GENERAL MEDICAL COUNCIL

England & Wales · Charity number 1089278

Details

Other names	GMC
Status	Registered
Legal form	Other
Registered	2001-11-09
Register	View on the Charity Commission register

Contact

Address	Regent's Place 350 Euston Road London NW1 3JN
Phone	0161 923 6602
Email	gmc@gmc-uk.org
Website	www.gmc-uk.org

Activities

Objects: (1A) THE OVER-ARCHING OBJECTIVE OF THE GENERAL COUNCIL IN EXERCISING THEIR FUNCTIONS IS THE PROTECTION OF THE PUBLIC. (1B) THE PURSUIT BY THE GENERAL COUNCIL OF THEIR OVER-ARCHING OBJECTIVE INVOLVES THE PURSUIT OF THE FOLLOWING OBJECTIVES:A) TO PROTECT, PROMOTE AND MAINTAIN THE HEALTH, SAFETY AND WELL-BEING OF THE PUBLICB) TO PROMOTE AND MAINTAIN PUBLIC CONFIDENCE IN THE MEDICAL PROFESSION AND THE ANAESTHESIA ASSOCIATE AND PHYSICIAN ASSOCIATE PROFESSIONS, AND C) TO PROMOTE AND MAINTAIN PROPER PROFESSIONAL STANDARDS AND CONDUCT FOR MEMBERS OF THE MEDICAL PROFESSION AND THE ANAESTHESIA ASSOCIATE AND PHYSICIAN ASSOCIATE PROFESSIONS.

Activities: We are an independent organisation that helps to protect patients and improve medical practice across the UK.

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Classification

- **How:** Provides Services, Provides Advocacy/advice/information, Sponsors Or Undertakes Research
- **What:** Education/training, The Advancement Of Health Or Saving Of Lives
- **Who:** The General Public/mankind

Geography

- Northern Ireland
- Scotland
- Throughout England And Wales

Finances

Period end	Income	Expenditure	Assets	Employees
2024-12-31	£167,543,346	£156,011,578	£73,526,334	1713
2023-12-31	£150,477,323	£144,061,345	£50,391,944	1662
2022-12-31	£135,212,534	£133,526,822	£54,852,400	1587
2021-12-31	£122,342,020	£122,147,240	£99,798,039	1522
2020-12-31	£109,867,066	£113,371,499	£64,581,668	1442

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Trustees

Name	Role	Appointed
Professor Caroline MacEwen	Chair	2021-01-01
Dr Alison Wright		2020-02-01
Dr Olamide Oguntimehin		2025-01-01
Dr Rajesh Patel		2020-02-01
Dr Rajiv Christopher Wijesuriya		2023-05-01
Dr Vanessa Davies		2021-01-01
Jane Ramsey		2025-01-01
John Douglas Millican		2023-05-01
PROFESSOR KEITH LLOYD		2025-01-01
Professor Deepa Mann-Kler		2021-01-01
Suzanne Shale		2021-01-01
Wendy Williams		2025-01-01

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GENERAL MEDICAL COUNCIL

England & Wales - Charity number 1089278

Accounts

General Medical Council

Annual Report 2024

Trustees' annual report and accounts for the year ended 31 December 2024

General Medical Council

General Medical Council

Annual Report 2024

Trustees' annual report and accounts for the year ended 31 December 2024

Presented to Parliament pursuant to section 52A of the Medical Act 1983 as amended by The Health Care and Associated Professions (Miscellaneous Amendments) Order 2008 (SI No.1774).

General Medical Council









Our annual report 2024

General Medical Council

About this report

Our trustees present this report and financial statement for the year ending 31 December 2024.

They confirm they have taken into account the Charity Commission's public benefit guidance when reviewing our aims and objectives and have had regard to this guidance when exercising any powers or duties or when making a decision to which the guidance is relevant. The trustees are satisfied that at all times we have operated for public benefit and that the activities as described in this report and accounts fully meet the public benefit requirements and support our charitable purpose.









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This publication is available in Welsh on our website.

Mae'r cyhoeddiad hwn ar gael yn Gymraeg ar ein gwefan.

Foreword

The UK medical workforce continues to change, becoming increasingly diverse both in terms of ethnicity and gender.

There are now more ethnic minority doctors on the register than white doctors, linked to large numbers of international graduates joining the workforce since 2016.[*] UK graduates are also increasingly diverse. 60% of the 2023/24 medical school intake across the UK was female.[†] And in 2024, we saw women get close to outnumbering men on the register for the first time, with the tipping point subsequently reached early in 2025. This diversity means it is more important than ever that healthcare leaders foster the supportive and inclusive cultures that enable doctors to provide the best possible care.

The demands on our health services have remained high, taking a toll on the wellbeing of the profession. Doctors report concerning experiences across a range of metrics, including burnout, dissatisfaction, and the ability to provide patients with a sufficient level of care.[‡] As well as being deeply damaging to doctors, these issues undermine the productivity and smooth running of our health services, creating consequent risks to the delivery of safe patient care.

Against this changing, and challenging, backdrop, we have played our part in supporting the UK's health systems to deliver high-quality care for the patients they serve.

In January 2024, the updated version of *Good medical practice* came into effect. The standards reflect a stronger focus on behaviours and values, recognising the pivotal role of culture and leadership in determining good outcomes for patients. 2024 saw our outreach teams speaking to doctors across the UK about applying the guidance in practice. As well as raising awareness of the updated standards, these sessions helped build relationships and foster trust and confidence within the profession.

At the heart of good culture is inclusion, and in October, we published an update on the equality, diversity and inclusion targets we set ourselves

* *The state of medical education and practice in the UK: workforce report (2024)* p.11

† *The state of medical education and practice in the UK: workforce report (2024)* p.32

‡ *The state of medical education and practice in the UK: workplace experiences report (2024)* p.11

in 2021. We saw how our efforts are bearing fruit, with a reduction in the disproportionality of employer fitness to practise referrals, a narrowing of the attainment gap in specialty training for internationally qualified doctors, and improved representation of ethnic minority colleagues in the GMC's own workforce.* But our analysis also highlighted the scale of the challenge, and the work remaining to achieve sustained systemic and cultural change. We remain committed to playing our role in achieving that change, both through the use of our data and the frontline support we provide through our outreach teams.

At the end of the year, we reached a significant milestone as physician associates (PAs) and anaesthesia associates (AAs) were brought into regulation for the first time. This important step will help assure both patients and the public that these professionals are appropriately trained, meet the standards that we set and that action can be taken when concerns are raised. It also represents the culmination of years of engagement with stakeholders across the UK. We continue to work closely with the UK Government on its proposed changes to the legislation that governs the way we operate, and look forward to seeing these reforms brought into effect, to the benefit of the public and profession alike.

2024 also saw the introduction of the Medical Licensing Assessment (MLA), which tests the knowledge, skills and behaviours of doctors who want to practise in the UK. The MLA sets a common threshold for safe practice across all medical graduates, meaning both UK students and international candidates will take assessments that draw from the same topics for the first time.† As well as strengthening patient safety and improving consistency, the MLA will enable course providers to be innovative in their offering to students, whilst maintaining high standards.

The expectations of doctors and those they care for are evolving, and we, and the wider health system, must be alert to those changes. A linear career, in a specific specialty, without breaks, is no longer the default for many, with locally-employed doctors now the fastest-growing doctor group.‡ They, and many others, are ill-served by the rigidity of the current system.

We continue to play a crucial role in overseeing undergraduate education and postgraduate training for doctors, taking action where necessary to ensure that training environments are fit for purpose and delivering against the needs of patients, both today and in the future. Through our *Future of education and career development (FutureEd)* programme, we are taking a critical look at the way doctors learn, train and practise, and considering what needs to change so that every doctor can reach their potential and enjoy a fulfilling career. This work was the focus of our annual symposium in November, and is a conversation that will continue as we build up to our 2026-30 strategy.

* Annual equality, diversity, and inclusion (ED&I) progress update 2024

† For more information please see our blog, *How we assess doctors new to UK practice is changing*

‡ *The state of medical education and practice in the UK: workforce report (2024)* p.11

We are fortunate to benefit from input and insight from outside of the GMC, which gives us a broad view of the profession and the wider landscape in which we work. From the clinical fellows who work within the GMC and share their frontline perspective, to the members of the public whose lived experience is so powerful; their contributions are immensely valuable and shape our work for the better.

As patients' needs shift, and the workforce charged with meeting them continues to change, collaboration across all parts of the system is more important than ever. We look forward to working with stakeholders in all parts of the UK, as we seek to serve the patients and the public who are at the heart of our work.



Charlie Massey
Chief Executive



Professor Dame Carrie MacEwen
Chair

Our role in the UK's healthcare systems

We are the independent regulator of doctors, physician associates (PAs) and anaesthesia associates (AAs) in the UK.*

We work with doctors, PAs, AAs, patients and other stakeholders to support good, safe patient care. We set the standards doctors, PAs, AAs and those who train them need to meet, and help them achieve them. If there are concerns these standards may not be met or that public confidence in doctors, PAs or AAs may be at risk, we can investigate, and take action if needed.

How we promote good, safe patient care

- We set the standards of patient care and professional behaviours doctors, PAs, and AAs need to meet. We set the values, knowledge, skills and behaviours expected of all doctors, PAs, and AAs working in the UK, and we support students, doctors, PAs, AAs and employers to understand and meet these standards.
- We make sure doctors, PAs and AAs get the education and training they need to deliver good care. We approve their undergraduate and / or postgraduate training and the assessments they must pass. We do this by assessing all courses and programmes and by carrying out reviews and regular monitoring. We also talk to students, trainees and educators to hear about their experiences.
- We check who is eligible to work as a doctor, PA or AA in the UK, and check they continue to meet the professional standards we set throughout their careers. We do this by maintaining separate official lists of these registered professionals, available online. When a doctor, PA or AA applies to join one of our registers, we check they meet our requirements to work in the UK and deliver good, safe patient care. To remain in practice, they must also continue to meet the professional standards we set, show that they are competent and show that they keep their knowledge and skills up to date.
- If serious concerns are raised with us about a doctor's, PA's or AA's behaviour, health or performance, we can investigate to determine whether patient safety or public confidence are at risk. As a result of our investigations, we may refer a case to the Medical Practitioners Tribunal Service (MPTS) for a hearing. MPTS tribunals make independent decisions about the cases we refer. They can suspend or restrict a doctor, PA or AA from carrying out their duties. In very serious cases, the tribunals may remove a doctor, PA or AA from our registers, meaning they can no longer work in the UK. The MPTS produces its own separate annual report.

* We began regulating physician associates (PAs) and anaesthesia associates (AAs) on 13 December 2024.

Our performance

Every year our performance as a regulator is assessed by the Professional Standards Authority (PSA). It is measured across our four core functions: education and training; registration; guidance and standards; and fitness to practise.

The PSA's latest annual assessment confirmed that we successfully met all 18 of its Standards of Good Regulation in 2023–2024. We are proud to have met all the standards set by the PSA since they were introduced in 2012. It means we are performing to a high standard as a regulator, and reflects the commitments we make in our work to standards such as:

- transparency
- public protection
- timeliness
- equality, diversity and inclusion.

In particular, the PSA noted improvements in the timeliness of our fitness to practise process, as we reached key decision points faster than the previous year and reduced the number of cases which have been open longer than one year. They also welcomed our updated version of *Good medical practice* (published in January 2024), and its increased focus on patient-centred care and fair workplace cultures.

General standards

5 out of 5

Guidance and standards

2 out of 2

Education and training

2 out of 2

Registration

4 out of 4

Fitness to practise

5 out of 5

Total standards met

18 out of 18

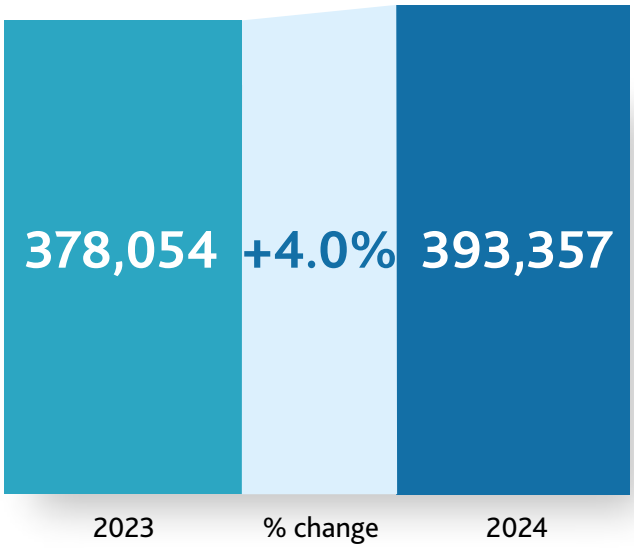
2024 at a glance



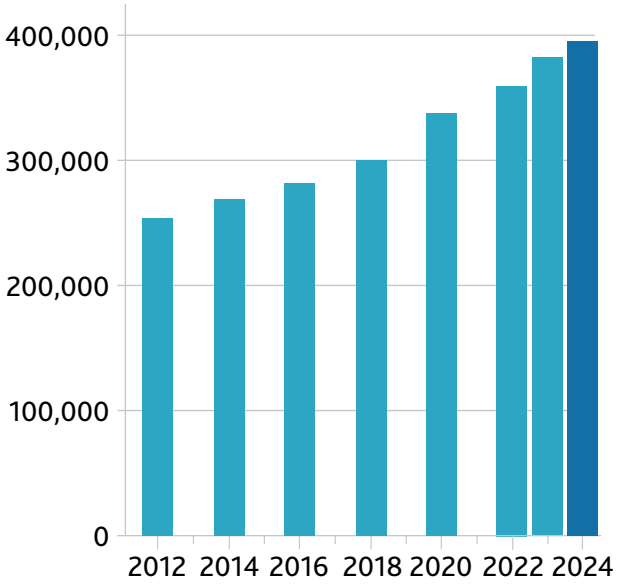
The medical register

All figures as of 31 December 2024 and 31 December 2023, unless otherwise specified.
Visit GMC Data Explorer to learn more about doctors' education and practice in the UK.

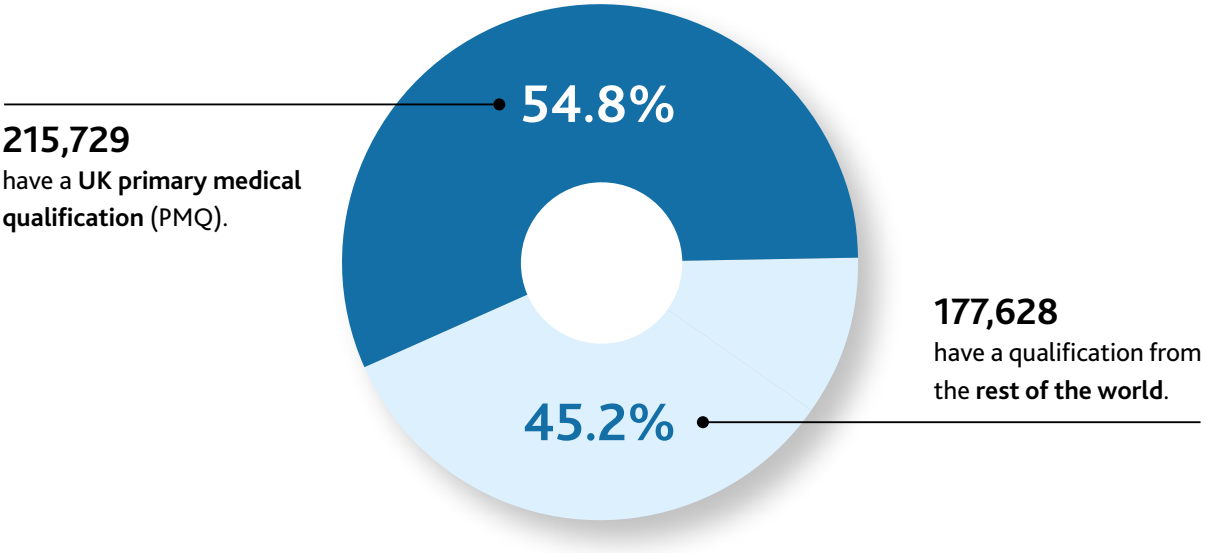
Total doctors on the register



Growth in registered doctors 2012–2024



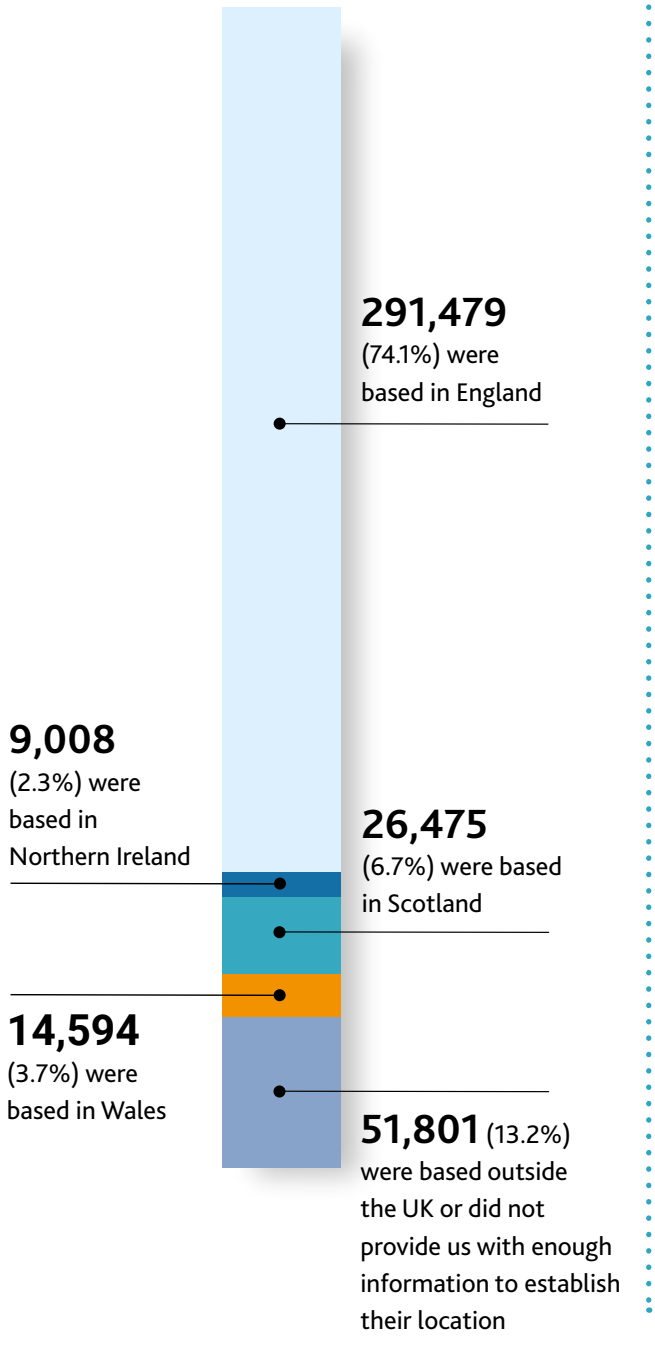
Where they graduated



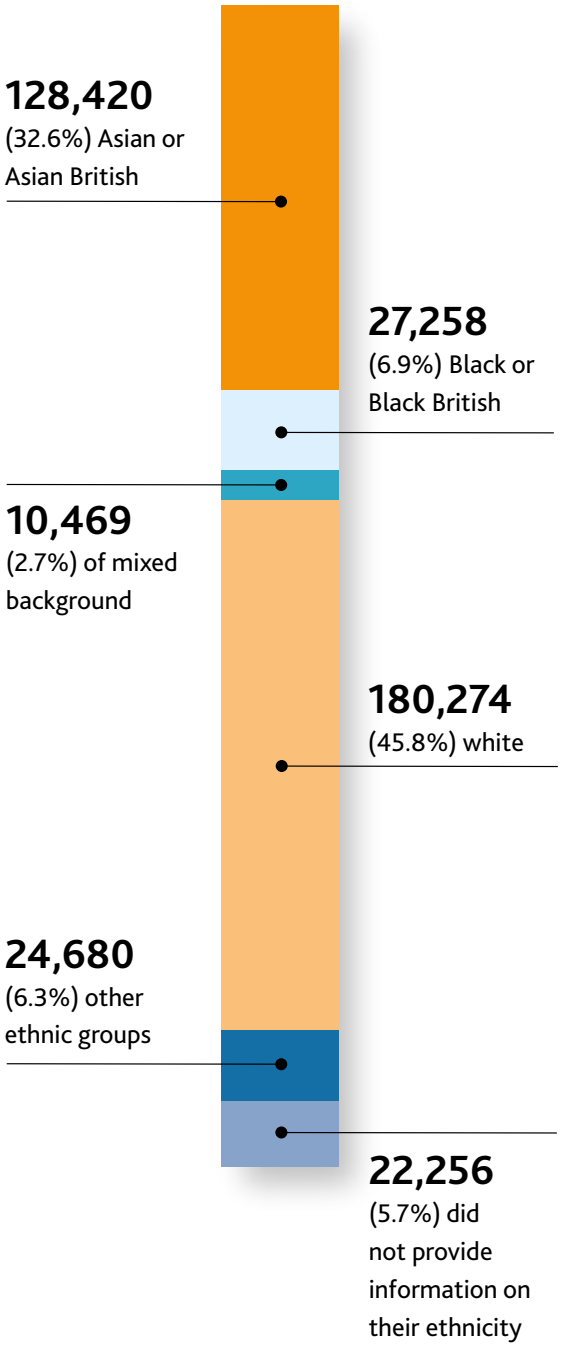
215,729
have a **UK primary medical qualification** (PMQ).

177,628
have a qualification from the **rest of the world**.

Doctors on the register by location*



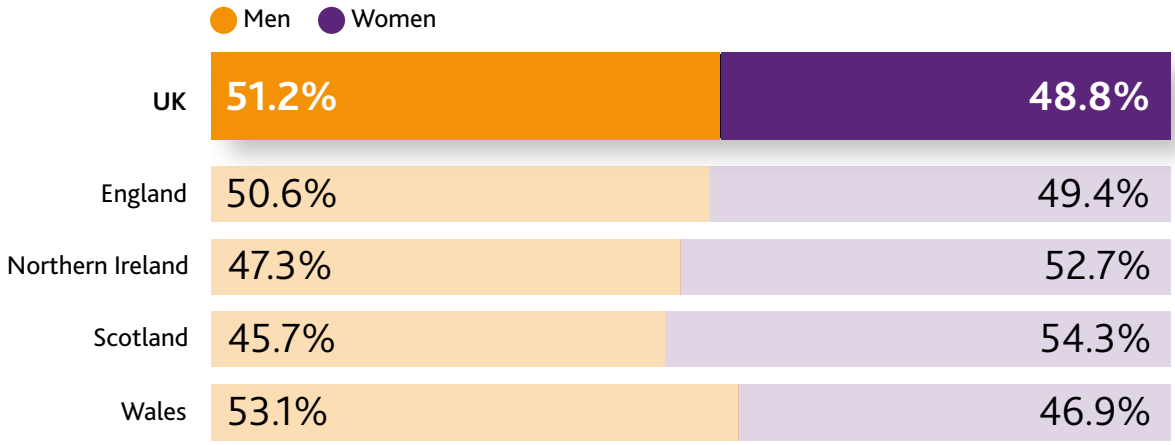
Doctors on the register by ethnicity



* The derived location of registered doctors is calculated using the following hierarchy:
1. where they work based on NHS practice history data
2. their training location based on the National training survey
3. the location of their designated body
4. their registered address.

Registered doctors located in the Channel Islands and the Isle of Man are included in the figures referring to England.

Doctors on the register by gender



Total doctors on the GP Register

80,237

Down **0.4%** from 2023 (**80,562**)

64,943 (80.9%) were located in **England**.

2,279 (2.8%) were located in **Northern Ireland**.

7,297 (9.1%) were located in **Scotland**.

3,236 (4.0%) were located in **Wales**.

2,482 (3.1%) either were located **outside the UK** or did not provide us with enough information to establish their location.

Total doctors on the Specialist Register

112,038

Up **1.4%** from 2023 (**110,478**)

85,674 (76.5%) were located in **England**.

2,744 (2.4%) were located in **Northern Ireland**.

8,408 (7.5%) were located in **Scotland**.

4,277 (3.8%) were located in **Wales**.

10,935 (9.8%) either were located **outside the UK** or did not provide us with enough information to establish their location.

In 2024, we granted:

28,564

applications for first entry to the register.

That is up

5.9% ↑

from 2023 (**26,969**).

9,285
(32.5%) were from doctors with a **UK PMQ**.

19,279
(67.5%) were from doctors with a qualification from **the rest of the world**.



4,188

applications to join the GP Register.

That is up

10.9% ↑

from 2023 (**3,776**).

2,339
(55.9%) were from doctors with a **UK PMQ**.

1,849
(44.1%) were from doctors with a qualification from **the rest of the world**.



5,516

applications to join the Specialist Register.

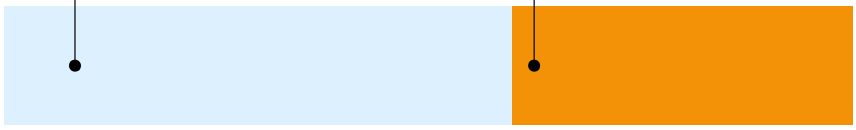
That is up

3.8% ↑

from 2023 (**5,316**).

3,164
(57.4%) were from doctors with a **UK PMQ**.

2,352
(42.6%) were from doctors with a qualification from **the rest of the world**.



Professional and linguistic assessments board (PLAB)

Doctors who graduate outside the UK, the EEA, or Switzerland usually need to take our Professional and Linguistic Assessments Board (PLAB) test in order to join the UK medical register.* The test is taken in two parts (PLAB 1, delivered in assessment centres around the world, and PLAB 2, undertaken in one of our testing centres in Manchester).

PLAB 1

21,058

candidates took PLAB 1 in 2024, a 3.9% decrease on 2023 (**21,916**).

14,849 (70.5%) passed the exam.

PLAB 2

19,346

candidates took PLAB 2 in 2024, a 23.2% increase on 2023 (**15,702**).

12,746 (65.9%) passed the exam.

* Exceptions to this include international graduates joining the register based on being sponsored by healthcare organisations, or based on postgraduate qualifications. In both these cases, doctors must still provide evidence of their competence and skills. For more information on the different routes to join the register, see www.gmc-uk.org/registration-and-licensing/join-the-register/before-you-apply/evidence-to-support-your-application.

Setting and maintaining standards

Revalidation

Every licensed doctor who practises medicine in the UK must prove they are meeting our standards every five years through a process called revalidation. Revalidation supports doctors to develop their practice, drives improvements in clinical governance, and gives patients confidence that doctors are fit to practise.

In 2024 we received

75,974

recommendations about revalidation.*

64,431 of the recommendations were submitted by designated bodies located in **England**.

2,081 were submitted by designated bodies located in **Northern Ireland**.

6,021 were submitted by designated bodies located in **Scotland**.

3,085 were submitted by designated bodies located in **Wales**.†

65,244

doctors were revalidated in 2024.

54,910 were located in **England**.

1,852 were located in **Northern Ireland**.

5,193 were located in **Scotland**.

2,647 were located in **Wales**.

642 either were based **outside the UK** or did not provide us with enough information to establish their location.

We made decisions on

99.2%

of the total recommendations we received in 2024 **within 5 working days** from when we received them, **exceeding our target of 95%.**

9,353 We approved **deferral of revalidation submission dates** for 9,353 doctors.

1,149 We **withdrew the licences** of 1,149 doctors on our register through failure to revalidate.‡

* Doctors can receive more than one recommendation.

† The remaining 356 are not associated to a specific location as they are the result of administrative processes necessary to consolidate data.

‡ If a doctor does not fulfil the requirements of revalidation, provides fraudulent information or fails to provide reasonably requested evidence, we can legally withdraw their licence. This process is different to that of being removed from the register, for example, following an MPTS hearing.

Outreach

Our outreach teams delivered training on our standards to:

34,399 **doctors** in **923 sessions** and

That is up **49.4%** from 2023 (23,031).

15,722 **medical students** in **126 sessions** across the UK.

That is up **19.4%** from 2023 (13,167).

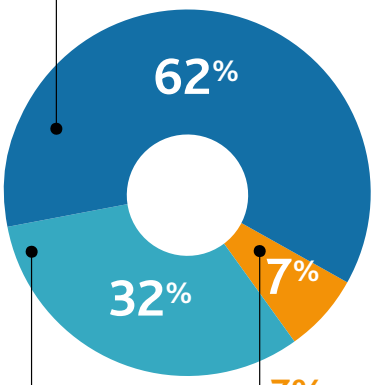
79% of doctors said they would **change their practice** as a result of the session.

Our standards enquiry team answered:

449 enquiries about our guidance.

That is down **3.4%** from 2023 (465).

62% of the enquiries were **from doctors** (2023: 57%).



32% **were from members of the public** (2023: 33%).

7% **were from others,** including staff from professional organisations, students and the police (2023: 10%).

Our outreach teams also deliver workshops aimed at helping doctors who are **new to UK practice** adjust to working in the UK's healthcare systems.

The team delivered **295 *Welcome to UK practice* workshops** in 2024, involving **11,223 doctors** – up **6.1%** from 2023 (**10,575**).

Our employer liaison advisers held **1,292** meetings with responsible officers.

They also provided fitness to practise advice in relation to **2,958** doctors.

Overseeing medical education and training

Quality assurance

We regulate all stages of a doctor's undergraduate and postgraduate education and training, setting standards and carrying out **quality assurance (QA)** work to make sure these are maintained.

Through our **proactive quality assurance** process, we check that medical schools and postgraduate training organisations are continuing to meet our standards and we look for innovative and notable practice in medical education and training. We also decide which organisations can award a UK primary medical qualification. To do this, we QA all institutions looking to establish a new medical school or programme to ensure our standards are met.

Our **reactive quality assurance** processes promote and encourage local management of concerns about the quality and safety of undergraduate medical education and postgraduate training, through which emerging issues affecting education and training environments can be raised and monitored.

If the issues are not resolved or worsen, cases can be escalated into our **enhanced monitoring process**, which we use to address serious concerns where additional support is required.

In 2024 we carried out **209** education QA visits.

That is down **15.0%** from 2023 (**246**).*

157 of the visits were in **England**.
18 of the visits were in **Northern Ireland**.
17 of the visits were in **Scotland**.
17 of the visits were in **Wales**.

169 were **QA visits to medical schools, or clinical environments** where medical education and training take place.
40 were **enhanced monitoring visits**, promoting the local resolution of concerns about postgraduate training.

From our QA visits, we found:

9 areas of **good practice or working well**.
396 areas where our **standards were met**, but where we **identified improvements** that could be made.
7 areas that **required improvement**.†

As a result of our reactive QA activities:

8 cases relating to postgraduate education **were escalated to our enhanced monitoring process**.‡
16 cases escalated previously **were resolved**.§

* We always carry out a minimum of one education QA activity per organisation per year. We may also carry out follow-up activities based on organisations' recommendations or our findings, which are counted in our totals. This inevitably leads to statistical variation in the number of QA activities we carry out from one year to another. This year, we have seen a small decline in QA activity because we did not need to undertake as many follow-up activities.

† Not all QA visits lead to specific findings like those listed here - in some cases nothing of significance is found, as nothing has changed since the previous visit, or nothing has been found worthy of particular note (ie education and training are working as expected). Here, we only report on the number of areas found to be particular examples of good practice, ie working well, or areas requiring improvement or where improvement is recommended. The figures on findings reported here therefore won't necessarily match the total number of visits we carried out.

‡ Enhanced monitoring cases usually concern a specific unit or department in a local education provider (LEP). Monitoring may relate to more than one concern in the same LEP, and a concern under monitoring may affect more than one unit, or an entire trust or health board.

§ Like with QA visits, not all enhanced monitoring visits result in escalation or de-escalation - in some cases the visits focus on monitoring progress towards the resolution of issues that had previously been escalated. The total number of visits therefore won't necessarily match the number of new or open cases or of cases whose status has changed during the year.

Supporting the people we serve

Patient Liaison Service

In 2024, our patient liaison service held 343 meetings with patients who had raised a concern with us.

96% of PLS meeting attendees satisfied or very satisfied with meeting experience in 2024.

95% of PLS meeting attendees agreed or strongly agreed that patient liaison staff showed empathy for their situation in 2024.

93% of PLS meeting attendees agreed or strongly agreed they were satisfied that their concerns had been understood during the meeting in 2024.

93% of PLS meeting attendees agreed or strongly agreed the meetings helped them to understand what action the GMC could take in 2024.

Contact Centre

Our contact centre answered

110,473

calls and

105,840

emails or letters.

73.5%

of the calls and emails we received were from doctors, and

26.3%

from members of the public and others.

The contact centre also handled

68,402

webchat sessions.



In 2024, we received

1,512

complaints about our service.

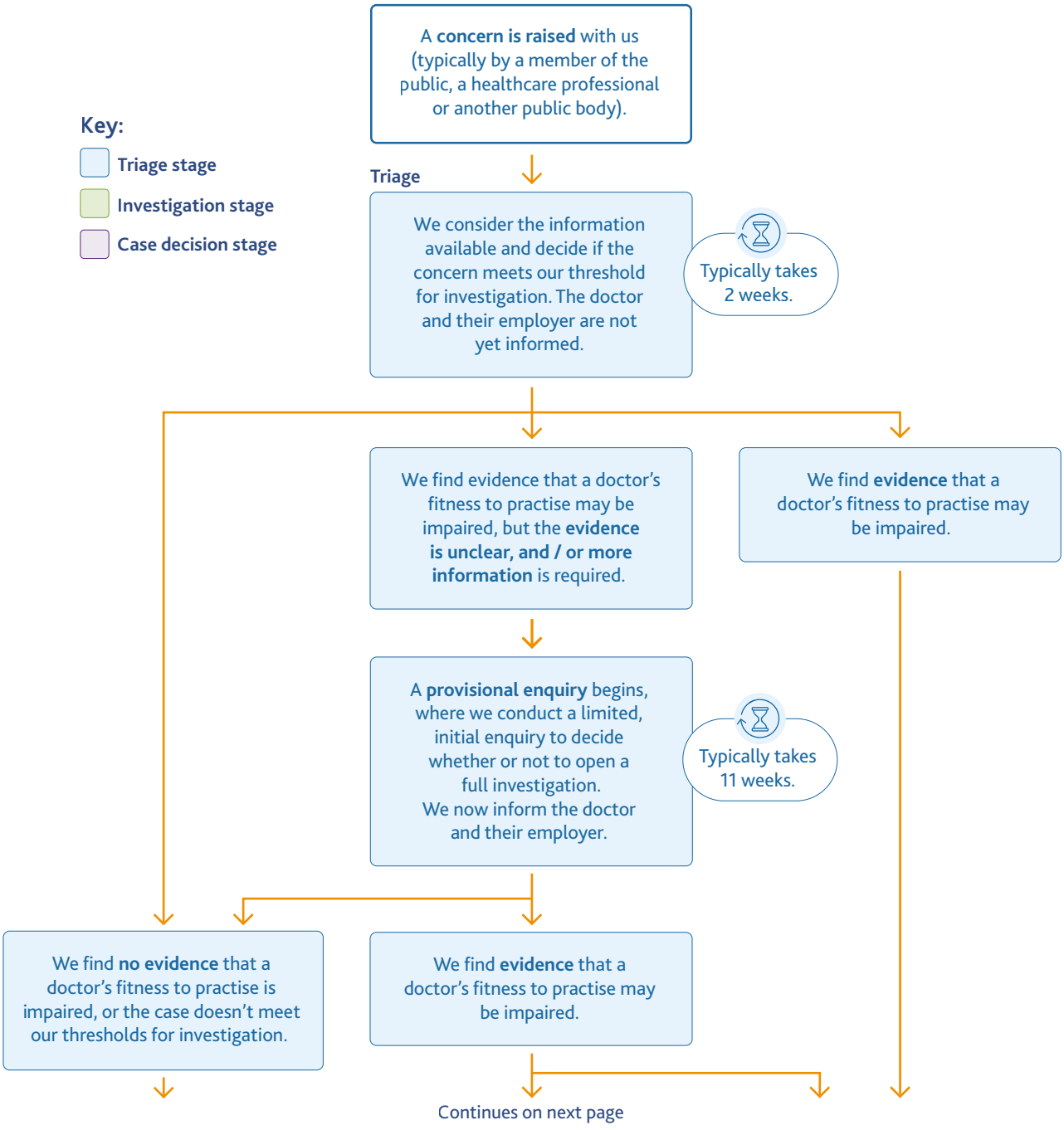
That is down

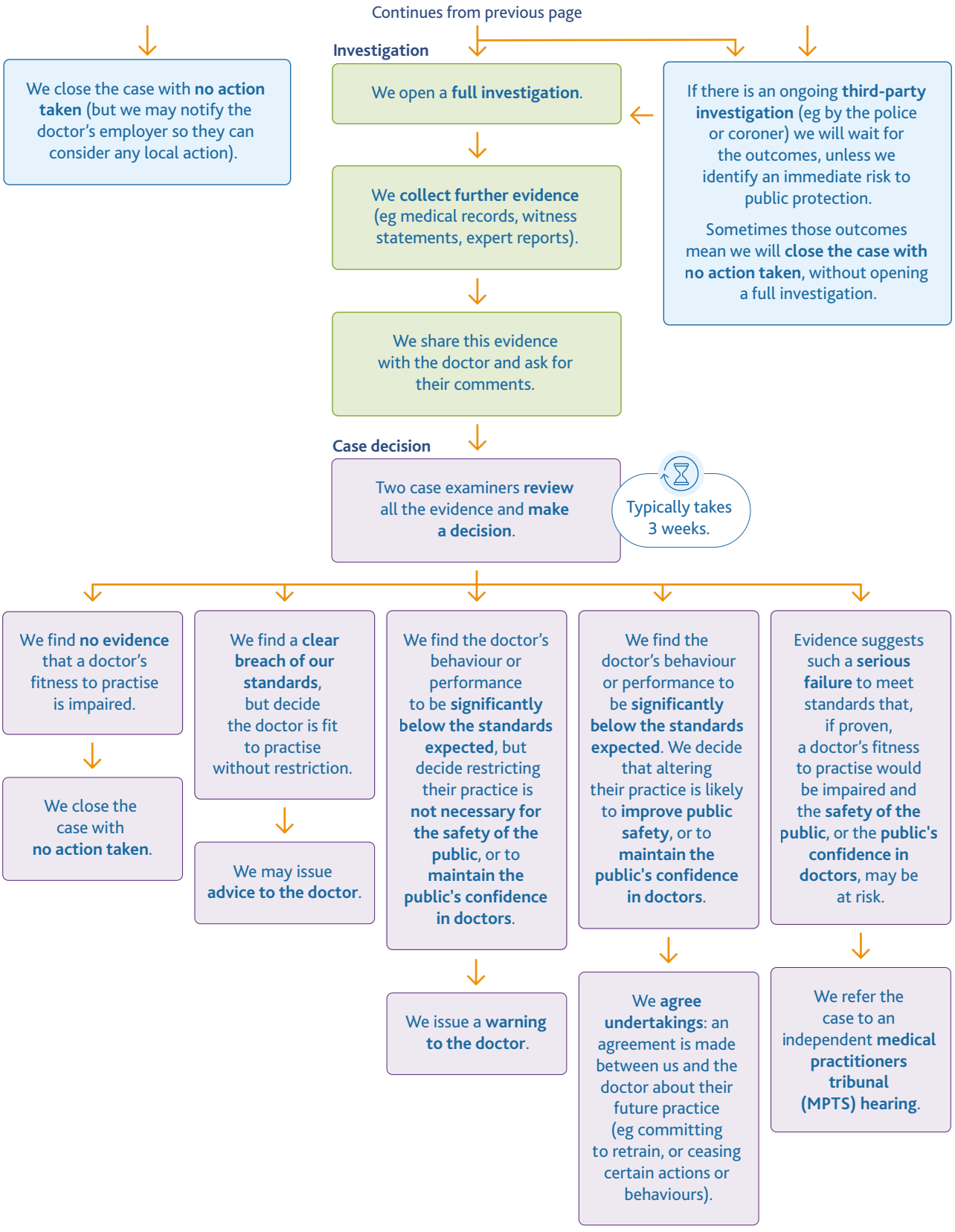
3.4%

from 2023 (**1,566**).

Investigating and acting on concerns

One of our key roles as a regulator is to investigate and act on concerns raised with us about the workforce and a doctor's fitness to practise. We break this process down into three stages, which we call 'Triage', 'Investigation' and 'Decision'. We usually reach 'Decision' within six months, but the length of each stage depends on a range of factors and consequently, in some cases, the process can take a number of years. You can find out more about this process via our How we investigate concerns webpages.




Continues from previous page
We close the case with **no action taken** (but we may notify the doctor's employer so they can consider any local action).
Investigation
We open a **full investigation**.
If there is an ongoing **third-party investigation** (eg by the police or coroner) we will wait for the outcomes, unless we identify an immediate risk to public protection.
Sometimes those outcomes mean we will **close the case with no action taken**, without opening a full investigation.
We **collect further evidence** (eg medical records, witness statements, expert reports).
We share this evidence with the doctor and ask for their comments.
Case decision
Two case examiners **review** all the evidence and **make a decision**.
Typically takes 3 weeks.
We find **no evidence** that a doctor's fitness to practise is impaired.
We close the case with **no action taken**.
We find a **clear breach of our standards**, but decide the doctor is fit to practise without restriction.
We may issue **advice to the doctor**.
We find the doctor's behaviour or performance to be **significantly below the standards expected**, but decide restricting their practice is **not necessary for the safety of the public**, or to **maintain the public's confidence in doctors**.
We issue a **warning to the doctor**.
We find the doctor's behaviour or performance to be **significantly below the standards expected**. We decide that altering their practice is likely to **improve public safety**, or to **maintain the public's confidence in doctors**.
We **agree undertakings**: an agreement is made between us and the doctor about their future practice (eg committing to retrain, or ceasing certain actions or behaviours).
Evidence suggests such a **serious failure** to meet standards that, if proven, a doctor's fitness to practise would be impaired and the **safety of the public**, or the **public's confidence in doctors**, may be at risk.
We refer the case to an independent **medical practitioners tribunal (MPTS) hearing**.

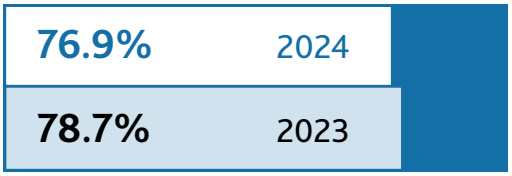
Concerns raised about registrants

10,769 concerns were raised with us in 2024.

This represents a **7.4%** increase on 2023 (10,031 concerns).

59.5%	**59.5%** were raised in relation to incidents that happened **in England**. That is a lower percentage than in 2023 (60.1%).
1.8%	**1.8%** were raised in relation to incidents that happened **in Northern Ireland** – a similar percentage to 2023 (1.5%).
6.0%	**6.0%** were raised in relation to incidents that happened **in Scotland** – a higher percentage than in 2023 (4.9%).
2.6%	**2.6%** were raised in relation to incidents that happened **in Wales** – the same percentage as in 2023 (2.6%).
30.8%	For **30.8%** of them, either there was **no incident location specified, or they happened outside the UK** – a similar percentage to 2023 (30.9%).

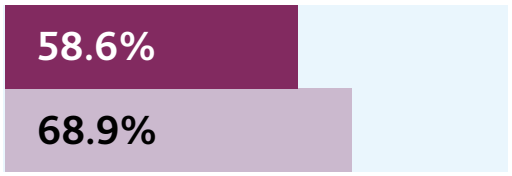
Percentage of concerns raised by the public



Of the **10,769** concerns that were raised with us in 2024, **76.9%** were raised by patients or members of the public. That is lower than 2023 (78.7%).



Of the 6,025 concerns raised in **England** in 2024, 73.5% were raised by patients or members of the public (a decrease from 74.1% in 2023).



Of the 196 concerns raised in **Northern Ireland** in 2024, 58.6% were raised by patients or members of the public (a decrease from 68.9% in 2023).



Of the 534 concerns raised in **Scotland** in 2024, 74.3% were raised by patients or members of the public (a decrease from 78.1% in 2023).



Of the 281 concerns raised in **Wales** in 2024, 67.0% were raised by patients or members of the public (an increase from 59.8% in 2023).



Of the 3,314 concerns raised with **no location specified** or that happened **outside the UK** in 2024, 88.1% were raised by patients or members of the public (a decrease from 89.3% in 2023).

Responding to concerns

Not all the concerns raised with us meet our threshold for an investigation. Sometimes a concern is best dealt with at a local level or by having a conversation with the doctor, or should be brought before another organisation. We only take action where we are concerned there may be a risk to patient safety or to public confidence in the medical profession.

Provisional enquiries

In certain cases, we make provisional enquiries, where we look at information at an early stage of a case, aiming to provide swifter resolution for patients and the professionals involved. If the evidence shows there is no future risk to patients, and regulatory action is not required, we will not move to a full investigation. For cases where we have concerns about patient safety, we will carry out a full investigation.

547

(**5.1%**) of the concerns we received in 2024 were **considered under provisional enquiry**.

~

That is similar to the percentage in 2023 (**4.9%**).

429

of these (**78.4%**) referred to concerns raised by **members of the public.**

↓

That is lower than the percentage in 2023 (**79.4%**).

In

470

cases (**85.9%**) we closed the provisional enquiry with **no action**.

In

63

cases (**11.5%**) we **progressed the case to investigation**.

In

14

cases (**2.6%**) the provisional enquiry was **still open** as of 25 March 2025.

Investigations opened in 2024

906

(**8.4%**) of the concerns we received in 2024 met our **statutory threshold for investigation**.

~

That is similar to the percentage in 2023 (**8.1%**).

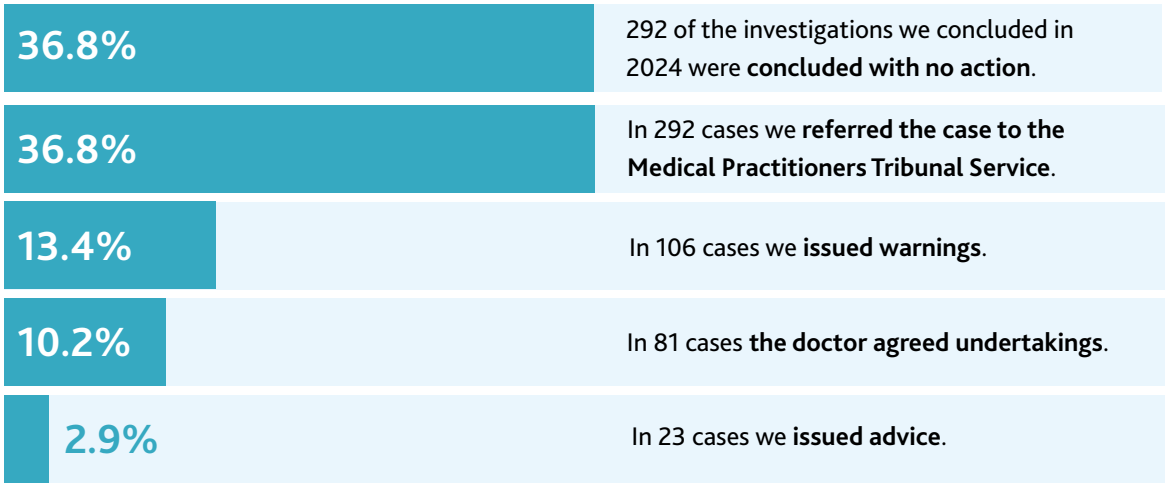
237

(**26.2%**) of these referred to concerns raised by **members of the public**.

↓

That is a lower percentage than in 2023 (**27.6%**).

Outcomes of investigations concluded in 2024



Outcomes of Medical Practitioners Tribunals Service tribunals

In 2024, the Medical Practitioners Tribunal Service held a total of 185 tribunals.

41.1%	In 76 cases, the tribunal **suspended** the doctor who had been referred to the tribunal.
36.2%	In 67 cases the doctor was **removed from the register**.
13.0%	In 24 cases the tribunal found **no impairment**.
4.9%	In 9 cases the doctor had **conditions put on their practice**.
3.2%	In 6 cases, while the tribunal found no impairment, it **issued a warning**.
1.1%	In 2 cases the doctor's practice was found to be impaired but **no further action was taken**.
0.5%	In 1 case the doctor **voluntarily removed themselves from the register**.
0%	There were no cases where the doctor agreed to undertakings.

Where we do not agree with the decisions made by a medical practitioner tribunal, we can appeal them.

In 2024 we made 4 appeals, compared to 2 in 2023. 1 appeal was successful and 3 appeals were outstanding as of 31 December 2024.

Delivering our strategy



Our strategy 2021–25

Our 2021–25 corporate strategy sets out the four themes that shape all our work, helping us to achieve our ten-year vision.



Where we want to be by 2030

Our vision is to be an effective, relevant and compassionate regulator for doctors, physician associates, anaesthesia associates, patients and the public, and as an employer. With 2025 the final year of our current strategy, we are reflecting on how we build on the progress we have made in order to shape our future strategic priorities.

Our 2021-2025 strategy has guided us through challenging times, including the COVID-19 pandemic, allowing us to flex and adapt to support our healthcare systems as they faced exceptional pressures. The learning from our mid-point assessment, conducted in 2023, provided us with valuable insight that will inform the development work for our next corporate strategy (2026-2030). We aim for the next strategy to be ambitious, whilst maintaining our focus on achieving the ten-year vision.

Progress in 2024

Our three-year business plan, which we review on a quarterly basis, summarises how we are targeting our resources at high-impact activities.

Below is a summary of the key activities we have undertaken in 2024 in support of our strategic goals.

Bringing PAs and AAs into regulation, and regulatory reform

On 13 December 2024 we began regulating physician associates (PAs) and anaesthesia associates (AAs), making us a multiprofessional regulator for the first time since the 1950s.*

We were asked to take on this role by the UK Government and the devolved governments in 2019, following a consultation on the subject. Since then, we have collaborated extensively with a wide range of organisations representing patients, doctors, PAs, AAs, employers and educators to define our approach to the regulation of these professions.

The legislation specifying that we would regulate PAs and AAs was approved by the UK and the Scottish parliaments between the end of 2023 and early 2024. Between March and May 2024, we consulted on the rules, standards and guidance by which we would regulate these professions. We reported on the outcome of this consultation in December, including on the changes to our initial proposals based on the feedback we received. Council approved the rules, standards and guidance in an extraordinary meeting, and on 16



December 2024 we invited physician associates and anaesthesia associates to apply to join our new register of PAs and AAs.

To join the register, PAs and AAs need to complete an application and provide evidence of their qualifications and, where applicable, work history and references to show they meet the standards expected of them.

Regulation is a vital step in strengthening both patient safety and public trust in these professions: it will help provide assurance to patients, employers and colleagues that PAs and AAs have the right level of education and training to provide safe care; that they can meet the professional standards expected of them; and that they can be held to account if serious concerns are raised.

We have also continued to work closely with the UK Government on its proposed changes to the legislation that governs the way that we and other healthcare regulators operate. Regulatory reform will help us respond more quickly and flexibly to doctors' and patients' needs, helping us achieve our 2030 vision to be an effective, relevant and compassionate regulator.

* The GMC had responsibility for the register of dentists between 1878 and 1921. The Dental Board took over maintaining the Dentists Register in 1921, but disciplinary cases and exam inspection powers were retained by the GMC until 1956 when they were transferred to the newly created General Dental Council.

The Medical Licensing Assessment

The Medical Licensing Assessment (MLA) is the most significant innovation introduced in undergraduate medical education in the UK for many years. It tests the core knowledge, skills and behaviours of doctors who want to practise in the UK and is designed to give patients and employers greater confidence in doctors starting work in the UK, wherever they were educated or trained. Its launch in 2024 followed years of development and engagement involving medical education stakeholders and our internal assessment development and assessment delivery teams.

From 2024, international doctors seeking registration via the examination route started to take the MLA-compliant version of the Professional and Linguistic Assessments Board (PLAB) assessment, and UK medical students started taking MLA-compliant assessments as part of their degrees. By passing tests that draw from the same topics and meet the same requirements (as set out in the MLA Framework), doctors and medical students can demonstrate that they have the core knowledge and skills necessary for safe practice. This will help to support greater consistency in what we can expect of doctors who are new to the register.

In 2025 the MLA will become part of our routine monitoring and quality improvement activity, and we will continue to work with medical schools to quality assure all aspects of the new assessment.

The future of education and career development (FutureEd)

The UK's population is increasingly diverse and exhibits increasingly complex needs, and medical education and training needs to reflect that. As part of our duty to regularly update our education framework, in 2024 we began a significant review which will see us implement a new framework by 2030.

We published a statement in March which set out our strategic aims, which are to:

- develop more diverse and better-supported educators, supervisors, trainers and mentors
- respond to wider national ambitions for increases in medical school capacity and innovation whilst maintaining standards
- support career development and lifelong learning for all doctors across different environments.*

We have started to engage across the four UK nations, to understand both what needs to change and how we can work with others to achieve our shared ambitions. As part of this, in November we held a one-day symposium, where delegates from different healthcare sectors explored what patients, carers, students and professionals need from medical education and training. We are using the learnings from the event and from a wide range of conversations to develop proposals we can test together in a more formal engagement phase.

* Following the publication of this statement, on 13 December 2024 we became a multiprofessional regulator; we will therefore also consider potential implications for physician associates (PAs) and anaesthesia associates (AAs) as part of this work.

We cannot achieve our aims without enabling greater equality, diversity and inclusion, which also includes understanding the diverse needs of the public. As such, our equality, diversity and inclusion (ED&I) work will be central to the success of the FutureEd programme.

Delivering our core functions

In addition to our large change programmes, we have also maintained a focus on effective delivery of our core areas of work. This included:

- actively responding to the growing professional workforce by expanding our PLAB capacity to avoid bottlenecks, and the new PLAB booking system showed several improvements, such as improved customer experience and reduced enquiries to the contact centre. There is more work to be done on supporting the retention of the workforce however, and this will remain a future focus for us.
- continuing to demonstrate effective management of the timeliness of our fitness to practise processes. We have seen sustained improvements across our defined service level agreements (for example, concluding or referring cases at the investigation stage) since the pandemic.
- ongoing quality assurance of postgraduate medical education and training. Last year we continued to review postgraduate curricula and their programmes of assessment to ensure they meet our standards, and gathered the views of 74,000 doctors in training and trainers about the quality of training through the national training survey. We also worked with training providers to check they are meeting the standards we set. Last year we escalated eight UK departments involved in postgraduate medical training, but not meeting our standards, to enhanced monitoring. When in enhanced monitoring, we have oversight of the improvement plan by the local education provider to make sure that it addresses the requirements we set, and we also attend locally-led visits to investigate the concern and encourage improvements. If we do not see sufficient improvement, we have the option of setting conditions on our approval of the training programme. When we do see progress, we can de-escalate or close an enhanced monitoring case and in 2024, we successfully de-escalated 16 cases from enhanced monitoring.

Supporting professional standards

Over the past year, we have worked to support the implementation of the updated professional standards, *Good medical practice*, which came into effect at the beginning of 2024. This guidance sets out the principles, values and standards of professional behaviour expected of all doctors, physician associates and anaesthesia associates registered with us.

In particular, we updated five key areas of *Good medical practice* to help our registrants:

- create respectful, fair and compassionate workplaces for colleagues and patients
- promote patient-centred care
- tackle discrimination
- champion fair and inclusive leadership
- support continuity of care and safe delegation.

Good medical practice has four domains: knowledge, skills and development; patients, partnership and communication; colleagues, culture and safety; and trust and professionalism. Feedback from our outreach teams shows that engagement with doctors to promote the four domains has enabled constructive and positive conversations to take place on challenging topics relating to discrimination and poor behaviours in the workplace. Sessions have also covered how *Good medical practice* relates to fitness to practise, including exploring together the types of concerns in which we may get involved.

Evaluation evidence shows that the vast majority of participating doctors rated these outreach sessions as either good or very good, and that the workshops not only shared excellent practical advice but also gave participants the chance to meet GMC staff and better understand the role of their regulator, which they appreciated. We will continue to focus on building relationships and confidence amongst the workforce during 2025 as part of a wider programme of work to build trust and confidence in our fitness to practise processes.

Using data, research and insight

As part of our work, we develop and share data, research and insights on medical education and practice to support the development of wider healthcare policies and plans across the UK. In 2024 we used these insights to contribute to some significant central government reviews and consultations, such as the Darzi review (an independent investigation of the NHS in England) and the 10 Year Health Plan for England, *Change NHS*.

Much of what we contributed and shared stemmed from our regular work to understand the medical workforce and the factors affecting retention, as well as our work to quality assure training environments for doctors in postgraduate training. This work included:

- the National training survey 2024, which showed concerning issues within the postgraduate training system, underlining the importance of increasing the capacity of the trainer workforce. As we highlighted earlier in this report, one of our strategic aims under our FutureEd work programme is to develop more diverse and better supported educators, trainers and supervisors. We are committed to working with others to achieve this.
- our *The state of medical education and practice in the UK: workforce report*, which highlighted that the medical workforce is in flux: the headcount of doctors is growing at an increasing rate and in recent years there has been an increase of doctors joining the UK register from abroad (in 2023 two-thirds of new joiners were non-UK graduates). We also highlighted that doctors' career paths are changing, with many doctors working in LE roles rather than entering formal training programmes. These roles are often poorly defined, with limited opportunities for progression. This changing picture of the workforce underlines that concerted, sustained efforts must be made to provide the induction, integration, and inclusion that are vital for all doctors to thrive in the UK.

- our *The state of medical education and practice in the UK: workplace experiences report*, which highlighted that the workplace experiences of doctors across the UK remain very concerning. Satisfaction remains low, and more doctors than ever report taking steps to leave UK practice, reflecting the sustained pressures doctors are under. Despite an increase in doctors on the register, job satisfaction and risk of burnout show no meaningful improvement since the steep deterioration we reported in 2023. Specific groups of doctors are finding workplace pressures more challenging than others. GPs are consistently struggling, along with doctors in training and trainers. And despite being the fastest-growing group on the register, LE doctors are less likely to feel part of a supportive team. This signals a critical need for positive change.
- commissioning independent research to explore doctors' satisfaction with practising in the UK and their attitudes towards migration. Around 3,000 doctors took part in the study which culminated in a number of possible actions for us and others in the healthcare system to consider as we work to improve the retention of doctors in the UK.

All our data and research work in 2024 has strengthened our position as a key health commentator and influencer on medical workforce issues.

Equality, diversity and inclusion

Equality, diversity and inclusion are integral to all our work as a regulator and employer.

In 2021, we established two targeted programmes:

- to eliminate disproportionate fitness to practise referrals in relation to ethnicity and origin of medical qualification by 2026
- to eliminate discrimination, disadvantage and unfairness in medical education by 2031.

We also have two further ED&I programmes of work: inclusivity within the GMC, and a review of regulatory fairness. We report on all four of these programmes to our Council, and publish an annual ED&I report to transparently share our progress towards these targets as well as consider what steps we and others need to take to improve.

There have been consistent improvements on all fairer employer referrals indicators and forecasts, demonstrating the impact of our work so far and moving us closer to our target. Key areas of work have focused on change and review of our referral processes, including improvements to the Responsible Officer (RO) referral form and implementation of a new feedback mechanism to ROs about triage outcomes; anti-bias training for staff involved in reviewing referrals; and providing support and training to system stakeholders.

We have also seen early signs of improvement for those in postgraduate specialty training, particularly for international medical graduates (IMGs) in training. In comparison to 2019 data, the attainment gap is closing between IMGs and other trainees. Evidence suggests that enhanced induction, targeted exam preparation, educator training and mentoring are making a real difference to exam performance. Our indices for those in foundation training show little or no change however, and it is clear that considerable work is needed over a longer period of time for measurable impact to be seen for those in the

early stages of their career. However, there is clear evidence of engagement and activity across both undergraduate and postgraduate training organisations which have established action plans (that they share with us annually).

Throughout 2024, we also continued to work on implementing the recommendations from a review of regulatory fairness that we conducted in 2022. We have explored our regulatory decisions in detail, and have considered and mapped the processes and approaches that exist to ensure we are making fair decisions. We also continued to implement a set of escalation principles, designed to empower colleagues dealing with fitness to practise cases to challenge decisions or raise concerns about a case. We have delivered tailored, interactive learning for all those working in decision-making roles throughout 2024, which uses case studies to show decision makers how to address bias in scenarios that they might face (for example, working with third-party organisations), and focuses on how to apply professional curiosity to high-impact decision making.

Internally, we have seen continued progress in relation to some inclusive employer measures. Performance against our overall workforce target (for 20% of our workforce to be from an ethnic minority background by 2026) is ahead of schedule; attraction rates for ethnic minority candidates remain high for all our roles; and the gap in engagement scores for ethnic minority colleagues and other colleagues continued to close. However, progress in other areas remains challenging. We did not meet our interim 2024 target for increasing representation of ethnic minority colleagues in our management profile, while our turnover rate for ethnic minority colleagues is higher than for other colleagues, though it is improving. We're focusing our efforts on responding to the outcomes from our People survey relating to workplace experiences, such as increasing opportunities for career advancement, as well as implementing a new exit interview reporting process.

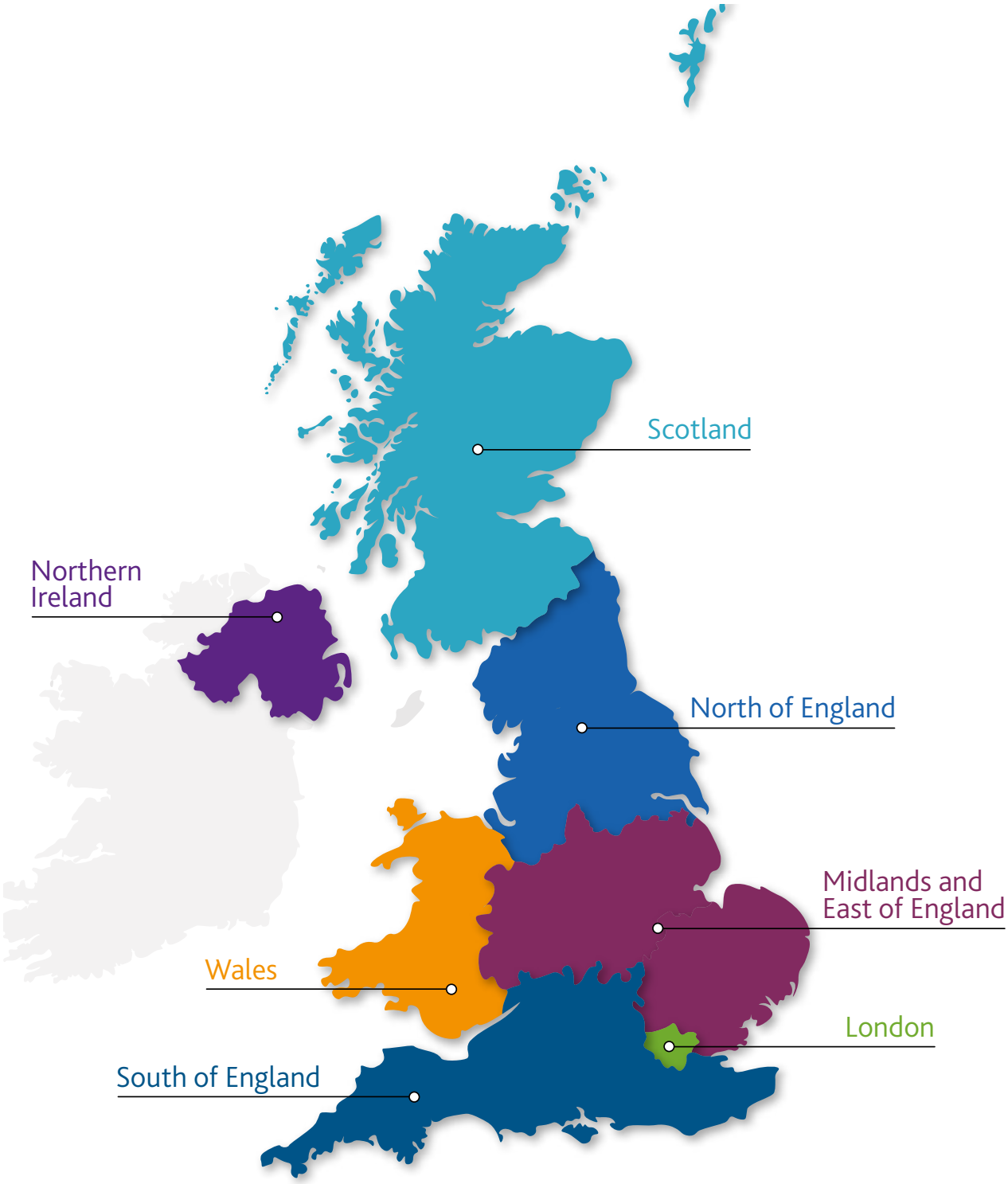
Investing in our people

In 2024 we made further progress on the *Investing in our people to deliver* theme of our strategy. This included:

- the progression of a new career development programme for ethnic minority staff and the successful rollout of our inclusion programme for managers and all colleagues. We also embedded fair decision-making principles into our One GMC behaviours
- achieving Level 2 Disability Confident Employer status
- receiving a positive Investor in People report, with significant improvement from silver to gold rating for 'people' and progress within the silver rating for 'wellbeing'
- seeing tangible examples of our delivery on our corporate social responsibility activities, including developing our work on our net zero plan.

Our plans for 2025 and beyond are summarised in our business plan. You can find more about this theme of our strategy in the *Corporate social responsibility* section later in this report.

Our work across the UK





Our outreach teams engage directly with doctors, PAs, AAs, students, employers, educators and other stakeholders to support the delivery of good, safe patient care.

The strong local relationships they build allow us to promote good practice and to influence positive, constructive change for doctors, PAs, AAs, patients and other stakeholders in the UK's healthcare systems.

The teams include regional or national liaison advisers, employer liaison advisers, senior advisers, operational coordinators and assistants, business and project managers, and 25 associates working across England, Northern Ireland, Scotland and Wales.

In England, the teams are organised to reflect the seven geographical NHS England regions: with the exception of London, each England outreach team covers two NHS regions and the integrated care systems they oversee. In Northern Ireland, Scotland and Wales the teams cover the entirety of the respective nation. This approach ensures that each region or nation is considered separately, so that productive relationships and engagement happen at the right level, through teams of a manageable and effective size.

In particular, the teams:

- train doctors, PAs, AAs and students on the professional standards and how to apply them
- advise clinicians, responsible officers, employers and others on promoting positive leadership and culture and protecting wellbeing in the workplace
- support responsible officers and others on improving the quality of referrals, and on promoting good clinical governance more generally, including the fair and effective local resolution of concerns
- work closely with colleagues responsible for overseeing education to check that the standards for education and training are met, and to address challenges in training environments when these emerge.

This external engagement builds positive relationships across our healthcare systems, helping also to improve understanding of who we are and what we do, fostering trust in our work.

In this section of the report, we highlight some of the work the teams have done in collaboration with partners in 2024. Each example helps to demonstrate the breadth of our outreach work and the positive impact of targeted, timely frontline support. They also show the value of building strong relationships and sharing expertise, with the aim of promoting good, safe patient care and improving work environments for doctors, PAs, and AAs and those who work with them.

You can find out more about our work in Northern Ireland, Scotland and Wales by reading our latest national reports, available on our website.

England

Breaking down barriers using *Good medical practice*

Reaching out to locum doctors

We know that many locum doctors (doctors who are employed on temporary contracts through an agency) do not have access to the same level of support as their Trust-employed colleagues, which can often lead to higher numbers of complaints being raised about them.

The temporary nature of their contracts, and the fact they may have relocated at short notice, can make starting a new position stressful for locums. Combined with the fact that many locum doctors have graduated outside the UK and are from an ethnic minority background, this can, unsurprisingly, lead to them feeling isolated in their work and finding themselves having to make decisions without the appropriate support mechanisms available.

Unfortunately, these factors also make it hard for us to reach and contact these doctors. Our outreach teams have been working hard to reduce referrals of locum doctors to the GMC for some years, including working with staff at the agencies who employ locums to help them understand how they can better support these doctors and make sure they select appropriate placements for them.

In 2024, outreach colleagues in the south of England developed a bespoke training session on the new *Good medical practice* designed specifically for locums. The team has built close relationships with locum agencies across the south, and they used these to develop and roll out bespoke online webinars for several hundred locums.

The first of this webinar series focused on the launch of the new *Good medical practice* guidance, and familiarised locum doctors with its key principles and updated sections. More than 250 locum doctors joined the first online seminar; due to its success, the session was used as a template for a tailored session which was rolled out to almost 200 GPs across the southeast.

