Council Agenda

Via MS Teams

Thursday 25 February 2021

10:15 – 12:15

10:15 – 10:18  M1  Chair’s business  
3 mins

10:18 – 10:20  M2  Minutes of the meeting on 10 December 2020  
2 mins

To Approve
10:20 – 10:40  M3  Chief Executive’s Report  
20 mins

To Note
10:40 – 11:05  M4  Assessing progress 2021-2025  
25 mins

To Note
11:05 – 11:20  
Break  
15 mins

11:20 – 11:50  M5  Equality, Diversity and Inclusion  
30 mins

To Approve
11:50 – 12:05  M6  Education Quality Assurance Update  
15 mins

To Note
12:05 – 12:10  M7  2021 Council Effectiveness Review proposal  
5 mins

To Note
12:10 – 12:15  M8  Any other business
5 mins

Below the line  M9  Report of the Executive Board 2020
To Note

Below the line  M10  2022 Council and Committee planning
To Approve
## Contents

| M2 - Minutes of the meeting on 10 December 2020 | 5 |
| M3 - Chief Executive's Report | 15 |
|   | Annex A - Performance Annex | 22 |
|   | Annex B - Corporate Opportunities and Risk Register (CORR) | 36 |
|   | Annex C - CORR summary slides | 40 |
| M4 - Assessing progress 2021-2025 | 47 |
| M5 - Equality, Diversity and Inclusion | 52 |
|   | Annex A - Targets and key performance indicators | 63 |
| M6 - Education Quality Assurance Update | 68 |
|   | Annex A - Supporting diagrams | 78 |
|   | Annex B - Proactive QA rollout summary for England, Wales, Scotland and Northern Ireland | 84 |
| M7 - 2021 Council Effectiveness Review proposal | 90 |
| M9 - Report of the Executive Board 2020 | 93 |
| M10 - 2022 Council and Committee planning | 99 |
|   | Annex A - 2022 Council and committee dates | 102 |
Minutes of the meeting held on 10 December 2020

Members present – via MS Teams
Clare Marx, Chair
Steve Burnett                     Suzi Leather
Christine Eames                  Rajesh Patel
Philip Hunt                      Denise Platt
Anthony Harnden                  Alison Wright
Deirdre Kelly                    Paul Knight

Others present
Charlie Massey, Chief Executive and Registrar
Paul Buckley, Director of Strategy and Policy
Shaun Gallagher, Director of Strategy and Policy
Una Lane, Director of Registration and Revalidation
Anthony Omo, Director of Fitness to Practise and General Counsel
Paul Reynolds, Director of Strategic Communications and Engagement
Neil Roberts, Director of Resources and Quality Assurance
Colin Melville, Medical Director and Director of Education and Standards
Melanie Wilson, Council Secretary
Chair’s business (agenda item M1)

1 The Chair welcomed members, the Senior Management Team (SMT) and observers to the meeting, including our five new Council members who take up post on 1 January 2021.

2 Council paid tribute to Dr Krishna Korlipara who recently passed away. Dr Korlipara was a Council member from 1984 until 2008 and Council were reminded of the contribution he made to the GMC.

Minutes of the meeting on 4 November 2020 (agenda item M2)

3 Council approved the minutes of the meeting on 4 November 2020 as a true record.

Chief Executive’s report (agenda item M3)

4 Council received the Chief Executive’s report providing an update on the organisation’s work and developments in the external environment affecting the GMC.

5 Council noted:

   a A survey was conducted with Doctors who were placed on the Medical Register on a temporary basis to assist during the pandemic. 3000 respondents said they were prepared to help the NHS during the pandemic and 1800 expressed interest in returning to permanent registration, which represents a significant potential resource.

   b A symposium was convened with the GMC, the Statutory Education Bodies, the Royal Colleges and the Chief Medical Officers of the four countries. Four areas were explored – registering final year medical students earlier and the impact that on how prepared they were, the role and definition of generalists and specialists and how that works in practice, the assessment burden and what can be done to ensure a smooth transition, and preparing doctors to be public health leaders.

   c The GMC is prepared for any outcome in relation to Brexit. Secondary legislation is in place to ensure the organisation can still register EEA doctors, however the criteria for recognition transfers from nationality to holding a relevant EEA qualification.

   d The GMC held its first virtual conference which was a success; over 350 external stakeholders attended.
The Chair and Chief Executive gave evidence to the Committee on racial disparity advising of the need for regulatory alignment and the importance of a high-quality induction in the NHS. An update will be provided to Council in February’s Council meeting.

6 During discussion, Council noted that:

a This year 768 Valued Awards were presented to employees within the organisation. A ‘stand up’ has been organised to thank employees for their hard work this year.

b Although there were several KPI’s missed with the contact centre’s performance, it was as a result of having to move the service to home working while there was a significant volume of calls coming into the organisation. Calls were still answered well within the industry standard and were still providing high quality advice.

c The enquiries in Northern Ireland are ongoing. Members were reminded of the impact on patients in terms of reduced capacity and confidence in the service.

d Although there was a high level of annual leave ‘sold’ by employees, this was not a welfare concern by the SMT as it was closely monitored by the HR team and was an optional arrangement provided to staff.

e The GMC had a large presence at the SAS doctors conference which was well received; further work would be done to increase the GMC’s presence at similar events in the future to build its links with frontline services.

7 Council also noted their thanks to the teams involved with organising and promoting the virtual conference.

8 Council:

a Noted the Chief Executive’s report and annexes.

2021 Business Plan and Budget (agenda item M4)

9 Council received a presentation on the 2021 business plan and budget.

10 Council noted:
a The current business plan highlights the key priorities for the organisation in the year.

b As a result of reflections on our recovery from the initial impact of the pandemic, the business planning process is changing from an annual approval process to a rolling approval process which will allow for a dynamic approach to changing priorities.

c The 2021 budget was created with two aims; short term planning in place to deliver the COVID recovery plan and medium-term planning to ensure free reserves are maintained within the target range.

d As in previous years, the Annual Retention Fee will be increased in line with the September CPI figure of 0.5%, a maximum of £2 for full registration. This will be effective from April 2021.

e Future and as yet unquantified risks may impact on the level of free reserves.

During discussion, Council noted that:

a The plan on a page concept was welcomed and was a vast improvement in sharing our priorities.

b The majority of the fees charged for ’Certificates of Eligibility’ goes to the relevant Royal College. Work will be done with the Royal Colleges to provide a breakdown of fees.

c The free reserves section in the budget is a projection that is reviewed on a regular basis and small adjustments would be made should the need arise.

Council:

a Approved the 2021-23 business plan

b Approved the 2021 draft budget

c Agreed authority be delegated to the Chair of Council to amend the GMC Registration Fees Regulations and the GMC Certification Fees Regulations.
Perceptions survey 2020 (agenda item M5)

13 Council received an update on the perceptions survey that was conducted with major stakeholders in 2020.

14 Council noted:

   a The field work was conducted in March of 2020 which was before the lockdown commenced.

   b Confidence in and support of the GMC has increased since the last survey in 2018.

   c The details of the survey will be published on the GMC’s website after this Council meeting.

   d The next survey will be conducted in 2022 which will include learning from this report and questions based on the corporate strategy.

15 During discussion, Council noted that:

   a The perception of the GMC from different age groups is substantially different, however this has been the case for many of the other surveys conducted.

   b External agencies are used to assist with the surveys to ensure an appropriate dip sample of the profession is used and the messaging is clear.

   c The Chair’s direct communication with the profession in an open and honest manner has increased the profession’s confidence in the GMC.

   d Engaging medical students in a more collaborative approach at the first opportunity has shown to increase the profession’s view of the GMC.

   e The events of 2018 caused a decrease in the confidence of the GMC and further work is being done to improve.

   f The perception of the GMC being fair, although increased, was still too low to satisfy Council members. A report will be made available to Council early next year on the progress made.

16 Council:

   a Considered the survey findings.
Report of the Investment Committee 2020 (agenda item M6)

17 Council received an update from the Chair of the Investment Committee on the performance of the Committee over 2020.

18 Council noted:

a The portfolio (as at 4 December) is £56.4 million which recovered from the drop in Quarter 1.

b The fund managers have performed in the top quartile of peer-group comparators.

c The Committee considered both the Statement of Purpose and Investment policy and recommended no changes at this time.

d Further work will be done to consider investment policies in the light of a climate change policy and wider environmental, social and corporate governance responsibilities (ESG)

e An induction is being planned for Steve Burnett, who take over as Chair in 2021 and new members who are scheduled to join the Committee.

f The fund managers and third-party advisers have had their contracts renewed so will continue to assist the Committee throughout 2021.

g Tim Scholefield will be stepping down as a Co-opted member in May so a recruitment process will begin early 2021.

19 During discussion, Council noted that:

a Renewable or alternative energy companies were performing well in 2020, so this may be the preferred direction of travel.

b Paul Reynolds is leading a group that is exploring the GMC’s Corporate Social Responsibility which is due to begin reporting to the Committees in 2021.

20 Council:

a Considered the report of the Investment Committee

b Considered the Committee’s Statement of Purpose and proposed no changes

c Considered the investment policy and proposed no changes.
d Wished to record their thanks to Dame Suzi Leather for her contributions to this Committee.

Report of the Medical Practitioners Tribunal Service Committee 2020 (agenda item M7)

21 Council considered the update from the MPTS on the work done by the organisation.

22 Council noted:

a The Hearings Centre in Manchester closed in March in order to free up the medical tribunal members and to protect the MPTS staff. The service moved to virtual hearings within 48 hours.

b The MPTS wished to express thanks to the frontline staff and the GMC’s IS teams for their assistance efforts in moving the service online.

c A detailed quality analysis was used to establish if anyone using the service would be disadvantaged by having their hearing held virtually rather than in person. A number of actions were created from this analysis and rolled out.

d The Hearings Centre temporarily reopened in August and undertook socially-distant hearings which complied with all health and safety regulations, however this closed again when a national lockdown was imposed.

e At the GMC’s annual conference, three members of the Medical Defence Union commented on the collaborative approach used by the MPTS when advising on virtual or face to face hearings.

f A more detailed review will be conducted in the future regarding the use of virtual hearings as a permanent feature of the MPTS.

23 During discussion, Council noted that:

a In Quarter 3 of 2020 there were a lower level of referrals to the MPTS, however this was due to the GMC pausing investigations at the beginning of the pandemic.

b Some members who used the service reported that they felt more comfortable with the virtual format as they were in their own surroundings and felt less intimitated.
Council meeting, 25 February 2021
Agenda item M2 – Minutes of the meeting on 10 December 2020

24 Council:
   a  Noted the report of the Medical Practitioners Tribunal Service Committee 2020

Report of the Audit and Risk Committee 2020 (agenda item M8)
25 Council received an update on the work of the Audit and Risk Committee in 2020 and confirmed that it was content with the assurance provided.

26 Council noted:
   a  The Committee is able to assure Council that the organisation has an excellent control framework.
   b  The Committee’s external auditors have advised that the organisation has a mature risk management process which is more mature than its comparators.
   c  The planned audit programme was paused due to the pandemic and instead the Committee focused on planned learning reviews which were conducted successfully.
   d  Cyber security remains at the forefront of the Committee’s work programme, however the results from the controlled tests done this year have been positive with a series of actions on how to improve.
   e  In 2021, the majority of the Committee’s work will be focused on the pandemic and lessons learned on how to further reduce risk and improve assurance.

27 During discussion, Council noted that:
   a  Liz Butler, a co-opted member of the Committee will step down in 2021.

28 Council:
   a  Noted the content of the Audit and Risk Report 2020
   b  Wished to record thanks to Professor Deirdre Kelly for her contributions to this Committee.
Council meeting, 25 February 2021  
Agenda item M2 – Minutes of the meeting on 10 December 2020

Report of the Remuneration Committee 2020 (agenda item M9)

29 Council considered the report of the Remuneration Committee on its work in 2020.

30 Council noted:

a The tax liability issue on expenses incurred by Council members travelling to the GMC’s office has not been concluded by HMRC but will be rolled into the Committee’s work programme for 2021.

b The remuneration of Board members has been considered by the Committee during a benchmarking exercise and found that there was no case to change Council member remuneration at this time.

c A formal review of Members’ remuneration would be considered biannually, and external advice should be considered to ensure independence.

d There is now a strong talent and succession planning strategy for the executive team and a strong pipeline should members of the Executive team decide to move on.

31 Council:

a Noted the contents of the Remuneration Committee 2020

b Wished to record thanks to Dame Denise Platt for her contributions to this Committee.

Any other business (agenda item M10)

32 Council thanked Suzi Leather, Christine Eames, Deirdre Kelly and Denise Platt for their service to the GMC Council for the last eight years.

33 Council also thanked Paul Buckley for his service to the GMC for the past 25 years.

34 Council noted that the next evening seminar and meeting would be on 24 and 25 February 2021.

Closing report on the 2018-20 corporate strategy (agenda item M11)

35 Council noted this below the line item.
Council meeting, 25 February 2021
Agenda item M2 – Minutes of the meeting on 10 December 2020

**Report of the GMC Group Personal Pension Plan Management Board 2020 (agenda item M12)**

36 Council noted this below the line item.

**Council forward work programme 2021 (agenda item M13)**

37 Council noted this below the line item.

Confirmed:

Clare Marx, Chair  
25 February 2021
### Purpose
This report outlines developments in our external environment and progress on our strategy since Council last met. Key points to note:

- We have continued to support the profession and health and care system through this peak of the pandemic by taking a flexible approach to regulation, and reassuring doctors that the context they are working in will be fully taken into account if any concerns are raised about their practice.

- We have begun construction work on our new temporary clinical assessment centre which will increase the capacity for international medical graduates to join the UK workforce.

- Charlie Massey attended the Health and Social Care Select Committee’s hearing for their inquiry on the Safety of maternity services in England to share our insights into maternity care and the importance of inclusive leadership and working cultures.

### Action
To note
Our immediate response to the Coronavirus pandemic

1 We are continuing to do what we can to support the profession and the healthcare system through this difficult period. Dame Clare Marx wrote to all registered doctors on 11 January 2021 to thank them for their work and professionalism in the face of huge practical and emotional challenges. She reminded doctors of the guidance available on our ethical hub, including information about prioritising access to treatment. And she reassured them that the context in which they’re working will be fully taken into account if any concerns are raised about their practice. We’ve also recently updated our joint statement with the other UK health and social care professional regulators to reinforce this message as we know it’s an issue that many are concerned about.

2 Colin Melville, as medical director of the GMC, also co-signed a joint letter to the profession from the UK Chief Medical Officers, NHS and Academy of Medical Royal Colleges on 12 January setting out how the organisations are supporting doctors through the pandemic. More recently Colin also wrote to all trainee doctors to explain how we are supporting their progression during the pandemic.

3 We are also continuing to support doctors and the system by taking a flexible approach to our regulatory functions during the pandemic. For example, we are continuing to take a flexible and proportionate approach to fitness to practise cases in discussion with employers, medical defence organisations, complainants, and affected doctors. We’re progressing open cases where we can, but we know that some employers and doctors won’t be able to assist with our investigations at this time. This means that some cases will progress more slowly, or not at all for the time being. We’ll also pause disclosure of new cases unless the individual is already aware (either from self-referral or via a police case), or where we need make an interim order to protect patient safety.

4 We are also giving maximum flexibility for revalidation to meet local needs. If a doctor isn’t ready to revalidate, they can defer their date without any impact on their ability, or licence to practice. In addition, ID checks for doctors joining the register have been paused and we are registering doctors who have met all other registration requirements.

Temporary emergency registration

5 Around 25,500 doctors continue to hold temporary emergency registration. We have continued to work with governments, NHS and employers across the UK to ensure doctors with temporary emergency registration can be deployed as effectively as possible. On Monday 26 January, we wrote to around 2,500
doctors who have taken voluntary erasure or given up their licence to practice since March 2020 to remind them that they are eligible for temporary emergency registration and they can quickly and easily apply for it. 161 of these doctors have contacted us to opt in (as of 10 February 2021).

**International medical graduates**

6 We’re continuing to do all we can to support overseas doctors into UK practice, as we continue running socially distanced PLAB2 tests. We are the only country that runs exams equivalent to PLAB2 which has restarted these assessments. The US, Australia and Canada all suspended their clinical skills exams last year and they have not restarted. On 1 February 2021, we started the build on our new temporary clinical assessment centre, which will double our current capacity and allow us to run socially distanced tests for around 11,000 international medical graduates each year, in line with our capacity before the pandemic. We expect the new temporary clinical assessment centre to open in June 2021.

