September 2019 - Council Meeting

MEETING
26 September 2019 10:00

PUBLISHED
19 September 2019
Agenda

Thursday 26 September 2019

10:00 - 13:00

Meeting

10:00 – 10:03 M1 Chair’s business
3 mins

10:03 – 10:05 M2 Minutes of the meeting on 12 June 2019
2 mins

10:05 – 10:25 M3 Chief Executive’s Report
20 mins

10:25 – 10:45 M4 Section 40A appeals update
20 mins

10:45 - 11:00 Break
15 mins

11:00 - 11:25 M5 Update on regulation of Physician Associates and Anaesthesia Associates
25 mins

11:25 - 11:50 M6 Update on implementing the current Corporate Strategy
25 mins

11:50 - 12:15 M7 Pension valuation
25 mins

12:15 – 12:45 M8 Update on the Staff Survey
30 mins
M9  Any other business

M10  Annual report of GMC Group Personal Pension Plan governance

M11  The Professional Standards Authority (PSA) Annual Review of our Performance 2017/18

M12  Council members’ register of interests

M13  Update to the Governance Handbook
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Minutes of the meeting on 12 June 2019

Members present

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

Others present

Charlie Massey, Chief Executive and Registrar
Susan Goldsmith, Deputy Chief Executive and Chief Operating Officer
Paul Buckley, Director of Strategy and Policy
Una Lane, Director of Registration and Revalidation
Anthony Omo, Director of Fitness to Practise and General Counsel
Neil Roberts, Director of Resources
Judith Chrystie, Assistant Director – Medical Licensing Assessment (substituting for 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 and observers to the meeting.

2 Apologies were received from Colin Melville, Medical Director and Director of Education and Standards.
Minutes of the meeting on 30 April 2019 (agenda item M2)

3 Council approved the minutes of the meeting on 30 April 2019 as a true record.

4 Council noted that, since the discussion on University of Buckingham Medical School at the last meeting, the GMC had received a satisfactory response from the University to complete the due diligence checks. Council had therefore given its approval on circulation for University of Buckingham Medical School to be added to the list of bodies that can award UK Primary Medical Qualifications.

Chief Executive’s report (agenda item M3)

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

   a Following publication of Dr Leslie Hamilton’s independent review into gross negligence manslaughter and culpable homicide on 6 June 2019 the GMC had accepted all the recommendations and intended to play a leading role in ensuring they are implemented.

   b The process of verifying the primary medical qualifications of all 3,117 doctors with a licence to practise in the UK who had registered under the previous Commonwealth route to registration had been completed with all the doctors confirmed as appropriately qualified. We have written to the four health departments and the Chair of the House of Commons Health and Social Care Committee to update them.

   c We are confident that we are prepared as we can be for any Brexit outcome on 31 October 2019. We have confirmation the UK qualifications of doctors will be recognised in the Republic of Ireland and have convened a group of European regulators to discuss recognition of UK medical qualifications in other countries.

6 During discussion, Council noted that:

   a Three full time members of staff in the Strategy and Policy directorate are engaged in responding to external enquiries, with other staff contributing.

   b Consideration would be given to a briefing at a seminar later in the year from Aon on the GMC’s aggregate financial risks to set the context for discussions on the Staff Superannuation Scheme.

   c The briefing for Colin Melville’s evidence session at the Public Administration and Constitutional Affairs Committee inquiry into the treatment of eating disorders in the NHS would be shared with Suzi Leather.
Chief Operating Officer’s report (agenda item M4)
7 Council considered the Chief Operating Officer’s Report.
8 Council noted that:
   a Parts of the business continue to experience high operational volumes and pressures, with high volumes of demand for the Professional Linguistic Assessments Board (PLAB) tests. There were also increased volumes of caseloads within Fitness to Practise with a consequent increase in the number of referrals to the Medical Practitioners Tribunal Service (MPTS).
   b The latest financial forecast to the end of the year was that expenditure would be higher than budgeted, but this was likely to be more than offset by additional income, including investment income, which had seen an improvement.
9 During discussion, Council noted that:
   a The increase in referrals reflected an increase in the most serious referrals from employers, as there had also been a drop in the number of less serious cases, that is those which result in doctors being issued with advice or warnings.
   b The Welsh language standards for regulators had not yet been published, so it was not clear what impact, if any, there would be on the implementation of the Medical Licensing Assessment (MLA).
10 Council noted the report, the Council portfolio at Annex A, the Corporate Opportunities and Risk Register at Annex B and the note on the 2018 Pension Scheme Triennial Valuation at Annex C.

Medical Licensing Assessment: approach to designing the content map (agenda item M5)
11 Council noted an update on the process for developing the MLA content map, which defined the knowledge, skills and behaviours that would be tested in the MLA.
12 Council noted that:
   a The engagement exercise had generated 97 responses, almost all being constructive. While there remain some concerns about the MLA concept, responses about the content map itself were generally positive.
   b Some responses considered that the lists of patient presentations and conditions were too long, at around 700 items.
During discussion, Council noted that:

a  Future changes to the MLA content would be more straightforward than changes to curricula.

b  The content bank did not yet include any material on addiction in mental health.

Council:

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

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

Medical Licensing Assessment: approach to delivering the Applied Knowledge Test (agenda item M6)

Council considered a paper setting out details of engagement with medical schools and the Medical Schools Council (MSC) on the MLA and proposed changes to the model for the Applied Knowledge Test (AKT). The key principles for the AKT which have been developed with medical school representatives were set out at Annex A, tabled at the meeting.

Council noted that:

a  The MSC’s Council had indicated support for the principals as the basis for future collaborative work on detailed practical design and delivery.

b  If the proposals were agreed it would maximise the time available for medical students to prepare for the MLA.

c  It was likely that four attempts at passing the MLA would be the maximum number allowed for both UK medical students and international applicants, although the number might be lower for individual medical schools, dependent on their internal processes.

During discussion, Council noted that further consideration would be given to how to sight Council on the prospective ongoing costs for the MLA.

Council:

a  Noted the key principles for the AKT which have been developed with medical school representatives.

b  Endorsed the key principles as a basis for further development.
c  Agreed to re-designate the first year of the MLA in 2022/23 as a further pilot year.

d  Agreed to apply the requirement for UK students to pass the MLA as part of their degree programme’s requirements for the award of a UK primary medical qualification from 2024.

Framework for GMC-regulated Credentials (agenda item M7)

19  Council received a paper providing the final engagement report on the draft framework for introducing GMC-regulated credentials.

20  Council noted that:

a  There were a number of minor updates to the engagement report which would be made following confirmation of quotes with respondents in recent days.

b  Council would receive a formal update after 18 months to two years, with any significant updates in the meantime, including on progress with developing a joint document with the UK Medical Education Reference Group to answer frequently asked questions, to be included in the Chief Executive’s report or Chief Operating Officer’s report.

c  There will be a significant amount of work required to establish the GMC-regulated credentials, but it was anticipated that they would become part of business as usual from 2021.

21  Council:

a  Noted the final report of engagement on the draft credentialing framework, subject to minor updates following confirmation of quotes with respondents.

b  Confirmed the introduction of GMC-regulated credentials, via a phased approach.

c  Noted plans to launch the framework and supporting documents including the funding statement supported by the UK Medical Education Reference Group.

Fitness to Practise Statistics Report 2018 (agenda item M8)

22  Council received the annual report of statistics on fitness to practise activities, which the GMC is required to publish under section 2 of the Medical Act 1983 as amended.

23  Council noted that:

a  After significant drops in enquiries about a doctor’s fitness to practise after 2015, the numbers had plateaued, both from members of the public and from persons acting in a public capacity, such as employers or the police.
b The proportion of cases closed by a case examiner, rather than going to full investigation, including those closed with advice being given to the doctor, decreased to 63% in 2018 from a high of 80% in 2014. This was a result of introducing provisional enquiries, as these cases would previously have been fully investigated and had a case examiner decision to conclude.

c The total number of doctors on the register now stood at 300,615, with 251,116 holding a licence to practise.

24 During discussion, Council noted that:

a We alert other authorities as and when necessary when relevant issues come up during investigations.

b Further consideration was being given to how human factors were taken into account in cases, including whether to more consistently ask about human factors.

c Further efforts were being made to make the process for enquiring about a doctor’s fitness to practise easier and more user-friendly, including simplifying the online complaint review form.

d Consideration would be given to providing for Council in future years a breakdown of complaints received showing the proportion relating to clinical concerns, by both members of the public and by employers.

25 Council:

a Noted the key figures and trends identified in fitness to practise activity in 2018.

b Approved the submission of the Fitness to Practise Annual Statistics Report 2018 to the Privy Council to be laid before Parliament alongside the Trustees’ Annual Report and Accounts 2018.

Report of the MPTS Committee (agenda item M9)

26 Council considered the report from the MPTS Committee, setting out the key activities of the MPTS since the last report to Council in December 2018.

27 Council noted that:

a There had been an unexpected increase in referrals, with the pattern uneven. Efforts were being made to even out the number of cases being considered at any one time by scheduling a higher proportion sooner than required by key performance indicators.
b A Tribunal appointment process had just been completed, with Tribunal member appointments offered to 23 medical and 25 legally qualified candidates.

c A long-term review of the Sanctions Guidance was underway aimed at making it easier for Tribunal members to use and to reflect learning from previous cases.

28 During discussion, Council noted that:

a Tribunals took into account systems issues where these were raised by the GMC, the doctor or their representative. The MPTS did not do anything with this information, as they consider it is for the GMC to take any appropriate action.

b There were currently two members of MPTS staff working on the Doctor Contact Service, offering support to doctors on the day of a hearing. A pilot initiative with BPP University Law School, based in the same building as the MPTS, would provide some support for unrepresented doctors, with a law student accompanying the doctor and taking notes for them, although they would not offer advice or representation.

29 Council:

a Noted the report of the MPTS Committee.

b Noted the draft MPTS Report to Parliament 2018.

c Approved the revised statement of purpose for the MPTS Committee at Annex C.

Report of the Audit and Risk Committee (agenda item M10)

30 Council considered the report of the Audit and Risk Committee activities since January 2019 and the Head of Internal Audit’s Annual Report 2018.

31 Council noted that:

a From its review of the Annual Report and Accounts, including the statement on risk, the Committee was satisfied that the 2018 accounts had been properly prepared and were in accordance with applicable accounting standards.

b The Committee proposed that Council hold a seminar session to consider how best to manage and challenge risks and risk thinking in relation to the GMC’s activities.

c The Committee recorded its thanks to Suzi Leather and John Morley, who were stepping down as members of the Committee after six years.

d The Committee were grateful for the support of Lindsey Mallors, Assistant Director Audit and Risk Assurance, and the Corporate Governance team.
32 During discussion, Council noted that:

   a When the next Council Effectiveness review takes place, it should incorporate a review of how each of the Committees of Council work with Council according to their respective remits.

   b The biography of Ken Gill would be circulated to Council for approval of his appointment as an independent member of the Audit and Risk Committee, as it had not been included in the agenda and papers circulated to Council.

33 Council:

   a Noted the report, including the issues raised with respect to business planning and financial scrutiny.

   b Noted the results of the Committee’s Effectiveness Review and the request to participate in a survey in late June.

   c Agreed that the Committee’s work provides sufficient assurance on the systems of control, risk management and governance of the GMC to support the Council’s activities.

   d Agreed to handle by correspondence the appointment of Ken Gill to the Audit and Risk Committee as an independent member.

Update on our strategic approach to communications and engagement (agenda item M11)

34 Council received a paper providing an update on our approach to communications and engagement at the GMC and progress with the priorities of rebuilding the medical profession’s confidence in the GMC and strengthening the organisation’s engagement with patients and the public.

35 Council noted that:

   a New channels of communication, particularly new websites for the GMC and MPTS had been developed, following work with focus groups, a survey and an online reference community. The new websites had been launched and were performing strongly.

   b The new guidance on supporting disabled learners in medical education and training, *Welcomed and valued*, had been published following a high level of engagement with influential stakeholders, ensuring that page views increased more than ten-fold from the previous guidance.

   c We are working to deliver enhanced engagement and increase our influence and responsiveness with stakeholders in the four countries of the UK. This includes
implementing a new structure for our outreach teams from early 2020, ahead of which a new Assistant Director for Public Affairs and Devolved Offices had just been appointed.

36 During discussion, Council noted that:

a. The GMC was engaging with employer representative organisations to get buy-in on common issues and using speaking engagements to promote messages to employers. There may be opportunities to explore how to engage the leadership of individual NHS trusts at Board level.

b. Engagement programmes should take into account the large numbers of doctors working in isolated environments.

c. As seven out of ten of our major partners had declined to be involved in our survey to benchmark perceptions of the GMC, further consideration would be given to improving the effectiveness of such invitations to respond to such surveys in future.

37 Council:

a. Noted the progress made by the directorate in delivering the vision articulated to Council in June 2018

b. Noted the identified areas for development in the next 12-18 months.

Review of Customer Complaints (agenda item M12)

38 Council received its regular review of corporate complaints, covering the period from October 2018 to March 2019.

39 Council noted that:

a. There had been a downward trend in customer complaints, with a spike following the announcement of the increase in the Annual Retention Fee.

b. Following media reports about the GMC investigating a doctor for allegedly asking a Muslim woman to remove her veil, the Corporate Review team received over 40 pieces of related correspondence, some of them described as vile and one was reported to the police.

c. The team which deals with difficult and sometimes upsetting items of correspondence receives a high level of support.

40 During discussion, Council noted that consideration would be given to providing Council with a breakdown of the source and outcome of complaints.
41 Council noted the review of customer complaints.

**Trustees’ Annual Report and Accounts 2018 and 2018 Impact Report (agenda item M13)**

42 Council considered the draft Trustees’ Annual Report and Accounts for the year ended 31 December 2017, noting that they had been reviewed by the Executive Board and the Audit and Risk Committee.

43 Council noted that the drafting process for the Trustees’ Annual Report and Accounts had strengthened the focus on supporting the profession and on patient safety.

44 During discussion, Council noted that:

   a The content of the Annual Report and Accounts, in relation to the remuneration policy for key management personnel, as required by the Charities Statement of Recommended Practice (Financial Reporting Standard 102), would be checked before submission to Parliament.

   b References to the Investment Sub-Committee should be changed to Investment Committee, following Council’s decision to change the name in April 2019.

45 Council:

   a Approved the 2018 Trustees’ Annual Report and Accounts.

   b Approved the Letter of Representation.

   c Authorised the Chair of Council to sign the 2018 Annual Report and Accounts, and the Letter of Representation, on its behalf.

   d Approved the 2018 Impact Report.

**Any Other Business (agenda item M14)**

46 Council noted that some members had experienced difficulty with the app for reading Council papers and that the functionality for accessing links would be checked.

47 Council noted that the away day would take place on 9 and 10 July and the next evening seminar and meeting would be on 25 and 26 September 2019 in London.

Confirmed:

Clare Marx, Chair

26 September 2019
Executive summary
This report outlines developments in our external environment and progress on our strategy since Council last met.

Key points to note:

- The Government has announced that they will legislate for the GMC to be the regulator for Physician Associates and Anaesthesia Associates. We are now working with the Department of Health and Social Care to determine timescales and costs;

- We will shortly be publishing our health and wellbeing review, led by Michael West and Denise Coia. This is the third, and final, independently-led project as part of our Supporting a Profession Under Pressure work programme.

Recommendations
Council is asked to:

a  Consider the Chief Executive’s report.

b  Approve the reappointment of Crowe as external auditor of the GMC’s accounts, including GMC Services International Ltd.
Developments in our external environment

Government appointments

1. A ministerial reshuffle took place this summer after Boris Johnson became the new Prime Minister. Matt Hancock remains in place as the Secretary of State at the Department of Health and Social Care (DHSC), with overall financial control and oversight of NHS delivery and performance.

2. Following a further ministerial reshuffle in September, Edward Argar MP is the new Minister of State for Health with responsibility for professional regulation, replacing Chris Skidmore, and prior to that, Stephen Hammond. Clare and I briefly met Edward Argar at a DHSC roundtable on education and training earlier this month. We will be seeking a proper introductory meeting in the near future and have also invited him to visit the new clinical assessment centre in Manchester during the Conservative Party Conference.

3. Caroline Dinenage remains in post as the Minister of State for Care, while Jackie Doyle-Price and Seema Kennedy have both left the Department. In their place, Nadine Dorries and Jo Churchill have been appointed as new DHSC ministers.

4. William Warr has been appointed as the new Special Advisor for Health at Number 10. Clare, Anthony Harnden and I had an introductory meeting with him on 28 August to set out the role of the GMC, and our priorities for reform, particularly streamlining the CESR / CEGPR route to registration.

Preparations for Brexit

5. While the political situation remains uncertain, we are continuing to work to make sure that doctors are supported in the event of a ‘no-deal’ exit from the European Union at the end of October.

6. As I have previously updated Council, the draft Medical Act amendments legislating for a ‘no-deal’ Brexit were adopted in March and will be enacted should we leave in those circumstances. We worked closely with DHSC officials and lawyers to make sure that the amended Act allows us to register doctors who qualified in the European Economic Area (EEA) in a timely and streamlined way without compromising standards.

7. We continue to work closely with the other professional regulators and the DHSC on the Serious Shortage Protocol that could be enacted in the event of a shortage of medicines, and specifically how doctors are signposted to guidance in the event that such a protocol needs to be issued. We are also developing FAQs to support doctors
on other Brexit-related questions that may arise and have communications plans in place in the run-up to 31 October.

The regulation of Physician Associates and Anaesthesia Associates

In July 2019 the UK Government, in agreement with the devolved administrations, announced its plans to make the GMC regulator of physician associates and anaesthesia associates.

We see this as an opportunity to support the development of a valuable new workforce which can complement and support, rather than replace, doctors in their roles.

We are in discussions with the Department of Health and Social Care to determine timescales and costs, and the Department has confirmed it will meet the set-up costs of this programme of work. We will, of course, work closely with other stakeholders as we develop the necessary regulatory frameworks for physician associates and anaesthesia associates.

Regulatory reform

The Government published its response to the consultation 'Promoting Professionalism, Reforming Regulation' in July 2019. We were particularly encouraged by the Government’s intention to give regulators greater flexibility in relation to their fitness to practise processes. We have made clear over many years that our current legislative framework is far too inflexible and prescriptive, and that this is not in the best interests of patients or registrants.

NHS People Plan

We are working closely with NHS England / Improvement and our partners on the development of the NHS People Plan in England, which is due to be published before the end of 2019.

We welcomed the Interim NHS People Plan which was published in June 2019. It is clear there is a consensus that retaining the excellent doctors and healthcare professionals we already have must be at the heart of building and growing a sustainable workforce. That means a step change in culture and leadership and a

1 https://www.gov.uk/government/consultations/promoting-professionalism-reforming-regulation
2 https://improvement.nhs.uk/resources/interim-nhs-people-plan/
renewed focus on improving the wellbeing and working environments of the people who are the bedrock of our health services.

14 We have a lot to contribute to this agenda and will soon have the recommendations from Michael West and Denise Coia’s wellbeing review, building on the Fair to Refer research\(^1\) published in June, about how we can work with others to help build a more inclusive, healthier and supportive working environment for doctors and all healthcare professionals.

*Publication of legal advice in the case of Dr Bawa-Garba*

15 On 1 August 2019 we published the legal advice\(^2\) which informed our Registrar’s decision to appeal in the case of Dr Hadiza Bawa-Garba.

16 This followed a ruling by the Information Commissioner’s Office instructing us to disclose this material, following a freedom of information request. We considered whether to appeal, as public authorities have a right to do, however we decided against doing so and have made the materials available on our website in the interests of transparency. The decision notice does not bind us in respect of future applications of the exemptions under Freedom of Information legislation, particularly given the exceptional and case-specific nature of this request.

*Inquiries and reviews*

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

*Infected blood inquiry*

18 We have been working closely with the inquiry team since late 2018 to provide any documents relevant to its terms of reference. The inquiry has formally asked us to submit three written statements under Rule 9 of the Inquiry Rules 2006. The latest was provided in August 2019 and they cover our governance, role, rules and procedures from the 1970s to the present day, as well as the disclosure of case files relevant to the inquiry. We expect these will be published by the inquiry in due course.


Elizabeth Dixon investigation

19 We have completed our disclosure to the Dixon investigation. We had expected the publication of the report this summer, although we understand this has been delayed until later in the year.

Gosport

20 I attended a families’ forum in July for those affected by the tragic events at Gosport War Memorial Hospital. This was organised by the DHSC, as an opportunity for families to hear from and discuss the actions being taken by the police, by healthcare bodies and regulators since the publication of the independent panel’s report in June 2018. I was able to update the families about the changes that have taken place at the GMC since the events in question, and our learning from the report about how we work with patients and their families.

Progress on our strategy

Supporting a Profession Under Pressure

16 We are approaching the publication of our third and final independent review, as part of our supporting a profession under pressure (SaPUP) work. The report, expected in October, will focus on the mental health and wellbeing of the profession. This follows the reports published in June on gross negligence manslaughter and culpable homicide and on the fairness of referrals to the GMC.

17 We have been able to identify cross-cutting themes from all three reports covering: the importance of induction and ongoing support; improving local investigation processes; the impact of strong clinical leadership; and the value of improving the monitoring and reporting of data.

18 Whilst there are clear recommendations for the GMC to take forward, the majority of the recommendations relate to the environment in which doctor’s practise. Therefore, we intend to convene our partners to work collaboratively on the delivery of the recommendations, and we are establishing a programme board and a four-country plan to govern this implementation. The overall success of this work and longer-term change to working environments will be dependent on strong stakeholder partnerships and a shared commitment to address the issues.

19 In other strands of our SaPUP programme, Council will be aware that we published The reflective practitioner – a guide for medical students, alongside the Medical Schools Council (MSC) in September 2019. This is a short piece of guidance tailored to support medical students on becoming a reflective practitioner and draws on the reflective practitioner guidance for all doctors published in September 2018. We also
announced in July 2019 that we are expanding our Welcome to UK practice workshops to support employers and provide more places for those new to working in the UK.

**Doctors in senior leadership roles**

20 In August, we published independent research entitled, *How doctors in senior leadership roles establish and maintain a positive patient-centred culture*[^1]. The findings from Dr Suzanne Shale, a medical ethics researcher, reveals positively-engaged leaders from diverse backgrounds are key to transforming organisations and culture, as well as improving our understanding of the challenges to realising this.

21 We want to ensure that supportive and compassionate cultures are the norm across our health services and are clear that strong clinical leadership is a vital ingredient in achieving this. Alongside the Fair to Refer research, and the forthcoming wellbeing review, this is another very important contribution to the ongoing conversation about these issues.

**LGBT Communities and Healthcare inquiry**

22 We submitted written evidence to the Women and Equalities Committee’s inquiry into ‘Health and Social Care and LGBT Communities’ in July 2019. The inquiry is looking at where health and social care provision for LGBT communities is adequate, whether discrimination is still occurring and what further steps need to be taken to address issues around access to health and social care for LGBT people.

23 Our written evidence highlighted the guidance that we set for doctors and their responsibility to treat patients fairly and without discrimination. Our evidence also touched on our education outcomes for medical students and doctors, our fitness to practise process and our work with external organisations such as GLADD (Gay and Lesbian Association of Doctors and Dentists). We also highlighted the ethical hub that we have developed on our website, as there is a section that is specifically devoted to trans healthcare.

**Executive Board**

24 The Executive Board met on 3 June, 24 June and 22 July 2019 to consider items on:

a The regular high-level updates on operational performance on areas including finance and people, customer service and learning as well as updates on corporate risks.

b Evaluation of the assurance assessments pilot\(^1\), which had started in January 2015, as a result of concerns being raised about doctors returning to unrestricted practice without having fully remediated. The purpose of an assurance assessment is to obtain an objective assessment of a doctor’s remediation before removing restrictions on their practice in cases involving clinical failings or deficient performance. The Board approved the recommendation that we will undertake assurance assessments before doctors with restrictions can return to unrestricted practice.

c The Corporate Strategy 2018-20\(^2\), noting that we have made good progress on all of our strategic aims, but that there are some areas that we need to address in the rest of 2019 and the 2020 business plan to deliver on all our commitments.

d The report of the Medical Advisory Board\(^3\) (MAB), noting the work of the MAB and agreeing its recommendation that we work towards amending our terminology in relation to substance and alcohol misuse, following the lead of the Royal College of Psychiatrists, instead referring to ‘substance and alcohol use disorders’.

e The programme to review the non-PLAB (Professional and Linguistic Assessments Board) routes and pathways to registration for international medical graduates\(^4\), in response to the current NHS workforce crisis and a number of interdependent pieces of work within the GMC. The Board agreed to explore the expansion of both the sponsorship and postgraduate qualification pathways to registration and a route to general registration for senior doctors.

f Content for *The reflective practitioner – a guide for medical students*, a targeted supplement to the more general *reflective practitioner* guidance produced in

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25 The Board also noted updates on:

a The Transformation Programme¹.

b Annual business continuity report².

c The project to procure, fit out and operationalise a new clinical assessment centre³.

d Mid-year HR report⁴.

e The Infected Blood Inquiry.