Later in 2024 the team provided further sessions to a locum agency in collaboration with experts from our standards team. These sessions focused on the key principles of *Good medical practice* by sharing case studies of doctors who had found themselves in difficulty, as well as explaining our fitness to practise thresholds and processes.

The team are planning further sessions for locums in 2025.

> “The GMC representative humanised *Good medical practice*”
>
> **A locum doctor who attended one of the training sessions**

Advocating for more active bystanders

Our standards make it clear that all doctors, PAs and AAs have a responsibility to tackle discrimination and abuse where it arises. Being an active bystander means considering how best to act, and how to support any individual who has experienced discriminatory or abusive behaviour.

In 2024, our outreach team in the north of England welcomed an opportunity to promote this theme within *Good medical practice* by working

closely with East Lancashire Teaching Hospitals NHS Trust. The Trust is working hard to become more proactively anti-racist, and our team developed some bespoke training sessions that could be delivered as part of its wider change programme.

> "Your presentation was both insightful and engaging. Your expertise and perspective added tremendous value to our programme, and the feedback we've received from attendees has been overwhelmingly positive. It was clear that your session resonated with many."
>
> **Feedback from the Trust organiser for the pilot bystander training session**

When a similar theme emerged in local conversations across the North East and Cumbria, our team created an interactive session which provided an opportunity for attendees to think about their responsibilities as an active bystander in speaking up and taking action where possible. Participants were also invited to reflect on how individual behaviours, as well as wider organisational culture, can impact their willingness to stand up and speak out.

Both sessions were so successful – attended by 83 doctors and other healthcare professionals – that our liaison advisers across the north developed this bystander session into one that was adaptable for wider rollout and use, building in important related aspects of leadership, improving working cultures and speaking up.

This broader bystander session is now being rolled out across the region in 2025, supported by the Regional Responsible Officer Network.

Combatting gender-based assault, abuse and discrimination

Addressing sexual assault and misconduct

In early 2024, our outreach team in London became aware of serious allegations about sexual assault and misconduct in the general surgery department of a London hospital.* Shortly afterwards, issues were also raised with NHS England by foundation programme doctors in the same department around the safety of their learning environment.

Our outreach team in London shared the allegations they had received immediately with the GMC's education quality assurance (QA) team. Our QA team, in turn, shared those allegations with NHS England, enabling them to triage the issues.

In order to better understand these concerns, our outreach team ran two workshops with the hospital's foundation programme doctors, which focused on practical tips for raising concerns and implementing the duty of candour. The team asked the doctors a range of questions about the culture of their workplace; thankfully, none of the doctors said they felt under pressure to remain silent. This intelligence allowed our team in London to

* All relevant authorities were engaged in this issue.

confirm that the concerns were confined to a single department at the hospital, rather than being a site-wide issue.

As a result of this intervention, NHS England has now taken steps to protect foundation programme doctors by withdrawing them from the affected hospital department. The GMC has further supplemented this protection by placing clear conditions on our approval of training in that department.

The hospital has recognised the value of our outreach team's intervention and has since asked them for help in engaging consultants with its wider programme to improve working culture across its site. The team is currently working with the hospital to deliver training on addressing sexual misconduct and harassment.

Creating a toolkit to tackle misogyny and sexism

Our outreach team in the Midlands and East of England has been working closely with a range of stakeholders throughout 2024 to help develop a new sexual safety toolkit, informed by the discrimination guidance within *Good medical practice*.

The project began following research undertaken by a medical student about experiences of misogyny and sexism. Their research captured discriminatory comments relating to gender roles and perceived abilities based on gender and also looked at whether concerns were dealt with effectively by the medical school and Trust.

This evolved into the creation of a fully developed, professional toolkit, with a working group – including members of the Midlands and East of England outreach team – coming together to look at what resources or interventions were available for people who have experienced misogyny and sexism, and how they could be collated as a single, easy to use toolkit to improve the experience of medical students and postgraduate doctors in training.

Our outreach team provided guidance to the working group around the professional standards for doctors in *Good medical practice*, and worked closely with all members to inform content, format and structure. Through a mix of text, video and in-person demonstrations and role-play, the toolkit develops users' understanding around handling sexist or misogynistic occurrences by drawing on real-life case studies. Users learn about microaggressions and bystander behaviours, and are given ideas about how to deal with experiences in the moment itself as well as after they have occurred.

The toolkit will sit within a suite of resources held by the NHS England Regional Workforce, Training and Education directorate to support organisations in addressing misogyny, sexism and sexual violence. It will be openly accessible to make sure it can benefit as many people as possible – from within Trusts, medical schools and beyond – and its content will be regularly reviewed to make sure it remains up to date.

Northern Ireland

Establishing and embedding ED&I training for early career doctors

The link between workplace cultures, staff wellbeing and safe patient care is well established. Doctors working in inclusive environments are more likely to provide safe patient care and to remain working in the UK's health services.

In Northern Ireland, training in equality, diversity and inclusion (ED&I) is offered to doctors who are trainers and those in leadership roles; however, no formal training is offered to early career doctors and medical students.

Our Northern Ireland outreach team wanted to address this by creating and embedding a new ED&I training module in the country's undergraduate and postgraduate training programmes, encouraging medical students and early career doctors to act when witnessing ED&I issues or unprofessional behaviour.

> "I think a full day could be dedicated to this session. Thoroughly enjoyed [it]."
>
> **An FY2 doctor who attended the new ED&I training**

They held focus groups with Foundation Year 1 (FY1) doctors and doctors in postgraduate training to shape and design the training module. The team also worked with the Northern Ireland Medical and Dental Training Agency (NIMDTA) to establish an additional new workshop for hospital specialty and GP trainees: this is now a permanent part of their professional development programme.

> "If you hope to change [Northern Ireland's] medical culture, this should be mandatory."
>
> **An FY2 doctor who attended the new ED&I training**

In 2024, the team delivered seven workshops to 209 Foundation Year 2 (FY2) doctors. Of the FY2 doctors who completed our evaluation of the workshop:

- 78% said they had never received training on ED&I issues before
- 95% rated the workshop as good or excellent
- 97% said the workshop helped them reflect on their practice
- 81% said their practice would change as a result of the workshop.

The team also collaborated with Queen's University Belfast and Ulster University in designing an ED&I module specifically for medical students in Northern Ireland. The module was delivered to 270 medical students at Queens University Belfast in 2024, and the first session will take place at Ulster University in early 2025.

Scotland

Caring for a workforce under pressure

The updated *Good medical practice* highlights the importance of trust, safety, communication and positive culture for doctors and their wider teams. We know that staff wellbeing is essential for these principles to be front and centre in workplaces.

2024 saw the culmination of a key piece of work to support this in the Scotland team, which started in 2022 with the development of a workshop based on the 2019 *Caring for doctors, caring for patients* report, which highlighted how workplace stress in healthcare organisations affects quality of care for patients, as well as doctors' own health.

> "This really helped unite a sense of positivity in a very challenging climate. I hope to take this forward and be more supportive for my colleagues."
>
> **Session participant**

The resulting new interactive *Caring for a workforce under pressure* (CfWUP) workshop focuses on examining wellbeing from the perspective of the workforce, enabling participants to discuss issues leading to burnout and to work through case studies to look for potential solutions.

The workshop is designed to build on the recommendations of the report and support those working in healthcare to make small but tangible improvements to their day-to-day workplace experience. It also aligns with a number of national priorities in Scotland, including the recently launched Scottish Government *Improving wellbeing and working cultures* framework and action plan.

In 2024 our Scotland team coordinated and delivered pilot sessions of the workshop in NHS Tayside, NHS Lanarkshire, NHS Greater Glasgow and Clyde and the Royal College of Emergency Medicine, as well as delivering a tailored session for senior leadership in NHS Highland.

Feedback from these pilot sessions was extremely positive, with 91% rating the workshop 'very good' or 'good', and participant feedback showing appreciation that we are taking positive action to support doctors. The team also followed up with attendees 3-6 months after their session to ask if they have made any positive changes since the session, and found their responses clearly demonstrate how this session can make a tangible day-to-day difference to a workforce under pressure.

In 2025, the team will continue to roll out the workshop across health boards in Scotland, using updated case studies and working with directors of medical education to identify areas and teams that would benefit most. They will also share the session with GMC colleagues so the workshop can be made available for use UK-wide if requested.

We are proud of how our contribution to the health service in Scotland has matured over the last two decades, and are keen to enhance this even further in the years ahead.

> "I am reassured that the GMC are on this and are fighting for our wellbeing."
>
> **Session participant**

Wales

Helping international doctors feel welcomed, valued and supported

The number of licensed doctors in Wales who attained their primary medical qualification outside the UK has increased by 40% since 2019, the largest increase of all four UK countries. The high number of doctors with an international qualification means it is crucial their inductions are tailored to be inclusive for clinicians from a broad variety of backgrounds, and help them hit the ground running when they start to practise in the UK.

> "This course takes the weight off my shoulders."
>
> **Feedback from workshop participant**

This topic was a key focus of discussion with system leaders at our spring UK Advisory Forum in Cardiff, with conversations about how induction best practice could make a tangible difference to cultures within teams and support good, safe patient care. The Forum also felt that a more standardised induction offer for this group of doctors was needed in Wales.

Since 2022, the Wales outreach team has been working with health boards to support induction programmes for doctors who graduated abroad, as part of their ongoing work to foster integration and inclusion. They created a full-day workshop which focuses on core standards from *Good medical practice*, ranging from confidentiality to communication skills and effective multidisciplinary working. This workshop was initially piloted in one health board in 2022, with variations trialled across two health boards the following year.

> "It was great to meet other IMGs and to know I am not alone."
>
> **Feedback from workshop participant**

In 2024, the team expanded this offer further, running five sessions across four health boards. At the request of Health Education and Improvement Wales (HEIW) we ran workshops on how to support internationally-qualified doctors at their Sharing Training Excellence in Multiprofessional Education conference in March. This also led to further discussion and strategic planning within HEIW and health boards about what practical activity needs to happen to make sure these doctors are supported in their transition to UK practice.

Rolling out these sessions more widely helps make sure that all newly-recruited international doctors receive the support and guidance they need within appropriate timeframes when joining the NHS in Wales. Embedding this workshop as business as usual within Wales also provides doctors with an essential peer support network at an early stage in their careers, while they are new to UK practice, and indeed the UK itself.

From 2025 we will be holding these sessions across five out of the seven Welsh health boards and run them three times a year in line with increased demand. We will also be enriching this offer of support to include supervisors of doctors who graduated abroad, with workshops focusing on effective cross-cultural communication and appropriate, timely feedback.

Corporate social responsibility



We are a socially responsible organisation, constantly looking for new ways to embed sustainability, social impact and ethics into what we do.

In 2024 we progressed efforts to reduce our carbon footprint and supported social mobility and widening participation in medical training in the UK.

Protecting the environment

We first launched our net zero plan in 2023, which set a target for us to become a net zero organisation by 2040. We have a more ambitious aim within this – to reach net zero emissions for scopes 1 and 2 by 2030* – underpinned by our commitment to reduce our emissions as much as possible before offsetting any residual emissions. Our Net Zero Working Group oversees progress on our net zero journey.

Our combined Scope 1 and Scope 2 market-based carbon dioxide emissions have reduced over the years, from 377 tonnes in 2019 to 169 tonnes in 2024, and we expect further reductions as we explore renewable tariffs and how we can further reduce our energy consumption. Our procurement and supply chain represents our largest area of emissions overall, and we are exploring ways in which we can engage with our top suppliers to reduce this.

Our business travel emissions have also reduced since 2019 (from 727 tonnes of carbon dioxide to 418 tonnes in 2024), as have our staff commuting and home-working emissions, as we switched to more virtual ways of working post-pandemic. We are developing a Green Travel Plan which will help us explore what we can do to reduce these further, and in 2024 we ran our second annual Travel and Homeworking Survey. This survey allows us to obtain data which is more relevant to our organisation than was previously used, meaning we can continue to reflect our emissions in this area using actual data obtained from colleagues.

Whilst these reductions are promising early indicators, we acknowledge that there are further actions we can take to reduce our emissions. As our 2030 target for scopes 1 and 2 approaches, we will be undertaking energy efficiency projects to reduce our energy consumption where possible. We will also explore how we can improve our datasets alongside ways we can take positive action to minimise our impact on the environment.

Sustainability in healthcare is a priority, and we recognise the connection, relevance, and impact on human health and the practice of individual doctors, physician associates (PAs), and anaesthetist associates (AAs). In 2024, we published an updated version of *Good medical practice* which set a specific duty that doctors, PAs, and AAs should choose sustainable solutions where possible, and consider supporting initiatives to reduce the environmental impact of healthcare.

In 2024 we also published a statement on planetary health, sustainability and climate change in medical education. We have been working with medical student representatives of the Planetary Health Report Card initiative – an international student advocacy group evaluating planetary

* Scope 1 emissions are the greenhouse gasses controlled and emitted directly by an organisation, which for the GMC is mainly our gas consumption. Scope 2 indirect emissions are those that are generated through the purchase and use of electricity.

health content in medical schools – to identify how planetary health, climate change and sustainability should be reflected in medical education. In setting the standards and outcomes for UK medical education, we play a vital role in ensuring that doctors enter the workforce with the necessary knowledge, skills and experience to incorporate planetary health and sustainable healthcare concepts into clinical decision making, and we are keen to progress this agenda.

Working with other regulators

We continue to coordinate the cross-regulator Corporate Social Responsibility (CSR) Group, which meets to share updates, ideas and progress on individual initiatives. Membership expanded further in 2024 and now includes the Nursing and Midwifery Council, General Dental Council, General Pharmaceutical Council, General Osteopathic Council, Health and Care Professions Council, General Chiropractic Council, General Optical Council and Social Work England. Representatives from the Greener NHS team are now also regular attendees at these meetings. Given the difference in size between the regulators, and the similarity in the groups' CSR missions, these meetings provide an ideal opportunity for all involved to share learning, best practice and resources.

The group met four times during 2024 for themed discussions, on topics such as responsible investment. When considering sustainability and regulation, and the growing influence of sustainable healthcare on education and training standards, we outlined the development and introduction of appropriate regulatory standards in our core standards.

Promoting social mobility

Apprenticeships provide exciting and varied career opportunities to those who may not have access to further education, or who particularly benefit from on-the-job training. In 2024 we welcomed five apprentices to different teams across the GMC, including in the Clinical Assessment Centre, Registration, Information Services, and in the Medical Practitioners Tribunal Service (MPTS). Apprenticeships vary in length and in 2024 we held a celebration event for everyone who completed their apprenticeship and 'graduated' to permanent roles at the GMC.



Widening participation in medical education continues to be a priority for us: young people must have a fair and equal opportunity to become our doctors of the future. In 2024 we hosted events for two London-based organisations, Melanin Medics and The Aspiring Medics, which each support racial diversity and widening participation in UK medical training and careers. These events provided a day packed with tutorials and speakers for attendees.

> One of the most useful things was getting to speak to people in different stages of their medicine career and hear their advice and tips to us.

1st year student, Lancaster Medical School

We also invited groups of foundation year students from medical schools at Edge Hill and Leeds universities, and first year students from Lancaster Medical School, to visit our office in Manchester. All these students had joined medical training through a widening participation scheme and these visits were part of a programme designed to give them additional support once at medical school. Students were able to learn more about our work, as well as about pioneering doctors from the past. These events provided valuable networking opportunities for students and offered an early introduction to their future professional regulator.

> It was good to meet and speak to students from other universities, I gained a better understanding of what the GMC does.

Foundation Year student, Edge Hill University Medical School

Supporting the community

Throughout 2024 we continued our partnership with the Royal Voluntary Service's Befriending Scheme, which connects volunteer members of staff with people at risk of being lonely or isolated through weekly companionship phone calls. The initiative provides invaluable support to elderly people, and many of our volunteers have formed lasting connections with the people they call.

> The mentoring I received from the GMC coach was invaluable and I was inspired as I prepared to re-enter the job market.

Business in the Community coaching participant

Some of our in-house coaches also continued to support a Business in the Community initiative guiding long-term unemployed individuals seeking to re-enter the workplace. In November colleagues from across the GMC held an open day at the office for participants in The Girls Network, a charity which supports teenage girls facing multiple barriers in school, such as low confidence and self-belief and a lack of professional female role models to inspire them. The event received very positive feedback from the girls and their teachers, who highlighted they enjoyed listening to female GMC staff sharing their own career journeys and life challenges, and also learning about the different careers at the GMC.

Our structure, governance and management

Council and other governance groups

Council is our governing body. It provides strategic direction, holds the executive to account, and takes major high-level policy decisions. It comprises 12 members from the four countries of the UK. Six are registrant members and six are lay members.

We are a registered charity and our Council members are also the trustees of the organisation.

They are all independently appointed by the Privy Council through a process that follows the Professional Standards Authority's guidance for making appointments to healthcare professional regulatory bodies.

The trustees between 1 January 2024 and 31 December 2024 were:

- Dame Carrie MacEwen (Chair)
- Steve Burnett
- Vanessa Davies
- Professor Anthony Harnden
- Lord Philip Hunt*
- Professor Paul Knight
- Professor Deepa Mann-Kler
- Douglas Millican
- Dr Raj Patel MBE
- Professor Suzanne Shale
- Dr Jeeves Wijesuriya
- Alison Wright.

Steve Burnett, Anthony Harnden and Paul Knight reached the end of their second term of office and demitted from Council on 31 December 2024.

A competitive process to replace them, as well as to fill the vacancy left by Philip Hunt, took place during 2024. Keith Lloyd, Olamide Oguntimehin, Jane Ramsey and Wendy Williams CBE were appointed by the Privy Council to join our Council from 1 January 2025.

All Council members are also asked to declare any conflicts of interest. These are listed in a register of interests published on our website.

Council members also participate in appraisal reviews, and in a 360-degree feedback process that takes place every two years. The process includes consideration of any learning and development needs and revisits actual or perceived conflicts of interest to make sure any potential conflicts identified are manageable.

As a charity, we take into account the seven principles set out in the Charity Governance Code (2020) and can demonstrate how we use these principles to guide our work on an 'apply or explain' basis.

There are two exceptions to the Code, which we explain rather than apply. Firstly, our Council and committees operate without a formally appointed deputy or vice chair. However, provisions are made in the *Governance Handbook* for chairs to nominate a deputy to assist during periods of absence. Secondly, as our appointments process is well established and thorough and is overseen by the Remuneration Committee and the Professional Standards Authority, a separate nominations committee is not considered necessary.

* Philip Hunt resigned as a Council member on 31 January 2024 due to a conflict of interest created by his return to a more active role in the House of Lords.

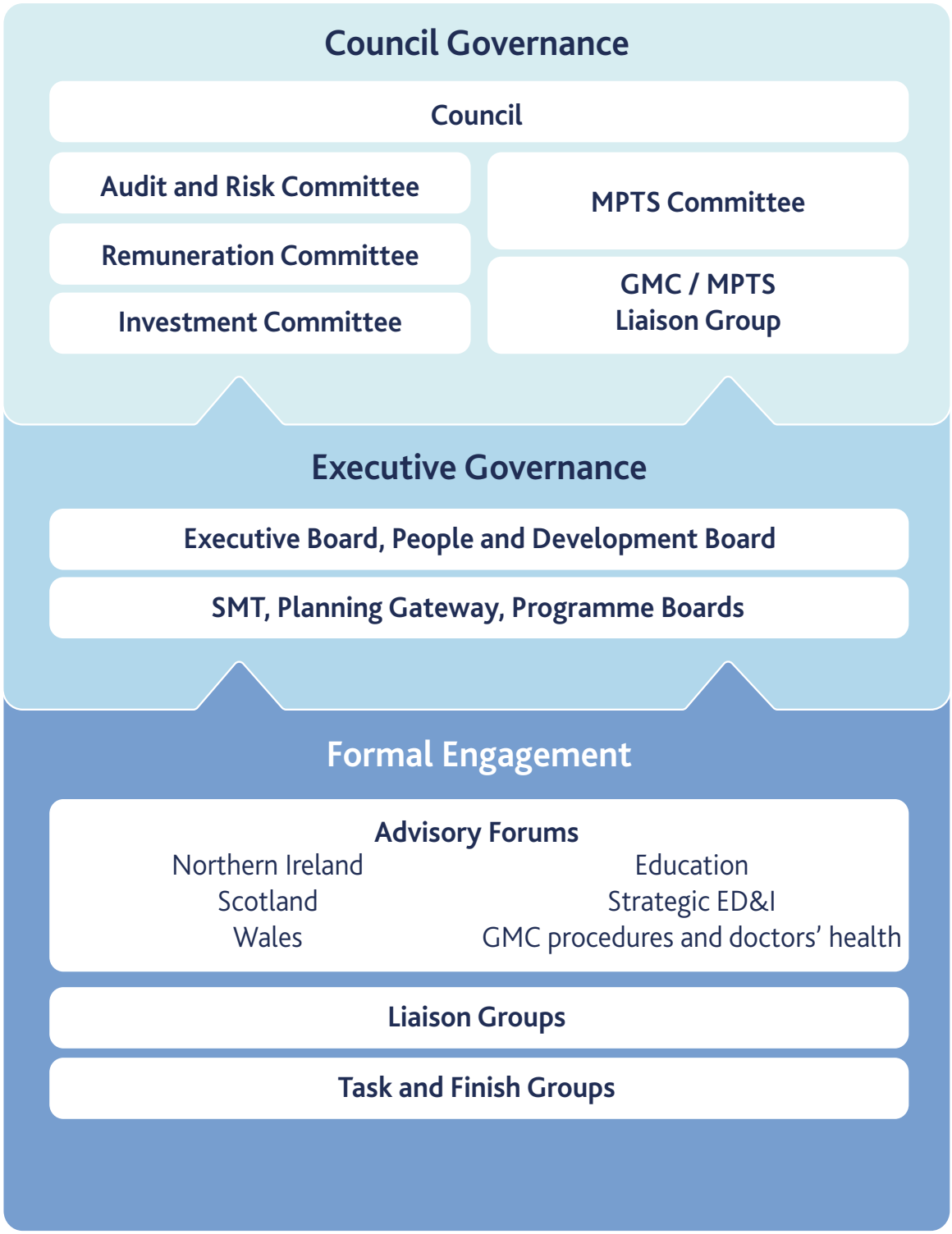
The *Governance Handbook* is the governing document of the organisation. In December 2024, we reviewed it to reflect the introduction of the Anaesthesia Associates and Physicians Associates Order (AAPAO). Changes were made to reflect that the GMC is now the regulator of doctors, PAs, and AAs. The schedule of authority (or scheme of delegation from Council) was updated, and introduced Authorised Decision Makers to perform roles under the AAPAO which are similar in nature to the roles performed by Assistant Registrars under the Medical Act. Any other minor updates are made with Council's approval on an ongoing basis, for example to the membership of committees.

As well as supporting Council in maintaining high standards of governance, our Corporate Governance team also provides training and advice to the organisation on matters of governance. Each committee accounts to Council through a formal report, and Council and each committee undertake to review the committees' effectiveness in delivering their statement of purpose, which is reviewed annually.

Council business is conducted in an open and transparent manner and the agenda and papers for each meeting are published on our website.

Council generally meets six times a year. It meets in London, in Manchester and once in either Belfast, Cardiff or Edinburgh. In addition, a strategic away day takes place once a year.

The diagram on the following page shows the different governance groups that assist Council in carrying out its responsibilities effectively. These have all been agreed by Council. The roles and activities of these groups are described in the pages that follow.


Council Governance
Council
Audit and Risk Committee
Remuneration Committee
Investment Committee
MPTS Committee
GMC / MPTS Liaison Group
Executive Governance
Executive Board, People and Development Board
SMT, Planning Gateway, Programme Boards
Formal Engagement
Advisory Forums
Northern Ireland
Scotland
Wales
Education
Strategic ED&I
GMC procedures and doctors' health
Liaison Groups
Task and Finish Groups

Audit and Risk Committee

In 2024 the Audit and Risk Committee (ARC) was chaired by Paul Knight. Its external co-opted members were Jon Hayes and Aneen Blackmore. Paul Knight demitted on 31 December 2024 and, following a three-month period of transition, the new chair, Vanessa Davies, took on the post from 1 January 2025.

The Committee plays a key part in our governance, providing Council with independent assurance about:

- the integrity of our financial statements
- the effectiveness of internal control, governance, and risk management systems
- the delivery of internal and external audit services.

The Committee met five times in 2024, and provided a short briefing note on key issues to Council after each meeting. It also formally reported to Council twice, in June and December. You can find more about its work in the *Audit and Risk Committee report* section later in this report.

Remuneration Committee

In 2024, the Remuneration Committee was chaired by Anthony Harnden (to be followed by Alison Wright as chair of the Committee from 1 January 2025).

The Committee advises Council on the remuneration, the terms of service and the expenses policy for Council members, including the Chair. It oversees the recruitment process of the Chair and Council members before their appointment by the Privy Council. It determines the appointment process for the Chief Executive and Medical Practitioners Tribunal Service (MPTS) Chair, and the remuneration, benefits and terms of service for the Chief Executive, Directors, MPTS Chair and MPTS Committee members.

In 2024, the Committee was actively engaged in the process to recruit four Council members. It is also responsible for making sure the assessment and measurement of performance, recruitment and succession planning take place within an appropriate framework for the senior management roles within its remit. The Committee reports annually to Council and met twice in 2024.

Investment Committee

Steve Burnett chaired the Investment Committee in 2024 – to be followed by Douglas Millican as chair of the Committee from 1 January 2025. The Committee's external co-opted members during 2024 were Keith MacKay and Mike Jennings.

The Committee is responsible for:

- implementing and reviewing our investment policy
- making sure the management of assets is consistent with the policy
- appointing and managing fund managers
- monitoring performance
- overseeing treasury management
- overseeing our investment in GMC Services International Limited (GMCSI).

The Committee reports on investment performance to Council at each Council meeting, and it reports on the performance of the portfolio to Council on an annual basis. It met five times in 2024.

GMC Services International

GMC Services International (GMCSI) was established by Council in 2016 as a wholly owned trading subsidiary of the GMC. Its main objective is to offer the GMC's support and expertise to countries and institutions working to improve standards of healthcare, who have less experience with the regulation of healthcare professionals and of medical education. Robust and effective governance arrangements are in place to ensure that our interests are protected and that our relationship with GMCSI is managed effectively.

Council has overall responsibility for GMCSI; the Investment Committee oversees our investment in GMCSI; and the Audit and Risk Committee considers the risks to the GMC from the operation of GMCSI, conducting routine internal audit and spot checks as appropriate.

Andrew McCulloch chaired the GMCSI Board during 2024. The Board comprised (in addition to the Chair) Paul Reynolds, Alison Wright, Deepa Mann-Kler, Colin Melville and Helen Featherstone. Thalia Georgiou and Victoria Cheston were appointed as independent Board members on 20 May 2024. The Board met four times in 2024.

Board of Pension Trustees

The GMC's defined benefit staff superannuation scheme is managed and administered by a board of trustees in accordance with the scheme's trust deed and rules. The trust makes sure the pension scheme's assets are kept separate from those of the employer, and is a separate entity to the GMC. Accordingly, it reports via its own, separate annual report.

The scheme's trustees are responsible for the proper running of the scheme, including the collection of contributions, the investment of assets and payment of the pension benefit commitments made by the employer.

Vanessa Davies chaired the Board during 2024, and the new chair, Graeme Coughey, took on the post from 1 January 2025. Vanessa, Steve Burnett, Paul Knight, Raj Patel and Ian Hodgson (who joined as a professional pension trustee in February 2024) are employer-nominated trustees.* John Foley, Paula Robblee, Martin Hart and Samantha Anthony are member-nominated trustees.

MPTS Committee

The Medical Practitioners Tribunal Service (MPTS) runs hearings that make independent decisions about whether doctors, physician associates (PAs) and anaesthesia associates (AAs) are fit to practise in the UK. It operates separately from the investigatory role of the General Medical Council. A key part of our governance structure is the statutory MPTS Committee, which makes sure the MPTS meets its responsibilities under the Medical Act 1983 and the Anaesthesia Associates and Physician Associates Order (AAPAO). Her Honour Judge Deborah Taylor was the Chair of the MPTS in 2024.†

The GMC / MPTS Liaison Group is another core part of our governance framework. It is chaired by the Chair of Council and oversees the working relationship between the MPTS and the functions of the GMC with which it interacts.

* Steve Burnett and Paul Knight demitted on 31 December 2024.

† Her Honour Deborah Taylor stepped down as Chair of the MPTS in April 2025. Gill Edelman is serving as acting MPTS Chair until a successor is appointed.

Executive Board and People and Development Board

The Executive Board is the senior decision-making and oversight forum providing strategic direction, scrutiny and reporting to Council by the GMC's senior management team. The Board meets monthly (except for August) and reports to every meeting of Council through the Chief Executive's report and via a separate annual report.

The People and Development Board is chaired by the Chief Executive and meets five times a year to bring focus to our people strategies. The outcome of its work is reported to Executive Board, and on to Council.

UK Advisory Forums

We have well-established Advisory Forums in Northern Ireland, Scotland and Wales, which make sure we have effective engagement and consultation with key interest groups in each country, and that our policies are suited to all parts of the UK. Through the forums we share and discuss early-stage views on policy development, which allows us to focus on medium and long-term priorities in dialogue with our partners.

Dame Carrie MacEwen chairs the three forums, which are also attended by the Chief Executive and nation-specific Council members and senior staff from the GMC. The wider invited membership differs from country to country and reflects the diverse range of those who have an interest and expertise in the areas under our regulation across the UK. The forums report on their work to the Executive Board twice a year.

Education Advisory Forum

The Education Advisory Forum engages with our key interest groups on education, training and assessment matters, making sure we are able to develop and promote a strategic approach to this work across all countries of the UK.

Colin Melville, Medical Director and Director of Education and Standards, chaired the Forum in 2024, and the invited membership reflects the diverse range of those who have an interest and expertise in medical education, training and assessment across the UK. The work of the Forum is reported to the Chief Executive and to Council through the Chief Executive's report.

Strategic Equality, Diversity and Inclusion Forum

Our Strategic Equality, Diversity and Inclusion (ED&I) Forum helps us make sure that our activities respond to the needs of diverse groups of registrants. Paul Reynolds, Director of Strategic Communications and Engagement, chairs the Forum which comprises organisations representing registrants with shared protected characteristics. It helps us meet our ED&I objectives by providing feedback and advice on our policies and strategies, raising issues and concerns requiring our attention in relation to ED&I. In 2024, the Forum discussed:

- our regulatory reform programme
- reviewing our ED&I engagement forums
- issues arising from the conflict in the Middle East
- our corporate strategy
- education reform
- MPTS sanctions banding guidance.

GMC Procedures and Doctors' Health Forum

Our Advisory Forum on GMC Procedures and Doctors' Health provides expert advice to our Executive Board on how we engage with vulnerable doctors in GMC processes. The Forum may, as required, advise on GMC policies, guidance and training for staff.

Membership includes representatives from the Royal College of Psychiatrists, the Royal College of GPs, the Faculty of Occupational Health, the Conference of Postgraduate Medical Deans, and NHS Providers.

Member attendance at Council, Boards and Committees in 2024*

Member	Council attendance†	Committee attendance
Dame Carrie MacEwen (Chair)	6/6	NA
Steve Burnett	6/6	9/9
Vanessa Davies	6/6	10/10
Professor Anthony Harnden	6/6	6/6
Lord Philip Hunt	0/0	1/1
Professor Paul Knight	5/6	10/10
Professor Deepa Mann-Kler	6/6	6/6
Douglas Millican	6/6	8/9
Dr Raj Patel	6/6	7/7
Professor Suzanne Shale	6/6	8/9
Dr Jeeves Wijesuriya	6/6	7/7
Alison Wright	5/6	6/6
Aneen Blackmore (ARC co-opted member)	N/A	5/5
Jon Hayes (ARC co-opted member)	N/A	5/5
Michael Jennings (IC co-opted member)	N/A	4/4
Keith Mackay (IC co-opted member)	N/A	4/4

* Attendance reflects the number of meetings for which attendance was possible.

† Includes six Council meetings.

Management

In 2024, our staff were under the direction of Chief Executive, Charlie Massey. He is supported by a team of directors, who, as of 31 December 2024 were:

- Shaun Gallagher, Director of Strategy and Policy
- Una Lane, Director of Registration and Revalidation
- Professor Colin Melville, Medical Director and Director of Education and Standards
- Anthony Omo, General Counsel and Director of Fitness to Practise*
- Paul Reynolds, Director of Strategic Communications and Engagement
- Neil Roberts, Director of Resources.

Key management personnel: remuneration policy

The Remuneration Committee is responsible for determining the remuneration, benefits and terms of service for the Chief Executive, Chair of the MPTS and directors. The Committee sets all aspects of salary or honoraria, the provision of other benefits, and any other arrangements or contractual terms for this group of staff. The Committee also oversees terms and conditions for Council members (including the Chair) by benchmarking and seeking independent market advice when necessary.

The Committee considers that we should provide remuneration and rewards that will attract and retain the high-calibre staff necessary to enable us to fulfil our statutory remit and deliver our strategic objectives.

In setting the base pay for individual posts, the Committee will take external advice on roles within its remit and align salaries with an appropriate market rate subject to resource considerations.

An annual consolidated pay award is considered with reference to the organisation's level of performance, the financial implications of any award, the award agreed for other GMC employees and wider market trends. An annual variable non-consolidated element is considered, reflecting personal performance and the same considerations applied to any consolidated award. We review the effectiveness of these arrangements on an annual basis.

Staff within the Remuneration Committee's remit will usually be entitled to the benefits package available to all GMC employees on the same terms. The Committee retains the ability to withdraw, adjust or change any benefits for staff within its remit, subject to any consultation and contractual requirements. The Committee considers any additional benefits in kind (such as relocation payments) on a case-by-case basis.

New external staff appointees within the Committee's remit are automatically enrolled into our defined contribution pension scheme. Where employees have existing agreed pension arrangements, such as membership of our defined benefit scheme, they retain this for the course of their employment, subject to any changes to the rules agreed by Pension Scheme trustees and the employer.

* From 1 November 2024, Anthony Omo undertook a three-month secondment; during his absence, Elizabeth Jenkins was the interim General Counsel and Director of Fitness to Practise.

The Committee makes sure that the equality and diversity implications of remuneration policy and related decisions are considered appropriately. Specifically, it ensures that:

- any salary differentials are supported by a formal job evaluation or independent external market advice
- any decisions relating to variable pay are supported by an objective assessment of performance
- any adjustment or changes to remuneration arrangements do not discriminate unlawfully.

Other decisions relating to terms of service are supported by appropriate advice on any equality and diversity implications.

2024 financial review

The accounts for the year ended 31 December 2024 have been prepared in accordance with the Charities Statement of Recommended Practice (FRS 102).

Our free reserves, which are total reserves less the defined benefit pension deficit and fixed assets, at the end of 2024 were £51.7 million, up from £44.8 million at the end of 2023, primarily driven by an anticipated operational surplus, which leaves reserves in the upper half of our target range.

- Total income increased by £17 million and total expenditure by £11.9 million.
- We continued to invest in our infrastructure, building a fourth Professional and Linguistic Assessments Board (PLAB) circuit reflecting the growing demand for this service. The circuit was opened in April 2024 and has been used to deliver over 3,000 PLAB tests.
- We expect to utilise some of our reserves to replace our finance and people team systems during the course of 2025 and 2026.
- We have constrained fee increases to below 2% in 2025.

Our total income and expenditure in 2024

In 2024, we generated unrestricted income of £164.4 million, which was £15.5 million higher than 2023. This was due to the increase in the size of the medical register, the impact of running more of the second part of the PLAB tests in 2024 than in 2023, and the subsequent increase in new applications to join the register.

We have a further £3.1 million of restricted income in our accounts, from the UK Government's Department of Health and Social Care (DHSC), to cover the cost of bringing physician associates (PAs) and anaesthesia associates (AAs) into regulation, including £0.5 million for the development of IT systems. These funds were fully spent in 2024. This increased the total restricted asset held on the balance sheet to £2.5 million.

We introduced a registration fee for PAs and AAs at the point regulation began on 13 December 2024, which is designed to recover the costs of regulation from those professions, in accordance with schedule 4, para 8 (3) of The Anaesthesia Associates and Physician Associates Order 2024.

Schedule 3, para 6 (b) of the Order also requires us to consider the impact of any changes to fees on the workforce of the health service in the United Kingdom, physician associates, anaesthesia associates, and the regulator. In December 2024 Council approved an inflationary uplift to the fee of 1.7%, to take effect in April 2025. We consider that a fee increase of this level will have no material impact on either the workforce, PAs or AAs, however it does allow us, the regulator, to continue to recover costs in line with schedule 4, para 8 (3) of the Order.

We generated £5,000 in fees from registering physician associates and anaesthesia associates. While regulation has started, the DHSC will continue to fund any difference between the costs of regulation and the income generated from PAs and AAs until at least April 2026.

Our unrestricted charitable expenditure in 2024 was £152.1 million, an increase of £11.9 million on 2023. This growth in expenditure was the result of both increased volumes across most core functions, most notably registration and revalidation, and the impact of inflation on our cost base, however charitable expenditure has grown to a lesser extent

than income. This has allowed us to constrain fee increases in 2025 to below 2% and continue to invest in our infrastructure to meet growing demand for our services.

We increased our legal provision by a further £0.7 million to reflect potential additional costs that may arise from outstanding legal cases.

The charity had no fundraising activities requiring disclosure under S162A of the Charities Act 2011.

Reserves policy and going concern

Our level of reserves and our reserves policy are reviewed annually, and any financial implications are addressed as part of the budget-setting process.

Our total reserves are made up of free reserves, reserves backed by fixed assets, and pension reserves.

We hold free reserves:

- to provide working capital to undertake our normal day-to-day business
- to provide funds to deal with any risks that materialise
- to provide funds to respond to new initiatives, opportunities and challenges that present themselves
- to cover the period before any changes to fee levels take full effect.

A significant proportion of our total reserves is represented by fixed assets, which cannot easily be converted into cash without adversely affecting our ability to fulfil our charitable aims and statutory obligations. The value of fixed assets is therefore disregarded for reserves policy purposes.

The value of pension reserves is also disregarded for reserves policy purposes. Our defined benefit scheme was closed to future accruals in 2018, and any deficit or surplus in the scheme can be managed over the medium term with no immediate impact on free reserves.

There is no standard formula that can be used to calculate the ideal level of free reserves. We follow the Charity Commission's guidance and set a target range based on our cash flow requirements and an assessment of the risks facing the organisation. We aim to hold free reserves at a level that is not excessive but does not put our solvency at risk. Over the medium term we target the mid-point of a reserves range between 20% to 35% of the annual expenditure for the next 12 months. We accept fluctuations within the range over the short term. We remained firmly within the range in 2024, and at the year-end free reserves were 31% of budgeted total expenditure for 2025.

We will also continue to review the purpose and scope of our reserves policy on an annual basis to make sure the thresholds reflect our current risk profile, cash flow requirements and operating environment.

Our total reserves at the end of 2024 were £73.5 million, increasing from the previous year by £23.1 million, driven by both a positive net income position and a decrease in the defined benefit pension liability of £14 million from £15.8 million in 2023, to £1.8 million in 2024.

Free reserves constituted £51.7 million of the balance of total reserves, with a further £23.5 million of reserves being represented by fixed assets, with both currently being partially offset by our pension deficit. We expect that reserves at the end

of 2025 will remain within the parameters of our reserves policy.

Most of our income comes from registration fees paid by doctors. All doctors must be registered with us to practise medicine in the UK, and so our income is relatively certain. Trustees remain of the view that the GMC is a going concern for the foreseeable future and have therefore prepared the financial statements on a going concern basis.

There are no material uncertainties related to events or conditions that cast significant doubt on our financial stability for the foreseeable future.

Investment policy

Council is responsible for determining and reviewing the overall investment policy, objectives, risk appetite and target returns. It has delegated responsibility for implementing the investment policy, appointing and managing fund managers and monitoring performance, to the Investment Committee, which regularly reports to Council.

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

We hold working capital for normal cash flow purposes. This is held in instant access bank accounts and provides sufficient flexibility to avoid temporary borrowing and / or the need to liquidate investments to deal with short-term variations in operational income and expenditure.

We revised our investment policy in 2024, with the aim of strengthening our ethical exclusions and approach to environmental, social and governance issues, in addition to reducing risk while maintaining investment returns.

Council is responsible for determining the level of risk for funds invested under management. We have a low-risk appetite with the aim of generating returns while protecting against volatility and capital loss. The target maximum value at risk (VAR) is 10% on a forward-looking basis.

Within our risk constraint the objectives of investing funds under management are to provide protection against inflation; to generate a modest level of return; and to diversify our funds to reduce the risk of capital and / or revenue loss. Our target rate of return on funds invested under management is inflation (CPI) plus 2% over a rolling five-year period.

Sustainable investment policy

We have adopted a comprehensive ethical investment approach. We believe that investing in certain companies or sectors would conflict with our charitable aims or may create reputational damage. We do not wish to profit directly from, or provide capital to, activities that are materially inconsistent with our charitable aims and so we specifically exclude investment in companies which derive more than 5% of revenues from tobacco (including vaping), alcohol, adult entertainment, gambling, high interest lending, and thermal coal and oil sands. We also exclude all companies with any exposure to cluster munitions and landmines.

Within our portfolios we also aim to promote good or improving environmental or social characteristics, provided that the companies in which the investments are made follow good governance practices. In acknowledgement of the climate crisis,

asset managers representing the GMC must have a credible Net Zero policy and report progress against that policy to the Investment Committee on an annual basis.

We invest only through fund managers who demonstrate the strongest environmental, social and governance (ESG) credentials and can report their ESG monitoring activities and approach.

Our approach to investing aims to deliver positive impact by changing company behaviours for the better through active ownership. We expect companies in which we invest to demonstrate responsible employment and corporate governance practices, to be conscientious with regard to environmental and social issues, and to deal fairly with customers and the communities in which they operate. When appointing fund managers, we take into consideration how they incorporate an assessment of a company's performance on ESG issues into their stock selection in addition to how they engage and influence the companies they invest in to improve their sustainability over time.

We also ensure their monitoring arrangements highlight companies that are under investigation for, or have been found guilty of, tax evasion or money laundering.

We chose CCLA Investment Management (CCLA) to manage our investments because of their strong track record and high standards in ethical investing. CCLA invest in a manner that prioritises environmental, social and governance factors, working with companies to urge them to commit to producing healthier products which are more accessible and more affordable.

Investment returns

Our funds under management were valued at £61.9 million at the end of 2024, compared with £61.6 million at the start of the year. Since the point of increasing our investment in June 2019 we have generated returns at a compounded annual growth rate of 3.98%.

Any cash not held as working capital or invested is held in medium-term deposits and / or interest-bearing accounts. We generated interest of £2.5 million on our cash balances, equivalent to an average annual rate of return of 4.82%. Cash held as working capital, and any residual cash, is shown on our balance sheet within current assets.

GMC Services International (GMSCI) Limited

The trading subsidiary was incorporated as a private company limited by shares on 16 December 2016. It is a wholly owned subsidiary of the GMC which utilises knowledge gained from the core activities of the GMC to provide services on a commercial basis, including consultancy, training, and accreditation. Any profits derived from these activities are gifted back to the GMC for the purpose of delivering the GMC's charitable aims.

The GMC invested £0.6 million as share capital in GMCSI. In its early years of operation GMCSI generated net losses but has recently been able to generate modest profits. In 2024, GMCSI generated a net profit of £24,040 and ended the year with net assets of £356,790. No profits have been gift-aided back to the GMC in 2024. GMCSI is projected to generate profits over the medium term.

The accounts presented here are consolidated group accounts to include our trading subsidiary GMCSI. The statement of financial activities shows the consolidated position for the GMC and GMCSI combined. The balance sheet shows separate columns for the group position (GMC and GMCSI combined) and the parent charity position (GMC). Separate company accounts have been prepared for GMCSI.

Trustees' responsibilities for the financial statements

The trustees are responsible for preparing the trustees' annual report and the financial statements in accordance with applicable law and United Kingdom Generally Accepted Accounting Practice (United Kingdom Accounting Standards). The law applicable to charities in England, Scotland and Wales requires the trustees to prepare financial statements for each financial year which give a true and fair view of the state of affairs of the charity and the group, and of the incoming resources and application of resources of the group for that period.

In preparing these financial statements, the trustees are required to:

- select suitable accounting policies and then apply them consistently
- observe the methods and principles in the Charities Statement of Recommended Practice (SORP)
- make judgements and estimates that are reasonable and prudent
- state whether applicable accounting standards have been followed, subject to any material departures being disclosed and explained in the financial statements
- prepare the financial statements on the going concern basis (unless it is inappropriate to presume that the charity will continue in business).

The trustees are responsible for keeping adequate accounting records that are sufficient to show and explain the charity's transactions, and to disclose, with reasonable accuracy at any time, the financial position of the charity, enabling them to make sure that the financial statements comply with the Charities Act 2011, the Charity (Accounts and Reports) Regulations 2008, the Charities and Trustee Investment (Scotland) Act 2005, the Charities Accounts (Scotland) Regulations 2006 (as amended), the Privy Council Directions issued under the Medical Act 1983 and the provisions of the charity's constitution. They are also responsible for safeguarding the assets of the charity and the group and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

Related party transactions

We require that all trustees and senior managers disclose details of any organisations in which they (and their close family members and business partners) hold a position of authority or other material interest, and whose business could bring them into financial contact with the GMC. Details of any actual transactions between the GMC and related parties in the year must also be disclosed. We also publish a register of interests on our website.

In 2024 all disclosures were made and there were no points of concern.

Audit and Risk Committee report

The Audit and Risk Committee (ARC) plays a key role in our governance. It provides Council with independent assurance about:

- the integrity of our financial statements
- the effectiveness of internal control, governance and risk management systems
- the delivery of internal and external audit services.

It also monitors our anti-fraud policies and any risks relating to the General Data Protection Regulations, and reviews arrangements for raising concerns.

The Committee bases its advice and decisions on guidance issued by the Financial Reporting Council, the Charity Commission, the Office of the Scottish Charity Regulator and, where appropriate, independent external advice.

The Committee has six members: four Council members and two co-opted members. Co-opted or independent members enhance the work of the Committee by bringing valuable additional skills and experience to the independent scrutiny of finance, risk and governance. All members of the Committee participate in an annual appraisal process.

The Committee bases its annual work programme on risk, with our Corporate Opportunities and Risk Register reflecting the key strategic risks we manage. The Committee's oversight and scrutiny play a valuable role in assuring that risks are being managed and opportunities are enhanced through effective systems of governance, internal control and risk management arrangements.

In 2024, the Committee met five times, providing Council with an immediate update on the urgent or emerging issues it discussed. It also submitted two formal reports on its work and findings. As part of its work programme, members had chance to learn more about and scrutinise specific areas of the business and their associated risks in seminar sessions and an extended seminar day.

Key activities during 2024

During 2024, the Committee followed a planned programme of work. As part of this, it:

- received and scrutinised 20 pieces of internal audit work and reporting, which evidenced that there are generally sound systems of internal control in place at the GMC
- considered and approved the internal audit plan and resources for 2025
- accepted the Head of Internal Audit's annual opinion for 2023, which provided substantial assurance that the systems of governance, risk management and internal control in operation during 2023 were generally well designed and working effectively to ensure the achievement of the GMC's objectives
- monitored the implementation of recommendations made in previous audit reports to make sure they were being managed effectively
- agreed a refreshed Internal Audit Charter to reflect the Global Internal Audit Standards from January 2025
- scrutinised the draft Trustees' Annual Report and Accounts 2023 and the draft National reports for Northern Ireland, Scotland and Wales; the Committee also approved the external auditor's terms of engagement, plan, scope and fee for the audit of the 2024 accounts
- reviewed the revised proposals and supporting arrangements for publishing the GMC's Gifts and Hospitality Register
- reviewed the performance of the external auditors and internal auditors (in the case of internal audit, this included overseeing the five year External Quality Assessment by the Institute of Internal Auditors: the assessor awarded the GMC the highest assessment rating and noted the maturity of the audit function)
- received the *Freedom to Speak Up Guardian Annual Report 2023*, the *Annual Report of the Data Protection Officer 2023*, and the GMC's first *Annual Safeguarding Report 2023*
- reviewed its Statement of Purpose.

In addition to the above, at each of its meetings the Committee also:

- begins each meeting with an unscripted discussion of emerging risks and issues and hears from senior management how these are being managed (this includes risks which are driven by external events as well as those arising in relation to the general running of GMC's business)
- considers the Corporate Opportunities and Risk Register (this is available as part of the Executive Board and Council papers published on our website and is updated on a regular basis).

* For the Head of Internal Audit's assessment for 2023, see Council papers, July 2024.

† For the Freedom to Speak Up Guardian's Annual Report for 2023, see Council papers, June 2024.

Risk management in 2024

Risk management arrangements are well embedded in the GMC's day-to-day activities, project work and strategic business discussions. Our Risk Management Framework and risk registers provide the tools for identifying, articulating, monitoring and managing operational and project risks. They focus on both threats and opportunities, recognising that understanding both can improve how the business is managed. Weekly reports of key updates are reviewed by the Risk Manager and Assistant Director of Audit and Risk Assurance. This provides the Committee and Senior Management Team with confidence that risk management is a live and closely monitored activity.

During 2024, the GMC started a refresh of the Risk Management Framework, including its approach to risk appetite. This work will continue in 2025.

Business resilience, and the ability to respond and adapt to incidents of both operational and reputational natures are also features of robust risk management. The GMC has a comprehensive set of business continuity and disaster recovery processes, and arrangements for managing reputational issues. All of these have been tested through exercises on a regular basis and activated to address real incidents during 2024.

The Committee considers the Corporate Opportunities and Risk Register at every meeting; this is available as part of the Executive Board and Council papers published on our website and is updated regularly. During the year, the Committee's discussions on the management of risk included:

- the potential implications of a change in government for healthcare, the role of regulation and the GMC
- external scrutiny relating to the introduction of regulation for physician associates (PAs) and anaesthesia associates (AAs); the sanctioning of doctors whose protests against climate change resulted in breaking the law; and, with respect to events in the Middle East, the handling of complaints both from and about individual doctors in relation to antisemitism and Islamophobia
- progress in relation to the implementation of the Medical Licensing Assessment (MLA), as it transitions to business as usual
- understanding the scale and complexity of the data, information and intelligence which is collected, shared (both from and to relevant organisations) and used to manage risk through the GMC's Patient Safety Intelligence Forum
- emerging developments in the external cyber security world in relation to the GMC's cyber protection, resilience, business continuity and disaster recovery arrangements
- improving understanding of the interactions between the legal team in the GMC's Fitness to Practise directorate and the Medical Practitioners Tribunal Service (MPTS); key features and improvements of MPTS hearing case management; and proposals on a new framework to support sanctions decision making in tribunals
- the business transformation opportunities in ways of working as the GMC prepares to introduce a new Enterprise Resource Planning system, and the challenges to manage its successful implementation.

These are all areas of business which will remain on our agenda in 2025.

Learning from events and issues

A component of organisational resilience is the willingness and ability to review and learn when things emerge suddenly or something goes wrong. The GMC continues to demonstrate a culture of continuous improvement, learning not only from internal events, but also considering the learning identified in reports and reviews which are published in relation to other organisations that have experienced difficulties and challenges.

There is also a robust approach to undertaking a significant event review (SER) if something has, or has the potential to, impact the organisation in a more serious way. For example, externally, this might be in relation to the action of others which has a detrimental impact on the GMC, and internally could be where there has been a failure of a key organisational control.

In 2024, no SERs were formally reported to the Audit and Risk Committee. However, two events took place towards the end of the year which we have now reviewed to identify learnings using our SER process and which were reported to the Committee in March 2025. The first, sadly, was in relation to a doctor who took their own life while under GMC fitness to practise processes. The second was in relation to a data breach, which was immediately reported to the Information Commissioner and for which it has been confirmed no action will be taken. Trustees reported the data breach as a serious incident to the Charity Commission.

Whilst learning from SERs is critical for improving future performance, we have many other mechanisms for learning and sharing better practices across the business. These include:

- consideration of external research and publicly available reports, such as those published by the Charity Commission or by other regulators, including the Professional Standards Authority
- independent reports from external assessors such as Investors in People, the International Standards Organisation, British Standards Institute and Institute of Customer Service
- regular liaison with other healthcare regulators
- peer review and local team quality control exercises
- audits undertaken by our internal corporate Quality Assurance team
- post-implementation reviews of new initiatives and projects
- a community of practice to share experiences of project management and supporting change
- broader insight from the work of internal audit.

Our work in 2025

The Committee has a full programme of work for 2025, with risk and assurance remaining the key focus of planned activities. As well as scrutinising the reports from the internal audit programme it approved in November 2024, and the trustees' Annual Report and Accounts 2024, it will be taking time to:

- understand the new Global Internal Audit Standards introduced by the Institute of Internal Auditors, and their impact on the delivery of the audit function and the Committee's responsibilities
- develop a shared understanding of risk appetite in the GMC context and how this might support Council in its decision making on the new corporate strategy, which will take effect from 2026
- make sure it has sufficient assurance regarding how the business-as-usual MLA is being delivered, including through the work of external parties, and how the GMC is maintaining relationships to oversee and quality assure the delivery of the applied knowledge test (AKT) and clinical and professional skills assessment (CPSA)
- continue to assure itself of the understanding and management of risks in delivering the new Enterprise Resource Planning system
- monitor the business-as-usual implementation of the regulation of physician associates and anaesthesia associates
- consider the opportunities and development of regulatory reform for doctors, as new legislation is progressed by government.

The Committee will, however, remain flexible in its work to ensure it is able to take account of and respond to emerging threats and opportunities.

Approved by the trustees on 27 June 2025 and signed on their behalf by:



Professor Dame Carrie MacEwen

Independent auditors' report to the trustees of the GMC

Opinion

We have audited the financial statements of the General Medical Council ('the charity') and ts subsidiary ('the group') for the year ended 31 December 2024 which comprise the Consolidated Statement of Financial Activities, Consolidated and Parent Balance Sheet, Consolidated Cash Flow Statement and notes to the financial statements, including significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and United Kingdom Accounting Standards, including Financial Reporting Standard 102 The Financial Reporting Standard applicable in the UK and Republic of Ireland (United Kingdom Generally Accepted Accounting Practice).

In our opinion the financial statements:

- give a true and fair view of the state of the group's and the parent charity's affairs as at 31 December 2024 and of the group's income and expenditure, for the year then ended;
- have been properly prepared in accordance with United Kingdom Generally Accepted Accounting Practice; and
- have been prepared in accordance with the requirements of the Charities Act 2011 and the Charities and Trustee Investment (Scotland) Act 2005 and Regulations 6 and 8 of the Charities Accounts (Scotland) Regulations 2006 (amended).

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the group in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the trustees' use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the charity's or the group's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the trustees with respect to going concern are described in the relevant sections of this report.

Other information

The trustees are responsible for the other information contained within the annual report. The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Matters on which we are required to report by exception

We have nothing to report in respect of the following matters in relation to which the Charities (Accounts and Reports) Regulations 2008 and the Charities Accounts (Scotland) Regulations 2006 requires us to report to you if, in our opinion:

- the information given in the financial statements is inconsistent in any material respect with the trustees' report; or
- sufficient and proper accounting records have not been kept by the parent charity; or
- the financial statements are not in agreement with the accounting records and returns; or
- we have not received all the information and explanations we require for our audit.

Responsibilities of trustees

As explained more fully in the trustees' responsibilities statement set out on page 57 the trustees are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the trustees determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the trustees are responsible for assessing the group and the parent charity's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the trustees either intend to liquidate the charity or to cease operations, or have no realistic alternative but to do so.

Auditor's responsibilities for the audit of the financial statements

We have been appointed as auditor under section 151 of the Charities Act 2011, and section 44(1)(c) of the Charities and Trustee Investment (Scotland) Act 2005 and report in accordance with the Acts and relevant regulations made or having effect thereunder.

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Details of the extent to which the audit was considered capable of detecting irregularities, including fraud and non-compliance with laws and regulations are set out below.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Extent to which the audit was considered capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We identified and assessed the risks of material misstatement of the financial statements from irregularities, whether due to fraud or error, and discussed these between our audit team members. We then designed and performed audit procedures responsive to those risks, including obtaining audit evidence sufficient and appropriate to provide a basis for our opinion.

We obtained an understanding of the legal and regulatory frameworks within which the charity and group operates, focusing on those laws and regulations that have a direct effect on the determination of material amounts and disclosures in the financial statements. The laws and regulations we considered in this context were the Medical Act 1983, Charities Act 2011 and The Charities and Trustee Investment (Scotland) Act 2005 together with the Charities SORP (FRS102) 2019. We assessed the required compliance with these laws and regulations as part of our audit procedures on the related financial statement items.

In addition, we considered provisions of other laws and regulations that do not have a direct effect on the financial statements but compliance with which might be fundamental to the charity's and the group's ability to operate or to avoid a material penalty. We also considered the opportunities and incentives that may exist within the charity and the group for fraud. The laws and regulations we considered in this context for the UK operations were General Data Protection Regulation (GDPR), and employment legislation.

Auditing standards limit the required audit procedures to identify non-compliance with these laws and regulations to enquiry of the trustees and other management and inspection of regulatory and legal correspondence, if any.

We identified the greatest risk of material impact on the financial statements from irregularities, including fraud, to be within estimates surrounding legal provisions, the defined benefit pension scheme balance and the override of controls by management. Our audit procedures to respond to these risks included enquiries of management, internal audit, legal counsel and the Audit & Risk Committee about their own identification and assessment of the risks of irregularities, sample testing on the posting of journals, reviewing accounting estimates for biases, reviewing regulatory correspondence with the Charity Commission and reading minutes of meetings of those charged with governance.

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations (irregularities) is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it. In addition, as with any audit, there remained a higher risk of non-detection of irregularities, as these may involve collusion, forgery, intentional omissions,

misrepresentations, or the override of internal controls. We are not responsible for preventing non-compliance and cannot be expected to detect non-compliance with all laws and regulations.

Use of our report

This report is made solely to the charity's trustees, as a body, in accordance with Part 4 of the Charities (Accounts and Reports) Regulations 2008 and Regulation 10 of the Charities Accounts (Scotland) Regulations 2006. Our audit work has been undertaken so that we might state to the charity's trustees those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the charity and the charity's trustees as a body, for our audit work, for this report, or for the opinions we have formed.

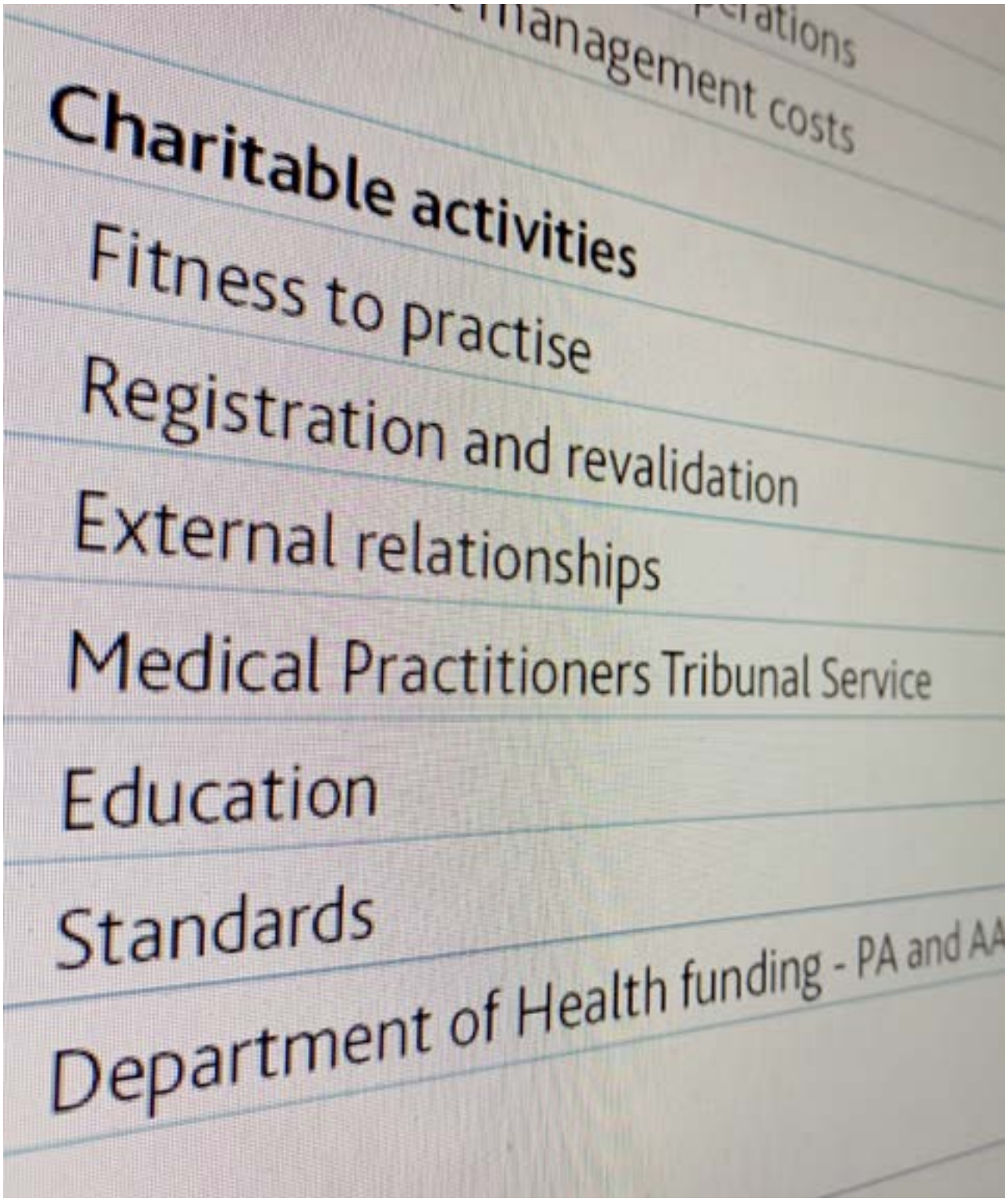
Crowe U.K. LLP
Statutory Auditor
55 Ludgate Hill
London
EC4M 7JW

Date: 7 July 2025

Crowe U.K. LLP is eligible for appointment as auditor of the charity by virtue of its eligibility for appointment as auditor of a company under section 1212 of the Companies Act 2006.

Crowe U.K. LLP is eligible for appointment as auditor of the charity under regulation 10(2) of the Charities Accounts (Scotland) Regulations by virtue of its eligibility under section 1212 of the Companies Act 2006.

Accounts 2024



Consolidated statement of financial activities for the year ended 31 December 2024

	Note	Unrestricted funds £'000	Restricted funds £'000	**Total 2024 £'000**	**Total 2023 £'000**
Income					
From charitable activities					
Registration	2	154,850	-	**154,850**	**139,595**
Specialist and GP registration	2	5,997	-	**5,997**	**5,846**
Revalidation	2	225	-	**225**	**168**
Other trading activities	3	284	-	**284**	**168**
Commercial trading operations	3	410	-	**410**	**442**
Investments	3	2,531	-	**2,531**	**2,065**
Department of Health funding - PA and AA regulation*	3	-	3,106	**3,106**	**1,567**
Other	3	141	-	**141**	**625**
Total incoming resources		164,438	3,106	**167,544**	**150,476**
Expenditure					
Raising funds					
Commercial trading operations	4	386	-	**386**	**365**
Investment management costs	4	288	-	**288**	**244**
		674	-	**674**	**609**
Charitable activities					
Fitness to practise	4	52,074	-	**52,074**	**48,998**
Registration and revalidation	4	50,531	-	**50,531**	**43,317**
External relationships	4	19,610	-	**19,610**	**18,320**
Medical Practitioners Tribunal Service	4	14,586	-	**14,586**	**14,911**
Education and Standards	4	15,330	-	**15,330**	**14,634**
Department of Health funding - PA and AA regulation	4	-	2,685	**2,685**	**1,256**
		152,131	2,685	**154,816**	**141,436**
Other expenditure					
Legal provision	11	684	-	**684**	**683**
Dilapidations provision	11	(162)	-	**(162)**	**1,333**
		522	-	**522**	**2,016**
Total expenditure	4	153,327	2,685	**156,012**	**144,061**
Operating surplus		11,111	421	**11,532**	**6,415**
Net gains/(Net losses) on investments	8	573	-	**573**	**5,224**
Net income/(Net loss)		11,684	421	**12,105**	**11,639**
Other recognised gains and losses					
Actuarial (loss) on defined benefit pension scheme	16	11,030	-	**11,030**	**(16,100)**
Net movement in funds		22,714	421	**23,135**	**(4,461)**
Total funds brought forward		48,270	2,122	**50,392**	**54,853**
Total funds carried forward		70,984	2,543	**73,527**	**50,392**

The General Medical Council incorporated a wholly owned trading subsidiary on 16 December 2016 with the purpose of providing services on a commercial basis including consultancy, training and accreditation. The Charity has taken exemption from presenting its unconsolidated profit and loss account.

The parent charity movement in funds for the year is £23,135,000 with subsidiary undertakings accounting for £24,000.

* The Department for Health and Social Care (DHSC) provided funding in 2024 to cover the cost of bringing physician associates (PAs) and anaesthesia associates (AAs) into regulation. Funding was restricted in nature, and was fully spent in the year. A proportion of the funds paid for IT System Development which has created an asset on the balance sheet. The net impact on GMC reserves is £421,000. The balance of the reserves will reduce as the asset is amortised.

Balance sheet

	Note	2024 Group £'000	2024 Charity £'000	2023 Group £'000	2023 Charity £'000
Fixed assets					
Intangible fixed assets	6	19,151	19,151	16,607	16,607
Tangible fixed assets	7	4,412	4,412	4,831	4,831
Investments	8	61,852	62,209	61,573	61,906
		85,415	**85,772**	**83,011**	**83,344**
Current assets					
Debtors and prepayments	9	35,475	35,555	30,975	31,065
Cash and bank balances		61,303	60,817	54,811	54,277
		96,778	**96,372**	**85,786**	**85,342**
Liabilities					
Creditors: amounts falling due within one year	10	(95,927)	(95,878)	(92,128)	(92,017)
Net current assets/(liabilities)		851	494	(6,342)	(6,675)
Total assets less current liabilities		**86,266**	**86,266**	**76,669**	**76,669**
Provisions for liabilities and charges	11	(10,965)	(10,965)	(10,443)	(10,443)
Net assets excluding pension scheme asset		**75,301**	**75,301**	**66,226**	**66,226**
Defined benefit pension scheme (liability)	16	(1,774)	(1,774)	(15,834)	(15,834)
Total net assets		**73,527**	**73,527**	**50,392**	**50,392**
Unrestricted income funds		72,758	72,758	64,104	64,104
Restricted income funds		2,543	2,543	2,122	2,122
Pension reserve		(1,774)	(1,774)	(15,834)	(15,834)
Total funds	12, 13	**73,527**	**73,527**	**50,392**	**50,392**

The financial statements were approved by the trustees and authorised for issue on 27 June 2025.
They were signed on behalf of trustees by:



Dame Carrie MacEwen
Chair of Council

Consolidated cash flow statement

	2024		2023	
	£'000	**£'000**	£'000	£'000
Cash flows from operating activities				
Net cash provided by/(used in) operating activities (note i below)		13,853		11,968
Cash flows from investing activities				
Dividends, interest and rents from investments	2,531		2,065	
Purchase of property, plant, equipment and intangibles	(9,892)		(10,334)	
Net cash used in investing activities		**(7,361)**		**(8,269)**
Change in cash and cash equivalents (note ii below)		**6,492**		**3,699**

Note (i)

Cash flow from operating activities		
Net incoming/(outgoing) resources	12,105	11,639
Investment income and interest	(1,988)	(2,012)
Net investment movement	(279)	(4,980)
Non-cash items - depreciation and amortisation	7,744	6,992
Non-cash items - assets written off	22	851
Pension scheme contribution	(3,572)	(3,567)
(Increase)/decrease in debtors	(4,500)	(3,690)
Increase/(decrease) in creditors and provisions	4,321	6,735
Net cash provided by/(used in) operating activities	**13,853**	**11,968**

Note (ii)	**Cash at bank and in hand**	**Total**
Cash and equivalents	**£'000**	**£'000**
Balances at 1 January 2024	54,811	**54,811**
Net increase in cash and cash equivalents	6,492	**6,492**
Balances at 31 December 2024	61,303	**61,303**

Notes to the accounts

General information

We are a statutory body governed by the Medical Act 1983 and are registered with the Charity Commission for England and Wales (1089278), and with the Office of the Scottish Charity Regulator (SC037750).