7 We have also recently introduced new routes to the register, which mean that doctors who have passed one of our acceptable overseas registration exams may no longer need to take PLAB. And those who gained their primary medical qualification in the EEA or Switzerland might be eligible for our new relevant European qualification route, which came into effect following the end of the Brexit transition period.

**Education and training**

8 The pandemic has continued to challenge medical education and training. On 25 January 2021, we published a joint statement with the Medical Schools Council setting out our approach to supporting final year medical students to respond effectively to the immediate healthcare crisis, recover lost learning opportunities and achieve the outcomes required for graduation so that they’re ready to join the medical workforce in summer 2021.

**Ethical issues**

9 We are continuing to update our ethical hub in response to emerging issues for the profession. For example, we have published information on decisions about prioritising access to treatment. We have continued to respond to ethical enquiries we have received on difficult issues arising from the pandemic.

10 On Thursday 18 February 2021, we published updated guidance on ‘Good practice in prescribing and managing medicines and devices’. We believe the
updated advice will help doctors as they navigate the increased use of remote medicine; supporting them to maintain good patient care in incredibly challenging circumstances. The guidance will come into force on 5 April 2021, giving doctors and employers six weeks to familiarise themselves with it.

**Issues and opportunities in the medium term**

11 We are updating our strategic position on workforce to ensure we and others are doing all we can to support the workforce in the short term through the pandemic and to build a sustainable medical workforce for the years to come. We are conscious of the great work that the profession has put in during the pandemic and our data and research shows that a focus on retention will be particularly important over the next few months. We will set out what we and others can do to support recruitment, retention and productivity of the medical workforce and will share our findings with Council in due course.

12 Our data and analysis will underpin our work. For example, research with the UK medical education bodies into the reasons why doctors leave the profession, *Completing the Picture*, will be published this Spring. We are also working closely with system colleagues across the UK to respond to the challenges, for example as members of the NHS England and NHS Improvement Task and Finish Group on Retention of the Medical Profession.

13 We are also working to embed the positive discussions we had at the education summit in November 2020, building on the flexibility shown the pandemic. The four workstreams we are working with partners on are: the impact and value of Foundation Interim Year 1 posts; supporting generalism across doctors’ careers; making progression more flexible; and doctors as public health leaders. We are pleased that in NHS CEO Sir Simon Stevens’ evidence to the Health and Social Care Select Committee inquiry on Coronavirus, he highlighted the current difficulty of changing specialty mid-career and that the pandemic has shown the benefits of making this easier for doctors and the system.

**Supporting our people**

14 The majority of our staff continue to work at home in line with government guidance. We have continued priority activities such as PLAB examinations, and some in-person MPTS hearings where virtual hearings are not possible.

15 Due to school closures and other caring issues faced by our colleagues, we have instituted additional flexibility to support our people in this difficult time. For example, we have added a new option to our support and flexibility
package, providing paid ‘lockdown leave’ to those who need it, equivalent to two normal working weeks. This is available all colleagues who have additional caring responsibilities and have used other forms of leave.

16 Acting on lessons learnt from earlier stages of the pandemic and our Recovery and Renewal work we’ve instigated a fortnightly survey of workload pressures to better understand how staff availability and additional work is impacting teams and morale. The most recent survey indicates pressures are levelling off but these continue to be monitored, with teams considering opportunities to pause work and relax performance targets to support staff wellbeing.

17 We continue to balance addressing our backlogs of work against our ambitions for change in the corporate strategy. For example, we are continuing with piloting digital ID checks to supplement face-to-face ID checks in the future. We have started engaging with colleagues across the organisation about what how they would want to work when social distancing ends, and how we might use the office space most effectively in future.

18 All our recovery work reinforces the need for our changed approach to business planning and prioritisation. This sees us more routinely reassessing the relative priority of our commitments against operational demands and stakeholder capacity. We will need to clearly articulate a sense of priority of all our activities and have a greater willingness to pause some activities to progress those we’ve considered to be a higher priority.

Inquiries and reviews

19 On 19 January, Charlie Massey attended the Health and Social Care Select Committee’s hearing for their inquiry on the Safety of maternity services in England, alongside Andrea Sutcliffe (Chief Executive at Nursing and Midwifery Council) and Professor James Walker (Clinical Director of Maternity Investigation Programme at Healthcare Safety Investigation Branch).

20 Charlie told the Committee about our evidence on maternity services, for example the data from our National training survey that shows that 14% of trainees in obstetrics and gynaecology report that they have experienced bullying against an average for all trainees of 6%. He set out the importance of multidisciplinary training and the need for inclusive leadership and workplace cultures, as well as the importance of legislative reform to support a just culture.

21 We continue to engage with a number of other reviews and inquiries across the UK. The main developments in the key inquiries since we last reported are:
a  We are working closely with the Shrewsbury and Telford maternity review, chaired by Donna Ockendon to finalise relevance criteria to inform potential disclosure. We have received a request from PSA relating to relevant fitness to practise data. We are working closely with the NMC to take a coordinated approach and are developing a joint statement for affected families to explain our respective fitness to practise processes. We are also engaging with the police who are conducting an investigation into the standards of maternity care provided by Shrewsbury and Telford Hospitals NHS Trust.

b  The Independent Neurology Inquiry was made a statutory inquiry towards the end of last year. We anticipate that the panel will publish their findings within the next three months and are preparing accordingly. We are also engaging with the RQIA over its review of Dr Watt’s patients.

c  The DHSC has published a written ministerial statement setting out their view on the recommendations of the Independent Medicines and Medical Safety Review, including on conflicts of interest. This states that any declaration should cover all clinical decision-making staff, not just doctors, with this information held where patients could most easily access it. We continue to engage with DHSC on this work.

d  We understand that DHSC will be publishing their response to the Paterson Inquiry shortly and we will respond in due course.

e  We continue to liaise with the Infected Blood inquiry, responding to their requests.

Operational performance

22  The annexed Performance report details exceptions to delivery for December 2020, against the 2018-2020 Corporate Strategy. Future reports to Council will focus on progress against the new 2021-2025 Corporate Strategy. The pandemic has resulted in missing several KPIs. The Senior Management Team continues to closely monitor these impacts, identifying appropriate responses and keeping the PSA updated on changes we are making to our regulatory approach.

23  Although some fitness to practise investigations are being delayed (since several organisations with whom we work, are unable to provide information we request in the usual timeframes) we are nevertheless continuing to progress investigations where there is a patient protection risk or where the employer is able to support an existing open investigation. We have approved additional resources across a number of teams to help process backlogs accrued from
earlier phases of the lockdown and we continue to actively monitor performance and team workloads to manage our response

Executive board
The Executive Board met on 14 December 2020 and 1 February 2021 to consider items on:

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

b  The findings of a compliance and governance review of equality, diversity and inclusion (ED&I), by consultants Campbell Tickell, endorsing proposed actions to ensure that Council and SMT continue to play a leading role in developing ED&I priorities (more detail is set out in the Board’s report to Council).

c  The draft Executive Board report to Council, ahead of consideration by Council on 25 February 2021, as well as an update to the Board’s statement of purpose to set out its role in defining our ambition and driving progress on ED&I, following up the Campbell Tickell report.

d  A digital process for identity verification, to enable all applicants applying for registration and restoration to the register to complete ID checks remotely using smartphone or webcam technology as part of their application.

e  The draft Annual Responsible Officer Board Report and Statement of Compliance for submission to NHS England.
M3 – Annex A

Performance annex

Data presented as at 31 December, 2020 (unless otherwise stated)
Commentary as at 28 January, 2021

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

<table>
<thead>
<tr>
<th>Core regulatory objective</th>
<th>Key Performance Indicator</th>
<th>Performance</th>
<th>Exception summary</th>
</tr>
</thead>
</table>
| We decide which doctors are qualified to work here and we oversee UK medical education and training. | Decision on 95% of all registration applications within 3 months | 97% | 97% | 97% | Registration and Revalidation missed KPI: 
* Staff shortages combined with increased call volumes resulted in us missing this service target. Online payment issues for PLAB drove higher than usual call volumes. Frontline staff assisting in the training of new starters temporarily further reduced headcount available to answer calls. For December we answered 9,568 out of 12,236 total calls (reflecting an abandonment rate of 22% (2,668 calls)). The average wait time for answered calls was around 2.5 mins (151 seconds). 15 new trainees have now been moved to live operations which has had a positive impact on the number of calls being answered and wait times. We hope this will continue and show an improvement for January figures. |
| | Answer 80% of calls within 20 seconds | 49% | 51% | 39% |  |
| | Decision on 95% of all revalidation recommendations within 5 working days | 100% | 100% | 100% |  |
| | Respond to 90% of ethical/standards enquiries within 15 working days | 72.7% | 88.5% | 92.2% |  |
| We set the standards that doctors need to follow, and make sure that they continue to meet these standards throughout their careers. | Conclude 90% of fitness to practise cases within 12 months | 90% | 91% | 90% | Fitness to Practise missed KPI: 
* The pandemic has caused some FTP investigations to be delayed. Whilst we have continued to progress investigations where possible, many organisations with whom we work, are unable to provide information we request in the usual timeframes. These issues are likely to impact on the performance against this target for the foreseeable future. |
| | Conclude or refer 90% of cases at investigation stage within 6 months | 91% | 94% | 94% |  |
| | Conclude or refer 95% of cases at the investigation stage within 12 months | 94% | 94% | 93% |  |
| | Commence 100% of Investigation Committee hearings within 2 months of referral | No cases | No cases | No cases | Forecasts 
* Forecast summaries have been removed for this report given the significant uncertainty and disruption to processes. |
| | Commence 100% of Interim Order Tribunal hearings within 3 weeks of referral | 100% | 100% | 100% |  |
## Operational Key Performance Indicator (KPI) summary

<table>
<thead>
<tr>
<th>Business support area</th>
<th>Key Performance Indicator</th>
<th>Performance</th>
<th>Exception summary</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Oct</td>
<td>Nov</td>
</tr>
<tr>
<td>Finance</td>
<td>2019/20 Income and expenditure [% variance +/- 2%]</td>
<td>3.12%</td>
<td>3.19%</td>
</tr>
<tr>
<td>HR</td>
<td>Rolling twelve month staff turnover within 8-15%</td>
<td>4.1%</td>
<td>3.7%</td>
</tr>
<tr>
<td>Information systems</td>
<td>IS system availability (%) – target 98.8%</td>
<td>99.99%</td>
<td>99.61%</td>
</tr>
<tr>
<td>Media monitoring</td>
<td>Monthly media score</td>
<td>542</td>
<td>1635</td>
</tr>
</tbody>
</table>
# Operational Key Performance Indicator (KPI) summary (last 12 months)

## Core regulatory objective

### We decide which doctors are qualified to work here and we oversee UK medical education and training.

<table>
<thead>
<tr>
<th>Core regulatory objective</th>
<th>Key Performance Indicator</th>
<th>Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Decision on 95% of all registration applications within 3 months</td>
<td>Jan: 97%, Feb: 97%, Mar: 97%, Apr: 99%, May: 96%, Jun: 99%, Jul: 96%, Aug: 97%, Sep: 97%, Oct: 97%, Nov: 97%, Dec: 97%</td>
</tr>
</tbody>
</table>

### We set the standards that doctors need to follow, and make sure that they continue to meet these standards throughout their careers.

<table>
<thead>
<tr>
<th>Core regulatory objective</th>
<th>Key Performance Indicator</th>
<th>Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Decision on 95% of all revalidation recommendations within 5 working days</td>
<td>Jan: 99%, Feb: 98%, Mar: 98%, Apr: 42%, May: 11%, Jun: 100%, Jul: 100%, Aug: 100%, Sep: 99%, Oct: 100%, Nov: 100%, Dec: 100%</td>
</tr>
<tr>
<td></td>
<td>Respond to 90% of ethical/standards enquiries within 15 working days</td>
<td>Jan: 92%, Feb: 95%, Mar: 96.5%, Apr: 97.7%, May: 89%, Jun: 89%, Jul: 97.4%, Aug: 92.7%, Sep: 95%, Oct: 72.7%, Nov: 88.5%, Dec: 92.2%</td>
</tr>
<tr>
<td></td>
<td>Conclude or refer 90% of cases at investigation stage within 6 months</td>
<td>Jan: 92%, Feb: 90%, Mar: 91%, Apr: 93%, May: 92%, Jun: 93%, Jul: 89%, Aug: 93%, Sep: 91%, Oct: 94%, Nov: 94%, Dec: 94%</td>
</tr>
<tr>
<td></td>
<td>Conclude or refer 95% of cases at the investigation stage within 12 months</td>
<td>Jan: 95%, Feb: 93%, Mar: 95%, Apr: 95%, May: 94%, Jun: 96%, Jul: 95%, Aug: 94%, Sep: 94%, Oct: 94%, Nov: 94%, Dec: 93%</td>
</tr>
<tr>
<td></td>
<td>Commence 100% of Investigation Committee hearings within 2 months of referral</td>
<td>Jan: 100%, Feb: N/A, Mar: N/A, Apr: 100%, May: No cases, Jun: No cases, Jul: No cases, Aug: No cases, Sep: No cases, Oct: No cases, Nov: No cases, Dec: No cases</td>
</tr>
<tr>
<td></td>
<td>Commence 100% of Interim Order Tribunal hearings within 3 weeks of referral</td>
<td>Jan: 100%, Feb: 100%, Mar: 100%, Apr: 100%, May: 100%, Jun: 100%, Jul: 100%, Aug: 100%, Sep: 100%, Oct: 100%, Nov: 100%, Dec: 100%</td>
</tr>
</tbody>
</table>

## Business support area

### Key Performance Indicator

<table>
<thead>
<tr>
<th>Business support area</th>
<th>Key Performance Indicator</th>
<th>Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finance</td>
<td>2019/20 Income and expenditure [% variance +/- 2%]</td>
<td>Jan: 2.63%, Feb: 0.98%, Mar: 2.71%, Apr: 3.51%, May: 3.63%, Jun: 3.42%, Jul: 3.40%, Aug: 3.61%, Sep: 3.06%, Oct: 3.12%, Nov: 3.19%, Dec: 3.07%</td>
</tr>
<tr>
<td>HR</td>
<td>Rolling twelve month staff turnover within 8-15%</td>
<td>Jan: 9.47%, Feb: 8.22%, Mar: 7.27%, Apr: 6.88%, May: 5.3%, Jun: 5.6%, Jul: 5%, Aug: 5%, Sep: 4.3%, Oct: 4.1%, Nov: 3.7%, Dec: 3.6%</td>
</tr>
</tbody>
</table>
The diagram below shows the key benefits of the 2018-2020 Corporate Strategy*. The RAG ratings indicate our progress with delivery of the activities that will realise these benefits, as at December 2020. More detail on exceptions is on slides 6-7.

* Future reports will focus on progress against the new 2021-2025 Corporate Strategy.

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

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

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

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

*These RAGs are based on delivery of strategic benefits envisioned in the GMC Corporate Strategy. While they may be affected by external issues and challenges they will not, as a necessity, reflect in all cases external opinion at that point in time as they are future focused on benefit delivery and the GMC contribution to that delivery.*
We continue to work with the Medical School Council (MSC) as they develop, on behalf of all UK medical schools, a formal proposal for GMC approval concerning an alternative approach to the Applied Knowledge Test (AKT) in UK medical schools. We're revising the programme plan to reflect the impact of this revised approach, and this exercise is partly dependent on the outcome of our work with the MSC. We're taking forward discussions with the MSC through an over-arching GMC-MSC Transition Group and a range of focused MSC task and finish groups. These exchanges remain constructive, although a range of issues still need to be resolved as we move beyond points of principle and into operational detail. As the outcome from those discussions will impact on significant areas of the MLA programme plan, we recommend the programme remains at amber.
At the end of December, the UK and EU agreed a trade agreement which has subsequently been adopted by the UK Parliament as the European Union (Future Relationship) Act 2020. The UK Government has put in place separate legislation to allow the GMC, and other healthcare professional regulators, to continue to recognise European qualifications. This commenced on 1 January 2021 and means that the GMC can continue to automatically recognise doctors who have qualified in Europe for a period of up to two years. Separately, the UK Government reached an agreement with the Swiss Government which means that we will continue to automatically recognise the medical qualifications of Swiss nationals for a period of up to four years from 1 January 2021. We successfully implemented this new registration system overnight on 31 December 2020.

