Council Agenda

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

Thursday 24 February 2022

10:20 – 13:00: Main meeting

10:20 – 10:23 M1 3 mins Chair’s business

10:23 – 10:25 M2 2 mins Minutes of the meeting on 9 December 2021 and actions log

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

10:50 – 11:15 M4 25 mins Equality, diversity and inclusion - Annual progress report

11:15 – 11:30 Break

11:30 – 11:55 M5 25 mins Progress on MAPs

11:55 – 12:20 M6 25 mins GMP review: approval to consult on revised draft

12:20 – 12:40 M7 20 mins Education Quality Assurance update

12:55 – 13:00 M9 Any other business
5 mins

Below-the-line items*

M10 Report of the Executive Board 2021
M11 2023 Council and Committee planning
M12 Council 2022 forward work programme

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

### Main meeting
- **M2 - Minutes of the meeting on 9 December 2021 and actions log**
  - 3
- **M2a - Council actions log**
  - 14
- **M3 - Chief Executive’s Report**
  - 15
  - Annex A - Performance Annex
  - 23
  - Annex B - Corporate Opportunities and Risk Register
  - 39
- **M4 - Equality, diversity and inclusion - Annual progress report**
  - 43
  - Annex A - Annual ED&I progress report
  - 44
  - Annex B - Performance projections
  - 45
- **M5 - Progress on MAPs**
  - 46
- **M6 - GMP review: approval to consult on revised draft**
  - 53
  - Annex A - An annotated working draft of revised Good medical practice
  - 60
  - Annex B - A detailed summary of changes to the document
  - 61
  - Annex C - The intelligence and research underpinning the review
  - 62
  - Annex D - Engagement and consultation
  - 63
  - Annex E - Planning for implementation
  - 64
  - Annex F - Explanatory guidance in scope
  - 65
- **M7 - Education Quality Assurance update**
  - 66
  - Annex A - QA process diagrams
  - 77
  - Annex B - Enhanced monitoring activity
  - 82
- **M8 - Report of the Investment Committee 2021**
  - 90
  - Annex A - Statement of Purpose of the Investment Committee
  - 94
  - Annex B - Investment Policy
  - 97
- **M10 - Report of the Executive Board 2021**
  - 102
- **M11 - 2023 Council and Committee planning**
  - 107
  - Annex A - 2023 Council and Committee dates
  - 110
- **M12 - Council 2022 forward work programme**
  - 113
Draft at 17 December 2021

To approve

Minutes of the meeting held on 9 December 2021

Members present – via MS Teams
Carrie MacEwen, Acting Chair
Steve Burnett
Vanessa Davies
Anthony Harnden (from item 6)
Philip Hunt
Paul Knight
Deepa Mann-Kler
Raj Patel
Suzanne Shale
Alison Wright

Others present
Charlie Massey, Chief Executive and Registrar
Shaun Gallagher, 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 and Engagement
Neil Roberts, Director of Resources
Melanie Wilson, Head of Corporate Governance and Council Secretary
Council meeting, 24 February 2022

Agenda item M2 – Minutes of the meeting on 9 December 2021

Chair’s business (agenda item M1)

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

2 Council noted that apologies had been received from Anthony Harnden for part of the meeting, as he was attending a meeting of the Joint Committee on Vaccination and Immunisation.

3 Council noted that since the last meeting members had approved on circulation the appointment of Michael Jennings as a co-opted member of the Investment Committee for an initial period of four years from 17 November 2021.

Minutes of the meeting on 3 November 2021 (agenda item M2)

4 Council approved the minutes of the meeting on 3 November 2021 as a true record, subject to the amendment of paragraph 10(a) to read as follows: 'Remote care has been highlighted as a new way of working; public attitudes and experience of it have ranged from positive to extremely negative.'

Chief Executive’s Report (agenda item M3)

5 Council considered the Chief Executive’s Report.

6 The Chief Executive and other members of SMT gave oral updates. Council noted that:

   a Following the emergence of the Omicron variant of COVID-19 and changes to government advice, revised messaging about working from home was being put into place. The impact on operations, particularly the effect on Professional and Linguistic Assessments Board (PLAB) tests of restrictions on travel from particular countries was being assessed.

   b Conversations with stakeholders at the recent UK Advisory Forum meetings in Scotland, Wales and Northern Ireland had focused on psychological safety and we have listened to concerns from the front line about the fear of making mistakes. This theme has been incorporated into the Acting Chair’s message to the profession and the messaging around the State of Medical Education and Practice, due for publication the following week.

   c The merging of Health Education England (HEE) into NHS England will bring workforce planning into one place, but might also not allow HEE to maintain the same degree of independence of action in relation to withdrawing trainees when there are safety issues. We would continue to make such
decisions where it is the right thing to do, even if we had to act without HEE support.

d The meeting with the Minister of State for Health, Edward Argar MP, had been very positive, with the Minister emphasising the importance of maintaining international recruitment into the workforce and regulatory reform.

e With the Chief Executive of the Nursing and Midwifery Council (NMC), we have met Sir Gordon Messenger, who is carrying out a leadership review in health and social care. We will write jointly with the NMC setting out some ideas for the review to consider. Sir Gordon Messenger’s review covers similar ground to Sir Stuart Rose’s NHS leadership review from 2015, with the potential to address issues for clinicians at the mid-career point moving across into management, such as in relation to pay and pensions.

f The Department of Health in Northern Ireland has issued a consultation on mandatory COVID-19 and flu vaccination for new recruits to the health and social care workforce to which we will respond in similar terms to the consultation in relation to healthcare workers in England.

g The Contact Centre had experienced another difficult month in October, with only 33% of calls answered within the 20 second key performance indicator (KPI) target, an average wait time of 3 minutes and 34% of calls being abandoned. A large volume of calls had resulted from doctors getting locked out of their GMC Connect accounts along with the release of 14,500 PLAB places, even when the release of those places had been staggered over the course of one week.

h The number of calls handled by the Contact Centre in the first ten months of 2021 had been approximately 256,000, an increase of around 20,000 on the same period in 2020, with increases in emails and webchats also experienced.

i Reaccreditation by the Institute of Customer Service and continuing high levels of customer satisfaction have provided some reassurance about the quality of service.

7 During the discussion Council noted that:

a Metrics for the operational KPI for the Contact Centre would be reviewed and Council would be updated on the process for reviewing KPIs.
The percentage changes set out in the ‘Investing in our people’ slide of the performance annex would be updated to make it clearer where they refer to percentage point changes in future.

8 Council:

a Noted the Chief Executive’s report and oral updates.

b Noted the Performance and Corporate Opportunities and Risk Register annexes.

Draft Business Plan and Budget 2022 (agenda item M4)

9 Council received a paper setting out the draft Business Plan and Budget for 2022.

10 Council noted that:

a The budget includes a greater element of contingency to take into account uncertainty generally and risks around the pension scheme deficit and regulatory reform.

b The increase in the Annual Retention Fee of 3.1% was based on the September 2021 Consumer Price Index, in accordance with a previous Council decision.

c To ensure that the free reserves policy reflects changes in the size of the organisation, the paper proposes linking the target range directly to expenditure, expressed in percentage terms, setting a target range of free reserves between 20% and 35% of annual expenditure.

d In the earlier confidential session Council had received an oral update on the impact on the Staff Superannuation Scheme of salary inflation running slightly higher than expected rate. At the 2018 triennial valuation, lower salary growth assumptions were agreed with Trustees of the Scheme, with the GMC making a commitment to cover any additional projected shortfall on this element of the valuation. The Trustees of the Scheme had asked for a payment of £1 million in the current financial year to cover this agreement. The GMC’s advisers have agreed that this amount is due, and the payment was being recommended for Council approval.

11 During the discussion Council noted that: 
Agenda item M2 – Minutes of the meeting on 9 December 2021

a  To reduce the costs of the annual retention fee for doctors who were not working, options included temporarily relinquishing the licence to practise or the 50% discount scheme if their gross taxable income falls below the threshold, currently £32,000.

b  Work on an equality impact assessment for the new fees framework that will be needed following regulatory reform was getting underway, and that fees framework will require Council approval.

c  The Business Plan and Budget does not receive a lot of external scrutiny, however wider communications will cover how we are focusing our work.

d  Although ‘patient involvement and experience’ was proposed for removal as a corporate priority after 2021, a task and finish group was in place to embed patient and public involvement into our work.

12  Council:

a  Approved the Business Plan and Budget for 2022.

b  Delegated authority to the Chair of Council to amend the GMC Registration Fees Regulations and GMC Certification Fees Regulations.

c  Updated the reserves policy to set the target range of free reserves between 20% and 35% of annual expenditure.

d  Approved the payment of £1 million to the Trustees of the GMC Staff Superannuation Scheme.

Equality, diversity and inclusion update (agenda item M5)

13  Council received its regular update on equality, diversity and inclusion (ED&I), with a particular focus on progress as an employer to support our ED&I ambitions.

14  Council noted that:

a  All recruitment measures were showing improved performance, including more diverse representation at all stages of the recruitment process.

b  The performance measure on progression showed that staff from underrepresented ethnic groups were now more likely than white staff to progress.
c There has been some reaction from part of the workforce about the high pace of change and any colleagues who did not feel well informed have been engaged with. However, generally the profile of this work and engagement has been high across the organisation.

15 During the discussion Council noted that:

a Advice and guidance had been provided to support some individual recruiting managers to ensure that positive action does not cause any concerns about positive discrimination.

b The dedicated Resourcing Outreach role in the HR function referred to in the paper had not yet been recruited.

c Issues of intersectionality of protected characteristics would be addressed in the next ED&I update, at Council in February 2022.

d Work has started on removing the terms BAME and BME from usage to describe Black, Asian and other minority ethnic groups and our internal review will draw on the recent work of the NHS Health and Race Observatory.

16 Council noted progress against our ED&I ambitions.

Post-Brexit routes to registration (agenda item M6)

17 Council received a paper outlining the plans in place to ensure that our international routes to registration are updated and expanded in preparation for the expected end of the EU exit standstill period in December 2022.

18 Council noted that:

a The programme of work on post-Brexit routes to registration is one of our top three priorities for the coming year, particularly in the wider context of workforce supply.

b Doctors from the European Economic Area (EEA) have made up 12% of all applications to join the register during 2019 and 2020, and any changes to the trend will be closely monitored.

c We do not anticipate that any individual EU country will seek a national-level mutual recognition agreement (MRA) for qualifications other than a cross-
border route to registration on the island of Ireland to facilitate ad hoc or emergency cross-border working.

d Following our loss of access to the European Commission’s database to exchange information with EU regulators, we have continued to share information with overseas regulators but no longer receive information in return. We have alerted the government to the issue, which may have patient safety implications and continue to discuss potential access to data with individual regulators, although there are significant considerations relating to the General Data Protection Regulation.

e We also make the point to government about the risks associated with being bound to MRAs which could be inconsistent across different countries and what that could mean for patient safety.

19 Council noted:

a The programme of work for the coming 12 months.

b The key external dependencies that may impact on delivery of the work.

c The risks and the next steps in the programme.

Report of the MPTS Committee 2021 (agenda item M7)

20 Council received an update on the work of the Medical Practitioners Tribunal Service (MPTS) since the last report to Council in June 2021.

21 Council noted that:

a Progress was being made with addressing the accumulation of cases resulting from the pandemic, with 51% more hearing days taking place in September 2021 compared to September 2019 and an increase in capacity in October to allow 17 cases to take place concurrently. Ten additional staff have also been recruited. The plan is to return to pre-pandemic hearing volume levels by the end of 2022.

b Interim Orders Tribunals (IOT) have all been held virtually since the start of the pandemic. This arrangement has been almost universally well received by those involved and the intention is for IOTs to continue to take place virtually unless there are exceptional circumstances.
c Medical Practitioner Tribunal (MPT) hearings have been taking place in a mixture of in-person and virtual formats, with an emphasis on ensuring that no disadvantage results from whichever format is used. In-person MPT hearings have increased to around 60% by November 2021, although the situation is being kept under review.

d For virtual hearings, the support of the Doctor Contact Service has been expanded to help lessen the isolation and stress doctors might encounter when attending a hearing, particularly those attending hearings alone or without legal representation.

e The MPTS have commissioned the GMC’s Chief Statistician to analyse the outcomes of in-person and virtual hearings over the two-year period from March 2020 to March 2022.

f The MPTS was grateful to the GMC for the support received in addressing the backlog of cases, in terms of both advice and financially.

g A significant number of legally qualified chairs (LQC) had left their roles, mostly to take up salaried judicial roles, so an additional 50 LQCs were being recruited.

22 During the discussion Council noted that:

a Although most doctors were members of a medical defence organisation (MDO), reasons for doctors representing themselves include not agreeing with their MDO’s advice or being ineligible to be represented. The MPTS gives advice to self-represented doctors about pro bono legal services and other free advice.

b As a result of the Professional Standards Authority’s appeal against the MPT decision to grant voluntary erasure to Michael Watt, the MPTS would not be commenting on the case but will act on any learning points following the outcome.

c The MPTS Vision states that the service treats all tribunal service users with respect and fairness, so data in relation to that, including any the GMC collects in relation to the experience of patients and witnesses should be shared with Council.

23 Council noted the report of the MPTS Committee.
Report of the Audit and Risk Committee 2021 (agenda item M8)  
24 Council received a report summarising the work of the Audit and Risk Committee since it last reported to Council in June 2021.

25 Council noted that:

  a Since the last report to Council membership of the Committee had changed as a result of the sad death of Lara Fielden, the retirement of Liz Butler as a co-opted member and the appointment of Jon Hayes as a co-opted member.

  b The Committee was grateful to staff supporting the work of the Committee and for Council members and others who had contributed to the Committee’s effectiveness survey.

  c Council should feel reassured about the strength of the system of risk management; and the absence of any red assurance ratings among the audit reviews indicate that the GMC is a well-run organisation. Any relevant issues would be signposted to Council when necessary.

  d There is an increasing risk of cybersecurity threats.

  e Council members are welcome to attend meetings of the Committee.

26 During the discussion Council noted that:

  a Council members would like to see the internal audit programme ahead of being signed off by the Committee.

  b The internal audit function has been looked at and there is now a mix of one-off audits and an ongoing advisory approach where appropriate, such as in relation of regulatory reform.

  c Audit work has just started on two externally-focused ED&I targets, and risks around the dividing line between positive action and positive discrimination is being kept under review.

27 Council:

  a Noted the report and the assurance provided by the work of the Committee.

  b Approved the changes to the Committee’s Statement of Purpose.
Report of the Remuneration Committee 2021 (agenda item M9)

28 Council received a report summarising the work undertaken by the Remuneration Committee in 2021.

29 Council noted that the Committee’s work during 2021 included:

   a An emergency meeting to handle arrangements for Clare Marx stepping down as Chair of the GMC, interim arrangements and planning the appointment process for a new Chair.
   
   b The pay award for the Chief Executive, Directors and Chair of the MPTS.
   
   c Succession planning, including for the Chair of the MPTS, who stands down at the end of 2022.
   
   d The Committee is grateful to Carrie MacEwen for taking on the Acting Chair role and to the Chief Executive and Council Secretary for supporting the Acting Chair during this period.

30 Council:

   a Noted the report.
   
   b Approved the changes to the Committee’s Statement of Purpose.

Compliments and complaints report (agenda item M10)

31 Council received the twice-yearly report on customer complaints and compliments.

32 Council noted that:

   a There had been 40% fewer complaints than in the previous six-month period.
   
   b Compliments received had been mostly in relation to how helpful the Contact Centre had been.
   
   c In relation to the 64 complaints which featured an element of ED&I or Equality Act issues, we were satisfied in each case that the complainant had been dealt with as their comparator would have been and there was no evidence of discrimination.
33 During the discussion Council noted that:

a Council would be provided with the percentage split of doctors and patients at the three stages of complaint in future reports

b The Corporate Review Team would consider what they can learn from liaison with other regulators in relation to complaints.

34 Council noted the review of customer complaints and compliments.

Any other business (agenda item M11)
35 Council noted that members would next meet at the Regulatory Reform workshop on 11 and 12 January 2022 and the next Council meeting will be on 23 and 24 February 2022.

Council forward work programme 2022 (agenda item M12)
36 Council noted the 2022 work programme.

Report of the GMC Pension Plan Management Board 2021 (agenda item M13)
37 Council welcomed the report on the GMC’s defined contribution pension plan as an important update for Council to receive each year.

38 Council noted the Report of the GMC Pension Plan Management Board.

Confirmed:

Carrie MacEwen, Acting Chair 24 February 2022
## GMC Council - Actions arising from meetings

Last updated: 09/02/2022

<table>
<thead>
<tr>
<th>Action</th>
<th>Director responsible &amp; lead for action</th>
<th>Status</th>
<th>Due date</th>
<th>Action update</th>
<th>Date last updated</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>8 and 9 December 2021</strong></td>
<td></td>
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<tr>
<td>M3 - Chief Executive’s Report - Operational key performance indicators for the Contact Centre to be reviewed and Council to be updated on how and when KPIs are reviewed.</td>
<td>Una Lane Rob Scanlon</td>
<td>Completed</td>
<td>14-Dec-22</td>
<td>We do not (yet) have a system that can report on customer experience/satisfaction measures so will continue reporting the 80% of calls against 20 seconds (industry standard benchmark) and supplement with average call wait times and abandonment rate. We have added a clearer description of the volumes of overall activity.</td>
<td>09-Feb-22</td>
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<td>In progress</td>
<td>14-Dec-22</td>
<td>Broader review to of KPIs to be included in business plan and priority setting in December within the constraints of current system capability. For full review following reg reform changes.</td>
<td>14-Feb-22</td>
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<td>M7 - Report of the MPTS Committee 2021 - The GMC and MPTS's feedback from doctors, witnesses and patients on the RP process to be shared with Council.</td>
<td>Anthony Omo &amp; Gavin Brown</td>
<td>In progress</td>
<td>30-Jun-22</td>
<td>Summary of complainant/witness journey from initial complaint to hearing/post-hearing in terms of support and obtaining feedback being drafted.</td>
<td>16-Dec-21</td>
</tr>
<tr>
<td>M10 - Compliments and complaints report - Council to be provided with the percentage split of doctors/patients at the three stages of complaint in future reports, and comparisons with complaints and compliments received by other regulators.</td>
<td>Charlie Massey Jennifer Broadley</td>
<td>In progress</td>
<td>3-Nov-22</td>
<td>Any lessons learned from other regulators to be included in the next report but direct comparisons are not possible due to unique nature of the data sets across each regulator.</td>
<td>13-Dec-21</td>
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This report outlines developments in our external environment and progress on our strategy since Council last met. Key points to note:

- The increase in COVID-19 cases meant we took the decision to cancel PLAB 2 exams in January and February due to the need for examiners to prioritise their clinical commitments. We have offered places in February to 800 candidates who had already travelled to the UK at the time of cancellation, or who had a job offer or a place in training.

- We have updated our COVID-19 guidance to decision makers to reassure the profession that we will take the prolonged nature of the pandemic into account if concerns are raised.

- We submitted a response to the Health and Social Care Select Committee inquiry on workforce, highlighting the importance of compassionate, inclusive cultures and sharing data from *The state of medical education and practice*, which was published in December 2021.