Appointment of external auditors

26 The Audit and Risk Committee is responsible for making recommendations to Council on the appointment, reappointment and removal of the external auditors. The current contract with Crowe UK expired this year, following the audit of the 2018 accounts. Following an open tender process, three suppliers were shortlisted and evaluated in line with criteria determined by the Audit and Risk Committee. While it was clear that all three suppliers were capable of providing the required level of service, Crowe submitted the strongest bid and the panel was confident that their independence and objectivity had not diminished over time. Council is therefore asked to approve the reappointment of Crowe as external auditor of the GMC’s accounts including GMCSI.

M3 – Annex A

Council portfolio

Data presented as at 31 July 2019 (unless otherwise stated)
Commentary as at 15 August 2019

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

<table>
<thead>
<tr>
<th>Core regulatory objective</th>
<th>Key Performance Indicator</th>
<th>Performance</th>
<th>Exception summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>We decide which doctors are qualified to work here and we oversee UK medical education and training.</td>
<td>Decision on 95% of all registration applications within 3 months</td>
<td>99% 98%</td>
<td>On track</td>
</tr>
<tr>
<td></td>
<td>Answer 80% of calls within 20 seconds</td>
<td>88% 87%</td>
<td>On track</td>
</tr>
<tr>
<td>We set the standards that doctors need to follow, and make sure that they continue to meet these standards throughout their careers.</td>
<td>Decision on 95% of all revalidation recommendations within 5 working days</td>
<td>99% 99%</td>
<td>On track</td>
</tr>
<tr>
<td></td>
<td>Respond to 90% of ethical/standards enquiries within 15 working days</td>
<td>91% 100%</td>
<td>On track</td>
</tr>
<tr>
<td>We take action to prevent a doctor from putting the safety of patients, or the public’s confidence in doctors, at risk.</td>
<td>Conclude 90% of fitness to practise cases within 12 months</td>
<td>91% 91%</td>
<td>On track</td>
</tr>
<tr>
<td></td>
<td>Conclude or refer 90% of cases at investigation stage within 6 months</td>
<td>92% 92%</td>
<td>On track</td>
</tr>
<tr>
<td></td>
<td>Conclude or refer 95% of cases at the investigation stage within 12 months</td>
<td>95% 96%</td>
<td>On track</td>
</tr>
<tr>
<td></td>
<td>Conclude 100% of Investigation Committee hearings within 2 months of referral</td>
<td>No cases due</td>
<td>On track</td>
</tr>
<tr>
<td></td>
<td>Commence 100% of Interim Order Tribunal hearings within 3 weeks of referral</td>
<td>100% 100%</td>
<td>On track</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Business support area</th>
<th>Key Performance Indicator</th>
<th>Performance</th>
<th>Exception summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finance</td>
<td>2017/18 Income and expenditure [% variance]</td>
<td>1.84% 1.84%</td>
<td>On track</td>
</tr>
<tr>
<td>HR</td>
<td>Rolling twelve month staff turnover within 8-15%</td>
<td>8.61% 8.76%</td>
<td>On track</td>
</tr>
<tr>
<td>Information systems</td>
<td>IS system availability (%)</td>
<td>99.88% 100%</td>
<td>On track</td>
</tr>
<tr>
<td>Media monitoring</td>
<td>Monthly media score</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Although coverage sentiment was affected by the Zholia Alemi case, overall our rolling six month positive coverage remains over 25 per cent, with negative coverage for the same period at 8%. Early coverage of our new Clinical Assessment Centre and the Medical Associate Professions regulation announcement boosted positive coverage during the period.
Strategic delivery – overall view

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

Corporate Strategy 2018-2020

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

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

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

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

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

Strategic aim 1: Supporting doctors in delivering good medical practice

Key benefit

Doctors are supported to deliver high quality care

Activities to deliver (by exception)

Public Interest Concerns

Lead indicators

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

Lag indicators

a. Perception Question (Drs) - %

Exception commentary

A key workshop had to be rescheduled from an earlier planned date to late August. This has resulted in a delay to overall project timescales and transition into business as usual. It is now expected that the project will deliver by the end of 2019.

Welcome to UK Practice Expansion Project

80% of doctors new to practice or new to the country accessing the programme by 2019.

a. NTS workload indicator - (%)
### Strategic delivery (by exception)

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

<table>
<thead>
<tr>
<th>Key benefit</th>
<th>Activities to deliver (by exception)</th>
<th>Lead indicators</th>
<th>Lag indicators</th>
<th>Exception commentary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors have a fulfilling / sustained career</td>
<td>Induction and Returners (Supporting a Profession Under Pressure)</td>
<td>TBD</td>
<td>a. Perception Question (Drs) - % Drs found career fulfilling</td>
<td>To effectively plan and prioritise our next steps in this project, further clarity on the nature and scale of the issues surrounding induction and support for new doctors and doctors returning to practise is required. The research we have commissioned internally (which is to be delivered by Q1 2020) as well as the research focused in Wales (to be delivered in Q3 2019) is expected to help us understand this issue clearer and understand how we may better support doctors. Induction and ongoing support are also key emergent themes of the recommendations from Supporting a Profession under Pressure and this will also influence how we progress this work.</td>
</tr>
</tbody>
</table>
Strategic delivery (by exception)

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

Key benefit

Contribute to public confidence in doctors

Activities to deliver (by exception)

Medical Licensing Assessment

Consensus on proposals for the Applied Knowledge Test

Lead indicators

Consensus on proposals for the Applied Knowledge Test

Lag indicators

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

Exception commentary

We have reviewed the MLA programme plan and resource requirements, considering June Council's decisions to endorse the key principles for developing the applied knowledge test (AKT) and to extend the timeframe for full operation of the MLA through a staged implementation. The development of the MLA content map, and our plans for quality assuring clinical and professional skills assessments (CPSAs), remain on track. We have begun to implement the revised plan, including for the AKT, which is now a more complicated model to develop, and restarted our delayed plans for recruiting additional resource to the programme. The stakeholder environment remains complex. On balance, we believe the programme status should stay at amber due to these factors.
Strategic aim 4: Meeting the change needs of the health services across the four countries of the UK

<table>
<thead>
<tr>
<th>Key benefit</th>
<th>Activities to deliver (by exception)</th>
<th>Lead indicators</th>
<th>Lag indicators</th>
<th>Exception commentary</th>
</tr>
</thead>
<tbody>
<tr>
<td>We are well prepared for and can influence legislative change</td>
<td>Preparing for Brexit</td>
<td>More certainty on likelihood of scenarios</td>
<td>Perceptions question - % stakeholders felt that they knew at least a fair amount about 'why the GMC is calling for legislative reform and the effects that such reform could have on the medical workforce on how well prepared for an can influence legislative change'</td>
<td>Internal plans to prepare the business for Brexit are complete. A high level of uncertainty remains around the likelihood of a 'no deal' Brexit and within the context of a new Prime Minister. The overall RAG for the project was downgraded from red to amber at the Executive Board meeting on 3 June to reflect our level of preparedness, however this will continue to be closely monitored as the situation develops.</td>
</tr>
</tbody>
</table>
### Financial summary

<table>
<thead>
<tr>
<th>Financial summary as at July 2019</th>
<th>Budget to July £000</th>
<th>Actual to July £000</th>
<th>Variance £000</th>
<th>%</th>
<th>Budget Jan - Dec £000</th>
<th>Forecast Jan - Dec £000</th>
<th>Variance £000</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Operational expenditure</strong></td>
<td>60,089</td>
<td>59,857</td>
<td>232</td>
<td>0%</td>
<td>105,541</td>
<td>106,326</td>
<td>(785)</td>
<td>(1)%</td>
</tr>
<tr>
<td>New initiatives fund</td>
<td>307</td>
<td>310</td>
<td>(3)</td>
<td>0%</td>
<td>3,500</td>
<td>3,500</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Capital expenditure</td>
<td>3,511</td>
<td>3,541</td>
<td>(30)</td>
<td>(1)%</td>
<td>6,580</td>
<td>6,632</td>
<td>218</td>
<td>3%</td>
</tr>
<tr>
<td>Clinical Assessment Centre expansion</td>
<td>3,981</td>
<td>3,981</td>
<td>0</td>
<td>0%</td>
<td>4,570</td>
<td>4,446</td>
<td>124</td>
<td>3%</td>
</tr>
<tr>
<td>Pension top up payment</td>
<td>1,900</td>
<td>1,900</td>
<td>0</td>
<td>0%</td>
<td>1,900</td>
<td>1,900</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Total expenditure</strong></td>
<td><strong>69,788</strong></td>
<td><strong>69,589</strong></td>
<td><strong>199</strong></td>
<td>0%</td>
<td><strong>122,091</strong></td>
<td><strong>122,534</strong></td>
<td>(443)</td>
<td>(0)%</td>
</tr>
<tr>
<td><strong>Operational income</strong></td>
<td>59,818</td>
<td>60,687</td>
<td>869</td>
<td>1%</td>
<td>107,237</td>
<td>108,411</td>
<td>1,174</td>
<td>1%</td>
</tr>
<tr>
<td>Investment income</td>
<td>1,040</td>
<td>3,288</td>
<td>2,248</td>
<td>216%</td>
<td>1,919</td>
<td>3,288</td>
<td>1,369</td>
<td>71%</td>
</tr>
<tr>
<td><strong>Total income</strong></td>
<td><strong>60,858</strong></td>
<td><strong>63,975</strong></td>
<td><strong>3,117</strong></td>
<td>5%</td>
<td><strong>109,156</strong></td>
<td><strong>111,699</strong></td>
<td><strong>2,543</strong></td>
<td>2%</td>
</tr>
</tbody>
</table>

**Surplus/ (deficit)**: **(8,930)** | **(5,614)** | **3,316** | **(12,935)** | **(10,835)** | **2,100**

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

- **Headcount changes**: The churn cut incorporated into the budget was 75 roles. To date headcount levels have been slightly over budget after adjusting for churn therefore there is an equivalent overspend. The churn assumption in the forecast has been reduced in line with experience to date.

- **Volume variance**: The budgeted number of hearing days to date is 1,515 and the actual number is 1,476. The reduction in hearing days against budget is due to a high level of cancelled and postponed hearings in Q2. There are a number of areas with reduced volumes, such as staff travel, the number of education visits, expert reports commissioned to date. These reductions are offset by the direct costs of hosting significantly more PLAB 1 candidates.

- **Unit cost increases**: Some external venue hire costs are higher than budget and renewal costs of some IS contracts have increased higher than anticipated. The PSA fees have also increased.

- **Unit cost decreases/efficiency savings**: The credit notes received from the accommodation service charge reconciliations more than offsets the under achievement of the efficiency target to date.

- **New activities not in plan**: The GNM review in Strategy & Policy, external consultancy review of team working in Strategic Communications & Engagement and a number of unplanned recruitment costs create the overspend to date.

- **Planned activities dropped/delayed**: A number of areas have rescheduled activity compared to budget however the forecast assumes many of these will take place later in the year. Significant areas are ad hoc maintenance for accommodation, travel and other staff related costs, fund manager investment fees and undertaking fewer Education visits. The amount of spend to date for the Human Factors work is significantly lower than expectations at this stage.

**Total**: 232
## Financial summary

<table>
<thead>
<tr>
<th>Key drivers of expenditure - Forecast</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Headcount changes</strong></td>
<td>(1,078)</td>
</tr>
<tr>
<td>Forecast headcount costs are increasing compared to budget in the second half of the year due to further dual running roles for instances such as parental leave and sickness absence.</td>
<td></td>
</tr>
<tr>
<td><strong>Volume variance</strong></td>
<td>28</td>
</tr>
<tr>
<td>There are additional costs due to holding a forecast 146 hearing days compared to budget, which drives direct associate fees and expenses in MPTS plus barrister fees in FTP. The forecast overspend is offset by lower staff travel across a number of areas, training fewer PLAB associates than budgeted and holding fewer PLAB 2 days as the assumed opening date of the dual centre was 1st July however the anticipated date is now the second week of August.</td>
<td></td>
</tr>
<tr>
<td><strong>Unit cost increases</strong></td>
<td>(142)</td>
</tr>
<tr>
<td>PSA fees have increased on renewal plus service charges at Hardman Street and some IS contracts have increased in price.</td>
<td></td>
</tr>
<tr>
<td><strong>Unit cost decreases/efficiency savings</strong></td>
<td>189</td>
</tr>
<tr>
<td>Efficiency savings are committed to over achieve, creating a £50k benefit. The remaining benefit is created by prior year service charge reconciliation providing a refund at Hardman Street. A number of other cost areas have reduced due to price changes.</td>
<td></td>
</tr>
<tr>
<td><strong>New activities not in plan</strong></td>
<td>(136)</td>
</tr>
<tr>
<td>The additional work undertaken to date plus further unplanned recruitment costs create the anticipated overspend at the end of 2019.</td>
<td></td>
</tr>
<tr>
<td><strong>Planned activities dropped/delayed</strong></td>
<td>361</td>
</tr>
<tr>
<td>The visits and monitoring programme has changed resulting in fewer overall visits and some of the underspends in ad hoc building maintenance to date are now forecast to the end of the year. The amount of spend against the Human Factors contract has reduced significantly.</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>(778)</td>
</tr>
</tbody>
</table>
## Financial - detail

### Expenditure as at July 2019

<table>
<thead>
<tr>
<th></th>
<th>Budget to July</th>
<th>Actual to July</th>
<th>Variance</th>
<th>Budget Jan - Dec</th>
<th>Forecast Jan - Dec</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td><strong>Staff costs</strong></td>
<td>36,533</td>
<td>36,927</td>
<td>(394)</td>
<td>62,987</td>
<td>64,065</td>
<td>(1,078)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(1)%</td>
<td>(2)%</td>
<td>(58)</td>
<td>(1)%</td>
</tr>
<tr>
<td><strong>Staff support costs</strong></td>
<td>2,209</td>
<td>2,166</td>
<td>43</td>
<td>4,142</td>
<td>4,200</td>
<td>(58)</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>2%</td>
<td>(1)%</td>
<td>(1)%</td>
<td>(3)%</td>
</tr>
<tr>
<td><strong>Office supplies</strong></td>
<td>1,084</td>
<td>1,092</td>
<td>(8)</td>
<td>1,900</td>
<td>1,951</td>
<td>(51)</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>(1)%</td>
<td>(3)%</td>
<td>(35)</td>
<td>(1)%</td>
</tr>
<tr>
<td><strong>IT &amp; telecoms costs</strong></td>
<td>2,097</td>
<td>2,094</td>
<td>3</td>
<td>3,483</td>
<td>3,518</td>
<td>(35)</td>
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<tr>
<td></td>
<td></td>
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<td>0%</td>
<td>(1)%</td>
<td>(1)%</td>
<td>(1)%</td>
</tr>
<tr>
<td><strong>Accommodation costs</strong></td>
<td>4,259</td>
<td>4,085</td>
<td>174</td>
<td>7,538</td>
<td>7,472</td>
<td>66</td>
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<td></td>
<td></td>
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<td>4%</td>
<td>1%</td>
<td>(66)</td>
<td>(1)%</td>
</tr>
<tr>
<td><strong>Legal costs</strong></td>
<td>2,425</td>
<td>2,437</td>
<td>(12)</td>
<td>4,254</td>
<td>4,295</td>
<td>(41)</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>(0)%</td>
<td>(1)%</td>
<td>(72)</td>
<td>(2)%</td>
</tr>
<tr>
<td><strong>Professional fees</strong></td>
<td>1,364</td>
<td>1,376</td>
<td>(12)</td>
<td>2,886</td>
<td>2,958</td>
<td>(58)</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>(1)%</td>
<td>(2)%</td>
<td>(72)</td>
<td>(2)%</td>
</tr>
<tr>
<td><strong>Council &amp; members costs</strong></td>
<td>239</td>
<td>231</td>
<td>8</td>
<td>422</td>
<td>423</td>
<td>(1)</td>
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<tr>
<td></td>
<td></td>
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<td>3%</td>
<td>(0)%</td>
<td>(0)</td>
<td>(0)%</td>
</tr>
<tr>
<td><strong>Panel &amp; assessment costs</strong></td>
<td>9,454</td>
<td>8,997</td>
<td>457</td>
<td>17,122</td>
<td>16,654</td>
<td>468</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>5%</td>
<td>3%</td>
<td>(53)</td>
<td>(3)%</td>
</tr>
<tr>
<td><strong>PSA Levy</strong></td>
<td>437</td>
<td>452</td>
<td>(15)</td>
<td>758</td>
<td>790</td>
<td>(32)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(3)%</td>
<td>(4)%</td>
<td>(32)</td>
<td>(4)%</td>
</tr>
<tr>
<td><strong>Under-achievement of efficiency savings</strong></td>
<td>(12)</td>
<td>0</td>
<td>(12)</td>
<td>(100)%</td>
<td></td>
<td></td>
</tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td><strong>Operational expenditure</strong></td>
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<td>105,541</td>
<td>106,326</td>
<td>(785)</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>0%</td>
<td>(1)%</td>
<td>(785)</td>
<td>(1)%</td>
</tr>
<tr>
<td><strong>New initiatives fund</strong></td>
<td>307</td>
<td>310</td>
<td>(3)</td>
<td>3,500</td>
<td>3,500</td>
<td>0</td>
</tr>
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<td></td>
<td></td>
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<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Capital expenditure</strong></td>
<td>3,511</td>
<td>3,541</td>
<td>(30)</td>
<td>6,580</td>
<td>6,362</td>
<td>218</td>
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<td></td>
<td></td>
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<td>(1)%</td>
<td>3%</td>
<td>(3)</td>
<td>(0)%</td>
</tr>
<tr>
<td><strong>Clinical Assessment Centre expansion</strong></td>
<td>3,981</td>
<td>3,981</td>
<td>0</td>
<td>4,570</td>
<td>4,446</td>
<td>124</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>0%</td>
<td>3%</td>
<td>(124)</td>
<td>(3)%</td>
</tr>
<tr>
<td><strong>Pension top up payment</strong></td>
<td>1,900</td>
<td>1,900</td>
<td>0</td>
<td>1,900</td>
<td>1,900</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Total expenditure</strong></td>
<td>69,788</td>
<td>69,589</td>
<td>199</td>
<td>122,091</td>
<td>122,534</td>
<td>(443)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>0%</td>
<td>(0)%</td>
<td>(443)</td>
<td>(0)%</td>
</tr>
</tbody>
</table>

### Income as at July 2019

<table>
<thead>
<tr>
<th></th>
<th>Budget to July</th>
<th>Actual to July</th>
<th>Variance</th>
<th>Budget Jan - Dec</th>
<th>Forecast Jan - Dec</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td><strong>Annual retention fees</strong></td>
<td>50,178</td>
<td>50,503</td>
<td>325</td>
<td>87,831</td>
<td>88,397</td>
<td>566</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td><strong>Registration fees</strong></td>
<td>1,871</td>
<td>2,108</td>
<td>237</td>
<td>4,418</td>
<td>4,657</td>
<td>239</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>13%</td>
<td>5%</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td><strong>PLAB fees</strong></td>
<td>4,730</td>
<td>4,901</td>
<td>171</td>
<td>10,305</td>
<td>10,534</td>
<td>229</td>
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<td></td>
<td></td>
<td></td>
<td>4%</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td><strong>Specialist application CCT fees</strong></td>
<td>1,829</td>
<td>1,817</td>
<td>(12)</td>
<td>2,660</td>
<td>2,585</td>
<td>(75)</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>(1)%</td>
<td>(3)%</td>
<td>(3)</td>
<td>(3)%</td>
</tr>
<tr>
<td><strong>Specialist application CESR/CEGPR fees</strong></td>
<td>576</td>
<td>713</td>
<td>137</td>
<td>915</td>
<td>1,167</td>
<td>252</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>24%</td>
<td>28%</td>
<td>28%</td>
<td>28%</td>
</tr>
<tr>
<td><strong>Interest income</strong></td>
<td>265</td>
<td>258</td>
<td>(7)</td>
<td>475</td>
<td>421</td>
<td>(54)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(3)%</td>
<td>(11)%</td>
<td>(11)%</td>
<td>(11)%</td>
</tr>
<tr>
<td><strong>Other income</strong></td>
<td>369</td>
<td>387</td>
<td>18</td>
<td>633</td>
<td>650</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>5%</td>
<td>3%</td>
<td>3%</td>
<td>3%</td>
</tr>
<tr>
<td><strong>Total Operational Income</strong></td>
<td>59,818</td>
<td>60,687</td>
<td>869</td>
<td>107,237</td>
<td>108,411</td>
<td>1,174</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td><strong>Investment income</strong></td>
<td>1,040</td>
<td>3,288</td>
<td>2,248</td>
<td>1,919</td>
<td>3,288</td>
<td>1,369</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>216%</td>
<td>71%</td>
<td>71%</td>
<td>71%</td>
</tr>
<tr>
<td><strong>Total income</strong></td>
<td>60,858</td>
<td>63,975</td>
<td>3,117</td>
<td>109,156</td>
<td>111,699</td>
<td>2,543</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>5%</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td><strong>Surplus / (deficit)</strong></td>
<td>(8,930)</td>
<td>(5,614)</td>
<td>3,316</td>
<td>(12,935)</td>
<td>(10,835)</td>
<td>2,100</td>
</tr>
</tbody>
</table>
# GMCSI summary and investments summary

<table>
<thead>
<tr>
<th>GMCSI summary as at July 2019</th>
<th>Budget YTD £000</th>
<th>Actual YTD £000</th>
<th>Variance £000</th>
<th>%</th>
<th>Budget Jan - Dec £000</th>
<th>Forecast Jan - Dec £000</th>
<th>Variance £000</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>GMCSI income</td>
<td>403</td>
<td>202</td>
<td>(201)</td>
<td>(50)%</td>
<td>707</td>
<td>614</td>
<td>(93)</td>
<td>(13)%</td>
</tr>
<tr>
<td>GMCSI expenditure</td>
<td>357</td>
<td>256</td>
<td>101</td>
<td>28%</td>
<td>602</td>
<td>524</td>
<td>78</td>
<td>13%</td>
</tr>
<tr>
<td>Profit/ (loss)</td>
<td>46</td>
<td>(54)</td>
<td>(100)</td>
<td></td>
<td>105</td>
<td>90</td>
<td>(15)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Investment summary 2019 to date</th>
<th>Value as at Dec 2018 £000</th>
<th>Current value £000</th>
<th>Increase in investment £000</th>
<th>2019 returns £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCLA managed funds</td>
<td>£20,578</td>
<td>£53,856</td>
<td>£30,000</td>
<td>£3,278</td>
</tr>
</tbody>
</table>

**Investments summary as at 30 June 2019 (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>20% - 45%</td>
<td>27.5%</td>
</tr>
<tr>
<td>Fixed interest</td>
<td>0% - 100%</td>
<td>15.8%</td>
</tr>
<tr>
<td>Cash and near-cash</td>
<td>0% - 15%</td>
<td>36.3%</td>
</tr>
<tr>
<td>Infrastructure and operating assets</td>
<td>0% - 10%</td>
<td>7.3%</td>
</tr>
<tr>
<td>Property</td>
<td>0% - 10%</td>
<td>8.3%</td>
</tr>
<tr>
<td>Other</td>
<td>0% - 20%</td>
<td>4.8%</td>
</tr>
</tbody>
</table>

**Investment returns**

- Target (CPI + 2%)          | 3.98%          
- CCLLA performance          | 5.88%          

---

Council meeting, 26 September 2019
### Legal summary (as at 14 August 2019)

The table below provides a summary of appeals and judicial reviews as at 14 August 2019:

<table>
<thead>
<tr>
<th></th>
<th>Open cases carried forward since last report</th>
<th>New cases</th>
<th>Concluded cases</th>
<th>Outstanding cases</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>s.40 (Practitioner) Appeals</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>16</td>
<td>4</td>
<td>11</td>
<td>9</td>
</tr>
<tr>
<td><strong>s.40A (GMC) Appeals</strong></td>
<td></td>
<td>0</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td><strong>PSA Appeals</strong></td>
<td></td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td><strong>Judicial Reviews</strong></td>
<td></td>
<td>4</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td><strong>IOT Challenges</strong></td>
<td></td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

**Explanation of concluded cases**

- **s.40 (Practitioner) Appeals**
  - 8 dismissed
  - 1 successful
  - 2 withdrawn

- **s.40A (GMC) Appeals**
  - N/A

- **Judicial Reviews**
  - 1 successful – decision quashed.
  - 1 permission refused
  - 1 dismissed.

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

- **PSA Appeals**
  - There have been no new referrals by PSA to the High Court under Section 29 since the last report; and 2 have concluded. In one, remittal was agreed to resolve both the s29 appeal and the competing s40 appeal in a cost-effective manner. The other was a partial success for PSA.

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

- **IOT challenges**
  - There has been no new application in the High Court challenging the imposition of interim orders since the last report; and the 1 application outstanding was withdrawn.

