in areas not currently covered by defined curricula leading to CCT; enabling flexibility; creating opportunities for doctors to develop skills or expertise as part of a properly governed process; regulating cosmetic surgery; and supporting cross-specialty areas.

100 These views were mirrored in feedback at COPMeD meetings, but we also heard concerns about challenges with managing and implementing credentialing, particularly about funding, and issues around resources.

101 One thought that credentialing was best kept limited to areas not currently covered by defined curricula leading to CCT but felt that a wider rollout would risk a move away from generalism as described in Shape of Training.

Individual respondents

102 Among the 97 individuals who commented on this section, slightly over half indicated in their comments that they were supportive of our proposals, which was a similar proportion to the overall responses. But almost a fifth of them made it clear they were against credentialing altogether, and about a third indicated some support for credentialing, but with caveats, or gave responses that were neutral or unsure.

103 Among doctors, the proportions of responses from consultants that were supportive, mixed, or against our proposals reflected similar proportions to overall responses. However among SAS doctors, there was a two thirds majority whose comments were clearly in support. And among doctors in training, only a third were supportive, with just under a third firmly against our proposals, and slightly more than a third saw some benefits to credentialing but expressed concerns or caveats. This is similar to response patterns from previous engagement and consultations on the introduction of credentials – summarised at Appendix 3 of this report.
Opportunities for doctors

104 A major theme in written responses, mentioned in about half of all comments, was how credentialing could affect doctors.

Development and recognition

105 Over a quarter of this number commented on the potential for credentials to offer doctors opportunities for development, with comments about improving and broadening skills, helping doctors who lack expertise in an area, and increasing access to training.

‘They do present an opportunity for doctors to develop a skill/expertise as part of a properly governed process and formal curriculum.’ (Specialty Advisory Committee in Oral and Maxillofacial Surgery)

106 Almost as many welcomed the potential for doctors to be formally recognised for areas of expertise.

107 However, a small number saw potential risks, or were critical of credentialing’s effects on the development and recognition of doctors. These cited the availability of other development opportunities; the limits to learning within a credential; possible loss of other opportunities if the ‘wrong’ areas become credentials; access concerns; and the ‘potential risk of consultants being disadvantaged if training they had undertaken within their CCT was not properly recognised as a result of a specific credential being established in the same or a similar area’. (BMA)

‘Significant concern has been raised by representative trainee groups that re-labelling credentials has the potential to create a ‘sub consultant’ grade, resulting in a workforce unprepared for the broader aspects of the Consultant grade.’ (Academy of Medical Royal Colleges and Faculties in Scotland)

Career flexibility

108 Another quarter of those commenting on how credentialing could affect doctors spoke positively about opportunities for flexible career pathways, individual career progress, and enabling practitioners to change specialty.

109 However, half this number questioned how much credentials would provide opportunities for career development. Some, including bodies representing doctors, and doctors in training, were concerned about the creation of a ‘two-tier’ system where doctors without a credential may deliver the same service as those who have it, but experience diminished career opportunities. Some thought this extra training wouldn’t appeal to doctors, others that limited places and competition would restrict flexibility for doctors. Others thought ‘there may be instances where having credential define a narrow area of practice might limit rather than enhance a doctor’s opportunities’. (COPSAS)
Opportunities for who?

110 There were a large number of comments about the potential benefits for credentials for SAS doctors. Many welcomed this as an opportunity for these doctors to gain formal recognition, expand clinical skills and specialty interests.

‘This will improve patient safety as well as providing opportunities for this lost tribe of doctors who currently have zero opportunity of progression and promotion.’ (SAS doctor, Scotland)

‘Positives for SAS is that there should be formal training and supervision provided with adequate time and support to achieve a Credential, which we suggest should be paid for by the employer, as it would be the employer who is requiring a trained specialist in this area.’ (NHS Education for Scotland SAS team)

111 However a small number saw risks of unintended consequences in SAS doctors gaining credentials, warning against confusion for patients, or ‘a cheaper stream of employment to fill service gaps’. (Doctor in training, England)

112 A few written responses specified that credentials should be for all doctors. And quite a few commented on whether credentials should be for other healthcare professionals, with some strongly against this, while others supported it. This was also a focus of discussion at several engagement meetings, with many doctors in training concerned about other healthcare professionals being enabled to undertake work that should be done by doctors, while others, such as trust representatives, saw benefits in this.

Increasing burden or wellbeing?

113 A small number of those responding in writing, as well as some of the doctors in training we met with, thought credentials could add to their bureaucracy and make life harder for doctors. But there were a few who said they thought the career opportunities brought by credentialing would lead to improved wellbeing for doctors.

‘It will improve flexibility, chances for betterment in skills and prevention of burnout.’ (Doctor in training, England)

Impact on training

114 Almost half of all written responses commented on how credentialing could affect training.

More flexible and responsive training

115 Most of those who commented on how credentialing could affect training, from a range of stakeholders including consultants, GPs, SAS doctors, doctors in training, and a cross section of organisations, noted beneficial effects. Many commented on the
flexibility credentialing would bring, by allowing additional training, training in cross-specialty areas, and supporting generalism.

116 A large number commented on how credentialing would make training more responsive, allowing doctors to be trained in new areas of medicine or technology, responding to change, and to where training is currently inadequate.

117 However, about half of this number thought the flexibility credentialing could provide had a downside. This view was expressed by a number of doctors in training, bodies representing doctors, and some colleges. Some thought credentials could result in reduced generalism, some expressed strong views that credentials were not suitable in particular specialties, and some said that there were other, better, options for making training more flexible.

‘Credentialing could undermine the generalist agenda of Shape of Training because training in even more focussed sub-specialty areas is likely to be very attractive to doctors and this may be at the expense of generalist training and practice.’

(Federation of the Royal Colleges of Physicians)

Risks to postgraduate training

118 About a quarter of all respondents had strong concerns about the potential for credentials to have a negative effect on postgraduate training.

119 The BMA remained firm in their position that postgraduate training mustn’t be affected, and were not reassured by the framework.

‘The broad proposals laid out include the development of credentials which will undermine, compete and overlap with the existing CCT.’

120 Many described a risk of training being shortened if areas were removed to become credentials. Some saw a potential for credentialing to diminish training in other ways, such as creating more competition for trainees in accessing training experiences. Some spoke of ‘watering down’ or reducing the skill and specialisation of trainees coming out of training, and lowering the standard of a CCT, resulting in a two-tier system, where consultants are no longer independent practitioners, and instead creating a level of ‘new consultants’ or ‘trainee consultants’.

121 Some mentioned specific areas that should not be ‘pushed out of routine training as this would lose the richness that specialised training brings to a generalist’s skills even if they’re not likely to be subspecialising in these fields in the future’.

122 Others spoke of credentialing leading to training on the cheap, and thought it would result in fewer CCT places.
Effect on services and workforce

*Flexibility for the service and workforce gaps*

**123** A large number welcomed credentialing as a way of creating a more flexible workforce, with benefits in helping to reduce workforce gaps. These views were expressed by a number of consultants and some doctors in training, as well as a cross section of all types of organisations.

**124** Several comments noted benefits for workforce flexibility, with one saying credentialing offered the opportunity to develop the workforce outside the traditional silo based system. Others said it offered a mechanism of rapid development of workforce for deficit areas of expertise.

> 'I think credentials will enable a huge amount of flexibility in allowing the workforce to respond to changing demands in a safe and regulated manner.' (GP, England)

**125** A number of these responses noted particular areas where credentialing could help with workforce gaps, such as mechanical thrombectomy, eating disorders, and addictions.

**126** 'If we are to have a sensible career path for doctors working in secondary care and have a workforce which is responsive to the changing needs of patient cohorts, it is vital we have a mechanism that equips people to respond in a way that is safe and has standards that are equivalent across the whole of the NHS. As we struggle to have a big enough workforce to support the unselected emergency cohort we must recognise that is not deliverable in the same way as the practitioner matures.' (Medical educator)

*Potential risks to services*

**127** Some respondents pointed out that as credentialing will only apply to a small number of specialty areas, it would be of limited benefit to the service.

**128** Others said there was a risk that credentials could restrict practice, by leading to doctors only working in the area they had credentialed in, making them less available in other areas. Others said it would lead to worse short-termism in workforce planning, and that non-doctors in doctor roles wouldn’t improve patient safety.

**129** Some cautioned that credentialing alone wouldn’t improve patient safety – that it needs to be integrated into lifelong learning and practice, and incorporated into systems ie revalidation and appraisal.

**130** There were comments that it wouldn’t be safe to introduce credentials in all areas, and particularly for doctors not on the specialist register going into certain areas eg colorectal surgery, urology; and that non-specialist doctors may find it difficult to keep up to date. Others said that credentials would not be appropriate for all specialties, with some mentioning specific areas, such as paediatrics. However while a couple of
doctors in training cautioned against credentials in paediatric surgery, one consultant stated ‘I think this new system is good and works well for Paediatric surgery’.

Benefits for patients

131 A number of respondents commented that credentialing would improve patient safety, with many of these citing areas lacking regulation such as cosmetic surgery, and where gaps exist. It was widely acknowledged that this is a key consideration.

‘The benefits for patients are clear, protection, safety and the knowledge that the highest medical regulatory body in the UK is validating such presentation of additional medical training ... Patient safety must be the overriding priority.’ (Body representing patients)

132 However some challenged the patient safety benefits of credentials to address workforce gaps.

‘I do not support the use of credentials to target areas of service need. The underlying reason for recruitment and retention must be addressed and not simply bypassed by issuing credentials to non-consultant grade doctors or health care professionals. There must be improvements in doctor’s contracts, work life balance and workforce planning. Credentials must not be used as a cheaper stream of employment to fill service gaps.’ (Doctor in training, England)

133 Many also made reference to the potential for credentials to bring improvements to patient care, and to give reassurance to patients.

‘We also think that credentialing in areas of practice which currently lack regulation, such as cosmetic surgery, is appropriate and will enhance patient confidence that a surgeon has acquired the range of technical and professional skills to be able to provide high quality, safe care.’ (Royal College of Surgeons of England)

134 Respondents described how credentials could bring benefits to patient safety through standardisation of care; addressing specific areas of patient need; and enabling employers to determine who is competent to practise safely.

Regulation and assurance

135 A number of respondents commented on the benefits credentialing could offer in supporting consistent standards, and providing assurance of quality and safety.

‘The Credentialing Framework will provide doctors’ with the opportunity to evidence areas which currently do not have standardised assessments. We believe this will support improved education and standards across identified areas.’ (Faculty of Sexual and Reproductive Healthcare)
Many mentioned the benefits credentialing would bring by regulating specific areas, such as cosmetic surgery. Some mentioned other areas which lacked national standards, such as eating disorders.

‘Doctors have more stringent requirements when presenting additional documents for recognition. It is in their interest to have specialist expertise validated by an influential and nationally recognised professional body. Therefore, proper and systematic process to enable these additional qualifications to be taken into account and proper oversight to give credence to such professional achievements is essential.’ (Body representing patients)

Other perceived benefits included bringing more consistency and quality assurance, and aligning practice with other parts of the world.

Specific areas credentials are needed

A lot of support came from stakeholders who felt that credentialing would be the solution for specific areas of practice. These ranged from areas where organisations or individuals are developing a proposal or see a clear and definite need, through to areas where credentialing might be a process which could add value.

Many respondents named cosmetic surgery as an area where credentialing was needed. Other reoccurring areas included addiction psychiatry, mechanical thrombectomy, pain medicine, and remote and rural medicine. There was a particularly strong call for a credential in eating disorders psychiatry.

‘At present there is no defined training for a doctor wishing to specialize in the treatment of eating disorders. it is a highly specialist, complex and high risk area requiring a high level of medical, psychiatric and psychotherapeutic skills and at present there is no way to access all of these necessary requirements ... Introducing credentials will be incredibly useful in standardizing training and setting out clearly what is required thus supporting doctors in being able to access the required training.’ (Faculty of Eating Disorders (Northern Ireland))

Cosmetic surgery

There were a lot of comments about cosmetic surgery, many from the large number of plastic surgeons and organisations representing plastic surgeons who responded.

Many said it was an area where credentials were clearly needed, but some disagreed. They emphasised that risks to patients were not from doctors practising cosmetic surgery, but from a wider community carrying out other cosmetic interventions.

Others questioned that if the purpose of developing a credential in cosmetic surgery was patient safety, then unless credentials were mandatory, they would not make much difference.
143 A private provider gave a very detailed response disagreeing with the view that doctors needed to be on the UK specialist register to practise cosmetic surgery safely, as doctors who had trained in other countries where plastic surgery was a specialty were not able to get onto the specialist register. But others were equally firm that the only safe doctors in this area were those who had trained in plastic surgery in the UK.

144 Some plastic surgeons, especially doctors in training, said their training covered all they needed for cosmetic surgery, while others said cosmetic surgery should be covered through CCT plus fellowships.

145 There was a clear interest from several respondents in making sure their views on cosmetic surgery were heard. Plastic surgery trainees in particular were very keen to be consulted as part of any proposals for credentials in cosmetic surgery.

More details are needed

146 In commenting on the case for change, many respondents raised issues discussed under other sections, indicating their view that the success of credentialing depends on getting the details right in the final framework and implementation. We covered them in the relevant sections.

Why credentials are needed – our response

147 We have revised and clarified our definitions and criteria for credentials, setting out principles and making it clear that there will be limited numbers of credentials, which will each have clearly defined entry requirements.

148 We have further developed our plans for a phased implementation which includes:

   a  introducing a small number of early adopters

   b  continuing engagement with stakeholders as we develop the first few credentials

   c  having a review point to allow learning and check for unintended consequences.

149 We will evaluate the impact of the credential, including its impact on relevant postgraduate training, through our data collection and monitoring mechanisms. Credentials will not be used to undermine or devalue the quality of postgraduate training.

Defining a credential

150 In the draft framework we described what we thought a credential would be. In the response form we asked for comments on ‘Defining credentials’ in the framework. We said we’re interested in views on:

   ■ whether we have described credentials clearly
■ if an alternative word should replace 'credentials' – and ideas welcome
■ any other thoughts on this section.

151 There were 150 comments on this section.

Clarity of descriptions

152 While talking to stakeholders during engagement, we heard from a number of stakeholders that our description of a credential in the draft framework wasn’t clear. This was often from those who were hearing about credentialing for the first time. We found that while many felt our descriptions could be improved, they were generally more supportive following a discussion or once we had answered questions.

153 A large number of written comments expressed approval of how we described credentials, with comments including 'clear', 'fairly clear', 'appropriate', 'reasonable', 'fine', 'good', 'satisfactory', and 'acceptable'. There were also a few comments saying the examples were helpful.

154 However, some of those who gave written feedback said they found the description of credentials unclear. Some found our descriptions ambiguous or open to interpretation. Others said more details or explanation was needed, or that the description relied on examples. One organisation representing doctors in training suggested we need to be careful with our wording.

‘The word “credentialing” is often used interchangeably with “regulation” and “certification”, which adds to the confusion.’

What is needed in defining credentials

155 Many told us what needed to be covered in a definition to explain what a credential is. And a lot expanded on what else needed to be explained about credentialing overall, to clarify any description of a credential.

‘The process and cost of training clinicians in a particular credential is not presented clearly. Further clarifications would permit a more specific response. The framework should define the following: example credentials, entry requirements, financial costs, delivery of training in credentials, methods of assessment, and defined outcomes for pilot evaluation.’ (British Orthopaedic Trainees Association (BOTA))

156 Some suggested we should clarify types of credentials, differentiating between those with significant workforce need, and those with ‘multiple special entry points’. Multiple definitions are likely to be needed ‘with associated qualifications, regulations, ownerships and standard operating procedures.’ (a joint response from the Royal College of Physicians of Edinburgh Trainees and Members Committee; Royal College of Physicians of London Trainees Committee; Royal College of Physicians and Surgeons of Glasgow Trainees' Committee)
157 Others said we need to clarify the scope and remit of what becomes a credential, indicating how many areas of clinical practice would eventually be included. One suggested we should be explicit about whether credentialing is only for small numbers of rare procedures in super-specialist centres, or for competence in a broader range of skills.

158 There were also comments that we need to clarify the level of attainment and what attributes will distinguish what needs to be delivered as a credential and what can be delivered in postgraduate training. Respondents suggested we need to clarify if credentials would be at pre- or post-CCT level, and that we should define how they would be different from subspecialties, and to justify the difference.

159 Some felt that credentials should be about a doctor providing a service or area of expertise, not demonstrating competence, which is done at CCT level.

160 Some said we need to clarify who credentials are for, whether doctors on the specialist or GP register, or other doctors and non-clinicians.

a One suggested it would be helpful to state that particular ‘credentials will be targeted at specific groups of doctors ... This will allay fears that credentials simply become additional hoops to jump through (or badges to collect), and will allay suspicions from doctors that credentials further an agenda to remove training from current CCT curricula.’ (Doctor in training)

b Another suggested that credentials should be for all doctors who are not in training. And others expressed concerns about other healthcare professionals; achieving qualifications ‘through the back door’ and the patient safety risk of ‘credentialing non specialists in specialist areas without the necessary foundation of experience or skills’ (The Dukes’ Club)

Implementation and implications

161 Some comments were about the implications of our description of credentials.

‘Credentials must not replace a CCT for entry to the specialist register and should not be allowed to become a window for under qualified people to take on practice that they have not been fully trained to undertake.’ (royal college)

162 A number warned of the risk of undermining CCT, diluting training, and creating a two-tier system of consultants.

‘We support the position that credentials should not overlap with any skill or competency already accredited in the existing curricula for award of a CCT. We are concerned that credentialing will result in the removal of content from existing postgraduate training and the devaluing of Certificate of Completion of Training (CCT).’ (Rouleaux Club)
Alternative terminology

163 Throughout engagement, we heard from some stakeholders that the term ‘credential’ was problematic, largely because it is used to mean different things within healthcare in the UK and elsewhere.

