Council Meeting - 23 April 2020

MEETING
23 April 2020 09:00

PUBLISHED
21 April 2020
## Council Agenda

**Via Skype**  
**Main meeting**  
**Thursday 23 April 2020**  
**09:00 – 11:00**

### Meeting

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<td>Chair’s business</td>
<td>3 mins</td>
<td>Clare Marx</td>
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<td>09:33 – 09:35</td>
<td>Minutes of the meeting on 26 February 2020</td>
<td>2 mins</td>
<td>Clare Marx</td>
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<td>09:35 – 09:45</td>
<td>Chief Executive’s Report</td>
<td>10 mins</td>
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<td>09:55 – 10:05</td>
<td>2019 Human Resources Report and Gender Pay Update</td>
<td>10 mins</td>
<td>Andrew Bratt</td>
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<td>Rebecca Clarke/ Andy Lewis/Tista Chakravarty-Gannon</td>
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<td>Judith Chrystie</td>
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<td>Section 40a appeals update</td>
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To approve

Minutes of the meeting on 27 February 2020

Members present

Clare Marx, Chair

Steven Burnett  Suzi Leather
Christine Eames  Raj Patel
Anthony Harnden  Denise Platt
Philip Hunt  Amerdeep Somal
Paul Knight  Alison Wright

Others present

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

Chair’s business (agenda item M1)

1 The Chair welcomed Raj Patel and Alison Wright to their first meeting of Council. The Chair also welcomed other members, the Senior Management Team and observers to the meeting.

2 Apologies were received from Deirdre Kelly.
Council noted, as previously declared by Philip Hunt for the purposes of transparency, in relation to matters set out in the Chief Executive’s report, that he held the position of Chair of the Heart of England NHS Foundation Trust from 2011-2014 (with reference to the Paterson inquiry) and was Health Minister from 1999-2003 and in 2007 (which involved some responsibilities in relation to the matters reviewed by the Infected Blood inquiry).

Minutes of the meeting on 12 December 2019 (agenda item M2)

Council approved the minutes of the meeting on 12 December 2019 as a true record.

Chief Executive’s report (agenda item M3)

Council considered the Chief Executive’s Report.

The Chief Executive gave an update on the report of the Paterson inquiry, noting that:

a. We are reflecting on the very serious findings of the report in advance of responding formally. Some of the recommendations are particularly relevant to our work, including proposals for a single repository for a doctor’s scope of practice information and a period of reflection for patients before giving consent for surgical procedures.

b. Baroness Cumberlege’s Independent Medicines and Medical Devices Safety Review was due to publish its report shortly and was also likely to address the issue of working across the NHS/private practice divide.

c. Three doctors have been referred to us by the inquiry.

d. We are in discussions with the Nursing and Midwifery Council, Professional Standards Authority and Care Quality Commission about the inquiry’s findings. We will also discuss the findings with DHSC ahead of the Department publishing its response after Easter 2020.

e. As well as considering the recommendations we will reflect deeply on the comments about their experiences with the GMC made by the patients involved and the Chief Executive has offered to speak to patients involved.

Council also noted that:

a. Following up the three independent reviews published during 2019 – on gross negligence manslaughter and culpable homicide, medical students' and doctors' wellbeing and rates of referrals the GMC receives from employers of certain groups of doctors – work is underway to take forward the recommendations. We are convening conversations in each of the four countries on the themes of
compassionate behaviour and leadership, induction, multi-disciplinary team working and regulatory alignment.

b The Chief Executive had met the Secretary of State for Health and Social Care, Rt Hon Matt Hancock MP, earlier in the year. DHSC’s priorities include getting regulation of the Medical Associate Professions (MAPs) in place by April 2021 and giving us more autonomy around how doctors get onto the specialist and GP registers. The Department is planning for a consultation on fitness to practise reform later in 2020.

c In response to the emerging outbreak of the Coronavirus (COVID-19), our established pandemic plan is in place, which sets out our critical capabilities, including the call centre, website and online services, fitness to practise processes and interim orders tribunals. Discussions were underway with DHSC about the potential for additional standards guidance for the profession and temporary registration processes. In the event of office closures, there is capacity for around 500 members of staff to access services remotely, with webmail access for others.

d As well as working with other UK regulators to set out some common advice for delivering safe care for patients and service users in the context of the Coronavirus outbreak, a statement is also being prepared on doctors’ responsibilities towards patients and the responsibilities of organisations to provide resources for doctors.

e The Parliamentary reception on 3 February 2020 had been successful, noting the comments by the Chair of the Health and Social Care Committee, Rt Hon Jeremy Hunt MP, about opportunities for the GMC Chair and Chief Executive to appear before the Committee.

8 During discussion, Council noted that:

a The Chief Executive’s letter to the Secretary of State for Health and Social Care on 13 February 2020 would be circulated to the new Council members.

b Council would be updated on the potential impact for our regulatory responsibilities of the Government’s proposed immigration policy, points system and NHS visas.

9 Council noted the Chief Executive’s report, Council portfolio, the Corporate Opportunities and Risk Register and the strategic lead and lag indicators for 2020.
Report of the Investment Sub-Committee 2019 and review of Investment Policy (agenda item M4)

10 Council received the report of the Investment Committee for 2019.

11 Council noted that:

   a 2019 had been a good year for its investments, with the increase in funds invested through its investment provider going smoothly, and results for GMC Services International looking more hopeful.

   b The impact of the Coronavirus outbreak on investments was being monitored and there is a provision for the Committee to hold an emergency meeting if the value of investments falls below a particular level.

   c Although we currently hold less than 0.6% of our portfolio in companies involved in the extraction of fossil fuels, the Committee will review the position on continuing its investment in these companies in the light of the GMC’s statutory purpose to protect, promote and maintain the health safety and well-being of the public. Council will be asked to consider any changes to the ethical investment policy at its meeting in July 2020.

12 Council:

   a Noted the report of the Investment Committee 2019.

   b Approved the revised Investment Policy.

   c Amended the Committee’s Statement of Purpose to reduce the number of Council members sitting on the Committee from five to four.

Proposal to roll out new Quality Assurance process for medical schools and postgraduate training organisations (agenda item M5)

13 Council received a proposal to roll out the piloted process for quality assurance (QA) of the management and delivery of medical education and training.

14 Council noted that:

   a The proposed new QA arrangements replace large-scale visits every five years with a risk-based annual cycle combining self-assessment, data and intelligence to determine which areas to investigate further, in terms of both risks and good practice.

   b The proposals have been developed following a pilot with five medical schools and two postgraduate training organisations across Wales and the West Midlands.

www.gmc-uk.org
c The proposals should reduce the burden on those bodies being quality assured and enable us to respond quickly where there are concerns.

15 During discussion, Council noted that:

a Although we do not survey students as part of the QA process, medical schools could be asked how they survey students.

b As with the much longer-term process for assessing new medical schools, teams dealing with individual bodies will need to be refreshed regularly to ensure that relationships do not become too familiar.

c Council members would be welcome to get involved with visits and Council could receive an annual report on the process.

16 Council approved the roll-out of the new quality assurance process for medical schools and postgraduate training organisations.

Programme for regulation of Medical Associate Professions (agenda item M6)

17 Council received an update on developments on the regulation of physician associates and anaesthesia associates.

18 Council noted that:

a Current planning was on the basis that legislation to commence regulation of MAPs could be in place in 18-24 months.

b Plans are in accordance with the regulatory principles agreed by Council, including proportionality and no cross-subsidisation from doctors’ fees, along with an annual retention fee for MAPs in the region of £200.

c It will be a significant undertaking to QA the 37 different courses offered by UK universities for physician associate qualifications, plus one which offers an anaesthesia associate course.

d Each of the four UK health departments has advised on the stakeholders we should involve in our discussions to date, which has resulted in some variation across the four countries in the level of engagement.

e Our conversations with DHSC have emphasised that new regulations relating to physician associates and anaesthesia associates should be worded flexibly enough to allow for further MAPs to be regulated in future.

f The intention is not to impose existing fitness to practise processes on MAPs, but there is a risk that temporary arrangements would need to be in place if
implementation is required by April 2021. Such a decision about fitness to practise processes would need to be taken by Council.

19 During discussion, Council noted that:

- A carefully phrased narrative will be needed to ensure that the professions are not seen as a stepping stone into the medical profession but a career in itself, while at the same time not discouraging those that want to follow that route.

- An informal opportunity for Council members and MAPs to meet would be explored.

20 Council noted the progress made in scoping and developing the MAPs programme, including the proposed programme priorities.

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

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

22 Council noted that:

- The University of Central Lancashire Medical School was predominantly private but that this does not change the QA processes we undertake.

- Following the conclusion of the QA process, Council was assured that the school meets the required standards.

23 Council approved the addition of the University of Central Lancashire to the list of bodies that can award UK Primary Medical Qualifications.

Governance update for 2020 (agenda item M8)

24 Council received a paper providing a stock-take of corporate governance matters at the GMC, setting the professional context for governance and describing the pipeline of developments for 2020.

25 Council noted that improvements include the introduction of a Senior Responsible Owner role for GMC staff who manage projects; new, clearer templates for Council papers; and a procurement process to review the market for apps used to access Council and committee papers.
26 During discussion, Council noted that:

a Summaries for all Council members following each committee meeting should be also made available on their board papers app.

b The template for Council papers would be updated to include a box to show the sponsoring director or senior responsible owner, and for ‘other implications’ to include implications relating to patients or the public.

27 Council noted the summary of governance improvements in preparation for a fuller discussion at the seminar in April in the context of the proposed introduction of unitary boards.

Any Other Business (agenda item M9)

28 There was no other business.

Report of Executive Board 2019 (agenda item M10)

29 Council noted the 2019 report of the Executive Board.

2021 Council and Committee planning (agenda item M11)

30 Council agreed the 2021 schedule of meetings.

Confirmed:

Clare Marx, Chair 23 April 2020
## Chief Executive’s Report

**Action**
To note

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

We have paused all non-essential regulatory activity for the duration of the emergency to enable all those in the healthcare system to focus maximum energy and attention on the care of patients.

**Decision trail**
N/A

**Recommendation(s)**
Council is asked to:

a. Consider the Chief Executive’s report.

b. Note the Council portfolio and the Corporate Opportunities and Risk Register

**Annexes**
Annex A: Council Portfolio
Annex B: Corporate Opportunities and Risk Register

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Responding to the Coronavirus (Covid-19) pandemic

1. We’ve had to respond with agility and pace to support doctors, patients and the health service at this time of national emergency. We’ve worked closely with the UK Government and the devolved administrations, the Chief Medical Officers, and partners across the health and care system, regulatory partners and medical education bodies.

2. I believe we should be proud of the way in which we have responded so far but must also recognise the possibility that there may well prove to be instances where things have gone wrong. I have no doubt that once this crisis passes, we will want to look very thoroughly at the decisions and steps we have taken and reflect on what we have done well and where we could have done better.

3. Below I have provided a recap of the key steps we have taken to respond to the pandemic so far, across our different functions. Council will be familiar with the vast majority of these as we have sought to keep you involved at every stage of this fast-moving situation.

Emergency registration

4. On Wednesday 25 March 2020, the Secretary of State wrote to me as the Registrar to activate our emergency powers under section 18a of the Medical Act (1983).

5. These powers allow us to waive our usual registration requirements and register anyone who we consider is a ‘fit and proper and suitably qualified person to be registered... with regard to an emergency’.

6. The UK government has asked us to give temporary registration to fully qualified and experienced doctors with a UK address who:

- left the register after March 2014
- were registered but didn’t have a licence to practise

7. All of these doctors are able to opt out of temporary registration or ask us to remove their temporary licence to practise at any point, for any reason.

8. Patient safety remains our priority. That is why we are not re-registering any doctors who had a fitness to practise sanction, investigation or restriction on their registration at the time they left the register or gave up their licence to practise.
We have re-registered doctors in four stages so far which I have set out below. We may yet register further cohorts of doctors, depending on how the pandemic progresses and what is asked of us by the UK Government:

i  On 20 March 2020, we wrote to 15,000 doctors with a UK address who had left the register or gave up their licence to practice in the last three years to let them know that we expected the government to ask us to give them temporary registration. This was before our emergency powers were activated, so we gave them an opportunity to opt out before they were added to the register. 11,894 doctors who hadn’t opted out were given temporary registration on 26 March 2020.

ii  On 29 March 2020 we added 3,582 doctors with a UK address to the register. These were doctors that we’d excluded from the original group for non-payment, or administrative reasons. Once we’d examined their records more closely, we decided to also give them temporary registration. We wrote to them on 30 March 2020 to let them know they’d been registered and to give them an opportunity to opt out.

iii  On 31 March 2020 we gave 12,190 doctors with a UK address, and who were already registered with us, a temporary licence to practice. We wrote to them on 2 April 2020 to tell them that their licence had been restored for the duration of the emergency, but we also let them know that they could opt out before we give their details to the health services.

iv  On 2 April 2020 we gave temporary registration to 6,800 doctors with a UK address who left the register between three and six years ago (2014-17). We wrote to them on 3 April 2020 to tell them that their registration has been restored for the duration of the emergency, but we also let them know that they could opt out before we give their details to the health services.

We are sharing the contact details of doctors who don’t opt out with the health services in the country of their registered address. The health services will contact them if they want them to return to work. We are also directing doctors in England, Northern Ireland and Wales to a survey being coordinated by NHS England which asks about their availability and practice. If their registered address is in Northern Ireland, or Wales, their information is being passed to the health service in the relevant country. Doctors in Scotland are being directed to a survey by NHS Scotland. This is so all the health services can better understand how and where doctors can be deployed.
11 As soon as a doctor receives an email from us confirming that we’ve given them temporary registration or a licence to practise, they can work in the health service if they’re asked and are willing to do so. If they choose to return to practise, they should receive induction and training before they start work. And routine pre-employment checks should be carried out.

12 Doctors with temporary registration are clearly indicated on the medical register and doctors who’ve been granted temporary registration will not have to revalidate.

**Doctors in training**

13 All postgraduate training rotations due to take place on 1 April 2020 have been paused. This would have involved over 20,000 trainees moving to new workplace settings at an already pressurised time for healthcare services.

14 Like all doctors, trainees may be asked to work flexibly as the coronavirus pandemic gets worse. This could mean carrying out alternative tasks or working in different clinical contexts. We’ve worked with postgraduate deans to develop guiding principles for those involved in doctors’ training. We’re all committed to making sure the pandemic does not compromise their long-term training needs. The principles include that:

- trainees shouldn’t be asked to carry out any activities beyond their level of competence
- trainees should receive appropriate induction and supervision if they’re deployed to a different clinical area
- interruptions to training should be considered during trainees’ Annual Review of Competence Progression (ARCP).

15 In relation to exams for doctors in training, following advice by the UK government:

- Colleges have decided to cancel all exams.
- Trainees will not be disadvantaged for missing exams due to circumstances out of their control that relate to coronavirus. Payments will carry over to next spring or be refunded, and progression won’t be automatically halted.
- We’re continuing to discuss options for those due to sit an exit exam required for CCT. We’ll provide further advice on this soon.
We’ve also made clear that following a request from the relevant national government and statutory education body, we will consider fully registering Foundation Year 1 doctors who apply for this and can provide a Certificate of Experience from their Foundation School, which will demonstrate they have already met the requirements set out in Outcomes for provisionally registered doctors. We will keep these doctors in their current F1 placements to ensure they are familiar with the work and training settings, but they could be asked to undertake a broader range of duties. Assurances of continued clinical and educational supervision should be in place for these doctors to enable them to take increasing responsibility for patient care, facilitate their decision making and support their learning in dealing with uncertainty and likely pressures they will experience.

