Council
Meeting Room 2.08
350 Euston Road,
London, NW1 3JN

Agenda

Wednesday 27 February 2019

10:20 - 13:00

10:20 – 10:25  M1 Chair’s Business  5 mins

10:25-10:25  M2 Minutes of the Meeting on 12 December 2018  0 mins

10:25– 10:50  M3 Chief Executive’s Report  25 mins

10:50 – 11:00  M4 Chief Operating Officer’s Report  10 mins

11:15 – 11:30  M5 Field Forces Review  15 mins

11:30 – 11:50  M6 Education Quality Assurance Review  20 mins

12:30 – 12:40  M9 Any Other Business  10 mins

M10 Report of the Executive Board
M11  2020 Council and Committee Planning
27 February 2019

Council

To approve

Minutes of the meeting on 12 December 2018

Members present

Terence Stephenson, Chair

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

Others present

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

These Minutes should be read in conjunction with the Council papers for this meeting, which are available on our website at http://www.gmc-uk.org
Chair’s business

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

Minutes of the meeting on 7 November 2018

2. Council approved the minutes of the meeting on 7 November 2018 as a true record.

Chief Executive’s Report

3. Council considered the Chief Executive’s Report, noting developments in the external environment, progress on the GMC’s strategic priorities and how the GMC’s major work programmes were progressing.

4. Council noted that:

   a. There remains a high level of uncertainty around the Withdrawal Agreement between the European Union and UK Parliament being approved by Parliament. A “no deal” exit from the European Union in March 2019 remained a possibility.

   b. The GMC is working closely with stakeholders as part of the ‘Supporting A Profession Under Pressure’ work stream. This includes the independent review into gross negligence manslaughter and culpable homicide, publishing new guidance on reflective practice and rolling out ‘human factors’ training to our investigators.

   c. A decision on who would regulate Medical Associate Professionals was expected shortly. The GMC has written to the DHSC to explain how we would regulate them, if selected.

   d. In light of the fraudulent registration of Ms Zholia Alemi, a full review of approximately 3000 doctors that entered the UK register on the same, now abolished, route to registration has commenced.

Chief Operating Officer’s Report

5. Council considered the Chief Operating Officer’s Report, Council Portfolio and Corporate Opportunities and Risk Register.

6. Council noted declarations of interest from Susan Goldsmith, Paul Buckley, Steve Burnett and Paul Knight in relation to their role as directors of GMC Services International (GMCSI)

7. During discussion, Council noted that:

   In general, performance was positive with two exceptions. In September the KPI to respond to 90% of ethical/standards enquiries within 15 days was missed due
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Agenda item M2 - Minutes of the Council meeting on 12 December 2018

2018 to a drop in staff resources; this was met in October. In October 2018 the KPI ‘to conclude 90% of fitness to practise cases within 12 months’ was missed due to four complex cases requiring higher levels of input from senior medical advisers.

a. The Clinical Assessment Centre facility will be increased with two circuits running in parallel. This is due to be operational by 2019, with external venues to be used in the interim.

b. Risk IT9 which relates to the recruitment and retention of staff and associates has been raised from ‘low’ to ‘significant’ which reflects the current recruitment campaign to recruit 650 associates for the increased demand for PLAB.

c. Risk AT4 has been added to the Corporate Risk Register which is in relation to the introduction of credentialing.

2019 Business Plan and Budget


9. Council also agreed to delegate authority to the Chair of Council to amend the GMC Registration Fees Regulations and GMC Certification Fees Regulations.

10. Council noted that:

a. A ‘pipeline’ for activities which are not fully scoped, or are considered a low priority item, has allowed the team to create a more robust and realistic business plan. This pipeline will be monitored throughout the year so the capacity to deliver is not exceeded.

11. During discussion, Council noted that:

a. GMCSI will enter its third year of operation. As of the 1 January 2019 GMCSI will take on the hiring of the Clinical Assessment Centre to generate additional revenue when not in use with PLAB exams.

b. Fees would only be increased in line with the Consumer Price Index (CPI) which currently sits at 2.5%. SMT have been asked to monitor expenditure on the new CAC.

Report of the Medical Practitioners Tribunal Service Committee 2018

12. Council considered the report from the MPTS Committee.

13. Council noted that:
a. The introduction of Legally Qualified Chairs (LQC) has been a success both in terms of the operational function of the tribunal and efficient management of the service.

b. There is now a requirement for parties to submit their bundles in advance of the hearing which has reduced the cost and length of hearings.

c. The accommodation, website and MPTS branding has been refreshed and will be gradually rolled out in 2019.

14. During discussion, Council noted that:

a. A joint training session with the Nursing and Midwifery Council for LQCs was successfully organised this year as a trial in order to pool resources and share best practice.

b. The Doctors Contact Service was expanded this year to support doctors on the day of the hearing. Since January, a total of 76 doctors were supported by the service.

c. Tribunal member diversity was a priority for the team, currently there are 297 tribunal members 48% are female and 20% identify as BME.

d. Forecast spend is expected to be 3% higher than budget for 2019 due to higher levels of referrals than was forecast.

e. The next report to council will contain further measures on how to streamline the tribunal process and produce further savings.

Report of the Audit and Risk Committee

15. Council noted the report of the Audit and Risk Committee, and approved the proposed changes to its Statement of Purpose.


17. Council noted that:

a. There is a good control framework in place across the organisation and internal audit recommendations have appropriate actions in place to address them.

b. Moore Stephens have been reappointed as internal audit delivery partners for three years commencing 1 January 2019.
Report of the Remuneration Committee 2018

18. Council considered the 2018 report of the Remuneration Committee and approved its updated Statement of Purpose.

19. Council noted that:

   a. The Remuneration Committee considered the annual pay award for the Chief Executive, Chief Operating Officer, Directors and Chair of the Medical Practitioners Tribunal Service. The Committee agreed that the base award of 1.5% as agreed for all other staff should be applied.

   b. All references of ‘Senior Medical Advisor’ have been removed from the statement of purpose as this title has been updated to ‘Medical Director and Director of Education and Standards’.

Council forward work programme 2019


21. Council noted that this was a working document and would consider it on a regular basis to consider whether changes would need to be made.

22. During discussion, Council noted that:

   a. It would be beneficial for Council members to continue to spend time with the operational teams within the organisation.

   b. There will be an opportunity to review the forward work plan in the summer, for the rolling 12 month period.

   c. The Corporate Governance team will begin work for the 2020 meeting schedule in January and will submit this for approval at the February 2019 Council meeting.

Committee membership 2019

23. Council noted the process for reviewing the membership of the Committees.

24. During discussion, Council noted that:

   a. Terence Stephenson has been completing the appraisal process with the current Chairs of the Committees. As part of this process Terence will make a recommendation to Clare Marx.

   b. Lord Hunt and Dr Michael Marsh, who take up their posts on the 1st January 2019, will be given roles on committees.
Any other business

25. The Chair thanked Council members for their work and contribution to discussions during his time as Chair of the Council and in particular to Helene Hayman who will also be stepping down as a member of Council in December.

26. Christine Eames gave an update on her experience at the GMC Valued Awards. Council was advised that it was an excellent evening and credit was given to all the teams that were nominated.

Confirmed:

Clare Marx, Chair 27 February 2019
Council meeting, 27 February 2019

Agenda item: M3
Report title: Chief Executive’s Report
Report by: Charlie Massey, Chief Executive, chiefexecutive@gmc-uk.org, 020 7189 5037
Action: To consider

Executive summary
This report outlines developments in our external environment and progress on our strategy since Council last met.

Key points to note:
- The legislative changes to the Medical Act in the event that the UK leaves the European Union without a deal have been approved in the House of Commons and are awaiting scheduling for debate in the House of Lords;

- We are working closely with NHS Improvement on developing the workforce implementation plan to support the recently published NHS long-term plan in England;

- The new process around exercising our right of appeal is operating effectively. However the Professional Standards Authority (PSA) has confirmed that the short timescales mean that it will not be able to provide input before our Executive Panel meets to make its decisions.

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

Brexit

1 The Department of Health and Social Care (DHSC) laid the draft Medical Act amendments legislating for a ‘no deal’ Brexit on 20 December 2018. We have been working very closely with DHSC officials and lawyers, as well as officials in the devolved governments, over the past 18 months 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.

2 At the time of writing, the statutory instrument has been approved by the House of Commons but is yet to be scheduled for debate in the House of Lords.

3 Under the ‘no deal’ framework, EEA nationals will be treated as International Medical Graduates (IMGs), but the IMG framework is being amended to recognise certain EEA qualifications as evidence of knowledge, skill and experience regardless of the nationality of the holder. If approved by Parliament, this should avoid the need for EEA doctors following our traditional IMG route to the register (which can take a considerable amount of time) and should ensure minimal disruption to the NHS workforce.

4 We have briefed parliamentarians on these proposals during debates in the parliamentary scrutiny committees, raising two substantial issues:

a The need to have guidance from DHSC on how our new powers to designate an EEA qualification as ‘non-comparable’ can be exercised.

b The need for the two-year Secretary of State review to be thorough and wide-ranging and provide the opportunity for us to revise our entire international registration framework in line with our calls for legislative reform and the introduction of a Medical Licensing Assessment (MLA).

5 In December 2018, the Executive Board agreed to fund additional capacity if required to make sure that we have sufficient staff in the right teams to deal with whatever exit scenario we face. For example, we anticipate that there may be a surge in applications from EEA doctors in the run up to March followed by a period of change as we embed new rules for gaining access to the register after March. We are confident that the plans we are making, which include options for changes to our IS systems, will help us successfully navigate these changes.
Workforce

6 We are working with NHS Improvement on the workforce implementation plan that follows the publication of the NHS long-term plan for England. We have been invited to join the steering group as well as various workstreams that will help develop the plan. Through our engagement we continue to highlight the themes set out in our workforce manifesto for improved supply and retention of doctors, increasing support for the profession and taking a systemic approach to the workforce challenge.

7 In Wales, the Government’s long-term plan for the integration of health and social care, A Healthier Wales, committed Health Education and Improvement Wales (HEIW) to developing a joint workforce strategy, with Social Care Wales, by the end of 2019. We have engaged with the lead in HEIW to present our data and offer support in informing their strategy and will remain engaged in the development of this important work through the year.

Medical Associate Professions

8 In February, the Department for Health and Social Care (DHSC) published its response to the consultation on the regulation of medical associate professions (MAPs) in the UK. This reaffirmed the Government’s intention to introduce statutory regulation for the physician associate and physicians’ assistant (anaesthesia) roles. It said that work is ongoing to evaluate whether we or the Health and Care Professions Council (HCPC) would be most appropriate to take on the regulation of these two roles.

9 As stated previously, we believe we would be well placed to take on the regulation of MAPs but we have also been clear that if asked to do so, doctors’ fees will not be used to subsidise the regulation of these new professional groups.

Zholia Alemi case

10 We continue primary source verification of the primary medical qualifications (PMQs) of all currently licensed doctors who had been registered under the same now abolished Commonwealth route to registration as Zholia Alemi. We enlisted the help of the Educational Commission for Foreign Medical Graduates (ECFMG) in this task and at the time of writing we have verified 2,200 doctors. There are four medical schools still to return data to ECFMG and we continue to work to complete this task as quickly as possible.

11 All doctors whose PMQ has been verified have received an email advising them of this, and we are starting to contact a small number of doctors whose PMQ we cannot yet verify because of name or date of birth discrepancies to ask them for more information.
12 We are also considering the implications and potential criteria of widening the scope of our primary source verification checks on international medical graduates who are already registered with the GMC.

**Online prescribing**

13 We are working closely with other regulators including the Care Quality Commission (CQC), the General Pharmaceutical Council (GPhC) and the Medicines and Healthcare products Regulatory Agency (MHRA) to tackle unsafe practices in online prescribing. This includes applying our existing prescribing guidance more tightly to these cases, considering what additional advice we can give and what more we can do to make sure doctors are aware of our guidance, and working with the DHSC to address the regulatory gaps in this fast-evolving sector.

**Cannabis-based products for medicinal use**

14 We continue to monitor developments following the change in the law in November 2018 to allow doctors on the Specialist Register to prescribe cannabis-based products for medicinal use. NHS England, the British Paediatric Neurology Association and the Royal College of Physicians have produced interim guidance, with NICE scheduled to produce guidance in October 2019. We are signposting doctors to these resources and to our guidance on unlicensed prescribing.

**Inquiries and reviews**

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

**Paterson Inquiry**

16 In early January 2019 we submitted written evidence to the Inquiry. Una Lane and I gave oral evidence in private session on 22 January 2019. The Panel’s questions focused on our fitness to practise procedures and how we handled individual complaints. We will be writing to the panel to provide further information on some of the issues discussed. The Inquiry is due to publish its findings in the summer of 2019.

**Infected Blood Inquiry**

17 We have established a positive working relationship with the Inquiry Team to make sure that we support their important work as effectively and efficiently as we can within the resources available. This demonstrates our commitment to learning from our interaction with the Gosport Independent Panel. We have met the Inquiry Team to discuss how best to provide the information they require from our records and we are working to provide them with the first round of disclosure as quickly as possible.
We anticipate that effective support for the Inquiry will require significant resource from across the business and that the Inquiry will run for the next two years.

**Independent Neurology Inquiry**

18 Dr Michael Watt is a consultant neurologist, practising in the NHS (Belfast Health and Social Care Trust) and in the independent sector in Northern Ireland. In May 2018 the Department of Health (NI) announced the establishment of a non-statutory independent inquiry to review the Trust’s recall of Dr Watt’s neurology patients (approximately 3,500 to date). Dr Watt’s registration is currently subject to an interim order of suspension.

19 In November 2018 we held an introductory meeting with the Inquiry Panel and have since been invited to formally give evidence in March 2019. We anticipate that the Panel will submit a report to the Department of Health (NI) in the autumn.

20 In parallel with the Inquiry, the Department also announced a number of other reviews to be undertaken by the Regulation and Quality Improvement Authority (RQIA), one of which is reviewing the Trust’s governance of outpatient services. In January 2019, Una Lane and Jane Kennedy from our Northern Ireland office met the review team, who were keen to understand how revalidation can support clinical governance. Information sharing, the role of responsible officers and regulatory requirements for designated bodies in relation to revalidation were also discussed.

21 The RQIA are in the process of establishing teams for a clinical review of the medical records of Dr Watt’s deceased patients (this is over a ten year period – although this might be extended) and for a review of governance in the independent sector in Northern Ireland. We anticipate that the RQIA will report the findings of both these reviews later in 2019.

**Abortion Law in Northern Ireland**

22 The Women and Equalities Committee are holding an inquiry into abortion law in Northern Ireland. Colin Melville and Sharon Burton from our Education and Standards team, gave oral evidence on behalf of the GMC on Wednesday 12 February 2019.

23 We are concerned by the evidence the Committee has heard about women receiving poor care and about doctors feeling confused, conflicted and concerned about how to balance their legal obligations and our professional guidance in this area.

24 We contributed to the 2016 guidance developed by the Department of Health (NI) which provides helpful advice for health and social care professionals covering many of the scenarios raised.
25 But it is clear that more could be done to ensure clinicians are aware of this guidance and that women and girls are aware of what they should be able to expect from doctors. We will work through our Northern Ireland office and with other stakeholders to support greater awareness and understanding of the guidance in this critical area.

Progress on our strategy

GMC right of appeal

26 As agreed with Council, we have established a new Executive Panel to consider whether we exercise our right of appeal in specific cases. The changes to our internal process follow receipt of independent legal advice from Sir Robert Francis QC which advised that it would be unlawful to suspend use of the GMC’s right of appeal or to delegate it to the PSA.

27 As part of the changes, Council had asked that we seek the input of the PSA as part of our consideration of appropriate clinical misconduct or deficient performance cases. We have sought this input from the PSA in the cases we have considered under the new process, however the PSA has since advised us that given the way the statutory timescales work they will not be able to provide this input before our Executive Panel meets to make its decisions.

28 While it would be useful to have the PSA view, we understand the reasons given. We continue to work closely with the PSA to discuss cases of concern and facilitate the effective and efficient exercise of our respective rights of appeal. The PSA are also of the view that our protocol in this area is working well.

Credentialing

29 Since September 2018 we have engaged with a range of stakeholders on a draft framework for identifying and approving credentials. Feedback has been generally positive, with many welcoming the opportunity for more consistency and quality assurance in areas where there are risks to patients or gaps in service. But some have raised concerns about the impact of credentials on postgraduate training and have called for more clarity on how they will work in practice.

30 In response, we are looking at ways of improving the framework, and better supporting how credentials will work in practice. We are also considering a new name to make it clearer what we are introducing and distinguish it from other developments in the NHS. Funding was a specific concern raised by both doctors in training and educationalists. We are working with the UK Medical Education Reference Group (UKMERG) to develop a statement from the four UK governments
about their commitment to financially support credentials where they are commissioned and funded to meet NHS service needs.

31 We will bring a report and recommendations for the introduction of credentials to Council in June 2019 and, if endorsed, a small number of ‘early adopters’ will start the approval process in 2019. We are discussing with UKMERG the priority areas for the small number of first credentials in 2019, and the medium and long-term direction of travel for future areas.

32 We also continue to engage with the four UK governments on the draft framework and any changes we consider in response to the engagement analysis. We will update Council on any proposed changes to the framework when the detailed analysis of responses is completed, ahead of reporting to Council in June 2019.

**Survey of SAS and locally employed doctors**

33 We will be launching a pilot survey of SAS and locally employed doctors in spring 2019. The main objective of the survey is to better understand the scale and extent of the challenges faced by this group of doctors. The survey will cover a range of topics to help us understand the experiences of this group, as they look to progress their careers outside of a formal training programme. Where applicable, we would like to include questions that are already asked of trainees and trainers in the national training survey, so we can make comparisons between the different groups of doctors.

**Reflective Practitioner guidance**

34 Following the publication of the reflective practitioner guidance in September 2018, we have worked with other statutory regulators of health and care professionals to develop a joint statement on team reflection. It sets out our common expectations for health and care professionals to be reflective practitioners who engage meaningfully in reflective practice and the benefits it brings. All nine UK health and care professional regulators have agreed the statement and it will be published jointly in March 2019.

35 We are also producing learning materials, including case studies, to publish on our website to support medical students and doctors in applying the guidance in practice. These materials will include a video training pack and online resource on how to have an effective reflective discussion and how to document it in appraisal and a doctor’s learning portfolio. In addition, the Medical Schools Council is currently working on producing supplementary guidance for students on how to apply the reflective practitioner guidance.
Executive Board

The Executive Board met on 26 November and 17 December 2018 and 28 January 2019 to consider items on:

a The 2019 business plan and budget and an additional budget proposal for the appointment and induction training for 25 new Medical Tribunal members.

b The release of necessary contingency funds so preparations for a ‘no deal’ Brexit could commence.

c The outcome of the Field Forces review, which set out to establish how to meet our strategic aim of shaping our outreach teams that work with frontline doctors, healthcare providers and systems regulators to align with local systems to support the delivery of our re-focused approach to regulation. The Board agreed the principle of a seven-region model in England alongside national offices in Wales, Scotland and Northern Ireland by the end of 2020.

d A new approach to managing our strategic relationships to help us meet the public commitment made in our Corporate Strategy that we will ‘strengthen collaboration with our regulatory partners across the health services’.

e An incremental approach to developing horizon scanning capacity during 2019.

f The new working arrangements for Health Education England (HEE) and NHS Improvement (NHSI) and the potential impact on the GMC’s educational quality assurance role.

g The results of the public consultation on our new advisory guidance for supporting disabled learners, Welcomed and valued, as part of the health and disability review. We plan to publish the guidance in April 2019 and supporting resources for medical schools and postgraduate training organisations are also in development.

h The content for an inter-regulatory statement on being a reflective practitioner, ahead of publication in quarter 1 of 2019.

i A refined approach to sharing of fitness to practise information internationally which aims to create a system which is centralised, focussed, and proactive, following a review of existing arrangements, including new draft principles for sharing such information; piloting a new notification system and two new systems to proactively seek information about doctors sanctioned overseas; and centralising the work within the Registration and Revalidation directorate.
j A draft policy on proactively disclosing information about a doctor’s fitness to practise history to their employer(s) outside of the fitness to practise process. This was subsequently agreed by Council on 12 December 2018.

k The policy framework for excluding information from the List of Registered Medical Practitioners (LRMP), to support decisions to exclude revalidation and training information in circumstances that affect certain organisations and individual doctors.

l An accommodation strategy to address the pressure on the availability of office accommodation in our premises in London and Hardman Street, Manchester.

37 The Board also noted updates on:

a The Public Interest Concerns pilot, which was started in July 2016 with the aim of testing changes to the way that employers and contractors of doctors make referrals into our fitness to practise procedures and the way we provide safeguards for doctors who are whistle-blowers.

b The consultation on our revised decision making and consent guidance, which closed on 23 January 2019.

c The Board’s annual report for 2018.

d The annual report of the GMC Group Personal Pension Plan Management Board.

e Progress we have made against our corporate strategy aims and the baseline measures that that will help demonstrate progress on our aims by 2020.