164 We asked those responding in writing if an alternative word should replace 'credentials' and welcomed suggestions.

165 Some gave reasons why the term ‘credential’ was appropriate, and the UK Medical Education Reference Group supported keeping it.

‘I would not change the name given this has become a common usage in the profession’ (Medical educator)

‘We also think the term is helpful in describing substantial training, different to continuous professional development (CPD). We would also like to note that the term has gained some traction in the healthcare community and indeed is now clearly described in the NHS Long Term plan (9), so it may be confusing to change it.’ (British Pharmacological Society)

166 Other respondents expressed clearly that they thought the term should be replaced, and gave reasons:

‘The term credentialing does have connotations in other areas and we are already seeing confusion in terminology around fellowships and credentials. An alternative term would be preferred.’ (The Royal College of Radiologists)

‘The term credentialing holds different meanings for different people. For example, [it] is also used to define the process for formally recognising the expertise and skills of Advanced Clinical Practitioners’ (Faculty of Sexual and Reproductive Healthcare)

167 Several gave thoughtful explanations about what should be considered in choosing the right terminology. These included making it accessible to the public with a clearer link to medicine, and creating a series of related names such as ‘regulated training module’ and ‘endorsed training module’.

168 Some commented on the variety of levels the term credentialing currently applied to, and the usefulness of a name which clarified the GMC element.

‘All different types are valid and required, but they need to be separated in nomenclature reflecting the other knowledge and training level as well as expectations of the post holder in due course.’ (Academy of Medical Royal Colleges)
‘Whatever term(s) are selected, it is likely to be important to include the prefix GMC, since some interprofessional credentials will have approval from more than one regulator and/or professional body’. (Royal College of Physicians)

169 There were numerous comments suggesting alternatives. It was not clear that all of these were against the term ‘credential’. A few said they thought it was fine but offered suggestions to be helpful, and others appeared neutral or didn’t indicate either way whether they thought ‘credentials’ should be replaced.

170 A list of suggestions for alternative terminology has been compiled and will be reviewed as this work develops.

Defining a credential – our response

171 We’ve refined the definition of a credential, describing the principles for credentials. This includes more explanation about what areas will become credentials.

172 We recognise the name is problematic for some and will continue to explore alternatives. In the meantime, we will distinguish them from credentials being proposed by other bodies by calling them ‘GMC-regulated credentials’.

173 In response to concerns about who will be able to do credentials, we are clarifying that entry requirements are needed for each credential. These will make sure that only suitably qualified doctors can gain the credential, in order to ensure patient safety.

174 We will look closely at issues raised and suggested requirements for credentials, as we develop operational guidance for credentialing bodies and approval processes.

Criteria and threshold for credentials

175 In the draft framework we set out proposals for what we would consider in determining whether an area of practice put forward as a potential credential should be approved. In the response form we asked for comments on ‘Identifying credentials’ in the framework. We said we’re interested in views on:

- whether we’ve got the criteria right
- anything we might need to be aware of in trying to balance the criteria correctly
- anything we should consider regarding the risk threshold
- any other thoughts on this section.

176 There were 132 written responses for this section.

Criteria for identifying appropriate areas for credentials

177 Many respondents commented that the criteria seem right, with some saying that the complexity of clinical areas of practice seemed covered.
‘We support the approach of considering a reasonable balance across the criteria rather than defining a fixed set of criteria to be met in all cases.’ (The Royal College of Radiologists)

178 A few offered suggestions for what else should be considered as part of the criteria. These included advice on assessing patient needs, the need to consider opportunities for doctors here too, the need for governance in new areas, the risks around an intervention itself, and suggested sources of tools for assessing risk and evidence.

‘We recommend consideration of factors that are aligned to other NHS priorities such as the research agenda and in keeping with increasing uptake of innovation.’ (British Pharmacological Society)

179 In identifying service need, a number of suggestions were offered. These included the involvement of people with a broad overview, and who are reviewing curricula, and the need for a fluid approach. Challenges were noted around workforce planning, and the challenge of underlying recruitment and retention issues that need to be addressed.

‘The most challenging issue for Paediatrics is workforce planning, which is difficult to predict accurately, especially in paediatrics, due to:
1) Very high number of LTFT trainees and maternity/paternity leave.
2) Increasing number of paediatricians retiring early.
Therefore accurately predicting workforce numbers and need for credentialing several years in advance will naturally be a ‘best judgement’ rather than an accurate forecast.’ (Royal College of Paediatrics and Child Health (RCPCH))

180 The challenge of dealing with credentials for profit was also raised here.

‘Understanding areas of need are acceptable; however what are the controls on “mission creep”. Is it not a possibility to create multiple credentials for one’s own gain? Strict policing would be necessary.’ (Association of Surgeons of Great Britain & Ireland (ASGBI))

Balancing the criteria

181 A number commented on what should be considered when balancing the criteria to make a decision on whether a credential was needed in an area of practice. These included a need for examples or guidance on weighting criteria, a suggestion that some criteria may be considered mandatory and others additional, the importance of transparency in the process, and advice about evidence.

‘Perhaps it would be helpful to state from where the evidence used to assess against these criteria will be obtained. For new areas this might be particularly problematic.’ (Faculty of Clinical Informatics)
A number of respondents commented on the priority of patient safety, with several saying that it trumps service need or workforce gaps, and that it is important to consider where risk is low, but consequences can be significant. And we need to avoid ‘finding a short-term solution to current system pressures regardless of the negative long-term impact this will have on the medical workforce and standards of patient care’ (BMA)

Some commented on what was needed for strategic oversight and engagement, and that appropriate stakeholders need to be part of the process with specialty associations, specialist advisory committees, statutory education bodies, and patient and public representation named. One said that clarity around roles and interplay between UKMERG and COG was needed. Another commented that practitioners needed to have a way to put forward areas for credentials, particularly in new areas where they might notice patient safety risks.

The risk threshold

Several comments were around the importance of being proportionate, and the risks of over-proliferation of credentials. Mention was made of other options, that credentials should be a regulatory tool, that we must first see if pre-CCT pathways can be improved before rushing to create a credential, and that credentials would be one of many ways for doctors to develop.

‘It should be recognised that such regulated credentials are part of an extensive continuum of CPD, educational resources, research and innovation through which all doctors enhance and develop their professional capabilities and improve clinical service delivery.’ (Royal College of Pathologists)

Criteria and threshold for credentials – our response

We have changed the criteria to factors which need to be considered. This will allow the proposal to bring the evidence that best supports the need for a credential in the area of practice. We have emphasised that patient safety and service need are the two key factors that COG will review. Other elements may be considered depending on the evidence.

We have also clarified the role of UKMERG and COG. We will introduce a task and finish group, with representation from SAS doctors, consultants, doctors in training, employers, patients, and specialty experts to help us review the small number of early adopters.

The regulatory process

In the draft framework we set out the processes we thought proposed credentials should go through to gain approval, and how credentials would be recognised for individual doctors. In the response form we asked for comments on ‘Regulating
credentials’ in the framework, and ‘How we propose to regulate credentials’ in the annex. We said we’re interested in views on:

- if approving credentials as part of the postgraduate training pathway is right
- if credentials should be recognised on the List of Registered Medical Practitioners
- any other thoughts on these sections.

There were 142 comments in this section.

**Approval as part of postgraduate training pathway**

There was strong support for approval as part of the postgraduate training pathway, from well over half of respondents. Comments included that this was essential, that it was necessary to avoid undermining training, and that the body of evidence in assessment and training should be considered.

A number of respondents appear to have interpreted ‘approving credentials as part of the PGT pathway’ as saying that credentials should be at the level of PGT, which they disagreed with.

‘No I think credentials should be post CCT. If the training is required for most doctors to do their work, then this should be part of the Speciality Curriculum.’ (Defence Medical Services)

Some noted that not all credentials would fit into the postgraduate training pathway as easily as others.

‘Whilst the current postgraduate training pathway approvals process is likely to contain elements that would be helpful in the process of approving regulated credentials, it is unlikely to be fit-for-purpose in its entirety. We need something that is proportionate and flexible, able to fill gaps left by current postgraduate training pathways, avoids stifling innovation, whilst providing adequate quality assurance. Something that is principle-based with a limited number of bureaucratic requirements may best fit the bill.’ (Royal College of Physicians)

One college objected to how long the process would take, and made a case for CAG being unnecessary for approving credentials, so approval should be given after COG and feasibility. Another college also suggested a more streamlined process should be considered for resource reasons.

**Recognition of credentials on LRMP**

Over half of the respondents in this section were supportive of this proposal, with comments saying why this was needed, including that it avoids confusion, it’s positive for patient safety, it informs and rewards, and provides evidence for employers.
However, others noted caveats to be considered.

a It needs to be seen as equivalent to endorsements, not ‘lesser quality’.

b It should not substitute for full training or shortcut to recruitment.

c This could be undermining to college training functions.

‘Credentials are not major professional qualifications and their difference must be carefully explained to the public.’ (Body representing patients)

One thought credentials should be on the specialist register, but others noted this proposal was problematic.

One said no because it would ‘imply to public that the more experienced senior doctors have less training than the younger (less expert) doctors’ (Consultant)

Some noted broader questions that need answering around how credentials will be recognised.

‘What will the “grandfathering” arrangements be for those with well-established practice in the area of a new credential? Any application process must be clear and simple.

‘Will there be a “CESR” type equivalence process for credential award for those who do not follow a formal training pathway? Those who undertake valuable posts overseas should be able to have their experience evaluated when they provide evidence they have met the standard for a credential.’ (Joint Committee on Surgical Training (JCST))

And some mentioned the work needed to clarify how credentials will be maintained, with several noting the need to avoid unnecessary burden.

‘It is important for both the doctor and the credentialing organisation that the process for the ongoing regulation of the credential is not unduly onerous. The role of the appraisal process as a mechanism to demonstrate continued competence is indicated, but the role of the credentialing body in providing assurance of the maintenance of capabilities remains unclear. There clearly needs to be close synergy between the GMC processes of credentialing and revalidation to minimise any burden.’ (Royal College of General Practitioners)

One college thought this would not assure public and employers, since revalidation does this – and care is team-based with lead consultant’s credential not enough to determine quality of care – and medical practice constantly changes and needs updating through CPD so having a credential doesn’t assure quality if they don’t update their skills.
‘RCPath recommends there should be greater recognition of the interrelationship between regulated credentialing and other governance systems to ensure patient safety.’ (Royal College of Pathologists)

The regulatory process – our response

200 We will continue to develop the processes for approving and quality assuring credentials, and adding them to the LRMP. We will consider issues raised by stakeholders as part of this work, including looking at ‘grandfather rights’ for those with substantial experience or expertise in the area of practice, and recognition of those who have covered the area in CCT training.

A phased approach to implementation

201 In the draft framework we outlined our plans for implementing credentials in a phased approach. In the response form we asked for comments on ‘Implementing credentials’ in the framework, and ‘Plans for implementation’ in the annex. We said we’re interested in views on:

- any issues we need to consider in our plans for implementing credentials
- any other thoughts on these sections.

202 There were 123 comments in this section. Many of the written responses had already raised concerns about implementation in other sections.

Support for a phased approach

203 While we did not ask stakeholders directly if they agreed with a phased introduction, a large number expressed support for this approach. Some commented that a phased approach was necessary due to a lack of clarity and details in our proposals.

204 Quite a few cautioned against bringing in credentials too quickly, with some saying our proposed timelines may be too ambitious. The Royal College of Physicians of Edinburgh urged ‘caution in terms of the introduction of credentialing ... April 2019 is too soon to start implementation when a number of significant concerns and questions remain.’

Level of readiness

205 A large number of stakeholders thought a phased approach was necessary due to how much is still unknown about how credentialing will work in practice. Many of these were raised in responses in other sections.

206 Questions were raised around numbers of credentials, timings, monitoring and evaluation, funding, resources and training time, assessment, quality assurance and quality management, the effects on training and the service, ownership and oversight of credentials, and how to safeguard against profit making ventures.
207 Other questions still to be answered were around who credentials will be available to, including access by less than full time workers, those on lower pay bands, other professions, and doctors in rural areas.

‘Concerns have been expressed that, unless implemented well, introduction of credentials could actually REDUCE flexibility for trainees with geographical and financial disparities resulting in inequality to training access. Moreover, competitive entry to programmes may preferentially favour more experienced, established consultants, reducing access to trainees. This may especially be the case in some areas of practice, particularly in the case of low volume procedures.’ (Federation of the Royal Colleges of Physicians)

208 And further unanswered questions around the role of a doctor once they’ve attained a credential were identified.

‘... how credentialing might will change things for SAS grade doctors in terms of career progression, recognition and responsibilities, remuneration, autonomous practice and title’ (North East & North Cumbria Medical & Dental Advisory Group)

209 Some also pointed out that other work going on to develop and improve postgraduate training, ie reviews of curricula and flexibility, may affect the credentialing landscape.

‘It would seem prudent to await the conclusion of this work and assess the complement of training programmes as a whole before any major decision on initiating new credentials ...’ (royal college)

**Timeliness needed for priority areas**

210 However, while many acknowledged the necessity for a phased approach, some commenters pointed out there was a need to push ahead with credentialing. Some mentioned areas where credentials were needed as soon as possible, or suggested areas which would be appropriate for early credentials.

‘Although a phased approach to implementation is sensible, it should be remembered that credentialing as a concept has been ongoing for some time, and having examples of working credentials in practice will be necessary to show the concept can work.’ (The Royal College of Radiologists)

211 Another reason for pressing on with credentials without too much delay was the fact that new subspecialties haven’t been able to be approved for several years, with one comment that ‘the ambiguities in relation to subspecialty need to be resolved urgently.’ (British Society for Gynaecological Endoscopy)
Other considerations

212 Some noted other issues that needed to be considered or where further work is needed to make sure we get things right:

- the need to monitor and review whether an area is or becomes more suited to being part of postgraduate curricula rather than a credential

- recognition of those already operating needs monitoring; how to assess grandfathering rights; and other qualifications such as diplomas could be converted or recognised as credentials.

213 A couple of respondents noted equality and diversity implications, with one saying ‘certain groups may choose not to undertake extra training or to prolong training eg women may not wish to do this if they have already had time out of training due to maternity leave.’ (Doctor in training, England)

Further piloting and engagement

214 A large number of respondents suggested further piloting was the best way to take credentialing forward, to allow for evaluation, review, and learning. Many of these also suggested further engagement was needed.

‘If implemented there must be slow specific implementation with piloting of individual subjects and alteration of the process in the light of experience.’ (Royal College of Physicians and Surgeons of Glasgow)

‘It is important as credentialing is developed for this information to be available and for consultation with key stakeholders to continue.’ (BMA)

A phased approach to implementation – our response

215 We said in the draft framework that we would introduce credentials using a phased approach, and following engagement we are developing more detailed plans for how we will do this. The experience and expertise shared with us during engagement has given us a good basis for further development.

216 We will begin with having a small number of proposed credentials submitted for approval in 2019 and 2020. These will be in priority areas which have been identified as areas of patient or service need, and which have the support of governments and the statutory education bodies.

217 During this time we will continue to engage with stakeholders, seeking views on the proposed credentials, and working with relevant stakeholder groups to develop operational processes.
218 We will include a review point in our plans, to allow us to assess the success of the framework and check for unintended consequences. We will undertake further engagement at this point.

219 We’re working with education bodies across the four UK countries to secure a public commitment to funding GMC-regulated credentials where approval is related to an NHS service need.

Supporting flexibility in training in other ways

220 In the draft framework we outlined some possibilities we were considering for providing more regulatory support for development outside of postgraduate training. In the response form we asked for comments on ‘Other developments to support flexibility’ in the framework. We said we’re interested in views on:

- endorsed training modules in postgraduate curricula
- whether QA processes for additional skills areas adds value
- any other thoughts on these sections.

Potential benefits to be explored

221 Many of the written comments were supportive of developing these proposals further, describing the benefits and opportunities endorsed training modules and additional skills areas could bring. These included more flexibility, development opportunities for doctors who don’t have access to training programmes, and enabling further quality assured training in specific areas to better fit service needs.

‘Endorsed modules to be offered to doctors who are not on a particular training pathway are a very good idea and will truly allow flexibility within the workforce and ability to meet the demands of the population.’ (GP)

222 There were a number of suggestions on how this work could develop, and on areas where these proposals could be helpful.

223 There was also a suggestion that there could be value in recognising endorsed modules on the register, along with credentials.

‘Although we can see the benefit of credentials being recognised on the list of RMPs, recognising modular competencies may also be helpful to note in this list. That way, trainees could also be recognised for the experience that they have achieved, even if part way through a CCT. Similarly, individuals working towards CESR, or who have completed part of their training and now in SAS grade could be acknowledged as having completed this part of their training.’ (NHS Education for Scotland SAS team)
In discussions, some colleges and specialty organisations were keen to use the credentialing framework in combination with *Excellence by design* as a model for developing 'additional skills areas' for future fellowships. And some noted similarities to what already happens in their field.