<table>
<thead>
<tr>
<th>Decision trail</th>
<th>Council receives this report at each full meeting.</th>
</tr>
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</table>
| Recommendations | a  To consider the Chief Executive’s report.  
                 b  To note the Performance Annex and the Corporate Opportunities and Risk Register. |
| Annexes         | Annex A: Performance Annex  
                 Annex B: Corporate Opportunities and Risk Register |
| Author contacts | Iona Twaddell, Head of the Office of the Chair and Chief Executive  
                 Any enquiries to: GovernanceTeamMailbox@gmc-uk.org |
| Sponsoring director/Senior Responsible Owner | Charlie Massey, Chief Executive |
Pandemic response

PLAB

1 In response to the Omicron COVID wave leading to an increasing number of infections and limited availability of medical examiners who needed to prioritise clinical work, Executive Board took the difficult decision in December 2021 to cancel PLAB 2 tests scheduled for January and February 2022. This allowed us to prioritise places in February for candidates who had already travelled to the UK at the time of cancellation, or who had a job offer or a place in training, as we reopened our clinical assessment centre on a limited basis.

2 We were able to offer places in February to around 800 of the 2,600 candidates who had a test previously scheduled. We also offered places to around 350 candidates who are already UK residents for tests throughout March, April, May and June. Any candidates that did not meet our priority criteria had the opportunity to secure a place between July and October from the point we announced the cancellations.

3 We also worked with the Department of Health and Social Care and UK Visas and Immigration about what exceptional assurance could be provided to allow candidates whose visas were due to expire imminently to complete their test in February. We offered letters of support to those who wanted to apply for a visa extension and for those who are interested in applying for clinical placements while they wait for their test.

4 Having increased our PLAB 2 capacity by investing in new facilities and additional staffing last year, we registered over 12,000 doctors from outside of the UK in 2021 alone. We continue to register 250 international medical graduates each week and expect to offer around 15,000 PLAB 2 places this year which is a new record. We are determined to maintain the supply of doctors into the UK and hope to resume normal PLAB 2 capacity in March 2022, providing it is safe and practical to do so.

Supporting the medical profession

5 We know that the ongoing pandemic is putting enormous pressure on medical professionals. We are doing what we can to reassure the profession that the context in which they are working will be taken into account if any issues are raised to us.

6 On 18 January, we published updated COVID-19 guidance for our fitness to practise decision makers. We published the guidance earlier in the pandemic to
help ensure they fully take the context of the emergency into account when they are assessing complaints about doctors.

7 While the majority of the guidance remains unchanged, we have added new advice to reflect the sustained nature of the pandemic and the enhanced impact this can have on fatigue, the availability of resources and workforce shortages. We stress the importance of considering concerns fairly and proportionately to the circumstances, while protecting patient safety and maintaining standards.

8 On 8 December 2021, we also reiterated our joint statement with other healthcare professional regulators to highlight that we know that registrants will be making difficult decisions around care provision in very challenging circumstances, and that context is understood and will be considered by regulators.

Investigations

9 We have taken a flexible and proportionate approach to our investigations during the pandemic but have continued to act when necessary to protect patients or in the public interest. We continue to do all we can to progress our investigations, but we know that some employers and doctors will take longer to assist us (as witnesses or experts or by providing information), given the ongoing pressures on the NHS.

10 Pandemic-related delays to third party processes, such as investigations by the police or employers, and proceedings in the criminal or coroner’s court, also impact our ability to progress investigations. That means some cases will progress more slowly for the time being and that the age profile of our investigations has increased. We are currently undertaking an external legal review of cases that are over two years old and have not reached a case examiner decision, to consider if they are impacted by an ongoing employer process and whether we should close our investigation until that process has concluded.

Education and training

11 We have worked collaboratively with education bodies, royal colleges and faculties through the pandemic to consider flexible changes to medical education and assessment. This approach has been underpinned by our established principles for education, which focus on patient safety and maintaining standards whilst being proportionate.
12 We understand that the impact of omicron has been largely felt in the cancellation of electives, and therefore the loss of training opportunities, rather than in active redeployment, but that this has had an effect particularly on top of previous missed training opportunities. The redeployments have been limited, and this raises the hope that some ground can be made up as the wave subsides. We are working with statutory education bodies to understand the scale of the issues and are looking to review derogations as well as considering the case for further changes.

Vaccination as a condition of deployment

13 The Government is consulting on revoking the regulations that make vaccination against COVID-19 a condition of deployment for health and social care workers in England, based on the latest emerging evidence. We have reviewed and updated our advice for doctors on vaccinations accordingly. The Secretary of State for Health and Social Care, Sajid Javid, wrote to professional regulators asking us to work with professional leaders in the United Kingdom and devolved governments to ensure that our current guidance on vaccination, and particularly vaccination for Covid, sends a clear message to registrants about their personal professional responsibilities in this regard.

14 Our position remains that doctors have a professional duty to protect patients from risks posed by their health, and to be immunised against common serious communicable diseases, unless contraindicated. We have released a joint statement with the Academy of Medical Royal Colleges to highlight this. We have also emphasised that being a good doctor means more than simply being a good clinician. Doctors can provide leadership to their colleagues and vision for the organisations in which they work and for the profession as a whole. Whether or not vaccination is required as a condition of deployment, it continues to be one of the most effective ways to protect patients, staff and the health service itself.

Offices

15 As of 27 January 2022, colleagues in our Manchester and London offices can return to working in the office on a voluntary basis. We have maintained our safety measures, so colleagues are asked to wear a face covering when not at their desk and to maintain social distancing of 1m+. Arrangements vary across the four countries of the UK, so we are working with our National Offices on arrangements for offices in Scotland, Wales and Northern Ireland. We are continuing to engage with colleagues on our longer-term approach, which we expect to implement after Easter.
Regulatory reform

16 We continue to liaise with DHSC on the drafting of the new legislation and are working through policy issues across a range of areas. We are hoping to see a full and settled draft this spring. The timetable remains under review and we will keep Council updated.

State of medical education and practice 2021

17 *The state of medical education and practice 2021 report* was published on 15 December 2021. The report looks at how the pandemic and the recovery of services are affecting doctors’ working environments and medical practice. It explores the experiences of those undertaking and delivering postgraduate training and the factors influencing the shape of the medical workforce. The final chapter focuses on learnings that we hope the UK health services can use in their work to support doctors and patient care.

18 The report highlighted that the pandemic has had the effect of pressing ‘fast-forward’ on what was already a precarious situation for healthcare staff. Doctors have continued to perform with distinction, but the research paints a worrying picture of rising burnout and growing workloads. The report emphasised the importance of a renewed focus on ensuring workplaces in our health services are inclusive and compassionate, particularly during such a challenging time.

A sustainable medical workforce

19 In January, we submitted evidence to the Health and Social Care Select Committee inquiry on workforce. Our evidence highlighted the importance of making the health services a better place to work for all staff, culture and leadership and that retention for the workforce is a priority for employers. We also noted the importance of addressing the disparate experience of ethnic minority doctors and that employers will need to plan to make the best use of newly regulated professions such as physicians associates and anaesthesia associates.

20 In December 2021, we also submitted evidence to the Health and Social Care Select Committee’s inquiry into the Future of General Practice. Our evidence highlighted the findings from *The state of medical education and practice*, which showed higher burnout levels for GPs. We also emphasised the importance of compassionate, inclusive working environments and leadership, as well as the importance of considering how best to incorporate physician associates into the GP workforce.
Council meeting – 24 February 2022
Agenda item M3 – Chief Executive’s Report

Legislation

21 The Health and Care Bill is now passing through the House of Lords. We provided medically qualified peers and those interested in our work with a briefing note ahead of the Second Reading, with a further detailed briefing on key amendments during the Committee Stage. We focussed on a probing amendment around the provisions on the new Secretary of State powers to remove a profession from regulation and abolish regulators, amendments proposing the creation of a separate register for cosmetic surgery and on proposals for the GMC to hold the conflict of interests register. The Minister, Lord Kamall, did not accept the amendments on a separate register and reaffirmed the government’s commitment to regulatory reform and the importance of consultation before making changes to the regulatory landscape. In responding to the cosmetic surgery register amendment, the Minister acknowledged the work of the GMC in developing credentials in this area.

22 Following our engagement with Peers, the Minister and Home Office officials, we were successful in securing changes to the Police, Crime, Sentencing and Courts Bill. The Government acknowledged our concerns about the impact of the Serious Violence Duty provisions within the Bill on patient confidentiality and brought forward amendments to protect this.

23 The Professional Qualifications Bill continues through the House of Commons. We secured a series of amendments to the Bill in the Lords that reaffirm the autonomy of regulators over their registers and commit to consultation with regulators before any secondary legislation is proposed, and acknowledgement of the importance of engaging with regulators on the negotiation of trade agreements. We briefed MPs on the amended Bill and provided written evidence to the public bill committee in the Commons.

Inquiries and reviews

Maternity inquiries

24 We continue to engage with a number of inquiries into maternity care failings. These include the Independent Investigation into East Kent Maternity Services which we are giving evidence to in interview form this Spring. We have been engaging with the Ockenden review into maternity services at Shrewsbury and Telford Hospital NHS Trust, but due to issues with their information governance arrangements were unable to disclose the information we had compiled. We understand that the review intends to publish its report in the coming weeks without this information.
Inquiry publications

25 We await the publication of the Independent Neurology Inquiry in Northern Ireland. This has been reviewing the circumstances surrounding the Belfast Health and Social Care Trust’s recall of neurology patients following concerns about the clinical practice of Michael Watt, with a focus on local clinical governance processes and complaints handling. We anticipate recommendations for the GMC and will brief Council about this inquiry and any recommendations for us in advance of publication.

26 The Independent review into West Suffolk Hospital NHS Foundation Trust published its report on 9 December 2021, which contained an advisory recommendation for the GMC.

Key implementation activity

27 We continue to support DHSC with the implementation of the Paterson Inquiry’s recommendations following the recent publication of their full response.

28 We continue to engage with DHSC on the implementation of Recommendation 8 of The Independent Medicines and Medical Devices Safety Review on conflicts of interest and will shortly be joining two recently established DHSC working groups to discuss how an employer-led approach should be implemented and monitored across all four countries.

Operational performance

29 The report at annex A details performance against our KPIs and the rationalised set of priorities, agreed in the Business Plan approved by Council in December 2021. Uncertainty over legislative timeframes is the primary driver of exceptions in our change priorities. This year there have been no changes to our KPIs but going forward it is our intention to routinely review our performance measures at the same point Council approve the business plan.

30 Our missed service target for the Contact Centre in November and December last year was driven in part due to the decision to cancel PLAB 2 for January and February, which led to an increase in call volumes during a period of sickness absence and annual leave. Annex A now includes additional data on Contact Centre timeliness, including the average call wait time and abandonment rate. In addition, the Corporate Opportunities and Risk Register, at Annex B, includes a new risk (threat) on safeguarding as escalated to the January Audit and Risk Committee meeting.
Executive Board

31 The Executive Board met on 20 December 2021 and 31 January 2022 to consider items on:

a The regular Performance and Risk Report, providing a high-level report on performance, including finance and people, customer service and learning, and updates on the key risks to achieving our strategic aims.

b A deep dive on risks relating the Medical Practitioners Tribunal Service (MPTS) to consider the extent to which individual board members are confident that the management of MPTS-level risks provide sufficient assurance to the Board collectively.

c The cancellation of scheduled PLAB 2 tests in January and February 2022 in response to the impact of increasing numbers of cases of the Omicron variant of COVID-19, with UK-based candidates and those with jobs prioritised for the restart.

d The approach for applying the 2022 pay award.

e Progress on the review of *Good medical practice*, ahead of the update given to Council at this meeting.

f The outcome of scoping work and next steps for the sex, gender and gender identity project, ahead of Council receiving an update, now scheduled for the June 2022 meeting.

g The draft Executive Board report to Council, ahead of consideration by Council at this meeting.
M3 – Annex A
Performance annex

Data presented as at 31 December 2021 (unless otherwise stated)
## Operational Key Performance Indicator (KPI) – since last report to Council

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Nov</th>
<th>Dec</th>
<th>Exception commentary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decision on 95% of all registration applications within 3 months</td>
<td>96%</td>
<td>96%</td>
<td></td>
</tr>
<tr>
<td>Decision on 95% of all revalidation recommendations within 5 working days</td>
<td>98%</td>
<td>98%</td>
<td></td>
</tr>
<tr>
<td>Respond to 90% of ethical/standards enquiries within 15 working days</td>
<td>100%</td>
<td>97.5%</td>
<td></td>
</tr>
<tr>
<td>Conclude 90% of fitness to practise cases within 12 months</td>
<td>93%</td>
<td>92%</td>
<td></td>
</tr>
<tr>
<td>Conclude or refer 90% of cases at investigation stage within 6 months</td>
<td>95%</td>
<td>96%</td>
<td></td>
</tr>
<tr>
<td>Conclude or refer 95% of cases at the investigation stage within 12 months</td>
<td>95%</td>
<td>95%</td>
<td></td>
</tr>
<tr>
<td>Commence 100% of Investigation Committee hearings within 2 months of referral</td>
<td>No cases</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Commence 100% of Interim Order Tribunal hearings within 3 weeks of referral</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>
| 2019/20 Income and expenditure [% variance +/- 2%] | 2.5% | 2.65% | **Finance**

The finance KPI is red as the cumulative variance between income and expenditure is 2.65%. Income is under budget due holding fewer PLAB 2 days than planned & also the cancellation of some PLAB 1 places in May. Expenditure is under budget as the variable costs linked to PLAB 2 days have been removed, we expect fewer hearing days and associated legal costs then budgeted, there is lower activity than planned in a number of areas, including staff expenses, as a result of additional lockdown restrictions and there is a higher level of vacancies now forecast than assumed in budget.

| Organisation | 2019/20 Income and expenditure [% variance +/- 2%] | 7.9% | 8.2% |
| Rolling twelve month staff turnover within 8-15% | | |
| IS system availability (%) – target 98.8% | 99.6% | 100% |
| Monthly media score | 162 | 115 | |

**Staff Turnover**

Staff turnover has been progressively increasing over the past 11 consecutive months. While it is in the bounds of what we would expect, continued increases may potentially create issues for us.
## Performance Indicators – Making every interaction matter

### Contact centre operations

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Answer 80% of calls within 20 seconds (KPI)</strong></td>
<td>57%</td>
<td>83%</td>
<td>80%</td>
<td>89%</td>
<td>83%</td>
<td>78%</td>
<td>68%</td>
<td>71%</td>
<td>48%</td>
<td>33%</td>
<td>57%</td>
<td>60%</td>
</tr>
<tr>
<td><strong>Answer 90% of emails and letters (enquiries and updates) within 4 working days</strong></td>
<td>82%</td>
<td>89%</td>
<td>96%</td>
<td>97%</td>
<td>92%</td>
<td>87%</td>
<td>80%</td>
<td>84%</td>
<td>59%</td>
<td>50%</td>
<td>53%</td>
<td>91%</td>
</tr>
<tr>
<td><strong>Average wait time (calls – seconds)</strong></td>
<td>87</td>
<td>19</td>
<td>26</td>
<td>17</td>
<td>21</td>
<td>34</td>
<td>44</td>
<td>57</td>
<td>96</td>
<td>221</td>
<td>61</td>
<td>73</td>
</tr>
<tr>
<td><strong>Abandonment rate</strong></td>
<td>14%</td>
<td>3%</td>
<td>5%</td>
<td>3%</td>
<td>3%</td>
<td>5%</td>
<td>6%</td>
<td>9%</td>
<td>15%</td>
<td>34%</td>
<td>9%</td>
<td>11%</td>
</tr>
</tbody>
</table>

The KPI to answer 80% of calls within 20 seconds has now been missed since June 2021. In November and December we answered 57% and 60% of calls within 20 seconds. The miss in December was contributed to by our decision to cancel PLAB 2 for January and February, which led to an increase in call volumes. This had a particular impact given sickness absence (in part due to Covid-19) and because of planned annual leave over the Christmas period. On a positive note, we managed to meet our KPI for responding to emails and letters through a combination of overtime and colleagues in the CAC team handling the majority of PLAB 2 related correspondence. Abandonment rates fluctuated throughout the month, rising when volumes increased after PLAB communications went out, but averaged at a total of 11% in December.

The performance challenges being experienced reflect a series of one-off events that drive significant contacts (systems upgrade, PLAB 1 release, PLAB 2 cancellations, temporary emergency registration communications) which compounds pressures from an underlying higher volume of activity across all channels.

- **Calls**
  - In 2021 we took c.184,000 calls compared to 161,000 in 2020 reflecting a 15% increase year on year.
  - For October-December we received 48,000 calls compared to 38,000 for the same period in 2020 (a 26% increase).

- **Correspondence**
  - In 2021 we answered 131,000 emails and letters compared to 119,000 in 2020 reflecting a 10% increase year on year.
  - For October-December we processed 32,000 emails and letters compared to 23,000 in the same period of 2020 (a 39% increase)

- **Web messaging**
  - In 2021 we dealt with 65,000 webchats, compared to 51,000 in 2020. For October-December webchat volumes decreased and are not comparable because we made the decision to turn this channel off for extended periods so we could focus on other channels.

The categorisation of queries show high volumes of contacts from International Medical Graduates, GMC Online based issues, and Fees queries, as well as questions about PLAB. In light of increasing volumes, a bid has been put forward to the February planning gateway for additional resource to give the team more resilience, and the capacity to engage in ongoing training and development.
## Operational Key Performance Indicator (KPI) – 12 month performance summary 2021

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Operations</strong></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decision on 95% of all registration applications within 3 months</td>
<td>97%</td>
<td>97%</td>
<td>92%</td>
<td>98%</td>
<td>99%</td>
<td>99%</td>
<td>98%</td>
<td>97%</td>
<td>97%</td>
<td>96%</td>
<td>96%</td>
<td>96%</td>
</tr>
<tr>
<td>Decision on 95% of all revalidation recommendations within 5 working days</td>
<td>99%</td>
<td>100%</td>
<td>99%</td>
<td>98%</td>
<td>98%</td>
<td>97%</td>
<td>99%</td>
<td>98%</td>
<td>98%</td>
<td>98%</td>
<td>98%</td>
<td>98%</td>
</tr>
<tr>
<td>Respond to 90% of ethical/standards enquiries within 15 working days</td>
<td>98.7%</td>
<td>98.3</td>
<td>96.5%</td>
<td>97.7%</td>
<td>100%</td>
<td>100%</td>
<td>96.1%</td>
<td>100%</td>
<td>94%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Conclude 90% of fitness to practise cases within 12 months</td>
<td>91%</td>
<td>89%</td>
<td>93%</td>
<td>89%</td>
<td>92%</td>
<td>93%</td>
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<td>91%</td>
<td>95%</td>
<td>93%</td>
<td>92%</td>
</tr>
<tr>
<td>Conclude or refer 90% of cases at investigation stage within 6 months</td>
<td>95%</td>
<td>94%</td>
<td>91%</td>
<td>95%</td>
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<td>96%</td>
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</tr>
<tr>
<td>Conclude or refer 95% of cases at the investigation stage within 12 months</td>
<td>95%</td>
<td>92%</td>
<td>96%</td>
<td>93%</td>
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<td>95%</td>
<td>95%</td>
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<tr>
<td>Commence 100% of Investigation Committee hearings within 2 months of referral</td>
<td>100%</td>
<td>No cases</td>
<td>No cases</td>
<td>No cases</td>
<td>100%</td>
<td>No cases</td>
<td>100%</td>
<td>No cases</td>
<td>100%</td>
<td>No cases</td>
<td>100%</td>
<td></td>
</tr>
<tr>
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<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>92%</td>
<td>100%</td>
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<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>

| **Organisation** |      |      |      |      |      |      |      |      |      |      |      |      |
| 2019/20 Income and expenditure [% variance +/- 2%] | 4.81%| 3.53%| 4.40%| 4.03%| 3.16%| 2.78%| 2.63%| 3.81%| 2.76%| 2.80%| 2.5% | 2.65%|
| Rolling twelve month staff turnover within 8-15% | 3.3% | 3.6% | 4%   | 4.5% | 4.6% | 5.2% | 6.2% | 6.8% | 6.8% | 7.5% | 7.9% | 8.2% |
| IS system availability (%) – target 98.8% | 99%  | 99.97%| 99.99%| 99.98%| 100% | 100% | 99.97%| 99.99%| 99.91%| 99.45%| 99.6%| 100% |
| Monthly media score | 217  | 282  | 1963 | 43   | 175  | -152 | 757  | 182  | 544  | 1016 | 162  | 115  |
| Answer 80% of calls within 20 seconds | 57%  | 83%  | 80%  | 89%  | 83%  | 78%  | 68%  | 71%  | 48%  | 33%  | 57%  | 60%  |
Corporate Strategy Delivery – Priority activities forecast February - December 2022 investment (project team resource)

These estimates include the immediate-project team time cost to deliver against our key priorities. This helps us to better quantify the relative size of our commitments and inform prioritisation decisions against their expected impact.