Safeguarding

38 Following the discussion at Council in December 2018, we are reviewing our safeguarding policies and procedures in line with guidance from the Charity Commission for England and Wales and the Office of the Scottish Charity Regulator. It is clear we have robust policies in place in many areas including information sharing agreements with the Disclosure and Barring Service and Disclosure Scotland; policies for when we need to refer matters to social services; protocols and guidance to staff around handling vulnerable individuals, including those who may be suicidal, as well as guidance and support for staff who are working offsite. This review work is ongoing and a paper will be brought to Council in April 2019.
Use of the Corporate Seal by the Chief Executive under his delegated authority in 2018

During 2018, in addition to the Regulations made by Council, as Chief Executive, I exercised the power delegated by Council to apply the Corporate Seal on the following occasions:

a. Relating to pension arrangements – GMC Staff Superannuation Scheme:
   i. Replacing the Fourth Definitive Trust Deed and Rules, with the Fifth Definitive Trust Deed and Rules.
   ii. Deed of Appointment and Removal of Trustee – The GMC Staff Superannuation Scheme.

b. Relating to fees:
   i. Removing the requirement for doctors to pay a transaction charge on credit card payments and bringing into effect the 2018 fee reductions.

c. Relating to property:
   i. Renewal of lease at Centurion House, Manchester.
   ii. Lease for additional accommodation in St James’s Buildings, Manchester.
Executive summary
This report provides an update on our operational performance, key projects and programmes, and other operational matters arising including:

- Financial summary
- Monitoring Strategic Progress in 2019
- GMC Services International Ltd (GMSCI) update
- Transformation Programme update
- Updates to the Corporate Opportunities and Risk Register (CORR)

Recommendation
Council is asked to consider the report and Annex A (Council portfolio) and Annex B (Corporate Opportunities and Risk Register) and Annex C (Strategic lead and lag indicators).
Issue

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 2018.

Operational Key Performance Indicators (KPIs)

In November 2018, we missed our target to Commence 100% of Interim Order Tribunal hearings within three weeks. Due to human error we failed to list the hearing within the service target. The parties to the hearing were content with the re-listed hearing date. There was no risk to the public and the hearing proceeded on 22 November 2018 without issue, with conditions imposed on the doctor’s registration. A reminder has been provided to the staff concerned as to the appropriate practice and an automated report put in place to reduce the likelihood of reoccurrence.

Strategic delivery

The strategic portfolio, at Annex A, shows the detail of our strategic delivery in 2018, by exception:

Strategic aim 1: Supporting doctors in delivering good medical practice

Welcome to UK Practise (WtUKP) - This project is reported amber. Our target as set out in our 2018-2020 corporate strategy is to expand the WtUKP course to 80% of all new International Medical Graduate (IMG) doctors joining the register by 2020. Due to the recent trend of significant increases in IMG doctors joining the register, as detailed in annex A, we are expecting approximately 6500 new IMG doctors per year in 2020. This is more than 2000 higher than we had anticipated in 2016, when the target was originally set. We are now considering options for addressing this increase in demand and I will report back to you in April 2019 on the outcome of that options appraisal.

Strategic aim 3: Strengthening our relationship with the public and the profession

Medical Licensing Assessment (MLA) – This project is reported red due to concerns highlighted during engagement and as we consider revisiting the overall programme plan. Staff and students in individual medical schools (MSs) have been engaged and, in the vast majority of meetings, constructive in discussing their comments, concerns and queries about the MLA in order to inform its further development. The Medical Schools Council (MSC) has raised its own concerns, and provided feedback it has received from medical schools. The MSC has also submitted an alternative approach for the design and delivery of the applied knowledge test (AKT). We have held initial
discussions about this alternative proposal with the Expert Reference Group supporting us in developing the AKT, and the MLA Programme Board. We are now exploring the alternative proposal in more detail, identifying the extent to which we can accommodate medical school and MSC concerns while still delivering Council’s aim for the MLA, and we’re considering whether we need to revisit the overall programme plan. While we do this, it would be appropriate to move the programme status from amber to red. In the meantime, we continue to engage with a range of stakeholders on other elements of the MLA, including the development of the MLA content map (blueprint). GMC’s Chair, CEO and Director of Education and Standards have stepped up their engagement with the MSC Chair and CEO.

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

6 Preparing for Brexit – This project is reported red, due to the high level of uncertainty around the Brexit Withdrawal Agreement following the defeat in Parliament on 15 January 2019. We have been working closely with the Department of Health and Social Care (DHSC) to provide detailed legal comments on the draft Medical Act amendments that were laid in Parliament on 20 December 2018, and which legislate for the ‘no deal’ scenario. In the meantime, we continue to put in place as robust plans as possible for the potential no-deal scenario. Our planning for Brexit is coordinated by our organisation-wide working group, which has been examining the impact that Brexit would have on the GMC since 2016. Although focusing currently on ‘no deal’ planning, we are also considering longer-term scenarios, and the risks and opportunities that Brexit presents for the GMC’s work. Our strategic approach to Brexit is outlined in the CEO report to Council.

7 We anticipate that there may be a surge in applications from EEA doctors in the run up to March 2019, followed by a transitional phase as we embed new rules for gaining access to the register after March. We are confident that the plans we have put in place, including changes to our procedures and IS systems, will help us successfully navigate issues in the event of a no deal. Additionally, in December 2018, the Executive Board agreed to fund additional capacity if required to ensure that we have the right staff in the right teams to deal with whatever scenario we face in March 2019.

Monitoring strategic progress in 2019

8 In April 2018, Council agreed our new benefits-first approach to monitoring and reporting on the 2018-2020 corporate strategy. This included setting some indicators to tell us whether we are on track to delivering our key strategic benefits. In line with this, we have set ourselves indicators to understand the context that we are working in and to establish a baseline from which improvements can be measured. However, the GMC is part of a much wider health system and working with others is key to
improving measures such as the confidence of the profession. There are a wide range of factors which contribute to doctors’ experience of their career, regulation and the health system including many beyond our immediate control, such as availability of funding. But that should not prevent us from taking steps, both as an individual organisation and in partnership with others, which will make a positive difference to patient and doctor safety.

9 This is the start of a process, and it is crucial that we establish a clear view of trends and data over a 12-month basis before we are able to set firm targets for the future. Although public confidence is realistically as high as can be expected, given the work programmes we are engaged in we would expect professional confidence in our work to increase. However, any significant movement in the measures we have adopted should be monitored and act as a trigger for deeper discussion about our contribution. The Strategic lead and Lag indicators are outlined for Council in Annex C.

Financial summary

10 We ended 2018 with a surplus of £1m, compared to a budgeted surplus of £6.9m. This is primarily due to a one-off pension top up payment of £4.1m which was made in July. This position is consistent with the Q3 forecast I reported to you in December. Income for 2018 was slightly higher (approximately 1%) than budgeted, primarily due to the increase in registration applications from IMG doctors, and Professional and Linguistic Assessments Board (PLAB) fees. Our total operational expenditure was approximately 3% higher than budgeted, driven by a variety of factors including higher overall headcount than budgeted, under achievement against our annual efficiency target and more MPTS hearings than was initially forecast together with additional expenditure related to additional PLAB days (the latter covered by additional income).

11 The draft 2019 income budget is £109.2 million. The total 2019 expenditure budget is £122 million (comprising operational expenditure of £110.6 million, and capital expenditure of £11.4 million). Our operational expenditure and capital expenditure combined will generate a deficit of £12.8 million in 2019. Our free reserves will therefore reduce to around £39.3 million at the end of 2019 with the target to stabilise at around £32 million by 2023.

GMC Services International

12 GMC Services International (GMCSI) will enter its third year of operation in 2019. In 2018, consulting revenue was lower than expected due to longer lead times for contract signing on projects than expected. However, business momentum continues to be strong as an increasing number of countries express interest in GMCSI services. Training revenue grew strongly in 2018 due to the existing contracts with ID Medical
and Medacs. Both contracts have been extended to 2019 and, together with income from new products as set out below, will provide a steady income stream to cover day to day operating costs.

13 The GMCSI team continues to develop new opportunities and products, while seeking to finalise some of the consulting opportunities we started to discuss in 2018. New products include medical school accreditation, which was launched in January 2019. Consulting is offered to international medical schools who express interest in raising their current standards of education and who are looking for support with their local medical school accreditation processes. GMCSI is already engaging with two potential clients and are in the process of submitting proposals.

14 In 2019 GMCSI will also assume responsibility from the GMC for managing revenue associated with the sale of the List of Registered Medical Practitioners (LRMP) and the hiring out of the Clinical Assessment Centre (CAC).

Transformation Programme update

15 In November 2018 we held two focus groups with staff, to inform understanding of how the Transformation Programme is making a difference to staff so far, and the Steering Group has begun to consider the feedback especially about communication and engagement methods.

16 We are delighted to have received Silver Investors in People Accreditation for the whole of the GMC and MPTS, and are currently launching our bespoke training programme for our leaders and managers as part of the Empower element of the Programme. We are set to launch our new Customer Service Strategy, part of the Enact element of the programme, which details our plan for delivering and improving customer service. The major changes we have made to policy development under the Envision element of the programme are reaching fruition through the completion of the pilot on our new Policy Framework. Finally, funding has been agreed by the Executive Board for a new Strategic Relationships Unit within the Engage element of the Programme and we are working with an external provider to develop options and costs for a new Relationship Management System.

Updates to the Corporate Opportunities and Risk Register (CORR)

New risks and opportunities

17 Three new risks, and two new opportunities have been added to the CORR since December 2018:

- A new risk (T4.3) on the Medical Licensing Assessment (MLA) has been added to the CORR. Because of challenges to the proposed MLA Applied Knowledge Test
(AKT) model by specific key stakeholders, there may be a lack of support for delivering the AKT in the way agreed by Council. This may lead to a less robust assessment, increasing costs and delays to the proposed timetable; or strained stakeholder relationships which could also impact on wider GMC activities. This risk is rated as Amber.

- A new risk (T4.2) on non-training posts and training pathways has been added to the CORR. There is a reputational risk that the profession believe the GMC are responsible for the unregulated training.

- A new risk (AT6) has been added to the CORR on the change in Leadership and reporting structure following the announcement that Health Education England (HEE) will work jointly with NHS Improvement (NHSI). The change in Leadership and structure could result in the education agenda not being pushed and potentially training opportunities reduced as a result of shared budgets.

- A new opportunity (OAP1) have been added to the CORR, on the potential for Credentialing to enable doctors to move more quickly to areas of practice where there is greatest patient and service need.

- A new opportunities (OAP2) have been added to the CORR, on the engagement with HEE & NHSI. This is an opportunity to develop longer term planning and promote training to be more central to workforce planning.

**Changes to risk ratings**

- The residual rating of risk AT1, relating to recruitment and transfer has been lowered from critical to significant. This reflects the fact that overall recruitment is stabilising.

- The residual rating of risk IT9, relating to difficulties in the recruitment and retention of staff has been lowered from critical to significant. This reflects the fact that turnover levels remain low.
M4 – Annex A – Council Portfolio

Council meeting
February 2019

Data presented as at 31 December 2018 (unless otherwise stated)
Commentary as at 30 January 2019

Working with doctors Working for patients
<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></td>
<td></td>
<td>Nov Dec</td>
<td>Forecast</td>
</tr>
<tr>
<td><strong>We decide which doctors are qualified to work here and we oversee UK medical education and training.</strong></td>
<td>Decision on 95% of all registration applications within 3 months</td>
<td>97% 98%</td>
<td>On track</td>
</tr>
<tr>
<td></td>
<td>Answer 80% of calls within 20 seconds</td>
<td>86% 84%</td>
<td>On track</td>
</tr>
<tr>
<td><strong>We set the standards that doctors need to follow, and make sure that they continue to meet these standards throughout their careers.</strong></td>
<td>Decision on 95% of all revalidation recommendations within 5 working days</td>
<td>100% 99%</td>
<td>On track</td>
</tr>
<tr>
<td></td>
<td>Respond to 90% of ethical/standards enquiries within 15 working days</td>
<td>90% 100%</td>
<td>On track</td>
</tr>
<tr>
<td><strong>We take action to prevent a doctor from putting the safety of patients, or the public’s confidence in doctors, at risk.</strong></td>
<td>Conclude 90% of fitness to practise cases within 12 months</td>
<td>93% 91%</td>
<td>On track</td>
</tr>
<tr>
<td></td>
<td>Conclude or refer 90% of cases at investigation stage within 6 months</td>
<td>91% 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% 96%</td>
<td>On track</td>
</tr>
<tr>
<td></td>
<td>Conclude 100% of Investigation Committee hearings within 2 months of referral</td>
<td>No cases</td>
<td>100% On track</td>
</tr>
<tr>
<td></td>
<td>Commence 100% of Interim Order Tribunal hearings within 3 weeks of referral</td>
<td>96%* 100%</td>
<td>On track</td>
</tr>
</tbody>
</table>

*One case was missed for this target. A hearing was re-listed for 22 November 2018 - two days outside the service target date - therefore the service target was not adhered to. More information is provided in the main report.

<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></td>
<td>Nov Dec</td>
<td>Forecast</td>
</tr>
<tr>
<td><strong>Finance</strong></td>
<td>2017/18 Income and expenditure [% variance]</td>
<td>-1.01% -2.08%</td>
<td>On track</td>
</tr>
<tr>
<td><strong>HR</strong></td>
<td>Rolling twelve month staff turnover within 8-15%</td>
<td>7.52 7.64</td>
<td>On track</td>
</tr>
<tr>
<td><strong>Information systems</strong></td>
<td>IS system availability (%)</td>
<td>99.99% 100%</td>
<td>On track</td>
</tr>
<tr>
<td><strong>Media monitoring</strong></td>
<td>Monthly media score</td>
<td>-1542 1598</td>
<td>Positive and neutral coverage was boosted by widespread stories on our SoMEP launch, as well as balanced reporting on Right of Appeal, which offset continued negative reporting of the Alemi case.</td>
</tr>
</tbody>
</table>

NB We are currently reviewing our operational KPIs with a view to introducing a revised suite of indicators during 2019.
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 4-5.

**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.**
   - Reduced regulatory burden
   - 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 focussed on benefit delivery and the GMC contribution to that delivery.**
Strategic delivery (by exception)

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

<table>
<thead>
<tr>
<th>Key benefit</th>
<th>Activities to deliver (by exception)</th>
<th>Lead indicators</th>
<th>Lag indicators</th>
<th>Exception commentary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors are supported to deliver high quality care</td>
<td>Welcome to UK Practice (WtUKP)</td>
<td>Plans for expansion of programme are in place</td>
<td>1. Perception Question (Drs) - % Drs feel supported 2. NTS Supportive Environment 3. NTS Workload Indicator</td>
<td>This project is reported amber. This is due to challenges in achieving the target of expanding the WtUKP course to 80% of all new IMG doctors joining the register by 2020. Due to significant increase in IMG doctors joining the register, achieving this aim is under threat. The project team is due to meet with the CEO (date TBC) to take him through options for dealing with this in the next stage of the project.</td>
</tr>
</tbody>
</table>

**Strategic aim 3: Strengthening our relationship with the public and the profession**

<table>
<thead>
<tr>
<th>Key benefit</th>
<th>Activities to deliver (by exception)</th>
<th>Lead indicators</th>
<th>Lag indicators</th>
<th>Exception commentary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contribute to public confidence in doctors</td>
<td>Medical Licensing Assessment</td>
<td>Consensus on proposals for the Applied Knowledge Test</td>
<td>1. Perceptions Q - % public are confident in UK doctors 2. MORI poll</td>
<td>This project is reported red due to concerns highlighted during engagement and as we consider revisiting the overall programme plan. The Medical Schools Council (MSC) has raised its own concerns and also submitted an alternative approach for the design and delivery of the applied knowledge test (AKT). We are now exploring the alternative proposal in more detail, identifying the extent to which we can accommodate medical school and MSC concerns while still delivering Council's aim for the MLA, and we're considering whether we need to revisit the overall programme plan. We continue to engage with a range of stakeholders on other elements of the MLA, including the development of the MLA content map (blueprint). GMC's Chair, CEO and Director of Education and Standards have stepped up their engagement with the MSC Chair and CEO.</td>
</tr>
</tbody>
</table>

*The refreshed lead and lag indicators are published at Annex C.*
Strategic delivery (by exception)

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

The project is reported red, due to the high level of uncertainty around the Brexit Withdrawal Agreement following the defeat in Parliament on 15 January 2019. As detailed in the Chief Executive’s Report, we have been working closely with the Department of Health and Social Care (DHSC) to provide detailed legal comments on the draft Medical Act amendments that were eventually laid in Parliament on 20 December 2018 and which legislate for the ‘no deal’ scenario. We are now largely content with the drafting and if the amendments are passed, it would represent significant mitigation of the risk to us. In the meantime, we continue to put in place as robust plans as possible for the potential no-deal scenario. The Executive Board have agreed what funds may need to be released to ensure that we have the right staff in the right teams to deal with whatever scenario we face in March 2019.
## Financial summary

### Financial summary as at December 2018

<table>
<thead>
<tr>
<th></th>
<th>Budget December</th>
<th>Actual December</th>
<th>Variance</th>
<th>Budget Jan - Dec</th>
<th>Q3 Forecast</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000 £000 %</td>
<td>£000 £000 %</td>
<td>£000 £000 %</td>
<td>£000 £000 %</td>
</tr>
<tr>
<td>Operational expenditure</td>
<td>99,180</td>
<td>101,541</td>
<td>-2,361 2%</td>
<td>99,180 101,927</td>
<td>-2,747 3%</td>
<td></td>
</tr>
<tr>
<td>New initiatives fund</td>
<td>2,500</td>
<td>2,476</td>
<td>24 0%</td>
<td>2,500 2,500</td>
<td>0 0%</td>
<td></td>
</tr>
<tr>
<td>Total expenditure</td>
<td>101,680</td>
<td>104,017</td>
<td>-2,337 2%</td>
<td>101,680 104,427</td>
<td>-2,747 3%</td>
<td></td>
</tr>
<tr>
<td>Pension top up payment</td>
<td>500</td>
<td>4,100</td>
<td>-3,600</td>
<td>500 4,100</td>
<td>-3,600</td>
<td></td>
</tr>
<tr>
<td>CAC Expansion</td>
<td>0</td>
<td>316</td>
<td>0</td>
<td>0 284</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total income</td>
<td>109,127</td>
<td>109,452</td>
<td>325 0%</td>
<td>109,127 109,840</td>
<td>713 1%</td>
<td></td>
</tr>
<tr>
<td><strong>Surplus/(deficit)</strong></td>
<td><strong>6,947</strong></td>
<td><strong>1,019</strong></td>
<td><strong>-5,928</strong></td>
<td><strong>6,947</strong></td>
<td><strong>1,029</strong></td>
<td><strong>-5,918</strong></td>
</tr>
</tbody>
</table>

### Capital Programme

<table>
<thead>
<tr>
<th></th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td><strong>6,000</strong></td>
</tr>
</tbody>
</table>

### Key drivers of expenditure - To date

<table>
<thead>
<tr>
<th>Key drivers of expenditure</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headcount changes</td>
<td>-540</td>
</tr>
<tr>
<td>Volume variance</td>
<td>-959</td>
</tr>
<tr>
<td>Unit cost increases</td>
<td>-66</td>
</tr>
<tr>
<td>Unit cost decreases/efficiency savings</td>
<td>-1,088</td>
</tr>
<tr>
<td>New activities not in plan</td>
<td>-350</td>
</tr>
<tr>
<td>Planned activities dropped/delayed</td>
<td>642</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>-2,361</strong></td>
</tr>
</tbody>
</table>

### Key changes

- **Headcount changes**: Our budgeting assumes a vacancy rate of 70 roles, throughout 2018 we have run 7 over budget on average after adjusting for churn, with the difference being due to parental leave, sickness leave, dual running and additional temps to cover work volumes.
- **Volume variance**: £587k additional costs are due to running additional MPTS hearing days to date. Additional costs are generated by the increase in scope of the GMC management and leadership programme. There are additional costs related to the increase in PLAB candidates plus some additional work on pensions driven by Council. These overspends are reduced by holding fewer performance assessments, investigation committees and CAG meeting than expected.
- **Unit cost increases**: PSA fees are marginally higher than budgeted and there has been a unit cost increase in invigilation & marking for PLAB 1 and role players for PLAB 2.
- **Unit cost decreases/efficiency savings**: Directorates were not able to achieve their annual efficiency target, with the exception of MPTS which generated efficiency savings above their target by increasing the proportion of Legally Qualified Chair hearings. In overall terms the aggregate savings achieved fell short of the target by -£1,088k.
- **New activities not in plan**: Some 2017 activities slipped into 2018 plus the Bawa-Garba learning review, policy summit costs, GNM review & HCSA learning review.
- **Planned activities dropped/delayed**: The rollout of meetings with Doctors & Patients has been deferred and depreciation is lower due to the timing of projects. Delayed spend includes the DT2020 costs which is still expected to generate further costs before the end of the year.
## 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>-191</td>
<td>Actual headcount now higher than assumed headcount after churn, due to parental leave cover &amp; additional temps to cover workload.</td>
</tr>
<tr>
<td>Volume variance</td>
<td>-1,462</td>
<td>MPTS hearing day increases generate an additional £521k in costs, the forecast is 2,453 hearing days and the budget was 2,152 days. Registration &amp; revalidation - there are additional costs of providing more CAC days &amp; PLAB 1 candidate places (115k), Resources - there is an increase in the scope of training programmes and new IS support contracts, bank charges increased due to PLAB application volumes, Strategic communications &amp; Engagement - there has been a significant increase in travel which is now reflected in the forecast.</td>
</tr>
<tr>
<td>Unit cost increases</td>
<td>-232</td>
<td>There has been an increase in some PLAB 1 invigilation &amp; marking unit costs and role player costs for PLAB 2. The PSA levy &amp; apprentice levy charges higher than budgeted and the VAT reconciliations for services charges at SJB are over expectations.</td>
</tr>
<tr>
<td>Unit cost decreases/efficiency savings</td>
<td>-947</td>
<td>The key aspect is the efficiency target not being met.</td>
</tr>
<tr>
<td>New activities not in plan</td>
<td>-357</td>
<td>Additional unbudgeted activities include the Bawa-Garba learning review, additional policy summits, the lessons learned review, legislative reform work, the GNM review, the mental health &amp; wellbeing review, pharmaceutical visits and some additional recruitment costs.</td>
</tr>
<tr>
<td>Planned activities dropped/delayed</td>
<td>-442</td>
<td>There has been a reduction in the depreciation forecast due to timing of projects, and a number of other activities have now been dropped or deferred to 2019, the survey consultation, consent guidance, research on quality assurance reviews and the meetings with doctors &amp; patients project.</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>-2,747</td>
<td></td>
</tr>
</tbody>
</table>