‘RCOG believes that certain modules/CiPs, particularly those that are based on clinical skills, could be made available to other doctors just as our ATSMs can already be taken by doctors not in training.’ (Royal College of Obstetricians & Gynaecologists)

Some stakeholders expressed caution, based on concerns about bureaucracy, limits to ‘freedom and flexibility’, and the risks of a ‘pick and mix; approach to training leading to fragmentation or diminishing of postgraduate training.

At this stage, these proposals are separate from the development and approval of credentials as set out in the framework. However some stakeholders pointed out, there are benefits to considering them together.

‘This area needs to be an essential part of the credentialing framework and not an afterthought. Many areas that do not meet the full criteria for a regulated credential will still be important for career flexibility. We suggest a hierarchy whereby all postgraduate training modules are listed (by colleges, faculties and specialist societies) but have different levels of recognition and QA depending on risks and benefits (ie some are Endorsed, and others Regulated).’ (The Faculty of Public Health)

**Supporting flexibility in training in other ways – our response**

We are not taking forward work in these areas until we have introduced credentialing. We will use the comments and thoughts about endorsed training modules and additional skills to better understand what is needed when we are ready to take this work forward.

As we are introducing credentials through a phased implementation, this will allow us to consider options for bringing endorsed training modules or additional skills areas into alignment with the credentialing framework.

**Any other comments**

In the response form we asked for any other feedback on the draft framework.

There were 77 comments in this section. Many reiterated or expanded on points made in previous sections, and all have been considered within those sections.
Appendix 1

Engagement meetings with stakeholders

Below is a list of meetings where we engaged on the draft framework, held during the engagement period, or shortly before or after. We met with some of the groups listed on more than one occasion.

<table>
<thead>
<tr>
<th>Group or event</th>
<th>Stakeholders represented</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Academy Training Forum</td>
<td>Academy of Medical Royal Colleges (AoMRC), colleges, postgraduate deans, National Association of Clinical Tutors UK, doctors in training representatives, and patient/lay representatives</td>
</tr>
<tr>
<td>Department of Health and Social Care, Professional Regulation Branch</td>
<td>Cosmetic surgery stakeholder</td>
</tr>
<tr>
<td>BMA Junior Doctors Committee (JDC)</td>
<td>Doctors in training represented by Chair of JDC and Deputy Chair for Education and Training</td>
</tr>
<tr>
<td>Health and Disability Reference Group</td>
<td>Doctors with disabilities</td>
</tr>
<tr>
<td>GMC Education Roundtable – Northern Ireland</td>
<td>Northern Ireland stakeholders including employers and directors of medical education, doctors, medical students, trainees and trainers</td>
</tr>
<tr>
<td>Royal College of Psychiatrists Credentialing Working Group</td>
<td>College representatives including SAS doctor</td>
</tr>
<tr>
<td>Joint Committee on Surgical Training Fellowships Reference Group</td>
<td>Advisory body to the four surgical Royal Colleges which includes trainees and patient representatives</td>
</tr>
<tr>
<td>Faculty of Clinical Informatics</td>
<td>Body representing clinical informaticians</td>
</tr>
<tr>
<td>20th Stevenage Anaesthesia Society Meeting</td>
<td>Anaesthetists</td>
</tr>
<tr>
<td>Conference of Postgraduate Medical Deans (COPMeD) and Committee of General Practice Education Directors (COGPED)</td>
<td>Postgraduate deans and representatives of doctors in training and SAS doctors</td>
</tr>
<tr>
<td>GMC Education Roundtable – Wales</td>
<td>Wales stakeholders including representatives of employers, government, trainees, and medical schools</td>
</tr>
<tr>
<td>British Association of Dermatologists</td>
<td>Medical educators</td>
</tr>
<tr>
<td>INR (Acute Stroke) Credential Project Board</td>
<td>Medical Directors and college leads from radiology and related specialties, and NHS</td>
</tr>
<tr>
<td>Medical Defence Union</td>
<td>Medical defence organisation</td>
</tr>
<tr>
<td>QUB/NIMDTA Clinical Education Day</td>
<td>Medical educators and trainers in Northern Ireland</td>
</tr>
<tr>
<td>Organisation</td>
<td>Key Stakeholders/Representatives</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>GMC Education Roundtable – Scotland</td>
<td>Scotland stakeholders including doctors, employers, medical educators, and government representatives</td>
</tr>
<tr>
<td>Shape of Training Implementation Group Scotland</td>
<td>NHS Education for Scotland, BMA, Scottish Government and other key stakeholders</td>
</tr>
<tr>
<td>NHS Improvement</td>
<td>NHS Improvement clinical, workforce and policy leads</td>
</tr>
<tr>
<td>Health Education England (HEE) SAS/Career Grade Doctor Working Group</td>
<td>SAS doctors and leading organisations including HEE, AoMRC, NHS Improvement and NHS Employers</td>
</tr>
<tr>
<td>Postgraduate Quality Leads</td>
<td>Quality leads from colleges, deaneries, HEE local teams</td>
</tr>
<tr>
<td>Faculty of Pain Medicine</td>
<td>Faculty training and curricula leads</td>
</tr>
<tr>
<td>Joint Council for Cosmetic Practitionans and the Cosmetic Practice Standards Authority</td>
<td>Cosmetics bodies which set standards and run a register of practitioners for non-surgical cosmetics</td>
</tr>
<tr>
<td>Academy of Medical Royal Colleges Trainee Doctors’ Group (ATDG)</td>
<td>Doctors in training representatives from college committees and groups</td>
</tr>
<tr>
<td>COPMeD Associate Deans for SAS Doctors (COPSAS)</td>
<td>Sub-group of COPMeD with all UK Associate Deans with SAS work as part of their portfolio</td>
</tr>
<tr>
<td>GMC doctors in training roundtable</td>
<td>Doctors in training representatives from key groups including BMA JDC, ATDG, Association of Surgeons in Training, and medical students</td>
</tr>
<tr>
<td>Royal College of Obstetricians and Gynaecologists advanced laparoscopic surgery training meeting</td>
<td>College education and training leads, and the President of the British Society for Gynaecological Endoscopy</td>
</tr>
<tr>
<td>Faculty of Medical Leadership and Management (FMLM) doctors in training</td>
<td>Doctors in training on the FMLM National Medical Director’s Clinical Fellow Scheme</td>
</tr>
<tr>
<td>Royal College of Paediatrics and Child Health curriculum development meeting</td>
<td>College curricula leads</td>
</tr>
<tr>
<td>Academy of Medical Royal Colleges patient lay group</td>
<td>Patient and lay representatives</td>
</tr>
<tr>
<td>British Sleep Society</td>
<td>Sleep specialists including representatives from physicians, anaesthetists, and neurologists</td>
</tr>
<tr>
<td>Curriculum Advisory Group (CAG) training day</td>
<td>CAG members which includes medical educators and assessment experts</td>
</tr>
<tr>
<td>GMC credentialing workshop for doctors in training</td>
<td>Doctors in training representing a number of specialties and organisations</td>
</tr>
<tr>
<td>Hull and East Yorkshire Hospital NHS trust</td>
<td>Consultant interventional radiologist</td>
</tr>
<tr>
<td>NHS West Midlands</td>
<td>Medical Director and colleagues</td>
</tr>
<tr>
<td>British Neurovascular Group</td>
<td>Neurosurgeons with a major clinical interest in vascular neurosurgery</td>
</tr>
<tr>
<td>Federation of Surgical Specialty Associations President</td>
<td>Consultant plastic surgeon and representative of surgical specialties</td>
</tr>
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</tr>
<tr>
<td>Curriculum Oversight Group</td>
<td>Governments and statutory education body representatives from four countries</td>
</tr>
<tr>
<td>The Transform Hospital Group</td>
<td>Cosmetic surgery provider</td>
</tr>
<tr>
<td>Faculty of Sexual and Reproductive Healthcare</td>
<td>Faculty curricula leads</td>
</tr>
<tr>
<td>East Midlands SAS regional conference</td>
<td>SAS doctors</td>
</tr>
<tr>
<td>NHS Employers reference group (curricula design)</td>
<td>NHS clinical, workforce and education representatives</td>
</tr>
<tr>
<td>Faculty of Public Health trainee representative</td>
<td>Doctor in training</td>
</tr>
<tr>
<td>Royal College of Physicians in Edinburgh trainee representative</td>
<td>Doctor in training</td>
</tr>
<tr>
<td>Royal College of General Practitioners trainee representative</td>
<td>Doctor in training</td>
</tr>
<tr>
<td>Faculty of Medical Leadership and Management trainee representative</td>
<td>Doctors in training</td>
</tr>
<tr>
<td>Faculty of Public Health trainee representative</td>
<td>Doctor in training</td>
</tr>
<tr>
<td>Scottish Academy Trainee Group representative</td>
<td>Doctor in training</td>
</tr>
<tr>
<td>Royal College of Psychiatrists trainee representative</td>
<td>Doctor in training</td>
</tr>
</tbody>
</table>
Appendix 2

Organisations who gave written feedback

Academy of Medical Royal Colleges
Academy of Medical Royal Colleges and Faculties in Scotland
Academy of Medical Royal Colleges Patient and Lay Committee
Association of Anaesthetists
Association of Otolaryngologists in Training
Association of Surgeons in Training
Association of Surgeons of Great Britain & Ireland
British Association of Aesthetic Plastic Surgeons
British Association of Dermatologists
British Association of Oral and Maxillofacial Surgeons
British Association of Surgical Oncology – The Association for Cancer Surgery
British Association of Urological Surgeons, Section of Trainees
British Gynaecological Cancer Society, Royal College of Obstetricians and Gynaecologists
British Medical Association
British Neurosurgical Trainees’ Association
British Neurovascular Group
British Obesity and Metabolic Surgery Society
British Orthopaedic Association
British Orthopaedic Trainees Association
British Pharmacological Society
British Society for Gynaecological Endoscopy
Conference of Postgraduate Medical Deans (COPMeD) Associate Deans for SAS Doctors
Defence Medical Services
Faculty of Clinical Informatics
Faculty of Eating Disorders (Northern Ireland)
Faculty of Eating Disorders, Royal College of Psychiatrists
Faculty of Eating Disorders, Royal College of Psychiatrists in Scotland
Faculty of Intensive Care Medicine
Faculty of Occupational Medicine
Faculty of Sexual and Reproductive Healthcare
Federation of the Royal Colleges of Physicians
Fellows in Training (Oral and Maxillofacial Surgery trainees)
Health Education England
Herrick Society
Institute of Psychosexual Medicine
Joint Committee on Surgical Training
London Aesthetics Show
Managed Clinical Network for Eating Disorders, North Scotland
National Association of Clinical Tutors UK
NHS Education for Scotland SAS team
NHS Employers
NHS Forth Valley
North East & North Cumbria Medical & Dental Advisory Group
Plastic Surgery Trainees Association
Rouleaux Club
Roux Group
Royal College of Anaesthetists
Royal College of General Practitioners
Royal College of Nursing
Royal College of Obstetricians & Gynaecologists
Royal College of Ophthalmologists
Royal College of Paediatrics and Child Health
Royal College of Pathologists
Royal College of Physicians
Royal College of Physicians and Surgeons of Glasgow
Royal College of Physicians of Edinburgh

www.gmc-uk.org
Royal College of Physicians of Edinburgh Trainees and Members Committee; Royal College of Physicians of London Trainees Committee; Royal College of Physicians and Surgeons of Glasgow Trainees' Committee

Royal College of Surgeons of England

Specialty Advisory Committee in Urology and British Association of Urological Surgeons

Society for Vascular Technology of Great Britain & Ireland

Society of British Neurological Surgeons

Specialty Advisory Committee in Oral and Maxillofacial Surgery

The Dukes' Club

The Faculty of Public Health

The Royal College of Radiologists

The Transform Hospital Group

Vascular Society
Appendix 3

Summary of findings in previous consultation

231 We carried out a public consultation on introducing regulated credentials in 2015, seeking feedback on broad principles and processes. Many of the findings of that earlier consultation reflect what we heard while engaging on our latest proposals.

232 The overall response in 2015 was positive, with two thirds of respondents agreeing with our reasons for introducing credentials. However, on reviewing that consultation we are struck by the difference of views between SAS doctors, consultants and doctors in training who held opposing views on most questions. A number of key concerns were identified.

a The scope of credentialing should be limited, and it shouldn’t duplicate or unpick existing specialty training.

b Linked to this was the need to delay the introduction of credentialing until political decisions had been made about Shape of Training.

c Respondents were concerned about the potential cost and burden of a new layer of regulation, noting that we were not proposing that possession of a credential would be a statutory requirement, and that credentials would only be established in areas where there was acknowledged need.

d More information was needed, as credentialing was a new concept. Some concerns reflected misunderstandings, and many comments were about how it might or might not be implemented.

e There were equality and diversity concerns around potentially limited access for SAS doctors, or senior doctors being pressured to get credentials they didn’t need. There were also concerns about the potential for adverse effects on women and part-time workers, and for trainees in the form of devalued training.

233 These findings led to a decision by our Council in 2016 that we should initially focus on plans to test our model on unrecognised (and unregulated) areas of medical practice to improve patient safety.

234 In 2017, publication of the Shape of Training implementation report and our new standards for postgraduate curricula, Excellence by design, led us to rescope our position to align with new requirements and recommendations.

235 Following this we developed a draft credentialing framework for engagement in 2018, expanding on the earlier model, and allowing us to seek more detailed feedback from stakeholders on our revised plans.
M7 – Framework for GMC-regulated credentials

M7 – Annex B

GMC-regulated credentials for doctors
A case for change

We are introducing a framework for GMC-regulated credentials for doctors. We recognise the name is problematic to some and will continue to explore meaningful alternatives. However, to address the immediate issues, we are intending to refer to them as GMC-regulated credentials.

What problems are we trying to solve?

There are two drivers supporting a process to approve credentials in discrete practice areas:

- Unregulated areas of practice where there may be significant patient safety risks.
- Where the capacity to train doctors is insufficient to meet patient or service needs.

All four UK governments have agreed that credentials are one of the mechanisms that will help them better support their medical workforce to develop in areas needed by the service and/or patients.

Benefits from this framework

This approach will offer a number of benefits including:

- Supporting the development of doctors for areas where they are needed by patients and the service – by facilitating doctors to acquire new skills in discrete areas of practice where they have the appropriate experience and qualifications to do so.

- Enabling patients and employers to confirm that a doctor is working at a specific level of expertise in these discrete areas of practice – by looking at the List of Registered Medical Practitioners (LRMP).

- Supporting more flexible career development and lifelong learning, facilitating doctors to change career direction or enhance their skills and expertise in discrete areas of practice through an approved and assured programme of learning, building on established skills, experience and qualifications.
Definition of GMC-regulated credentials

GMC-regulated credentials will be focused in areas where consistent clinical standards recognised across the UK are necessary to support better and safer patient care. We are facilitating a process to support the development of GMC-regulated credentials for doctors that are delivered in an assured and educationally supervised environment.

Our aim with GMC-regulated credentials is to reduce risks to patients and support the service to provide better patient care. They will be limited to discrete areas of practice where gaps in training or service have raised concerns about patient safety.

Employers and others will be able to use credentials as one of the ways they can develop a more agile medical workforce to better meet the needs of patients. Individuals will be able to use these opportunities as one way to extend or enhance their career in areas that relate to, or complement, their specialty or area of practice.

Principles for GMC-regulated credentials

Aimed at doctors

We will only endorse credentials for doctors. We recognise that in some cases there is an ambition to develop packages of learning for other healthcare professionals or multi-professional teams. While we are not opposed to these developments, our regulatory remit as a statutory body covers education and postgraduate training of doctors only.

When doctors have completed their postgraduate training, where a component of it is comparable to a GMC-regulated credential, we will automatically recognise they have attained the credential on the List of Registered Medical Practitioners (LRMP).

Limited scope of practice

GMC-regulated credentials are significant areas of medical practice that are narrower than the breadth of a specialty or more general area of practice. They build on, and recognise, capabilities and expertise gained through training and/or experience, and will have entry requirements to reflect this. A credential will recognise that doctors have demonstrated, at a minimum, that they have achieved a defined level of expertise in the discrete area of practice.

Eligibility requirements for a GMC-regulated credential will describe the required level of training and experience necessary to access the approved learning programme, or have comparable capabilities recognised, in the specific area of practice. The organisation proposing the credential will identify and describe the entry requirements for a credential, basing them on the necessary expertise and experience that will minimise risk to patients.
We anticipate that in many clinical areas, doctors will access GMC-regulated credentials only in areas that relate to the knowledge, skills and capabilities that have been gained through their general, specialty or subspecialty training or experience. This may limit many credentials to doctors who are on the Specialist and GP register in a relevant area. We believe that most of the early proposed credentials would be likely to fit in this group.

In some areas of practice, it may be appropriate to allow access to doctors who are not on the Specialist and GP registers. In order to better understand how this can be done in a way that safeguards patients, we will consider a limited number of early adopter proposals that have wider eligibility, allowing us to explore how SAS doctors may access credentials. We will use this experience to engage again if we think that further GMC-regulated credentials could have more widely accessible entry requirements.

Where doctors have met the requirements of a GMC-regulated credential, recognition on the LRMP will be specific to that discrete area of practice.

Because of their limited scope, GMC-regulated credentials are not intended to replace the requirements of postgraduate training that lead to a Certificate of Completion of Training (CCT) / a Certificate of Completion of GP Training (CCGPT) or the comparable outcomes described in a Certificate of Eligibility for Specialist Registration (CESR) / a Certificate of Eligibility for GP Registration (CEGPR). It is not possible to use only GMC-regulated credentials to obtain a CCT/CCGPT or CESR/CEGPR. But doctors may use credentials as part of their evidence to help support their applications for routes onto the registers.