**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, 2013 - 2019

**Graph 2:** Applications received for first registration from European Economic Area graduates, 2013 - 2019
Trends in registration applications

**Graph 3:** PLAB 1 & 2 assessments taken 2012-2019
(Showing volume each year, 1 August to 31 July, percentage figures show year on year change)

**Graph 4:** Number of doctors on the register with a licence to practise (End of year 2013 - 2018 to July 2019)
C3 – Annex A

Corporate Opportunities and Risk Register

Working with doctors Working for patients
Corporate Risk Register (CORR) Overview

**Residual rating summary**
- Red: 2
- Green: 10
- Amber: 14
- Emerging: 0

**Residual rating higher than risk appetite**
- Red: 2
- Green: 0
- Amber: 1

**Increased residual rating**
- Red: 0
- Green: 0
- Amber: 0
- Emerging: 0

**De-escalated/closed**
- Red: 1
- Green: 0
- Amber: 0
- Emerging: 0

---

**Increased residual rating**

- Red: 2
- Green: 10
- Amber: 14
- Emerging: 0

- Red: 2
- Green: 0
- Amber: 7
- Emerging: 0

- Red: 0
- Green: 0
- Amber: 0
- Emerging: 0

---

**Business Risks - Active threat above risk appetite**

**T4.3** – Because of challenges to the proposed MLA Applied Knowledge Test model by specific key stakeholders, and the submission of an alternative proposal for its design and delivery, there may be a lack of support from some stakeholders for delivering the MLA in the way agreed by Council. This may lead to a less robust assessment, damage to the credibility of the MLA and increasing costs and delays to the proposed timetable, or strained stakeholder relationships which could also impact on wider GMC activities.

**Business Risks – Active threats**

- **AT1** – Recruitment and transfer activity remains high and could challenge teams ability to deliver their functions effectively and impact on other key initiatives such as development of the policy profession.
- **AT2** – Continued stretched resources and finances in the health environment, create the potential for increased patient safety incidents, which could strategically impact the GMC’s role as the regulator upholding professional standards for doctors and trainees and create operational pressures on fitness to practise referral and education monitoring services.
- **IT9** – Difficulties in the recruitment and retention of staff and associates with the required skills and experience may challenge our ability to deliver our functions effectively.
- **IT11** – Adverse economic events create a significant deficit in the Defined Benefit (DB) Scheme which the employer needs to cover, and/or a fall value of the GMC’s investments.

**Opportunities**

- **AOP1** – Credentialing would provide some opportunities for doctors to move more quickly to areas of practice where there is greatest need to better meet patient and service need. This flexibility will allow doctors to have a clear way to develop, plan or re-focus their careers to ensure they use their skills and experience to the greatest effect. Credentialing will also give employers a mechanism to train/develop their medical workforce relatively quickly in areas where there are local service areas that won’t be met by training alone.
- **AOP2** – Following the announcement that Health Education England (HEE) will work jointly with NHS Improvement (NHSI), there could be an opportunity to develop longer term planning and promote training to be more central to workforce planning.

**Key updates**

- **AT7** – Risk de-escalated to Outreach Programme register - Changes in the structure of outreach teams lead to staff finding alternative roles inside or outside of the GMC. This impedes the delivery of the new model and results in a reduction of service. This increases pressure on remaining staff and potentially effects our reputation externally.

**General** – Ownership of opportunities and threats held by the COO have been reassigned to SMT members.
Key to risks coding

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

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

   For overarching strategic risks and opportunities:
   - OSOP1 etc. for opportunities, and OST1, etc. for threats

2. Business risks and how we manage them:
   - Operational risks we are actively managing AOP1, etc. for opportunities and AT1, etc. for threats
   - Inherent risks in our business of being a regulator IOP1 etc. for opportunities and IT1, etc. for threats
<table>
<thead>
<tr>
<th>ID</th>
<th>Opportunity</th>
<th>Opportunity risk detail</th>
<th>Owner</th>
<th>Impact</th>
<th>Assuredance</th>
<th>Risk appetite</th>
<th>Further action detail</th>
</tr>
</thead>
<tbody>
<tr>
<td>OSOP1</td>
<td>Opportunity</td>
<td></td>
<td>P. Buckley</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OSOP2</td>
<td>Opportunity</td>
<td></td>
<td>P. Reynolds</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OSOP3</td>
<td>Opportunity</td>
<td></td>
<td>P. Reynolds</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

**Impact Assessment**
- • Through enhancing our engagement across all of our activities, we empower and develop members of staff to build strong and mutually beneficial relationships with stakeholders, and develop understanding of the impact of GMC decisions/interventions, so that we achieve the full impact of our ambition to be collaborative.
- • Identification, prioritisation and coordination of engagement activities by the new Strategic Communication Directorate.
- • Empowering and Developing Our People – Transformation Programme.
- • Impact Assessments.
- • The 2019/20 programme is being implemented by work strands sharing evidence and expertise from across the GMC, and in collaboration with medical schools and other key stakeholders.
- • Corporate strategy commitments at team level to increase level of ownership and engagement from staff.
- • L&D functions - delivering support and training to staff members in managing relationships with stakeholders.

**Strategic Risks and how we manage them**
- • Council away discussions in July.
- • Transformation Programme exception-based update at Alternative Executive Board meetings.
- • Scoping options for ‘Collective Effect’ work considered at Executive Board 29 Oct 2018.
- • Council verbal update on 2019 Field Forces (now renamed as "Outreach") implementation (February 2019).
- • Plexus review.
- • PSA annual Performance Review report was published on 31 January 2018.
- • All standards of Good Regulation met for the 5th year in a row.
- • GMC to take part in the PSA pilot of the revised standards of good regulation - we are piloting standards 2, 3 and 5 which relate to ED&I, Risk and Governance. The Pilot is due to conclude in September 2019.

**Further action required?**
- • Yes.
- • No.
- • Yes.

**Further action detail**
- • Outreach structure currently being implemented, full go live January 2020.
- • Development of next Corporate Strategy from 2021 underway, update at September Council and seminar in November 2019.
- • Understanding of strategic direction with our key partners tested in 2018 trading survey.
- • Continued focus on Local first principles.
- • Patient and Public Engagement Plan, including a live engagement strategy, with our outreach teams and Directors taking up to ensure the work we are doing within the business is promoted to external partners and stakeholders. Next FMP Forum scheduled for November.
- • Medical Licensing Assessment (MLA) – will assess new practitioners against a common threshold of safe practice.
The GMC’s regulatory effectiveness, credibility and reputation may erode over time if we don’t keep ahead of regulatory development and legislative change as well as changes in the UK health environment in both the devolved nations and in England, which might restrict our ability to understand how these impact on individual doctors’ practice in order to deliver functions to full efficiency or develop as a regulator

**Mitigation (for threats)**

- Coordination Group set up in March 2019
- Coordination group identified potential opportunities to align recommendations with other emerging priorities, including the NHS Long Term Plan, HEE mental wellbeing report, PSA research on public confidence, Kirk review, SOMEP and workforce reports, new SAS doctor survey
- Men overlaps between recommendations mapped out and presented to SMT 15 April
- On 12 June 2019 we presented the progress with GMM and Plan to refer reviews to the Council, and our plans for communication and engagement were well received.

**STRATEGIC THEMES**

- Domestic legislation – active engagement with DHSC including over the use of a 60 orders to amend the Medical Act and NICE/HTA on the long-term health plan to explore if it can deliver a new professional regulation reform
- European legislation – skilled and resourced team to monitor and represent our interests at the European level and advise the organisation about any new EU developments. We also convened the Alliance of UK Health Regulators on Europe and jointly coordinate the European Network of Medical Regulators on Europe to develop common positions when new European policy and legislative initiatives emerge and jointly engage with decision-makers if required.
- UK Advisory Forums held twice a year
- Patient Safety Intelligence Forum (PSIF): Engagement teams – our field forces bringing insight back into the business which assists in developing our understanding of the healthcare system.
- Better sharing of information and intelligence between engagement teams and business and using information effectively.
- Training Template surveys – State of Medical Education and Practice in the UK (SOMEP)
- GMC Senior Leadership Team engagement within the external environment - with insight picked shared with the rest of the business.
- Engagement with Medical Defence Organisations (MDO's)
- Implementation of strategy relationships operating model from 2019 onwards and deployment of new Stakeholder Relationship Management (SRM) system (subject to resource requirements being agreed) will deliver new stream of intelligence into the organisation about changes in external environment
- M&A - assessment blueprint to be formed in context of changes to the wider environment
- TRF Programme - Reducing burdens and improving the appraisal experience for doctors (Workstream 2)
- Strategy are many unscrew - regulatory mercy moves a mercy Leadership update – more evidence led policy
- HR/Learning and Development - Talent teams – more resource in these teams to identify develops talent within the business and attract external talent into the business in data-related roles.
- Centralised data team established within the Strategic and Policy Directorate
- Development of data pipeline
- New Strategy function beginning rapid review on collective effect to be followed by review on maintaining the impact of our field force
- Business planning & budget setting process
- Trained and skilled staff in project management
- PMM methodology and reporting: update on risks and project delivery every month via highlight reports with daily availability of progress for all including Portfolio Lead, Sponsor, Project Manager & PMO
- Revised process for New Initiative Fund bids and in-year projects requiring new resources/budget approved by SMT in February 2019
- MS Project Online implemented to enable reporting within full portfolio approach (January 2019)
- Regular review of the business plan and real-assessment of priorities by SMT

**Reward And Recognition**

- CIPD/FCSA Programme – delivered updates at each meeting
- CIPD pay strategy update 2019
- Review of 2019 business plan and budget approved by Executive Board (Nov 2018) and Council (Dec 2018)
- Recruitment & Development
- Excellent Officers to corporate project delivery reported at every other meeting

**Operational**

- Delivery progress update as part of CIPD report at each meeting
- 2019 business plan and budget approved by Executive Board (Nov 2018) and Council (Dec 2018)
- Council
- Executive Board
- Responsible for overseeing the progress of Trusts. Council and Executive Board

**Ongoing Monitoring**

- Strategic oversight of Trusts to ensure alignment with the Trust’s strategic objectives
- Risk Management (June 2019, green amber)
- Review of 2019 business plan and budget (February 2019, green amber)
- Review of Changes to Corporate Benefits
- Realisation (June 2017, green amber)

**Future action detail**

- Planning for the implementation of Phase 3 is underway. Resource requirements for 2020 to be identified as part of scoping (Oct)
- We are involved in all the workstreams of the NHS People Plan which are relevant to our wider ambitions, in particular those which can support the delivery of our SAPPF initiatives.
- April 2019: We launched our professional behaviour pilot.
- August 2018: We published independent research on clinical leadership, highlighting that positively-engaged leaders, from diverse backgrounds, are key to transforming organisational cultures.
- We are developing a workforce report for publication in the autumn of 2019 to influence the next version of the NHS People Plan.

- We responded to the consultation on the shape of healthcare regulation in January 2018 and are awaiting the government’s response to the consultation
- In the absence of primary legislation, we will work closely with officials to identify priorities for opportunities presented by one or more the proposed Section 60 Orders in the areas of FTP and governance.
- Department of Health and Social Care (DHSC) response to consultation on the regulation of Medical Associate Professors published February 2019 announcing the introduction of statutory regulation for Physician Associates and Physician Associates (anesthetists).
- July 2019: DHSC announced GMC would be invited to regulate PAs and AAs. A letter sent to DHSC accepting invitation to regulate subject to certain conditions being met, in particular transitional funding, and fit for purpose legislation. Director of R&L will lead the first phase (scoping) of the project to introduce regulation for PAs and AAs.
- July 2019: DHSC published the results of its 2017 consultation on return of professional regulation. We were already working with DHSC on two potential Section 60 orders to take forward part of the proposed reforms: one on FTP and one on GNM. We continue to work with DHSC on these. A third Section 60 relating to international registration under discussion.
- September 2019: Edward Argar was appointed Minister of State at the Department of Health and Social Care on 10 September 2019. He replaced Chris Skidmore MP who was Minister of State between August and September.
- September 2019: Dame Clare Marx, Anthony Hordern and Charlie Massay met with NO’s health adviser to discuss our legislative priorities.

**Further Action required?**

- Yes
- No

**Risk appetite**

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

**OST3 Threat**

**P. Reynolds**

**Likelihood**

Quite Likely

**Impact**

Moderate

**Assessment**

SIGNIFICANT

- Work to align our communications activity to avoid overburdening our stakeholders or creating engagement fatigue
- SMT engagement and influencing activities with external organisations
- Joint working frameworks (eg - CQC/NHS/E/GMC)
- Launch of our 2018-2020 Corporate Strategy and communications around this
- MLA - building links with external partners through joint work on design and delivery
- Education to work with Health Education England (HEE) and examiners to ensure our Quality Assurance (QA) is proportionate. We also need to be assured their quality management is effective. Part of review of QA
- Taking Revolution Forward (TRF) Programme implemented
- BLS engagement activities - building relationships with external partners and explaining what we are aiming to achieve; liaison teams in place
- Implementation of strategic relationships operating model from 2019 onwards (subject to resource requirements being agreed) will deliver closer collaborative working with our regulatory partners
- The MLA will establish a minimum threshold clearly linked to our regulatory function and the need to ensure patient safety: demonstrating that an individual is capable of functioning safely on the first day of clinical practice in the UK. If stakeholders accept that, we will be in a better position to drive consistent future improvement
- Our quality assurance role involves us ensuring our standards are met. Our review of QA and traction needed to make the
- Regular communications and engagement between GMC senior leadership and the Department of Health and Social Care, and system regulators across the four countries
- Engagement on NHS People Plan
- Council and Board Review Assurance

**OST5 Threat**

**P. Reynolds**

**Likelihood**

Quite Likely

**Impact**

Moderate

**Assessment**

SIGNIFICANT

- Daily media and social media and political monitoring
- Analysis of weekly media issues log
- Monthly high profile case reviews by media team and R&P
- Proactive stakeholder management handling on a case by case basis
- Monthly report to CDO on Rule 12, complaints, correspondence from high profile figures or organisations and other high profile issues
- Outreach to provide intelligence reports and help us respond on emerging or live issues
- SMT standing agenda item on complex and contentious decisions being made
- Council receives a 6 monthly complaints analysis and trend briefing note
- A formal crisis plan developed to mitigate against media coverage that could be potentially damaging to our reputation with doctors, patients and the wider public
- Supporting the Profession Under Pressure programme of work
- Support the Profession Under Pressure programme of work
- Education to work with Health Education England (HEE) and examiners to ensure our Quality Assurance (QA) is proportionate. We also need to be assured their quality management is effective. Part of review of QA
- Taking Revolution Forward (TRF) Programme implemented
- BLS engagement activities - building relationships with external partners and explaining what we are aiming to achieve; liaison teams in place
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- Our quality assurance role involves us ensuring our standards are met. Our review of QA and traction needed to make the
- Regular communications and engagement between GMC senior leadership and the Department of Health and Social Care, and system regulators across the four countries
- Engagement on NHS People Plan
- Council and Board Review Assurance

**Further action detail**

- Publication of the SAPUP reviews provides us with an opportunity to enhance perceptions of the GMC and to explain how and why we make the decisions which we do.
- MLA - building links with external partners through joint work on design and delivery
- Executive Board in December 2018 approved funding to establish new Strategic Relationships Unit in SGU/EDC/Undertaking. This is enabling us to implement a new approach to relationship management with organisations which we class as regulatory partners. The Strategic Unit is providing support to help us understand strategic alignment with partner organisations, and identity opportunities for future partnership working
- Engagement on the NHS People Plan to continue
- Crisis Plan designed by NR and PB has been approved and sections of the Organisational Business Continuity plan have been updated
- We are in the process of realigning our outreach teams and will make structural changes in January 2020 in order to enhance our engagement with regulatory partners at a regional and local level
- September 2019: Chief Executive met with NHS England regional medical directors to discuss future ways of working
- We are in the process of developing our next corporate strategy which provides us with an opportunity to engage with and ensure alignment of our ambitions with our regulatory partners.
<table>
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</tr>
</thead>
<tbody>
<tr>
<td>OP1</td>
<td>Opportunity</td>
<td>We use our contact with the large cohort of international and European medical graduates who join the Register each year, to make sure they understand our role and the ways in which we can support them, enhancing their ability to achieve and maintain good practice and their perception of us as their regulator</td>
<td>Anthony Omo</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
<td>Yes</td>
<td>Low</td>
</tr>
<tr>
<td>TI1</td>
<td>Threat</td>
<td>Non-training grade doctors is an increasing cohort of the doctor population and has an increasing impact on training. We have identified these impacts in our QA visits. This can be positive, as they fill rota gaps, or negative, as they compete for training opportunities with trainees. Any training of this doctor cohort is heterogeneous and currently outside of the oversight and regulation of ourselves, Health Education England (HEE) and deaneries. We do not set standards or survey this cohort about their training. We do sometimes speak to these doctors on QA visits however</td>
<td>P. Reynolds</td>
<td>Moderate</td>
<td>Moderate</td>
<td>SIGNIFICANT</td>
<td>Yes</td>
<td>Unlikely</td>
</tr>
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</table>
| TI2 | Threat | • Strategy and Policy Directorate – Regulatory Policy Teams & the Policy Leadership Group (PLG) – enabling us to deliver more evidence-led policy and understand more about how our standards and guidance interact in a team-based environment  
• Insights gained from our PIP investigation work in relation to patient care, and from medical CE inputs into the investigation process  
• Insight brought back into the business by our outreach teams, aiding our understanding of the different environments in which doctors work  
• Intelligence Module available for use  
• Developed Office expertise - able to inform organisation of behaviours and environment in the different regions  
• Increased collaboration with other regulators through various forums e.g Inter-regulator group and Special Measures and Challenge Provider Oversight Group  
• We attend quality management visits that are increasingly multidisciplinary, Health Education England (HEE) and deaneries have a remit for non-medical learners also. Our evidence on training environments focusses on the whole environment, and we also collect evidence on team working. Other solutions to issues in training are multidisciplinary, such as nurse practitioners, physician associates  
• In our QA visits, we interrogate our standards, which includes how training environments enable trainee doctors to fulfil the duty of candour | R. Leadby | Low | Low | Low | Yes | Moderate |

**STRATEGY C: AIM 1 - Supporting doctors in maintaining good practice**

- Welcome to UK Practice sessions now promoted by GMC on Facebook, with content for IMGs continuing to be produced and distributed across our digital channels (e.g. Facebook Live session in September)  
- Digital Transformation 2020 programme - changes to the information on our website, making it easier to navigate and personalise  
- The MLA will be a touchpoint for all International Medical Graduates (IMGs) (and potentially EEA), with an assessment blueprint covering ethics and professionalism. Information packs or Welcome to UK Practice sessions for IMGs could potentially be linked to MLA stages (e.g. first application, passing AKT, passing CSA)
In cases where there are high profile patient safety issues and potentially unsafe environments for doctors and doctors in training, there are challenges in working effectively and collaboratively with other regulatory partners causing an adverse reputational impact for the GMC.

**T2.1 Threat**

- Information sharing agreement in place with Care Quality Commission (CQC)
- Working closely with the Health and Social Care Regulators Forum to improve collaboration
- Education enhanced monitoring processes in place
- Internal processes to manage communications
- We help ensure available and appropriately trained staff through our mandatory training on Information Security/Data Protection and training courses such as Influencing & Stakeholder engagement training
- Escalating concerns protocol has been developed
- Protocol in place with the CQC to encourage collaborative working
- Quarterly working group with CQC
- Improved info sharing via the FTP safeguarding team with CQC
- GMC (Outreach teams) engaged in the NHS regional restructure – attending regional meetings to share intel.

**Opportunity**

- Updates on high profile patient safety environments provided through CEO briefings
- Audit and Risk Committee
- CEO update at each meeting

**Mitigation (for threats)**

- Working towards information sharing agreements in other regulators including devolved nations
- We are currently undertaking a lessons learned exercise, including whether there are ways to improve our joint working with other regulators
- Health and Social Care Regulators Forum have agreed actions and work streams to improve collaboration across the system
- Influence existing structures and fora to support information sharing
- Agree a process for defining and communicating roles and responsibilities
- Improve the use of data and insight – GMC to set up working group and feedback on analysis of current practice
- Develop a culture of proactively sharing information and briefings

**Assurance**

- Yes

**Risk appetite**

- Low
### STRATEGY AIM 3 - Strengthening our relationship with the public and the profession

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<tbody>
<tr>
<td>GPS 1 Opportunity</td>
<td>If we fail to strengthen relationships with members of the public, we will not be able to demonstrate the impact our work is having which will feed into our reputation as an effective and transparent regulator in the eyes of the public and the profession.</td>
<td>P. Reynolds</td>
<td>LOW</td>
<td>Patient and Public Working Group established</td>
<td>Patient and Public engagement workstream reported through Engage Board as part of Transformation Portfolio</td>
<td>Annual tracking survey results to understand perceptions of patients and the public (September/October)</td>
<td>Better aligning work streams led by Fitness to Practise</td>
<td>Patient and Public engagement in our work and preparation for the next Corporate Strategy</td>
<td>Council considered current Corporate Strategy success measures at its meeting in November 2018</td>
<td>Full range of strategic lead and lag indicators, updated for 2019, included as part of COO Report to Council February 2019</td>
<td>Yes</td>
<td>Roundtable with patient organisations scheduled for November 2019.</td>
<td>Strategic Relationships Unit has been created and the team are developing Annual Relationship Improvement plans for regulatory partners, meeting with the strategic stakeholder to build the relationships and developing ways to provide more strategic briefings to SMT</td>
</tr>
<tr>
<td>GPS 2 Opportunity</td>
<td>We have the opportunity to be a more proactive regulator and demonstrate our understanding of the environment in which the profession is working as well as showing a willingness to speak up about issues facing the profession, allowing us to provide further support to doctors.</td>
<td>P. Reynolds</td>
<td>LOW</td>
<td>Being more vocal about the pressures in our narratives to external world</td>
<td>Holding other stakeholders to account</td>
<td>Bringing stakeholders together through various forums to deliver their part in addressing system pressures</td>
<td>Using campaign to speak up and raise concerns based on solid evidence and insight, such as publication of NTS results (July)</td>
<td>SAS survey ran between 1 May 2019-12 June 2019, providing an opportunity to proactively gather and understand doctors’ views</td>
<td>Several opportunities available in 2019 linked to completion of projects in Supporting a Profession under Pressure (SAPUP) programme, as well as regular publications such as NTS and SOMEP</td>
<td>Communications and co-ordination plan for responding to SAPUP recommendations in development, following publication of GNM and FtR reviews in June 2019</td>
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**OP3.1 Opportunity**

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

- Patient and Public Working Group established
- Patient and Public engagement workstream reported through Engage Board as part of Transformation Portfolio
- Annual tracking survey results to understand perceptions of patients and the public (September/October)
- Better aligning work streams led by Fitness to Practise
- CDD-led patient representatives at GMC Conference (March 2019) and spoke at Patient Safety Conference (May 2019)

**Council**
- Discussions at Council Away days (July 2018 and 2019) about Patient and Public engagement in our work and preparation for the next Corporate Strategy
- Council considered current Corporate Strategy success measures at its meeting in November 2018
- Full range of strategic lead and lag indicators, updated for 2019, included as part of COO Report to Council February 2019

**Further action detail**
- Strategic Relationships Unit has been created and the team are developing Annual Relationship Improvement plans for regulatory partners, meeting with the strategic stakeholder to build the relationships and developing ways to provide more strategic briefings to SMT
- Research carried out in the summer of 2018 to baseline perceptions for our Corporate Strategy 2019-2020 shows confidence in the profession and in regulation among patients and the public remains high. Majority of patient organisations surveyed for the exercise agreed that we listen to them and use their views to shape our work
- Regional Liaison Service to maintain relationships with local patient organisations in England during 2019
- Patient and relatives charter due to be launched in the autumn

**OP3.2 Opportunity**

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

- Being more vocal about the pressures in our narratives to external world
- Holding other stakeholders to account
- Bringing stakeholders together through various forums to deliver their part in addressing system pressures
- Using campaign to speak up and raise concerns based on solid evidence and insight, such as publication of NTS results (July)
- SAS survey ran between 1 May 2019-12 June 2019, providing an opportunity to proactively gather and understand doctors’ views

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- Regional Liaison Service to maintain relationships with local patient organisations in England during 2019
- Patient and relatives charter due to be launched in the autumn

**Further action detail**
- Several opportunities available in 2019 linked to completion of projects in Supporting a Profession under Pressure (SAPUP) programme, as well as regular publications such as NTS and SOMEP
- Communications and co-ordination plan for responding to SAPUP recommendations in development, following publication of GNM and FtR reviews in June 2019
STRATEGY AIM 4 - Meeting the changing needs of the health services across the four countries of the UK

T4.1 Threat

Impact

Highly Likely

Major

CRITICAL

Assessment

Further action required?