The free reserves forecast at the end of 2018 are £52.1m, which has moved slightly from the Q2 forecast of £52.3m.
## Financial – detail

### Expenditure as at December 2018

<table>
<thead>
<tr>
<th>Description</th>
<th>Budget December</th>
<th>Actual December</th>
<th>Variance</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff costs</td>
<td>57,547</td>
<td>58,087</td>
<td>-540</td>
<td>1%</td>
</tr>
<tr>
<td>Staff support costs</td>
<td>3,450</td>
<td>3,762</td>
<td>-312</td>
<td>9%</td>
</tr>
<tr>
<td>Office supplies</td>
<td>1,842</td>
<td>1,810</td>
<td>32</td>
<td>2%</td>
</tr>
<tr>
<td>IT &amp; telecoms costs</td>
<td>3,356</td>
<td>3,210</td>
<td>146</td>
<td>4%</td>
</tr>
<tr>
<td>Accommodation costs</td>
<td>5,726</td>
<td>5,709</td>
<td>17</td>
<td>0%</td>
</tr>
<tr>
<td>Legal costs</td>
<td>4,159</td>
<td>4,291</td>
<td>-312</td>
<td>9%</td>
</tr>
<tr>
<td>Professional fees</td>
<td>2,188</td>
<td>2,398</td>
<td>-210</td>
<td>10%</td>
</tr>
<tr>
<td>Council &amp; members costs</td>
<td>541</td>
<td>493</td>
<td>48</td>
<td>9%</td>
</tr>
<tr>
<td>Panel &amp; assessment costs</td>
<td>13,781</td>
<td>14,118</td>
<td>-337</td>
<td>2%</td>
</tr>
<tr>
<td>Depreciation</td>
<td>7,057</td>
<td>6,930</td>
<td>127</td>
<td>2%</td>
</tr>
<tr>
<td>PSA Levy</td>
<td>710</td>
<td>733</td>
<td>-23</td>
<td>3%</td>
</tr>
<tr>
<td>Under-achievement of efficiency savings</td>
<td>(1,177)</td>
<td>0</td>
<td>-1,177</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Operational expenditure</strong></td>
<td>99,180</td>
<td>101,541</td>
<td>-2,361</td>
<td>2%</td>
</tr>
<tr>
<td>New initiatives fund</td>
<td>2,500</td>
<td>2,476</td>
<td>24</td>
<td>0%</td>
</tr>
<tr>
<td>CAC &amp; Bedford House Expansion</td>
<td>0</td>
<td>316</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Pension top up payment</td>
<td>500</td>
<td>4,100</td>
<td>-3,600</td>
<td>720%</td>
</tr>
<tr>
<td><strong>Total expenditure</strong></td>
<td>102,180</td>
<td>108,433</td>
<td>-6,253</td>
<td>6%</td>
</tr>
</tbody>
</table>

### Income as at December 2018

<table>
<thead>
<tr>
<th>Description</th>
<th>Budget December</th>
<th>Actual December</th>
<th>Variance</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual retention fees</td>
<td>93,551</td>
<td>93,871</td>
<td>320</td>
<td>0%</td>
</tr>
<tr>
<td>Registration fees</td>
<td>3,546</td>
<td>3,949</td>
<td>403</td>
<td>11%</td>
</tr>
<tr>
<td>PLAB fees</td>
<td>5,662</td>
<td>6,300</td>
<td>638</td>
<td>11%</td>
</tr>
<tr>
<td>Specialist application CCT fees</td>
<td>2,582</td>
<td>2,522</td>
<td>-60</td>
<td>2%</td>
</tr>
<tr>
<td>Specialist application CESR/CEGPR fees</td>
<td>801</td>
<td>999</td>
<td>198</td>
<td>25%</td>
</tr>
<tr>
<td>Interest income</td>
<td>570</td>
<td>735</td>
<td>165</td>
<td>29%</td>
</tr>
<tr>
<td>Investment income</td>
<td>1,141</td>
<td>42</td>
<td>-1,099</td>
<td>96%</td>
</tr>
<tr>
<td>Other income</td>
<td>1,274</td>
<td>1,034</td>
<td>-240</td>
<td>19%</td>
</tr>
<tr>
<td><strong>Total Income</strong></td>
<td>109,127</td>
<td>109,452</td>
<td>325</td>
<td>0%</td>
</tr>
</tbody>
</table>

### Surplus / (deficit)

<table>
<thead>
<tr>
<th>Description</th>
<th>Budget Jan - Dec</th>
<th>Q3 Forecast</th>
<th>Variance</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6,947</td>
<td>1,019</td>
<td>-5,928</td>
<td>0%</td>
</tr>
</tbody>
</table>

### Operational expenditure

<table>
<thead>
<tr>
<th>Description</th>
<th>Budget Jan - Dec</th>
<th>Q3 Forecast</th>
<th>Variance</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>57,547</td>
<td>57,778</td>
<td>-231</td>
<td>0%</td>
</tr>
<tr>
<td>New initiatives fund</td>
<td>3,450</td>
<td>4,034</td>
<td>-584</td>
<td>17%</td>
</tr>
<tr>
<td>CAC &amp; Bedford House Expansion</td>
<td>1,842</td>
<td>1,863</td>
<td>-21</td>
<td>1%</td>
</tr>
<tr>
<td>Pension top up payment</td>
<td>2,188</td>
<td>2,434</td>
<td>-246</td>
<td>11%</td>
</tr>
<tr>
<td><strong>Total operational expenditure</strong></td>
<td>99,180</td>
<td>101,927</td>
<td>-2,747</td>
<td>3%</td>
</tr>
</tbody>
</table>

### Surplus / (deficit)

<table>
<thead>
<tr>
<th>Description</th>
<th>Budget Jan - Dec</th>
<th>Q3 Forecast</th>
<th>Variance</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6,947</td>
<td>1,029</td>
<td>-5,918</td>
<td>3%</td>
</tr>
</tbody>
</table>
### GMCSI summary and investments summary

#### GMCSI summary as at December 2018

<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>1,186</td>
<td>198</td>
<td>-988</td>
<td>83%</td>
</tr>
<tr>
<td>GMCSI expenditure</td>
<td>1,119</td>
<td>535</td>
<td>584</td>
<td>52%</td>
</tr>
<tr>
<td>Profit/(loss)</td>
<td>67</td>
<td>-337</td>
<td>-404</td>
<td></td>
</tr>
</tbody>
</table>

#### Budget Jan - Dec £000

<table>
<thead>
<tr>
<th></th>
<th>Forecast £000</th>
<th>Variance £000</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>GMCSI income</td>
<td>1,186</td>
<td>-971</td>
<td>82%</td>
</tr>
<tr>
<td>GMCSI expenditure</td>
<td>1,119</td>
<td>567</td>
<td>51%</td>
</tr>
<tr>
<td>Profit/(loss)</td>
<td>67</td>
<td>-337</td>
<td>-404</td>
</tr>
</tbody>
</table>

#### Finance - investments summary as at 31st December 2018 (figures are updated quarterly)

<table>
<thead>
<tr>
<th></th>
<th>Original value £000</th>
<th>Current value £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital value of funds invested</td>
<td>£10,000</td>
<td>£20,578</td>
</tr>
</tbody>
</table>

#### 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>26.9%</td>
</tr>
<tr>
<td>Fixed interest</td>
<td>0% - 100%</td>
<td>15.2%</td>
</tr>
<tr>
<td>Cash and near-cash</td>
<td>0% - 15%</td>
<td>34.3%</td>
</tr>
<tr>
<td>Infrastructure and operating assets</td>
<td>0% - 10%</td>
<td>8.1%</td>
</tr>
<tr>
<td>Property</td>
<td>0% - 10%</td>
<td>9.5%</td>
</tr>
<tr>
<td>Other</td>
<td>0% - 20%</td>
<td>6.0%</td>
</tr>
</tbody>
</table>

#### Investment returns

<table>
<thead>
<tr>
<th></th>
<th>Annual</th>
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</thead>
<tbody>
<tr>
<td>Target (CPI + 2%)</td>
<td>4.14%</td>
</tr>
<tr>
<td>CCLA performance</td>
<td>1.09%</td>
</tr>
</tbody>
</table>
The table below provides a summary of appeals and judicial reviews as at 16 January 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>16</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>s.40A (GMC) Appeals</td>
<td>4</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>PSA Appeals</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Judicial Reviews</td>
<td>6</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>IOT Challenges</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

**Explanation of concluded cases**

- **s.40 (Practitioner) Appeals**
  - 1 successful
  - 3 unsuccessful
  - 3 withdrawn

- **s.40A (GMC) Appeals**
  - 1 successful
  - 1 unsuccessful

- **Judicial Reviews**
  - 1 successful
  - 1 unsuccessful

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

- **PSA Appeals**
  - N/A

**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**
  - 1 new challenge, 1 concluded case (1 unsuccessful)

**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.
Graph 1: Registration applications received by month
- International Medical Graduates

Graph 2: Registration applications received by month
- European Economic Area Medical Graduates
Trends in registration applications

Graph 3: PLAB 1 & 2 assessments taken 2012-2018
(Showing volume each year, 1 January-31 December,
percentage figures show year on year change)

Graph 4: Number of Doctors on the register with a Licence Practice
(End of year 2012 - 2018)
M4 – Chief Operating Officer’s report

M4 – Annex B

Corporate Opportunities and Risk register
**Strategic Risks – Active threats**

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.

OST3 – If external partners do not share our strategic priorities and vision, and/or are unable to commit sufficient resources to work with us, we will not be able to secure the support and traction required to make progress on delivering on our strategic aims.

T4.1 - Because we do not know the outcome of the UK Government’s Brexit negotiations, we may not position ourselves to respond effectively, which may have a significant impact on our effective use of resources, in particular our capacity to facilitate the PLAB test and maintain continuity of service if EEA doctors are reclassified as IMG doctors. Risk updated to reflect the Medical Act amendments in preparation for EU exit laid before parliament in December 2018.

**New risk**

T4.3 - Because of challenges to the proposed MLA 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.

**New risk**

AT6 – Following the announcement that Health Education England (HEE) will work jointly with NHS Improvement (NHSI), 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.

**New risk**

T4.2 - There is an increase in non-training posts and training pathways which include training that is not GMC approved. This can potentially cause a reputational risk that the professions believe the GMC is responsible for the unregulated training.

**New Opportunities**

AOP1 – Credentialing would provide opportunities for doctors to move more quickly to areas of practice where there is greatest need and allow employers and workforce planners to better meet patient and service need.

AOP2 – 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.

**Key updates**

OST5 – Contentious circumstances and/or media coverage may cause reputational damage or a loss of public confidence in us and our role, affecting stakeholders’ willingness to work with us. Updated to reflect the position on right of appeal.

OP3.1 – 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. Updated to reflect further engagement with patients and the public.

**Business Risks – Active threats**

AT1 – Recruitment and internal transfer activity remain high and could impact on teams’ ability to effectively deliver functions. The inherent assessment status changed from critical to significant as the overall recruitment is stabilising.

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. The inherent assessment status has changed from critical to significant due to a drop in the turnover levels.
Key to risks coding

The CORR is divided into two sections with the following numbering convention:

1. Strategic opportunities and risks and how we manage them in delivering our corporate strategy:
   • Aim 1 - OP1.1, OP1.2 etc. for opportunities and T1.1, T1.2 etc. for threats
   • Aim 2 - OP2.1, OP2.2 etc. for opportunities, and T2.1, T2.2 etc. for threats
   • Aim 3 - OP3.1, OP3.2 etc. for opportunities, and T3.1, T3.2 etc. for threats
   • Aim 4 - OP4.1, OP4.2 etc. for opportunities, and T4.1, T4.2 etc. for threats
   For overarching strategic risks and opportunities:
   • OSOP1 etc. for opportunities, and OST1, etc. for threats

2. Business risks and how we manage them:
   • Operational risks we are actively managing AOP1, etc. for opportunities and AT1, etc. for threats
   • Inherent risks in our business of being a regulator IOP1 etc. for opportunities IT1, etc. for threats
### Strategic risks and how we manage them

**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
- RAF/DOSL colleagues - provide regular advice in relation to our core functional areas (PM, 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
- SIMPELLA 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 consultation around regulatory reform - opportunity to shape the future of medical regulation and legislation
- Council and/or Board Review Assurance
- Executive Board in December 2018 approved funding to establish a new Strategic Relationships Unit in 2019, enabling us to begin strengthens our strategic relationships in UK (England)
- Annual internal audit programme

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

**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**

- New Strategic Communication and Engagement Directorate
- Regional Liaison Service (RLS) and Employee 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 reputations - not are the remains of what truly qualified doctors from UK medical schools need to know and be able to do when they start work for the first time are up to date and fit for purpose.
- L&D and Monitoring teams in regular contact with students, trainees and educators during QAs 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
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- Council and/or Board Review Assurance
- Executive Board in December 2018 approved funding to establish a new Strategic Relationships Unit in 2019, enabling us to begin strengthens our strategic relationships in UK (England)
- Annual internal audit programme
The GMC’s regulatory effectiveness, credibility and reputation may erode over time if we don’t keep abreast of widening political and policy changes and challenges, such as changes to support workforce agenda.

The volume and complexity of the programme of work we seek to undertake may exceed our capacity to deliver particularly if we do not have sufficient capacity, experience and expertise within our data functions, then will not be able to continue to use our data and insights to greater effect in anticipating and highlighting emerging risks, to support doctors in delivering high quality healthcare and, to inform the development of new policies and interventions.

If our external partners do not share our strategic priorities and vision or have different standards and approaches and/or have insufficient resources to commit to working with us, we will not be able to secure the support and traction needed to make the progress envisaged on our strategic aims and could impact the speed at which we are able to develop and provide collective assurance.

<table>
<thead>
<tr>
<th>ID</th>
<th>Threat / Opportunity</th>
<th>Opportunity/risk detail</th>
<th>Owner</th>
<th>Unlikely</th>
<th>Remote</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
<th>Very High</th>
<th>Further action</th>
<th>Risk appetite</th>
</tr>
</thead>
<tbody>
<tr>
<td>OST1</td>
<td>Threat</td>
<td>• Domestic legislation - active engagement with DfHE including over the use of a 6.60 orders to amend the • Medical Act and NHS/NHSI on the long term health plan to explore if it can deliver some professional regulation reform • Chief Executive leadership has been reformed to assess regulations to develop common positions around the future shape of regulation • European legislation - we are committed to work with our European partners to support the development of new policies and legislation to ensure regulatory change is informed and effective. We also commit the Group of twelve UK Health and Medical regulators to work together to develop common approaches to the future shape of regulation • Internal EU exit and legislative reform working group established • Understanding and respond to political and health environment - skilled and resourceful ED teams consider and manage developments in the external environment with consideration of key country strategic risk portfolio</td>
<td>Paul/Bedley &amp; Paul Reynolds</td>
<td>Positive</td>
<td>Likely</td>
<td>Moderate</td>
<td>Very High</td>
<td>Moderate</td>
<td>Low</td>
<td>Low</td>
<td>LOW</td>
</tr>
<tr>
<td>OST2</td>
<td>Threat</td>
<td>• The GMC’s regulatory effectiveness, credibility and reputation may erode over time if we don’t keep abreast of widening political and policy changes and challenges, such as changes to support workforce agenda.</td>
<td>P.Buckley</td>
<td>Low</td>
<td>Likely</td>
<td>Moderate</td>
<td>High</td>
<td>Very High</td>
<td>Low</td>
<td>Low</td>
<td>LOW</td>
</tr>
<tr>
<td>OST3</td>
<td>Threat</td>
<td>• Work to align our communications activity to avoid overburdening our stakeholders or creating engagement fatigue • GRT engagement and influencing activities with external organisations • Joint working framework (v.g. OJEU/NSAC/GRC) • Launch of our new Corporate Strategy and communications around this • HLA - building blocks with external partners through work on design and delivery • Education to work with Health Education England (HEE) and awareness to ensure our Quality Assurance (QA) is appropriately. We also need to be around quality management to effectiveness. Part of review of QA • Taking Variation Forward (TVF) Programme implemented • ELS engagement activities - building relationships with external partners and explaining what we are aiming to achieve, liaison teams in place • 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 organization about changes in external environment • Engagement with Medical Defence Organisations (PDCO) • Development of data profession • Centralised data team established within the Strategy and Policy Directorate • New Strategy Function beginning rapid review on collective effort to be followed by review on maximising the impact of our field force • Business planning &amp; budget setting process • Trained and skilled staff in project management • HMI 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, PMO and COO • Repatriation exercise April 2018</td>
<td>P.Buckley</td>
<td>Moderate</td>
<td>Likely</td>
<td>High</td>
<td>Very High</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
<td>LOW</td>
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</table>

• Meeting with other professional regulators to discuss OJEU policy for regulatory reform and Brexit (3 Feb) • We responded to the consultation on the shape of healthcare regulation in January 2018 and are awaiting the government’s response to the consultation. The prospects for securing legislative reform nevertheless remain extremely uncertain and unlikely to be taken forward before 2018/19 • Department of Health (DH) consultation on the regulation of Medical Associates Professionals launched 27 October 2017 and we submitted a response on 7th December 2017. DH are now analysing responses and we await the final report on the outcome. • If the absence of primary legislation, we will work closely with officials to identify priorities for opportunities presented by one or more Section 60 Orders in the interim as well as engaging closely with NHS and NMS to explore if the long term plan for the NHS in England and the associated Health Bill can include aspects of professional regulation reform. • The Department have recently published their response to the consultation on the introduction of nursing associates and a draft Order was introduced to Parliament on 22 January. • We are currently exploring the following: - Potential new Health Bill – making the case for a section to include legislative reform – Queen’s Speech 2019 - Section 60 orders – seeking RP reform and other changes to support workforce agenda • We responded to the consultation on the shape of healthcare regulation in January 2018 and are awaiting the government’s response to the consultation. The prospects for securing legislative reform nevertheless remain extremely uncertain and unlikely to be taken forward before 2018/19 • Department of Health (DH) consultation on the regulation of Medical Associates Professionals launched 27 October 2017 and we submitted a response on 7th December 2017. DH are now analysing responses and we await the final report on the outcome. • If the absence of primary legislation, we will work closely with officials to identify priorities for opportunities presented by one or more Section 60 Orders in the interim as well as engaging closely with NHS and NMS to explore if the long term plan for the NHS in England and the associated Health Bill can include aspects of professional regulation reform. • The Department have recently published their response to the consultation on the introduction of nursing associates and a draft Order was introduced to Parliament on 22 January. • We are currently exploring the following: - Potential new Health Bill – making the case for a section to include legislative reform – Queen’s Speech 2019 - Section 60 orders – seeking RP reform and other changes to support workforce agenda • We responded to the consultation on the shape of healthcare regulation in January 2018 and are awaiting the government’s response to the consultation. The prospects for securing legislative reform nevertheless remain extremely uncertain and unlikely to be taken forward before 2018/19 • Department of Health (DH) consultation on the regulation of Medical Associates Professionals launched 27 October 2017 and we submitted a response on 7th December 2017. DH are now analysing responses and we await the final report on the outcome. • If the absence of primary legislation, we will work closely with officials to identify priorities for opportunities presented by one or more Section 60 Orders in the interim as well as engaging closely with NHS and NMS to explore if the long term plan for the NHS in England and the associated Health Bill can include aspects of professional regulation reform. • The Department have recently published their response to the consultation on the introduction of nursing associates and a draft Order was introduced to Parliament on 22 January. • We are currently exploring the following: - Potential new Health Bill – making the case for a section to include legislative reform – Queen’s Speech 2019 - Section 60 orders – seeking RP reform and other changes to support workforce agenda
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<tbody>
<tr>
<td>1</td>
<td>Threat</td>
<td>GST5</td>
<td>P. Reynolds</td>
<td>Daily media and social media and political monitoring</td>
<td>Daily media and social media and political monitoring</td>
<td>High Risk</td>
<td>Audit and Risk Committee</td>
<td>• Chief Executive gave evidence at the UK Parliament’s Health and Social Care Committee as part of the committee’s inquiry into Patient safety and gross negligence manslaughter in healthcare, on 16 October 2018. The one-off session arose following the case of Dr Bawa-Garba, the purpose being for the committee to consider lessons learnt and how similar cases should be dealt with in future.</td>
<td>No</td>
<td>Further action detail</td>
<td>Medium</td>
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There may be circumstances and/or media coverage which suggests the profession or public find our actions, decisions and commentary on topics contentious and, without access to all the evidence, could potentially damage the confidence doctors have in us, our reputation with doctors and patients, and result in stakeholders being less willing to work collaboratively in delivering our key organisational priorities.
### Strategic Aim 1: Supporting doctors in maintaining good practice

<table>
<thead>
<tr>
<th>ID</th>
<th>Threat/Oppportunity</th>
<th>Opportunity/risk detail</th>
<th>Owner</th>
<th>Likelihood</th>
<th>Impact</th>
<th>Assessment</th>
<th>Residual Risk with Controls in Place</th>
<th>Assurance</th>
<th>Further Action Required?</th>
<th>Further action detail</th>
</tr>
</thead>
<tbody>
<tr>
<td>OP1.1</td>
<td>Opportunity</td>
<td>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</td>
<td>P. Reynolds</td>
<td>Quite Likely</td>
<td>Moderate</td>
<td>SIGNIFICANT</td>
<td>LOW Yes</td>
<td>Yes</td>
<td>Participation in Welcome to UK Practice programme increased by 80% in 2018 compared to 2017 levels. Options in development for achieving participation target promised by Corporate Strategy.  Welcome to UK Practice sessions now promoted by GMC on Facebook, with content for IMGs continuing to be produced and distributed across our digital channels (e.g. Facebook Live session in September) 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 for IMGs could potentially be linked to MLA stages: (e.g. first application, passing AKT, passing CPSA)</td>
<td></td>
</tr>
<tr>
<td>TP1.2</td>
<td>Threat</td>
<td>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</td>
<td>S. Goldsmith</td>
<td>Possible</td>
<td>Moderate</td>
<td>SIGNIFICANT</td>
<td>HIGH Yes</td>
<td>Yes</td>
<td>The MLA assessment blueprint will be based on revised Outcomes for Graduates, CPD and other sources with strong emphasis on HE/QA. In the development process we will talk to clinical practitioners and assessors so could share any insight from those conversations</td>
<td></td>
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</table>