**Proportionate response to risk**

We will only approve and assure credentials if there is a demonstrable and evidenced need for recognised standards. This will only apply where there is a significant risk to patients or a gap or need in service provision. In order to be approved, the proposals for a credential will have to meet strict criteria, including providing evidence or information that describes issues related to patient safety and/or gaps in service delivery in the discrete area of practice.

**Assuring the quality of credentials**

GMC-regulated credentials will be developed and assured using the GMC standards and processes. Where possible, credentials will be evaluated alongside relevant specialties and subspecialties. Using our approval and quality assurance processes, we will aim for credentials to complement, rather than compete, with postgraduate training. We will expect organisations proposing a credential to consider, as part of the approval process, the impact of the credential on training, the service it will affect and the current professional workforce, and to set out the entry requirements for participants.
We expect that as part of the development and delivery of GMC-regulated credentials, the roles of trainers, supervisors and other required support will be described. Where organisations are seeking to deliver an approved credential, adequate resources should be identified for supervisors, trainers and learners. These expectations are already set out in our standards for curricula, *Excellence by design* and our standards for the delivery of training, *Promoting excellence*.

**Identifying potential credentials**

The majority of learning and development, outside of formal training, will not need approved standards and outcomes. Some areas, however, warrant the same treatment as postgraduate training.

In most cases, the UK Medical Education Reference Group (UKMERG) – which includes representatives from the four UK governments and their statutory education bodies, will prioritise and recommend discrete areas of practice that could be considered as possible credentials in order to help support patients and/or the service. Representatives of the UKMERG, where necessary, may support relevant organisations to scope out, develop and pilot areas before they are proposed to the GMC for approval as a credential.

Employers and workforce planners across the UK – as well as Health Education England, the Northern Ireland Medical and Dental Training Agency, NHS Education for Scotland, and Health Education and Improvement Wales – will have the flexibility to commission or fund credentials based on patient and service needs.

**Facilitating GMC-regulated credentials**

The GMC is providing processes to approve and assure credentials against our standards for medical education and training. We have aligned our processes to those we currently use in postgraduate training. We are also introducing a process to recognise doctors with credentials on the List of Registered Medical Practitioners (LRMP).
Approval of credentials

The Curriculum Oversight Group

Organisations that want to develop a GMC-regulated credential will submit proposals to our Approvals team. We expect that in most cases, these will be areas identified, supported and recommended by UKMERG.

Proposals will be considered by our Curriculum Oversight Group (COG). Organisations that want to develop a credential will submit a ‘purpose statement’ (like a business case) that describes the rationale, evidence and feasibility for an area of practice to become a GMC-regulated credential. The COG will evaluate this information based on patient safety factors, including service need, and in line with our standards, *Excellence by design*. It will advise the GMC on whether the proposal has met the patient safety criteria for a credential.

Organisations will have to show explicitly how they have or intend to engage and consult key groups such as relevant patient/population groups, the profession including consultants, SAS doctors and doctors in training as well as experts in the field. We also require evidence that the credential is feasible and the quality can be maintained over time.

We recognise that credentials, as a new development, may impact on existing structures and processes. To better anticipate and address possible consequences from the credential, we will ask organisations to consider the impact of the credential in the purpose statement on patients, the service, training and the current medical workforce. We also expect specific information about equality and diversity and any potential issues with differential attainment to be identified. These expectations are already required for postgraduate training in both *Excellence by design* and *Promoting excellence*. We will expect clear entry criteria to ensure that those taking the credential have the relevant skills and experience to do so safely.

Threshold for approving a credential

The decision to approve a credential by the GMC has to be a proportionate response to an identified patient risk or service need. Our Curriculum Oversight Group (COG) will make a recommendation, based on the evidence in the proposal developed by the relevant organisation or body, on whether an area of practice needs training:

- with consistent UK-wide professional/clinical standards and outcomes, and
- in a governed and educationally supervised environment.

The COG will look at evidence against a number of patient safety factors and consider on balance if the credential will address patient and/or service needs proportionately. We
recognise that the factors will vary between proposals and over time. We will continuously review them to make sure they remain appropriate and relevant. Risk to patients and service need are the key considerations underpinning any evaluation.

The main factors that will be considered are:

- Service/patient needs – whether the proposed credential will support the development of doctors to address or better manage service needs or gaps.

- Significant risk to patients – whether there are specific risks to patients identified in the area e.g. new or emerging area or practice; no approved training pathway.

Other considerations might include:

- Complexity and expertise in the clinical care.

- Scope of practice – whether there are other mechanisms, besides credentials, that better support development in the area of practice. We would consider if it should be part of the general specialty curriculum or if it can be managed effectively through fellowships, other training opportunities, flexibility procedures and continuing professional development.

- Clinical context – whether the area will support or facilitate the development of expertise to better support new, different or innovative service/care environments, including private or charity sector.

**The Curriculum Advisory Group**

If the purpose statement is approved at COG, the organisation will be able to develop a curriculum and appropriate assessments or evaluations for the next stage of our approval process. These will be reviewed by our Curriculum Advisory Group (CAG) to ensure they are educationally sound and can realistically be delivered.

The GMC will make the final decision to endorse the credential.

**Quality assurance**

Where GMC-regulated credentials are delivered, our standards – *Promoting excellence* – will apply. These standards describe our expectations for the quality of the learning and the environment in which that learning is delivered.

We will ensure credentials will not be used to undermine or devalue the quality of postgraduate training. Our approval process, focusing on patient safety as the primary indicator for a credential, will limit GMC-regulated credentials to where they are a
proportionate response. We will ensure the quality of the training or approach to delivering the credential through our quality assurance processes. We will evaluate the impact of the credential, including its impact on relevant postgraduate training, through our data collection and monitoring mechanisms.

**Recognition on register**

We will recognise the award of a credential on a doctor’s entry on the LRMP in a similar way to how we record approved trainers. This will remain separate from being on the specialist or GP registers, but will allow employers, other professionals and patients to see if a doctor has been endorsed in a credential.

We will be clear in any communications that doctors with GMC-regulated credentials have demonstrated they have met UK approved standards and outcomes. Where doctors don’t have or want a credential, appraisal and revalidation will continue to reassure patients, employers and others that doctors are practising safely.

**Maintaining credentials**

GMC-regulated credentials, similar to postgraduate curricula, will be reviewed regularly through our curricular approval processes. The COG, looking across both postgraduate training curricula and credentials, will consider whether a credential should be decommissioned if the conditions that resulted in the approval of the credential have changed.

We expect doctors with GMC-regulated credentials will confirm they’re continuing to meet the relevant standards and expectations. This will feed into appraisal and revalidation.

As part of the phased implementation, we will further explore and develop the detail of how this will work in practice over the coming months. If doctors decide to no longer maintain their credentials, we will remove the endorsement from the LRMP.
Report title: Report of the Medical Practitioners Tribunal Service Committee

Report by: Dame Caroline Swift, Chair of the MPTS, dame.caroline.swift@mpts-uk.org, 0161 240 7115

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 December 2018. Key points to note:

- In 2019 and beyond, we are focussing on maximising MPTS resources, managing our workload more effectively and supporting the delivery of a high quality service to all users.
- We are implementing changes to our pre-hearing case management processes throughout 2019.
- These changes will allow for smarter listing of hearings, with cases where both parties are ready to proceed being listed sooner.
- All new hearings will be subject to pre-hearing case management, to ensure more hearings are ready to proceed on the first day.

On 21 May 2019, the GMC/MPTS Liaison Group agreed a revised Operating Framework for the MPTS. An update to the statement of purpose for the MPTS Committee requires Council approval. The main change is to permit the Committee, if the Chair is absent from a meeting, to nominate another member of the Committee to chair the meeting.

Recommendations
Council is asked to
a. Consider the report of the MPTS Committee.
c. Approve the revised statement of purpose for the MPTS Committee (Annex C).
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 Privy Council, summarising our recent performance and the work of the MPTS Committee.

2 This paper is the MPTS Committee’s first report of 2019.

3 The MPTS Committee met on 6 February 2019 and considered updates on tribunal members training, the MPTS annual business plan and the Committee’s own annual work programme.

4 It also met on 8 May 2019 and considered updates on quality assurance of tribunal decisions and our approach to empanelment of tribunals.

5 The MPTS will lay its third annual report before Parliament later this year. A copy of the text is attached for Council’s information.

Operational update

6 As previously reported, the MPTS has made changes to its procedures in recent years to provide a more efficient and effective tribunal service, including: requiring parties to submit a hearing bundle in advance in most Medical Practitioners Tribunal (MPT) hearings, the use of Legally Qualified Chairs (LQCs) in most hearings, and greater use of pre-hearing case management.

7 We believe it is important to minimise the stressful impact delays can have on doctors, witnesses and all those involved in our hearings. Therefore, to support the delivery of a high quality service to all users, in 2019 we are focussed on maximising MPTS resources and managing our workload more effectively.

8 In 2018 we carried out a review of our pre-hearing case management service, to identify opportunities for continuous improvement, ensure efficient use of our resources and consider how best to meet the needs of those attending hearings.

9 The review recommended changes that we will implement throughout 2019. We have liaised closely with colleagues in both the Fitness to Practise directorate, and in organisations representing doctors in our hearings.

10 The changes we are making will allow for smarter listing of hearings, with cases where both parties are ready to proceed being listed sooner. This will reduce the peaks and troughs we currently see in our hearings calendar.

11 We will set clear expectations about the level of information we require from both parties after a case is referred to the MPTS. We will also publish our expected timescales for listing different types of cases.

www.mpts-uk.org
12 All new MPT hearings will be subject to pre-hearing case management, regardless of hearing length. Pre-hearing meetings will be held earlier, so that we use our powers to issue legally binding case management directions at the earliest opportunity.

13 The MPTS is developing guidance documents and forms to assist parties engaging with these revised processes. It will also be offering training sessions to colleagues in GMC Legal, the medical defence organisations and other regular users.

14 To help deliver these changes and improve the service we provide, we restructured the MPTS from the start of 2019. Our staff are now in four sections: Operations, Tribunal Development, Case Management and Communications & Corporate Affairs.

15 Our Doctor Contact Service continues to offer support to doctors on the day of a hearing, particularly those attending alone or without legal representation. In 2018 our service helped 109 individual doctors on 159 occasions. Between January and March 2019, the service has already helped 34 doctors on 79 occasions.

16 The Service aims to help lessen the isolation and stress doctors might encounter when attending a hearing. A member of our staff unconnected to the doctor’s case can be available to support them at any time.

17 We have also made improvements to the facilities available to witnesses called to our hearings by the GMC and by doctors. These include a new purpose-built waiting room and new online resources to help witnesses familiarise themselves with the hearings process.

Support services update

18 The MPTS is operationally separate from the GMC in all activities that impact on independent tribunal decision-making. In other areas, we share resources with the rest of the GMC.

19 As previously reported, in late 2018 we worked with our colleagues in GMC Facilities to improve our 7th floor reception and other facilities, including a new witness waiting room.

20 In 2019 we will be working with our Facilities colleagues to make improvements to the rest of our hearing centre. This includes making it easier for visitors to find their way around, with a more logical ordering of hearing room numbers, and colour coding of corridors. We will also be improving the rooms used by doctors when attending hearings.

Tribunal members

21 The MPTS ran an appointment campaign in January 2019 for new LQCs and medical tribunal members. We received a high number and standard of applications for both types of role. Following our competency-based assessment process, we have appointed...
25 new LQCs and 23 new medical tribunal members, all of whom will receive full induction training before beginning to sit on hearings from the late summer.

22 As of December 2018, the MPTS had 297 tribunal members: 157 lay members and 140 medical members, of whom 48% are female and 20% identify as BME.

23 This compares favourably with the most recently published figures for courts in England and Wales (29% female and 7% BME) and tribunals in England and Wales (49% female and 15% BME). (Source: https://www.judiciary.uk/publications/judicial-diversity-statistics-2018)

24 It also compares well with the UK population (51% female and 13% BME). (Source: www.ons.gov.uk/census/2011census)

Quality assurance

25 The MPTS Quality Assurance Group (QAG) meets monthly to review a proportion of written tribunal determinations. The purpose of these reviews is to make sure the determinations are clear, well-reasoned and compliant with the relevant case law and guidance.

26 The QAG also identifies issues which can usefully be incorporated into future tribunal training sessions, and learning points which are sent out in tribunal circulars.

27 Some of the learning points we have issued since our last update to Council include:

- The need to explain clearly how any case law or guidance referred to supports the tribunal’s reasoning.

- The need clearly to explain the level of supervision (close or direct) required when imposing conditions on a doctor’s registration.

28 All learning points issued to tribunal members can be viewed at www.mpts-uk.org/learning_points

Hearing outcomes

29 Hearing outcomes for the previous three years and the first quarter of 2019 are provided at Annex A.

30 As previously reported, there were a higher number of referrals in 2018 than in previous years. That trend has continued into 2019.

31 In the calendar year 2018, 247 doctors appeared at new MPT hearings. 26% of those doctors had their name erased from the medical register, 41% were suspended and 10%
given conditions. 17% were found not impaired and a further 4% found not impaired but issued with a warning. In two hearings (>1%), the tribunal decided no action was necessary after a finding of impairment. In three hearings (1%) the tribunal accepted an application for voluntary erasure from the register.

32 While more doctors appeared at new MPT hearings in 2018 than in the previous calendar year, the proportion of different outcomes was broadly similar. In 2017, 195 doctors appeared at new MPT hearings. 32% of those doctors had their name erased from the medical register, 39% were suspended and 7% given conditions. 14% were found not impaired and a further 7% found not impaired but issued a warning. In the remainder of hearings (just under 2%), the tribunal granted an application for voluntary erasure, or decided no action was necessary after a finding of impairment.

33 If the GMC believes a doctor is consistently or explicitly refusing to comply with a direction to undergo a health, performance, or English language assessment, it may refer them to the MPTS for a non-compliance hearing.

34 10 new non-compliance hearings were held in 2018, with a suspension imposed in seven cases and non-compliance not found in three cases.

35 15 restoration hearings were held 2018, with the doctor’s application being refused in ten cases.

Looking ahead

36 Our next report will provide an update on the implementation of changes to our pre-hearing case management processes.
Hearing outcomes: Jan 2016 – Mar 2019

Medical practitioners tribunals

<table>
<thead>
<tr>
<th>New MPT hearing outcomes</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>Q1-3 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impaired: Erasure</td>
<td>70</td>
<td>62</td>
<td>65</td>
<td>14</td>
</tr>
<tr>
<td>Impaired: Suspension</td>
<td>93</td>
<td>76</td>
<td>101</td>
<td>34</td>
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<tr>
<td>Impaired: Conditions</td>
<td>17</td>
<td>13</td>
<td>25</td>
<td>3</td>
</tr>
<tr>
<td>Impaired: No action</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Not impaired: warning</td>
<td>11</td>
<td>13</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td>Not impaired</td>
<td>34</td>
<td>27</td>
<td>41</td>
<td>7</td>
</tr>
<tr>
<td>Voluntary erasure</td>
<td>2</td>
<td>0</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Undertakings</td>
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<tr>
<td>Total</td>
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<td>195</td>
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<table>
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<tr>
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<tr>
<td>Suspension</td>
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<td>8</td>
<td>7</td>
<td>1</td>
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Council meeting, 12 June 2019

Agenda item M9 – Report of the MPTS Committee

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<th>Conditions</th>
<th>2016</th>
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<th>2019</th>
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<tbody>
<tr>
<td>Non-compliance not found</td>
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<td>1</td>
<td>3</td>
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<td>10</td>
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<table>
<thead>
<tr>
<th>Outcomes in restoration hearings</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
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<tr>
<td>Application granted</td>
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<td>8</td>
<td>5</td>
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<tr>
<td>Application refused</td>
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Interim orders

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<tr>
<th>New interim orders tribunal hearing outcomes</th>
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<th>2018</th>
<th>2019</th>
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<tbody>
<tr>
<td>Suspension</td>
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<td>43</td>
<td>48</td>
<td>11</td>
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<tr>
<td>Conditions</td>
<td>233</td>
<td>238</td>
<td>247</td>
<td>53</td>
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<tr>
<td>No action</td>
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<td><strong>Total</strong></td>
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Number of review hearings

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<th>2017</th>
<th>2018</th>
<th>2019</th>
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</thead>
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<td>6</td>
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<tr>
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<td>351</td>
<td>462</td>
<td>112</td>
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<td><strong>Total</strong></td>
<td>1312</td>
<td>1035</td>
<td>1036</td>
<td>239</td>
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</table>

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Statement of purpose of the Medical Practitioners Tribunal Service Committee

Purpose

1. The Medical Practitioners Tribunal Service (MPTS) is a statutory committee of the General Medical Council established under Section 1 (3) (g) of the Medical Act 1983 (as amended) and constituted in accordance with the MPTS Rules¹.

2. The MPTS is responsible for providing a hearings service to the GMC that is efficient, effective and clearly separate from the investigatory role of the Fitness to Practise Directorate within the General Medical Council.

Duties and activities

3. The MPTS Committee is responsible for ensuring:

a. The delivery of a hearings service that demonstrates efficiency and effectiveness.

b. The appointment of Medical Practitioners Tribunal and Interim Orders Tribunal members (including chairs) and that appropriate systems for the appointment, training, assessment and, where required, the removal of tribunal members are in place.

c. The appointment of legal assessors and case managers and that appropriate systems for the appointment, training, assessment and, where required, the removal of case managers are in place.

d. Maintenance of a system for declaration and registration and publication of Committee members’ private interests.

e. Consideration of matters by a Medical Practitioners Tribunal/Interim Orders Tribunal.