1. Principal accounting policies

(i) Accounting convention

The financial statements have been prepared to give a 'true and fair' view and have departed from the Charities (Accounts and Reports) Regulations 2008 only to the extent required to provide a 'true and fair' view. This departure has involved following the Charities SORP (FRS 102) first published on 16 July 2014, updated 1 October 2019.

Our financial statements have been prepared on a going concern basis and in accordance with the Charities Statement of Recommended Practice (FRS 102) - effective 1 October 2019, applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland, the Charities Act 2011, the Charities and Trustee Investment (Scotland) Act 2005, the Charities Accounts (Scotland) Regulations 2006 and UK Generally Accepted Practice as it applies from 1 October 2019. As detailed in the Trustees' Report, the Trustees remain of the view that the GMC is a going concern and there are no material uncertainties related to events or conditions that cast significant doubt on our financial stability for the foreseeable future. The GMC meets the definition of a public benefit entity under FRS 102.

(ii) On 16 December 2016 the GMC incorporated a trading subsidiary, GMC Services International LTD, company number 10530157, which is wholly owned by share capital by the General Medical Council.

(iii) A separate statement of financial activities has not been presented for the charity alone as this is not considered to be materially different from the consolidated statement of financial activities (SOFA). For the parent charity the net movement in funds is shown beneath the SOFA, with commercial activities from our subsidiary being separately identified on the face of the SOFA on page 69.

(iv) The principal accounting policies adopted in the preparation of the financial statements, which have been applied consistently, are detailed below.

Incoming resources

Income is included in the statement of financial activities when all of the following criteria are met:

- Entitlement – control over the rights or other access to the economic benefit has passed to the GMC
- Probability – it is more likely than not that the economic benefits will flow to the GMC
- Measurement – the value can be measured reliably.

The following specific policies apply:

- Annual retention fees relate to services associated with regulation over a 12-month period. Income is deferred and released to the statement of financial activities on a straight-line basis over the period to which the income relates.
- Registration fees, including provisional registration fees, are recognised when registration is granted.

- Professional and Linguistic Assessments Board (PLAB) fees are recognised when the examinations are sat.
- Income from investments and funds held on deposit is recognised when it is receivable and the amount can be accurately measured.

All income is recognised gross.

Basis for recognising liabilities

Expenditure includes staffing costs, office costs, committee costs, legal costs, accommodation costs, purchase of assets, and financial, actuarial and professional costs.

Resources expended are included in the statement of financial activities on an accruals basis. All liabilities are recognised as soon as there is a legal or constructive obligation committing the charity to expenditure.

Basis for allocation of resources expended

The majority of our resources are expended directly in pursuit of our charitable aims, and are identified as such in the statement of financial activities.

Accommodation costs, governance costs and other support costs are apportioned to charitable activities on the basis of staff head count across the organisation.

Irrecoverable VAT

Any irrecoverable VAT is charged to the statement of financial activities as part of the relevant item of expenditure, or capitalised as part of the cost of the related asset where appropriate.

Taxation

We apply appropriate exemptions from taxation on income and gains available to charities, so no taxation is payable on the net incoming resources of the charity. The charity's subsidiary company is subject to Corporation Tax in the same way as any commercial organisation.

Debtors

Trade and other debtors are normally recognised at the settlement amount due after any trade discount offered. Prepayments are normally valued at the amount prepaid net of any trade discounts due.

Creditors and provisions for liabilities

Creditors and provisions are recognised when the charity has a present legal or constructive obligation as a result of a past event. They are recognised when it is probable that a transfer of economic benefit will be required to settle the obligation and a reliable estimate can be made of the amount of the obligation. Creditors and provisions are normally recognised at their settlement amount after allowing for any trade discounts due.

Critical accounting judgments and key sources of estimation uncertainty

The key sources of estimation uncertainty that have a significant effect on the amounts recognised in the financial statements are:

- All unsettled claims for legal costs made against the GMC are reviewed on a case-by-case basis at the year end. Provisions are based on historical experience and a detailed assessment of the specific details of current cases. The final settlement of cases is dependent on a number of factors, so the accuracy of the provision is subject to a significant degree of uncertainty.

- Provisions for property dilapidation costs are made for all leased buildings. They are assessed on a case-by-case basis reflecting the different configurations of leased buildings and the cost to revert to their original state. We apply annual inflationary increases in line with CPI, and periodically seek third-party advice to ensure our estimates remain appropriate.
- Provisions for holiday pay are based on the actual level of accrued holiday entitlement outstanding at the year end and salaries of each staff member.

Tangible fixed assets

Tangible fixed assets are stated at cost, net of depreciation and any provision for impairment. Expenditure is only capitalised where the cost of the asset or group of assets acquired exceeds £5,000.

Intangible fixed assets

Intangible fixed assets comprise computer software. They are stated at cost, net of amortisation and any provision for impairment. Expenditure is only capitalised where the cost of the asset or group of assets acquired exceeds £5,000.

Depreciation

Depreciation is provided so as to write off the cost, less estimated residual value, of the assets evenly over their estimated lives.

The estimated useful lives are as follows:

- leasehold buildings and leasehold improvements – the lesser of five years or the remaining term of the lease
- furniture, fixtures, and office fittings – the lesser of five years or the remaining term of the lease
- information technology (IT) equipment – three years
- intangible assets (IT software) – three years
- other office equipment – three years for IT-related items and five years for all other items.

Depreciation rates are reviewed on a regular basis comparing actual lives of assets with the accounting policy rates.

Licensed IT software

Development costs for implementing new IT systems are capitalised and depreciated over the lesser of 3 years or the useful life of the asset. The first year licence costs are capitalised as they are necessary to bring the asset into use, subsequent year licence costs are treated as operating expenditure.

Operating leases

Rent payable under operating leases is charged to the statement of financial activities on a straight-line basis over the period of the lease.

Financial instruments

The charity has financial assets and liabilities of a kind that qualify as basic financial instruments. Basic financial instruments are initially recognised at transaction value and subsequently measured at amortised cost. Financial assets held at amortised cost consist of cash and bank balances, short-term deposits (cash flow statement), investments held in cash deposits (note 8) together with trade and other debtors (note 9). Financial liabilities held at amortised cost comprise trade and other creditors, tax and social security creditors and accruals (note 10).

Investments

Our investment policy separates our funds into four categories: those which are required as working capital for the normal day-to-day operation of the business; those which we invest under management; those which we may decide to invest in a trading subsidiary; and the remaining cash balance which fluctuates during the year. Funds held as cash for the normal day-to-day operation of the business are shown on the GMC's balance sheet within current assets, while funds held for the longer term are shown as investments.

Pensions

We have a defined benefit pension scheme for permanent employees. The scheme was closed to new members on 30 June 2013, and for future accrual to existing members on 31 March 2018, and replaced by a defined contribution scheme. The surplus or deficit of the defined benefit scheme is recognised on the balance sheet. Changes in the assets and liabilities of the scheme are disclosed and allocated as follows:

- Charges relating to current or past service costs, and gains and losses on settlements and curtailments, are included within staff costs and charged to the statement of financial activities.
- Interest on the net defined benefit asset / liability is shown as a net amount of other finance costs or as an incoming resource alongside investment income and interest. Actuarial gains and losses are recognised immediately in other recognised gains and losses on investments.
- The assets, liabilities and movements in the surplus or deficit of the scheme are calculated by qualified independent actuaries as an update to the latest full actuarial valuation. Details of the defined benefit scheme assets, liabilities and major assumptions are shown in the notes to the accounts.
- Our defined contribution pension scheme was set up on 1 July 2013. Contributions to the scheme are charged to the statement of financial activities in the year in which they are payable to the scheme.

Funds and reserves

The majority of our funds are unrestricted, and so can be expended at the trustees' discretion in pursuit of our charitable aims. Restricted funds will be expended in line with the purpose of the funding.

Termination payments

Termination payments are accounted for as soon as the organisation is aware of the obligation to make the payment.

2. Income from charitable activities

	Unrestricted funds £'000	**Total 2024 £'000**	Unrestricted funds £'000	**Total 2023 £'000**
Registration				
Annual retention fees	122,242	**122,242**	112,228	**112,228**
Registration fees	6,904	**6,904**	6,622	**6,622**
Provisional registration fees	267	**267**	234	**234**
PLAB fees	25,335	**25,335**	20,392	**20,392**
Other fees	102	**102**	119	**119**
	154,850	**154,850**	139,595	**139,595**
Specialist and GP registration				
Certificates of Completion of Training fees	3,918	**3,918**	3,583	**3,583**
Certificate of Eligibility for Specialist Registration/ Certificate of Eligibility for General Practitioner Registration fees	2,025	**2,025**	2,196	**2,196**
Other fees	54	**54**	67	**67**
	5,997	**5,997**	5,846	**5,846**
Revalidation				
Revalidation annual return	168	**168**	133	**133**
Revalidation assessment	57	**57**	35	**35**
	225	**225**	168	**168**

3. Income from raising funds

	Unrestricted funds £'000	Restricted funds £'000	**Total 2024 £'000**	Unrestricted funds £'000	Restricted funds £'000	**Total 2023 £'000**
Activities for raising funds						
Other trading activities*	284	-	**284**	168	-	**168**
Commercial trading operations†	410	-	**410**	442	-	**442**
Other‡	141	-	**141**	625	-	**625**
	835	-	**835**	1,235	-	**1,235**
Investment income						
Bank interest	2,531	-	**2,531**	2,065	-	**2,065**
	2,531	-	**2,531**	2,065	-	**2,065**
Department of Health funding						
Funding to cover expenditure on PA and AA regulation§	-	3,106	**3,106**	-	1,567	**1,567**

* Other trading activities include the reimbursement of costs of staff seconded to external bodies.

† Income from commercial trading operations is derived from GMC Services International Ltd, a wholly owned subsidiary, which provides services on a commercial basis including consultancy, training & accreditation.

‡ Other income includes reimbursement of legal fees from appeals.

§ The Department of Health and Social Care has provided funding for the GMC to implement the regulation of physician associates and anaesthesia associates, which commenced on 13 December 2024.

4. Total expenditure

Charitable activity and support cost allocation

	Direct staffing costs £'000	Direct costs £'000	Allocated costs £'000	**Total 2024 £'000**	Direct staffing costs £'000	Direct costs £'000	Allocated costs £'000	**Total 2023 £'000**
Expenditure on								
Commercial trading operations	325	61	-	**386**	308	57	-	**365**
Investment management costs	-	288	-	**288**	-	244	-	**244**
Total expenditure on raising funds	325	349	-	**674**	308	301	-	**609**
Fitness to practise	23,821	6,336	21,917	**52,074**	22,576	6,532	19,890	**48,998**
Registration and revalidation	17,239	14,104	19,188	**50,531**	16,030	11,164	16,123	**43,317**
External relationships*	11,146	815	7,649	**19,610**	10,554	834	6,932	**18,320**
Medical Practitioners Tribunal Service	5,227	4,072	5,287	**14,586**	5,134	4,903	4,874	**14,911**
Education and Standards	9,006	226	6,098	**15,330**	8,745	323	5,566	**14,634**
Department of Health funding - PA and AA regulation	1,704	981	-	**2,685**	859	397	-	**1,256**
Total charitable expenditure	68,143	26,534	60,139	**154,816**	63,898	24,153	53,385	**141,436**
Other expenditure - legal provision	-	684	-	**684**	-	683	-	**683**
Other expenditure - dilapidation provision	-	(162)	-	**(162)**	-	1,333	-	**1,333**
Total group expenditure	68,468	27,405	60,139	**156,012**	64,206	26,470	53,385	**144,061**

* External relationships include the work done by our Regional Liaison Service, strategic relationships, our devolved offices, and our European and international development activities.

Support costs allocated to charitable activities

	Management £'000	IT £'000	Human resources £'000	Finance £'000	Procurement £'000	Facilities £'000	Governance £'000	**Total 2024 £'000**	Management £'000	IT £'000	Human resources £'000	Finance £'000	Procurement £'000	Facilities £'000	Governance £'000	**Total 2023 £'000**
Fitness to practise	4,379	7,364	2,458	1,006	241	4,982	1,487	**21,917**	4,364	5,925	2,434	899	177	4,650	1,441	**19,890**
Registration and revalidation	3,834	6,447	2,152	881	211	4,361	1,302	**19,188**	3,538	4,803	1,973	728	143	3,770	1,168	**16,123**
External relationships	1,528	2,570	858	351	84	1,739	519	**7,649**	1,521	2,065	848	313	62	1,621	502	**6,932**
Medical Practitioners Tribunal Service	1,056	1,776	593	243	58	1,202	359	**5,287**	1,069	1,452	597	220	43	1,140	353	**4,874**
Education and Standards	1,218	2,049	684	280	67	1,386	414	**6,098**	1,221	1,658	681	252	49	1,302	403	**5,566**
Total charitable expenditure	12,015	20,206	6,745	2,761	661	13,670	4,081	**60,139**	11,713	15,903	6,533	2,412	474	12,483	3,867	**53,385**

Support costs are allocated to charitable activities on the basis of staff head count across the organisation.

Support cost recharges have been made to both the trading subsidiary, GMC Services International Ltd, and the PA and AA regulation project throughout the year on a direct basis, using the logic of allocation outlined above, and are therefore treated separately to the year end allocation.

Group expenditure by type

	Charitable activities 2024	Expenditure on raising funds 2024	Department of Health funding - PA and AA regulation 2024	Other expenditure 2024	Total 2024	Charitable activities 2023	Expenditure on raising funds 2023	Department of Health funding - PA and AA regulation 2023	Other expenditure 2023	Total 2023
	£'000	**£'000**	**£'000**	**£'000**	**£'000**	£'000	£'000	£'000	£'000	**£'000**
Staffing costs	97,039	325	1,704	-	**99,068**	89,983	308	859	-	**91,150**
Office costs	1,567	45	788	-	**2,400**	2,158	44	332	-	**2,534**
Council and committee costs	454	-	-	-	**454**	395	-	-	-	**395**
Panel and assessment costs	20,132	-	120	-	**20,252**	18,031	-	65	-	**18,096**
Legal costs	4,414	-	-	684	**5,098**	4,594	-	-	683	**5,277**
Accommodation costs	9,020	-	-	(162)	**8,858**	8,048	-	-	1,333	**9,381**
Financial, actuarial and professional costs	4,463	304	-	-	**4,767**	3,739	257	-	-	**3,996**
Purchase of assets - charged to revenue	7,349	-	-	-	**7,349**	5,389	-	-	-	**5,389**
Assets written off	22	-	-	-	**22**	851	-	-	-	**851**
Depreciation	2,215	-	-	-	**2,215**	2,231	-	-	-	**2,231**
Amortisation	5,457	-	73	-	**5,530**	4,761	-	-	-	**4,761**
	152,132	674	2,685	522	**156,013**	140,180	609	1,256	2,016	**144,061**

Total resources expended

	2024	2023
	£'000	£'000
Operating lease costs: leasehold property and equipment	4,408	3,453
Audit fees	55	55

5. Staff

Total costs of all staff	2024 £'000	2023 £'000
Salaries	**74,908**	70,082
Social security costs	**8,444**	7,317
Superannuation costs defined contribution scheme	**11,502**	9,999
Redundancy costs	**165**	130
Other staffing costs	**4,049**	3,622
	99,068	91,150

During the year the General Medical Council made termination payments of £80,000 (2023: £86,000) which included £50,000 relating to and accrued in 2023. At year end payments of £135,000 were outstanding (2023: £50,000).

Average staff numbers in the year by category	2024	2023
Fitness to practise	**460**	460
Registration and revalidation	**403**	373
External relationships	**161**	160
Medical Practitioners Tribunal Service	**111**	113
Education and Standards	**128**	128
Governance and management	**194**	178
Resources	**255**	249
	1,712	1,586
GMC Services International Ltd	**1**	1
	1,713	1,587

The number of staff whose total employee benefits (excluding employer pension contributions) fell into higher salary bands was:

	2024	2023
GMC		
£60,000-£70,000	74	74
£70,001-£80,000	50	50
£80,001-£90,000	44	38
£90,001-£100,000	40	29
£100,001-£110,000	11	10
£110,001-£120,000	8	9
£120,001-£130,000	10	9
£130,001-£140,000	11	7
£140,001-£150,000	4	3
£150,001-£160,000	3	3
£160,001-£170,000	2	2
£170,001-£180,000	1	-
£210,001-£220,000	-	3
£220,001-£230,000	4	3
£230,001-£240,000	2	-
£270,001-£280,000	-	1
£280,001-£290,000	1	-
	265	241
MPTS		
£60,000-£70,000	2	1
£70,001-£80,000	2	2
£80,001-£90,000	-	1
£90,001-£100,000	2	2
£120,001-£130,000	1	-
£130,001-£140,000	1	1
	8	7
Total	273	248

	2024	2023
Number of staff included above for whom retirement benefits are accruing		
GMC defined contribution pension scheme	271	246
	271	246

The senior management team includes the Chief Executive, six permanent directors and one temporary director to cover a secondment in 2024. The total employee benefits (including employer pension contributions) of the senior management team was £1,888,896 in 2024 (2023: £1,812,679).

Senior management team remuneration	Basic salary 2024	Basic salary 2023
	£'000	£'000
Charlie Massey – Chief Executive	277	264
Paul Reynolds – Director of Strategic Communications and Engagement	226	216
Shaun Gallagher – Director of Strategy and Policy	226	216
Una Lane – Director of Registration and Revalidation	226	216
Neil Roberts – Director of Resources	226	216
Professor Colin Melville – Director of Education and Standards	226	216
Anthony Omo – Director of Fitness to Practise*	184	216
Elizabeth Jenkins – Director of Fitness to Practise†	42	-

* Anthony Omo was seconded to the Nursing and Midwifery Council on the 28 October 2024.

† Elizabeth Jenkins is temporarily the Director of Fitness to Practise from 28 October 2024. The remuneration disclosed covers the period from 28 October 2024 to 31 December 2024.

All GMC staff, including the senior management team, are entitled to pension contributions of 15% of salary into the GMC Group Personal Pension Plan and may exchange contributions for salary.

The Chief Executive and Directors receive non-consolidated pay. In both 2024 and 2023 payments were below 3% of basic salary for all members of the senior management team.

All GMC staff, including the senior management team, are entitled to buy and sell leave and to the taxable benefit of private medical insurance. These costs and benefits are not included in the table above.

The Chief Executive's salary is 7.6 (2023: 7.6) times the median salary and 11.8 (2023: 12.3) times the lowest salary.

There were no related party transactions in the year that require disclosure other than payments made to trustees as disclosed in notes 17 and 18.

6. Intangible fixed assets

Group and charity

	Computer software and systems development £'000
Cost	
Balance at 1 January 2024	**37,376**
Additions	**8,076**
Disposals	**(2,648)**
Impairment	
Balance at 31 December 2024	**42,804**
Amortisation	
Balance at 1 January 2024	**20,769**
Amortisation charge for year	**5,530**
Disposals	**(2,646)**
Impairment	
Balance at 31 December 2024	**23,653**
Net book value at 1 January 2024	**16,607**
Net book value at 31 December 2024	**19,151**

Intangible assets incorporates all IT software development costs including, but not limited to, the development of our strategic applications, Siebel, Livelink and Agresso, the development of IT security systems, facilities management systems and website. Intangible assets also include the systems to support working from home and mobile applications.

7. Tangible fixed assets

Group and charity

	Buildings	Fixtures, furniture and equipment	IT equipment	Total
	£'000	£'000	£'000	£'000
Cost				
Balance at 1 January 2024	2,188	16,194	7,151	**25,533**
Additions	-	1,271	544	**1,815**
Disposals	(369)	(582)	(2,062)	**(3,013)**
Balance at 31 December 2024	1,819	16,883	5,633	**24,335**
Depreciation				
Balance at 1 January 2024	2,148	12,614	5,940	**20,702**
Depreciation charge for year	40	1,344	830	**2,214**
Disposals	(369)	(562)	(2,062)	**(2,993)**
Balance at 31 December 2024	1,819	13,396	4,708	**19,923**
Net book value at 1 January 2024	40	3,580	1,211	**4,831**
Net book value at 31 December 2024	-	3,487	925	**4,412**

8. Investments

Managed funds	Group		Charity		
	Listed Investments	Total	Listed Investments	Equity investment in group undertakings	Total
	£'000	£'000	£'000	£'000	£'000
The valuation at the end of the year consisted of					
As at 1 January 2024	61,573	**61,573**	61,573	333	**61,906**
Additions	35,103	**35,103**	35,103	-	**35,103**
Disposals	(35,397)	**(35,397)**	(35,397)	-	**(35,397)**
Gain on investments	573	**573**	573	-	**573**
Reversal of impairment*	-	**-**	-	24	**24**
Balance at 31 December 2024	**61,852**	**61,852**	**61,852**	**357**	**62,209**

* The General Medical Council incorporated a wholly owned trading subsidiary on 16 December 2016. Having previously been impaired by £267,000 due to trading losses incurred, we have revalued the investment by £24,000 in 2024 as a result of profits generated by the company thereby increasing its net assets.

Listed investments are managed by CCLA Investment Management Ltd. Investment management fees of £287,693 were incurred (2023: £243,805).

9. Debtors

	2024		2023	
	Group	**Charity**	Group	Charity
	£'000	**£'000**	£'000	£'000
Amounts falling due within one year				
Registration debtors	**26,772**	**26,772**	23,756	23,756
Prepayments and accrued income	**7,168**	**7,274**	6,299	6,410
Other debtors	**1,535**	**1,509**	920	899
	35,475	**35,555**	30,975	31,065

10. Creditors

	2024		2023	
	Group	**Charity**	Group	Charity
	£'000	**£'000**	£'000	£'000
Amounts falling due within one year				
Trade creditors	**1,221**	**1,220**	1,055	1,050
Tax and social security	**2,155**	**2,153**	2,106	2,105
Holiday pay	**1,193**	**1,193**	1,139	1,139
Accruals	**8,393**	**8,352**	6,785	6,734
Deferred income	**82,965**	**82,960**	81,043	80,989
	95,927	**95,878**	92,128	92,017

Charity deferred income

Income from annual retention fees is deferred and released to the statement of financial activities on a straight-line basis over a 12-month period from the date of renewal. All deferred income brought forward from the previous year is released to the statement of financial activities in the following year. Professional and Linguistic Assessments Board (PLAB) fees are deferred to the date the examination is sat. Commercial income is recognised at the point the service is delivered.

	Annual retention fees	**PLAB fees**	**Revalidation assessment fees**	**Commercial activities**	**Total**
	£'000	**£'000**	**£'000**	**£'000**	**£'000**
Deferred income at 1 January 2024	66,700	14,234	55	54	**81,043**
Resources deferred during the year	73,503	9,426	31	5	**82,965**
Amounts released from previous years	(66,700)	(14,234)	(55)	(54)	**(81,043)**
Deferred income at 31 December 2024	**73,503**	**9,426**	**31**	**5**	**82,965**

11. Provisions

Group and charity

	2024	2023
	£'000	£'000
Dilapidations	**4,312**	4,474
Legal claims	**6,653**	5,969
	10,965	10,443

Dilapidations - each year we review our property leases and make a provision for dilapidations, where the cost can be reasonably estimated.

Legal claims - each year we make a provision for potential costs related to ongoing legal cases. We are reflecting potential additional costs that may arise following the outcome of an employment tribunal. Further details in relation to the ongoing case cannot be provided in order to avoid prejudicing proceedings.

	Dilapidations	Legal claims	Total
	£'000	**£'000**	**£'000**
Provisions at 1 January 2024	4,474	5,969	**10,443**
Provisions created during the year	-	1,099	**1,099**
Utilisation of provision	(20)	(189)	**(209)**
Amounts released from previous years	(142)	(226)	**(368)**
Provisions at 31 December 2024	**4,312**	**6,653**	**10,965**

12. Group fund movements in the year

Group and charity

	Unrestricted funds	Restricted funds	Pension fund	2024 Total
	£'000	**£'000**	**£'000**	**£'000**
At 1 January 2024	64,104	2,122	(15,834)	50,392
Net incoming/(outgoing) resources	8,654	421	14,060	23,135
At 31 December 2024	**72,758**	**2,543**	**(1,774)**	**73,527**

	Unrestricted funds	Restricted funds	Pension fund	2023 Total
	£'000	£'000	£'000	£'000
At 1 January 2023	56,290	1,811	(3,248)	54,853
Net incoming/(outgoing) resources	7,814	311	(12,586)	(4,461)
At 31 December 2023	**64,104**	**2,122**	**(15,834)**	**50,392**

13. Net assets by fund

Group and charity

Fund balances at 31 December 2024 are represented by

	Unrestricted funds	Restricted fixed asset funds	Pension reserve	2024 Total funds
	£'000	£'000	£'000	£'000
Intangible fixed assets	16,608	2,543	-	19,151
Tangible fixed assets	4,412	-	-	4,412
Investments	61,852	-	-	61,852
Current assets	96,778	-	-	96,778
Current liabilities	(95,927)	-	-	(95,927)
Provisions for liabilities and charges	(10,965)	-	-	(10,965)
Pension scheme liability	-	-	(1,774)	(1,774)
Total net assets	**72,758**	**2,543**	**(1,774)**	**73,527**

Fund balances at 31 December 2023 are represented by

	Unrestricted funds	Restricted fixed asset funds	Pension reserve	2023 Total funds
	£'000	£'000	£'000	£'000
Intangible fixed assets	14,485	2,122	-	16,607
Tangible fixed assets	4,831	-	-	4,831
Investments	61,573	-	-	61,573
Current assets	85,786	-	-	85,786
Current liabilities	(92,128)	-	-	(92,128)
Provisions for liabilities and charges	(10,443)	-	-	(10,443)
Pension scheme liability	-	-	(15,834)	(15,834)
Total net assets	**64,104**	**2,122**	**(15,834)**	**50,392**

The restricted intangible asset represents the capitalised cost of the IT system developed to regulate physician associates and anaesthesia associates.

14. Capital commitments

Capital expenditure authorised and contracted but unspent at 31 December 2024 amounted to £358,020. The equivalent figure for 2023 was £340,679.

15. Operating lease commitments

	Land and buildings		Equipment	
	2024	2023	**2024**	2023
Expiry date	**£'000**	£'000	**£'000**	£'000
Within one year	**4,445**	3,780	**38**	21
In years two to five	**17,353**	14,767	**38**	-
After more than five years	**1,339**	3,051	**94**	-
	23,137	21,598	**170**	21

Commitments include our obligations under our buildings and equipment leases. They are calculated up to the first lease break clause or lease end where there is no break clause in the agreement. Commitments are calculated on a cash basis rather than incorporating rent free benefits.

16. Superannuation schemes

The GMC has two staff pension schemes:

GMC Group Personal Pension Plan

This is a defined contribution pension scheme, which was set up on 1 July 2013. We started auto enrolment on 1 November 2013. At the end of 2024 there were 1,724 members of staff contributing to this scheme. It meets the government's requirements following the introduction of automatic enrolment. Individuals can choose to make additional contributions by deduction from salary to the scheme. Under the terms of FRS102, contributions are accounted for as a defined contribution scheme based on actual contributions paid through the year.

GMC Staff Superannuation Scheme

This is a funded scheme of the defined benefit type, providing retirement benefits based on final salary. The top-up arrangement is an unfunded scheme.

This scheme was closed to new members on 30 June 2013, and replaced by the GMC Group Personal Pension Plan. The scheme was closed to future accruals, other than those linked to salary changes, for existing members on 31 March 2018 therefore at the end of 2018 there were no members of staff contributing to this scheme.

The FRS 102 valuation has been based on a full assessment of the liabilities for the Scheme as at 31 December 2021. The present values of the defined benefit obligation, the related current service cost and any past service costs were measured using the projected unit credit method.

Actuarial gains and losses have been recognised in the period in which they occur (but outside the profit and loss account) through the Other Comprehensive Income (OCI).

The GMC recognises surplus in accordance with the requirements of FRS 102 Section 18. The trustees of the Scheme do not have the unilateral right to commence wind-up of the Scheme. Thus, the GMC assumes that the Scheme continues in existence until the last benefit payments are made to members, at which point any residual assets are returned to the GMC in line with the rules of the Scheme.

The GMC made a top-up payment to the scheme of £3.5 million in 2024. A further £2.5 million will be paid in 2025 before reverting to £1.5 million until 2031 under the terms of the recovery plan agreed as part of the 2021 triennial valuation.

Responsibility for investing pension scheme assets rests with pension trustees. The Pensions Act 1995 requires trustees to draw up a Statement of Investment Principles, setting out the scheme's investment strategy. Pension trustees are required to consult the employer (GMC) when drawing up the strategy, but do not require the employer's formal agreement. Following consultation with the GMC, in 2014 the pension trustees adopted a fiduciary management approach to the investment of the scheme's assets.

The principal assumptions used by the independent qualified actuaries to calculate the liabilities under FRS102 are set out below.

Main financial assumptions

	31 December 2024	31 December 2023
	%pa	%pa
Retail prices index inflation	2.9	2.9
Consumer price index inflation	2.6	2.6
Rate of general long-term increase in salaries	3.6	3.6
Pension increases (excess over guaranteed minimum pension)	2.6	2.6
Discount rate for scheme liabilities	5.5	4.4

Mortality assumptions

The mortality assumptions are based on standard mortality tables which allow for expected future mortality improvements. The assumptions are that a member currently aged 65 will live on average for a further 22 years (2023: 21.9 years) if they are male and for a further 24 years if they are female (2023: 23.9 years).

For a member who retires in 2044 at age 65 the assumptions are that they will live on average for a further 23.1 years after retirement if they are male and for a further 25.1 years after retirement if they are female.

Scheme asset allocation

	31 December 2024		31 December 2023	
	£'000	**%**	£'000	%
Delegated consulting services	**131,420**	**99%**	149,947	100.0
Other	**773**	**1%**	52	-
Total	**132,193**	**100%**	149,999	100.0

The Delegated Consulting Service (DCS) is a fiduciary management solution that invests in a wide range of underlying assets in order to meet the Scheme's specific investment objectives. The underlying asset allocation changes over time, based on the views of the fiduciary manager within the overall bounds set by the trustees. Under this approach the majority of scheme assets are invested in pooled funds. The managers of the pooled funds are required to have in place a policy on social, environmental and ethical considerations.

None of the Scheme assets are invested in the Company's financial instruments or in property occupied by, or other assets used by, the GMC.

Reconciliation of funded status to balance sheet

	31 December 2024	31 December 2023
	£'000	£'000
Fair value of assets	**132,193**	149,999
Present value of funded defined benefit obligations	**(133,167)**	(164,982)
Funded status	**(974)**	(14,983)
Present value of unfunded defined benefit obligation	**(800)**	(851)
Asset/(liability) recognised on the balance sheet	**(1,774)**	(15,834)

Amounts recognised in income statement

	31 December 2024	31 December 2023
	£'000	£'000
Financing cost		
Interest on net defined benefit liability	**543**	53
Pension income recognised in profit and loss	**543**	53

Amounts recognised in Other Comprehensive Income (OCI)

	31 December 2024	31 December 2023
	£'000	£'000
Asset (losses)/gains arising during the year	**(24,197)**	(10,536)
Liability gains/(losses) arising during the year	**35,226**	(5,564)
Actuarial (loss)/gain on defined benefit pension scheme	**11,029**	(16,100)

Changes to the present value of the defined benefit obligation during the year

	31 December 2024	31 December 2023
	£'000	£'000
Opening defined benefit obligation (DBO)	**165,833**	160,232
Interest expense on DBO	**7,213**	7,208
Actuarial (gains)/losses on liabilities	**(35,226)**	5,564
Net benefits paid out	**(3,851)**	(7,171)
Closing defined benefit obligation	**133,969**	165,833

Changes to the fair value of scheme assets during the year

	31 December 2024	31 December 2023
	£'000	£'000
Opening fair value of scheme assets	**149,999**	156,984
Interest income on scheme assets	**6,670**	7,155
(Loss) on scheme assets	**(24,197)**	(10,536)
Contributions made by the company	**3,572**	3,567
Net benefits paid out	**(3,851)**	(7,171)
Closing fair value of scheme assets	**132,193**	149,999

Actual return on scheme assets

	31 December 2024	31 December 2023
	£'000	£'000
Interest income on scheme assets	**6,670**	7,155
Gain/(loss) on scheme assets	**(24,197)**	(10,536)
Actual return on scheme assets	**(17,527)**	(3,381)

17. Related party transactions

	2024	2023
	£	£
Trustee honoraria		
Dame Carrie MacEwen (Chair)	110,000	110,000
Steve Burnett*	18,000	18,000
Vanessa Davies	18,000	18,000
Professor Anthony Harnden*	18,000	18,000
Lord Philip Hunt†	1,500	18,000
Professor Paul Knight*	18,000	18,000
Professor Deepa Mann-Kler	18,000	18,000
Dr Raj Patel	18,000	18,000
Professor Suzanne Shale	18,000	18,000
Dr Alison Wright	18,000	18,000
Dr Jeeves Wijesuriya‡	18,000	12,000
Douglas Millican‡	18,000	12,000

* Demitted as Council member December 2024

† Demitted as Council Member January 2024

‡ Appointed as Council member May 2023

Honoraria payments are permitted by the governing document of the General Medical Council, The Medical Act 1983, paragraph 17, schedule 1.

Medical Practitioners Tribunal Service Committee members	2024	2023
Her Honour Judge Deborah Taylor*	120,832	98,456
Gill Edelman (Gillian Gordon)	3,720	3,720
Joy Hamilton†	413	3,720
Professor Jacky Hayden‡	7,440	7,440
Dr Simon Mackenzie‡	3,607	3,720
Barbara Larkin§	3,292	-
Dr Stephen Webb¶	930	-

* Appointed as Chair of MPTS Committee March 2023

† Demitted as MPTS Committee member February 2024

‡ Demitted as MPTS Committee member December 2024

§ Appointed as MPTS Committee member February 2024

¶ Appointed as MPTS Committee member October 2024

Audit and Risk Committee co-opted members	2024	2023
Aneen Blackmore*	-	-
Jon Hayes	3,315	3,752
Kenneth Gill†	-	930

* Appointed as Audit and Risk Committee member October 2023

† Demitted as Audit and Risk Committee member March 2023

Investment Committee co-opted members	2024	2023
Keith Mackay	1,300	2,688
Michael Jennings	1,755	2,086

GMC Services International Ltd	2024	2023
Dr Andrew McCulloch	1,950	318
Thalia Georgiou*	975	-
Victoria Cheston*	-	-

* Appointed as GMCSI Board member May 2024

18. Travel and subsistence expenses claimed in 2024

	2024	2023
	£	£
Trustees		
Dame Carrie MacEwen (Chair)	3,248	4,661
Steve Burnett*	2,703	3,259
Vanessa Davies	5,129	3,733
Professor Anthony Harnden*	1,375	1,323
Lord Philip Hunt†	-	952
Professor Paul Knight*	4,797	3,419
Professor Deepa Mann-Kler	7,380	3,773
Dr Raj Patel	2,630	2,837
Professor Suzanne Shale	1,169	510
Alison Wright	330	628
Dr Jeeves Wijesuriya‡	2,661	1,706
Douglas Millican‡	2,040	1,421

* Demitted as Council member December 2024

† Demitted as Council Member January 2024

‡ Appointed as Council member May 2023

Variations in expenses reflect that the trustees, committee members and the Senior Management Team live in different parts of the UK and are required to travel around the UK on GMC business, including to our offices in London, Manchester, Edinburgh, Belfast and Cardiff, and occasionally outside the UK. This also reflects that different numbers of meetings and events are attended by individuals. Deepa Mann-Kler is based in Belfast, and Vanessa Davies is based in Edinburgh.

Adjustments are also made for those with disabilities, which may mean that additional expenses are incurred for travel and accommodation according to specific needs.

Medical Practitioners Tribunal Service Committee members	2024	2023
Her Honour Judge Deborah Taylor*	90	81
Gill Edelman (Gillian Gordon)	528	724
Joy Hamilton†	-	1,107
Professor Jacky Hayden‡	582	774
Dr Simon Mackenzie‡	758	683
Barbara Larkin§	2,038	-
Dr Stephen Webb¶	330	-

* Appointed as Chair of MPTS Committee March 2023

† Demitted as MPTS Committee member February 2024

‡ Demitted as MPTS Committee member December 2024

§ Appointed as MPTS Committee member February 2024

¶ Appointed as MPTS Committee member October 2024

Audit and Risk Committee co-opted members	2024	2023
Aneen Blackmore*	237	-
Jon Hayes	310	519
Kenneth Gill†	-	29

* Appointed as ARC Committee member October 2023.

† Demitted as ARC Committee member March 2023.

Investment Committee co-opted members	2024	2023
Keith Mackay	-	-
Michael Jennings	69	21

GMC Services International Ltd	2024	2023
Dr Andrew McCulloch	125	-
Thalia Georgiou*	111	-
Victoria Cheston*	-	-

* Appointed as GMCSI Board member May 2024

	2024	2023
Senior management team		
Charlie Massey – Chief Executive	8,792	6,521
Shaun Gallagher – Director of Strategy and Policy	4,759	4,074
Una Lane – Director of Registration and Revalidation	4,195	5,101
Professor Colin Melville – Director of Education and Standards	9,895	5,648
Anthony Omo – Director of Fitness to Practise*	3,423	3,691
Elizabeth Jenkins – Director of Fitness to Practise†	2,395	-
Paul Reynolds – Director of Strategic Communications and Engagement	10,339	416
Neil Roberts – Director of Resources and Quality Assurance	7,938	9,969

* Anthony Omo was seconded to the Nursing and Midwifery Council on the 28 October 2024.

† Elizabeth Jenkins is temporarily the Director of Fitness to Practise from 28 October 2024. The expenses disclosed covers the period from 28 October 2024 to 31 December 2024.

Reference and administrative information

We are independent of the UK Government and of those we regulate, and are accountable to Parliament. Our powers are given to us by Parliament through the Medical Act 1983.

We are registered with the Charity Commission for England and Wales (1089278), and with the Office of the Scottish Charity Regulator (SC037750). We are not currently required to be registered separately with the Northern Ireland Charity Commission.

Our principal places of business are 3 Hardman Street, Manchester M3 3AW and Regent's Place, 350 Euston Road, London NW1 3JN. We also have offices in Belfast, Cardiff and Edinburgh; a centre for hearings, where the Medical Practitioners Tribunal Service is based, at St James's Buildings, 79 Oxford Street, Manchester M1 6FQ; and a Clinical Assessment Centre, in 3 Hardman Square, Manchester M3 3EB.

Our trustees have a duty to act impartially and objectively, and to take steps to avoid any conflict of interest arising as a result of their membership of, or association with, other organisations or individuals. As trustees, members have a duty to avoid putting themselves in a position where their personal interests conflict with their duty to act in the interests of the charity, unless authorised to do so. To make this fully transparent, we publish a register of members' interests on our website.

Day-to-day management of the organisation is delegated to the Chief Executive, Charlie Massey. You can read more about our governance and management arrangements earlier in this report.

We work with the Professional Standards Authority (PSA), an independent body, which is accountable to Parliament and scrutinises and oversees our work, together with other health and social care professional regulatory bodies in the UK.

Information requests

In 2024, we received 484 requests for personal information under the UK General Data Protection Regulation (GDPR). This was an increase of 8% from 2023. We also received 793 information requests under the Freedom of Information Act in 2023, down 6% from 2023.

We achieved 86% against our target to respond to 80% of personal information requests within the statutory timeframe. For Freedom of Information requests, we achieved 86% against our target of responding to 90% within 20 working days.

Our registration reference with the Information Commissioner's Office is Z7423389.

Paying for goods and services

We paid 97% of valid and undisputed invoices within 30 days and did not pay any interest to suppliers due to late payment in excess of 30 days.

Professional advisers

Bankers	National Westminster Bank Plc 250 Bishopsgate London EC2M 4AA
Investment adviser	Mercer Limited 1 Tower Place West Tower Place London EC3R 5BU
Solicitors	The majority of our legal work is carried out by our in-house legal team.
Auditors	Crowe U.K. LLP 2nd Floor, 55 Ludgate Hill London EC4M 7JW
Actuary and pension scheme adviser	Aon Parkside House, Ashley Road Epsom Surrey KT18 5BS

Email: **gmc@gmc-uk.org**
Website: **gmc-uk.org**
Telephone: **0161 923 6602**

General Medical Council, 3 Hardman Street, Manchester M3 3AW

Textphone: **please dial the prefix 18001** then **0161 923 6602** to use the Text Relay service.

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To ask for this publication in another format or language, please call us on **0161 923 6602** or email us at **gmc@gmc-uk.org**.

I ofyn am y cyhoeddiad hwn mewn fformat neu iaith arall, ffoniwch ni ar **0161 923 6602** neu e-bostiwch ni ar **gmc@gmc-uk.org**.

You are welcome to contact us in Welsh. We will respond in Welsh, without this causing additional delay.

Mae croeso i chi gysylltu â ni yn Gymraeg. Byddwn yn ymateb yn Gymraeg, heb i hyn achosi oedi ychwanegol.

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GENERAL MEDICAL COUNCIL

England & Wales - Charity number 1089278

Accounts

General Medical Council

Annual Report 2023

Trustees' annual report and accounts for the year ended 31 December 2023

General Medical Council

General Medical Council

Annual Report 2023

Trustees' annual report and accounts for the year ended 31 December 2023

Presented to Parliament pursuant to section 52A of the Medical Act 1983 as amended by The Health Care and Associated Professions (Miscellaneous Amendments) Order 2008 (SI No.1774).

General Medical Council



Our annual report

2023

General Medical Council

About this report

Our trustees present this report and financial statement for the year ending 31 December 2023.

They confirm they have taken into account the Charity Commission's public benefit guidance when reviewing our aims and objectives and have had regard to this guidance when exercising any powers or duties or when making a decision to which the guidance is relevant. The trustees are satisfied that at all times we have operated for public benefit and that the activities as described in this report and accounts fully meet the public benefit requirements and support our charitable purpose.









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This publication is available in Welsh on our website.

Mae'r cyhoeddiad hwn ar gael yn Gymraeg ar ein gwefan.

Foreword

As it marked its 75th birthday in 2023, the NHS faced severe challenges. There remained a backlog from the pandemic, with waiting times in accident and emergency and general practice under scrutiny, and waiting lists for elective surgery climbing higher than ever. Prolonged periods of industrial action added to the disruption.

Workforce shortages, combined with unprecedented demand, put extraordinary pressure on services and those who work within them.

More doctors than ever before told us they were at risk of burnout, had taken hard steps to leave UK practice and, worryingly, were regularly finding it difficult to provide sufficient care to patients, as the pressure of working under strain took its toll. This highlighted an urgent need to improve working conditions to ensure the future sustainability of the workforce and, crucially, to safeguard patient care.

In June we published *The state of medical education and practice in the UK: workplace experiences report*, which revealed sharp increases in work intensity, job dissatisfaction and the numbers of doctors feeling unable to cope. With doctors choosing to step away, reducing their hours or leaving UK practice altogether, a vicious cycle was intensifying pressure on colleagues with inevitable impacts on the provision of patient care.

As the independent regulator, it is our responsibility to promote patient safety and uphold standards of care, and in August we launched an updated version of our professional standards, *Good medical practice*, in advance of it coming into effect in January 2024. The updated standards have a much-strengthened focus on professional behaviours and the importance of workplace culture. A number of new duties were introduced, and for the first time the standards set out that all doctors have a responsibility to contribute to a respectful, fair, supportive and compassionate workplace culture.

While not a panacea for deep-rooted, systemic problems, we know that a good working environment for doctors can act as a protective factor against stress. Combined with compassionate leadership, it also means doctors should feel more able to speak up when things are going wrong: an essential safeguard for patients. The changes we made to *Good medical practice* are intended to help create cultures where all doctors feel valued, and feel the sense of belonging that we know results in better teamworking and better patient care.

A critical component of good workplace culture is inclusion. While internationally trained doctors have always made a significant contribution to our health services, UK-trained workforce diversity has increased dramatically over recent years. *The state of medical education and practice in the UK: workforce*

report showed that over half of new registrants in 2022 were doctors who graduated outside the UK.

During the year we improved our registration pathways to remove unnecessary bureaucratic barriers to doctors choosing to come and work in the UK. We increased our Professional and Linguistic Assessments Board (PLAB) exam capacity, revised our postgraduate qualification criteria and introduced digital ID checks. We also made our process for applying for specialist or GP registration more flexible. These steps have helped us welcome more talented doctors and allow them access to the opportunities they want, with significant benefits for patients.

Unfortunately, we know that international medical graduates, many of whom are from a Black or minority ethnic background, often have worse experiences than others at work and inclusive approaches to enhancing workplace should be seen as a priority.

Several significant projects were rolled out across the UK to raise awareness of the challenges international medical graduates face as they integrate into the UK medical workforce. We worked alongside devolved legislatures and stakeholders, showcased good practice and helped teams on the ground put support programmes in place. We also piloted sessions for supervisors to help raise awareness of the *Welcoming and Valuing International Medical Graduates* guidance we developed in collaboration with NHS England and other partners.

We also worked to tackle some of the structural problems that stand in the way of equality, diversity and inclusion (ED&I). We made encouraging progress against our targets, including those for fairer employer referrals and fairer training cultures, although there remains a long way to travel. We also published a regulatory fairness review, and made progress implementing changes in line with its recommendations before the end of the year, with work set to continue.

Sustained endeavour from all parties is required if we are to level the playing field. Without such effort, the retention challenge will not go away. We must enable talented doctors to flourish if we hope to retain them and not deprive patients of quality care.

While there are similar challenges and objectives across geographies, our offices in England, Northern Ireland, Scotland and Wales have national strategies designed to meet the needs of their workforce and patient community. This allows their outreach and engagement teams to drive positive changes that are meaningful in a national context. We held six UK Advisory Forums in 2023, two in each of the devolved nations. This long-established format allows us to consult with stakeholders on our policies, ensuring that they will deliver best results for patients and doctors across all parts of the UK's healthcare systems. 2023 also saw celebrations in Scotland as our national office there marked 20 years since it opened in the wake of devolution.

Looking to the future, it will be our responsibility to ensure that standards in medical education and training are maintained as ambitious plans to scale up numbers of medical students are delivered. We welcome innovative approaches from education providers that reflect the changing demands on our healthcare services and the changing composition of the workforce. Reforms to medical education and training will help us increase job satisfaction and career longevity, providing a more robust workforce to meet patient need.

We are also now on the pathway to regulatory reform, another overdue development. The legislation that governs how we work is 40 years

old, and while it has been modified in that time to accommodate developments such as Brexit or other practical matters, we are eager for the UK Government and the devolved legislatures to make more substantial changes that will allow us to regulate in a more modern, effective and compassionate way. Good progress towards reform was made in 2023, with the legislative Order for the regulation of physician associates (PAs) and anaesthesia associates (AAs) laid at the end of the year. We are now required by law to start regulating these groups from December 2024. We made known that we will use an alphabetical prefix for these professionals on public-facing registers, and provided reassurance that under regulation, doctors, PAs and AAs will be treated as three distinct professions. Regulation will maximise the benefit these professionals can bring to the workforce while ensuring good, safe patient care.

Regulatory reform will also allow for the modernisation of medical education and training. A more substantial, diverse and better supported educator workforce is urgently needed, and increased flexibility and innovation in training will benefit doctors and better meet the needs of patients.

Thanks to exceptional work from our people, our regulator, the Professional Standards Authority (PSA), once again confirmed that we met all standards in transparency, public protection, timeliness, and equality, diversity and inclusion. We advanced our internal ED&I work, and our corporate social responsibility agenda, focusing on sustainability, social mobility and community support. We shared our ambition to become a more compassionate regulator, improving the experiences of those interacting with us, and made further changes to our systems and processes with this goal in mind. As we discharge our responsibilities to promote patient safety and public confidence in the profession, we must also ensure we play a positive role in society and the communities in which we operate. It is essential that we hold, and are held to, high standards.

Our health services face more challenging years ahead. Action is needed to find solutions to workforce problems and improve the workplace experiences of all doctors working in UK practice, wherever they work and wherever they have trained. We will continue to play our part but collaborative efforts are needed to ensure that patients can receive safe care of the highest quality, both now and in the future.





Charlie Massey
Chief Executive





Professor Dame Carrie MacEwen
Chair

Our role in the UK's healthcare systems

We are the independent regulator of doctors in the UK.

We work with doctors, patients and other stakeholders to support good, safe patient care. We set the standards doctors and those who train them need to meet, and help them achieve them. If there are concerns these standards may not be met or that public confidence in doctors may be at risk, we can investigate, and take action if needed.

How we promote good, safe patient care

- We set the standards of patient care and professional behaviours doctors need to meet. We set the values, knowledge, skills and behaviours expected of all doctors working in the UK, and we support students, doctors and employers to understand and meet these standards.
- We make sure doctors get the education and training they need to deliver good care. We approve undergraduate and postgraduate medical training in the UK, and the assessments medical students and doctors in training must pass. We do this by assessing all courses and programmes and by carrying out reviews and regular monitoring. We also talk to students, trainees and educators to hear about their experiences.
- We check who is eligible to work as a doctor in the UK, and check they continue to meet the professional standards we set throughout their careers. We do this by maintaining an official list called the medical register. When a doctor applies to join the medical register, we check they meet our requirements to work in the UK and deliver good, safe patient care. To remain in practice, doctors must also continue to meet the professional standards we set, show that they are competent and show that they keep their knowledge and skills up to date. We check this through a process called revalidation, working with employers to make sure they have processes in place to manage doctors' appraisals or complaints about a doctor's practice, and asking them to confirm that doctors are working to the standards we set, and that they regularly review their own performance.
- We investigate where there are concerns that patient safety, or the public's confidence in doctors, may be at risk, and take action if needed. If serious concerns are raised with us about a doctor's behaviour, health or performance, we can investigate to determine whether patient safety, or the public's confidence in doctors, is at risk. As a result of our investigations, we may refer a case to the Medical Practitioners Tribunal Service (MPTS) for a hearing. MPTS tribunals make independent decisions about the cases we refer. They can suspend or restrict a doctor from carrying out their duties. In very serious cases, the tribunals may remove a doctor from the medical register, meaning they can no longer work in the UK. The MPTS produces its own separate annual report.

Our performance

Every year our performance as a regulator is assessed by the Professional Standards Authority (PSA). It is measured across our four core functions: education and training; registration; guidance and standards; and fitness to practise.

The PSA's latest annual assessment confirmed that we successfully met all 18 of its Standards of Good Regulation in 2022–2023. We are proud to have met all the standards set by the PSA since they were introduced in 2012. It means we are performing to a high standard as a regulator, and reflects the commitment we make in our work to standards such as:

- transparency
- public protection
- timeliness
- equality, diversity and inclusion.

General standards

5 out of **5**

Guidance and standards

2 out of **2**

Education and training

2 out of **2**

Registration

4 out of **4**

Fitness to practise

5 out of **5**

Total standards met

18 out of **18**

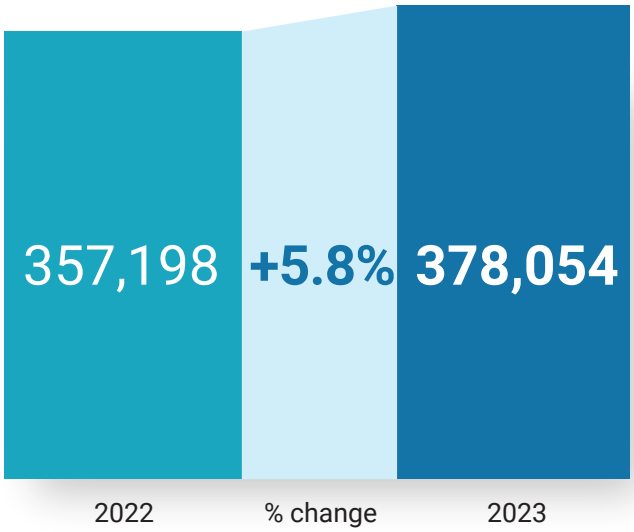
2023 at a glance



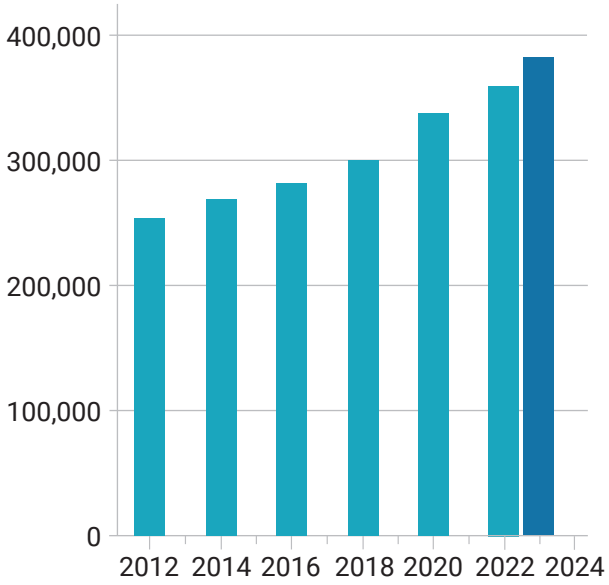
The medical register

All figures as of 31 December 2023 and 31 December 2022, unless otherwise specified.
Visit GMC Data Explorer to learn more about doctors' education and practice in the UK.

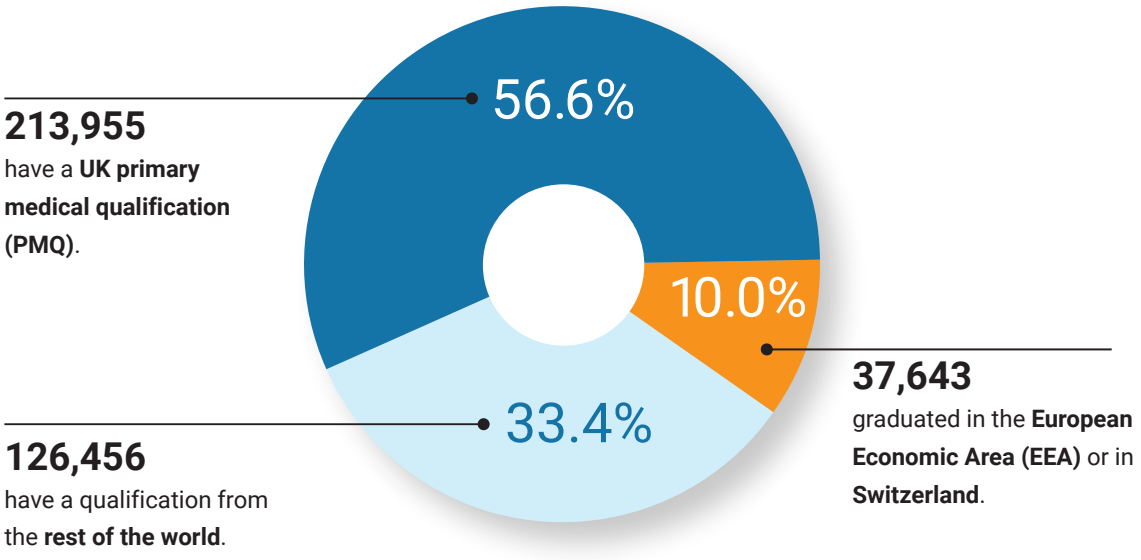
Total doctors on the register



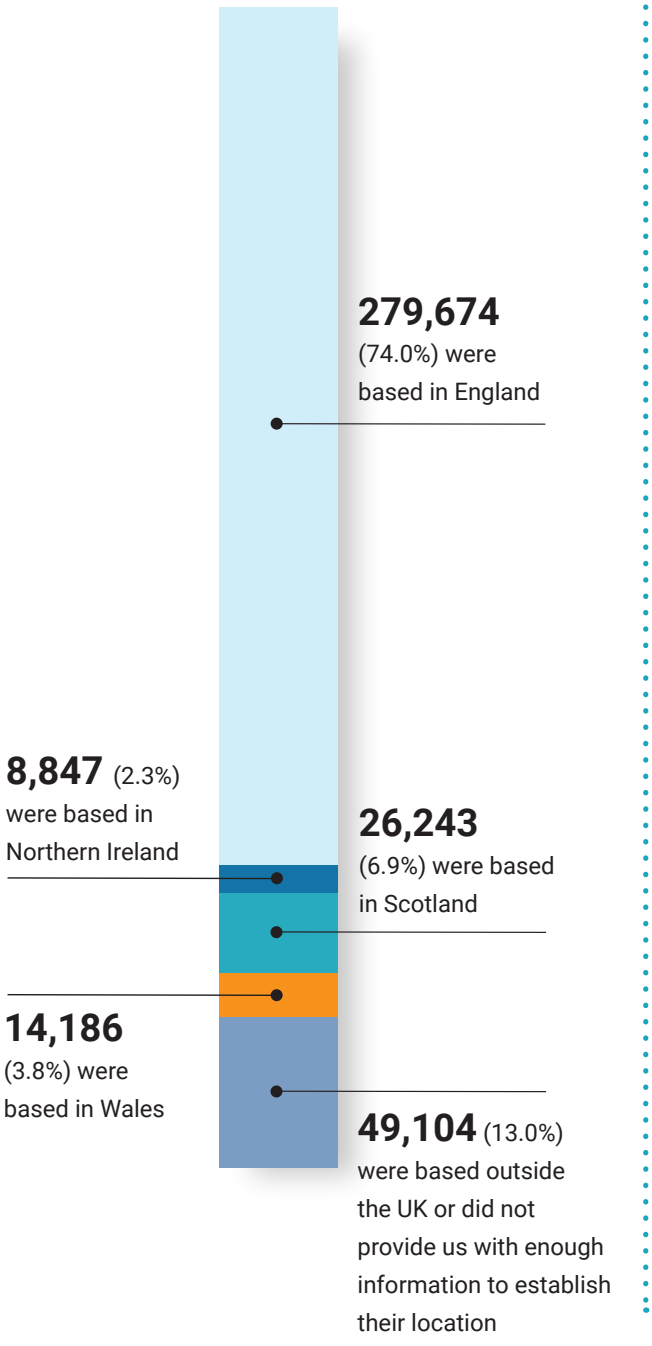
Growth in registered doctors 2012–2023



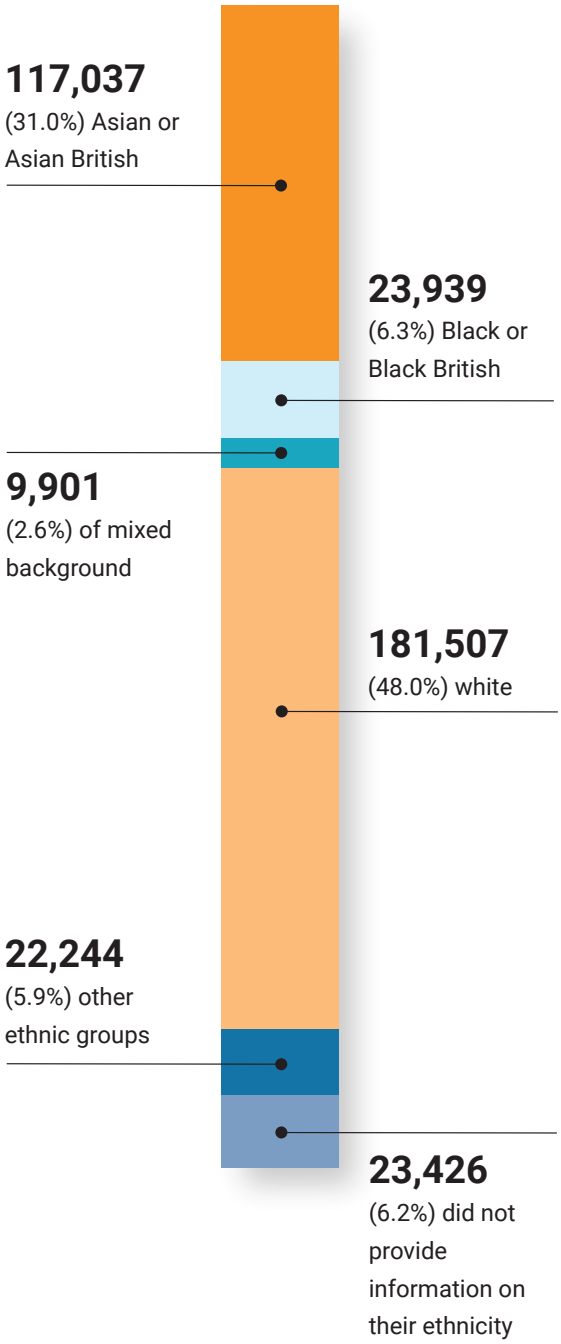
Where they graduated



Doctors on the register by location*



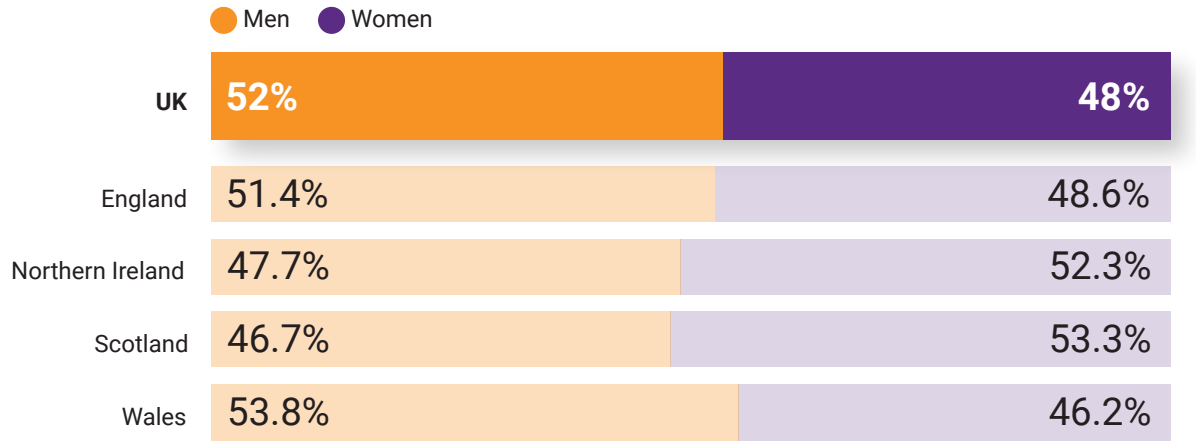
Doctors on the register by ethnicity



* The derived location of registered doctors is calculated using the following hierarchy:
1. where they work based on NHS practice history data
2. their training location based on the National training survey
3. the location of their designated body
4. their registered address.

Registered doctors located in the Channel Islands and the Isle of Man are included in the figures referring to England.

Doctors on the register by gender



Total doctors on the GP Register

80,562

Up **2.5%** from 2022 **(78,619)**

64,692 (80.3%) were located in **England**.
2,278 (2.8%) were located in **Northern Ireland**.
7,452 (9.3%) were located in **Scotland**.
3,289 (4.1%) were located in **Wales**.
2,851 (3.5%) either were located **outside the UK** or did not provide us with enough information to establish their location.

Total doctors on the Specialist Register

110,478

Up **2.9%** from 2022 **(107,327)**

83,735 (75.8%) were located in **England**.
2,721 (2.5%) were located in **Northern Ireland**.
8,366 (7.6%) were located in **Scotland**.
4,250 (3.8%) were located in **Wales**.
11,406 (10.3%) either were located **outside the UK** or did not provide us with enough information to establish their location.

In 2023, we granted:

26,969

applications for first entry to the register.

That is up

26.9% ↑

from 2022 (**21,255**).

8,301
(30.8%) were from doctors with a **UK PMQ**.

2,887
(10.7%) were from doctors who graduated in the **EEA** or in **Switzerland**.

15,781
(58.5%) were from doctors with a qualification from **the rest of the world**.



3,776

applications to join the GP Register.

That is up

14.1% ↑

from 2022 (**3,309**).

2,189
(58%) were from doctors with a **UK PMQ**.

219
(5.8%) were from doctors who graduated in the **EEA** or in **Switzerland**.

1,368
(36.2%) were from doctors with a qualification from **the rest of the world**.



5,316

applications to join the Specialist Register.

That is up

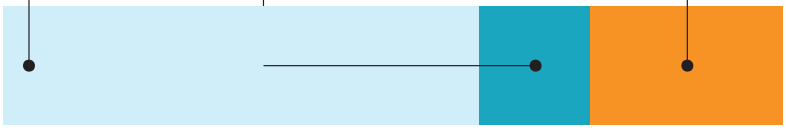
10.8% ↑

from 2022 (**4,799**).

3,233
(60.8%) were from doctors with a **UK PMQ**.

754
(14.2%) were from doctors who graduated in the **EEA** or in **Switzerland**.

1,329
(25%) were from doctors with a qualification from **the rest of the world**.



Professional and Linguistic Assessments Board

Doctors who graduate outside the UK, the EEA or Switzerland usually need to take our Professional and Linguistic Assessments Board (PLAB) test in order to join the UK medical register.* The test is taken in two parts (PLAB 1, delivered in assessment centres around the world, and PLAB 2, undertaken in one of our testing centres in Manchester).

PLAB 1

21,916

candidates took PLAB 1 in 2023, a 51.5% increase on 2022 (**14,470**).

15,781 (72%) passed the exam.

PLAB 2

15,702

candidates took PLAB 2 in 2023, a 16% increase on 2022 (**13,533**).

9,884 (62.9%) passed the exam.

* Exceptions to this include international medical graduates joining the register based on being sponsored by healthcare organisations, or based on postgraduate qualifications. In both these cases, doctors must still provide evidence of their competence and skills. For more information on the different routes to join the register, see www.gmc-uk.org/registration-and-licensing/join-the-register/before-you-apply/evidence-to-support-your-application.

Setting and maintaining standards

Revalidation

Every licensed doctor who practises medicine in the UK must prove they are meeting our standards every five years through a process called revalidation. Revalidation supports doctors to develop their practice, drives improvements in clinical governance and gives patients confidence that doctors are fit to practise.

In 2023 we received

56,254

recommendations for revalidation.*

48,026 of the recommendations were submitted by designated bodies located in **England**.

1,645 were submitted by designated bodies located in **Northern Ireland**.

3,955 were submitted by designated bodies located in **Scotland**.

2,443 were submitted by designated bodies located in **Wales**.†

47,933

doctors were revalidated in 2023.

40,564 were located in **England**.

1,364 were located in **Northern Ireland**.

3,371 were located in **Scotland**.

2,101 were located in **Wales**.

533 either were based **outside the UK** or did not provide us with enough information to establish their location.

We made decisions on

98.5%

of the total recommendations we received in 2023 **within 5 working days** from when we received them, **exceeding our target of 95%.**

7,160 We approved **deferral of revalidation submission dates** for 7,160 doctors.

582 We **withdrew the licences** of 582 doctors on our register through failure to revalidate.‡

* Doctors can receive more than one recommendation.

† The remaining 185 are not associated to a specific location as they are the result of administrative processes necessary to consolidate data.

‡ If a doctor does not fulfil the requirements of revalidation, provides fraudulent information or fails to provide reasonably requested evidence, we can legally withdraw their licence. This process is different to that of being removed from the register, for example, following an MPTS hearing.

Outreach

Our outreach teams delivered training on our standards to:

23,031 **doctors** in **672 sessions** and

That is up **3.7%** from 2022 (22,210).

13,167 **medical students** in **114 sessions** across the UK.

That is up **7.9%** from 2022 (12,205).

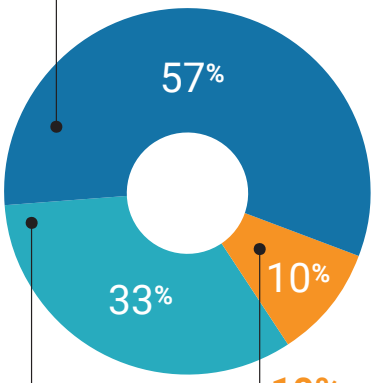
79% of doctors said they would **change their practice** as a result of the session.

Our standards enquiry team answered:

465 enquiries about our guidance.

That is up **5.4%** from 2022 (**440**).

57% of the enquiries were **from doctors** (2022: 52%)



33% from **members of the public** (2022: 34%)

10% **were from others,** including staff from professional organisations, students and the police (2022: 14%).

Our outreach teams also deliver workshops aimed at helping doctors who are **new to UK practice** adjust to working in the UK's healthcare systems.

The team delivered **296 *Welcome to UK practice* workshops** in 2023, involving **10,575 doctors** – up **19.8%** from 2022 (**8,829**).

Our employer liaison advisers held **1,222** meetings with responsible officers.

They also provided fitness to practise advice in relation to **2,417** doctors.