- 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 roles 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, 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 deaneries 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 (opportunities)
- International Association of Medical Regulatory Authorities (IARMA) - potential to work with other regulators in the forum
- Continued promotion of content relevant to IMG and EEA doctors (such as information about PLAB, the MLA, English language checks) on social media, our other digital channels, and broadcast media
- Participation in Welcome to UK Practice programme increased by 80% in 2018 compared to 2017 levels. Options in development for achieving participation target promised by Corporate Strategy.
- Welcome to UK Practice sessions now promoted by GMC on Facebook, with content for IMGs continuing to be produced and distributed across our digital channels (e.g. Facebook Live session in September)
- 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 for IMGs could potentially be linked to MLA stages: (e.g. first application, passing AKT, passing CPSA)
### STRATEGIC AIM 2: Strengthening collaboration with our regulatory partners across the health services

<table>
<thead>
<tr>
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<td>T2.1 Threat</td>
<td>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</td>
<td>Susan Goldsmith</td>
<td>Quite Likely</td>
<td>Major</td>
<td>CRITICAL</td>
<td>• Information sharing agreement in place with CQC&lt;br&gt;• Working closely with the Health and Social Care Regulators Forum to improve collaboration&lt;br&gt;• Education enhanced monitoring process in place&lt;br&gt;• Internal processes to manage communications&lt;br&gt;• We help ensure available and appropriately trained staff through our mandatory training on Information Security/Data Protection and training courses such as Influencing &amp; Stakeholder engagement training&lt;br&gt;• Escalating concerns protocol has been developed</td>
<td>Council&lt;br&gt;• Acting Chief Executive's Report (June 2016), North Middlesex Audit and Risk Committee&lt;br&gt;• CEO/COO update at each meeting&lt;br&gt;• CE gave evidence to the Health Select Committee about the impact of Brexit on medical regulation (February 2017)</td>
<td>Yes&lt;br&gt;• Working towards information sharing agreements in other regulators including devolved nations&lt;br&gt;• We are currently undertaking a lessons learned exercise, including whether there are ways to improve our joint working with other regulators&lt;br&gt;• Health and Social Care Regulators Forum have agreed actions and work streams to improve collaboration across the system&lt;br&gt;• Influence existing structures and fora to support information sharing&lt;br&gt;• Agree a process for defining and communicating roles and responsibilities&lt;br&gt;• Improve the use of data and insight - GMC to set up working group and feedback on analysis of current practice&lt;br&gt;• Develop a culture of proactively sharing information and briefings</td>
<td>Low</td>
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## STRATEGIC AIM 3 - Strengthening our relationship with the public and the profession

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<tr>
<td>OP3.1 Opportunity</td>
<td>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.</td>
<td>P. Reynolds</td>
<td>Quite Likely</td>
<td>Moderate</td>
<td>SIGNIFICANT</td>
<td>Council and/or Board Review</td>
<td>Further action required?</td>
<td>Yes</td>
<td>Council # Council Away day (July 2018) about Patient and Public engagement and plans for meeting objectives set out in the Corporate Strategy. Council to consider Corporate Strategy success measures baseline report results at its meeting in Nov 2018.</td>
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| 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. | P. Reynolds | LOW | LOW | No | Council | | | Yes | | | | | |

### Risk Appraoch

- **Roundtable with patient organisations held in October 2018**: We have committed to holding two roundtables in 2018, with the first in late June focusing on FTP’s ‘signposting’ review.
- **Creation of Strategic Relationships Unit in Q2 2019 onwards 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 its 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**: Several opportunities available in 2019 linked to completion of projects in SARUP programme, as well as regular publications such as NTS and SOMEP.
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<td>T4.1</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 believes the GMC are responsible for the unregulated training.</td>
<td>Colin Melville</td>
<td>High/Lqky</td>
<td>Prior</td>
<td>• Establishement of cross-Department Brexit working group led by the UK, European and International Affairs team to assess 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>Yes</td>
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<td>Medium</td>
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<td>• Active engagement with key influencers to influence post-Brexit proposals for healthcare regulation and accountability</td>
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<td>• Links with UK and European regulators to ensure influence and leadership of key networks is maintained</td>
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<td>• Publication of analysis of licensed doctors with an EEA PRQ and of doctors with EDA nationality</td>
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<td>• Design and implementation of engagement campaign to try to ensure that post Brexit legal framework does not prohibit application of MRA to EDA doctors or impede reform under flexibility review</td>
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<td>• Regular meetings with similar organisations / regulators impacted by Brexit to share intelligence and updates on respective preparations</td>
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<td>• Regular meetings with DHS/GSE and DE&amp;EU officials</td>
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<td>• Regular SFT engagement with UK Government officials</td>
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<td>• Programme of engagement with external stakeholders and governments throughout 2017 and 2018 to push for reform of health professions provisions in RPQ Directive</td>
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<td>• UK, European &amp; International Team – engagement work with other UK healthcare and non-healthcare regulators, and horizon scanning</td>
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<td></td>
<td>• Preparing for Brexit project</td>
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<td>• Establishment of RAS EU exit steering group</td>
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<td>• Creation of policy register to track policy change needed ahead of Brexit</td>
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<td>• Operational planning work undertaken by R&amp;QA including financial implications of scenario planning</td>
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<td>• Policy decisions taken on impact of Brexit on education policy</td>
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<td>• The NLG is being developed so as to accommodate EEA doctors as IMGs or under RPQ. We have also developed outline plans for assessing ourselves about new registrants’ professional practice in the UK. Agile monitoring and presentation will demonstrate both our recognition of workforce pressures and our commitment to patient safety.</td>
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<td>• Reviewing our approach to Specialist/GS registration</td>
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<td>• IS scoping completed and build underway</td>
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<td>• Exploring future clinical assessment centre capacity</td>
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<td>• On 15 October 2018 we published an insight report on our data about doctors with a European Primary Medical Qualification, and warned that doctors from the EEA are becoming increasingly worried about the post-Brexit landscape</td>
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<td>• November 2018 SCREP message on need for post-Brexit clarity</td>
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<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 believes the GMC are responsible for the unregulated training.</td>
<td>Colin Melville</td>
<td>High/Lqky</td>
<td>Prior</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</td>
<td>Yes</td>
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<td>• We are reviewing the CESR(CP) route that will enable doctors joining an approved training programme partway through to gain a CCT which is important for worldwide recognition</td>
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<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</td>
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<td>• On 19 March, both in relation to planning for Brexit. Our most recent letter to Gavin Lamer provides estimated timings and timings involved with changing over systems from the current EEA system to an international system of registration.</td>
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<td>• Meetings and engagement with DHS/GSE to discuss their ‘no deal’ policy proposal of August 2018</td>
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<td>• Submitted detailed legal comments on OFHC ‘no deal’ legal drafting</td>
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<td>• On 20 December 2018, Medical Act amendments were laid before parliament, in preparation for a potential no-deal scenario.</td>
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<td>• On 9 January 2019, the Professional Standards Authority (PSA) wrote to us to seek our views on particular concerns about impact of a no-deal Brexit on effectiveness of our regulators, or our ability to protect the public:</td>
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<td>ID</td>
<td>Threat / Opportunity</td>
<td>Risk detail</td>
<td>Owner</td>
<td>Likelihood</td>
<td>Impact</td>
<td>Mitigation (for threats)</td>
<td>Enhancement (for opportunities)</td>
<td>Action</td>
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<td>AT1</td>
<td>Threat</td>
<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>Neil Roberts</td>
<td>Low</td>
<td>Low</td>
<td>Recruitment of additional HR staff</td>
<td>• Recruitment plan/tracking system and weekly update to SMT</td>
<td>Yes</td>
<td>• Induction of new HR staff</td>
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<td>Headcount forecasts produced by Finance are reviewed monthly</td>
<td>• Regular monitoring of staff turnover, which remains stable and low</td>
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<td>Arrangements in place to quickly source temporary workers when needed</td>
<td>• Enhanced monitoring process in place</td>
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<td>• Chair’s annual letter to the profession</td>
<td>• Legal advice taken on our compliance with Sections 15 and 22 of the Gender Recognition Act (GRA) 2004</td>
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<td>• Inclusive leadership reflected in management and leadership development programmes. Inclusion plan timeline outlined with HR and inclusion dialogue planned in September/October 2018</td>
<td>• Equality &amp; Diversity operationalisation (July 2016, amber-red)</td>
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<td>• Enhanced Monitoring and Governance Audit (November 2017, amber-red)</td>
<td>• Scoping of research opportunities with Roger Kline in relation to key requirements for further insight in relation to representation patterns.</td>
<td>Yes</td>
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<td>• update via COO report (ongoing)</td>
<td>• Currently reviewing the Academy of Medical Royal Colleges draft guidance on reasonable adjustments</td>
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<td>£10 million in funding agreed for a new policy Leadership Group and Research Forum</td>
<td>• Will publish our own ‘Welcomed and valued’ document, replacing ‘Gateways to the profession’, as a guide for supporting disabled doctors and students</td>
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<td>• SCQF-tarbellised framework linked into key strategic plans and key transformation boards, i.e. new Policy Leadership Group and Research Forum</td>
<td>• To support the development of skills and capabilities in deaneries, royal colleges and local training providers to address fairness in education and training</td>
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<td>AT2</td>
<td>Threat</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 upholding professional standards for doctors and trainees and create operational pressures on fitness to practise referrals and education monitoring services</td>
<td>Susan Goldsmith</td>
<td>Moderate</td>
<td>Low</td>
<td>• Monitoring and forecasting of Fitness to Practise cases loads</td>
<td>• Ongoing engagement with Department of Health (England) (DH(E)), Health Education England, and other stakeholders</td>
<td>Yes</td>
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<td></td>
<td>• Monitoring of external environment</td>
<td>• Active engagement with doctors about potential situations which may put patients at risk</td>
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<td>• Enhanced monitoring process in place</td>
<td>• Chair’s annual letter to the profession</td>
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<td>• Enhanced activities in directorate business plans and further work underway to complete full benefits mapping to inform 2016/2017 plans</td>
<td>• Skill and fully resourced team to promote E&amp;D in our work</td>
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<td>• Equality analysis undertaken as a component of all major project and policy activity</td>
<td>• E&amp;D training for all staff and associates and further work to develop this to incorporate inclusion</td>
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<td>• Enhanced Monitoring Audit</td>
<td>• Gladstone of staff vacancy rates and staff turnover through the quarterly CIO report</td>
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<td>• Equality, Diversity and Inclusion (E&amp;D) team linked into key strategic plans and key transformation boards, i.e. new Policy Leadership Group and Research Forum</td>
<td>• Fitness to Practise performance against Service Level Agreement (SLA) reported to each Council through the CIO report</td>
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<td>• Update via COO report (ongoing)</td>
<td>• Enhanced Monitoring Audit (November 2016, amber-red)</td>
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<td>• Scotch – Enhanced Monitoring (November 2017 amber)</td>
<td>• To support the development of skills and capabilities in deaneries, royal colleges and local training providers to address fairness in education and training</td>
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<td>AT3</td>
<td>Threat</td>
<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 reputational damage</td>
<td>Susan Goldsmith</td>
<td>Low</td>
<td>Low</td>
<td>• To support the development of skills and capabilities in deaneries, royal colleges and local training providers to address fairness in education and training</td>
<td>• Joined AoMRC working group to develop guidance on making reasonable adjustments in high stakes exams, subject to further discussions being finalised on specific content</td>
<td>Yes</td>
<td>• Induction of new HR staff</td>
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<td>ID</td>
<td>Threat / Opportunity</td>
<td>Risk detail</td>
<td>Owner</td>
<td>Stakeholder</td>
<td>Step</td>
<td>Mitigation (for threats)</td>
<td>Enhancement (for opportunities)</td>
<td>Further action detail</td>
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<td>AT4</td>
<td>Threat</td>
<td></td>
<td>Colin Melville</td>
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<td>Step</td>
<td>A full engagement plan is in place to ensure ongoing communication with key organisations for the engagement period between September 2018 - January 2019. Engagement will mainly take the form of presentations to groups on the draft framework, including including the framework for views and comments.</td>
<td>We have been engaging with groups, via workshops and meetings including the GMC, QPCs and local regional meetings. We have worked closely with the UK Medical Education Reference Group (UKMERG) in developing the framework and have agreed on the direction of travel.</td>
<td>We have been engaging with groups, via workshops and meetings including the GMC, QPCs and local regional meetings. We have worked closely with the UK Medical Education Reference Group (UKMERG) in developing the framework and have agreed on the direction of travel.</td>
<td>Yes</td>
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<td>AT5</td>
<td>Risk</td>
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<td>Colin Melville</td>
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<td>Step</td>
<td>Following the announcement that Health Education England (HEE) &amp; NHS Improvement (NHIS) will work jointly with NHLS, 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>Credentialing would provide 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.</td>
<td>Credentialing would provide 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.</td>
<td>No</td>
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<tr>
<td>AOP1</td>
<td>Opportunity</td>
<td></td>
<td>Colin Melville</td>
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<td>Step</td>
<td>A project comes workshop is being run in January and February to agree narratives for launch. 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>A project comes workshop is being run in January and February to agree narratives for launch. 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>
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<td>Yes</td>
</tr>
</tbody>
</table>

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**Further action detail:**

**AT4 Threat**

- We have been engaging with groups, via workshops and meetings including the GMC, QPCs and local regional meetings. We have worked closely with the UK Medical Education Reference Group (UKMERG) in developing the framework and have agreed on the direction of travel.

**AT5 Risk**

- Following the announcement that Health Education England (HEE) & NHS Improvement (NHIS) will work jointly with NHLS, 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.

**AOP1 Opportunity**

- A full engagement plan is in place to ensure ongoing communication with key organisations for the engagement period between September 2018 - January 2019. Engagement will mainly take the form of presentations to groups on the draft framework, including including the framework for views and comments.

---

**Likelihood**

- Quite Likely

---

**Impact**

- Major

---

**Assessment**

- SIGNIFICANT
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</thead>
<tbody>
<tr>
<td>AOF2</td>
<td>Opportunity</td>
<td>Following the announcement that HEE will work jointly with 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&lt;br&gt;• Partner with external stakeholders to develop shared agenda to influence HEE &amp; NHSI medium-long term planning</td>
<td>• Exception based reporting to Executive Board and Council through corporate updates.</td>
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<tr>
<td>ID</td>
<td>Threat / Opportunity</td>
<td>Risk detail</td>
<td>Owner</td>
<td>Unlikely</td>
<td>Moderately likely</td>
<td>Low</td>
<td>Likely</td>
<td>Unlikely</td>
<td>Moderate</td>
<td>High</td>
<td>Further action detail</td>
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<tr>
<td>274</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>QNI-L</td>
<td>QNI-L</td>
<td>QNI-L</td>
<td>QNI-L</td>
<td>QNI-L</td>
<td>QNI-L</td>
<td>QNI-L</td>
<td>No</td>
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<tr>
<td>275</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>QNI-L</td>
<td>QNI-L</td>
<td>QNI-L</td>
<td>QNI-L</td>
<td>QNI-L</td>
<td>QNI-L</td>
<td>QNI-L</td>
<td>No</td>
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<tr>
<td>276</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>Grain Brown</td>
<td>QNI-L</td>
<td>QNI-L</td>
<td>QNI-L</td>
<td>QNI-L</td>
<td>QNI-L</td>
<td>QNI-L</td>
<td>QNI-L</td>
<td>No</td>
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<tr>
<td>277</td>
<td>Threat</td>
<td>Doctors under conditions or undertakings do not comply with their sanctions and patients are harmed as a consequence</td>
<td>Anthony Omo</td>
<td>QNI-L</td>
<td>QNI-L</td>
<td>QNI-L</td>
<td>QNI-L</td>
<td>QNI-L</td>
<td>QNI-L</td>
<td>QNI-L</td>
<td>No</td>
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</table>

**Mitigation (for threats)\**

- Documented and procedures to investigate and monitor concerns
- Checklists: systematic quality assurance enable short focused visits to explore specific issues
- Trained and available staff and Associates
- Enhanced Monitoring Information Published on our website quarterly
- Relationships with other delivery partners
- Sharing of information across the organisation PDSF and RLS, Employee Liaison Service (ELS) via Joint Working Intelligence Group

**Enhancement (for opportunities)\**

- Internal Oversight Group
- Established, documented procedures
- Public: consultation used for developing and validate guidance
- Trained and available staff
- Extensive outreach and engagement activities to promote ethical guidance
- Proactive communications strategy and website improvements
- Use of: the digital strategy and new products to enhance doctors' use of the guidance, and app (launched December 2018)
- Transformation of our online digital offer - through Digital Transformation 2020

**Council and/or Board Review\**

- Council
  - Operational Key Performance Indicators (KPIs) reported each meeting
  - Council Seminar on the implementation of our guidance and supporting materials scheduled for April 2019
  - Executive Board
    - Regular updates during guidance development (ongoing)

- Council
  - MPS formal report to Council (6 monthly)
  - MPS Advisory Committee
    - Quarterly reports to MPS Advisory Committee

- Executive Board
  - Implementation of Section 60 requirements (March 2016 - November 2016, green-amber)
  - Annual tracking survey 2016 and 2017 indicated good awareness of our guidance
  - Implementation of Section 60 requirements (March 2016 - November 2016, amber-green)

- Other Assurance
  - Professional Standards Authority (PSA) Performance Review 2015/16 Standards of good regulation met
  - Review of MPS outcomes and affected characteristics, no issues identified with bias toward gender or ethnicity (Feb 2017)

**Assurance**

- Internal Audit
  - MPS operational review (November 2016, green-amber)
  - Implementation of Section 60 requirements (March 2016 - November 2016, green-amber)
  - Annual tracking survey 2016 and 2017 indicated good awareness of our guidance

- Some indication of good awareness (March 2016 - November 2016, green-amber)

- Professional Standards Authority (PSA) Performance Review 2015/16 Standards of good regulation met

- Improvement of MPS outcomes and affected characteristics, no issues identified with bias toward gender or ethnicity (Feb 2017)
### INHERENT OPERATIONAL RISKS

<table>
<thead>
<tr>
<th>ID</th>
<th>Threat / Opportunity</th>
<th>Risk detail</th>
<th>Owner</th>
<th>Utilitarian Impact</th>
<th>Further action detail</th>
<th>Risk appetite</th>
</tr>
</thead>
<tbody>
<tr>
<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>£10m</td>
<td>Further mitigation including implementing a fraud control framework</td>
<td>Low</td>
</tr>
<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>£10m</td>
<td>Unit Recruitment for new GMCSI Board member</td>
<td>Low</td>
</tr>
<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>£10m</td>
<td>Unit Recruitment for new GMCSI Board member</td>
<td>Low</td>
</tr>
<tr>
<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</td>
<td>Neil Roberts</td>
<td>£10m</td>
<td>Unit Recruitment for new GMCSI Board member</td>
<td>Low</td>
</tr>
<tr>
<td>IT12</td>
<td>Threat</td>
<td>Due to operating a global trading subsidiary, there is a risk of reputational harm which may impact on our charitable mission and our ability to effectively deliver some aspects of core regulatory services</td>
<td>Charlie Passay</td>
<td>£10m</td>
<td>Unit Recruitment for new GMCSI Board member</td>
<td>Low</td>
</tr>
</tbody>
</table>

### Mitigation (for threats) & Enhancement (for opportunities)

- Business planning and budget setting processes to ensure funds are allocated appropriately
- Monthly management reporting and review
- Financial Regulations and financial controls including delegated authorities by the Exec Board
- Procurement processes including policy, training, response plan, public interest disclosure policy and anti-fraud and corruption policy
- Gifts and hospitality policy
- Oversight of Investment Policy by Investment Sub Committee
- Training to support procurement processes include Sourcing, Purchasing (e-learning), Anti-Fraud and Contract Management

### Likelihood

- Quite Likely
- Significant
- Moderate
- Low

### Impact

- Major
- Significant
- Moderate
- Low

### Further action detail

- Transformed 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 relationship with the healthcare system.
M4 – Strategic Lead and Lag Indicators