**Medical students**

As we do every year, we are inviting final year students to apply for provisional registration in April. However, we are ready to process applications at an earlier point than usual as part of the UK Government’s response to the pandemic.

This means that final year students who have been graduated by their medical school, will be available to work as interim Foundation Year 1 doctors before August, if they’re asked and are willing to do so.

We are following our usual policies and procedures and don’t need emergency powers to bring provisional registration forward. We wrote to medical schools on 31 March 2020 to outline next steps and we have emailed all final year medical students to invite them to submit their application. Given the extraordinary circumstances, we won’t charge students a fee to register this year.

The placement of these new provisionally registered interim Foundation Year 1 doctors will be facilitated by medical schools working with foundation schools and in support of service providers. Deploying these doctors will take account of the need for induction, supervision, and support for their wellbeing, and into roles appropriate to their skill set and that best support delivery of frontline services.

**Standards and ethics**

We understand that doctors are working under immense pressure during the coronavirus (COVID-19) pandemic. Our guidance provides a framework for ethical decision making and doctors should follow it as far as they can, using professional judgement to apply it to the situations they face. Nevertheless, we have also been clear that as the situation develops, we recognise it is likely that
some doctors will need to depart from established procedures to care for patients.

22 To support doctors at this time we have published a series of website pages on our 'ethical hub' which provide further guidance on key current topics such as health and wellbeing, working safely, remote consultations, decision-making and consent and confidentiality and social media.

23 Whenever a concern about a doctor is raised with us, we always consider it on the specific facts of the case. This includes taking into account the situation in which the professional is working and any protocols in place at the time. We know that health services are under intense pressure at the current time, and managers and clinicians are making difficult decisions about how to provide care to patients, often in extremely challenging circumstances. The scale of the challenges to delivering safe care would be relevant to a question about the clinical care provided by a doctor.

**Fitness to Practise**

24 We are continuing to assess and respond to any concerns we receive, prioritising those that present the greatest risk to patients. There are four important fitness to practise services that we must continue to deliver to protect the public:

i  Consider any new referrals or complaints, and any new information on existing cases, to consider whether there are any immediate public safety concerns

ii  Interim order applications and review hearings

iii  Substantive order review hearings

iv  Relevant court interim order extension applications.

25 All other casework is continuing to the best of our ability in these difficult circumstances. We are changing our approach to seeking information from employers and healthcare professionals, so that we only ask them for information if it relates to an immediate patient safety concern. This means that we may not be able to progress some cases as efficiently as we would normally for the time being.

26 The Medical Practitioners’ Tribunal Service has postponed most of its hearings as part of the response to the ongoing coronavirus pandemic and closed its hearing centre. As indicated above, the MPTS are continuing to hold interim
orders tribunals (IOT) and medical practitioners’ tribunal (MPT) review hearings to ensure the public is protected. These hearings are being held remotely.

Revalidation
27 Doctors due to revalidate before the end of September 2020 will have their revalidation date deferred by one year. We’re doing this to give responsible officers and doctors more time to reschedule and complete appraisals. We contacted all ROs to let them know about our decision on 18 March.

Education
28 Our education quality assurance visits and enhanced monitoring processes have been paused for the duration of the emergency.

29 We have extended trainer recognition for a year where it is due to expire before September 2020. We have also postponed our 2020 national training surveys for both doctors in training and trainers.

Business continuity and staff support
30 We have successfully moved, almost overnight, from a largely office-based to an overwhelmingly home-based organisation. I’d like to especially thank our resources team for ensuring this has run so smoothly. All of our offices are shut, though we have volunteers going into the Manchester and London offices once a week to check and scan any new post we receive.

31 We have redeployed some staff to support areas under high demand due to the new arrangements, including the contact centre. We have also issued new guidance to managers and teams on topics such as childcare, volunteering, applying best practice on home working and dealing with processes like probation and performance management remotely.

32 We are doing a staged rollout of DSE assessments starting with teams that haven’t ordinarily worked from home previously. I have also held two all-staff calls to update colleagues on the changes to the business and to thank everyone for their commitment and hard work at this very challenging time.

Progress on our strategy
Executive Board
33 The Executive Board met on 24 February and 23 March 2020 to consider items on:

a Coronavirus/COVID-19 response and impact across the business, as reported in detail above.
b High level reports on performance, including finance and people, customer service and learning, and updates on the key risks to achieving our strategic aims. Data on performance and risk is set out in the annexes to this report.

c Plans for the development for the 2020 staff survey, and the draft Human Resources report for 2019, ahead of its consideration by Council at this meeting.

d A draft 3 to 5 year plan for becoming a more inclusive organisation. The plan is intended to strengthen the approach that we take to setting measures and key performance indicators to drive meaningful progress on this agenda, and to mobilise leaders to support our work to achieve an inclusive workplace.

e Regulation of the Medical Associate Professions, ahead of Council’s discussion on 27 February 2020.

f A series of proposals reforming routes to registration, including:

i Proposals to reform Specialist and GP registration and the abolition of the APS scheme, which will need to be included in changes to the Medical Act via a S60 Order on International Registration.

ii Proposals arising from a review of the different routes which international medial graduates (IMGs) can register with us, which will strengthen the assurance of the current sponsorship and postgraduate qualification pathways to full registration. We will also revise an existing discretionary pathway to full registration used for a small number of senior medical leaders each year.

iii A change to our specialist registration policy that acknowledges the training and experience that doctors have gained outside of a UK training programme. The changes enable doctors who would otherwise have been awarded a Certificate of Eligibility for Specialist Registration Combined Programme (CESR-CP) to instead be eligible for a Certificate of Completion of Training, subject to meeting a minimum period of training.

g The removal of the small administrative fee charged to any doctor when applying to remove their name voluntarily from the register, with the change taking effect from 1 April 2020.
Our accommodation strategy, including how we are managing our leases and making the most of our office space.

Changes to corporate risks and issues

34 As Council and Audit and Risk Committee are already aware, we have recently been reflecting on the Corporate Opportunity and Risk Register (CORR) content and structure. Our risk management framework is well embedded across the organisation and the CORR presents a documented record of key risks (both threats and opportunities) facing us and assurance as to how they are being managed. Over time the CORR had grown in its level of detail and granularity and with some inevitable overlap. Whilst this detail is important in understanding key controls and drivers for managing and mitigating risk, it made it more challenging to digest the key risks for members and the Executive collectively.

35 A refresh of the Register by directorate senior management teams has therefore provided the opportunity to take stock of the current key risks facing us. SMT agreed that the CORR should be updated so that it captured a smaller number of key strategic threats and opportunities with each directorate risk register underpinning the mitigations and enhancements which were within their sphere of responsibility.

36 At the same time, we have taken the opportunity to introduce an integrated system platform for risk management. The tool allows risks to be updated and reviewed in real time. The tool is scheduled to be demonstrated to the Audit and Risk Committee in May to enable them to provide assurance to Council of the continuing robustness of our risk management arrangements.

37 The eight refreshed corporate risks are outlined in Annex A. These risks, at an overarching thematic level, map to the most significant risks being managed at directorate level. For example, the former CORR had specific risks on investments, fraud, complexity of work programme, and attracting a skilled workforce and health and safety. These risks all continue to exist and be managed on directorate registers, however they are reflected in the revised CORR by the more thematic risk on a lack of available resources impacting our ability to deliver services.

38 This strategic view of risks and opportunities improves the CORR’s value as a communications and assurance tool which still enables Council to see how the Executive is managing strategic risk across the business. The visibility of the underlying detail is available to all the Senior Management Team through the new integrated platform and we will be undertaking regular risk deep dives at
Executive Board meetings to assure ourselves that risks continue to be actively scrutinised, challenged and managed.
M3 Annex A – Council Portfolio

Council meeting
April 2020
M3 – Annex A

Council portfolio

Data presented as at 28 Feb 2020 (unless otherwise stated)
Commentary as at 24 March 2020

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

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<th>Core regulatory objective</th>
<th>Key Performance Indicator</th>
<th>Performance</th>
<th>Exception summary</th>
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<tbody>
<tr>
<td>We decide which doctors are qualified to work here and we oversee UK medical education and training.</td>
<td>Decision on 95% of all registration applications within 3 months</td>
<td>97%</td>
<td>97%</td>
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<td></td>
<td>Answer 80% of calls within 20 seconds</td>
<td>86%</td>
<td>86%</td>
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<td>We set the standards that doctors need to follow, and make sure that they continue to meet these standards throughout their careers.</td>
<td>Decision on 95% of all revalidation recommendations within 5 working days</td>
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<td>98%</td>
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<td>Respond to 90% of ethical/standards enquiries within 15 working days</td>
<td>92%</td>
<td>95%</td>
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<td></td>
<td>Conclude 90% of fitness to practise cases within 12 months</td>
<td>92%</td>
<td>88%</td>
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<tr>
<td></td>
<td>Conclude or refer 90% of cases at investigation stage within 6 months</td>
<td>92%</td>
<td>90%</td>
</tr>
<tr>
<td></td>
<td>Conclude or refer 95% of cases at the investigation stage within 12 months</td>
<td>95%</td>
<td>93%</td>
</tr>
<tr>
<td></td>
<td>Commence 100% of Investigation Committee hearings within 2 months of referral</td>
<td>100%</td>
<td>No cases</td>
</tr>
<tr>
<td></td>
<td>Commence 100% of Interim Order Tribunal hearings within 3 weeks of referral</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Fitness to practise missed KPIs:**
A combination of factors have combined to impact on performance:
- Staffing within the Regional Investigation Teams (RIT) and Provisional Enquiry (PE) teams – a number of vacancies remain unfilled. Although a number of new starters have joined recently, there is a time lag to reach full performance following completion of training.
- An increase in cases requiring additional forms of investigation, for example dishonesty. We have seen a significant increase in the number of witness statements in RIT cases, which add additional time to process. The monthly average has risen from 11 per month in the first half of 2019, to a recent average of 45 per month. We are looking into the drivers behind this increase.
- An increase in cases being referred to tribunal which are awaiting a hearing, means the overall case length increases.

**Forecasts**
- Forecast summaries are marked in amber due to Covid-19 and with the steps to significantly reprioritise our work programme (to focus on patient care and protection), the effects on performance are unknown at this time.

<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>Finance</td>
<td>2019/20 Income and expenditure [% variance]</td>
<td>2.63%</td>
<td>0.98%</td>
</tr>
<tr>
<td>HR</td>
<td>Rolling twelve month staff turnover within 8-15%</td>
<td>9.47%</td>
<td>8.22%</td>
</tr>
<tr>
<td>Information systems</td>
<td>IS system availability (%) – target 98.8%</td>
<td>100%</td>
<td>99.88%</td>
</tr>
</tbody>
</table>
| Media monitoring      | Monthly media score | 111 | 975 | | Percentage of positive/neutral coverage was affected by the Paterson inquiry coverage and inquest into Dr Suresh; Charlie's Westminster health forum speech achieved positive coverage.
Strategic delivery – overall view

The diagram below shows the key benefits of the 2018-2020 Corporate Strategy. The RAG ratings indicate our progress with delivery of the activities that will realise these benefits. More detail on exceptions is on Slides 4-6.
To note - these updates are recorded as at end of February 2020. The full effects of Covid-19 on our work programme continues to be assessed but will result in a significant reprioritisation of activity to focus on patient care and protection.

**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) Expansion Project</td>
<td>80% of doctors new to practice or new to the country accessing the programme by 2020</td>
<td>a. NTS workload indicator - (%)</td>
<td>As of 24 March 2020, Covid-19 has resulted in the suspension of WtUKP sessions. As at end of February, the project was reporting amber to reflect the continued growth of the target cohort, forecast to be 11,999 doctors in 2020 (February 2020 forecast). This was a rise of over 1,500 registrants since the last forecast (July 2019 forecast). 2019 total workshop attendance has grown by 37% in attendance from the previous year and is equivalent to 30% of IMG/EEA doctors who gained registration in 2019.</td>
</tr>
<tr>
<td></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>The programme remains amber due to the complex stakeholder environment.</td>
</tr>
<tr>
<td></td>
<td>Professional Behaviours and Patient Safety</td>
<td>Contribution towards a safer workforce who are better able to deliver good medical practice</td>
<td>1. Perceptions Q - % public are confident in UK doctors 2. MORI poll</td>
<td>There have been a number of staff changes impacting resourcing of the project. Current focus is on delivery of existing delivery commitments and first phase evaluation. It is now anticipated that recruitment for key project staff will be completed in Quarter 4.</td>
</tr>
</tbody>
</table>
Strategic delivery (by exception)

To note - these updates are recorded as at end of February 2020. The full effects of Covid-19 on our work programme continues to be assessed but will result in a significant reprioritisation of activity to focus on patient care and protection.

Strategic aim 1: Supporting doctors in delivering good medical practice

Key benefit

Doctors are supported to deliver high quality care

Activities to deliver (by exception)

Public Interest Concerns

Lead indicators

A consistent process for employers and contractors to make referrals to the GMC early is in place

Lag indicators

1. Perceptions Q - % public are confident in UK doctors
2. MORI poll

Exception commentary

We are still on target to publish our BAU process in Quarter 2 2020, but are now proposing to transfer the pilot to BAU in early Quarter 3 2020.

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

Key benefit

Public confidence in GMC

Activities to deliver (by exception)

Sanctions guidance Review

Lead indicators

Improved sanctions guidance more timely & consistent decisions, with fewer risks of legal challenge

Lag indicators

1. Perceptions Q - % public confident in way Drs are regulated.

Exception commentary

Progress is reporting in red as a result of needing to amend project scope and timescales due to indicative timetable for progressing and consulting on legislative reform, which would have coincided with our timetable for publicly consulting on a significant review of the Sanctions Guidance. A review is currently under way to confirm the resources now required to deliver the changes in line with a new scope and timescale, aligned with any proposal for legislative reform.
Strategic delivery (by exception)

To note - these updates are recorded as at end of February 2020. The full effects of Covid-19 on our work programme continues to be assessed but will result in a significant reprioritisation of activity to focus on patient care and protection.

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

Activities to deliver (by exception)

- We are well prepared for and can influence legislative change
- 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

Our plans to prepare the business for EU exit were completed in advance of 31 January 2020, however, the rating reflects the uncertainty that remains with trade talks between the UK and EU and a high degree of uncertainty whether they will be completed and ratified by the end of the transition period on 31 December.