Overseeing medical education and training

Quality assurance

We regulate all stages of a doctor's undergraduate and postgraduate education and training, setting standards and carrying out **quality assurance (QA)** work to make sure these are maintained.

Through our **proactive quality assurance** process, we check that medical schools and postgraduate training organisations are continuing to meet our standards and we look for innovative and notable practice in medical education and training. We also decide which organisations can award a UK primary medical qualification. To do this, we QA all institutions looking to establish a new medical school or programme to ensure our standards are met.

Our **reactive quality assurance** processes promote and encourage local management of concerns about the quality and safety of undergraduate medical education and postgraduate training, through which emerging issues affecting education and training environments can be raised and monitored.

If the issues are not resolved or worsen, cases can be escalated into our **enhanced monitoring process**, which we use to address serious concerns where additional support is required.

In 2023 we carried out **246** education QA visits.

That is down **4.7%** from 2022 (**258**).*

186 of the visits were in **England**.
13 of the visits were in **Northern Ireland**.
24 of the visits were in **Scotland**.
23 of the visits were in **Wales**.

190 were **QA visits to medical schools, or clinical environments** where medical education and training take place.
56 were **enhanced monitoring visits**, promoting the local resolution of concerns about postgraduate training.

From our QA visits, we found:

64 areas of **good practice or working well**.
28 areas where our **standards were met**, but where we **identified improvements** that could be made.
9 areas that **required improvement**.†

As a result of our enhanced monitoring visits:

8 cases relating to postgraduate education **were escalated to our enhanced monitoring process**.‡
16 cases escalated previously **were resolved**.§

* We always carry out a minimum of one education QA activity per organisation per year. Sometimes we make follow-up visits in some organisations, which are counted in our totals; we also don't undertake QA visits in organisations while they're affected by industrial action, which happened several times during 2023. This inevitably leads to statistical variation in the number of QA activities we carry out from one year to another, including small declines, as is the case this year.

† Not all QA visits lead to specific findings like those listed here - in some cases nothing of significance is found, as nothing has changed since the previous visit, or nothing has been found worthy of particular note (ie. education and training are working as expected). Here, we only report on the number of areas found to be particular examples of good practice, ie. working well, or areas requiring improvement or where improvement is recommended. The figures on findings reported here therefore won't necessarily match the total number of visits we carried out.

‡ Enhanced monitoring cases usually concern a specific unit or department in a local education provider (LEP). Monitoring may relate to more than one concern in the same LEP, and a concern under monitoring may affect more than one unit, or an entire trust or health board.

§ Like with QA visits, not all enhanced monitoring visits result in escalation or de-escalation - in some cases the visits focus on monitoring progress towards the resolution of issues that had previously been escalated. The total number of visits therefore won't necessarily match the number of new or open cases or of cases whose status has changed during the year.

Supporting the people we serve

In 2023, we received

1,566

complaints about our service.

This is an

18%

decrease on 2022 (**1,916**).

In 2023 our patient liaison service held 273 meetings with patients who had raised a concern with us.

93.3% of those who responded to a survey after attending a patient liaison meeting were satisfied or very satisfied with the patient meeting experience.

90% agreed or strongly agreed that patient liaison staff showed empathy for their situation.

90% agreed or strongly agreed that the meetings helped them to understand what action the GMC could take.

86.7% agreed or strongly agreed that they were satisfied that their concerns had been understood during the meeting.

Our contact centre answered

152,320

calls and

105,378

emails or letters.

76.1%

of the calls and emails we received were from doctors, and

23.9%

from members of the public and others.

The contact centre also handled

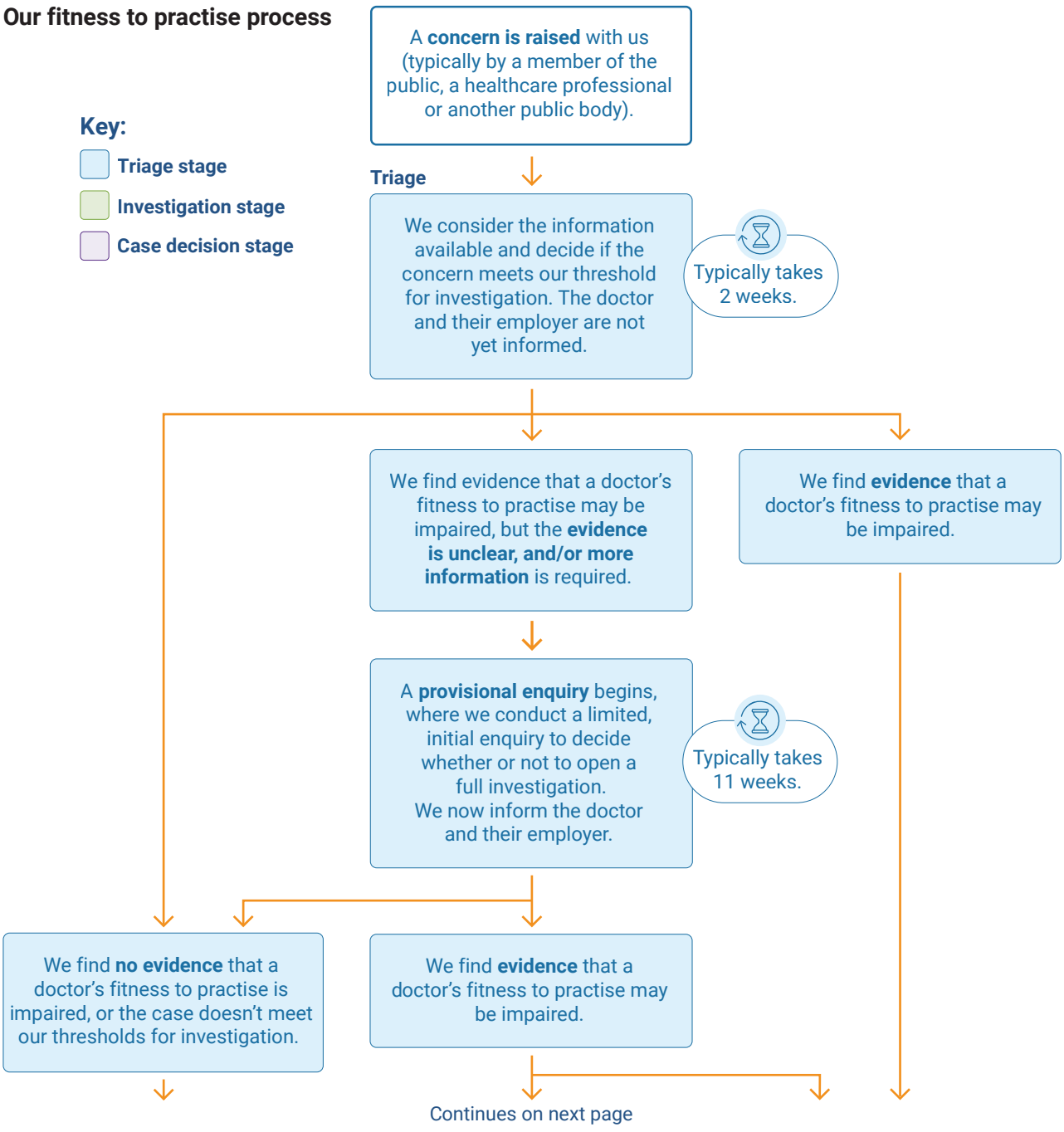
34,502

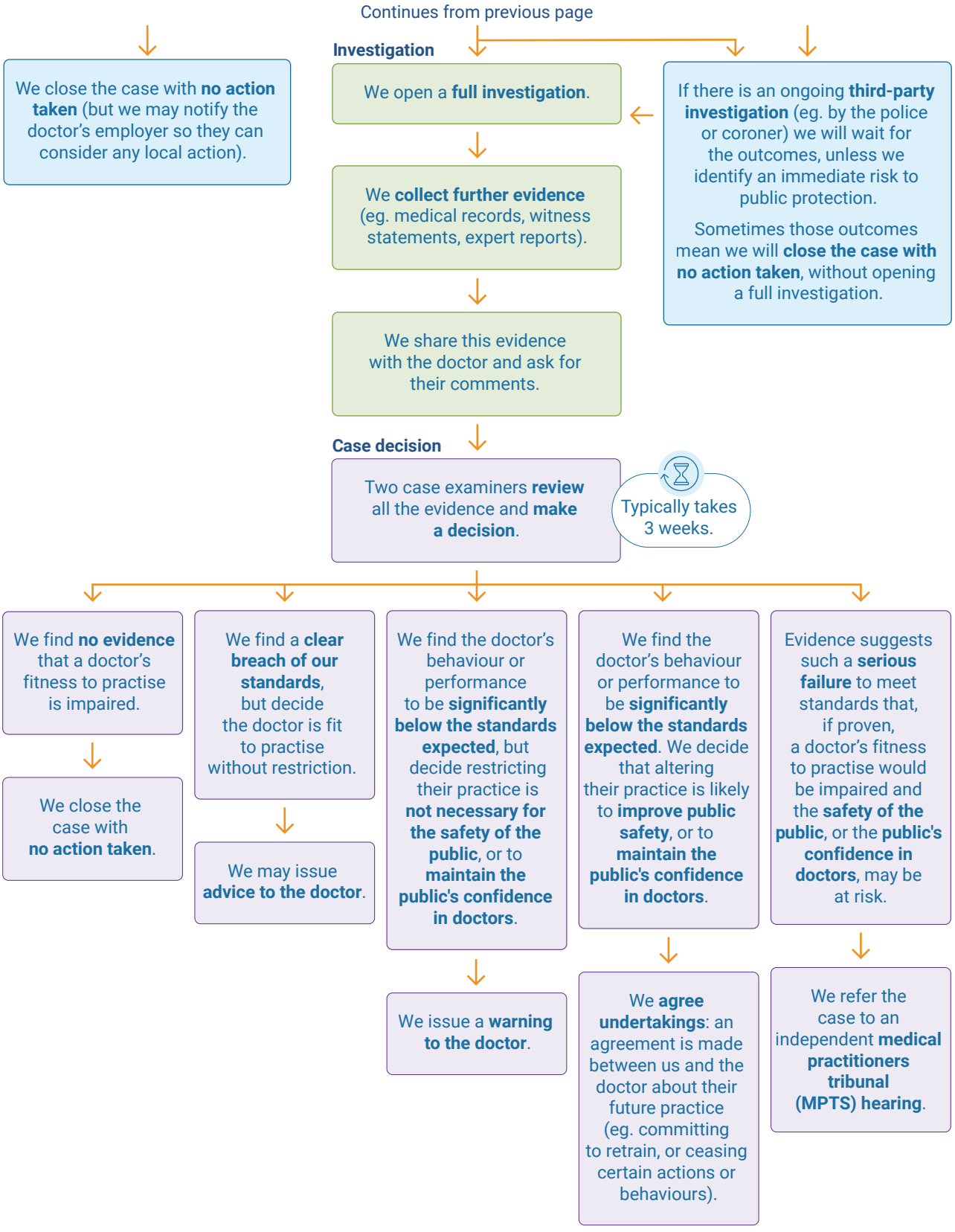
webchat sessions.



Investigating and acting on concerns

One of our key roles as a regulator is to investigate and act on concerns raised with us about the workforce and a doctor's fitness to practise. We break this process down into three stages, which we call 'Triage', 'Investigation' and 'Decision'. We usually reach 'Decision' within six months, but the length of each stage depends on a range of factors and consequently, in some cases, the process can take a number of years. You can find out more about this process via our How we investigate concerns webpages.




Continues from previous page
We close the case with **no action taken** (but we may notify the doctor's employer so they can consider any local action).
Investigation
We open a **full investigation**.
If there is an ongoing **third-party investigation** (eg. by the police or coroner) we will wait for the outcomes, unless we identify an immediate risk to public protection.
Sometimes those outcomes mean we will **close the case with no action taken**, without opening a full investigation.
We **collect further evidence** (eg. medical records, witness statements, expert reports).
We share this evidence with the doctor and ask for their comments.
Case decision
Two case examiners **review** all the evidence and **make a decision**.
Typically takes 3 weeks.
We find **no evidence** that a doctor's fitness to practise is impaired.
We close the case with **no action taken**.
We find a **clear breach of our standards**, but decide the doctor is fit to practise without restriction.
We may issue **advice to the doctor**.
We find the doctor's behaviour or performance to be **significantly below the standards expected**, but decide restricting their practice is **not necessary for the safety of the public**, or to **maintain the public's confidence in doctors**.
We issue a **warning to the doctor**.
We find the doctor's behaviour or performance to be **significantly below the standards expected**. We decide that altering their practice is likely to **improve public safety**, or to **maintain the public's confidence in doctors**.
We **agree undertakings**: an agreement is made between us and the doctor about their future practice (eg. committing to retrain, or ceasing certain actions or behaviours).
Evidence suggests such a **serious failure** to meet standards that, if proven, a doctor's fitness to practise would be impaired and the **safety of the public**, or the **public's confidence in doctors**, may be at risk.
We refer the case to an independent **medical practitioners tribunal (MPTS) hearing**.

Concerns raised about registrants

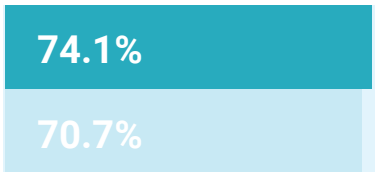
10,031 **concerns were raised with us in 2023.** This represents a **12.8%** increase on 2022 (8,893 concerns).

60.1%	**60.1%** were raised in relation to incidents that happened **in England**. That is a lower percentage than in 2022 (62%).
1.5%	**1.5%** were raised in relation to incidents that happened **in Northern Ireland** – a lower percentage than in 2022 (2%).
4.9%	**4.9%** were raised in relation to incidents that happened **in Scotland** – a similar percentage to 2022 (5%).
2.6%	**2.6%** were raised in relation to incidents that happened **in Wales** – a higher percentage than in 2022 (2%).
30.9%	For **30.9%** of them either there was **no incident location specified, or they happened outside the UK** – a higher percentage than in 2022 (29%).

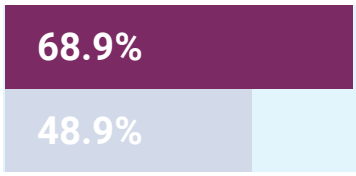
Percentage of concerns raised by the public



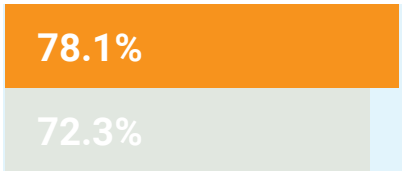
Of the 10,031 concerns that were raised with us in 2023, 78.7% were raised by patients or members of the public. That is higher than 2022 (74.7%).



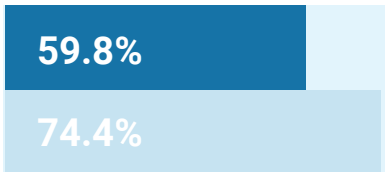
Of the 6,025 concerns raised in **England** in 2023, 74.1% were raised by patients or members of the public (an increase from 70.7% in 2022).



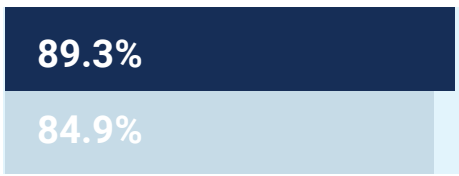
Of the 151 concerns raised in **Northern Ireland** in 2023, 68.9% were raised by patients or members of the public (an increase from 48.9% in 2022).



Of the 494 concerns raised in **Scotland** in 2023, 78.1% were raised by patients or members of the public (an increase from 72.3% in 2022).



Of the 259 concerns raised in **Wales** in 2023, 59.8% were raised by patients or members of the public (a decrease from 74.4% in 2022).



Of the 3,102 concerns raised with **no location specified** or that happened **outside the UK** in 2023, 89.3% were raised by patients or members of the public (an increase from 84.9% in 2022).

Responding to concerns

Not all the concerns raised with us meet our threshold for an investigation. Sometimes a concern is best dealt with at a local level or by having a conversation with the doctor, or should be brought before another organisation. We only take action where we are concerned there may be a risk to patient safety or to public confidence in doctors.

Provisional enquiries

In certain cases, we make provisional enquiries, where we look at information at an early stage of a case, aiming to provide swifter resolution for patients and the professionals involved. If the evidence shows there is no future risk to patients, and regulatory action is not required, we will not move to a full investigation. For cases where we have concerns about patient safety, we will carry out a full investigation.

490

(**4.9%**) of the concerns we received in 2023 were **considered under provisional enquiry**.

That is lower than the percentage in 2022 (**5.4%**).

389

of these (**79.4%**) referred to concerns raised by **members of the public.**

That is higher than the percentage in 2022 (**78.4%**).

In

419

cases (**85.5%**) we closed the provisional enquiry with **no action**.

In

53

cases (**10.8%**) we **progressed the case to investigation**.

In

18

cases (**3.7%**) the provisional enquiry was **still open** as of 04 March 2024.

Investigations opened in 2023

814

(**8.1%**) of the concerns we received in 2023 met our **statutory threshold for investigation**.

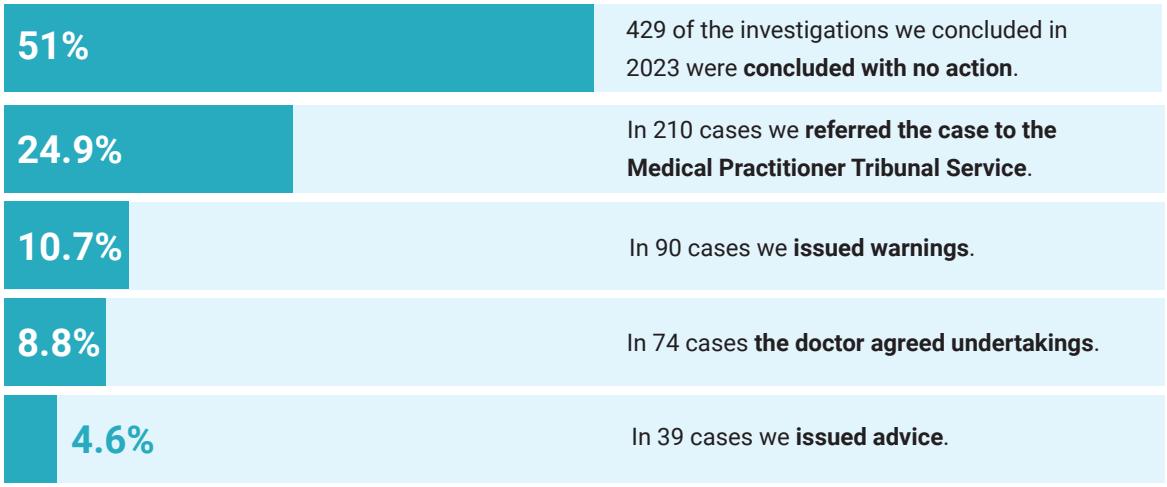
That is a lower percentage than in 2022 (**8.9%**).

225

(**27.6%**) of these referred to concerns raised by **members of the public**.

That is a higher percentage than in 2022 (**22.1%**).

Outcomes of investigations concluded in 2023



Outcomes of Medical Practitioners Tribunals Service tribunals

In 2023, the Medical Practitioners Tribunal Service held a total of 250 tribunals.

43.6%	In 109 cases the tribunal **suspended** the doctor who had been referred to the tribunal.
24%	In 60 cases the doctor was **removed from the register**.
19.6%	In 49 cases the tribunal found **no impairment**.
6%	In 15 cases, while the tribunal found no impairment, it **issued a warning**.
5.2%	In 13 cases the doctor had **conditions put on their practice**.
0.8%	In 2 cases doctors **voluntarily removed themselves from the register**.
0.8%	In 2 cases the doctor's practice was found to be impaired but **no further action was taken**.
0%	There were no cases where the doctor agreed to undertakings.

Where we do not agree with the decisions made by a medical practitioner tribunal, we can appeal them.

In 2023 we made **2** appeals, compared to **10** in 2022. **1** appeal was successful and **1** appeal was outstanding as of 31 December 2023.

Delivering our strategy



Our strategy 2021–25

Four themes shape all our work, helping us to achieve our ten-year vision.



Where we want to be by 2030

Our vision is to be an effective, relevant and compassionate regulator for doctors, patients and the public, and as an employer.

In November 2020, we published our 2021–25 corporate strategy. As widely documented, the post-COVID challenges facing our healthcare systems were exceptional. Therefore, whilst we considered the ambitions we originally set as part of our strategy to be relevant during the pandemic, we carefully assessed how we could deliver against them, deliberately targeting our resources at fewer strategic priorities and activities.

Progress in 2023

Our three-year business plan, which we review on a quarterly basis, summarises how we are targeting our resources at high-impact activities.

Below is a summary of the key activities we have undertaken in 2023 in support of our strategic goals.

Updating *Good medical practice*

In August 2023, we published an updated version of *Good medical practice*, the professional standards for doctors across the UK, followed by more detailed guidance in December. The standards are fundamental in supporting doctors to practise effectively and underpin the standard of care patients receive. They will also apply to physician associates (PAs) and anaesthesia associates (AAs) once these professions come under our regulation.

To develop *Good medical practice*, we ran our biggest ever consultation on the professional standards, listening to and acting on feedback from thousands of healthcare professionals, patients and others supporting the UK's health services. We were also guided by findings from public inquiries, our own and others' research and data, and other developments in healthcare.

These sources highlighted a range of issues that are highly relevant to patient care, medical practice and professional standards. These included the negative impact that poor workplace environments and cultures have on patient safety and doctors' wellbeing, and the prevalence and damaging impacts of bullying, discrimination, harassment and sexual misconduct in healthcare.



As a result of this engagement and collection of insights, the changes we made strengthen expectations of doctors in key areas such as leadership, addressing sexual misconduct and other unprofessional behaviours, and multidisciplinary teamworking. The updated standards have a stronger focus on behaviours and values which create respectful, fair and supportive workplaces. These types of environments enable good teamwork, they make everyone feel safe to speak up and they empower doctors to provide good patient care.

To accompany the changes, our outreach teams have run briefing sessions for thousands of doctors, educators, responsible officers and medical students across the UK and have developed resources specifically designed to help tackle discrimination and create compassionate cultures. In the longer term we'll be looking for opportunities to embed the revised professional standards into medical education and continuing professional development across a professional's career, and to work in partnership with others (such as regulators, employers and professional bodies) to influence culture and practice.

Regulatory reform

We have continued to work closely with the UK Government on its proposed changes to the legislation that governs the way that we and other healthcare regulators operate. Regulatory reform will help us respond more quickly and flexibly to doctors' and patients' needs and help us achieve our 2030 vision to be an effective, relevant and compassionate regulator.

The first step in the reform sees us becoming a multiprofessional regulator, responsible not only for doctors but also for PAs and AAs across the UK. The legislation required for this change was laid at the end of 2023 and has since passed. In line with the new duties placed on us by this legislation, our governing document and charitable objects will be changing, in relation to our registration as a charity in England, Scotland and Wales, as required.

Bringing PAs and AAs under our regulation will make sure these professionals have the knowledge and skills to work safely in the UK. It's important that patients understand the difference between doctors, PAs and AAs, so our published registers will make it very clear which profession an individual is registered to practise. We'll also use a different format for doctors', PAs' and AAs' GMC reference numbers. To prepare for the change, we have designed detailed regulatory processes for registration, education and fitness to practise for these professions. PAs and AAs will come under our regulation in December 2024, following a consultation on the rules, policies and guidance as the basis of our regulation of these professions.

The Medical Licensing Assessment

We continued the work to introduce the Medical Licensing Assessment (MLA), a new assessment framework designed to test the core knowledge, skills and behaviours of doctors who want to practise in the UK. This involved extensive engagement with medical schools and the Medical Schools Council. From the 2024-25 academic year onwards, students at UK medical schools will need to pass MLA-compliant assessments as part of their degree before they can join the medical register. The assessments will test their applied medical knowledge through a national test, set and delivered by medical schools and overseen by the GMC, and their clinical and professional skills. The topics to be assessed are set out in our MLA content map.

Throughout 2023 we collected and reviewed submissions and evidence from medical schools, to check whether they met our MLA requirements. Our Professional and Linguistic Assessments Board (PLAB) test for international doctors will also become compliant with these requirements during 2024.

Through the introduction of the MLA, students at UK medical schools and international doctors will take tests that draw from the same topics and meet the same requirements. This will improve consistency in what we expect of doctors new to the medical register, by testing whether they demonstrate the core knowledge and skills necessary for safe practice.

Improving and expanding registration processes

We are seeing unprecedented numbers of doctors who graduated outside the UK registering with the GMC: in 2023 we granted registration to just under 19,000 internationally qualified doctors, compared to around 8,300 UK graduates. We have continued to work on expanding our registration pathways in response to demand.

In our registration exam, just under 22,000 doctors sat part 1 and over 15,500 sat part 2, an increase of over 7,000 and 2,000 places respectively compared to 2022. We have revised our criteria and streamlined pathways to accept international postgraduate qualifications or exam passes from more than 30 countries. By improving flexibility for UK specialty and associate specialist (SAS) doctors and international specialists applying for specialist or GP registration, we estimate an average reduction of around 20% in the evidential burden on applicants. We also implemented digital ID checks for doctors applying for registration, streamlining our routes to registration and reducing barriers for non-UK qualified doctors joining the medical workforce.

Data, research and insight

As part of our work, we develop and share data, research and insights on medical education and practice to support the development of wider healthcare policies and plans across the UK.

The 2023 edition of our *The state of medical education and practice in the UK: workplace experiences* report shares concerning data about doctors' working lives and the challenges to providing care to patients. It outlines immediate actions that can be taken to improve patient care and doctors' experiences. The report describes approaches to building virtuous cycles of workplace improvement which can provide a strong sense of belonging and help doctors feel better supported and more valued. Key findings and messages from this report have influenced wider policy considerations on workforce, specifically retention, and we hope it will continue to inform important national and local workforce discussions.

Our *The state of medical education and practice in the UK: workforce report* highlighted that the UK will remain reliant on the skill and expertise of international medical graduates into the foreseeable future. It also showed that the number of locally employed doctors is growing much faster than the number of SAS doctors, and that pathways through specialty training are less linear and rigid – which has advantages for healthcare systems and doctors. Through our outreach teams we have identified a number of areas where SAS doctors could be better supported to achieve their full potential, including recognition of the SAS role and access to appropriate development and progression, for example onto the Specialist Register. As a result, we have developed a range of SAS-specific materials for our training sessions, as well as wider materials for all doctors looking at how to create workplaces that are inclusive to all.

We hope these insights will assist policy makers and healthcare leaders from all four countries of the UK achieve the shared ambition of developing a sustainable workforce.

Equality, diversity and inclusion

Equality, diversity and inclusion are integral to all our work as a regulator and employer.

In 2021, we established targets to eliminate disproportionate fitness to practise referrals in relation to ethnicity and origin of medical qualification by 2026. We also aim to eliminate discrimination, disadvantage and unfairness in medical education by 2031.

Our focus on this intensified during 2023 as we embedded the lessons learnt from the pandemic. Our ongoing monitoring shows we've made good progress on most of our measures, although there is still some way to go. We know the extent of the challenge ahead but our commitment remains as we continue to work to achieve these targets.

Throughout the year, we also continued to work on implementing the recommendations from a review of regulatory fairness that we conducted in 2022. We have been working on identifying which of our regulatory decisions have high impact and the new regulatory decision-making principles that will apply to those decisions. To support our people, we have developed a set of escalation principles to enable a culture of professional curiosity, where colleagues feel they can challenge decisions or raise concerns about a case at the earliest opportunity, and we have worked with external partners to design and deliver learning for decision makers and improved induction learning for new staff.

We have also continued to work with partners to help make sure local investigation processes are fair and consistent, capturing examples of good practice in local complaint handling, and exploring how we can share these to encourage organisations to embed them in their own local processes.

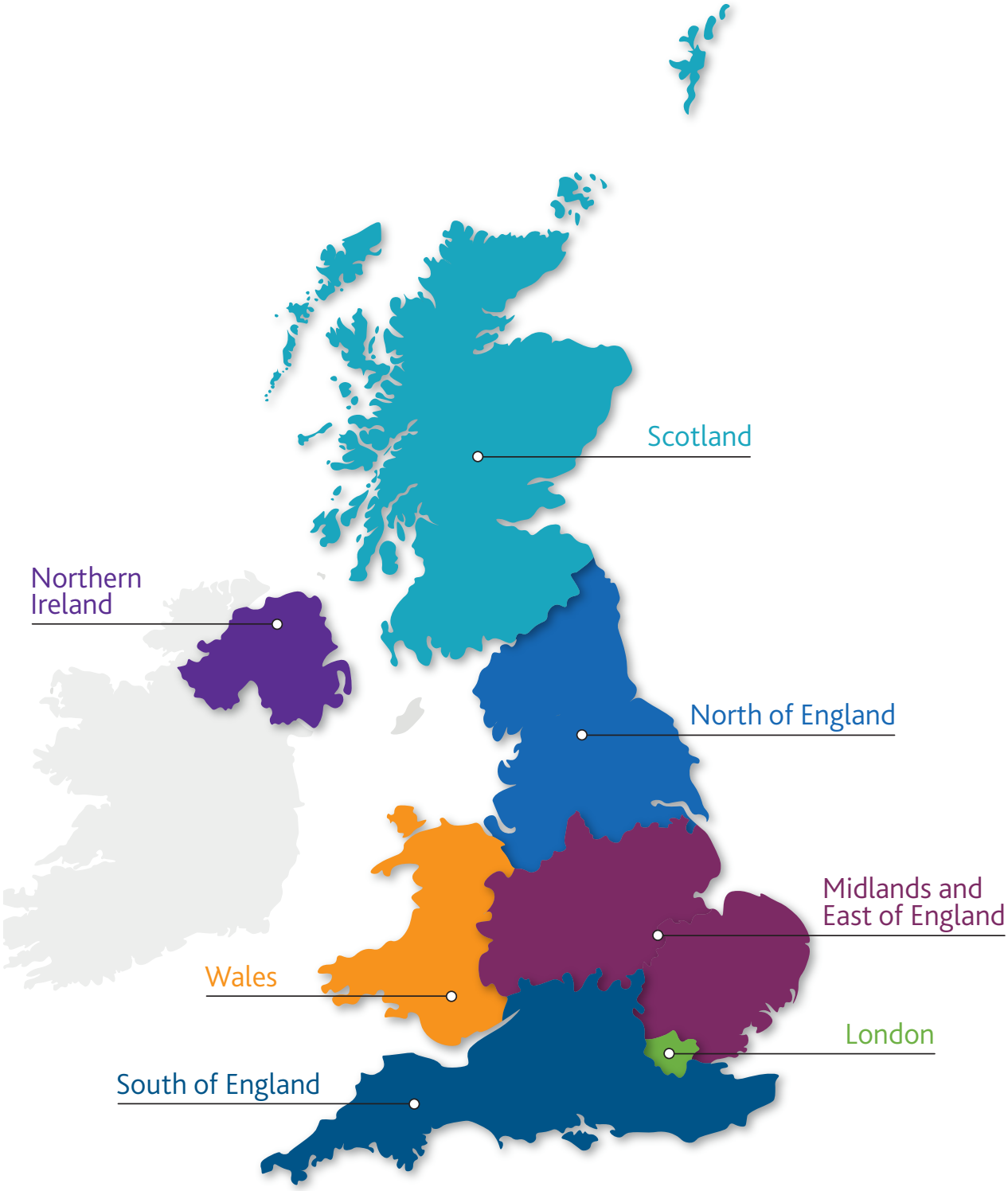
Investing in our people

We made further progress on the *Investing in our people to deliver* theme of our strategy, focusing on:

- making improvements to the diversity of our workforce across the organisation, including the introduction of our inclusion programme for managers
- working towards *Investors in People* Gold accreditation
- strengthening our activities to embed the GMC behaviours framework, including the launch of an eLearning module on professional behaviours.

Our plans for 2024 and beyond are summarised in our business plan.

Highlights from across the UK





Our outreach teams engage directly with doctors, students, employers, educators and other stakeholders to support the delivery of good, safe patient care.

The strong local relationships they build allow us to promote good practice and to influence positive, constructive change, for doctors, patients and other stakeholders in the UK's healthcare systems.

The teams include regional or national liaison advisors, employer liaison advisers, senior advisors, operational coordinators and assistants, business and project managers, and 30 associates working across England, Northern Ireland, Scotland and Wales.

In England, the teams are organised to reflect the seven geographical NHS England regions: with the exception of London, each England outreach team covers two NHS regions and the integrated care systems they oversee. In Northern Ireland, Scotland and Wales the teams cover the entirety of the respective nation. This approach ensures that each region or nation is considered separately, so that productive relationships and engagement happen at the right level, through teams of a manageable and effective size.

In particular, the teams:

- train doctors and students on the professional standards and how to apply them
- advise clinicians, responsible officers, employers and others on promoting positive leadership and culture and protecting wellbeing in the workplace
- support responsible officers and others on improving the quality of referrals, and on promoting good clinical governance more generally, including the fair and effective local resolution of concerns
- work closely with colleagues responsible for overseeing education to check that the standards for education and training are met, and to address challenges in training environments when these emerge.

This external engagement builds positive relationships across our healthcare systems, helping also to improve perceptions of who we are and what we do, fostering trust in our work.

In this section of the report, we take a tour around the UK to highlight some of the work the teams have done in collaboration with partners in 2023. Each highlight helps to demonstrate the breadth of our outreach work and the positive impact of targeted, timely frontline support. The examples also show the value of building strong relationships and sharing expertise, with the aim of promoting good, safe patient care and improving work environments for doctors and those who work with them.

England

Supporting doctors who graduated outside the UK

Doctors who gained their medical qualification abroad ('international medical graduates') are among the fastest growing groups of professionals on the UK medical register, and hospital trusts often rely heavily on the skills and experience these doctors bring to our healthcare systems.

These doctors also face many unique challenges when they join our workforce, from the differences in how various cultures give and provide feedback, to some of the unwritten rules of workplace culture. It is therefore vital that we provide them with the support they need and help make sure the environments they work in allow them to flourish and provide high-quality patient care.

During 2023, our outreach teams across England did significant work to increase our engagement with this important group of doctors and their employers.

In London, our team worked closely with various trusts to help strengthen the support they provide for doctors with international qualifications. For example, the team helped identify eligible doctors to take part in a very comprehensive induction programme in north-west London, and to make sure those doctors have access to one of our *Welcome to UK Practice* workshops as a standard part of their induction. The induction covers topics ranging from NHS structure and function, handover and referral practices, to communication skills, pastoral support and quality improvement. The sessions also have the added benefit of enabling doctors new to UK practice to quickly build a strong peer network.

The team also worked closely with consultants whose job it is to supervise doctors new to UK practice. In September and October, they piloted sessions for supervisors to help raise awareness of the *Welcoming and Valuing International Medical Graduates* guidance we developed in collaboration with NHS England and other partners, and to enhance supervisors' ability to support these doctors effectively so they can thrive within their trust and specialty.

> "Given the changing face of the UK medical workforce, it is crucial that our supervisors have access to 'top-up' training to enhance their skills and knowledge in supervising and supporting international medical graduates. It was great to work with the GMC to develop a bespoke workshop and deliver a pilot session to enthusiastic educators in London, which I hope will enhance the learning and training experience of international medical graduates, and reduce differential attainment, incivility, excessive GMC referrals, and barriers to career progression."

Professor Sujesh Bansal, Consultant Anaesthetist and Honorary Clinical Professor at Manchester Academic Health Science Centre, who helped organise the sessions

88% of participants rated these pilot sessions as 'very good', with anecdotal feedback from supervisors describing it as a 'fantastic' and 'excellent' session that was particularly helpful in providing them with a better understanding of cultural preferences and expectations, as well as possible communication challenges.

Elsewhere in the south of England, our outreach team has been considering the findings of our *Fair to refer?* report, which examined the possible impacts and outcomes for doctors who graduated outside the UK when they are not given effective inductions upon joining UK practice for the first time. The report evidenced that lack of support systems and awareness of the NHS is associated with higher rates of referral to the GMC.

In 2023 the team worked with four trusts in south-west England to help new doctors who graduated abroad adapt to practice in the UK and confidently provide good, safe patient care from the start of their experience here. Working with recruitment leads, and using our data on where these doctors have joined the workforce, the team delivered a series of tailored workshops at each trust to bolster the trust's existing local induction, aiming to embed the standards we set as early as possible with new starters.

In approaching this work, the team made targeted efforts to address the specific needs of different cohorts of doctors who graduated outside the UK and their employers. For example, where hospitals predominantly recruit in late summer, they targeted August inductions to reach new clinicians as soon as possible. While in hospitals where doctors were joining at various points in the year, and had therefore already had some introduction to UK practice, they established quarterly sessions. In addition, at Royal Cornwall they engaged with doctors on the GP training scheme, using patient safety case studies to demonstrate how the professional standards we set can be applied in specific situations.

> "Today's session brought a more positive outlook for me. It shows the GMC cares about how doctors care for patients."
>
> **Session participant**

Similarly, in the north of England our outreach team worked closely with the NHS England North international medical graduate network to run sessions for doctors who qualified abroad, aimed at helping them understand our responsibilities as a regulator, and our role in supporting doctors in delivering good, safe patient care.

The sessions provided an overview of our role, as well as detailed information and data on our fitness to practise process. They also explored with participants the updated version of *Good medical practice*, the professional standards for all doctors in the UK, and heard of many unacceptable examples of racism and discrimination that participants had already experienced in the short time they had worked in the UK.

All the sessions were well received by participants and their employers, and as usual, this work also helped the team develop fruitful contacts that will enable us to expand the reach of our support in this area in the future.

> “I’m less anxious about any significantly increased risk of losing my licence because I am an international medical graduate.”
>
> **Session participant**

> “I will make more time for reflection and take consideration of some of the reasons for GMC referrals in my day-to-day practice.”
>
> **Session participant**

Our ambition is that all doctors coming from abroad to join the medical workforce are welcomed and supported throughout their journey in UK practice.

Responding to concerns regarding lack of consent for intimate examinations

Consent during anaesthesia

Since 2022, our East of England regional liaison adviser (RLA) has been delivering professionalism sessions for year four medical students at the University of East Anglia and Anglia Ruskin University. As part of a session on the topic of consent, our RLA included a case study from her own experience as a medical student 20 years earlier, where she had been expected to perform intimate examinations on anaesthetised patients without having gained proper consent prior to the procedure.

During the discussions, it became clear that students at both universities had also been put in the same situation, 20 years later. Whilst some students had refused, others had felt pressurised to perform the intimate examinations.

We immediately raised this issue with the professionalism leads at both universities, who in turn contacted the teaching hospitals in question together with a copy of the standards in relation to intimate examinations and chaperones, and a copy of the university’s own guidance.

We also ran consent workshops with maternity staff at the teaching hospitals, to reinforce what is expected when supervising medical students.

Our outreach team has since worked closely with our education policy team to develop a bespoke communication on the matter, which has now been shared with all medical schools in the UK. The communication reiterated the standards expected of doctors regarding intimate examinations and consent, and how these would also be updated in new guidance on intimate examinations and chaperones coming into effect in January 2024.

Consent during maternity care

We also received a request for assistance from a trust that had received several patient complaints about consent during maternity care. One accusation of assault had already been taken to the police.

In response, our RLA designed a tailor-made two-hour workshop on consent for doctors working in obstetrics and gynaecology at the trust. The session has since been delivered at four hospitals to an audience of over 100 doctors.

In addition to covering the standards expected of doctors, the workshop references current medical literature as well as guidance from the Nursing and Midwifery Council (NMC), Royal College of Obstetricians and Gynaecologists, the National Institute for Health and Care Excellence, and the UK Government's Department of Health and Social Care. It also includes case studies demonstrating how consent should be approached in different scenarios, such as consent for intimate examinations, patients in labour, and patients who disagree or change their mind.

These workshops have been very popular and have generated a lot of discussion, and in feedback surveys 99% of doctors said that they would change their practice as a result of the activity. We are now expanding the delivery of these sessions and will be sharing the approach with all our RLAs across the UK so that they can consider delivering similar sessions with the providers in their areas.

Northern Ireland

Helping doctors challenge unprofessional behaviour

The standards described in *Good medical practice* highlight that doctors have a responsibility to challenge the unprofessional behaviour of colleagues.

How to do this effectively and successfully is at the core of our *Professional Behaviours and Patient Safety* workshop, which we rolled out in Northern Ireland in 2023.

The sessions aim to support doctors and employers in considering the impact of unprofessional behaviours on patient safety, personal wellbeing and workplace culture, and to develop their skills and confidence in challenging such behaviours.

The training programme is inspired by 'cup of coffee' intervention research conducted by Vanderbilt University, which has shown that the majority of healthcare professionals tend to improve their behaviour after just one informal intervention conversation.

The half-day interactive workshop uses case studies and role-play to help participants:

- define and identify unprofessional behaviours in practice
- reflect on their own behaviours and responsibilities
- understand the harmful impact of unprofessional behaviours on patient safety
- develop individual and practical skills to challenge unprofessional behaviours in the workplace.

The first sessions, held in September, were delivered in collaboration with the NMC, involving doctors, midwives and human resources colleagues at the Southern Health and Social Care Trust. We then ran a session at the Belfast Health and Social Care Trust, in October, involving a group of senior doctors at the trust.

Attendees commented that the 'pioneering' workshop gave them the opportunity to reflect on their practice, and develop skills to tackle unprofessional behaviours in clinical settings.

> "The workshop was very engaging and the facilitators were very personable and were able to bring things to life with examples. I am now more self-aware and have greater insight of my behaviours and their impact on others."
>
> **Session participant**

Working with NMC colleagues to deliver the workshops with multidisciplinary teams, and working with medical leaders, has also highlighted and strengthened the positive impact that collaboration across professional groups can bring. Following the success of these first sessions, we are planning to roll the programme out further across other Health and Social Care Trusts in Northern Ireland during the course of 2024.

Scotland

Celebrating 20 years of our Scotland office

This year we celebrated the twentieth anniversary of the establishment of our team and our office in Edinburgh. Created in 2003 in response to devolution, the team helps us to better understand and support doctors, patients and other healthcare stakeholders in the country.

Our outreach team, and colleagues responsible for quality assuring medical education, work with organisations in Scotland's healthcare system to support doctors to practise to the standards we set and manage concerns at a local level. They engage with stakeholders to raise awareness of our role and functions and support the development of our policy and guidance, making sure it recognises the legislation and environments within which doctors work. They also share data and insight to improve systems and practice, and to prevent patient safety risks arising.

In the last five years alone, in line with the objectives set in our business plans, our Scotland team hosted almost 400 events and workshops, engaging with over 14,500 doctors and medical students, and over 300 educators.*

As in every devolved country, twice a year we bring our Scottish partners together through our UK Advisory Forum, with representatives from the Scottish Government, medical leaders, representatives from medical education bodies and improvements bodies, and patient representative organisations. The forum allows us to focus on long-term priorities, seek views on policy development and identify areas of mutual interest that require co-operation.

* Data from January 2019 and December 2023.

In the last 20 years GMC Scotland has refined and enhanced its contribution across the healthcare environment in the country. Over recent years we have welcomed the opportunity to work even more closely with key stakeholders in the Scottish health system. Highlights include the creation of the Medical Workforce Wellbeing Stakeholder Group with British Medical Association (BMA) Scotland and the Academy of Medical Royal Colleges, and the recent formation of the Fairer Working Cultures Group with the National Ethnic Minority Forum, Scottish Government and BMA Scotland. We are hopeful these partnerships can help to improve the working lives of doctors in Scotland, ultimately impacting positively on patient safety. We have also welcomed the opportunity to collaborate more with our system partners on the identification of risk, including through structures such as the Sharing Health and Care Intelligence Network.

> "The GMC's input, sharing their wealth of intelligence and insight, has been critical for us in developing a greater focus on system-level risks and identifying emerging risks. They have also made a major contribution to establishing a culture of trust, collaboration and co-operation between partners."
>
> **Simon Watson, Medical Director and Director of Safety, Healthcare Improvement Scotland**

We are proud of how our contribution to the health service in Scotland has matured over the last two decades, and are keen to enhance this even further in the years ahead.

Wales

Embracing the Welsh Language Standards

In 2023, we marked a key milestone in our goal to enhance our Welsh language provision. Following the Senedd's approval of the Welsh Language Standards (No.8) Regulations in July 2022, in June 2023 the Welsh Language Commissioner issued a compliance notice to professional regulators in healthcare. The aim of the standards is to promote and facilitate use of the Welsh language and ensure it is not treated less favourably than the English language in Wales. As such, the standards form part of the Welsh Government's commitment to enable people to live their lives through the medium of Welsh.

On 6 December 2023 we renewed our commitment to Welsh speakers as we applied the new standards to our work, joining some of our key partners in Wales already subject to their own set of standards. Colleagues from across the organisation worked throughout the year to develop tools, guidance and processes to support compliance. The standards cover key areas of our work such as correspondence, meetings and events, publicity and advertising materials, our website and social media, recruitment, policy development and opportunities for staff to learn Welsh.

This work was supported by a joint regulators' forum which we convened and co-chaired with the NMC. The forum is dedicated to sharing ideas, challenges and good practice, and includes representation from each healthcare regulator and the Professional Standards Authority.

As part of this work, we also cultivated a positive relationship with colleagues at the Welsh Language Commissioner's office and in June attended a positive introductory meeting with the new Commissioner, Efa Gruffudd Jones. This relationship has been further strengthened by the creation of a brand new role within GMC Wales: our new Welsh Language Standards Manager will liaise with key stakeholders in Wales and work with them to assure a smooth transition from the project we set up to achieve compliance, to ensuring compliance as 'business as usual'.

Enhancing our Welsh language provision is a significant contribution to our commitment to making every interaction matter, making sure that everyone who deals with us is met with empathy, efficiency and respect, in line with our corporate strategy. In doing this, we are responding to the diverse needs of patients, students, registrants and the bilingual context in Wales: this is crucial to our role as a competent, sensitive four-country regulator. Working towards compliance has also provided a tangible opportunity to raise awareness of the Welsh language across the organisation, and to strengthen our relationships and reputation in Wales - particularly opening up conversations around the role of bilingual medical education in patient safety and patient-centred care.

We hope Welsh speaking patients, students, registrants, and all other professionals and members of the public interacting with us will feel more comfortable having the opportunity to do so in their preferred language.

> "2023 was an exciting time for me to join the GMC as we implemented the Welsh Language Standards. As a Welsh speaker myself, I understand the importance of making it as easy as possible for people to engage with us in their preferred language, and I have been delighted to see colleagues across the GMC embrace these standards and embed them in our work across the organisation."

Gethin Matthews-Jones, Head of GMC Wales

Corporate social responsibility



Corporate social responsibility

We are a socially responsible organisation, constantly looking for new ways to embed sustainability, social impact and ethics into what we do.

In 2023 we made progress with our corporate social responsibility (CSR) agenda in several ways.

Protecting the environment

In 2022 we announced our ambition to become a net zero organisation by 2040, alongside a new plan specifying our targets to reduce our carbon footprint, eliminating scope 1 and 2 carbon emissions by 2030, and scope 3 emissions by 2040.

We have now taken several steps on this journey. We have calculated our carbon emissions since our baseline year of 2019, established a working group to implement our net zero plan and are currently working on projects that will help us make more efficient use of energy on site. We will be calculating our emissions annually moving forward so that we can better track our progress, and we are working on improving our data so that we can have a more accurate picture of our emissions.

Everyone in the organisation has a part to play in helping us achieve net zero, and we look forward to working with colleagues and suppliers to reach this important goal. Key next steps for 2024 include developing a 'Green Travel Plan' that will help us to reduce emissions associated with business travel and commuting, and developing a supplier sustainability survey to better understand our supply chain emissions.

Promoting social mobility

As part of our commitment to CSR and to equality, diversity and inclusion, we expanded our existing apprenticeship opportunities. Apprenticeships provide exciting and varied career opportunities to those who may not have access to further education, or who particularly benefit from on-the-job training.

We also worked with the Social Mobility Foundation, Edge Hill Medical School and Lancaster Medical School to host joint events for A Level and first-year medical students from less advantaged backgrounds. Widening participation in medical education continues to be a priority for us as we want young people to have a fair and equal opportunity to become our doctors of the future. The events were extremely well received and provided valuable networking opportunities for many bright and capable individuals, as well as an early introduction to their future professional regulator.

Supporting the community

In May 2023 we launched a new initiative to repurpose older generation laptops in the organisation and donate them to small community organisations across the UK. We have been working with Business in the Community to distribute these, donating 125 laptops by the end of the year. We are hoping to extend this scheme in 2024 to include more electronic equipment.

We continued our partnership with the Royal Voluntary Service's Befriending Scheme. Through the scheme, volunteer members of staff have weekly companionship phone calls with people at risk of being lonely or isolated. The scheme provides invaluable support to elderly people, and many of our volunteers have formed lasting connections with the people they call.

> "I love the fact that I can put a smile on someone's face. I remember when I first called my contact, she sounded very tired and her mood was a bit down, but by the end of the call you could really feel a difference in her tone and energy."
>
> **GMC befriender**

Colleagues have also continued to take part in our volunteer reading scheme. The volunteers spend time twice a week reading with secondary school students who need additional support with literacy. We have seen impressive results from programme participants, with some students showing reading age improvements of up to seven years within an academic year.

Throughout 2023 some of our in-house coaches supported a Business in the Community initiative guiding long-term unemployed individuals seeking to re-enter the workplace.

> "My coachee's confidence grew within a few sessions and just having someone to chat through aims and ambitions really spurred her on to be proactive in applying for jobs, securing interviews and subsequently gaining a new job, which is absolutely fantastic!"
>
> **GMC coach who took part in our initiative for long-term unemployed individuals**

Others worked with senior leaders in a small environmental charity, helping our coaches and the charity workers alike build confidence in their respective fields. Provided by recently qualified in-house coaches over Microsoft Teams, there are usually three to six sessions. Coaching starts with a 'chemistry chat' to check the style of the coach will suit the person being coached, and coaching then covers individuals' current challenges and future aspirations.

> "I've found the sessions to be really useful in helping me figure out areas where I would like to see change/improvement, but don't always have the headspace during the week to properly consider what needs to be done or actions to take. I always feel better after a session, and more in control of whatever problem I am trying to overcome."
>
> **Environmental charity employee who took part in our coaching scheme**

Benchmarking and working with partners to promote CSR

We continue to play an active role within the Cross-regulator CSR Group, whose membership expanded further and now also includes the Nursing and Midwifery Council (NMC), General Dental Council, General Pharmaceutical Council, Health and Care Professionals Council, Social Work England, General Chiropractic Council and General Optical Council.

The group met four times during 2023, discussing topics such as the regulation of sustainable healthcare, environmental matters and responsible procurement.

Colleagues in our Information Systems department also developed an app allowing staff to report on their volunteering work, which enables us to collate better data on the impact of these activities too.

Our structure, governance and management

Council and other governance groups

Council is our governing body. It provides strategic direction, holds the executive to account, and takes major high-level policy decisions. It comprises 12 members from the four countries of the UK. Six are medical members and six are lay members.

We are a registered charity and our Council members are also the trustees of the organisation.

They are all independently appointed by the Privy Council through a process that follows the Professional Standards Authority's guidance for making appointments to healthcare professional regulatory bodies.

The 12 trustees between 1 January 2023 and 31 December 2023 were:

- Professor Dame Carrie MacEwen (Chair)
- Mr Steve Burnett
- Dr Vanessa Davies
- Professor Anthony Harnden
- The Rt Hon Lord Hunt of Kings Heath PC*
- Professor Paul Knight
- Professor Deepa Mann-Kler
- Mr Douglas Millican (from 1 May 2023)
- Dr Jeeves Patel
- Professor Suzanne Shale
- Dr Rajiv Wijesuriya (from 1 May 2023)
- Miss Alison Wright.

All Council members are also asked to declare any conflicts of interest. These are listed in a register of interests published on our website.

Council members also participate in appraisal reviews, and in a 360-degree feedback process that takes place every two years. The process includes consideration of any learning and development needs and revisits actual or perceived conflicts of interest to make sure any potential conflicts identified are manageable.

As a charity, we take into account the seven principles set out in the Charity Governance Code (2020) and can demonstrate how we use these principles to guide our work on an 'apply or explain' basis.

There are two exceptions to the Code, which we explain rather than apply. Firstly, our Council and committees operate without a formally appointed deputy or vice chair. However, provisions are made in the *Governance Handbook* for chairs to nominate a deputy to assist during periods of absence. Secondly, as our appointments process is well established and thorough and is overseen by the Remuneration Committee and the Professional Standards Authority, a separate nominations committee is not considered necessary.

The *Governance Handbook* is the governing document of the organisation. In 2022, we reviewed it following internal audit work to reflect updates to the process for appointing assistant registrars, and to review the schedule of authority (or scheme of delegation from Council). Minor updates are made with Council's approval on an ongoing basis, for example to the membership of committees.

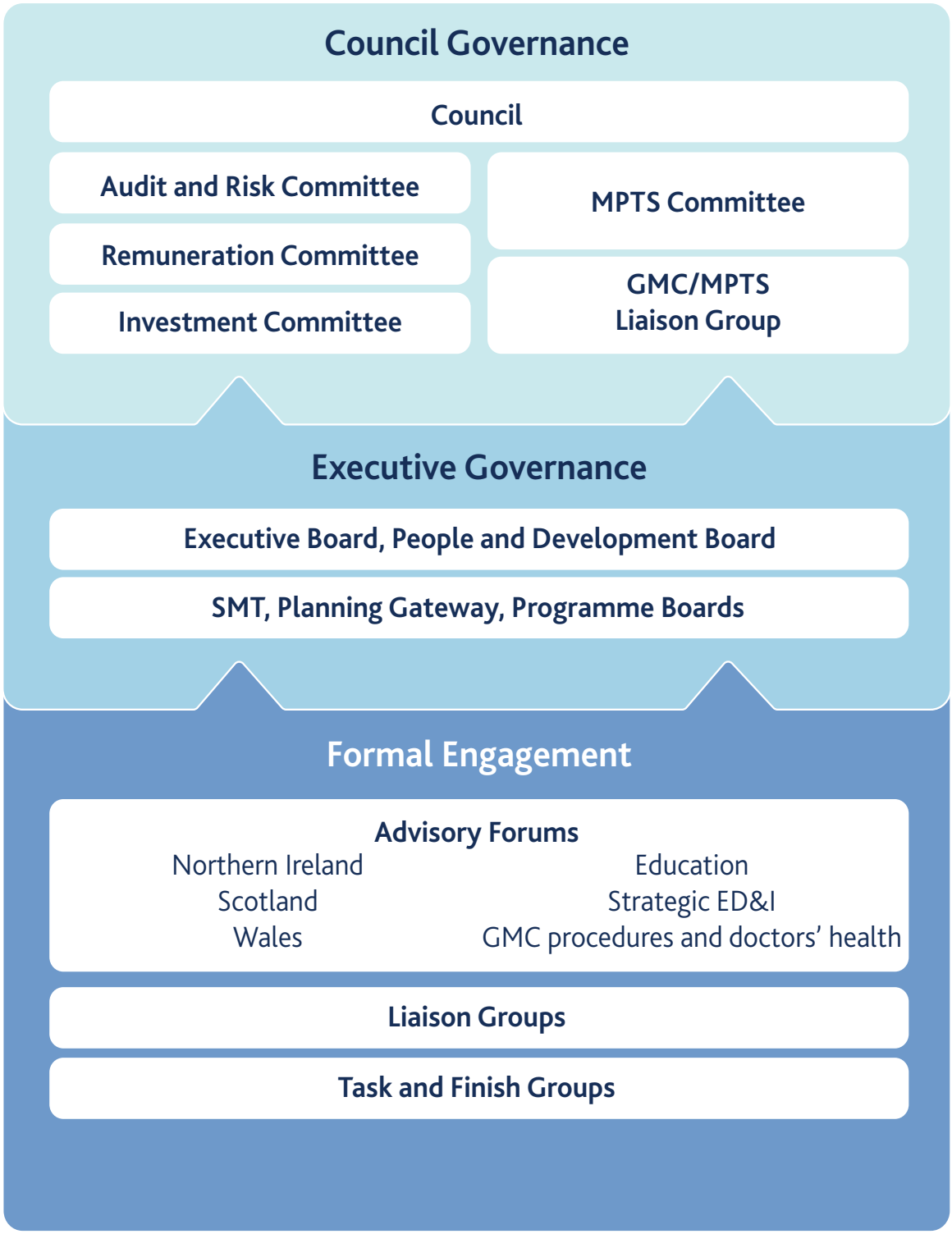
* Lord Hunt of Kings Heath resigned as a Council member on 31 January 2024 due to a conflict of interest created by his return to a more active role in the House of Lords. Recruitment to replace him was still underway at the time this report was approved by Council. The report should therefore be considered as having been approved and signed by the remaining 11 trustees listed above.

Our Corporate Governance team is charged with supporting Council in maintaining high standards of governance, on an 'apply or explain' basis, in line with the good practice set out within the Charity Governance Code. The team also provides training and advice to the organisation on matters of governance. Each committee accounts to Council through a formal report, and Council and each committee undertake to review the committees' effectiveness in delivering their statement of purpose, which is reviewed annually.

The diagram on the following page shows the different governance groups that assist Council in carrying out its responsibilities effectively. These have all been agreed by Council. The roles and activities of these groups are described in the pages that follow.

Council business is conducted in an open and transparent manner and the agenda and papers for each meeting are published on our website.

Council generally meets six times a year. It meets in London, in Manchester and once in either Belfast, Cardiff or Edinburgh.


Council Governance
Council
Audit and Risk Committee
Remuneration Committee
Investment Committee
MPTS Committee
GMC/MPTS Liaison Group
Executive Governance
Executive Board, People and Development Board
SMT, Planning Gateway, Programme Boards
Formal Engagement
Advisory Forums
Northern Ireland
Scotland
Wales
Education
Strategic ED&I
GMC procedures and doctors' health
Liaison Groups
Task and Finish Groups

Audit and Risk Committee

In 2023 the Audit and Risk Committee (ARC) was chaired by Paul Knight. Its external co-opted members were Jon Hayes and Ken Gill (until March 2023). Aneen Blackmore was appointed as Ken Gill's successor from 1 November 2023 following a competitive process.

The Committee plays a key part in our governance, providing Council with independent assurance about:

- the integrity of our financial statements
- the effectiveness of internal control, governance, and risk management systems
- the delivery of internal and external audit services.

The Committee met five times in 2023, and provided a short briefing note on key issues to Council after each meeting. It also formally reported to Council twice. You can find more about its role and work in the Audit and Risk Committee section later in this report.

Remuneration Committee

In 2023, the Remuneration Committee was chaired by Anthony Harnden. The Committee advises Council on the remuneration, the terms of service and the expenses policy for Council members, including the Chair. It oversees the recruitment process of the Chair and Council members before their appointment by the Privy Council. It determines the appointment process for the Chief Executive and Medical Practitioners Tribunal Service (MPTS) Chair, and the remuneration, benefits and terms of service for the Chief Executive, directors, MPTS Chair and MPTS Committee members.

In 2023, the Committee was actively engaged in the process to recruit two Council members. It is also responsible for making sure the assessment and measurement of performance, recruitment and succession planning take place within an appropriate framework for the senior management roles within its remit. The Committee reports annually to Council and met twice in 2023.

Investment Committee

Steve Burnett chaired the Investment Committee (IC) in 2023. Its external co-opted members during the year were Keith MacKay and Mike Jennings.

The Committee is responsible for:

- implementing and reviewing our investment policy
- making sure the management of assets is consistent with the policy
- appointing and managing fund managers
- monitoring performance.

It also has responsibility for overseeing our investment in GMC Services International Limited (GMCSI), including ensuring compliance with our Investment Policy, scrutinising GMCSI's business plan, and assessing the potential levels of investment risk and return. The Committee reports on investment performance to Council via post-meeting circulars. It reports on the performance of the portfolio to Council directly on an annual basis. It met five times in 2023.

GMC Services International

GMC Services International (GMCSI) was established by Council in 2016 as a wholly owned trading subsidiary of the GMC. Its main objective

is to offer the GMC's support and expertise to countries and institutions working to improve standards of healthcare, who have less experience with the regulation of healthcare professionals and of medical education. Robust and effective governance arrangements are in place to make sure that our interests are protected and that our relationship with GMCSI is managed effectively.

Council has overall responsibility for GMCSI. As outlined above, our Investment Committee scrutinises its business plan to ensure compliance with our Investment Policy, and the Audit and Risk Committee considers the risks to the GMC from the operation of GMCSI, conducting routine internal audit and spot checks as appropriate.

Andrew McCulloch chaired the GMCSI Board during 2023. The Board comprised (in addition to the Chair) Paul Reynolds, Alison Wright and Colin Melville. Helen Featherstone joined the Board on 1 March 2023 and Deepa Mann-Kler joined on 20 November 2023. The Board met four times in 2023.

Board of Pension Trustees

The GMC's defined benefit staff superannuation scheme is managed and administered by a board of trustees in accordance with the scheme's trust deed and rules. The trust makes sure the pension scheme's assets are kept separate from those of the employer, and is a separate entity to the GMC.

The scheme's trustees are responsible for the proper running of the scheme, including the collection of contributions, the investment of assets and payment of the pension benefit commitments made by the employer.

Deirdre Kelly chaired the Board during 2023. Deirdre, Steve Burnett, Raj Patel and Vanessa Davies are employer-nominated trustees. Danny Dubois (until 31 May 2023), John Foley, Paula Robblee and Martin Hart are member-nominated trustees. Samantha Anthony joined the Board as a member-nominated trustee from 1 June 2023.

MPTS Committee

A key part of our governance structure is the statutory MPTS Committee. The Committee oversees the delivery of the hearing service for doctors and makes sure the service meets its responsibilities under the Medical Act 1983.

Her Honour Judge Deborah Taylor took up the post of Chair of the MPTS in March 2023, succeeding Dame Caroline Swift, whose tenure ended on 31 December 2022.

The GMC/MPTS Liaison Group is another core part of our governance framework. It is chaired by the Chair of Council, and oversees the working relationship between the MPTS and the functions of the GMC with which it interacts.

Executive Board, and People and Development Board

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

The Board meets monthly (except for August) and reports to every meeting of Council through

the Chief Executive's report and via a separate annual report.

The People and Development Board is chaired by the Chief Executive and meets five times a year to bring focus to our People strategies. The outcome of its work is reported to Executive Board, and on to Council.

UK Advisory Forums

We have a well-established programme of Advisory Forums meetings in Northern Ireland, Scotland and Wales.

The forums make sure we have effective engagement and consultation with interest groups, and that our policies are suited to all parts of the UK. The invited membership differs from country to country and reflects the diverse range of those who have an interest and expertise in the areas under our regulation across the UK. The forums report on their work to the Executive Board twice a year.

Education Advisory Forum

The Education Advisory Forum began work in February 2019. The forum engages widely and effectively with our key interest groups on education, training and assessment matters, making sure we are able to develop and promote a strategic approach to this work across all countries of the UK.

Colin Melville, Medical Director and Director of Education and Standards, chairs the forum and the invited membership reflects the diverse range of those who have an interest and expertise in medical education, training and assessment across the UK. The work of the forum is reported to the Chief Executive and to Council through the Chief Executive's report.

Strategic Equality, Diversity and Inclusion Forum

Our Strategic Equality, Diversity and Inclusion (ED&I) Forum helps us make sure that our activities respond to the needs of diverse groups of registrants. Paul Reynolds, Director of Strategic Communications and Engagement, chairs the forum which comprises organisations representing registrants with shared protected characteristics. It helps us meet our ED&I objectives by providing feedback and advice on our policies and strategies, raising issues and concerns requiring our attention in relation to ED&I. In 2023, the forum discussed:

- our progress against our ED&I targets
- our regulatory fairness review
- bullying, harassment and discrimination
- changes to how doctors demonstrate requirements for specialist and GP registration
- our review of *Good medical practice*, and
- the redesign of our processes as part of our regulatory reform programme.

GMC Procedures and Doctors' Health Forum

Our Advisory Forum on GMC Procedures and Doctors' Health provides expert advice to our Executive Board on how we engage with vulnerable doctors in GMC processes. The forum may, as required, advise on GMC policies, guidance and training for staff.

Membership includes representatives from the Royal College of Psychiatrists, the Royal College of GPs, the Faculty of Occupational Health, the Conference of Postgraduate Medical Deans, and NHS Providers.

Member attendance at Council, Boards and Committees in 2023*

Member	Council attendance†	Committee attendance
Carrie MacEwen (Chair)	6/6	N/A
Steve Burnett	5/6	9/9
Vanessa Davies	5/6	5/6
Anthony Harnden	5/6	4/6
Philip Hunt	6/6	7/7
Paul Knight	6/6	5/5
Deepa Mann-Kler	6/6	5/7
Douglas Millican	4/4	2/2
Rajesh Patel	6/6	8/10
Suzanne Shale	6/6	5/5
Jeeves Wijesuriya	4/4	1/1
Alison Wright	6/6	5/6
Aneen Blackmore (ARC co-opted member)	N/A	1/1
Ken Gill (ARC co-opted member)	N/A	2/2
Jon Hayes (ARC co-opted member)	N/A	5/5
Michael Jennings (IC co-opted member)	N/A	3/4
Keith Mackay (IC co-opted member)	N/A	4/4

Management

In 2023, our staff were under the direction of Chief Executive, Charlie Massey. He is supported by a team of directors, who as of 31 December 2023 were:

- Shaun Gallagher, Director of Strategy and Policy
- Una Lane, Director of Registration and Revalidation
- Colin Melville, Medical Director and Director of Education and Standards
- Anthony Omo, General Counsel and Director of Fitness to Practise
- Paul Reynolds, Director of Strategic Communications and Engagement
- Neil Roberts, Director of Resources.

* Attendance reflects the number of meetings for which attendance was possible.

† Includes six Council meetings and one strategic away day.

Key management personnel: remuneration policy

The Remuneration Committee is responsible for determining the remuneration, benefits and terms of service for the Chief Executive, Chair of MPTS and directors. The Committee sets all aspects of salary or honoraria, the provision of other benefits, and any other arrangements or contractual terms for this group of staff. The Committee also oversees terms and conditions for Council members (including the Chair) by benchmarking and seeking independent market advice when necessary.

The Committee considers that we should provide remuneration and rewards that will attract and retain the high-calibre staff necessary to enable us to fulfil our statutory remit and deliver our strategic objectives.

In setting the base pay for individual posts, the Committee will take external advice on roles within its remit and align salaries with an appropriate market rate subject to resource considerations.

An annual consolidated pay award is considered with reference to the organisation's level of performance, the financial implications of any award, the award agreed for other GMC employees and wider market trends. An annual variable non-consolidated element is considered, reflecting personal performance and the same considerations applied to any consolidated award. We review the effectiveness of these arrangements on an annual basis.

Staff within the Remuneration Committee's remit will usually be entitled to the benefits package available to all GMC employees on the same terms. The Committee retains the ability to withdraw, adjust or change any benefits for staff within its remit, subject to any consultation and contractual requirements. The Committee considers any additional benefits in kind (such as relocation payments) on a case-by-case basis.

New external staff appointees within the Committee's remit are automatically enrolled into our defined contribution pension scheme. Where employees have existing agreed pension arrangements, such as membership of our defined benefit scheme, they retain this for the course of their employment, subject to any changes to the rules agreed by trustees and the employer.

The Committee makes sure that the equality and diversity implications of remuneration policy and related decisions are considered appropriately. Specifically, it ensures that:

- any salary differentials are supported by a formal job evaluation or independent external market advice
- any decisions relating to variable pay are supported by an objective assessment of performance
- any adjustment or changes to remuneration arrangements do not discriminate unlawfully.

Other decisions relating to terms of service are supported by appropriate advice on any equality and diversity implications.

2023 financial review

The accounts for the year ended 31 December 2023 have been prepared in accordance with the Charities Statement of Recommended Practice (FRS 102).

- Our free reserves by the end of 2023 were £44.8 million, up from £39.2 million at the end of 2022. We saw £5.2 million of this improvement driven by a gain on our investment fully recouping losses in the previous year.
- We also saw income growth of £16.2 million, which was in excess in growth of our cost base, driving a surplus of £6.1 million.
- We invested in our infrastructure, including building a fourth Professional and Linguistic Assessments Board (PLAB) circuit to deliver against the growing demand for this service.
- Furthermore, our healthy reserves position enabled us to restrict the increase applied to fees in 2024.

Our total income and expenditure in 2023

In 2023 we generated unrestricted income of £148.9 million, which was £16.2 million higher than 2022. This was due to the increase in the size of the medical register and the impact of running more PLAB tests in 2023 than in 2022, accompanied by a subsequent increase in new applications to join the register.