¹ The General Medical Council (Constitution of the Medical Practitioners Tribunal Service) Rules Order of Council 2015.
f High quality standards of decision-making by Medical Practitioners Tribunals and Interim Orders Tribunals are maintained.

g High quality standards of case management by case managers are maintained.

h The setting and maintenance of guidance for the MPTS tribunals, case managers, and legal assessors, as required.

i That the MPTS applies the equality and diversity strategy and policies of the GMC.

j Notification of Medical Practitioners Tribunal and Interim Orders Tribunal decisions as required by the Medical Act.

k Effective liaison with all users of the hearings service provided by the MPTS.

l An annual report which meets the requirements of Section 52B of the Medical Act 1983 as amended.

Delegations

4 The delivery of the operational requirements of the MPTS may be delegated by the GMC Council to the Chair of the MPTS or to such other officer of the General Council as specified in Council’s Schedule of Authority. Responsibility for the day-to-day operational management of the MPTS rests with the Executive Manager, MPTS.

Membership

5 The membership of the MPTS Committee, as constituted in accordance with the MPTS Rules, is the Chair of the MPTS and four other MPTS members, two medical and two lay. The MPTS is chaired by the Chair of the MPTS.

6 One medical and one lay member will be currently sitting MPTS tribunal members. The remaining medical and lay members may be external co-opted or demitted MPTS tribunal members.

7 When the appointed chair of the MPTS Committee is absent from a meeting, or has had to withdraw owing to a conflict of interest, the meeting is chaired by another member of the MPTS Committee nominated by the members of the Committee present.

8 The Executive Manager, MPTS will attend Committee meetings but is not a member of the Committee.

9 The Committee may invite other members of MPTS or GMC staff, or external parties to attend or present at individual meetings so as to progress its business.
10 The quorum for meetings of the MPTS Committee is three.

Working Arrangements

11 The MPTS Committee meets at least four times a year. At the discretion of the Chair of the MPTS, additional meetings can be convened, if required. Formal decision-making is supported by papers setting out options and recommendations.

12 Papers for each meeting will normally be sent electronically, and in hard copy on request, to MPTS Committee members at least seven days in advance of meetings. Work may be progressed electronically outside of the meetings, including the use of teleconference and videoconference facilities, at the discretion of the Chair.

13 In discussion of agenda items the intention is to reach agreement by consensus. Voting occurs only when consensual agreement cannot be reached and is by show of hands. If the votes are equal the person who chairs the meeting has a casting vote in addition to his/her vote as a member of the Committee.

14 The MPTS Committee Secretary minutes each meeting and aims to circulate the minutes, as cleared by the Chair of the MPTS, to members for comments within two weeks of the meeting. The MPTS Committee approves minutes at the next Committee meeting. Minutes record the conclusions of the MPTS Committee on the issues considered.

15 Where matters are being discussed outside a face-to-face meeting, for example by exchange of emails or teleconference calls or videoconferences, the MPTS Committee Secretary will liaise with the Chair of the MPTS to agree the most appropriate mechanism for seeking views depending on the issue. In such instance the conclusions of the MPTS Committee will be reported at the next Committee meeting and recorded in the minutes.

16 The MPTS Committee agenda, minutes and papers will be published on the MPTS website. Papers relating to a decision being made will be published in accordance with our publication scheme.

Accountability and reporting

17 The Chair of the MPTS is accountable to the General Medical Council through the Chair of the GMC’s Council, and will report to Council on its work to fulfil the statutory duties for which it is accountable to the Privy Council on a twice-yearly basis. The report will summarise the performance of the MPTS during the previous reporting period, and the work of the MPTS Committee.

18 In addition, the MPTS will report annually to Parliament (via the Privy Council). This report will be coordinated for submission with the GMC Trustees’ annual report and accounts.

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Executive summary
This report provides an update to Council on the Audit and Risk Committee’s activities since January 2019. It notes:

- From its review of the Annual Report and Accounts, including the statement on risk, the Committee is satisfied that the accounts have been properly prepared and are in accordance with applicable accounting standards.
- That substantial assurance was given by the Head of Internal Audit in her annual opinion indicating that the systems of governance, risk management and internal control in operation during 2018 were generally well designed and working effectively to ensure the achievement of the GMC’s objectives.
- There have been no serious incidents to report to the Charity Commission.

Recommendation
Council is asked to:

a) Note the report.
b) Consider the issues raised with respect to business planning and financial scrutiny.
c) Note the results of the Committee’s Effectiveness Review and the request to participate in a survey in late June.
d) Consider whether the Committee’s work provides sufficient assurance on the systems of control, risk management and governance of the GMC to support the Council’s activities.
e) Appoint Ken Gill to the Audit and Risk Committee as an independent member with effect from 1 August 2019.
Introduction

1. The Audit and Risk Committee (the Committee) provides Council with independent assurances on the effectiveness of arrangements established by the Executive to ensure that:

- The robustness of processes used to prepare the financial statements and the integrity of those preparing the statements are sound.

- The systems of internal control, governance and risk management which support the organisation’s decision-making, management and oversight are effective for its operations.

- Both the external and internal audit services (delivered by Crowe UK and BDO LLP respectively), provide high standards of technical expertise and customer service to satisfy the GMC’s requirements and global auditing standards.

2. The Committee has met three times since its last report to Council, in formal session and seminar on 24 January, 14 March and 16 May (in Manchester). The seminar in January focused on the Committee’s own effectiveness review and in March on work and risk within MPTS. In May, following the introduction of training roll out to decision-makers on human factors in response to the Dr Bawa-Garba case, the Committee experienced a shortened training session.

3. Seminars continue to be an important feature of the Committee’s business, supporting its role in understanding and providing appropriate scrutiny and challenge as it carries out its work. All of the sessions have been welcomed by members. Seminars for the rest of the year include topics related to HR and the staff survey, and using case studies to look at the role of risk and risk responsibilities in organisations. This will have a particular focus on the potential effects of risk thinking, challenge and scrutiny not being joined up across an organisation.

4. The Committee propose that a similar risk-type seminar would be valuable for a full Council seminar to enable Council members to consider how best to manage and challenge risks and risk thinking in relation to the GMC’s activities.

5. Committee meetings are supported by the Executive Team and have included the attendance of relevant directors and assistant directors when audit reports relating to their area of business have been presented. The Executive and their teams provide the Committee with high levels of confidence in management of controls, governance and reporting arrangements and appreciate the commitment given to attending the meetings alongside other work pressures.

6. Last year the Committee piloted and introduced a new approach to discussion and executive attendance for the presentation of audit reports in order to try and ease the pressure on agendas and achieve an appropriate balance between risk and audit, by
only discussing green rated internal audit reports if members had raised a particular aspect they wished to explore in advance. Following feedback through the Committee’s effectiveness review, the Committee has adjusted its approach to allow time for such discussions because by not discussing green reports there were potential missed opportunities to celebrate success and glean learning from areas of the business where controls and assurance were working really effectively. However, to alleviate the time pressures on staff, presence at the meeting has become more flexible with skype attendance introduced for colleagues not in the same physical location as the meeting venue.

The Committee has also continued to welcome observers and there continues to be interest to attend from colleagues across the business. The Assistant Director Audit and Risk Assurance contacts all observers after each meeting and without exception receives very positive feedback from them about the opportunity to learn and understand more about the Committee’s role and the GMC’s formal governance arrangements.

Areas to bring to Council’s attention arising from the Committee’s responsibilities and activities are outlined below.

Risk management

Each year, as the trustees of a registered charity, Council is required to make a positive statement in the GMC’s Annual Report, confirming that the major risks to which the charity is exposed, as identified by the trustees, have been reviewed, and that systems have been established to mitigate those risks. The Audit and Risk Committee plays a key role in providing assurance to Council that risk management arrangements are in place and have operated effectively. To achieve this the Committee continues to:

- use risk as the basis for its approach to oversight and scrutiny bringing a balanced consideration of forward looking risks and issues alongside its backward look at audit work to gain assurance on systems of internal control and risk management;
- consider the Corporate Opportunities and Risk Register at each meeting;
- oversee delivery of an internal audit programme of work which is risk based.

The Committee is therefore able to fulfil its role of providing assurance to Council that risk management arrangements are in place and operating effectively. There have been no risks arising which the GMC has not been prepared for and there have been incidents to report to the Charity Commission. The Committee is able to confirm that the risk statement in the Annual Report is an accurate reflection of the risks that the GMC has been and continues to manage.
11 This year’s internal audit review of risk management, the scope of which has been agreed by the Chair of the Committee, is currently underway (to maintain independence from the responsibilities for risk which sit with the Assistant Director of Audit and Risk Assurance, the review report will also be presented directly to the Chair of the Committee). It includes, for the first time, a survey of all heads of section and assistant directors. This approach was considered following feedback to the Committee through its effectiveness review process that asking for wider views beyond the Executive on risk issues may provide an additional layer of depth to understanding both opportunities and threats at different levels of GMC activity. The findings from the audit will be reported in our next report to Council.

**Internal audit management arrangements**

**2018 performance**

12 The 2018 annual evaluation of internal audit’s performance was completed in January. 2018 was the final year of a four year co-sourcing contract with Moore Stephens and their new contract, following a full procurement process led by the Chair of the Committee, took effect from 1 January 2019. The performance review takes account of the views of Committee members, the Executive and auditees and assesses the key performance indicators for the internal audit service.

13 Performance overall remains solid, evidenced through the satisfaction expressed by all parties with the service they receive from the audit team. Internal audit work continues to have visibility and a positive profile across the business. Both auditees and the Executive indicate that the function adds value to their business areas. The transition of our contracted internal audit firm Moore Stephens to BDO LLP, through a merger of the two firms, has provided access to a wider range of expertise, including cyber security and penetration testing. We will be using BDO to conduct this year’s penetration audit. A summary of internal audit performance review for 2018 is at Annex A.

14 The Committee concluded that the co-sourced arrangement continues to operate effectively and with the start of the new three year contract, are pleased to note the opportunity taken to introduce continuous improvement to overall audit delivery and management.

**Head of Internal Audit annual report**

15 At its meeting on 14 March 2019, the Committee received the annual report and opinion from the Head of Internal Audit. The opinion is given in accordance with the Institute of Internal Auditors Practice guidance in the context of a risk based audit programme which the Committee had agreed, and has been delivered with appropriate audit resources and skills.
16 The Committee was pleased to see that the opinion awarded substantial assurance on the effectiveness of the GMC’s arrangements in place to ensure delivery of corporate objectives. The full report, at Annex B, provides the results of all the internal audit and assurance work conducted during the year. The opinion is provided in the context of an audit programme which has aimed to push and support the organisation in risk based areas in line with its culture for continuous improvement and the audit team has adopted an individual, intelligent and transparent approach to commissioning, using its knowledge of the business, risks and management information when scoping audit activity.

Delivery of 2019 internal audit programme to date

17 To date this year, the Committee has overseen the completion of five audit reviews in line with the 2019 programme. In all cases, the Committee has scrutinised the audit findings and satisfied themselves that the management actions proposed are appropriate.

18 The assurance ratings awarded to reports can range from red to green with red/amber, amber and green/amber in between. The reviews and assurance ratings for completed audits are given in the following table.

<table>
<thead>
<tr>
<th>Audit review</th>
<th>Assurance rating</th>
<th>Number of recommendations (high priority)</th>
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</thead>
<tbody>
<tr>
<td>1 2018 IA recommendations follow up</td>
<td>Green</td>
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</tr>
<tr>
<td>2 Business planning and budgeting</td>
<td>Green amber</td>
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<tr>
<td>3 Corporate quality assurance</td>
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</tr>
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<td>4 Interim orders review on papers</td>
<td>Green amber</td>
<td>7</td>
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<tr>
<td>5 Voluntary erasure</td>
<td>Green amber</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>18 (2)</td>
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</table>

19 There were two high priority recommendations from the business planning and budgeting review. The first related to producing a high-level business plan with costs and activities for the whole period of the Corporate Strategy. Annually more granular plans outlining how strategic objectives will be delivered each year of the Strategy should then be developed. To achieve this Council will need to have agreed the next Corporate Strategy in advance of the 2021 business planning exercise. Proposals to bring forward Council’s 2020 away day is a key step to facilitating this earlier timetable.
The second high priority recommendation was to redress the balance between planning for growth and business as usual activities. Currently, 95.5% of the GMC’s budget is spent on delivering BAU and only 4.5% on growth or new initiatives yet the business planning and budgeting process focus is weighted towards the latter. The Executive has recently begun an internal expenditure and investment review to better understand its cost base, the opportunities for improving effectiveness in focusing effort and resource on corporate priorities and to bring together a holistic picture of current and future spend and investment – all of which will help alleviate budget pressures in the short, medium and long term.

The Committee’s discussion raised the question of whether there is an appropriate level of financial oversight and scrutiny at Council, and whether there is sufficient exposure of costs and choices when making strategic decisions. This may be an area Council wish to consider further.

Reporting audit progress

At each meeting, the Committee received an audit progress report, including an update on the status of actions arising from internal audit work. The Committee can again report that there is continued effort to close outstanding audit actions and the audit tracker is being kept up to date. At the time of this report there were no overdue actions outstanding. It was also pleasing to note that the audit of implemented recommendations completed in 2018 evidenced that actions are being taken promptly and having the intended impact.

Business assurance map

The business assurance map provides the GMC with a structured means of identifying and mapping the main sources of assurance across the organisation. It gives a simple but comprehensive picture for effective and focused management of principal risks, triangulating the outcomes form assurance activities internally and externally driven. The most recent update in January 2019 evidenced the benefit of collaborative working between the Quality Development and Quality Assurance Team and Internal Audit in delivering an ever more holistic and integrated approach to providing assurance across the business.

The map continues to demonstrate that the GMC’s risk and controls environment is mature, that known risks are captured in the corporate and directorate level risk registers and that risk management activity is embedded at all levels.

Significant Event Reviews

There has only been one significant event reviews presented to the Committee during this period. It was a particularly complex case relating to the preparations for an MPTS tribunal hearing where the allegations listed were not entirely understood with
the impact that witnesses were prepared to attend a hearing regarding clinical concerns which had not been listed. The clinical concerns have since been reviewed through the Rule 12 process which concluded that the cases be closed. The Committee were pleased to note a number of key learning points had arisen and were being implemented from the review.

**Trustees’ Annual Report and Accounts 2018**

26 At its meeting on 16 May 2019, the Committee scrutinised the Annual Report and Accounts 2018 and received the Audit Findings report of the external auditor. The external auditor had no significant findings to report. The Committee considered the Annual Report and Accounts to be well prepared. The main financial statements are supported by more detailed notes. A small number of minor adjustments to the supporting narrative of these, to aid clarification and understanding for general readers of the accounts, have been made following feedback from Committee members.

**Follow up of the Committee’s annual review of its effectiveness**

27 In line with good practice, the Committee has again undertaken an annual review of its own effectiveness. This year the scope of the review was extended and comprised:

- a self-effectiveness questionnaire completed by members, Executive and audit attendees (nine responses received);
- a survey of wider Council members (one response received);
- a survey of assistant directors (seven responses received).

28 The response rates to the Council and assistant director survey were disappointing possibly reflecting that the surveys were circulated in early December before the Christmas break. To address this, the Committee is proposing to repeat these surveys in late June this year and would encourage all Council members not on the Committee to participate.

29 The review demonstrates that there continues to be a very high level of consensus amongst members and attendees of the Committee’s operational effectiveness. However, members expressed some disappointment with the distribution of late papers (which related primarily to the learning review following the case of Jack Adcock/Dr Bawa-Garba).

30 Wider analysis suggested two areas for particular consideration:
Whether the balance of risk discussion and activity fully addressed the GMC’s significant risk areas and was appropriately balanced with basic control activities;

How the Committee’s presence is felt in the organisation, both in terms of the time spent with members of staff when they attend ARC meetings and how it communicates its work – both at Council and more broadly.

31 Actions the Committee has taken since the review include:

- making more explicit links in meeting minutes to areas of the Corporate Opportunities and Risk Register to illustrate where key risks the organisation faces are being discussed;

- inviting the CEO to participate in the end of meeting wash up session with members to discuss the meeting, any points that needed further consideration and learning for future meetings;

- including a survey of heads of section and assistant directors which includes questions on where they may identify risks which have not been raised through the Executive;

- noting that a discussion on longer term succession planning is needed as several Committee members will demit office at the end of 2020.

32 As noted in paragraph 2, to address the issue of how the Committee communicates its work and whether there is sufficient focus on its activities by the wider Council, the Committee is keen to promote a full Council seminar looking at case studies which emphasise individuals’ roles and responsibilities for risk management and scrutiny across boards and executives.

Recruitment of new independent Committee member

33 At the end of July, John Morley’s term of office comes to an end after eight years serving on the Committee as an independent member. John has been an active Committee member providing valuable insight, observations and sharp-eyed scrutiny of the Committee’s activities and reports, and we would like to thank him for his contribution and service to the GMC.