There are currently no arrangements in place, other than in Switzerland, to allow doctors who qualified in the UK to have their qualifications automatically recognised in other EEA states. This means that doctors holding a UK qualification will be treated as third country nationals and the recognition of their medical qualifications will be governed by the national policies and rules of each EU member state. The EU still has to decide whether to deem the UK’s data protection regime adequate, although this is more likely now that a trade agreement has been reached. Therefore, we continue to report in Amber. A temporary arrangement has been agreed to allow continued EU-to-UK transfers from 1 January 2021 for four months (extendable to six) to prevent organisations having to rely on alternatives such as standard contractual clauses. In case this is not granted, we have signed a data sharing agreement with the Medical Council of Ireland to allow them to continue to share sensitive data with us.

We continue to work closely with DHSC and the Department for Business, Energy & Industrial Strategy (BEIS) on the system for recognising professional qualifications that will be put in place after this two-year period. We understand that BEIS will be putting forward a Recognition of Professional Qualifications Bill in the next session of Parliament.
## Financial summary

<table>
<thead>
<tr>
<th>Financial summary as at Dec 2020</th>
<th>Budget 2020</th>
<th>Forecast 2020</th>
<th>Actual 2020</th>
<th>Variance</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td></td>
</tr>
<tr>
<td>Operational expenditure</td>
<td>112,007</td>
<td>100,308</td>
<td>99,795</td>
<td>12,212</td>
<td>11%</td>
</tr>
<tr>
<td>New initiatives fund</td>
<td>3,500</td>
<td>1,500</td>
<td>1,263</td>
<td>2,237</td>
<td>0%</td>
</tr>
<tr>
<td>Capital expenditure</td>
<td>6,412</td>
<td>6,417</td>
<td>6,353</td>
<td>59</td>
<td>1%</td>
</tr>
<tr>
<td>Pension top up payment</td>
<td>1,300</td>
<td>1,300</td>
<td>1,300</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Total expenditure</td>
<td>123,219</td>
<td>109,525</td>
<td>108,711</td>
<td>14,508</td>
<td>12%</td>
</tr>
</tbody>
</table>

| Operational income              | 117,006     | 107,749       | 107,845     | (9,161)  | (8)%|

| Operational surplus/(deficit)   | (6,213)     | (1,776)       | (866)       | 5,347    |    |

## Financial summary as at Dec 2020

<table>
<thead>
<tr>
<th>Financial summary as at Dec 2020</th>
<th>Budget 2020</th>
<th>Forecast 2020</th>
<th>Actual 2020</th>
<th>Variance</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td></td>
</tr>
<tr>
<td>Investment income</td>
<td>2,044</td>
<td>1,679</td>
<td>2,476</td>
<td>432</td>
<td>21%</td>
</tr>
</tbody>
</table>

| Total surplus/(deficit)         | (4,169)     | (97)          | 1,610       | 5,779    |    |
## Financial summary

<table>
<thead>
<tr>
<th>Income forecast movement</th>
<th>Value</th>
<th>Commentary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income reduction - permanent</td>
<td>(676)</td>
<td>Waiving the provisional registration fee for part of 2020 reduces income by £399k, the reduction in the BOE base rate has a knock on effect to interest income returns &amp; offering free places to 240 PLAB 2 candidates reduces income by circa £200k.</td>
</tr>
<tr>
<td>Income reduction - temporary</td>
<td>(8,485)</td>
<td>The remainder of the reduction income is driven by the closure of the PLAB centre, reopening at a lower capacity and the knock on effect to IMG application volumes through the PLAB route.</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>(9,161)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Expenditure forecast movement</th>
<th>Value</th>
<th>Commentary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headcount changes/natural variations in</td>
<td>518</td>
<td>We have held a higher than average vacancy rate due to recruitment being slowed through parts of the year.</td>
</tr>
<tr>
<td>forecast</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Permanent reduction in expenditure</td>
<td>6,892</td>
<td>There are a number of areas which delivered actual savings in 2020, these are staff expenses, office supplies, a reduction in research expenditure and lower associates fees and expenses due to restricted education visits training events and other ad hoc meetings where a backlog is not generated. The NIF ended £2.2m under budget.</td>
</tr>
<tr>
<td>New activities/costs generated by Coronavirus</td>
<td>(1,876)</td>
<td>The key increase in cost is additional annual leave either sold or carried into 2021 by employees, £1.2m. There are further additional costs forecast to enable socially distanced PLAB tests. Identified efficiencies are £0.5m away from target.</td>
</tr>
<tr>
<td>Temporary reduction in expenditure</td>
<td>8,974</td>
<td>There were 1,805 hearing days against a budget of 2,770 in MPTS in 2020. FTP costs linked to hearings also differed as well as TOC costs. PLAB 2 days resumed with lower candidate capacity and therefore there has been a reduction in variable costs to hold the test days, which will be borne in future years as capacity increases.</td>
</tr>
</tbody>
</table>
## Financial - detail

<table>
<thead>
<tr>
<th>Expenditure as at Dec 2020</th>
<th>Budget 2020</th>
<th>Forecast 2020</th>
<th>Actual 2020</th>
<th>Variance</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td></td>
</tr>
<tr>
<td>Staff costs</td>
<td>68,521</td>
<td>69,013</td>
<td>69,039</td>
<td>(518)</td>
<td>(1)%</td>
</tr>
<tr>
<td>Staff support costs</td>
<td>4,356</td>
<td>2,499</td>
<td>2,412</td>
<td>1,944</td>
<td>45%</td>
</tr>
<tr>
<td>Office supplies</td>
<td>1,910</td>
<td>1,161</td>
<td>1,125</td>
<td>785</td>
<td>41%</td>
</tr>
<tr>
<td>IT &amp; telecoms costs</td>
<td>4,174</td>
<td>4,119</td>
<td>4,178</td>
<td>(4)</td>
<td>(0)%</td>
</tr>
<tr>
<td>Accommodation costs</td>
<td>7,053</td>
<td>7,475</td>
<td>6,880</td>
<td>173</td>
<td>2%</td>
</tr>
<tr>
<td>Legal costs</td>
<td>4,016</td>
<td>2,490</td>
<td>2,695</td>
<td>1,321</td>
<td>33%</td>
</tr>
<tr>
<td>Professional fees</td>
<td>3,072</td>
<td>2,881</td>
<td>2,909</td>
<td>163</td>
<td>5%</td>
</tr>
<tr>
<td>Council &amp; members costs</td>
<td>532</td>
<td>407</td>
<td>429</td>
<td>103</td>
<td>19%</td>
</tr>
<tr>
<td>Panel &amp; assessment costs</td>
<td>18,068</td>
<td>9,433</td>
<td>9,298</td>
<td>8,770</td>
<td>49%</td>
</tr>
<tr>
<td>PSA Levy</td>
<td>825</td>
<td>830</td>
<td>830</td>
<td>(5)</td>
<td>(1)%</td>
</tr>
<tr>
<td>Under/over-achievement of efficiency savings</td>
<td>(520)</td>
<td>0</td>
<td>0</td>
<td>(520)</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Operational expenditure</strong></td>
<td><strong>112,007</strong></td>
<td><strong>100,308</strong></td>
<td><strong>99,795</strong></td>
<td><strong>12,212</strong></td>
<td><strong>11%</strong></td>
</tr>
<tr>
<td>New initiatives fund</td>
<td>3,500</td>
<td>1,500</td>
<td>1,263</td>
<td>2,237</td>
<td>0%</td>
</tr>
<tr>
<td>Capital expenditure</td>
<td>6,412</td>
<td>6,417</td>
<td>6,353</td>
<td>59</td>
<td>1%</td>
</tr>
<tr>
<td>Pension top up payment</td>
<td>1,300</td>
<td>1,300</td>
<td>1,300</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Total expenditure</strong></td>
<td><strong>123,219</strong></td>
<td><strong>109,525</strong></td>
<td><strong>108,711</strong></td>
<td><strong>14,508</strong></td>
<td><strong>12%</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Income as at Dec 2020</th>
<th>Budget 2020</th>
<th>Forecast 2020</th>
<th>Actual 2020</th>
<th>Variance</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td></td>
</tr>
<tr>
<td>Annual retention fees</td>
<td>93,465</td>
<td>93,553</td>
<td>93,622</td>
<td>157</td>
<td>0%</td>
</tr>
<tr>
<td>Registration fees</td>
<td>5,558</td>
<td>4,093</td>
<td>4,038</td>
<td>(1,520)</td>
<td>(27)%</td>
</tr>
<tr>
<td>PLAB fees</td>
<td>12,962</td>
<td>5,595</td>
<td>5,576</td>
<td>(7,386)</td>
<td>(57)%</td>
</tr>
<tr>
<td>Specialist application CCT fees</td>
<td>2,730</td>
<td>2,759</td>
<td>2,790</td>
<td>60</td>
<td>2%</td>
</tr>
<tr>
<td>Specialist application CESR/CEGPR fees</td>
<td>1,400</td>
<td>1,195</td>
<td>1,263</td>
<td>(137)</td>
<td>(10)%</td>
</tr>
<tr>
<td>Interest income</td>
<td>256</td>
<td>179</td>
<td>179</td>
<td>(77)</td>
<td>(30)%</td>
</tr>
<tr>
<td>Other income</td>
<td>635</td>
<td>375</td>
<td>377</td>
<td>(258)</td>
<td>(41)%</td>
</tr>
<tr>
<td><strong>Total Operational Income</strong></td>
<td><strong>117,006</strong></td>
<td><strong>107,749</strong></td>
<td><strong>107,845</strong></td>
<td><strong>(9,161)</strong></td>
<td><strong>(8)%</strong></td>
</tr>
</tbody>
</table>
## GMCSI summary and investments summary

<table>
<thead>
<tr>
<th>GMCSI summary as at Dec 2020</th>
<th>Budget Dec £000</th>
<th>Actual Dec £000</th>
<th>Variance £000</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>GMCSI income</td>
<td>626</td>
<td>316</td>
<td>(310)</td>
<td>(50)%</td>
</tr>
<tr>
<td>GMCSI expenditure</td>
<td>581</td>
<td>303</td>
<td>278</td>
<td>48%</td>
</tr>
<tr>
<td>Profit/(loss)</td>
<td>45</td>
<td>13</td>
<td>(32)</td>
<td></td>
</tr>
</tbody>
</table>

### Investment summary 2020

<table>
<thead>
<tr>
<th>Investment summary 2020</th>
<th>Value as at Dec 2019 £000</th>
<th>Value as at 31 Dec £000</th>
<th>2020 returns £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCLA managed funds</td>
<td>£54,765</td>
<td>£57,020</td>
<td>2,255</td>
</tr>
</tbody>
</table>

### Investments summary as at 31 December 2020 (figures are updated quarterly)

<table>
<thead>
<tr>
<th>Asset Allocation</th>
<th>GMC thresholds</th>
<th>Current allocation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equities</td>
<td>0% - 45%</td>
<td>28.7%</td>
</tr>
<tr>
<td>Bonds and Cash</td>
<td>20% - 80%</td>
<td>52.7%</td>
</tr>
<tr>
<td>Alternatives</td>
<td>0% - 45%</td>
<td>18.6%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Investment returns</th>
<th>1 year rolling</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target (CPI + 2%)</td>
<td>2.65%</td>
</tr>
<tr>
<td>CCLA performance</td>
<td>4.55%</td>
</tr>
</tbody>
</table>

* Return after fees
<table>
<thead>
<tr>
<th>Open cases carried forward since last report</th>
<th>New cases</th>
<th>Concluded cases</th>
<th>Outstanding cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>s.40 (Practitioner) Appeals</td>
<td>13</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>s.40A (GMC) Appeals</td>
<td>3</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>PSA Appeals</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Judicial Reviews</td>
<td>6</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>IOT Challenges</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**Explanation of concluded cases**

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

**New referrals by PSA to the High Court under Section 29**

- **PSA Appeals**: 1 new referral

**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 no new applications in the High Court challenging the imposition of interim orders since the last report; and therefore a total of two applications outstanding.

**Any other litigation of particular note**

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

Graph 1: Applications received for first registration from international medical graduates, 2015 - 2020

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

**Graph 3:** PLAB 1 & 2 assessments taken 2015 - 2020
(Showing volume each year, 1 January to 31 December, percentage figures show year on year change)

**Graph 4:** Number of doctors on the register with a licence to practise
(End of year 2015 - December 2020)
Corporate Opportunities and Risk Register
### Corporate Opportunities & Risk Register - January 2021

#### Threats

<table>
<thead>
<tr>
<th>ID</th>
<th>Threat / Opportunity</th>
<th>Title</th>
<th>Category</th>
<th>Detail</th>
<th>Owner</th>
<th>Likelihood</th>
<th>Impact</th>
<th>Residual</th>
<th>Further Action Detail</th>
<th>Risk Appetite</th>
</tr>
</thead>
<tbody>
<tr>
<td>T04</td>
<td>Operational Threat</td>
<td>Legislative reform and policy</td>
<td>Strategic / Policy</td>
<td>Following review of DHSC’s approach to legislative reform programme in Q2 2020, and the plans to consolidate the majority of proposed changes into one Section (along an International Registration Section 60) together with expected delivery over the next 12-14 months, there is a threat that the scale and complexity of changes impacts on our ability to successfully implement the whole programme within expected timeframes</td>
<td>Shaun Gallagher</td>
<td>CRITICAL</td>
<td>CRITICAL</td>
<td>CRITICAL</td>
<td>Need to quantify the resources required across directorates to successfully manage the work. Potentially reprioritising existing commitments or stopping other projects to enable delivery</td>
<td>Medium</td>
</tr>
<tr>
<td>T05</td>
<td>Operational Threat</td>
<td>Availability of resources</td>
<td>Resource</td>
<td>If we do not have a high calibre flexible workforce, appropriate technological capability and a financially sustainable business model we may not continue to provide the current level of service to all our customers and stakeholders</td>
<td>Neil Roberts</td>
<td>CRITICAL</td>
<td>CRITICAL</td>
<td>CRITICAL</td>
<td></td>
<td>Medium</td>
</tr>
<tr>
<td>T06</td>
<td>Operational Threat</td>
<td>Ability to work with others</td>
<td>Strategic / Policy</td>
<td>If we are unable to work collaboratively with our external partners, we may not be able to achieve the ambitions of the corporate strategy, reducing our potential impact on patient safety and doctors’ practice</td>
<td>Paul Beswick</td>
<td>CRITICAL</td>
<td>CRITICAL</td>
<td>CRITICAL</td>
<td></td>
<td>Medium</td>
</tr>
</tbody>
</table>
### Opportunities

- **Gold**
  - **Paper:** Regulatory reform (November 2019)
  - **Survey:** Annual perceptions survey  (November 2019)
  - **Report:** Revising our approach to the regulator's response to the COVID-19 pandemic (December 2020)
  - **Report:** Review of performance metrics (during the bi-monthly Performance and Risk Report)
  - **Report:** People planning across the United Kingdom (November 2019)
  - **Meeting:** Strategic Fire Panel (November 2019)
  - **Meeting:** Executive Board (November 2019)

- **Gold**
  - **Review:** Review of performance metrics through the quarterly GQD report:
    - Internal Audit
    - Interim Order Tribunals (January 2020, green amber)
    - Interim Review on Papers (May 2019, green amber)
  - **Review:** Review of performance metrics through the bi-monthly Performance and Risk Report
  - **Meeting:** Executive Board
  - **Meeting:** Council
  - **Meeting:** Audit and Risk Committee

- **Silver**
  - **Review:** Review of performance metrics (2019-20, passed)
  - **Review:** COVID learning reviews (GMC Case Studies: How the regulator responded to emerging evidence of higher prevalence of COVID-19 infection in BAME people)
  - **Review:** Review of performance metrics (2019-20, passed)
  - **Review:** COVID learning reviews (GMC Case Studies: How the regulator responded to emerging evidence of higher prevalence of COVID-19 infection in BAME people)
  - **Review:** Other assurance: Review of performance metrics (2019-20, passed)

- **Green**
  - **Review:** Review of performance metrics (2019-20, passed)
  - **Review:** Review of performance metrics (2019-20, passed)
  - **Review:** Review of performance metrics (2019-20, passed)
  - **Review:** Review of performance metrics (2019-20, passed)
  - **Review:** Review of performance metrics (2019-20, passed)

### Threats

- **Very high**
  - **Paper:** Regulatory reform (November 2019)
  - **Survey:** Annual perceptions survey

- **High**
  - **Review:** Review of performance metrics through the quarterly GQD report
  - **Meeting:** Executive Board
  - **Meeting:** Council
  - **Review:** Review of performance metrics through the bi-monthly Performance and Risk Report

- **Medium**
  - **Review:** Review of performance metrics
  - **Meeting:** Executive Board
  - **Meeting:** Council