The estimated values on this slide and the next reflect 2022 estimated time-cost of project teams only. They do not account for all associated costs (such as communications support or outreach teams) though we intend to improve our practice on an ongoing basis, which we also expect to improve workload management.
Corporate Strategy Delivery – Priority activities forecast February – December 2022 investment (project team resource)

**Developing a Sustainable Workforce**
- MLA 1,564,000
- C-19 - Recovery response 774,000
- Post-Brexit registration programme 439,000

**Enabling professionals to provide safe care**
- Fair training cultures 175,000
- SPUP PMO 42,000
- Fairer employer referrals 10,000
- GMP 611,000

**Making every interaction matter**
- Regulatory fairness programme 119,000
- C-19 recover response 55,000

**Investing in our people**
- Regulatory reform 4,654,000
- Investing in our people 315,000
## Enabling professionals to provide safe care

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

### 2021-23 Priority activities

<table>
<thead>
<tr>
<th>2021-23 Priority activities</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Review of Good medical practice</strong></td>
<td><strong>Why:</strong> Want to make sure our standards for professions we regulate reflect current patient and public expectations – and that our approach to embedding those with the profession maximises their relevance and application to care. <strong>When:</strong> Complete by Q3 2023 <strong>Who:</strong> Colin Melville; Mark Swindells</td>
</tr>
<tr>
<td><strong>Faireer Employer referrals</strong></td>
<td>We are finalising a draft version of the guidance to submit to consultation, as well as finalising the consultation narrative and questions for the main survey. A separate Council agenda item refers.</td>
</tr>
<tr>
<td><strong>Faireer training cultures</strong></td>
<td><strong>Why:</strong> To eliminate differentials in employer fitness to practise referrals <strong>When:</strong> by 2026 <strong>Who:</strong> Anthony Omo</td>
</tr>
<tr>
<td></td>
<td>RO referral form changes have now been implemented. Outreach met with approximately 90% of the designated bodies identified as having referral data indicating disproportionality. Work continues to develop feedback mechanisms with Responsible Officers on triage and Case Examiner decision outcomes. To support the delivery of the NHS England People Plan workstream titled ‘Tackling the disciplinary gap’, work underway with NHS Resolution to draft a shared narrative. Narrative reviewed by Comms colleagues in Jan 2022. Work to review how we deal with employer referrals and development of training to assist Assistant Registrars to counteract bias is underway. Training to be delivered Q1 2022.</td>
</tr>
<tr>
<td></td>
<td><strong>Why:</strong> To deliver on our commitment to eliminate discrimination, disadvantage and unfairness for all index measures of fair medical education and training pathways. <strong>When:</strong> September 2031 <strong>Who:</strong> Colin Melville</td>
</tr>
<tr>
<td></td>
<td>We have now published a breakdown of the trainer population by demographic characteristics within the SOMEPE data tables. This will assist Deaneries develop their Action Plans. Quantitative evaluation of the psychiatry exam interventions continues to indicate positive results for those attending, and suggests potential for reducing differential attainment. Funding has been agreed for three of these courses to run in 2022, to confirm findings and provide Edge Hill university with data for the qualitative analysis. We have agreed with the AoMRC to run a joint workshop for colleges in spring. Engagement meetings have been held with the Royal College of Surgeons England (Development of a college action plan to address attainment gap), Royal College of Psychiatry (Review of Curricula Programme of Assessment in the context of FTC), the HEE Y&amp;H EDI Lead (Recruitment and Selection), and the UKFPO Directors Forum to present an overview of this work.</td>
</tr>
</tbody>
</table>

*All projects reporting green unless stated*
Developing a sustainable medical workforce

- We work with workforce organisations to support more professionals who meet the required standards to join and remain in the UK medical workforce.
- Education and training are relevant, accessible and supportive, giving all professionals the skills they need to better meet future patient needs.
- Training for the medical workforce is more flexible, throughout their careers.

<table>
<thead>
<tr>
<th>2021-23 Priority activities</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Introducing the medical licensing assessment</strong></td>
<td>Discussions with medical schools and the Medical School Council (MSC) are ongoing, subject to directions, of a proposal for a university-led applied knowledge tests (AKT). Work has begun on monitoring Council’s directions, and regular meetings of the joint oversight group required by Council have started. Engagement is now moving into the details of the piloting stage, and how medical schools will demonstrate that they can meet the GMC’s requirements for compliant AKTs and clinical and professionals skills assessments (CPSAs). The programme is currently on track against agreed plans, but anticipates a resource gap over the next few months due to vacancies and recruitment lead times. The complex task of assuring that all AKTs and CPSAs meet the GMC’s standards and requirements has begun. Intensive and useful CPSA engagement sessions are underway, which begin the formal process for assessing schools’ CPSAs are compliant.</td>
</tr>
<tr>
<td><strong>Why?</strong> Want to give patients greater confidence that they will receive a consistent level of core knowledge, skills and behaviours from any doctor practising in the UK. UK medical schools will deliver the Assessment embedded within final exams for a UK medical degree, overseen and regulated by us, and we will administer the assessment for IMG doctors. <strong>When:</strong> Q4 2025 <strong>Who:</strong> Colin Melville; Judith Chrystie</td>
<td></td>
</tr>
<tr>
<td><strong>Post-Brexit registration pathways</strong></td>
<td>The overall status is amber. There remains a high degree of uncertainty about the timeframes for delivery and we remain in close dialogue with DHSC. DHSC have confirmed their plan that the PMET Order amendments will not be included in the end of standstill s60, and instead will be progressed as a standalone rules change. This means it won't be included in DHSC’s Brexit consultation, and instead will require us to engage with stakeholders to feed into an explanatory memorandum. We are updating our engagement plans accordingly. They are also exploring whether the legislative changes needed for the EFTA trade deal and cross border solution on the island of Ireland will also be separated from the end of standstill s60, as well as what the review by the Secretary of State (currently specified in the Medical Act) may entail. The board agreed to pause the MRA framework project following the Professional Qualifications Bill progressing through the House of Lords. The wording of the Bill means that it is now unlikely that we will be given powers to develop MRAs in the short term.</td>
</tr>
<tr>
<td><strong>Why?</strong> To ensure we have efficient and effective routes for skilled professionals to gain registration and maximise the number of skilled doctors available to the UK medical workforce. To start, we will expand our Clinical Assessment capacity for international medical graduates to respond to Covid and manage the UKs post-Brexit registration approach for EU professionals. <strong>When:</strong> Q4 2022 <strong>Who:</strong> Una Lane; Kirstyn Shaw</td>
<td></td>
</tr>
</tbody>
</table>
# Making every interaction matter

## Regulatory Reform and MAPs

**Why?** To improve the design and delivery of our functions so that we can be more responsive to the changing needs and expectations of patients, the health system, and the professions. To expand the medical workforce and the contribution by our professionals to quality patient care, while continuing to safeguard patients. We will deliver equivalent statutory functions across MAPs and doctors.

**When:** Changes for MAPs to come into effect summer 2023, remaining changes to be implemented by Q4 2024.

**Who:** Shaun Gallagher; Tim Aldrich for Regulatory Reform; Una Lane; Clare Barton

For MAPs.

The overall status is amber.

We continue to meet regularly with DHSC to review the timetable, but are yet to see a full and settled draft of the new legislation and have concerns that we will not see this by end of January (which is the deadline we are currently working to). There is also a risk that Covid 19 may affect the current timetable, either because staff are off unwell, or because DHSC prioritise their resource to support their pandemic response. We have a meeting with DHSC on 19 Jan to discuss unresolved policy issues and we will be holding a stock take meeting in February to review the feasibility of current milestones.

MAPs is amber to reflect uncertainty over the timescale and the need for additional funding from DHSC. We have updated our programme plans for the revised delivery date of Summer 2023, but current progress with legislative drafting suggests this may be ambitious. We have submitted revised financial requirements to DHSC including a significant increase in the budget for 2022/23: in addition to incurring project costs for longer, we will receive no fee income in this year as had originally been forecast. We await a response from DHSC on this.

## Regulatory Fairness

**Why?** We are focussed on making fairness central to our work and we’re reviewing the fairness and transparency of high-stakes decision we make

**When:** September 2022

**Who:** Shaun Gallagher

The overall status is amber.

The procurement process for the expert review of our fairness audit approach (the assurance stocktake) did not attract any appointable suppliers. We are seeking feedback from prospective suppliers to understand why they did not tender for the work and based on that feedback will revisit our approach. Unlike other activity in the review, this has few consequent dependencies so the impact is primarily to timelines for end-delivery but this is a set-back in our preferred timeframes for learning and improving our approach.

The remainder of the work is being delivered to schedule. The first Regulatory Fairness Review Board took place on 13 December. Both the cross-directorate high-stakes decision controls framework group and the data publication working group convened for the first time in December. We continue to deliver learning needs analysis workshops with the aim of completion in Q2 2022. The Review and ED&I team have agreed that there is a requirement for a service delivery equality policy and this is now in development with an aim to be reviewed by the Regulatory Fairness Review Board by Q2 2022.

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*All projects reporting green unless stated*
Investing in our people
to deliver our ambitions

2021-23 Priority activities

<table>
<thead>
<tr>
<th>Why?</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>To ensure our approach as an organisation to leadership, support and ongoing improvement attracts and retains the right people to meet our ambitions - we will strive for Gold accreditation from Investors in People. To treat our people fairly and model the commitment we ask of the health service – that diverse and inclusive environments support better outcomes for all - we will achieve maturity against the TIDE framework. <strong>When:</strong> Q2 2023 <strong>Who:</strong> Neil Roberts; Andrew Bratt.</td>
<td>We have maintained the silver level of IIP accreditation overall, and also gained a silver IIP wellbeing accreditation for the first time. We have made significant progress towards Gold across all areas of the standard. In 2018 we had 2 themes at Bronze, 23 Silver and 2 Gold, whereas in 2021 we have 15 themes at Silver and 12 at Gold. Our focus for 2022-4 will be on continuing to embed our people management policies and procedures across the organisation to ensure further consistency. We have now launched our new inclusion programmes for GMC colleagues. Approx. 430 GMC leaders will complete the Fostering Inclusion programme which consists of six modules that will be completed over 12 months. Our Professional Behaviours e-learning will be completed by all GMC colleagues. Our Developing Diverse Talent and Leadership programmes are available to all colleagues from ethnic groups underrepresented in our leadership roles.</td>
</tr>
</tbody>
</table>

*All projects reporting green unless stated*
Our target is to eliminate differentials within our own staffing performance, in minority ethnic recruitment, representation across staffing levels, retention, progression, pay and employee engagement by 2026.

### Underlying measures and targets

<table>
<thead>
<tr>
<th>Underlying measures and targets</th>
<th>Actual</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Applications</strong></td>
<td>22.8%</td>
<td>32.1%</td>
</tr>
<tr>
<td>(2020 (%)</td>
<td>(2020 (Vol)</td>
<td>(2021 (%)</td>
</tr>
<tr>
<td><strong>Interviews</strong></td>
<td>15.2%</td>
<td>22.4%</td>
</tr>
<tr>
<td>(Vol)</td>
<td>(Vol)</td>
<td>(Vol)</td>
</tr>
<tr>
<td><strong>Offers</strong></td>
<td>14.6%</td>
<td>13.3%</td>
</tr>
<tr>
<td>(Vol)</td>
<td>(Vol)</td>
<td>(Vol)</td>
</tr>
<tr>
<td><strong>Workforce</strong></td>
<td>8%</td>
<td>16%</td>
</tr>
<tr>
<td>(Vol)</td>
<td>(Vol)</td>
<td>(Vol)</td>
</tr>
</tbody>
</table>

**Increase the level of BME representation at Level 3 and above**

| Applications | 29.4% | 40.0% | 2026 |
| Interview    | 18.2% | 27.4% | 2026 |
| Offers       | 18.2% | 30.2% | 2026 |
| Workforce    | 14.3% | 16.0% | 2026 |

**Increase the level of BME representation at all levels**

| Applications | 22.8% | 32.1% | 2026 |
| Interview    | 15.2% | 22.4% | 2026 |
| Offers       | 14.6% | 13.3% | 2026 |
| Workforce    | 8%    | 16%   | 2026 |

**Reduce differential turnover rates for BME staff compared to the average to improve retention and for rates to be within 1-2% of each other by end of 2023**

<table>
<thead>
<tr>
<th>BME (%)</th>
<th>Non-BME (%)</th>
<th>1-2%</th>
<th>2026</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.2</td>
<td>7.8</td>
<td>0.4%</td>
<td>1.0%</td>
</tr>
</tbody>
</table>

**Proportion of BME staff receiving promotion and grade progression is proportionate to our workforce at the relevant grade/level**

<table>
<thead>
<tr>
<th>BME (%)</th>
<th>Non-BME (%)</th>
<th>18%</th>
<th>18%</th>
</tr>
</thead>
<tbody>
<tr>
<td>17.7</td>
<td>14.3</td>
<td>3.4%</td>
<td>18%</td>
</tr>
</tbody>
</table>

**Pay differentials within a confined band limited to 2% from 2023**

| 50.0% | 6/12 | 41.7% | 5/12 | 2.0% | N/A | 2.0% |

---

*difference is not set against the 2023 figure, the target is that the proportion of staff will be equal across BME and Non-BME

**2020 is an unrealistic baseline year given the pandemic. Retention rates for BME staff have historically been outside of this range – in 2019 the difference in retention rates against the average for BME staff was 3.9%.

Data covers the period 1 Jan - 31 Dec 2021.
## Financial summary (December 2021)

<table>
<thead>
<tr>
<th>Financial summary as at Dec 2021</th>
<th>Budget 2021</th>
<th>Forecast 2021</th>
<th>Actual 2021</th>
<th>Variance Budget to Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Operational expenditure</td>
<td>118,897</td>
<td>109,499</td>
<td>109,481</td>
<td>9,416</td>
</tr>
<tr>
<td>New initiatives fund</td>
<td>1,056</td>
<td>0</td>
<td>0</td>
<td>1,056</td>
</tr>
<tr>
<td>Pension top up payment</td>
<td>1,300</td>
<td>2,300</td>
<td>2,300</td>
<td>(1,000)</td>
</tr>
<tr>
<td>Capital expenditure</td>
<td>8,438</td>
<td>8,563</td>
<td>7,684</td>
<td>754</td>
</tr>
<tr>
<td><strong>Total expenditure</strong></td>
<td>129,691</td>
<td>120,362</td>
<td>119,465</td>
<td>10,226</td>
</tr>
<tr>
<td>Operational income</td>
<td>126,102</td>
<td>119,582</td>
<td>119,460</td>
<td>(6,642)</td>
</tr>
<tr>
<td>Operational surplus/(deficit)</td>
<td>(3,589)</td>
<td>(780)</td>
<td>(5)</td>
<td>3,584</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Financial summary as at Dec 2021</th>
<th>Budget 2021</th>
<th>Forecast 2021</th>
<th>Actual 2021</th>
<th>Variance Budget to Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Investment income</td>
<td>2,282</td>
<td>4,080</td>
<td>4,879</td>
<td>2,597</td>
</tr>
<tr>
<td><strong>Total surplus/ (deficit)</strong></td>
<td>(1,307)</td>
<td>3,300</td>
<td>4,874</td>
<td>6,181</td>
</tr>
</tbody>
</table>
## Financial detail (December 2021)

<table>
<thead>
<tr>
<th>Expenditure as at Dec 2021</th>
<th>Budget 2021</th>
<th>Forecast 2021</th>
<th>Actual 2021</th>
<th>Variance budget to actual</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Staff costs</td>
<td>73,880</td>
<td>72,850</td>
<td>72,765</td>
<td>1,115</td>
</tr>
<tr>
<td>Staff support costs</td>
<td>3,489</td>
<td>2,468</td>
<td>2,378</td>
<td>1,111</td>
</tr>
<tr>
<td>Office supplies</td>
<td>1,740</td>
<td>707</td>
<td>679</td>
<td>1,061</td>
</tr>
<tr>
<td>IT &amp; telecoms costs</td>
<td>4,531</td>
<td>4,501</td>
<td>4,533</td>
<td>(2)</td>
</tr>
<tr>
<td>Accommodation costs</td>
<td>7,745</td>
<td>7,049</td>
<td>6,941</td>
<td>804</td>
</tr>
<tr>
<td>Legal costs</td>
<td>4,344</td>
<td>4,226</td>
<td>4,278</td>
<td>66</td>
</tr>
<tr>
<td>Professional fees</td>
<td>3,037</td>
<td>3,389</td>
<td>3,480</td>
<td>(443)</td>
</tr>
<tr>
<td>Council &amp; members costs</td>
<td>384</td>
<td>366</td>
<td>359</td>
<td>25</td>
</tr>
<tr>
<td>Panel &amp; assessment costs</td>
<td>18,465</td>
<td>13,197</td>
<td>13,225</td>
<td>5,240</td>
</tr>
<tr>
<td>PSA Levy</td>
<td>858</td>
<td>843</td>
<td>843</td>
<td>15</td>
</tr>
<tr>
<td>Under/over-achievement of efficiency savings</td>
<td>424</td>
<td>(97)</td>
<td>0</td>
<td>424</td>
</tr>
<tr>
<td><strong>Operational expenditure</strong></td>
<td><strong>118,897</strong></td>
<td><strong>109,499</strong></td>
<td><strong>109,481</strong></td>
<td><strong>9,416</strong></td>
</tr>
<tr>
<td>New initiatives fund</td>
<td>1,056</td>
<td>0</td>
<td>0</td>
<td>1,056</td>
</tr>
<tr>
<td>Pension top up payment</td>
<td>1,300</td>
<td>2,300</td>
<td>2,300</td>
<td>(1,000)</td>
</tr>
<tr>
<td>Capital expenditure</td>
<td>8,438</td>
<td>8,563</td>
<td>7,684</td>
<td>754</td>
</tr>
<tr>
<td><strong>Total expenditure</strong></td>
<td><strong>129,691</strong></td>
<td><strong>120,362</strong></td>
<td><strong>119,465</strong></td>
<td><strong>10,226</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Income as at Dec 2021</th>
<th>Budget 2021</th>
<th>Forecast 2021</th>
<th>Actual 2021</th>
<th>Variance budget to actual</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Annual retention fees</td>
<td>99,258</td>
<td>99,383</td>
<td>99,316</td>
<td>58</td>
</tr>
<tr>
<td>Registration fees</td>
<td>5,667</td>
<td>5,179</td>
<td>5,132</td>
<td>(535)</td>
</tr>
<tr>
<td>PLAB fees</td>
<td>16,584</td>
<td>10,447</td>
<td>10,388</td>
<td>(6,196)</td>
</tr>
<tr>
<td>Specialist application CCT fees</td>
<td>2,755</td>
<td>2,934</td>
<td>2,948</td>
<td>193</td>
</tr>
<tr>
<td>Specialist application CESR/CEGPR fees</td>
<td>1,216</td>
<td>1,086</td>
<td>1,134</td>
<td>(82)</td>
</tr>
<tr>
<td>Interest income</td>
<td>78</td>
<td>81</td>
<td>84</td>
<td>6</td>
</tr>
<tr>
<td>Other income</td>
<td>544</td>
<td>472</td>
<td>458</td>
<td>(86)</td>
</tr>
<tr>
<td><strong>Total Operational Income</strong></td>
<td><strong>126,102</strong></td>
<td><strong>119,582</strong></td>
<td><strong>119,460</strong></td>
<td><strong>(6,642)</strong></td>
</tr>
</tbody>
</table>
### GMCSI summary (December 2021)