In addition, we are reflecting a further £1.6 million of restricted income in our accounts from the UK Government's Department of Health and Social Care to cover the cost of implementation work to bring physician associates and anaesthesia associates under our regulation. These funds were fully spent in 2023, including a further £0.3 million on the development of IT systems which were capitalised this year. This increased the total restricted asset held on the balance sheet to £2.1 million, which is as yet undepreciated.

We are pleased to report that by the end of 2023 our investments generated gains of £5.2 million, more than offsetting the £4.8 million loss incurred in the previous year.

Our unrestricted charitable expenditure in 2023 was £140.2 million, which was an increase of £10.4 million on 2022. This growth in expenditure in 2023 when compared to 2022 was the result of increased volumes across core functions, most notably registration and revalidation, but also the impact of a prolonged period of high inflation being built into our cost base. However, new working patterns and greater use of IT-enabled forums, as well as clearing backlogs initially driven by the COVID-19 pandemic, have continued to generate efficiencies in our cost base which means charitable expenditure has grown to a lesser extent than income. This has allowed us to restrict fee increases in 2024 and invest in our infrastructure to support our registrants better. Most notably, the continuing demand for PLAB saw us approve the build of our fourth PLAB circuit, the costs of which have been capitalised and will start to be depreciated once the circuit has opened in 2024.

We increased our dilapidations provision by £1.3 million to make sure our obligations under our building leases can be met, with this increase reflecting price surges within the construction industry. We expect this provision to increase annually until the point of exiting any of our sites. A further £0.7 million was also added to our legal provision to reflect potential additional costs that may arise from outstanding legal cases.

The charity had no fundraising activities requiring disclosure under S162A of the Charities Act 2011.

Reserves policy and going concern

Our level of reserves and our reserves policy are reviewed annually, and any financial implications are addressed as part of the budget setting process.

Our total reserves are made up of free reserves, reserves backed by fixed assets and pension reserves.

We hold free reserves:

- to provide working capital to undertake our normal day-to-day business
- to provide funds to deal with any risks that materialise
- to provide funds to respond to new initiatives, opportunities and challenges that present themselves
- to cover the period before any changes to fee levels take full effect.

A significant proportion of our total reserves is represented by fixed assets, which cannot easily be converted into cash without adversely affecting our ability to fulfil our charitable aims and statutory obligations. The value of fixed assets is therefore disregarded for reserves policy purposes.

The value of pension reserves is also disregarded for reserves policy purposes. Our defined benefit scheme was closed to future accruals in 2018, and any deficit or surplus in the scheme can be managed over the medium term, with no immediate impact on free reserves.

There is no standard formula that can be used to calculate the ideal level of free reserves. We follow the Charity Commission's guidance and set a target range based on our cash flow requirements and an assessment of the risks facing the organisation. We aim to hold free reserves at a level that is not excessive, but does not put our solvency at risk. Over the medium term we target the mid-point of a reserves range between 20% to 35% of the annual expenditure for the next 12 months. We accept fluctuations within the range over the short-term. We remained firmly within the range in 2023 and at the year end free reserves were 28% of budgeted total expenditure for 2024.

We will also continue to review the purpose and scope of our reserves policy on an annual basis to make sure the thresholds reflect our current risk profile, cash flow requirements and operating environment.

Our total reserves at the end of 2023 were £50.4 million, reducing from the previous year by £4.5 million. Actuarial movements on our defined benefit scheme were the key driver of this reduction, with our pension liability increasing by £12.6 million in 2023 to £15.8 million.

Free reserves constituted £44.8 million of the balance of total reserves, with a further £21.4 million of reserves being represented by fixed assets, with both currently being partially offset by our pension deficit. We expect that reserves at the end of 2024 will remain within the parameters of our reserves policy.

Most of our income comes from registration fees paid by doctors, and all doctors must be registered with us to practise medicine in the UK. Trustees therefore remain of the view that the GMC is a going concern for the foreseeable future, and have

therefore prepared the financial statements on a going concern basis.

There are no material uncertainties related to events or conditions that cast significant doubt on our financial stability for the foreseeable future.

Investment policy

Council is responsible for determining and reviewing the overall investment policy, objectives, risk appetite and target returns. It has delegated responsibility for implementing the investment policy, appointing and managing fund managers, and monitoring performance, to the Investment Committee, which regularly reports to Council.

Our investment policy separates our funds into four categories:

- those which are required as working capital for normal day-to-day operation of the business
- those which we may invest under management
- those which we may invest in a trading subsidiary
- any residual cash balance.

We hold a minimum of £15 million as working capital for normal cash flow purposes. This is held in instant-access bank accounts and provides sufficient flexibility to avoid temporary borrowing and/or the need to liquidate investments to deal with short-term variations in operational income and expenditure.

We increased our managed investment to £50 million in June 2019. Our target rate of return on funds invested under management is inflation (CPI) plus 2% over a rolling five-year period. This reflects our relatively low risk appetite. We seek to provide protection against inflation; to generate a modest level of return; and to diversify our funds to reduce the risk of capital and/or revenue loss.

While we have adopted a comprehensive ethical approach to investments, we have revised our investment policy and will implement this in 2024. Our ethos remains the same and we believe that investing in certain companies or sectors would conflict with our charitable aims or may create reputational damage. We do not wish directly to profit from, or provide capital to, activities that are materially inconsistent with our charitable aims, so we specifically exclude investment in companies that derive more than 10% (reduced to 5% from 2024) of their revenue from tobacco, alcohol, gambling, pornography, high-interest rate lending and the extraction of thermal coal or oil sands. We also exclude all companies with any exposure to cluster munitions and landmines from our investment approach from 2024 (previously 10%). We also do not invest in companies that are under investigation for, or have been found guilty of, tax evasion or money laundering in the past three years. As we will follow the in-house investment policy of our fund managers, in selecting them we ensure the two policies are fully compatible. While the 10% revenue limit mentioned above was the maximum for our own policy throughout 2023, invested funds were subject to lower tolerances around thermal coal and oil sands (5%) and cluster munitions and landmines (0%) based on our current fund manager's policy.

We chose CCLA Investment Management to manage our investments because of their strong track record and high standards in ethical investing. CCLA invest in a manner that prioritises environmental, social and governance factors, working with companies to urge them to commit to producing healthier products, which are more accessible and more affordable.

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

We invest only through fund managers who demonstrate the strongest environmental, social and governance credentials. When appointing fund managers, we take into consideration how they incorporate an assessment of a company's performance on environmental, social and governance issues in their stock selection.

Our funds under management were valued at £61.6 million at the end of 2023, compared with £56.6 million at the start of the year, recovering by the end of the year from a notably volatile period in 2022, which saw losses of £4.8 million. Since the point of increasing our investment in June 2019 we have generated returns at a compounded growth rate of 4.78%.

Any cash not held as working capital or invested is held in medium-term deposits and/or interest-bearing accounts. We generated interest of £2.1 million on our cash balances, equivalent to an average annual rate of return of 4.21%. Cash held as working capital, and any residual cash, is shown on our balance sheet within current assets.

GMC Services International Limited

The trading subsidiary GMC Services International Limited (GMCSI) was incorporated as a private company limited by shares on 16 December 2016. It is a wholly owned subsidiary of the GMC which utilises knowledge gained from the core activities of the GMC to provide services on a commercial basis, including consultancy, training and accreditation. Any profits derived from these activities are gifted back to the GMC for the purpose of delivering the GMC's charitable aims.

The GMC invested £0.6 million as share capital in GMCSI. In its early years of operation GMCSI generated net losses but has recently been able to generate modest profits. In 2023, GMCSI generated a net profit of £76,227 and ended the year with net assets of £332,750. No profits have been gift-aided back to the GMC in 2023. GMCSI is projected to generate profits over the medium term.

The accounts presented here are consolidated group accounts to include our trading subsidiary GMCSI. The statement of financial activities shows the consolidated position for the GMC and GMCSI combined. The balance sheet shows separate columns for the group position (GMC and GMCSI combined) and the parent charity position (GMC). Separate company accounts have been prepared for GMCSI.

Trustees' responsibilities for the financial statements

The trustees are responsible for preparing the trustees' annual report and the financial statements in accordance with applicable law and United Kingdom Generally Accepted Accounting Practice (United Kingdom Accounting Standards). The law applicable to charities in England, Scotland and Wales requires the trustees to prepare financial statements for each financial year which give a true and fair view of the state of affairs of the charity and the group, and of the incoming resources and application of resources of the group for that period.

In preparing these financial statements, the trustees are required to:

- select suitable accounting policies and then apply them consistently
- observe the methods and principles in the Charities Statement of Recommended Practice (SORP)
- make judgements and estimates that are reasonable and prudent
- state whether applicable accounting standards have been followed, subject to any material departures being disclosed and explained in the financial statements
- prepare the financial statements on the going concern basis unless it is inappropriate to presume that the charity will continue in business.

The trustees are responsible for keeping adequate accounting records that are sufficient to show and explain the charity's transactions, and to disclose, with reasonable accuracy at any time, the financial position of the charity, enabling them to make sure that the financial statements comply with the Charities Act 2011, the Charity (Accounts and Reports) Regulations 2008, the Charities and Trustee Investment (Scotland) Act 2005, the Charities Accounts (Scotland) Regulations 2006 (as amended), the Privy Council Directions issued under the Medical Act 1983 and the provisions of the charity's constitution. They are also responsible for safeguarding the assets of the charity and the group and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

Related party transactions

We require that all trustees and senior managers disclose details of any organisations in which they (and their close family members and business partners) hold a position of authority or other material interest and whose business could bring them into financial contact with the GMC. Details of any actual transactions between the GMC and related parties in the year must also be disclosed. We also publish a register of interests on our website.

In 2023, all disclosures were made and there were no points of concern.

Audit and Risk Committee report

The Audit and Risk Committee (ARC) plays a key role in our governance. It provides Council with independent assurance about:

- the integrity of our financial statements
- the effectiveness of internal control, governance and risk management systems
- the delivery of internal and external audit services.

It also monitors our anti-fraud policies and any risks relating to the General Data Protection Regulations, and reviews arrangements for raising concerns.

The Committee bases its advice and decisions on guidance issued by the Financial Reporting Council, the Charity Commission, the Office of the Scottish Charity Regulator and, where appropriate, independent external advice.

The Committee has six members: four Council members and two co-opted members. Co-opted or independent members enhance the work of the Committee by bringing valuable additional skills and experience to the independent scrutiny of finance, risk and governance. All members of the Committee participate in an annual appraisal process.

The Committee bases its annual work programme on risk, with our Corporate Opportunities and Risk Register reflecting the key strategic risks we manage. The Committee's oversight and scrutiny play a valuable role in assuring that risks are being managed and opportunities are enhanced through effective systems of governance, internal control and risk management arrangements.

In 2023, the Committee met five times and submitted two formal reports on its work and findings to Council. As well as this, members had the opportunity to learn more about and scrutinise specific areas of the business and their associated risks in seminar sessions and an extended seminar day. Their discussions included:

- the history of fitness to practise legislation, and the differences between the GMC's regulatory processes and the criminal justice system
- current decision points from receipt of a complaint at triage through to hearing referral
- the impact of the potential changes in fitness to practise through regulatory reform
- the risk thresholds for escalation to enhanced monitoring in Education
- practicalities of the supportive approach we can adopt in enhanced monitoring, including in conjunction with other organisations
- the four-year proactive quality assurance process for medical schools and postgraduate training organisations.

Key activities during 2023

During 2023, the Committee followed a planned programme of internal audit work. As part of this, it:

- considered the output from discussion with the Executive on the principles behind the development of a financial stress-testing model to strengthen financial scenario-planning exercises and support financial resilience
- scrutinised the draft Trustees' Annual Report and Accounts 2022 and the draft national reports for Northern Ireland, Scotland and Wales, including reviewing the trustees' risk statement
- considered the external auditor's management report in relation to the financial statements for 2022
- considered the external auditor's terms of engagement, plan and audit scope for the external audit of the 2023 financial statements and approved the fee
- accepted the Head of Internal Audit's annual opinion for 2022,* which provided substantial assurance that the systems of governance, risk management and internal control in operation during 2022 were generally well designed and working effectively to ensure the achievement of the GMC's objectives
- reviewed the performance of both external and internal audit
- approved the internal audit programme for 2023 and scrutinised 15 audit reports and findings to satisfy itself that the actions being taken were appropriate
- received the results of an independent test of our cyber security control arrangements
- monitored the implementation of recommendations made in previous audit reports to make sure they were being managed effectively
- received the *Freedom to Speak Up (FtSU) Guardian Annual Report 2022*† and heard from FtSU champions to gain insight into some of the concerns raised, how they were handled and how learning feeds into wider organisational development.

In addition to the above, at each of its meetings the Committee also:

- discussed a wide range of strategic risks, providing an important backdrop to its understanding of the challenges and opportunities the GMC was facing
- considered the assurance it had with respect to how the organisation was responding to emerging threats and opportunities
- challenged our Corporate Opportunities and Risk Register
- reviewed findings and lessons learned from work undertaken in relation to significant adverse events.

* For the Head of Internal Audit's assessment for 2023, see Council papers, July 2024.

† For the Freedom to Speak Up Guardian's Annual Report for 2023, see Council papers, June 2024.

Risk management in 2023

Mature risk management arrangements are embedded in the GMC's day-to-day activities, project work and strategic business discussions. Our Risk Management Framework and risk registers provide the tools for identifying, articulating, monitoring and managing operational and project risks. They focus on both threats and opportunities, recognising that understanding both can improve how the business is managed. A business's resilience, and ability to respond and adapt, are also features demonstrating robust risk management.

Unscripted risk discussions at the start of every Committee meeting provide us a valuable opportunity to consider both current risks faced by the GMC as well as emerging potential risks in the wider external environment. The Committee also considers the Corporate Opportunities and Risk Register at every meeting; this is available as part of the Executive Board and Council papers published on our website and is updated on a regular basis.

In 2023 we continued to operate in a dynamic and turbulent wider external environment throughout the year, with the Committee promptly considering the impact of the evolving economic and healthcare landscape, reflecting on the reputational, political, financial and operational risks we faced and might face in the future if the organisation were not properly prepared to manage the challenges ahead.

In particular, the Committee's considerations on the management of risk included:

- using scenarios to test the financial model developed to support the GMC's financial resilience
- considering the requirements and implications of regulatory reform and the opportunities provided to modernise our statutory processes
- how the GMC is managing preparations for new registration pathways following Brexit
- preparing for the introduction of the Medical Licensing Assessment in 2024
- preparations for bringing physician associates and anaesthesia associates into regulation
- responding to a range of public investigations and inquiries.

In addition, the Committee has maintained a focus on the GMC's external and internal-facing ambitions in relation to equality, diversity and inclusion, and in particular the elimination of disproportionate patterns of fitness to practise referrals based on doctors' ethnicity and place of qualification, and eliminating discrimination, disadvantage and unfairness in undergraduate and postgraduate medical education and training. The Committee has also been keen to understand how the recommendations made in the independent regulatory fairness review conducted in 2022 are being addressed as the GMC seeks to accelerate the pace of its work to consider fairness in its processes.

Learning from events and issues

Organisational resilience develops not only from embedded risk management arrangements and operational excellence and efficiency, but also from how an organisation reacts when things emerge suddenly or something goes wrong. To develop resilience, a business must be willing to learn, and the GMC's culture of continuous improvement is an important component of its resilience. This includes a robust approach to undertaking learning reviews and significant event reviews (SERs) to identify opportunities to improve. A significant event is where an incident had or could have had the potential for a material adverse effect on the organisation. Carrying out such reviews allows us to identify and address root causes so that learnings are used to strengthen controls for the future where appropriate. The organisation's audit and risk assurance function provides guidance, support, challenge and independent quality assurance for SERs, their findings and actions.

There were four such events in 2023. Two of them related to operational matters, namely:

- a doctor leaving the Clinical Assessment Centre with the wrong passport
- a GMC third-party supplier which suffered a security breach (though no GMC data was compromised).

The other two related to the death of a doctor which occurred while the doctor was subject to a GMC fitness to practise process, and the death of a doctor who had been subject to health monitoring before relinquishing their licence to practise.

Each of these events was scrutinised by the Committee and reviewed in line with the policy for reporting to the Charity Commission, and Trustees determined that based on detailed analysis they did not reach the threshold for serious incident reporting.

Whilst learning from SERs is critical for improving future performance, we have many mechanisms for learning and sharing better practices across the business. These include:

- consideration of external research and publicly available reports, such as those published by the Charity Commission or by other regulators
- regular liaison with other healthcare regulators
- local team quality control exercises
- audits undertaken by our internal corporate Quality Assurance team
- post-implementation reviews of new initiatives and projects
- a Community of Practice to share experiences of project management and supporting change
- broader insight from the work of internal audit.

As in previous years, in 2023 the Committee also took the opportunity to look at a number of case studies where organisations had found themselves in difficulty, to consider if there were learning opportunities for the GMC and the Committee in relation to the quality of reporting and the assurances it sought through its activities.

Our work in 2024

Maintaining risk at the heart of its considerations, the Committee will remain flexible in its activities and work programme to ensure it is able to take account of and respond to emerging threats and opportunities. Being able to adapt quickly is itself an indicator of strong risk management arrangements and organisational resilience.

The Committee anticipates 2024 being as busy and challenging as 2023. It will continue to focus on risks in relation to key areas of operations and gain assurance on new organisational change programmes. In particular, it is keen to continue to understand the risks around, and seek assurance on:

- transitioning the Medical Licensing Assessment from a programme of change to a 'business as usual' activity
- the implementation of the regulation of physician associates and anaesthesia associates
- opportunities for legislative changes through regulatory reform
- ensuring the benefits of moving to digital identification checks are fully realised.

Members of the Committee will also participate in the re-tender of our external audit contract, which has come to the end of its term.

Approved by the trustees on 2 July 2024 and signed on their behalf by:



Dame Carrie MacEwen

Independent auditors' report to the trustees of the GMC

Opinion

We have audited the financial statements of the General Medical Council ('the charity') and its subsidiary ('the group') for the year ended 31 December 2023, which comprise the Consolidated Statement of Financial Activities, Balance Sheet, Consolidated Cash Flow Statement and notes to the financial statements, including significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and United Kingdom Accounting Standards, including Financial Reporting Standard 102, The Financial Reporting Standard applicable in the UK and Republic of Ireland (United Kingdom Generally Accepted Accounting Practice).

In our opinion the financial statements:

- give a true and fair view of the state of the group's and the parent charity's affairs as at 31 December 2023 and of the group's income and expenditure, for the year then ended;
- have been properly prepared in accordance with United Kingdom Generally Accepted Accounting Practice; and
- have been prepared in accordance with the requirements of the Charities Act 2011 and the Charities and Trustee Investment (Scotland) Act 2005 and Regulations 6 and 8 of the Charities Accounts (Scotland) Regulations 2006 (amended).

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the group in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the trustees' use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the charity's or the group's ability to continue as a going concern for a period of at least 12 months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the trustees with respect to going concern are described in the relevant sections of this report.

Other information

The trustees are responsible for the other information contained within the annual report. The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Matters on which we are required to report by exception

We have nothing to report in respect of the following matters in relation to which the Charities (Accounts and Reports) Regulations 2008 and the Charities Accounts (Scotland) Regulations 2006 require us to report to you if, in our opinion:

- the information given in the financial statements is inconsistent in any material respect with the trustees' report; or
- sufficient and proper accounting records have not been kept by the parent charity; or
- the financial statements are not in agreement with the accounting records and returns; or
- we have not received all the information and explanations we require for our audit.

Responsibilities of trustees

As explained more fully in the trustees' responsibilities statement set out on page 55, the trustees are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the trustees determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the trustees are responsible for assessing the group and the parent charity's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the trustees either intend to liquidate the charity or to cease operations, or have no realistic alternative but to do so.

Auditor's responsibilities for the audit of the financial statements

We have been appointed as auditor under section 151 of the Charities Act 2011, and section 44(1)(c) of the Charities and Trustee Investment (Scotland) Act 2005 and report in accordance with the Acts and relevant regulations made or having effect thereunder.

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Details of the extent to which the audit was considered capable of detecting irregularities, including fraud and non-compliance with laws and regulations, are set out below.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Extent to which the audit was considered capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We identified and assessed the risks of material misstatement of the financial statements from irregularities, whether due to fraud or error, and discussed these between our audit team members. We then designed and performed audit procedures responsive to those risks, including obtaining audit evidence sufficient and appropriate to provide a basis for our opinion.

We obtained an understanding of the legal and regulatory frameworks within which the charity and group operate, focusing on those laws and regulations that have a direct effect on the determination of material amounts and disclosures in the financial statements. The laws and regulations we considered in this context were the Medical Act 1983, Charities Act 2011 and the Charities and Trustee Investment (Scotland) Act 2005 together with the *Charities SORP (FRS 102) 2019*. We assessed the required compliance with these laws and regulations as part of our audit procedures on the related financial statement items.

In addition, we considered provisions of other laws and regulations that do not have a direct effect on the financial statements but compliance with which might be fundamental to the charity's and the group's ability to operate or to avoid a material penalty. We also considered the opportunities and incentives that may exist within the charity and the group for fraud. The laws and regulations we considered in this context for the UK operations were the General Data Protection Regulation (GDPR), and employment legislation.

Auditing standards limit the required audit procedures to identify non-compliance with these laws and regulations to enquiry of the Trustees and other management and inspection of regulatory and legal correspondence, if any.

We identified the greatest risk of material impact on the financial statements from irregularities, including fraud, to be within estimates surrounding legal provisions, the defined benefit pension scheme balance and the override of controls by management. Our audit procedures to respond to these risks included enquiries of management, internal audit, legal counsel and the Audit and Risk Committee about their own identification and assessment of the risks of irregularities, sample testing on the posting of journals, reviewing accounting estimates for biases, reviewing regulatory correspondence with the Charity Commission and reading minutes of meetings of those charged with governance.

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations (irregularities) is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it. In addition, as with any audit, there remained a higher risk of non-detection of irregularities, as these may involve collusion, forgery, intentional omissions,

misrepresentations or the override of internal controls. We are not responsible for preventing non-compliance and cannot be expected to detect non-compliance with all laws and regulations.

Use of our report

This report is made solely to the charity's trustees, as a body, in accordance with Part 4 of the Charities (Accounts and Reports) Regulations 2008 and Regulation 10 of the Charities Accounts (Scotland) Regulations 2006. Our audit work has been undertaken so that we might state to the charity's trustees those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the charity and the charity's trustees as a body, for our audit work, for this report or for the opinions we have formed.

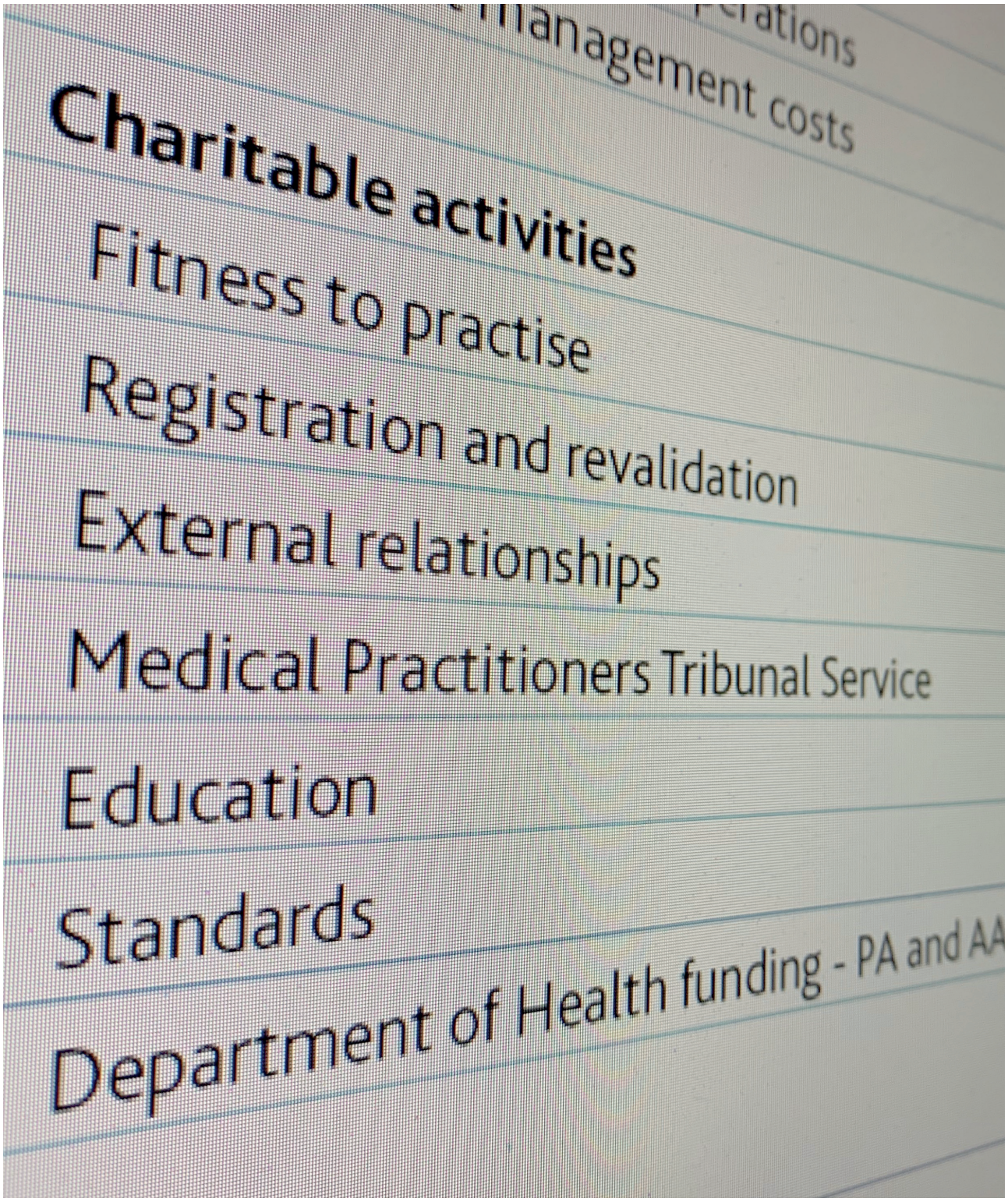
Crowe U.K. LLP
Statutory Auditor
55 Ludgate Hill
London
EC4M 7JW

3 July 2024

Crowe U.K. LLP is eligible for appointment as auditor of the charity by virtue of its eligibility for appointment as auditor of a company under section 1212 of the Companies Act 2006.

Crowe U.K. LLP is eligible for appointment as auditor of the charity under regulation 10(2) of the Charities Accounts (Scotland) Regulations by virtue of its eligibility under section 1212 of the Companies Act 2006.

Accounts 2023



Consolidated statement of financial activities for the year ended 31 December 2023

	Note	Unrestricted funds £'000	Restricted funds £'000	**Total 2023 £'000**	**Total 2022 £'000**
Income					
From charitable activities					
Registration	2	139,595	-	**139,595**	**125,851**
Specialist and GP registration	2	5,846	-	**5,846**	**4,714**
Revalidation	2	168	-	**168**	**182**
Other trading activities	3	168	-	**168**	**159**
Commercial trading operations	3	442	-	**442**	**351**
Investments	3	2,065	-	**2,065**	**1,236**
Department of Health funding - PA and AA regulation*	3	-	1,567	**1,567**	**2,506**
Other	3	625	-	**625**	**214**
Total incoming resources		148,909	1,567	**150,476**	**135,213**
Expenditure					
Raising funds					
Commercial trading operations	4	365	-	**365**	**325**
Investment management costs	4	244	-	**244**	**209**
		609	-	**609**	**534**
Charitable activities					
Fitness to practise	4	48,998	-	**48,998**	**47,633**
Registration and revalidation	4	43,317	-	**43,317**	**37,122**
External relationships	4	18,320	-	**18,320**	**16,760**
Medical Practitioners Tribunal Service	4	14,911	-	**14,911**	**14,875**
Education	4	12,408	-	**12,408**	**11,308**
Standards	4	2,226	-	**2,226**	**2,060**
Department of Health funding - PA and AA regulation	4	-	1,256	**1,256**	**1,551**
		140,180	1,256	**141,436**	**131,309**
Other expenditure					
Legal provision	11	683	-	**683**	**1,398**
Dilapidations provision	11	1,333	-	**1,333**	**286**
		2,016	-	**2,016**	**1,684**
Total expenditure	4	142,805	1,256	**144,061**	**133,527**
Operating surplus		6,104	311	**6,415**	**1,686**
Net gains/(Net losses) on investments	8	5,224	-	**5,224**	**(4,846)**
Net income/(Net loss)		11,328	311	**11,639**	**(3,160)**
Other recognised gains and losses					
Actuarial (loss) on defined benefit pension scheme	16	(16,100)	-	**(16,100)**	**(41,785)**
Net movement in funds		(4,772)	311	**(4,461)**	**(44,945)**
Total funds brought forward		53,042	1,811	**54,853**	**99,798**
Total funds carried forward		48,270	2,122	**50,392**	**54,853**

The GMC incorporated a wholly owned trading subsidiary on 16 December 2016 with the purpose of providing services on a commercial basis including consultancy, training and accreditation. The charity has taken exemption from presenting its unconsolidated profit and loss account.

The parent charity movement in funds for the year is (£4,849,000) with subsidiary undertakings accounting for a further £77,000.

* The Department for Health and Social Care provided funding in 2023 to continue implementation work to bring physician associates (PAs) and anaesthesia associates (AAs) under regulation with the GMC. Funding was restricted in nature, and was fully spent in the year.
  A proportion of the funds paid for IT system development, which has created an asset on the balance sheet. The net impact on GMC reserves is £311,000. The balance of the reserves will reduce when the asset is amortised in future periods.

Balance sheet

	Note	2023 Group £'000	2023 Charity £'000	2022 Group £'000	2022 Charity £'000
Fixed assets					
Intangible fixed assets	6	16,607	16,607	14,524	14,524
Tangible fixed assets	7	4,831	4,831	4,423	4,423
Investments	8	61,573	61,906	56,593	56,849
		83,011	**83,344**	**75,540**	**75,796**
Current assets					
Debtors and prepayments	9	30,747	30,837	27,057	27,101
Cash and bank balances		54,811	54,277	51,112	50,750
		85,558	**85,114**	**78,169**	**77,851**
Liabilities					
Creditors: amounts falling due within one year	10	(91,900)	(91,789)	(87,181)	(87,119)
Net current liabilities		(6,342)	(6,675)	(9,012)	(9,268)
Total assets less current liabilities		**76,669**	**76,669**	**66,528**	**66,528**
Provisions for liabilities and charges	11	(10,443)	(10,443)	(8,427)	(8,427)
Net assets excluding pension scheme (liability)		**66,226**	**66,226**	**58,101**	**58,101**
Defined benefit pension scheme (liability)	16	(15,834)	(15,834)	(3,248)	(3,248)
Total net assets		**50,392**	**50,392**	**54,853**	**54,853**
Unrestricted income funds		64,104	64,104	56,290	56,290
Restricted income funds		2,122	2,122	1,811	1,811
Pension reserve		(15,834)	(15,834)	(3,248)	(3,248)
Total funds	12, 13	**50,392**	**50,392**	**54,853**	**54,853**

The financial statements were approved by the trustees and authorised for issue on 2 July 2024.
They were signed on behalf of trustees by:



Dame Carrie MacEwen
Chair of Council

Consolidated cash flow statement

	2023		2022	
	£'000	**£'000**	£'000	£'000
Cash flows from operating activities				
Net cash provided by/(used in) operating activities (note i below)		11,968		12,290
Cash flows from investing activities				
Dividends, interest and rents from investments	2,065		522	
Purchase of property, plant, equipment and intangibles	(10,334)		(8,521)	
Net cash used in investing activities		**(8,269)**		**(7,999)**
Change in cash and cash equivalents (note ii below)		**3,699**		**4,291**

Note (i)

Cash flow from operating activities		
Net incoming/(outgoing) resources	11,639	(3,160)
Investment income and interest	(2,012)	(1,236)
Net investment movement	(4,980)	5,056
Non-cash items - depreciation and amortisation	6,992	7,581
Non-cash items - assets written off	851	-
Pension past service cost and curtailment	-	100
Pension scheme contribution	(3,567)	(1,362)
(Increase)/decrease in debtors	(3,690)	(3,016)
Increase/(decrease) in creditors and provisions	6,735	8,327
Net cash provided by/(used in) operating activities	**11,968**	**12,290**

Note (ii)	**Cash at bank and in hand**	**Total**
Cash and equivalents	**£'000**	**£'000**
Balances at 1 January 2023	51,112	**51,112**
Net increase in cash and cash equivalents	3,699	**3,699**
Balances at 31 December 2023	54,811	**54,811**

Notes to the accounts

General information

We are a statutory body governed by the Medical Act 1983 and are registered with the Charity Commission for England and Wales (1089278), and with the Office of the Scottish Charity Regulator (SC037750).

1. Principal accounting policies

(i) Accounting convention

The financial statements have been prepared to give a 'true and fair' view and have departed from the Charities (Accounts and Reports) Regulations 2008 only to the extent required to provide a 'true and fair' view. This departure has involved following the *Charities Statement of Recommended Practice (FRS 102)* first published on 16 July 2014, updated 01 October 2019.

Our financial statements have been prepared on a going concern basis and in accordance with the *Charities Statement of Recommended Practice (FRS 102)*, effective 01 October 2019, applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland, the Charities Act 2011, the Charities and Trustee Investment (Scotland) Act 2005, the Charities Accounts (Scotland) Regulations 2006 and UK Generally Accepted Practice as it applies from 01 October 2019. The GMC meets the definition of a public benefit entity under FRS 102.

(ii) On 16 December 2016 the GMC incorporated a trading subsidiary, GMC Services International Ltd, company number 10530157, which is wholly owned by share capital by the GMC.

(iii) A separate statement of financial activities has not been presented for the charity alone as this is not considered to be materially different from the consolidated statement of financial activities (SOFA). For the parent charity the net movement in funds is shown beneath the SOFA, with commercial activities from our subsidiary being separately identified on the face of the SOFA on page 67.

(iv) The principal accounting policies adopted in the preparation of the financial statements, which have been applied consistently, are detailed below.

Incoming resources

Income is included in the statement of financial activities when all of the following criteria are met.

- Entitlement - control over the rights or other access to the economic benefit has passed to the GMC.
- Probability - it is more likely than not that the economic benefits will flow to the GMC.
- Measurement - the value can be measured reliably.

The following specific policies apply:

- Annual retention fees relate to services to be provided over a 12-month period. Income is deferred and released to the statement of financial activities on a straight-line basis over the period to which the income relates.
- Registration fees, including provisional registration fees, are recognised when registration is granted.
- Professional and Linguistic Assessments Board (PLAB) fees are recognised when the examinations are sat.
- Income from investments and funds held on deposit is recognised when it is receivable and the amount can be accurately measured.

All income is recognised gross.

Basis for recognising liabilities

Expenditure includes staffing costs, office costs, committee costs, legal costs, accommodation costs, purchase of assets, and financial, actuarial and professional costs.

Resources expended are included in the statement of financial activities on an accruals basis. All liabilities are recognised as soon as there is a legal or constructive obligation committing the charity to expenditure.

Basis for allocation of resources expended

The majority of our resources are expended directly in pursuit of our charitable aims, and are identified as such in the statement of financial activities.

Accommodation costs, governance costs and other support costs are apportioned to charitable activities on the basis of staff head count across the organisation.

Irrecoverable VAT

Any irrecoverable VAT is charged to the statement of financial activities as part of the relevant item of expenditure, or capitalised as part of the cost of the related asset where appropriate.

Taxation

We apply appropriate exemptions from taxation on income and gains available to charities, so no taxation is payable on the net incoming resources of the charity. The charity's subsidiary company is subject to corporation tax in the same way as any commercial organisation.

Debtors

Trade and other debtors are normally recognised at the settlement amount due after any trade discount offered. Prepayments are normally valued at the amount prepaid net of any trade discounts due.

Creditors and provisions for liabilities

Creditors and provisions are recognised when the charity has a present legal or constructive obligation as a result of a past event. They are recognised when it is probable that a transfer of economic benefit will be required to settle the obligation and a reliable estimate can be made of the amount of the obligation. Creditors and provisions are normally recognised at their settlement amount after allowing for any trade discounts due.

Critical accounting judgments and key sources of estimation uncertainty

The key sources of estimation uncertainty that have a significant effect on the amounts recognised in the financial statements are listed below.

- All unsettled claims for legal costs made against the GMC are reviewed on a case-by-case basis at the year end.
- Provisions are based on historical experience and a detailed assessment of the specific details of current cases. The final settlement of cases is dependent on a number of factors, so the accuracy of the provision is subject to a significant degree of uncertainty.
- Provisions for property dilapidation costs are made for all leased buildings. They are assessed on a case-by-case basis reflecting the different configurations of leased buildings and the cost to revert to their original state. We apply annual inflationary increases in line with the consumer price index, and periodically seek third-party advice to ensure our estimates remain appropriate.
- Provisions for holiday pay are based on the actual level of accrued holiday entitlement outstanding at the year end and salaries of each staff member.

Tangible fixed assets

Tangible fixed assets are stated at cost, net of depreciation and any provision for impairment. Expenditure is only capitalised where the cost of the asset or group of assets acquired exceeds £5,000.

Intangible fixed assets

Intangible fixed assets comprise computer software. They are stated at cost, net of amortisation and any provision for impairment. Expenditure is only capitalised where the cost of the asset or group of assets acquired exceeds £5,000.

Depreciation

Depreciation is provided so as to write off the cost, less estimated residual value, of the assets evenly over their estimated lives.

The estimated useful lives are as follows:

- leasehold buildings and leasehold improvements – the lesser of five years or the remaining term of the lease
- furniture, fixtures, and office fittings – the lesser of five years or the remaining term of the lease
- information technology (IT) equipment – three years
- intangible assets (IT software) – three years.

Depreciation rates are reviewed on a regular basis comparing actual lives of assets with the accounting policy rates.

Licensed IT software

Development costs for implementing new IT systems are capitalised and depreciated over the lesser of three years or the useful life of the asset. The first year licence costs are capitalised as they are necessary to bring the asset into use; subsequent year licence costs are treated as operating expenditure.

Operating leases

Rent payable under operating leases is charged to the statement of financial activities on a straight-line basis over the period of the lease.

Financial instruments

The charity has financial assets and liabilities of a kind that qualify as basic financial instruments. Basic financial instruments are initially recognised at transaction value and subsequently measured at amortised cost. Financial assets held at amortised cost consist of cash and bank balances, short-term deposits (cash flow statement), investments held in cash deposits (note 8) together with trade and other debtors (note 9). Financial liabilities held at amortised cost comprise trade and other creditors, tax and social security creditors and accruals (note 10).

Investments

Our investment policy separates our funds into four categories: those which are required as working capital for the normal day-to-day operation of the business, those which we invest under management, those which we may decide to invest in a trading subsidiary, and the remaining cash balance, which fluctuates during the year.

Funds held as cash for the normal day-to-day operation of the business are shown on the GMC's balance sheet within current assets, while funds held for the longer term are shown as investments.

Pensions

We have a defined benefit pension scheme for permanent employees. The scheme was closed to new members on 30 June 2013, and for future accrual to existing members on 31 March 2018, and replaced by a defined contribution scheme. The surplus or deficit of the defined benefit scheme is recognised on the balance sheet. Changes in the assets and liabilities of the scheme are disclosed and allocated as follows.

- Charges relating to current or past service costs, and gains and losses on settlements and curtailments, are included within staff costs and charged to the statement of financial activities.
- Interest on the net defined benefit asset/liability is shown as a net amount of other finance costs or as an incoming resource alongside investment income and interest. Actuarial gains and losses are recognised immediately in other recognised gains and losses on investments.
- The assets, liabilities and movements in the surplus or deficit of the scheme are calculated by qualified independent actuaries as an update to the latest full actuarial valuation. Details of the defined benefit scheme assets, liabilities and major assumptions are shown in the notes to the accounts.
- Our defined contribution pension scheme was set up on 1 July 2013. Contributions to the scheme are charged to the statement of financial activities in the year in which they are payable to the scheme.

Funds and reserves

The majority of our funds are unrestricted, and so can be expended at the trustees' discretion in pursuit of our charitable aims. Restricted funds will be expended in line with the purpose of the funding.

Termination payments

Termination payments are accounted for as soon as the organisation is aware of the obligation to make the payment.

2. Income from charitable activities

	Unrestricted funds £'000	**Total 2023 £'000**	Unrestricted funds £'000	**Total 2022 £'000**
Registration				
Annual retention fees	112,228	**112,228**	104,494	**104,494**
Registration fees	6,622	**6,622**	4,722	**4,722**
Provisional registration fees	234	**234**	455	**455**
PLAB fees	20,392	**20,392**	16,103	**16,103**
Other fees	119	**119**	77	**77**
	139,595	**139,595**	125,851	**125,851**
Specialist and GP registration				
Certificates of Completion of Training fees	3,583	**3,583**	3,197	**3,197**
Certificate of Eligibility for Specialist Registration/ Certificate of Eligibility for General Practitioner Registration fees	2,196	**2,196**	1,476	**1,476**
Other fees	67	**67**	41	**41**
	5,846	**5,846**	4,714	**4,714**
Revalidation				
Revalidation annual return	133	**133**	114	**114**
Revalidation assessment	35	**35**	68	**68**
	168	**168**	182	**182**

3. Income from raising funds

	Unrestricted funds £'000	Restricted funds £'000	**Total 2023 £'000**	Unrestricted funds £'000	Restricted funds £'000	**Total 2022 £'000**
Activities for raising funds						
Other trading activities*	168	-	**168**	159	-	**159**
Commercial trading operations†	442	-	**442**	351	-	**351**
Other‡	625	-	**625**	214	-	**214**
	1,235	-	**1,235**	724	-	**724**
Investment income						
Other finance income - pension scheme (note 16)	-	-	**-**	714	-	**714**
Bank interest	2,065	-	**2,065**	522	-	**522**
	2,065	-	**2,065**	1,236	-	**1,236**
Department of Health funding						
Funding to cover expenditure on PA and AA regulation§	-	1,567	**1,567**	-	2,506	**2,506**

* Other trading activities include the reimbursement of costs of visiting overseas medical schools and the reimbursement of costs of staff seconded to external bodies.

† Income from commercial trading operations is derived from GMC Services International Ltd, a wholly owned subsidiary, which provides services on a commercial basis including consultancy, training and accreditation.

‡ Other income includes reimbursement of legal fees from appeals, and until we ceased charging transaction fees attached to registration status changes in April 2023, these were also included.

§ The Department of Health and Social Care has provided funding for the GMC to start implementation work to bring physician associates (PAs) and anaesthesia associates (AAs) under regulation with the GMC. The work is ongoing and legislation is expected to be in place for regulation to start on 13 Dec 2024.

4. Total expenditure

Charitable activity and support cost allocation

	Direct staffing costs £'000	Direct costs £'000	Allocated costs £'000	Total 2023 £'000	Direct staffing costs £'000	Direct costs £'000	Allocated costs £'000	Total 2022 £'000
Expenditure on								
Commercial trading operations	308	57	-	**365**	287	38	-	**325**
Investment management costs	-	244	-	**244**	-	209	-	**209**
Total expenditure on raising funds	308	301	-	**609**	287	247	-	**534**
Fitness to practise	22,576	6,532	19,890	**48,998**	21,792	6,944	18,897	**47,633**
Registration and revalidation	16,030	11,164	16,123	**43,317**	14,065	9,308	13,749	**37,122**
External relationships*	10,554	834	6,932	**18,320**	9,733	691	6,336	**16,760**
Medical Practitioners Tribunal Service	5,134	4,903	4,874	**14,911**	5,089	5,199	4,587	**14,875**
Education	7,443	322	4,643	**12,408**	6,883	245	4,180	**11,308**
Standards	1,302	1	923	**2,226**	1,219	7	834	**2,060**
Department of Health funding - PA and AA regulation	859	397	-	**1,256**	1,049	502	-	**1,551**
Total charitable expenditure	63,898	24,153	53,385	**141,436**	59,830	22,896	48,583	**131,309**
Other expenditure - legal provision	-	683	-	**683**	-	1,398	-	**1,398**
Other expenditure - dilapidation provision	-	1,333	-	**1,333**	-	286	-	**286**
Total group expenditure	64,206	26,470	53,385	**144,061**	60,117	24,827	48,583	**133,527**

* External relationships include the work done by our Regional Liaison Service, strategic relationships, our devolved offices, and our European and international development activities.

Support costs allocated to charitable activities

	Management £'000	IT £'000	Human resources £'000	Finance £'000	Procurement £'000	Facilities £'000	Governance £'000	Total 2023 £'000	Management £'000	IT £'000	Human resources £'000	Finance £'000	Procurement £'000	Facilities £'000	Governance £'000	Total 2022 £'000
Fitness to practise	4,364	5,925	2,434	899	177	4,650	1,441	**19,890**	3,416	5,852	2,495	886	163	4,651	1,434	**18,897**
Registration and revalidation	3,538	4,803	1,973	728	143	3,770	1,168	**16,123**	2,485	4,259	1,815	645	119	3,383	1,043	**13,749**
External relationships	1,521	2,065	848	313	62	1,621	502	**6,932**	1,145	1,963	836	297	55	1,559	481	**6,336**
Medical Practitioners Tribunal Service	1,069	1,452	597	220	43	1,140	353	**4,874**	829	1,421	605	215	40	1,129	348	**4,587**
Education	1,019	1,383	568	210	41	1,086	336	**4,643**	756	1,295	552	196	36	1,029	317	**4,181**
Standards	202	275	113	42	8	216	67	**923**	151	258	110	39	7	205	63	**833**
Total charitable expenditure	11,713	15,903	6,533	2,412	474	12,483	3,867	**53,385**	8,782	15,048	6,413	2,278	420	11,956	3,686	**48,583**

Support costs are allocated to charitable activities on the basis of staff head count across the organisation.

Support cost recharges have been made to both the trading subsidiary, GMC Services International Ltd, and the PA and AA regulation project throughout the year on a direct basis, using the logic of allocation outlined above, and are therefore treated separately to the year end allocation.

Group expenditure by type

	Charitable activities 2023	**Expenditure on raising funds 2023**	**Department of Health funding - PA and AA regulation 2023**	**Other expenditure 2023**	**Total 2023**	Charitable activities 2022	Expenditure on raising funds 2022	Department of Health funding - PA and AA regulation 2022	Other expenditure 2022	**Total 2022**
	£'000	**£'000**	**£'000**	**£'000**	**£'000**	£'000	£'000	£'000	£'000	**£'000**
Staffing costs	89,983	308	859	-	**91,150**	82,261	288	1,049	-	**83,598**
Office costs	2,158	44	332	-	**2,534**	1,781	24	444	-	**2,249**
Council and committee costs	395	-	-	-	**395**	407	-	-	-	**407**
Panel and assessment costs	18,031	-	65	-	**18,096**	16,770	-	28	-	**16,798**
Legal costs	4,594	-	-	683	**5,277**	4,706	-	-	1,398	**6,104**
Accommodation costs	8,048	-	-	1,333	**9,381**	7,637	-	-	286	**7,923**
Financial, actuarial and professional costs	3,739	257	-	-	**3,996**	4,028	222	30	-	**4,280**
Purchase of assets - charged to revenue	5,389	-	-	-	**5,389**	4,587	-	-	-	**4,587**
Assets written off	851	-	-	-	**851**	-	-	-	-	**-**
Depreciation	2,231	-	-	-	**2,231**	2,595	-	-	-	**2,595**
Amortisation	4,761	-	-	-	**4,761**	4,986	-	-	-	**4,986**
	140,180	609	1,256	2,016	**144,061**	129,758	534	1,551	1,684	**133,527**

Total resources expended

	2023	2022
	£'000	£'000
Operating lease costs: leasehold property and equipment	3,453	3,669
Audit fees	55	51

5. Staff

Total costs of all staff	2023 £'000	2022 £'000
Salaries	**70,082**	63,993
Social security costs	**7,317**	6,992
Superannuation costs defined benefit scheme	**-**	100
Superannuation costs defined contribution scheme	**9,999**	9,082
Redundancy costs	**130**	80
Other staffing costs	**3,622**	3,351
	91,150	83,598

During the year the GMC made termination payments of £86,000 (2022: £236,000) which included £6,000 relating to and accrued in 2022. At year end payments of £50,000 were outstanding (2022: £6,000).

Average staff numbers in the year by category	2023	2022
Fitness to practise	**460**	465
Registration and revalidation	**373**	338
External relationships	**160**	156
Medical Practitioners Tribunal Service	**113**	113
Education	**107**	103
Standards	**21**	20
Governance and management	**178**	165
Resources	**249**	226
	1,661	1,586
GMC Services International Ltd	**1**	1
	1,662	1,587

The number of staff whose total employee benefits (excluding employer pension contributions) fell into higher salary bands was:

	2023	2022
GMC		
£60,000-£70,000	74	59
£70,001-£80,000	50	50
£80,001-£90,000	38	46
£90,001-£100,000	29	12
£100,001-£110,000	10	11
£110,001-£120,000	9	10
£120,001-£130,000	9	7
£130,001-£140,000	7	3
£140,001-£150,000	3	4
£150,001-£160,000	3	2
£160,001-£170,000	2	-
£210,001-£220,000	3	6
£220,001-£230,000	3	-
£260,001-£270,000	-	1
£270,001-£280,000	1	
	241	211
MPTS		
£60,000-£70,000	1	2
£70,001-£80,000	2	-
£80,001-£90,000	1	2
£90,001-£100,000	2	2
£110,001–£120,000	-	1
£120,001-£130,000	1	-
	7	7
Total	248	218

	2023	2022
Number of staff included above for whom retirement benefits are accruing		
GMC defined contribution pension scheme	248	217
Not in scheme	-	1
	248	218

The senior management team includes the Chief Executive and six permanent directors in 2023. The total employee benefits (including employer pension contributions) of the senior management team was £1,812,679 in 2023 (2022: £1,759,804).

Senior management team remuneration	Basic salary 2023	Basic salary 2022
	£'000	£'000
Charlie Massey - Chief Executive	264	255
Paul Reynolds - Director of Strategic Communications and Engagement	216	208
Anthony Omo - General Counsel and Director of Fitness to Practise	216	208
Shaun Gallagher - Director of Strategy and Policy	216	208
Una Lane - Director of Registration and Revalidation	216	208
Neil Roberts - Director of Resources	216	208
Colin Melville - Medical Director and Director of Education and Standards	216	208

All GMC staff, including the senior management team, are entitled to pension contributions of 15% of salary into the GMC Group Personal Pension Plan and may exchange contributions for salary.

The Chief Executive and Directors receive non-consolidated pay. In both 2023 and 2022, payments were below 3% of basic salary for all members of the senior management team.

All GMC staff, including the senior management team, are entitled to buy and sell leave and to the taxable benefit of private medical insurance. These costs and benefits are not included in the table above.

The Chief Executive's salary is 7.6 (2022: 7.6) times the median salary and 12.3 (2022: 12.8) times the lowest salary.

There were no related party transactions in the year that require disclosure other than payments made to trustees as disclosed in notes 17 and 18.

6. Intangible fixed assets

Group and charity

	Computer software and systems development £'000
Cost	
Balance at 1 January 2023	**34,833**
Additions	**7,693**
Disposals	**(4,242)**
Impairment	**(908)**
Balance at 31 December 2023	**37,376**
Amortisation	
Balance at 1 January 2023	**20,309**
Amortisation charge for year	**4,761**
Disposals	**(4,242)**
Impairment	**(59)**
Balance at 31 December 2023	**20,769**
Net book value at 1 January 2023	**14,524**
Net book value at 31 December 2023	**16,607**

Intangible assets incorporates all IT software development costs including, but not limited to, the development of our strategic applications, Siebel, Livelink and Agresso, the development of IT security systems, facilities management systems and website. Intangible assets also include the systems to support working from home and mobile applications. We have recognised an impairment of £849,000 in 2023 relating to the cost of implementing a new HR system to interface with existing technologies. In July 2023 a decision was made to suspend this implementation and costs previously recognised have been impaired and all subsequent costs expensed.

7. Tangible fixed assets

Group and charity

	Buildings	Fixtures, furniture and equipment	IT equipment	Total
	£'000	£'000	£'000	£'000
Cost				
Balance at 1 January 2023	2,188	14,622	7,383	**24,193**
Additions	-	1,915	726	**2,641**
Disposals	-	(343)	(958)	**(1,301)**
Balance at 31 December 2023	2,188	16,194	7,151	**25,533**
Depreciation				
Balance at 1 January 2023	2,074	11,537	6,159	**19,770**
Depreciation charge for year	74	1,418	739	**2,231**
Disposals	-	(341)	(958)	**(1,299)**
Balance at 31 December 2023	2,148	12,614	5,940	**20,702**
Net book value at 1 January 2023	114	3,085	1,224	**4,423**
Net book value at 31 December 2023	40	3,580	1,211	**4,831**

8. Investments

Managed funds	Group		Charity		
	Listed Investments	Total	Listed Investments	Equity investment in group undertakings	Total
	£'000	£'000	£'000	£'000	£'000
The valuation at the end of the year consisted of					
As at 1 January 2023	56,593	**56,593**	56,593	256	**56,849**
Additions	27,560	**27,560**	27,560	-	**27,560**
Disposals	(27,804)	**(27,804)**	(27,804)	-	**(27,804)**
Gain on investments	5,224	**5,224**	5,224	-	**5,224**
Reversal of impairment*	-	**-**	-	77	**77**
Balance at 31 December 2023	**61,573**	**61,573**	**61,573**	**333**	**61,906**

* The GMC incorporated a wholly owned trading subsidiary on 16 December 2016. Having previously been impaired by £343,000 due to trading losses incurred, we have revalued the investment by £77,000 in 2023 as a result of profits generated by the company thereby increasing its net assets.

Listed investments are managed by CCLA Investment Management Ltd. Investment management fees of £243,805 were incurred (2022: £209,170).

9. Debtors

	2023		2022	
	Group	**Charity**	Group	Charity
	£'000	**£'000**	£'000	£'000
Amounts falling due within one year				
Registration debtors	**23,682**	**23,682**	20,935	20,935
Prepayments and accrued income	**6,299**	**6,410**	5,785	5,849
Other debtors	**766**	**745**	337	317
	30,747	**30,837**	27,057	27,101

10. Creditors

	2023		2022	
	Group	**Charity**	Group	Charity
	£'000	**£'000**	£'000	£'000
Amounts falling due within one year				
Trade creditors	**981**	**976**	1,427	1,420
Tax and social security	**2,102**	**2,101**	1,945	1,933
Holiday pay	**1,139**	**1,139**	1,107	1,107
Accruals	**6,635**	**6,584**	8,404	8,361
Deferred income	**81,043**	**80,989**	74,298	74,298
	91,900	**91,789**	87,181	87,119

Charity deferred income

Income from annual retention fees is deferred and released to the statement of financial activities on a straight-line basis over a 12-month period from the date of renewal. All deferred income brought forward from the previous year is released to the statement of financial activities in the following year. Professional and Linguistic Assessments Board (PLAB) fees are deferred to the date the examination is sat. Commercial income is recognised at the point the service is delivered.

	Annual retention fees	**PLAB fees**	**Specialist and GP registrationfees**	**Revalidation assessment fees**	**Commercial activities**	**Total**
	£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Deferred income at 1 January 2023	61,800	12,433	24	42	-	**74,299**
Resources deferred during the year	66,700	14,234	-	55	54	**81,043**
Amounts released from previous years	(61,800)	(12,433)	(24)	(42)	-	**(74,299)**
Deferred income at 31 December 2023	**66,700**	**14,234**	**-**	**55**	**54**	**81,043**

11. Provisions

Group and charity

	2023	2022
	£'000	£'000
Dilapidations	**4,474**	3,141
Legal claims	**5,969**	5,286
	10,443	8,427

Dilapidations - each year we review our property leases and make a provision for dilapidations, where the cost can be reasonably estimated. Given the recent prolonged period of high inflation, we sought external advice around likely costs to meet our lease obligations around dilapidations and used this to rebase the estimate included in the accounts, which led to an increase in the provision of £1.3million.

Legal claims - each year we make a provision for potential costs related to ongoing legal cases. In 2021 we increased the provision to reflect potential additional costs that may arise following the outcome of an employment tribunal. The outcome is still outstanding in 2024, but may have implications for a wider group of individuals. Further details in relation to the ongoing case cannot be provided in order to avoid prejudicing proceedings.

	Dilapidations	Legal claims	Total
	£'000	**£'000**	**£'000**
Provisions at 1 January 2023	3,141	5,286	**8,427**
Provisions created during the year	1,333	1,422	**2,755**
Utilisation of provision	-	(20)	**(20)**
Amounts released from previous years	-	(719)	**(719)**
Provisions at 31 December 2023	**4,474**	**5,969**	**10,443**

12. Group fund movements in the year

Group and charity

	Unrestricted funds	Restricted funds	Pension fund	2023 Total
	£'000	**£'000**	**£'000**	**£'000**
At 1 January 2023	56,290	1,811	(3,248)	54,853
Net incoming/(outgoing) resources	7,814	311	(12,586)	(4,461)
At 31 December 2023	**64,104**	**2,122**	**(15,834)**	**50,392**

	Unrestricted funds	Restricted funds	Pension fund	2022 Total
	£'000	£'000	£'000	£'000
At 1 January 2022	62,381	856	36,561	99,798
Net incoming/(outgoing) resources	(6,091)	955	(39,809)	(44,945)
At 31 December 2022	**56,290**	**1,811**	**(3,248)**	**54,853**

13. Net assets by fund

Group and charity

Fund balances at 31 December 2023 are represented by

	Unrestricted funds	Restricted fixed asset funds	Pension reserve	2023 Total funds
	£'000	£'000	£'000	£'000
Intangible fixed assets	14,485	2,122	-	16,607
Tangible fixed assets	4,831	-	-	4,831
Investments	61,573	-	-	61,573
Current assets	85,558	-	-	85,558
Current liabilities	(91,900)	-	-	(91,900)
Provisions for liabilities and charges	(10,443)	-	-	(10,443)
Pension scheme liability	-	-	(15,834)	(15,834)
Total net assets	**64,104**	**2,122**	**(15,834)**	**50,392**

Fund balances at 31 December 2022

	Unrestricted funds	Restricted fixed asset funds	Pension reserve	2022 Total funds
	£'000	£'000	£'000	£'000
Intangible fixed assets	12,713	1,811	-	14,524
Tangible fixed assets	4,423	-	-	4,423
Investments	56,593	-	-	56,593
Current assets	78,169	-	-	78,169
Current liabilities	(87,181)	-	-	(87,181)
Provisions for liabilities and charges	(8,427)	-	-	(8,427)
Pension scheme liability	-	-	(3,248)	(3,248)
Total net assets	**56,290**	**1,811**	**(3,248)**	**54,853**

14. Capital commitments

Capital expenditure authorised and contracted but unspent at 31 December 2023 amounted to £340,679. The equivalent figure for 2022 was £799,978.

15. Operating lease commitments

	Land and buildings		Equipment	
	2023	2022	**2023**	2022
Expiry date	**£'000**	£'000	**£'000**	£'000
Within one year	**3,780**	4,580	**21**	48
In years two to five	**14,767**	5,158	**-**	-
After more than five years	**3,051**	1,443	**-**	-
	21,598	11,181	**21**	48

Commitments include our obligations under our buildings and equipment leases. They are calculated up to the first lease break clause or lease end where there is no break clause in the agreement. Commitments are calculated on a cash basis rather than incorporating rent-free benefits.

16. Superannuation schemes

The GMC has two staff pension schemes:

GMC Group Personal Pension Plan

This is a defined contribution pension scheme, which was set up on 1 July 2013. We started auto enrolment on 1 November 2013. At the end of 2023 there were 1,689 members of staff contributing to this scheme. It meets the government's requirements following the introduction of automatic enrolment. Individuals can choose to make additional contributions by deduction from salary to the scheme. Under the terms of FRS 102, contributions are accounted for as a defined contribution scheme based on actual contributions paid through the year.

GMC Staff Superannuation Scheme

This is a funded scheme of the defined benefit type, providing retirement benefits based on final salary. The top-up arrangement is an unfunded scheme.

This scheme was closed to new members on 30 June 2013, and replaced by the GMC Group Personal Pension Plan. The scheme was closed to future accruals, other than those linked to salary changes, for existing members on 31 March 2018; therefore at the end of 2018 there were no members of staff contributing to this scheme.

The FRS 102 valuation has been based on a full assessment of the liabilities for the scheme as at 31 December 2021. The present values of the defined benefit obligation, the related current service cost and any past service costs were measured using the projected unit credit method.

Actuarial gains and losses have been recognised in the period in which they occur (but outside the profit and loss account) through the Other Comprehensive Income.

The GMC recognises surplus in accordance with the requirements of FRS 102 Section 18. The trustees of the scheme do not have the unilateral right to commence wind-up of the scheme. Thus, the GMC assumes that the scheme continues in existence until the last benefit payments are made to members, at which point any residual assets are returned to the GMC in line with the rules of the scheme.

The GMC made a top-up payment to the scheme of £3.5million in 2023. A further £3.5million and £2.5million will be paid in 2024 and 2025 respectively before reverting to £1.5million until 2031 under the terms of the recovery plan agreed as part of the 2021 triennial valuation.

Responsibility for investing pension scheme assets rests with pension trustees. The Pensions Act 1995 requires trustees to draw up a Statement of Investment Principles, setting out the scheme's investment strategy. Pension trustees are required to consult the employer (GMC) when drawing up the strategy, but do not require the employer's formal agreement. Following consultation with the GMC, in 2014 the pension trustees adopted a fiduciary management approach to the investment of the scheme's assets.

The principal assumptions used by the independent qualified actuaries to calculate the liabilities under FRS 102 are set out below.

Main financial assumptions

	31 December 2023	31 December 2022
	%pa	%pa
Retail prices index inflation	2.9	3.1
Consumer price index inflation	2.6	2.7
Rate of general long-term increase in salaries	3.6	3.7
Pension increases (excess over guaranteed minimum pension)	2.6	2.7
Discount rate for scheme liabilities	4.4	4.6

Mortality assumptions

The mortality assumptions are based on standard mortality tables which allow for expected future mortality improvements. The assumptions are that a member currently aged 65 will live on average for a further 21.9 years (2022: 22.2 years) if they are male and for a further 23.9 years if they are female (2022: 24.1 years).

For a member who retires in 2043 at age 65 the assumptions are that they will live on average for a further 23.0 years after retirement if they are male and for a further 25.0 years after retirement if they are female.

Scheme asset allocation

	31 December 2023		31 December 2022	
	£'000	**%**	£'000	%
Delegated consulting services	**149,947**	**100%**	155,728	99%
Other	**52**	**-**	1,256	1%
Total	**149,999**	**100%**	156,984	100%

The Delegated Consulting Service is a fiduciary management solution that invests in a wide range of underlying assets in order to meet the scheme's specific investment objectives. The underlying asset allocation changes over time, based on the views of the fiduciary manager within the overall bounds set by the trustees. Under this approach the majority of scheme assets are invested in pooled funds. The managers of the pooled funds are required to have in place a policy on social, environmental and ethical considerations.

None of the scheme assets are invested in the company's financial instruments or in property occupied by, or other assets used by, the GMC.

Reconciliation of funded status to balance sheet

	31 December 2023	31 December 2022
	£'000	£'000
Fair value of assets	**149,999**	156,984
Present value of funded defined benefit obligations	**(164,982)**	(159,407)
Funded status	**(14,983)**	(2,423)
Present value of unfunded defined benefit obligation	**(851)**	(825)
Asset/(liability) recognised on the balance sheet	**(15,834)**	(3,248)

Amounts recognised in income statement

	31 December 2023	31 December 2022
	£'000	£'000
Operating cost		
Current service cost	-	-
Past service cost	-	100
Financing cost		
Interest on net defined benefit liability	**53**	(714)
Pension income recognised in profit and loss	**53**	(614)

Amounts recognised in Other Comprehensive Income

	31 December 2023	31 December 2022
	£'000	£'000
Asset (losses)/gains arising during the year	**(10,536)**	(175,762)
Liability gains/(losses) arising during the year	**(5,564)**	133,977
Actuarial (loss)/gain on defined benefit pension scheme	**(16,100)**	(41,785)

Changes to the present value of the defined benefit obligation during the year

	31 December 2023	31 December 2022
	£'000	£'000
Opening defined benefit obligation (DBO)	**160,232**	292,995
Interest expense on DBO	**7,208**	5,525
Actuarial (gains)/losses on liabilities	**5,564**	(133,977)
Net benefits paid out	**(7,171)**	(4,411)
Past service cost	**-**	100
Closing defined benefit obligation	**165,833**	160,232

Changes to the fair value of scheme assets during the year

	31 December 2023	31 December 2022
	£'000	£'000
Opening fair value of scheme assets	**156,984**	329,556
Interest income on scheme assets	**7,155**	6,239
(Loss) on scheme assets	**(10,536)**	(175,762)
Contributions made by the company	**3,567**	1,362
Net benefits paid out	**(7,171)**	(4,411)
Closing fair value of scheme assets	**149,999**	156,984

Actual return on scheme assets

	31 December 2023	31 December 2022
	£'000	£'000
Interest income on scheme assets	**7,155**	6,239
Gain/(loss) on scheme assets	**(10,536)**	(175,762)
Actual return on scheme assets	**(3,381)**	(169,523)

17. Honoraria

	2023	2022
	£	£
Trustees		
Professor Dame Carrie MacEwen (Chair)*	110,000	97,083
Mr Steve Burnett	18,000	18,000
Dr Vanessa Davies	18,000	18,000
Professor Anthony Harnden	18,000	18,000
Lord Philip Hunt	18,000	18,000
Professor Paul Knight	18,000	18,000
Professor Deepa Mann-Kler	18,000	18,000
Dr Rajesh Patel	18,000	18,000
Professor Suzanne Shale	18,000	18,000
Miss Alison Wright	18,000	18,000
Dr Jeeves Wijesuriya†	12,000	-
Mr Douglas Millican†	12,000	-

* Appointed Chair from May 2022.

† Appointed as Council Member May 2023.

Honoraria payments are permitted by the governing document GMC, the *Medical Act 1983*, paragraph 17, schedule 1.

Medical Practitioners Tribunal Service Committee members	2023	2022
Dame Caroline Swift*	-	97,657
Ms Gill Edelman (Gillian Gordon)	3,720	3,720
Mrs Joy Hamilton	3,720	3,720
Professor Jacky Hayden	7,440	7,440
Dr Simon Mackenzie†	3,720	1,113
Dr Tushar Vince *	-	1,166
Her Honour Judge Deborah Taylor‡	98,456	-

* Demitted as MPTS Committee member 2022.

† Appointed as MPTS Committee member 2022.

‡ Appointed as Chair of MPTS Committee March 2023.

Audit and Risk Committee co-opted members	2023	2022
Ms Aneen Blackmore*	-	-
Mr Jon Hayes	3,752	3,255
Mr Kenneth Gill†	930	4,030

* Appointed as ARC Committee member October 2023.

† Demitted as ARC Committee member March 2023.

Investment Committee co-opted members	2023	2022
Mr Keith Mackay	2,688	2,945
Mr Michael Jennings	2,086	2,480

GMC Services International Ltd	2023	2022
Dr Andrew McCulloch	318	310

18. Travel and subsistence expenses claimed in 2023

	2023	2022
	£	£
Trustees		
Professor Dame Carrie MacEwen (Chair)*	4,661	1,812
Mr Steve Burnett	3,259	2,840
Dr Vanessa Davies	3,733	1,395
Professor Anthony Harnden	1,323	555
Lord Philip Hunt	952	383
Professor Paul Knight	3,419	3,127
Professor Deepa Mann-Kler	3,773	5,133
Dr Rajesh Patel	2,837	1,631
Professor Suzanne Shale	510	431
Miss Alison Wright	628	-
Dr Jeeves Wijesuriya†	1,706	-
Mr Douglas Millican†	1,421	-

* Appointed Chair from May 2022.

† Appointed as Council Member May 2023.

Medical Practitioners Tribunal Service Committee members	2023	2022
Dame Caroline Swift*	-	25
Mrs Gill Edelman (Gillian Gordon)	724	-
Mrs Joy Hamilton	1,107	-
Professor Jacky Hayden	774	508
Dr Simon Mackenzie†	683	328
Dr Tushar Vince*	-	-
Her Honour Judge Deborah Taylor‡	81	-

* Demitted as MPTS Committee member 2022.

† Appointed as MPTS Committee member 2022.