- **Low**
  - **Review:** Review of performance metrics
  - **Meeting:** Executive Board
  - **Meeting:** Council

### Operational Threats

<table>
<thead>
<tr>
<th>Operational Threat</th>
<th>Event</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operational</td>
<td></td>
<td>The impact of an event is the external or internal environment causes irreversible damage to our systems.</td>
</tr>
<tr>
<td>Operational Opportunity</td>
<td>Timeframe</td>
<td>Strategic / Policy Development, sharing and working with others using our insight capability provides an opportunity to shape public debate, influence the external environment and deliver more proactive regulation</td>
</tr>
<tr>
<td>-------------------------</td>
<td>-----------</td>
<td>---------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>We use our research and insights to highlight key issues facing the medical profession, suggesting courses of action which healthcare systems can take to improve workforce and workplace issues. We leverage our communications channels (such as media and social media) and engagement opportunities to raise awareness of our research and insights and secure external support for the issues and recommendations we are highlighting. We use our influence to bring regulatory partners and key stakeholders together to drive positive changes in practice and training environments.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Shaun Gallagher**

**GOLD**

**QUITE LIKELY**

<table>
<thead>
<tr>
<th>Operational Opportunity</th>
<th>Timeframe</th>
<th>Operational Developing more proactive engagement with patients and the public provides an opportunity to understand and demonstrate that all our activities are aligned with patient safety, so that we gain their trust and confidence as an effective and transparent regulator. Better involvement with patients and the public will allow us to develop better policy and implement it more effectively.</th>
<th>Paul Reynolds</th>
<th>SILVER</th>
<th>MODERATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>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). Over information easily accessible for patients and public about how the work we do can support them (e.g., our charter for patients, relatives, and carers - update published on our website in December 2020). Regular assessment of patients and the public's perceptions of our work through research (such as our perceptions survey). Roundtable with patient leaders from all four UK countries, meeting twice a year to explore policy issues and initiatives at an early stage of their development. This is supplemented by twice-yearly UKAF meetings in Scotland, Wales and Northern Ireland plus ongoing engagement with patient organisations throughout the year. Our online complaints form has been updated and went live in early December 2020.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Paul Reynolds**

**SILVER**

**MODERATE**

<table>
<thead>
<tr>
<th>Operational Opportunity</th>
<th>Timeframe</th>
<th>Operational Developing more proactive engagement with patients and the public provides an opportunity to shape public debate, influence the external environment and deliver more proactive regulation</th>
<th>Paul Reynolds</th>
<th>SILVER</th>
<th>MODERATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>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). Over information easily accessible for patients and public about how the work we do can support them (e.g., our charter for patients, relatives, and carers - update published on our website in December 2020). Regular assessment of patients and the public's perceptions of our work through research (such as our perceptions survey). Roundtable with patient leaders from all four UK countries, meeting twice a year to explore policy issues and initiatives at an early stage of their development. This is supplemented by twice-yearly UKAF meetings in Scotland, Wales and Northern Ireland plus ongoing engagement with patient organisations throughout the year. Our online complaints form has been updated and went live in early December 2020.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Paul Reynolds**

**SILVER**

**MODERATE**

| Operational Opportunity | Timeframe | Executive Board: Paper: Strategic approach to patient and public involvement (November 2020) Executive Board: Annual perceptions survey showing the public's confidence in how doctors are regulated and feedback on working relationships with patient and public bodies. Executive Board: L2 (Head of Section) Programme Lead to take charge of strategic delivery from Q2 2021 onwards. Policy teams to identify opportunities during 2021 for involving patients in their work (in progress). New guide for LGBT patients (about the care they can expect from a doctor) to be published in February 2021. Factsheet explaining our threshold for acting on fitness to practise concerns in development. Next roundtable with patient organisations likely to be held in Q2 2021. Legislative reform and our review of Good Medical Practice may be included as topics for engagement. | Medium | | |
Council meeting – 25 February 2021

Agenda item M3
Chief Executive’s Report

CORR summary slides
Threats - Post-mitigation rating summary

Critical threats

200 - Legislative reform – remains red (critical) after mitigation. Following review of DHSC's approach to legislative reform programme in Q2 2020, and the plans to consolidate the majority of proposed changes into one Section 60s (plus an international registration Section 60) together with expected delivery over the next 12-14 months, there is a threat that the scale and complexity of changes impacts on our ability to successfully implement the whole programme within expected timeframes.

Active Threats above risk appetite

152 – Legislative Reform - remains red (critical) after mitigation (see text above)
148 – Delivery of Statutory Functions - remains amber (significant) after mitigation. If we fail to deliver our core statutory functions, there is a potential impact on patient safety, public confidence, and the GMC's reputation as a leading regulator.
151 – Responding to a changing environment - remains amber (significant) after mitigation. Inability to respond effectively to changes in the external environment, including legislation and wider social impact changes, could lessen our influence and reduce public, profession and political confidence in our role.

Opportunities

26 – Strength of government - The strength of the government provides an opportunity to drive forward our ambitions for change.
27 – Deriving more insight from our data capability - Developing, sharing and working with others using our insight capability provides an opportunity to shape public debate, influence the external environment and deliver more proactive regulation.
28 – Working with patients and public - Developing more proactive engagement with patients and the public provides an opportunity to understand and demonstrate that all our activities are aligned with patient safety, so that we gain their trust and confidence as an effective and transparent regulator. Better involvement with patients and the public will allow us to develop better policy and implement it more effectively.

Key updates

- Pension Deficit risk has now been closed, as no longer an active threat. It has now happened and we are building the implications in to future financial planning.
- Legislative Reform (added to the CORR in November) remains critical after mitigation.
CORR Overview – Annex slides

Working with doctors Working for patients
## Our Corporate risks

Below are the corporate risks that make up the Corporate Opportunities and Risk Register (CORR).

<table>
<thead>
<tr>
<th>Corporate risk</th>
<th>Opportunity / Threat</th>
<th>Ownership</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Unplanned event</td>
<td>Threat</td>
<td>Neil Roberts, Director of Resources</td>
</tr>
<tr>
<td>2. Strength of government</td>
<td>Opportunity</td>
<td>Paul Reynolds, Director of SC&amp;E</td>
</tr>
<tr>
<td>3. Working with patients and public</td>
<td>Opportunity</td>
<td>Paul Reynolds, Director of SC&amp;E</td>
</tr>
<tr>
<td>4. Ability to work with others</td>
<td>Threat</td>
<td>Paul Reynolds, Director of SC&amp;E</td>
</tr>
<tr>
<td>5. Availability of resources</td>
<td>Threat</td>
<td>Neil Roberts, Director of Resources</td>
</tr>
<tr>
<td>6. Delivery of our Statutory functions</td>
<td>Threat</td>
<td>All relevant Directors</td>
</tr>
<tr>
<td>7. Legislative reform</td>
<td>Threat</td>
<td>Shaun Gallagher, Director of S&amp;P</td>
</tr>
<tr>
<td>8. Responding to a changing environment</td>
<td>Threat</td>
<td>Paul Reynolds, Director of SC&amp;E</td>
</tr>
<tr>
<td>9. Deriving more insight from our data capability</td>
<td>Opportunity</td>
<td>Shaun Gallagher, Director of S&amp;P</td>
</tr>
</tbody>
</table>
### Corporate Risk Register (CORR) Overview

#### Mapping of Underpinning risks

<table>
<thead>
<tr>
<th>1 (Threat): Unplanned Event</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Underpinning risk</strong></td>
</tr>
<tr>
<td>Fraud</td>
</tr>
<tr>
<td>Business continuity</td>
</tr>
<tr>
<td>Business continuity - SC&amp;E T9</td>
</tr>
<tr>
<td>Health and Safety</td>
</tr>
<tr>
<td>Cyber risk</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2 (Opportunity): Strength of Government</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Underpinning risk</strong></td>
</tr>
<tr>
<td>Achieving legislative reform - SC&amp;E O2</td>
</tr>
<tr>
<td>UK Government health and social care policy ambition</td>
</tr>
<tr>
<td>Legislative framework</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3 (Opportunity): Working with patients and public</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Underpinning risk</strong></td>
</tr>
<tr>
<td>Working with patients and the public - SC&amp;E O1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4 (Threat): Ability to work with others</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Underpinning risk</strong></td>
</tr>
<tr>
<td>Burden on stakeholders and audiences - SC&amp;E T2</td>
</tr>
<tr>
<td>Quality of our relationships - SC&amp;E T3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5 (Threat): Availability of Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Underpinning risk</strong></td>
</tr>
<tr>
<td>Recruitment and retention</td>
</tr>
<tr>
<td>Attracting talent</td>
</tr>
<tr>
<td>Health and safety of our people - SC&amp;E T7</td>
</tr>
<tr>
<td>Internal engagement - SC&amp;E T8</td>
</tr>
<tr>
<td>Prioritisation Maturity</td>
</tr>
<tr>
<td>Scope-creep and definition of done</td>
</tr>
<tr>
<td>Work programme scale and complexity</td>
</tr>
<tr>
<td>Software licences</td>
</tr>
<tr>
<td>IT System Availability</td>
</tr>
</tbody>
</table>
### 6 (Threat): Delivery of our Statutory functions

<table>
<thead>
<tr>
<th>Underpinning risk</th>
<th>Opportunity / Threat</th>
<th>Directorate</th>
<th>Owner / Assigned owner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approve an overseas training location which cannot meet Promoting Excellence standards</td>
<td>Threat</td>
<td>E&amp;S</td>
<td>Jessica Lichtenstein / Jane Cannon</td>
</tr>
<tr>
<td>Granting specialist registration to ineligible applicants operations</td>
<td>Threat</td>
<td>E&amp;S</td>
<td>Jessica Lichtenstein / Stephen Gunliffe</td>
</tr>
<tr>
<td>Ineffective review of information for an Interim Orders Tribunal</td>
<td>Threat</td>
<td>FtP</td>
<td>Anthony Omo / Joanna Farrell</td>
</tr>
<tr>
<td>IOT/HCE – Timeframes</td>
<td>Threat</td>
<td>FtP</td>
<td>Anthony Omo / Anthony Egerton</td>
</tr>
<tr>
<td>IOT/HCE – Demonstrating Progression</td>
<td>Threat</td>
<td>FtP</td>
<td>Anthony Omo / Anthony Egerton</td>
</tr>
<tr>
<td>FtP cases</td>
<td>Threat</td>
<td>FtP</td>
<td>Anthony Omo / Anthony Egerton</td>
</tr>
<tr>
<td>Decision Making and Public Safety</td>
<td>Threat</td>
<td>FtP</td>
<td>Anthony Omo / Joanna Farrell</td>
</tr>
<tr>
<td>Decision Quality and Validity</td>
<td>Threat</td>
<td>FtP</td>
<td>Anthony Omo / John Smyth</td>
</tr>
<tr>
<td>Management of cases referred for an MPT hearing</td>
<td>Threat</td>
<td>FtP</td>
<td>Anthony Omo / Anthony Egerton</td>
</tr>
<tr>
<td>S40A Appeals</td>
<td>Threat</td>
<td>FtP</td>
<td>Anthony Omo / Anthony Egerton</td>
</tr>
<tr>
<td>Appeals</td>
<td>Threat</td>
<td>MPTS</td>
<td>Gavin Brown</td>
</tr>
<tr>
<td>Adjudication process timeliness</td>
<td>Threat</td>
<td>MPTS</td>
<td>Gavin Brown</td>
</tr>
<tr>
<td>Quality of Tribunal Decision making</td>
<td>Threat</td>
<td>MPTS</td>
<td>Gavin Brown</td>
</tr>
<tr>
<td>Registration of doctors</td>
<td>Threat</td>
<td>R&amp;R</td>
<td>Una Lane / Lindsey Westwood</td>
</tr>
<tr>
<td>Revalidation of doctors</td>
<td>Threat</td>
<td>R&amp;R</td>
<td>Una Lane / Blake Dobson</td>
</tr>
<tr>
<td>Outreach processes - SC&amp;E T1</td>
<td>Threat</td>
<td>SC&amp;E</td>
<td>Andy Lewis / Janet Gray</td>
</tr>
<tr>
<td>Equality and diversity compliance</td>
<td>Threat</td>
<td>S&amp;P</td>
<td>Shaun Gallagher / Robert Scanlon</td>
</tr>
<tr>
<td>GMCSI</td>
<td>Threat</td>
<td>S&amp;P</td>
<td>Shaun Gallagher / Helen Featherstone</td>
</tr>
</tbody>
</table>

### 7 (Threat): Legislative Reform

<table>
<thead>
<tr>
<th>Underpinning risk</th>
<th>Opportunity / Threat</th>
<th>Directorate</th>
<th>Owner / Assigned owner</th>
</tr>
</thead>
<tbody>
<tr>
<td>MAPs and legislative reform</td>
<td>Threat</td>
<td>R&amp;R</td>
<td>Una Lane / Clare Barton</td>
</tr>
</tbody>
</table>

### 8 (Threat): Responding to a changing environment

<table>
<thead>
<tr>
<th>Underpinning risk</th>
<th>Opportunity / Threat</th>
<th>Directorate</th>
<th>Owner / Assigned owner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information sharing with the CQC</td>
<td>Threat</td>
<td>Resources</td>
<td>FtP</td>
</tr>
<tr>
<td>Trainee feedback during the pandemic</td>
<td>Threat</td>
<td>E&amp;S</td>
<td>Samara Morgan / Tulsi Patel</td>
</tr>
<tr>
<td>External pressures challenge our ability to regulate</td>
<td>Threat</td>
<td>FtP</td>
<td>Anthony Omo</td>
</tr>
<tr>
<td>Evaluating our impact - SC&amp;E T11</td>
<td>Threat</td>
<td>SC&amp;E</td>
<td>Paul Spindler</td>
</tr>
<tr>
<td>Responding to emerging issues - SC&amp;E T10</td>
<td>Threat</td>
<td>SC&amp;E</td>
<td>Stephanie McNamara / Paul Spindler</td>
</tr>
<tr>
<td>Brexit transition</td>
<td>Threat</td>
<td>S&amp;P</td>
<td>Shaun Gallagher / Shannon Wheeler</td>
</tr>
<tr>
<td>Policy strategy</td>
<td>Threat</td>
<td>S&amp;P</td>
<td>Shaun Gallagher / Richard Marchant</td>
</tr>
<tr>
<td>Understanding the external environment</td>
<td>Threat</td>
<td>S&amp;P</td>
<td>Shaun Gallagher / David Darton</td>
</tr>
</tbody>
</table>

### 9 (Opportunity): Deriving more insight from our data capability

<table>
<thead>
<tr>
<th>Underpinning risk</th>
<th>Opportunity / Threat</th>
<th>Directorate</th>
<th>Owner / Assigned owner</th>
</tr>
</thead>
<tbody>
<tr>
<td>tbc</td>
<td>tbc</td>
<td>tbc</td>
<td>tbc</td>
</tr>
</tbody>
</table>
## Action
To note

## Purpose
Following the publication of the corporate strategy in November, this item is to update Council on our proposed approach for assessing progress 2021-2025.

## Decision trail
SMT approved this approach on 11 January. They had some feedback on the detail which is reflected here and/or is being picked up in related workplans.

## Recommendation(s)

- a. To note the proposed approach
- b. To note ongoing efforts to improve monitoring and evaluation

## Annexes
Annex A: slides summarising the core elements to assess progress for each strategic theme.

## Author contacts
- **David Darton**, Assistant Director for Data, Research and Insight  
  David.Darton@gmc-uk.org,
- **Katie Fawkner-Corbett**, Principal Strategy Adviser  
  Katie.Fawkner-Corbett@gmc-uk.org,

## Sponsoring director/Senior Responsible Owner
- **Shaun Gallagher**, Director for Policy and Strategy  
  Shaun.Gallagher@gmc-uk.org
Background

1 Recent Council, Executive Board and Senior Management Team discussions of the 2018-20 corporate strategy and the latest (2020) perceptions survey emphasised the importance of:

- Setting out the approach to assessing progress at the start of the strategy;
- Being objective and reflecting a range of internal and external sources;
- Informing ongoing planning and prioritisation discussions.

2 Since Council signed off the corporate strategy for 2021-2025 in September, efforts have been focussed on implementation – including business planning; how we will assess progress; and how we can use that analysis to inform ongoing prioritisation.