Strategic lead and lag indicators

<table>
<thead>
<tr>
<th>Aim</th>
<th>Benefit</th>
<th>2019 projects</th>
<th>Lead indicators (primary)</th>
<th>Lag indicators (aligned to strategic benefit)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Supporting doctors in delivering good medical practice</td>
<td>Doctors are supported to deliver high quality care</td>
<td>1. Updated consent guidance</td>
<td>1. Guidance reflects shifts in legal, policy and workplace environments</td>
<td>Measure (Lag)</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td>a. Perception Question (Drs) - %</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Supporting a Profession under Pressure – Health and Wellbeing</td>
<td>2. Development of a three year strategy to consolidate, communicate and enhance our efforts to support doctors who may be facing mental health difficulties.</td>
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<tr>
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<td></td>
<td>3. Medical Licensing Assessment (MLA)</td>
<td>3. Establish policy, and put in place operational infrastructure, resources and processes are place to deliver a live run of the MLA in 2022.</td>
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<tr>
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<td>4. Review of end of life care guidance</td>
<td>4. To ensure that the guidance remains compatible with the law, fit for purpose and relevant to medical practice.</td>
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<td></td>
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<td>5. Credentialing Programme</td>
<td>5. Develop and introduce a regulatory framework to provide assurance for areas with no/limited regulatory oversight and high patient risk.</td>
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<tr>
<td><strong>6. Health and disability review</strong></td>
<td>Implementing and evaluating the guidance through releasing a series of supporting resources and developing evaluation metrics.</td>
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<tr>
<td><strong>7. Welcome to UK Practice Expansion Project</strong></td>
<td>80% of doctors new to practice or new to the country accessing the programme by 2019.</td>
<td>b. NTS Workload Indicator</td>
<td>Jul-18</td>
<td>Annual</td>
</tr>
<tr>
<td><strong>8. Consulting on changes to our patient feedback requirements for revalidation</strong></td>
<td>Redefine the revalidation requirements for patient feedback to increase its value for doctors’ learning and make it easier for patients to take part.</td>
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<tr>
<td><strong>9. Raising and acting on concerns</strong></td>
<td>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.</td>
<td></td>
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<tr>
<td><strong>10. Reflective practice</strong></td>
<td>Updating resources and supplementary guidance to support doctors.</td>
<td></td>
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<tr>
<td><strong>1. Implementation of Flexibility Review Programme</strong></td>
<td>Work with the Academy of Medical Royal Colleges to develop a more flexible approach for training and transfer between specialities.</td>
<td>a. Perception Question (Drs) - % Drs found career fulfilling</td>
<td>77%</td>
<td>Oct-18</td>
</tr>
<tr>
<td><strong>2. Fair Training Pathways (Differential Attainment)</strong></td>
<td>Deliver a programme of engagement to share current knowledge with a view to influencing cultural change within the training system.</td>
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<tr>
<td><strong>3. Supporting a Profession under Pressure: Induction and Returners</strong></td>
<td>Work with healthcare providers to make sure doctors feel supported when they begin a new role or return to practice after time away.</td>
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<tr>
<td><strong>1. Tests of Competence</strong></td>
<td>Bringing the tests of competence, assurance assessment and revalidation knowledge test process in house, including the system and operational development work required to support this.</td>
<td>a. Perception Question (Drs) - % Doctors confident in way regulated</td>
<td>34%</td>
<td>Oct-18</td>
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<tr>
<td><strong>2. Sanctions Guidance review</strong></td>
<td>We consult publically on the current Sanctions Guidance to ensure a wide range of perspectives can be considered.</td>
<td>b. RLS measure</td>
<td>85%</td>
<td>Dec-17</td>
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<tr>
<td><strong>3. Supporting Reflective Practice</strong></td>
<td>Review how and where we request information relating to appraisal, insight and remediation. Amend documentation where required to improve the clarity and consistency of the requests.</td>
<td>c. (National) Media Monitoring</td>
<td>10.9% positive</td>
<td>2018 average</td>
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</tbody>
</table>

Enhanced trust in our role

- **Doctors have a fulfilling / sustained career**
- **Inductors and returners**
<table>
<thead>
<tr>
<th>Increased confidence in the QA of training environments</th>
<th>1. Review of Education QA</th>
<th>1. Phase 2 - pilots of new quality assurance approaches (including visits), and potential public consultation on emerging and developing proposals.</th>
<th>a. NTS Satisfaction - Trainers (Annual)</th>
<th>71.13%</th>
<th>Jul-18</th>
<th>Annual</th>
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<tbody>
<tr>
<td></td>
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<td></td>
<td>b. NTS Satisfaction - Trainees (Annual)</td>
<td>79.01%</td>
<td>Jul-18</td>
<td>Annual</td>
</tr>
<tr>
<td>Improved identification of risk</td>
<td>1. Harms reduction</td>
<td>1. Completion of harms reduction projects and work with stakeholders to identify potential interventions.</td>
<td>a. Maturity model currently in development to improve measurement of risk identification</td>
<td>1. In development</td>
<td>Dec-18</td>
<td>Annual</td>
</tr>
<tr>
<td></td>
<td>2. Exception Reporting and Rota Monitoring arrangements across UK</td>
<td>2. We work with other and make best use of our data to identify risks and ensure concerns raised by others are acted upon.</td>
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<tr>
<td>Smart working</td>
<td>1. Expand the use of Provisional Enquiries</td>
<td>1. Reduce the amount of time taken from receipt of complaint to outcome of investigation by reduce the number of stream 1 investigations</td>
<td>a. Perceptions Question - The requirements the GMC places on me are reasonable and proportionate (%Yes)</td>
<td>Drs 43%, RO's 72%, 47 key Stakeholders, 83%</td>
<td>Oct-18</td>
<td>Annual</td>
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<td></td>
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<td></td>
<td>b. Provisional Enquiries KPI (but Drs) - in year figure - % within 84 days</td>
<td>77% 59% within 63 days.</td>
<td>Jul-18</td>
<td>84-day closure 78%* 63-day closure 56%*</td>
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<td></td>
<td>Dec-18</td>
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<tr>
<td>2. Strengthening collaboration with regulatory partners</td>
<td>Local First</td>
<td>1. Work with others to ensure concerns are addressed locally where appropriate, only involving GMC action where this is necessary, reducing that duplication.</td>
<td>a. Emerging Concerns KPI - RRPs held (since launch)</td>
<td>2</td>
<td>Nov-18</td>
<td>6</td>
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www.gmc-uk.org
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<thead>
<tr>
<th>Enhanced perception of regulation (amongst regulatory peers)</th>
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<tbody>
<tr>
<td>1. Gross Negligence Manslaughter - independent review recommendations</td>
<td>1. The independent review will develop recommendations to encourage a renewed focus on a just culture, reflective and individual practice.</td>
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<tr>
<td></td>
<td>b. Perceptions Question - The GMC takes action to protect patients before they are put at risk</td>
<td>Doctors 40%, RO’s 56%, P&amp;P 53%, Stk 77%</td>
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<tr>
<td></td>
<td>a. Perceptions Question - 50 key stakeholders % felt relationship good</td>
<td>92%</td>
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<tr>
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<td>b. PSA Assessment - % standards met</td>
<td>100%</td>
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<td></td>
<td>c. Trade media coverage - medical trades</td>
<td>18.9% positive 48.0% neutral 33.1% negative</td>
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<tr>
<td></td>
<td>18.9% positive 48.0% neutral 33.1% negative</td>
<td>47.0% positive 45.5% neutral 7.6% negative</td>
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<thead>
<tr>
<th>3. Strengthening our relationship with the public</th>
<th>Public confidence in GMC</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>1. Restoration</td>
<td>1. To enhance guidance to assist Tribunals in making proportionate and consistent restoration decisions, including consideration of how to deal with new issues of FTP raised during restoration hearings.</td>
<td>a. Perceptions Q - % public confident in way Drs are regulated.</td>
</tr>
<tr>
<td>2. Respond to public inquiries and reviews</td>
<td>2. Engage with current public inquiries and reviews providing accurate, relevant and timely evidence.</td>
<td>84%</td>
</tr>
<tr>
<td>3. Supporting a Profession under Pressure: Gross Negligence Manslaughter Review &amp; Recommendations</td>
<td>3. Deliver and consider how to respond to recommendations from the review.</td>
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</tbody>
</table>
### Digital Transformation 2020

1. Deliver a new social intranet that delivers business benefits throughout the organisation, including improved staff engagement, productivity, cross-organisational working.

<table>
<thead>
<tr>
<th>Service</th>
<th>Details</th>
<th>Responsible Team</th>
<th>Timeline</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICS Customer Effort - Call Centre</td>
<td>1. to follow TBC</td>
<td></td>
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<tr>
<td>ICS Net Promoter Score - Web</td>
<td>2. to follow TBC</td>
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</table>

### Tribunal members appointments - medical and LQC

2. To appoint a suitable number of Medical and LQC associates to ensure our hearings can continue to run and to enable hearings to be quorate.

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Enhanced Customer Service</td>
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### Gross Negligence Manslaughter - independent review recommendations

1. The independent review will develop recommendations to encourage a renewed focus on a just culture, reflective and individual practice.

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<td>Contribute to public confidence in doctors</td>
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<td>ICS Customer Effort - Call Centre</td>
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### Additional Clinical Assessment Centre (CAC) accommodation provision

1. Increase CAC accommodation provision to accommodate increase in demand and avoid reputational damage.

<table>
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### Review of Field Forces

2. To respond to consultation findings on MAPs, taking forward any recommendations as appropriate.

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### Brexit - Prepare for Brexit

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### Medical Associate Physicians consultation

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### Clinical Assessment Centre expansion - operational implementation

3. Expansion of current facilities to meet increased demand for PLAB assessments - including the identification, modification and operational roll out of new facilities.

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### 4: Regulatory model and interventions are relevant, effective, appropriate, and better meet the needs of the UK countries

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### Perceptions Question - % agreement as to whether regulatory model and interventions are relevant, effective and appropriate and better meet needs of the 4 countries

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### UKAF - qualitative feedback

Due end November 2019

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### MORI poll

91%

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55% Stakeholders

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### Perceptions Question - % public are confident in UK doctors

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<td>1. 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</td>
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Executive summary
We said in our corporate strategy we would realign our outreach teams by 2020. The Council away day in July 2018 identified the need to work more collectively with regulatory partners and more closely in the countries and regions. From August to November 2018, the strategy team worked closely with colleagues across GMC to review our teams delivering functions in the field (the regional liaison service, employer liaison service, education visits and monitoring team and devolved offices) to ensure they can deliver our corporate strategy and align with the external environment. After gathering evidence through an internal survey, workshops and conversations internally and externally, the project team proposed a new model, which SMT agreed in December. This means that:

- By the end of 2020, we will have a seven-region model in England alongside national offices in Wales, Scotland and Northern Ireland.
- Line management for these teams will sit in the respective regional or national teams, supported by our central teams.
- These regional (and national) teams will sit within the Strategic Communications and Engagement directorate.

This model will be implemented by the end of 2020, overseen by Susan Goldsmith with Paul Reynolds, Director of Strategic Communications and Engagement the client director.

Recommendation
Council is asked to note the future model for the GMC’s field force teams.
Background

1. We said in our corporate strategy we would realign our outreach teams by 2020. The review considered our engagement ‘in the field’, including considering the following teams:

- The regional liaison service (RLS), which delivers education sessions and presentations to doctors and patients.
- The employer liaison service (ELS), which offers advice and assurance to responsible officers.
- The devolved offices, which provide liaison, policy and public affairs functions within the devolved nations.
- The education visits and monitoring team, which quality assures medical education and training.

2. Our teams that deliver functions in the field are an integral part of the GMC and of the UK’s healthcare systems. These teams deliver excellent work and have built strong relationships with our external stakeholders. However, we know from that there is more we can do to build on this: in particular we need to do more to achieve our corporate strategy aims of strengthening collaboration with our regulatory partners and meeting the changing needs of the health services across the four countries.

3. Several factors mean this is the right time to make these changes. This includes the ambition in our corporate strategy to shift the emphasis of our work from acting when things go wrong to supporting all doctors in delivering the highest standards of care. If we can strengthen our local presence and get closer to front line doctors and support the delivery of the highest possible standard of clinical care. This will protect the public and potentially reduces the need for the GMC to take action after things go wrong. We are also making the change because of external factors, such as the direction of the NHS in England, the shift to more integrated care systems, and the regionalisation of NHS England and NHS Improvement.

4. We heard from teams about changes we can make to enable them to be more effective, such as providing more consistent administrative support across teams and coordinating our priorities better. We heard feedback that information is not always shared effectively, different teams work to different regional boundaries in England and that there may be duplication in some of the work we do. We also heard feedback from external organisations that interacting with different parts of the GMC can feel like interacting with different organisations.
The Council Away day in July 2018 was also a key factor in beginning the work in August 2018. These helpful discussions identified the need to work more collectively with regulatory partners and work more closely in the countries and regions, with one action being - “Collective Effect’ and ‘Field Forces Reviews’ to examine how best to maximise capabilities to best effect in country and – significantly – in the English regions”.

To develop our thinking, we undertook six workshops with colleagues in teams working the field, two joint workshops with representation from across the GMC, an internal survey, regular discussions and meetings with members of the Advisory Group, lessons from the collective effect review – including feedback from Responsible Officers and other external partners and SMT and Executive Board discussions.

The model

After discussion at Executive Board in November and initial decisions at SMT, it has been agreed that the teams will now be organised by region rather than by function. The model means that:

- By the end of 2020, we will have a seven-region model in England (aligned with NHS England and NHS Improvement’s regions) alongside national offices in Wales, Scotland and Northern Ireland (through which all functions in country will report).

- Line management for these teams will sit in the respective regional or national teams, supported by our central teams.

- These regional (and national) teams will sit within the Strategic Communications and Engagement directorate.

- There will be matrix management with professional hubs who will maintain technical skills.

SMT also agreed to deliver some quick wins identified by the teams in the course of the project. For example, looking at how our Data Strategy will improve and simplify our data collection and analysis.

The Education QA function is also changing as a result of the QA review (item X) and implementing the field forces review will support us in getting closer to our education stakeholders once the final model is agreed.
Communications and engagement

10 We have begun engaging with key audiences about the direction of travel with this work and will continue to promote what is a positive opportunity for the GMC, our external partners and all of our teams.

11 As well as proactively communicating our ambitions and timetable with external partners, including all UK responsible officers and key stakeholder organisations across the four countries, internal teams are also fully engaged and are playing a key role in progressing this work.

12 We will keep our partners updated at regular milestones such as when the new field forces structure is agreed and how it will be implemented and look for opportunities to seek their views on our plans. We will provide reassurance that they will receive the same high level of support and service throughout the course of this project, while emphasising that our aim is to increase the level of support we can offer them in future.

13 We will also continue to develop our narrative and lines to take for all field forces teams, reiterating our corporate strategy vision of moving more upstream, getting closer to doctors, patients and the healthcare economy and what this means for the future of regulation.

Next steps

14 Implementation will be carried out over the next two years with affected staff closely involved and kept up to date. We assume that the majority of staff will continue in their current role, largely unchanged. Effective change management and regular communication with teams will be very important. Effective risk management will also be essential and it will be a priority to maintain the current high standard of BAU activities while we implement our proposed new approach to the field force.

15 An initial implementation workshop on 15 January agreed the structure of the project. Susan Goldsmith will take responsibility for the project until implementation and will chair the programme board. The project team will be led by Sunil Kapur, AD of QA and CI, and with representatives from all the field force teams. Paul Reynolds, Director of Strategic Communications and Engagement, is the client director.

16 An outline timetable is as follows:

- Detailed design of the model in early 2019, sharing progress as quickly and as often as possible with the teams involved. A high level model will be confirmed by the end of March 2019.
■ Phased rollout will begin in Q3 2019, with the new model introduced in one or two regions or countries by Q4 2019.

■ The plans will be adapted based on the initial sites in 2020, with rollout completed by end of 2020.
Executive summary

Our current model of quality assurance (QA) of medical education and training operates through a hierarchy of organisations carrying out quality management and control activities that we check periodically. This is reinforced with a monitoring mechanism enabling each of these organisations to respond to concerns (including our enhanced monitoring process which has been considered separately by the audit and risk committee).

Council advised us in April 2018 to consider an enhanced version of the current model, and we have since undertaken thorough research and engagement. We are proposing to pilot a new, risk-based model in which:

- organisations are required to periodically re-declare they meet our standards and
- we undertake collaborative assurance activity spread between the re-declaration points.

This is an opportunity to rejuvenate the enterprise of QA for us and our stakeholders by working more collaboratively and flexibly to reduce burden and duplication, and be more proportionate and focussed. The model will enable us to strengthen our relationships to gain more frequent assurance, and reduce the risks associated with our previous approach of indefinite approval and relying on spikes of activity that assure us for short periods of time.

Recommendations
Council is asked to:

a  Approve the proposed approach for QA.
b  Approve the delivery of pilots during 2019.
Why do we quality assure medical education and training

1 The purpose of our quality assurance (QA) work is to secure our standards, as required by the Medical Act*. By undertaking this work we help to promote high standards of medical education and training. We are the only UK regulator with a specific responsibility to check the quality of doctors’ undergraduate and postgraduate education and training.

2 Our regulation of education and training of the doctors of the future is the most upstream part of our work, impacting on patient safety and the quality and effectiveness of the health service in the UK.

Why are we doing this review?

Opportunities to improve

3 With this review we have opportunities to improve our system of assurance and take a sharper, more focussed approach to encouraging innovation and tackling poor practice in medical education and training.

4 We also have an opportunity to improve the public narrative around how our work adds value to medical education and training, and the service as a whole, by emphasising not just the support we will offer to stakeholders and the assurance we provide for the public, but also the regulatory powers† we can use‡.

5 Through this work, we can utilise more of our extensive evidence base, bring in information from elsewhere, and use both more intelligently. And we can improve the way data is presented to key audiences, including the public and doctors in training.§

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* As set out in sections 5(1) and 34H(1)(b) of the Medical Act 1983.
† Organisations must comply with requests made for information for the purposes of the quality assurance of medical education and training; as such requests are made pursuant to our statutory obligation under the Medical Act 1983 to secure standards of education. This enables us to visit organisations and set requirements and recommendations. Our strongest sanction where standards are not being met is to withdraw approval of the postgraduate programme, or to remove a medical school from the list of bodies that are able to award a UK Primary Medical Qualification. We are also able to apply conditions to any approval that we have given.
‡ We will develop this narrative throughout 2019 ready for a roll out of the new model in 2020.
§ We will develop and test our use of data, the underlying systems and the way we report information throughout 2019.
Research

6 Our research* has shown that our current processes are sometimes perceived as burdensome, requiring duplication and onerous exchange of data. How we use the data we collect is not always clear to our stakeholders. There is a risk that if we continue with the same model many of our stakeholders will disengage and make QA significantly more difficult for us. A summary of our research findings is in Annex A.

7 Our proposal therefore includes ways of reducing duplication and the administrative burden on stakeholders, which we hope will enable them to focus more on encouraging innovation and tackling poor practice.

8 We can also strengthen our relationships with those stakeholders, encouraging more frequent, but focussed contact. This should help make our monitoring and enhanced monitoring processes more responsive as contact with us will become more natural and supportive.

Engagement and feedback

9 The consensus view from stakeholders† about this proposal is that they like the direction of travel, and are keen to see the detail. We will continue to keep engaging as we add more detail and test different aspects of the new approach.

10 Stakeholders (including the groups immediately affected by this proposal: medical schools and postgraduate organisations) have welcomed our commitment to reduce the burden of duplicate data requests and work collaboratively. They are also encouraged by our proposal to gain more frequent assurance through ongoing dialogue. And we have heard no major concerns about the proposition of more frequent contact, or us taking a more responsive regulatory position.

11 We acknowledge that this proposal has different implications for different organisations. For example some are keen that we keep a regulatory distance and check their work. Whereas others want our support to encourage training providers to act. While the model allows for tailored approaches, we are mindful that we need a measure of consistency and we have planned to test approaches to achieve this.

* We undertook a literature review that showed QA across sectors and around the world has turned its focus to risk-based and/or thematic QA and co-operation with other regulators. We also commissioned UCL to undertake structured interviews with stakeholders and other regulators. This found that our current practices are robust overall, but we have a heavily data-driven approach and should strengthen relationships, be more flexible and focus more on good practice.

† We have presented the proposal to a broad range of stakeholders at events throughout autumn 2018; including postgraduate organisations, medical schools, medical royal colleges, doctors in training and groups of stakeholders from each of the four countries.
12 We also acknowledge that medical schools are undergoing a period of change as we prepare for the roll out of the medical licensing assessment (MLA). Medical school quality managers are comfortable with the proposals set out here which will reduce duplication as described and ensure that we have a single overall process for the QA of general undergraduate education and the MLA.

13 We will continue to engage directly with stakeholders as the detail of this proposal develops throughout 2019.

14 You can find a detailed explanation of our approach to this review and a summary of the research findings and stakeholder engagement in Annex A.

Proposal
This section of the paper is supported by a series of diagrams, which you can find in annex B.

The current approach

15 Our assurance is achieved in the round through standard setting; approving medical schools, postgraduate programmes and locations and postgraduate curricula; gathering and analysing self-assessments and evidence; visiting to check organisations meet our standards; monitoring (and enhanced monitoring) of concerns; and identifying and promoting good practice. You can find a longer description of this in annex A and diagram 1 in annex B.

16 Our assurance depends on a hierarchy of organisations (see diagram 2 at annex B) carrying out quality management and quality control activities that we check through scheduled activity and a sampling system. Having set the standards in *Promoting Excellence*, we quality assure medical schools and postgraduate organisations against those standards, and they in turn quality manage local education providers (LEPs), who undertake quality control processes.

17 The system is reinforced with a monitoring (and enhanced monitoring) mechanism enabling us and the organisations to respond to concerns that emerge through a variety of evidence sources.

18 The principle way in which we check medical schools and postgraduate organisations are meeting our standards is through a regional/national review which is scheduled

* *Promoting Excellence*, our standards for the management and delivery of medical education and training, was published in 2015.
once in a five year cycle and takes place over a few months. Prior to the review, we ask for comprehensive evidence that each of the organisations we are visiting meet our standards. During the review we visit the offices of the postgraduate organisation, the medical school, and a sample of training providers. We speak to learners, educators, and managers/leaders through structured meetings. We then report on our findings, including areas working well and any requirements and recommendations for each training provider.

19 Regional/national reviews are expensive and resource-intensive for us and the organisations we visit. We put together a team of between six and eight GMC associates and they are supported by two to three GMC staff. Along with associate fees, travel and subsistence is paid for between eight and twenty visits or meetings over the course of a few months. Planning the review begins six to twelve months in advance and requires significant resources from both us and the organisations we’ll visit. We know that some external organisations have previously hired project managers to specifically handle the extra work required to co-ordinate a GMC review.

20 We now need to consider whether our current approach gives us and our stakeholders maximum return on our investment; can we work within the same resourcing infrastructure to improve the impact and effectiveness of our QA?