<table>
<thead>
<tr>
<th>GMCSI summary as at Dec 2021</th>
<th>Budget 2021 £000</th>
<th>Forecast 2021 £000</th>
<th>Actual 2021 £000</th>
<th>Variance budget to actual £000</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>GMCSI income</td>
<td>388</td>
<td>230</td>
<td>239</td>
<td>(149)</td>
<td>(38)%</td>
</tr>
<tr>
<td>GMCSI expenditure</td>
<td>384</td>
<td>238</td>
<td>246</td>
<td>138</td>
<td>36%</td>
</tr>
<tr>
<td>Profit/(loss)</td>
<td>4</td>
<td>(8)</td>
<td>(7)</td>
<td>(11)</td>
<td></td>
</tr>
</tbody>
</table>
Investment Committee Update

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

2) Holdings as at 31 December 2021

<table>
<thead>
<tr>
<th></th>
<th>£millions</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Equities</td>
<td>21.9</td>
<td>35.5%</td>
</tr>
<tr>
<td>Fixed Interest</td>
<td>9.6</td>
<td>15.6%</td>
</tr>
<tr>
<td>Property</td>
<td>4.0</td>
<td>6.5%</td>
</tr>
<tr>
<td>Infrastructure</td>
<td>3.2</td>
<td>5.2%</td>
</tr>
<tr>
<td>Other Income</td>
<td>2.0</td>
<td>3.2%</td>
</tr>
<tr>
<td>Private Equity</td>
<td>1.1</td>
<td>1.8%</td>
</tr>
<tr>
<td>Cash</td>
<td>19.9</td>
<td>32.3%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>61.7</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

2) History of portfolio valuation

3) Performance Overall
The following sets out the investment returns achieved by our chosen Investment managers compared to the target

<table>
<thead>
<tr>
<th>Performance Period</th>
<th>As at 31 December</th>
<th>3 Months</th>
<th>12 Months</th>
<th>3 Years (p.a)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Our Actual Portfolio</td>
<td>3.55%</td>
<td>8.59%</td>
<td>7.86%</td>
<td></td>
</tr>
<tr>
<td>Target: CPI + 2%</td>
<td>2.90%</td>
<td>7.40%</td>
<td>4.43%</td>
<td></td>
</tr>
<tr>
<td>Actual minus Target</td>
<td>0.65%</td>
<td>1.19%</td>
<td>3.43%</td>
<td></td>
</tr>
</tbody>
</table>

Conclusion: Our managers have exceed target by 1.19% over the last year and an average of 3.43% p.a over each of the last 3 years. The latest valuation at 21 January 2022 is a total fund value of £60.0m.
## Legal summary (as at 17 January 2021)

The table below provides a summary of appeals and judicial reviews as at 17 January 2022:

<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><strong>s.40 (Practitioner) Appeals</strong></td>
<td>17</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td><strong>s.40A (GMC) Appeals</strong></td>
<td>1</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td><strong>PSA Appeals</strong></td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td><strong>Judicial Reviews</strong></td>
<td>0</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td><strong>IOT Challenges</strong></td>
<td>3</td>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>

### Explanation of concluded cases

**s.40 (Practitioner) Appeals**
- 3 GMC successful –
- 3 appeals dismissed
- 1 GMC unsuccessful – appeal allowed by consent

**s.40A (GMC) Appeals**

**Judicial Reviews**

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

**PSA Appeals**
- There has been one new referral by PSA to the High Court under Section 29 since the last report, and zero concluded.

### 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 have been three new applications in the High Court challenging the imposition of interim orders since the last report, and two concluded (one claim was withdrawn and one where the order was terminated – GMC unsuccessful), therefore four challenges 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.
Corporate Opportunities and Risk Register
<table>
<thead>
<tr>
<th>#</th>
<th>Operational Threat</th>
<th>Category</th>
<th>Title</th>
<th>Detail</th>
<th>Owner</th>
<th>Mitigations/Enhancement</th>
<th>Council Lead or Board Assurance</th>
<th>Further Assurance</th>
<th>Further Action Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>231</td>
<td>Operational Threat</td>
<td>GEMI Strategy</td>
<td>Compliance Policy</td>
<td>The assurance we can evidence that our regulatory decision-making is fit for purpose through our strategy (SEMI) targets, tailoring focus area of opportunity for improve our decision-making.</td>
<td>Bruce Gallagher</td>
<td>Equality, Diversity and Inclusion (SEMI) strategic objectives published within the corporate strategy and supported by focused targets based on evidence and routine monitoring and reporting of progress</td>
<td>Executive Board</td>
<td>Review of GEMI compliance and governance review (Campbell Tickell) (2021)</td>
<td>Strategy and policy GEMI compliance and governance review (Campbell Tickell)</td>
</tr>
<tr>
<td>232</td>
<td>Operational Threat</td>
<td>GEMI Strategy</td>
<td>Analytics Strategy</td>
<td>The insights relative to influence change across the health and educational system, and within the GMC, do not define programs at a pace to meet our strategy (SEMI) targets, tailoring focus area of opportunity for improve our decision-making.</td>
<td>Bruce Gallagher</td>
<td>Ongoing functional targets to focus specific whole efforts</td>
<td>Executive Board</td>
<td>Review of GEMI compliance and governance review (Campbell Tickell) (2021)</td>
<td>Strategy and policy GEMI compliance and governance review (Campbell Tickell)</td>
</tr>
<tr>
<td>233</td>
<td>Operational Threat</td>
<td>GEMI Strategy</td>
<td>Availability of resources</td>
<td>If we don’t ensure and retain an appropriately skilled and experienced workforce, we face potential future challenges.</td>
<td>Neil Roberts</td>
<td>Our HIF and leadership strategy is tailored towards attracting and retaining a high calibre workforce that can deliver on all aspects of our strategy.</td>
<td>Executive Board</td>
<td>Review of GEMI compliance and governance review (Campbell Tickell) (2021)</td>
<td>Strategy and policy GEMI compliance and governance review (Campbell Tickell)</td>
</tr>
</tbody>
</table>

### Resource Management

- **Operational Threat**
- **Title**: Resource Management
- **Detail**: If we don't ensure and retain an appropriately skilled and experienced workforce, we face potential future challenges.

<table>
<thead>
<tr>
<th>Owner</th>
<th>Mitigations/Enhancement</th>
<th>Council Lead or Board Assurance</th>
<th>Further Assurance</th>
<th>Further Action Details</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Executive Board</td>
<td>Review of GEMI compliance and governance review (Campbell Tickell) (2021)</td>
<td>Strategy and policy GEMI compliance and governance review (Campbell Tickell)</td>
</tr>
</tbody>
</table>
Operational Threat | Strategy | Policy | Potential impact on patient safety and regulatory treatment
--- | --- | --- | ---
Safety of at-risk groups | Engagement with other regulatory bodies to identify opportunities for collaboration and improvement (such as through the Chief Executive Officer Regulatory Desk (CEDAR) group) | Level 1 | Reduce potential impact on patient safety and regulatory treatment
Safeguarding at the GMC | Being involved in key strategic decisions that impact the regulator’s corporate strategy/ the impact of the strategy | Level 2 | Reduce potential impact on patient safety and regulatory treatment
Safeguarding at the GMC | … | Level 2 | Reduce potential impact on patient safety and regulatory treatment

**Operational Threat:** The impact of an event in the external environment, whether planned or unplanned, may risk the regulator’s ability to deliver on its regulatory standards. The regulator may have to adjust its approach to delivering on its regulatory standards to ensure it can continue to meet its safeguarding obligations as an employer. Safety of at-risk groups may also be affected by unplanned events.

**Strategy:** Engage with other regulatory bodies to identify opportunities for collaboration and improvement (such as through the Chief Executive Officer Regulatory Desk (CEDAR) group) and being involved in key strategic decisions that impact the regulator’s corporate strategy.

**Policy:** Reduce potential impact on patient safety and regulatory treatment.

---

**Operational Threat:** The regulator’s ability to deliver on its strategic priorities may be affected by unplanned events.

**Strategy:** Engage with other regulatory bodies to identify opportunities for collaboration and improvement (such as through the Chief Executive Officer Regulatory Desk (CEDAR) group) and being involved in key strategic decisions that impact the regulator’s corporate strategy.

**Policy:** Reduce potential impact on patient safety and regulatory treatment.
### Operational Opportunity: Deriving more insight from our data capability

**Braun Gallagher**

- We use our research and insights to highlight key issues facing the medical profession, suggesting courses of action which healthcare providers 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 change in practice and training environments.
- Continue to use data to contribute to regulatory, legislative and external engagement.
- Provide data support to the rest of the GMC in managing our response to the Covid-19 pandemic.
- Exploring innovative ways of utilizing data and insight with regulatory partners.

**Highly Likely**

- **Paper**: Review of UK Advisory Forum meetings (December 2019)
- **Executive Board**: Risk 'deep dive' (March 2021)
- **Internal audit**: Arrangements for assessing progress in the delivery of the Corporate Strategy (July 2021, green-amber)
- **Other assurance**: Corporate strategy and stakeholder perceptions baseline survey (published March 2019).

### Operational Opportunity: Working with patients and public

**Paul Reynolds**

- Champion for patients established at SMT level to ensure senior-level overview of our engagement.
- Strategic approach to patient and public involvement agreed by Executive Board (in November 2020)
- Programme governance to direct and oversee work in place.
- Clear information easily accessible for patients and public about how we work and can support them (such as on our website).
- Regular assessment of patients and the public’s perceptions of our work through research (such as on our website).
- Regular engagement with patient leaders in all four countries of the UK (such as through our roundtable and UKAF meetings).
- Accessing stakeholder networks to learn how other organisations engage meaningfully and well with patients and public.
- Insights and perspectives from patients regularly shared with the organisation to inform their work (e.g. Brown Bag Lunches and Insight reports).

**Quite Likely**

- **Council**: Discussions at Council Away days (July 2019) about patient and public engagement in our work and preparation.
- **Strategic approach to communications and engagement update** (June 2019).
- **Corporate Strategy 2021-2025**: Session on patient and public involvement at Council Away Day (September 2021).
- **Paper**: Annual update on communications and engagement (July 2021)
- **Executive Board**: Risk 'deep dive' (February 2021)
- **Paper**: Strategic approach to patient and public involvement (November 2021).
- Annual perceptions survey showing the public’s confidence in how doctors are regulated and feedback on working relationships with patient and public bodies.
- Insights and perspectives from patients shared in weekly external update.
- Work being re-scoped following rejection of programme plans by Planning Gateway/SMT.
- Planning next meeting of patient roundtable on 18 May 2022.
- Standards team in process of appointing research provider to support patient engagement for review of Good medical practice. Provider expected to be appointed in late May.
- Outreach ‘signposting’ pilot underway with NHI’s role of Whig and implementable role of Whig.
- Work in progress on engagement at MDG partnerships in partnership with The Reeves Association (planned for April 2022).
- Working with MDG/Btg’s last internal workshop on PPI by policy, engagement and operational leads (expected March/April 2022).
**Council meeting – 24 February 2022**

**Agenda item M4**  
**Equality, diversity and inclusion - Annual progress report**

| Paper withheld from publication | Please note that this paper is withheld from publication until March 2022.  
For further information, please contact the Corporate Governance team via email, GovernanceTeamMailbox@gmc-uk.org. |

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**Paper withheld from publication**

Please note that this annex is withheld from publication until March 2022.

For further information, please contact the Corporate Governance team via email, [GovernanceTeamMailbox@gmc-uk.org](mailto:GovernanceTeamMailbox@gmc-uk.org).
| Paper withheld from publication | Please note that this annex is withheld from publication. Performance projections will be published once our approach to projecting potential performance has been finalised.

For further information, please contact the Corporate Governance team via email, GovernanceTeamMailbox@gmc-uk.org. |
**Council meeting – 24 February 2022**

**Agenda item M5**

**Progress on MAPs**

<table>
<thead>
<tr>
<th>Action</th>
<th>To note</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Purpose</strong></td>
<td>This report updates Council on the regulation of physician associates (PAs) and anaesthesia associates (AAs). Although legislation is progressing more slowly than hoped, we are well advanced in delivering core programme outputs. We have designed routes to registration, established an education quality framework and published interim professional standards. Engagement with stakeholders remains extremely positive and our communications to PAs and AAs continue to be well received. Becoming a multi-professional regulator presents new challenges, especially as the number and role of PAs and AAs in the workforce continues to develop. Upcoming work will address some complex issues around local governance and supervision for PAs and AAs, and the extension of prescribing responsibilities.</td>
</tr>
<tr>
<td><strong>Decision trail</strong></td>
<td>Council has received regular updates on MAPs since the programme began, most recently at the June 2021 meeting.</td>
</tr>
</tbody>
</table>
| **Recommendations** | a  To note the progress made on the core regulatory framework  
b  To note the emerging issues outlined and offer any reflections |
| **Annexes** | None |
| **Author contacts** | **Clare Barton**, Assistant Director, MAPs  
**Helen Arrowsmith**, Programme Manager, MAPs  
Any enquiries to: GovernanceTeamMailbox@gmc-uk.org |
| **Sponsoring director/Senior Responsible Owner** | **Una Lane**, Director of Registration and Revalidation |
Background

1 In July 2019, the Department of Health and Social Care (DHSC), with the support of the four UK governments, asked us to regulate PAs and AAs, two of the four medical associate professions (MAPs). We have now completed many aspects of regulatory design, and work continues as we await the legislation needed to bring our new responsibilities into effect.

2 All MAPs programme costs are being met by DHSC under a formal agreement which prevents any cross-subsidisation from fees paid by existing registrants. The agreement includes set-up costs plus transitional funding for running costs until these are fully covered by fees paid by PA and AA registrants.

3 This report has three sections and updates Council on:
   - Legislation and the revised timeline for starting regulation
   - Our progress on regulatory design: what’s either done or underway
   - Emerging issues to consider, including workforce development

Legislative development and timeline

4 DHSC intend to bring PAs and AAs into regulation at the same time as making wider reforms to the GMC’s powers and duties.¹ The decision to couple the legislative changes in this way means PA/AA regulation is not now expected to begin until summer 2023 at the earliest.

5 There have been two significant delays to the regulatory timeline since we began our programme. Whilst this is disappointing for stakeholders, our work continues uninterrupted and additional funding has been requested from DHSC to cover increased costs incurred due to the delay. We have kept in close contact with key stakeholders across the four nations throughout and this has helped to maintain positive relationships and confidence in the GMC.

6 The draft legislation identifies three groups that will be regulated by the GMC:
   - Medical practitioners (ie, doctors)
   - Physician associates
   - Anaesthesia associates

¹ As set out in the March 2021 consultation, Regulating healthcare professionals, protecting the public
With the exception of some transitional provisions, we understand that the powers and duties laid out in our revised legislation will apply equally to all three professions; any differences in application across professions will be specified in GMC rules or policy.

**Work completed or underway**

**Registration and assessment**

7 We have completed processes for our two priority PA/AA registration groups: the transitional cohort of existing practitioners and future qualifiers from UK universities. Attention is now focused on:

a. Designing a registration route for overseas-qualified PAs and AAs. This is not straightforward because, unlike doctors, there is no internationally accepted title or scope of practice for PA or AA roles, and these professionals aren't regulated in many countries outside North America.

b. Developing a registration assessment for AAs to match the one that already exists for PAs. A pass in our designated assessment will be a requirement for entry to the GMC register, for both UK and overseas professionals.

8 PAs and AAs will be separately identified on our register. We'll be exploring how best to present the three registrant groups on the public-facing register to allow users to search either across the whole register or just within one profession.

**Education**

9 Our priorities for PA and AA education are to update the existing curriculum for each profession and establish a quality assurance (QA) process for UK courses. We've made strong progress in both these areas. All 37 course providers (35 for PAs and two for AAs) have engaged voluntarily in a baseline QA exercise, completed a self-assessment against our published standards, and received initial feedback on strengths and areas for improvement. We'll continue to support current and future providers in the run up to regulation.

10 We've developed high-level education outcomes for MAPs and worked with the colleges and others to create PA and AA curricula that are outcome-focused and can meet our standards. Over 100 organisations and individuals responded to our recent engagement on the draft curricula, offering high levels of support. We'll support the respective colleges/faculties to make further revisions prior to formal approval by the GMC and will ask course providers to implement the new curricula from September 2023.
Professional standards

11 We published *Good medical practice (GMP) for PAs and AAs* in October 2021 together with accompanying case studies. These standards will operate from the start of regulation until we publish new ethical guidance for all registrants emerging from the wider GMP review. Publishing interim standards gives PAs and AAs, students, and educators, time to prepare for our expectations, and we know from feedback that this has been appreciated. We’re currently considering how our Outreach teams can support future/new registrants, both before and after regulation.

Fitness to practise

12 We expect PAs and AAs will be subject to the revised fitness to practise processes enabled by reformed legislation, although details are still to be confirmed. These same processes are expected to apply to doctors, subject to the outcome of consultation and appropriate transitional provisions.

13 In the meantime, we are supporting the Faculty of PAs/Royal College of Physicians in handling concerns about the conduct of PAs on the managed voluntary register. Although we don’t yet have any regulatory remit, we have a shared interest with colleges and employers in maintaining high standards of professional conduct and ensuring a smooth transition to regulation.