3 This proposal reflects a review of approaches taken by similar organisations. It has been approved by SMT and builds on advice from the Policy Leadership Group and Strategic Communications and Engagement colleagues. It is intended to be pragmatic and proportionate given the challenges all organisations face of:

- Objectively assessing all work;
- Attribution – it is very difficult to show how individual activities contribute to higher-level ambitions;
- The pandemic – which is highlighting things we need to accelerate in our strategy while simultaneously requiring that we review some other activities – in large part because we need to take account of other stakeholders’ circumstances. This doesn’t change the fundamental need for us to assess progress against our strategy which remains relevant and necessary.

4 The approach will continue to evolve as we confirm our priorities (for example as we firm up plans on legislative reform) and as our approach to monitoring and evaluation improves (through implementing the new business planning processes).
Proposed approach

Assessing progress on our work relies on looking at a range of sources. Across the four themes of our strategy, we will be triangulating information from three core elements:

- **Activity-level information**: through existing reporting channels and information collected through the new planning gateway process (operational data, project monitoring and evaluation);

- **Informal stakeholder feedback**: logged through Engage (our new internal stakeholder relationship management tool); monitored through our annual relationship plan review process; and supplemented by tailored questions in 2022 and 2024;

- **Strategic level indicators and analysis**: drawing on internal and external evidence. The indicators vary – some closely reflect our efforts, whilst others (particularly on ‘Enabling professionals to provide safe care’ and ‘Developing a sustainable medical workforce’) reflect changes in the broader healthcare system and environment. They will be contextualised with analysis from a range of sources.

The available information varies across these three elements, and across the four strategic themes – which reinforces the importance of triangulation from different sources and not looking at any single measure in isolation. The slides included at Annex A summarise our current position across the four strategic themes.

Two key aspects of this approach are that we will:

- Maintain a consistent approach over the five years and ensure we have sufficient information to understand trends. However, the analysis will become more comprehensive over the five years as our internal approach to monitoring and evaluation improves, and as we include any new external analysis that becomes available. For example, many of our current operational measures focus on timeliness. As we make process improvements under legislative reform and ‘Making every interaction matter’, our aspiration is to have a more balanced view of measures reflecting time, cost, quality and customer experience.

- Focus on understanding the direction of travel by triangulating across sources. We will consider targets if appropriate at an activity level and in
relation to ED&I (where, as discussed with Council, we are setting regulatory and employment targets in line with the step change in our ambitions).

7 The main vehicles for reporting on progress will be the Annual Report (which will focus on activity-level information) complemented by reports to Council in Q4 2022 and Q4 2024 (which will give a broader assessment reflecting all three core elements). A final assessment of progress will be reflected in our next corporate strategy.

8 The assessment of progress will inform our priorities on an ongoing basis. As such, our new Planning Gateway process is designed to be flexible and responsive. This will include ensuring we reflect on the latest analysis available to review and confirm our priorities.

9 It will obviously take time for evidence to build, but as it does, it will be reflected in relevant Council papers – for example, the CEO report. From 2022, we are planning an annual Council seminar to reflect on progress against the corporate strategy.

Other implications

10 This work is closely related to other cross-cutting efforts. In particular:

- **Our approach to business planning and prioritisation** – successful implementation of these processes, especially in terms of monitoring and evaluation, will be vital for us to understand progress. Through the new Planning Gateway process, we will ensure that we have a firmer view at the outset of activity about the expected impact and benefits, and through more rigorous project closure processes, capture more insightful data about what it does deliver.

- **Equality, Diversity and Inclusion** – plans to improve measures, analysis and targets are an integral part of how we will assess progress and the accompanying slides reflect the related Council discussion on ED&I [Agenda item M5].

- **Reporting** – we currently produce a number of reports for internal and external audiences. In the coming months, we will be considering if and how we can streamline and improve the reporting cycle and make more explicit links to our strategic priorities.
Internal audit and the Audit and Risk Committee – will contribute in terms of overall assurance to the Council and Executive that the corporate strategy is being successfully implemented and delivering the anticipated outcomes.

Next steps

11 The Data, Research and Insight teams will be leading work to firm up the proposals included in Annex A, and we will continue to work closely with others across the business on the related efforts set out in paragraph 10.

12 We are happy to discuss any questions or clarifications from Council members on the proposed approach.
### Action
To approve

### Purpose
To seek Council’s approval of setting equality, diversity and inclusion (ED&I) measures, targets and actions to address race inequality. This is part of our wider commitment to building more inclusive and supportive working environments and meaningfully addressing impacts of inequalities for all.

### Decision trail
29 September and 4 November 2020 Council endorsed a step-change in the scale of our ED&I ambitions as a regulator and employer – wanting to demonstrate a stronger leadership role in addressing the impacts of longstanding inequality highlighted by the pandemic.

### Recommendation(s)
- **a** To approve the measures and targets set out in paragraph 6 and detailed in Annex A.
- **b** To note the enhanced transparency and accountability we are proposing on ED&I performance set out in paragraphs 7 to 10.

### Annexes
Annex A: Targets and key performance indicators

### Author contacts
- **Claire Light**, Head of ED&I
  claire.light@gmc-uk.org, 0161 923 6595
- **Robert Scanlon**, Assistant Director, Business Planning & ED&I
  robert.scanlon@gmc-uk.org, 020 7189 5305

### Sponsoring director/Senior Responsible Owner
- **Shaun Gallagher**, Director Strategy & Policy
  shaun.gallagher@gmc-uk.org, 0207 189 5015
- **Anthony Omo**, General Counsel and Director of Fitness to Practise,
  anthony.omo@gmc-uk.org 020 7189 5117
Background

1 In September 2020 Council agreed to a step-change in ambition, wanting to provide stronger leadership and more focus to equality, diversity and inclusion, with an immediate focus on addressing racial discrimination and disadvantage in the health service and within our own organisation.

2 The evidence is compelling that action is required to improve the wellbeing and sustainability of the workforce and with it improve patient experience and care. In 2020 38% of all licensed doctors in the UK were BME. This proportion is growing, 61% of new doctors joining the register in 2020 are BME, up from 42% in 2017. As the number of BME doctors in the UK workforce grows, the evidence is clear that they continue to experience disadvantage and differential treatment – in particular, BME students/trainees experience an attainment gap in medical education and training, and employers are significantly more likely to refer BME doctors to the GMC for fitness to practise concerns, than their white peers.

3 Both issues have been long-standing concerns for the GMC. Our research and analysis on fairness in referrals (published June 2019) and on differential attainment (published annually) has demonstrated the sustained nature of these issues and provided insights to their causes and impacts. In September, Council agreed to set targets to reflect our ambition and impatience for change, and to lend common focus to efforts across the system.

Targets, monitoring & reporting

4 Despite the complexity of the issues, we know that more inclusive and supportive working environments have a proven impact on promoting fairer outcomes and positive patient outcomes within NHS organisations, such as providing improved patient satisfaction, quality of patient care and (in the acute sector) reduced patient mortality.\(^1\) Research shows that a large part of disadvantage stems from being part of the ‘out group’. The reality is that those in the ‘out group’ enjoy lesser protective factors than the ‘in group’. This manifests in reduced quality and frequency of feedback and limited informal mentoring and sponsorship.

---

\(^1\) Caring for Doctors, Caring for Patients - Longitudinal analyses of data from the NHS Staff Survey in England, have consistently shown associations between staff reports of stressful and unsupportive work Environments.
5 Inclusive and supportive environments are shown by research evidence to be a critical factor in reducing these disparities, as well as benefitting all staff.\(^2\) Caring working environments for doctors also improves the quality of care, patient safety and the sustainability of our health services.

6 We are asking Council to approve targets to:

- reduce year on year the disproportionality in fitness to practise referrals from designated bodies based on race and place of primary medical qualification (PMQ) - with an overall target to eliminate disproportionality by 2026.
- eliminate discrimination, disadvantage and unfairness for all index measures of fair medical education and training pathways by 2031.
- eliminate differentials within our own staffing performance, in BME recruitment, representation across staffing levels, retention, progression, pay and employee engagement by 2026.

7 We know these targets are ambitious and can only be achieved if we are successful in influencing others who hold levers to effect positive change.

8 Although the end-points of these targets are 5 and 10 years away, we will publish progress against the targets annually, to maintain focus on whether change is happening. Where progress is lacking or urgent action is needed, we will prioritise our engagement and advocacy with stakeholders.

9 In March we will publish the complete set of protected characteristics data that we hold about our registrants (anonymised) through Data Explorer on our website, to signal our commitment to greater transparency on this agenda.

10 From April we will publish the findings of routine independent fairness audits that test that our regulatory decisions have been made fairly and consistently with our guidance. We will publish our first of these reports, covering our fitness to practise function.

Eliminating disproportionality in fitness to practise referrals from designated bodies based on race and PMQ by 2026

11 Employers are significantly more likely to refer BME doctors than white doctors to the GMC for fitness to practise concerns. Overall referral numbers and rates

\(^2\) https://journals.lww.com/academicmedicine/Fulltext/2020/05000/Belonging,_Respectful_Inclusion,_and_Diversity_in_1.aspx
are low, but the referral rate for BME doctors (0.77%) is twice the referral rate for white doctors (0.38%); and the referral rate for non-UK qualified doctors (1.01%) is 3 times that of UK doctors (0.33%). This is particularly important because a much higher proportion of employer referrals result in an investigation (77% versus 9% from the public). Similarly, a higher proportion of employer referrals result in onward referral onto the MPTS following investigation (7% of first complaints are from employers, but employer referrals make up 39% of referrals to the MPTS). By focussing on improving this metric, we hope to drive more supportive environments that intervene earlier to give doctors the local support they need to provide quality patient care and avoid referral.

12 At the designated body (DB) level we can statistically identify whether the composition of referrals, by ethnicity and primary medical qualification (PMQ) region, is inconsistent with the composition of doctors connected to the DB, therefore signalling potential referral disproportionality. We are proposing a performance measure underpinning our target, that we will monitor and report against:

- **KPI1** - percentage of DBs with evidence of disproportionality, for either ethnicity or PMQ region (see chart in Annex A).

  While this will enable us to identify which DBs we should target our engagement with, many DBs make very few referrals and so are hard to statistically identify as disproportionate. Because of the low volume of referrals, we also need to pool 5 years of referral data in our analysis. This will be repeated annually and give insights into shifts in progress but there will be some time-lag in the measure. To balance this, we’re proposing a complementary national measure to monitor and report against.

- **KPI2** - difference in rates of referral between BME and white doctors and between ‘UK PMQ’ vs ‘non-UK PMQ’ at a national level.

13 We have identified 50-60 DBs that show indicative disproportionality in their referral patterns for ethnicity or PMQ. Being based on 5 years of pooled data, this number is likely to change each time, because DBs become active or inactive, merge, unmerge, doctors switch connections, and the rolling window

---

3 The six workplace factors at play in disproportionate referrals are: inadequate support in transitioning to new environments; lack of effective, honesty and timely feedback; focus on blame rather than learning; inaccessible leadership; working patters that leave doctors isolated; some doctors treated as outsiders.

4 https://www.england.nhs.uk/medical-revalidation/emp-bod-hr/des-body/
of the analysis will be different. This data is a pointer to the organisations we want to engage with, but inclusion on the list is not in and of itself a failing.

14 We have already been taking actions to address disparity in referrals, but with the setting of these targets we will put further actions in place to support improvement. To date we have re-focussed our ‘Supporting a Profession Under Pressure’ programme to strengthen the ED&I focus and aims; we have commenced a project in fitness to practice to scope changes to referral processes; we have supported NHSE/I to integrate referral data in to the Medical Workforce Race Equality Standard and offered to support similar collaboration across the other nations; and we have identified the tools needed for our outreach services to engage in these conversations with partners.

Looking forward:

- We will start immediately a programme of meetings with each with the Responsible Officers (RO)\(^5\) from each of the relevant bodies and complete this programme by December 2021. In doing so we will understand their view on the local culture based on the factors identified in ‘Fair to Refer’ and underlying causes for these trends. As part of these discussions we will understand any existing action or improvement plans in place.

- Within six months of meeting the RO - where it would add value to build understanding of the issues at play or help secure commitment to improvement on this agenda - we will engage with the Board to highlight the issues.

- We will develop a first draft of supporting data and FAQs by the end of March 2021 that provide Outreach with support and direction for their discussions with ROs on disproportionality. This will help ensure a consistent and considered approach to discussing this complex topic and set a framework for discussing all protected characteristics.

- We will work collaboratively with those national and regional stakeholders who have similar aspirations to tackle inequalities. NHSE/I and NHS Resolution have indicated the desire to collaborate on this and we will commence scoping opportunities by the end of June 2021.

- By September 2021 we will change our referral form after consulting with ROs. The amended referral will require RO’s to confirm the steps that they

---

have taken to ensure that a referral is appropriate before it is submitted to the GMC.

- We will reflect on our progress as part of our annual report this year. These steps complement existing changes where we require every referral of a doctor by an employer to be discussed with an Employer Liaison Adviser before being accepted. This conversation allows us to bring to bear our insights.

- We will implement a feedback loop between the FtP investigation, through our Outreach team and back to the RO on outcomes of investigation, to build understanding of the application of our thresholds and RO considerations to ensure fairness and enhance future moderation of referrals.

Eliminating discrimination, disadvantage and unfairness for all index measures of fair medical education and training pathways by 2031

15 Differential attainment is the term that describes the gap between attainment levels of different groups of students/trainees, and it occurs across many professions. In medicine, it exists in both undergraduate and postgraduate contexts, across exam pass rates, recruitment and Annual Review of Competence Progression (ARCP) outcomes and can be an indicator that experiences within medical education and training may not be fair. Differentials that exist because of ability are expected and appropriate. Differentials connected solely to age, gender or ethnicity of a particular group demonstrate unfairness.

16 The medical education and training attainment gap has not improved at a UK level since 2015. Exam pass rates reflect a 12%-point difference between White and BME UK graduated trainees, rising to over 30% for overseas graduates. We see similar differences across specialty exams.

17 We also know that BME doctors feel less prepared on entry to foundation year, which fails to build the right platform for them to maximise their important contribution to the workforce.

18 We have been working with others to understand and take action to address this issue through our differential attainment programme and we have a relative richness of data and insight. We have identified the following underlying measures to form an index of fairness in education and training outcomes. This has been based on the completeness and availability of data across the four countries and across the education and training pathway.
Relative difference between the average Educational Performance Measure (EPM) score for white and BME undergraduates across all medical schools – average score in 2019 for white undergraduates was 6.05 and the average for BME was 4.93.

Differences in medical school final exam pass rates – *This data collection is new and we will have access to it for analysis in 2021.*

Real difference in preparedness level FY1/FY2 – *The proportion of white doctors in 2019 who stated they were ‘adequately prepared’ for their first foundation post’ was 70.2% and the proportion of BME was 62.4%.

Sense of inclusivity and support based on National Training Survey responses – *There are differences in scores for perceived inclusivity levels between UK White (81.6) and UK BME (77.2) and between all UK (80.1) and all international medical graduates (IMG) (76.0) trainees.*

Unsatisfactory Outcomes for Annual Review of Competency Progression (ACRPs) Excluding exam fails – *There are differences in the rates of unsatisfactory outcomes across all specialties and training levels. Differences exist between UK white (4.8%) and UK BME (7.1%) trainees and between all UK (5.6%) and all IMG trainees (15.7%).*

Specialty Examination Pass Rates – *There are differences in specialty examination pass rates across all UK specialties and training levels. Differences exist between UK white (77.7%) and UK BME (65.4%) trainees and between all UK (73.2%) and all IMG trainees (43.8%).*

19 We are proposing to measure each of these to provide insight against our target to eliminate discrimination, disadvantage and unfairness in medical education and training pathways. The full index and the differentials we see in each measure is detailed in Annex A, but our aspiration across all of these measures is simple – where there is a gap, to close it.

20 To date we have increased our quality assurance focus and requirements on ED&I; we now require postgraduate (PG) deans to submit action plans annually; we are developing the guidance to support royal colleges to submit these action plans from 2021; we are sharing data on the attainment gap within training programmes with PG deans and royal colleges; collaborating and funding evaluation of promising interventions; sharing case studies online; supported the Medical Schools Council (MSC) in the scoping of guidance on inclusivity; and are now part of the MSC ED&I Alliance. New steps we will now take to support the targets include:
Council meeting, 25 February 2021
Agenda item M5 – Equality, Diversity & Inclusion

- We will require all education and training bodies to provide us with an annual action plan of how they intend to make progress in addressing differential attainment. We will monitor progress against these plans. Where we identify actions that make rapid gains, we will showcase and share these with other bodies, embedding this into our QA regime.

- We will collaborate with the Medical Schools Council (MSC) and the newly formed ED&I Alliance between the MSC and medical schools to ensure diversity is better reflected in medical curricula and all aspects of medical teaching and learning through the publication of joint guidance.