What is different about the proposed approach?

Sharper, more focused approach

21 The proposed approach is risk-based and intelligence-led. It is sharper and more focussed and will enable us to commit resources to the right areas:

   a Where we are concerned that standards are not being met.

   b Where there is evidence of excellence that should be promoted.

22 We will gain a more frequent assurance, rather than checking organisations every five years. This will enable us to be more responsive to concerns at an early stage as well as identifying and sharing good practice.

23 The process requires that organisations engage with us, which will encourage stronger, more honest and open relationships. Poor engagement will lead to regulatory action.

24 The proposed approach will improve the value for money return on our investment and while potentially cheaper, we acknowledge that in a risk-based system it is possible that the frequency or scale of concerns we discover and have to manage
could increase. We argue however that the management of any concerns that arise is value for money and gives a better return than scheduled visiting, regardless of the cost.

Re-declaration points

25 Our proposal for the new approach is that we seek more frequent assurance, spreading our QA activity out between two ‘re-declaration points’ (see diagram 3 at Annex B). Each organisation will be required to re-declare that their medical school or postgraduate training programme continues to meet our standards periodically. This period will likely be between three and five years. Diagram 4 at Annex B shows the difference between the current and proposed approaches.

26 Currently, there is no end date given to anything we approve, which introduces an inherent risk that we are effectively indefinitely accountable for all training once it’s approved. The introduction of re-declaration points for medical schools and postgraduate organisations will limit the risk we have under the current system.

27 We don’t expect any organisation to tell us that medical education and training in their patch is perfect. In fact this would cast doubts on their integrity. What we are aiming for is that they have a good handle on the concerns in their patch, that they can demonstrate how they are tackling those concerns, and that they have embedded an improvement focussed culture.

28 The purpose of the re-declaration then is not for them to say “we meet all your standards”, but “we meet all your standards, with some exceptions that we have already identified and are addressing”. If this process is a success, we will know about all the concerns ourselves and be confident that the organisation has processes in place to tackle them.

29 In an example where we have significant concerns with the organisation as a whole, we might consider deferring re-declaration, which would have a reputational consequence for that organisation. More likely however is that our concerns would be focussed on a particular programme or training location at which we could take specific regulatory action that could be reported.

30 It is our intention with this model that an organisation would not reach the re-declaration point (3-5 years later) with such concerns. We would aim to ensure actions are in place to address concerns as soon as they arise.

31 So far, no stakeholder has raised any objection at the idea of ‘re-declaring’. However we will need to be mindful of the potential administrative burden this could carry and work to make sure the process is as straightforward as possible.
More frequent assurance and reduction of burden

32 Between the re-declaration points we will have more frequent contact with the medical schools and the postgraduate organisations in an open dialogue. This will include an annual meeting. But otherwise the frequency will be determined by a number of factors, including our confidence in the organisation, the levels of concern that exist, their willingness to engage with the process and the amount of activity they and we are undertaking at any given time.

33 The starting point will be a periodic self-assessment questionnaire in which they will tell us what information they hold and what activity they have planned (including scrutiny from other regulators). We will analyse that alongside other information that we hold and carry out a collaborative gap analysis with them.

34 We recognise that self-assessment does bring the risk of attempts to mislead the regulator. However, by limiting our request to ‘what evidence do you have and what activities have you planned that demonstrate you meet our standards?’, we believe it will be difficult for organisations to hide lack of quality management activity (for example). But this is a key aspect of the process to be tested in our pilots.

35 Where there are gaps in assurance, for example against a particular standard or within a specific programme, we will ask the organisation to provide evidence, or invite us to observe some of their activity, such as educator training, or an LEP visit. In the interests of burden reduction, we will not ask the organisation to reformat information for our benefit, unless completely necessary.

36 If an organisation cannot or does not provide evidence, then we will seek assurance, selecting appropriately from a quality assurance toolkit. This toolkit will include a variety of activities, including visits.

37 Our aim is to use internal and external peer-review systems to benchmark our decision making processes as the model develops. This will help ensure consistency, and the use of GMC associates in this process will help ensure that our actions are proportionate.

38 Mindful of our statutory duties, we will always seek to agree our QA activity with the medical school or postgraduate organisation so that we are working collaboratively to achieve the assurance needed. However the option to use our regulatory powers when necessary remains a core element of the toolkit.

39 Good engagement from an organisation with our processes will inevitably lead to a good relationship with us upon which we can build a responsive and proactive approach. Poor engagement will lead us to question, challenge, scrutinise and take more regulatory action, which carries with it financial and resource burdens, and reputational risk.
The concept of more frequent assurance and more frequent contact, offset by a reduction in burden and a more supportive approach has been warmly welcomed by stakeholders in our engagement so far. They agree that the process described does appear less burdensome in principle and that more frequent contact will help us all be more responsive to concerns.

Diagrams 5a and 5b at annex B give a hypothetical example of how the process might work in practice, comparing the experiences of an organisation that engages with the process against one that doesn’t.

Risks and opportunities

Moving to a more flexible approach to QA comes with a number of risks. They include:

a The potential to apply our processes inconsistently across the UK

- Our standards provide consistency throughout medical education and act as a benchmark. Underpinning our flexible approach to securing these standards will be a template for minimum regulatory contact, which we will develop in the pilots. This will ensure that every organisation has received a minimum level of scrutiny between its re-declarations.

- We will also undertake internal peer review to ensure consistency in decision making. And we will explore the possibility of adding GMC audits of an organisation’s quality management decisions to our QA toolkit.

b The perception that stopping the scheduled regional reviews will mean that the GMC will be losing critical opportunities to engage with students and doctors

- Within the direct remit of our proposal for QA it is critical that we retain the ability to hear from students and doctors on the front line of training. In particular, we recognise the value of the GMC talking directly to students and doctors without intermediaries.

- Firstly, we are retaining the option of visiting local education providers as part of the QA toolkit, although it will no longer be our standard approach. Further, we are developing other mechanisms for talking directly to students and doctors that may be more proportionate than visits, which we can deploy more readily.

- Secondly, more broadly across the GMC, our field forces in all four countries enable us to engage with students and doctors including opportunities for direct engagement without intermediaries such as supervisors and employers.
One of the aims of the ongoing review of our field forces is to improve the effectiveness of each engagement by ensuring that the right intelligence is gathered, directed to the right place, and handled accordingly. This goes hand-in-hand with the changes proposed in this paper which seek to improve the effectiveness of our use of data and intelligence about education and training, and builds on our position that we want every interaction between the GMC and students and doctors to matter.

c Challenges in demonstrating externality

- We will continue to use GMC associates in our QA activity, in leading visits, reviewing self-assessments and other evidence and observing quality management activities.

- We will also continue to develop our reporting systems, improving the transparency of the QA process by bringing more information into the public domain, via our website.

d Ensuring that we continue to hold organisations to account

- Closer working relationships must not affect our ability to hold organisations to account. Our monitoring (and enhanced monitoring) processes will continue. These have been improved throughout 2018, and we have introduced clearer risk thresholds for scrutiny. We expect responsiveness to concerns will improve under the proposed model with more frequent contact and stronger relationships.

It also provides a number of opportunities for broader improvement, including:

a Developing collective effect with other regulators

- The model has a built-in mechanism for receiving and analysing external evidence. This allows us to significantly advance our collective effect with other regulators through joint use of evidence. Other collective effect mechanisms, such as joint visits can be added to the QA toolkit.

b Making better use of information gathered by the wider GMC

- This more flexible approach to receiving and analysing information will enable us to build on, contribute to and incorporate the positive work and engagement happening around the GMC, including the relationships developed by the devolved offices and the employer and regional liaison services; and the information exchanged at operational and strategic meetings such as JWIGs, JSOGs and NHS oversight group.
Incorporating the QA required for the medical licensing assessment

The model will be adapted to incorporate QA of the applied knowledge test and the clinical and professional skills assessment from the medical licensing assessment.

Value for money and costs

44 We anticipate that this change will be cost neutral for the GMC; we have budgeted as such for 2019. But it will offer better value for money by ensuring staff and associates spend more time observing or analysing a broader range of quality management activity.

45 The new approach may be cheaper for medical schools and postgraduate organisations as we are aiming to work with their schedules and aiming to reduce the time or money spent on activities for our benefit only. Furthermore, as we are not planning to undertake GMC-led LEP visits as standard, there may be a lower cost on the service overall (LEP visits require doctors be released from other duties to meet with us). As our activity levels will be more evenly spread over the course of several years, rather than intensively over a few months, it will make it easier for us and stakeholders to budget, and manage resources and expenditure.

46 We are not planning to change our headcount, but our staff will be engaged in different types of task, such as desk-based thematic reviews.

47 We may increase the number of visits we undertake, but these will be shorter, more focussed and use smaller teams. This will enable us to offset the cost of more visits, with a significant reduction in our hotel and subsistence bill.

48 Recent regional reviews have cost between £45,000 and £95,000 in staff and associate travel and expenses, depending on the size of the region. This is an annual cost of between £3,000 and £5,500 per organisation regulated. We expect the annual per organisation expense costs to be similar in our proposed approach. As described above, the levels of activity for each organisation will change according to the risks identified.

49 As an example of value for money, a regional review would include a two-day visit to each medical school in the region with five associates and two staff at a cost of £7,500 per visit on travel and expenses. Our proposed model would require fewer broad-ranging, long visits and more short, focussed observation visits, costing around £1,000 each for one staff member and one associate. It follows that we could undertake seven observations for the price of one two-day visit.
Proposed pilots

50 Postgraduate organisations and medical schools in Wales and West Midlands have agreed to work with us on piloting this proposal during 2019. These were the first two regions reviewed under the current regional/national review process in 2011.

51 Our overall objective is to ensure that the proposed model will assure us that medical schools and postgraduate organisations meet the standards set out in *Promoting Excellence*.

52 We will aim to test each of the principles of the new model, including alternative methods for delivery of each of those principles. That is, where possible, we will test one idea in region 1, and an alternative idea in region 2, and then compare their effectiveness.

53 During the pilots we will work with the participating organisations to develop:

   a A self-assessment questionnaire, which we anticipate organisations will complete annually.

   b A matrix of standards to be achieved and the evidence an organisation will be expected to provide in order to demonstrate they meet our requirements.

   c Although our aim is to work flexibly with organisations, to achieve consistency we will develop a template for minimum regulatory contact that must be met within the period between re-declaration points.

   d A QA toolkit. These are the activities we will undertake selectively where there are areas an organisation cannot otherwise assure us of, or where there may be good practice we want to promote. Some of these are activities that are already established such as GMC-led LEP visits. Whereas others will be new activities, and could include observing educator training or auditing quality management decisions.

Measuring success

54 We will develop specific measures around our levels of assurance that will help determine whether the proposal is successful. For example one measure might be around whether we can close enhanced monitoring cases more quickly in the pilot regions.

55 We will also develop detailed questionnaires and run focus groups with participating organisations and, importantly the GMC associates who will observe this work.
We are working to set up two task-and-finish groups (one undergraduate, one postgraduate) which will enable organisations across the four countries to observe the progress of the pilot and give their views.

We also have the option of a spot check by our auditors Moore Stephens to provide assurance of our progress.

**Further developments**

Alongside the pilots we will undertake other workstreams to add the necessary processes or infrastructure to enable us to roll out the proposed approach, or to fulfil the broader scope of the review. These include:

- **a** Improvement of our IT, data and reporting systems

  We will need to ensure our systems enable the capture and exchange of the different types of information required for the new process. We will also look to develop dashboards or other appropriate reporting mechanisms to enable stakeholders to see what information we hold about an organisation. In doing so, we will aim to ensure information is available on an accessible, user-friendly platform and encourage groups beyond medical schools and postgraduate organisations, for example doctors in training, to engage with it.

- **b** Consider the impact of the changes on QA of primary and community care

  We will undertake a separate work stream focussed on improving QA of training primary and community care settings. We will work with the Royal College of GPs and other colleges with relevant specialties; and we’ll consider whether our data collection, analysis and regulatory activity are appropriate and proportionate to the risks in these settings.

- **c** Work with medical royal colleges to clarify their role in QA.

  We engage with colleges directly on a number of core business quality assurance processes such as the approval of curricula, the approval of training programmes and annual specialty return meetings. We also work directly with colleges on a number of active work programmes that will have an impact on quality assurance, including credentialing and the flexibility review.

We recognise that colleges have unique specialty expertise but varying resources available to commit to QA. However we have paused the annual specialty return which will enable us to focus on reviewing the college role in our quality assurance processes throughout 2019.
The current education quality assurance model and the scope of this review

The GMC is responsible for the quality assurance (QA) of undergraduate and postgraduate medical education in the UK. We take a holistic approach to QA and help reduce harms by:

a Setting requirements for what we expect doctors to learn, including the skills and knowledge we expect them to have at various stages of their training (graduation, and at the end of provisional registration), and the management and delivery of training.

b Approving medical schools, postgraduate curricula and assessments, postgraduate training programmes, and approving GP trainers and recognising other trainers.

c Monitoring the delivery of training by gathering evidence, including the national training surveys and self-assessment mechanisms (medical school annual return and annual specialty return from medical royal colleges). We work extensively with local training organisations to ensure our standards are being met (through dean’s reports, enhanced monitoring, and regular engagement).

d Visiting to quality assure organisations that manage or provide medical education and training on a scheduled basis as part of regional/national, specialty-wide or thematic reviews and setting and monitoring requirements for action where standards are not being met.

e Identifying and promoting areas of good practice

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1 This includes 'deaneries', now known as Health Education England local offices, Northern Ireland Medical and Dental Training Agency, Health Education and Improvement Wales and NHS Education for Scotland.

2 Known as local education providers (LEPs).
Because our schedule of regional/national reviews came to an end in December 2018, we have focussed on the need to consider how we regularly engage with those we regulate, and particularly whether that should be on periodic or more risk based basis.

We have undertaken a programme of work to strengthen both our regular and enhanced monitoring of postgraduate environments following the Audit and Risk Committee report on enhanced monitoring in January 2017. This has taken place concurrently with the wider QA review. We recognise there is also a case for considering enhancements to the other elements of our QA framework (for example approvals and surveys) but propose to take this work forward once we have completed this phase of the review.

The case for the review

The regional cycle of visits agreed by Council came to an end in 2018. Before we initiate another cycle, we identified an opportunity to review our approach to visits. However, we considered it sensible to review our whole approach to quality assurance, of which visits are just one part.

We last reviewed our approach to quality assurance in 2012, following the merger with the Postgraduate Medical Education and Training Board (PMETB) in 2010. Research we commissioned at that time suggested that our approach was “clearly regarded by UK and overseas healthcare regulators as at the forefront of excellence in regulatory practice”. However, it also showed that there was the beginning of a shift from cyclical, predetermined checks to risk-based models of assurance across the whole regulatory landscape.

Our approach has developed and strengthened through the introduction of new standards, the evolution of enhanced monitoring, the growth of the reach of, and respect for, the national training surveys (NTS), and continuous improvement in many other areas, including approvals. The introduction of the Employer Liaison Service and the Regional Liaison Service has helped consolidate our external relationships and improved our gathering of soft intelligence. We also have a significantly richer evidence base to call upon six years later, including a strengthened NTS, a trainer survey, data on postgraduate exam, ARCP, and recruitment into training programmes, and the movements of doctors through training pathways.

The UK healthcare sector itself has changed since 2012. The NHS is now under more pressure, resources are scarce and doctors’ morale is widely reported as at an all-time low. Increase in private-sector provision of healthcare has made quality assurance of training environments more complex, as has the increase in healthcare provision in community settings. Our stakeholders, who are all involved in quality assurance at

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3 The research was undertaken by Colin Wright Associates and published on 8 May 2012.
some level, are all under pressure and anything we can do to relieve our regulatory burden would be well-received.

8 Based on our cycle of reviews coming to an end, the time that has elapsed since the last review, and the changes that have occurred within the GMC, across the regulatory landscape and within the UK healthcare sector during that period, we believe now is the right time for a holistic review of our approach.

9 We have deliberately not planned a new cycle of regional review visits and indicated to stakeholders that we intend to use 2019 develop our thinking about the future of our QA, and particularly engagement with those we regulate.

Our approach to this review

10 In late 2016 the audit and risk committee (ARC) commissioned an audit into enhanced monitoring, a function of our quality assurance framework. Following the results of that audit, we began a separate project focusing on improving enhanced monitoring. The ARC recently undertook a further audit of enhanced monitoring, which resulted in a positive outcome and commendation for the improvements made.

11 In April 2018 we discussed enhanced monitoring and our wider approach to QA at a seminar and Council advised that we should develop an improved version of our current model.

12 Both the improvements to enhanced monitoring and wider QA review have continued and developed since April 2018, and are managed in conjunction with aligned objectives. A timeline for both projects is included at Annex A.

Approach to this review: research

13 In 2012 our research showed that the GMC’s approach was “at the forefront of excellence” in worldwide quality assurance thinking at the time. A number of aspects of our approach stood out at the time, including our use of the national training survey and our inclusion of doctors in training and medical students in the quality assurance panels.

14 In 2018 we set out to learn as much as we could about how worldwide approaches to quality assurance have moved on in the last six years with two pieces of research. The first piece was a literature review looking at the QA models from regulators in multiple sectors and multiple countries and asked:

*What can the GMC learn from other QA frameworks/models/programmes to improve its own?*

4 See page 6 of the 2012 research.
This research found that overall our approach to QA remains strong. In some ways we are still at the cutting edge, for example other regulators do not have the benefit of a comprehensive national survey of service users. Some themes that were emerging in the 2012 research are now central to QA thinking such as risk-based QA, thematic QA and collective assurance. The report also concludes that our self-assessment mechanisms could be strengthened.

The second piece was undertaken by University College London (UCL) and asked regulators from multiple sectors and multiple countries, along with our stakeholders:

*What are the strengths and weaknesses of the GMC’s quality assurance framework?*

This research found that overall the consensus is that our approach is comprehensive, robust and proportionate to the risks involved. The report also commends our standards as being ‘comprehensive and detailed’. There is a sense that our standards in particular are an exemplar for regulators around the world.

The main negative findings set out in the report pertain to the overlapping remits of regulators. Stakeholders reported that there isn’t a clear distinction between the responsibilities of various bodies conducting checks upon them and that there is often duplication of effort in providing information or evidence to these bodies.

Another negative finding is that stakeholders feel that our approach is heavily data driven. Part of the problem underpinning this particular complaint is that we ask them to provide a lot of information but we do not always clearly communicate why we are asking for it nor demonstrate what we do with that information or what regulatory action it leads to.

Areas that the research considered critical to the future of QA are building strong relationships, taking a flexible approach to QA, giving timely feedback and taking more of an enhancement, rather than accountability-led approach.

Overall there were no surprises in the report and our proposed model accommodates the major findings. Our ongoing relationships mean that we have a good understanding of how our stakeholders feel about our processes and we are able to constantly reflect on improvements we might make.

*Approach to this review: engagement*

High-level engagement on the QA review began in 2017 when we asked stakeholders for general feedback our approach to QA. In 2018 we began more focussed engagement, starting with questions around specific concepts within QA, such as time-limiting approval or published ratings.

In Q3 2018 we were in a position to present an early version of this proposal and get stakeholders direct feedback on the model.
24 Overall we have had broad encouragement for the proposal set out here. Stakeholders welcome our proposal to be more flexible and take local context into account. Medical schools in particular are keen that we improve our self-assessment mechanisms. Everybody agrees that relationships are the key to good QA and, as highlighted by the research, the ability for a stakeholder to have an individual they can contact within the GMC is highly valued. The intention would be that such relationships reduce the number of occasions that formal GMC interventions are required. Challenges from our engagement include the different local contexts. For example some organisations are keen that we keep a regulatory distance and check their work. Whereas others want our support to encourage training providers to act. While the model allows for different approaches, we are mindful that we need to achieve a measure of consistency, which is why we are proposing to develop a template for minimum regulatory contact, to be tested in the regional pilots.

25 Finally, we have considered whether we can deliver our statutory duty in a way which maintains or enhances our assurance without increasing the burden on others or even reduces the burden. Resource challenges will be most keenly felt by the medical schools who will be preparing themselves for the medical licensing assessment (MLA) and in the regional offices of Health Education England (HEE) who have seen deep resource cuts in recent years as HEE work towards centralisation of their quality assurance functions and face an uncertain future following the recent announcement of the merger with NHS Improvement. Royal Colleges and Faculties are also under resourced, but also differently sized and structured, making it difficult to develop a role they can all fulfil.
Assurance is achieved through a variety of activities

**Assurance**

- Continuous exchange of self-assessment and external evidence, including surveys

**Approval**
- Of medical schools, postgraduate programmes and locations and postgraduate curricula

**QA activity**
- Including national/regional reviews, thematic reviews and small specialty reviews

**Promotion of good practice**

**Monitoring of concerns**

Possible sanctions include withdrawal of approval

**GMC standards**
*We are statutorily obliged to secure our standards in medical education*
Checks that medical schools and postgraduate organisations meet GMC standards

Medical schools and postgraduate organisations conduct quality management activity to ensure that local education providers meet GMC standards

Around 4,500 local education providers deliver education and training that meets GMC standards
## QA steps

<table>
<thead>
<tr>
<th>Step</th>
<th>Activity</th>
<th>Details</th>
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| 1    | Re-declaration against standards                                        | • Medical schools and postgraduate organisations make a periodic re-declaration against the standards every four years (time period TBC).  
• We will work with each organisation to then assure us they meet each standard over the QA period. |
| 2    | Self-assessment to assure the GMC                                       | • Organisations complete an annual questionnaire to tell us what evidence they hold and what activity they’ll be undertaking.  
• They can also tell us if opportunities arise in-year. For example if another regulator is visiting or they are undertaking some unplanned activity that we can observe. |
| 3    | Triangulation and gap analysis                                           | • We use our extensive data, evidence and intelligence to identify areas of concern and good practice, including information from other sources, such as other regulators.  
• We have strong signalling mechanisms from students, doctors in training and trainers through our surveys and other reporting channels. |
| 4    | Quality activity                                                          | • Our aim is to be as light touch as possible, only asking for evidence where required.  
• We will observe QM activity where possible, rather than looking at documents  
• For areas we aren’t assured, we will select activities from our QA toolkit, such as GMC-led visits, audits of QM decisions, surveys, thematic reviews. |
# What is different?