To note - these updates are recorded as at end of February 2020. The full effects of Covid-19 on our work programme continues to be assessed but will result in a significant reprioritisation of activity to focus on patient care and protection.
## Financial summary

<table>
<thead>
<tr>
<th>Financial summary as at Feb 2020</th>
<th>Budget Feb</th>
<th>Actual Feb</th>
<th>Variance</th>
<th>Budget 2020</th>
<th>Forecast 2020</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Operational expenditure</td>
<td>17,723</td>
<td>17,301</td>
<td>422</td>
<td>112,168</td>
<td>112,160</td>
<td>8</td>
</tr>
<tr>
<td>New initiatives fund</td>
<td>60</td>
<td>60</td>
<td>0</td>
<td>3,500</td>
<td>3,500</td>
<td>0</td>
</tr>
<tr>
<td>Capital expenditure</td>
<td>743</td>
<td>743</td>
<td>0</td>
<td>6,250</td>
<td>6,250</td>
<td>0</td>
</tr>
<tr>
<td>Pension top up payment</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1,300</td>
<td>1,300</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total expenditure</strong></td>
<td>18,526</td>
<td>18,104</td>
<td>422</td>
<td>123,218</td>
<td>123,210</td>
<td>8</td>
</tr>
<tr>
<td>Operational income</td>
<td>18,229</td>
<td>17,973</td>
<td>(256)</td>
<td>117,006</td>
<td>118,269</td>
<td>1,263</td>
</tr>
<tr>
<td>Investment income</td>
<td>366</td>
<td>(766)</td>
<td>(1,132)</td>
<td>2,234</td>
<td>1,102</td>
<td>(1,132)</td>
</tr>
<tr>
<td><strong>Total income</strong></td>
<td>18,595</td>
<td>17,207</td>
<td>(1,388)</td>
<td>119,240</td>
<td>119,371</td>
<td>131</td>
</tr>
<tr>
<td>Operational surplus/(deficit)*</td>
<td>(297)</td>
<td>(131)</td>
<td>166</td>
<td>(6,212)</td>
<td>(4,941)</td>
<td>1,271</td>
</tr>
<tr>
<td><strong>Total surplus/(deficit)</strong></td>
<td>69</td>
<td>(897)</td>
<td>(966)</td>
<td>(3,978)</td>
<td>(3,839)</td>
<td>139</td>
</tr>
</tbody>
</table>

### Key drivers of expenditure - To date £000

<table>
<thead>
<tr>
<th>Key changes</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headcount changes</td>
<td>180</td>
</tr>
<tr>
<td>Volume variance</td>
<td>160</td>
</tr>
<tr>
<td>Unit cost increases</td>
<td>0</td>
</tr>
<tr>
<td>Unit cost decreases/efficiency savings</td>
<td>(37)</td>
</tr>
<tr>
<td>New activities not in plan</td>
<td>0</td>
</tr>
<tr>
<td>Planned activities dropped/delayed</td>
<td>119</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>422</td>
</tr>
</tbody>
</table>

*Operational surplus/deficit removes impact of investment returns

**Key changes**

- **Headcount changes**
  - Budgeted operation headcount is 1,388 FTE after adjusting for churn, a reduction of 40 FTE. Actual operational headcount is 1,354 FTE resulting in the underspend year to date. We anticipate the forecast to be in line with budget due to additional dual running, parental leave and other unknown operational headcount demands.

- **Volume variance**
  - There has been a reduction in activity in Education and Standards compared to budget in visits, MLA & approvals and the associated staff expenses. Costs have been lower as some PLAB 2 days had reduced capacity due to lower demand, which results in savings in associates fees and expenses.

- **Unit cost increases**
  - A number of areas have not identified efficiencies in line with the target to date. This is offset by a reduction in electricity reconciliation costs.

- **Unit cost decreases/efficiency savings**
  - The underspend for delayed costs is primarily in resources for areas of spend which can fluctuate month by month such as stationery and postage.
### Financial summary

#### Key drivers of expenditure – To date

<table>
<thead>
<tr>
<th>Key drivers of expenditure</th>
<th>£000</th>
<th>Key Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headcount changes</td>
<td>196</td>
<td>We expect headcount to move closer to budget by the end of the year.</td>
</tr>
<tr>
<td>Volume variance</td>
<td>(241)</td>
<td>The overspend related to the variable cost of hosting 6,400 additional PLAB 1 candidates compared to budget. The impact of Coronavirus has not yet been factored into the forecast.</td>
</tr>
<tr>
<td>Unit cost increases</td>
<td>0</td>
<td>The benefit from the electricity reconciliation charges will continue to the end of the year.</td>
</tr>
<tr>
<td>Unit cost decreases/efficiency savings</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>New activities not in plan</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Planned activities dropped/delayed</td>
<td>23</td>
<td>The underspend to date in quality assurance in Education &amp; Standards is expected to continue to the end of the year.</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>8</td>
<td></td>
</tr>
</tbody>
</table>

#### Income Forecasts

<table>
<thead>
<tr>
<th>Income Forecasts</th>
<th>£000</th>
<th>Key Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>PLAB fees</td>
<td>1,330</td>
<td>The forecast does not take account of the potential impact of candidate volumes in relation to Coronavirus. Expected returns are based on our target of CPI plus 2%. The spread of Coronavirus has impacted on returns in February and continues to impact returns in March. We have not yet incorporated March's volatility in our forecast.</td>
</tr>
<tr>
<td>Investment income</td>
<td>(1,132)</td>
<td></td>
</tr>
</tbody>
</table>

29
### Financial - detail

#### Expenditure as at Feb 2020

<table>
<thead>
<tr>
<th>Item</th>
<th>Budget Feb £000</th>
<th>Actual Feb £000</th>
<th>Variance £000</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff costs</td>
<td>11,034</td>
<td>10,854</td>
<td>180</td>
<td>2%</td>
</tr>
<tr>
<td>Staff support costs</td>
<td>627</td>
<td>556</td>
<td>71</td>
<td>11%</td>
</tr>
<tr>
<td>Office supplies</td>
<td>263</td>
<td>233</td>
<td>30</td>
<td>11%</td>
</tr>
<tr>
<td>IT &amp; telecoms costs</td>
<td>684</td>
<td>665</td>
<td>19</td>
<td>3%</td>
</tr>
<tr>
<td>Accommodation costs</td>
<td>1,287</td>
<td>1,243</td>
<td>44</td>
<td>3%</td>
</tr>
<tr>
<td>Legal costs</td>
<td>620</td>
<td>616</td>
<td>4</td>
<td>1%</td>
</tr>
<tr>
<td>Professional fees</td>
<td>345</td>
<td>345</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Council &amp; members costs</td>
<td>65</td>
<td>59</td>
<td>6</td>
<td>9%</td>
</tr>
<tr>
<td>Panel &amp; assessment costs</td>
<td>2,736</td>
<td>2,598</td>
<td>138</td>
<td>5%</td>
</tr>
<tr>
<td>PSA Levy</td>
<td>132</td>
<td>132</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Under/over-achievement of efficiency savings</td>
<td>(70)</td>
<td>0</td>
<td>(70)</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Operational expenditure</strong></td>
<td><strong>17,723</strong></td>
<td><strong>17,301</strong></td>
<td><strong>422</strong></td>
<td><strong>2%</strong></td>
</tr>
<tr>
<td>New initiatives fund</td>
<td>60</td>
<td>60</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Capital expenditure</td>
<td>743</td>
<td>743</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Pension top up payment</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Total expenditure</strong></td>
<td><strong>18,526</strong></td>
<td><strong>18,104</strong></td>
<td><strong>422</strong></td>
<td><strong>2%</strong></td>
</tr>
</tbody>
</table>

#### Income as at Feb 2020

<table>
<thead>
<tr>
<th>Item</th>
<th>Budget Feb £000</th>
<th>Actual Feb £000</th>
<th>Variance £000</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual retention fees</td>
<td>15,244</td>
<td>15,168</td>
<td>(76)</td>
<td>(0)%</td>
</tr>
<tr>
<td>Registration fees</td>
<td>689</td>
<td>710</td>
<td>21</td>
<td>3%</td>
</tr>
<tr>
<td>PLAB fees</td>
<td>1,595</td>
<td>1,407</td>
<td>(188)</td>
<td>(12)%</td>
</tr>
<tr>
<td>Specialist application CCT fees</td>
<td>340</td>
<td>370</td>
<td>30</td>
<td>9%</td>
</tr>
<tr>
<td>Specialist application CESR/CEGPR fees</td>
<td>202</td>
<td>192</td>
<td>(10)</td>
<td>(5)%</td>
</tr>
<tr>
<td>Interest income</td>
<td>53</td>
<td>56</td>
<td>3</td>
<td>6%</td>
</tr>
<tr>
<td>Other income</td>
<td>106</td>
<td>70</td>
<td>(36)</td>
<td>(34)%</td>
</tr>
<tr>
<td><strong>Total Operational Income</strong></td>
<td><strong>18,229</strong></td>
<td><strong>17,973</strong></td>
<td><strong>(256)</strong></td>
<td><strong>(1)%</strong></td>
</tr>
<tr>
<td>Investment income</td>
<td>366</td>
<td>(766)</td>
<td>(1,132)</td>
<td>(309)%</td>
</tr>
<tr>
<td><strong>Total income</strong></td>
<td><strong>18,595</strong></td>
<td><strong>17,207</strong></td>
<td><strong>(1,388)</strong></td>
<td><strong>(7)%</strong></td>
</tr>
</tbody>
</table>

### Surplus / (deficit)

| Surplus / (deficit)                      | 69              | (897)          | (966)         |     |
## GMCSI summary and investments summary

### GMCSI summary as at Feb 2020

<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>44</td>
<td>44</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>GMCSI expenditure</td>
<td>75</td>
<td>59</td>
<td>16</td>
<td>21%</td>
</tr>
<tr>
<td><strong>Profit/(loss)</strong></td>
<td>(31)</td>
<td>(15)</td>
<td>16</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Budget 2020 £000</th>
<th>Forecast 2020 £000</th>
<th>Variance £000</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>GMCSI income</td>
<td>626</td>
<td>626</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>GMCSI expenditure</td>
<td>581</td>
<td>581</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Profit/(loss)</strong></td>
<td>45</td>
<td>45</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

### Investments summary as at 30 December 2019 (figures are updated quarterly)

<table>
<thead>
<tr>
<th>Investment summary 2020</th>
<th>Value as at Dec 2019 £000</th>
<th>Current value £000</th>
<th>2020 returns £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCLA managed funds</td>
<td>£54,765</td>
<td>£53,999</td>
<td>(766)</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>0% - 45%</td>
<td>28.0%</td>
</tr>
<tr>
<td>Bonds and Cash</td>
<td>20% - 80%</td>
<td>51.8%</td>
</tr>
<tr>
<td>Alternatives</td>
<td>0% - 45%</td>
<td>20.2%</td>
</tr>
</tbody>
</table>

### Investment returns

<table>
<thead>
<tr>
<th></th>
<th>1 year rolling</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target (CPI + 2%)</td>
<td>3.31%</td>
</tr>
<tr>
<td>CCLA performance</td>
<td>10.52%</td>
</tr>
</tbody>
</table>
### Legal summary (as at 13 March 2020)

The table below provides a summary of appeals and judicial reviews as at 13 March 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>13</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>s.40A (GMC) Appeals</td>
<td>4</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>PSA Appeals</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Judicial Reviews</td>
<td>4</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>IOT Challenges</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

#### Explanation of concluded cases

- **s.40 (Practitioner) Appeals**: 1 dismissed, 1 successful
- **s.40A (GMC) Appeals**: N/A
- **Judicial Reviews**: 4 permission refused

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

#### Any other litigation of particular note

We continue to deal with a range of other litigation, including cases before the Employment Tribunal, the Employment Appeals Tribunal and the Court of Appeal.
Graph 1: Applications received for first registration from international medical graduates, 2015 - 2020

Graph 2: Applications received for first registration from European Economic Area graduates, 2015 - 2020
Trends in registration applications

**Graph 3:** PLAB 1 & 2 assessments taken 2015-2019
(Showing volume each year, 1 March to 29 February, percentage figures show year on year change)

**Graph 4:** Number of doctors on the register with a licence to practise
(End of Feb 2015 - Feb 2020)
M3 Annex B – Corporate Opportunities & Risk Register