- From this year, we will use the National Training Survey (NTS) to enhance our understanding of inclusivity and fairness of environments.

- We will triangulate this information with the other information we have about the working environments. This has the dual impact of building our insight and understanding at a system level, but our NTS data also provides the bedrock for our Quality Assurance function to target visits and QA activity around identified points of concern around culture and fairness.

21 By the end of 2021, we will also look across our suite of professional and ethical standards to agree a timeline for review. A key principle for review will be to ensure the documents reflect our ambitions for ED&I.

Views of stakeholders and engagement approach

22 We are alive to the risk of resistance to our proposals given the complexity of the causal factors, challenges of changing culture, and perceptions of burdening an already pressurised system. We’ve sought feedback from stakeholders on our proposals over preceding months and will continue to collaborate with stakeholders at national and regional level on driving forward change. Pandemic pressures have meant that the scale and depth of our engagement has been more limited than usual, and notable gaps in our understanding of stakeholder views are in those working in frontline delivery of services and education stakeholders. But the engagement we’ve had so far has given us a sense of the issues to consider:

- There was overarching and universal support for our focus areas and for setting targets. A number of stakeholders felt it was an important signal from the regulator to the system.

- The majority of our stakeholders agreed that the spotlight the pandemic has shone on race inequalities makes this the right time for our proposals
and that this needs to become ‘must do’, not ‘nice to do’. Some raised concerns about how it would be received by an exhausted system – making it more critical for us to emphasise the case for change. Our implementation approach will need to manage this risk by acknowledging the need to work with, and not against those who create the environments in which doctors practise and learn.

- There was some divergence of views on whether the timeframes for change were ambitious enough. A number of stakeholders noted the complexity of the differential attainment education landscape with some suggesting change was on a ‘two-generation timeframe’. We have reflected this feedback into our final proposals, including being more ambitious with the target on referrals, and by emphasising elimination ‘by’ the end date. Within those timeframes we will expect to see incremental gains ‘in the right direction’. We will scrutinise progress annually with a view to progress as fast as possible – capitalising on and working with others to make progress as rapidly as possible.

23 We know that many of our partners have active and wide-ranging agendas targeted on addressing these issues. The NHSE People Plan67 committed to measures to address systematic inequalities; the RCGP ED&I Strategy8 committed to resolving the issues related to differential attainment and some trusts such as Imperial College Hospital9 have already made changes that have entirely addressed disparities. The Medical Workforce Race Equality Standard is part of a clear direction of travel to heightened transparency and accountability for consistency and fairness in the medical workforce. We have had reference to these initiatives in framing our proposals and sought to maximise alignment. We will continue over coming months to refine and hone our approach in how we focus and take forward action.

Eliminating differentials within the GMC in BME recruitment, representation across staffing levels, retention, progression, pay and employee engagement by 2026.

24 Improving our own inclusivity has been a sustained ambition for us. In 2019 we commissioned the Employers Network for Equality and Inclusion (ENEI) to undertake an Inclusion Gap Analysis. We were found to be mid-range on their framework between Equality and Inclusion. Despite having made strong progress on this agenda we don’t believe our current diversity as an

---

7 https://www.england.nhs.uk/about/equality/equality-hub/equality-standard/fair-experience/
9 https://www.imperial.nhs.uk/about-us/blog/tackling-race-inequality
organisation is as reflective as it should be of those that we regulate, and those we regulate for.

25 We have examples of positive performance in some areas of diversity. We continue to see a steady increase in representation of women in management roles with a further increase in women at Level 2 (57% in 2019, up from 54%).

26 We know from our staff survey that the GMC is a good place to work for the majority of our staff but that experience is not consistent. We have a difference of 15% in engagement scores between white and black staff.

27 We established an inclusivity index in our survey for the first time in 2020, which gives us a clear benchmark that will inform and support our continued programmes of work around ED&I. BME employees indicated a lower sense of inclusion than white staff. Now this benchmark has been established, we have a clear starting point from which we can evaluate future progress.

28 Our BME representation for the whole workforce at the end of 2020 was 14.3%. Our BME representation at level 3 (our middle management grade) was 12.0%, level 2 (a senior manager heading a section or function) 8%, and for senior management roles (Assistant Director and above) just over 5%. Although we perform well in terms of attraction rates for BME candidates in recruitment processes, we have high attrition rates for BME candidates, and the resulting appointment rate is much lower. In years prior to 2020 we also have differential turnover rates for BME staff compared to the average in our workforce.

29 Our November Council update provided a detailed outline of our commitments and action to become a more inclusive employer that we have further refined. Our key interventions included:

- In February we updated our competency framework to include specific behaviours and skills on inclusion. All staff have been asked to include a specific ED&I element in their personal development plans.

- The setting of wide-ranging targets and measures around recruitment, retention, progression, pay equality and inclusivity targeting the issues above, that we will report against from this year and ongoing. Annex A presents our interim performance targets proposed year on year.

- By the end of 2021 we will have completed mandatory leadership development sessions on inclusion for level 3 managers and above. This will also include a talent management programme for BME staff that includes leadership development support, coaching, mentoring and...
enhanced access to external training targeted below head of section level. Promote the mentoring scheme with a focus on raising awareness, ensuring accessibility to all BME colleagues and supporting the career progression of BME colleagues.

30 From this year we will also report against the NHS Workforce Race Equality Standard (WRES). The WRES is a set of measures that seeks to highlight the experience of BME employees and promote their equal access to career opportunities and fair treatment in the workplace. It is a requirement for NHS commissioners and NHS healthcare providers in England to participate. Arms-length bodies have been invited to participate. CQC and NMC have done so since 2017 and 2019 respectively. Participation in the scheme demonstrates our willingness to be part of a system focussed on driving improvement, and to be transparent and accountable for our performance. There are not equivalent reporting schemes in the other UK nations, but our devolved offices are proactively engaging with stakeholders to determine the appetite for participation in similar arrangements where appropriate.

Next steps

31 Subject to Council endorsement of our approach, we will immediately embed these measures and targets into our performance reporting framework. We will report on our progress annually and review whether further action needs to be taken.

32 We have developed a communications plan to support how we promote our messages and commitment. Given the pressures on the external environment we plan to be opportunistic in our approach to communications, increasingly drawing on these commitments as part of our public response to key discussions and the work of our partners. Internally we will continue to promote our inclusivity commitments, including in the performance development plan discussions that all staff have in February.
Targets and key performance indicators

**TARGET:** Eliminate disproportionality in fitness to practise referrals from designated bodies based on race and PMQ by 2026

<table>
<thead>
<tr>
<th>KPI1: % of DBs with evidence of disproportionality, for ethnicity and PMQ region (See chart below showing proportions of enquires)</th>
<th>Ethnicity and PMQ</th>
<th>4.5%</th>
</tr>
</thead>
</table>

KPI2: Difference in rates of referral between BME and white doctors and between UK and non-UK doctors

| Ethnicity | 0.39% (0.77% BME, 0.38% white) |
| PMQ | 0.68% (0.33% UK, 1.01% non-UK) |

**KPI1:** % of DBs with evidence of disproportionality, for ethnicity and PMQ region

Annex A
**TARGET: Eliminate discrimination, disadvantage and unfairness for all index measures of fair medical education and training pathways by 2031**

<table>
<thead>
<tr>
<th>Index measures</th>
<th>Baseline / trend</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Undergraduate education – EPM</strong></td>
<td>2019 data:</td>
</tr>
<tr>
<td>Difference between mean Educational</td>
<td>White: <strong>6.05</strong> (n=4,409, 95% CIs: 5.97 – 6.13)</td>
</tr>
<tr>
<td>Performance Measure (EPM) scores,</td>
<td>BME: <strong>4.93</strong> (n=2,641, 95% CIs: 4.82 – 5.04)</td>
</tr>
<tr>
<td>across all UK medical schools.</td>
<td></td>
</tr>
<tr>
<td>The EPM is a measure of clinical and</td>
<td></td>
</tr>
<tr>
<td>non-clinical skills, knowledge and</td>
<td></td>
</tr>
<tr>
<td>performance up to the point of</td>
<td></td>
</tr>
<tr>
<td>application to postgraduate education.</td>
<td></td>
</tr>
<tr>
<td>It is used in applications to</td>
<td></td>
</tr>
<tr>
<td>foundation training. Score is out of</td>
<td></td>
</tr>
<tr>
<td>10, with 1 the lowest and 10 the</td>
<td></td>
</tr>
<tr>
<td>highest and best performing decile.</td>
<td></td>
</tr>
<tr>
<td><strong>Undergraduate education – exam</strong></td>
<td>Data not available to baseline until 2021/22.</td>
</tr>
<tr>
<td>Differences in medical school exam</td>
<td></td>
</tr>
<tr>
<td>pass rates, across all UK medical</td>
<td></td>
</tr>
<tr>
<td>schools.</td>
<td></td>
</tr>
<tr>
<td>This data collection is new and we</td>
<td></td>
</tr>
<tr>
<td>will have access to it for analysis in</td>
<td></td>
</tr>
<tr>
<td>2021.</td>
<td></td>
</tr>
<tr>
<td>**Undergraduate education – F1</td>
<td>2019 data:</td>
</tr>
<tr>
<td>preparedness**</td>
<td>White: <strong>70.2%</strong> (n=4,261, 95% CIs: 68.8% – 71.6%)</td>
</tr>
<tr>
<td>Difference in preparedness levels of</td>
<td>BME: <strong>62.4%</strong> (n=2,508, 95% CIs: 60.5% – 64.3%)</td>
</tr>
<tr>
<td>new F1 doctors, as measured in the</td>
<td></td>
</tr>
<tr>
<td>NTS.</td>
<td></td>
</tr>
<tr>
<td>We asked foundation year 1 doctors the</td>
<td></td>
</tr>
<tr>
<td>question ‘I was adequately prepared</td>
<td></td>
</tr>
<tr>
<td>for my first foundation post’. The</td>
<td></td>
</tr>
<tr>
<td>measure shows the proportion of</td>
<td></td>
</tr>
<tr>
<td>respondents that agreed or strongly</td>
<td></td>
</tr>
<tr>
<td>agreed with the statement.</td>
<td></td>
</tr>
</tbody>
</table>
### Postgraduate education - inclusivity

Difference in perceived inclusivity levels, as measured in the NTS.

The responses to the survey question ‘my department/unit/practice provided a supportive environment for everyone regardless of background, beliefs or identity’ were converted into a score out of 100, with higher scores indicating higher levels of support.

| 2020 data: |  
| --- | --- |
| UK White: **81.6** (n=15,845, 95% CIs: 81.3 – 81.9) |  
| UK BME: **77.2** (n=6,770, 95% CIs: 76.6 – 77.7) |  
| ALL UK: **80.1** (n=23,370, 95% CIs: 79.8 – 80.4) |  
| ALL IMG: **76.0** (n= 3,475, 95% CIs: 75.2 – 75.7) |  

### Postgraduate education - ARCP

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

| 2018/19 data: |  
| --- | --- |
| UK White: **4.8%** (n=32,024, 95% CIs: 4.5% – 5.0%) |  
| UK BME: **7.1%** (n= 15,322, 95% CIs: 6.7% – 7.6%) |  
| ALL UK: **5.6%** (n=49,200, 95% CIs: 5.4% – 5.8%) |  
| ALL IMG: **15.7%** (n= 7,266, 95% CIs: 14.9% – 16.6%) |  

### Postgraduate education - exam

Difference in specialty examination pass rates, across all UK specialties and training levels. Data provided by royal colleges and faculties.

| 2018/19 data: |  
| --- | --- |
| UK white: **77.7%** (n= 17,856 attempts for 13,020 trainees, 95% CI: 77.1% – 78.3% ) |  
| UK BME: **65.4%** (n= 9,940 attempts for 6,759 trainees, 95% CI 64.5% to 66.3% ) |  

A3
**TARGET: eliminate differentials in BME recruitment, representation across staffing levels, retention, progression, pay and employee engagement**

<table>
<thead>
<tr>
<th>Underlying measures and targets</th>
<th>2020</th>
<th>2023</th>
<th>2026</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase the level of BME representation at <strong>Level 3 and above</strong></td>
<td><strong>Applications</strong></td>
<td>22.8%</td>
<td>27%</td>
</tr>
<tr>
<td></td>
<td><strong>Interviews</strong></td>
<td>15.2%</td>
<td>22%</td>
</tr>
<tr>
<td></td>
<td><strong>Offers</strong></td>
<td>14.6%</td>
<td>17%</td>
</tr>
<tr>
<td></td>
<td><strong>Workforce</strong></td>
<td>11.1%</td>
<td>16%</td>
</tr>
<tr>
<td>level of BME representation at Level 2+</td>
<td>8%</td>
<td>14%</td>
<td>20%</td>
</tr>
<tr>
<td>level of BME representation at level 3</td>
<td>12%</td>
<td>16%</td>
<td>20%</td>
</tr>
<tr>
<td>Increase the level of BME representation at all levels</td>
<td><strong>Applications</strong></td>
<td>29.4%</td>
<td>37%</td>
</tr>
<tr>
<td></td>
<td><strong>Interviews</strong></td>
<td>18.2%</td>
<td>32%</td>
</tr>
<tr>
<td></td>
<td><strong>Offers</strong></td>
<td>18.2%</td>
<td>27%</td>
</tr>
<tr>
<td></td>
<td><strong>Workforce</strong></td>
<td>14.3%</td>
<td>17%</td>
</tr>
<tr>
<td>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</td>
<td>0.8%</td>
<td>2.0%</td>
<td>1.0%</td>
</tr>
<tr>
<td>Proportion of BME staff receiving promotion and grade progression is proportionate to our workforce at the relevant grade/level</td>
<td><strong>BME</strong></td>
<td>15%</td>
<td>18%</td>
</tr>
<tr>
<td></td>
<td><strong>Non-BME</strong></td>
<td>16%</td>
<td>18%</td>
</tr>
<tr>
<td>Pay differentials within in a confined band limited to 2% from 2023</td>
<td>2%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

1 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%.
Council meeting, 25 February 2021
Agenda item M5 – Equality, Diversity and Inclusion

| **TARGET:** eliminate differentials in BME recruitment, representation across staffing levels, retention, progression, pay and employee engagement |
|---------------------------------|------|------|------|
| **Underlying measures and targets** | 2020 | 2023 | 2026 |
| Improve overall inclusivity index score | 63% | 72% | 80% |
| Ensure engagement scores for all BME groups are no less than 5% of the GMC average. | GMC Engagement Score | 80% | 80% | 80% |
| Black/African/Caribbean/Black British | 65% | 70% | 75% |
### Purpose

In February 2020, Council approved a revised approach to proactive quality assurance (QA) of undergraduate and postgraduate medical education and training. Unsurprisingly, the pandemic has brought challenges in rolling out this new approach to QA, as well as to our broader quality assurance oversight. Nonetheless, much has been achieved in the last twelve months including the development and instigation of ‘virtual’ activities.

For Council’s information, this paper summarises the main developments in our QA rollout as well as providing brief updates on other activities such as new school oversight and enhanced monitoring of challenged training providers in postgraduate training. We have also taken the opportunity to reflect more broadly on the impact of the pandemic in delivering our statutory education functions.

### Decision trail

Council approved a revised approach to quality assurance in February 2020.

### Recommendation

Council is asked to note the education quality assurance update.

### Annexes

- Annex A: GMC approach to quality assurance
- Annex B: Proactive QA rollout summary for England, Wales, Scotland and Northern Ireland

### Author contacts

**Martin Hart,** Assistant Director, Education and Standards  
[martin.hart@gmc-uk.org](mailto:martin.hart@gmc-uk.org), 020 7189 5408

### Sponsoring director/Senior Responsible Owner

**Colin Melville,** Medical Director and Director of Education and Standards  
[colin.melville@gmc-uk.org](mailto:colin.melville@gmc-uk.org), 0161 923 6772
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 those organisations continue to meet our standards through our proactive quality assurance processes. This includes checking that they, in turn, 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 (including an exercise with undergraduate and postgraduate institutions in Wales and the West Midlands in 2019), 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)

---

\(^1\) 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.
they complete a self-assessment that asks them to demonstrate how they 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 aren’t 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 will 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. Where we become aware of significant challenges in postgraduate training we may use our ‘enhanced monitoring’ process (see below) to focus improvement in departments with particular challenges.

g 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. This may include highlighting on our website or using other fora (such as our regular quality leads meetings) to share notable practice.

h When fully rolled out, we will produce an annual summary for each organisation which will include information about the self-assessment, any activities we’ve undertaken and any requirements, recommendations, good or notable practice we’ve identified.