Communication and engagement

14 We continue to engage widely with PAs, AAs, doctors, patients, and other stakeholders. Our External Advisory Group meets quarterly; we’ve created an information hub on the GMC website; and over 1,500 individuals have signed up to receive regular news or contribute views via our ‘Community of Interest’. The programme team regularly speak at stakeholder events, including the recent PA and AA national conferences where we reached over 700 people.

15 Our communication and engagement strategy is regularly updated to respond to changes and emerging risks in the external environment, as well as the needs of different audience groups. Activity over the coming months will target PA/AA students, employers and doctors. Later, we’ll explore what information would be helpful for the wider healthcare team. In addition, our upcoming GMP consultation (which covers all three registrant groups) provides an opportunity to engage patients and increase their understanding of these new professions.

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2 There is an AA voluntary register held by the Royal College of Anaesthetists, but no code of conduct or fitness to practise process, so concerns about AA conduct can only be raised with employers.
We remain mindful of the impact of the pandemic and system pressures. The current situation reinforces the value of developing PAs and AAs as regulated professionals who can contribute to a sustainable NHS workforce. But our engagement activity needs to be proportionate and targeted at this time.

Emerging issues and longer-term regulatory development

Prescribing

The DHSC has begun work with PA and AA professional bodies, NHS England and the devolved administrations to extend prescribing responsibilities to PAs and AAs after regulation. We support this important step in increasing the utility of these professions and are contributing to discussions. The decision on prescribing will be made by the Commission on Human Medicines and requires a separate public consultation and legislative process.³

We don’t yet know how prescribing will operate for these professions but access to prescribing is likely to involve a period of supervised clinical practice and learning/assessment after qualification. The GMC would be responsible for quality assuring that learning. We might also develop a view on the best training mechanism for different cohorts, bearing in mind that existing PA/AAs already have experience of recommending medications and, in future, we will oversee the pharmacology/prescribing content of approved PA and AA courses.

Post-qualification education, training, and development

Future implementation of prescribing sharpens the focus on governance and lifelong learning arrangements for PAs and AAs. There is currently no structured post-qualification education and training for PA/AAs such as exists for doctors with foundation and specialty training. Instead, PAs and AAs develop within local governance structures and non-statutory guidance.⁴ Whilst that isn’t necessarily a problem, it limits our ability as regulator to influence how PAs and AAs develop their knowledge, skills and scope of practice after entry to the register. For example, should we wish to require minimum levels of supervision for newly qualified PA/AAs, we have no obvious mechanism to do so.

³ Alongside prescribing, PAs and AAs are currently prevented by law from ordering X-rays and ionising radiation. However, once they are regulated, this will be possible without further legislation, provided the PA/AA has been approved by their employer and undergone the appropriate training.

⁴ Health Education England, with input invited from all four countries, are working on a core capabilities framework covering the four MAPs professions. We have been closely involved in this project, which will provide a valuable structure for PA/AA career development, but it doesn’t include profession-specific training and isn’t a regulatory or quality assurance mechanism.
At the programme scoping stage we decided to defer consideration of the post-qualification arena until after we had established the essential, core regulatory framework. Delays to the regulatory timescale offer a potential opportunity for us to develop thinking in this area, although we remain mindful of the principle of proportionality and financial constraints whilst the number of practising PAs and AAs is comparatively small.

Questions have also arisen as to whether there will be pathways to move between the PA/AA and doctor professions without the need to re-qualify from scratch. We need to consider how we would respond to the emergence of a ‘fast-track’ conversion qualification and how best to display on our register those who are qualified in more than one profession.

**Governance and revalidation**

As with doctors, the GMC isn’t responsible for deployment decisions or local clinical governance arrangements for PAs and AAs. However, we can influence these including through our revalidation policy. We have begun considering revalidation for PAs and AAs and we’re revising our existing clinical governance handbook so that it applies to all GMC-registered professionals.

There won’t be a revalidation requirement for PAs and AAs immediately upon registration, but employers are keen to understand our expectations to inform local workforce planning and governance arrangements. For example, we are often asked whether appraisal practices for doctors should now also be applied to PA/AAs, and if we intend to maintain the exam-based re-certification process that currently operates for PAs on the voluntary register. We therefore intend to engage stakeholders on revalidation options during the first half of this year.

**Multi-disciplinary team working**

PAs and AAs are still relatively small and new professions. At the time writing, there are around 2,800 PAs and 160 AAs practising in the UK. It’s likely they will grow in both number and scope of practice in the coming years, and this may occur differently in different sectors or parts of the UK. Such development presents a significant opportunity for the NHS workforce, but it may also create challenges if integration of PAs and AAs into teams isn’t well managed. We know doctors and other healthcare professionals sometimes have concerns about the potential adverse impact of changing workforce composition on role boundaries (including patient understanding of these), line management responsibilities, pay and professional development opportunities.
We’re already engaging with the professions, employers, and educators to make sure the future PA/AA regulatory framework supports workforce needs and is capable of keeping pace with changing circumstances. We’ll keep listening, as well as sharing progress, as regulation of PAs and AAs moves closer.

We welcome reflections from Council on the emerging issues presented here.
Council meeting – 24 February 2022

Agenda item M6

GMP review: approval to consult on revised draft

| Action | To note progress on the review of *Good medical practice* and approve plans to move to public consultation on a revised draft. |
| Purpose | This paper summarises progress on the review of GMP and seeks approval to consult on the revised text in Annex A. It gives an overview of: our intelligence gathering and engagement activity; equality analysis; key changes to be tested in consultation; consultation plans and implementation strategy. |
| Decision trail | We updated Council on plans to review *Good medical practice* at the Council meeting on 25 February 2021. SMT approved the Planning Gateway recommendation to progress the review to delivery stage in May 2021. The review was discussed at the Council away day in September 2021 and progress was summarised in Council circular 27/21. |
| Recommendations | To approve plans to move to public consultation on a revised draft of *Good medical practice*. |
| Annexes | Annex A: An annotated working draft of revised *Good medical practice*  
Annex B: A detailed summary of changes to the document  
Annex C: The intelligence and research underpinning the review  
Annex D: Engagement and consultation  
Annex E: Planning for implementation  
Annex F: Explanatory guidance in scope |
| Author contacts | **Mark Swindells**, Assistant Director, Standards and Guidance  
**Fionnula Flannery**, Head of Strategy and Planning, Standards |
| Any enquiries to: GovernanceTeamMailbox@gmc-uk.org |
| Sponsoring director/Senior Responsible Owner | **Colin Melville**, Medical Director and Director of Education and Standards |
Council meeting – 24 February 2022

Agenda item M6 – GMP review: approval to consult on revised draft

**Background to the review**

1 In May 2021, SMT agreed to progress to delivery stage the review of *Good medical practice* (GMP) and ten pieces of associated explanatory guidance. SMT agreed that the review supports our corporate strategy ambitions and is a timely opportunity to:

- prepare for our regulation of physician associates (PAs) and anaesthesia associates (AAs)
- capture the changes in healthcare and wider society since the previous update eight years ago
- fit with upcoming regulatory reform which will give us new rules, systems and processes for fitness to practise (FtP), registration and education. Refreshed professional standards will support that change: new system, new standards.

2 In September 2021, we updated Council on the key insights emerging from our intelligence gathering to date, and sought Council’s input into the future model, style, tone and scope of the future professional standards. We also provided a background reading pack on the history of GMP, which is available on Board Intelligence. Council members may find it helpful to refresh their memories of that ahead of this meeting.

3 Key steers from the away day discussion included that we should:

- publish shared professional standards for all our registrants, and future proof for other groups we may be asked to regulate
- retain the succinctness and four domain structure of GMP, and resist calls to turn it into a narrative, virtue signalling document
- enhance the content on communication
- engage meaningfully with patients as well as professionals in the development of the revised standards.

4 This paper summarises progress on the review since then and seeks agreement to publish a revised draft of GMP for consultation.

**Intelligence gathering and research**

5 We carried out a range of pre-consultation activities to develop the evidence base for the review. These included:

- desk research, with support from our intelligence, data and research teams, to identify relevant findings from recent reviews and public inquiries; external reports and research; and insights from internal data sources
Agenda item M6 – GMP review: approval to consult on revised draft

- a three-part research project which looked at: guidance models used by other regulators; how our guidance is used internally by different parts of the organisation; how external audiences use our guidance and materials
- a targeted four country stakeholder survey.

More detail on this activity and the evidence base we developed is at Annex C.

External advisory forum and pre-consultation engagement

In September, we held the first meeting of the GMP Advisory Forum, chaired by Professor Emma Cave, Professor of Healthcare Law at the University of Durham. The twelve members bring together experience and perspectives from across the four countries of the UK, ranging from clinical leaders, practising clinicians (doctor, PA and AA) and patient advocates, to experts on medical ethics and equality, diversity and inclusion. The group met four times in 2021 and we expect it to meet on a further three occasions following the consultation analysis in the autumn of 2022.

Given the extremely challenging environment across the UK’s health services, we have mostly used existing forums and mechanisms to test emerging insights and ideas with key stakeholder audiences. We have sought views at meetings including our patient roundtable, doctors in training roundtable, strategic Equality Diversity and Inclusion (ED&I) forum, responsible officers’ reference group, legal counsel forum, and the Black and Minority Ethnic (BME) doctors’ forum.

We have also carried out targeted engagement with the British Medical Association, defence bodies and other regulators to keep them informed about progress on the review, and identified opportunities to promote the review at senior level meetings and events, including with written updates at the UK advisory forums.

Internal oversight and engagement

The project has been overseen by an internal project board, made up of workstream leads and representatives of the teams across the GMC that are delivery partners to the review. A senior oversight group made up of assistant directors across the GMC has been kept informed through update emails and direct engagement from the project sponsor.

Alignment with the regulatory reform programme has been maintained through the project sponsor attending the regulatory reform programme board, and through quarterly meetings between the project management teams. We are also engaging directly with the Department of Health and Social Care (DHSC) and colleagues on the regulatory reform programme to make sure there are no unintended consequences of regulatory changes to our standards model. These discussions are ongoing.
Internal engagement has been through bespoke workshop sessions with colleagues across the GMC; sessions at existing meetings; and three cross-GMC workshops on our implementation strategy. We also brought together an equality, diversity and inclusion (EDI) working group, and a drafting steering group, made up of colleagues with policy, drafting, clinical, ftp decision making and communications expertise, which met four times to advise on the style, tone and content of the revised guidance.

Equality, diversity and inclusion

ED&I has been at the heart of our scoping, engagement, drafting, and consultation and implementation planning activity. A key objective of the intelligence and evidence gathering phase was to identify ways in which the professional standards or their implementation may have adverse impacts on registrants or patients/members of the public who share protected characteristics, and to identify opportunities to advance equality.

In addition to the recognised protected characteristics, we identified in early scoping that country of primary medical qualification and socio-economic status are also drivers of inequalities in healthcare, both for patients and for registrants. We have therefore been looking into how that might affect their interaction with GMP or any issues which are particularly prevalent to these groups.

We have tested and explored the impacts of these insights in a series of workshops with the external advisory forum as well as groups such as the strategic ED&I forum. These activities have been central to redrafting of the guidance. We have also completed the initial draft of the equality impact analysis (EqIA), which will be reviewed and updated as our work continues and issues emerge.

Key changes to the guidance

We started with a good, highly regarded product, so our approach has been ‘evolution, not revolution’. Our overarching ambition for redrafting GMP has been to shift the tone of the guidance to be more empathic, to recognise the context medical professionals are working in, and to position the guidance as empowering and supporting medical professionals to practise well in the interests of patients.

Our scoping and engagement activity found that there was strong support for the style and level of detail in current GMP. Stakeholders were keen for us to keep the four domain structure, but saw value in moving content around to give greater prominence to certain themes (such as communication and team working) and to make navigation more intuitive. There was appreciation for the succinctness of GMP, but also appetite to further contextualise duties and to acknowledge the environments that medical professionals are practising in. There was general support...
Council meeting – 24 February 2022

Agenda item M6 – GMP review: approval to consult on revised draft

for the proposal to create shared professional standards for doctors, physician associates, and anaesthesia associates.

18 Stakeholders generally wanted us to retain the terms ‘you must’ and ‘you should’ to express duties, but there was interest in exploring some form of ‘I will’ statements, which we are exploring by reformulating the existing ‘duties of a doctor’ in the front of GMP. There were also calls to make clearer the interaction between the professional standards and fitness to practise/local processes.

19 The thematic priorities we identified for new or amended professional duties were:

- tackling bias and discrimination in healthcare
- patient centred care, decision making and communication
- team working (including working in multi-disciplinary teams)
- leadership and interprofessional behaviours (including civility and sexual misconduct between colleagues).

20 Taking all this into account, the key changes we propose to test in consultation are:

- a new introductory section, which shifts the focus from what is expected of registrants to an account of what the professional standards are for and who they benefit. We have also given a fuller account of how our professional standards are used in fitness to practise decision making
- reworked four domains, with content organised more thematically than in the current version of GMP and a new ‘narrative arc’ that more clearly draws the connection between healthcare cultures and outcomes for patients. Each domain now opens with a preamble intended to frame the duties in positive language, improve the overall tone and more clearly describe how the document coheres as a whole

<table>
<thead>
<tr>
<th>Domain</th>
<th>2013 GMP</th>
<th>Redrafted GMP</th>
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<tbody>
<tr>
<td>1. Knowledge, skills and performance</td>
<td>Working with colleagues</td>
<td></td>
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<tr>
<td>2. Safety and Quality</td>
<td>Working with patients</td>
<td></td>
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<tr>
<td>3. Communication, partnership and teamwork</td>
<td>Professional capabilities</td>
<td></td>
</tr>
<tr>
<td>4. Maintaining trust</td>
<td>Maintaining trust</td>
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new or revised duties in relation to all the themes identified in paragraph 18 above. In particular, we have drawn several key principles from our Leadership and management and Decision making and consent guidance into GMP. We have also added expanded duties in relation to conflicts of interest and communicating as a professional (including on social media) and are exploring how the new draft can address sexual harassment, remote consultations, use of artificial intelligence and new technologies, and issues to do with sustainability and global health.

21 A revised, annotated working draft of revised GMP is at Annex A, and a more narrative account of what has changed is at Annex B. We propose that the draft should be finalised following the Council discussion, and following tone of voice review, with final approval of the consultation text delegated to the Director of Education and Standards.

22 There has been a high level of support for these changes when we have tested them internally and externally, but we can still expect significant scrutiny and challenge during consultation. We anticipate the most likely areas of controversy will be in relation to:

- the overall burden of the new professional duties, given the ongoing impact of the pandemic and workforce pressures
- our decision to consult on shared professional standards for doctors, physician associates, and anaesthesia associates
- new duties that attempt to influence how registrants behave towards each other, particularly in relation to civility, promotion of positive and inclusive cultures, self-awareness and reflection, and personal/sexual relationships between colleagues
- the extent to which the revised professional standards respond to live debates in healthcare and wider society about discrimination, equality and inclusion.

23 We have identified mitigations, which will inform our engagement and communication plans.

Plans for public consultation

24 We propose to consult on the draft guidance for 12 weeks, starting in late April/early May.

25 We will use consultation methods including questionnaires, meetings and events. During the consultation, outreach colleagues and liaison advisors based in the national offices will promote the consultation to a range of audiences, and will ask
Council meeting – 24 February 2022

Agenda item M6 – GMP review: approval to consult on revised draft

polling questions linked to the consultation in their sessions with frontline practitioners. They will deliver this via a mix of bespoke sessions and add-ons to existing sessions.

26 We have also commissioned an external behavioural insight specialist (ICE Creates) to conduct research and engagement with over 200 patients with lived experience of the healthcare system. This research is targeted at groups who are unlikely to participate in a written consultation and who we think we would find it difficult to reach ourselves. During the public consultation they will run dedicated online focus groups for people living in English regions, Wales, Northern Ireland and Scotland to act as a sounding board for policy ideas.

27 Further detail on our approach to communication and engagement planning and stakeholder mapping is at Annex D.

Post consultation actions and timings

28 We expect to analyse the consultation responses between late July and September 2022 and reconvene the GMP Advisory Forum from September to advise on post-consultation drafting. We expect the revised version of GMP to be approved by Executive Board and Council in early 2023. Our intention is that the guidance will be ready for publication in 2023, but timings will be agreed nearer the time, taking account of the key delivery dates for regulatory reform.

29 Ten pieces of explanatory guidance are also in scope for review (these are listed at Annex F). These are not part of the consultation on GMP but will be reviewed post-consultation, drawing on feedback we receive on the core guidance. Given that the explanatory guidance expands upon principles that we will consult on in the GMP consultation, we are currently planning to develop these pieces of guidance through targeted engagement with key stakeholders, rather than through further public consultation. We will however review this decision when we begin to draft the guidance, taking account of our existing policy and forthcoming duty to consult in the new legislation.

Planning for implementation and publication

30 In parallel to the guidance development, the implementation workstream has been working with colleagues across the GMC to develop a framework for how we support and enable registrants to put professional standards into practice.

31 A detailed account of the work to date, evidence gathered, and working hypotheses is at Annex E.
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<tr>
<td>Please note that this annex is withheld from publication until the consultation is published, currently planned for week commencing 25 April 2022.</td>
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<tr>
<td>For further information, please contact the Corporate Governance team via email, <a href="mailto:GovernanceTeamMailbox@gmc-uk.org">GovernanceTeamMailbox@gmc-uk.org</a>.</td>
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Council meeting – 24 February 2022

Agenda item M6
GMP review: approval to consult on revised draft

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Council meeting – 24 February 2022

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Council meeting – 24 February 2022

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Council meeting – 24 February 2022

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Council meeting – 24 February 2022  

Agenda item M7  
Education Quality Assurance update

<table>
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<tr>
<th>Action</th>
<th>To note</th>
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<tr>
<td>Purpose</td>
<td>In February 2020, Council approved a revised approach to proactive quality assurance (QA) of undergraduate and postgraduate medical education and training. We have continued to implement this despite the pandemic and, although we and the system have faced challenges, continue to provide oversight of the quality of medical education and training. This paper summarises the main developments in our QA in 2021, including the development of new medical schools, our ongoing oversight of postgraduate training (including enhanced monitoring) and our early work to engage with MAPs providers.</td>
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<tr>
<td>Decision trail</td>
<td>Council approved a revised approach to quality assurance in February 2020 (paper M5).</td>
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<tr>
<td>Recommendation</td>
<td>To note the Education quality assurance update.</td>
</tr>
</tbody>
</table>
| Annexes         | Annex A: QA process diagrams  
Annex B: Enhanced monitoring activity |
| Author contacts | Martin Hart, Assistant Director, Education and Standards  
Any enquiries to: GovernanceTeamMailbox@gmc-uk.org |
| Sponsoring director/Senior Responsible Owner | Colin Melville, Medical Director and Director of Education and Standards |
Background

1 Diagram 1 in Annex A reminds members of our high-level approach to assurance. In brief:

   a The Medical Act\(^1\) requires us to secure our standards\(^2\). We do this by first approving medical schools, postgraduate programmes and training locations, and postgraduate curricula.

   b We then check that organisations continue to meet our standards through our proactive quality assurance (PQA) processes. This includes checking that the education bodies have mechanisms for checking the standards are met by the organisations they commission to deliver training.

   c Our reactive quality assurance processes, including monitoring, enhanced monitoring and setting conditions, enable us to respond to any concerns arising from anywhere in the medical education system. Diagram 2 in Annex A shows how our proactive and reactive processes are aligned, and the responsibilities of the various organisations involved in the processes.

   d Our approach is underpinned by our intelligence, data and evidence, including the national training surveys. These inform and enhance all parts of our assurance processes.