Yes

Further action detail

- We continue to raise the case for return to the BAG framework to enable us to check the competency of EEA doctors and to ensure a single route to the medical register for all doctors, regardless of where they qualified, in the future.
- We have worked closely with the UK Department of Health and Social Care and the devolved governments to ensure amendments to the Medical Act do not have a detrimental impact on the workforce needs of the NHS.
- In Northern Ireland we undertook a project to identify the range of regulatory issues that need to be considered further as the Executive's policy to increase the cross-border delivery of healthcare is implemented.
- Submitted 11 sets of detailed legal comments on DHSC no-deal legal drafting over 18 months.
- On 20 December 2018, Medical Act amendments were tabled before parliament, in preparation for a potential no-deal scenario. We briefed Peers and MNs on the amendments and succeeded in getting our concerns noted on public record. The amendments were adopted in March 2019.
- On 9 January 2019, the Professional Standards Authority (PSA) wrote to us to seek our views on particular concerns about impact of a no-deal Brexit on effectiveness of our registrants, or our ability to protect the public. Our reply, signed by Paul Buckley, was sent on 16 January 2019.
- We plan to produce our latest data publication on EEA doctors towards August/early September.

Opportunity

Information shared with Council on our overall approach to flexibility in April 2019

Council

Further action required?

Yes

Further action detail

- Undertake and demonstrate we have undertaken - full consideration of proposals.
- Explore revising AKT model to timescale to accommodate proposals.
- Continue regular liaison and engagement between GMC (including senior staff) and stakeholders across the undergraduate and postgraduate medical education community to gain a comprehensive understanding of views.

There is an increase in non-training posts and training pathways which include training that is not GMC approved. There is a regulation now that the profession believe the GMC are responsible for the unregulated training.

Because of challenges to the proposed MLA Applied Knowledge Test (AKT) model by key academic stakeholders and the submission of an alternative proposal for the design and delivery of the applied knowledge test (AKT), there may be a lack of support from some stakeholders for delivering the AKT in the way agreed by Council. This may lead to a delay in support of, or scuppered stakeholder relationships which could also impact on wider GMC activities.

- We have been working on the Flexibility project, some of the outcomes of this review will help mitigate the issues arising from training pathways. Executive Board have approved the initial recommendations on this and we will now work with partners to implement them.
- We are reviewing the CESR(CP) route that will enable doctors joining an approved training programme pathway through to gain a CCT which is important for worldwide recognition.
- We plan to produce our latest data publication on EEA doctors towards August/early September.
- We have worked closely with the UK Department of Health and Social Care and the devolved governments to ensure amendments to the Medical Act do not have a detrimental impact on the workforce needs of the NHS.
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### Business risks and how we manage them

**Active Operational Risks**

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<thead>
<tr>
<th>ID</th>
<th>Threat / Opportunity for</th>
<th>Risk detail</th>
<th>Owner</th>
<th>Lead Officer</th>
<th>Impact of</th>
<th>Likelihood of</th>
<th>Risk control</th>
<th>Council and/or Board Review</th>
<th>Assurance</th>
<th>Further Action Required</th>
<th>Further action detail</th>
</tr>
</thead>
<tbody>
<tr>
<td>AT1</td>
<td>Threat</td>
<td>Recruitment and transfer activity remains high and could challenge teams ability to deliver their functions effectively and impact on other key initiatives such as development of the policy profession</td>
<td>Neil Roberts</td>
<td>Q&amp;A &amp; HR</td>
<td>Low or Medium</td>
<td>Quite Likely</td>
<td>Low</td>
<td>1. Monitoring of staff turnover and other indicators through the bi-annual Operational Performance and Risk Review report</td>
<td>Yes</td>
<td>No Implementation of SAPU recommendations</td>
<td>Enhanced monitoring process in place</td>
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<td>Continuously stretched resources and finances in the health environment create the potential for increased patient safety incidents which could strategically impact the GMC's role as the regulator upholding professional standards for doctors and trainees and create operational pressure on finances to práctica referrals and education monitoring services</td>
<td>Anthony Onsu</td>
<td>Q&amp;A &amp; HR</td>
<td>Low or Medium</td>
<td>Quite Likely</td>
<td>Low</td>
<td>1. Internal audit of recruitment processes (June 2019, green amber)</td>
<td>Yes</td>
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<td>We do not comply with our statutory obligations on Equality and Diversity, leading to legal challenges, financial loss and/or unfair outcomes, all of which could lead to reputational damage.</td>
<td>Paul Buckley</td>
<td>Q&amp;A &amp; HR</td>
<td>Low or Medium</td>
<td>Moderate</td>
<td>Low</td>
<td>1. Executive Board considered a paper on the policy and how the framework may run in practice</td>
<td>Yes</td>
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<td>We are moving towards the implementation of GMC-regulated credentials in 2019, stakeholders may not react positively to it potentially causing potential operational impact</td>
<td>Colin McClure</td>
<td>Q&amp;A &amp; HR</td>
<td>Low or Medium</td>
<td>Moderate</td>
<td>Low</td>
<td>1. Exception based reporting to Executive Board and Council through corporate updates</td>
<td>Yes</td>
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<tr>
<td></td>
<td></td>
<td>The implementation is phased and we are working with a small number of early adopters in 2019 and 2020 and approved, to the introduction of GMC regulated credentials.</td>
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<tr>
<td>ID</td>
<td>Threat / Opportunity</td>
<td>Risk detail</td>
<td>Owner</td>
<td>Likelihood</td>
<td>Impact</td>
<td>Assessment</td>
<td>Mitigation (for threats)</td>
<td>Enhancement (for opportunities)</td>
<td>Schedule risk with controls in</td>
<td>Council and/ or Board Review</td>
<td>Assurance</td>
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<td>AT6</td>
<td>Risk</td>
<td>Following the announcement that Health Education England (HEE) &amp; NHS Improvement (NHSI), will work jointly with NHSI, there is a risk that the change in leadership and the reporting structure, could result in the Education agenda not being pushed and potentially training opportunities reduced as a result of shared budgets.</td>
<td>Colin Melville</td>
<td>Quite Likely</td>
<td>Moderate</td>
<td>CRITICAL</td>
<td>• Engage with Health Education England (HEE) &amp; NHS Improvement (NHSI) through various forums to promote the training and education agenda and influence at an early stage</td>
<td>• Be proactive in developing and sharing actions</td>
<td>Council and/or Board Review</td>
<td>Assurance</td>
<td>No</td>
</tr>
<tr>
<td>ACP1</td>
<td>Opportunity</td>
<td>Credentialing would provide some opportunities for doctors to move more quickly to areas of practice where there is greatest need to better meet patient and service need. This flexibility will allow doctors to have a clear way to develop, plan or focus their careers to ensure they use their skills and experience to the greatest effect. Credentialing will also give employers a mechanism to train and develop their medical workforce relatively quickly in areas where there are local service gaps that won’t be met by training alone.</td>
<td>Colin Melville</td>
<td>Quite Likely</td>
<td>Moderate</td>
<td>SIGNIFICANT</td>
<td>• Exception based reporting to Executive Board and Council through corporate updates. • The Executive Board considered a paper detailing the potential impact of the new arrangements, including risks and opportunities, in December 2018.</td>
<td>Council and/or Board Review</td>
<td>Assurance</td>
<td>No</td>
<td>Exception based reporting to Executive Board and Council through corporate updates.</td>
</tr>
<tr>
<td>ACP2</td>
<td>Opportunity</td>
<td>Following the announcement that Health Education England (HEE) will work jointly with NHS Improvement (NHSI), there could be an opportunity to develop longer term planning and promote training to be more central to workforce planning.</td>
<td>Colin Melville</td>
<td>Quite Likely</td>
<td>Moderate</td>
<td>CRITICAL</td>
<td>• Engage with HEE &amp; NHSI through various forums to promote the training and education agenda</td>
<td>• Partner with external stakeholders to develop shared agendas to influence HEE &amp; NHSI medium-long term planning</td>
<td>Council and/or Board Review</td>
<td>Assurance</td>
<td>No</td>
</tr>
<tr>
<td>ID</td>
<td>Threat</td>
<td>Opportunity</td>
<td>Risk detail</td>
<td>Responsible</td>
<td>Risk appetite</td>
<td>Risk pro-control</td>
<td>Mitigation (for threats)</td>
<td>Assurance</td>
<td>Further Action required?</td>
<td>Further action detail</td>
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<tr>
<td>IT1</td>
<td>Threat</td>
<td>Application of key controls and processes lead us to reach the wrong conclusion in investigating a doctor’s fitness to practise with an impact on patient safety, registrants, witnesses and/or the reputation of the GMC</td>
<td>Una Lane</td>
<td>Medium</td>
<td>• Documented process and procedures</td>
<td>• Training and available staff</td>
<td>• Employee Liaison Advisor (ELA) engagement with Respondible Officers (ROs) to help identify and manage concerns</td>
<td>Internal Audit</td>
<td>Yes</td>
<td>• Review of Legal Services (June 2017, green/amber)</td>
<td>• Review of the use of independent expert witnesses in FTP activity (June 2017, green)</td>
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<tr>
<td>IT2</td>
<td>Threat</td>
<td>We register an individual who is not properly qualified and/or fit to practise with an impact on patient safety and our reputation</td>
<td>Una Lane</td>
<td>Medium</td>
<td>• Documented process and procedures</td>
<td>• ID graduate</td>
<td>• Disciplinary exchange with competent authorities informs our processes (including Internal Market Information alert mechanism)</td>
<td>Internal Audit</td>
<td>No</td>
<td>• Implementation of Outreach structure to ensure statutory process in ROs continue effectively</td>
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<td>IT3</td>
<td>Threat</td>
<td>We revalidate an individual who is not fit to practise within the UK has prompted activity which supports further mitigation against the threat of revalidating an individual who is not properly qualified.</td>
<td>Una Lane</td>
<td>Low</td>
<td>• Documented process and procedures</td>
<td>• Regular performance monitoring and reporting</td>
<td>• Support for Revalidation: making recommendations through the Employee Liaison Service</td>
<td>Show assurance</td>
<td>Yes</td>
<td>• Finalisation of Taking Revalidation Forward - commitment to ongoing study (final report published Q1 2018)</td>
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<tr>
<td>IT4</td>
<td>Threat</td>
<td>Our quality assurance processes fail to identify a lack of compliance with standards for education, training and curricula with a potential impact on patient safety and our reputation</td>
<td>Gail Mohanty</td>
<td>Low</td>
<td>• Documented process and procedures</td>
<td>• Training and available staff and Associates</td>
<td>• Local governance systems identify and address performance concerns</td>
<td>Operational Key Performance Indicators (KPIs) reported each meeting</td>
<td>No</td>
<td>• Finalisation of Taking Revalidation Forward - consulting on changes to our patient feedback requirements for revalidation</td>
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</table>

For IT1, the key controls and processes are identified to mitigate the threat of reaching the wrong conclusion in investigating a doctor’s fitness to practise. For IT2, the risk pro-control measures include documented processes and procedures, ID graduates, and disciplinary exchange with competent authorities. For IT3, the key controls include documented processes, regular performance monitoring, and support for Revalidation. For IT4, the key controls include documented processes and procedures to investigate and monitor concerns. The table outlines the mitigation strategies and assurance activities for each threat, along with the corresponding response and action required.
|----|----------------------|-------------|-------|------------|--------|-----------|---------------------------|----------|------------------------|---------------------|
| 1T5 | Threat               | Low awareness and use of our ethical guidance by doctors limits the impact on raising standards of medical practice with a consequent impact on patient care | Colin Melville | Quite Likely | Moderate | SIGNIFICANT | • Internal standards and ethics oversight group  
  • Established, documented procedures  
  • Public consultation used to develop and validate guidance  
  • Trained and available staff  
  • Extensive outreach and engagement activities to promote ethical guidance  
  • Proactive communications strategy and website improvements  
  • Transformation of our online digital offer - through Digital Transformation 2020 | Council  
  Approved decisions to go to consultation on draft guidance and decisions to publish new/revised guidance. Seminars held with Council Sept 2018 and April 2019 on guidance and implementation | No | Internal audit review of Standards and Ethics (August 2018); green-amber further trading survey planned in 2019 Guidance developed in line with the policy framework. Major consultations are audited by independent auditors with expertise in consultation practice |
| 1T6 | Threat               | Patient safety is impaired and/or reputational damage is caused by not providing an effective and timely adjudication process | Gavin Brown | Quite Likely | Major | CRITICAL | • Documented process and procedures (Adjudication Manual)  
  • Regular performance monitoring and reporting  
  • Trained and available staff (including MPTS induction)  
  • Tribunal members training and assessment (including Induction programme)  
  • S60 changes implemented to bring further assurance to MPTS process including binding case management decisions | Council  
  • MPTS formal report to Council (8 monthly)  
  • Interim Order Panel service targets reported to each meeting | No | 2017/8 PSA Performance review - met all standards |
| 1T7 | Threat               | Doctors under conditions or undertakings do not comply with their sanctions and patients are harmed as a consequence | Anthony Omo | Unlikely | Major | SIGNIFICANT | • Case Review Team - documented processes and skilled resource  
  • Sanctions are listed on the List of Registered Medical Practitioners  
  • Notification of oversea regulators (if required)  
  • Publication of public hearing minutes  
  • Daily downloads of the register are sent to primary and secondary healthcare organisations  
  • Continuing development of GMC/RO relationships | Executive Board  
  • Publication and disclosure of immediate/interim orders and warnings (June 2017)  
  • Warnings - publication and disclosure (September 2017)  
  • Publication and disclosure - revised written policy (January 2018) | No | |
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Executive summary

As agreed with Council, we established with effect from the beginning of 2019 a new s40A Executive Panel to consider whether we exercise our right of appeal in specific cases. The decisions of the s40A Executive Panel are published on the GMC website on the Recent Appeal Decisions page. The changes to our internal process followed receipt of independent legal advice from Sir Robert Francis QC which advised that it would be unlawful to suspend use of the GMC’s right of appeal or to delegate it to the Professional Standards Authority (PSA).

The purpose of this paper is to provide an update to Council on the operation of the s40A Executive Panel and its exercise of the GMC’s right of appeal.

Recommendation

Council is asked to note the contents of this update.

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

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

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

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

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

4. In the period between 1 January and 9 August 2019, the PSA issued one s29 appeal in the case of Dr Hilton. This was a dishonesty case regarding Dr Hilton’s explanation to a patient regarding a screw that was misaligned during surgery. Whilst the MPT found that Dr Hilton had acted dishonestly, in the particular circumstances of the case they did not find his fitness to practise to be impaired. They did not issue a warning.

5. We considered this case prior to the Executive Panel being instituted in January 2019; the registrar considered that the action of the MPT, whilst unusual, was within a range of reasonable responses, as it was an isolated case and Dr Hilton had shown a good level of reflection. The court which heard PSA’s appeal refused their appeal against the finding of no impairment. The judge did, however, agree with the PSA that the MPT should have issued a warning.

6. The PSA has joined us in being party to our s40A appeal in the case of Dr Zafar.

7. As the exercise of the GMC’s right of appeal under s40A is the final stage of fitness practise proceedings in respect of an individual Doctor it is an operational decision in the exercise of the GMC’s statutory fitness to practise functions. Accordingly, Council initially approved the delegation to the Registrar of exercising the right to appeal under Section 40A at its meeting on 30 September 2015.
Following publication of the Williams Review\(^2\), and in response to certain of its recommendations, Council approved a proposal to amend the delegation for decision-making in respect of s40A appeals which now rests with the s40A Executive Panel.

The purpose of this paper is to update Council on the operation of the s40A Executive Panel since it assumed the decision-making role in relation to GMC appeals under s40A Medical Act 1983 in January 2019, and the decisions which the Panel has made.

The s40A Executive Panel

With effect from January 2019, decisions as to whether to exercise the GMC’s right of appeal are no longer be taken by the Registrar alone, having regard to legal and other advice, but are instead taken by an Executive Panel consisting of the Chief Executive and Registrar (acting as chair), the Medical Director and Director of Education and Standards and the General Counsel and Director of Fitness to Practise (or their nominated Deputies if not available).

There is an established, three stage process supporting the s40A Executive Panel in its decision-making:

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

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

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

Meetings of the s40A Executive Panel are chaired by the Chief Executive and Registrar. The Assistant Director, Corporate Directorate acts as clerk to the Panel and

records the s40A Executive Panel’s Decision in the form of a Note of Decision which is approved by the Panel and signed by the chair.

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

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

15 The decisions of the s40A Executive Panel are also now published on the GMC website on the Recent Appeal Decisions page.

The s.40A Executive Panel’s Decisions

16 As at 9 August 2019 there have been 14 meetings of the s40A Executive Panel during which it has considered whether to exercise the GMC’s right of appeal in relation to a total of 17 Doctors. The number of cases which have concluded at an MPTS hearing during this period is 250. Of these 250 cases 120 had an outcome different to the sanction we had sought at the outset to the case. The three-stage process described in paragraph 11 was applied to these 120 cases.

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

18 As that table confirms, the s40A Executive Panel have decided to exercise the power to appeal in 3 cases to date, namely the cases of Dr Zafar, Dr Saeed and Professor Walton:

a Dr Zafar:
Dr Zafar had provided a false medical report in the course of litigation relating to a road traffic accident (in December 2011) involving Mr Iqbal (a taxi driver) and the insurance company of the other driver, Liverpool Victoria Insurance Company Limited (“LVI”).

He was found by the High Court to be in contempt of court by reason of the manner in which he had provided that evidence to the court and was sentenced to six months’ imprisonment suspended for 2 years.

The s40A Executive Panel concluded that the decision by the MPT to suspend Dr Zafar’s registration for a period of 12 months was insufficient to protect the public, having failed to reflect the true seriousness of Dr Zafar’s conduct, attached too much significance to mitigation, and failed properly to engage with the provisions of the Sanctions Guidance concerning erasure.

The PSA has since confirmed they will join us by becoming a party to this appeal.

b Dr Saeed:

Dr Saeed was convicted of Controlling and Coercive Behaviour and Assault Occasioning Actual Bodily Harm on his wife, and, on 29 August 2018, was sentenced to:

- 22 months Imprisonment suspended for 2 years;
- 200 hours unpaid work;
- Rehabilitation Activity Requirement for 30 days;
- Restraining Order until further order.

The s40A Executive Panel concluded that the decision by the MPT to suspend Dr Saeed’s registration for a period of 12 months was insufficient to protect the public, having failed to reflect the true seriousness of Dr Saeed’s misconduct, failed to properly engage with Sanctions Guidance on erasure, and attached too much significance to mitigation.

It was also noted that the case involved a criminal conviction for violence, rather than matters of clinical competence, and the fact that the doctor was not present at the hearing meant that assessments of insight were not based on in-person testimony. Both of these factors lent weight to the merits of an appeal in the view of the Panel.

c Professor Walton:

Professor Walton was alleged to have been dishonest in regularly undertaking private work at Summertown Health Centre and Queen Mary
University of London during his employment at Warwick Medical School without having sought authority to do so as advised by the Dean and as required by the terms of his employment. In addition, it was alleged that Professor Walton had been dishonest in his conversations about his private work with the Head of Division.

- The MPT found proven that the Dean had not agreed for Professor Walton to be paid directly for his work for the Health Centre (as approval for him to carry out such work had not been properly sought by Professor Walton or granted) and therefore what he stated to the Head of Division was dishonest. It was also found proven that Professor Walton had been carrying out up to two days per week work at the Health Centre during his employment at Warwick and therefore he had been dishonest in what he had informed the Head of Division as he was aware at the time of this conversation that he was being paid for four sessions per week by the Health Centre.

- The Panel had concerns with the MPT’s decision only to suspend Professor Walton from the medical register for a period of six months for the following reasons:
  - The MPT appeared to have misdirected themselves when determining the factual allegations regarding when Professor Walton’s obligation to apply to undertake private work and declare any conflicts of interest arose;
  - The MPT’s categorisation of the dishonesty not being persistent was questionable;
  - The MPT’s determination on sanction failed to reflect the findings in the determination on impairment that Professor Walton had failed to reflect or undertake any remediation in respect of his dishonest conduct; this was also repeated in the MPT’s decision not to direct a review;
  - The panel felt that the MPT had placed far too much weight on Professor Walton’s previous good character when determining the length of sanction when balanced against the very serious nature of the findings;
  - The MPT had failed to consider any of the factors which were present which pointed to erasure.

- The Panel concluded that, as a result of the errors which the MPT made in their determination of this case, the outcome was not sufficient to protect the public

19 Each of those appeals has been issued and served on the Doctors and are awaiting a hearing date.
20 The s40A Executive Panel has declined to issue an appeal in the other 14 cases, for the reasons set out in their decisions in each of the respective cases, copies of which are published on the GMC website.

Conclusion

21 In December we put to Council, and Council agreed, a number of recommendations in the light of advice which we had sought from Sir Robert Francis QC on a range of changes to our decision-making processes surrounding our right of appeal on MPTS tribunal decisions (s40A appeals). This in turn had followed on from our consideration of Recommendations made by the Williams Review and the discussion which took place before the House of Commons Health and Social Care Committee in October 2018 in relation to the Williams Review and its recommendations.

22 These developments have now been fully implemented.

23 Throughout 2019, decisions regarding the exercise of the GMC’s power to appeal have been taken by the s40A Executive Panel and, to date, three GMC appeals have been issued following a decision of the s40A Executive Panel. Full details of all of the s40A Executive Panel’s decisions can be accessed via the GMC website.

24 Council is asked to note this update.
M4 – Section 40A Appeals update

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Executive summary
In July 2019 the Government invited the GMC to take on the regulation of two additional professions; physician associates (PAs) and anaesthesia associates (AAs). We have confirmed our readiness to regulate both groups, subject to the Government providing set up and transitional funding to cover the cost of bringing them into regulation and the development of appropriate, future-proofed legislation.

This paper outlines our initial thinking about how we will approach the work ahead and the regulatory model needed.

Recommendations
Council is invited to:
- Consider the overarching principles that should govern our approach to regulating PAs and AAs.
- Note our initial plans for scoping the work ahead.
Background

1. The GMC regulates doctors. Since 2015 we have been approached on a number of occasions about taking on the regulation of physician associates. In 2016 we undertook preliminary scoping work to help us better understand the role of PAs, whether they should be regulated and, if so, whether the GMC was the appropriate body to do so. In February 2017 Council agreed that, if requested by Government, we should be prepared to regulate PAs subject to certain conditions being met. The conditions included stakeholder support for us taking this on, provision of transitional funding from Government, a financially sustainable regulatory model and legislation that is fit for purpose in supporting the model.

2. In October 2017 the Government consulted on the future regulation of four professions: PAs, AAs, surgical care practitioners (SCPs) and advanced critical care practitioners (ACCPs). These discrete groups were collectively described as medical associate professions (MAPs). In our response of December 2017 we said that all four MAPs professions should be regulated and that we would be prepared to take this on, provided our conditions were met.

3. The Government’s initial response was published in February 2019. It stated that only PAs and AAs from the four MAPs professions were to be brought into regulation and that further work was needed to decide who the regulator should be; GMC or HCPC. In July 2019 it was announced that GMC was the preferred regulator for both PAs and AAs.

PAs and AAs: some basics

Physician Associates

4. PAs are:

‘...healthcare professionals with a generalist medical education, who work alongside doctors, physicians, GPs and surgeons providing medical care as an integral part of the multidisciplinary team. Physician associates are dependent practitioners working with a dedicated supervisor, but are able to work autonomously with appropriate support.’

5. There are 1,181 PAs on the Faculty of Physician Associates Voluntary Register. We think this represents approximately 70% of the practising PAs in the UK.

* www.fparcp.co.uk/about-fpa/faqs
†† As at 20 August 2019.
6 There are approximately 1,600 PA students in training* spread across 37 training programmes.

7 The Government has committed to having 1,000 PAs available to work in primary care in England by 2020. The *Interim NHS People Plan* estimates the total number of PAs will increase to 2,800 by the end of 2020, rising to over 5,900 by the end of 2023.

*Anaesthesia Associates*

8 AAs:

‘...perform duties delegated to them by their medical anaesthetic supervisor. These will include pre and post-operative patient assessment and care, maintenance anaesthesia and (under direct supervision) conduct the induction and emergence from anaesthesia. AAs will also deputise for anaesthetists in a variety of situations where their airway and venous cannulation skills will assist in patient care and where medically qualified anaesthetists cannot be available.’†

9 As at December 2018, there were approximately 189 qualified AAs in the UK.‡ The Royal College of Anaesthetists runs a 27-month training programme with a national assessment based at the University of Birmingham leading to a Postgraduate Diploma in Anaesthetic Practice.

*Developing our regulatory approach*

10 During our preliminary scoping work in 2016 we identified some broad principles that should govern our approach to the regulation of new professions. It is right that these should now be tested:

*Parity of regulatory esteem*

11 We are the General Medical Council but are about to become a multi-professional regulator. We cannot regard ourselves as principally the regulator of doctors, with PAs and AAs as supplementary groups of lesser regulatory significance. Our case for taking on PAs and AAs alongside doctors was based upon the coherence of regulating

* Figures provided by Department of Health and Social Care
† [https://www.rcoa.ac.uk/careers-training/anaesthesia-related-professionals/physicians-assistant-anaesthesia/faqs](https://www.rcoa.ac.uk/careers-training/anaesthesia-related-professionals/physicians-assistant-anaesthesia/faqs)
‡ Figures provided by Department of Health and Social Care
them as part of the medical team. All three professions must therefore be afforded parity of esteem in our regulatory approach.