‡ Appointed as Chair of MPTS Committee March 2023.

Audit and Risk Committee co-opted members	2023	2022
Ms Aneen Blackmore*	-	-
Mr Jon Hayes	519	278
Mr Kenneth Gill†	29	522

* Appointed as ARC Committee member October 2023.

† Demitted as ARC Committee member March 2023.

Investment Committee co-opted members	2023	2022
Mr Keith Mackay	-	56
Mr Michael Jennings	21	127

GMC Services International Ltd	2023	2022
Dr Andrew McCulloch	-	-

	2023	2022
Senior management team		
Mr Charlie Massey - Chief Executive	6,521	4,903
Mr Shaun Gallagher - Director of Strategy and Policy	4,074	3,982
Mrs Una Lane - Director of Registration and Revalidation	5,101	2,603
Dr Colin Melville - Medical Director and Director of Education and Standards	5,648	3,906
Mr Anthony Omo - General Counsel and Director of Fitness to Practise	3,691	3,769
Mr Paul Reynolds - Director of Strategic Communications and Engagement	416	3,697
Mr Neil Roberts - Director of Resources	9,969	7,491

Variations in expenses reflect that the trustees, committee members and the senior management team live in different parts of the UK and are required to travel around the UK on GMC business, including to our offices in London, Manchester, Edinburgh, Belfast and Cardiff, and occasionally outside the UK.

Adjustments are also made for those with disabilities, which may mean that additional expenses are incurred for travel and accommodation according to specific needs.

Reference and administrative information

We are independent of the UK Government and of those we regulate, and are accountable to Parliament. Our powers are given to us by Parliament through the Medical Act 1983.

We are registered with the Charity Commission for England and Wales (1089278), and with the Office of the Scottish Charity Regulator (SC037750). We are not currently required to be registered separately with the Northern Ireland Charity Commission.

Our principal places of business are 3 Hardman Street, Manchester M3 3AW and Regent's Place, 350 Euston Road, London NW1 3JN. We also have offices in Belfast, Cardiff and Edinburgh; a centre for hearings, where the Medical Practitioners Tribunal Service is based, at St James's Buildings, 79 Oxford Street, Manchester M1 6FQ; and a Clinical Assessment Centre, in 3 Hardman Square, Manchester M3 3EB.

Our trustees have a duty to act impartially and objectively, and to take steps to avoid any conflict of interest arising as a result of their membership of, or association with, other organisations or individuals. As trustees, members have a duty to avoid putting themselves in a position where their personal interests conflict with their duty to act in the interests of the charity, unless authorised to do so. To make this fully transparent, we publish a register of members' interests on our website.

Day-to-day management of the organisation is delegated to the Chief Executive, Charlie Massey. You can read more about our governance and management arrangements earlier in this report.

We work with the Professional Standards Authority (PSA), an independent body, which is accountable to Parliament and scrutinises and oversees our work, together with other health and social care professional regulatory bodies in the UK.

Information requests

In 2023, we received 450 requests for personal information under the UK General Data Protection Regulation (GDPR). This was an increase of 10.6% from 2022. We also received 845 information requests under the Freedom of Information Act in 2023, up 3% from 2022.

We achieved 78% against our target to respond to 80% of personal information requests within the statutory timeframe. For Freedom of Information requests, we achieved 85.2% against our target of responding to 90% within 20 working days.

Our registration reference with the Information Commissioner's Office is Z7423389.

Paying for goods and services

We paid 96% of valid and undisputed invoices within 30 days and did not pay any interest to suppliers due to late payment in excess of 30 days.

Professional advisers

Bankers	Royal Bank of Scotland 250 Bishopsgate London EC2M 4AA
Investment adviser	Mercer Limited 1 Tower Place West Tower Place London EC3R 5BU
Solicitors	The majority of our legal work is carried out by our in-house legal team.
Auditors	Crowe U.K. LLP 2nd Floor, 55 Ludgate Hill London EC4M 7JW
Actuary and pension scheme adviser	Aon Parkside House, Ashley Road Epsom Surrey KT18 5BS

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General Medical Council, 3 Hardman Street, Manchester M3 3AW

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To ask for this publication in another format or language, please call us on **0161 923 6602** or email us at **gmc@gmc-uk.org**.

I ofyn am y cyhoeddiad hwn mewn fformat neu iaith arall, ffoniwch ni ar **0161 923 6602** neu e-bostiwch ni ar **gmc@gmc-uk.org**.

You are welcome to contact us in Welsh. We will respond in Welsh, without this causing additional delay.

Mae croeso i chi gysylltu â ni yn Gymraeg. Byddwn yn ymateb yn Gymraeg, heb i hyn achosi oedi ychwanegol.

Published July 2024
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GENERAL MEDICAL COUNCIL

England & Wales - Charity number 1089278

Accounts

General Medical Council

Annual Report 2022

Trustees' annual report and accounts for the year ended 31 December 2022

General Medical Council

General Medical Council

Annual Report 2022

Trustees' annual report and accounts for the year ended 31 December 2022

Presented to Parliament pursuant to section 52A of the Medical Act 1983 as amended by The Health Care and Associated Professions (Miscellaneous Amendments) Order 2008 (SI No.1774).

General Medical Council









Our annual report

2022

General
Medical
Council

About this report

Our trustees present this report and financial statement for the year ending 31 December 2022.

They confirm they have taken into account the Charity Commission's public benefit guidance when reviewing our aims and objectives and have had regard to this guidance when exercising any powers or duties or when making a decision to which the guidance is relevant. The trustees are satisfied that at all times we have operated for public benefit and that the activities as described in this report and accounts fully meet the public benefit requirements and support our charitable purpose.



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This report is also available in Welsh, at:
www.gmc-uk.org/about/how-we-work/corporate-strategy-plans-and-impact/annual-reports

Foreword

2022 was once again a story of sustained pressure on the health service and those who use and staff it. Healthcare professionals continued to deliver outstanding care despite difficult circumstances. But as the echoes of the pandemic continued to reverberate, longer-term trends around wellbeing and workloads compounded existing challenges. While patients endured long waits for diagnosis and treatment, doctors across all groups cited burnout, stress and patient safety issues as reasons for leaving the profession.

The environment in which a doctor works correlates directly to the quality of care they can provide. Considerable evidence tells us that enabling practitioners to perform to the highest standards is at the root of good patient outcomes. That's why promoting positive workplace cultures and the provision of meaningful support for all doctors continued to be central to our work in 2022.

Fostering environments where doctors feel valued and listened to has become particularly important as increasing numbers have reported job dissatisfaction and taking active steps to leave the NHS, or the profession entirely. We are working closely with local employers and national partners to foster compassionate and inclusive leadership so that doctors feel they belong and can thrive.

The composition of the medical register continues to grow and evolve. There are more doctors on the register than ever before with a broad mix of ethnic groups. The gender split is now almost equal across all four home nations. Within this more diverse profession, flexible attitudes to training and deployment are essential. Recognising individual needs will not only enable each member of the workforce to provide their maximum contribution, but will also help retain the experienced professionals we have, which is crucial for safe patient care.

Of the doctors who joined the workforce in 2021, over half were international medical graduates (IMGs) compared to only 39% for UK graduates. Ensuring that doctors new to the UK, navigating a different society and health system, feel supported and included is vital, both for them and the care they provide. Yet many find their development and performance undermined by discrimination and disadvantage in day-to-day practice. 2022 saw us ramp up our efforts to improve ethnic minority doctors' experiences of medicine, including maintaining momentum on our targets to eliminate differential attainment in medical education and training by 2031 and disproportionality in fitness to practise referrals by 2026.

The rise in IMG numbers has been accompanied by a rapid and significant increase in those who hold specialty and associate specialist (SAS) and locally employed (LE) posts. Previously a welcome, but small part of the workforce, SAS and LE doctors are now a major contributor. Our work to improve the CESR route was welcomed by this cohort, as were our efforts to widen opportunities for SAS doctors, for example in primary care.

Throughout the year, our outreach teams continued to work across the four nations to address local concerns; be it coordinating with partners to roll out our free *Welcome to UK Practice* induction programme for IMGs, working with responsible officers (ROs) to improve support for locum doctors or helping put our data into practice to target interventions.

Our performance as a regulator is vital to secure the trust of the public and those whom we regulate. We were pleased to meet all standards set by our regulator, the Professional Standards Authority (PSA), this year, and every year since they were introduced.

However, we are not complacent. To be the most effective, compassionate regulator we can be, we need to constantly review our processes and their impact on the profession and the public. In 2022, we continued to push for reform to the legislation that governs how we work. Because of the current legal framework, we find ourselves spending a disproportionate amount of our time and resources investigating doctors. Our ambition is to transform the way we regulate, and we are reassured that the UK government has committed to updating legislation as a top priority. We believe these changes will play an important role in addressing wider workforce challenges.

While this is undoubtedly a challenging time for the health service, we continue to see pioneering work programmes and examples of best practice. Done right, these initiatives make a tangible difference, with each small improvement adding up to significant change, both to doctors and those they treat.

Our ability to drive forward progress and deliver high quality care rests on the continued collaboration of all those who make up the health system, including the patients we serve. This past year saw us strengthen this partnership across the four nations, and we look forward to working closely with colleagues again in the year ahead.





Charlie Massey
Chief Executive





Professor Dame Carrie MacEwen
Chair

Our role in the UK's healthcare systems

We are the UK's independent regulator of doctors. Our role is to protect the health, safety, and well-being of patients and the public. We do this by:

- promoting and maintaining professional standards for doctors
- overseeing UK medical education and training
- taking action when the safety of patients or the public's confidence in doctors is at risk.

How we keep patients safe

Keeping patients safe and protecting public confidence in doctors is at the core of our work.

- We set the standards for doctors. Our standards define what makes a good doctor. They set out the professional values, knowledge, skills, and behaviours required of all doctors working in the UK. To develop our standards and guidance, we consult with patients, doctors, employers, and educators.
- We oversee all stages of doctors' undergraduate and postgraduate education and training in the UK. We make sure doctors get the education and training they need to deliver high-quality care throughout their careers. We do this by setting out the outcomes needed for graduates and by approving curricula for postgraduate education. We also monitor training environments to support safe, effective learning.
- We manage the UK medical register. We check doctors' qualifications before they join the register. When necessary, we check their skills. We also check with medical schools or previous employers to find out if they have any concerns about a doctor's ability to practise safely.
- We make sure doctors keep their knowledge and skills up to date. We do this through revalidation, a system that checks that all doctors have an annual appraisal and that they are following the standards we set. Revalidation is a fundamental part of effective clinical governance, which we support also through the advice our outreach teams provide to responsible officers (ROs) on the frontline. The process gives patients and the public assurance that doctors in the UK are part of a governed system. It also supports the identification and management of concerns at an early stage.
- We investigate and act on concerns about doctors. When someone raises a concern about a doctor with us, we assess whether it meets our threshold for investigation. If it does, we investigate. At the end of the investigation, we decide what action we need to take. This can include taking no action, issuing advice or a warning, restricting the doctor's practice, or agreeing with them and their employer that they will retrain, or work under supervision. In some situations, we refer the case to the Medical Practitioners Tribunal Service (MPTS). The MPTS runs tribunal hearings that make decisions about whether doctors are fit to practise medicine. It is accountable to the GMC Council and to the UK Parliament, but operates separately from the investigatory role of the GMC, and its tribunal hearings are fully independent in their decision making. It produces its own separate annual report.

Our performance

Every year our performance as a regulator is assessed by the Professional Standards Authority (PSA). It is measured across our four core functions: education and training; registration; guidance and standards; and fitness to practise.

The PSA's latest annual assessment confirmed that we successfully met all 18 of its Standards of Good Regulation in 2021 - 2022. We are proud to have met all 18 standards set by the PSA since they were introduced in 2012. It means we are performing to a high standard as a regulator, and reflects the commitment we make in our work to standards such as:

- transparency
- public protection
- timeliness
- equality, diversity, and inclusion.

General standards

5 out of **5**

Guidance and standards

2 out of **2**

Education and training

2 out of **2**

Registration

4 out of **4**

Fitness to practise

5 out of **5**

Total standards met

18 out of **18**

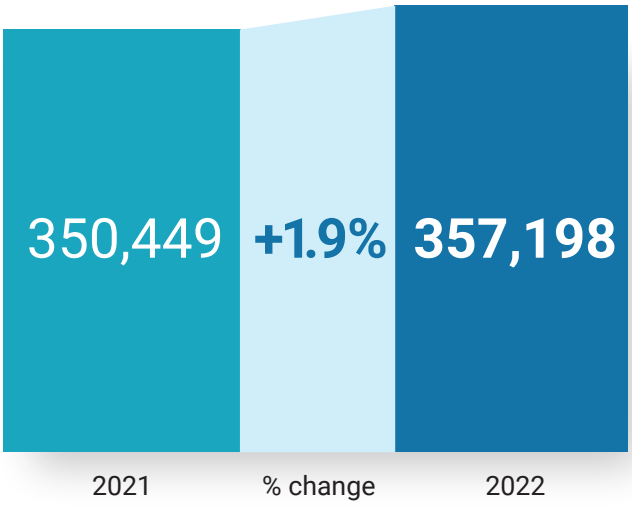
2022 at a glance



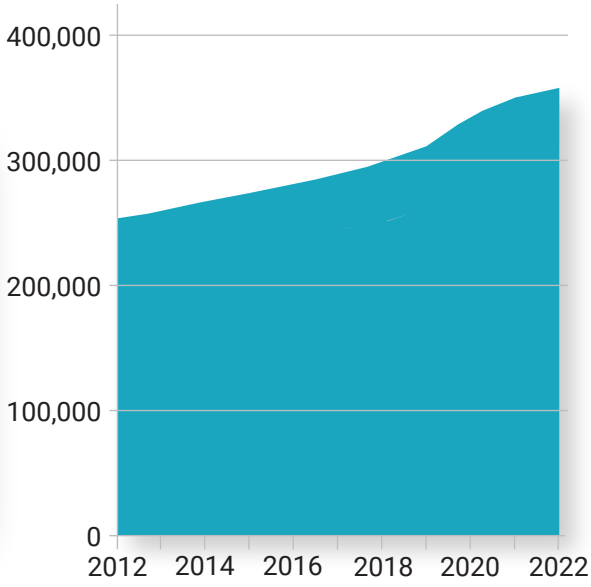
The medical register

All figures as of 31 December 2022 and 2021 respectively, unless otherwise specified.
Visit GMC Data explorer to learn more about doctors' education and practice in the UK.

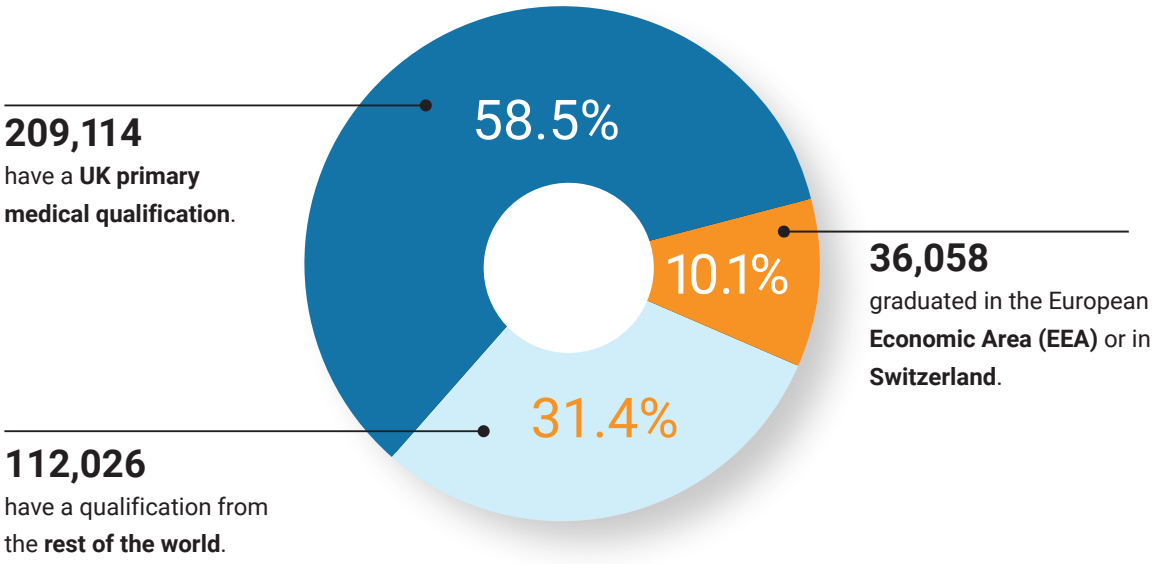
Total doctors on the register



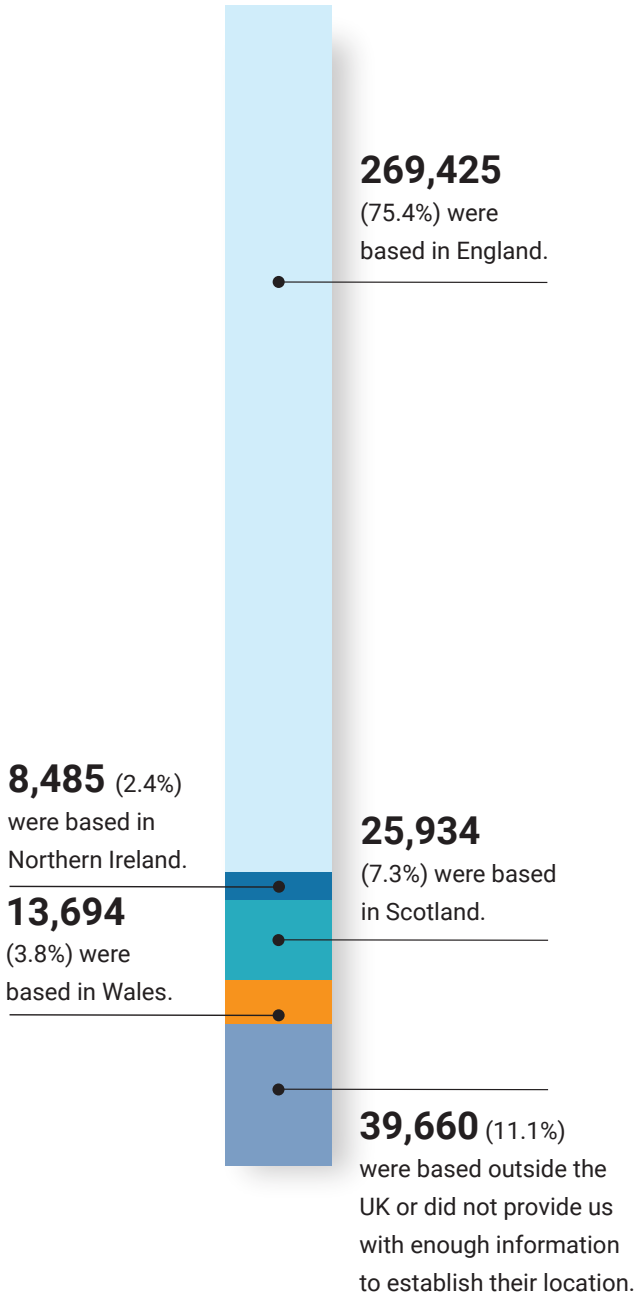
Growth in registered doctors 2012–2022



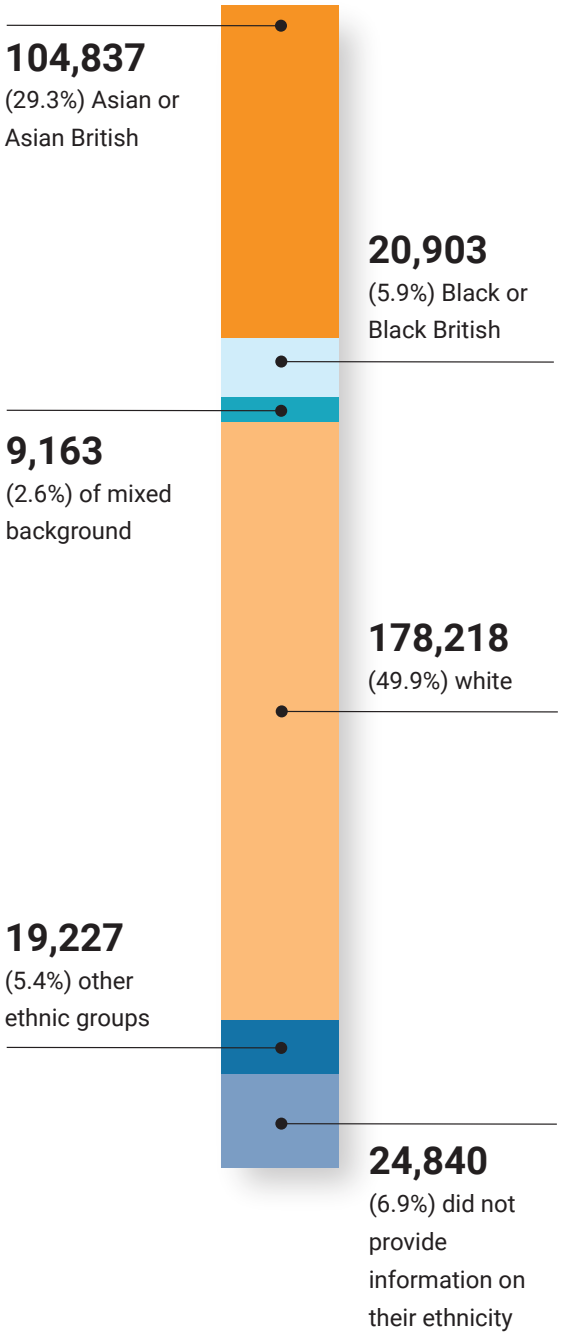
Where they graduated



Doctors on the register by location*



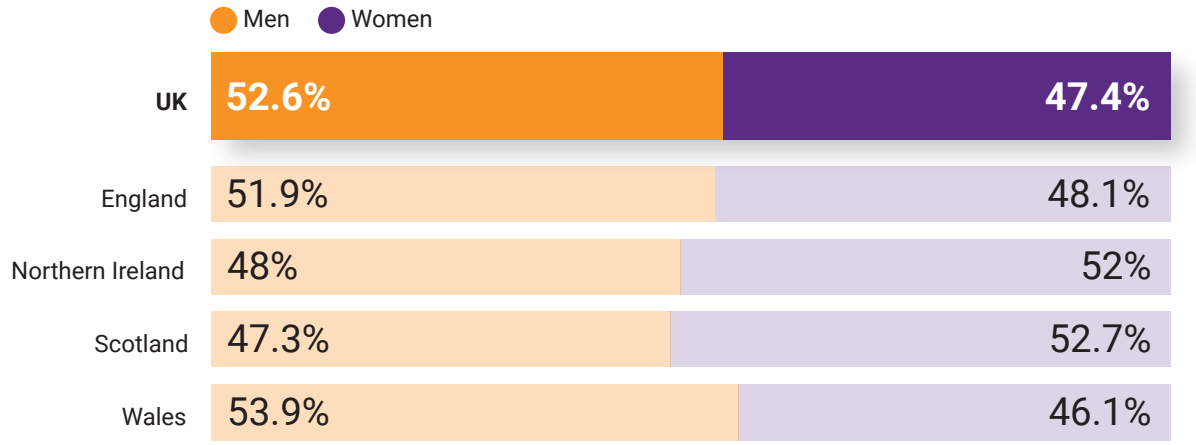
Doctors on the register by ethnicity



* The derived location of registered doctors is calculated using the following hierarchy:
1. where they work based on NHS practice history data
2. their training location based on the National training survey
3. the location of their designated body
4. their registered address.

Registered doctors located in the Channel Islands and the Isle of Man are included in the figures referring to England.

Doctors on the register by gender



Total doctors on the GP Register

78,619

Down **1.3%** from 2021 (**79,685**)

63,267 (80.5%) were residing in **England**.
2,268 (2.9%) were residing in **Northern Ireland**.
7,419 (9.4%) were residing in **Scotland**.
3,313 (4.2%) were residing in **Wales**.
2,352 (3%) either were located **outside the UK** or did not provide us with enough information to establish their location.

Total doctors on the Specialist Register

107,327

Up **0.3%** from 2021 (**107,009**)

81,472 (76%) were residing in **England**.
2,610 (2.4%) were residing in **Northern Ireland**.
8,289 (7.7%) were residing in **Scotland**.
4,104 (3.8%) were residing in **Wales**.
10,852 (10.1%) either were located **outside the UK** or did not provide us with enough information to establish their location.

In 2022, we granted:

21,255

applications for first entry to the register.

That is up

6.4% ↑

from 2021 (**19,977**).

7,819
(36.8%) were from doctors with a **UK PMQ**.

2,033
(9.6%) were from doctors who graduated in the **EEA** or in **Switzerland**.

11,403
(53.6%) were from doctors with a qualification from **the rest of the world**.



3,309

applications to join the GP Register.

That is down

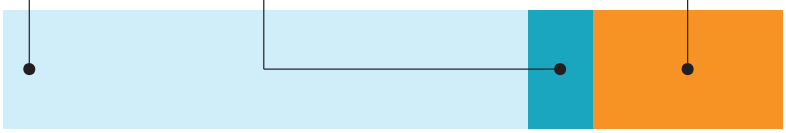
0.5% ↓

from 2021 (**3,326**).

2,186
(66%) were from doctors with a **UK PMQ**.

174
(5.3%) were from doctors who graduated in the **EEA** or in **Switzerland**.

949
(28.7%) were from doctors with a qualification from **the rest of the world**.



4,799

applications to join the Specialist Register.

That is up

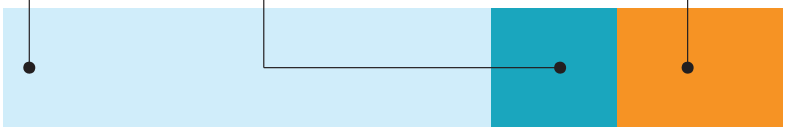
4% ↑

from 2021 (**4,613**).

3,146
(65.6%) were from doctors with a **UK PMQ**.

563
(11.7%) were from doctors who graduated in the **EEA** or in **Switzerland**.

1,090
(22.7%) were from doctors with a qualification from **the rest of the world**.



Professional and linguistic assessments board (PLAB)

Doctors who graduate outside the UK, the EEA, or Switzerland usually need to take our Professional and Linguistic Assessments Board (PLAB) test in order to join the UK medical register.* The test is taken in two parts (PLAB 1, delivered in assessment centres around the world, and PLAB 2, undertaken in one of our testing centres in Manchester).

PLAB 1

14,470

candidates took PLAB 1 in 2022, a 38.7% increase on 2021 (**10,431**).

10,259 (70.9%) passed the exam.

PLAB 2

13,533

candidates taking PLAB 2 in 2022, a 56.5% increase on 2021 (**8,648**).

8,775 (64.8%) passed the exam.

* Exceptions to this include international medical graduates joining the register based on being sponsored by healthcare organisations, or based on postgraduate qualifications. In both these cases, doctors must still provide evidence of their competence and skills. For more information on the different routes to join the register, see www.gmc-uk.org/registration-and-licensing/join-the-register/before-you-apply/evidence-to-support-your-application.

Setting and maintaining standards

Revalidation

Every licensed doctor who practises medicine in the UK must prove they are meeting our standards every five years through a process called revalidation. Revalidation supports doctors to develop their practice, drives improvements in clinical governance, and gives patients confidence that doctors are fit to practise.

In 2022 we received

50,462

recommendations for revalidation.

Depending on where they work, single doctors can receive more than one recommendation.

42,164 of the recommendations were submitted by designated bodies located in **England**.

1,532 were submitted by designated bodies located in **Northern Ireland**.

4,286 were submitted by designated bodies located in **Scotland**.

2,257 were submitted by designated bodies located in **Wales**.*

40,568

doctors were revalidated in 2022.

33,696 were located in **England**.

1,172 were located in **Northern Ireland**.

3,513 were located in **Scotland**.

1,743 were located in **Wales**.

444 either were based **outside the UK** or did not provide us with enough information to establish their location.

We made decisions on

96.2%

of the total recommendations we received in 2022 **within 5 working days** from when we received them, **exceeding our target of 95%.**

9,082 We approved **deferral of revalidation submission dates** for 9,082 doctors.

841 We **withdrew the licences** of 841 doctors on our register through failure to revalidate.†

* The remaining 145 are not associated to a specific location as they are the result of administrative processes necessary to consolidate data.

† If a doctor does not fulfil the requirements of revalidation, provides fraudulent information, or fails to provide reasonably requested evidence, we can legally withdraw their licence. This process is different to that of being removed from the register, for example, following an MPTS hearing.

Outreach

Our outreach teams delivered training on our standards to:

22,210 **doctors** in **829 sessions** and

That is up **31%** from 2021 (16,974).

12,205 **medical students** in **109 sessions** across the UK.

That is up **49%** from 2021 (8,218).

93% of the doctors and **98%** of the students who evaluated one of our outreach workshops across the UK said **their knowledge of the GMC's role and standards improved**.

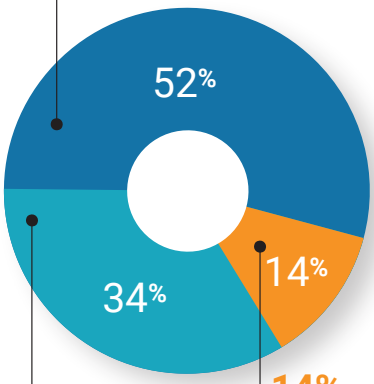
84% of the doctors and **94%** of the students who evaluated a session across the UK said **it had improved their impression of the GMC**.

Our standards enquiry team answered:

440 enquiries about our guidance.

That is down **28.6%** from 2021 (**616**).

Around **52%** of the enquiries were **from doctors** (2021: 54%)



34% from **members of the public** (2021: 34%)

14% **were from others,** including staff from professional organisations, students and the police (2021: 12%).

Our outreach teams also deliver workshops aimed at helping doctors who are **new to UK practice** adjust to working in the UK's healthcare systems.

The team delivered **251** ***Welcome to UK practice*** **workshops** in 2022, involving **8,829 doctors** – up **36%** from 2021 (**6,471**).

Our employer liaison advisers held **1,313** meetings with responsible officers.

They also provided fitness to practise advice in relation to **2,467** doctors.

Overseeing medical education and training

Quality assurance

We regulate all stages of a doctor's undergraduate and postgraduate education and training in the UK. We set standards and expected outcomes, and we carry out quality assurance (QA) work to make sure standards are maintained.

Our proactive quality assurance processes promote and encourage local management of concerns about the quality and safety of undergraduate medical education and postgraduate training. Our enhanced monitoring process helps to address serious concerns where additional support is required.

In 2022 we carried out **258** education QA visits.

That is up **24%** from 2021 (**208**).

203 of the visits were in **England**.
8 of the visits were in **Northern Ireland**.
33 of the visits were in **Scotland**.
14 of the visits were in **Wales**.

209 were **QA visits to new medical schools, established medical schools, or clinical environments** where medical education and training take place.

49 were **enhanced monitoring visits**, aimed at promoting the resolution of concerns about the quality of postgraduate training locally.

From our QA visits, we found:

27 areas of **good practice or working well**.
19 areas where our **standards were met**, but where we **identified improvements** that could be made.
4 areas that **required improvement**.*

As a result of our enhanced monitoring visits:

12 cases relating to postgraduate education **were escalated to our enhanced monitoring process**.
8 **enhanced monitoring cases** escalated previously **were resolved**.

We also run a reactive quality reporting system, through which emerging issues affecting education and training environments can be raised and monitored. The system allows medical schools and postgraduate training organisations to raise issues and provide updates on their resolution. If the issues are not resolved or worsen, cases can be escalated into our enhanced monitoring process.

* Not all QA visits lead to specific findings like those listed here – in some cases nothing of significance is found, as nothing has changed since the previous visit, or nothing has been found worthy of particular note (ie. education and training are working as expected).

Supporting the people we serve

In 2022, we received

1,916

complaints about our service.

This is a

1.7% ↑

increase on 2021 (**1,884**).

In 2022 our patient liaison service held 230 meetings with patients who had raised a concern with us.

92%	of those who responded to a survey after attending a patient liaison meeting were satisfied or very satisfied with the patient meeting experience.
97%	agreed or strongly agreed that patient liaison staff showed empathy for their situation.
95%	agreed or strongly agreed that they were satisfied that their concerns had been understood during the meeting.
95%	agreed or strongly agreed that the meetings helped them to understand what action the GMC could take.

Our contact centre answered

158,230

calls and

123,883

emails or letters.

77%

of the calls and emails we received were from doctors, and

23%

from members of the public and others.

The contact centre also handled

28,369

webchat sessions.



Investigating and acting on concerns

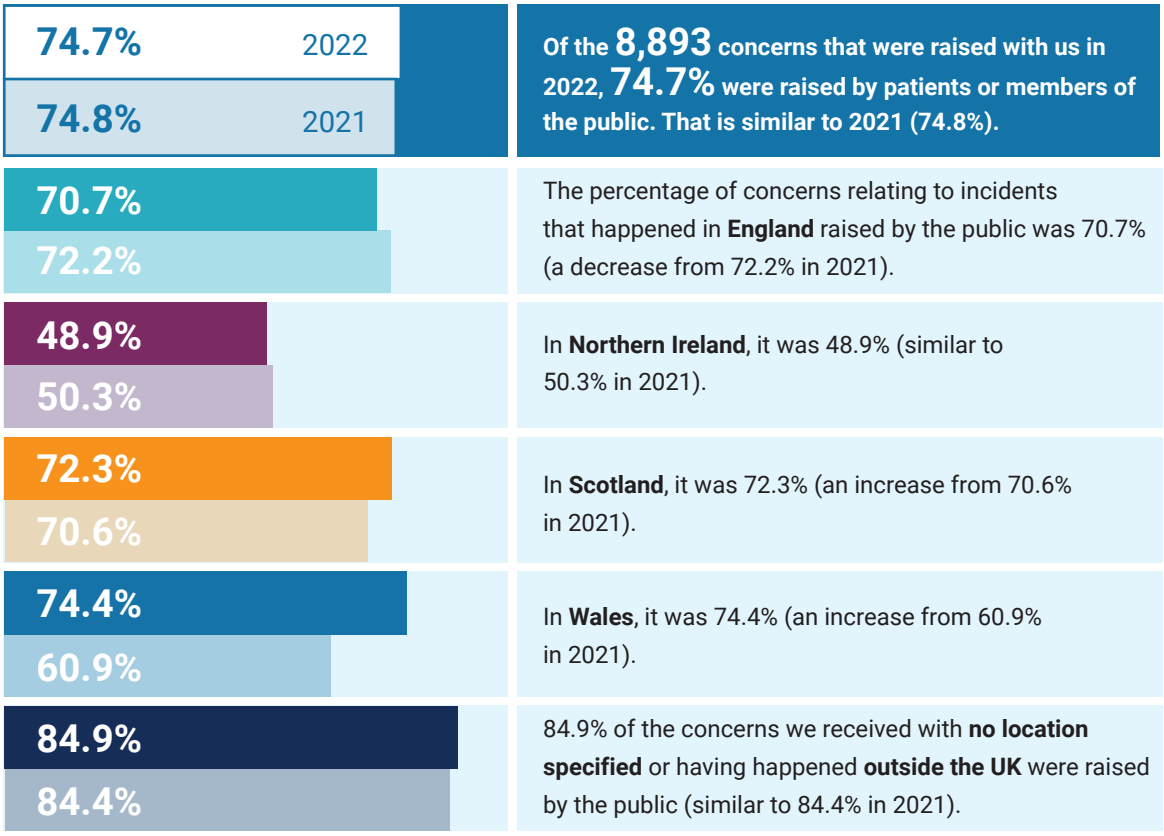
Concerns raised about registrants

8,893 **concerns were raised with us in 2022.**

This represents a **2%** decrease on 2021 (9,074 concerns).

62%	**62%** were raised in relation to incidents that happened **in England**. That is a lower percentage than in 2021 (62.7%).
2%	**2%** were raised in relation to incidents that happened **in Northern Ireland** – a similar percentage than in 2021 (2.2%).
5%	**5%** were raised in relation to incidents that happened **in Scotland** – a higher percentage than in 2021 (4.2%).
2%	**2%** were raised in relation to incidents that happened **in Wales** – a lower percentage than in 2021 (2.8%).
29%	For **29%** of them either there was **no incident location specified, or they happened outside the UK** – a higher percentage than in 2021 (28.2%).

Percentage of concerns raised by the public



Of the 8,893 concerns that were raised with us in 2022, 74.7% were raised by patients or members of the public. That is similar to 2021 (74.8%).

The percentage of concerns relating to incidents that happened in **England** raised by the public was 70.7% (a decrease from 72.2% in 2021).

In **Northern Ireland**, it was 48.9% (similar to 50.3% in 2021).

In **Scotland**, it was 72.3% (an increase from 70.6% in 2021).

In **Wales**, it was 74.4% (an increase from 60.9% in 2021).

84.9% of the concerns we received with **no location specified** or having happened **outside the UK** were raised by the public (similar to 84.4% in 2021).

Responding to concerns

Not all the concerns raised with us meet our threshold for an investigation. Sometimes a concern is best dealt with at a local level or by having a conversation with the doctor, or should be brought before another organisation. We only take action where we are concerned there may be a risk to patient safety or to public confidence in the medical profession.

In certain cases, we make provisional enquiries, where we look at information at an early stage of a case, aiming to provide swifter resolution for patients and the professionals involved. If the evidence shows there is no future risk to patients, and regulatory action is not required, we will not move to a full investigation. For cases where we have concerns about patient safety, we will carry out a full investigation.

Provisional enquiries

476

(**5.4%**) of the concerns we received in 2022 were **considered under provisional enquiry**.

→ That is the same percentage as 2021 (**5.4%**).

373

of these (**78.4%**) referred to concerns raised by **members of the public.**

→ That is a similar percentage to 2021 (**78%**).

In **396** cases (**83%**) we closed the provisional enquiry with **no action**.

In **63** cases (**13%**) we **progressed the case to investigation**.

In **17** cases (**4%**) the provisional enquiry was **still open** as of 20 March 2023.

Investigations opened in 2022

788

(**8.9%**) of the concerns we received in 2022 met our **statutory threshold for investigation**.

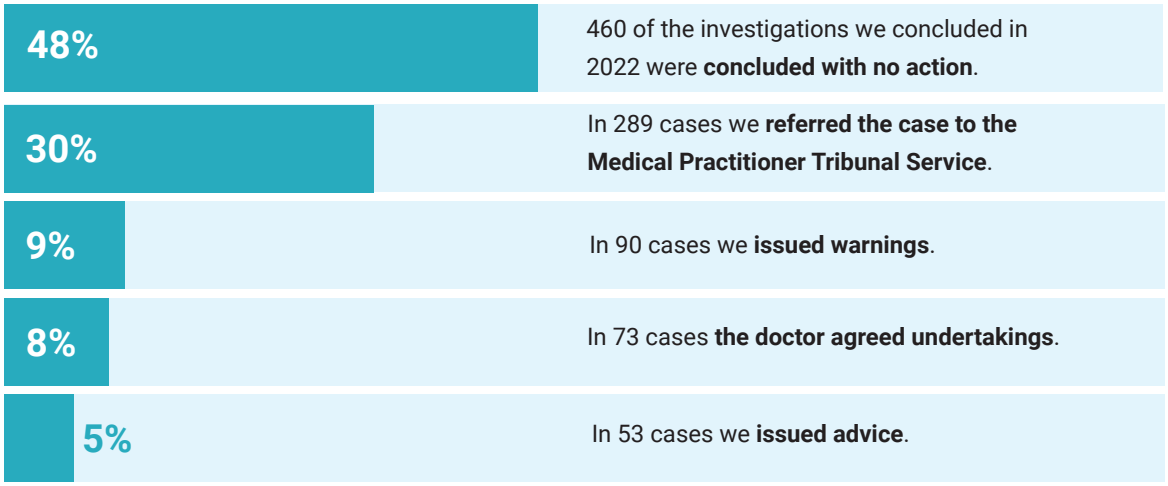
That is a lower percentage than in 2021 (**10.2%**).

174

(**22.1%**) of these referred to concerns raised by **members of the public**.

That is a lower percentage than in 2021 (**23.1%**).

Outcomes of investigations concluded in 2022



Outcomes of Medical Practitioners Tribunals Service tribunals

In 2022, the Medical Practitioners Tribunal Service held a total of 273 tribunals.

37%	In 101 cases, the tribunal **suspended** the doctor who had been referred to the tribunal.
24.9%	In 68 cases the doctor was **removed from the register**.
21.2%	In 58 cases the tribunal found **no impairment**.
7.7%	In 21 cases, while the tribunal found no impairment, it **issued a warning**.
6.6%	In 18 cases the doctor had **conditions put on their practice**.
1.5%	In 4 cases the doctor's practice was found to be impaired but **no further action was taken**.
0.7%	In 2 cases doctors **voluntarily removed themselves from the register**.
0.4%	In 1 case the doctor **agreed to undertakings**.

Where we do not agree with the decisions made by a medical practitioner tribunal, we can appeal them.

In 2022 we made **10** appeals. That is the same as 2021. **1** of the appeals we made was unsuccessful, while **9** of them were agreed by consent.

Delivering our strategy



Our strategy 2021–25

Four themes will shape all our work, helping us to achieve our ten-year vision.



What we'll do to achieve this

Together, we'll use these four themes to shape every aspect of our work, including:

- managing the UK medical register and revalidation
- setting standards for medical practice
- overseeing medical education and training
- investigating and acting on concerns.

How we'll work

Our values help us to make our strategy a reality.

- Equality
- Integrity
- Excellence
- Collaboration
- Fairness

Equality, diversity and inclusion are integral to all our work as a regulator and employer.

Where we want to be by 2030

Our vision is to be an effective, relevant and compassionate multiprofessional regulator for patients, the public and medical professionals, and as an employer.

In November 2020, we published our 2021–25 corporate strategy. As widely documented, the post-COVID challenges facing healthcare and the medical profession have been exceptional. Therefore, whilst the ambitions we originally set as part of our strategy remain relevant, we have carefully assessed how we can deliver against them, and we have deliberately targeted our resources at fewer strategic priorities and activities.

Equality, diversity and inclusion are integral to all our work as a regulator and employer, and this focus strengthened over 2022 as we learned lessons from the pandemic and other developments.

Progress in 2022

Our three-year business plan, which we review on a quarterly basis, summarises how we are targeting our resources at our high-impact activities.

Our recent ED&I: targets, progress, and priorities report describes progress in 2022 on our equality, diversity and inclusion targets as an employer and as a regulator. The report shows some encouraging progress, and there is evidence of significant activity taking place across the UK's healthcare systems to address disproportionalities, signalling the potential for long-term change. For example, the disproportionate pattern of fitness to practise referrals we receive from employers in relation to a doctor's ethnicity and place of qualification is on track to continue to reduce toward the targets we set. We can cautiously report that four out of the five education and training measures we identified as part of our targets also show some continued improvement - the exception being doctors' self-reported preparedness for their first foundation year post. And as an employer, we are on track to have 20% of our staff from an ethnic minority background by 2026 – but need to do further work on meeting our target for ethnic minority employees in management roles. We will continue to dedicate our efforts to supporting this work.

Throughout 2022, we also continued to work closely with the UK Government's Department of Health and Social Care on their proposed changes to the legislation that governs the way that we and other healthcare regulators operate. Regulatory reform will help us respond more quickly and flexibly to protect patients and support doctors. It is therefore vital to achieving our 2030 vision to be an effective, relevant and compassionate multi-professional regulator, as well as to delivering on our strategic theme around Making every interaction matter.

A review of regulatory fairness we conducted in 2022, and a review that considered a specific fitness to practise case, both concluded that compassion, support, and fairness are critical to effective regulation, both for our registrants and for patients. We accepted the recommendations of both reviews in full. We either started addressing them through existing programmes of work in 2022 or we are initiating new work to ensure we deliver all the recommendations across both reviews.

The challenges and uncertainties facing the UK's healthcare systems and the medical

profession also had a key role in shaping our priorities in connection with our *Enabling professionals to provide safe care* and *Developing a sustainable medical workforce* strategic themes. In relation to them, in 2022 we focused on priorities such as:

- successfully updating our registration processes to reflect the end of Brexit standstill arrangements
- working to support a legislative change allowing us to modify the application process for Certificates of Eligibility for Specialist or GP Registration so that doctors who are not in formal training roles can also apply
- consulting extensively on the review of our *Good medical practice* guidance. The guidance sets out the standards of patient care and professional behaviour expected of all medical professionals registered with us, and we wanted to make sure it's fit for future practice. In recognition of the enormous pressures doctors are under, we also updated the set of resources offered via the ethical hub on our website, to include a new question and answer section on how to apply our guidance in times of high service demand
- continuing to make progress on the development of the Medical Licensing Assessment (MLA) The MLA will test the core knowledge, skills and behaviours of doctors new to medical practice in the UK, strengthening our ability to monitor and approve the standard for entry to the medical profession over time. From 2024, the MLA will be introduced for doctors who graduated overseas. Students graduating from UK medical schools from the 2024-25 academic year onwards will also need to pass the new assessment, as part of their degree programme, before they can join the register
- making fairness more central to our work: following the regulatory fairness review conducted last year we're now developing an implementation plan to ensure fairness and transparency across all the high-impact regulatory decisions we make.

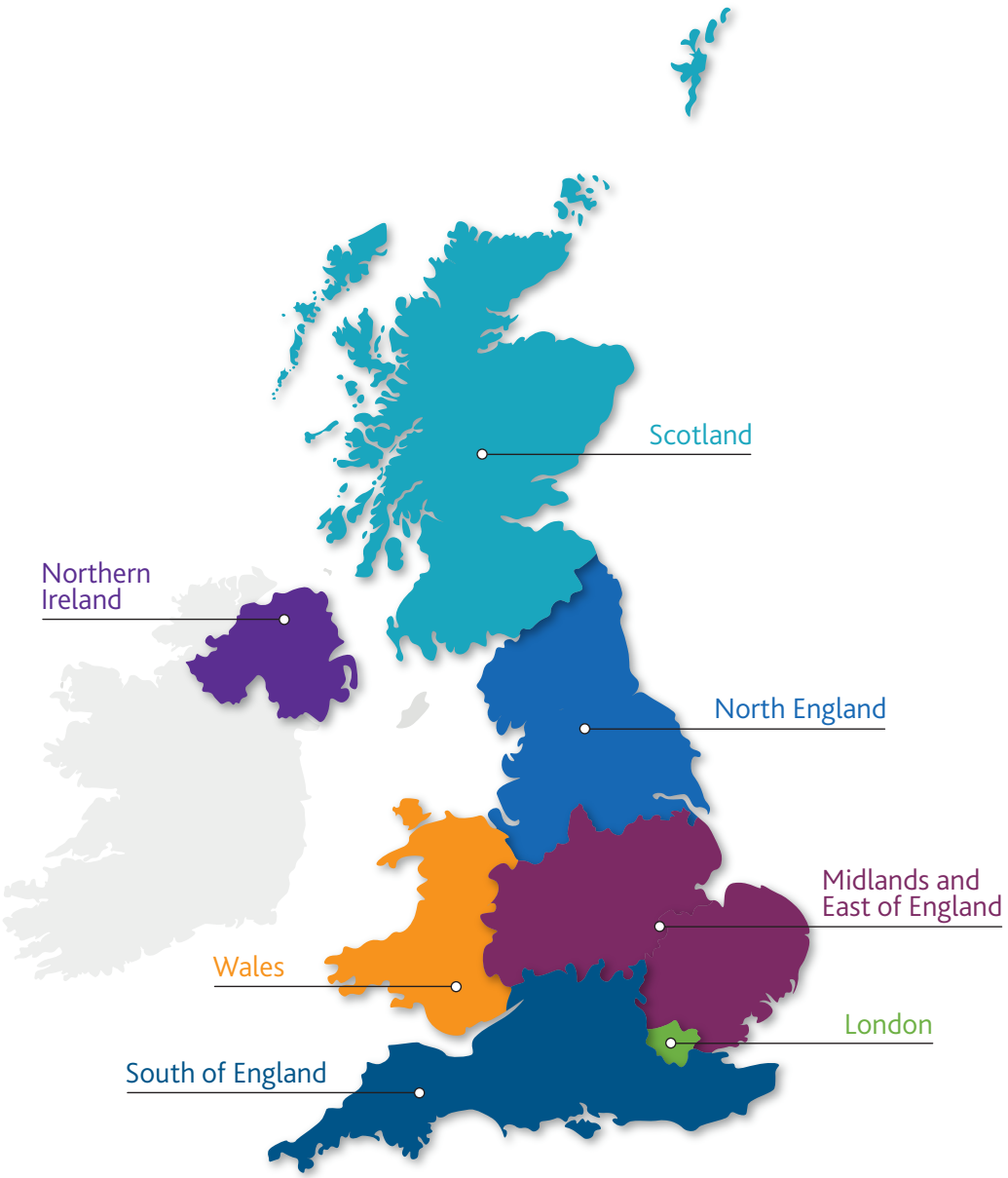
Alongside this, we have continued to develop and share data, research, and insights on medical education and practice to support the development of wider healthcare policies and plans across the UK. Our *2022 State of medical education and practice in the UK Workforce Report* highlighted the ongoing change in the shape of the medical workforce, including a 40% increase in the number of specialty and associate specialty (SAS) and locally employed (LE) doctors over the last 5 years, an increase in ethnic diversity, and a changing balance between international and UK recruitment. These findings have informed the wider policy debate, and have important implications for workforce planning.

We also made further progress on the *Investing in our people to deliver* theme of our strategy, focusing in particular on:

- delivering improvements to the diversity of our people
- working towards *Investors in People* Gold accreditation
- managing a smooth transition to hybrid office working.

Our plans for 2023 and beyond are summarised in our business plan, available on our website.

Highlights from across the UK



Highlights from across the UK

Our outreach teams engage directly with doctors, students, employers, educators, and other stakeholders in the UK's healthcare systems.

In England, the teams are organised to reflect the seven geographical NHS England regions: with the exception of London, each England Outreach team covers two NHS regions and the integrated care systems they oversee.

In Northern Ireland, Scotland and Wales the teams cover the entirety of the respective nation.

This approach ensures that each region or nation is separately considered, so that productive relationships and engagement happen at the right level, through teams of a manageable and effective size.

The teams provide:

- training on our standards and how to apply them
- information on our role
- information on the support we provide
- expert advice on clinical governance, culture, and leadership, as well as on specific issues or cases to responsible officers (ROs), clinicians in positions of leadership, and their employers.

In this section of the report, we take a tour around the UK to highlight some of the work the teams have done in collaboration with partners in 2022. Each highlight helps to demonstrate the breadth of our outreach work and the positive impact of targeted, timely frontline support. The examples also show the value of building strong relationships and sharing expertise, with the aim of promoting patient safety and improving work environments for doctors.









Supporting the induction of international medical graduates in England

There can be many differences between practising medicine in the UK and overseas, and it can be challenging for the increasing number of internationally-qualified doctors joining the UK medical workforce to adapt to different requirements and working in a new culture.

To address this, our outreach teams offer international medical graduates (IMGs) a number of workshops and sessions designed to help them settle in to their new roles in the UK's healthcare systems—including our *Welcome to UK practice* workshops. These half-day events provide doctors with information on the UK's healthcare systems, practical guidance on different ethical scenarios they may encounter, and networking opportunities.

Building on this, in England we have been working closely with partners to develop a comprehensive induction offer for IMGs, as well as for doctors returning to practice after a break. As part of this, we previously worked with Health Education England (HEE) to co-produce their *Career Refresh for Medicine* induction for returners. And since 2019, we have been working with NHS England's Medical Workforce Race Equality Standard team, the British Medical Association (BMA), the Medical Protection Society and HEE to develop *Welcoming and Valuing International Medical Graduates*, a new approach that sets minimum standards for IMG induction. The new induction package offers:

- a comprehensive welcome to the UK
- local orientation
- support with living in the UK, covering topics such as bank accounts, shopping, and accommodation
- an introduction to the NHS, and information on its computer systems.
- communication modules
- specific modules for medical specialties
- our *Welcome to UK practice* workshop.

Throughout 2022, we worked closely with our partners to pilot and evaluate the proposed induction programme and to produce a final version for launch. We also linked with healthcare leaders and collaborated with doctors' organisations to raise the profile of the initiative, making sure the need for this new approach was firmly on the national agenda.

The induction launched in June 2022, and we have received positive feedback on the difference it has made both from IMGs and from employers using the programme. Our ambition is that all employers in England and across the UK will roll this out to make sure the increasing cohorts of IMGs joining the medical workforce are welcomed and supported through their journey in UK practice.



South England

Getting it right for locum doctors

Locum doctors are key to enabling healthcare providers to manage service demands flexibly and effectively. Their number has been consistently growing across the UK.

Due to the nature of their role, locum doctors can face some unique challenges. As detailed in research we published in 2018, they have to quickly integrate into teams whose work practices and environment may be different to what they have previously experienced. Their induction may not always be as comprehensive as for other doctors, and as evidenced in our *Fair to Refer?* research, moving frequently to new teams can leave them feeling isolated or without support, and at disproportionate risk of referral.

In 2022, our South England outreach team made a number of targeted efforts to improve support for locums and their employers, including structured discussion with ROs and targeted engagement at RO network meetings.

Positive results from this work included:

- a medical leader from the Channel Islands creating an exit interview process for all locums, allowing organisations to gather insights about their experiences, give feedback about performance, and foster a culture of reflection and learning for all
- an RO from the home counties working with their medical staffing manager to develop a standard operating protocol for locums. The process aims to provide a better experience for locum doctors, helping them to work safely. For example, as part of the protocol, a formal induction checklist must now be completed before an agency locum is appointed, providing assurance from the relevant service manager that appropriate measures will be taken to support them.

The support provided by our South England outreach team is part of a UK-wide programme of work our outreach teams have put in place across the UK to support locum doctors, agencies, and those who commission locum services. As part of this programme:

- our employer liaison advisers now discuss early termination of locum contracts with ROs



- our national and regional liaison advisers deliver supportive workshops to locum doctors, including induction and support on challenging areas such as speaking up
- we are developing training materials for locum agency staff on the support we can provide as a regulator and about our fitness to practise work.







London

Working with the independent sector to enhance patient safety and doctors' wellbeing

The independent sector employs a significant number of doctors across the UK, and is extremely diverse in terms of the services it provides and the size of the organisations involved. While the majority of doctors work primarily in the NHS, many also have secondary roles in independent organisations. And with the current pressures on the NHS, the private sector has a role to play in supporting healthcare recovery. As many large private healthcare organisations have their headquarters in London, our London outreach team has developed strong ties with the independent sector, and has been working with partners in the sector to continue to protect and enhance patient safety.

For example, our employer liaison advisers for the area contributed to the development of the Independent Healthcare Provider Network (IHPN)'s Medical Practitioner Assurance Framework. The Framework is the first comprehensive guide to effective clinical governance for consultants in the private sector. It encourages a 'ward-to-board' clinical governance structure with clear lines of accountability up and down the organisation. It also standardises how performance issues should be addressed and the main ways in which organisations recruit and contract doctors.

As many doctors work both in the NHS and in the independent sector, when the Framework was launched, our outreach teams also updated all organisations responsible for doctors' appraisal and revalidation (known as Designated Bodies)

across the UK about its introduction and invited ROs to discuss it.

On a similar topic, one of our employer liaison advisers was also invited to share knowledge and expertise regarding complaint handling in a session organised by the IHPN, alongside speakers from the Parliamentary and Health Service Ombudsman and the Independent Sector Complaints Adjudication Service. This enabled us to share our views and recommendations on early and fair management of concerns with a wide, highly specialised audience.

Good complaint handling at an early stage can often address patient concerns effectively through local resolution ultimately reducing the number of concerns raised with us. This has undoubtedly positive impacts both on patient safety and on doctors' wellbeing, and is therefore something we always keenly support through our work.



Midlands and East England

Supporting a GP provider in applying best practice and protecting patient safety

In June 2022, BBC Panorama broadcast an investigation into the largest independent provider of NHS GP services in the UK. The provider is also the largest employer of physician associates (PAs) in primary care. The investigation raised several allegations, including concerns around the oversight, supervision, and caseloads of PAs.

This raised concerns for us, in particular around the supervisory and support role played by some doctors working for the organisation.

An employer liaison adviser in our Midlands and East England outreach team approached the organisation's RO. They had an in-depth discussion about the issues raised in the BBC programme and how these issues could impact patient safety.

The RO was open about the challenges in providing primary care, including sickness absence and staff shortages, but confirmed there were business continuity plans designed to address these issues. They also confirmed that an action plan had been agreed with the local clinical commissioning group to address the concerns raised in the Panorama investigation, and that the Care Quality Commission had agreed the provider was progressing well with the plan.

A key outcome of the conversation, however, was that it led to direct engagement between the provider's RO, its Chief Medical Officer, and GMC colleagues working on the introduction of regulation of PAs.

The topics discussed included best practice in relation to governance arrangements, career development, and scope of practice, with further contact planned as work to implement the regulation of physician associates and anaesthesia associates develops.

This is a demonstration of the value of our outreach work: proportionate, targeted interventions on the frontline designed around healthcare organisations' needs, often reacting quickly to issues raised in the news or via other channels, with the ultimate aim of improving work environments and protecting patient safety.



North England

Reaching out to diverse groups

The consultation on the review of our *Good medical practice* guidance closed in July 2022. We had a very positive response, with over 4,600 individuals taking part from across the UK.

The principles in the guidance are relevant to all doctors, whatever their role, level, specialty, or sector, and they will also apply to physician associates and anaesthesia associates once we start regulating these professions.

Because of the importance of the guidance, we wanted the consultation to have as broad a reach as possible. Our outreach team played a key role) in this respect.

For our GMC North England outreach team, running workshops and events on the new guidance provided an excellent opportunity to engage with a diverse range of stakeholders, including specific ethnic minority groups.

As part of this work, one of our regional liaison advisers ran a consultation with the Sudanese Junior Doctors Association UK and delivered two sessions on the new guidance at the Sudanese British Primary Care Association's annual conference in Manchester. We also led discussions on the new guidance with the British Islamic Medical Association, which resulted in the production of a podcast in collaboration with the association. These activities contributed significantly to building partnerships with diverse groups in northern England, and we expect these partnerships to develop further in the coming years.

The work of our GMC North England outreach team in this space reflects the approach we took across the UK. As a result of our focus on securing diverse voices, our UK teams:

- delivered 200 consultation workshops, 50% of which involved ethnic minority groups
- harnessed the expertise of doctors' organisations such as the Medical Women's Federation; the Association of Lesbian, Gay, Bisexual, Transgender, Questioning, and Others Doctors and Dentists; and the British Association of Physicians of Indian Origin.

In 2023, we will engage with these and other partners to help implement the new guidance which they have all helped shape.



Northern Ireland

Supporting doctors and medical students in their use of social media

The standards expected of doctors do not change because they are communicating through social media rather than face to face or through traditional media, but new challenges can arise. That is why, as part of our work, we also provide guidance on doctors' use of social media.

To help with applying this guidance, our outreach teams regularly engage with doctors and medical students, offering virtual or face-to-face interactive sessions which cover issues such as:

- the use of instant messaging
- patients recording consultations and sharing them on social media
- expressing opinions on social media
- maintaining professional boundaries
- protecting patient confidentiality.

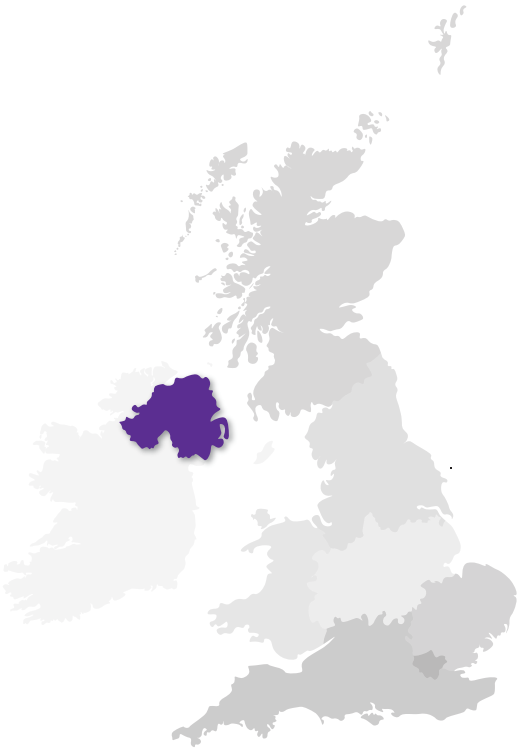
It is also important that medical students, as the doctors of tomorrow, are aware of both the advantages and the pitfalls connected with social media use. This applies to medical work in general but also relates to their role as students.

The necessity of clear guidelines around social media use for students came clearly to the fore when Queen's University Belfast proactively contacted our Northern Ireland outreach team to ask them to provide guidance to their students on the topic.

In response, one of our liaison advisers delivered an interactive session on our guidance to third-year

students at the university, targeting this cohort as they were about to begin their first clinical placements. The session covered a number of scenarios, including:

- how to deal with patients who want to connect on social media
- advice on the sharing of photographs that may inadvertently contain patient details on messenger apps and social media
- coping with criticism of doctors or other medical professionals on social media
- the importance of maintaining the confidence of patients and the public in the medical profession when posting on social media.







Feedback from students and university staff was very positive. They felt that the case studies presented were very relevant, and that the discussions on how to manage these situations prepared students well for clinical practice.

This new, interactive session will now be provided as a standard part of our engagement with medical students in Northern Ireland, adding to the support we provide to doctors and medical students across the UK regarding the use of these communication tools. We also often point medical students to our advice on using social media via other communication channels, including e-newsletters and social media posts, and the theme of the 2022 edition of our annual student professionalism competition was 'How to use social media safely and professionally.'

Scotland

Supporting partners on equality, diversity, and inclusion

Since we introduced specific targets around equality, diversity, and inclusion (ED&I) in 2021, our policy and frontline teams across the UK have been working towards these goals, with the aim of supporting fair and inclusive working cultures.

Inequalities and exclusion are typically systemic issues, so much of our work has focused on supporting partners across the UK's healthcare systems in addressing such problems.

As part of this, in 2022 our Scotland team:

- shared data on ED&I with the Scottish Government, education bodies, and medical representative organisations, to help inform and shape policy decisions
- joined forces with the NHS National Ethnic Minority Forum and the BMA Scotland Race Equalities Forum to create the Scottish Fairer Working Cultures Joint Working Group. The Group is focused on improving the fairness of healthcare training and working environments for ethnic minority doctors and IMGs in Scotland.

Apart from system-wide work, our UK-wide outreach teams also deliver targeted interventions.

For example, in one case, our Scotland office was made aware of Black and Minority Ethnic (BME) medical students experiencing discrimination during their clinical placements in a Scottish Health Board. This is unacceptable, so in response, our outreach team approached the ED&I Champion in the Board to offer support to their work to address cultural issues among staff. The support came in the form of our liaison advisers delivering a series of sessions to students, trainees, consultants, and equalities groups within the Board, covering topics related to addressing cultural issues, for example team-based reflective practice and raising concerns. The team also delivered sessions on implementing the recommendations of the *Fair to refer?* research we commissioned on disproportionality in referrals to the GMC based on ethnic origin.

As part of our evaluation approach, before and after sessions participants are asked whether they were optimistic that disproportionate referral of BME and IMG doctors would be addressed.



The percentage of those who said they were optimistic typically increased after these sessions. For example, in one case only 12% agreed before the session, compared with 45% at the end. In another case, agreement increased from 25% to 78%.

These sessions have since been incorporated into the Board's own ED&I work, and our outreach team will continue to support them and any others with their ED&I work going forward. Information about this work and its impact has also been shared with other Outreach teams across the UK, so they can apply the learnings from these activities in engagement activities in their areas, as part of our overall ED&I work.



Wales

Supporting medical students and educators in the north of Wales

At present, there are no medical schools in the north of Wales, and prospective students from the area have traditionally had to travel or move to other areas to study medicine—for example at Cardiff University or Swansea University.

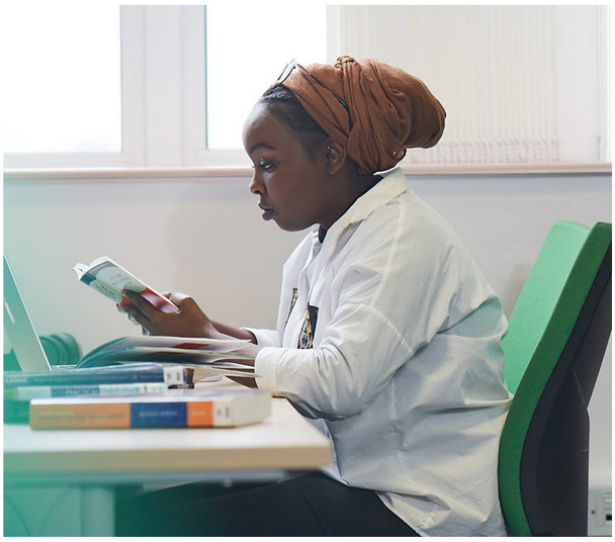
Since 2019, however, a dedicated programme of studies called C21 has given medical students at Cardiff University the option to study four years of their MBBCh degree based at the School of Medical Sciences at Bangor University in the north of Wales. In the meantime, the Welsh Government has been working with partners including Bangor University, Cardiff University, and Betsi Cadwaladr University Health Board to create a new medical school in the region, anticipated to open in 2024.

To prepare for and support these developments, during 2022 our liaison adviser for the north of Wales worked with Bangor University to deliver tailored interactive sessions to students on the C21 programme covering varied topics, such as our role as a regulator; our standards, leadership and management; and myths and realities about our fitness to practise work.

The sessions were a key first step in a series of efforts to build and develop strong relationships with medical students and medical education staff in the region, and they received very positive feedback.

We will continue to work with Bangor School of Medical Sciences and with educators and students in the north of Wales on the C21 programme, including on the application process. We will also





continue to offer our advice and expertise to help the school in its transition to full medical school status, which will allow students to complete an entire medical degree in the north of Wales.



> “Thank you so much for the teaching that you delivered yesterday to the C21NW students. I met with the students this morning and they found the session very helpful and informative.”

Dr Nia Jones, Clinical Senior Lecturer in Medical Education (Primary Care and Year 5 Lead), Bangor University.

Corporate social responsibility



Corporate social responsibility

We strive to be a socially responsible organisation. We want to embed sustainability, social impact, and ethics into everything we do. From standalone initiatives to everyday activities, we try to carry out our work in a way that benefits the environment and society.

In 2022, we made progress with our corporate social responsibility (CSR) agenda in several ways.

Protecting the environment

- Given our purpose is to protect the public, it's key that we play our part also in tackling climate change.

In 2022, we announced our ambition to become a net zero organisation by 2040. During the year we took a number of steps on this journey, including launching a programme of staff engagement, and working to calculate our carbon footprint.

Importantly, calculating our footprint has allowed us to develop a net zero plan for the organisation. The plan sets out what we will be doing in the coming years to reach net zero emissions and tackle climate change. It specifies targets to reduce our carbon footprint, eliminating scope 1 and 2 emissions by 2030, and scope 3 emissions by 2040.

Everyone in the organization will have a part to play in helping us achieve net zero, and we look forward to working with colleagues and others to help us reach this important goal.

Supporting the community

- We partnered with the Royal Voluntary Service's Befriending Scheme. Volunteer befrienders give weekly companionship phone calls to people at risk of being lonely or isolated. The scheme provides invaluable support to elderly people, and many of our volunteers have formed lasting connections. As the programme has been such a success, we plan to extend it and to expand our volunteer base in the coming year.

> "A simple call can make such a difference to a person's day. I love the fact that I can put a smile on someone's face."
>
> **Salma, Trainee Solicitor and volunteer befriender**

- A number of our colleagues have continued to take part in our volunteer reading scheme. The volunteers spend time twice a week reading with secondary school students who need additional support with literacy. We have seen impressive results from programme participants, with some students showing reading age improvements of up to seven years.
- We also partnered with the National Literacy Trust, which organised and coordinated three book reading events at primary schools in deprived areas in Greater Manchester. These were equally well received and some GMC volunteers from these events have continued their volunteer role in their own time.

Promoting social mobility

- As part of our commitment to CSR and to equality, diversity, and inclusion, we expanded our existing apprenticeships offer. Apprenticeships provide exciting and varied career opportunities to those who may not have access to further education or who particularly benefit from on-the-job training. From 2023, we will be recruiting 20 or more new apprentices every year across multiple departments, with at least 50% from ethnic minority groups.