4 We plan to evaluate the process when all organisations have completed two self-assessments and again when we have completed a full cycle (see diagram 4, Annex 1)

5 The remainder of this paper is devoted to short updates on our activities since February 2020 covering:
Council meeting, 25 February 2021
Agenda item M6 – Education Quality Assurance Update

a Engagement with established medical schools

b Developments with new medical schools (who go through a multi-year process with us until the first cohort of students graduate) and those medical schools with programmes overseas

c Engagement with postgraduate training bodies

d Our enhanced monitoring activities to support locations that have particular training challenges

e Our early work to engage with medical associate professional programmes (MAPs)

f A brief update on the audit work in progress which will focus on our decision making last year during the pandemic.

6 Annex B provides a short narrative summary of the QA roll out in the four countries of the UK. As the cycles of QA are completed, narrative reports and end of year assessments will be published.

7 Inevitably 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

8 The GMC’s approach to the regulation of education and training during the pandemic has been the maintenance of standards and outcomes. The students and trainee doctors whose education we oversee will be embarking on careers in medicine that are likely to last more than 40 years. It is important that we acknowledge this when making decisions to address the unique circumstances faced at the present time.

9 However, we recognise that the pandemic has required us to change the way we assure ourselves that standards and outcomes are being met. Across undergraduate and postgraduate, we have sought to embed the following principles in our approach:

- Patient safety
- Maintaining standards
Meeting outcomes (not time served)

Competence (not quantity of evidence)

Proportionate approaches

Supporting diverse patient and doctor populations

**Established medical schools**

10 Medical schools, and indeed the university sector as a whole, has faced many issues this year. The GMC have worked closely with the Medical Schools Council (MSC), the four statutory education bodies and the UK Foundation Programme Office to support the continued teaching of medical students.

11 At the start of the pandemic, the focus was on meeting a UK governments’ request for medical schools to graduate their final year students early. This was designed to allow early provisional registration with the GMC so that graduates could – if they wished - start their careers early as “Foundation interim Year 1” doctors. Just over 7,000 doctors obtained early registration with the GMC in 2020. Whilst facilitating this, we worked closely with medical schools to ensure that they only graduated students who had completed their course and assessments and to ensure that any adjustments made (e.g. to final assessments) were reasonable.

12 We have commissioned research, led by Gill Vance at the University of Newcastle, to evaluate the experience of interim F1s. This is due to report in early February.

13 The disruption to A level examinations in 2020 (and now 2021) had a significant impact on the medical school intake to UK universities. As a result, almost one thousand additional students were admitted to medical school in autumn 2020 (approximately 14% increase in the number of UK students). Some institutions had already had significant increases as a result of the planned expansion 2018-2020. We recognise the need to examine the effects of this in forthcoming quality assurance activities. We have already identified those medical schools that have had significant increase in cohort numbers and this will be addressed in engagement activities with these schools over the next period.

14 The more recent focus has been on ensuring that latter cohort of students could continue their studies, including the safe completion of clinical placements. This has included supporting their status as key workers across the UK, ensuring they are properly protected when in clinical environments and
recognising that this group have now had almost twelve months disruption to their studies. A survey of medical schools undertaken by the GMC and MSC indicates that, despite the disruption, most medical schools expect to be able to graduate on schedule this year. They have stressed that this cohort of students are understandably anxious and may need greater support and induction prior to starting as F1 doctors in August.

15 Whilst conventional visits to universities and local education providers have not been possible, the GMC has embraced the use of technology to make ‘virtual’ visits a key element of our quality assurance activity. As with other sectors, we have recognised the benefits and limitations of video conferencing, but it has undoubtedly been an important factor in us maintaining QA this year.

16 As you will see from the four country summary (Annex B), most medical schools have engaged with our new QA process as planned with just a few requesting postponements as a result of the pandemic.

New and overseas medical schools and programmes

17 Two new medical schools admitted their first students in 2020 (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. We have also arranged virtual visits with new schools that had already admitted students (Aston, Anglia Ruskin and Sunderland), including meetings with students.

18 We have also had virtual visits with two institutions planning to admit students in 2021 – Brunel University (a private medical school) and the University of Ulster (we had undertaken a ‘real’ visit in 2019).

19 There remains interest amongst a number of other universities in opening medical schools – some hoping for additional state funded expansion, others considering the private route. We have a clear staged process for engaging with such institutions as proposals are brought to us.

20 We continue to engage with two innovative programmes in Scotland (see Annex B) – the ScotGEM programme (a graduate entry programme delivered by the University of Dundee and the University of St Andrews) and the Edinburgh HCP programme (a programme designed to enable existing healthcare professionals to become doctors).

21 Members should also be aware that we continue to have responsibility for the oversight of a number of programmes delivered by UK universities overseas.
Two programmes (Barts programme in Malta, and Aberdeen’s in Sri Lanka Medical Pathway programme) are being overseen through our multi-year visit programme until the first students graduate. A real visit took place to Sri Lanka in January 2020 and a virtual visit to Malta in July 2020.

**Postgraduate training bodies**

22 The understandable decision to scale back and delay our National Training Surveys in 2020 has had an impact on both GMC quality assurance and postgraduate training bodies oversight of postgraduate training. That said, the survey’s focus on the impact of the first wave of the pandemic will be vital to help understanding as we and others seek to manage the future training of doctors affected by the pandemic.

23 More than 80% of doctors in training reported disruption caused by coronavirus reduced their access to the learning they need to progress their careers. At the same time, around three-fifths of trainees, and four-fifths of trainers, saw their work change significantly during the spring peak. The decision to postpone training rotations will clearly have a significant impact on training progressions.

24 There have also been significant challenges to postgraduate assessments. Given the GMC’s role in approving postgraduate curricula and assessments, this has proved to be a key issue for the GMC. At the time of writing (January 2021), all college exams have been cancelled. All the bodies involved have sought to reassure trainees that they will not be disadvantaged by missing exams because of circumstances out of their control related to COVID-19 and in particular.

25 Although there have been challenges, postgraduate training bodies have continued their work and liaison with the GMC throughout the pandemic. As with undergraduate activity, virtual visits have been undertaken to provide assurance that training standards are being met.

**Enhanced monitoring**

26 ‘Enhanced monitoring’ is the process we use when serious concerns have been raised about the quality of training in a local education provider which cannot be resolved locally. Therefore, these serious concerns meet a threshold for us to be more directly involved. In enhanced monitoring, we work with postgraduate training organisations to ensure that our standards are met.

27 A key feature of enhanced monitoring oversight is the need to meet trainees face to face to hear directly from them about their training experience.
Although ‘virtual’ enhanced monitoring visits have taken place, we believe that in person engagement is the more valuable approach to deal with these challenging situations.

28 The pandemic has resulted in different effects on existing enhanced monitoring cases.

29 As examples, the disruption to regular clinical activity provided an opportunity to address some longstanding issues with Foundation trainees at Brighton and Sussex University Hospitals NHS Trust. This had been a long-standing EM case where we had imposed conditions on the safe experience of Foundation trainees in general surgery. The Trust took the opportunity of reduced general surgery activity to address some of the issues and a positive meeting was held with trainees in early September. The Trust remains in enhanced monitoring whilst we check the sustainability of the improvements made but we and HEE are hopeful that a corner has been turned with a challenging environment for trainees.

30 Weston Area Health NHS Trust is also a long standing EM case with a series of training challenges in various departments. It has been subject to GMC conditions and currently faces particular challenges in its emergency and medicine departments. Much expectation of improvement rested on the merger of the trust with the University of Bristol Hospital NHS Foundation Trust which was competed in April 2020. However, the pandemic has brought additional challenges to Weston. The hospital faced a significant COVID outbreak in May which caused it to close following reports that as many as 6% of the 1700 staff were infected. At the time of writing, the hospital is closed to new admissions due to a further COVID outbreak. A virtual EM visit, involving the GMC and HEE took place in January. Whilst there had been some improvements in emergency medicine, the trainees in medicine continue to have an unsatisfactory training experience and we are engaging with HEE and other stakeholders to consider next steps for training at this location.

31 At the time of writing there are currently 38 open EM cases, with conditions attached to GMC approval to deliver a programme of training at 5 sites. The current list of open cases is available on our website.

Medical Associate Professionals (MAPs) programmes

32 We are also beginning our work to engage with universities that deliver MAPs programmes ahead of the expected start of statutory regulation by the GMC in 2022. There are currently 38 universities offering physician associate programmes and one offering a programme for anaesthesia associates.
33 Our approach to accreditation and quality assurance of these programmes will build on our revised framework for medical education. As part of a ‘baselining’ exercise, we will ask all course providers to complete a self-assessment questionnaire in 2021. These will be analysed alongside other data and evidence (including the results of the PA national examination delivered by the Faculty of Physician Associates) so that we can begin a programme of initial accreditation and subsequent quality assurance.

34 In January 2021, we have hosted a series of virtual meetings with MAP programme providers to introduce them to our approach and the GMC more generally.

Audit

35 Finally, Council may like to note that an audit has been commissioned to review how the GMC has fulfilled its statutory function in relation to the quality of medical education, including enhanced monitoring arrangements, in response to the pandemic.

36 The review will:

- consider the approach to risk management, governance and decision-making relevant to changes in managing quality assurance over the last nine months
- review any system or control adaptations, how they have operated in practice and the relevant management information and local quality assurance arrangements have
- assess any impact arising from the pandemic on the wider roll out plans for proactive quality assurance (as reported to Council in February 2020)
- reflect on the challenges of continuing to support reactive quality assurance, especially in postgraduate training
- review how any learning from the pandemic response is informing opportunities and continuous improvement for the future application of QA arrangements
- Consider how feedback is utilised to inform and improve the QA processes
- Consider the approach taken to quality assure ED&I and how the GMC’s ED&I ambitions are built into the QA process.
The final report will be presented to the Audit and Risk Committee at its meeting in March 2021.

For trainers and trainees there exists the National Training Surveys. We also engage directly with groups of students, trainees and trainers as a quality activity.
Supporting diagrams
M6 - Annex A
Supporting diagrams

Martin Hart, Assistant Director, Education
Assurance is achieved through a variety of activities

Assurance

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

<table>
<thead>
<tr>
<th>Proactive</th>
<th>Reactive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality assurance</td>
<td>GMC</td>
</tr>
<tr>
<td><strong>Collaboration to gain continuous assurance that standards are being met</strong></td>
<td></td>
</tr>
<tr>
<td>Quality management</td>
<td>Medical schools and postgraduate training organisations</td>
</tr>
<tr>
<td><strong>Work together to ensure standards are met</strong></td>
<td></td>
</tr>
<tr>
<td>Quality control</td>
<td>Local education providers</td>
</tr>
</tbody>
</table>
**Quality assurance cycle**

**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>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reduce risk</strong> 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><strong>Improve the assurance</strong> 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><strong>Improve customer satisfaction</strong></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><strong>Improve value for money</strong></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)
Proactive QA rollout summary for England, Wales, Scotland and Northern Ireland

Four country quality assurance update

1 This annex provides a narrative update on progress with the roll out of the Proactive Quality Assurance process across the UK.

England

London

Proactive Quality Assurance (PQA) process

2 The five medical schools in London were due to submit their self assessment questionnaire (SAQ) between June 2020 and February 2021. Three (Kings College, Barts Queen Mary’s and University College London) were submitted on schedule, feedback meetings were held and quality activities are being identified.

3 Imperial has delayed its submission due to pandemic pressures and is now planning to submit its SAQ at the end of February. St George’s has also delayed and we hope to confirm a submission date in due course.

4 HEE London submitted its SAQ on time in October, had a feedback meeting in November and quality activities are being identified.

New schools and overseas programmes

5 There are three overseas programmes overseen by London medical schools. One of the two St George’s programmes (the ‘international’ programme largely delivered in the United States) is ending and we are quality assuring the teach out of the final students on the course. The St George’s programme with the University of Nicosia in Cyprus (with teaching in the US and Israel) continues, with ongoing oversight of the course and it’s postgraduate teaching programme (F1 equivalent).
Council meeting, 25 February 2021
Agenda item M6 – Education and Quality Assurance Update

6 The Barts programme in Malta is going through our multi year process (currently has students in years 1-4)

7 Brunel University have been engaging with us and plan to admit students to a private programme in January 2022

South

Proactive Quality Assurance (PQA) process

8 Southampton, Oxford and Buckingham medical schools were due to submit their SAQs in 2020. Buckingham and Oxford requested short delays but feedback meetings have been held and quality activities scheduled.

9 HEE Thames Valley and HEE Wessex also submitted SAQs on schedule in 2020, feedback meetings have been held and quality activities scheduled.

10 In 2021 the remaining medical schools in the region (Bristol, Exeter, Brighton and Sussex and Plymouth) are due to submit their SAQs.

New schools and programmes

11 Kent Medway Medical School admitted its first students in 2020. A virtual visit has been held.

Midlands and East

Proactive Quality Assurance (PQA) process

12 HEE West Midlands, Birmingham, Keele and Warwick medical schools were part of the pilot PQA process in 2019. As such, 2020 was the second year for these bodies. Second SAQ submissions were delayed for Keele and Birmingham, but the cycle continued as planned for Warwick with quality activities including a Differential Attainment awayday to discuss actions and learning.

13 Health Education East of England submitted their first SAQ in December with a feedback meeting in January 2021.
The Defence Deanery, Norwich, Cambridge, Leicester and Nottingham medical schools will also submit SAQs in 2021.

**New Schools and programmes**

Aston Medical School and Anglia Ruskin Medical School both in year 3, have virtual visits taking place over January/February. Both were offered the opportunity to defer due to the pandemic but chose to go ahead.

**North**

Proactive quality assurance

HEE North West, Lancaster, Manchester and Liverpool medical schools all submitted SAQs as planned in 2020 with feedback meetings held. HEE Yorkshire and Humber, HEE North East and the other medical schools in the region are all due to submit in 2021.

A number of quality activities have taken place although with a greater focus on document review than in person visits/activities.

**New medical schools and programmes**

Edge Hill medical school admitted its first students in 2020. A virtual visit will take place at the end of January 2021.

A real visit to Sunderland medical school took place in January 2020.

**Wales**

Proactive Quality Assurance (PQA) process

Educational organisations in Wales – HEIW, Cardiff and Swansea – were part of our pilot of our new approach to quality assurance, carried out in 2019, and submitted their first Self-Assessment Questionnaire (SAQ) as part of that pilot cycle. The pilot cycle concluded in January 2020.

The three organisations each submitted their year two SAQ in 2020 – Swansea in February, Cardiff in July and HEIW in December. We have completed the scrutiny, held feedback meetings and undertaken quality activities with both...
medical schools, and are now looking at arranging end of cycle meetings as well as confirming submission dates for year three SAQs in 2021. We have undertaken two SAQ linked activities for each school, which have been a combination of document reviews and an observation.

22 The HEIW SAQ was submitted the end of December and so we are in the process of scrutinising that, and we will agree activities with HEIW when we meet to discuss their submission.

23 The pandemic has had minimal impact on the PQA process, other than HEIW requesting a one-month extension on their submission date, and we have been proportionate in the number and type of activities we have selected, to acknowledge the pressure educational organisations are under and the limits on the types of activities we are able to undertake remotely as well as being proportionate to any risks identified in the SAQ.

New Schools and programmes

24 Welsh Government have established a task and finish group to explore the feasibility of a third medical school, in north Wales. Jenny Duncan, Head of the Wales National Office, will feed into this group and we are providing input in terms of our new school process.

25 Cardiff continues to deliver its C21 programme (North Wales), delivered in Bangor with support from Bangor University. This falls outside of our new school/programme process as it is the Cardiff programme but delivered in North Wales from year two onwards, but was covered in the Cardiff SAQ submission, and we undertook a quality activity, observing a meeting between Cardiff and the students based in Bangor.

Northern Ireland

Proactive Quality Assurance (PQA) process

26 We will be rolling out the PQA process to educational organisations in Northern Ireland – NIMDTA and QUB – in 2021, in line with the phased roll out across the UK. Exact dates for the SAQ submission are to be agreed, however we have had discussions with both organisations on planning for this. Current plans are for a May submission for QUB, and November for NIMDTA, TBC.
New Schools and programmes

27 Ulster University is scheduled to take their first cohort of Northern Ireland Graduate Entry medical School (NIGEMS) students in September 2021. We will be contacting Ulster shortly for an update on the recruitment of both staff and students, and in line with our new school process we will be meeting with Ulster in the summer to check their readiness for the intake. We have had feedback from QUB that work between the two schools on how they will manage clinical placements given the two schools will be using the same LEPs are ongoing and productive, pandemic notwithstanding.