Proportionality

12 Notwithstanding the parity of esteem principle, our operating model should reflect the differences in the education and practice of the different professions, and the regulatory risks involved. For example, although we will wish to be satisfied about the standards for education and training of PAs and AAs, and that they remain up to date and fit to practise, it does not follow that our operational arrangements for education quality assurance or revalidation must be identical to those for doctors. It is worth noting that PAs currently re-certify every six years by taking the Faculty of Physician Associates (FPA) national examination. That may be an entirely appropriate revalidation model for a profession whose practice is based around generalist skills. Similarly, it does not necessarily follow that the two-tier system of registration and licensing we have for doctors must be replicated for PAs and AAs.

Flexibility

13 Although at present the Government only intends to bring PAs and AAs into regulation, it has not ruled out regulating SCPs and ACCPs at a future date. Our operating model (including our IT systems), should therefore be designed to accommodate the future development of MAPs as a whole.

Lift and shift

14 Having signalled our willingness to regulate PAs and AAs, we will be under pressure to deliver as quickly as possible. To some extent the implementation timetable is beyond our control because it depends upon the Government delivering legislation that is fit for purpose. The Department of Health and Social Care (DHSC) estimates that it will take between 18 and 24 months to develop and lay the necessary legislation. As matters stand, and given the uncertain political climate, it seems unlikely that any legislation could be ready before 2021 at the earliest.

15 However, to minimize delay our preliminary thinking is that we should, where possible, initially adopt the mechanisms put in place by the FPA and Royal College of Anaesthetists to support their existing voluntary registers. The advantage of this lift and shift approach is that it would allow us to introduce a basic level of statutory regulation at the earliest opportunity in the interests of patient safety. The disadvantage is that this may expose us to some regulatory risk in the short term if the adopted mechanisms are not initially as robust as those we are used to for doctors. Further work with the FPA and the College to understand their existing systems will enable us to assess the potential risk and decide whether this is the correct approach.
Legislative model

16 How we regulate PAs and AAs will depend upon the legislative model. When the Government introduced regulation for nursing associates it did so essentially by inserting the term ‘nursing associate’ into the Nursing and Midwifery Order alongside the terms ‘nurse’ and ‘midwife’. If this approach were to be replicated for PAs and AAs it would simply impose on them all the shortcomings that we know exist in the Medical Act for regulating doctors.

17 We should, therefore, insist on a regulatory model for PAs and AAs which reflects the aspirations for legislative reform set out in the Government’s proposals Promoting Professionalism: Reforming Regulation. There is a real opportunity for PAs and AAs to be early adopters of the more flexible legislative model that we, and the Government, are seeking for all professions.

No cross subsidisation

18 We made clear in our offer to Government that doctors must not be expected to fund the transitional cost of bringing new professions into regulation. This principle has been accepted by DHSC officials. It is now a matter of agreeing the sum required. Our initial estimate of transitional costs was between £3.5m and £4.5m, but this will be tested through our proposed scoping work (see paragraph 24 below). The final figure may be higher or lower depending on our more detailed analysis.

19 However, the ongoing costs for regulating PAs and AAs once the transition is complete must be borne by the GMC. Again, doctors should not be expected to carry the cost of PA and AA regulation through an increased annual retention fee (ARF). The cost of PA and AA regulation must be borne by those professions. Our aim is that their fees should initially be no higher than those paid for inclusion in their respective voluntary registers. The scoping work ahead will provide clarity on costs. Our expectation is that costs will reduce as the number of PAs and AAs increases and we are able to benefit from economies of scale. We will want to discuss with DHSC transitional funding to cover the period until the numbers are sufficient to become self-funding.

20 However, the principle that doctors must not bear the cost of regulating new professions does not mean regulatory separation with different processes and systems individuallycosted for each profession. It seems probable that there would be greater coherence and efficiency if regulatory functions and activities can be aligned. For example, a single education quality assurance visit might reasonably look at the education and training provisions for both doctors and PAs in the same location.

21 We will apply these principles to the scoping work ahead.
Scoping

22 Although we undertook some initial scoping in 2016 looking at the feasibility of regulating PAs, we now need to carry out full due diligence for both PAs and AAs. Una Lane (Director of Registration and Revalidation) will lead the programme of work on bringing PAs and AAs into regulation. She is currently putting together a team to support her in taking this work forward and is working closely with Neil Roberts (Director of Resources) and other colleagues in focusing initially on scoping out what that programme might look like and, in particular, the likely costs.

23 Una Lane, Director of Registration and Revalidation, will establish and chair an internal programme board. Details are being finalised but, at present, we expect to have a small core team working on the project full time. It will probably comprise an Assistant Director (AD) lead, a programme manager, and additional administrative support. There will be a number of work streams to support the programme and these will report into the board. The work streams will include policy/legislation, education and assessment, operations, resource and IS, communications and engagement. Individual work streams will be supported by staff from across the business working on the project for a percentage of their time. We expect DHSC to cover the backfill costs. We are also planning to establish an external advisory group involving all key stakeholders to support the work.

24 On 2 September 2019 we met DHSC officials for preliminary discussions about how to take the work forward and the funding arrangements needed to support the work. DHSC has agreed in principle to fund the set up and implementation costs. We will now prepare a business case detailing our anticipated costs for the initial set up and scoping phase of the project. This scoping should enable us to reach a shared view of our legislative requirements, the set up and transitional funding needed for implementation and the provisional timetable. The scoping will need to cover, among other things:

- Legislative requirements (including the need for PAs and AAs to be able to prescribe)
- Grandfathering arrangements for PAs and AAs not already on their respective voluntary registers
- IT systems requirements
- Staffing and resources
- GMC governance and the implications for the size and shape of Council
- Registration and annual retention fees
Development of regulatory functions: education, standards, registration, revalidation/re-certification and fitness to practise

Operating model and internal organisation

Implementation and phasing

Set up, transitional and ongoing costs of regulation.

Over a longer timescale, particularly as these professions develop, there will be wider implications for our regulatory model. These will include, but not be limited to, such issues as the relationship between PAs, AAs and doctors in the clinical team; the need for the sort of educational and system infrastructure upon which we depend for regulating doctors, and the arrangements for registering international graduates.

Communications

During the scoping phase of the work, effective communication and engagement will be crucial. We will establish a stakeholder reference group to enable us to test our thinking. One to one meetings with key individuals and organisations have already begun.

Most of the stakeholder groups who responded to the consultation and the Government announcement have welcomed the GMC as the preferred choice of regulator. Those who support the decision include PAs and AAs, the devolved administrations, the Academy of Medical Royal Colleges, a number of individual colleges and Health Education England. Both students and practising PAs and AAs have already been in touch for information about how the GMC intends to regulate them.

However, the British Medical Association (BMA) and medical trainees have said that they are ‘fundamentally opposed’ to the decision. The BMA is concerned that the GMC will lose its focus on doctors. Medical trainees are concerned, among other things, about the impact on their own training opportunities. This highlights the need for our communication and engagement work to cover both doctors and PAs/AAs as our regulatory responsibilities expand. In doing so it will be a priority to listen to and address the concerns that have been raised by the medical profession. There is also learning to be taken from the experience of the Nursing and Midwifery Council, General Dental Council and General Pharmaceutical Council in bringing new professions into the regulated team.
Next steps

29 The immediate next step is to submit our formal business case to DHSC officials so that they can, we hope to agree and release the funding necessary for the initial set up and scoping work required, from which more detailed implementation plans will be developed.

30 We will update Council on progress before the end of the year.
Executive summary

The GMC Corporate Strategy 2018-20 was launched in January 2018. This report provides an update on the progress we have made and is consistent with a report to Executive Board in June 2019.

We have made good progress on all of our strategic aims, but there are some areas we need to address in the rest of 2019 and the 2020 business plan to deliver on all our commitments.

We have also achieved several other programmes of work that were not related to our strategy but further our strategic aims, including delivering three large-scale reviews as part of the Supporting a Profession Under Pressure work, and coped with unprecedented increases in operational activities in several areas of the business particularly Fitness to Practise and Registration.

Recommendations
Council is recommended to:

a  Note the progress we have made towards achieving our corporate strategy.

b  Note the next steps for council on the development of the next corporate strategy.
Progress on 2018-2020 Corporate Strategy

1 We have achieved many of the projects set out in the corporate strategy and are working on others. We have also delivered an additional wide programme of work which furthers our strategic aims, Supporting a Profession Under Pressure, including delivering three large scale reviews. We have also successfully managed unprecedented increases in operational areas such as Fitness to Practise and Registration. Notably, while Registration has processed more applications and is seeing increased contact with registrants, the number of complaints has fallen, which is encouraging. We have also opened the new Clinical Assessment Centre over the summer which allows us to process larger numbers of applicants for PLAB 2 assessments.

2 The rest of this paper focuses on highlighting progress against commitments made within the 2018-20 Corporate Strategy.

3 **Aim 1: Supporting doctors in delivering good medical practice**

- We have commissioned extensive research published in the State of Medical Education and Practice in the UK (SOMEP) to understand doctors’ experience of practice and motivations. This has informed discussion about pressures in the system across the UK and has been cited, for example, by the NHS in England in development of the People Plan.

- We have made significant progress on increasing attendance at Welcome to UK Practice (WtUKP), with a 52% increase in attendance at our workshops in 2018 (an extra 930 doctors). An independent evaluation has shown that WtUKP improves awareness and understanding of the ethical issues. In 2019 we expect to provide training to ~5,148 doctors. Whilst this exceeds the 80% figures projected at the time of the corporate strategy (4,874), it now only represents 58% given the very significant and unforeseeable increase in international medical graduates coming into the UK in the last year.

- We’ve completed one of three harms reduction projects as stated in the corporate strategy on communication and are currently identifying next steps to take this forward. A second project - exploring the standards that we receive the greatest number of complaints for is currently on hold due to reprioritisation. We have also begun implementing additional harms-related projects such as piloting the Professional Behaviours and Patient Safety programme and we are undertaking other work including on induction and returners and clinical leadership which focus on safety and culture in the clinical environment.

- The education policy team is scoping out a project on continuing professional development for next year.
We are planning to phase aspects of the Medical Licensing Assessment (MLA) in from 2022, replacing the Professional and Linguistic Assessments Board (PLAB) exam in 2023 and requiring UK students to pass the MLA as part of their degree from 2024 for the award of a UK Primary Medical Qualification.

4 Aim 2: Strengthening collaboration with our regulatory partners across the health services

- We have launched the emerging concerns protocol to share and escalate information at an early stage with regulatory partners. New partners continue to join the scheme and feedback on its value, albeit early in its existence, is positive. New Regulatory Review Panels are becoming an established part of the regulatory environment in England.

- We developed the *Professional Behaviours and Patient Safety* programme in collaboration with others and this is currently being piloted, with significant interest from many providers and the system.

- We are currently identifying pilot sites for local first, with pilots due to start in autumn 2020. The corporate strategy commits us to have piloted local first by the end of 2020.

5 Aim 3: Strengthening our relationship with the public and the profession

- We have progressed our digital transformation strategy including launching new GMC and MPTS websites. Analysis suggests significant improvements in their usability and effectiveness. Further opportunities in this space will be identified in the development of the next Corporate Strategy.

- As part of the better signposting project, we have carried out research on patients’ needs so we can signpost them to the most appropriate organisation to support them. We will be publishing research we commissioned about what patients and the public consider when they want to raise a concern about a doctor. We are now scoping out workstreams to identify and take advantage of earlier opportunities to effectively signpost members of the public.

- As well as reflective practice guidance and support for speaking up, the Supporting a Profession Under Pressure programme has led to publication of the Gross Negligence Manslaughter and Culpable Homicide review and the Fair to Refer review, with the Mental Health and Wellbeing review due in autumn. We are proactively planning how to ensure maximum value and impact through coordination across the GMC and in engagement with system initiatives across the UK. This work will form the centrepiece in UKAF meetings in the autumn.
We have published a white paper on legislative reform, entitled “Why does healthcare regulation matter?”, contributing towards our corporate strategy commitment of undertaking a campaign of work to increase understanding of the value of regulation.

We’ve completed an audit of all our engagement with medical students across all our channels. Our existing reference community of medical students will be engaged in the development of a full engagement plan.

Our patient and public engagement plan is in progress with significant engagement including for example, the patient and public engagement forum, the draft patient and relatives charter, the patient safety summit Susan spoke at, the Regional Liaison Service engagement (albeit more limited this year), the patient breakfast at the GMC Conference, the public/patient newsletter, and the GMC support for the Patient Safety Learning Organisation. This work has been led by Susan Goldsmith as Patient and Public Engagement champion. Una Lane will be taking this role on upon Susan’s departure.

We have consulted on changing requirements for patient feedback in revalidation following the recommendation in Taking Forward Revalidation.

6 Aim 4: Meeting the changing needs of the health services across the four countries of the UK

We have created new data products which are tailored to each of the four countries and were shared at UK Advisory Forums in autumn 2018, and incorporated them into the publicly available GMC Data Explorer as well as our internal data dashboards.

We have reviewed our outreach teams and we’ll start implementing a new structure from January 2020 onwards, establishing our regional model for England which will work alongside our national offices in Wales, Scotland and Northern Ireland.

We have extended the range of services in the four countries (eg successfully running PLAB 1 in Scotland and Wales).

We have made extensive preparations for Brexit.

Measuring and evaluating progress

7 Our approach to measuring and evaluating uses both ‘leading’ and ‘lagging’ indicators. Many of the activities set out above against aims 1-4 demonstrate delivery of leading indicators. The Chief Executive’s report contains reporting by exception these. Performance against our ‘lagging’ indicators (measurement of impact) is
expected to take longer to demonstrate and will be measured against a baseline established last year and shared with Council in February 2019.

8 Due to the volume of surveys required during 2019 the planned tracking survey has been postponed and will go into the field in early 2020. As a number of ‘lagging’ measures for the current corporate strategy rely on the survey to be updated, they should now be reported upon in Q2 of 2020. In parallel we are planning to review how we approach the carrying out of surveys across the GMC given increasing volumes and frequency including requests to assist external partners.

9 Executive Board decided in June that biannual internal audit reports should be commenced to offer further assurance that the strategic aims are being met. These will start in 2020.

Next steps for Council

10 We are keen to learn from lessons of the current corporate strategy. In particular we are seeking to create a baseline for measuring performance before the launch of the strategy, to better sequence the development of the strategy with business planning, and to ensure the work of our operational functions is more clearly reflected.

11 At the November 2019 Council meeting, Council will have the opportunity to discuss initial thinking on the vision and next corporate strategy building on engagement and analysis over the summer (including at the Council away day in July).

12 At the Council away days in March 2020, we will present proposals for the vision and strategy, with the key decisions to be made.

13 In summer 2020, the strategy will come to Council for sign off.
## Agenda item: M7

**Report title:** Pension valuation

**Report by:** Andrew Bratt, Assistant Director - HR  
[andrew.bratt@gmc-uk.org](mailto:andrew.bratt@gmc-uk.org), 0161 923 6215

**Action:** To consider

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### Executive summary

The 2018 triennial valuation for the GMC pension scheme has been undertaken by the Scheme’s Trustees in consultation with the employer.

Subject to sign off from Council and Trustees, the process will be concluded and the valuation will be signed off by the scheme actuary. This process requires the agreement of both parties to the actuarial assumptions that underpin the valuation and an agreed recovery plan that sets out how the scheme’s deficit, as of 31 December 2018, will be closed.

### Recommendations:

That Council:

- **a** Agree the 2018 valuation (Annex A)
- **b** Agree a seven-year recovery plan, involving six annual payments of £1.3m in 2020-2025 (in addition to the £1.9m previously committed and paid in 2019)
- **c** Note the planned work on an Integrated Risk Management Plan and the potential implications for the scheme of the possible changes to how RPI is calculated
Background

1 The GMC has a defined benefit (DB) pension scheme that closed to the future accrual of benefits in April 2018. The scheme is managed by a Board of Trustees independently of Council. The primary duty of Trustees is to ensure the scheme pays the benefits that the employer has promised.

2 Every three years the scheme is subject to a valuation process that assesses the schemes assets against these pension promises, known as Technical Provisions. This process informs the long-term funding position of the scheme. The assessment of the scheme’s assets is straightforward. Determining the liabilities is more complex. To do this, the scheme must make assumptions about future salary growth and turnover for current GMC staff with accrued benefits linked to final salary, future Consumer Price Inflation (CPI) and life expectancy. There also needs to be an assessment of the extent to which future investment growth will help to meet pension liabilities.

3 The valuation process needs to be agreed by the Trustees and the employer as sponsor by the end of March 2020.

4 If the valuation process produces a deficit, as it has for 2018, both parties are required by law to agree a recovery plan. This plan sets out how the deficit is to be closed over an agreed period of time. This process is governed by the Pension Regulator’s (tPR) guidance. In very general terms the regulator would expect to see recovery plans of less than seven years for ‘strong’ employers. The strength of an employer is its ability to meet future funding requirements and respond to any changes in circumstances. This is assessed through a covenant review process. For the 2018 valuation this was undertaken for Trustees by Ernst and Young (previously this had been an internal assessment undertaken by the Trustees).

5 They assessed the covenant as ‘tending to strong’ which is the second highest of four assessment levels. The covenant has previously been assessed as ‘strong’ and this rating principally reflects the increasing size of the pension scheme relative to the GMC and the planned reduction in GMC reserves.

The 2018 Valuation

6 The 2018 valuation assessed the liabilities and assets as of 31 December 2018. The summary valuation report document is at Annex A. This sets out the valuations assumptions that Council is asked to agree.

7 The Chief Operating Officer’s report to Council in June provided an update on the process and initial valuation results showing scheme assets at £230.2m, liabilities at £248m and a deficit of £17.8m. These were based on the Trustees’ initial proposed assumptions, prior to discussions with the employer.
As reported in June the two main changes since 2015 have been:

a. A slowing in the assumed improvement in life expectancy having a positive impact in the scheme’s funding position and;

b. A significant shift to retiring scheme members selecting a pension only option and not taking a tax-free lump sum. This has had a negative impact on the scheme’s funding position as the pension only option represents the highest expected cost of the options available.

Following discussions with the Trustees, and based on our advisers’ input, we have agreed assumptions on future CPI increases, the discount rate and future mortality, which are the key assumptions in calculating the value of the Scheme's liabilities.

The main change since the initial results were produced results from our agreement with the Trustees that there will be a reduction in the assumptions about future salary increases. This impacts on our assessment of the liabilities for existing staff with final salary service in the scheme. This has been justified based on our expectations around future pay growth and that (proportionately) increases are likely to be skewed towards newer employees with no Scheme membership. We have agreed this on the basis that we will address any negative impact if salary increases go beyond the agreed assumptions.

The impact of adopting all these assumptions, which are agreed by both sets of advisers, would see the value placed on the Scheme's liabilities reduce to £242m and leave a deficit of around £12m.

Recovery Plan and Long Term Funding

The long term aim of the Scheme’s trustees is to reach self-sufficiency. This is the point that no further financial contributions from the employer are expected to be required. After this point the Trustees would then seek to reach a ‘buy-out’ position where the scheme’s liabilities would be met through the purchase of annuities. At this point, the risks to the Council related to running a scheme are extinguished. In February 2018, Council confirmed that it was comfortable with an indicative 10-year period for moving to self-sufficiency, but not yet a formal commitment to this as a definitive target.

In agreeing this, Council confirmed its wish to use the 2018 valuation to inform future funding arrangements. To take this forward, a series of discussions have taken place with a sub-group of Trustees and the Chief Executive, with both parties advised independently. One outcome of this is that the Technical Provisions basis is now structured in such a way that it will evolve towards a self-sufficiency basis over a 10-year period.
14 Assuming Council is comfortable with the draft valuation then the next stage of the process is to agree a Recovery Plan. This is a statutory requirement. The length of a plan is subject to tPR guidance, but within this there is scope for the parties to discuss and consider options.

15 While there must be a plan for the deficit to be closed, the balance between how much of this deficit is expected to be closed by cash contributions (from the employer) and how much is expected to be from anticipated future investment growth needs to be agreed. Having a longer-term plan is helpful as it allows us to see if experience improves the position, meaning that the contribution adjustments needed are not as great.

16 As part of the valuation process an assumption on investment growth (2.3% above gilt yields) has been provisionally agreed. As the expected returns on the asset portfolio are 2.8% p.a. above gilts, the assumption used contains a margin for prudence.

17 The proposed employer cash contribution to close the deficit is £1.3m per year for 6 years, starting in 2020. This replaces, and is not in addition to, the £0.5m previously agreed by Council for 2020 and 2021. However, these payments are in addition to the £1.9m already committed and paid in 2019. This means that a total of £9.7m in cash contributions would be committed, versus the initial deficit of £11.6m.

18 If Council agrees this proposal the Chief Executive will sign off the finalised valuation process with Trustees. This is documented through a formal recovery plan, schedule of contributions and an updated statement of funding principles.

Risk Management and Contingency Planning

19 Once the valuation process is concluded Trustees will be reviewing their overall strategy for managing risk. We expect to update Council on this during 2020. Trustees will also want to develop and, ideally, agree a contingency plan with the employer covering how we might respond to sudden negative events affecting the scheme’s funding position. We will ensure that Council receives appropriate advice at the relevant stages of this work and prior to agreeing any approach.

20 The main risk issue Trustees are currently considering relates to the potential impact changes in the calculation of Retail Prices Index (RPI) could have. The scheme’s liabilities moved from being linked to RPI to Consumer Prices Index (CPI) in 2011. This had a very positive impact in the scheme and reduced liabilities by around £30m because it reduced annual uplifts in pensions (in payment and deferment).

21 The challenge for the scheme is that it can only, and does, hedge its CPI risks through RPI linked products. This is mainly because suitable CPI linked products have
not been available. A recent House of Lords report cast doubt on how RPI is calculated. If changes are made it could see a shift in the gap between CPI and RPI (and a negative funding impact).

22 The position on this is uncertain. More options to hedge CPI are emerging and Trustees will need to consider the benefits alongside the costs of making changes. No action is required from Council but as part of the valuation process and looking at future risk Trustees wanted to advise that this issue is likely to be part of the longer-term risk management approach.

23 The Trustees and employer are also considering ways to enhance the options available to members at retirement, with a view to helping members and using this to manage the size of the risks building up in the Scheme.

Conclusion

24 The valuation process is complex. A range of assumptions relating to the long term on areas such as life expectancy and inflation need to be considered. These then need to be agreed by both parties alongside a future funding plan.

25 To facilitate this there have been meetings between both the employer and trustees, supported by extensive expert advice. The Chair of Council has been updated on the process and the proposals here reflect the agreement both parties hope to reach.
Valuation results

The formal actuarial valuation as at 31 December 2018 can be summarised as follows:

Funding level
- The Scheme's assets were £230.2M and the liabilities (“technical provisions”) were £241.8M.
- This corresponds to a deficit of £11.6M, and a funding level of 95.2%.

Reasons for change since the last valuation
- More members have been taking the (more costly) pension-only option and it is has been assumed this will continue in future. This has increased the liabilities.
- Allowing for latest mortality data and trends (improvements in life expectancy slowing down) has reduced the liabilities.
- The absolute size of the liabilities has increased significantly since the last valuation due to interest rates falling which has led to an expectation of future investment returns being lower in the future. The Trustees' approach to hedging both interest rates and inflation has significantly protected the Scheme and seen the assets also increase significantly since the 2015 valuation.
- The Trustee and Employer agreed a long-term target of Gilts+0.25% p.a. by 31 December 2028 and the discount rate approach was changed to be consistent with this.
- The Trustees agreed to reflect the Employer's view that future salary increases would be lower than previously assumed.

Technical Provisions - key assumptions
- Discount rate of Gilts+2% p.a. up to 31 December 2028 and then Gilts+0.25% p.a. thereafter.
- Salary increases in line with CPI+1% p.a. (plus promotional increases).
- 75% of members assumed to take the pension-only option, 25% of members take the highest tax-free lump sum option.

Recovery plan
The 11.6M deficit would be removed over a 7-year recovery plan with assumed investment returns of Gilts+2.3% p.a. and additional lump sum contributions as follows:
- £1.9M (already paid in 2019);
- £1.3M payable in each year of 2020, 2021, 2022, 2023, 2024 and 2025.

Regular contributions
In addition to the lump sum recovery plan contributions, the Employer needs to continue paying contributions for the following:
- The expenses of administering the Scheme.
- Levy payments to the Pension Protection Fund and other regulatory bodies.
- The cost of any augmentations to benefits.
Valuation results

The 2018 valuation results are shown below alongside the results from the previous valuation and the illustrative results if no changes had been made to the assumptions except allowing for updated market conditions.