Council meeting
April 2020

General Medical Council

Working with doctors Working for patients
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Opportunity</td>
<td>New government environment changing</td>
<td>Responding to a new government environment causes our corporate strategy, including legislation and policy, to be subject to change.</td>
<td>Neil Roberts</td>
<td>Paul Spindler</td>
<td>Q&amp;A Helpdesk</td>
<td>• Implement new public affairs strategy (2020) • Implement new Relationship Management System (and 2020) • Transition to a new business planning model to support the 2021-25 Corporate Strategy, aligned to New Initiative Bid process (Sep 2020)</td>
<td>HIGH</td>
<td>CRITICAL</td>
<td>• Seminar: Four countries update (September 2019) • Paper: People planning across the United Kingdom (November 2019) • Paper: Regulatory reform (November 2020) • Review of UK Advisory Forum meetings (December 2010)</td>
<td>Yes</td>
<td>Operational</td>
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<tr>
<td>2</td>
<td>Opportunity</td>
<td>New government environment changing</td>
<td>Responding to a new government environment causes our corporate strategy, including legislation and policy, to be subject to change.</td>
<td>Neil Roberts</td>
<td>Paul Spindler</td>
<td>Q&amp;A Helpdesk</td>
<td>• Implement new public affairs strategy (2020) • Implement new Relationship Management System (and 2020) • Transition to a new business planning model to support the 2021-25 Corporate Strategy, aligned to New Initiative Bid process (Sep 2020)</td>
<td>HIGH</td>
<td>CRITICAL</td>
<td>• Seminar: Four countries update (September 2019) • Paper: People planning across the United Kingdom (November 2019) • Paper: Regulatory reform (November 2020) • Review of UK Advisory Forum meetings (December 2010)</td>
<td>Yes</td>
<td>Operational</td>
<td></td>
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<tr>
<td>3</td>
<td>Threat</td>
<td>Unplanned event</td>
<td>The impact of an event in the external or internal environment causes our systems to be compromised or our activities to be subject to challenge, potentially leaving us vulnerable to delivery of key functions central to patient safety and reputational damage.</td>
<td>Neil Roberts</td>
<td>Sunil Kapoor</td>
<td>Q&amp;A Helpdesk</td>
<td>• Continue to engage with the Department of Health and Social Care on potential Section 60 orders that will reform aspects of fitness to practise investigations, our governance, and the requirements of international registration</td>
<td>HIGH</td>
<td>CRITICAL</td>
<td>• Paper: Regulatory reform (November 2020) • Paper: People planning across the United Kingdom (November 2019)</td>
<td>Yes</td>
<td>Resource</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Threat</td>
<td>Unplanned event</td>
<td>The impact of an event in the external or internal environment causes our systems to be compromised or our activities to be subject to challenge, potentially leaving us vulnerable to delivery of key functions central to patient safety and reputational damage.</td>
<td>Neil Roberts</td>
<td>Sunil Kapoor</td>
<td>Q&amp;A Helpdesk</td>
<td>• Continue to engage with the Department of Health and Social Care on potential Section 60 orders that will reform aspects of fitness to practise investigations, our governance, and the requirements of international registration</td>
<td>HIGH</td>
<td>CRITICAL</td>
<td>• Paper: Regulatory reform (November 2020) • Paper: People planning across the United Kingdom (November 2019)</td>
<td>Yes</td>
<td>Resource</td>
<td></td>
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<tr>
<td>5</td>
<td>Threat</td>
<td>Unplanned event</td>
<td>The impact of an event in the external or internal environment causes our systems to be compromised or our activities to be subject to challenge, potentially leaving us vulnerable to delivery of key functions central to patient safety and reputational damage.</td>
<td>Neil Roberts</td>
<td>Sunil Kapoor</td>
<td>Q&amp;A Helpdesk</td>
<td>• Continue to engage with the Department of Health and Social Care on potential Section 60 orders that will reform aspects of fitness to practise investigations, our governance, and the requirements of international registration</td>
<td>HIGH</td>
<td>CRITICAL</td>
<td>• Paper: Regulatory reform (November 2020) • Paper: People planning across the United Kingdom (November 2019)</td>
<td>Yes</td>
<td>Resource</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Opportunity</td>
<td>New government</td>
<td>The strength of the new government provides an opportunity to drive forward our ambitions for change.</td>
<td>Neil Roberts</td>
<td>Paul Spindler</td>
<td>Q&amp;A Helpdesk</td>
<td>• Regular Chief and CEO engagement with Government to identify shared goals • Regular contact with government departments to influence legislative proposals • Active engagement with stakeholders to build support for legislative reform</td>
<td>LOW</td>
<td>LOW</td>
<td>• Paper: Regulatory reform (November 2020) • Paper: People planning across the United Kingdom (November 2019)</td>
<td>Yes</td>
<td>Strategic / Policy</td>
<td></td>
</tr>
<tr>
<td>Opportunity</td>
<td>Deriving more insight from our data capability</td>
<td>Developing, sharing and working with others using our insight capability provides an opportunity to shape public debate, influence the external environment and deliver more proactive regulation.</td>
<td>Paul Buckley, David Darton</td>
<td>GOLD</td>
<td>We use our research and insights to highlight key issues facing the medical profession, suggesting courses of action which healthcare systems can take to improve workforce and workplace issues. We leverage our communications channels (such as media and social media) and engagement opportunities to raise awareness of our research and insights and secure external support for the issues and recommendations we are highlighting. We use our influence to bring regulatory partners and key stakeholders together to drive positive changes in practice and training environments.</td>
<td>GOLD</td>
<td>Paper: Review of UK Advisory Forum meetings (December 2019)</td>
<td>Yes</td>
<td>Embed outputs from horizon scanning scrum process in FFG and other GMC-wide forums</td>
<td>Strategic / Policy</td>
<td></td>
<td></td>
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<tr>
<td>Opportunity</td>
<td>Working with patients and public</td>
<td>Developing more proactive engagement with patients and the public provides an opportunity to understand and demonstrate that all our activities are aligned with patient safety so that we gain their trust and confidence as an effective and transparent regulator.</td>
<td>Una Lane, Robert Khan</td>
<td>SILVER</td>
<td>Champion for patients established at SMT level to ensure senior-level overview of our engagement. Patient Charter published (Nov 2019). We set clear engagement objectives through our Patient and public engagement plan, refreshed annually. We regularly assess patient and public perceptions through annual research. We established a roundtable with patient leaders from all four UK countries, to explore policy issues and initiatives at an early stage of their development. This is supplemented by twice-yearly UKAF meetings in Scotland, Wales and Northern Ireland plus ongoing engagement with patient organisations.</td>
<td>SILVER</td>
<td>Kick-off</td>
<td>Agile Strategic approach to communications and engagement – an update (June 2018). Discussions at Council Away days (July 2018 and 2019) about patient and public engagement in our work and preparation for the next Corporate Strategy. Council considered current Corporate Strategy success measures baseline report results at its meeting in November 2018</td>
<td>MEDIUM</td>
<td>Q1 2020: Annual tracking survey to understand views of regulation among patients and the public, and to check the health of our relationships with key patient bodies around the UK</td>
<td>Operational</td>
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</table>
### Action

To note

### Purpose

The purpose of this paper is to allow Council to review the report by the Professional Standards Authority (PSA) on the GMC’s performance review for 2018/19.

The report was published on 13 March 2020 and finds that the GMC continues to meet all 24 Standards of Good Regulation. This followed a targeted review into our Fitness to Practise, Registration, and Standards functions.

This paper highlights the Authority’s findings, areas of good practice, and the learnings we have drawn from the review.

### Decision trail

We last reported to Council on the outcomes of the previous PSA Annual Performance Review for 2017/18 in September 2019.

### Recommendation

Council is recommended to note:

The Professional Standards Authority’s review of our performance against the Standards of Good Regulation for the 2018/19 period, including that we were found to have met all the standards.

### Annexes

None

### Author contacts

**Robert Scanlon**, Assistant Director for Business Planning and Equality, Diversity and Inclusion  
Robert.Scanlon@gmc-uk.org, 020 7189 5305

### Sponsoring director/Senior Responsible Owner

**Paul Buckley**, Director of Strategy and Policy  
paul.buckley@gmc-uk.org, 020 7189 5022
Background

1 The Professional Standards Authority for Health and Social Care, referred to in this paper as ‘the Authority’, is responsible for overseeing the work of the GMC, and nine other statutory health and social care regulators. The performance review is the Authority’s annual check on how well regulators are protecting the public and promoting confidence in their professionals and themselves.

2 The performance review involves an assessment of information available about a regulator’s performance against the Standards of Good Regulation\(^1\). For the 2018/19 performance review period there were 24 Standards, covering four key areas:
   - Guidance and standards
   - Education and training
   - Registration
   - Fitness to Practise (FtP).

3 A range of information is considered during the initial assessment, including Council papers, policy and guidance documents, a dataset relating to our functions including volumes and timeliness of processes, third party feedback, review of final FtP decisions, and a check of the Register. If the Authority’s internal panel decides that further information is required to decide on whether the Standards have been met, a ‘targeted review’ usually follows.

4 We have consistently been assessed as meeting all Standards each year since the current process was introduced in 2012.

5 The Authority have announced Dame Glenys Stacey DBE as their new Chair. The appointment was made by the Privy Council and Dame Glenys took up her post on 1 April 2020. She will succeed George Jenkins OBE who stepped down from his role on 31 March 2020 after four years with the Authority.

6 Dame Glenys’ former roles have included Chief Regulator and Chief Executive of Ofqual, Chief Executive of Animal Health, and most recently as Her Majesty’s Chief Inspector of Probation.

7 We will focus our engagement with Dame Glenys on improving regulatory alignment and collaboration, responding to the current and future longer-term system implications of Covid-19, and further improving our overall relationship with the PSA.

Key findings and lessons

8 Our performance review for the 2018/19 period covers 1 September 2018 to 31 August 2019. On reviewing our initial evidence submission, the Authority determined that a ‘targeted review’ was necessary to reach a conclusion against several Standards. The areas of focus and findings for each of these are set out below.

a The Authority reviewed our approach to consulting with stakeholders during the development of our revised Consent guidance.

b An audit of a sample of doctors’ entries on the Register.

c Further information about how we responded when an individual, Zholia Alemi, was convicted for fraud following discovery that she had gained registration in 1995 by forging a medical qualification from New Zealand.

d How we are accommodating the significant increase in applications for registration received from IMG doctors since 2017.

e As with previous targeted reviews, Fitness to Practise (FtP) timeliness continued to be an area of focus. We provided detailed information about the complex factors that can impact on how quickly we are able to deal with FtP cases, and which can cause fluctuations in the median times for our FtP process. External factors include receiving incomplete information at the time of receiving a case, availability of Panel members, and in some cases requiring information from their parties such as the policy. We outlined the actions we have taken to progress cases as swiftly as possible, which include increasing resource and periodic reviews of older cases by senior managers. We also provided an update on improvements to accuracy and timeliness of publishing hearing outcomes.

9 The Authority were satisfied that the further evidence we provided for the targeted review demonstrated that the GMC had met all 24 Standards.

10 Areas that the Authority drew attention to and which they indicated were strengths include:
a Registrations – the report sets out the Authority’s view that we took appropriate action in response to the case of Zholia Alemi, who as outlined above was convicted of fraud. The report notes that all the doctors in our subsequent check of doctors who had gained entry through the same route as Alemi were found to be appropriately qualified. The targeted review also noted our work to expand capacity to ensure that the significant increases in applications for registration from EU/EEA and IMG doctors are processed within reasonable timeframes.

b Fitness to Practise - Although the report notes increases in some FtP median times, such as the median time to make Interim Order Panel (IOP) decisions, the report accepts that external factors that can cause fluctuations and the report notes that the GMC ‘remains one of the faster regulators in making interim order decisions’ (paragraph 6.14).

c Supporting a Profession under Pressure – launched in 2018, this programme aims to better understand how environmental factors affects doctors’ wellbeing and consequently, delivery of safe patient care. It involved three independently commissioned reviews. Areas highlighted include our publication of co-produced guidance for doctors on being a ‘reflective practitioner’, and publication of independent research to understand why some groups of doctors are referred to the FtP process more, or less than others through our Fair to Refer2 report. The Authority noted its interest in continuing to monitor progress in this area through the 2019/20 performance review.

11 Although we were pleased to have again met all 24 of the Standards, the process, the performance report and recent reports from inquiries and reviews continue to give us cause to reflect on how we can improve across our functions. This tone was reflected in our public response to the report3.

12 Our stakeholder feedback on our Consent guidance consultation and the Authority’s question on LRMP help text were useful reminders of the importance of understanding the needs of those that interact with us and adopting a strong customer focus. This was reinforced by the findings of the Paterson Inquiry4 where the experiences of those that interacted with us at that time fell short of what we would expect them to experience today. While we have made considerable progress in this regard over recent years, we accept there is more we can do, and are working to ensure a concerted focus on the importance of

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every one of our interactions with the public, profession and stakeholders as part of our emerging Corporate Strategy.

13 In recent years, and particularly since the Francis Inquiry report in 2013 into events at Mid-Staffordshire NHS Trust, we have worked with other regulators and system partners to bring greater alignment to our approach to sharing insight and data, managing risk to patients and supporting the multi-professional context in which most healthcare is now delivered. This has resulted in a number of successful initiatives such as the Emerging Concerns Protocol, and joint statements between professional regulators on high-risk areas of practice such as online prescribing. But we recognise the need to do much more towards more effective collaboration and regulatory alignment across the whole healthcare system to identify and act on risks to patient safety. This has been another theme that was highlighted by the Paterson Inquiry and a key priority for us to improve against. We have been actively discussing with a range of key partners including the NMC, CQC and the Authority themselves how to make progress, at pace, to improve collaboration further.

14 At the time of writing this paper, our efforts to improve collaboration and regulatory alignment are focused on working with others to manage the profound effects of Covid-19 on the healthcare system. The experience of this response now and into the future, will no doubt provide further cause for us to reflect on how we regulate to best affect to protect the public, enable the profession to give good quality care, and work with others to do this in a way that minimises regulatory burden.

Preparing for our 2019/20 performance review

15 The Authority has updated its assessment framework to include five new cross-cutting Standards that will apply to us for our 2019/20 review and beyond. These will be in addition to the existing standards covering regulatory functions and include: accuracy and availability of information; clarity of purpose and policy development; equality and diversity consideration; reporting and applying learning from inquiries and reviews; and stakeholder engagement and consultation.\(^5\) We engaged with the PSA throughout the consultation on the revised Standards and participated in a pilot against three of the new Standards in 2019.

16 Our 2019/20 performance review cycle is due to begin in August 2020. We will continue to engage with the Authority as the situation continues to evolve with

Covid-19 to consider if the planned August timing for our next review remains appropriate.
### Council meeting 23 April 2020

#### Agenda item M5

**2019 Human Resources Report and Gender Pay Update**

<table>
<thead>
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<th>Action</th>
<th>To note</th>
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| **Purpose**  | This report provides a summary of the main HR monitoring data for 2019 including more detailed information on diversity and pay.  

The report includes the 2019 gender pay figures and an update on the work being undertaken in this area and the latest position ahead of 2020 reports being finalised.  

The report also includes an update on work undertaken following the 2019 Staff Survey. |
| **Decision trail** | N/A |
| **Recommendation(s)** | To note the 2019 Human Resources and Gender Pay Reports |

| **Annexes** | a. Our recruitment, turnover and absence monitoring data (Annex A)  
b. Our profile as an employer in terms of diversity (Annex B)  

| **Author contacts** | **Andrew Bratt, Assistant Director**  
Human Resources, Resources Directorate [andrew.bratt@gmc-uk.org](mailto:andrew.bratt@gmc-uk.org), 0161 925 6215 |
| **Sponsoring director/Senior Responsible Owner** | **Neil Roberts, Director Resources**  
Resources Directorate, [neil.roberts@gmc-uk.org](mailto:neil.roberts@gmc-uk.org), 0161 923 6230 |
Human Resources Report 2019

1. Our Human Resources (HR) policies, procedures and infrastructure exist to ensure that we recruit, retain and develop a diverse, talented and committed workforce while meeting our statutory obligations as an employer.

2. The report covers:
   
   a. Our recruitment, turnover and absence monitoring data (Annex A)
   
   b. Our profile as an employer in terms of diversity (Annex B)
   
   
   d. An update on the staff survey follow up work.

HR Data Monitoring

3. Our 2019 data, along with the 2019 staff survey, continues to suggest a good employee relations environment. We have not seen any major changes in our work force and we continue to perform well in terms of recruiting and retaining staff.

4. From our 2019 data there are two trends to highlight:

   **Turnover**

5. Voluntary staff turnover has seen a slight increase to 8.67% for 2019 (up from 8.0% in 2018). This level of turnover is at the bottom end of the band we expect turnover to be in (8 to 15%) and continues to reflect, perhaps, our position as a stable employer in a more uncertain working environment during 2019. We also have very positive feedback on flexible working which aids retention.

6. While our overall recruitment experience is positive, we continue to operate in a very competitive market for some roles (e.g. data and information systems).

7. The level of internal staff movement is around twice that of our turnover rate. Promotions in 2019 totalled 84 (87 in 2018) while transfers increased from 99 to 165. Combined with colleagues leaving around a third of our posts are affected by a staffing change each year.

8. Within all staffing movements we had 12 probation periods extended, none were failed.
Council meeting, 23 April 2020
Agenda item M5 – 2019 Human Resources Report and Gender Pay Update

**Absence**

9 We have historically enjoyed low sickness absence levels but in 2019 we saw a slight increase.

10 In 2018 we saw overall absence at around 3%. In 2019 this was 3.15%. This equates to 7.9 days per year and is above the CIPD 2019 average of 5.9 days but below the public sector average.

11 Mental health related issues, specifically anxiety, are the main reason for employee absence. In 2019 it accounted for 31.8% of absences (28.9% in 2018). Half of these absences are ones we would classify as long term (20+ days)

12 Mental Health is an area where we have an extensive programme of work to support staff and line managers. This has included extensive training events, a mental health champions network and an employee lead Mental Health interest group.

**Diversity, Equality and Inclusion**

13 Our new Equality, Diversity and Inclusion Strategy aims include having a workforce that reflects our local labour markets; increasing the number of job offers made to applicants from under-represented groups and improving the percentage of under-represented groups at senior levels.

14 To support this work, we monitor and analyse our data for equality and diversity (E&D) for our major HR processes and monitor the composition of our workforce. An overview of this is set out at Annex B.