2 Following extensive piloting and feedback, Council agreed to roll out the model illustrated in diagram 3 in Annex A.

3 In essence, the model is as follows:

   a Medical schools and postgraduate training organisations (PTOs)\(^3\) sign a declaration every four years that signifies their intention to meet the standards. This is a confirmatory process for organisations, similar to our revalidation model for individual doctors.

   b Every year (with a staggered initial roll out to manage GMC capacity and the fact that some institutions will have had greater recent scrutiny by the GMC) they complete a self-assessment that asks them to demonstrate how they

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\(^1\) As set out in sections 5(1) and 34H(1)(b) of the Medical Act 1983


\(^3\) Postgraduate training organisations are Health Education England and its local offices, NHS Education for Scotland, Health Education and Improvement Wales and the Northern Ireland Medical and Dental Training Agency.
meet the standards of *Promoting Excellence* through the outcomes of their day-to-day activities, policies and processes.

c We scrutinize their submission along with the data and evidence we hold and identify areas where either a) we are not assured or b) there is potential good practice. We meet each organisation to discuss their submission and agree activities that we will undertake to gain the assurance that we need.

d We undertake a range of activities including document requests, observing their various quality management activities, and potentially full-scale GMC visits. Some of these activities will involve GMC associates.

e We gather structured feedback directly from students, trainees and trainers on a regular basis to ensure that these groups have opportunities to report directly to the regulator about their training provider. We also gather structured feedback directly from local education providers about their relationships with medical schools and PTOs. The GMC’s outreach teams will also be engaged with this work.

f If we are not assured, we may set requirements and recommendations which we will then monitor until we have the requisite assurance. If we identify notable or good practice (this could be areas working well or innovation and excellence), we will seek to promote this to other organisations who may be able to benefit from this.

g We have now reached the point where we are now starting to produce the annual summaries for each organisation which includes information about the self-assessment, activities we have undertaken and any requirements, recommendations, good or notable practice we have identified.

4 We plan to evaluate the process when all organisations have completed two self-assessments and when we have completed a full cycle. (see diagram 4, Annex A)

5 We have also embarked on a further phase of QA review to consider our education relationship with the medical royal colleges. This year we have done a useful pilot exercise with the Royal College of General Practitioners (RCGP) to understand how we can work better together, share intelligence and make use of the college’s expertise.

6 The remainder of this paper is devoted to short updates on our activities since February 2021 covering:
The Proactive Quality Assurance (PQA) process.

The ongoing impact of the pandemic, including the results of our survey of existing medical schools and the research undertaken into the experience of interim F1 doctors.

The growth in the number of universities seeking to establish medical schools (including private medical schools) and the expansion of medical student numbers (both planned and unplanned as a result of changes to A levels in 2020 and 2021).

Our work with postgraduate training bodies and our work with locations that have particular training challenges (enhanced monitoring).

Our work with medical associate professionals (MAPs) course providers to baseline our understanding of the courses and to satisfy ourselves that they meet our standards ahead of statutory regulation in 2023.

The audit report that went to the ARC in March 2021.

As last year, the pandemic has had an impact on the delivery of our statutory education functions, and we note the successes and challenge we have faced over the last twelve months.

GMC’s approach

As we noted last year, the GMC’s approach to the regulation of education and training during the pandemic has been the maintenance of standards and outcomes. Across undergraduate and postgraduate, we have sought to embed the following principles in our approach:

- Patient safety
- Maintaining standards
- Meeting outcomes
- Competence
- Proportionate approaches
- Supporting diverse patient and doctor populations
Proactive QA process

9 In December 2021, we completed the roll out of the new proactive quality assurance process to all UK medical schools (35) and postgraduate training organisations (16).

10 We have analysed 53 self-assessment questionnaires (SAQ) and we have completed over 100 quality activities. These are designed to allow organisations to demonstrate how they quality manage their education and training and include observation of key committee meetings, attending quality management visits, document requests and reviews and meeting students and trainees.

11 We have drafted 19 Annual Quality Assurance Summaries (AQAS) which note the self-assessment, quality activities and summarises our engagement with the organisation over the year. For postgraduate organisations, this includes a summary of enhanced monitoring activity and differential attainment. We list any areas of notable practice, areas working well, requirements and recommendations. We also detail the areas of focus and next steps in the process. These AQAS reports will be published on our website in 2022.

Impact of the pandemic

12 The pandemic continued to have an impact on our quality assurance with the vast majority of activities remaining virtual. We were able to make a number of in person visits to medical schools and for enhanced monitoring and were reminded of the added value of these activities. During the latest Omicron wave, and with government recommendations to work from home in place until January 2021, our activities again moved on-line and were scheduled sensitively recognising the pressures on the NHS.

Undergraduate survey

13 In June 2021 we wrote to undergraduate quality leads to ask them about the continuing impact of Covid-19 on their ability to deliver their planned schedule of curricula and assessments. This included a link to an eight-question survey in which we asked a series of questions about changes made to final assessments and graduation arrangements for the 2020/2021 student cohort. We also asked questions on how each school has evaluated the changes made for the previous year’s graduating cohort and whether schools intended to make any permanent changes to their curricula or assessments because of the pandemic.

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4 In person visits to Brunel, Chester and Lancaster medical schools, in person enhanced monitoring visits to Lincoln and Wales
14 All established schools had been able to deliver final assessments for their graduating cohort. Most schools made adaptations to their planned delivery of written and clinical assessments. A number of schools undertook written assessments online with remote proctoring or invigilation whereas others could hold written assessments in person with appropriate social distancing.

15 All schools were able to deliver an assessment of clinical skills for their graduating cohorts. Most schools delivered formal clinical examinations (such as Objective Structured Clinical Examinations [OSCEs]) in person, although adaptations were made to meet the restrictions of the pandemic. For example, reducing the number of stations and/or replacing real patients with simulated patients.

16 For schools that did not hold a formal final year OSCE, other methods were used to assure schools of students’ clinical competence including programmatic assessment or a suite of workplace-based assessments.

17 All schools indicated that they were able to return to delivery more in keeping with a ‘normal’ final year for 2020-21. However, some accommodations were needed to deal with the disruption caused by the pandemic including making up for lost placement time and changes to electives. Decisions as to graduate were largely guided by university’s processes and procedures but did involve consultation with a variety of bodies, including the GMC.

Interim F1 research

18 We commissioned research from Gill Vance and colleagues into the work and wellbeing of interim F1 doctors during the pandemic: [2020 Medical Graduates: The work and wellbeing of interim Foundation Year 1 doctors during COVID-19](#)

19 In brief, the researchers concluded that FiY1 was a largely valuable experience which eased the transition to practice. Medical students were attracted to the FiY1 role for their own learning, to contribute to the NHS in a time of need, or through a sense of obligation. FiY1s’ work was similar to the work of F1s and those who had worked as FiY1s felt more prepared for starting F1 than those who had not been working since April 2020 or those who had worked in non-FiY1 clinical roles.

20 The FiY1 experience had limited impact on participants’ wellbeing and although participants faced challenging experiences during their FiY1 posts, these were not necessarily negative if accompanied by support from colleagues.
Merger of Health Education England (HEE) with NHS England

21 In postgraduate training, a significant development has been the proposal to merge Health Education England (HEE) into NHS England. Although this merger is expected to create a stronger organisation that aligns workforce, financial and service planning with education and training, we will want to ensure that concerns about training and trainee experience remain a priority for the merged organisation. As members know, we sometimes make difficult decisions with HEE to withdraw trainees (eg Weston, East Kent, North Middlesex). The merger may make it harder for HEE to make such decisions with significant operational implications for NHSE/I, and therefore we need to be ready for the possibility of standing more alone in making those tough judgements.

New medical schools and expansion of medical student numbers

22 The five ‘new’ medical schools in England that were created in the 2017 expansion have now all admitted their first students (Aston, Anglia Ruskin, Sunderland, Kent Medway and Edge Hill). These institutions had been visited by the GMC as part of our new schools process and ‘virtual’ visits have been arranged since the start of the pandemic.

23 There are now three further schools that are planning to admit students from 2022 on a private basis (i.e. outside the Office for Student’s (OfS) intake controls). Due to OfS rules, they will be largely restricted to taking students from overseas only. These are at Brunel University, Worcester University (Three Counties) and Chester University. As the Medical Act requires us to consider accreditation of all undergraduate medical education in the UK (irrespective of whether or not it is publicly funded) we have engaged with these schools as part of our new schools’ process. We managed to visit Brunel and Chester in person in 2021 and will visit Three Counties in February 2022.

24 We continue to monitor carefully the effect of this expansion, in particularly focusing QA attention on the schools with the largest increases in numbers and areas of the country where clinical placement capacity is most challenged.

25 In Northern Ireland, the University of Ulster admitted its first students in 2021.

26 In Wales, plans are developing for a third medical school at the University of Bangor. We have had meetings with Cardiff University (the contingency school), the Welsh Government and Health Education Improvement Wales.
We continue to engage with two innovative programmes in Scotland the ScotGEM programme (a graduate entry programme delivered by the University of Dundee and the University of St Andrews) and the Edinburgh HCP (Health Care Professions) programme (a programme designed to enable existing healthcare staff to become doctors).

Also in Scotland, the government is making a commitment to a significant increase in the number of medical students. It has not yet committed to a new medical school although this remains under discussion in Scotland.

There is increased lobbying for a more systematic increase in the number of medical school places. The Royal College of Physicians launched a campaign (Double or Quits) to increase the number of places by 7,500 and the Medical Schools Council has also recently suggested that the UK needs a further 5,000 medical school places.

We continue to have responsibility for the oversight of a number of programmes delivered by UK universities overseas. This year has seen the development of a new programme from Kings University in conjunction with Sustech University in Shenzhen, China. We also continue to oversee the Queen Mary’s programme in Malta.

Postgraduate training and enhanced monitoring

We use enhanced monitoring to promote and encourage local management of concerns about the quality and safety of medical education and training.

We require more frequent progress updates from those responsible for managing these concerns. We can provide representation on a locally led visit to investigate a concern or check on progress. We publish information on enhanced monitoring cases on our website. We share information with other healthcare regulators where appropriate.

Issues that require enhanced monitoring are those that could affect patient safety or training progression or quality. Issues are usually referred to us if there are concerns that the standards in Promoting Excellence are not being met and they meet the following criteria:

- Persistent and serious patient safety concerns
- Doctors in training’s safety is at risk
Annex B provides a visual summary of enhanced monitoring activity in 2021. The overall number of cases has remained reasonable static with six cases having GMC imposed conditions in place (two in Scotland and four in England).

Among the notable cases in England, the long-term challenges at University Hospitals Bristol NHS Foundation Trust (Weston site) have remained a key area of focus. 2021 has seen some progress with greater engagement from the Trust to secure long-term solutions (and the ultimate return of a number of trainees who have been withdrawn from the Trust by Health Education England).

Full details of all our enhanced monitoring cases are published on our website (with the exception of those cases that could identify individuals or are not yet in the public domain).

We are taking the opportunity in 2022 to reflect on our enhanced monitoring process and consider whether any changes are appropriate. We have good support from postgraduate training organisations and many of them value the input the GMC brings to often very challenged training providers. Our ability to impose conditions and ultimately the threat of withdrawing training recognition often helps focus attention of local education providers on finding sustainable solutions to problems that ultimately undermine training and patient experience.

However, we are aware that some departments remain in enhanced monitoring for lengthy periods and that progress in resolving issues, even with GMC intervention, can be very slow. We are considering whether there are operational improvements we can make to our processes and practices to ensure GMC interventions lead to long term solutions and drive-up training standards.

We intend to have a series of internal workshops with Education and Standards colleagues and with other GMC colleagues who work with us on enhanced monitoring (notably outreach and communications). We will also talk to postgraduate deans (probably via COPMED – the Council of Postgraduate Medical Education Deans). We hope to complete this review within six months and will of course report back to Council on any improvements we make.

We conducted our annual engagement meetings with postgraduate training organisations where we discussed differential attainment and outlined our ask of them to develop action plans detailing what they are doing to address the attainment gaps in their regions. These action plans are currently being
submitted and will be considered as part of the wider GMC work to eliminate
discrimination, disadvantage and unfairness in undergraduate and postgraduate
medical education.

Our work with MAPs course providers

41 Ahead of statutory regulation, we have begun a programme of engagement
with those higher education institutions that deliver Physician Associate or
Anaesthesia Associate courses.

42 Mirroring our process for medical schools, we have developed a self-assessment
questionnaire (SAQ), mapped to Promoting Excellence. We are using the results
of this to ‘baseline’ our understanding of MAPs courses and we have met
(virtually) all 36 course providers at a series of quality seminars.

43 Early indications are that course providers have good systems for supporting
students, identifying and managing concerns and complying with university and
national regulations on teaching and curriculum.

44 The most frequent areas where we have identified a need for improvement are
quality management of placements, internal educational governance systems
and managing risk.

45 We have identified regional differences with some regions benefiting from
regional approaches and collaboration which is reflected in the quality of
teaching and governance systems.

46 We will prepare an overarching report in the next few months on the early
indications of the quality of MAPs education and are now developing tailored QA
approaches for each institution (including some in person visits) and will
continue to support course providers ahead of statutory regulation.

47 We have also run a recruitment campaign for MAPs education associates and
student associates. We received 149 associate applications and 41 student
applications and recruited 12 education associates and 6 students to help us
with our quality assurance work.

Audit

48 An audit was undertaken of our approach to QA during the pandemic in early
2021. The purpose of this review was to assess how the GMC fulfilled its
statutory function in relation to the quality of medical education, including
enhanced monitoring arrangements in response to COVID-19, to provide
assurance that the quality of medical education has been maintained throughout the pandemic.

49 We were pleased that the audit confirmed that we had a sound system of internal controls in place to achieve our objectives and that the controls were being consistently applied. The review concluded that the QAMI Team reacted swiftly and decisively to deal with the challenges of assuring the quality of education provision in the face of the coronavirus pandemic. This ensured that the GMC continued to fulfil its statutory duties with respect to quality assuring the provision of medical education.
M7 – Annex A
QA process diagrams

Working with doctors Working for patients
Assurance is achieved through a variety of activities. Assurance is achieved through a variety of activities.

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

**Proactive QA**
- Checking medical schools, postgraduate training organisations and colleges are doing their job

**Reactive QA**
- Responding to any concerns, and promoting good practice, where evidence arises

**Evidence, data and intelligence**
- Continuous exchange and review of self-assessment and external evidence, including surveys

**Secure GMC standards**
- We are statutorily obliged to secure our standards for medical education
Proactive and reactive QA

**Proactive**
- Quality assurance
- Quality management
- Quality control

**Reactive**
- GMC
- Enhanced monitoring
- Routine monitoring
- Local monitoring

**Diagram 2**
- Collaboration to gain continuous assurance that standards are being met
- Work together to ensure standards are met
- Risk threshold for enhanced monitoring
- Risk threshold for routine monitoring
**Declaration**: organisations will re-declare that they meet the standards of Promoting Excellence. If we have serious concerns about an organisation’s ability to meet the standards, we may defer their re-declaration.

**Self-assessment**: organisations will review their data and intelligence, as well as any we hold, and complete a self-assessment questionnaire.

**Triangulation and gap analysis**: we will review organisations’ completed self-assessment questionnaires alongside our data and intelligence. We will meet with every organisation to discuss what quality activity is required.

**Quality activity**: we will undertake proportionate regulatory activity to seek assurance or to confirm evidence of excellence, innovation or notable practice. Activities may include document requests, meetings, shadowing, observations, visits and document reviews.

**Regulatory assessment**: if we are not assured we will undertake further activity and ask the organisation to provide a response in their annual self-assessment. If we are assured we will say so in our annual quality summary.
Post-roll-out evaluation plan

<table>
<thead>
<tr>
<th>Objective</th>
<th>Aims</th>
<th>Test</th>
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<tbody>
<tr>
<td>Reduce risk to the quality of medical education and training</td>
<td>We will be more likely to know about something going wrong, and we’ll know about it sooner. Achieved through more frequent checks, broader knowledge of QM activities, better use of more evidence.</td>
<td>Key indicator metrics, such as enhanced monitoring, national training survey and other data.</td>
</tr>
<tr>
<td>Improve the assurance of the public and the profession</td>
<td>We will clearly demonstrate how we gain assurance, that our processes have improved, and by make information about our regulation more accessible and easier to use.</td>
<td>Feedback, surveys and web analytics</td>
</tr>
<tr>
<td>Improve customer satisfaction</td>
<td>We will reduce burden, cost and duplication, and regulate more collaboratively and flexibly, for medical schools and postgraduate organisations.</td>
<td>A variety of customer feedback mechanisms</td>
</tr>
<tr>
<td>Improve value for money</td>
<td>We will increase the proportion of time staff and associates spend on activities that add direct value to our assurance. We will reduce the use of associates in general. We will absorb the QA of the MLA with minimal increase in headcount.</td>
<td>Analysis of budgets and staff activities</td>
</tr>
</tbody>
</table>

Evaluation 1: after 2 years (all orgs have completed 2 self-assessments)
Evaluation 2: after 5 years (all orgs have completed a full cycle)
M7 – Annex B
Enhanced monitoring activity
12 month summary

**Number of enhanced monitoring concerns by month**

<table>
<thead>
<tr>
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<td>34</td>
<td>34</td>
<td>36</td>
<td>35</td>
<td>35</td>
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</tbody>
</table>

**Enhanced monitoring activities by month**
Location of EM cases

6 cases have conditions. These are:

1. University Hospitals Sussex NHS Foundation Trust
2. University Hospitals Bristol and Weston NHS Foundation Trust
3. Ayrshire & Arran
4. London North West University Healthcare NHS Trust
5. Central and North West London NHS Foundation Trust
6. NHS Tayside
## Number of enhanced monitoring cases by organisation

<table>
<thead>
<tr>
<th>Postgraduate training organisation</th>
<th>Number of enhanced monitoring cases ever</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Education North West**</td>
<td>22</td>
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<tr>
<td>Health Education North East</td>
<td>5</td>
</tr>
<tr>
<td>Health Education West Midlands</td>
<td>8</td>
</tr>
<tr>
<td>Health Education East Midlands</td>
<td>10</td>
</tr>
<tr>
<td>Health Education Thames Valley</td>
<td>5</td>
</tr>
<tr>
<td>Health Education London*</td>
<td>40</td>
</tr>
<tr>
<td>Health Education KSS</td>
<td>6</td>
</tr>
<tr>
<td>Health Education Wessex</td>
<td>2</td>
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<tr>
<td>Health Education South West</td>
<td>2</td>
</tr>
<tr>
<td>Health Education East of England</td>
<td>22</td>
</tr>
<tr>
<td>Health Education Yorkshire and the Humber</td>
<td>10</td>
</tr>
<tr>
<td>Northern Ireland Medical and Dental Training Agency</td>
<td>7</td>
</tr>
<tr>
<td>NHS Education for Scotland</td>
<td>23</td>
</tr>
<tr>
<td>Health Education and Improvement Wales</td>
<td>10</td>
</tr>
</tbody>
</table>

*comprises of South London, NW London and North Central and East London

**including a case under 'Northern Deanery'
Level 1 – assurance that issues can be managed locally, with a potential serious risk to patients and/or safety/well-being of trainees.