<table>
<thead>
<tr>
<th>Value of past service benefits for:</th>
<th>Previous (2015) valuation results (£M)</th>
<th>Previous valuation assumptions updated for 2018 market conditions and 2018 membership data (£M)</th>
<th>2018 valuation results (£M)</th>
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</thead>
<tbody>
<tr>
<td>Actives / Employed members</td>
<td>85.7</td>
<td>114.5</td>
<td>121.6</td>
</tr>
<tr>
<td>Deferreds</td>
<td>52.6</td>
<td>84.6</td>
<td>86.7</td>
</tr>
<tr>
<td>Pensioners</td>
<td>26.2</td>
<td>42.4</td>
<td>33.4</td>
</tr>
<tr>
<td>Value of liabilities</td>
<td>164.5</td>
<td>241.5</td>
<td>241.8</td>
</tr>
<tr>
<td>Value of assets</td>
<td>165.1</td>
<td>230.2</td>
<td>230.2</td>
</tr>
<tr>
<td>Past service surplus/deficit</td>
<td>0.6</td>
<td>(11.3)</td>
<td>(11.6)</td>
</tr>
<tr>
<td>Funding ratio</td>
<td>100.4%</td>
<td>95.3%</td>
<td>95.2%</td>
</tr>
</tbody>
</table>
**Agenda item:** M8  
**Report title:** Update on the Staff Survey  
**Report by:** Andrew Bratt, Assistant Director - HR, Andrew.bratt@gmc-uk.org, 0161 923 6215  
**Action:** To note

### Executive Summary
The 2019 Staff Survey shows a slight increase in the level of employee engagement since 2018.

The Survey results continue to provide positive feedback on the GMC as a place to work while helping identify priority areas for further work.

### Recommendation
Council is asked to note the Staff Survey findings and the related ongoing work programmes.
**Issue**

1. The Staff Survey provides a detailed analysis into key aspects of our performance as an employer helping us identify areas of strong performance along with opportunities for improvement.

**Overview**

2. We are now operating on an annual cycle for surveys to help us better track our performance and assess the impact of the work we have undertaken.

3. The 2019 survey is the first with a new provider (BMG) but retains the ability to track our performance from previous surveys and benchmark externally. We have retained significant capacity to analyse employee views across the GMC and by individual directorates and teams (subject to sufficient responses to preserve anonymity). We can also analyse the results by location and diversity strand. The survey results are summarised in annex A.

4. With a participation rate of 89% (up 3% on last year) the survey is a comprehensive and representative view of our employee’s opinions.

5. Overall the results show some areas of improvement on last year’s survey as well as some themes that require further work. Our 2018 survey produced an engagement score of 72/100 and we saw an increase to 73 this year.

6. The survey contains 42 questions we can track and 12 showed an improvement while 18 showed a decline. The areas that have seen the greatest improvement are opportunities to work in other parts of the GMC; personal development planning; employee benefits; feeling valued; and line managers keeping colleagues up to date. The main areas of decline were confidence around raising issues; new projects and initiatives being thought through and; our values being at the centre of what we do.

7. Methods of measuring engagement vary between employers. Around 50% of UK employers report good or very good levels of employee engagement (source Xpert HR). Employee engagement tends to be higher in smaller organisations (under 1000 employees). We benchmark well where we can identify direct comparators. For example, the Civil Service (an engagement score of 62%), the Care Quality Commissions (61%); Local Government and Social Care Ombudsman (67%) and the Parliamentary and Health Service Ombudsman (67%).

8. Our results compared with public sector bodies remains very good. Of the 25 comparable questions 20 are significantly above the survey provider’s public-sector benchmark. The most positive are recommending the GMC as an employer; developing your career; developing new skills and; pride on working for the GMC.
9  Working hours and engaging with staff opinions and ideas are significantly below the public-sector benchmark.

**Next Steps**

10  Directorates and teams also have tailored reports to support their work on the most important issues in their own areas.

11  In 2018 we reported on an extensive programme of work (Empowering and Developing our Staff) that related closely to last year’s survey results. The 2019 survey shows some good progress in these areas and we have a range of work that relates to the staff survey in our plans.

12  There are some issues where there is feedback we need to respond positively to. We have identified three themes that have the scope to cover the areas we want to achieve progress on and further improve levels of employee engagement. Each is led by a Director who will ensure we develop a programme of work and coordinate existing activity covering each of the following themes:

   a  Workloads and working hours (Anthony Omo)

   b  Openness, inclusion and transparency (Paul Reynolds)

   c  Change management (Neil Roberts)
M8 – Update on the Staff Survey

GMC 2019 Staff Survey - Top Lines Report
Background

1. BMG Research were commissioned in late 2018 to complete the General Medical Council (GMC) staff survey in 2019. For the survey, BMG met with representatives from the GMC to gain greater knowledge of the organisation and the objectives of the staff survey. The previous questionnaire was used to maintain comparability but was updated to reflect any changes, and to make the questions more specific. The latest 2019 survey was carried out by means of a self-completion online survey sent to all staff by email.

2. The following report provides a summary of the key findings derived from the survey undertaken during April/May 2019, including, where possible, benchmarking with other similar organisations, comparisons with 2018 and 2017 (where possible), and an exploration of variations across different employee groups and areas of the organisation.

3. All staff were given the opportunity to complete a survey. A total of 1,158 responses were received, giving a response rate of 89%, which was up 3% from the 2018 staff survey.

Summary

4. There is a lot for the GMC to be proud of in these survey results. There have been some clear improvements in staff perceptions on a number of areas since 2018, demonstrating how the GMC continues to progress on its journey. The 2019 results show a pattern of stability, maintaining levels of positivity (which is no mean feat) and continued improvement in key areas, however there is also a level of deterioration. Of the 42 comparable questions also asked in 2018, 12 have remained stable and 12 have improved significantly, whilst 18 measures that have significantly deteriorated.

5. In addition to this positive progress in some areas, the GMC continues to perform well compared to its peers. Comparison of the survey results against the BMG Public Sector benchmarks sees 20 of the 25 benchmarked questions scoring significantly more positively, and just 2 see the GMC scoring less positively. In fact, the positive differences reach as high as 27% points (staff advocacy).

6. Employee Engagement has remained stable with a score of 73 compared to 72 in 2018.

7. From a directorate perspective, it is staff in the Corporate directorate and Registration and Revalidation that are overall the most positive, with the highest engagement scores (78 and 80 respectively). However, staff in Education and Standards, Strategic Comms and Engagement and Fitness to Practise are generally the least positive about working at the GMC.
Another directorate that has something to celebrate is MPTS, where clear gains have been made in positivity. In particular, job satisfaction has risen by 16% points.

The level of job satisfaction has significantly increased at a total level, from 78% in 2018 to 82% in 2018, but has not quite recovered to the 2017 score (84%). It is also above the BMG average by 13% points.

In many cases it feels like positive scores dropped in 2018 and now in 2019 they are beginning to recover back to previous levels. For instance, some measures that feed into engagement follow this pattern (pride, recommendation, commitment as well job satisfaction as just described).

However, the intention to be working for the GMC in 12 months’ time is slowly trending downwards, from 78% in 2017 down to 75% in 2019.

Line management is a clear strength at the GMC and is in the top three highest scoring survey themes and all positive scores are around eight in ten and above. Where comparable, scores are above the BMG benchmark and results are mostly stable since 2018 with some notable improvements. One watch out is on managers involving staff in decisions that affect the way they work which has seen a decline since 2018 (-2% points).

The biggest increase from the 2018 survey is in terms of the GMC providing opportunities to working in different parts of the organisation, which has increased by 16% points and is now in fact 30% points higher than in 2017, showing that the effort put into this area has really paid dividends. Talent development, an area struggled by many is also a section where the positive differences to the BMG benchmark are vast, with career development 25% points above the benchmark.

On the flip side, the largest negative difference compared to 2018 is staff feeling confident that they can raise an issue with the organisation without it being held against them, which has decreased by 21% points (question wording has changed slightly since 2018). Looking further at the theme of fairness and transparency, there is a trend of decreases, as four out of the five measures that can be compared have significantly declined from 2018 to 2019. The three further measures to decrease since 2018 are staff feeling that sexual harassment is not an issue (-4% points), and that discrimination (-5% points) and bullying (-4% points) is not an issue. However, it should be noted that the positivity of these questions is high, 90%, 80% and 79% respectively and the overall theme is the fifth highest out of twelve themes in the survey.

The lowest scoring theme in the survey is ‘Managing Change’, which is not uncommon in staff surveys. However, the second largest negative change compared to 2018 is that new projects and initiatives affecting the whole organisation are well thought out before they are implemented, which has decreased by 10% points to 31% (question
wording has changed slightly since 2018). Moreover, the proportion that actively disagrees with this now outweighs positivity (42%). Further perceptions of change have significantly decreased, at an overall organisation change management perspective (-4% points) and at a directorate level (-8% points). The overall positive score at a directorate level being lowest amongst staff in Strategic Comms and Engagement and Education and Standards.

16 The second lowest scoring theme is Senior Management, again this is not uncommon, as we tend to see a large proportion of staff that state they neither agree nor disagree, most likely a result of awareness of some of the things that Senior Management do being low, therefore not being able to give a directional response. Further to this, four out of the five measures that can be compared to the BMG benchmark are significantly above, particularly in terms of staff believing that action will be taken on the feedback from this survey (+13% points). However, it should be noted that the two measures that can be tracked to 2018 have both significantly decreased. Perhaps most importantly staff’s views that they are confident in the way that senior Management are leading the GMC (-6% points).

17 A further area that is clearly a pinch point for GMC is staff needing to work additional hours to get their job done, only 40% agree with this (down from 42%), but 48% actively disagree. It is also 20% points lower than the BMG benchmark. This stretch is most felt amongst staff in Strategic Comms and Engagement (29%) and Fitness to Practise (35%).

18 Perceptions around the GMC’s strategy and values peaked during the 2018 launch but have now tapered off as activity surrounding these has died down. The largest drop is from 2018 is in relation to values being at the heart of the way staff work (-7% points), with over two thirds that agree (67%) and is now 1% below 2017. Staff are also less likely to agree they understand the GMC’s overall corporate strategy (-3% points) and that they understand how their priorities align to the overall corporate strategy (-4% points).

19 Finally, the proportion of staff that are satisfied with their overall benefits and that feel they are paid fairly have both significantly increased since 2018 (+7% points and +2% points respectively). Additionally, these measures are both significantly above the BMG benchmark (+15% points and +16% points respectively).
What the GMC is doing well

20 A clear strength within the GMC is line management. Around nine in ten staff agree that their manager treats them with respect and fairness (92%) and that their manager cares for their health and wellbeing (89%). In the case of the former, this is significantly above the BMG public sector benchmark [1] of 81% (+11% points). Further to that, nine in ten staff (91%) agree that they are committed to achieving high standards and that they work with others to support safe, high-quality care (89%). Whilst nine in ten (90%) staff agree that sexual harassment is not an issue, this has significantly decreased since 2018 (-4% points). This will be explored in more detail further in the report.

<table>
<thead>
<tr>
<th>% positive score (i.e. strongly agree/agree)</th>
<th>2018 Survey</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>• My manager treats me with respect and fairness</td>
<td>92%</td>
<td>81%</td>
</tr>
<tr>
<td>• The GMC is committed to achieving high standards</td>
<td>91%</td>
<td></td>
</tr>
<tr>
<td>• There is helpful and effective co-operation between Staff in your team</td>
<td>91%</td>
<td></td>
</tr>
<tr>
<td>• Sexual harassment is not an issue where I work</td>
<td>90%</td>
<td>94%</td>
</tr>
<tr>
<td>• We work with others to support safe, high-quality care</td>
<td>89%</td>
<td></td>
</tr>
<tr>
<td>• Your manager cares about your health and wellbeing</td>
<td>89%</td>
<td></td>
</tr>
</tbody>
</table>

[1] Benchmark
What could the GMC be doing better?

21 In terms of the lowest scoring indicators in the survey, approaching one third (31%) of staff agree that new projects and initiatives affecting the whole organisation are well thought out before they are implemented, with 42% that actively disagree with this. This has also significantly decreased since 2018, by 10% points (although a slight change in question wording). Furthermore, Senior Management is a low scoring area, with just 39% that agree they welcome ideas and opinions, 43% that agree they are good at explaining the reasons why decisions are made (down 6% points from 2018) and 44% that agree they are role models for the organisation’s values. However, in the case of the latter two, both are significantly above the BMG benchmark (+4% points and +9% points respectively). Finally, only 40% of staff agree that they do not need to work additional hours to get the job done, with 48% that actively disagree with this. This has decreased by 2% points from 2018, and down 9% points from 2017 and also sits significantly below the BMG benchmark.

<table>
<thead>
<tr>
<th>% positive score (i.e. strongly agree/agree)</th>
<th>2018 Survey</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>31%  • New projects and initiatives affecting the whole organisation are well thought out before they are implemented</td>
<td>41%</td>
<td></td>
</tr>
<tr>
<td>39%  • Senior Management welcome my ideas and opinions</td>
<td>42%</td>
<td>43%</td>
</tr>
<tr>
<td>40%  • I do not need to work additional hours to get my job done</td>
<td>42%</td>
<td>60%</td>
</tr>
<tr>
<td>43%  • Senior Management are good at explaining the reasons why decisions are made</td>
<td>49%</td>
<td>39%</td>
</tr>
<tr>
<td>44%  • Senior Management are role models for the organisation’s values</td>
<td>42%</td>
<td>35%</td>
</tr>
</tbody>
</table>
Benchmarking

22 Benchmarking is a useful technique to effectively place the 2019 staff survey results into context with other similar organisations. BMG Research maintains a database of results from organisations they have worked with over a number of years. The benchmark used for this analysis is made up of over 100 UK wide public sector organisations. This benchmark has been used as a comparison throughout the report. In total, comparison was possible for 25 questions contained within the 2019 survey. Amongst these, the majority (20) are significantly above the BMG benchmark, 3 are in line and just 2 fall below average.

The chart over the page shows the top 14 questions that significantly exceed the BMG public sector benchmark. As is shown below, some of the positive differences are very large, highlighting the positive position the GMC sits in comparisons to other similar organisations. The largest positive variance to the BMG benchmark is that staff would recommend working for the GMC, which is 27% points higher than the BMG benchmark. Furthermore, elements of training and development are highlighted, with staff at the GMC much more likely to agree they have the opportunity to develop their career (+25% points), have opportunities to develop new skills (+24% points) and believe the GMC positively encourages training and development (+20% points) compared to the benchmark.
I would recommend working for the GMC: 87% (+27)
I have the opportunity to develop my career at the GMC: 65% (+25)
I have opportunities to develop new skills: 78% (+24)
I am proud to say that I work for the GMC: 87% (+21)
I believe the GMC positively encourages training and development: 80% (+20)
I have the tools / equipment I need to do my job effectively: 82% (+19)
The GMC has an open and honest culture: 57% (+17)
My manager gives me regular feedback on my performance: 80% (+16)
I am paid fairly for the job that I do compared with the amount I could earn elsewhere for a similar role: 57% (+16)
I am satisfied with the overall benefits package provided by the GMC: 72% (+15)
I have access to the training and development I need to do my job: 78% (+14)
I believe that action will be taken on the feedback from this survey: 54% (+13)
I feel valued as a member of staff at the GMC: 66% (+13)
Job satisfaction: 82% (+13)
24 As mentioned previously, only 2 questions are significantly below the BMG benchmark. The largest negative difference to the BMG benchmark is the number of staff who feel they do not need to work additional hours to get the job done (-20% points). Clearly an area for further investigation.

Employee Engagement

25 How the employee engagement index is calculated: For each of the six questions in the table below, counts are ran on those that answered either strongly agree or agree, before generating a total count for all six questions.

26 A weighting is then applied, five for strongly agree and four for agree, these are then added together before being divided by the sample, which has also been multiplied by five. A summary of this formula is:

\[
\frac{(\text{Agree Strongly Count} \times 5) + (\text{Agree Count} \times 4)}{(\text{Total Population} \times 5)}
\]

27 This creates a value between 0 and 6, this is then used to calculate its proportion to the maximum possible value (6), and this proportion is the index score. For example, a value of 5.2 out of 6, equates to an index score of 86.7.

28 Staff are also segmented into one of three states of engagement: engaged, passive, or disengaged, using the six engagement questions below. The explanations for each of the classifications are:

a Engaged – respondents must have selected ‘Agree’ or ‘Agree strongly’ to all questions

b Passive - respondents must have selected ‘Disagree’, ‘Disagree strongly’, or ‘Neither/nor’ to at least one question and ‘Agree’ or ‘Agree strongly’ to at least one question

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**Agenda item M8 – Update on the Staff Survey**

Disengaged – respondents must have selected ‘Disagree’, ‘Disagree strongly’, or ‘Neither/nor’ to all questions

### Table 1: Engagement measures

<table>
<thead>
<tr>
<th>Q no.</th>
<th>Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1/1</td>
<td>I am proud to say that I work for the GMC</td>
</tr>
<tr>
<td>Q1/2</td>
<td>I would recommend working for the GMC</td>
</tr>
<tr>
<td>Q1/3</td>
<td>I speak positively about the services that the GMC provides</td>
</tr>
<tr>
<td>Q1/5</td>
<td>I am committed to going the extra mile for the GMC</td>
</tr>
<tr>
<td>Q2/5</td>
<td>I intend to be working for the GMC in 12 months’ time</td>
</tr>
<tr>
<td>Q24</td>
<td>Job Satisfaction</td>
</tr>
</tbody>
</table>

### Employee Engagement

The following Figure presents the engagement scores for overall GMC and each directorate. At 73, the engagement score is similar to levels in 2018 (72). The highest performing directorate is Registration and Revalidation (80), which has also increased since 2018 (+6), along with staff in the Corporate Directorate (+6) and MPTS (+8).

The lowest performing directorates in terms of engagement are Strategic Comms and Engagement and Education and Standards.

### Figure 7: Employee engagement index scores

<table>
<thead>
<tr>
<th></th>
<th>2019</th>
<th>2018</th>
<th>% change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>73</td>
<td>72</td>
<td>+1</td>
</tr>
<tr>
<td>Registration and Revalidation</td>
<td>80</td>
<td>74</td>
<td>+6</td>
</tr>
<tr>
<td>Corporate Directorate</td>
<td>78</td>
<td>72</td>
<td>+6</td>
</tr>
<tr>
<td>Resources</td>
<td>75</td>
<td>73</td>
<td>+2</td>
</tr>
<tr>
<td>Strategy and Policy</td>
<td>74</td>
<td>75</td>
<td>-1</td>
</tr>
<tr>
<td>Fitness to Practise</td>
<td>72</td>
<td>73</td>
<td>-1</td>
</tr>
<tr>
<td>MPTS</td>
<td>72</td>
<td>64</td>
<td>+8</td>
</tr>
<tr>
<td>Strategic Communications &amp; Engagement</td>
<td>68</td>
<td>67</td>
<td>+1</td>
</tr>
<tr>
<td>Education and Standards</td>
<td>67</td>
<td>70</td>
<td>-3</td>
</tr>
</tbody>
</table>
The majority of staff are engaged (59%), with only 2% disengaged. This is an improvement on 2018 when 42% of staff were engaged, 53% passive, and 6% disengaged.

Staff survey results

The following tables show the results for each question under each section of the 2019 staff survey. Each question shows the percentage for Agree responses (agree strongly or agree), neither Agree or Disagree, and Disagree (disagree strongly and disagree).
The way we work

At the GMC there is a culture which encourages (please say any that apply):

- Giving and receiving regular feedback
- Good internal customer service
- Good leadership
- Recognition of achievement
- Two-way feedback on written communication
- Inclusivity
- Accountability
- Collaboration
- Empowerment
- Innovative ideas

Working together

- I feel I am respected by the people I directly work with: Agree: 87%, Neither: 6%, Disagree: 5%
- My directorate has the resources to do a good job: Agree: 64%, Neither: 14%, Disagree: 21%
- There is helpful and effective co-operation between Staff in your team: Agree: 94%, Neither: 6%, Disagree: 5%
- There is helpful and effective co-operation between Teams within your directorate: Agree: 70%, Neither: 16%, Disagree: 14%
- There is helpful and effective co-operation between Your directorate and other directorates: Agree: 53%, Neither: 27%, Disagree: 21%
- The GMC listens to organisations we work with, but remains independent: Agree: 78%, Neither: 17%, Disagree: 5%
Sharing information

- How information is cascaded through the GMC is working well for me:
  - Agree: 64%
  - Neither: 20%
  - Disagree: 16%

- My line manager keeps me up to date on my area of work:
  - Agree: 80%
  - Neither: 7%
  - Disagree: 5%

- When important decisions are made at the GMC, my manager explains to me the reasons why they have been made:
  - Agree: 63%
  - Neither: 21%
  - Disagree: 16%

- I am encouraged to put forward ideas for improving the way things are done:
  - Agree: 78%
  - Neither: 12%
  - Disagree: 9%

- I feel that my views and ideas are listened to:
  - Agree: 67%
  - Neither: 19%
  - Disagree: 14%

Leadership and management

- I am confident in the way that Senior Management are leading the GMC:
  - Agree: 57%
  - Neither: 27%
  - Disagree: 10%

- Senior Management welcome my ideas and opinions:
  - Agree: 39%
  - Neither: 42%
  - Disagree: 19%

- I feel confident to talk to Senior Management:
  - Agree: 55%
  - Neither: 22%
  - Disagree: 23%

- Senior Management are approachable:
  - Agree: 57%
  - Neither: 21%
  - Disagree: 22%

- Senior Management make time for staff:
  - Agree: 59%
  - Neither: 29%
  - Disagree: 21%

- Senior Management listen to the views of staff:
  - Agree: 47%
  - Neither: 34%
  - Disagree: 19%

- I believe that action will be taken on the feedback from this survey:
  - Agree: 54%
  - Neither: 25%
  - Disagree: 21%

- Senior Management are good at explaining the reasons for why decisions are made:
  - Agree: 47%
  - Neither: 27%
  - Disagree: 26%

- Senior Management are role models for the organisation's values:
  - Agree: 64%
  - Neither: 31%
  - Disagree: 18%

- Senior Management have communicated a clear vision of what the GMC is trying to achieve:
  - Agree: 55%
  - Neither: 26%
  - Disagree: 16%

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Managing change

- Changes to the overall organisation are managed well: 45% Agree, 32% Neither, 23% Disagree
- Changes at a local level within my Directorate are managed well: 35% Agree, 23% Neither, 20% Disagree
- New projects and initiatives affecting the whole organisation are well thought out before they are implemented: 31% Agree, 27% Neither, 42% Disagree
- I feel I have had the opportunity to contribute to changes that affect my job: 53% Agree, 25% Neither, 22% Disagree

Fairness and transparency

- The GMC provides an inclusive environment for people from all backgrounds: 84% Agree, 10% Neither, 6% Disagree
- I am confident that I can raise an issue with the organisation without it being held against me: 55% Agree, 26% Neither, 19% Disagree
- Bullying is not an issue where I work: 79% Agree, 11% Neither, 10% Disagree
- Sexual harassment is not an issue where I work: 90% Agree, 6% Neither, 2% Disagree
- Discrimination is not an issue where I work: 80% Agree, 12% Neither, 8% Disagree

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**Being at work**

- **Your manager cares about your health and wellbeing**: 89% Agree, 5% Neither, 4% Disagree
- **Senior Management cares about your health and wellbeing**: 36% Agree, 28% Neither, 15% Disagree
- **I feel comfortable discussing my health and wellbeing with my manager**: 81% Agree, 8% Neither, 10% Disagree
- **I am paid fairly for the job that I do compared with the amount I could earn elsewhere for a similar role**: 57% Agree, 14% Neither, 29% Disagree
- **I am satisfied with the overall benefits package provided by the GMC**: 72% Agree, 16% Neither, 12% Disagree

**Overall**

- **Satisfied with Job**: 82 Satisfied, 10 Neither, 9 Dissatisfied

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Agenda item: M10

Report title: Annual report of GMC Group Personal Pension Plan governance

Report by: Samuel Delaney-Curtis, Corporate Governance Manager, Corporate Directorate, samuel.delaney-curtis@gmc-uk.org, 0161 923 6741

Action: To note

Executive summary
This report summarises the work of the GMC Group Personal Pension Plan Management Board undertaken during 2019. This includes the regular monitoring of investment performance and administration, considering the impact of legislative changes, work to develop alternative Default Investment Options for the GMC Group Personal Pension Plan in response to legislative changes, work to develop an ethical investment fund option, member engagement and the issuing of communications to members.

Recommendation
Council is asked to note the 2019 report for GMC Group Personal Pension Plan Management Board.
**Background**

1. The GMC Group Personal Pension Plan Management Board is an advisory forum which monitors and reviews the operation of the GMC Group Personal Pension Plan provided by Aviva to GMC staff on a 'defined contribution' (DC) basis. This arrangement differs materially from the Trust based, Defined Benefit (DB) Scheme governance arrangements. As a Group Personal Pension Scheme is not Trust based it does not create liabilities for the GMC in the same way a defined benefit scheme does.

2. The Board is due to have met three times during 2019, 14 February, 13 June and 10 October. At each meeting the Board receives advice from the GMC’s pension advisers, Aon.