34 Following a recruitment round in April led by the Chair of the Committee, a successor to John has been nominated, Ken Gill. We seek Council’s approval to the appointment. Ken brings a wealth of experience and expertise to the role and his biography is attached for your information at Annex C. We have undertaken the recruitment in sufficient time to allow for a transition handover with both John and Ken attending the July meeting.
Adding value

35 The Committee’s role is to add value to the GMC through supporting the achievement of good governance. It believes it is achieving this through:

a Being clear on its role and purpose and continuing to check that this is still appropriate for the business’s needs.

b Developing agendas and a programme of work which are pertinent to regular business and emerging issues so that meetings are relevant and focused.

c Providing scrutiny of the Corporate Opportunities and Risk Register, supporting the risk management framework and risk maturity journey.

d Ensuring that Council are informed of significant risks and their mitigation.

e Holding management to account by calling directors and senior staff to meetings to respond to the findings from audit reviews and following through on the implementation of audit recommendations where appropriate and proportionate to the audit conclusions.

f Meeting internal and external auditors without management present.

g Regular dialogue between the Chair and Assistant Director of Audit and Risk Assurance between meetings.

h Holding regular seminar sessions to give greater depth of background knowledge to members on key topics and inviting auditors to provide broader insight from global and national risk and audit trends in the financial, political and health environments.

i Providing more time on agendas for reflecting on broader opportunity/risk issues and horizon scanning.
Review of internal audit performance 2018

Approach to review of internal audit performance

1. The review of internal audit performance has been drawn from three sources of information:
   - Committee and executive satisfaction questionnaires
   - Auditee satisfaction questionnaires
   - Analysis of audit key performance indicators.

Summary of findings

2. In summary, the fourth year of the co-sourcing arrangement has continued to build on the learning and knowledge it has acquired over the last three years. Analysis indicates there is some fluctuation this year between ‘strongly agree’ and ‘agree’ responses though overall performance remains solid as summarised in the table below. (NB the ARC and Executive survey had more respondents last year).
Response to satisfaction statement 2018  |  ARC and Executive survey  |  Auditees survey
---|---|---
Strongly agree  |  70  |  205
  2017  |  92  |  234
Agree  |  63  |  150
  2017  |  55  |  134
Neither  |  3  |  25
  2017  |  2  |  26
Disagree  |  9  |  
  2017  |  4  |  
Strongly disagree  |  2  |  
  2017  |  4  |  

KPIs 2018  
*2017 in italics*

- Scoping meeting held two-four weeks in advance 100% (100%)
- Scope approved by sponsor five days in advance 100% (100%)
- Close meeting held 90% (89%)
- First report draft within ten days 90% (84%)
- Management responses within ten days 85% (83%)
- Final report within five days 95% (79%)

**Learning for 2019**

3 The team will continue to be vigilant under its new Moore Stephens day-to-day lead to ensure we maintain the high levels of customer service and visibility that audit currently enjoys. We have taken the opportunity in transition and handover meetings to make some small changes to audit oversight and management in 2019. This includes a quality assurance checklist for auditors to complete for each piece of work and guidance to support report writing using the new template. We have also amended scopes to include a fuller timeframe for the audit work and reporting cycle. Monthly planning meetings are scheduled and an induction programme has been arranged for the new lead to help him get up to speed with GMC business.

4 The team has also reflected on the two pieces of work in relation to the Jack Adcock/Dr Bawa-Garba case. This was an extraordinary situation for the GMC and with hindsight, we should have adapted our approach from the more traditional audit review model adopted. Whilst both reviews contributed to providing assurance through independent reflection and analysis of events and activities surrounding the case, it is recognised that there were elements which could have been better handled. These include:
- taking more time to seek a broader understanding of where learning and assurance was expected (especially the right of decision-making review)

- taking an opportunity to ‘step back’ from the detailed work once completed to reflect more widely before finalising the reports

- testing out findings with a wider audience range than the Executive.

5 We also recognise that we put ourselves under pressure to conduct the work and deliver reports to the Committee which could have been more realistically timetabled. Whilst there were constraints to consider, not least of which was the impending change to the GMC’s Chair, this would have avoided the necessity of the second audit report being distributed late to the Committee. All of this is useful learning for any future reviews of such a particularly significant nature.

Committee and attendee satisfaction

6 Detailed analysis of the survey is at Annex A. Overall there continues to be a high level of satisfaction. Both Committee members and attendees have responded ‘agree’ or ‘strongly agree’ to every question in the survey, except two where there were three responses of ‘neither agree or disagree’.

7 The results suggest that the co-sourcing arrangement is still working effectively. Relationships between the audit team and the Committee and Executive remain strong with sufficient independence and objectivity demonstrated. Internal audit is seen to have led to improvements in the management of key risk areas and have a positive impact on achievement of GMC outcomes.

Auditee performance satisfaction

8 Overall the results of the questionnaires continue to be encouraging and reflect the effort the audit team makes in delivering a customer service focused on providing assurance as well as adding value. A detailed analysis of all 26 responses received is at Annex B and reflected in broad terms in the table below where 5 indicates ‘strongly agree’ and a 1 ‘strongly disagree’. Bracketed figures refer to 2017.

<table>
<thead>
<tr>
<th>Satisfaction area</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audit planning</td>
<td></td>
<td>2 (0)</td>
<td>2 (0)</td>
<td>14 (16)</td>
<td>29 (36)</td>
</tr>
<tr>
<td>Communication and conduct</td>
<td>2 (3)</td>
<td>3 (3)</td>
<td>15 (15)</td>
<td>70 (60)</td>
<td>103 (119)</td>
</tr>
</tbody>
</table>
In particular, the detailed analysis reveals there is a general satisfaction from auditees with:

- involvement in audit scoping
- preparation by auditors in advance of site visits and interviews
- professionalism and engagement of the audit team
- timeliness of first draft reports
- willingness to listen to management comments on draft reports (but not be inappropriately influenced)
- audit work providing assurance and value to business areas.

There are some slight fluctuations between ‘agree’ and ‘agree strongly’ which internal audit are cognisant of and will need to pay attention to in 2019. In particular:

- audits being conducted with minimal disruption to routine business
- reports addressing the agreed scope.

For the Jack Adcock/Dr Bawa-Garba learning review, one director respondent disagreed that they had the opportunity to discuss and contribute to the audit scope and whether there were areas of potential added value.

On the procurement audit one respondent considered that the audit team were not sufficiently knowledgeable of public sector best practice guidance (rather than commercial) and emerging procurement practices.

There were two scores each for ‘strongly disagree’ and ‘disagree’ with respect to the digital media review and whether the audit findings were discussed with respondents. There were 14 participants in this review – all of whom were sent a copy of the draft report for accuracy – but who would not necessarily be included in a closing meeting to discuss findings. The findings were discussed with the key leads and director. This piece of work also had areas where interviewees felt the auditor had not understood fully how the project had been run and four respondents disagreed that the first draft of the report accurately reflected the position. However, respondents agreed and
strongly agreed that the comments they provided were given appropriate consideration and reflected in the second draft.

**Key performance indicators**

**14** The KPIs overall show good performance and given the ebbs and flows of day-to-day business it is pleasing to see slight improvements in key areas and in particular the improvement in management responses to draft reports. Timeliness, whilst overall improved this year given audits have not been scheduled over the summer period, will always continue to require close management attention. The two reviews in relation to the Jack Adcock/Dr Bawa-Garba case both took longer than 10 days to get to a first draft report, though as noted above, are excluded from the detailed analysis given they were not routine pieces of audit work.

**15** The Assistant Director Audit and Risk Assurance is conscious of the continual vigilance needed to ensure the audit programme runs smoothly and remains sighted on maintaining audit profile and visibility, customer service and empathy with the general business pressure in planning arrangements as well as the principle that individuals who have contributed to audits out of courtesy should see a draft report to comment on for factual accuracy.
Head of Internal Audit Annual Report

Executive summary

The delivery of internal audit services and position within the governance framework

1 The GMC’s internal audit service is delivered through a co-sourcing model. The Head of Internal Audit (HOIA) role is carried out by the Assistant Director of Audit and Risk Assurance (ADA&RA), supported by an external audit team provided by Moore Stephens (who following a merger became BDO LLP from 4 February 2019). Internal audit work has been planned and conducted in accordance with the International Standards for the Professional Practice of Internal Auditing and reflects the ethos of the Public Sector Internal Audit Standards, which include the requirement for an annual report from the ‘Chief Audit Executive’.

2 The Council is collectively responsible for the organisation’s system of internal control, governance and risk management in delivering the GMC’s strategic aims. It puts in place arrangements to provide assurance on the overall effectiveness of delivery of its corporate objectives and the internal audit function supports the assessment and understanding of how well those arrangements are working in practice. Internal audit is also a catalyst for positive change, supporting delivery of the GMC’s Corporate Strategy 2018-2020, continuous improvement and providing opportunities for shared learning across the organisation.

3 An independent, objective and evidenced based HOIA opinion contributes to the assurance available to the Chief Executive, Chief Operating Officer, Executive, Audit and Risk Committee and Council in making their own assessment of the effectiveness of the arrangements in place.

Head of Internal Audit opinion

4 This opinion is given in accordance with the Institute of Internal Auditors Practice Guide: Formulating and Expressing Internal Audit Opinions. The planned audit programme in 2018 was risk driven, discussed with the Senior Management Team and agreed by the Audit and Risk Committee.
5 A comprehensive risk-based audit programme has been delivered during 2018 resourced with appropriate skills drawing on specific subject matter expertise as required. This year we piloted agile audit reviews, working with the Committee to determine areas of focus as the year progressed. This proved a success pilot providing the Committee with flexibility to address emerging risk areas and will be continued in 2019.

6 The opinion is not given on the basis of individual audit results, but in the context of an audit programme which has aimed to push and support the organisation in risk based areas, in line with its culture for continuous improvement. The audit approach strives for excellent customer service with high quality work which combines providing assurance to the Audit and Risk Committee and Executive with value add to the teams subject to audit review. The audit team adopts an individual, intelligent and transparent approach to commissioning using its knowledge of the business, risks and management information when scoping audit activity, and involves senior management and auditees in the preparatory stages whilst maintaining independence and control of all audit activity and reporting.

7 Having adopted the approach outlined above, overall **substantial assurance** can be given that the systems of governance, risk management and internal control in operation during 2018 were generally well designed and working effectively to ensure the achievement of the GMC’s objectives. There have been no areas of major failure identified and the organisation’s system of risk management continues to mature and embed, including increasing focus on risk appetite and opportunity management.

8 This opinion is based on:

a Outcomes of the audit reviews for 2018.

b Management’s approach to implementation of the recommendations raised in audit reports.

c Outcomes and analysis of two significant event reviews undertaken in 2018.

d Insight in to the control environment through:

i arrangements for setting and monitoring business objectives

ii risk management

iii information for decision making

iv performance reporting
The audit programme delivery costs were £356,356 (£298,345 in 2017) in the draft accounts against a budget of £325,371 (£300,676). The £31k overspend related to the cost of the learning review and audit of appeal decision-making following the case of Jack Adcock/Dr Bawa-Garba which were conducted by senior colleagues from Moore Stephens.

**Detailed audit activity**

The risk-based audit programme comprised operational compliance audits, spot checks for short targeted reviews, and audit work on areas with a clear key strategic impact – for example the Transformation Programme, learning review and digital media strategy. A summary of audit activity is given in the table below and all reviews have been reported to the Committee as they have progressed throughout the year. The Committee has also had an update on the implementation of previously agreed audit actions at each of its meetings.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Work completed in 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Programmed reviews</td>
<td>18 internal audit reviews, five spot checks and independent reviews of cyber security and BS10008 (a standard that underpins the legal admissibility and evidential weight of electronic information and the documents that are scanned to our systems).</td>
</tr>
<tr>
<td>Follow up of previous actions</td>
<td>Regular progress checks undertaken on outstanding actions. During 2018 60 new recommendations were raised. At the end of February there were 8 actions to be completed in 2019 and two overdue actions (both had appropriate explanations and follow up arrangements are in place).</td>
</tr>
<tr>
<td>Risk management</td>
<td>Refresh of the Risk Management Framework (RMF), audit review of the RMF arrangements.</td>
</tr>
<tr>
<td>Significant event reviews</td>
<td>Two Significant Event Reviews (SERs).</td>
</tr>
</tbody>
</table>

**Analysis of 2018 programmed reviews**

The audit programme included review of each of the statutory functions and a range of emerging risk areas. It was reviewed mid-year and discussed with the Audit and Risk Committee, concluding that the emerging risk areas remained appropriate to review. All the reviews were designed to assess the extent to which effective internal controls...
were in place to manage the specific risks. The audit ratings for each review are based on a five-point scale of green through to red. Each review and the level of assurance provided is shown in the table below.

<table>
<thead>
<tr>
<th>Audit review</th>
<th>Assurance rating</th>
<th>Number of recommendations (high priority)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2017 IA follow up</td>
<td>Green</td>
<td>0</td>
</tr>
<tr>
<td>2 UK graduates’ registration</td>
<td>Green amber</td>
<td>2</td>
</tr>
<tr>
<td>3 FtP health assessments</td>
<td>Green</td>
<td>2</td>
</tr>
<tr>
<td>4 *Transformation programme 1</td>
<td>Green</td>
<td>4</td>
</tr>
<tr>
<td>5 GDPR readiness</td>
<td>Green</td>
<td>3</td>
</tr>
<tr>
<td>6 Procurement</td>
<td>Green</td>
<td>4</td>
</tr>
<tr>
<td>7 Whistleblowing arrangements</td>
<td>Green amber</td>
<td>1</td>
</tr>
<tr>
<td>8 *Transformation programme 2</td>
<td>Green amber</td>
<td>4</td>
</tr>
<tr>
<td>9 Anti-fraud arrangements</td>
<td>Green</td>
<td></td>
</tr>
<tr>
<td>10 Business continuity</td>
<td>Green amber</td>
<td></td>
</tr>
<tr>
<td>11 Risk management</td>
<td>Green amber</td>
<td>5</td>
</tr>
<tr>
<td>12 Performance reporting</td>
<td>Green amber</td>
<td>1</td>
</tr>
<tr>
<td>13 Digital media strategy</td>
<td>Green amber</td>
<td>2 (1)</td>
</tr>
<tr>
<td>14 Crisis management learning review</td>
<td>No rating</td>
<td>N/A</td>
</tr>
<tr>
<td>15 ISO 27001</td>
<td>Green amber</td>
<td>5</td>
</tr>
<tr>
<td>16 BS10008</td>
<td>1 minor nonconformity</td>
<td>N/A</td>
</tr>
<tr>
<td>17 Cyber security</td>
<td>1 medium, 4 low risk</td>
<td>N/A</td>
</tr>
<tr>
<td>18 Enhanced monitoring</td>
<td>Green amber</td>
<td>5</td>
</tr>
<tr>
<td>19 *E&amp;S Quality Assurance</td>
<td>Green</td>
<td>0</td>
</tr>
<tr>
<td>20 MPTS – governance arrangements</td>
<td>Green amber</td>
<td>4</td>
</tr>
<tr>
<td>21 *MPTS segregation of systems</td>
<td>Green amber</td>
<td>3</td>
</tr>
<tr>
<td>22 Financial controls: fees/billing</td>
<td>Green amber</td>
<td>3</td>
</tr>
<tr>
<td>23 Transformation Programme - new directorates establishment</td>
<td>Green amber</td>
<td>4 (1)</td>
</tr>
<tr>
<td>24 Appeals decision-making</td>
<td>No rating</td>
<td>N/A</td>
</tr>
<tr>
<td>25 *Incident management</td>
<td>Green</td>
<td>4</td>
</tr>
</tbody>
</table>
12 Overall 60 recommendations were made in the audit reviews conducted during 2018, only two of which were high priority. The first related to the digital media strategy and considering whether more detailed financial cost collection would be of benefit to the GMC, and if so, how this might be achieved. The second was in relation to the establishment of the Strategy and Policy and Strategic Communications and Engagement directorates. Whilst there are wider success measures in place for the Transformation Programme overall, the directorates need to develop their detailed success criteria for the changes they are seeking to achieve and ensure they monitor this over time.

13 Having reported previously on the improvement needed with respect to enhanced monitoring in the Education and Standards Directorate, it is pleasing to note that significant progress has now been made and this year’s review was rated green-amber.

14 At the 22 February 2019 there were eight actions not yet due and two outstanding. Both of these have satisfactory explanations for the current level of progress and continue to be monitored. Progress in implementing recommendations has been reported regularly to the Executive Board and to each meeting of the Audit and Risk Committee.

15 In addition to the work above, cyber security penetration testing was undertaken, commissioned by the Assistant Director Audit and Risk Assurance (ADA&RA) through an independent supplier. The cyber security review adopted a ‘hacker’ approach to make the work as realistic as possible to the increasing information security attacks noted in the media. This included two phishing tests, an increasingly common tactic used by hackers, both of which were identified quickly by the GMC’s in-house security team. Overall the review concluded that in comparison to other organisations, the GMC is taking a proactive and mature approach towards cyber security.

16 The ADA&RA also separately commissioned an independent review of the GMC’s BS 10008 (the British Standard for best practice in the implementation and operation of electronic information management systems) to which the GMC became fully accredited in 2016. The GMC is one of the first few organisations to hold BS 10008 accreditation and the independent reviewer was again complimentary about the work of the team concluding that the information management system at the GMC is effective in ensuring the trustworthiness of electronic information.

17 Taking a holistic overview of the individual reviews conducting during the year there are four features of note:

<table>
<thead>
<tr>
<th>Total</th>
<th>60 (2)</th>
</tr>
</thead>
</table>

*indicates spot check review
Risk is discussed at all levels of the organisation and is embedded in operational activities. Audit reviews are not identifying new risks or areas of risk-related non-performance.

There remains a drive for continuous improvement.