15 In 2018 we saw a significant change 30% of our job applicants come from a BME background with 19.8% of our offers being made to BME candidates. 2019 sees this the attraction figure increase for BME candidates (32.8%) and a further small increase in offers made to BME candidates with 20.4% of offers. We have continued to develop our recruitment process and training support and further initiatives planned to broaden our intake.

16 This increase in appointments has contributed to a slow but steady increase in our BME workforce as a percentage. The other main points to note here is that 21% of promotions go to BME staff (14% of our workforce). Appointment data paints a positive picture but turnover within this group remains twice that of the remaining sections of the workforce.
17 Representation in manager roles remains below the wider workforce profile. While we have also seen an increase in BME staff at level 2 our senior staffing is not in line with the make-up of our workforce or the local labour markets we recruit in.

18 For female applicants, we have historically seen women becoming increasingly well represented as our recruitment process moves forward. In 2018 we saw this pattern change with women making up 49.2% applicant pool and secure 51.8% of job offers. 2019 saw us return to a previous pattern with 58.5% of applications coming from women who received 73.4% of offers.

19 Level 3 management (62.1%) of our workforce is almost in line with the GMC’s gender profile. We continue to see a steady increase in representation of women in management roles with a further increase in women at Level 2 (57%, up from 54%).

20 Despite these improvements, our workforce gender balance (at senior management level for women and lower graded roles for men) remains the main driver of our gender pay gap.

21 We have had an ongoing programme on work on our recruitment processes. We have strong processes in place to provide adjustments for candidates with a disability and sign up as a Disability Confident employer later this year, a process that will be informed by independent expert advice.

22 This work is part of a long-term ED&I programme agreed by the Executive Board. This includes work on further embedding our Inclusion work into training and role descriptions; using our data more extensively to develop a more detailed set of measures and KPIs; and continuing to use external assessment of our progress.

23 Our plans also include new initiatives (such as GMC wide internship programme) that will focus this activity on areas where there is clear scope for improvement (e.g. BME hires in London). We will have a greater inclusion focus within our existing processes (such as apprenticeships and graduate intakes).

Gender Pay Reporting

24 We have reported pay by gender and ethnicity on an annual basis since 2012. To allow comparisons we have included updated data for each grade by gender and ethnicity as of 31 December 2018 and 2019.
Annex C includes our 2019 equal pay data calculated in line with the Gender Pay Gap Reporting requirements.

On gender we reported an overall pay gap of 15% for March 2018. For March 2019 the gender pay gap had fallen to 14%.

We do not yet know the final 2020 figure and the requirements of pay gap reporting mean a variety of factors in one month (March) will impact on the result. Our pay gap based on our FTE salaries would show a slight fall to below 14% for March 2020, and the pay award will reduce the gap further.

To address differentials within pay bands we have structured our annual pay award in a way that helps narrow differentials at each level. Colleagues who are above the pay band receive no consolidated annual pay increase, while the pay award is weighted towards those in the lower sections of the pay bands. We are working to remove average pay differential within pay bands over the next two to three pay award rounds.

To support this we are reviewing senior manager salaries currently to help identify and address anomalies. We also have plans to review and update our job classification criteria that underpin our grading structure during 2020.

Staff Survey

Last year we reported on the outcomes of our staff survey and undertook to provide an update on progress. There are three main work-streams covering wellbeing, workloads and change management.

Wellbeing

Supporting and developing employee wellbeing has been an area of significant investment over the last three years. Our absence figures have shown a slight increase and, like many other employers, we have seen an increase in the proportion of mental health related absence reported.

We have established programmes and services to support staff and line managers. Since 2017 we have delivered wellbeing specific training sessions to 950 colleagues. These include areas such as mental health awareness. In addition to the classroom-based training above, we also have a suite of over 20 digital learning resources which are directly linked to wellbeing.
Alongside this work we engaged extensively with colleagues to develop a single corporate wellbeing plan. This brings together all aspects of our employee focused support such as employee networks, counselling and employee assistance and employee benefits. We will be seeking external validation of our work through the Investors In people accreditation relating to employee wellbeing.

We have also updated our existing policies on absence management and developed new policies on other aspects of employee welfare (e.g. bereavement, menopause awareness). This aspect of our work is being supported by a new ‘people Essentials’ training programme for all GMC managers. This includes support and guidance on maintaining a supportive and inclusive working environment.

Workloads

The workloads project team have been running workshops with colleagues from each directorate to identify whether colleagues think working additional hours to get their jobs done is a problem and, if so, what the potential solutions might be. These workshops have identified common themes such as recruitment planning and capacity modelling.

We have also investigated the issue further with those who were unable to attend the workshops through surveys tailored for individual teams. The feedback from the workshops and surveys are informing local staff briefing sessions, (which had to be postponed in March due to COVID-19) and the next stages of the work will be taken forward by devising action plans with Directors and Assistant Directors, to be progressed by local project teams.

Change Management

Our third workstream covers change management. Our continuous improvement (CI) team have analysed the survey data and engaged with colleagues through a series of forums and workshops. Although there were many examples of change being delivered well, we have identified three areas for improvement:

37.1 Visibility of decision making for change initiatives

37.2 How we communicate and engage with staff throughout the change

37.3 The level of consistency in how projects are sponsored and delivered
To make progress several initiatives are underway. The first is the review and redesign of our business planning process to ensure that we have clearer and better defined ‘gates’ where we make key decisions about projects.

The second is the identification and promotion of existing change management training. The CI team have also started piloting change management sessions at the early stage of projects to ensure that how we deliver projects is carefully considered.

In support of sponsorship we are in the early stages of implementing a Senior Responsible Officer role for our projects to help provide better consistency and accountability.

Alongside this work we have scheduled training for senior managers on best practice on employee engagement and change management. This is a programme that dovetails with training provided for staff forum representatives.

Next Steps

We are committed to reviewing progress through our 2020 staff survey. This is now scheduled for June and we will report the outcome to Council in the Autumn.
HR Monitoring Overview

**Turnover**

1. Turnover (based on leavers) remained stable and low in comparison to wider benchmarks.

   * Labour turnover rates: 2019 XpertHR Survey

   ** Voluntary turnover includes Resignation, Voluntary Redundancy, and Normal Retirement.

     Total Turnover includes voluntary turnover plus Compulsory Redundancy, Fixed Term Contracts and Dismissal.

2. The overall level of staff movement was much higher. Total internal moves increased in 2019 (driven by transfers).
Council meeting, Thursday 23 April 2020
Agenda item M5 Annex A – 2019 Human Resources Report and Gender Pay Update

<table>
<thead>
<tr>
<th></th>
<th>2018</th>
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<tbody>
<tr>
<td>Promotions</td>
<td>87</td>
<td>84</td>
</tr>
<tr>
<td>Transfers / Temporary Transfers*</td>
<td>99</td>
<td>165</td>
</tr>
<tr>
<td>Total</td>
<td>186</td>
<td>249</td>
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Notes:

The numbers reported above for Temporary Transfers, Promotions, and Transfers are based on when the staff member started the post (not when they were appointed).

Temporary Transfers includes temporary transfers at the same grade, secondments and temporary promotions.

**Probation analysis**

3 In 2019 we had 12 probation periods extended (5.6% of all probations completed in 2019). We have no probation periods not confirmed.

**Employee Absence**

4 Absence levels continue to be stable, and slightly above the national average
5  Sickness by Reason

![Sickness Absence by Reason - 2019](image)

![Sickness Absence by Reason - 2018](image)

6  Figures Sickness absence - average days lost per employee

<table>
<thead>
<tr>
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<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
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<tr>
<td>GMC average days lost</td>
<td>6.3</td>
<td>7.0</td>
<td>7.4</td>
<td>7.9</td>
</tr>
<tr>
<td>CIPD Average days lost (All)</td>
<td>6.3</td>
<td>7.4</td>
<td>6.1</td>
<td>5.9</td>
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<tr>
<td>CIPD Average days lost (Public Sector)</td>
<td>8.5</td>
<td>9.3</td>
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[CIPD Health and Well-being at work survey report].

7  Approximately 49.8% (47.4% in 2018) of all absence would be classified as long term i.e. the absence totals 20 days or more.
Equality and Diversity
Workforce profile comparison - 2017 to 2019

GMC Workforce profile - Ethnicity 2017-2019

GMC Workforce profile - Age 2017-2019

GMC Workforce profile - Gender 2017-2019

GMC Workforce Profile - Disability 2017-2019
## Workforce profile by location and comparison with UK

<table>
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<tr>
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<th>London Population*</th>
<th>GMC Manchester</th>
<th>Manchester Population*</th>
<th>North West Population*</th>
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<tbody>
<tr>
<td>Asian</td>
<td>8.67%</td>
<td>18.49%</td>
<td>7.25%</td>
<td>17.09%</td>
<td>6.20%</td>
<td>7.28%</td>
</tr>
<tr>
<td>Black</td>
<td>5.33%</td>
<td>13.32%</td>
<td>2.24%</td>
<td>8.64%</td>
<td>1.39%</td>
<td>2.57%</td>
</tr>
<tr>
<td>Mixed</td>
<td>6.67%</td>
<td>4.96%</td>
<td>2.46%</td>
<td>4.60%</td>
<td>1.57%</td>
<td>3.06%</td>
</tr>
<tr>
<td>Not responded/Other</td>
<td>5.33%</td>
<td>3.44%</td>
<td>2.59%</td>
<td>3.06%</td>
<td>0.63%</td>
<td>2.50%</td>
</tr>
<tr>
<td>White</td>
<td>74.00%</td>
<td>59.79%</td>
<td>85.59%</td>
<td>66.61%</td>
<td>90.21%</td>
<td>84.58%</td>
</tr>
</tbody>
</table>
GMC compared to UK population

GMC compared to the UK population

- **Female**: GMC 63%, UK 51%
- **Male**: GMC 37%, UK 49%
- **BME**: GMC 14%, UK 14%
- **Disabled**: GMC 6%, UK 18%
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Promotion and Progression

Diversity in management roles at 31 December 2019

Promotions by diversity strand
(Number of promotions compared to GMC population)

Grievances by Diversity Strand

Disciplinaries by Diversity Strand
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Workforce Profile

GMC workforce profile - Gender by Level

GMC workforce profile - Ethnicity by Level
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Management Roles 2015-2019

Number of female staff at Management Grades 2015-2019
(GMC female population at Dec 2019 is 63.0%)

Number of BME staff at Management Grades 2015-2019
(GMC BME population at Dec 2019 is 13.6%)
## Recruitment progression by diversity strands

<table>
<thead>
<tr>
<th>Diversity</th>
<th>Applications</th>
<th>1st Interview</th>
<th>2nd Interview</th>
<th>Offer</th>
</tr>
</thead>
<tbody>
<tr>
<td>BME</td>
<td>1024</td>
<td>32.8%</td>
<td>170</td>
<td>21.7%</td>
</tr>
<tr>
<td>Non BME</td>
<td>1989</td>
<td>63.7%</td>
<td>586</td>
<td>74.7%</td>
</tr>
<tr>
<td>Female</td>
<td>1787</td>
<td>58.5%</td>
<td>494</td>
<td>64.7%</td>
</tr>
<tr>
<td>Male</td>
<td>1234</td>
<td>40.4%</td>
<td>266</td>
<td>34.8%</td>
</tr>
<tr>
<td>Disabled</td>
<td>33</td>
<td>1.1%</td>
<td>5</td>
<td>0.6%</td>
</tr>
</tbody>
</table>
Comparison to other organisations – Ethnicity

GMC Ethnicity compared to other organisations

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Non-BME</th>
<th>BME</th>
<th>Not Known</th>
</tr>
</thead>
<tbody>
<tr>
<td>All GMC</td>
<td>84.6%</td>
<td>13.6%</td>
<td></td>
</tr>
<tr>
<td>GMC Devolved Offices &amp; Homeworkers</td>
<td>89.0%</td>
<td>11.0%</td>
<td></td>
</tr>
<tr>
<td>GMC Manchester</td>
<td>85.6%</td>
<td>12.5%</td>
<td></td>
</tr>
<tr>
<td>GMC London</td>
<td>74.0%</td>
<td>23.3%</td>
<td></td>
</tr>
<tr>
<td>Equality and Human Rights Commission</td>
<td>81.0%</td>
<td>16.0%</td>
<td></td>
</tr>
<tr>
<td>Nursing and Midwifery Council</td>
<td>60.0%</td>
<td>37.0%</td>
<td></td>
</tr>
<tr>
<td>CIPD</td>
<td>82.0%</td>
<td>13.0%</td>
<td></td>
</tr>
<tr>
<td>Information Comission</td>
<td>81.0%</td>
<td>9.0%</td>
<td></td>
</tr>
<tr>
<td>Manchester Council</td>
<td>74.9%</td>
<td>18.7%</td>
<td></td>
</tr>
<tr>
<td>FCA</td>
<td>72.0%</td>
<td>21.0%</td>
<td></td>
</tr>
<tr>
<td>Metropolitan Police</td>
<td>94.0%</td>
<td>6.0%</td>
<td></td>
</tr>
<tr>
<td>Greater Manchester Police</td>
<td>93.47%</td>
<td>6.5%</td>
<td></td>
</tr>
</tbody>
</table>

* Benchmark data taken from organisations websites.
### Comparison to other organisations – Gender

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>All GMC</td>
<td>63.0%</td>
<td>37.0%</td>
</tr>
<tr>
<td>GMC Devolved Offices &amp; Homeworkers</td>
<td>60.4%</td>
<td>39.6%</td>
</tr>
<tr>
<td>GMC Manchester</td>
<td>62.6%</td>
<td>37.4%</td>
</tr>
<tr>
<td>GMC London</td>
<td>67.3%</td>
<td>32.7%</td>
</tr>
<tr>
<td>Equality and Human Rights Commission</td>
<td>61.0%</td>
<td>39.0%</td>
</tr>
<tr>
<td>Nursing and Midwifery Council</td>
<td>64.0%</td>
<td>36.0%</td>
</tr>
<tr>
<td>CIPD</td>
<td>69.0%</td>
<td>31.0%</td>
</tr>
<tr>
<td>Information Comission</td>
<td>60.4%</td>
<td>39.7%</td>
</tr>
<tr>
<td>Manchester Council</td>
<td>66.2%</td>
<td>33.8%</td>
</tr>
<tr>
<td>FCA</td>
<td>52.0%</td>
<td>48.0%</td>
</tr>
<tr>
<td>Metropolitan Police</td>
<td>40.3%</td>
<td>59.7%</td>
</tr>
<tr>
<td>Greater Manchester Police</td>
<td>40.8%</td>
<td>59.2%</td>
</tr>
</tbody>
</table>

* Benchmark data taken from organisations websites*
Council meeting, Thursday 23 April 2020
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**Attraction, Recruitment and Retention**