3. The Board comprises four employer nominated members and four Plan member nominated members, and is chaired by the Director of Resources. Changes in membership during 2019 included the appointment of two employee-nominated Board members - Aidan Kielty and Nathan Fountain-Tucker.

4. A new employer-nominated Board member is in the process of being appointed and is expected to be in post by the end of 2019.

**Monitoring the investment performance and administration of the GMC Group Personal Pension Plan**

5. The Board receives regular updates on Aviva’s investment performance and administration, including advice from Aon on its assessment of Aviva’s performance. Investment performance has been within expectations and no concerns have been raised by Plan members regarding the administration service. An established monthly procedure is also in place to meet the GMC’s auto enrolment requirements.

6. Aviva has continued to offer a competitive annual management charge of 0.33% for the default options.

7. The Plan’s Default Investment Option (DIO) has previously been designed on the assumption that members would use at least 75% of their pension pot to purchase an annuity. However, under changes announced in the 2014 and 2015 budgets, defined contribution pension scheme members now have greater flexibility in how they access their benefits at retirement.

8. It was originally intended that the new DIO would be implemented from 30 November 2017. However, Aviva later notified the Committee that the proposed change to the new DIO required a change to terms and conditions and had therefore delayed the implementation, resulting in delaying the switch to the new DIO until early 2019.
9 Aviva agreed to notify plan members and invite them to transfer to the new default investment option. Aviva committed that scheme members’ accounts would be adjusted so that they would not be at a financial disadvantage as a result of the delayed transfer.

10 A deadline of 3 December 2018 was set and members were reminded about the transfer option which was taken up by 61% of scheme members. The members who did not respond were moved the new scheme after a 90 day consultation.

11 As at 30 April 2019 the number of active members of the DC scheme was 1302. At 3 May 2019 the total value of scheme members’ assets under management was £17,093,048.22.

12 At the Board’s meeting on 13 June 2019, it was noted that Aon reported that with Aviva’s management of all of the investment funds as they have been performing in line with benchmarks.

13 Due to low usage, Aviva decided to stop offering the microsite service, a mini version of the Aviva website which is just for GMC staff, and instead focus on the ‘MyAviva’ app which offers more functions and a detailed breakdown of the user’s pension in real time.

14 In response to staff feedback an ethical investment fund option has been developed.

Communications and Member Engagement

15 Member engagement between GMC staff and Aviva continues to remain low, while this is typical for pension savings in general the Board wants to encourage members to understand their pensions. A communications schedule has been agreed by the board which will include further seminars, newsletters and drop in sessions.

16 The Board will be fully engaged in this and are planning a range of events to raise awareness of the benefits of the GMC’s pension scheme in the final quarter of 2019.

Risk Register

17 The Board has monitors the Risk Register at each meeting to provide an overview of the risks associated with running the GMC Group Personal Pension Plan and the mitigation measures in place or required. The Risk Register will continue to be developed and regularly monitored by the Board.

Keeping up to date with legislative change

18 The Board receives updates at each meeting from Aon on legislative changes effecting DC pension schemes.

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Executive summary
On 21 June 2019, the Professional Standards Authority (PSA) published our Annual Review of Performance for 2017/18 covering the period 1 September 2017 to 31 August 2018. The report finds that we met all 24 of the PSA’s Standards of Good Regulation. We are one of only two regulators that have been assessed as meeting all Standards, every year, since the current process was introduced in 2012. The review considered changes to our policies and guidance since the last review, performance data on timeliness of our processes, our response to recommendations from the Williams Review, and a more detailed investigation against the FtP standards including an audit of our provisional enquiries process.

From 2019/20 the PSA will be assessing performance against a revised set of Standards of Good Regulation. The GMC has engaged in the PSA’s consultations on, and early pilots of, the new Standards.

Recommendations
Council is recommended to note:

a. The PSA’s report on our performance for the 2017/18 performance review period, which concludes that we met all 24 of the Standards of Good Regulation.

b. The PSA’s proposals to introduce a revised set of Standards for the 2019/20 performance review cycle.
The PSA’s Annual Review of GMC Performance 2017/18

Background

1. The PSA for Health and Social Care is an independent body, accountable to the UK Parliament. It oversees the work of the GMC, and the other eight statutory bodies that regulate health professionals in the UK and social workers in England. As part of their work to review regulators’ performance they undertake an annual ‘performance review’ of regulators against the Standards of Good Regulation*. 

2. Together with the General Osteopathic Council (GOsC), we are one of only two regulators that have been assessed as meeting all Standards, every year, since the current process was introduced by the PSA in 2012. Four other regulators met all Standards in the 2017/18 period: the General Chiropractic Council, GOsC, General Pharmaceutical Council, and the Pharmaceutical Society of Northern Ireland. For those regulators who did not meet all Standards, the issues and concerns identified by the PSA related mainly to fitness to practise†.

2017/2018 Performance review process

3. The final report, Annual review of Performance 2017-18‡, sets out the PSA’s assessment of our performance for the period 1 September 2017 to 31 August 2018. During their initial review, the PSA considered a range of information including Council papers, policy and guidance documents, data relating to our functions including timeliness of FtP and registration processes, third party feedback, information available to the PSA through their review of final FtP decisions under the Section 29 process, and a check of the Register.

4. After considering the evidence, the PSA determined that a further ‘targeted review’ was necessary to reach a conclusion against the following FtP Standards:

   - Standard 1 - Anybody can raise a concern, including the regulator, about the fitness to practise of a registrant.

Standard 3 - Where necessary, the regulator will determine if there is a case to answer and if so, whether the registrant’s fitness to practise is impaired or, where appropriate, direct the person to another relevant organisation.

Standard 5 - The fitness to practise process is transparent, fair, and proportionate and focused on public protection.

Standard 6 – Fitness to practise cases are dealt with as quickly as possible taking into account the complexity and type of case and the conduct of both sides. Delays do not result in harm or potential harm to patients and service users. Where necessary the regulator protects the public by means of interim orders.

Standard 7 - All parties to a fitness to practise case are kept updated on the progress of their case and supported to participate effectively in the process.

Standard 8 - All fitness to practise decisions made at the initial and final stages of the process are well reasoned, consistent, protect the public and maintain confidence in the profession.

5 The targeted review considered a range of additional information relating to these Standards, including our Provisional Enquiries (PE) process. A provisional enquiry is a limited, initial enquiry at the triage stage of the FtP process to help us decide whether to close the complaint or open a full investigation. The PSA also audited closed fitness to practise cases, which included reviewing cases that were dealt with as provisional enquiries, and those closed at triage without a provisional enquiry.

6 As with previous years, we provided a significant amount of contextual briefing and further evidence in relation to FtP timeliness. This is a recurring area that the PSA raise concerns about during each review. We explained the impact of case complexity and external factors on overall case progression, and the steps we take to ensure we are being as proactive as we can.

7 As part of the targeted review process the PSA also considered the Williams Review* (published June 2018), which was a rapid policy review commissioned by the Government to look at issues in relation to gross negligence manslaughter (GNM) and professional regulation in England. We provided evidence to the PSA on our participation with the Williams review; and on our own independently-led, UK-wide review into how GNM and culpable homicide (in Scotland) are applied to medical practice, which we had commissioned in January 2018.

Findings and areas of note

Following the targeted review, the PSA concluded that the GMC had met all 24 Standards of Good Regulation.

FtP timeliness and the PE process remained areas of interest.

In our previous performance review for 2016/17*, the PSA had noted the significant impact the PE process was having on the number of cases referred for investigation; and the 2017/18 report again highlights the contribution the PE process has made to the timely resolution of FtP cases (paragraph 6.67). The audit ‘did not identify any cases where we determined that the outcome was not sufficient to protect the public’, and that the way the GMC carried out PEs was ‘consistent with its guidance, and that it applied the appropriate test in making decisions about provisional enquiries’ (paragraph 6.87).

The Williams Review report recommended that while waiting for the law to be changed to remove its power of appeal, the GMC should review its process for deciding whether to appeal. During the performance review period we confirmed to the PSA that we had reviewed and changed our processes. This includes introducing a decision-making panel, as recommended by the Williams Review; and publishing the panel’s decisions.

At the time of the performance review, we had initiated our Supporting a Profession under Pressure programme to address the issues that have been raised with us about the environments in which doctors work, and the impact of system pressures on medical practice. The focus of this work was noted by the PSA as aligning with and furthering the recommendations of the Williams Review (paragraph 6.52).

Two of the reviews we had commissioned externally, Independent review of gross negligence manslaughter and culpable homicide†, and Fair to Refer‡, have since been published. The recommendations from these reviews set out a range of detailed actions for us, employers and organisations with regulatory governance functions. Whilst we plan how best to work with others to implement these far-reaching recommendations, we continue to take forward a number of actions including work to better understand the diversity of our registrants, and research into the issues associated with support for induction. A third review to identify the factors that impact on the wellbeing of medical students and doctors across the UK is expected to

publish this Autumn. Acting on these reviews will be in the interests of both doctors, and the patients they care for.

14 Other areas the PSA highlighted in support of our meeting the standards, include:

- Guidance and Standards – our redesigned website that is accessible and easy to understand; and our collaboration with others to issue interim guidance in response to legal developments regarding withdrawing clinically assisted nutrition and hydration following sudden onset brain injury.

- Education and Training – in June 2018 we published an updated version of *Outcomes for graduates*[^1], which sets out the knowledge and skills required by all graduates from UK medical schools.

- Registration – we processed applications for registration more quickly, despite a significant increase in volumes received from International Medical Graduates (IMGs); and introduced a primary source verification (PSV) scheme to verify IMGs’ medical qualifications in June 2018.

- Fitness to Practise – we worked in collaboration with others to publish a joint protocol[^2] setting out a clearly defined mechanism for organisations with a role in the quality and safety of care provision to share information. The PSA noted they had received positive feedback from stakeholder organisations about the action the GMC has taken to support registrants who are subject to FtP cases.

### Proposals to revise the Standards of Good Regulation

15 In November 2018 the PSA’s Board agreed a revised set of Standards[^3]. The new Standards continue to measure the regulators’ four core functions, but have been reduced and rationalised from 24, to 18. They include a new set of General Standards, covering cross-cutting areas such as Equality and Diversity, and managing risk. The new Standards are also worded in a less prescriptive way, as the PSA seeks to promote more agility and flexibility amongst the regulators.

16 We contributed to the PSA’s consultation on the revised Standards to confirm our broad support of the inclusion of wider regulatory activities, such as collaboration and

risk. However, we also expressed some disappointment in relation to some areas that we believe are important to the assessment of regulators’ performance, including:

- The binary met/not met approach does not allow for a nuanced approach in describing performance, particularly in areas that may be affected by a range of factors beyond the regulators’ control, such as FtP timeliness and the constraints of the legislative framework;

- The process tends to focus on timeliness data and ‘end-point’ regulatory outcomes without due consideration of the value of broader interventions by regulators to promote good practise;

- The current Standards and process are not used to pro-actively share good practice between the professional regulators.

The PSA proposes to introduce the revised Standards for the 2019/20 performance review cycle, following early piloting. The GMC has engaged with the PSA throughout the consultation on the revised Standards and early pilots against the new Standards.

**Conclusion**

Despite consistently meeting the standards since 2012, this achievement has not come without challenges. Variability in complaint volumes, constraints of the legislative framework, and the PSA’s binary assessment of *met or not met*, which does not always allow for more nuanced consideration of case complexity relative to investigation processes, are all contributory factors that make meeting the standards highly challenging. FtP timeliness is a recurrent focus area that we anticipate will continue, until significant legislative reform is achieved.

Our 2018/19 performance review has now commenced. It is currently in the early stages, and we expect it to follow a similar timeline to previous reviews, with publication in summer 2020.
Executive summary
As a matter of best practice, members of Council (and indeed the senior management team) are asked to update their Register of Interests biannually, or whenever there is a material change. This register is published on the GMC’s website.

In order to enhance this practice and to increase awareness of each other’s interests and areas of expertise, the Register of Council Members’ Interests is included below and will be presented to Council to note on an annual basis. SMT interests continue to be published on the website, but Council members, as the Charity’s trustees, will also have their register noted by the Council.

Recommendation
Council is asked to note the Register of Members’ Interests.
The Register of Interests

1. The Register of Interests is published on the GMC website at the following address:
   
   https://www.gmc-uk.org/about/how-we-work/governance/council/council-member-register-of-interests

2. The current Register of Interests is published as follows for each Council member:

   **Dame Clare Marx (GMC Ref No: 2387293) - Chair**

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal College of Surgeons England</td>
<td>Fellow (former President)</td>
</tr>
<tr>
<td>British Orthopaedic Association</td>
<td>Honorary Fellow (former President)</td>
</tr>
<tr>
<td>Royal College of Surgeons Edinburgh</td>
<td>Fellow</td>
</tr>
<tr>
<td>Royal College of Physicians and Surgeons Glasgow</td>
<td>Honorary Fellow</td>
</tr>
<tr>
<td>Royal College of Physicians</td>
<td>Fellow</td>
</tr>
<tr>
<td>Royal College of Physicians Edinburgh</td>
<td>Fellow</td>
</tr>
<tr>
<td>Faculty of Medical Leadership and Management</td>
<td>Senior Fellow (former Chair)</td>
</tr>
<tr>
<td>Royal Australasian College of Surgeons</td>
<td>Honorary Fellow</td>
</tr>
<tr>
<td>American College of Surgeons</td>
<td>Honorary Fellow</td>
</tr>
<tr>
<td>East Suffolk and North Essex NHS Foundation Trust</td>
<td>Employee</td>
</tr>
<tr>
<td>British Palawan Trust</td>
<td>Trustee</td>
</tr>
<tr>
<td>Exeter University</td>
<td>Honorary Doctorate of Science 2017</td>
</tr>
<tr>
<td>Leeds University</td>
<td>Honorary Doctorate of Medicine 2018</td>
</tr>
<tr>
<td>Bristol University</td>
<td>Honorary Doctorate of Science 2019</td>
</tr>
<tr>
<td>Royal College of Psychiatrists</td>
<td>Honorary Fellow</td>
</tr>
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</table>

www.gmc-uk.org
**Steven Burnett**

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Position</th>
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<tbody>
<tr>
<td>Golden Charter</td>
<td>Non-Executive Director</td>
</tr>
<tr>
<td>Theatr Clwyd, North Wales</td>
<td>Voluntary Board Member</td>
</tr>
<tr>
<td>Government Internal Audit Agency</td>
<td>Chair</td>
</tr>
<tr>
<td>Institute of Actuaries</td>
<td>Fellow</td>
</tr>
<tr>
<td>GMC Services International Ltd</td>
<td>Director</td>
</tr>
<tr>
<td>GMC Pension scheme</td>
<td>Trustee</td>
</tr>
</tbody>
</table>

**Dr Shree Datta (GMC Ref No: 6076715)**

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Position</th>
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<tbody>
<tr>
<td>Hermiston Court Limited</td>
<td>Director</td>
</tr>
<tr>
<td>King’s College Hospital</td>
<td>Consultant Obstetrician and Gynaecologist</td>
</tr>
<tr>
<td>King’s College Medical School</td>
<td>Associate Clinical Dean</td>
</tr>
<tr>
<td>Royal College of Obstetricians and Gynaecologists</td>
<td>Paid Member</td>
</tr>
<tr>
<td>Royal Society of Medicine</td>
<td>Paid Member</td>
</tr>
<tr>
<td>British Medical Association</td>
<td>Paid Fellow</td>
</tr>
<tr>
<td>Medical Protection Society</td>
<td>Paid Member</td>
</tr>
<tr>
<td>Medical Women’s Federation</td>
<td>Paid Member</td>
</tr>
<tr>
<td>PMP</td>
<td>Paid Member</td>
</tr>
<tr>
<td>BMJ Group</td>
<td>Non-Executive Director</td>
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### Lady Christine Eames

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Position</th>
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<tbody>
<tr>
<td>Cancer Focus</td>
<td>Trustee</td>
</tr>
<tr>
<td>Homestart</td>
<td>Patron</td>
</tr>
<tr>
<td>Hunterhouse College</td>
<td>Governor</td>
</tr>
<tr>
<td>Barnardos</td>
<td>Committee member</td>
</tr>
<tr>
<td>Abbeyfield Belfast</td>
<td>Trustee and Vice-Chair</td>
</tr>
<tr>
<td>Mother’s Union</td>
<td>Former World President</td>
</tr>
</tbody>
</table>

Two sons Consultant Orthopaedic Surgeons, one Daughter-in-law a GP and one Daughter-in-law a Consultant Dermatologist.
Mr Michael Eames and Dr Elizabeth McMullan (Eames) are Directors of an Independent Health Care Provider.
Mr Niall Eames is a Partner in Private Consulting Rooms and Clinical Director of Orthopaedics for Belfast Trust.

### Professor Anthony Harnden (GMC Ref No: 2807869)

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morland House Surgery, Wheatley, Oxfordshire</td>
<td>Partner</td>
</tr>
<tr>
<td>University of Oxford</td>
<td>Professor of Primary Care</td>
</tr>
<tr>
<td>St Hugh’s College, University of Oxford</td>
<td>Governing Body fellow</td>
</tr>
<tr>
<td>Royal College of General Practitioners</td>
<td>Fellow</td>
</tr>
<tr>
<td>Medical Defence Union</td>
<td>Member</td>
</tr>
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</table>
Council meeting, 26 September 2019

Agenda item M12 – Council members’ Register of Interests

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Committee of Vaccination and Immunisation</td>
<td>Deputy Chairman</td>
</tr>
<tr>
<td>Medical Defence Union</td>
<td>Paid Member</td>
</tr>
<tr>
<td>British Medical Association</td>
<td>Paid Member</td>
</tr>
</tbody>
</table>

**Lord Hunt of Kings Heath**

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>House of Lords</td>
<td>Labour Member</td>
</tr>
<tr>
<td>Privy Council</td>
<td>Councillor</td>
</tr>
<tr>
<td>British Fluoridation Society</td>
<td>President</td>
</tr>
<tr>
<td>Health Care Supply Association</td>
<td>President</td>
</tr>
<tr>
<td>Hospital Caterers Association</td>
<td>President</td>
</tr>
<tr>
<td>Royal College of Ophthalmologists</td>
<td>Trustee</td>
</tr>
<tr>
<td>Foundation for liver Research</td>
<td>Trustee</td>
</tr>
<tr>
<td>Royal College of Physicians</td>
<td>Honorary Fellow</td>
</tr>
<tr>
<td>Royal College of GPs</td>
<td>Honorary Fellow</td>
</tr>
<tr>
<td>Faculty of Public Health</td>
<td>Honorary Fellow</td>
</tr>
<tr>
<td>Faculty of Dental Surgery, Royal College of Surgeons</td>
<td>Honorary Fellow</td>
</tr>
<tr>
<td>GS1 UK</td>
<td>President</td>
</tr>
<tr>
<td>Philip Hunt Consultancy</td>
<td>Self-employed consultant</td>
</tr>
<tr>
<td>Eden &amp; Partners</td>
<td>Consultant and trainer</td>
</tr>
<tr>
<td>SweatCo Ltd</td>
<td>Advisory Board Member</td>
</tr>
</tbody>
</table>
TenXHealth
Advisory Board Chair

Brother-in-law owns Happy Computers, which also trades as Happy Ltd, and has undertaken training for some GMC staff up to 2015.

Step daughter-in-law undertakes market research/business intelligence for market research agencies on behalf of pharmaceutical companies.

Philip Hunt was appointed a non-executive director of the Heart of England NHS Trust in October 2010 and subsequently became Chairman in April 2011 serving until July 2014. [Surgeon Mr Ian Paterson was excluded from practice at the trust in May 2011. The Independent Review led by Sir Ian Kennedy was commissioned and reported under his Chairmanship].

Professor Deirdre Kelly (GMC Ref No: 2598565)

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Position</th>
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</thead>
<tbody>
<tr>
<td>Birmingham Children’s Hospital NHS Foundation Trust</td>
<td>Consultant Paediatric Hepatologist</td>
</tr>
<tr>
<td>University of Birmingham</td>
<td>Professor of Paediatric Hepatology</td>
</tr>
<tr>
<td>Academic/private/legal practice</td>
<td>Self employed</td>
</tr>
<tr>
<td>Novartis/Roche/Sanofi Pasteur/Astellas</td>
<td>Consultant/Advisory Board Member on the design of clinical trials in children/standards of formulation for immunosuppression and therapy of viral hepatitis</td>
</tr>
<tr>
<td>Roche, Novartis, Gilead, Bristol Myers Squibb, Astellas, Schering Plough, Lumena Pharma, Janssen Pharma, Merck, Sharp &amp; Dohme, Vertex Pharma, Sanofi Pasteur</td>
<td>The Liver Unit at Birmingham Children’s Hospital receives grants/payment of trial expenses for clinical trials in children with viral hepatitis and/or immunosuppression</td>
</tr>
<tr>
<td>American Association for the Study of Liver Diseases</td>
<td>Fellow</td>
</tr>
<tr>
<td>American Gastroenterological Association</td>
<td>Member</td>
</tr>
<tr>
<td>American Society of Transplantation</td>
<td>Member</td>
</tr>
<tr>
<td>British Association for the Study of the Liver</td>
<td>Member</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>British Transplantation Society</td>
<td>Member</td>
</tr>
<tr>
<td>British Society of Paediatric Gastroenterology, Hepatology and Nutrition</td>
<td>Member</td>
</tr>
<tr>
<td>British Viral Hepatitis Group</td>
<td>Member</td>
</tr>
<tr>
<td>European Association for the Study of Liver</td>
<td>Member</td>
</tr>
<tr>
<td>European Society for Paediatric Gastroenterology, Hepatology and Nutrition</td>
<td>Member</td>
</tr>
<tr>
<td>International Paediatric Transplant Association</td>
<td>Member</td>
</tr>
<tr>
<td>Royal College of Physicians</td>
<td>Fellow</td>
</tr>
<tr>
<td>Royal College of Paediatrics and Child Health</td>
<td>Fellow</td>
</tr>
<tr>
<td>Royal College of Physicians of Ireland</td>
<td>Fellow</td>
</tr>
<tr>
<td>Muscular Dystrophy Campaign – Services Development Committee (from Oct 2010)</td>
<td>Member</td>
</tr>
<tr>
<td>British Medical Association</td>
<td>Member</td>
</tr>
<tr>
<td>International Liver Transplant Society</td>
<td>Member</td>
</tr>
<tr>
<td>The Transplantation Society</td>
<td>Member</td>
</tr>
<tr>
<td>Children Living with Inherited Metabolic Diseases (CLIMB – from 1999)</td>
<td>Medical Advisor</td>
</tr>
<tr>
<td>GMC Pension scheme</td>
<td>Trustee</td>
</tr>
<tr>
<td>Breast Cancer UK</td>
<td>Trustee</td>
</tr>
</tbody>
</table>
Health Research Board Clinical Research Coordination Ireland (HRB CRCI) | Advisory Board Member
---|---
ICAT | Advisory Board Member
HCV National Register Steering Meeting | Member
NICE Guidelines | Chair

### Professor Paul Knight (GMC Ref No: 2343239)

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Position</th>
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<tbody>
<tr>
<td>Glasgow Royal Infirmary</td>
<td>Consultant</td>
</tr>
<tr>
<td>Glasgow University</td>
<td>Honorary Professor</td>
</tr>
<tr>
<td>Royal College of Physicians Edinburgh</td>
<td>Fellow</td>
</tr>
<tr>
<td>Royal College of Physicians and Surgeons of Glasgow</td>
<td>Fellow</td>
</tr>
<tr>
<td>Royal College of Physicians in Ireland</td>
<td>Fellow</td>
</tr>
<tr>
<td>Royal College of Physicians in London</td>
<td>Fellow</td>
</tr>
<tr>
<td>British Geriatrics Society</td>
<td>Past President / Member</td>
</tr>
<tr>
<td>European Union Geriatric Medicine Society</td>
<td>Past President</td>
</tr>
<tr>
<td>Scottish Association of Medical Directors</td>
<td>Executive Member/Treasurer</td>
</tr>
<tr>
<td>Age and Ageing Editorial Board</td>
<td>Chairman</td>
</tr>
<tr>
<td>Glasgow City Health and Social Care Partnership</td>
<td>Consultant Geriatrician and older people's adviser</td>
</tr>
<tr>
<td>Atlas of Variation Group, Scottish Government Health Department</td>
<td>Chair</td>
</tr>
<tr>
<td>GMC Services International ltd</td>
<td>Deputy Chair</td>
</tr>
<tr>
<td>Organisation</td>
<td>Position</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------</td>
<td>----------------------------</td>
</tr>
<tr>
<td>Swedish Research Council review panel for Clinical Therapy Research</td>
<td>Member</td>
</tr>
<tr>
<td>Swedish Research Council review panel for Clinical Therapy Research</td>
<td>Member</td>
</tr>
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</table>

**Dame Suzi Leather**

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal College of Obstetricians and Gynaecologists (RCOG) and RPSH</td>
<td>Honorary fellow</td>
</tr>
<tr>
<td>Hospiscare Devon</td>
<td>Vice President</td>
</tr>
<tr>
<td>Office of the Independent Adjudicator for Higher Education</td>
<td>Chair</td>
</tr>
<tr>
<td>Labour Party</td>
<td>Member</td>
</tr>
<tr>
<td>Donor Conception Network</td>
<td>Patron</td>
</tr>
<tr>
<td>Devon Sustainability and Transformation Partnership (STP)</td>
<td>Independent Chair</td>
</tr>
</tbody>
</table>

Brother, sister, sister-in-law, daughter and a niece are all practising doctors.