High quality guidance and processes are in place across the business and there are high levels of general compliance with it.

Local management information and reporting is good.

Audit review has also identified a number of themes where further consideration is needed:

- Continued silo working – there are examples of where this is breaking down but there remains more to do in enabling coordination and collaboration across teams and building trust.

- Lack of clarity and/or complicated governance arrangements – particularly at the start of projects.

- Linked to hierarchy, the real extent of empowerment to be flexible and make decisions in the absence of support systems in place that act as enablers.

- Organisational values being spoken about but not always followed up by action.

- Lack of clarity on resource need and availability through the business planning process.

- Planning and operating to capacity impacting on resilience within teams when key events occur.

As in previous years, audit work continues to be viewed by senior management as a valuable tool and colleagues take a constructive approach to audit reviews and reports, with recommendations shared with teams and owned by management. This is evidenced in the high levels of satisfaction expressed in a review of internal audit performance and the audit satisfaction questionnaire completed by teams after each audit has taken place.

**Spot checks**

A spot check is a short, focused piece of review targeted at a specific area of the business as directed by management or the Audit and Risk Committee. Spot checks can be used to:
a. Provide ongoing assurance to areas where operational performance is good and where a full internal audit may not by warranted (subject to spot check results).

b. Review an area where operational performance has or appears to be deteriorating.

c. Review an area where there may be emerging concerns about operational or management performance.

21. Five spot checks were undertaken during the year. These were used to provide assurance on:

- set up arrangements for the Transformation Programme
- effectiveness of arrangements put in place to plan to plan, manage and measure the benefits delivered through the Programme
- governance and set up arrangements for the Education Quality Assurance review
- the robustness of the Data Disclosure Incident Rating Procedure being fit for purpose against a changing external environment and providing appropriate mitigation in helping the GMC to manage its reputation with respect to breaches
- a review of the technology environment used by Fitness to Practise (FTP) and The Medical Practitioners Tribunal Service (MPTS) to confirm there is sufficient segregation so that the investigatory and adjudication processes are independent, impartial and fair.

Risk management

22. Risk thinking is integral to the work of the Committee and delivery of the audit programme. This year there has been a refresh of the Corporate Opportunities and Risk Register as over a period of time, the number of risks had grown and were more practically being managed at a directorate level. The refresh has allowed the Committee to focus on key strategic opportunities and risks to delivering the Corporate Strategy and the strategic active risks which the GMC is currently facing.

23. The Committee has also introduced an open risk discussion at the start of every meeting. Following this the Chief Executive provides a strategic update drawing on events in the external environment and meetings with government officials and key stakeholders. The Chief Operating Officer updates the Committee on the implications of external events for the GMC and any operational impacts. She draws attention to changes on the Corporate Opportunities and Risk Register and the Corporate Issues Log, which provide the Committee with a holistic picture of the key risk matters the organisation is managing.
24 2018 has been a particularly challenging year as the GMC has continued to manage ongoing risks and opportunities as well as those which emerged during the year. These have included the continuing uncertainty of Brexit which has generated significant risks which the organisation has addressed by working through a number of potential risk scenarios to ensure it is prepared for the final outcome. It has also faced particular operational pressures in registration teams from a substantial increase in the number of international medical graduates seeking to join the UK register. To address these rising pressure, it has expanded the knowledge test exam capacity across the world and in the UK by holding the exam in Edinburgh for the first time, as well as London and Manchester. It has also delivered some of the clinical assessments at new venues in Cambridge and London and in July this year will be opening a new clinical assessment centre in Manchester doubling its capacity to practically assess doctors from overseas who wish to work here.

25 A significant challenge emerged during the year, following the death of 6 year old Jack Adcock (in 2011), and the case of the doctor responsible for Jack’s care on the day he died, who was subsequently convicted of gross negligent manslaughter. Following a hearing by the Medical Practitioners’ Tribunal Service (MPTS), the doctor was not erased from the medical register and the GMC used its right of appeal to challenge that decision. This was upheld in the High Court. The doctor appealed the decision of the High Court to the Court of Appeal which found in favour of the doctor. The GMC accepted the Court of Appeal’s judgment and undertook an important and detailed review of all aspects of its handling of the case to identify learnings on both how it approached the decision to appeal and how it conducted itself as an organisation in the aftermath of the adverse reaction from parts of the profession. It was able to use some of the crisis management learning from this work in handling a registration fraud which emerged at the end of 2018.

26 These are excellent examples of the GMC’s maturity in dynamic risk thinking and management. The Audit and Risk Committee is therefore able to provide Council with assurance that risks and issues are properly considered and the Risk Management Framework is operating effectively across the organisation. Council also regularly discusses risks, particularly at a strategic level and the Corporate Opportunities and Risk Register is published on the website with Council papers, demonstrating the organisation’s risk management transparency.

Significant event reviews

27 A significant event is where an incident did or could have had the potential for a material adverse effect on the organisation. Carrying out a review allows identification of how the incident occurred and the learning from this to strengthen controls for the future where appropriate. The Audit and Risk Assurance function provides guidance, support, challenge and independent quality assurance over significant event reviews (SERs), their findings and action plans. Last year the GMC piloted, in relevant
circumstances, a more facilitative learning approach to undertaking significant event reviews. This adopts a ‘continuous improvement’ workshop style to drawing out the significant factors contributing to an SER, providing a more open and supportive learning approach.

28 This approach has been continued in 2018. It worked particularly well in the case of an SER where at an MPTS hearing the tribunal was asked to consider a set of specific allegations about a lack of indemnity insurance cover but in preparing for the hearing, there was also an assumption that a number of clinical concerns were to be considered at the same hearing, which was not the case. Working with relevant teams across the GMC identified a number of learning points and areas for improvement which are now being addressed.

29 Sadly the second SER related to a doctor committing suicide whilst under fitness to practise processes. It did not identify control failures or areas where handling of the case was contrary to internal processes and guidance. However, further training has been provided to relevant staff on drafting papers/letters, particularly in cases where there are health implications for doctors.

30 The Charity Commission requires the GMC to report serious incidents as defined by their trustee guidance. There were no such incidents to report in 2018.

Quality management of internal audit

31 The performance of internal audit is kept under ongoing review and is drawn from three sources of information:

a Audit and Risk Committee member and Executive satisfaction questionnaires.

b Auditee satisfaction questionnaires.

c Analysis of audit key performance indicators.

32 Overall the results of the questionnaires continue to be positive and reflect the effort the audit team makes in delivering a customer service focused on providing assurance as well as adding value. This is particularly pleasing given the challenges posed by some of the emerging risks.

33 The co-sourcing arrangement continues to work effectively and following a full procurement exercise during the year, led by the Chair of the Audit and Risk Committee, Moore Stephens (now BDO) has been reappointed to continue the existing relationship bringing a level of audit specialism and expertise which complements the detailed knowledge of the organisation brought by an in-house Head of Internal Audit. Relationships between the audit team and the Committee and Executive remain strong with sufficient independence and objectivity demonstrated and the profile of internal
audit continues to be visible across the organisation. Most importantly, internal audit is seen to have a positive impact on the achievement of GMC outcomes.

34 A summary of internal audit performance for the year is given in the following table.

<table>
<thead>
<tr>
<th>Response to satisfaction statement 2018</th>
<th>ARC and Executive survey</th>
<th>Auditees survey</th>
<th>KPIs 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>70</td>
<td>205</td>
<td>2017 in italics</td>
</tr>
<tr>
<td>2017</td>
<td>92</td>
<td>234</td>
<td>Scoping meeting held two-four weeks in advance 100% (100%)</td>
</tr>
<tr>
<td>Agree</td>
<td>63</td>
<td>150</td>
<td>Scope approved by sponsor five days in advance 100% (100%)</td>
</tr>
<tr>
<td>2017</td>
<td>55</td>
<td>134</td>
<td></td>
</tr>
<tr>
<td>Neither</td>
<td>3</td>
<td>25</td>
<td>Close meeting held 90% (89%)</td>
</tr>
<tr>
<td>2017</td>
<td>2</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>Disagree</td>
<td>9</td>
<td>4</td>
<td>First report draft within ten days 90% (84%)</td>
</tr>
<tr>
<td>2017</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>2</td>
<td>4</td>
<td>Management responses within ten days 85% (83%)</td>
</tr>
<tr>
<td>2017</td>
<td></td>
<td></td>
<td>Final report within five days 95% (79%)</td>
</tr>
</tbody>
</table>

35 As ever, there is always room for improvement in the timeliness of delivering parts of audit reporting and we continue to focus on robust upfront planning and management of key delivery dates. The audit team is also alert to emerging risk areas where assurance is needed and continues to liaise closely with Executive colleagues as to how it continues to deliver value to the business.

36 In 2019 the GMC is due for an external quality assessment of its internal audit function. In preparation, during 2018 the Chartered Institute of Internal Auditors undertook a readiness review and concluded that it conformed to 62 of the 64 standards. To fully conform with the standards Moore Stephens were asked to confirm what the GMC’s risk maturity level is (this was done in July 2018) and to consider the inclusion of value for money audits looking specifically at the economy of operations in the audit programme. To address this, we have included a value for money element in each of the programmed reviews for 2019 where relevant.
37 The assessor also noted a number of areas of good practice including:

- adopting an agile planning methodology to address new and emerging risks
- using external specialists to perform reviews of more technical areas such as IT security
- using a Business Assurance Framework which maps all sources of assurance for key risks across the three lines of defence
- internal audit reports include sections which reconcile the work performed to the GMC’s strategic risks.

38 As part of the ongoing quality assurance of audit work, as well as Moore Stephens’ own internal arrangements, the Assistant Director of Audit and Risk Assurance attended Moore Stephens offices and has reviewed a sample of audit working papers on two occasions during 2018. This demonstrated that audit work was supported by detailed working papers and results of testing were on file. The ADA&RA also reviewed all draft reports with the exception of the risk review during the year.

**Independence of the Assistant Director Audit and Risk Assurance**

39 It is important that the Assistant Director Audit and Risk Assurance is, and is seen to be, independent of management decision making. To facilitate this, the role is accountable to the Chair of the Audit and Risk Committee with day-to-day line management through the Chief Operating Officer. To maintain independence in the audit work relating to risk, the ADA&RA plays no part in the scoping of audits, and discussions and reporting of findings are conducted by the Moore Stephens Partner directly with the Chair of the Audit Committee, who sponsors the review. If the ADA&RA is involved in delivering audit reviews, the Partner from Moore Stephens undertakes a review of the report and challenge of the evidence and conclusions drawn.

40 During 2018 the ADA&RA provided interim line management support to the Governance Team for a period of six weeks. This did not impact on other day-to-day responsibilities and no decision-making was undertaken which was subject to audit review. Appropriate arrangements were put in place through the Moore Stephens Partner, should they have been needed, in the event of any conflict arising.

41 The ADA&RA is regularly challenged by the Partner, Moore Stephens, on safeguards for maintaining independence and the Audit and Risk Committee meets separately with Moore Stephens at least once a year without the ADA&RA being present. The Committee also took part in an unconscious bias training session in January 2018 led by the GMC’s Equality and Diversity Manager.
Executive summary
At the Council meeting in June 2018 we outlined our vision for strengthening our approach to communications and engagement at the GMC. Case studies in an Annex to this paper demonstrate we have improved our capability in several places.

Our two key priorities in the past 12 months have been rebuilding the medical profession’s confidence in the GMC and strengthening the organisation’s engagement with patients and the public. Analysis of our media environment and feedback from doctors’ representatives suggest we have had some success in rebuilding confidence at the strategic level of the profession. The results of our next tracking survey, scheduled for the autumn of 2019, will tell us whether the perception of the profession as a whole has changed as a result of our work.

There are several areas where we must improve our performance and impact. We are taking steps to improve the management of our national-level relationships. In early 2020 we will implement a new structure for our outreach teams which will enable enhanced engagement with stakeholders in the regions of England as well as the devolved nations.

Recommendations
Council is asked to:

a. Note the progress made by the directorate in delivering the vision articulated to Council in June 2018.

b. Note the identified areas for development in the next 12-18 months.
Remembering our vision

1 The Strategic Communications and Engagement Directorate was established in January 2018. Its formation has been part of a wider programme of change designed to help the organisation better shape and respond to developments in our external environment. Our strategy, policy and engagement capabilities have all been enhanced to make us better, pacier and more collaborative in our work with external stakeholders.

2 As was noted by the report by Moore Stephens in November 2018:
   a The creation of the directorate has been successfully delivered.
   b It has led to improvements in our working practices and agility, and the ability of our teams to concentrate on the quality of their outputs.
   c Teams within the directorate have a better clarity of purpose and identity within the organisation.

3 At the Council meeting in June 2018 we outlined our vision for strengthening our approach to communications and engagement at the GMC (see Annex A). To achieve our mission as a professional regulator, we said that building our influence was essential and that we must be seen as a relevant, proactive and engaging actor in our environment. With this influence we can deliver positive change, externally and internally, in the three areas of practice, policy and perception.

4 The vision outlined to Council describes the outcomes which we expect to be present at the point our ambition is achieved. Since then, to guide our development we have taken these outcomes and created a set of capability statements. These capabilities apply to the communications and engagement we deliver both inside and outside the organisation, and they make clear the focus, culture and approach we wish to have as a directorate and across the GMC as a whole.

5 Those capabilities are:

   a **Capability 1**: We are agile and respond effectively to issues which could affect our reputation and to the changing needs of the four countries of the UK.
   b **Capability 2**: Our audiences and stakeholders find us easy to communicate with and engage. We are an organisation that listens, hears and acts, and we are sensitive to the diverse needs of our audiences and stakeholders.
   c **Capability 3**: We have strong and productive relationships with key influencers and stakeholder organisations. We manage these wisely as assets and seek out opportunities to work with them in partnership to protect patients from harm.
Council meeting, 12 June 2019

Agenda item M11 – Update on our strategic approach to communications and engagement

**d** Capability 4: We give our audiences and stakeholders the information they want, when they want it and how they want it. We tailor our products, content, engagement and channels to their diverse needs and contexts.

**e** Capability 5: We seek opportunities to influence our environment, and speak out where we see issues are causing harm to patients and doctors. We are proactive and relevant.

**f** Capability 6: We use data, insights, analysis and best practice to shape how we communicate and engage with our audiences and stakeholders. We continuously learn and improve.

We are in the process of reviewing our performance against these capability areas, and will use the results to create a programme of ongoing improvement (which will cover areas such as our 'knowledge, skills and behaviours'). Our template for this work comes from the UK Government’s Communications Service, which runs a capability review programme of Whitehall departments and arm’s length bodies. Each review uses a framework of capability statements common across Whitehall to evaluate whether a department or body is undertaking the right communication, in the most effective way, using the right skills mix. It identifies areas of strength as well as areas for improvement.

**Priority 1: Rebuilding the profession’s confidence in the GMC**

Since the early part of 2018, one of our key priorities has been to rebuild the profession’s trust and confidence in the organisation. Our standing with doctors and their relationship with us were adversely affected by the decision taken to appeal the outcome of Dr Bawa-Garba’s tribunal and subsequent events associated with this case.

The independent research which we commissioned in the summer of 2018 to baseline perceptions of the organisation for the Corporate Strategy showed that three in four doctors had lost some confidence in the GMC over the previous 12 months, because of this particular case. Only 34% of doctors expressed confidence in how they were regulated by the GMC, down from 57% in a similar survey run in 2016.

We saw this trend in several other places:

a Our analysis of media coverage in 2018 ([Annex B](#)) shows negative mentions of the GMC in the media exceeded 10% in seven months of that year – compared to two months in 2017.

b In the summer of 2018, 70 agenda motions about the GMC were submitted for debate at the BMA’s Annual Representative Meeting (ARM) by regional branches of that organisation. Over 70% of these motions were negative in tone, many of which declared no confidence in the GMC and a belief that we were not fit for

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purpose. In comparison, at the 2017 ARM there were 22 motions of which only one was negative.

In addition, several representatives of the profession used public platforms to express their concerns:

‘The GMC’s intervention sent shockwaves through the profession – it now has serious work to do if it is to regain the trust and confidence of doctors’ – Dr Chaand Nagpaul, Chair of the BMA’s Council (October 2018).

Recent public statements by doctors’ representatives suggest that we may have had some success in rebuilding the confidence that we lost among these strategic-level relationships, and that it may have returned to the level which we saw right before the profile of the case increased in early 2018:

‘...this intervention from the GMC, whose responsibility it is to guarantee patient safety, is welcome...it is positive to see the GMC recognising the pressures doctors are under, noting that the profession is on the brink of ‘breaking point’, and laying out ways to begin addressing this.’ – Dr Chaand Nagpaul, Chair of the BMA’s Council, responding to the findings of State of medical education and practice 2018 (December 2018)

We see this sentiment reflected in our media environment which our data suggests is much improved (Annex B). The results of our next tracking survey, scheduled for the autumn of 2019, will tell us whether the perceptions of the profession as a whole are different – as a result of our continued engagement with them, our communications, the communications of other organisations and, of course, the passage of time.

We do not expect their perceptions to have changed significantly. Restoring the profession’s confidence will take more time and we must sustain our efforts. In saying that, our experience of 2018 suggests that achieving a permanent state of confidence will be hard to achieve. A study by the Economist Intelligence Unit for KPMG on ‘Building trust in regulation’ highlights the fragile nature of the relationships which typically exist between regulators and those they regulate. Another ‘lightening rod’ case could easily undermine our work to date.