<table>
<thead>
<tr>
<th></th>
<th>Applications (3049)</th>
<th>Offers (232)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>58.5%</td>
<td>73.4%</td>
</tr>
<tr>
<td>BME</td>
<td>32.78 %</td>
<td>20.4%</td>
</tr>
<tr>
<td>Disabled</td>
<td>1.1%</td>
<td>0.9%</td>
</tr>
<tr>
<td>16-24</td>
<td>15.9%</td>
<td>19.4%</td>
</tr>
<tr>
<td>25-34</td>
<td>37.2%</td>
<td>47.8%</td>
</tr>
<tr>
<td>35-44</td>
<td>20.5%</td>
<td>21.1%</td>
</tr>
<tr>
<td>45-54</td>
<td>13.3%</td>
<td>8.6%</td>
</tr>
<tr>
<td>55-64</td>
<td>4.2%</td>
<td>0.9%</td>
</tr>
<tr>
<td>65+</td>
<td>0.2%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Not Stated</td>
<td>8.8%</td>
<td>2.2%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Joiners (218)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>64.7%</td>
</tr>
<tr>
<td>BME</td>
<td>18.3%</td>
</tr>
<tr>
<td>Disabled</td>
<td>9.6%</td>
</tr>
<tr>
<td>16-24</td>
<td>17.8%</td>
</tr>
<tr>
<td>25-34</td>
<td>51.1%</td>
</tr>
<tr>
<td>35-44</td>
<td>16.4%</td>
</tr>
<tr>
<td>45-54</td>
<td>10.5%</td>
</tr>
<tr>
<td>55-64</td>
<td>3.2%</td>
</tr>
<tr>
<td>65+</td>
<td>0.9%</td>
</tr>
<tr>
<td>Not Stated</td>
<td>17.8%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Leavers (120)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>56.7%</td>
</tr>
<tr>
<td>BME</td>
<td>18.3%</td>
</tr>
<tr>
<td>Disabled</td>
<td>10.0%</td>
</tr>
<tr>
<td>16-24</td>
<td>7.5%</td>
</tr>
<tr>
<td>25-34</td>
<td>50.8%</td>
</tr>
<tr>
<td>35-44</td>
<td>26.7%</td>
</tr>
<tr>
<td>45-54</td>
<td>5.0%</td>
</tr>
<tr>
<td>55-64</td>
<td>7.5%</td>
</tr>
<tr>
<td>65+</td>
<td>1.7%</td>
</tr>
<tr>
<td>Not Stated</td>
<td>0.8%</td>
</tr>
</tbody>
</table>

- Offers include internal transfers/promotions where a full recruitment campaign was run.
- Joiners figures report any staff member who joined the GMC between January and December 2019. Some of these staff may have been recruited during Q4 2018.
- Joiners only contains employees new to the organisation and does not include internal transfers/promotions.
Pay & Gender Pay Gap Reporting
Promotion, Pay & Progression – Ethnicity London

Equal Pay - London Average Hourly Rate (£) by ethnicity by grade Dec 2019 (ex IS and Data and Legal pay bands)

Equal Pay - London Average Hourly Rate (£) by ethnicity by grade 2018

Equal Pay - London Average Hourly Rate (£) by ethnicity by grade 2017
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Promotion, Pay & Progression – Ethnicity Manchester

Equal Pay - Manchester Average Hourly Rate (£) by ethnicity by grade Dec 2019 (ex IS and Data and Legal pay bands)

Equal Pay - Manchester Average Hourly Rate (£) by ethnicity by grade 2018

Equal Pay - Manchester Average Hourly Rate (£) by ethnicity by grade 2017
Promotion, Pay & Progression – Gender London

Equal Pay - London Average Hourly Rate (£) by gender by grade 2019

<table>
<thead>
<tr>
<th>Grade</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>L2</td>
<td>£45.00</td>
<td>£42.00</td>
</tr>
<tr>
<td>L3</td>
<td>£40.00</td>
<td>£38.00</td>
</tr>
<tr>
<td>L4</td>
<td>£35.00</td>
<td>£33.00</td>
</tr>
<tr>
<td>L5</td>
<td>£30.00</td>
<td>£28.00</td>
</tr>
<tr>
<td>L6</td>
<td>£25.00</td>
<td>£23.00</td>
</tr>
</tbody>
</table>

Equal Pay - London Average Hourly Rate (£) by gender by grade 2018

<table>
<thead>
<tr>
<th>Grade</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>L2</td>
<td>£45.00</td>
<td>£42.00</td>
</tr>
<tr>
<td>L3</td>
<td>£40.00</td>
<td>£38.00</td>
</tr>
<tr>
<td>L4</td>
<td>£35.00</td>
<td>£33.00</td>
</tr>
<tr>
<td>L5</td>
<td>£30.00</td>
<td>£28.00</td>
</tr>
<tr>
<td>L6</td>
<td>£25.00</td>
<td>£23.00</td>
</tr>
</tbody>
</table>

Equal Pay - London Average Hourly Rate (£) by gender by grade 2017

<table>
<thead>
<tr>
<th>Grade</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>L2</td>
<td>£45.00</td>
<td>£42.00</td>
</tr>
<tr>
<td>L3</td>
<td>£40.00</td>
<td>£38.00</td>
</tr>
<tr>
<td>L4</td>
<td>£35.00</td>
<td>£33.00</td>
</tr>
<tr>
<td>L5</td>
<td>£30.00</td>
<td>£28.00</td>
</tr>
<tr>
<td>L6</td>
<td>£25.00</td>
<td>£23.00</td>
</tr>
</tbody>
</table>
Promotion, Pay & Progression – Gender Manchester

Equal Pay - Manchester Average Hourly Rate (£) by gender by grade 2019 (ex IS and Data and Legal pay bands)

Equal Pay - Manchester Average Hourly Rate (£) by gender by grade 2018

Equal Pay - Manchester Average Hourly Rate (£) by gender by grade 2017
Gender Pay Gap Reporting

1. Our final 2019 figures are as follows:

   1.1 the difference between the mean hourly rate of pay of male full-pay relevant employees and that of female full-pay relevant employees

   1.1.1 14.0% - This means that based on the average hourly rate female employees are paid 14.0% less than male employees.

   1.2 the difference between the median hourly rate of pay of male full-pay relevant employees and that of female full-pay relevant employees

   1.2.1 6.7% - This means that based on the median hourly rate female employees are paid 6.7% less than male employees.

   1.3 the difference between the mean bonus pay paid to male relevant employees and that paid to female relevant employees

   1.3.1 58.5% - This means that based on the average bonus pay female employees are paid 58.5% less than male employees.

   1.4 the difference between the median bonus pay paid to male relevant employees and that paid to female relevant employees

   1.4.1 20% - This means that based on the median bonus payments female employees are paid 20% more than male employees. The majority of the bonus payments are part of the valued recognition scheme and are vouchers with the most typical amounts being £50 and £100.

   1.5 the proportions of male and female relevant employees who were paid bonus pay

   1.5.1 Proportion of Males receiving bonus – 36.8%

   1.5.2 Proportion of Females receiving bonus – 41.3%

   1.6 the proportions of male and female full-pay relevant employees in the lower, lower middle, upper middle and upper quartile pay bands.
1.6.1 The results are in the table below

<table>
<thead>
<tr>
<th>Quartile</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lower pay band</td>
<td>55.3%</td>
<td>44.7%</td>
</tr>
<tr>
<td>Middle pay band</td>
<td>61.5%</td>
<td>38.5%</td>
</tr>
<tr>
<td>Uper pay band</td>
<td>66.7%</td>
<td>33.3%</td>
</tr>
<tr>
<td>Upper Quartile pay band</td>
<td>66.7%</td>
<td>33.3%</td>
</tr>
</tbody>
</table>

1.6.2 Currently the GMC staff gender profile is 63.0% Female and 37.0% Male.
### Action
To note

### Purpose
To note the progress made in delivery of our Welcome to UK practice (WtUKP) workshop to internationally qualified doctors and the impact of Covid-19 on our planned activities. To note our plans to drive further attendance through a focus on marketing and engagement across the four countries of the UK particularly thorough collaboration with health sector partners, online provision and suggested success measures.

### Decision trail
April 2019: Council was updated on the growth rate of IMG/EEA applications and the initiatives planned to drive attendance.

### Recommendation(s)
- **a** To note progress for the WtUKP expansion project.
- **b** To agree to the proposed success criteria for delivery and development in 2020.
- **c** To note the intervention’s place in our next corporate strategy.

### Annexes
A supplementary reading pack has some further detail to support information already included in the paper.

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  tista.chakravarty-gannon@gmc-uk.org, 0161 250 6822
- **Andy Lewis**, Assistant Director England, Strategic Communications and Engagement, WtUKP Sponsor  
  andy.lewis@gmc-uk.org, 0161 250 6849

### Sponsoring director/Senior Responsible Owner
**Paul Reynolds**, Director, Strategic Communications and Engagement  
Paul.reynolds@gmc-uk.org, 020 7189 5053
Executive summary

1. WtUKP is our workshop to support internationally qualified doctors transitioning to practice in the UK. It’s delivered face-to-face over a half-day.

2. We’ve delivered significant growth in attendance through the initiatives we outlined to Council in April 2019 plus others.

3. We’ve also developed our workshop infrastructure including integrating booking into GMC online, inducting associates to deliver the workshop and filling key posts to market and support the administration of the workshop, and we’ve expanded workshop capacity so much that we can be confident in the level of supply and can turn our attention more fully to driving demand for those places.

4. Building upon this infrastructure, we will shift our focus to marketing, engagement and online delivery options in 2020, including delivering on the commitment made by stakeholders in Northern Ireland to make WtUKP mandatory and collaborating with NHS England’s Workforce Race Equality Standard (WRES) Steering Group and Health Education England (HEE) to recommend the workshop. Our Outreach team will utilise our greater data capability to help health boards and trusts engage with their eligible doctors.

5. Covid-19 has impacted our delivery. As a result of national restrictions, we have cancelled all sessions up to 30 June 2020. Feedback from Outreach engagement with providers suggests there may be residual demand and we are exploring remote delivery. We’ll outline the steps we’re taking in response below.

What is Welcome to UK practice?

6. WtUKP is our intervention to support doctors who qualified outside of the UK and are new to UK practice. It was developed in response to the disproportionate rate of fitness to practise referrals of internationally qualified doctors and is designed to help these doctors identify and navigate key areas of cultural and ethical difference.

7. It’s offered as a free, half-day, face-to-face workshop, with interactive video scenarios and group discussion in our five UK offices and in local healthcare settings.

8. WtUKP was independently evaluated by Newcastle University in 2018, finding evidence of the short- and long-term benefits of the workshop as a face-to-face educational intervention. This included improved awareness and understanding of the ethical issues covered and an improved perception of the GMC.
9 Our current corporate strategy set a target of increasing attendance at WtUKP to 80% of new IMG/EEA doctors by the end of 2020.

10 Key terms: doctors are ‘eligible’ for the workshop if they gained their primary medical qualification outside of the UK and registered in the UK, with a licence to practise, in the last 12 months. Our ‘cohort’ is all the doctors who are eligible on a given day; the size of the ‘cohort’ changes daily as doctors begin or finish those 12 months. For example, the cohort grew by 20% from the start to the end of 2019.

2019 – piloting initiatives and delivering growth

Performance of initiatives proposed to April 2019 Council

11 We briefed Council in April 2019 of our plans to increase attendance over the following 12 months. All initiatives have had a positive impact. Notable achievements are:

a Aligning WtUKP with mandatory ID checks. We have legal advice that we are unable to mandate attendance at WtUKP. However, ID checks for doctors are mandatory. When doctors’ WtUKP workshops are scheduled on the same day as their ID checks, average workshop attendance is significantly higher than for standalone sessions. Prior to the impact of COVID-19, 7% of the planned 2020 ID check capacity was paired with WtUKP workshops; the equivalent of 10% of our cohort. We are working with Registration colleagues to increase this collaboration in Q3/Q4.

![Figure 1: Attendance at workshops paired with an ID check in January 2020](image)

b Integrated booking system. Doctors can now book WtUKP using GMC Online, the same platform as the rest of their registration journey. This has enabled improved communication with the doctor and more in-depth reporting capabilities. Access to enhanced data started on 1 March 2020 and we are analysing the data to understand the impact of this new capability and booking behaviours.
c **Improved branding.** Our marketing is now focussed on the doctors within our target cohort and products have also been developed for employers. Advertising of WtUKP has increased including using Facebook live sessions, email bulletins, LinkedIn and Facebook advertising and issuing text message reminders.

d **External engagement.** The following are notable developments from increased external engagement activity:

- In Northern Ireland, all the necessary stakeholders have opted to make WtUKP a mandatory part of induction (with the consequences of non-attendance are at the employer’s discretion).

- Health Education England (HEE), has agreed to recommend the workshop to the 623 doctors they anticipate arriving through their EMIT, WAST, IPGMTS and Clinical Radiology recruitment schemes in FY 2020/21.

- The National Association of Medical Personnel Specialists (NAMPS), whose members are often responsible for recruiting doctors in our target cohort, has invited us to speak to their Executive Board in May 2020 and agreed to promote the workshop to their members.

- In England, the BMA have begun sponsoring our office-based workshops and, in some regions, there is now a local, reciprocal agreement to deliver WtUKP in trusts where the BMA is already doing a session.

- NHS Employers have agreed to collaborate on marketing; working with us to develop case studies that will promote the workshop to employers.
Growth in capacity and attendance

12 Total attendance in 2019 (3,692) was 37% higher than in 2018 and represents a 109% growth versus 2017 before the project began (Figure 2). Most growth was achieved in our office-based workshops where we had 827 more attendees in 2019 but there was growth in our local sessions where we saw 125 more attendees.

13 In April 2019, we also committed to test if we could grow England office-based workshop capacity – the number of workshop places we can offer - to the scale required to serve all eligible doctors. We wanted to be able to promote the workshop to national stakeholders, confident that we could accommodate the demand it may drive. So, we added more sessions to Q3 and 4 and, in 2020, have planned to deliver almost 14,000 spaces in our workshops, enough to cater to our total eligible cohort and absorb any growth resulting from the maturing impact of our marketing and engagement initiatives.

14 We also wanted to learn how offering more flexibility to doctors might impact attendance. Following the 2019 mid-year increase in capacity, overall attendance rose from 171 attendees to 295 per month but fill rates (attendance as a percentage of capacity) dropped from 40% to 27%. So, we know that
increased attendance options will not drive demand organically without supporting marketing and engagement.

15 In 2019, attendance in London was routinely higher than in Manchester. In both locations, attendance was better at morning and evening sessions, than in the afternoon. Mondays and Sundays were the least popular days. We ran more Saturday sessions than any other day of the week at which attendance was consistently good, especially in London.

16 Delivery of WtUKP has resulted in de-prioritising other Outreach activity such as engaging patients, medical students and intelligence reporting.

2020 - next steps delivering on existing commitments

17 With workshop infrastructure in place, our focus can turn to marketing, engagement and making attendance at WtUKP feel like a natural part of the registration process. We are also encouraging external organisations to include WtUKP in their induction programmes.

18 In 2019, around 1,000 doctors booked WtUKP workshops but subsequently cancelled or ‘no showed’ on the day. When you consider this audience alongside those who did attend, we can see we’re already engaging almost as many doctors as we anticipated would be our target cohort when the project was created (around 5,000 before the rise in IMG/EEA registrations). In 2020, we will seek to understand the reasons for cancellation and ‘no showing’ and convert more of this group to attend.

19 We have planned additional resource to support marketing activity from the resumption of face-to-face delivery. We will focus on: converting those who are already interacting with our systems to bookings; targeted marketing towards eligible doctors and their employers; engaging those organisations with levers to drive attendance; and embedding work to support the delivery of WtUKP initiatives across the seven new integrated Outreach teams.