> “I can’t put into words just how much the GMC programme has helped me. The support I’ve been given every step of the way has set me up for life.”
>
> **Oliver, Automation and Delivery Support Engineer**

- Widening participation in medical education continues to be a priority for us. We want young people to have a fair and equal chance of becoming our doctors of the future. So, we work with organisations who support young people from less advantaged backgrounds. During the summer, we worked with our partners at the Social Mobility Foundation to hold events aimed at potential future doctors. The programme received positive feedback from our attendees.

> “I was able to see what I could potentially become in the future and get a clearer idea of why so many people are a part of the medical field. I also enjoyed the clinical fellow who spoke of her experience as an anaesthetist, as I just felt like she was exactly what I wanted to be.”
>
> **Participant at Social Mobility Foundation event**

Benchmarking and working with partners to promote CSR

- We continue to work with Business in the Community, using their Business Tracker to benchmark our CSR work. The tracker allows us to measure our progress compared to other organisations.
- We also established a cross-regulator CSR group, which includes the Nursing and Midwifery Council, the General Dental Council, the General Pharmaceutical Council, the Health and Care Professionals Council, and Social Work England. The group met twice during the year, discussing environmental matters and the development of policies to reach net zero targets.



Our structure, governance, and management

Council and other governance groups

Council is our governing body. It provides strategic direction, holds the executive to account, and takes major high-level policy decisions. It comprises twelve members from the four countries of the UK. Six are medical members and six are lay members.

We are a registered charity and our Council members are also the trustees of the organisation.

They are all independently appointed by the Privy Council through a process that follows the Professional Standards Authority's guidance for making appointments to healthcare professional regulatory bodies.

The trustees between 1 January 2022 and 31 December 2022 were:

- Mr Steve Burnett
- Dr Vanessa Davies
- Professor Anthony Harnden
- The Rt Hon Lord Hunt of Kings Heath PC
- Professor Paul Knight
- Professor Dame Carrie MacEwen
- Professor Deepa Mann-Kler
- Dr Raj Patel
- Miss Suzanne Shale
- Miss Alison Wright.*

Dame Carrie MacEwen was Acting Chair of Council from January to May 2022, having been appointed to the role after Dame Clare Marx stepped down due to ill health in July 2021. Following an open recruitment process, in May 2022 Dame Carrie was appointed as Chair, and she has been leading Council since.

In November 2022 Dame Clare Marx died from pancreatic cancer at her home in Suffolk. A tireless advocate for the leadership required to bring about change in our health services, she was the first woman to hold the post of Council Chair since the GMC was established in 1858. Prior to taking up the role, she was the first woman President in the history of the British Orthopaedic Association (2008–09) and the Royal College of Surgeons of England (2014–17), and was Chair of the Faculty of Medical Leadership and Management until the end of 2018, where she was instrumental in establishing the national clinical fellows initiative.

Dame Clare left a profound legacy right across the medical profession and wider health services. Her leadership, her wisdom and the importance she attributed to exhibiting kindness in day-to-day in medical work touched many in the healthcare sector and at the GMC, and her loss has been felt just as strongly.

As a way to recognise her leadership and her achievements, from 2022 onwards the clinical fellows joining the GMC cohort will be known as the Marx clinical fellows.

* At the end of 2022 Council had two vacancies, one for a lay member and one for a registrant member. Recruitment for these positions commenced in November 2022 and final interviews took place in March 2023, leading to the appointment of Mr Douglas Millican as a lay member and Dr Rajiv Wijesuriya as a registrant member.

All Council members are also asked to declare any conflicts of interests. These are listed in a register of interests published on our website.

Council members also participate in appraisal reviews, and in a 360-degree feedback process that takes place every two years. The process includes consideration of any learning and development needs and revisits actual or perceived conflicts of interest to make sure any potential conflicts identified are manageable.

As a charity, we take into account the seven principles set out in the Charity Governance Code (2020) and can demonstrate how we use these principles to guide our work on an 'apply or explain' basis.

There are two exceptions to the Code, which we explain rather than apply. Firstly, our Council and committees operate without a formally appointed deputy or vice-chair. However, provisions are made in the *Governance Handbook* for chairs to nominate a deputy to assist during periods of absence, which was enacted in 2022. Secondly, as our appointments process is well established and thorough and is overseen by the Remuneration Committee and the Professional Standards Authority, a nominations committee is not considered necessary.

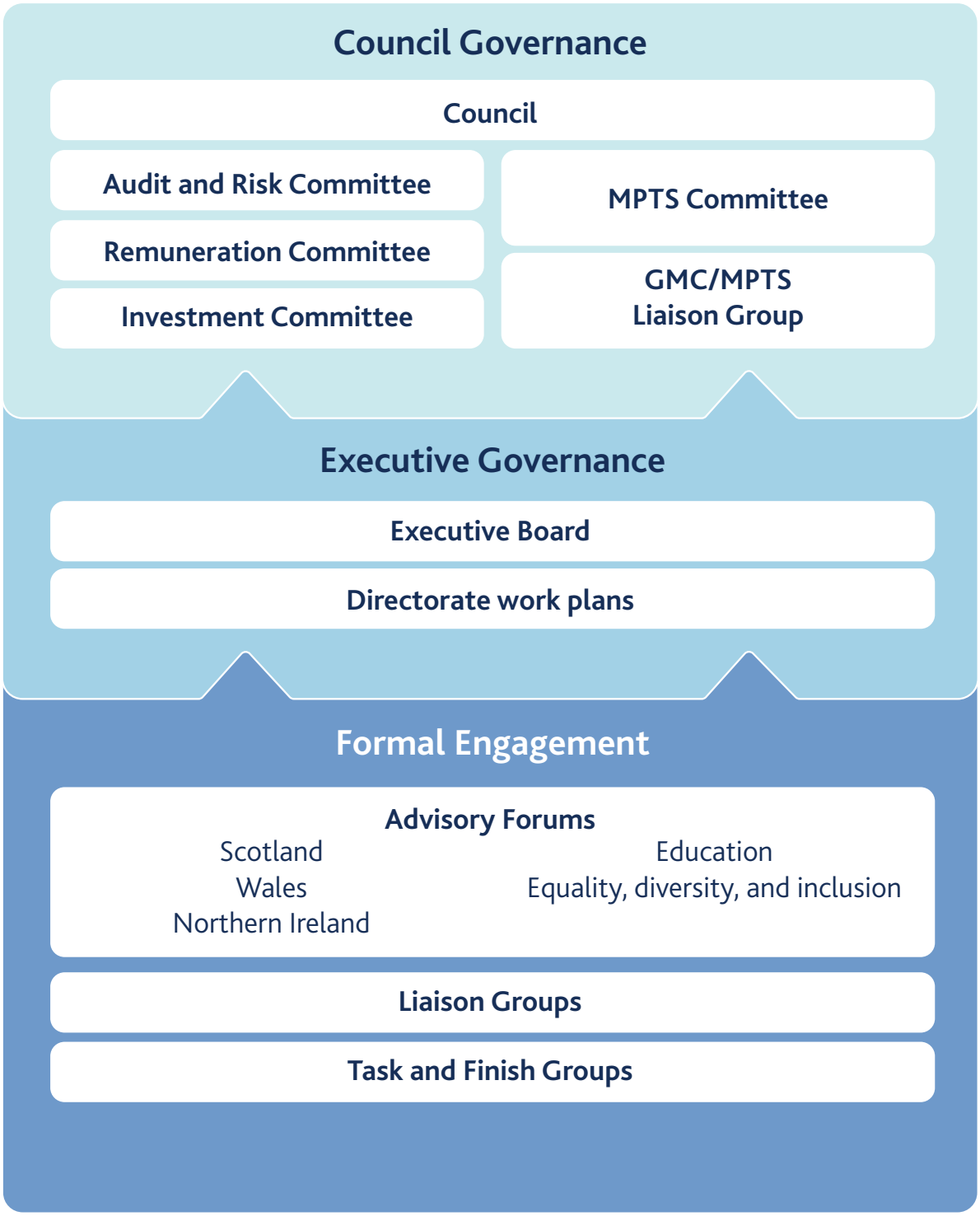
The *Governance Handbook* is the governing document of the organisation. In 2022, we reviewed it following internal audit work to reflect updates to the process for appointing assistant registrars, and to review the schedule of authority (or scheme of delegation from Council). Minor updates are made with Council's approval on an ongoing basis, for example to the membership of committees.

Our Corporate Governance team is charged with supporting the Council in maintaining high standards of governance, on an 'apply or explain' basis, in line with the good practice set out within the Charity Governance Code. The team also provides training and advice to the organisation on matters of governance. Each committee accounts to the Council through a formal report, and the Council and each committee undertake to review their effectiveness in delivering its statement of purpose, which is reviewed annually.

The diagram on the next page shows the different governance groups that assist Council in carrying out its responsibilities effectively. These have all been agreed by Council. The roles and activities of these groups are described in the pages that follow.

Council business is conducted in an open and transparent manner and the agenda and papers for each meeting are published on our website.

Council generally meets six times a year. In line with our commitments to 4-country working and to reducing our environmental impact, it meets twice in London, once in Manchester and once in either Belfast, Cardiff or Edinburgh. The remaining two meetings are held virtually.


Council Governance
Council
Audit and Risk Committee
Remuneration Committee
Investment Committee
MPTS Committee
GMC/MPTS Liaison Group
Executive Governance
Executive Board
Directorate work plans
Formal Engagement
Advisory Forums
Scotland
Wales
Northern Ireland
Education
Equality, diversity, and inclusion
Liaison Groups
Task and Finish Groups

Audit and Risk Committee

In 2022 the Audit and Risk Committee was chaired by Paul Knight. Its external co-opted members were Jon Hayes and Kenneth Gill.

The Committee plays a key part in our governance, providing Council with independent assurance about:

- the integrity of our financial statements
- the effectiveness of internal control, governance, and risk management systems
- the delivery of internal and external audit services.

The Committee met five times in 2022, and reports to Council twice a year. You can find more about its role and work in the Audit and Risk Committee Report section of this report (see page 53).

Remuneration Committee

In 2022, the Remuneration Committee was chaired by Anthony Harnden. The Committee advises Council on the remuneration, the terms of service, and the expenses policy for Council members, including the Chair. It oversees the recruitment process of the Chair and Council members before their appointment by the Privy Council. It determines the appointment process for the Chief Executive and Medical Practitioners Tribunal Service (MPTS) Chair, and the remuneration, benefits, and terms of service for the Chief Executive, directors, MPTS Chair, and MPTS Committee members.

In 2022, the committee was actively engaged in the process to recruit a new Chair of Council and a new Chair of the MPTS.

And it oversaw the commencement of the recruitment process for two Council members. It is also responsible for making sure the assessment and measurement of performance, recruitment, and succession planning take place within an appropriate framework for the senior management roles within its remit. The Committee reports annually to Council and met twice in 2022.

Investment Committee

Steve Burnett chaired the Investment Committee in 2022. Its external co-opted members during the year were Keith MacKay and Mike Jennings.

The Committee is responsible for:

- implementing and reviewing our investment policy
- making sure the management of assets is consistent with the policy
- appointing and managing fund managers
- monitoring performance.

It also has responsibility for overseeing the GMC's investment in GMC Services International Limited (GMCSI), including ensuring compliance with the GMC's Investment Policy, scrutinising GMCSI's business plan, and assessing the potential levels of investment risk and return. The Committee reports on investment performance to Council via post-meeting circulars. It reports on the performance of the portfolio to Council directly on an annual basis. It met five times in 2022.

GMC Services International

GMC Services International (GMCSI) was established by Council in 2016 as a wholly owned trading subsidiary of the GMC. Its main objective is to offer the GMC's support and expertise to countries and institutions which are working to improve standards of healthcare, who have less experience with the regulation of healthcare professionals and of medical education. Robust and effective governance arrangements are in place to ensure that our interests are protected and that our relationship with GMCSI is managed effectively.

While Council has overall responsibility for GMCSI, the Audit and Risk Committee considers the risks to the GMC from the operation of GMCSI, conducting routine internal audit and spot checks as appropriate.

Andrew McCulloch chaired the GMCSI Board during 2022. Up until October 2022 the Board comprised (in addition to the Chair) Paul Reynolds, Anthony Harnden, Alison Wright, and Colin Melville. In October 2022 Anthony Harnden stood down as a member of the Board. He will be replaced by a new Council member during the course of 2023.

Board of Pension Trustees

The GMC's defined benefit staff superannuation scheme is managed and administered by a board of trustees in accordance with the scheme's trust deed and rules. The trust makes sure the pension scheme's assets are kept separate from those of the employer.

The scheme's trustees are responsible for the proper running of the scheme, including the collection of contributions, the investment of assets, and payment of the pension benefit commitments made by the employer.

Deirdre Kelly chaired the Board during 2022. Deirdre, Steve Burnett, Raj Patel, and Vanessa Davies are employer-nominated trustees. Danny Dubois, John Foley, Paula Robblee, and Martin Hart are member-nominated trustees.

Medical Practitioners Tribunal Service

A key part of the governance structure is the statutory MPTS Committee. Dame Caroline Swift chaired the Committee in 2022, reaching the end of her tenure on 31 December 2022. The Committee oversees the delivery of the hearing service for doctors and makes sure the service meets its responsibilities under the Medical Act 1983.

The GMC/MPTS Liaison Group is a core part of our governance framework. It is chaired by the Chair of Council. It oversees the working relationship between the MPTS and the functions of the GMC with which it interacts.

During 2022, a recruitment process took place to seek a successor for Dame Caroline as Chair of the MPTS. Her Honour Judge Deborah Taylor took up the post in March 2023.

Executive Board

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

The Board meets monthly (except for August) and reports to every meeting of Council through the Chief Executive's report and via a separate annual report.

UK Advisory Forums

We have a well-established programme of Advisory Forums meeting in Northern Ireland, Scotland, and Wales.

The Forums make sure we have effective engagement and consultation with interest groups, and that our policies are suited to all parts of the UK. The invited membership differs from country to country and reflects the diverse range of those who have an interest and expertise in the areas under our regulation across the UK. The Forums report on their work to the Executive Board twice a year.

Education Advisory Forum

The Education Advisory Forum began work in February 2019. The Forum engages widely and effectively with our key interest groups on education, training, and assessment matters, making sure we are able to develop and promote a strategic approach to this work across all countries of the UK.

Colin Melville, Medical Director and Director of Education and Standards chairs the Forum, and the invited membership reflects the diverse range of those who have an interest and expertise in medical education, training, and assessment across the UK. The work of the Forum is reported to the Chief Executive and to Council through the Chief Executive's report.

Equality, Diversity and Inclusion Forum

Our Strategic Equality, Diversity, and Inclusion (ED&I) Forum helps us make sure that our activities respond to the needs of diverse groups of doctors. The forum comprises organisations representing doctors with shared protected characteristics. It helps us meet our ED&I objectives by providing feedback and advice on our policies and strategies, raising issues and concerns requiring our attention in relation to ED&I. In 2022, the forum discussed:

- our new ED&I targets
- fairness and transparency
- bullying, harassment, and discrimination
- our review of *Good medical practice*, and
- the redesign of our processes as part of our regulatory reform programme.

Member attendance at Council, Boards, and Committees in 2022*

Member	Council attendance†	Committee attendance
Steve Burnett	7/7	10/10
Vanessa Davies	7/7	5/7
Anthony Harnden	7/7	5/5
Philip Hunt	7/7	7/7
Paul Knight	6/7	5/5
Caroline MacEwen	7/7	5/5
Deepa Mann-Kler	7/7	5/7
Rajesh Patel	7/7	10/10
Suzanne Shale	7/7	5/5
Alison Wright	6/7	6/6
Ken Gill (ARC co-opted member)	n/a	5/5
Jon Hayes (ARC co-opted member)	n/a	5/5
Michael Jennings (IC co-opted member)	n/a	5/5
Keith Mackay (IC co-opted member)	n/a	5/5

Management

In 2022, our staff were under the direction of Chief Executive Charlie Massey. He is supported by a team of directors, who, as at 31 December 2022 were:

- Shaun Gallagher, Director of Strategy and Policy
- Una Lane, Director of Registration and Revalidation
- Colin Melville, Medical Director and Director of Education and Standards
- Anthony Omo, General Counsel and Director of Fitness to Practise
- Paul Reynolds, Director of Strategic Communications and Engagement
- Neil Roberts, Director of Resources.

* Attendance reflects the number of meetings for which attendance was possible.

† Includes six Council meetings and one strategic away day.

Key management personnel: remuneration policy

The Remuneration Committee is responsible for determining the remuneration, benefits, and terms of service for the Chief Executive, Chair of MPTS, and directors. The Committee sets all aspects of salary or honoraria, the provision of other benefits, and any other arrangements or contractual terms for this group of staff.

The Committee considers that we should provide remuneration and rewards that will attract and retain the high-calibre staff necessary to enable us to fulfil our statutory remit and deliver our strategic objectives.

In setting the base pay for individual posts, the Committee will take external advice on roles within its remit and align salaries with an appropriate market rate subject to resource considerations.

An annual consolidated pay award is considered with reference to the organisation's level of performance, the financial implications of any award, the award agreed for other GMC employees, and wider market trends. An annual variable non-consolidated element is considered, reflecting personal performance and the same considerations applied to any consolidated award. We review the effectiveness of these arrangements on an annual basis.

Staff within the Remuneration Committee's remit will usually be entitled to the benefits package available to all GMC employees on the same terms. The Committee retains the ability to withdraw, adjust, or change any benefits for staff within its remit, subject to any consultation and contractual requirements. The Committee considers any additional benefits in kind (such as relocation payments) on a case-by-case basis.

New external staff appointees within the Committee's remit are automatically enrolled into our defined contribution pension scheme. Where employees have existing agreed pension arrangements, such as membership of our defined benefit scheme, they retain this for the course of their employment, subject to any changes to the rules agreed by trustees and the employer.

The Committee makes sure that the equality and diversity implications of remuneration policy and related decisions are considered appropriately. Specifically, it ensures that:

- any salary differentials are supported by a formal job evaluation or independent external market advice
- any decisions relating to variable pay are supported by an objective assessment of performance
- any adjustment or changes to remuneration arrangements do not discriminate unlawfully.

Other decisions relating to terms of service are supported by appropriate advice on any equality and diversity implications.

2022 financial review

The accounts for the year ended 31 December 2022 have been prepared in accordance with the Charities Statement of Recommended Practice (FRS 102).

Our total income and expenditure in 2022

Over the course of 2022, the impact of the coronavirus pandemic on our day-to-day business activities waned, with most of our core services to support doctors and patients largely returning to pre-pandemic operational norms.

In 2022, we generated unrestricted income of £132.7 million, which was £13.0 million higher than 2021. This was due to the increase in the size of the medical register and the impact of running more Professional and Linguistic Assessments Board (PLAB) tests in 2022 than in 2021, and the subsequent increase in new applications to join the register.

In addition, we are reflecting a further £2.5 million of restricted income in our accounts from the UK Government's Department of Health and Social Care (DHSC) to cover the cost of implementation work to bring physician associates and anaesthesia associates under our regulation. These funds were fully spent in 2022, and, as with 2021, some funding was used to develop IT systems. A further £0.9 million was therefore capitalised this year, with a total restricted asset of £1.8 million held on the balance sheet, as yet undepreciated.

The gains of £4.9 million we saw on our investments in 2021 were eroded in 2022, with a loss on investments recorded this financial year of £4.8 million. This was substantially the result of volatile market movements including but not limited to the war in Ukraine, historically high inflation and the UK Government's September 2022 mini-budget. As we move into 2023 we are now seeing an upward trajectory in these investments.

Our unrestricted charitable expenditure in 2022 was £129.8 million, which was an increase of £11.9 million on 2021. This growth in expenditure in 2022 when compared to 2021 was intended. Costs increased as we continued with our recovery plans and backlog reduction, which saw increased capacity for both PLAB tests and tribunals throughout the year. However, while our cost base did see an increase, it was not to the level anticipated, with some continued disruption from the pandemic having an impact on spend, most notably the cancellation of PLAB exams in the early part of 2022.

We increased our dilapidations provision by £0.3 million to make sure our obligations under our building leases can be met. We expect this provision to increase annually until the point of exiting any of our sites. A further £1.4 million was also added to our legal provision to reflect potential additional costs that may arise from outstanding legal cases.

Our other core activities continued throughout 2022 relatively unimpeded by the ongoing impact of the pandemic, with our focus shifting from recovery to efficient delivery of our core statutory function. To this end, we have seen some efficiencies generated as a result of the pandemic, with new working patterns and greater use of IT-enabled forums as opposed to face-to-face activities. We expect these to continue into future years.

The charity had no fundraising activities requiring disclosure under S162A of the Charities Act 2011.

Reserves policy and going concern

Our level of reserves and our reserves policy are reviewed annually, and any financial implications are addressed as part of the budget-setting process.

Our total reserves are made up of free reserves, reserves backed by fixed assets, and pension reserves.

We hold free reserves:

- to provide working capital to undertake our normal day-to-day business
- to provide funds to deal with any risks that materialise
- to provide funds to respond to new initiatives, opportunities and challenges that present themselves
- to cover the period before any changes to fee levels take full effect.

A significant proportion of our total reserves is represented by fixed assets, which cannot easily be converted into cash without adversely affecting our ability to fulfil our charitable aims and statutory obligations. The value of fixed assets is therefore disregarded for reserves policy purposes.

The value of pension reserves is also disregarded for reserves policy purposes. The defined benefit scheme was closed to future accruals in 2018, and any deficit or surplus in the scheme can be managed over the medium term, with no immediate impact on free reserves.

There is no standard formula that can be used to calculate the ideal level of free reserves. We follow the Charity Commission's guidance and set a target range based on our cash flow requirements and an assessment of the risks facing the organisation. We aim to hold free reserves at a level that is not excessive but does not put our solvency at risk.

Based on our analysis of cash flows and the risks facing the organisation, our policy has historically been to maintain free reserves in the range of £25 million to £50 million. However, to make sure that the free reserves policy continued to reflect changes in the size of the organisation, from 2022 we have linked the target range directly to expenditure, expressed in percentage terms: our target range of free reserves was therefore between 20% and 35% of annual expenditure. This was achieved throughout 2022, and at the year-end.

We will also continue to review the purpose and scope of our reserves policy on an annual basis to make sure the thresholds reflect our current risk profile, cash flow requirements and operating environment.

Our policy is to maintain actual free reserves in line with the target level over the medium term. If our actual reserves vary significantly from the target range set out in our reserves policy, we take action to address the variation as part of the annual budget-setting process to bring actual reserves back into line within a reasonable period.

Our total reserves at the end of 2022 were £54.9 million, reducing from the previous year by £44.9 million. Actuarial movements on the defined benefit scheme were the key driver of this reduction. In 2022 markets were generally more volatile, but during September and October the movement in bond markets was unprecedented and significant, resulting in a decline in the value of our pension assets and liabilities. However, the value of assets reduced at a faster rate than the pension obligation which in turn saw our pension asset reduce from £36.6 million to a liability of £3.2 million.

Free reserves constituted £39.2 million of the balance, with a further £18.9 million of reserves being represented by fixed assets.

As part of our strategy we have planned to limit expenditure growth in 2023 to make sure we operate efficiently and effectively, and have sufficient funds to respond to any unanticipated demands, arising from initiatives invested in over the course of this year. We expect that reserves at the end of 2023 will remain within the parameters of our reserves policy.

Most of our income comes from registration fees paid by doctors. All doctors must be registered with us to practise medicine in the UK, and so our income is relatively certain. Trustees remain of the view that the GMC is a going concern for the foreseeable future, and have therefore prepared the financial statements on a going concern basis.

There are no material uncertainties related to events or conditions that cast significant doubt on our financial stability for the foreseeable future.

Investment policy

Council is responsible for determining and reviewing the overall investment policy, objectives, risk appetite and target returns. It has delegated responsibility for implementing the investment policy, appointing and managing fund managers, and monitoring performance, to the Investment Committee, which regularly reports to Council.

Our investment policy separates our funds into four categories:

- those which are required as working capital for the normal day-to-day operation of the business
- those which we may invest under management
- those which we may invest in a trading subsidiary
- any residual cash balance.

We hold a minimum of £15 million as working capital for normal cash flow purposes. This is held in instant access bank accounts and provides sufficient flexibility to avoid temporary borrowing and/or the need to liquidate investments to deal with short-term variations in operational income and expenditure.

We increased our managed investment to £50 million in June 2019. Our target rate of return on funds invested under management is inflation (CPI) plus 2% over a rolling five-year period. This reflects our relatively low risk appetite. We seek to provide protection against inflation; to generate a modest level of return; and to diversify our funds to reduce the risk of capital and/or revenue loss.

We have adopted a comprehensive ethical approach to investments. We believe that investing in certain companies or sectors would conflict with our charitable aims or may create reputational damage. We do not wish directly to profit from, or provide capital to, activities that are materially inconsistent with our charitable aims, so we specifically exclude investment in companies that derive more than 10% of their revenue from tobacco, alcohol, gambling, pornography, high-interest rate lending, cluster munitions and landmines, and the extraction of thermal coal or oil sands. We also do not invest in companies that are under investigation for, or have been found guilty of, tax evasion or money laundering in the past three years. As we will follow the in-house investment policy of our fund managers, in selecting them, we ensure the two policies are fully compatible. While the 10%

revenue limit mentioned above is the maximum for our own policy, our current invested funds are subject to lower tolerances around thermal coal and oil sands (5%) and cluster munitions and landmines (0%) based on our current fund manager's policy.

We chose CCLA Investment Management (CCLA) to manage our investments because of their strong track record and high standards in ethical investing. CCLA invest in a manner that prioritises environmental, social and governance factors, working with companies to urge them to commit to producing healthier products, which are more accessible and more affordable.We may invest in companies whose activities are consistent with, or supportive of, our charitable aims. We expect companies in which we invest to demonstrate responsible employment and corporate governance practices, to be conscientious regarding environmental and social issues, and to deal fairly with people and the communities in which they operate. We may also use our position as an investor to actively engage with and influence the corporate behaviour of those companies we invest in.

We invest only through fund managers who demonstrate the strongest environmental, social and governance credentials. When appointing fund managers, we take into consideration how they incorporate an assessment of a company's performance on environmental, social and governance issues in their stock selection.

Our funds under management were valued at £56.6 million at the end of 2022, compared with £61.6 million at the start of the year, reflective of market volatility and historically high levels of inflation in 2022. Since the point of increasing our investment in June 2019 we have generated returns at a compounded growth rate of 3.6%.

Any residual cash not held as working capital or invested is held in medium-term deposits and/or interest-bearing accounts. We generated interest of £0.5 million on our cash balances, equivalent to an average annual rate of return of 1.15%. Cash held as working capital, and any residual cash, is shown on our balance sheet within current assets.

GMC Services International Limited

The trading subsidiary was incorporated as a private company limited by shares on 16 December 2016. It is a wholly owned subsidiary of the GMC which utilises knowledge gained from the core activities of the GMC to provide services on a commercial basis, including consultancy, training, and accreditation. Any profits derived from these activities are gifted back to the GMC for the purpose of delivering the GMC's charitable aims.

The GMC invested £0.6 million as share capital in GMCSI. In its early years of operation GMCSI generated net losses but has been able to recently generate modest profits. In 2022, GMCSI generated a net profit of £26,077 and ended the year with net assets of £256,523. No profits have been gift-aided back to the GMC in 2022. GMCSI is projected to generate profits over the medium term.

The accounts presented here are consolidated group accounts to include our trading subsidiary GMCSI. The statement of financial activities shows the consolidated position for the GMC and GMCSI combined. The balance sheet shows separate columns for the group position (GMC and GMCSI combined) and the parent charity position (GMC). Separate company accounts have been prepared for GMCSI.

Trustees' responsibilities for the financial statements

The trustees are responsible for preparing the trustees' annual report and the financial statements in accordance with applicable law and United Kingdom Generally Accepted Accounting Practice (United Kingdom Accounting Standards). The law applicable to charities in England, Scotland and Wales requires the trustees to prepare financial statements for each financial year which give a true and fair view of the state of affairs of the charity and the group and of the incoming resources and application of resources of the group for that period.

In preparing these financial statements, the trustees are required to:

- select suitable accounting policies and then apply them consistently
- observe the methods and principles in the Charities Statement of Recommended Practice (SORP)
- make judgements and estimates that are reasonable and prudent
- state whether applicable accounting standards have been followed, subject to any material departures being disclosed and explained in the financial statements
- prepare the financial statements on the going concern basis unless it is inappropriate to presume that the charity will continue in business.

The trustees are responsible for keeping adequate accounting records that are sufficient to show and explain the charity's transactions, and to disclose, with reasonable accuracy at any time, the financial position of the charity, enabling them to make sure that the financial statements comply with the Charities Act 2011, the Charity (Accounts and Reports) Regulations 2008, the Charities and Trustee Investment (Scotland) Act 2005, the Charities Accounts (Scotland) Regulations 2006 (as amended), the Privy Council Directions issued under the Medical Act 1983 and the provisions of the charity's constitution. They are also responsible for safeguarding the assets of the charity and the group and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

Related party transactions

We require that all trustees and senior managers disclose details of any organisations in which they (and their close family members and business partners) hold a position of authority or other material interest and whose business could bring them into financial contact with the GMC. Details of any actual transactions between the GMC and related parties in the year must also be disclosed. We also publish a register of interests on our website.

In 2022, all disclosures were made and there were no points of concern.

Audit and Risk Committee report

The Audit and Risk Committee plays a key role in our governance. The Committee provides Council with independent assurance about:

- the integrity of our financial statements
- the effectiveness of internal control, governance, and risk management systems
- the delivery of internal and external audit services.

It also monitors our anti-fraud policies and any risks relating to the *General Data Protection Regulations* and reviews arrangements for raising concerns.

The Committee bases its advice and decisions on guidance issued by the Financial Reporting Council, the Charity Commission, the Office of the Scottish Charity Regulator and, where appropriate, independent external advice.

The Committee has six members– four Council members and two co-opted members. Co-opted or independent, members enhance the work of the Committee by bringing valuable additional skills and experience to the independent scrutiny of finance, risk, and governance. All members of the Committee participate in an annual appraisal process.

In 2022, the Committee met five times and submitted two formal reports on its work and findings to Council. As well as this, members had the opportunity to learn more about and scrutinise specific areas of the business and their risks in three seminar sessions and a day observing operations at the Medical Practitioners Tribunal Service (MPTS) and in our call centre.

The Committee bases its annual work programme on risk, with our Corporate Opportunities and Risk Register reflecting the key strategic risks we manage. The Committee's oversight and scrutiny play a valuable role in assuring that risks are being managed and opportunities are enhanced through effective systems of governance, internal control, and risk management arrangements.

Key activities during 2022

During 2022, the Committee followed a planned programme of internal audit work. It scrutinised 19 audit reports, which included considering how the organisation continues to respond to new ways of working after the pandemic. Specifically, the Committee checked progress on plans for backlog recovery in our Fitness to Practise department and in the MPTS, and completed regular reviews of progress with our work to support the Government's regulatory reform programme. Towards the end of the year, the Committee turned its attention to broader organisational resilience, reflecting the emerging risks of the global financial crisis and the potential for fuel shortages.

At each of its meetings, the Committee:

- discussed a wide range of strategic risks to provide an important backdrop to its understanding of the challenges and opportunities the GMC was facing
- considered the assurance it had with respect to how the organisation was responding to emerging threats and opportunities
- challenged our Corporate Opportunities and Risk Register

- scrutinised audit and learning review findings to satisfy itself that the actions being taken were appropriate
- monitored the implementation of recommendations made in previous audit reports to make sure they were being managed effectively
- reviewed any findings and lessons learned from work undertaken in relation to significant adverse events.

Other key activities in 2022 included:

- undertaking an internal audit procurement exercise
- scrutinising the Annual report and accounts 2021
- reviewing the Head of Internal Audit's annual report and opinion which provided substantial assurance that the systems of governance, risk management and internal control in operation during 2022 were generally well designed and working effectively to ensure the achievement of the GMC's objectives
- scrutinising an independent test of our cyber security control arrangements
- reviewing concerns raised to our Freedom to Speak Up (FTSU) Guardian, as reported in its 2021 Annual Report
- holding a seminar to understand how we are addressing our corporate social responsibility agenda
- scrutinising the principles behind the development of a financial stress-testing model to strengthen financial scenario-planning exercises.

The Committee also spent a day at our Manchester offices observing an MPTS hearing, shadowing telephone calls to the Contact Centre and observing part of a Clinical Assessment Centre PLAB exam. In advance of reviewing the Annual Report and Accounts, the Committee held a financial reporting seminar.

Risk management in 2022

Risk management continues to be inherent in discussions and operations at all levels of the business and is integral to the work of the Committee. Open risk discussion at the start of every meeting provides the opportunity to consider both current risks the GMC faces and emerging areas in the wider external environment. We have a mature set of risk management arrangements embedded in our day-to-day activities, and risk registers are used as a tool for identifying, articulating, monitoring, and managing operational and project risks and opportunities to improve how the business is managed. Our Corporate Opportunities and Risk Register is available as part of the Executive Board and Council papers published on our website and is updated on a regular basis.

Throughout 2022, the wider context continued to be turbulent. As part of its work, the Committee promptly considered the impact of the evolving economic and energy crises that marked the year, aiming specifically to assess and improve organisational resilience. This included reflecting on the reputational, political, financial, and operational risks we might face in the future if the organisation were not properly prepared to manage the challenges ahead.

The management of risks in relation to other key areas of activity included:

- the requirements and implications of regulatory reform
- managing preparations for the impact of Brexit
- preparing for the introduction of the Medical Licensing Assessment in 2024
- a continued focus on the organisation's work on regulatory fairness, the elimination of disproportionate patterns of fitness to practise concerns referrals based on doctors' ethnicity and place of qualification, and eliminating discrimination, disadvantage, and unfairness in undergraduate and postgraduate medical education and training
- responding to a range of public investigations and inquiries.

The organisation also managed and responded to significant issues as they arose. The court case of Zholia Alemi in February 2023 resulting in a jail sentence for forging her medical qualifications (allegedly from New Zealand) in 1995, and fraudulently securing positions as a hospital psychiatrist over a 20-year period, are a reminder of the importance of the GMC's regulatory role, including registering doctors from overseas. All qualifications submitted with a registration application are now primary source verified (including for doctors with EEA qualifications) and we are confident that such an application received today would not pass our strict controls and review processes.

Learning from events and issues

The GMC has a strong culture of learning and continuous improvement. This includes a robust approach to undertaking learning reviews and significant event reviews (SERs) to identify opportunities to improve. A significant event is where an incident did or could have had the potential for a material adverse effect on the organisation. Carrying out SERs allows the organisation to identify how incidents occur and learnings are used to strengthen controls for the future where appropriate. The organisation's audit and risk assurance planning provides guidance, support, challenge, action plans, and independent quality assurance for SERs and their findings.

There were six SERs in 2022.

- Four related to fraudulent registration applications by doctors.
- One related to a delay between referral of a case for legal preparation and listing for a tribunal hearing.
- One related to the lapse of the sponsorship licence granted by the Home Office which enables the GMC to sponsor skilled workers from overseas to work in the UK.

Each of these was scrutinised by the Audit and Risk Committee and reviewed in line with the policy for reporting to the Charity Commission. Trustees determined these events did not reach the threshold for serious incident reporting. Nevertheless, the findings from each review provided welcome opportunities to reflect on processes and systems and to implement improvements where they were identified.

The committee also discussed issues arising in relation to the handling of a fitness to practise case regarding a doctor who faced sanctions that were later overturned. The outcome of the case generated concerns about the GMC's processes and decision making, including whether bias played any part.

In response to these concerns, the GMC commissioned an independent learning review, co-chaired by Professor Iqbal Singh CBE and Martin Forde KC, to identify whether there were lessons to be learnt from the case. While the review found no clear or conclusive evidence to suggest that biased thinking affected the case, it did find that the GMC missed multiple opportunities to assess whether the allegations at the centre of the case were serious enough to be referred to a tribunal, which the organisation apologised for. The review also emphasised that the GMC needs to do more to embed a culture of professional and cultural curiosity and speaking up, and that it was vital for it to continue to proactively seek out bias.

These findings provided further momentum for the GMC to pursue its equality, diversity, and inclusion (ED&I) ambitions and the targets set by Council in this respect in 2021. The targets provide a way of holding the organisation to account for playing a part in effecting change. They also show a commitment to influencing and working with other organisations in the system who can make a difference.

Our work in 2023

In 2023, the Committee will continue to focus on risks in relation to key areas of operations and assurance on the organisational change programmes we worked on during 2022, including:

- preparing for the implementation of the regulation of physician associates and anaesthesia associates
- the final stages of the post-Brexit transition
- the legislative changes we have been seeking through regulatory reform.

It will also be seeking assurance that positive operational changes that have emerged after the pandemic, such as maximising the benefits of holding virtual tribunal hearings and introducing digital identification checks for doctors wishing to join the medical register, are being realised.

Approved by the trustees on 15 June 2023 and signed on their behalf by:



Dame Carrie MacEwen

Independent auditors' report to the trustees of the GMC

Opinion

We have audited the financial statements of the General Medical Council ('the charitable company') and its subsidiary ('the group') for the year ended 31 December 2022 which comprise the Consolidated Statement of Financial Activities, Consolidated Balance Sheet, Consolidated Statement of Cash Flows and notes to the financial statements, including significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and United Kingdom Accounting Standards, including Financial Reporting Standard 102 The Financial Reporting Standard applicable in the UK and Republic of Ireland (United Kingdom Generally Accepted Accounting Practice).

In our opinion the financial statements:

- give a true and fair view of the state of the group's and the charitable company's affairs as at 31 December 2022 and of the group's income and expenditure, for the year then ended;
- have been properly prepared in accordance with United Kingdom Generally Accepted Accounting Practice; and
- have been prepared in accordance with the requirements of the Companies Act 2006 and the Charities and Trustee Investment (Scotland) Act 2005 and Regulations 6 and 8 of the Charities Accounts (Scotland) Regulations 2006 (amended).

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the charitable company in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the trustee's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the charitable company's or the group's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the trustees with respect to going concern are described in the relevant sections of this report.

Other information

The trustees are responsible for the other information contained within the annual report. The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Opinions on other matters prescribed by the Companies Act 2006

In our opinion based on the work undertaken in the course of our audit

- the information given in the trustees' report, which includes the directors' report and the strategic report prepared for the purposes of company law, for the financial year for which the financial statements are prepared is consistent with the financial statements; and
- the strategic report and the directors' report included within the trustees' report have been prepared in accordance with applicable legal requirements.

Matters on which we are required to report by exception

In light of the knowledge and understanding of the group and charitable company and their environment obtained in the course of the audit, we have not identified material misstatements in the strategic report or the directors' report included within the trustees' report.

We have nothing to report in respect of the following matters in relation to which the Companies Act 2006 and the Charities Accounts (Scotland) Regulations 2006 requires us to report to you if, in our opinion:

- adequate and proper accounting records have not been kept; or

- the financial statements are not in agreement with the accounting records and returns; or
- certain disclosures of trustees' remuneration specified by law are not made; or
- we have not received all the information and explanations we require for our audit.

Responsibilities of trustees

As explained more fully in the trustees' responsibilities statement set out on page 52, the trustees (who are also the directors of the charitable company for the purposes of company law) are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the trustees determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the trustees are responsible for assessing the charitable company's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the trustees either intend to liquidate the charitable company or to cease operations, or have no realistic alternative but to do so.

Auditor's responsibilities for the audit of the financial statements

We have been appointed as auditor under section 44(1)(c) of the Charities and Trustee Investment (Scotland) Act 2005 and under the Companies Act 2006 and report in accordance with the Acts and relevant regulations made or having effect thereunder.

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Details of the extent to which the audit was considered capable of detecting irregularities, including fraud and non-compliance with laws and regulations are set out below.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Extent to which the audit was considered capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We identified and assessed the risks of material misstatement of the financial statements from irregularities, whether due to fraud or error, and discussed these between our audit team members. We then designed and performed audit procedures responsive to those risks, including obtaining audit evidence sufficient and appropriate to provide a basis for our opinion.

We obtained an understanding of the legal and regulatory frameworks within which the charitable company and group operates, focusing on those laws and regulations that have a direct effect on the determination of material amounts and disclosures in the financial statements. The laws and regulations we considered in this context were the Companies Act 2006, Medical Act 1983 and The Charities and Trustee Investment (Scotland) Act 2005 together with the Charities SORP (FRS102). We assessed the required compliance with these laws and regulations as part of our audit procedures on the related financial statement items.

In addition, we considered provisions of other laws and regulations that do not have a direct effect on the financial statements but compliance with which might be fundamental to the charitable company's and the group's ability to operate or to avoid a material penalty. We also considered the opportunities and incentives that may exist within the charitable company and the group for fraud.

The laws and regulations we considered in this context for the UK operations were, General Data Protection Regulation (GDPR), and employment legislation.

Auditing standards limit the required audit procedures to identify non-compliance with these laws and regulations to enquiry of the Trustees and other management and inspection of regulatory and legal correspondence, if any.

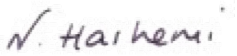
We identified the greatest risk of material impact on the financial statements from irregularities, including fraud, to be within the timing of recognition of grant income, estimates surrounding legal provisions, dilapidations and the override of controls by management. Our audit procedures to respond to these risks included enquiries of management, internal audit, legal counsel and the Audit & Risk Committee about their own identification and assessment of the risks of irregularities, sample testing on the posting of journals, reviewing accounting estimates for biases, reviewing regulatory correspondence with the Charity Commission, testing MAPS income from underlying funding agreement with the Department for Health and Social Care through to the financial statements and reading minutes of meetings of those charged with governance.

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations (irregularities) is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures

required by auditing standards would identify it. In addition, as with any audit, there remained a higher risk of non-detection of irregularities, as these may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. We are not responsible for preventing non-compliance and cannot be expected to detect non-compliance with all laws and regulations.

Use of our report

This report is made solely to the charitable company's members, as a body, in accordance with Chapter 3 of Part 16 of the Companies Act 2006, and to the charitable company's trustees, as a body, in accordance with Regulation 10 of the Charities Accounts (Scotland) Regulations 2006. Our audit work has been undertaken so that we might state to the charitable company's members those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the charitable company and the charitable company's members as a body and the charitable company's trustees as a body, for our audit work, for this report, or for the opinions we have formed.



Naziar Hashemi
Senior Statutory Auditor
For and on behalf of
Crowe U.K. LLP
Statutory Auditor
55 Ludgate Hill
London
EC4M 7JW

Date 27th June 2023

Consolidated statement of financial activities for the year ended 31 December 2022

	Note	Unrestricted funds £'000	Restricted funds £'000	**Total 2022 £'000**	Total 2021 £'000
Income					
From charitable activities					
Registration	2	125,851	-	**125,851**	114,545
Specialist and GP registration	2	4,714	-	**4,714**	4,047
Revalidation	2	182	-	**182**	107
Other trading activities	3	159	-	**159**	337
Commercial trading operations	3	351	-	**351**	239
Investments	3	1,236	-	**1,236**	154
Department of Health funding - MAPS*	3	-	2,506	**2,506**	2,605
Other	3	214	-	**214**	308
Total incoming resources		132,707	2,506	**135,213**	122,342
Expenditure					
Raising funds					
Commercial trading operations	4	325	-	**325**	246
Investment management costs	4	209	-	**209**	249
		534	-	**534**	495
Charitable activities					
Fitness to practise	4	47,633	-	**47,633**	46,882
Registration and revalidation	4	37,122	-	**37,122**	29,803
External relationships	4	16,760	-	**16,760**	15,319
Medical Practitioners Tribunal Service	4	14,875	-	**14,875**	14,012
Education	4	11,308	-	**11,308**	9,941
Standards	4	2,060	-	**2,060**	1,920
Department of Health funding - MAPS	4	-	1,551	**1,551**	1,749
		129,758	1,551	**131,309**	119,626
Other expenditure					
Legal provision	11	1,398	-	**1,398**	144
Dilapidations provision	11	286	-	**286**	1,882
		1,684	-	**1,684**	2,026
Total expenditure	4	131,976	1,551	**133,527**	122,147
Operating surplus		731	955	**1,686**	195
Net (losses)/gains on investments	8	(4,846)	-	**(4,846)**	4,879
(Net loss)/Net income		(4,115)	955	**(3,160)**	5,074
Other recognised gains and losses					
Actuarial (loss)/gain on defined benefit pension scheme	16	(41,785)	-	**(41,785)**	30,143
Net movement in funds		(45,900)	955	**(44,945)**	35,217
Total funds brought forward		98,942	856	**99,798**	64,581
Total funds carried forward		53,042	1,811	**54,853**	99,798

The General Medical Council incorporated a wholly owned trading subsidiary on 16 December 2016 with the purpose of providing services on a commercial basis including consultancy, training and accreditation. The Charity has taken exemption from presenting its unconsolidated profit and loss account. The Charity movement in funds for the year is (£45,900,000).

* The Department for Health and Social Care (DHSC) provided funding in 2022 to continue implementation work to bring physician associates and anaesthesia associates under regulation with the General Medical Council. Funding was restricted in nature, and was fully spent in the year. A proportion of the funds paid for IT System Development which has created an asset on the balance sheet. The net impact on GMC reserves is an increase of £955,000. The balance of the reserves will reduce when the asset is amortised in future periods.

Balance sheet

	Note	2022 Group £'000	2022 Charity £'000	2021 Group £'000	2021 Charity £'000
Fixed assets					
Intangible fixed assets	6	14,524	14,524	11,702	11,702
Tangible fixed assets	7	4,423	4,423	6,305	6,305
Investments	8	56,593	56,849	61,649	61,879
		75,540	**75,796**	**79,656**	**79,886**
Current assets					
Debtors and prepayments	9	27,057	27,101	24,041	24,096
Cash and bank balances		51,112	50,750	46,821	46,502
		78,169	**77,851**	**70,862**	**70,598**
Liabilities					
Creditors: amounts falling due within one year	10	(87,181)	(87,119)	(80,538)	(80,504)
Net current liabilities		(9,012)	(9,268)	(9,676)	(9,906)
Total assets less current liabilities		**66,528**	**66,528**	**69,980**	**69,980**
Provisions for liabilities and charges	11	(8,427)	(8,427)	(6,743)	(6,743)
Net assets excluding pension scheme (liability)/asset		**58,101**	**58,101**	**63,237**	**63,237**
Defined benefit pension scheme (liability)/asset	16	(3,248)	(3,248)	36,561	36,561
Total net assets		**54,853**	**54,853**	**99,798**	**99,798**
Unrestricted income funds		56,290	56,290	62,381	62,381
Restricted income funds		1,811	1,811	856	856
Pension reserve		(3,248)	(3,248)	36,561	36,561
Total funds	12, 13	**54,853**	**54,853**	**99,798**	**99,798**

The financial statements were approved by the trustees and authorised for issue on 15 June 2023.
They were signed on behalf of trustees by:



Dame Carrie MacEwen
Chair of Council

Consolidated cash flow statement

	2022		2021	
	£'000	**£'000**	£'000	£'000
Cash flows from operating activities:				
Net cash provided by/(used in) operating activities (note i below)		12,290		16,902
Cash flows from investing activities:				
Dividends, interest and rents from investments	522		84	
Purchase of property, plant, equipment and intangibles	(8,521)		(8,293)	
Net cash used in investing activities		**(7,999)**		**(8,209)**
Change in cash and cash equivalents (note ii below)		**4,291**		**8,693**

Note (i)

Cash flow from operating activities	
Net incoming/(outgoing) resources	(3,160)
Investment income and interest	(1,236)
Net investment movement	5,056
Non-cash items - depreciation and amortisation	7,581
Non-cash items - assets written off	-
Pension past service cost and curtailment	100
Pension scheme contribution	(1,362)
(Increase)/decrease in debtors	(3,016)
Increase/(decrease) in creditors and provisions	8,327
Net cash provided by/(used in) operating activities	**12,290**

Note (ii)	**Cash at bank and in hand**	**Total**
Cash and equivalents	**£'000**	**£'000**
Balances at 1 January 2022	46,821	**46,821**
Net increase in cash and cash equivalents	4,291	**4,291**
Balances at 31 December 2022	51,112	**51,112**

Notes to the accounts

General information

We are a statutory body governed by the Medical Act 1983 and are registered with the Charity Commission for England and Wales (1089278), and with the Office of the Scottish Charity Regulator (SC037750).

1. Principal accounting policies

(i) Accounting convention

The financial statements have been prepared to give a 'true and fair' view and have departed from the Charities (Accounts and Reports) Regulations 2008 only to the extent required to provide a 'true and fair' view. This departure has involved following the Charities SORP (FRS 102) first published on 16 July 2014, updated 1 October 2019.

Our financial statements have been prepared on a going concern basis and in accordance with the Charities Statement of Recommended Practice (FRS 102) - effective 1 October 2019, applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland, the Charities Act 2011, the Charities and Trustee Investment (Scotland) Act 2005, the Charities Accounts (Scotland) Regulations 2006 and UK Generally Accepted Practice as it applies from 1 October 2019. The GMC meets the definition of a public benefit entity under FRS 102.

(ii) On 16 December 2016 the GMC incorporated a trading subsidiary, GMC Services International LTD, company number 10530157, which is wholly owned by share capital by the General Medical Council.

(iii) The principal accounting policies adopted in the preparation of the financial statements, which have been applied consistently, are:

Incoming resources

Income is included in the statement of financial activities when all of the following criteria are met:

- Entitlement - control over the rights or other access to the economic benefit has passed to the GMC
- Probability - it is more likely than not that the economic benefits will flow to the GMC
- Measurement - the value can be measured reliably.

The following specific policies apply:

- Annual retention fees relate to services to be provided over a 12-month period. Income is deferred and released to the statement of financial activities on a straight-line basis over the period to which the income relates.
- Registration fees, including provisional registration fees, are recognised when registration is granted.
- Professional and Linguistic Assessments Board (PLAB) fees are recognised when the examinations are sat.
- Income from investments and funds held on deposit is recognised when it is receivable and the amount can be accurately measured.

All income is recognised gross.

Basis for recognising liabilities

Expenditure includes staffing costs, office costs, committee costs, legal costs, accommodation costs, purchase of assets, and financial, actuarial and professional costs.

Resources expended are included in the statement of financial activities on an accruals basis. All liabilities are recognised as soon as there is a legal or constructive obligation committing the charity to expenditure.

Basis for allocation of resources expended

The majority of our resources are expended directly in pursuit of our charitable aims, and are identified as such in the statement of financial activities.

Accommodation costs, governance costs and other support costs are apportioned to charitable activities on the basis of staff head count across the organisation.

Irrecoverable VAT

Any irrecoverable VAT is charged to the statement of financial activities as part of the relevant item of expenditure, or capitalised as part of the cost of the related asset where appropriate.

Taxation

We can take advantage of the exemptions from taxation on income and gains available to charities, so no taxation is payable on the net incoming resources.

Debtors

Trade and other debtors are normally recognised at the settlement amount due after any trade discount offered. Prepayments are normally valued at the amount prepaid net of any trade discounts due.

Creditors and provisions for liabilities

Creditors and provisions are recognised when the charity has a present legal or constructive obligation as a result of a past event. They are recognised when it is probable that a transfer of economic benefit will be required to settle the obligation and a reliable estimate can be made of the amount of the obligation. Creditors and provisions are normally recognised at their settlement amount after allowing for any trade discounts due.

Critical accounting judgements and key sources of estimation uncertainty

The key sources of estimation uncertainty that have a significant effect on the amounts recognised in the financial statements are:

- All unsettled claims for legal costs made against the GMC are reviewed on a case-by-case basis at the year end. Provisions are based on historical experience and a detailed assessment of the specific details of current cases. The final settlement of cases is dependent on a number of factors, so the accuracy of the provision is subject to a significant degree of uncertainty.
- Provisions for property dilapidation costs are made for all leased buildings. They are assessed on a case-by-case basis reflecting the different configurations of leased buildings and the cost to revert to their original state.
- Provisions for holiday pay are based on the actual level of accrued days and salaries of each staff member.

Tangible fixed assets

Tangible fixed assets are stated at cost, net of depreciation and any provision for impairment. Expenditure is only capitalised where the cost of the asset or group of assets acquired exceeds £5,000.

Intangible fixed assets

Intangible fixed assets comprise computer software. They are stated at cost, net of amortisation and any provision for impairment. Expenditure is only capitalised where the cost of the asset or group of assets acquired exceeds £5,000.

Depreciation

Depreciation is provided so as to write off the cost, less estimated residual value, of the assets evenly over their estimated lives.

The estimated useful lives are as follows:

- Leasehold buildings and leasehold improvements - the lesser of five years or the remaining term of the lease.
- Furniture, fixtures, and office fittings - the lesser of five years or the remaining term of the lease.
- Information Technology (IT) equipment -three years.
- Intangible assets: (IT software) - three years.
- Other office equipment - three years for IT-related items and five years for all other items.

Depreciation rates are reviewed on a regular basis comparing actual lives of assets with the accounting policy rates.

Licensed IT software

Development costs for implementing new IT systems are capitalised and depreciated over the lesser of 3 years or the useful life of the asset. The first year license costs are capitalised as they are necessary to bring the asset into use, subsequent year license costs are treated as operating expenditure.

Operating leases

Rent payable under operating leases is charged to the statement of financial activities on a straight-line basis over the period of the lease.

Financial instruments

The charity has financial assets and liabilities of a kind that qualify as basic financial instruments. Basic financial instruments are initially recognised at transaction value and subsequently measured at amortised cost. Financial assets held at amortised cost consist of cash and bank balances, short-term deposits (cash flow statement), investments held in cash deposits (note 8) together with trade and other debtors (note 9). Financial liabilities held at amortised cost comprise trade and other creditors, tax and social security creditors and accruals (note 10).

Investments

Our investment policy separates our funds into four categories: those which are required as working capital for the normal day to day operation of the business; those which we invest under management; those which we may decide to invest in a trading subsidiary; and the remaining cash balance which fluctuates during the year.

Funds held as cash for the normal day to day operation of the business are shown on the GMC's balance sheet within current assets, while funds held for the longer term are shown as investments.

Pensions

We have a defined benefit pension scheme for permanent employees. The scheme was closed to new members on 30 June 2013, and for future accrual to existing members on 31 March 2018, and replaced by a defined contribution scheme. The surplus or deficit of the defined benefit scheme is recognised on the balance sheet. Changes in the assets and liabilities of the scheme are disclosed and allocated as follows:

- Charges relating to current or past service costs, and gains and losses on settlements and curtailments, are included within staff costs and charged to the statement of financial activities.
- Interest on the net defined benefit asset/liability is shown as a net amount of other finance costs or as an incoming resource alongside investment income and interest. Actuarial gains and losses are recognised immediately in other recognised gains and losses on investments.
- The assets, liabilities and movements in the surplus or deficit of the scheme are calculated by qualified independent actuaries as an update to the latest full actuarial valuation. Details of the defined benefit scheme assets, liabilities and major assumptions are shown in the notes to the accounts.
- Our defined contribution pension scheme was set up on 1 July 2013. Contributions to the scheme are charged to the statement of financial activities in the year in which they are payable to the scheme.
- 1 member of staff who transferred to the GMC on the merger with the Postgraduate Medical Education and Training Board (PMETB), contribute to the NHS multi-employer scheme and contributions to the scheme are charged to the statement of financial activities in the year in which they are payable to the scheme.

Funds and reserves

The majority of our funds are unrestricted, and so can be expended at the trustees' discretion in pursuit of our charitable aims. Restricted funds will be expended in line with the purpose of the funding.

Termination payments

Termination payments are accounted for as soon as the organisation is aware of the obligation to make the payment.

2. Income from charitable activities

	Unrestricted funds	**Total 2022 £'000**	Unrestricted funds	**Total 2021 £'000**
Registration				
Annual retention fees	104,494	**104,494**	99,025	**99,025**
Registration fees	4,722	**4,722**	4,630	**4,630**
Provisional registration fees	455	**455**	416	**416**
PLAB fees	16,103	**16,103**	10,388	**10,388**
Other fees	77	**77**	86	**86**
	125,851	**125,851**	114,545	**114,545**
Specialist and GP registration				
Certificates of Completion of Training fees	3,197	**3,197**	2,949	**2,949**
Certificate of Eligibility for Specialist Registration/ Certificate of Eligibility for General Practitioner Registration fees	1,476	**1,476**	1,072	**1,072**
Other fees	41	**41**	26	**26**
	4,714	**4,714**	4,047	**4,047**
Revalidation				
Revalidation annual return	114	**114**	98	**98**
Revalidation assessment	68	**68**	9	**9**
	182	**182**	107	**107**

3. Income from raising funds

	Unrestricted funds	Restricted funds	**Total 2022**	Unrestricted funds	Restricted funds	Total 2021
			£'000			£'000
Activities for raising funds						
Other trading activities*	159	-	**159**	337	-	337
Commercial trading operations†	351	-	**351**	239	-	239
Other‡	214	-	**214**	308	-	308
	724	-	**724**	884	-	884
Investment income						
Other finance income - pension scheme (note 16)	714	-	**714**	70	-	70
Bank interest	522	-	**522**	84	-	84
	1,236	-	**1,236**	154	-	154
Department of Health funding						
Funding to cover expenditure on Medical Associate Professionals regulation¶	-	2,506	**2,506**	-	2,605	2,605

* Other trading activities include the reimbursement of costs of visiting overseas medical schools and the reimbursement of costs of staff seconded to external bodies.

† Income from commercial trading operations is derived from GMC Services International Ltd, a wholly owned subsidiary, which provides services on a commercial basis including consultancy, training and accreditation.

‡ Other income includes reimbursement of legal fees from appeals and transaction fees generated through registration status changes.

¶ The Department of Health and Social Care have provided funding for the General Medical Council to start implementation work to bring physician associates and anaesthesia associates under regulation with the General Medical Council. The work is ongoing and legislation is expected to be in place for regulation to start no sooner than 2024.

4. Total expenditure

Charitable activity and support cost allocation

	Direct staffing costs £'000	Direct costs £'000	Allocated costs £'000	Total 2022 £'000	Direct staffing costs £'000	Direct costs £'000	Allocated costs £'000	Total 2021 £'000
Expenditure on:								
Commercial trading operations	287	38	-	**325**	216	30	-	246
Investment management costs	-	209	-	**209**	-	249	-	249
Total expenditure on raising funds	287	247	-	**534**	216	279	-	495
Fitness to practise	21,792	6,944	18,897	**47,633**	21,354	6,774	18,754	46,882
Registration and revalidation	14,065	9,308	13,749	**37,122**	12,077	5,915	11,811	29,803
External relationships*	9,733	691	6,336	**16,760**	8,948	602	5,769	15,319
Medical Practitioners Tribunal Service	5,089	5,199	4,587	**14,875**	4,782	4,972	4,258	14,012
Education	6,883	245	4,180	**11,308**	5,841	345	3,755	9,941
Standards	1,219	7	834	**2,060**	1,109	13	798	1,920
Department of Health funding - MAPS	1,049	502	-	**1,551**	1,196	553	-	1,749
Total charitable expenditure	59,830	22,896	48,583	**131,309**	55,307	19,174	45,145	119,626
Other expenditure - legal provision	-	1,398	-	**1,398**	-	144	-	144
Other expenditure - dilapidation provision	-	286	-	**286**	-	1,882	-	1,882
Total group expenditure	60,117	24,827	48,583	**133,527**	55,523	21,479	45,145	122,147

* External relationships include the work done by our Regional Liaison Service, strategic relationships, our devolved offices, and our European and international development activities.

Support costs allocated to charitable activities

	Management £'000	IT £'000	Human resources £'000	Finance £'000	Procurement £'000	Facilities £'000	Governance £'000	Total 2022 £'000	Management £'000	IT £'000	Human resources £'000	Finance £'000	Procurement £'000	Facilities £'000	Governance £'000	Total 2021 £'000
Fitness to practise	3,416	5,852	2,495	886	163	4,651	1,434	**18,897**	3,249	6,066	2,367	875	161	4,678	1,358	**18,754**
Registration and revalidation	2,485	4,259	1,815	645	119	3,383	1,043	**13,749**	2,046	3,820	1,490	551	102	2,946	856	**11,811**
External relationships*	1,145	1,963	836	297	55	1,559	481	**6,336**	999	1,866	728	269	50	1,439	418	**5,769**
Medical Practitioners Tribunal Service	829	1,421	605	215	40	1,129	348	**4,587**	738	1,377	537	199	37	1,062	308	**4,258**
Education	756	1,295	552	196	36	1,029	317	**4,181**	650	1,215	474	175	32	937	272	**3,755**
Standards	151	258	110	39	7	205	63	**833**	138	258	101	37	7	199	58	**798**
Total charitable expenditure	8,782	15,048	6,413	2,278	420	11,956	3,686	**48,583**	7,820	14,602	5,697	2,106	389	11,261	3,270	**45,145**

Support costs are allocated to charitable activities on the basis of staff head count across the organisation.

Support cost recharges have been made to both the trading subsidiary, GMCSI, and the MAPS project throughout the year on a direct basis therefore are treated separately to the year end allocation.

Group expenditure by type

	Charitable activities 2022	**Expenditure on raising funds 2022**	**Department of Health funding - MAPS 2022**	**Other expenditure 2022**	**Total 2022**	Charitable activities 2021	Expenditure on raising funds 2021	Department of Health funding - MAPS 2021	Other expenditure 2021	Total 2021
	£'000	**£'000**	**£'000**	**£'000**	**£'000**	£'000	£'000	£'000	£'000	£'000
Staffing costs	82,261	288	1,049	-	**83,598**	74,880	216	1,196	-	76,292
Office costs	1,781	24	444	-	**2,249**	1,412	24	530	-	1,966
Council and committee costs	407	-	-	-	**407**	359	-	-	-	359
Panel and assessment costs	16,770	-	28	-	**16,798**	13,220	-	-	-	13,220
Legal costs	4,706	-	-	1,398	**6,104**	4,408	-	-	144	4,552
Accommodation costs	7,637	-	-	286	**7,923**	7,016	-	-	1,882	8,898
Financial, actuarial and professional costs	4,028	222	30	-	**4,280**	4,115	255	23	-	4,393
Purchase of assets - charged to revenue	4,587	-	-	-	**4,587**	4,301	-	-	-	4,301
Assets written off	-	-	-	-	**-**	1	-	-	-	1
Depreciation	2,595	-	-	-	**2,595**	3,163	-	-	-	3,163
Amortisation	4,986	-	-	-	**4,986**	5,002	-	-	-	5,002
	129,758	534	1,551	1,684	**133,527**	117,877	495	1,749	2,026	122,147

Total resources expended includes:

	2022	2021
Operating lease costs: leasehold property and equipment	3,669	3,639
Audit fees	48	43

5. Staff

	2022	2021
	£'000	£'000
Total costs of all staff		
Salaries	**63,993**	59,022
Social security costs	**6,992**	6,189
Superannuation costs - defined benefit scheme	**100**	-
Superannuation costs - defined contribution scheme	**9,082**	8,487
Redundancy costs	**80**	202
Other staffing costs	**3,351**	2,392
	83,598	76,292

During the year the General Medical Council made termination payments of £236,000 (2021: £40,000) which included £162,000 relating to decisions made and accrued in 2021. At year-end payments of £6,000 were outstanding (2021: £162,000).

	2022	2021
Average staff numbers in the year by category		
Fitness to practise	**465**	478
Registration and revalidation	**338**	301
External relationships	**156**	147
Medical Practitioners Tribunal Service	**113**	109
Education	**103**	96
Standards	**20**	20
Governance and management	**165**	154
Resources	**226**	217
	1,586	1,522
GMC Services International Ltd	**1**	1
	1,587	1,523

The number of staff whose total employee benefits (excluding employer pension contributions) fell into higher salary bands was:

	2022	2021
GMC		
£60,000-£70,000	59	52
£70,001-£80,000	50	57
£80,001-£90,000	46	28
£90,001-£100,000	12	14
£100,001-£110,000	11	7
£110,001-£120,000	10	11
£120,001-£130,000	7	9
£130,001-£140,000	3	3
£140,001-£150,000	4	4
£150,001-£160,000	2	1
£200,001-£210,000	-	6
£210,001-£220,000	6	-
£250,001-£260,000	-	1
£260,001-£270,000	1	-
	211	193
MPTS		
£60,000–£70,000	2	2
£70,001–£80,000	-	1
£80,001–£90,000	2	2
£90,001–£100,000	2	1
£110,001–£120,000	1	1
	7	7
Total	218	200

	2022	2021
Number of staff included above for whom retirement benefits are accruing		
GMC defined contribution pension scheme	217	197
NHS defined benefit pension scheme	-	1
Not in scheme	1	2
	218	200

The senior management team includes the Chief Executive and six permanent directors in 2022. The total employee benefits (including employer pension contributions) of the senior management team was £1,759,804 in 2022. The equivalent figure for 2021 was £1,705,118.

Senior management team remuneration	**Basic salary 2022**	**Basic salary 2021**
	£'000	**£'000**
Charlie Massey - Chief Executive	255	248
Shaun Gallagher - Director of Strategy and Policy	208	202
Una Lane - Director of Registration and Revalidation	208	203
Colin Melville - Director of Education and Standards	208	203
Anthony Omo - Director of Fitness to Practise	208	203
Paul Reynolds - Director of Strategic Communications and Engagement	208	203
Neil Roberts - Director of Resources	208	203

All GMC staff, including the senior management team, are entitled to pension contributions of 15% of salary into the GMC Group Personal Pension Plan and may exchange contributions for salary.

The Chief Executive and Directors receive non consolidated pay. In 2022 payments were below 3% of basic salary for all members of the senior management team. No payments were made in 2021.

All GMC staff, including the senior management team, are entitled to buy and sell leave and to the taxable benefit of private medical insurance. These costs and benefits are not included in the table above.

The Chief Executive's salary is 7.57 (2021: 7.67) times the median salary and 12.8 (2021: 13.2) times the lowest salary.

There were no related party transactions in the year that require disclosure other than payments made to Trustees as disclosed in notes 17 and 18.

6. Intangible fixed assets

Group and charity

	Computer software and systems development £'000
Cost	
Balance at 1 January 2022	**30,949**
Additions	**7,808**
Disposals	**(3,924)**
Balance at 31 December 2022	**34,833**
Amortisation	
Balance at 1 January 2022	**19,247**
Amortisation charge for year	**4,986**
Disposals	**(3,924)**
Balance at 31 December 2022	**20,309**
Balance at 1 January 2022	**11,702**
Net book value at 31 December 2022	**14,524**

Intangible assets incorporates all IT software development costs including, but not limited to, the development of our strategic applications, Siebel, Livelink and Agresso, the development of IT security systems, facilities management systems and website. Intangible assets also include the systems to support working from home and mobile applications.

7. Tangible fixed assets

Group and charity

	Buildings	Fixtures, furniture and equipment	IT equipment	Total
	£'000	£'000	£'000	£'000
Cost				
Balance at 1 January 2022	2,188	14,532	8,072	**24,792**
Additions	-	147	566	**713**
Disposals	-	(57)	(1,255)	**(1,312)**
Balance at 31 December 2022	2,188	14,622	7,383	**24,193**
Depreciation				
Balance at 1 January 2022	2,000	10,070	6,417	**18,487**
Depreciation charge for year	74	1,524	997	**2,595**
Disposals	-	(57)	(1,255)	**(1,312)**
Balance at 31 December 2022	2,074	11,537	6,159	**19,770**
Net book value at 1 January 2022	188	4,462	1,655	**6,305**
Net book value at 31 December 2022	114	3,085	1,224	**4,423**

8. Investments

Managed funds

	Group		Charity		
	Listed Investments	Total	Listed Investments	Equity Investment in Group Undertakings	Total
	£'000	£'000	£'000	£'000	£'000
The valuation at the end of the year consisted of:					
As at 1st January 2022	61,649	**61,649**	61,649	230	**61,879**
Additions	18,789	**18,789**	18,789	-	**18,789**
Disposals	(18,999)	**(18,999)**	(18,999)	-	**(18,999)**
Gain on investments	(4,846)	**(4,846)**	(4,846)	-	**(4,846)**
Reversal of Impairment*	-	**-**	-	26	**26**
Balance at 31 December 2022	**56,593**	**56,593**	**56,593**	**256**	**56,849**

* The General Medical Council incorporated a wholly owned trading subsidiary on 16 December 2016. Having previously been impaired by £370,000 due to trading losses incurred, we have reversed the impairment of the investment by £26,000 in 2022 as a result of profits generated by the company thereby increasing its net assets.

Listed investments are managed by CCLA Investment Management Ltd. Investment management fees of £209,170 were incurred (2021: £249,422).