We can provide our reputation with a layer of protection by improving the awareness and understanding which doctors and medical students have of our role. Our liaison services already do this well, resulting in positive impact. In 2018 our advisers in the four countries of the UK engaged with 24.8k doctors and 15.4k medical students. Our evaluation shows 71% of doctors left these sessions with an improved impression of the GMC.

The question is how we can achieve this same effect on an even larger scale. Our organisation has hundreds of touchpoints with the profession – through our
registration, revalidation, education and fitness to practise processes. Each touchpoint is a communications opportunity to explain and reinforce our value. We are scoping a significant review of those touchpoints to ensure we are making the most of them.

15 The reviews that we have commissioned for our *Supporting a profession under pressure* programme, plus our more recent work on professional behaviours and clinical leadership, present us with new opportunities to demonstrate our understanding of the issues experienced by doctors and our relevance to their places of work. Once those reviews with their recommendations are published, we will leverage the influence we have built with our partner organisations to pursue a material change on the ground for the profession and their patients.

16 In the meantime, we will continue our approach of:

a Speaking out where we see issues are causing harm to doctors and their patients – through our flagship reports such as *The State of medical education and practice*, as well as our research and data – using the media in concert with our range of communications channels to ensure our message gets across.

b Finding and using trusted voices to speak on our behalf – such as Dr Hannah Barham-Brown, a doctor with a disability who recently welcomed our ‘Welcomed and valued’ guidance:

‘Medicine is a hard career without having to worry about how medical schools and colleagues will address your disability, so the GMC producing this work in conjunction with so many of us is hugely appreciated and has the potential to make much-needed change.’

c Engaging our audiences and stakeholders in the development of policies, guidance and solutions, co-producing them where possible.

d Engaging with doctors on the frontline so we fully understand the context in which they are practising and training – through the work of our four country liaison advisers, as well as visits and engagement by our Chair and senior leadership team.
Priority 2: Strengthening our engagement with patients and the public

17 Rebuilding the profession’s confidence in the GMC has been one of our primary areas of focus. Our second priority has been the improvement of our engagement with patients and the public. The corporate strategy says we want ‘the public...[to] find it easy to engage with us and influence our work and have a compassionate and consistent experience when they do’.

18 Our consultation on our revised *Decision making and consent* guidance, which closed in January, demonstrates a clear appetite from patients to be involved in our work – as long as the topic and our approach is right. This consultation achieved a higher than expected response from patients (over 300 individual responses). Our understanding of what is important to patients and our use of the patient voice in our social media promotion played a key role in generating this response.

19 In early 2019 we developed a plan for strengthening our engagement with patients across the year. This contains three areas of focus:

a *Developing our relationships with patient bodies in the four countries.* To facilitate this we will hold two roundtables with patient bodies during the course of 2019. Our first meeting this year will be held in June, as part of which we will discuss how we can work together with patient bodies to signpost patients better when their complaint about a doctor would be more appropriate for another organisation to deal with. We will also explore the issue of remote prescribing before we hold a call for evidence which may identify areas where we can strengthen our guidance in this area for doctors. This year we will also support the Deputy Chief Executive, in her new role as our senior-level champion for patients, to build her relationships with patient leaders.

b *Improving our customer service for patients and their families.* As part of this we will develop and embed a new charter, so that patients and their families are clear about the service they can expect from the GMC. We will also explore how we can routinely understand the experience of patients who come into contact with our services, to help us evaluate whether the commitments promised in that charter are being delivered and to identify opportunities for improvements. We will link this to the broader work we are doing as an organisation to improve our customer service.

c *Strengthening the involvement of patients in our policy work.* We have an aspiration to involve patients earlier, better and more often in the development of our policies and standards – as we have done as we have developed our new requirements for patient feedback prior to formal consultation. The GMC’s policy profession discussed the broader subject of public involvement as part of an internal summit in April, and has identified a number of learning opportunities.
20  Strengthening these areas will position us well to engage with patients about a range 
of issues in 2020, such as our new corporate strategy.

Our priorities for development

21  While we have made good progress in strengthening various capabilities in the past 
12 months (as illustrated by the examples in Annex C), there are several areas 
where we must improve our performance and impact. This section sets out our 
priorities for development in the next 12-18 months. As mentioned above, we will 
continue to focus our efforts on rebuilding the profession’s confidence in the 
organisation and on strengthening our engagement with patients and the public.

Priority 3: Enhancing our digital engagement

22  Our three-year digital transformation programme will end in December 2019. By this 
point we will have delivered new websites for the GMC and MPTS, and a new intranet 
that will support the ongoing transformation of our internal culture. We will also have 
completed work on a number of other digital projects aimed at enhancing our 
engagement with our audiences. We are already considering how further digital 
transformation can stimulate positive changes in the services we provide to doctors, 
patients, employers and our other ‘customers’, and we envisage this may form a 
major feature of our next corporate strategy.

Priority 4: Strengthening our national and local relationships

23  The second aim of our corporate strategy states we will ‘[strengthen our] 
collaboration with our regulatory partners across the health services’ and that we will 
evidence this in ‘year on year improvements in perceptions of our collaborative 
working’, as measured by feedback surveys (including our annual survey of 50 key 
partners).

24  A survey to benchmark perceptions of the GMC in the summer of 2018 for the 
Corporate Strategy showed that 92% of the 47 stakeholder organisations surveyed 
believed our overall working relationship at that time was ‘good’. While these results 
were positive, it’s worth noting that seven of our ten major partners were approached 
but declined to participate in this research.

25  We are taking steps to improve the management of our external relationships and 
respond to the appetite expressed by our partners to take a more strategic and 
proactive approach to our engagement with them. As one stakeholder told us, they 
want to ‘move from a somewhat reactive way of working together to a more 
systematic programme of work...’.

26  A strategic approach designed to focus our efforts on growing those relationships 
which have the greatest value to our work was agreed by Executive Board in June 
2018. This has been followed by the development of a Relationship framework (which
we are using to categorise our main stakeholders and drive our relationship building activity), and the establishment of a new strategic relationships team (which will release capacity for us to deliver a greater quantity of public affairs work in Westminster and Whitehall). Our strategic relationships team will work with the Devolved Offices to develop the first set of relationship improvement plans for our regulatory partners in the four UK nations for the start of 2020.

27 In early 2020 we will implement a new structure for our outreach teams – specifically our Regional Liaison Service (RLS), Devolved Offices and Employer Liaison Service (ELS). The ELS will move from the Fitness to Practise directorate to Strategic Communications and Engagement, and reporting arrangements will change so that members of these services will work in teams aligned to particular geographies. This will enable us to deliver enhanced engagement with stakeholders in these areas, increasing our influence and responsiveness in all four countries of the UK but especially in the regions of England.

28 As we develop a detailed operating model for our new outreach function, we will explore how we can strengthen our engagement with providers – a critical audience given our need to influence the environments and cultures in which doctors practise and train to make them more conducive to the delivery of good medical practice. At present the responsibility for engaging with providers is divided across our outreach teams. As part of our review we will explore whether there are opportunities to streamline and improve this engagement with local organisations.

Priority 5: Improving our evaluation

29 Our evaluation and insights programme has to date focused on strengthening our measurement of individual channels (such as media coverage, social media and website performance). Maturing this capability has been a necessary first step, however we recognise the need to evolve this capability. There are two areas we can consider:

a Demonstrating the effect which our work has had on the GMC’s achievement of its strategic aims and benefits – what measurement experts class as ‘impact’. A precursor to this will be the development of an evaluation framework.

b Sophisticating our approach by combining and analysing data from a range of sources to form a more holistic picture of an individual customer’s interests and needs.

30 If we use the example of an international medical graduate, our current approach is to separately evaluate their engagement with GMC news for doctors, their involvement in a Welcome to UK practice session, and their experience of a service such as our Contact Centre or a PLAB assessment.
It may be advantageous to move towards a more granular approach in the future, analysing our data at the level of an individual customer rather than a cohort in order to understand where the opportunities might be for enhancing our support and relationship with that individual over time. Such an approach, however, carries implications for our technology, operations and information governance, and we will have to carefully explore these issues before reaching any decision on a way forward.
Our vision for strengthening communications and engagement at the GMC (June 2018)

1. Achieving our mission (‘prevent harm, drive improvement’) requires influence. We must be seen as a relevant, proactive and engaging actor in the healthcare environment.

2. We achieve this by having:
   a. A powerful and compelling narrative about our vision and strategy
   b. Positive, coordinated relationships with our key stakeholders
   c. Advocates in the political/public policy space
   d. A media profile which shows we are relevant and part of the debate
   e. Continued engagement ‘on the ground’
   f. Tailored proactive and reactive communications
   g. Effective channels which enable us to reach our audiences in variety of ways

All of the above elements must be planned and executed as one to achieve maximum impact.
Our measure is for 90% of media coverage in a month to be positive and/or neutral in tone; therefore negative coverage should not exceed 10%. Our media team completes a daily evaluation of our coverage.
How we have grown our capabilities – case studies

1 The past 12 months have seen us improve our performance and impact in several key areas. In some areas our data shows we are exceeding external benchmarks.

   Capability 1: Agile and responsive

2 Traditional media remains an important way of communicating our agenda and influencing opinion. Our media environment in 2018 was extremely challenging, shaped by several high profile issues – namely, the case of Dr Bawa-Garba, the rapid policy review conducted by Professor Sir Norman Williams, the publication of the Gosport inquiry, and the Zholia Alemi case. While the circumstances of each issue were quite different (some, for example, were wholly within our control), our management of them improved substantially throughout 2018 and we were able to limit the damage to our reputation through proactive and skilled engagement with journalists and politicians. In this we were aided by the lessons from the learning review of the Jack Adcock/Dr Bawa-Garba case which we have actively applied to our work.

3 Our Devolved Offices continue to enable the organisation’s engagement with audiences and stakeholders in Scotland, Wales and Northern Ireland, providing expert advice to policy and operational teams about stakeholders and responding to issues affecting us within their countries. The success of their approach is what we want to replicate in the seven regions of England through the review of our outreach teams. We are increasing the size of our liaison service in each Devolved Office (in order to increase our engagement with doctors as well as support corporate priorities such as Welcome to UK Practice) as well as their policy and external affairs functions. In 2019, following our involvement in shaping the development of England’s workforce plan, we have started to explore what contribution we could make to the workforce strategies of Scotland, Wales and Northern Ireland. Our data on the UK’s medical workforce is one of our key assets, and our Devolved Offices are facilitating work between our data
teams and workforce leads in their countries to demonstrate the tangible support we can give to these agendas.

**Capability 2: Easy to communicate with and engage**

4 Making our new website accessible to all our audiences has been a key objective of our digital transformation programme. We measure its accessibility in two main ways: through Siteimprove (a website improvement tool) and through external reviews by a specialist organisation called Shaw Trust.

5 Siteimprove checks our website for errors and ranks it against the international standard Web Content Accessibility Guidelines (WCAG). The old version of the GMC website averaged a score of 85%. The new website’s score in April 2019 was 95.7%. The industry benchmark for government/public sector organisations is 72.1%.

6 In addition, we asked Shaw Trust to complete an accessibility assessment of our website, both prior to launch and several months after. This involved a thorough audit using both automated evaluation tools and manual testing by users who have a disability. The tests enabled us to deliver a highly accessible website at launch, and since then, to continuously improve its accessibility, reaching the scores mentioned above.

**Capability 4: Tailoring products and content to our audiences**

7 Our routine evaluation highlights several improvements in our ability to produce audience-tailored content.

8 We have seen increased engagement from our people with our internal communications. In 2018 there was a 65% increase in views of intranet articles compared to 2017. This is due to our tighter management of the intranet and the introduction of content guidelines which have led to fewer but better articles being published. Recently, we have introduced a set of narratives to give further structure to our internal communications activity. We will build on this engagement with the introduction of a new, user-focused intranet for the organisation towards the end of 2019.

9 While we achieved less media coverage for our 2018 *The state of medical education and practice* report, our presentation of the report on our website generated 35% more views (18k views in total) while the time people spent on the report’s website pages increased – from under five minutes to over eight minutes. We achieved this by studying how other organisations present their reports in a digital, user-friendly way and using the vastly improved capability of our new website.
Despite the high profile issues we faced during 2018, the profession’s engagement with **GMC news for doctors** did not change. Across the eight editions of the bulletin that year, there was an average open rate of 46.9% compared to 46.5% in 2017. The open rate peaked in December 2018 with an open rate of 60%, however this is normal as this month’s edition typically includes details of the following year’s annual retention fee. We have significantly improved the design and content of this product over the past two years, testing different approaches to gradually drive up the open rate to its current level. While our typical level of engagement is strong and compares favourably to the standard relevant to our sector (21%), we will consider what more we can do to increase this over 50%.

By 2020 our corporate strategy says we will see ‘increased engagement with digital content...that support good practice.’ Analysis of our website performance shows that the average time spent on a web page about our ethical guidance has increased by over 40% since 2017 and that the ‘bounce rate’ – the percentage of visitors who navigate away from the site after viewing only one page – for this particular section of our website has reduced by 10% in that time.

**Capability 5: Influencing our environment**

Over the past year, we have actively developed our relationships with parliamentarians and we are seeing signs that we are securing greater impact for the organisation in Westminster.

We have influenced legislation which touches on our regulatory remit. We liaised closely with civil servants to ensure that the Statutory Instrument (SI) amending the Medical Act in anticipation of a ‘no deal’ Brexit did not adversely impact our statutory functions, the NHS workforce or patient safety. We submitted detailed legal and policy commentary to officials from the Department of Health and Social Care on 11 iterations of the draft Act over a period of 18 months. When the SI was eventually laid before Parliament, in December 2018, we signalled our support and encouraged the passage of the legislation in both the Commons and the Lords through detailed oral and written briefings. These outlined the impact of the changes for the GMC, highlighting our outstanding concerns with the drafting yet strongly advising the adoption of the Instrument to provide much needed legal certainty to help to manage any potential disruption to the NHS medical workforce and avoid a ‘cliff edge’. Our efforts ensured the SI was adopted.

We have been asked to appear five times in front of four different House of Commons committees on issues including the new Health Safety Investigations Branch, gross negligence manslaughter in healthcare, abortion law in Northern Ireland, eating disorders, and LGBT healthcare provision.
15 We have held a series of topic-specific parliamentary roundtables working with peers and MPs who were either critical of us or felt we should be taking action in a specific area, to bring together other relevant stakeholders to explore what the wider collective approach should be. Those topics include the provision of training to understand eating disorders, and combatting bullying and undermining in the NHS.

16 Finally, we have worked with the organisation’s data teams to develop a bespoke tool which allows us to give every MP in the House of Commons an in-depth analysis of what GMC data tells them about the health economy in their constituency in England and how this can be supported by our policy and legislative agenda. This is already improving our reputation with MPs and started to secure positive engagement and support for the GMC’s goals.

17 The interest we are seeing in our work with the UK Parliament is driven by our efforts to change the reach and nature of our parliamentary engagement. Levels of that engagement vary from country to country, and to some extent this is shaped by the country itself (the Assembly in Northern Ireland is currently suspended, for example). That said, we are committed to building on the progress we have made over the past 12 months and will aim to develop a new, four-country approach to public affairs by the end of 2019 (mirroring an approach we have developed to improve the management of our strategic relationships). This work will be aided by the arrival of a new Assistant Director for Public Affairs and the Devolved Offices in the early summer.

*Capability 6: Using data, insights, analysis and best practice*

18 We started to develop our evaluation capability towards the end of 2016, beginning with a regular analysis of media coverage and engagement with our regular e-newsletter for the medical profession, *GMC news for doctors*. This work has been informed by guidance produced by the Association for the Measurement and Evaluation of Communication (AMEC).

19 We produce a performance report every month, showing the impact we have had on our internal and external audiences. This report includes the following key measures for our main communications channels:

- **a** The sentiment of our media coverage – we aim for at least 90% of GMC mentions in the media every month to be positive or neutral in tone. As *Annex A* shows, we have achieved 95-96% for the first four months of 2019.

- **b** The engagement we achieve for *GMC news for doctors* – we aim for each edition to have been opened by at least 40% of the profession. In April 2019 we achieved an open rate of 42%.

- **c** Customer satisfaction with our website – we are piloting the use of a ‘net promoter score’. This tool can be used to gauge the ‘loyalty’ of an organisation’s customers.
As one might expect, this measure is used by the commercial sector more than the public sector. Scores vary across industries, however one that is higher than zero is generally deemed good, and a score of over 50 is considered excellent. Our monthly score since the autumn of 2018 has been in the range of 16-20.

20 We continue to strengthen this capability in order to drive and support a culture of learning and innovation. For example, we routinely analyse the engagement of different cohorts within the profession (such as career stage, area of primary medical qualification, and ethnicity) with *GMC news for doctors* to help us understand what content these groups like best – see the figures below. Towards the end of 2018 we procured a new tool to help us track and analyse conversations on social media. This data, when combined with our analysis of media coverage, should over time provide us with a better picture of our reputation among the profession.

**Figure 1**: Analysis of open rates for *GMC news for doctors* by professional cohort (January 2017 – April 2019). This shows we typically achieve higher rates of engagement with doctors who are not in postgraduate training and not on the Specialist or GP registers.
Figure 2: Analysis of open rates for *GMC news for doctors* by doctor’s area of primary medical qualification (PMQ) (January 2017 – April 2019). This shows we typically achieve higher rates of engagement with doctors who qualified outside of the UK.
**Figure 3**: Analysis of open rates for *GMC news for doctors* by doctor’s ethnicity (January 2017 – April 2019). This shows there is not much variation in levels of engagement between doctors with different ethnicities.