Four country engagement

Northern Ireland

20 The Chief Medical Officer has mandated the workshop as part of induction. The idea behind the workshop is so popular that stakeholders have broadened the cohort to include doctors new to practice in Northern Ireland, not just the UK. Anyone who has previously practiced in Wales, Scotland or England is also invited to attend. This has diluted the audience so that despite the commitment to the workshop and an increase in sessions delivered and overall attendance,
the attendance rate across our narrower, non-UK qualified eligible cohort was 39% in January 2020. In 2020, continued regular communication and more detailed reporting unlocked by our improved access to data should help us focus in and close that gap.

Wales

21 In Wales, conversations are ongoing with key stakeholders after the Chief Medical Officer expressed support for making WtUKP a standard part of induction for eligible doctors in Wales. Capacity is in place to support delivery of workshops in the Cardiff office and at Health Boards across Wales.

22 We aim to grow attendance at local workshops. In Mid- and North Wales this will mean a disproportionate increase in sessions planned as attendance levels are lower due to the size of the target cohort and travel burden on doctors.

Scotland

23 In Scotland, conversations with key stakeholders are ongoing. The three largest concentrations of eligible doctors are in Edinburgh, Glasgow and Aberdeen. NHS Greater Glasgow & Clyde has committed to act as a ‘host Board’ for the West of Scotland, opening session availability there. Workshops in our Edinburgh office are already scheduled which will direct eligible local doctors to via targeted engagement. Liaison adviser resource is in place to provide the required capacity in Aberdeen.

England

24 NHS England’s Workforce Race Equality Standard (WRES) Steering Group are piloting a mandatory induction for all IMG secondary care doctors in England which includes attendance at WtUKP. We don’t hold complete data, but we estimate this could represent around 35% of our total eligible cohort.

25 HEE anticipate recruiting 623 doctors in FY2020/21 through schemes in which WtUKP will be a recommended part of induction.

26 11 designated bodies (DBs) have over 50 eligible doctors who haven’t attended the workshop (at time of writing). A new external dashboard will enable key stakeholders to look up which of their doctors are eligible to attend and to compare their performance with other DBs. The dashboard will be online by Q3 2020.

27 Of these 11, two DBs have over 100 doctors; locum agency NES Healthcare and University Hospitals Birmingham. (The additional reading pack includes our plans to engage both.)
There’s a clear link between running sessions locally and increased attendance but often trusts are unable to release many doctors to attend on the same day. To avoid poor attendance, we are developing a collaboration with HEE in which they will coordinate a workshop and offer it across a region. We’ve had some localised success with this in 2019 and are looking to roll it out across England in 2020.

Case study: Successful collaboration with HEE South West

HEE South West organise full-day sessions at which the standard WtUKP workshop is delivered in the morning and there is additional content in the afternoon on other issues IMG doctors can find challenging. In 2019, HEE South West ranked in the top three organisations for overall workshop attendance despite having a comparatively small eligible cohort, outside the top 30 largest.

Responding to Covid-19

Face-to-face sessions were cancelled following the implementation of national restrictions in response to Covid-19. We have also suspended marketing as we review our approach over this period.

To be able to respond to the potential market for an online workshop over this period we are developing WtUKP Online to pilot from Q2. This will be focussed on those who are in our eligible cohort but not currently working (whether in the UK or elsewhere). This 3.5-hour digital version of the workshop will be as close a replica of the primary product as possible. It will be led by a team of experienced liaison advisers and include interactive elements. Demand over this time is uncertain but we recognise there may be long-term value in online delivery.

We were to consider developing an online version in 2021 as an alternative to support doctors facing difficulties attending face-to-face sessions. We have brought this work forward and postponed planned 2020 engagement that required meetings with stakeholders and event attendance.

Of note, we are also developing a one-hour, pandemic-specific, self-led, eLearning module. Ethical fundamentals for new and returning doctors will be a guidance refresher made available to doctors in the WtUKP cohort who are already working in the UK, final year medical students joining the register early and s18 returners. This follows requests for GMC support and we will explore how this additional approach could be used to support induction.
**WtUKP online pilot: success criteria/objectives**

34 We recommend that the success of our online delivery be measured by the following criteria:

34.1 **Perception:** positive feedback received from the profession that continued access to a version of the workshop was supportive.

34.2 **Attendance:** consistent levels of take-up whilst recognising it’s difficult to predict the appetite for the workshop in the current climate.

34.3 **Learning:** this pilot represents an opportunity to test online delivery platforms, methods and administrative processes and capture lessons to inform the build of permanent offering from 2021 onwards.

**Face-to-face delivery: success criteria/objectives**

35 The growth rate of WtUKP attendance in 2019 was 37% and we have yet to see the full impact of the planned enhancements to grow attendance. We anticipated the same rate of growth again or greater in the following year. As delivery has now been paused due to COVID-19, we’ll begin measuring against these criteria when it resumes.

36 We recommend that success be measured by the following criteria:

36.1 **Attendance:** at least 5058 doctors in a year, beginning when face-to-face delivery resumes; matching or exceeding 2019’s growth rate (37%).

36.2 **Partnership working:** Outreach engage the three trusts or health boards with the largest eligible cohorts by April 2021.

36.3 **Partnership working:** Outreach engage locum agency NES Healthcare by year end 2020.

36.4 **Partnership working:** as well as an overall increase in attendance, use of data to increase percent of eligible cohort that attend workshops in Northern Ireland.

36.5 **Partnership working:** HEE’S eligible EMIT, IPGMTS and clinical radiology recruits are attending workshops as standard by April 2021.
36.6 **Efficiency:** number of office-based workshops run with less than 10 doctors is no more than three per quarter within six months from when face-to-face delivery resumes.

37 We would like to return to Council in 2021 to evaluate the success of this model and talk about what need there is for potential alternative, blended product offerings.

2021 and beyond

38 Our vision is to engage all internationally qualified doctors new to UK practice, to support their induction into the UK workplace and give them a positive start in their relationship with the regulator.

39 The project’s vision is to deliver high attendance in perpetuity, so our focus should not end after. From 2021, WtUKP fits clearly under the ‘sustainable medical workforce’ and ‘delivering change together’ themes of the next corporate strategy.

40 However, it is likely that, without mandating WtUKP, we will see a decreasing return of our investment some way below 100% attendance at the workshops based on the existing model. To close the gap further we propose exploring the following:

- Maintaining high quality face-to-face workshops delivered with flexibility at our national offices and at regional and local venues.

- Continuing our efforts to identify partnership working where WtUKP is mandated as part of national/regional/local induction.

- Increasing alignment of WtUKP office-based workshops with ID checks

- Piloting a ‘train the trainer’ model with organisations that are delivering consistent, well-attended workshops over a minimum period.

- Building on 2020’s *WtUKP Online* pilot to develop a two-part online solution; an e-learning module which unlocks an interactive, trainer-led webinar.
<table>
<thead>
<tr>
<th>Action</th>
<th>To discuss</th>
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<tbody>
<tr>
<td>Purpose</td>
<td>The statutory determination is the legal mechanism by which the GMC will make both parts of the MLA a required feature of a UK medical degree in order for that degree to be recognised as a primary UK qualification (UK PMQ). Determinations are binding on medical schools, who must act in accordance with them. Under the GMC’s schedule of authority for delegated powers, the decision to issue the statutory determination lies with the Registrar. Subject to Council’s views on, and approval of, the approach to developing the statutory determination, we intend to finalise it over the spring and summer for publication in September 2020 and full implementation of the MLA in 2023. This will give universities time to change their regulations to make both parts of the MLA a required feature of their medical degrees for students graduating from 2024. However, the paper also identifies the impact of COVID-19 on the MLA and the potential that a change to the full implementation timetable will be necessary.</td>
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<tr>
<td>Decision trail</td>
<td>N/A</td>
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<tr>
<td>Recommendation(s)</td>
<td>a To approve the approach to developing the statutory determination. b To note the impact of COVID-19 to the MLA’s delivery timetable and the potential need to reschedule full implementation of the MLA.</td>
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<tr>
<td>Annexes</td>
<td>N/A</td>
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<tr>
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</tr>
</tbody>
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What is the statutory determination?

1 A statutory determination issued under the Medical Act 1983 is the legal mechanism by which the GMC will make a pass in both parts of the MLA (the Applied Knowledge Test (AKT) and the Clinical Professional Skills Assessment (CPSA)) a required feature of a UK medical degree in order for that degree to be recognised as a primary UK qualification (UK PMQ). A UK PMQ is a medical degree awarded by a body on the GMC’s approved list of bodies able to award medical degrees. A statutory determination issued by the GMC is binding on medical schools, who must act in accordance with it.

2 Issuing statutory determinations under our section 5 powers is not novel. Outcomes for graduates and the associated list of practical skills and procedures are statutory determinations, albeit not branded as such.

How the statutory determination means the MLA becomes binding

3 To discharge the Council’s statutory functions in relation to medical education and training, the GMC is required to make determinations of the extent of knowledge and skill required for the granting of a primary UK qualification; and the standard of proficiency required from candidates at qualifying examinations; and secure the maintenance of that standard.

4 Bodies (or combinations of bodies) may only be included on the approved list of awarding bodies if they require a standard of proficiency from students sitting their exams that conforms to the standard the GMC has determined.

5 Hence, once the GMC has made determinations that the knowledge and skill and standard of proficiency includes a pass in both elements of the MLA, in order to remain on the approved list, medical schools must include the CPSA and AKT within their degree programmes for those degrees to constitute a UK PMQ.

Publication of the statutory determination

6 To be binding, a statutory determination needs to the published. We are aiming to do so in September 2020 for full implementation of the MLA in 2023. This will give universities time to change their regulations to make both parts of the MLA a required feature of their medical degrees for those graduating from 2024. Should a university choose not to make the MLA a requirement for graduation, we will need to remove that institution from the list of bodies.

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1 Section 5

2 Following the revised timetable approved by Council in June 2019.
approved to award a medical degree. Any student graduating from that university from 2024 onwards will not hold a UK PMQ that entitles them to registration with a licence to practise.

Publication opens a window for judicial review of our decision to introduce the MLA.

The format of the statutory determination

There is no set format for the statutory determination. After some consideration and subject to Council’s views, we’re proposing that the statutory determinations will comprise two parts:

- a main body to explain the rationale for the MLA and confirm the GMC’s determination that it needs to be a required feature of medical degrees.
- annexes explaining the detail around the MLA, including the steps that schools will be required to take, to provide a clear statement of what the MLA is.

This format will make it easier for the GMC to amend detail without having to revisit the entire statutory determination. For example, we could add a new CPSA requirement by amending the annex containing the CPSA requirements. We would have to reissue the determination with a new date, and the specific change being made could itself be challenged. However, the advice we have received is that, unless the amendment was fundamental to the MLA, it would not re-open the possibility of a judicial review of the decision to introduce the MLA itself.

Developing the statutory determination

So far, we’ve:

- discussed the format and content internally, including with MLA Programme Board.
- liaised regularly with GMC Legal and sought external leading counsel’s advice.

3 The MLA content map, the applied knowledge test (AKT) delivery standards, the clinical and professional skills assessment requirements (CPSA), the CPSA quality assurance model, and GMC-set AKT operational policies (on reasonable adjustments, number of permissible attempts, examination misconduct, fit to sit and mitigating circumstances, and appeals).
Council meeting 23 April 2020

Agenda item M7 – The MLA – approach to the statutory determination and its annexes for publication

- engaged extensively with medical schools to discuss the detail of the MLA, including detail that will be annexed to the statutory determination.

- begun to engage with academic registrars through groups of the Academic Registrars Council – the academic registrars will be responsible for regulatory change through university governance procedures.

- undertaken an initial equality analysis to inform and refine development of the MLA detail to be included in the statutory determination.

11 Over the late spring and early summer, we’re planning to:

- meet with the academic registrar and medical school assessment lead at each university to understand individual impact of the statutory determination. However, this ambition might of course be affected by their availability, given the likely impact of COVID-19 on their time.

- define the detail as necessary to reflect feedback from these discussions.

- continue to seek strategic steers from the MLA Programme Board, if necessary.

- continue our equality analysis and further refine our approach, as necessary.

- develop a communications and engagement plan to support publication of the statutory determination in September. This will include consideration of how we engage more broadly with stakeholders, including patients and the public, about the MLA and the benefits it will bring.

COVID-19 – impact on MLA implementation

12 As we reported to Council in February 2020, we are working hard across several fronts to develop the MLA. This includes procuring the AKT item bank and a software platform to deliver the test, recruiting associates needed to operationalise the MLA, developing plans to trial and pilot the AKT, continuing with a CPSA quality assurance pilot and assuring compliance by 2023, and further engagement with universities and medical schools. Our development and implementation timetable is already very tight.

13 Inevitably, the impact of COVID-19 on the GMC and key delivery partners may raise unforeseen challenges to our current timelines: not only for publishing the statutory determination in September 2020, but across the entire MLA programme (on matters such the timeframes for trailing and piloting the AKT and the recruitment of assessment experts as MLA associates for operational
functional governance groups (as these individuals will often be clinicians and/or working within undergraduate education or postgraduate training)).

14 We are currently exploring the possibility of delaying our engagement with academic registrar staff until September/October 2020 and publishing the statutory determination in early 2021. This would reduce the time available to medical schools/universities to change their regulations to implement the MLA but it would allow us to maintain the overall programme delivery timetable.

15 We are carefully considering how to mitigate other risks: for example, we can manage travel restrictions by holding meetings virtually and we are doubling up on some expert meetings and holding individual conversations with experts to still gain this important input. However, we don’t yet know what the pandemic’s impact will be on:

- the health and availability of GMC staff to progress the programme as swiftly as planned; or
- the health, availability and willingness at the moment of key stakeholders to participate in MLA development. For example, given the likely need for clinicians and assessment experts to deliver priority care and/or to focus on contingency planning locally, the MLA is unlikely to remain a priority.

16 We continue to review the situation and to try to assuage the risks and impact to the overall programme timetable of the COVID-19 situation.
Action | To note
---|---
Purpose | As agreed with Council, we established with effect from the beginning of 2019 a new s40A Executive Panel to consider whether we exercise our right of appeal in specific cases. The decisions of the s40A Executive Panel are published on the GMC website on the Recent Appeal Decisions page.

This paper is the second update to Council on the operation of the s40A Executive Panel and its exercise of the GMC’s right of appeal since the new process was put into place from January 2019.

Decision trail | N/A

Recommendation(s) | Council is asked to note the contents of this update

Annexes | Annex A: List of s40A appeals heard between 10 August 2019 and 31 March 2020

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1 [https://www.gmc-uk.org/concerns/hearings-and-decisions/recent-appeal-decisions](https://www.gmc-uk.org/concerns/hearings-and-decisions/recent-appeal-decisions)
Council meeting, 23 April 2020
Agenda item M8 – Section 40A appeals update

Background

1 The GMC’s right of appeal was introduced following the separation of its investigation and adjudication functions with the creation of the Medical Practitioners Tribunal Service (MPTS). It has made it possible for the GMC to exercise our own right of appeal in cases where we consider that Medical Practitioners Tribunals (MPTs) have made decisions which are not adequate to protect the public, which includes public confidence in the profession.