Level 2 - some assurance that issues can be managed locally, with a potential serious risk to patients and/or safety/well-being of trainees.

Level 3 - limited assurance that issues can be dealt with locally, with a potential or current risk to patient and/or safety/well-being of trainees.

Level 4 – no assurance that issues can be improved, with a current risk to patient safety and safety/well-being of trainees. Plans to remove trainees are being/have been put in place.

Level 5 – trainees have been removed, although the key issues within the healthcare environment may not have been resolved.
Conditions

Working with doctors Working for patients
<table>
<thead>
<tr>
<th>QA Code</th>
<th>Trust/Health Board</th>
<th>Site</th>
<th>Programmes</th>
<th>Conditions</th>
</tr>
</thead>
</table>
| QA5176  | Weston Area Health NHS Trust | Weston General Hospital | Acute Care Common Stem Severn; Core Anaesthetics Training Severn; Core Medical Training Severn; Emergency medicine; Foundation; General Surgery | 1. A senior clinical decision maker, who has been assessed and deemed competent to provide supervision to doctors more junior, must be physically present and available to provide timely and appropriate supervision and direct clinical input to patient care in the emergency department at all times (when a Foundation doctor or GP trainee is working in this area).  
2. The Trust must ensure that there is an adequate staffing level in the emergency department to ensure patient safety, with clear lines of responsibility for clinical supervision and published guidelines for escalation.  
3. Consultant review must be made available on site for urology patients over weekends and a clear policy must be implemented for urological review of new patients over the weekend so that an F2 does not have to provide ongoing care without a clear treatment plan and direct on site supervision. |
| QA5462  | Brighton and Sussex University Hospitals NHS Trust | Royal Sussex County Hospital | Foundation - South Thames | 1. The Trust must ensure that Foundation doctors working on the general surgery wards have on-site access to support from a competent, more senior colleague who must be suitably qualified to guide and teach the Foundation doctors and deal with problems as they arise. The senior colleague must be primarily based on the wards during the daytime (seven days a week) and immediately accessible at all times.  
2. The Trust must ensure that there are enough staff members so that Foundation doctors have appropriate working patterns and workload.  
3. Foundation doctors must be released to attend their dedicated teaching sessions and given access to other educational opportunities, such as the Emergency Department and theatre.  
4. The Trust must work towards meeting all mandatory requirements and standards for Foundation doctors working in general surgery as set out by Health Education England Kent Surrey Sussex (HEE KSS). |
| QA8595  | Ayrshire & Arran | University Hospital Ayr | Acute internal medicine - West; Core Medical Training - West W05435; Foundation; General (internal) medicine | 1. NHS Ayrshire & Arran must ensure that core medical trainees are provided with appropriate learning opportunities and feedback. |
1. The Trust must ensure measures are put in place within the haematology department to promote a culture that both seeks and responds to feedback from learners and educators on compliance with standards of patient safety and care, and on education and training.

2. Haematology trainees must have an appropriate level of clinical supervision at all times by an experienced and competent supervisor, who can advise or attend as needed, on the wards and in the laboratory. The level of supervision must meet the individual learner’s competence, confidence and experience; and provide educational opportunities with feedback given to the learner. The support and clinical supervision must be clearly outlined to the learner and the supervisor.

3. There must be a clear system in place for handover of haematology patients to the acute medical take at night, as well as a system in place for learners to be aware of which haematology patients have come in overnight. Handover of care must be organised and scheduled to provide continuity of care for patients and maximise the learning opportunities for doctors in training in clinical practice.

4. Haematology trainees must not be subjected to, or subject others to, behaviour that undermines their professional confidence, performance or self-esteem. The learning environment and culture within the haematology department must value and support education and training so that learners are able to demonstrate what is expected in Good medical practice and to achieve the learning outcomes required by their curriculum.

<table>
<thead>
<tr>
<th>QA Code</th>
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<th>Programmes</th>
<th>Conditions</th>
</tr>
</thead>
</table>
| QA10194 | London North West University Healthcare NHS Trust | Northwick Park Hospital | Haematology | 1. The Trust must ensure measures are put in place within the haematology department to promote a culture that both seeks and responds to feedback from learners and educators on compliance with standards of patient safety and care, and on education and training.  
2. Haematology trainees must have an appropriate level of clinical supervision at all times by an experienced and competent supervisor, who can advise or attend as needed, on the wards and in the laboratory. The level of supervision must meet the individual learner’s competence, confidence and experience; and provide educational opportunities with feedback given to the learner. The support and clinical supervision must be clearly outlined to the learner and the supervisor.  
3. There must be a clear system in place for handover of haematology patients to the acute medical take at night, as well as a system in place for learners to be aware of which haematology patients have come in overnight. Handover of care must be organised and scheduled to provide continuity of care for patients and maximise the learning opportunities for doctors in training in clinical practice.  
4. Haematology trainees must not be subjected to, or subject others to, behaviour that undermines their professional confidence, performance or self-esteem. The learning environment and culture within the haematology department must value and support education and training so that learners are able to demonstrate what is expected in Good medical practice and to achieve the learning outcomes required by their curriculum. |
| QA11130 | Central and North West London NHS Foundation Trust | Hillingdon Hospital; Park Royal Centre for Mental Health; St Charles Hospital; The Gordon Hospital | Core Psychiatry Training, General psychiatry | 1. No doctor in training will review an acute inpatient without an appropriately qualified member of staff accompanying them. Concerns affecting the safety of patients or trainees must be addressed by the Trust immediately and effectively. |
| QA10483 | NHS Tayside | Trust-wide | General Psychiatry | 1. NHS Tayside must ensure learning is facilitated through effective reporting mechanisms, feedback and local clinical governance activities.  
2. NHS Tayside must ensure that learners have access to an appropriate level of supervision at all times, including out of hours. |
### Purpose
The Investment Committee is required by its Statement of Purpose to report annually to Council on its activities. This report outlines the Investment Committee’s work since its last report to Council in December 2020.

### Decision trail
This report has been considered by the Investment Committee at its meeting in November 2021.

### Recommendations
- a To discuss the annual report of the Investment Committee.
- b To discuss and approve the updated Statement of Purpose.

### Annexes
- Annex A: Statement of Purpose of the Investment Committee
- Annex B: Investment Policy

### Author contacts
- **Samuel Curtis**, Corporate Governance Manager
  
  Any enquiries to: GovernanceTeamMailbox@gmc-uk.org

### Sponsoring director/Senior Responsible Owner
- **Neil Roberts**, Director of Resources
Background

1. The Investment Committee is required by its Statement of Purpose to report annually to Council on its activities. Since its last report to Council on 10 December 2020, the Committee has met four times in 2021- February, May, September and November.

2. Steve Burnett was appointed as Chair of the Committee from 2021, along with Carrie MacEwen, Deepa Mann-Kler and Lara Fielden. During 2021 we sadly lost Lara and, due to an illness, and the Chair of Council, Clare Marx, stepped down from the position. Carrie was appointed as acting Chair of Council until a substantive appointment is made. In order to meet the quoracy requirements set out in the Committee’s Statement of Purpose, Carrie will continue her membership on this Committee.

3. Due to conflicts of interest and workloads, two of the Committee’s three co-opted members stepped down during the year: David Stewart and Tim Scholefield. A recruitment exercise was conducted in September 2021 and Council approved the appointment of Michael Jennings as a co-opted member. Michael attended his first meeting in November 2021. The Committee is content to operate with two co-opted members for the time being.

Investment Policy

4. The current investment policy includes a number of ethical restrictions on our investments. The Investment Committee has started work to develop a more comprehensive approach to ethical, social and governance issues. To this end the Committee is undertaking a project with our independent investment adviser (ARC) and our external fund manager (CCLA) to generate more comprehensive ethical data on the aggregate portfolio. This may lead us to revise the Investment Policy. We will update Council in due course.

Statement of Purpose

5. There has been one change to the Committee’s Statement of Purpose, which is a point of clarification, to add the quoracy details of the Committee. This information is usually stored centrally in the Governance handbook, however the Committee recommended it be highlighted in the SoP too. Council is asked to review it and consider if it is still meeting Committee’s needs.

GMC funds under management

6. The GMC originally placed £50 million under investment through its external fund manager CCLA. Returns varied throughout 2021 due to the ongoing
impact on financial markets of the COVID pandemic, and the portfolio ended the year with a value of £61.6 million. The value of the portfolio at the latest valuation on 31 January 2022 is £59.97 million.

7 Our fund manager CCLA performed well over the year 2021 and exceeded the CPI+2% target of 7.40% set by GMC with a return of 8.59%. Over the last 3 years CCLA have achieved an average of 7.86% per annum versus a target of 4.43% per annum. This outcome has been achieved whilst operating within the mandated risk constraints given to CCLA.

8 The portfolio comprises around 48% bonds and cash, 35% equities and 16% property and alternatives.

9 CCLA’s performance is reviewed by the Committee on a quarterly basis and has been in the top quartile of their peer group comparators over the year.

10 The funds have all been managed within the agreed ethical criteria set out in our investment policy.

**GMC Services International**

11 The Committee have been updated on GMCSI’s activities throughout the year. However due to the pandemic many GMCSI projects in the pipeline have been delayed. The Committee will continue to monitor the activities of GMCSI in 2022.

**Treasury management**

12 The Committee consider a report on the GMC’s in-house management of its cash balances at each meeting.

13 The value of our investments, plus any cash balances we hold, are typically higher than the level of our free reserves, largely because many doctors pay their annual fees in advance.

14 The GMC’s cash holdings at the end of 2021 were £46.5 million with a blended interest rate of 0.25%.

**Investment Risk Register**

15 The Committee reviewed and updated the Investment Risk Register at each of its meetings. This included consideration of the potential investment risks relating to the UK’s withdrawal from the EU and the pandemic.
The Committee’s external adviser, Asset Risk Consultants Ltd (ARC), provide an external perspective on the risk register and have advised that it adequately addressed the risks and mitigations relating to its investments.

Committee effectiveness review

In November 2020, the Committee held an effectiveness review. Due to the changes of the Committee, focus has been on induction and ensuring the Committee have a solid foundation and support network for financial process.

The Committee still has Governance support in the form of a committee secretary and training support in the form of CCLA and ARC providing sessions on specific financial topics.

Independent investment advice

ARC advised the Committee on all elements within the Committee’s remit (excluding GMCSI). In addition to this, a review session is led by ARC during each meeting examining the fund manager’s quarterly report providing expertise on the technical elements of the report.

The current contract for independent investment advice expires in May 2022 and the Committee is currently running a retendering exercise.

Investment Objective and ESG

The Committee is working with ARC and CCLA to invest in a conservative and well diversified portfolio. The focus is around long-term responsible investment. The investment portfolio will therefore be constructed in a sustainable manner and given due consideration to ethical, environmental, social and governance issues.

A benchmarking exercise will be developed in 2022 and Council will be updated once this has been implemented.
Statement of purpose of the Investment Committee

**Purpose**

1. The purpose of the Investment Committee is to provide a forum for implementing and reviewing Council’s Investment Policy.

2. Council is ultimately responsible for determining and reviewing the overall Investment Policy, objectives, risk appetite and target returns. Operational decision-making and implementation of the policy is delegated to the Investment Committee.

**Duties and activities**

3. The Investment Committee:

   a. Ensures the management of the assets, including the assets of any trading subsidiary of the GMC in which the GMC has made an investment, is consistent with the Investment Policy set by Council.

   b. Monitors the Investment Policy to ensure it remains appropriate, and to recommend changes to Council as appropriate.

   c. Implements changes to the Investment Policy as appropriate.

   d. Establishes and monitors the investment management structure to ensure that it is appropriate to meet the agreed Investment Policy. This includes decisions about the appointment of fund managers, the number of fund managers used, the proportion of assets managed by each manager, and their mandates.

   e. Agrees the terms of appointment of the investment fund managers, including their fee scales.

   f. Implements changes to the investment management structure as appropriate.

   g. Sets asset allocation parameters, based on advice from fund managers and/or external advisers, and monitors the actual asset allocations chosen.
by the fund manager, to ensure consistency with the policy. Where more than one fund manager is appointed, the Committee will also monitor the aggregate asset allocation to ensure it provides sufficient diversification to reduce the risk of capital and/or revenue loss.

- **Monitors the performance of each fund manager against agreed objectives by means of regular review of the investment results and other information.**

- **Monitors the corporate governance activities, policies and exercising of voting rights of the investment fund managers.**

- **Meets with the investment fund managers at least biannually to discuss their performance, actions and future strategy.**

- **Considers and approves any investment by the GMC in a trading subsidiary.**

- **Monitors and has oversight of any investment by the GMC in a trading subsidiary –on a financial, programme-related or mixed motive investment basis to ensure the expected return is delivered, reporting to Council at least annually on this. This would include meeting with representatives of the trading subsidiary at least biannually.**

- **Monitors and reacts to legislative, financial and economic changes affecting, or potentially affecting, the Investment Policy.**

- **Reviews, and makes recommendations to Council on, the Investment Policy so that it remains consistent with, and supportive to, Council’s overall business plan, budget and reserves policy.**

**Working arrangements**

4 The Investment Committee meets quarterly. Additional meetings may be scheduled if necessary.

5 Draft minutes should be cleared by the Chair and circulated to members for comment within two weeks of the meeting. The Committee approves the minutes at its next meeting.

6 Membership of the Investment Committee comprises:

- **Four members of Council, one of whom will be appointed as Chair of the Committee.**
b Up to three external, co-opted members, with extensive investment experience.

c The Director of Resources and the Assistant Director of Finance.

7 The role of the external co-opted members is to bring their experience and knowledge of investments to the work of the Committee. Co-opted members are not appointed as advisers to the Committee. They are expected to act as full members of the Committee, while recognising that they are not trustees or members of Council.

8 Quoracy for Committee meetings will be three as outlined in line with B2 of the Governance Handbook.

9 In the event that a vote needs to be taken, only Council members will be entitled to vote, in line with Annex B1 of the Governance Handbook.

10 The Committee may engage professional external advisers to undertake a periodic review/health check of the investment arrangements, and to provide professional advice. External advisers will attend Committee meetings as necessary.

11 Fund managers who are appointed to manage investment funds on behalf of the GMC will be expected to attend Committee meetings at least biannually.

12 The Chair and/or directors of trading subsidiaries will attend Committee meetings at least biannually.

13 Other staff may attend Investment Committee meetings as necessary.

14 A summary of the performance of funds invested under management and funds invested through a trading subsidiary will be reported to Council as part of the normal reporting of financial performance within the Chief Executive’s report. In addition, the Committee will report annually to Council on its activities.

[This version of the Investment Committee’s Statement of purpose was approved by Council on 24 February 2022]
Investment Policy

Introduction

1 As a matter of prudent financial management we must hold sufficient reserves to:
   a Provide working capital to undertake our day to day business
   b provide funds to deal with any risks that materialise
   c provide funds to respond to new initiatives, opportunities and challenges that present themselves
   d cover the time period before any changes to fee levels takes full effect

2 This ensures that our regulatory independence is underpinned by a strong and stable financial base.

3 In addition to our reserves we typically hold significant cash sums during the year because our expenditure is broadly linear while our fee income is concentrated in the summer months.

4 This policy sets out the approach we will take with all of the funds that we hold. It supports our charitable aims and our statutory purpose as set out in the Medical Act 1983 and is in line with Charity Commission guidance on investments.

5 Our funds can be separated into four categories: those which are required as working capital for the normal day to day operation of the business; those which we may invest under management; those which we may invest in a trading subsidiary; and any residual cash balance.

Working capital

6 The Investment Committee will ensure that we hold sufficient working capital for normal cash-flow purposes. The Committee will determine an appropriate amount from time to time which provides sufficient flexibility to avoid temporary borrowing and/or the need to liquidate investments to deal with short term variations in operational income-and expenditure. Any changes to the actual
amount of working capital held will be notified to Council through the report of
the Chief Executive Officer to the Council.

7 Working capital will be held as cash in instant access interest-bearing accounts
in UK banks which are subject to regulation by the Financial Conduct Authority.

8 As a minimum, the bank must hold at least two out of three of the following
short term credit ratings:

- Moody’s P-2
- Fitch F1
- Standard and Poor’s A-2

9 Working capital will be managed by the Director of Resources who will seek to
secure the most advantageous interest rates available, within the constraints of
the policy. Funds may be moved between banks during the year to achieve this,
but the primary requirements for working capital funds are security and
liquidity.

Funds invested under management

10 After taking account of our working capital requirement we have determined
that we will invest up to £50 million under management. This amount is
reviewed annually by Council.

Attitude to risk

11 We have a low risk appetite. We wish to protect against volatility, capital loss
and the erosion of asset value by inflation.

Objectives

12 When investing funds under management our objectives are: to provide
protection against inflation; to generate a modest level of return; and to
diversify our funds to reduce the risk of capital and/or revenue loss.

13 Our target rate of return on funds invested under management is inflation (CPI)
plus 2% over a rolling five year period.

14 Funds under management will be invested in a broad range of quoted
investments, bonds and other debt securities issued by public and corporate
bodies, third party regulated funds, regulated and unregulated in-house funds,
money market instruments, foreign exchange, private equity and cash
(including deposits in pooled cash funds).
Asset allocation parameters will be determined by the Investment Committee, based on advice from fund managers and/or external advisers, to ensure that funds are diversified to reduce the risk of capital and/or revenue loss. The Investment Committee will monitor compliance with those parameters. The parameters will be reviewed periodically to ensure that they remain consistent with our low risk appetite. If more than one fund manager is used, the Investment Committee will monitor the aggregate asset allocation to ensure it provides sufficient diversification.

**Ethical considerations**

We have adopted a comprehensive ethical investment approach. We believe that investing in certain companies or sectors would conflict with our charitable aims, or may create reputational damage. We do not wish to profit directly from, or provide capital to, activities that are materially inconsistent with our charitable aims and so we specifically exclude investment in companies whose principal purpose involves: tobacco; alcohol; gambling; pornography; high-interest rate lending; cluster munitions and landmines; and the extraction of thermal coal or oil sands. We recognise that many large companies are involved in a broad range of business activities. Given this we do not invest in companies that derive more than 10% of their revenue from an excluded area. This allows us to invest in, for example, the retail sector while excluding tobacco companies.

We do not invest in companies that are under investigation for, or been found guilty of, tax evasion or money laundering in the last three years.

We recognise that when fund managers invest through a third party or pooled funds, we cannot directly influence the selection of individual investments. In these circumstances we require the fund managers to ensure that the proportion of excluded investments in the pooled fund is less than 10%.

We may invest in companies whose activities are consistent with, or supportive of, our charitable aims. We expect companies in which we invest to demonstrate responsible employment and corporate governance practices, to be conscientious with regard to environmental and social issues, and to deal fairly with customers and the communities in which they operate. We may also use our position as an investor to actively engage with and influence the corporate behaviour of those companies we invest in.