<table>
<thead>
<tr>
<th>Change</th>
<th>Benefit</th>
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<tbody>
<tr>
<td>1. No ‘grand tour’ of regional reviews</td>
<td>• They are expensive and not frequent enough to assure us</td>
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<tr>
<td>2. Introduction of re-declaration points</td>
<td>• Limits risks of indefinite approval</td>
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<td></td>
<td>• Positive assertion from bodies</td>
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<tr>
<td>3. Build a supportive, ongoing dialogue with postgraduate organisations and medical schools, meaning more, frequent, but lighter-touch contact</td>
<td>• Strengthens relationships</td>
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<td></td>
<td>• More frequent or continuous assurance</td>
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<td></td>
<td>• Improves our ability to respond to concerns</td>
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<td>4. Take a more collaborative, flexible approach</td>
<td>• Works in all contexts and locations</td>
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<tr>
<td>5. Require less information and evidence to be submitted, and be clearer about how we will use what we do ask for</td>
<td>• Less duplication</td>
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<td></td>
<td>• Reduces wasted administration time</td>
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<td></td>
<td>• Less confusion</td>
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<td>6. Observe a broader range of quality management activities</td>
<td>• Broader assurance against full range of standards (particularly at UG level)</td>
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<td></td>
<td>• More opportunity to promote good practice</td>
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<td>7. Incorporate more of the GMC’s evidence base and external evidence into assurance process</td>
<td>• Better use of intelligence</td>
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<td></td>
<td>• Collective effect</td>
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<tr>
<td>8. Regulatory activity based on triangulation of self-assessment and wider intelligence</td>
<td>• Risk-based</td>
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QA steps: year 1 in focus

**Assured**
- Self-assessment questionnaire is complete and on time
- Good engagement with process at annual meeting. Organisation has clear QM schedule. GMC invited to observe QM activities.
- Year 2 annual meeting is shorter and more focussed
- Smaller scale GMC visit to organisation, later in re-declaration period

**Not assured**
- Self-assessment questionnaire is late and incomplete
- Poor engagement with process at annual meeting
- Larger scale GMC visit to organisation, early in re-declaration period

**More assured**
- GMC-led LEP visit
- Early observations of QM activity in year 2
- Year 2 annual meeting is longer with a broader scope
Concern from intelligence leads to GMC regulatory action in year 2. Positive engagement ensures back to normal in year 3.

Self-assessment complete and on time, positive meeting, and expected levels of analysis, lead to GMC observing some QM activity in year 1.

Late, incomplete self-assessment and poor engagement at meeting leads to extra scrutiny in analysis phase and more GMC regulatory action in year 2.

Self-assessment complete and better engagement at meeting enables us to reduce our scrutiny and regulatory action in year 3.

No self-assessment submitted and no meeting leads to intense scrutiny of evidence and immediate plan for full GMC review, including multiple visits.

Improved, but still poor engagement means GMC regulatory action continues.

Poor engagement continues leading to deferral of re-declaration and reputational risk to the org.
between five and ten years to between 15 and 20 years, depending on the type of record.

41 On 26 March 2018 the Board noted an update on our confidentiality guidance to doctors, to bring it in line with the requirements of the GDPR. There were no substantial changes to the guidance but we clarified how doctors should approach consent when considering disclosing information in the public interest and updated the legal annex and references to data protection law throughout the guidance.

**Governance**

42 On 29 January 2018 the Board considered the establishment of the Policy Leadership Group (PLG). This is intended to address a gap identified by an internal audit report in 2017 which recommended that some form of central oversight be established for the coordination and development of policy across the business. The Board approved the Terms of Reference for the PLG and considered the relationship between the PLG and the Executive Board.

43 On 26 March 2018 the Board agreed the terms of reference for a new Data, Research and Insight Sponsoring Group, to oversee the programme to support the new corporate strategy and provide the necessary data, analytical and insight capabilities to respond to the external environment and increasingly act as an upstream regulator.

44 On 1 October 2018, the Board agreed revised governance arrangements for the GMC Group Personal Pension Plan, including an updated statement of purpose for the renamed GMC Group Personal Pension Plan Management Board.

45 Also on 1 October 2018, the Board approved the establishment of the Strategy & Policy Technology Programme Board to provide oversight of cross-directorate work on telemedicine and new technology, which will ensure that the impact of doctors’ use of current, new and emerging technology on the way that we regulate is kept under review.

**Other regular reports**

46 On 29 January 2018, the Board agreed the Modern Slavery Statement 2017, in accordance with the Modern Slavery Act that requires us to publish an annual statement on the activities that we have performed to eliminate modern slavery in our business and supply chains. It was agreed to delegate to the Chief Operating Officer the approval of future Modern Slavery Statements.

47 On 30 April 2018 the Board agreed the draft 2017 Trustees’ Annual report and accounts, the Impact Report and annual fitness to practise statistics for submission to Council.
48  On 30 April and 1 October 2018 the Board discussed reports on corporate complaints received, ahead of Council’s consideration of the complaints reports and the annual review of customer complaints.

49  On 1 October 2018 the Board also noted the annual health and safety report.

50  On 17 December 2018 the Board noted the annual report of the GMC Group Personal Pension Plan Management Board.
Council meeting, 27 February 2019

Agenda item: M7
Report title: Practical skills and procedures list – approval for publication
Report by: Judith Chrystie, Assistant Director, Medical Licensing Assessment, judith.chrystie@gmc-uk.org, 020 7189 5459
Considered by: MLA Programme Board
Action: To consider

Executive summary
In April 2018, Council approved the post-consultation draft of Outcomes for Graduates (referred to in this paper as ‘the Outcomes’) for publication. Outcomes sets out what newly qualified doctors from all medical schools who award UK Primary Medical Qualifications must be able to know and do.

Council approved decoupling the practical procedure list from the Outcomes to allow further consideration of its content with stakeholders. We have now re-drafted the practical procedures in the light of consultation feedback and further stakeholder engagement. A new version is at Annex A.

Recommendations
Council is asked to:

a Approve the revised list of practical skills and procedures for publication (Annex A).
b Approve the separation of the core practical skills and procedures from Outcomes for graduates (para 18).
c Agree the removal of the core practical procedures for provisionally registered doctors from Outcomes for provisionally registered doctors (paras 19 – 21).
Background

1. The Outcomes for graduates (‘Outcomes’) sets out what newly qualified doctors graduating from UK medical schools that award UK Primary Medical Qualifications must be able to know and do. The Outcomes provide:
   - a guide for students on what they need to learn
   - a basis for medical schools to develop their curricula
   - a framework against which we regulate medical schools
   - a guide for employers and those designing postgraduate training on what newly qualified doctors can be expected to know and do.

2. The practical skills and procedures are a minimum set of practical skills annexed to the Outcomes that newly qualified doctors must have so they can practise safely when they start work.

3. The previous version of the Outcomes was produced in 2009. We ran a public consultation on a revised draft of the Outcomes which closed on 10 January 2018. Following the conclusion of the consultation, we updated the Outcomes and received Council’s approval to publish them in summer 2018 with a requirement that schools meet them by summer 2020.

4. We uncoupled the practical procedures from the Outcomes because we received a great deal of feedback on both the structure and content of the list of practical procedures, and how they flow through to foundation training and the foundation programme curriculum.

5. In addition to reviewing the list of practical procedures in the Outcomes, we took the opportunity to review the list of core procedures in Outcomes for provisionally registered doctors to ensure that it is up to date and meaningfully supports the transition between undergraduate and foundation training.

Consultation response: headline points on the practical procedures

6. We received 202 responses in all to the Outcomes consultation. There was a broad acceptance that there should be a practical procedures list included in the Outcomes, with 73% of individuals and 73% of organisations agreeing. The main reasons respondents gave for this was that the list provided clarity for medical schools, students and employers on what needed to be taught and assessed.

7. There was less agreement on whether there were procedures missing from the list or procedures that shouldn’t be included.
8 Respondents also suggested that we needed to clarify the level of competence and skill required for each procedure.

Engagement

9 We explored the issues with undergraduate and postgraduate stakeholders in summer 2018. The feedback broadly chimed with that from the consultation and there was enthusiasm for a more structured and detailed list which included the level of experience we expect newly qualified doctors to have for each of the procedures when they start work, as well as the level of supervision they will require.

10 We brought together a working group in October 2018 to help us work through the issues. This group included representatives from the Foundation Programme, the UK Council of Clinical Skills Teachers, the Nursing and Midwifery Council (NMC), students and educationalists.

How we reviewed the list

Criteria for inclusion/exclusion

11 We used the 2015 Newcastle research on work activities performed by F1 doctors to inform the group’s approach, specifically Appendix J – Example of activity prioritisation matrix which gives six criteria derived from the research to help us think about whether something needs to be included, or whether it is already covered elsewhere in the main Outcomes document.

12 We also mapped the procedures to the NMC standards of proficiency for registered nurses, Future nurse, as the research identified a number of procedures that were more often done by nurses than doctors.

13 Finally, we looked at the 2018 F1 induction survey data and identified procedures which F1s reported they felt unprepared for.

Reasonable adjustments

14 We looked at the practical procedures in light of the consultation draft of Welcome and valued, our revised version of Gateways to the professions, our guidance for medical educators on how to support disabled students and doctor.

15 In the consultation draft of Welcome and Valued, we said that the Outcomes (including the practical procedures) are competency standards, but that schools may make adjustments to the mode of assessing, giving the example of Venepuncture.
16 The working group recognised that there was a balance to be struck between ensuring that a newly qualified doctor was safe and excluding doctors from joining the profession. For that reason, we considered what would be a core list of procedures to ensure confidence in the practical skills of newly qualified doctors.

**Level of competence**

17 The group considered various ways of describing the outcome expected for each procedure and settled on a descriptor of the level at which the newly qualified doctor would be safe to practice.

**Ongoing review of the practical skills and procedures**

18 The group recommended that the practical skills and procedures should remain uncoupled from the Outcomes to allow periodic review to ensure that the list was up to date and reflected current practice.

**Core clinical and procedural skills for provisionally registered doctors**

19 The list of practical procedures in *Outcomes for provisionally registered doctors with a licence to practise* has not been updated since 2009. It consists of fifteen core procedures which overlapped with the previous list of procedures in the Outcomes, but had no defined relationship with them.

20 The foundation programme representatives on the working group recommended that the list be removed. The group agreed that there was little value to an F1 having to get a skill like venepuncture signed off a year after getting it signed off at graduation. The group also noted that the practical skills needed in the foundation programme depended on a doctor’s placement.

21 The working group recommended that we should maintain a single list of practical skills and procedures in the Outcomes and that this should be also used in the Foundation Programme to reassess any doctor who had either not been through a UK primary medical qualification (and thus been assessed on the practical skills and procedures through their degree), or whose competence in a particular procedure was questioned. The Foundation Programme Curriculum would be redrafted to reflect this.

**The Medical Licensing Assessment**

22 The Outcomes, including the list of practical skills and procedures, will be one of the documents we use to inform the blueprint for our Medical Licensing Assessment (MLA), alongside *Good medical practice*, the Foundation Programme Curriculum, Hospital Episode Statistics and equivalent statistics for primary and mental health.
care. An assessment blueprint is a template used to define the content of a test and helps to make sure that the programme of assessments covers all of the outcomes. We plan to bring the MLA blueprint to Council in summer 2019.

Implementing the revised Outcomes

23 We will expect medical schools to have reflected the revised Outcomes, including the list of practical skills and procedures, in curricula within two years of the date of publication, so by summer 2020. We will ask medical schools to update regularly on their progress.

24 For students starting after summer 2020, medical schools must provide us with evidence to show that their learning is directed towards the Outcomes and that students’ progress towards meeting the Outcomes at graduation is assessed. This evidence must include medical schools’ curricula – which we expect to be mapped to the Outcomes – and assessment blueprints – which we expect to show when and how students are assessed on their learning against the Outcomes.

25 If we are not satisfied that the curriculum and assessments at a medical school are resulting in graduates being able to meet the Outcomes we will require the medical school to make changes so the Outcomes are met in accordance with our Quality Assurance Framework.

26 The list of practical skills and procedures will be reviewed on a more frequent basis than the rest of the Outcomes to ensure that it remains up to date and reflects current practice.

Next steps

27 Subject to Council’s views and approval, we intend to publish the revised list of practical skills and procedures in March 2019.
M7 – Practical skills and procedures list – approval for publication

M7 – Annex A

Practical skills and procedures

Purpose of the practical skills and procedures

We set the standards and requirements for all stages of medical education and training in *Promoting excellence: standards for medical education and training* (2016, pdf) and hold a list of universities entitled to issue medical degrees (also known as UK primary medical qualifications).

Our *Outcomes for graduates* (2018, pdf) set out what newly qualified doctors from all medical schools must know and be able to do.

The practical skills and procedures set out the core set and minimum level of performance that newly qualified doctors must have when they start work for the first time so they can practise safely.

Provisions for encouraging diversity in medicine

We believe that equality, diversity and inclusion are integral to our work as a regulator. We are committed to supporting diversity in medicine.

We expect organisations to make supportive and pragmatic adjustments for learners to enable achievement of the practical skills and procedures, including where learners have long-term health conditions and disabilities, while also abiding by the Equality Act. Further detailed information can be found in our publications *Welcomed and valued, Promoting Excellence* and *Promoting excellence - equality and diversity considerations* (2017, pdf).

How the procedures relate to our other standards and guidance

Our *Outcomes for graduates* (the outcomes) set out what newly qualified doctors from all medical schools who award UK primary medical qualifications must know and be able to do.

The practical skills and procedures supplements the outcomes by defining the core
diagnostic, therapeutic and practical skills and procedures newly qualified doctors must be able to perform safely and effectively, and identifying the level of supervision needed to ensure patient safety.

*Promoting excellence* sets out the standards and requirements for the management and delivery of undergraduate and postgraduate medical education and training. The outcomes and the practical skills and procedures set out what we expect newly qualified doctors to be able to know and do and should be read alongside *Promoting excellence*.

We expect all newly qualified doctors to practise in accordance with the professional requirements set out in *Good medical practice* and related guidance.

**Responsibility for delivering the procedures**

- **Medical schools** must provide an education that allows newly qualified doctors to meet all the outcomes, including the practical skills and procedures specified in this list, and therefore to be fit to practise safely as a doctor when they graduate.

- **Local education providers** working with medical schools must provide and quality manage clinical placements and learning opportunities that give medical students the opportunities to build knowledge, skills and practical experience to meet the outcomes and to safely and effectively carry out practical skills and procedures by the time they qualify.

- **Medical students** are responsible for their own learning. They should refer to the outcomes and the practical skills and procedures specified in this list during their undergraduate education to understand what we expect them to be able to know and do by the time they graduate.

**What must newly qualified doctors demonstrate for satisfactory completion?**

**Three levels of competence**

*Safe to practise in simulation*

The newly qualified doctor is safe to practise in a simulated setting and is ready to move to direct supervision. This means that the newly qualified doctor will not have performed the procedure on a real patient during medical school, but on a simulated patient or manikin. This means that they will have some knowledge and skill in the procedure but will require direct supervision when performing the procedure on patients.

*Safe to practise under indirect supervision*

The newly qualified doctor is ready to perform the procedure on a patient under indirect supervision. This means that the newly qualified doctor will have performed the procedure on real patients during medical school under direct supervision at first and, as their
experience and skill became sufficient to allow them to perform the procedure safely with indirect supervision. By indirect supervision, we mean that the newly qualified doctor is able to access support to perform the procedure if they need to – for example by locating a colleague and asking for help.

**Safe to practise under direct supervision**

The newly qualified doctor is ready to perform the procedure on a patient under direct supervision. This means that the newly qualified doctor will have performed the procedure on real patients during medical school under direct supervision. By direct supervision, we mean that the medical student or newly qualified doctor will have a supervisor with them observing their practice as they perform the procedure. As the newly qualified doctor’s experience and skill becomes sufficient to allow them to perform the procedure safely they will move to performing the procedure under indirect supervision.

**Generic requirements**

There are both generic requirements and specific procedure requirements for each procedure. Newly qualified doctors should comply with local and national guidelines, and employers will also typically have protocols for the safe performance of each procedure which should be followed.

**Generic requirements for each procedure**

The following generic requirements apply to each procedure:

- introduce themselves
- check the patient’s identity
- confirm that the procedure is required
- explain the procedure to the patient (including possible complications and risks) and gain informed consent for the procedure (under direct supervision where appropriate)
- follow universal precautions to reduce the risk of infections, including:
  - control the risk of cross infection, and take appropriate steps for personal safety
  - follow approved processes for cleaning hands before procedures or surgical operations
  - correctly use personal protective equipment (for example gloves, gowns and masks)
  - employ safe disposal of clinical waste, needles and other sharps
• dispose of all equipment in the appropriate receptacles

■ label samples appropriately according to local guidelines
■ accurately document the procedure according to local guidelines
■ ensure confidentiality
■ interpret any results and act appropriately on them; and
■ arrange appropriate aftercare/monitoring.

It’s important to remember that newly qualified doctors who enter the Foundation Programme will work under educational and clinical supervision and in a multidisciplinary team. In accordance with the Foundation Programme Curriculum, they will need to demonstrate that they are refining their skills and that they are able to take responsibility appropriately whilst recognising and working within the limits of their competence.

1 The newly qualified doctor must recognise the need to seek advice on unexpected or unusual results.
### Assessment of patient needs

<table>
<thead>
<tr>
<th>No</th>
<th>Procedure</th>
<th>Description</th>
<th>Level of competence</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Take baseline physiological observations and record appropriately</td>
<td>Measure temperature, respiratory rate, pulse rate, blood pressure, oxygen saturations and urine output.</td>
<td>Safe to practise under indirect supervision</td>
</tr>
<tr>
<td>2</td>
<td>Carry out peak expiratory flow respiratory function test</td>
<td>Explain to a patient how to perform a peak expiratory flow, assess that it is performed adequately and interpret results</td>
<td>Safe to practise under indirect supervision</td>
</tr>
<tr>
<td>3</td>
<td>Perform direct ophthalmoscopy</td>
<td>Perform basic ophthalmoscopy and identify common abnormalities.</td>
<td>Safe to practise under indirect supervision</td>
</tr>
<tr>
<td>4</td>
<td>Perform otoscopy</td>
<td>Perform basic otoscopy and identify common abnormalities.</td>
<td>Safe to practise under indirect supervision</td>
</tr>
</tbody>
</table>

### Diagnostic procedures

<table>
<thead>
<tr>
<th>No</th>
<th>Procedure</th>
<th>Description</th>
<th>Level of competence</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Take blood cultures</td>
<td>Take samples of venous blood to test for the growth of infectious organisms.</td>
<td>Safe to practise under direct supervision</td>
</tr>
<tr>
<td>No</td>
<td>Procedure</td>
<td>Description</td>
<td>Level of competence</td>
</tr>
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</tr>
<tr>
<td>6</td>
<td>Carry out arterial blood gas and acid base sampling from the radial artery in adults</td>
<td>Insert a needle into a patient’s radial artery (in the wrist) to take a sample of arterial blood and interpret the results.</td>
<td>Safe to practise under direct supervision</td>
</tr>
<tr>
<td>7</td>
<td>Carry out venepuncture</td>
<td>Insert a needle into a patient’s vein to take a sample of blood for testing. Make sure that blood samples are taken in the correct order, placed in the correct containers, that these are labelled correctly and sent to the laboratory promptly.</td>
<td>Safe to practise under indirect supervision</td>
</tr>
<tr>
<td>8</td>
<td>Measure capillary blood glucose</td>
<td>Measure the concentration of glucose in the patient’s blood at the bedside using appropriate equipment. Record and interpret the results.</td>
<td>Safe to practise under indirect supervision</td>
</tr>
<tr>
<td>9</td>
<td>Carry out a urine multi dipstick test</td>
<td>Explain to patient how to collect a midstream urine sample. Test a sample of urine to detect abnormalities. Perform a pregnancy test where appropriate.</td>
<td>Safe to practise under indirect supervision</td>
</tr>
<tr>
<td>No</td>
<td>Procedure</td>
<td>Description</td>
<td>Level of competence</td>
</tr>
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<tr>
<td>10</td>
<td>Carry out a 3- and 12-lead electrocardiograph</td>
<td>Set up a continuous recording of the electrical activity of the heart, ensuring that all leads are correctly placed.</td>
<td>Safe to practise under indirect supervision</td>
</tr>
<tr>
<td>11</td>
<td>Take and/or instruct patients how to take a swab</td>
<td>Use the correct technique to apply sterile swabs to the nose, throat, skin and wounds. Make sure that samples are placed in the correct containers, that these are labelled correctly and sent to the laboratory promptly and in the correct way.</td>
<td>Safe to practise under indirect supervision for nose, throat, skin or wound swabs</td>
</tr>
</tbody>
</table>

**Patient care**

<table>
<thead>
<tr>
<th>No</th>
<th>Procedure</th>
<th>Description</th>
<th>Level of competence</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>Perform surgical scrubbing up</td>
<td>Follow approved processes for cleaning hands and wearing appropriate personal protective equipment before procedures or surgical operations.</td>
<td>Safe to practise under direct supervision</td>
</tr>
</tbody>
</table>
### Agenda item M7 Annex A – Practical skills and procedures list