Scotland

Proactive Quality Assurance (PQA) process

28 We rolled out the PQA process to educational organisations in Scotland – NES and the five medical schools - in 2020, and all have submitted their first SAQs.

29 NES submitted their SAQ in July 2020, and we have undertaken two SAQ linked activities in addition to routine activities. We are now planning the end of cycle meeting to bring the first cycle to a close and confirm the submission date of this year’s SAQ, likely to be June 2021.

30 The five Scottish medical schools all submitted their first SAQs in the Autumn 2020, and we met with both Glasgow and St Andrews in January to provide feedback on their submission and agree quality activities. We have similar meetings scheduled with Dundee, Aberdeen, and Edinburgh over January and February.

31 The pandemic has had minimal impact on the PQA process, other than two schools requesting a one-month extension on their submission date, and we have been proportionate in the number and type of activities we have selected, to acknowledge the pressure educational organisations are under and the limits on the types of activities we are able to undertake, as well as the risks identified in each SAQ.

New Schools and programmes

32 Aberdeen have updated us on progress with the Sri Lanka Medical Pathway (SLMP) through their SAQ submission, and we will review this when we meet to discuss their SAQ. This programme is being quality assured through the PQA
approach, but with additional targeted activities as appropriate. For example, it is likely one of the quality activities will be to meet virtually with the two cohorts of SLMP students currently at Aberdeen.

33 ScotGEM continues its progress through our new school process, and we are planning a virtual visit in March 2020. The Scottish Government consultation on St Andrews does not directly impact on this process, however if the prohibition on St Andrews as an awarding body is lifted then we will need to seek agreement from Council for St Andrews to be added to our list of approved awarding bodies (albeit in combination with Dundee).

34 Edinburgh HCP-Med has its first cohort of students, and as with SLMP we are quality assuring this through the School’s PQA process. We observed an online teaching session and held a feedback session with students in December and are arranging a meeting with educators involved in the programme for the spring.
### Purpose
To inform Council about the intention to commission a partner to undertake a review of Council’s effectiveness, giving a broad outline of the expected timeline.

### Recommendation(s)
Council is asked to note that a Council Effectiveness review will be commissioned in 2021.

<table>
<thead>
<tr>
<th>Action</th>
<th>To note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purpose</td>
<td>To inform Council about the intention to commission a partner to undertake a review of Council’s effectiveness, giving a broad outline of the expected timeline.</td>
</tr>
<tr>
<td>Decision trail</td>
<td>n/a</td>
</tr>
<tr>
<td>Recommendation(s)</td>
<td>Council is asked to note that a Council Effectiveness review will be commissioned in 2021.</td>
</tr>
<tr>
<td>Annexes</td>
<td>n/a</td>
</tr>
<tr>
<td>Author contacts</td>
<td>Melanie Wilson, Council Secretary</td>
</tr>
<tr>
<td></td>
<td><a href="mailto:melanie.wilson@gmc-uk.org">melanie.wilson@gmc-uk.org</a> , 0161 240 8331</td>
</tr>
<tr>
<td>Sponsoring director/Senior Responsible Owner</td>
<td>Sophie Brookes, Assistant Director, Corporate</td>
</tr>
<tr>
<td></td>
<td><a href="mailto:sophie.brookes@gmc-uk.org">sophie.brookes@gmc-uk.org</a>, 020 7189 5048</td>
</tr>
</tbody>
</table>
Background

1 As part of the organisation’s commitment to good practice, and in line with the principles of the Charity Governance Code, “The board reviews its own performance and that of individual trustees, including the chair. This happens every year, with an external evaluation every three years. Such evaluation typically considers the board’s balance of skills, experience and knowledge, its diversity in the widest sense, how the board works together and other factors relevant to its effectiveness.”

2 To date, the pattern of Council effectiveness reviews for the GMC has been to hold an annual ‘in house’ exercise informed by individual member appraisals with the Chair and a light-touch questionnaire (survey monkey) completed by Members and Directors which is reported back to Council. This is supplemented by a formal deeper dive every four years, commissioned from an external firm or audit provider.

3 The external review was due in 2020 but due to the twin issues of the pandemic and the fact that five Council members were coming to the end of their term of office in 2020, it was deemed appropriate on both counts to delay the review. In conversation with the Chair, it was agreed that a sensible timing for the review would be during the summer of 2021, allowing the new members to develop some familiarity with the organisation but not so long after their start date to lose the advantage of their fresh perspective on our systems and processes.

4 In addition, the legislative reform programme proposes the introduction of a unitary board to replace our current arrangements, with acknowledgement from the Department of Health and Social Care of the need for an orderly transition period of up to two years. This Effectiveness Review process therefore represents an opportunity to help identify the strengths and weaknesses of our current ways of working as part of the transition path to the new arrangements and identifying any gaps that we need to address as we move to new systems, processes, relationships, skills and knowledge that will be required to form a highly effective unitary board.

Next steps

5 Subject to agreeing funding (in the April round), the Corporate Governance team will seek quotes for the work via a mini tender, in partnership with Procurement colleagues.
6 The outline timescale for the work will be fieldwork during late June to early August, with a seminar or paper to review results reported to the September or November meeting of Council. This will be confirmed once our partner firm is appointed and timelines are confirmed.

7 We expect the fieldwork to take the form of questionnaires or interviews with Members and SMT, an inventory of the skills we have around the Council table, a review of our documentation, some stakeholder testing and if time allows, for observation of a Council meeting in progress. The main reference point will be the Charity Governance Code, and any other good practice guidance about the functioning of highly effective boards that the successful bidder can bring.

8 The outcomes from this work will be used to identify any gaps or development needs and a development plan will be created to help ensure a smooth transition to the new unitary board arrangements in due course.
<table>
<thead>
<tr>
<th>Action</th>
<th>To note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purpose</td>
<td>This report summarises the work undertaken by the Executive Board during 2020, setting out the decisions taken, policies and guidance agreed and reports noted across a range of strategic issues.</td>
</tr>
<tr>
<td>Decision trail</td>
<td>Council receives a report on the work of the Executive Board annually (in addition to updates included in the Chief Executive’s report at each meeting). This paper has been agreed by the Executive Board.</td>
</tr>
<tr>
<td>Annexes</td>
<td>n/a</td>
</tr>
</tbody>
</table>
| Author contacts| Dale Langford, Corporate Governance Manager  
dale.langford@gmc-uk.org, 020 240 8346        |
| Sponsoring director/Senior Responsible Owner | Charlie Massey, Chief Executive  
chiefexecutive@gmc-uk.org, 020 7189 5037 |
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).

2 The Board met 11 times during 2020, on:

- 27 January 2020
- 24 February 2020
- 23 March 2020
- 27 April 2020
- 1 June 2020
- 29 June 2020
- 20 July 2020
- 21 September 2020
- 19 October 2020
- 27 November 2020
- 14 December 2020

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

Key matters considered by the Executive Board in 2020

Response to the pandemic

4 The Board’s first meeting of the year included a short item of any other business on the potential implications as a result of the emerging threat of a novel coronavirus, should the Secretary of State declare an emergency, such as in relation to consent and registration.

5 From February, the Board regularly discussed the response to COVID-19, the impact across the business and plans for recovery, including plans for restarting MPTS hearings at the hearings centre and tests for the Professional and Linguistics Assessment Board (PLAB) at the clinical assessment centre when it became safe to do so.

6 The Board considered plans to create a temporary additional clinical assessment centre at our Manchester offices to deal with the backlog of doctors waiting to take the PLAB tests, as approved by Council on 4 November 2020.
Operational performance and risk

7 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.

8 In addition, the Board conducts regular ‘deep dive’ risk reviews, taking one of the overarching risks or opportunities in the Corporate Opportunities and Risk Register, to explore the relevant underlying risks from directorate registers that map to the strategic risk.

Strategy

9 The Board noted progress towards meeting the 2018-20 corporate strategy aims (21 September 2020), which Council was updated on at the meeting on 10 December 2020.

Business planning

10 At its meetings on 21 September and 27 November 2020, the Board considered the draft Business Plan and Budget, ahead of consideration by Council on 29 September and 10 December 2020.

Equality, diversity and inclusion

11 The Board received a draft 3 to 5 year plan for becoming a more inclusive organisation. The plan is intended to strengthen the approach that we take to setting measures and key performance indicators to drive meaningful progress on this agenda, and to mobilise leaders to support our work to achieve an inclusive workplace. (24 February 2020)

12 The Board considered papers on accelerating progress on ED&I as an employer and regulator (29 June and 20 July 2020), including a presentation from the Chairs of the BME Network on how SMT can help and engage with Network members.

13 The Board reviewed the findings of a compliance and governance review of ED&I, by consultants Campbell Tickell, endorsing proposed actions to ensure that Council and SMT continue to play a leading role in developing ED&I priorities. We also noted the action we will take to put in place training provision about the Human Rights Act, for shaping policies and making decisions, and to ensure we respond to the Gender Recognition Act across all our regulatory functions (14 December 2020)
**Registration and Revalidation**

14 The Board approved new guidance for medical practitioners tribunals on the key factors to take into account when considering restoration following voluntary or administrative erasure. These hearings are arranged when a doctor’s restoration application is referred to the MPTS by GMC case examiners if they are not satisfied the doctor is fit to be restored to the medical register without the matter being considered at a hearing. (27 January 2020)

15 The Board approved a series of proposals reforming routes to registration (24 February and 23 March 2020), including:

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

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

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

16 The Board considered the outline design of the Applied Knowledge Test element of the Medical Licensing Assessment (27 January 2020)

17 The Board approved the removal of the small administrative fee charged to any doctor when applying to remove their name voluntarily from the register, with the change taking effect from 1 April 2020. (24 February 2020)

18 The Board agreed our approach to confirming the good standing of doctors who had both their registration and licence restored under section 18A of the Medical Act (emergency powers) during the pandemic. These doctors’ Certificates of Current Professional Standing will mention that they held a period of temporary registration in 2020 granted under our emergency powers and that there were no outstanding fitness to practise sanctions or investigations.
when we granted their registration. It will also mention that we do not undertake all our usual fitness to practise checks when we grant or revoke this type of registration. This is to reflect the different processes we have in place for temporary registration during an emergency, to ensure enough doctors are quickly available to support the NHS. (20 July 2020)

19 The Board considered the introduction of accepting passes in overseas registration licensing exams as alternative evidence of knowledge and skill for registration, given the current backlog of applicants waiting to take PLAB 2. The Board approved three overseas registration/licensing exams as acceptable evidence of knowledge and skills for registration. (19 October 2020)

20 Having paused identity checks in person as a result of the pandemic, the Board approved a digital process for identity verification, to enable all applicants applying for registration and restoration to the register to complete ID checks remotely using smartphone or webcam technology as part of their application. The digital ID process will assist colleagues in making decisions, rather than using artificial intelligence or algorithms to do the work. (14 December 2020)

Human resources and pensions

21 The Board noted the 2019 Human Resources and Gender Pay Report (23 March 2020), which was considered by Council at its meeting on 23 April 2020.

22 Plans for the staff survey (24 February 2020) and results of the survey (21 September 2020) were reviewed by the Board, as reported to Council on 4 November 2020.

23 The Board noted an update on GMC Staff Superannuation Scheme funding and agreed to progress work on changes to life assurance cover to maximise the benefits for scheme members survivors/dependants (21 September 2020), as approved by the Remuneration Committee in October 2020.

24 The Board considered outline proposals for the 2021 pay award framework. (27 November 2020).
Governance

25 The Board established a programme board to oversee the legislative reform programme, to be chaired by the new Director of Strategy & Policy. (21 September 2020)

Facilities

26 The Board considered a paper on accommodation strategy (23 March 2020), including how we are managing our leases and making the most of our office space.

Other regular reports

27 The Board received the following reports:

a The draft Executive Board report to Council, ahead of consideration by Council on 27 February 2020.

b Updates on GMC Services International Ltd (23 March 2020 and 27 November 2020).

c The draft 2019 Trustees’ Annual report and accounts and the annual fitness to practise statistics, for submission to Council (27 April 2020). Council agreed the Trustees’ Annual report and accounts at its meeting on 8 July 2020.

d Update on corporate complaints received, ahead of Council’s consideration of the complaints report (27 April and 19 October 2020).

e The work of the Business Continuity Working Group and Compliance Team, including the business continuity exercises, training and how we managed the business continuity incident response to the pandemic (20 July 2020).

f The annual health and safety report (21 September 2020).

g The annual report of the GMC Group Personal Pension Plan Management Board (27 November 2020), on which Council also received an update on 10 December 2020.

h The draft Annual Responsible Officer Board Report and Statement of Compliance for submission to NHS England (14 December 2020).
## Action
To approve

## Purpose
This paper sets out the proposed dates of Council and Committee meetings in 2022.

## Decision trail
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 2022 will be considered by Council at the meeting in December 2021.

## Recommendation
To agree the 2022 schedule of meetings

## Annexes
Annex A: 2022 Council and committee dates

## Author contacts
**Dale Langford**, Corporate Governance Manager, [dale.langford@gmc-uk.org](mailto:dale.langford@gmc-uk.org), 0161 240 8346

## Sponsoring director/Senior Responsible Owner
**Sophie Brookes**, Assistant Director - Corporate [sophie.brookes@gmc-uk.org](mailto:sophie.brookes@gmc-uk.org), 020 7189 5048
Council

1 The draft schedule of Council meetings for 2022 is at Annex A. In 2015 Council agreed that it should meet six times each year as the work programme requires this for Council’s business, and to have an away day. It is proposed that Council should continue to meet with this frequency and that the dates will be utilised for meetings, and/or seminars and confidential discussions, subject to the requirements of the forward work programme as it develops. Council seminars take place the evening before Council meetings, proposed to run from 16:30 to 19:00.

2 It was agreed at the Council away day in 2016, that two Council meetings per year would be held in Manchester. We propose that Council should continue to meet in Manchester twice yearly, assuming a return to meetings in person, in April and September 2022. Although it is not yet clear whether we will be able to trial a meeting in Edinburgh in November 2021, the November 2022 Council meeting is provisionally scheduled for Belfast.

3 Arrangements set out in this paper will be subject to review in the light of legislative reform and the possibility that we will move to a unitary board arrangement before the end of 2022.

Committees and other groups

4 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 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.

5 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.

6 We have taken into account dates of school holiday periods, as far as is possible at this early stage, and major religious festivals. We avoided scheduling meetings in early January, late July, August and late December. 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.

7 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.

8  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.
2022 Council meetings

The proposed meeting schedule for Council is as follows:

Wednesday 23 February 2022, 16:30-19:00 (Evening seminar)
Thursday 24 February 2022, 09:00-13:00 – London

Wednesday 27 April 2022, 16:30-19:00 (Evening seminar)
Thursday 28 April 2022, 09:00-13:00 – Manchester

Tuesday 21 June 2022, 16:30-19:00 (Evening seminar)
Wednesday 22 June 2022, 09:00-13:00 – London

Tuesday 12 and Wednesday 13 July 2022, Council away day – Residential/overnight

Wednesday 28 September 2022, 16:30-19:00 (Evening seminar)
Thursday 29 September 2022, 09:00-13:00 – Manchester

Wednesday 2 November 2022, 16:30-19:00 (Evening seminar)
Thursday 3 November 2022, 09:00-13:00 – TBC

Tuesday 13 December 2022, 16:30-19:00 (Evening seminar)
Wednesday 14 December 2022, 09:00-13:00 – London
2022 Committee and other group meetings

**Audit and Risk Committee**
- Thursday 27 January 2022
- Thursday 31 March 2022
- Wednesday 26 May 2022
- Tuesday 13 September 2022
- Thursday 17 November 2022

**Investment Committee**
- Tuesday 15 February 2022
- Thursday 12 May 2022
- Friday 23 September 2022
- Tuesday 22 November 2022

**Remuneration Committee**
- Tuesday 22 March 2022
- Tuesday 11 October 2022

**Board of Pension Trustees**
- Wednesday 9 March 2022
- Wednesday 18 May 2022
- Tuesday 19 July 2022
- Thursday 15 September 2022
- Tuesday 8 November 2022
Council meeting, 25 February 2021
Agenda item M11 – 2022 Council and committee planning

GMC/MPTS Liaison Group
   Wednesday 8 June 2022
   Wednesday 30 November 2022

GMCSI Board
   Thursday 17 March 2022
   Monday 30 June 2022
   Wednesday 14 September 2022
   Thursday 1 December 2022