**Dame Denise Platt DBE**

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Position</th>
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<tbody>
<tr>
<td>Family Action</td>
<td>Vice Patron</td>
</tr>
<tr>
<td>Methodist Homes for the Aged</td>
<td>Patron</td>
</tr>
<tr>
<td>NSPCC</td>
<td>Honorary Council Member</td>
</tr>
<tr>
<td>NIHR School of Social Care Research, LSE</td>
<td>Member, Advisory Board</td>
</tr>
<tr>
<td>Solicitors Regulation Authority</td>
<td>Board member, Chair People Strategy Committee, member Business Oversight Board</td>
</tr>
<tr>
<td>Organisation</td>
<td>Position</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>Association of Directors of Adult Social Services</td>
<td>Honorary Life Member</td>
</tr>
<tr>
<td>University of Bedfordshire</td>
<td>Honorary Fellow and Member of the University Court</td>
</tr>
<tr>
<td>Parliamentary and Political Service Honours Committee</td>
<td>Independent Member</td>
</tr>
</tbody>
</table>

**Amerdeep Somal**

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<thead>
<tr>
<th>Organisation</th>
<th>Position</th>
</tr>
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<tbody>
<tr>
<td>Financial Ombudsman Service</td>
<td>Independent Assessor</td>
</tr>
<tr>
<td>Ministry of Justice</td>
<td>Judge Immigration and Asylum Chamber</td>
</tr>
<tr>
<td>Ministry of Justice</td>
<td>Judge Social Security and Child Support Chamber</td>
</tr>
</tbody>
</table>
Executive summary

Following the restructure of the executive team precipitated by the departure of Susan Goldsmith as Chief Operating Officer, the Governance Handbook has been amended.

A tracked changes version of the relevant chapters of the document is attached along with a summary of the changes made. The changes chiefly concern the delegation of powers to the Chief Executive and executive team as described in chapters 4, 8 and 10, and removes references throughout to the Chief Operating Officer’s role.

We have taken the opportunity to make other minor changes to improve the drafting of the document. The full Governance Handbook is available for Council members on the Board Intelligence app and published on our website*.

Recommendation
Council is asked to approve the changes to the Governance handbook.

* https://www.gmc-uk.org/about/how-we-work/governance/our-governance-model
Governance Handbook
Chapters 4, 8 and 10

UPDATED
30 April 2019 to 26 September 2019
Chapter 4: Role of each component of the governance framework

Council
1 The role of Council is as described in Chapter 3 of this Governance handbook.

2 The Council has agreed that there will be other components of our governance framework and these are set out below.

Governance Committees
3 The Governance Committees are the:
   a Audit and Risk Committee
   b Remuneration Committee.

4 In addition to the Governance Committees, the Council is advised by an Investment Committee.

Medical Practitioners Tribunal Service
5 The Medical Practitioners Tribunal Service (MPTS) is a statutory committee of Council. The MPTS has responsibility for the delivery of the adjudication function including the Operations Section and Tribunal Development Section. The MPTS is led by the Chair of the MPTS who is a member of the MPTS Committee, together with four other appointed Committee members, two medical and two lay.

6 The MPTS has been established to provide an efficient and effective hearings service to all parties to hearings which is clearly separate from the investigatory and case presentation roles of the Fitness to Practise Directorate within the GMC.

7 The MPTS is also responsible for managing tribunal decision-makers which includes the recruitment, training, and performance management of tribunal members, case managers and legal assessors.

8 The MPTS will be required to submit an annual report to Parliament which meets the requirements of Section 52B of the Medical Act 1983 as amended.
9 The GMC/MPTS Liaison Group is chaired by the Chair of Council and is made up of the Chair and Executive Manager MPTS, the Chief Executive and Chief Operating Officer and other directors of the GMC as required. A member or members of the MPTS Committee may be invited to attend a meeting of the Liaison Group at the discretion of the MPTS Chair, as required. It acts to oversee the working relationship between the MPTS and the functions of the GMC with which it interacts. The Group supports the delivery of the hearings service provided by the MPTS, ensuring that working arrangements are established and operate effectively.

**Governance of the GMC’s pension arrangements**

10 The GMC’s Staff Superannuation Scheme, which is now closed to future accrual, is managed and administered by a Board of Trustees, in accordance with the Scheme’s Trust Deed and Rules. Council appoints the employer-nominated trustees to the Board of Pension Trustees.

11 There is a management board which oversees the GMC Group Personal Pension Plan, the GMC’s defined contribution (DC) pension scheme, the membership of which is nominated by the Executive or by Plan members. Council receives annual reports on the governance of the DC pension scheme.

**Executive Governance**

12 The Executive Board, chaired by the Chief Executive, is a decision-making forum which also provides support, advice and recommendations on areas including:

- supporting Council in strategy development
- policy development priorities and significant changes to existing policy
- external engagement in the organisation’s strategy and policy development
- information and research to support strategy and policy development
- linkage between policy development and legislation
- business and operational planning
- performance management and reporting, including financial due diligence
- resource management (including budget, staff, infrastructure)
- risk management and related controls
- quality assurance, efficiency and continuous improvement.
13 The work of the Board is reported to Council through the reports of the Chief Executive and Chief Operating Officer and an annual report of its activities.

External engagement channels

UK Advisory Forums

14 An advisory forum will be convened in each of the three parts of the UK with devolved administrations to provide a structured forum for us to engage in long-range discussions on priorities with key interest groups.

Education Advisory Forum

15 An Education Advisory Forum provides advice on matters related to medical education and training, on the assessments we run or oversee and on broader policy considerations for the design of curricula and assessment systems, in light of Council’s statutory purpose to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine.

Liaison groups

16 The Executive Board makes decisions in relation to establishing liaison groups and other forms of engagement with other organisations or interests on matters of policy and related operational issues. These may formalise a day-to-day relationship with a particular organisation or may bring together different perspectives as a sounding board on a particular issue or subject.

Task and Finish groups

17 The Executive Board makes decisions on the commissioning of Task and Finish Groups to provide time limited, focused input on a particular topic or issue. Typically, these will enable specific expertise or experience to be applied to achieve an agreed outcome, or for a range of relevant perspectives to be brought together quickly.

18 Any MPTS task and finish/working groups should be agreed by the Chair of the MPTS and authorised by the Chief Executive. In the event of any disagreement, the issue will be considered by the GMC/MPTS Liaison Group, which will provide advice to the Registrar.

19 MPTS task and finish/working groups will report to the Chair of the MPTS who will include an update on work undertaken in the MPTS Report to Council. It should be noted that where the work raises policy issues for the GMC requiring consideration by the Executive Board, a report will be made to the Board in line with current practice.
External input to programme or project boards

20 The Executive Board may commission time limited programme or project boards to be accountable for specific outcomes or outputs that require the participation of external interests for delivery.

Approach to Equality, and Diversity and Inclusion

21 Council agrees our strategic aims on issues of equality, diversity and inclusion (ED&I) and then holds the executive accountable for their delivery.

22 The Director of Strategy and Policy Chief Operating Officer as senior sponsor will lead on articulating our commitment on equality, diversity and inclusion issues and raising their profile with staff and interest groups, as well as providing assurance to Council on behalf of the Chief Executive.

23 The Executive Board will approve the ED&I strategy and monitor progress at a high-level. The ED&I Steering Group will ensure that ED&I is integrated into the GMC’s core activities and is responsible for considering the equality duties and monitoring and delivering appropriate actions.

24 A Strategic Equality, Diversity and Inclusion Advisory Group with external members will be established to act as a sounding board to inform the development of the ED&I strategy and GMC activities.

Governance model

25 The diagram on the following page shows the Governance model.
Chapter 8: The role of the executive

1. The executive takes forward the operational work of the organisation in line with our statutory purpose, and according to the strategic aims, business plan, policies and schedule of delegated authority agreed by Council.

2. The executive team is led by the Chief Executive and comprises the Chief Executive and the directors, the Chief Operating Officer/Deputy Chief Executive and the Directors. The Directors and the Executive Manager – Medical Practitioners Tribunal Service are accountable and report to the Chief Operating Officer, who reports to the Chief Executive.

The Chief Executive is responsible for the performance of the executive and is accountable to Council for it, making regular reports to Council. The Chief Operating Officer is responsible to the Chief Executive for the operational management of the organisation, including the performance of each Director and their directorates, and the MPTS.

3. On a day-to-day basis the Chief Executive is in regular contact with the Chair of Council, working in partnership with him/her to ensure the effective conduct of business.

4. If it is known that the Chief Executive will be absent for any period, then the Chief Executive may delegate his or her responsibilities to the Chief Operating Officer and Deputy Chief Executive another member of the executive for any period of time specified by them and agreed with the Chair of Council to be necessary. The Chief Executive will report the exercise of these powers to Council in advance of the authority being delegated.

5. The Chief Executive is responsible for our overall operation, organisation and management, for the budgeting and management of our financial resources, and for ensuring that proper systems of staff appointment, training, allocation of work, delegation of duties and accountability, performance, appraisal, remuneration and discipline are in place.

6. The Chief Executive is also responsible for ensuring that policy development and implementation are properly carried out by the executive, with clear, impartial and well-founded advice and recommendations being offered to Council as required.
The Chief Executive chairs the Executive Board, which is part of our formal executive governance arrangements. It is a decision making and oversight forum established to provide strategic direction, scrutiny and reporting to Council by the GMC’s senior management team on significant policy, strategy, finance, performance, operational delivery and resource management issues.
Chapter 10: GMC financial regulations

Section A - Introduction

Section B - Financial management

Section C - Financial planning

Section D - Risk management and control of resources

Section E - Financial systems and procedures

Section F - External arrangements
Section A – Introduction

Purpose

1 To ensure that high standards of financial integrity are maintained at all times.

2 The regulations are part of our corporate governance arrangements and are supported by a range of detailed and periodically updated policies, procedures and instructions on specific financial issues. Where any instances of conflict or ambiguity arise, the Financial Regulations take precedence.

3 It is not possible to cover every eventuality within these regulations. Where a particular circumstance is not specifically referred to and there is any doubt as to the correct course of action, guidance should be sought from the Assistant Director, Finance and Procurement.

4 In exceptional circumstances, it may be necessary to waive the requirements of Financial Regulations temporarily. This can be done only by the Chief Operating Officer or the Chief Executive, in consultation with the Chair of Council.

5 Financial Regulations apply to all staff, members and associates of the GMC, which includes the Medical Practitioners Tribunal Service (MPTS). Failure to comply with Financial Regulations, or instructions issued under them, may result in disciplinary action. It is the responsibility of senior managers (Chief Executive, Chief Operating Officer, directors, assistant directors, heads of section, the Chair of the MPTS and the Executive Manager of the MPTS) to ensure that staff are aware of their responsibilities under these regulations, that they receive appropriate training and that they comply with them.

Section B - Financial management

6 The GMC is a registered charity and is subject to the financial reporting requirements set out in the Charities Act 2011, the Charities (Accounts and Reports) Regulations 2008, the Statement of Recommended Practice for Accounting and Reporting by Charities, the Charities and Trustee Investment (Scotland) Act 2005 and the Charities Accounts (Scotland) Regulations 2006.

Council and committees

7 The powers and duties of the GMC are laid out in the Medical Act 1983 as amended. The Council (as the Trustees of the GMC) has overall responsibility for the financial management of the GMC. A comprehensive description of the role of Council and its committees is set out in the Governance handbook.

8 The Council has established an Audit and Risk Committee, responsible for ensuring the integrity of the financial statements, reviewing the organisation’s system of
internal control, governance and risk management systems and to appoint, monitor and review both the internal and external audit services.

Executive

9 Council has established an Executive Board. Its purpose is to review operational performance and organisational capacity, as part of the GMC’s executive governance arrangements. Full details are set out in the Statement of Purpose of the Executive Board. The executive lead and the Chair of the Board is the Chief Executive. The Executive Board reports to Council through both the Chief Executive and the Chief Operating Officer.

10 One or both of the Director of Resources and the Assistant Director, Finance and Procurement must be a member of one of the six CCAB bodies, or another body of accountants established in the UK and approved by the Secretary of State.

Section C - Financial planning

Medium Term Financial Forecast

11 The medium term financial forecast should be prepared annually, cover a three year period and forecast the likely expenditure, income and reserves over that period.

Budgeting

12 The annual budget sets out overall income, revenue and capital expenditure, allocations to directorates and projects, proposed fee levels and the impact on reserves.

13 Budget managers should prepare draft plans and estimated costs for the activities of their directorates. It is the responsibility of senior managers to ensure that their draft budgets reflect the aims and objectives set out in the annual business plan. Draft budget proposals are scrutinised by the Executive Board.

14 The annual budget comes into effect only when approved by Council.

Budget monitoring and control

15 Financial information to enable budget managers to monitor and control their expenditure effectively should be provided monthly.

16 Budget managers are responsible for controlling income and expenditure against their budget and for monitoring service delivery and performance against targets. Forecasts of income, expenditure and headcount should be prepared on a quarterly basis, are updated monthly based on discussions with budget managers.
17 Budget managers should take any remedial action necessary to avoid actual expenditure exceeding budget. Budget managers must advise their Director at the earliest opportunity if they feel that costs cannot be absorbed within their cost centre budget. It is then the responsibility of the Director to ensure that individual cost centre overspends can be managed and absorbed within the overall Directorate budget. Where a Directorate expects to spend more than their approved budget the Director must advise the Chief Operating Officer, Chief Executive and Director of Resources, who will decide what further action to take.

18 Regular reports of budgetary performance and variances should be provided to the Executive Board, and to Council as part of the Chief Operating Officer’s Report.

19 The Chief Operating Officer or Chief Executive may seek Council’s agreement to an additional budget allocation within the year. Any requests for additional funding should clearly identify any financial impact in future years.

**Budget virement**

20 The transfer of budgets between directorates can only be made with the approval of the Chief Operating Officer, Chief Executive. Transfers between budget heads within the same directorate can be made with the approval of the Director of Resources.

**Maintenance of reserves**

21 The Director of Resources should advise the Executive Board on the appropriate levels of reserves. Council should approve the reserves policy annually.

**Investment policy**

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

23 The Investment Sub-Committee establishes and monitors the investment management structure to ensure that it is appropriate to meet the agreed investment policy, and reports annually on its activities to Council.

24 All funds held by the GMC are controlled by the Director of Resources, who will oversee all borrowing, investment or financing and report to the Executive Board at regular intervals. A summary of investment performance is reported as part of the normal reporting of financial performance to the Executive Board, and within the Chief Operating Officer’s Chief Executive’s report to Council.
Section D - Risk management and control of resources

Risk management

25 Overall responsibility for risk management resides with Council.

26 Responsibility for overseeing risk management arrangements is delegated to the Audit and Risk Committee. The Committee reviews the risk management framework and obtains assurance from the internal auditors that the arrangements in place are effective.

27 The responsibilities of managers and staff are set out in the Risk Management Framework.

Internal control

28 Council is responsible for setting and maintaining a framework of delegation and internal control.

29 The Audit and Risk Committee is responsible for reviewing internal control and systems.

30 The Assistant Director of Audit and Risk Assurance is responsible for reviewing the effectiveness of the systems of internal control and risk management, providing assurance to Council through the Audit and Risk Committee.

31 It is the responsibility of management to establish effective systems of internal control and risk management. These arrangements need to ensure compliance with all relevant statutes and regulations, and other relevant statements of best practice. They should ensure that GMC funds are properly safeguarded and used economically, efficiently and effectively.

32 The Executive Board monitors operational performance, resource management, risk management and related controls, quality assurance, efficiency and continuous improvement.

Audit requirements

33 The Audit and Risk Committee makes recommendations to Council on the appointment, reappointment and removal of the external auditors.

34 External auditors and internal auditors have authority to:

a access all assets, records, documents and correspondence relating to any financial and other transactions
b require and receive such explanations as are necessary concerning any matter under examination

c access records belonging to third parties, such as contractors when required.

Fraud and corruption

35 The Director of Resources and Quality Assurance is responsible for the development and maintenance of an anti-fraud policy.

36 Staff should report any suspected fraud in accordance with the GMC’s Anti-Fraud Policy and, if appropriate, the Public Interest Disclosure (whistle-blowing) Policy.

Declaration of interests

37 Guidance for members on the disclosure of interests is set out in the Governance handbook.

38 Staff should disclose immediately to the Director of Resources any personal interest in, or benefit arising from, a transaction or financial arrangement involving the GMC, including any interest in a business trading with the GMC. Declarations will be recorded and retained by the Director of Resources.

Asset management

39 The Director of Resources is responsible for maintaining a fixed asset register.

40 Senior managers should ensure that records and assets within their areas of responsibility are properly maintained and securely held. The Director of Resources is responsible for ensuring that contingency plans for the security of assets and the continuity of business in the event of disaster or system failure are in place. Disposal of assets should be in accordance with procedures laid down by the Director of Resources.

Remuneration

41 The Remuneration Committee is responsible for advising Council on the remuneration, terms of service and the expenses policy for Council members including the Chair; and for determining the appointment and suspension/removal process, remuneration, benefits and terms of service for the Chair of the MPTS and members of the MPTS Committee. The Remuneration Committee is also responsible for setting the remuneration, benefits and terms of service for the Chief Executive, Chief Operating Officer/Deputy Chief Executive, and directors.

42 The Chief Executive and the Chief Operating Officer are responsible for determining policy on the remuneration, benefits and terms of service of all other GMC staff.
Senior managers, in consultation with the Assistant Director – Human Resources, are responsible for setting and approving changes to staff salaries within the constraints of the overall policy.

**Staffing**

43 The **Chief Operating Officer** is responsible for ensuring that proper systems of staff appointment, training, allocation of work, delegation of duties and accountability, performance, appraisal, remuneration and discipline are in place.

44 The Executive Board has established a People and Development Board, with membership consisting of the Senior Management Team plus the Assistant Director of Human Resources. The Board meets quarterly to consider outcomes from development mapping, key staff risks and succession planning, high level analysis of preliminary appraisal ratings and reviews of learning and development activity and data.

45 Budget managers are responsible for controlling staff numbers by developing budget proposals that are sufficient to cover estimated staffing levels in the year, and adjusting staffing as necessary to a level that can be funded within the approved budget.

46 Budget managers may only recruit temporary staff during the year where the costs can be absorbed within directorate budgets approved by Council.

47 Recruitment of permanent staff over and above those included in the annual budget must be approved by the **Chief Operating Officer**.

**Section E - Financial systems and procedures**

**General**

48 The Director of Resources is responsible for selecting appropriate accounting policies and for ensuring that systems are applied consistently, and for determining the accounting procedures to be followed and the accounting records to be maintained.

49 The Director of Resources is responsible for ensuring that the annual statement of accounts is prepared in accordance with the Charities Statement of Recommended Practice and applicable law. Council is responsible for approving the annual report and accounts.

50 The Director of Resources is responsible for providing financial training to all relevant staff.

51 Senior managers are responsible for the proper operation of financial procedures within their areas.
Where key members of staff with financial responsibilities are absent, senior managers must ensure that named deputies are identified so that financial procedures continue to operate securely and effectively.

Arrangements relating to the procurement of goods and services are set out in the GMC’s Procurement Policy.

**Income and expenditure**

The Chief Executive and the Chief Operating Officer may authorise expenditure within the constraints of the annual budget approved by Council. Directors and staff may authorise expenditure within the limits set out in the Schedule of authority, within the constraints of approved directorate budgets. When authorising expenditure, consideration must be given to any ongoing financial impact as these costs will need to be incorporated in future years’ budgets.

The Director of Resources is responsible for maintaining a scheme of financial delegation that identifies staff authorised to act on the GMC’s behalf in respect of raising orders, making payments, and collecting income, together with the limits of their authority. The Director of Resources will determine arrangements for the collection, banking and recording of income, and for payments to suppliers and other third parties.

Senior managers are responsible for ensuring that the scheme of financial delegation is operating effectively in their area.

The Chief Operating Officer and/or the Director of Resources will approve the bank mandate authorising bank signatories and their limits.

Outstanding debts can only be written off in exceptional circumstances. Individual debts of up to £10k can be written off with the approval of the Assistant Director of Finance. Individual debts up to £25k can only be written off by the Director of Resources, who will provide a periodic summary to the Executive Board. Individual debt write offs of more than £25k will be referred to the Executive Board and be subject to approval by the Chief Operating Officer.

Where goods or services are provided by the GMC to external organisations, they should be charged on a full cost recovery basis. Any difference from this would require approval from Chief Operating Officer.

Where goods or services are provided to a trading subsidiary, they should be charged on a full cost recovery basis.
Staff, members and associates

61 The Director of Resources is responsible for all payments of salaries, allowances and expenses to staff, members and associates.

Taxation

62 The Director of Resources is responsible for ensuring the GMC complies with the relevant guidance and legislation on all matters relating to taxation.

63 The Director of Resources is responsible for maintaining the GMC’s tax records, making all tax payments, receiving tax credits and submitting tax returns by their due date as appropriate.

Trading

64 No company or commercial enterprise that exploits any activity carried out by, or exploits any rights belonging to the GMC may be established by staff, Council members or associates without the prior written approval of the Chair of Council and the Chief Operating Officer in consultation with the Chief Executive.

65 No trading subsidiaries can be established without the approval of Council.

66 Any activities carried out through a trading subsidiary should be subject to the same high standards of conduct and financial integrity that apply to all other GMC activities. Detailed working arrangements between the GMC and a trading subsidiary should be set out in an Operating Agreement.

Section F - External arrangements

 Partnerships and joint projects

67 No partnerships or joint projects which create material financial risk can be entered into without the approval of Council.

68 Any partnerships or joint projects should be subject to the same high standards of conduct and financial administration that apply to all other GMC activities.

69 The Director of Resources should ensure that the accounting arrangements to be adopted for partnerships and joint projects are satisfactory, and that the financial risks have been fully appraised before agreements are entered into.

70 Partnerships and joint projects should be subject to the same level of audit review as other GMC activities.
External funding

71 The Director of Resources is responsible for ensuring that all funding is received and properly recorded in the GMC’s accounts.

Work for third parties

72 Any proposals for the GMC to undertake work for third parties must be consistent with the GMC’s charitable purpose and the Medical Act 1983. Contractual arrangements should be approved by the Chief Operating Officer. Work that is not consistent with the GMC’s charitable purpose and the Medical Act 1983 can only be undertaken through a trading subsidiary.
## Governance Handbook change Log

<table>
<thead>
<tr>
<th>Section</th>
<th>Change</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Role of each component of the governance framework</td>
<td>At paragraph 22, changing Executive Sponsor for equality, diversity and inclusion from Chief Operating Officer to Director for Strategy and Policy. Amended version of Governance diagram inserted</td>
</tr>
<tr>
<td>5</td>
<td>Role of the Chair of Council</td>
<td>Remove reference to Chief Operating Officer role</td>
</tr>
<tr>
<td>8</td>
<td>Role of the executive</td>
<td>Remove references to Chief Operating Officer role and clarify distribution of their responsibilities amongst executive</td>
</tr>
<tr>
<td>9</td>
<td>Schedule of authority</td>
<td>Remove references to Chief Operating Officer role</td>
</tr>
<tr>
<td>10</td>
<td>GMC financial regulations</td>
<td>Remove references to Chief Operating Officer. Clarify directors’ responsibility for budgets, and frequency of information provided to budget managers</td>
</tr>
<tr>
<td>A1</td>
<td>Working arrangements</td>
<td>Remove reference to Chief Operating Officer role</td>
</tr>
<tr>
<td>B3</td>
<td>Role descriptions of Committee Chairs</td>
<td>Remove reference to Chief Operating Officer role</td>
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<td>-------------------------------------------------</td>
</tr>
<tr>
<td>B4a</td>
<td>Statement of Purpose for the Audit and Risk Committee</td>
<td>Remove reference to Chief Operating Officer role</td>
</tr>
<tr>
<td>B4b</td>
<td>Statement of Purpose of the Remuneration Committee</td>
<td>Remove reference to Chief Operating Officer role</td>
</tr>
<tr>
<td>B4c</td>
<td>Statement of Purpose of the Board of Trustees of Staff Superannuation Scheme</td>
<td>Remove reference to Chief Operating Officer role</td>
</tr>
<tr>
<td>B4e</td>
<td>Statement of Purpose of the GMC/MPTS Liaison Group</td>
<td>Remove reference to Chief Operating Officer role</td>
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<tr>
<td>B4f</td>
<td>Statement of Purpose of the Investment Committee</td>
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