**Approval for publication**

<table>
<thead>
<tr>
<th>No</th>
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<th>Description</th>
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</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td>Set up an infusion</td>
<td>Set up and run through an intravenous infusion. Have awareness of the different equipment and devices used.</td>
<td>Safe to practise under direct supervision</td>
</tr>
<tr>
<td>14</td>
<td>Use correct techniques for moving and handling, including patients who are frail</td>
<td>Use, or direct other team members to use, approved methods for moving, lifting and handling people or objects, in the context of clinical care, using methods that avoid injury to patients, colleagues, or oneself.</td>
<td>Safe to practise under indirect supervision</td>
</tr>
</tbody>
</table>

### Prescribing

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>Instruct patients in the use of devices for inhaled medication</td>
<td>Explain to a patient how to use an inhaler correctly, including spacers, and check that their technique is correct.</td>
<td>Safe to practise under indirect supervision</td>
</tr>
<tr>
<td>16</td>
<td>Prescribe and administer oxygen</td>
<td>Prescribe and administer oxygen safely using a delivery method appropriate for the patient’s needs and monitor and adjust oxygen as needed.</td>
<td>Safe to practise under indirect supervision</td>
</tr>
</tbody>
</table>
### Council meeting, 27 February 2019

**Agenda item M7 Annex A – Practical skills and procedures list**

**Approval for publication**

<table>
<thead>
<tr>
<th>No</th>
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<th>Level of competence</th>
</tr>
</thead>
<tbody>
<tr>
<td>17</td>
<td>Prepare and administer injectable (intramuscular, subcutaneous, IV) drugs</td>
<td>Preparation and administration of injectable drugs and prefilled syringes.</td>
<td>Safe to practise under direct supervision</td>
</tr>
</tbody>
</table>

### Therapeutic procedures

<table>
<thead>
<tr>
<th>No</th>
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</tr>
</thead>
<tbody>
<tr>
<td>18</td>
<td>Carry out intravenous cannulation.</td>
<td>Insert a cannula into a patient’s vein and apply an appropriate dressing.</td>
<td>Safe to practise under direct supervision</td>
</tr>
<tr>
<td>19</td>
<td>Carry out safe and appropriate blood transfusion</td>
<td>Following the correct procedures, give a transfusion of blood (including correct identification of the patient and checking blood groups). Observe the patient for possible reactions to the transfusion, and take action if they occur.</td>
<td>Experienced in a simulated setting; further training required before direct supervision</td>
</tr>
<tr>
<td>20</td>
<td>Carry out male and female urinary catheterisation</td>
<td>Insert a urethral catheter in both male and female patients.</td>
<td>Safe to practise under direct supervision</td>
</tr>
<tr>
<td>21</td>
<td>Carry out wound care and basic wound closure and dressing</td>
<td>Provide basic care of surgical or traumatic wounds and apply dressings appropriately.</td>
<td>Safe to practise under direct supervision</td>
</tr>
<tr>
<td>No</td>
<td>Procedure</td>
<td>Description</td>
<td>Level of competence</td>
</tr>
<tr>
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</tr>
<tr>
<td>22</td>
<td>Carry out nasogastric tube placement</td>
<td>Pass a tube into the stomach through the nose and throat for feeding and administering drugs or draining the stomach’s contents. Know how to ensure correct placement.</td>
<td>Safe to practise in simulation</td>
</tr>
<tr>
<td>23</td>
<td>Use local anaesthetics</td>
<td>Inject or topically apply a local anaesthetic. Understand maximum doses of local anaesthetic agents.</td>
<td>Safe to practise under direct supervision</td>
</tr>
</tbody>
</table>
Agenda item: M10
Report title: Report of the Executive Board 2018
Report by: Charlie Massey, Chief Executive chiefexecutive@gmc-uk.org, 020 7189 5037
Considered by: Executive Board
Action: To note

Executive summary
This report summarises the work undertaken by the Executive Board during 2018, setting out the decisions taken, policies and guidance agreed and reports noted across a range of strategic issues.

The Executive Board is the senior decision-making and oversight forum established to provide strategic direction, scrutiny and reporting to Council by the GMC’s senior management team on significant policy, strategy, finance, performance, operational delivery and resource management issues. It ensures that the GMC is a high-performing and agile regulator that understands its registrants, the health care systems in which it operates and the views of its key stakeholders.

Recommendation
Council is asked to:

- Note the Report of the Executive Board 2018.
Background

1. The Executive Board was established in 2017 as part of a wider package of changes within the organisation to support our ambition to become a more agile, confident and connected regulator, help streamline our governance structures and inject greater pace and agility into our decision-making.

2. The Executive Board was established as a decision-making forum and to promote collective executive decision-making by the senior management team (SMT).

3. The Board met 11 times during 2018, on:
   
   - 29 January 2018
   - 26 February 2018
   - 26 March 2018
   - 30 April 2018
   - 4 June 2018
   - 25 June 2018
   - 23 July 2018
   - 1 October 2018
   - 29 October 2018
   - 26 November 2018
   - 17 December 2018

4. Over the period of this report, the Executive Board has undertaken a programme of work which fulfils its duties and responsibilities, as set out in the Board’s statement of purpose. Council has received regular updates on the Board’s work through the Chief Executive’s and Chief Operating Officer’s reports to Council.

Key matters considered by the Executive Board in 2018

Operational performance and risk

5. At alternate meetings, the Board considered the Operational Performance and Risk Review, providing high level reports on performance, including finance and people, customer service and learning, and updates on the key risks to achieving our strategic aims.

6. At its meeting on 1 October 2018, the Board conducted its annual review of the Corporate Opportunities and Risk Register, with each of the specific risks and risk management issues considered in depth.

7. In addition to consideration of the Operational Performance and Risk Review at its meeting on 26 November 2018, the Board considered potential risks to the GMC’s educational aims, as a result of the new working arrangements for Health Education England (HEE) and NHS Improvement (NHSI). The Board agreed that the new risk should be added to the corporate risk register and would continue to monitor the developments with HEE and NHSI.

Strategy

8. On 25 June 2018 the Board carried out the first biannual review of the Corporate Strategy, to explore: if any adjustments were required to the strategic aims in the
light of the Jack Adcock/Dr Bawa-Garba case and the supporting doctors under pressure programme; how well the Corporate Strategy had ‘landed’ internally and externally; and what further the GMC might do to best implement the strategy. The Board agreed that the Corporate Strategy was relevant and focused in the right areas, agreed in principle to adopt a ‘one GMC’ strategy approach rather than having multiple directorate, section or thematic strategies, and agreed the need for the development of a high level operating model to assist with resourcing, cross organisational prioritisation and delivering of ‘one GMC’.

9 Also on 25 June 2018 the Board considered a new approach to developing and managing our strategic relationships, aimed at improving our relationships with key stakeholders and partners. The approach will focus our resources on relationships with the highest strategic value, take a more proactive approach to relationships, and provide a framework to give relationships direction and structure. The Board approved the new approach which will deliver a range of benefits for the GMC and stakeholders in areas such as planning and being a more assertive regulator.

10 On 29 October 2018 the Board considered proposals on how we could make the various parts of the GMC achieve greater collective effect, by working with a number of parties towards shared purposes, focusing on the outcomes of our strategic aims and the associated benefits. This work is designed to build on our Corporate Strategy commitments to strengthen collaboration with regulatory partners and meet the changing needs of the health services across the four countries.

11 At its meeting on 26 November 2018 the Board considered the outcome of the Field Forces review. The review set out to establish how to meet our strategic aim of shaping our outreach teams that work with frontline doctors, healthcare providers and systems regulators to align with local systems to support the delivery of our re-focused approach to regulation. The Board agreed the principle of a seven-region model in England alongside national offices in Wales, Scotland and Northern Ireland by the end of 2020.

12 On 17 December 2018 the Board considered an update on progress we have made against our corporate strategy aims and the baseline measures that that will help demonstrate progress on our aims by 2020. For each of the four strategic aims, the report sets out achievements during 2018, future plans and the baseline measures identified. We intend to publish this content later in 2019 as part of the publication of the annual report, to show the progress we have made in implementing our corporate strategy.

13 Also on 17 December 2018 the Board agreed a new approach to managing our strategic relationships to help us meet the public commitment made in our Corporate Strategy that we will ‘strengthen collaboration with our regulatory partners across the health services’. The proposals included the establishment of a Strategic Relationships Unit within the Strategic Communications & Engagement directorate and development of a new Stakeholder Relationship Management system.
Forward planning, including Brexit

14 On 29 January 2018 the Board considered a number of exit scenarios reflecting the continued uncertainty with Brexit negotiations and our preparations for the operational implications to the GMC of the UK leaving the European Union. Key policy areas include registration routes for EEA graduates, CESR and CEGPR routes, minimum training periods and fitness to practise information sharing as well as any implications with respect to Northern Ireland.

15 On 25 June 2018 the Board noted an update on the first cycle of the horizon scanning programme, which provided key findings and discussion points on areas such as: risks and opportunities to the delivery of safe and effective medical practice; the ability of the system to support this; and the ability of our regulatory model to facilitate this.

16 On 17 December 2018 the Board agreed an incremental approach to developing horizon scanning capacity during 2019 adding, as far as possible, horizon scanning elements to existing processes rather than creating a new framework and set of processes.

17 Also on 17 December 2018 the Board approved the release of necessary contingency funds so preparations for a ‘no deal’ Brexit could commence. Contingencies could include the recruitment of additional staff or use of overtime to manage potential increases in applications from doctors from the European Economic Area and to make changes to IS systems.

Business planning

18 On 30 April 2018 the Board agreed to explore different approaches to business planning for 2019 and agreed that SMT would have a further discussion on mapping the organisation’s priority activities against our strategic aims. The annual business planning cycle brings together strategic, directorate and budget planning processes. The Business Plan sets out how we will meet our core regulatory objectives and strategic aims during the following calendar year. The budget is prepared in accordance with the Business Plan, so that we can be confident we have the resources to deliver on our objectives.

19 On 23 July 2018 the Board considered initial proposals for new measures and thresholds to monitor performance of our statutory functions and business-critical services. The Board agreed to further work in consultation with all directorates to develop the new suite of business measures, which would replace existing service level agreements and key performance indicators, for implementation during 2019 and reviewed every two years.

20 On 26 November 2018 the Board agreed the 2019 business plan and budget, ahead of consideration by Council at the 12 December meeting. The Board also approved an additional budget proposal for the appointment and induction training for 25 new
Medical Tribunal members, in tandem with the appointment of 25 Legally Qualified Chairs, which had already been approved by the Senior Management Team. The approved programme will ensure that Tribunals are appropriately resourced in 2019 to meet quorum requirements and hearings can proceed in a timely manner.

Guidance for the profession

On 23 July 2018 the Board considered new Reflective practitioner guidance, which is aimed at addressing concerns from doctors that they are no longer able to reflect honestly, openly and safely, as a result of fears of recrimination. The Board agreed for publication the new guidance on reflective practice, which has been produced in collaboration with the British Medical Association and co-authored with the Academy of Medical Royal Colleges, Conference of Postgraduate Medical Deans, and Medical Schools Council.

On 29 October 2018 the Board endorsed new guidance co-authored by the British Medical Association and Royal College of Physicians, on decisions about Clinically-assisted nutrition and hydration and adults who lack capacity to consent, which was published on 12 December 2018.

On 17 December 2018 the Board agreed the content for an inter-regulatory statement on being a reflective practitioner, ahead of publication in quarter 1 of 2019. Following agreement by the chief executives of the healthcare regulators, a statement on supporting being a reflective practitioner and endorsing the use of group reflection has been jointly developed. The statement is jointly produced by eight health regulators.

Medical education and training

On 26 February 2018 the Board agreed a proposal for a public consultation on the revised guidance on health and disability in medical training, subject to further work on the communications approach. We have been undertaking a work programme on health and disability, centred on the revision of our guidance in this area, Gateways to the professions. We have engaged with an external group of experts and talked with individuals and organisations across the four countries. The principles of the previous guidance have been maintained, but the majority of the content has been re-organised to reflect a balance between the role and considerations of the GMC, the medical schools and postgraduate providers in relation to health and disability.

On 26 March 2018 the Board noted an update on progress against the actions we set out in Adapting for the future, A plan for improving the flexibility of postgraduate medical training, to follow up our commitments to introduce educational reforms that would support greater flexibility through outcomes and more generic professional and transferable skills elements.

On 17 December 2018 the Board considered the results of the public consultation on our new advisory guidance for supporting disabled learners Welcomed and valued
consultation, as part of the health and disability review. The Board noted the revisions to the draft guidance made as a result of the consultation process, signed off the latest version of the draft guidance and delegated authority to the Director of Education & Standards to approve the final version for publication. Publication and accompanying communications activity are currently planned for Quarter 2 of 2019.

**Publication and disclosure policies**

27 At its meeting on 26 November 2018 the Board considered a draft policy on proactively disclosing information about a doctor’s fitness to practise history to their employer(s) outside of the fitness to practise process, ahead of consideration of the policy by Council on 12 December 2018.

28 On 17 December 2018 the Board considered the policy framework for excluding information from the List of Registered Medical Practitioners (LRMP). We have developed a framework to support decisions to exclude revalidation and training information in circumstances that affect certain organisations and individual doctors. This is specifically where we are assured that publication of that information on LRMP presents a significant risk of serious harm to the physical or mental wellbeing of the doctor. We anticipate the policy will cover cases involving, but not limited to, domestic violence, stalking or harassment.

**Updates on programmes**

29 The Board noted updates on the following programmes:

a The first stages of setting up a Local First pilot to support local resolution of concerns about doctors (at the meeting on 26 March 2018).

b The better signposting programme (at the meeting on 26 March 2018), which detailed the further work being done to make navigation of healthcare complaints easier for patients and public to understand.

c The Harms reduction programme (at the meeting on 23 July 2018), which arose from a commitment in the Corporate Strategy to identify, understand and address problems which present a risk of harm to both patients and doctors. The Harms reduction programme aims to identify opportunities to intervene before harm occurs, and to support and embed wider learning about how and why such things occur.

d Plans to prepare for a formal consultation on our requirements for patient feedback, including communication and engagement plans (at the meeting on 1 October 2018).

e The Public Interest Concerns pilot (at the meeting on 17 December 2018), which was started in July 2016 with the aim of testing changes to the way that employers and contractors of doctors make referrals into our fitness to practise
procedures and the way we provide safeguards for doctors who are whistle-blowers’. The Board approved the pilot model for roll out to business as usual with the improvements highlighted in the paper.

**Presentation by Clinical Fellows**

**30** On 1 October 2018 the Board received a presentation by the new cohort of Clinical Fellows on a range of issues they have experienced in frontline medical roles, which was in the form of a role-playing scenario on one morning in a chaotic and noisy emergency department. The Senior Management Team agreed to consider further how to address the issues raised around the GMC’s communications with individual registrants, messaging for employers about basic working conditions and clarifying what the GMC does and does not require for processes like revalidation.

**Human resources**

**31** On 26 February 2018 the Board agreed the pay matrix to apply to the April 2018 pay award.

**32** Also on 26 February 2018 the Board noted an update on the staff survey, which has moved from a two yearly to a yearly cycle. The update included a detailed timetable, an update on the scope of the survey and a slimmed down set of questions.

**33** On 23 July 2018 the Board considered the mid-year HR report, noting data on turnover and recruitment and absence rates. The Board noted updates to the flexitime policy and travel disruption policy for consultation, updates to a number of clauses to be included in new employment contracts and agreed to an increase in the number of days leave that can be bought or sold from three to five per year, with effect from 1 January 2019.

**34** Also on 23 July 2018 the Board agreed outline proposals for a pay strategy for 2019, including options to address the gender pay gap, and agreed to end the current restrictions on appointment salaries for internal candidates, an approach which was aimed at addressing the issue of differential starting salaries.

**Accommodation**

**35** On 26 March 2018 the Board considered the appointment of property consultants to evaluate and cost options for providing greater capacity for the Clinical Assessment Centre (CAC), our dedicated facility for assessing the clinical and communication skills of doctors. Increasing candidate numbers since 2015 mean the CAC is now working at near full capacity and consideration is required of how we will meet demand moving into 2019.

**36** On 1 October 2018 considered the final proposals for the project for constructing and putting into operation the new CAC for oversight by the CAC Expansion Implementation Board. The project was approved and would be funded from income.
generated by PLAB fees and other related sources, with costs expected to be recouped over a five year period.

37 On 29 October 2018 the Board approved the acquisition of and relocation to new, larger premises in Belfast to improve the Northern Ireland office’s capacity to accommodate the growth of cross-GMC activity, stakeholder engagement and the expansion in staffing levels over the past ten years.

38 On 17 December 2018 the Board considered an accommodation strategy to address the pressure on the availability of office accommodation in our premises in London and Hardman Street, Manchester. The Board agreed to increase the level of scheduled home working to accommodate headcount increases, and allow for the implementation of more flexible workspace; to engage architects to update the Hardman Street workplace audit and produce the same for London during 2019; engage property consultants to review London and Manchester property options prior to the 2020 budget setting process; and to reconfigure the reception and meeting room area in London to provide more flexible workspace.

Data protection and records retention

39 On 26 February 2018 the Board agreed a revised approach to processing personal data in line with the requirements of the General Data Protection Regulation (GDPR), which comes into force on 25 May 2018. As a public authority, when we are processing personal data to fulfil our functions under the Medical Act we have a lawful basis for doing so. In the words of the GDPR, we are processing data in a way which is ‘necessary for the performance of a task carried out in the public interest or in the exercise of official authority’. In these instances the regulation is clear that we should not seek consent from data subjects because data subjects would not be able to provide truly freely-given consent when engaging with organisations like the GMC and where our statutory role sometimes requires us to disclose data in the public interest, even where consent has been refused. The Board therefore agreed that we will process personal data without consent where this is ‘in the exercise of official authority’. Additionally, we will provide detailed, up-front information to data subjects in respect of our processing activities in the form of a privacy notice. Overall, following legal advice, we are satisfied that our approach brought us into line with the new regulation and ensures that data subjects have a clearer understanding of the ways in which we process their personal information.

40 On 26 February 2018 the Board also agreed the implementation of a revised retention and disposal policy for case records. Our Records Retention and Disposal Policy balances the need to retain information for regulatory purposes with the requirements of the Data Protection Act and other legislation. We are asked to provide increasing volumes of material to public inquiries, often of a historic nature, so it is essential that our processes for maintaining patient safety are open to scrutiny. The revised policy extends the retention period for case records from...
Executive summary
This paper sets out the proposed dates of Council and Committee meetings in 2020.

Recommendation
Council is asked to agree the 2020 schedule of meetings.
Council

1. The draft schedule of Council meetings for 2020 is at Annex A. In 2015 Council agreed that it should meet six times each year as the work programme requires this for Council’s business, and to have an away day. It is proposed that Council should continue to meet with this frequency and that the dates will be utilised for meetings, and/or seminars and confidential discussions, subject to the requirements of the forward work programme as it develops.

2. It was agreed at the Council away day on 6 July 2016, that two Council meetings per year would be held in Manchester. We propose that Council should continue to meet in Manchester twice yearly, in June and December 2020.

Committees and other groups

3. The draft schedule also contains the proposed dates of Committees (Audit and Risk Committee, Remuneration Committee, Investment Sub-Committee, and the Board of Pension Trustees), and other group meetings and is at Annex B. The frequency of these meetings has been determined in accordance with the working arrangements set out in their statements of purpose.

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

5. We have taken into account dates of school holiday periods, as far as is possible at this early stage, and major religious festivals. We avoided scheduling meetings in early January, late July, August and late December 2020. However, due to the number of meetings required and the fact that half terms and summer holidays vary between schools and different regions, and in each of the four countries, it is not always possible to completely avoid these periods.

6. We have also considered the reporting arrangements required and have sought to achieve a schedule that links with the production of performance and financial information to allow for Council’s review of appropriate and timely data.

7. The full meeting schedule will also be uploaded and available for members to view via the Board Intelligence app, and will be updated should any changes be made.
2020 Council meetings

The proposed meeting schedule for Council is as follows:

Wednesday 26 February 2020, 18:00-20:00 (Evening seminar)
Thursday 27 February 2020, 09:00-13:00

Wednesday 22 April 2020, 18:00-20:00 (Evening seminar)
Thursday 23 April 2020, 09:00-13:00

Wednesday 10 June 2020, 18:00-20:00 (Evening seminar)
Thursday 11 June 2020, 09:00-13:00

Tuesday 6 and Wednesday 7 July 2020, Council away day – Residential/overnight

Monday 28 September 2020, 18:00-20:00 (Evening seminar)
Tuesday 29 September 2020, 09:00-13:00

Tuesday 3 November 2020, 18:00-20:00 (Evening seminar)
Wednesday 4 November 2020, 09:00-13:00

Wednesday 9 December 2020, 18:00-20:00 (Evening seminar)
Thursday 10 December 2020, 09:00-13:00
2020 Committee and other group meetings

Audit and Risk Committee
- Wednesday 22 January 2020
- Wednesday 18 March 2020
- Wednesday 13 May 2020
- Wednesday 15 July 2020
- Tuesday 15 September 2020
- Wednesday 11 November 2020

Investment Sub-Committee
- Tuesday 28 January 2020
- Thursday 7 May 2020
- Tuesday 22 September 2020
- Tuesday 19 November 2020

Remuneration Committee
- Tuesday 24 March 2020
- Thursday 22 October 2020
**Board of Pension Trustees**

- Tuesday 3 March 2020
- Tuesday 19 May 2020
- Thursday 2 July 2020
- Wednesday 23 September 2020
- Wednesday 25 November 2020

**GMC/MPTS Liaison Group**

- Wednesday 27 May 2020
- Wednesday 25 November 2020

**GMCSI Board**

- Wednesday 5 February 2020
- Wednesday 6 May 2020
- Tuesday 8 September 2020
- Monday 30 November 2020

**MPTS Committee**

- Tuesday 4 February 2020
- Tuesday 12 May 2020
- Wednesday 16 September 2020
- Wednesday 18 November 2020