2 The terms of the GMC’s right of appeal are contained in s40A Medical Act 1983. Section 40A(3) provides as follows:

“The General Council may appeal against a relevant decision to the relevant court if they consider that the decision is not sufficient (whether as to a finding or a penalty or both) for the protection of the public.”

3 The PSA retains its right to refer cases to the High Court under s29 of the National Health Service Reform and Health Care Professionals Act 2002. However, if the GMC issues a s40A appeal, the PSA cannot also refer under s29. Instead, they can choose to join the GMC’s appeal as a party pursuant to s40B Medical Act 1983.

4 In the period since the previous update to Council, covering 10 August 2019 – 31 March 2020, the PSA issued 1 s29 appeal. That was in the case of Dr David Dighton. That case was not considered by the Panel for possible appeal under s40A as the MPT directed that the Doctor’s registration be suspended for 12 months, with a review, which was the outcome which the GMC had considered sufficient to protect the public in that case.

5 The PSA has not currently joined us in being party to any of the s40A appeals issued in this period. This paper is the second update to Council on the operation of the s40A Executive Panel and its exercise of the GMC’s right of appeal since the new process was put into place from January 2019, and the decisions which the Panel has made.

The s40A Executive Panel

6 With effect from January 2019, decisions as to whether to exercise the GMC’s right of appeal are no longer be taken by the Registrar alone, having regard to legal and other advice, but are instead taken by an Executive Panel consisting of the Chief Executive and Registrar (acting as chair), the Medical Director and Director of Education and Standards and the General Counsel and Director of Fitness to Practise (or their nominated Deputies if not available).
7 There is an established, three stage process supporting the s40A Executive Panel in its decision-making:

a Firstly, an assessment is undertaken by senior GMC lawyers (with input from the external counsel who conducted the case at the MPTS) of the determinations in all concluded MPT hearings where the tribunal’s decision did not meet the GMC submission on sanction. This assessment is to determine whether there are, in principle, any realistic grounds of appeal and which would suggest that the MPTS decision is insufficient to protect the public or public confidence in the profession.

b If this assessment identifies there may be realistic grounds of appeal, external legal advice is then obtained from a different expert counsel as to the legal merits of an appeal. This advice is then incorporated into a submission from the Deputy General Counsel for consideration by the s40A Executive Panel at a meeting.

c The s40A Executive Panel will then consider the case at a meeting and make a decision, having regard to the legal advice received and all the circumstances of the case, to determine whether we should exercise our right of appeal.

8 Meetings of the s40A Executive Panel are chaired by the Chief Executive and Registrar. The Assistant Director, Corporate Directorate (or his nominated deputy) acts as clerk to the Panel and records the s40A Executive Panel’s Decision in the form of a Note of Decision which is approved by the Panel and signed by the chair.

9 Also, in attendance is the Deputy General Counsel (or his nominated deputy), who provides legal advice to the Panel, primarily in the form of a written submission circulated to the Panel ahead of the meeting which itself includes a copy of Legal Advice provided by external specialist counsel.

10 In making their decisions, the s40A Executive Panel also has regard to the Guidance for Decision-makers in relation to s40A appeals, an updated version of which was published on the GMC website. This update incorporated relevant clarification as to the applicable legal principles provided by the courts of both England and Wales and Scotland in cases which they have decided since the introduction of the right of appeal in December 2015; and reflected changes to the decision-making process in response to recommendations from the Williams Review and in line with advice received from Sir Robert Francis QC.
Council meeting, 23 April 2020
Agenda item M8 – Section 40A appeals update

11 The decisions of the s40A Executive Panel are also published on the GMC website on the Recent Appeal Decisions page. The publication is for 3 months in cases where a s40A appeal was not pursued, and 28 days following the last appeal judgement publication for the appeal cases.

The s.40A Executive Panel’s Decisions

12 In the period between 10 August 2019 and 31 March 2020 the s40A Executive Panel has considered whether to exercise the GMC’s right of appeal in relation to a total of 19 Doctors. The number of cases which concluded at an MPTS hearing during this period is 257. Of these 257 cases 99 had an outcome different to the sanction we had sought at the outset to the case. The three-stage process described in paragraph 7 was applied to these 99 cases, resulting in the referral of those 19 cases for consideration by the Panel.

13 Details of the dates of the meetings, the Doctors whose cases were considered by the Panel at those meetings and the outcome of the s40A Executive Panel’s consideration of each case are set out in the table at Annex A.

14 As that table confirms, the s40A Executive Panel have decided to exercise the power to appeal in 5 cases since the last update:

a Dr Haris

- The MPT found proven that Dr Haris had intimately examined two separate patients without clinical indication in either case (and in one of the cases had specifically recorded that no intimate examination had taken place). In both cases, the Dr Haris failed to obtain consent and failed to record his actions. In addition, he had initially denied both cases at the MPT hearing.

- However, the MPT found that whilst Dr Haris’ acts towards Patients A & B could reasonably be perceived as overtly sexual, based on the evidence, the actions were not for Dr Haris’ own sexual gratification and, therefore, were not sexually motivated.

- The Panel considered the MPT’s findings regarding the doctor’s action not being sexually motivated and noted that this finding relied upon the submission of a Consultant Forensic Psychiatrist that Dr Haris may be asexual (which could be understood through the diagnosis that Dr

2 https://www.gmc-uk.org/concerns/hearings-and-decisions/recent-appeal-decisions

3 Dr Ubhi’s meeting is listed for the 6 April.
Haris is either on the autistic spectrum or Asperger’s syndrome. The Panel felt that the MPT had placed too much weight on the testimony of the psychiatrist, given it was based on the information that Dr Haris had told them.

- The Panel also felt that the MPT placed too much weight on the testimony of Dr Haris’ friend and sister, given their relationships to Dr Haris.

- Whatever the explanation, the panel was concerned that a doctor could have acted in such a way from both a patient safety perspective, and the GMC’s role to uphold public confidence in the profession. Even if these actions were not sexually motivated, the impact on the patients is a substantial violation by a professional in a position of great trust.

- The Panel also felt that the MPT’s consideration of whether to suspend Dr Haris was inadequate. The Panel found the MPT’s reference to the public “not being vengeful” and that public interest is “a two-way street” odd, and not relevant to the guidance, and hence found that the MPT’s reasoning to be inadequate. The Panel did not feel that the MPT had properly addressed the severity and gravity of Dr Haris’ misconduct or the public interest test.

b Dr Awan

- In 2016, Dr Awan was working as a GP in Leeds and Wakefield. The GMC received a Dr Awan referral from South Yorkshire Police on 15 January 2016. They had undertaken a covert operation on a “chat site” called Lycos. Dr Awan had engaged in dialogue with someone who he believed to be a 13 year old girl. Dr Awan had used the username “Medic333”. Dr Awan engaged in further exchanges with Person A by text message and WhatsApp on 21 January 2016.

- Dr Awan made inappropriate and sexually motivated remarks to her. Further, Dr Awan persisted in trying to speak with Person A over the phone and sought to do so at a time when an adult would not be present. Dr Awan told Person A that he was a doctor during the initial conversation on Lycos.

- In October 2017, Dr Awan moved to Canada where he works as a GP.
The GMC sought the Doctor’s erasure from the register, but the MPT determined to suspend Dr Awan’s registration for a period of nine months.

In reviewing this case, the Panel noted that the MPT found Dr Awan’s actions to be sexually motivated. The Panel was disturbed at the finding that Dr Awan had abused his position as a doctor in such a way. Given this finding of the MPT, the Panel found that the MPT did not appear to have considered all of the relevant elements of the sanctions guidance.

The Panel also found that the MPT’s reasoning regarding the public interest in not depriving the public of the services of an otherwise competent doctor, was flawed. The GMC’s role is to protect patient safety and hold a register of doctors licenced to practice in the United Kingdom. The Panel found that the MPT’s reasoning was irrelevant as Dr Awan left the UK to practise in Canada in October 2017 and he does not refer to any intention to return to practise in the UK in his witness statement.

c Dr Armstrong

Whilst working as a locum GP at eight different practices, Dr Armstrong was not registered on the Medical Performers List (‘MPL’) as is required and which she knew was required; whilst working at one of the practices as a locum she informed an administrator that she was on the MPL, when she knew that she was not. NHS England commenced an investigation and Dr Armstrong failed to co-operate with that investigation.

Following referral to the GMC, Dr Armstrong was made the subject of an interim order of suspension on her registration, following which Dr Armstrong made applications to Nuffield Health and Push Doctor and failed to declare the GMC investigation and her suspension.

In June 2018, Dr Armstrong returned to Australia and applied for a GP position and again failed to disclose that she was subject to an interim order. Upon the Australian practice making enquires with her she provided false information about the interim suspension and GMC investigation; Dr Armstrong subsequently withdrew her application for the GP post.
Dr Armstrong admitted all of the allegations including that she had acted dishonestly. However, the MPT found her fitness to practise not to be impaired and issued her with a warning.

The Panel struggled to see how the MPT concluded that the doctor’s fitness to practise was not impaired. Specifically, the Panel felt it illogical that the MPT could conclude that there was no impairment, given the persistent and multifaceted dishonesty.

The Panel concluded that the MPT’s decision was insufficient to protect the public because the MPT had erred in its finding on misconduct, had failed to attach significance to the seriousness of Dr Armstrong misconduct and had attached too much weight to matters of mitigation.

d  Dr Udoye

The allegations in this case related to Dr Udoye’s application for the GP Induction & Refresher Scheme (‘the Scheme’) and declarations made on the registration form, subsequent practice as a GP as part of the Scheme and submission of claims (to cover the costs of indemnity, Annual Retention Fee and bursary) in 2016-2017, when he knew he was not eligible to do so because he was not on the GP Register or National Medical Performers List. It was alleged that Dr Udoye’s actions had been dishonest.

The MPT found that Dr Udoye was not practising as an ‘independent’ GP and, therefore, that the factual allegation was not found proved. This, in turn, meant that the allegation of dishonesty that stemmed from the earlier allegation relating to Dr Udoye practising as a GP fell away and was not considered by the MPT. The MPT did not as a consequence find misconduct.

The Panel felt that it is implausible therefore that Dr Udoye, having attempted and failed to secure a CEGPR, was unfamiliar with the process and status implications of being on the GP register.

The Panel could not follow the MPT’s findings in respect of the MPT’s deliberations about the term “independent GP”. They considered that the MPT had failed to understand the nature of the case by the GMC in relation to the meaning of “practising as a GP”;

This misinterpretation of the GMC’s case had caused the MPT to fail to go on to address the other elements of the allegation, which in turn, potentially impacted on the finding of no misconduct;

The Panel considered that the MPT appeared also to have erred in its understanding and/or application of the principles in relation to drawing an adverse inference from the doctor’s silence (set out in the case of R (On the application of Kuzmin) v General Medical Council [2019] EWHC 2129);

The Panel felt that the MPT’s decision not to consider these allegations in full, and to conclude that Dr Udoye’s actions did not amount to misconduct, was insufficient to protect the public.

e  Dr Donadio

The MPT found the majority of the allegations proven including that Dr Donadio had falsely represented himself as being able to carry out locum shifts as a Consultant; that Dr Donadio had worked in breach of his interim order of conditions between 12 July 2018 (the date by which the MPT were satisfied that Dr Donadio would have been aware of the outcome of the interim orders tribunal) and 10 August 2018 and that he had done so dishonestly, as his actions had permitted him the opportunity to work in a position which was prohibited by his conditions.

In finding misconduct, the MPT found that Dr Donadio’s misconduct was not isolated and had the potential to put patients at risk. The MPT noted Dr Donadio’s ‘lack of candour’ with the GMC and MPTS and that he chose to put his own interests above others and his duties as a doctor. Whilst the MPT noted a lack of repetition, they also acknowledged that Dr Donadio had been working outside of the UK. The MPT determined the conduct was remediable but that the doctor must develop insight before any such remediation could take place.

In finding impairment, the MPT noted Dr Donadio’s complete denials and that ‘it was more likely than not’ that he had failed to develop any insight, noting there had been no evidence presented as to insight or remediation and therefore remained a risk. The MPT found that even had this evidence been presented a finding of impairment was required to uphold public confidence and standards.
The MPT declined to direct the Doctor’s erasure, however, and instead determined to suspend his registration for 12 months.

The Panel were of the view that the failure to erase Dr Donadio fell outside the range of sanctions open to the MPT given the gravity of the misconduct. In that:

- Dr Donadio’s conduct was of the ‘utmost seriousness’ given that working in breach of the interim order imposed on his registration requiring supervision and to work at a level below that of a Consultant, posed a direct threat to patient safety;

- the dishonesty was particularly serious in this case, it was repeated and was for financial gain;

- Dr Donadio’s conduct demonstrated a disregard for his obligations to his regulator;

- there was no evidence of insight or remediation and it is noted that Dr Donadio’s communications can be described as ‘indignant’ and seeking to blame each of those appeals has been issued and served on the Doctors.

15 The appeal in Dr Haris’ case is currently listed for hearing on 29 April 2020. The others are still currently awaiting a hearing date.

16 In the previous update to Council, discussed at the September 2019 meeting, the Executive Panel had decided to exercise the right of appeal in three cases: Dr Saeed, Dr Zafar and Professor Walton.

16.1 The appeal in the case of Professor Walton was heard by the High Court on 5 December 2019. In a judgment handed down on 19 December 2019, Mr Justice Henshaw allowed the GMC’s appeal, on the grounds that the MPT misinterpreted the GMC’s case against Professor Walton and as a result failed to consider making further findings of dishonesty against Professor Walton. The case was therefore remitted back to the MPT for reconsideration in a proper construction of the allegation.

16.2 The appeal in the case of Dr Saeed was heard by the High Court on 21 January 2020. Mr Justice Murray reserved his judgment, which is currently still awaited.
16.3 The appeal in the case of Dr Zafar, which the PSA also joined as a party under s40B Medical Act 1983, was heard by the Divisional Court on 11 March 2020. Lord Justice Davis and Mr Justice Holgate reserved their judgment, which is currently still awaited.

17 The s40A Executive Panel has declined to issue an appeal in the other 14 cases, for the reasons set out in their decisions in each of the respective cases, copies of which were published on the GMC website in accordance with the GMC’s Publication and Disclosure policy.

18 Council is asked to note this update.
This annex sets out the s.40A Executive Panel decisions that were reached between the period 10 August 2019 and 31 March 2020.

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Doctor UID</th>
<th>S40A Executive Panel Meeting date</th>
<th>Appeal Issued?</th>
<th>Case/Allegation Type</th>
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<tbody>
<tr>
<td>Varadarajan</td>
<td>Sadagopan</td>
<td>3376629</td>
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<td>Norrish</td>
<td>Alan</td>
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<td>Haris</td>
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<td>Awan</td>
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<td>Simawi</td>
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<td>Zaccheddu</td>
<td>Renato</td>
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<td>Armstrong</td>
<td>Louise</td>
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<td>Mohamed</td>
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<td>Sait</td>
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<td>Udoye</td>
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<td>Sadler</td>
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<td>Donadio</td>
<td>Anthony</td>
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<td>Ramakrishnan</td>
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