We will invest only through fund managers who demonstrate the strongest environmental, social and governance (ESG) credentials. When appointing fund managers we will take into consideration how they incorporate an assessment of companies performance on ESG issues into their stock selection.
Funds invested through a trading subsidiary

21 Where we have the power to do so we may invest funds in a trading subsidiary of the GMC.

22 Investments in a trading subsidiary may take the form of loan capital and/or share capital.

23 Any funding provided to a trading subsidiary must be justifiable as an appropriate investment of the GMC’s resources, e.g. by means of specific investment advice and may take the form of:
   a A financial investment to generate a financial return to be used to further our charitable objectives (requiring advice).
   b A straightforward grant of money or a programme-related investment, to directly deliver one or more of our charitable objectives (not normally requiring advice).
   c A mixed-motive investment, combining elements of both financial and programme-related investments (requiring advice as far as appropriate).

24 Any investment in a trading subsidiary will be subject to the same ethical considerations as funds invested under management.

25 Any investment in a trading subsidiary will require specific approval by the Investment Committee and must comply with HMRC’s requirements for qualifying investments.

Residual cash balance

26 Any residual cash not held as working capital or invested will be held in medium term deposits and/or interest-bearing accounts.

27 Medium term deposits and interest-bearing accounts will be held in UK banks which are subject to regulation by the Financial Conduct Authority. As a minimum, the bank must hold at least two out of three of the following short term credit ratings:
   - Moody’s P-2
   - Fitch F1
   - Standard and Poor’s A-2

28 No single deposit should exceed £5 million, with a maximum exposure of £40 million per bank (including any funds held as working capital in instant access interest-bearing accounts). Term deposits should be spread on a rolling
maturity basis, and maturity dates for deposits should be no longer than 18 months.

29 Funds will be managed by the Director of Resources who will seek to secure the most advantageous interest rates available, within the constraints of the policy.

Management, reporting and monitoring

30 Council is responsible for determining and reviewing the overall investment policy, objectives, risk appetite and target returns.

31 Council has delegated to the Investment Committee responsibility for implementing the investment policy, appointing and managing fund managers, monitoring performance and reporting to Council. Full responsibilities are set out in the Investment Committee’s statement of purpose.

32 Day to day investment decisions are delegated to investment fund managers in line with this policy and are accountable to the Investment Committee for performance. The Investment Committee may determine benchmarks against which to measure performance.

33 Investment fund managers are required to provide quarterly valuation and performance data.

Approval and review

34 The Investment Policy will be reviewed by Council annually, on the advice of the Investment Committee. This will reflect the Council’s overall financial position, its budgetary requirements, and any changes to the reserves policy.

[This version was approved by Council on the 24 February 2022]
### Action
- To note

### Purpose
This report summarises the work undertaken by the Executive Board during 2021, setting out the decisions taken, policies and guidance agreed, and reports noted across a range of strategic issues.

### Decision trail
Council receives a report on the work of the Executive Board annually, in addition to the updates included in the Chief Executive’s report at each meeting.

This paper has been agreed by the Executive Board.

### Recommendation
To note the report of the Executive Board 2021.

### Annexes
None

### Author contacts
- **Dale Langford**, Corporate Governance Manager
  
  Any enquiries to: [GovernanceTeamMailbox@gmc-uk.org](mailto:GovernanceTeamMailbox@gmc-uk.org)

### Sponsoring director/Senior Responsible Owner
- **Charlie Massey**, Chief Executive
Background

1. The Executive Board was established in 2017 as a decision-making forum and to promote collective executive decision-making by the senior management team (SMT). The Board is required by its statement of purpose to submit an annual report to Council, as well as regularly reporting to Council via the Chief Executive’s report.

2. The Board met 11 times during 2021, on the following dates:

   - 1 February 2021
   - 1 March 2021
   - 29 March 2021
   - 26 April 2021
   - 1 June 2021
   - 28 June 2021
   - 1 July 2021 (26 July 2021)
   - 27 September 2021
   - 25 October 2021
   - 29 November 2021
   - 20 December 2021

Key matters considered by the Executive Board in 2021

Operational performance and risk

3. In alternate months, the Board considered the Performance and Risk Report, providing high level reports on performance, including finance and people, customer service and learning, and updates on the key risks to achieving our strategic aims.

4. In the same meetings as the Performance and Risk Report, the board conducted a series of risk deep dives. The aim of these discussions is to focus on a single corporate risk and consider the extent to which individual board members are confident that the directorate level risks that underpin it provide sufficient assurance to the Board collectively that the corporate risk is being managed. A similar approach applies to deep dives relating to opportunities.

5. Risk deep dives during 2021 covered the following risks and opportunities: Working with patients and the public (1 February 2021), Deriving insight from our data capability (29 March 2021), Unplanned event (1 June 2021), ED&I strategic delivery and ED&I compliance (26 July 2021), Responding to changes in external environment (27 September 2021). The final such discussion of the year, on 29 November 2021, examined the Corporate Opportunities and Risk Register more broadly to provide assurance it still covers the right strategic risks.
Pandemic response and recovery

6 The Board discussed pandemic response and recovery throughout the year, including:

   a Establishing a Recovery and Renewal Taskforce and approving the resumption of all paused investigations (29 March 2021).

   b Agreeing plans for a phased return to the office when social distancing ends, in a way that supports the effective delivery of our functions (26 April 2021).

   c Approving the reconfiguration of office space at 3 Hardman Street in Manchester to rebalance the office space between desks and collaborative areas for the return to the office. (28 June 2021).

   d Agreeing to cancel scheduled PLAB 2 tests in January and February 2022 in response to the impact of increasing numbers of cases of the Omicron variant, with UK-based candidates and those with jobs prioritised for the restart (20 December 2021).

Business Plan and Budget

7 At its meetings on 27 September and 29 November 2021, the Board considered the draft Business Plan and Budget, ahead of consideration by Council on 9 December 2021.

Equality, diversity and inclusion

8 The Board discussed the Governance and Compliance Review on equality, diversity and inclusion (ED&I), as reported to Council on 29 April 2021 (26 April 2021).

9 ED&I targets for recruitment are included in the Board’s regular Performance and Risk Report and, as referred to in paragraph 5, the Board also conducted a risk deep dive on ED&I strategic delivery and ED&I compliance.

Policy

10 The Board approved changes to how we consider allegations of violence and dishonesty (1 March 2021). These included updated guidance for decision makers so that further action may not be needed where a doctor’s behaviour outside their professional practice does not pose a risk to patients or to public
The Board agreed to publish annually, from December 2021, data on **Doctors who have died whilst in FTP proceedings** for a three-year rolling period, with the cause of death data broken down into broad categories (1 March 2021).

The Board agreed to discontinue an exercise to verify the primary medical qualifications of a group of licensed doctors who had previously joined the Register via a route other than the PLAB test (26 July 2021).

The Board agreed a **Policy for granting temporary emergency registration** (27 September 2021), reflecting on the approach we are taking to granting temporary emergency registration as part of our response to the pandemic. The new policy provides a framework for developing an approach to support the response required for a particular emergency rather than detailing the approach itself.

**Other regular reports**

The Board received the following reports:

- a. The draft Executive Board report to Council (1 February 2021), ahead of consideration by Council on 25 February 2021.
- b. **The annual research report for 2020**, providing an overview of the research programme managed within the Data, Research and Insight Hub during 2020, highlighting key findings, and how we make sure the quality of research is to a high standard and makes an impact (1 March 2021).
- c. **Plans for the staff survey** (1 March 2021) and results of the survey (25 October 2021) were reviewed by the Board, as reported to Council on 3 November 2021.
- d. Updates on the progress of regulatory reform (29 March, 1 June, 28 June, 26 July, 27 September, 29 November 2021).
- e. The **annual report of the Data Protection Officer**, providing an overview of our information governance activities in 2020 (29 March 2021).
- f. Updates on GMC Services International Ltd (1 June and 29 November 2021).
The work of the Medical Advisory Board (MAB) that will provide advice to the Executive Board on how the organisation engages with vulnerable doctors in GMC processes (1 June 2021).

The draft 2020 Trustees’ Annual report and accounts and the annual fitness to practise statistics, for submission to Council (26 April 2021). Council agreed the Trustees’ Annual report and accounts for 2020 at its meeting on 9 June 2021.

Update on corporate complaints received, ahead of Council’s consideration of the complaints reports (26 April and 25 October 2021).


The annual health and safety report, providing an overview of health and safety activities and accident/incident information for 2020 (27 September 2021).

The annual report of the GMC Group Personal Pension Plan Management Board (29 November 2021), on which Council also received an update on 9 December 2021.


The approach for applying the 2022 pay award (20 December 2021).
<table>
<thead>
<tr>
<th>Action</th>
<th>To approve</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purpose</td>
<td>This paper sets out the proposed dates of Council and Board/Committee meetings in 2023.</td>
</tr>
<tr>
<td>Decision trail</td>
<td>Council notes the dates for the following year’s meetings in February each year. Each committee chair has been consulted on the proposed dates for their committee. Council’s work programme for 2023 will be considered by Council at the meeting in December 2022.</td>
</tr>
<tr>
<td>Recommendation</td>
<td>To agree the 2023 schedule of meetings.</td>
</tr>
<tr>
<td>Annexes</td>
<td>Annex A: 2023 Council and committee dates</td>
</tr>
<tr>
<td>Author contacts</td>
<td>Melanie Wilson, Head of Corporate Governance and Council Secretary</td>
</tr>
<tr>
<td></td>
<td>Any enquiries to: <a href="mailto:GovernanceTeamMailbox@gmc-uk.org">GovernanceTeamMailbox@gmc-uk.org</a></td>
</tr>
<tr>
<td>Sponsoring director/ Senior Responsible Owner</td>
<td>Sophie Brookes, Assistant Director Corporate Directorate</td>
</tr>
</tbody>
</table>
Background

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

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

3. The full meeting schedule will also be uploaded and available for members to view via the Board Intelligence app and will be kept updated should any changes be made.

4. Arrangements set out in this paper will be subject to review in the light of regulatory reform and the possibility that we will move to a unitary board arrangement before the end of 2023.

5. Additional briefings or meetings may be held as required. The Corporate Governance Team will endeavour to arrange these at a convenient time for all.

Council

6. The draft schedule of Council meetings for 2023 is at Annex A. Council meets six times each year to meet the needs of the work programme, and has an away day/night, usually in July. Council seminars take place the evening before Council meetings, between 16:30 to 19:00.

7. Of the six meetings, one will be held in Manchester, one in one of the national offices, one ‘virtual’, and the remaining three in London.

Committees and other groups

8. The draft schedule at Annex A also contains the proposed dates of other meetings involving Council members, including the Audit and Risk Committee, Remuneration Committee, Investment Committee, GMCSI Board and the Board of Pension Trustees. The frequency of these meetings has been determined in accordance with the working arrangements set out in their statements of purpose.
As usual, it will be open to Chairs, in consultation with other members, to decide as the work programmes develop, whether there is a need to hold all of the proposed meetings scheduled, or indeed if additional meetings are required.
2023 Council and Committee dates

The proposed meeting schedule for Council is as follows:

Tuesday 28 February 2023, 16:30-19:00 (Evening seminar)
Wednesday 1 March 2023, 09:00-13:00 – London

Wednesday 26 April 2023, 16:30-19:00 (Evening seminar)
Thursday 27 April 2023, 09:00-13:00 – Manchester

Tuesday 20 June 2023, 16:30-19:00 (Evening seminar)
Wednesday 21 June 2023, 09:00-13:00 – London

Tuesday 11 and Wednesday 12 July 2023, Council away day – Residential/overnight

Wednesday 27 September 2023, 16:30-19:00 (Evening seminar)
Thursday 28 September 2023, 09:00-13:00 – Virtual

Wednesday 1 November 2023, 16:30-19:00 (Evening seminar)
Thursday 2 November 2023, 09:00-13:00 – Devolved nation tbc

Tuesday 12 December 2023, 16:30-19:00 (Evening seminar)
Wednesday 13 December 2023, 09:00-13:00 – London
2023 Committee and other group meetings

Audit and Risk Committee
  Thursday 26 January 2023
  Wednesday 29 March 2023
  Thursday 25 May 2023
  Tuesday 12 September 2023
  Thursday 16 November 2023

Investment Committee
  Tuesday 14 February 2023
  Wednesday 10 May 2023
  Thursday 21 September 2023
  Tuesday 21 November 2023

Remuneration Committee
  Tuesday 21 March 2023
  Tuesday 10 October 2023

Board of Pension Trustees
  Wednesday 8 March 2023
  Tuesday 16 May 2023
  Wednesday 19 July 2023
  Wednesday 20 September 2023
  Tuesday 14 November 2023
Council meeting – 24 February 2022

Agenda item M11 – 2023 Council and Committee planning

**GMC/MPTS Liaison Group**

- Wednesday 7 June 2023
- Wednesday 29 November 2023

**GMCSI Board**

- Thursday 16 March 2023
- Thursday 29 June 2023
- Tuesday 26 September 2023
- Thursday 30 November 2023
Council 2022 forward work programme

*Draft as of: 15 February 2022*

<table>
<thead>
<tr>
<th>Date and time:</th>
<th>Meeting:</th>
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<tbody>
<tr>
<td>Wednesday 23 February (evening seminar) and Thursday 24 February 2022 (Meeting) 09.00 – 13.00 – <strong>London</strong></td>
<td>Council</td>
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<tr>
<td><strong>Evening seminar 16:00-17:30</strong></td>
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<tr>
<td>▪ Learning from Inquiries and Reviews Pensions update</td>
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<td>▪ Pensions update</td>
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**Confidential items**

- Safeguarding update
- Update on regulatory reform- unitary boards
- Annual Review of Governance Framework: GMC and GMCSI (Below the line)

**Meeting**

- Chief Executive’s report
- Equality, diversity and inclusion – Annual progress report
- Progress on MAPs
- Quality Assurance update
- Update on GMP
- Report of the Investment Committee 2021

**Below the line**

- Report of Executive Board
- 2023 meeting schedule
- 2022 Council forward work programme

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<thead>
<tr>
<th>Date and time:</th>
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<tbody>
<tr>
<td>Wednesday 27 April (evening seminar) and Thursday 28 April 2022 (Meeting) 09.00 – 13.00 – <strong>London</strong></td>
<td>Council</td>
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<tr>
<td><strong>Evening seminar (tbc)</strong></td>
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<tr>
<td>Corporate social responsibility</td>
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**Confidential items**

-
### Meeting
- Chief Executive’s report
- Equality, diversity and inclusion impact report
- PSA annual review of our performance
- Human Resources report 2021
- Biannual s40a appeals update
- Communications and Engagement update
- Update on regulatory reform
- Freedom to speak up guardian annual report
- Approval of awarding bodies: [tbc]

### Below the line
- Council members’ register of interest
- 2022 Council forward work programme

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**Date and time:**

<table>
<thead>
<tr>
<th>Meeting:</th>
<th>Council</th>
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<tbody>
<tr>
<td>Tuesday 21 June (evening seminar) and Wednesday 22 June 2022 (Meeting) 09.00 – 13.00 Manchester</td>
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**Confidential items**
- GMCSI [Andrew McCulloch/Paul Reynolds]

**Meeting**
- Chief Executive’s report
- Equality, diversity and inclusion [tbc]
- Report of the MPTS Committee
- Trustees’ Annual Report and Accounts 2021
- Fitness to Practise Statistics Report 2021
- Report of the Audit and Risk Committee
- Compliments and Complaints report
- Update on regulatory reform
- Update on credentials (tbc?)
- Update on Brexit standstill
- Sex, gender and gender identity consultation

**Below the line**
- 2022 Council forward work programme
## Agenda item M12 – Council 2022 forward work programme

<table>
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<th>Date and time:</th>
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<tr>
<td>Tuesday 12/Wednesday 13 July 2022</td>
<td>Council Away Day</td>
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<tr>
<td><strong>Update on the Corporate Strategy</strong></td>
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<td><strong>Regulatory reform</strong></td>
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<th>Date and time:</th>
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<tr>
<td>Wednesday 28 September (evening seminar) and Thursday 29 September 2022 (meeting) 09:00 – 13:00</td>
<td>Council</td>
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<tr>
<td><strong>Seminar</strong></td>
<td></td>
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<tr>
<td>▪ Perceptions audit</td>
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<tr>
<td>▪ tbc</td>
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<tr>
<td><strong>Confidential items</strong></td>
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<tr>
<td>▪ Outline draft Business Plan and Budget 2023</td>
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<tr>
<td>▪ SoMEP report – early messages (tbc)</td>
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<tr>
<td><strong>Meeting</strong></td>
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<tr>
<td>▪ Chief Executive’s report</td>
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<tr>
<td>▪ Equality, diversity and inclusion update</td>
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<tr>
<td>▪ Biannual s40a Appeals Update</td>
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<tr>
<td>▪ <em>Adapting to the future</em> report</td>
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<tr>
<td>▪ Update on Education reform</td>
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<tr>
<td>▪ Pensions update – re triennial valuation <em>(tbc: here or November)</em></td>
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<tr>
<td><strong>Below the line</strong></td>
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<tr>
<td>▪ Council members’ register of interest</td>
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<tr>
<td>▪ 2022 Council forward work programme</td>
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<tr>
<th>Date and time:</th>
<th>Meeting:</th>
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<tbody>
<tr>
<td>Wednesday 2 November (evening seminar) and Thursday 03 November 2022 (Meeting) 09.00 – 13.00</td>
<td>Edinburgh</td>
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<tr>
<td><strong>Evening seminar</strong></td>
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<tr>
<td>▪ Scotland focus plus stakeholder dinner</td>
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<tr>
<td><strong>Confidential items</strong></td>
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Council meeting – 24 February 2022

Agenda item M12 – Council 2022 forward work programme

- Update on the staff survey

**Meeting**
- Chief Executive’s report
- Equality, diversity and inclusion update
- SOMEP report – final draft (tbc)
- Compliments and Complaints report
- Update on *Good medical practice* consultation
- Update on regulatory reform
- PPI update
- Pensions update – re triennial valuation
- Update on the staff survey

**Below the line**
- 2022 Council forward work programme

**Date and time:**

<table>
<thead>
<tr>
<th>Date and time:</th>
<th>Meeting:</th>
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</thead>
<tbody>
<tr>
<td>Wednesday 13 December (evening seminar) and Thursday 14 December 2022 (Meeting) 09.00 – 13.00 - London</td>
<td>Council</td>
</tr>
</tbody>
</table>

**Evening seminar 17:00 – 19:00 to be followed by dinner**

- Tbc

**Confidential items**

- Draft Business Plan and Budget 2023
- GMCSI

**Meeting**

- Chief Executive’s report
- 2023 Business Plan and Budget
- Three-year business plan (activities, monitoring/reporting, evaluating)
- Report of the Medical Practitioners Tribunal Service Committee 2022
- Report of the Audit and Risk Committee 2022
- Report of the Remuneration Committee 2022
- Update on regulatory reform
- MLA – update on MSC pilots (tbc)

**Below the line**

- Council forward work programme 2023
- Committee membership 2023
- Annual report on DC pension scheme
- 2022 Council forward work programme