9. Debtors

	2022		2021	
	Group	**Charity**	Group	Charity
	£'000	**£'000**	£'000	£'000
Amounts falling due within one year				
Registration debtors	**20,935**	**20,935**	18,810	18,810
Prepayments and accrued income	**5,785**	**5,849**	5,054	5,121
Other debtors	**337**	**317**	177	165
	27,057	**27,101**	24,041	24,096

10. Creditors

	2022		2021	
	Group	**Charity**	Group	Charity
	£'000	**£'000**	£'000	£'000
Amounts falling due within one year				
Trade creditors	**1,427**	**1,420**	877	872
Tax and social security	**1,945**	**1,933**	1,829	1,825
Holiday pay	**1,107**	**1,107**	1,106	1,106
Accruals	**8,404**	**8,361**	9,050	9,025
Deferred income	**74,298**	**74,298**	67,676	67,676
	87,181	**87,119**	80,538	80,504

Charity deferred income

Income from annual retention fees is deferred and released to the statement of financial activities on a straight-line basis over a 12 month period from the date of renewal. All deferred income brought forward from the previous year is released to the statement of financial activities in the following year. Professional and Linguistic Assessments Board (PLAB) fees are deferred to the date the examination is sat.

	Annual retention fees	**PLAB fees**	**Specialist and GP registration fees**	**Revalidation assessment fees**	**Total**
	£'000	**£'000**	**£'000**	**£'000**	**£'000**
Deferred income at 1 January 2022	57,356	10,222	57	41	**67,676**
Resources deferred during the year	61,800	12,433	24	42	**74,299**
Amounts released from previous years	(57,356)	(10,222)	(57)	(41)	**(67,676)**
Deferred income at 31 December 2022	**61,800**	**12,433**	**24**	**42**	**74,299**

11. Provisions

Group and charity

	2022	2021
	£'000	£'000
Dilapidations	**3,141**	2,855
Legal claims	**5,286**	3,888
	8,427	6,743

Dilapidations - each year we review our property leases and make a provision for dilapidations, where the cost can be reasonably estimated. Legal claims - Each year we make a provision for potential costs related to ongoing legal cases. Within this provision we hold an estimate for the additional sums due to a wider group of individuals but arising from the determination of a single employment tribunal. The full financial implications of this legal proceeding have yet to be determined, and therefore the amounts remain unsettled in the current year. We are choosing not to disclose further information until the matter is fully settled so as not to prejudice proceedings.

	Dilapidations	Legal claims	Total
	£'000	**£'000**	**£'000**
Provisions at 1 January 2022	2,855	3,888	**6,743**
Provisions created during the year	286	1,743	**2,029**
Amounts released from previous years	-	(345)	**(345)**
Provisions at 31 December 2022	**3,141**	**5,286**	**8,427**

12. Group fund movements in the year

Group and charity

	Unrestricted funds	Restricted funds	Pension fund	2022 Total
	£'000	**£'000**	**£'000**	**£'000**
At 1 January 2022	62,381	856	36,561	99,798
Net incoming/(outgoing) resources	(6,091)	955	(39,809)	(44,945)
At 31 December 2022	**56,290**	**1,811**	**(3,248)**	**54,853**

	Unrestricted funds	Restricted funds	Pension fund	2021 Total
	£'000	£'000	£'000	£'000
At 1 January 2021	60,593	-	3,988	64,581
Net incoming/(outgoing) resources	1,788	856	32,573	35,217
At 31 December 2021	**62,381**	**856**	**36,561**	**99,798**

13. Net assets by fund

Group and charity

Fund balances at 31 December 2022 are represented by

	Unrestricted funds	Restricted fixed asset funds	Pension reserve	2022 Total funds
	£'000	£'000	£'000	£'000
Intangible fixed assets	12,713	1,811	-	14,524
Tangible fixed assets	4,423	-	-	4,423
Investments	56,593	-	-	56,593
Current assets	78,169	-	-	78,169
Current liabilities	(87,181)	-	-	(87,181)
Provisions for liabilities and charges	(8,427)	-	-	(8,427)
Pension scheme asset	-	-	(3,248)	(3,248)
Total net assets	**56,290**	**1,811**	**(3,248)**	**54,853**

	Unrestricted funds	Restricted fixed asset funds	Pension reserve	2021 Total funds
	£'000	£'000	£'000	£'000
Intangible fixed assets	10,846	856	-	11,702
Tangible fixed assets	6,305	-	-	6,305
Investments	61,649	-	-	61,649
Current assets	70,862	-	-	70,862
Current liabilities	(80,538)	-	-	(80,538)
Provisions for liabilities and charges	(6,743)	-	-	(6,743)
Pension scheme asset	-	-	36,561	36,561
Total net assets	**62,381**	**856**	**36,561**	**99,798**

14. Capital commitments

Capital expenditure contracted but unspent at 31 December 2022 amounted to £799,978. The equivalent figure for 2021 was £63,936.

15. Operating lease commitments

	Land and buildings		Equipment	
	2022	2021	**2022**	2021
Expiry date	**£'000**	£'000	**£'000**	£'000
Within one year	**4,580**	**4,557**	**48**	**97**
In years two to five	**5,158**	**8,624**	**-**	**48**
After more than five years	**1,443**	**2,530**	**-**	**-**
	11,181	**15,711**	**48**	**145**

Commitments include our obligations under our buildings and equipment leases. They are calculated up to the first lease break clause or lease end where there is no break clause in the agreement. Commitments are calculated on a cash basis rather than incorporating rent free benefits.

16. Superannuation schemes

The GMC has three staff pension schemes:

GMC Group Personal Pension Plan

This is a defined contribution pension scheme, which was set up on 1 July 2013. We started auto enrolment on 1 November 2013. At the end of 2022 there were 1,587 members of staff contributing to this scheme. It meets the government's requirements following the introduction of automatic enrolment. Individuals can choose to make additional contributions by deduction from salary to the scheme. Under the terms of FRS102, contributions are accounted for as a defined contribution scheme based on actual contributions paid through the year.

NHS Multi-Employer Scheme

We have 0 members of staff who contribute to the NHS multi-employer scheme (2021: 1 member of staff), which is a defined benefit scheme. The staff member transferred to the GMC on the merger with PMETB. The scheme operates as a pooled arrangement, with contributions paid at a centrally agreed rate. The trustees are unable to confirm the GMC's share of the underlying assets and liabilities of the NHS scheme and so, under the terms of FRS102, contributions are accounted for as if the scheme were a defined contribution scheme based on actual contributions paid through the year.

GMC Staff Superannuation Scheme

This is a funded scheme of the defined benefit type, providing retirement benefits based on final salary. The top-up arrangement is an unfunded scheme.

This scheme was closed to new members on 30 June 2013, and replaced by the GMC Group Personal Pension Plan. The scheme was closed to future accruals for existing members on 31 March 2018 therefore at the end of 2018 there were no members of staff contributing to this scheme.

The FRS 102 valuation has been based on a full assessment of the liabilities for the Scheme as at 31 December 2021. The present values of the defined benefit obligation, the related current service cost and any past service costs were measured using the projected unit credit method.

Actuarial gains and losses have been recognised in the period in which they occur (but outside the profit and loss account) through the Other Comprehensive Income (OCI).

The GMC recognises surplus in accordance with the requirements of FRS 102 Section 18. The trustees of the Scheme do not have the unilateral right to commence wind-up of the Scheme.Thus, the GMC assumes that the Scheme continues in existence until the last benefit payments are made to members, at which point any residual assets are returned to the GMC in line with the rules of the Scheme.

The GMC made a top up payment to the scheme of £1.3m in 2022 and this will increase to a fixed annual contribution of £1.5m each year until 2031 under the terms of the recovery plan agreed as part of the 2021 triennial valuation. A further £5.0m between 2023 and 2025 will also be paid into the pension scheme to fund the deficit.

Responsibility for investing pension scheme assets rests with pension trustees. The Pensions Act 1995 requires trustees to draw up a Statement of Investment Principles, setting out the scheme's investment strategy. Pension trustees are required to consult the employer (GMC) when drawing up the strategy, but do not require the employer's formal agreement. Following consultation with the GMC, in 2014 the pension trustees adopted a fiduciary management approach to the investment of the scheme's assets.

The principal assumptions used by the independent qualified actuaries to calculate the liabilities under FRS102 are set out below.

Main financial assumptions

	31 December 2022	31 December 2021
	%pa	%pa
Retail Prices Index inflation	3.1	3.1
Consumer Price Index inflation	2.7	2.7
Rate of general long-term increase in salaries	3.7	3.7
Pension increases (excess over guaranteed minimum pension)	2.7	2.7
Discount rate for scheme liabilities	4.6	1.9

Mortality assumptions

The mortality assumptions are based on standard mortality tables which allow for expected future mortality improvements. The assumptions are that a member currently aged 65 will live on average for a further 22.2 years (2021: 22.7 years) if they are male and for a further 24.1 years if they are female (2021: 24.5 years).

For a member who retires in 2042 at age 65 the assumptions are that they will live on average for a further 23.2 years after retirement if they are male and for a further 25.3 years after retirement if they are female.

Scheme asset allocation

	31 December 2022		31 December 2021	
	£'000	**%**	£'000	%
Delegated consulting services	**155,728**	**99%**	327,665	99%
Other	**1,256**	**1%**	1,891	1%
Total	**156,984**	**100%**	329,556	100%

The Delegated Consulting Service (DCS) is a fiduciary management solution that invests in a wide range of underlying assets in order to meet the Scheme's specific investment objectives. The underlying asset allocation changes over time, based on the views of the fiduciary manager within the overall bounds set by the trustees. Under this approach the majority of scheme assets are invested in pooled funds. The managers of the pooled funds are required to have in place a policy on social, environmental and ethical considerations.

None of the Scheme assets are invested in the Company's financial instruments or in property occupied by, or other assets used by, the GMC.

Reconciliation of funded status to balance sheet

	31 December 2022	31 December 2021
	£'000	£'000
Fair value of assets	**156,984**	329,556
Present value of funded defined benefit obligations	**(159,407)**	(291,864)
Funded status	**(2,423)**	37,692
Present value of unfunded defined benefit obligation	**(825)**	(1,131)
(Liability)/asset recognised on the balance sheet	**(3,248)**	36,561

Commitments include our obligations under our buildings and equipment leases. They are calculated up to the first lease break clause or lease end where there is no break clause in the agreement. Commitments are calculated on a cash basis rather than incorporating rent free benefits.

Amounts recognised in income statement

	31 December 2022	31 December 2021
	£'000	£'000
Operating cost:		
Past service cost	**100**	-
Financing cost:		
Interest on net defined benefit liability/(asset)	**(714)**	(70)
Pension income recognised in profit and loss	**(614)**	(70)

Amounts recognised in Other Comprehensive Income (OCI)

	31 December 2022	31 December 2021
	£'000	£'000
Asset (losses)/gains arising during the year	**(175,762)**	19,325
Liability gains/(losses) arising during the year	**133,977**	10,818
Actuarial (loss)/gain on defined benefit pension Scheme	**(41,785)**	30,143

Changes to the present value of the defined benefit obligation during the year

	31 December 2022	31 December 2021
	£'000	£'000
Opening defined benefit obligation (DBO)	**292,995**	302,281
Interest expense on DBO	**5,525**	4,213
Actuarial (gains) on liabilities	**(133,977)**	(10,818)
Net benefits paid out	**(4,411)**	(2,681)
Past service cost	**100**	-
Closing defined benefit obligation	**160,232**	292,995

Changes to the fair value of Scheme assets during the year

	31 December 2022	31 December 2021
	£'000	£'000
Opening fair value of Scheme assets	**329,556**	306,269
Interest income on Scheme assets	**6,239**	4,283
(Loss)/gain on Scheme assets	**(175,762)**	19,325
Contributions made by the company	**1,362**	2,360
Net benefits paid out	**(4,411)**	(2,681)
Closing fair value of Scheme assets	**156,984**	329,556

Actual return on Scheme assets

	31 December 2022	31 December 2021
	£'000	£'000
Interest income on Scheme assets	**6,239**	4,283
Gain/(loss) on Scheme assets	**(175,762)**	19,325
Actual return on Scheme assets	**(169,523)**	23,608

17. Honoraria

	2022	2021
Trustees		
Dame Clare Marx (Chair)*	-	64,167
Professor Dame Carrie MacEwen (Acting Chair)†	97,083	41,055
Mr Steve Burnett	18,000	18,000
Dr Vanessa Davies‡	18,000	18,000
Professor Anthony Harnden	18,000	18,000
Lord Philip Hunt	18,000	18,000
Professor Paul Knight	18,000	18,000
Ms Lara Fielden¶	-	12,000
Professor Deepa Mann-Kler‡	18,000	18,000
Dr Rajesh Patel	18,000	18,000
Dr Suzanne Shale‡	18,000	18,000
Miss Alison Wright	18,000	18,000

* Demitted as Council Member and Chair 31 July 2021.

† Appointed as Council Member in January 2021 and Acting Chair from 1 August 2021 and appointed chair from 1 May 2022.

‡ Appointed as a Council Member in 2021.

¶ Appointed as a Council Member January 2021, deceased August 2021.

Honoraria payments are permitted by the governing document of the General Medical Council, The Medical Act 1983, paragraph 17, schedule 1.

Medical Practitioners Tribunal Service Committee members	2022	2021
Dame Caroline Swift	97,657	93,286
Mrs Joy Hamilton	3,720	3,720
Professor Jacky Hayden	7,440	7,440
Gill Edelman (Gillian Gordon)*	3,720	564
Dr Tushar Vince¶	1,166	564
Dr Simon Mackenzie†	1,113	-
Dr Patricia Moultrie‡	-	3,156
Mrs Judith Worthington‡	-	3,156

* Appointed as MPTS Committee member 2021.

† Appointed as an MPTS Committee member 2022.

‡ Demitted as MPTS Committee member 2021.

¶ Appointed as MPTS Committee member 2021 and demitted in April 2022.

Audit and Risk Committee co-opted members	2022	2021
Elizabeth Butler*	-	1,473
Jon Hayes†	4,030	930
Kenneth Gill	3,255	2,945

* Demitted as ARC co-opted member 2021.

† Appointed as ARC co-opted member 2021.

Investment Committee co-opted members	2022	2021
Keith Mackay	2,945	2,170
Tim Scholefield*	-	620
David Stewart*	-	-
Michael Jennings†	2,480	620

* Demitted as IC co-opted member 2021.

† Appointed as IC co-opted member 2021.

GMC Services International Ltd	2022	2021
Dr Andrew McCulloch	310	-

18. Travel and subsistence expenses claimed in 2022

	2022	2021
Trustees		
Dame Clare Marx (Chair)*	-	-
Professor Dame Carrie MacEwen (Acting Chair)†	1,812	236
Mr Steve Burnett	2,840	732
Dr Vanessa Davies‡	1,395	706
Professor Anthony Harnden	555	184
Lord Philip Hunt	383	-
Professor Paul Knight	3,127	1,689
Ms Lara Fielden¶	-	-
Professor Deepa Mann-Kler‡ **	5,133	2,878
Dr Rajesh Patel	1,631	942
Dr Suzanne Shale‡	431	-
Miss Alison Wright	-	-

* Demitted as Council Member and Chair 31 July 2021.

† Appointed as Council Member in January 2021 and Acting Chair from 1 August 2021.

‡ Appointed as a Council Member in 2021.

¶ Appointed as a Council Member January 2021, deceased August 2021.

** Professor Mann-Kler is our Council representative based in Northern Ireland and as such incurs higher travel and subsistence expenses to carry out her responsibilities as a Council Member.

Medical Practitioners Tribunal Service Committee members	2022	2021
Dame Caroline Swift	25	463
Mrs Joy Hamilton	-	-
Professor Jacky Hayden	508	302
Gill Edelman (Gillian Gordon)*	-	167
Dr Tushar Vince¶	-	-
Dr Simon Mackenzie†	328	-
Dr Patricia Moultrie‡	-	-
Mrs Judith Worthington‡	-	-

* Appointed as MPTS Committee member 2021

† Appointed as MPTS Committee member 2022

‡ Demitted as MPTS Committee member 2021

¶ Appointed as MPTS Committee member 2021 and demitted in April 2022

Audit and Risk Committee co-opted members	2022	2021
Elizabeth Butler*	-	-
Jon Hayes†	278	241
Kenneth Gill	522	-

* Demitted as ARC co-opted member 2021.

† Appointed as ARC co-opted member 2021.

Investment Committee co-opted members	2022	2021
Keith Mackay	56	74
Tim Scholefield*	-	-
David Stewart*	-	-
Michael Jennings†	127	26

* Demitted as IC co-opted member 2021.

† Appointed as IC co-opted member 2021.

GMC Services International Ltd	2022	2021
Dr Andrew McCulloch	-	-

	2022	2021
Senior management team		
Charlie Massey - Chief Executive	4,903	1,118
Shaun Gallagher - Director of Strategy and Policy	3,982	1,355
Una Lane – Director of Registration and Revalidation	2,603	971
Colin Melville - Director of Education and Standards	3,906	392
Anthony Omo – Director of Fitness to Practise	3,769	-
Paul Reynolds - Director of Strategic Communications and Engagement	3,697	156
Neil Roberts – Director of Resources	7,491	2,164

Variations in expenses reflect that the trustees, committee members and the Senior Management Team live in different parts of the UK and are required to travel around the UK on GMC business, including to our offices in London, Manchester, Edinburgh, Belfast and Cardiff, and occasionally outside the UK.

Adjustments are also made for those with disabilities, which may mean that additional expenses are incurred for travel and accommodation according to specific needs.

Reference and administrative information

We are independent of UK government and the medical profession and accountable to Parliament. Our powers are given to us by Parliament through the *Medical Act 1983*.

We are registered with the Charity Commission for England and Wales (1089278), and with the Office of the Scottish Charity Regulator (SC037750). We are not currently required to be registered separately with the Northern Ireland Charity Commission.

Our principal places of business are 3 Hardman Street, Manchester M3 3AW and Regent's Place, 350 Euston Road, London NW1 3JN. We also have offices in Belfast, Cardiff and Edinburgh; a centre for hearings, where the MPTS is based, at St James's Buildings, 79 Oxford Street, Manchester M1 6FQ; and a Clinical Assessment Centre, in 3 Hardman Square, Manchester M3 3EB.

Our trustees have a duty to act impartially and objectively, and to take steps to avoid any conflict of interest arising as a result of their membership of, or association with, other organisations or individuals. As trustees, members have a duty to avoid putting themselves in a position where their personal interests conflict with their duty to act in the interests of the charity, unless authorised to do so. To make this fully transparent, we publish a register of members' interests on our website.

Day-to-day management of the organisation is delegated to the Chief Executive, Charlie Massey. You can read more about our governance and management arrangements from page 40.

We work with the Professional Standards Authority (PSA), an independent body, which is accountable to Parliament and scrutinises and oversees our work, together with other health and social care professional regulatory bodies in the UK.

Information requests

In 2022, we received 407 subject access requests under the General Data Protection Regulation (GDPR). This was an increase of 1.2% from 2021. The number of information requests we received under the Freedom of Information Act 2000 (FOI) in 2022 was 820. This was a 2.5% decrease from 2021.

We achieved 82.2% against our target of responding to 80% of subject access requests within the statutory timeframe. We achieved 85.6% against our target of responding to 90% of FOI requests within 20 working days.

Paying for goods and services

We paid 98% of valid and undisputed invoices within 30 days and did not pay any interest to suppliers due to late payment in excess of 30 days.

Professional advisers

Bankers	Royal Bank of Scotland 250 Bishopsgate London EC2M 4AA
Solicitors	The majority of our legal work is carried out by our in-house legal team.
Auditors	Crowe U.K. LLP 2nd Floor, 55 Ludgate Hill London EC4M 7JW
Actuary and pension scheme adviser	Aon Parkside House, Ashley Road Epsom Surrey KT18 5BS

Email: gmc@gmc-uk.org

Website: gmc-uk.org

Telephone: 0161 923 6602

Textphone: **please dial the prefix 18001** then **0161 923 6602** to use the Text Relay service

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Published July 2023

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The GMC is a charity registered in England and Wales (1089278) and Scotland (SC037750).

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GENERAL MEDICAL COUNCIL

England & Wales - Charity number 1089278

Accounts

General Medical Council

Annual Report 2021

Trustees annual report and accounts for the year ended 31 December 2021

General Medical Council

General Medical Council

Annual Report 2021

Trustees annual report and accounts for the year ended 31 December 2021

Presented to Parliament pursuant to section 52A of the Medical Act 1983 as amended by The Health Care and Associated Professions (Miscellaneous Amendments) Order 2008 (SI No.1774).

General Medical Council









Our annual report 2021

General Medical Council

About this report

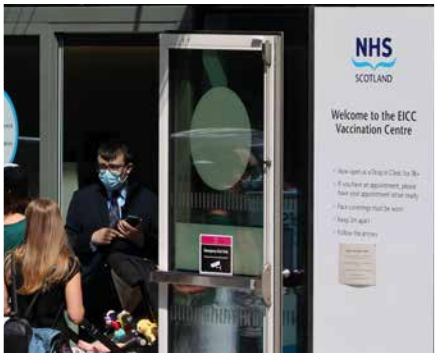
Our trustees present this report and financial statement for the year ending 31 December 2021.

They confirm they have taken into account the Charity Commission's public benefit guidance when reviewing our aims and objectives and have had regard to this guidance when exercising any powers or duties or when making a decision to which the guidance is relevant. The trustees are satisfied that at all times we have operated for public benefit and that the activities as described in this report and accounts fully meet the public benefit requirements and support our charitable purpose.











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Foreword

2021 continued to put our healthcare systems under severe strain. Two years into the COVID-19 pandemic, healthcare professionals were still delivering excellent care under exceptionally difficult circumstances. Some tragically lost their lives, and that loss is deeply felt.

We have seen health services and healthcare workers adapt and innovate rapidly to do the best they can for patients, and their compassion and dedication has been remarkable. But that has taken a toll on doctors' health and well-being. The acute emergency of COVID-19 has now given way to a sustained pressure, and with that come new, longer-term challenges. Our 2021 *The state of medical education and practice in the UK* (SOMEP) report underlined this, with doctors telling us of increasing workloads, fatigue, and burnout, and 23% indicating that they intended to leave the profession.

For doctors to thrive and provide the best patient care, we need inclusive, supportive work environments and compassionate leadership that puts doctors' well-being – and the positive effect it has on patient safety – to the fore. The advantages for patients are clear. Inclusive, communicative teams in which doctors are comfortable asking for help and expressing concerns provide the safest care and create environments where teams learn from mistakes. The GMC has a key role in working alongside employers and doctors to create those environments.

Much or our work in 2021 focused on providing that support at a difficult time for healthcare services across the UK.

In postgraduate training, we approved derogations to curricula so that doctors in training could progress safely and flexibly during the pandemic and, as part of our enhanced monitoring process, we took decisive action to protect patients and doctors in training, including working with health education authorities to remove trainees from training environments where necessary. In undergraduate education, we supported medical schools in making decisions about graduating students whose studies had been disrupted as a result of the pandemic, and continued the rollout of our proactive education quality assurance process to make sure schools maintain the quality of the training they offer even in challenging circumstances.

To reduce pressures on doctors and employers, we rescheduled revalidation submission dates, and worked with colleagues across the system to discuss how appraisals could be used to support doctors to think about and process their experiences of working through the pandemic. In addition, we have taken a flexible and proportionate approach to investigations, knowing that some employers, doctors, and other organisations may take longer to assist with our investigations during this pressurised time, meaning some cases could progress more slowly.

It was also important to us to reassure doctors that we know they are still working in exceptional circumstances. So, we issued updated guidance for decision makers on taking the current context into account when considering complaints. During the winter of 2021 we also launched a campaign of support, reassurance and recognition, in anticipation of seasonal pressures on our health services.

The pandemic also had an impact on our work to support the development of a more sustainable workforce. Enabling international medical graduates to join our health services is essential, and in 2020 this flow was heavily impacted by travel restrictions and social distancing. In order to address this, we opened a second clinical assessment centre, bringing testing capacity back to pre-pandemic levels so that more new doctors can join the UK medical workforce. As a result, over 10,000 international medical graduates joined the UK medical register in 2021.

While significant challenges remain, there are also opportunities that should be embraced. Our 2021 SOMEP report evidenced that supportive, collaborative cultures had improved across healthcare teams. We also saw our health services adapt and innovate rapidly. These are things we must learn from and build upon for the future: the benefits are clear, for both patients and doctors.

2021 was also the year in which we committed to targets to tackle racial inequalities in medicine, working with partners across healthcare services to lay foundations for improvements in fairness.

We know that doctors from ethnic minority backgrounds, or who qualified outside the UK, are significantly more likely to be referred to us by their employers, and that they also face barriers when it comes to medical education and training. Beyond the obvious need to address a situation that is fundamentally unfair, with just under 65% of new doctors identifying as being from a mixed, Black, or Asian ethnic minority background, our health services will not be able to retain the professionals they need, let alone enable doctors to fulfil their potential and maximise their contribution, if we do not offer them the support and inclusivity they should rightly expect. We have identified two targets in this respect: we want to see the end of inequality in referrals by 2026 and in educational attainment by 2031.

These are ambitious targets, and we cannot achieve them alone, so we will continue to engage and work with employers, educators, and other stakeholders to deliver real change. As part of this work, we are also reviewing the fairness of our own processes.

As we look ahead, there are fundamental changes on the horizon for medical regulation.

We expect legislative reforms to empower us to be a more flexible and responsive regulator, one that can deal with complaints more quickly and reduce stress for everyone involved. We will also be able to streamline our registration processes to sustain a steady flow of new doctors into the UK's healthcare systems. We will have new powers linked to education and training, so we can support medical professionals through their studies and career. In a historic move for medical regulation, legislative reforms will also bring two new professional groups under our regulatory umbrella: physician associates (PAs) and anaesthesia associates (AAs). PAs and AAs are pivotal to healthcare teams. Our planning to bring these groups under our regulation has been informed by productive engagement with PAs, AAs, and other healthcare professionals and we look forward to continuing to develop these relationships.

We also made further preparations to introduce a new assessment for doctors wishing to join the medical register – the Medical Licensing Assessment. Graduates who pass the assessment will have demonstrated they meet an agreed standard of proficiency – giving patients, employers, and fellow doctors greater confidence in their competence and their skills, wherever they trained. We must also look ahead to our review of *Good medical practice*, the core guidance that outlines the values, knowledge, and behaviours we expect from members of the profession. It underpins not only doctors' practice, but also their education and training, and is at the heart of what it means to be a good doctor.

There is much to do towards recovery, renewal, and reform as we emerge from the most acute phase of the pandemic, but as this report sets out, we have made considerable progress in what was year one of our five-year corporate strategy.

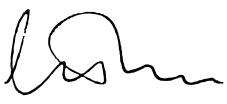
Our role is to make sure medical professionals continue to be trained and supported to deliver the safest and most effective care to patients and the public. We are confident that we remain on course to play this role, working with doctors, employers, and educators to protect and promote patient safety across the UK.





Charlie Massey, Chief Executive





Professor Dame Carrie MacEwen, Chair

Our role in the UK's healthcare systems

We are the UK's independent regulator of doctors. Our role is to protect the health, safety, and well-being of patients and the public. We do this by:

- promoting and maintaining professional standards for doctors
- overseeing UK medical education and training
- taking action when the safety of patients or the public's confidence in doctors is at risk.

How we keep patients safe

Keeping patients safe and protecting public confidence in doctors is at the core of our work.

- We set the standards for doctors. Our standards define what makes a good doctor. They set out the professional values, knowledge, skills, and behaviours required of all doctors working in the UK. To develop our standards and guidance, we consult with patients, doctors, employers, and educators.
- We oversee all stages of doctors' undergraduate and postgraduate education and training in the UK. We make sure doctors get the education and training they need to deliver high-quality care throughout their careers. We do this by setting out the outcomes needed for graduates and by approving curricula for postgraduate education. We also monitor training environments to support safe, effective learning.
- We manage the UK medical register. We check doctors' qualifications before they join the register. When necessary, we check their skills. We also check with medical schools or previous employers to find out if they have any concerns about a doctor's ability to practise safely.
- We make sure doctors keep their knowledge and skills up to date. We do this through revalidation, a system that checks that all doctors have an annual appraisal and that they are following the standards we set. Revalidation is a fundamental part of clinical governance. It gives patients and the public assurance that doctors in the UK are part of a governed system. It also supports the identification and management of concerns at an early stage.
- We investigate and act on concerns about doctors. When someone raises a concern about a doctor with us, we assess whether it meets our threshold for investigation. If it does, we investigate. At the end of the investigation, we decide what action we need to take. This can include taking no action, issuing advice or a warning, or agreeing that the doctor will restrict their practice, retrain, or work under supervision. In some situations, we refer the case to the Medical Practitioners Tribunal Service (MPTS).

The MPTS is independent in its decision making and operates separately from the investigatory role of the GMC. It produces its own separate annual report.

Our performance

Every year, the Professional Standards Authority assesses our performance as a regulator across our four core functions: education and training, registration, guidance and standards, and fitness to practise.

Its latest annual assessment confirmed that we successfully met all 18 of its Standards of Good Regulation in 2020–2021. This means we are performing to a high standard as a regulator. It also reflects the commitment we make in our work to standards such as:

- transparency
- public protection
- equality, diversity, and inclusion
- timeliness.

General standards

5 out of **5**

Guidance and standards

2 out of **2**

Education and training

2 out of **2**

Registration

4 out of **4**

Fitness to practise

5 out of **5**

Total standards met

18 out of **18**

2021 at a glance

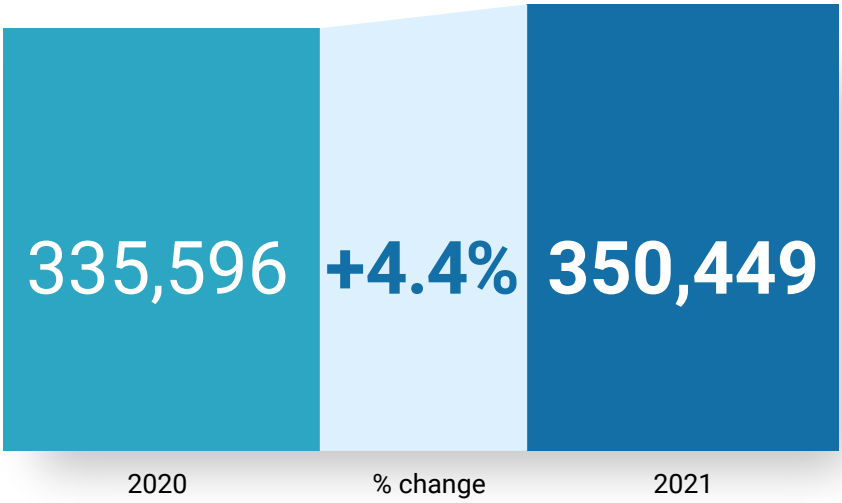


2021 at a glance

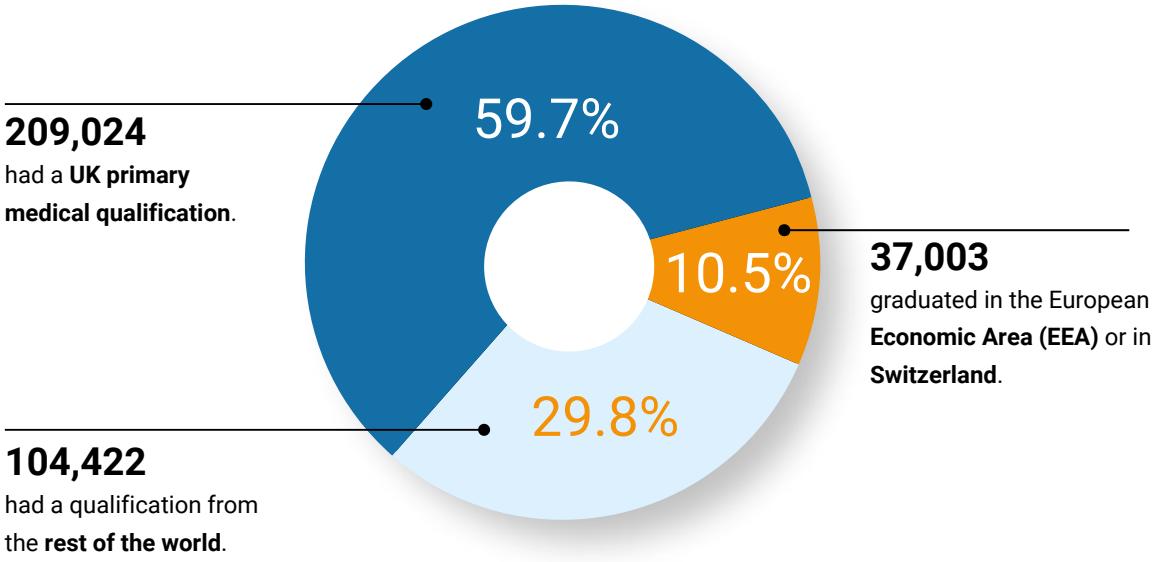
The medical register

All figures as of 31 December 2021 (or 2020) unless otherwise specified.
Visit GMC Data explorer to learn more about doctors' education and practice in the UK.

Total doctors on the register*



Where they graduated



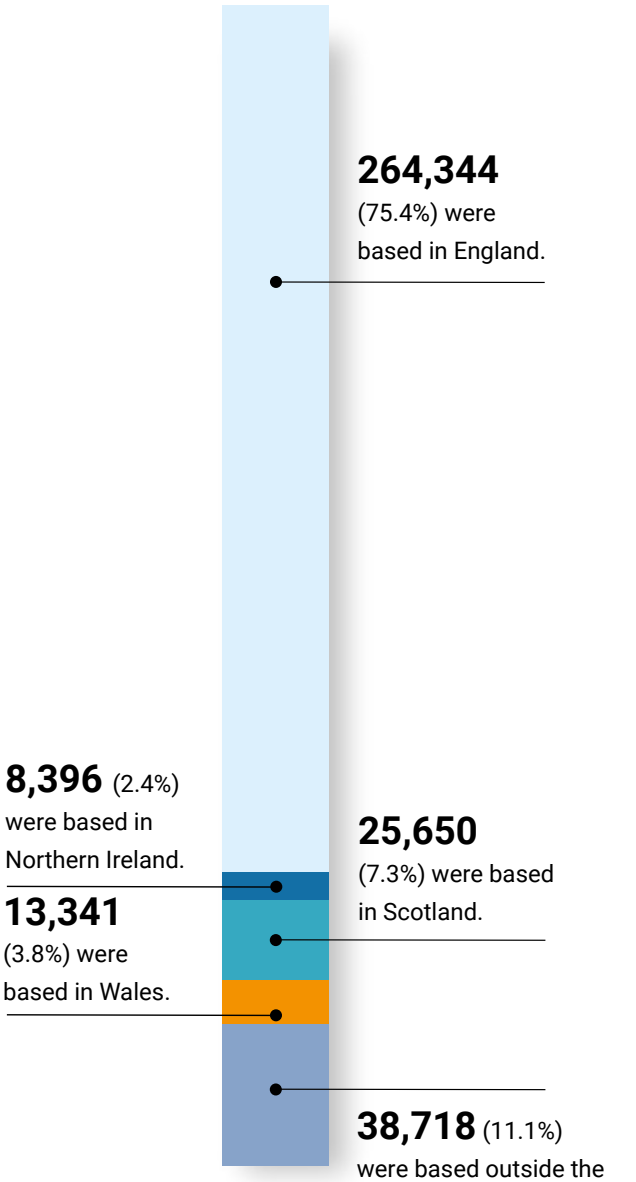
209,024
had a **UK primary medical qualification**.

37,003
graduated in the European **Economic Area (EEA)** or in **Switzerland**.

104,422
had a qualification from the **rest of the world**.

* Including doctors with temporary emergency registration (TER) – see pages 10 and 37 for more information.

Doctors on the register by location*



264,344 (75.4%) were based in England.

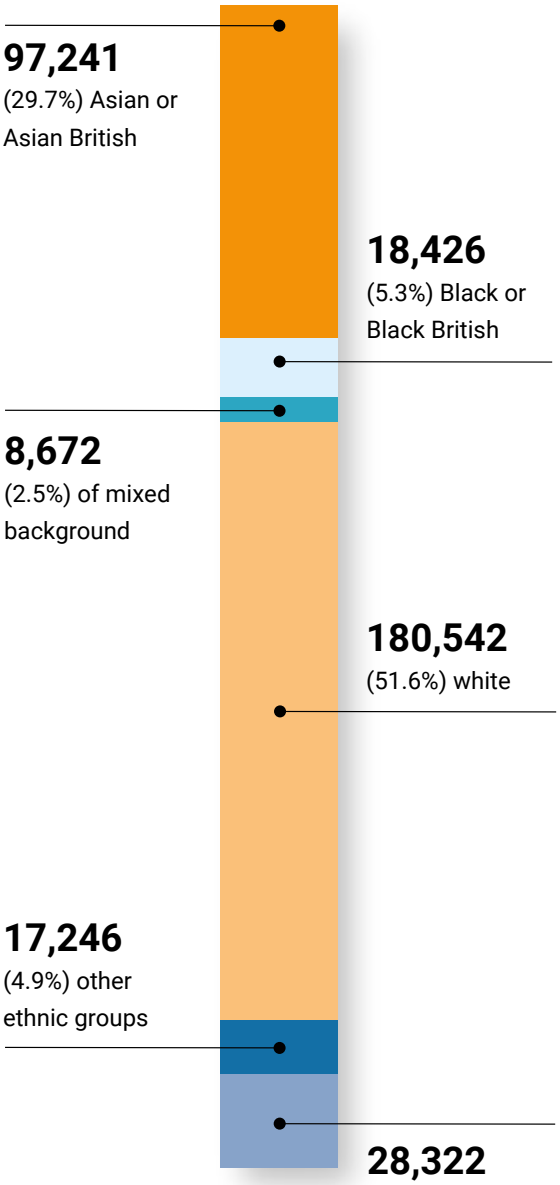
8,396 (2.4%) were based in Northern Ireland.

25,650 (7.3%) were based in Scotland.

13,341 (3.8%) were based in Wales.

38,718 (11.1%) were based outside the UK or did not provide us with enough information to establish their location.

Doctors on the register by ethnicity



97,241 (29.7%) Asian or Asian British

18,426 (5.3%) Black or Black British

8,672 (2.5%) of mixed background

180,542 (51.6%) white

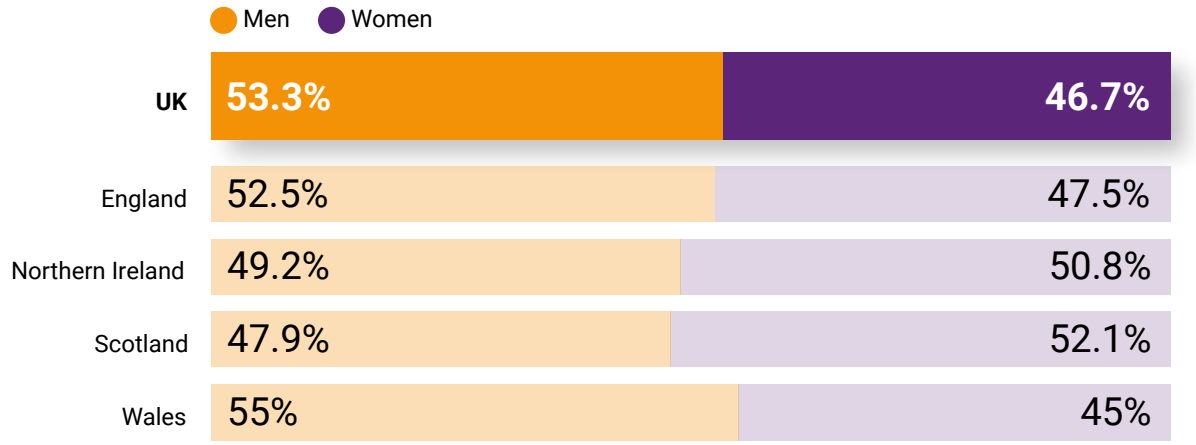
17,246 (4.9%) other ethnic groups

28,322 (8%) did not provide information on their ethnicity

* The derived location of registered doctors is calculated using the following hierarchy:
1. where they work based on NHS practice history data
2. their training location based on the National Training Survey
3. the location of their designated body
4. their registered address.

Registered doctors located in the Channel Islands and the Isle of Man are included in the figures referring to England.

Doctors on the register by gender



Total doctors on the GP Register*

79,685

Up **2.6%** from 2020 (**77,659**)

64,676 (81.2%) were residing in **England**.
2,204 (2.8%) were residing in **Northern Ireland**.
7,457 (9.4%) were residing in **Scotland**.
3,284 (4.1%) were residing in **Wales**.
2,064 (2.6%) either were located **outside the UK** or did not provide us with enough information to establish their location.

Total doctors on the Specialist Register*

107,009

Up **2.5%** from 2020 (**104,383**)

80,920 (75.6%) were residing in **England**.
2,577 (2.4%) were residing in **Northern Ireland**.
8,330 (7.8%) were residing in **Scotland**.
4,136 (3.9%) were residing in **Wales**.
11,046 (10.3%) either were located **outside the UK** or did not provide us with enough information to establish their location.

* Including doctors with temporary emergency registration (TER) – see pages 10 and 37 for more information.

Temporary emergency registration

As part of its response to the COVID-19 pandemic, in 2020 the UK Government asked us to give temporary emergency registration (TER) to doctors who had left the register in recent years. A number of these doctors played a valuable role in patient care and vaccine rollout during the pandemic. The UK Government has since asked regulators to close TER in September 2022.*

As of 31 December 2021,

22,718

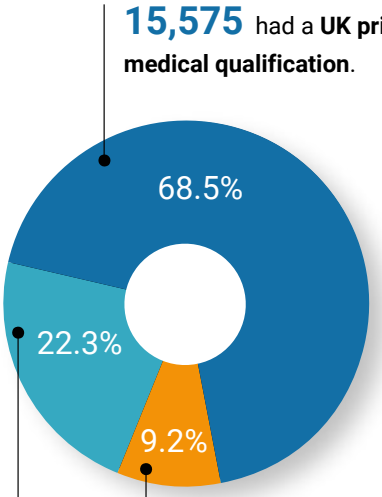
doctors on our register held **TER** with a licence to practise.

That is

10.2% ↓

fewer than at the same date in 2020.

TER doctors by where they graduated

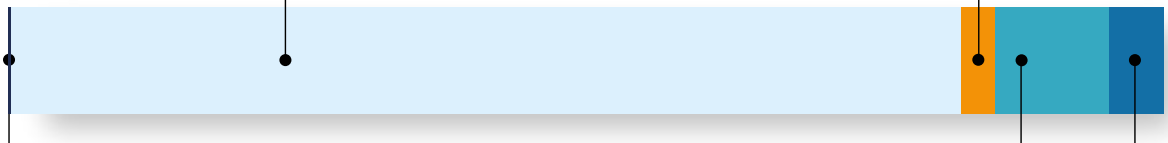


15,575 had a **UK primary medical qualification**.

2,082 had graduated in the **EEA** or in **Switzerland**.

5,061 had a qualification from the **rest of the world**.

TER doctors by location



18,642
(82%) were residing in **England**.

656
(2.9%) were residing in **Northern Ireland**.

201
(0.9%) were based **outside the UK** or did not provide us with enough information to establish their location.

2,194
(9.7%) were residing in **Scotland**.

1,025
(4.5%) were residing in **Wales**.

* For more information on temporary emergency registration, see page 37.

In 2021, we granted:

19,977

applications for first entry to the register.

That is up

13.7% ↑

from 2020 - (**17,234**).

7,377 (36.9%) were from doctors with a **UK PMQ**.

2,591 (13%) were from doctors who graduated in the **EEA** or in **Switzerland**.

10,009 (50.1%) were from doctors with a qualification from the **rest of the world**.



3,326

applications to join the GP Register.

That is up

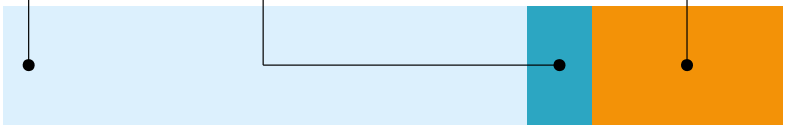
10.7% ↑

from 2020 (**2,970**).*

2,299 (69.1%) were from doctors with a **UK PMQ**.

191 (5.8%) were from doctors who graduated in the **EEA** or in **Switzerland**.

836 (25.1%) were from doctors with a qualification from the **rest of the world**.



4,613

applications to join the Specialist Register.

That is down

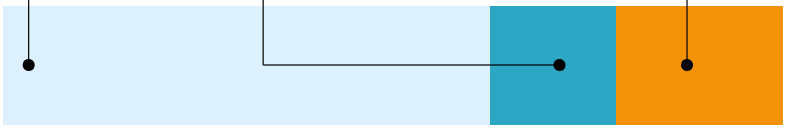
3.1% ↓

from 2020 (**4,755**).*

2,959 (64.1%) were from doctors with a **UK PMQ**.

680 (14.8%) were from doctors who graduated in the **EEA** or in **Switzerland**.

974 (21.1%) were from doctors with a qualification from the **rest of the world**.



Professional and linguistic assessments board (PLAB)

Doctors who graduate outside the UK, the EEA, or Switzerland usually need to take our Professional and Linguistic Assessments Board (PLAB) test in order to join the UK medical register.* The test is taken in two parts (PLAB 1, delivered in assessment centres around the world, and PLAB 2, undertaken in one of our testing centres in Manchester).

PLAB 1

In 2020 and 2021 our capacity to deliver PLAB 1 tests around the world was severely impacted due to the rise in COVID-19 cases across the globe. In many cases we were forced to cancel testing due to local restrictions and in the interest of safety.

10,431

candidates took PLAB 1 in 2021, a very similar number to 2020 (10,601).

We appreciate that the challenges with the delivery of PLAB 1 have been frustrating for candidates. We have been working hard to increase the availability of PLAB 1 places, and hope that the vaccine rollout will allow us to welcome more doctors to UK practice soon.

PLAB 2

In 2021 we made significant investments to increase PLAB 2 examination capacity following the pandemic, including the creation of a second PLAB 2 circuit in Manchester.†

This resulted in

8,648

candidates taking PLAB 2 in 2021, a 136.7% increase on 2020 (3,654).

* Exceptions to this include international medical graduates joining the register based on being sponsored by healthcare organisations, or based on postgraduate qualifications. In both these cases, doctors must still provide evidence of their competence and skills. For more information on the different routes to join the register, see www.gmc-uk.org/registration-and-licensing/join-the-register/before-you-apply/evidence-to-support-your-application.

† See page 37 for more information.

Setting and maintaining standards

Revalidation

Every licensed doctor who practises medicine in the UK must prove they are meeting our standards every five years through a process called revalidation. Revalidation supports doctors to develop their practice, drives improvements in clinical governance, and gives patients confidence that doctors are fit to practise.

As part of our response to the pandemic, in 2020 and 2021 we postponed revalidation submission dates for around 60,000 doctors, helping healthcare settings cope with system pressures by making sure doctors could spend as much time as possible providing care.

In 2021 we received

65,893

recommendations for revalidation.

55,488 of the recommendations were submitted by designated bodies located in **England**.

2,100 were submitted by designated bodies located in **Northern Ireland**.

5,125 were submitted by designated bodies located in **Scotland**.

3,035 were submitted by designated bodies located in **Wales**.*

53,322

doctors were revalidated in 2021.†

44,778 were located in **England**.

1,580 were located in **Northern Ireland**.

4,152 were located in **Scotland**.

2,327 were located in **Wales**.

485 either were based **outside the UK** or did not provide us with enough information to establish their location.

We made decisions on

98.2%

of the total recommendations we received in 2021 **within 5 working days** from when we received them, **exceeding our target of 95%.**

11,041 We approved **deferral of revalidation submission dates** for 11,041 doctors.

398 We **withdrew the licences** of 398 doctors on our register.‡

* The remaining 145 are not associated to a specific location as they are the result of administrative processes necessary to consolidate data.

† Depending on where they work, single doctors can receive more than one recommendation.

‡ If a doctor does not fulfil the requirements of revalidation, provides fraudulent information, or fails to provide reasonably requested evidence, we can legally withdraw their licence. This process is different to that of being removed from the register, for example, following an MPTS hearing.

Outreach

Our outreach teams delivered training on our standards to:

16,974 **doctors** in **527 sessions** and

That is up **73.6%** from 2020 (9,776).

8,218 **students** in **71 sessions** across the UK.

That is up **9.2%** from 2020 (7,529).*

93% of the doctors and **93%** of the students who attended one of our outreach workshops across the UK said **their knowledge of the GMC's role and standards improved**.

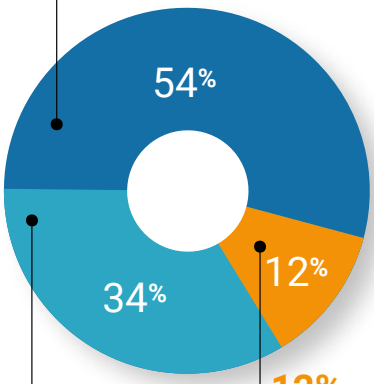
84% of the doctors and **87%** of the students who attended a session across the UK said **it had improved their impression of the GMC**.

Our standards enquiry team answered:

613 enquiries about our guidance.

That is down **18.9%** from 2020 (**756**).

Around **54%** of the enquiries were **from doctors** (2020: 65%)



34% from **members of the public** (2020: 22%)

12% **were from others,** including staff from professional organisations, students and the police (2020: 13%).

Our outreach teams also deliver workshops aimed at helping doctors who are **new to UK practice** adjust to working in the UK's healthcare systems.

The team delivered **208 Welcome to UK Practice workshops** in 2021, involving **6,471 doctors** – up **72%** from 2020 (**3,762**).†

Our employer liaison advisers held **1,284** meetings with responsible officers.

They also provided fitness to practise advice in relation to **2,205** doctors.

* We have seen a smaller increase in student engagement due to the continued disruption in higher education caused by the ongoing pandemic.

† See page 31 for more information.

Overseeing medical education and training

Quality assurance

We regulate all stages of a doctor's undergraduate and postgraduate education and training in the UK. We set standards and expected outcomes, and we carry out quality assurance (QA) work to make sure standards are maintained.

Our undergraduate and postgraduate QA processes promote and encourage local management of concerns about the quality and safety of medical education and training.

At the onset of the pandemic in 2020, we had to suspend education QA visits temporarily for safety reasons. Later in the year, we were able to resume them virtually, and in 2021 we were able to significantly increase the number of visits.

In 2021 we carried out **208** education QA visits.

That is up **136%** from 2020 (**88**).

165 of the visits were in **England**.
6 of the visits were in **Northern Ireland**.
24 of the visits were in **Scotland**.
13 of the visits were in **Wales**.

154 of them were **QA visits to new medical schools, established medical schools, or clinical environments** where medical education and training take place.

54 of them were **enhanced monitoring visits**, aimed at promoting the resolution of concerns about the quality of postgraduate training locally.

From our QA visits, we found:

19 areas of **good practice or working well**.

21 areas where our **standards were met**, but where we **identified improvements** that could be made.

18 areas that **required improvement**.*

As a result of our enhanced monitoring visits:

9 cases relating to postgraduate education **were escalated to our enhanced monitoring process**.

10 **enhanced monitoring cases** escalated previously **were resolved**.

In order to make sure postgraduate training could continue even if affected by the pandemic, we worked with partners to apply some changes to curricula and exams.

By the end of 2021, we had **approved 80 derogations** to training curricula and temporary changes to **114 examination components**.

We also supported medical schools in **making decisions about graduating students** whose studies had been disrupted as a result of the pandemic.

* Not all QA visits lead to specific findings like those listed here – in some cases nothing of significance is found, as nothing has changed since the previous visit, or nothing has been found worthy of particular note (ie. education and training are working as expected).

Supporting the people we serve

In 2021 our Corporate review team received **1,884** **complaints** about our service.*

This is a **2.3%** decrease on 2020 (**1,928**).

It also logged **6,543** **compliments**.

This is a **100.9%** increase on 2020 (**3,257**).*

In 2021 our patient liaison service held 285 meetings with patients who had raised a concern with us.

88%	of those who attended one of our patient meetings were satisfied or very satisfied with the patient meeting experience.
96%	agreed or strongly agreed that patient liaison staff showed empathy for their situation.
92%	agreed or strongly agreed that they were satisfied that their concerns had been understood during the meeting.
95%	agreed or strongly agreed that the meetings helped them to understand what action the GMC could take.

Our contact centre answered **162,504** calls and **131,157** emails or letters.

77% of the calls and emails we received were from doctors, and **23%** from members of the public and others.

The contact centre also handled **65,178** webchat sessions.

* This significant increase is also partially due to efforts we made to make sure colleagues consistently capture and record the compliments we receive.

Investigating and acting on concerns

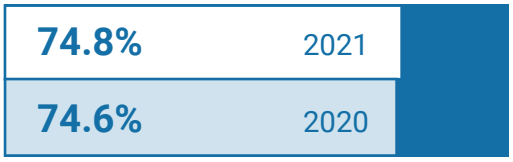
Concerns raised

9,074 **concerns were raised with us in 2021.**

This represents a **7.2%** increase on 2020 (8,468 concerns).

62.7%	**5,685** were raised in relation to incidents that happened **in England**. That is a similar percentage to 2020 (62%).
2.2%	**199** were raised in relation to incidents that happened **in Northern Ireland** – a slightly higher percentage than in 2020 (1.8%).
4.2%	**381** were raised in relation to incidents that happened **in Scotland** – a slightly lower percentage than in 2020 (4.9%).
2.8%	**253** were raised in relation to incidents that happened **in Wales** – around the same percentage as in 2020.
28.2%	For **2,556** of them either there was **no incident location specified, or they happened outside the UK** – a similar percentage to 2020 (28.5%).

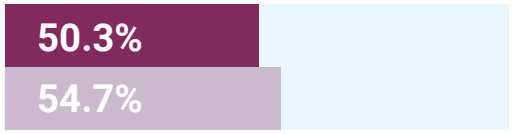
Percentage of concerns raised by the public



Of the 9,074 concerns that were raised with us in 2021, 74.8% were raised by patients or members of the public. That is very similar to 2020 (74.6%).



The percentage of concerns relating to incidents that happened in **England** raised by the public was 72.2% (a slight increase from 70.7% in 2020).



In **Northern Ireland**, it was 50.3%, (a decrease from 54.7% in 2020).



In **Scotland**, it was 70.6%, (similar to 2020 - 70.2%).



In **Wales**, it was 60.9% (a decrease from 66.8% in 2020).



84.4% of the concerns we received with no location specified or having happened **outside the UK** were raised by the public (a slight decrease from 85.9% in 2020).

Investigations

Not all the concerns raised with us meet our threshold for an investigation. Sometimes a concern is best dealt with at a local level or by having a conversation with the doctor, or should be brought before another organisation. We only take action where we find there may be a risk to patient safety or to public confidence in doctors.

925

(**10.2%**) of the concerns we received in 2021 met our **statutory threshold for investigation**.

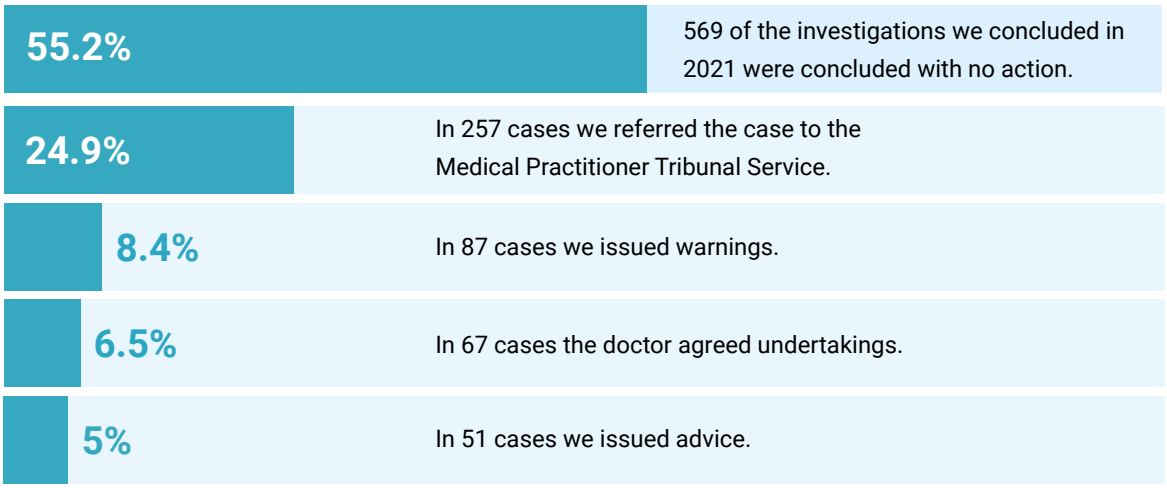
That is a lower percentage than in 2020 (**12.3%**).

214

(**23.1%**) referred to concerns raised by **members of the public**.

That is a lower percentage than in 2020 (**28.1%**).

Outcomes of investigations



Provisional enquiries

In certain cases, we make provisional enquiries, where we look at information at an early stage of a case, to provide swifter resolution for patients and doctors. If the evidence shows there is no future risk to patients, and regulatory action is not required, we will not move to a full investigation. For cases where we have concerns about patient safety, we will carry out a full investigation.

490

(**5.4%**) of the concerns we received in 2021 were **considered under provisional enquiry**.

↑

That is a higher percentage than in 2020 (**4.9%**).

382

of these (**78%**) referred to concerns raised by **members of the public.**

→

That is a similar percentage to 2020 (**77.3%**).

In

333

cases (**68%**) we closed the provisional enquiry with **no action**.

In

64

cases (**13%**) we **progressed the case to investigation**.

In

93

cases (**19%**) the provisional enquiry was **still open** as of 31 December 2021.

Outcomes of Medical Practitioners Tribunals Service tribunals

In 2021, the Medical Practitioners Tribunal Service held a total of 269 tribunals.

33.8%	In 91 of them, the tribunal suspended the doctor who had been referred to the tribunal.
26.4%	In 71 cases the tribunal found no impairment.
21.6%	In 58 cases the doctor was removed from the register.
10.4%	In 28 cases, while the tribunal found no impairment, it issued a warning.
5.2%	In 14 cases the doctor had conditions put on their practice.
1.5%	In 4 cases doctors voluntarily removed themselves from the register.
0.7%	In 2 cases the doctor's practice was found to be impaired but no further action was taken.
0.4%	In 1 case the doctor agreed to undertakings.

Where we do not agree with the decisions made by a medical practitioner tribunal, we can appeal them.

In 2021 we made 10 appeals. That is 1 more than in 2020. 1 of the appeals we made was successful, while for 9 of them, as of 31 December 2021, we did not yet have a decision.

Delivering on our strategy



Delivering on our strategy

2021 marked the first 12 months of our 2021–2025 strategy. The strategy is underpinned by our 2030 vision to be an ever more effective, relevant, and compassionate regulator – for patients, for the public, for professionals, and as an employer.

Four main themes shape all our work:

In this section of the report, we describe how we worked to achieve these goals in 2021 through various initiatives, in close collaboration with our partners.



Responding to the pandemic

Throughout the year, COVID-19 significantly impacted on our operations. As in 2020, much of our work in 2021 focused on supporting doctors, students, and employers at a particularly difficult time. As part of this:

- we introduced temporary emergency registration in 2020 for doctors who left the register in recent years. Many of these doctors, a number of whom remained active in 2021, played a valuable role in delivering patient care. Others provided vital support for the vaccination programme.
- we opened a new temporary clinical assessment centre to allow Professional and Linguistic Assessments Board tests to continue at pre-pandemic capacity, allowing more doctors to join the profession.
- we approved a number of temporary changes to education curricula to support safe and flexible progression for doctors in training.
- we supported medical schools in making decisions about graduating students whose studies had been disrupted as a result of the pandemic.
- we rescheduled revalidation dates to ease pressure on doctors and their employers.
- we issued a joint statement with other professional regulators, assuring health and social care staff that we understood and would consider the contextual challenges caused by the pandemic when making decisions about fitness to practise or revalidation.
- we introduced new guidance for decision makers in fitness to practise, taking into account the circumstances and challenges brought about by the pandemic.

Equality, diversity, and inclusion

The pandemic also highlighted longstanding inequalities, including the impacts of racial discrimination and disadvantage.

We are fostering equality, diversity, and inclusion (ED&I) in everything we do as a regulator and employer. Tackling discrimination and inequality is the right and fair thing to do. It is also vital to helping retain doctors working in the UK and to supporting high-quality patient care. So, we have embedded ED&I into each aim of our strategy.

Reflecting this, in February 2021 we committed to achieving specific targets to tackle racial inequalities. We want to eliminate inequalities in fitness to practise referrals by 2026 and in student attainment based on race or other factors linked to ethnicity by 2031. We cannot achieve these targets alone as improvement relies on wider, systemic change. So during 2021, we worked with different partners across the UK's healthcare systems to start laying the base for these improvements.



Enabling professionals to provide safe care

Research shows that healthcare professionals who work in supportive environments where well-being is a priority are better able to give patients safe, high-quality care. We work with partners to improve working environments and cultures, making them supportive, inclusive, and fair for medical professionals. As a result, patients will benefit from safer and better care and the profession will keep and attract more professionals. We also continue to work with patients and medical professionals to make sure our guidance remains relevant and effective and that it represents patients' diverse needs. We addressed this aim in 2021 through a number of initiatives.

Updating our guidance

Reviewing *Good medical practice*

Good medical practice is the core guidance that all doctors working in the UK must follow. It shapes the way they care for patients by describing the values and behaviours they need to show.

We published the current version of *Good medical practice* in 2013. Since then, patients' expectations and the way healthcare is delivered have changed. We are also preparing to take on the regulation of physician associates (PAs) and anaesthesia associates (AAs). So we are reviewing the guidance to make sure it meets patients' needs and supports the medical professionals we regulate to provide safe, high-quality care. There are four main areas where we propose to update the guidance:

- patient-centred care, decision making, and communication with patients
- tackling bias and discrimination in the treatment of patients and professionals
- working effectively with colleagues
- leadership and organisational culture.

Since we started the review:

- we have invited doctors, patients, and other stakeholders to sign up to our community of interest. They will receive updates about the review and help to shape our work.
- we have undertaken scoping to develop an evidence base including: researching findings from recent reviews and public inquiries, gaining insights from PAs and AAs on the interim standards, and reviewing intelligence gathered from targeted engagements with stakeholders.
- we have commissioned research on how our guidance is currently used by doctors and other healthcare professionals.

To help with the review, we also set up an advisory forum. The forum acts as a sounding board for key decisions around the review and the changes we are planning to make. Its 12 members bring a wealth of expertise in areas such as medical ethics, patient care, multi-disciplinary working, and equality and diversity.

We expect to complete the review and publish a new version of *Good medical practice* in 2023. During 2022, we will consult with doctors, patients, employers, and other stakeholders in the UK's healthcare systems. We have also commissioned an external behavioural insight specialist to research and engage with over 200 patients with experience of the healthcare system. Inputs from these activities will help us decide what changes we need to make.

It is our ambition that the new edition of *Good medical practice* better reflect the needs and expectations of patients, service users, and carers and the context in which medical practitioners work. It will support professionals to work in partnership with the people they care for, and to navigate the challenges of delivering high-quality, person-centred care in a service under pressure. We will also strengthen duties around equality, diversity, and inclusion. We hope the changes will help make workplace culture safer and more responsive for patients, and our health services more inclusive, fair, civil, and compassionate for all.

Updates to our ethical hub

Our ethical hub is a collection of online resources exploring how to apply our guidance in practice. It focuses on areas which doctors often ask about or find challenging. The resources include case studies, decision tools, flowcharts, and videos. They are all designed to support doctors with common ethical scenarios, such as adult safeguarding, trans healthcare, and caring for people with learning disabilities.

In 2021, we made several changes to the hub. In particular:

- we updated the style of our menus, which has resulted in increased engagement with our learning materials
- we updated our Professional and Linguistic Assessments Board test guidance in light of the pandemic
- we published new content regarding identifying and tackling sexual misconduct
- we provided additional information on remote consultations
- we added more information about our upcoming regulation of PAs and AAs
- we improved our decision-making flowchart, complementing our updated guidance
- we updated our advice in relation to COVID-19, simplified the information available and added detailed information about vaccination.

In 2021, the hub pages maintained a high volume of visitors. Keeping the pages up to date has contributed to this retention rate. For example, during 2021, our COVID-19 hub saw a total of 78,153 page views, showing the importance of keeping our data accurate and regularly updated as a useful reference point for doctors aiming to provide safe, effective care.



Prescribing

In February 2021, we published our updated *Good practice in prescribing and managing medicines and devices* guidance. The new guidance came into effect on 5 April 2021. We updated it after a call for evidence on remote consultations and prescribing that launched in 2019. We wanted to understand if our guidance was keeping pace with changes in this area. The new guidance also responds to the surge in remote consultations we saw in recent years. This rise has only been increased by the onset of the pandemic.

We received 75 responses to our consultation from individuals and organisations with experience in this field. These responses helped us to shape the update.

The guidance provides updated advice on both face-to-face and remote prescribing. It is vital that the principles of good practice apply whether in a face-to-face or a remote setting. We also produced some common scenarios to support the guidance.

> The updated guidance was received very positively. Five days after it was launched it had already been downloaded almost 5,000 times.

The new guidance helps prescribers to understand their responsibilities. In turn, this helps them to prescribe in a safe, informed way. It supports doctors who are navigating what for many has become a new reality of remote medicine, helping them maintain good patient care amid challenging circumstances.



Working with partners to identify and address risks to patient safety

Maternity care

Maternity is a complex area of medicine that requires teamwork across disciplines. When things go wrong, the impact can be tragic. It is also an area that has markedly worse outcomes for women from ethnic minority backgrounds.

The issues and concerns in the UK's maternity services are well documented and go back at least two decades – with several high-profile cases, various reviews and inquiries, reports from other regulators, maternity services featuring regularly in both national and regional joint services oversight groups, and various maternity-specific efforts nationally and locally.

There is a significant amount of work going on across providers, regulators, and others to understand and improve maternity care. We have been working with partners to understand and act on concerns and to help improve the culture in maternity departments.

Sharing data and insights

Across UK healthcare, governments, providers, regulators, and others are committed to building, understanding, and acting on data and insights. We share that commitment and are taking an increasingly collaborative approach – including sharing our maternity data and insights to help identify risks early, increase cohesion between regulators, and address emerging issues. As part of this, we are currently working with the Nursing and Midwifery Council (NMC) and the Care Quality Commission (CQC) on a shared data platform to explore measures that might help identify struggling maternity departments.

Improving workplace cultures

Our outreach teams have been engaging with the National Health Service England/Improvement (NHSEI) Culture Working Group and regional perinatal oversight groups to shape and improve maternity culture. Our current focus is joint work with the NMC, Health Education England (HEE), and NHSEI to develop our guidance and deliver Professional Behaviour and Patient Safety (PBPS) sessions for targeted maternity units. The sessions can be delivered face to face or virtually, with content focusing on maternity care. We are now working with NMC and Regional Chief midwives to deliver PBPS sessions in all regions in England over 2022.

In collaboration with the NMC and Regional Chief Midwives, we have also been delivering joint regional events to maternity professionals, for example, on duty of candour.



Monitoring and addressing emerging risks

We continue to engage with the National and Regional Joint Strategic Oversight Group (JSOG) framework in England. The framework provides a forum for healthcare regulators, NHS England, and NHS Improvement to share and discuss intelligence on emerging risks to patient safety and to develop common approaches to address them. The other partners in the framework include the Care Quality Commission, Health Education England, and the Nursing and Midwifery Council.

In 2021, we contributed to discussions at a national level on the quality of training and on leadership. At a regional level, we continued to work with other regulators and stakeholders to share data and intelligence. We also continued to oversee and address areas of emerging risk.

Engaging with doctors, students, and other partners to promote safe care

> “Thank you both very much for such a fantastic workshop yesterday. The trainees were enthusiastic and learned a lot from the case scenarios and discussion.”
>
> - Training programme director

Our outreach teams and colleagues from our education quality assurance teams meet with doctors, students, employers, educators, and other partners in the UK’s healthcare systems to:

- improve understanding of our role and the support we offer
- promote and support excellence in medical education and practice
- identify and address risks to patients before harm occurs
- monitor the quality of medical education, working with partners to address challenges in training environments
- support employers in delivering revalidation, addressing and managing concerns about doctors, and strengthening training environments
- support the continuous development of local clinical governance systems to maintain and improve patient care.

In 2021, our regional and national liaison advisers held just under 600 interactive workshops, involving around 17,000 doctors and 8,200 students. The majority of the workshops were held online due to the ongoing pandemic. The ethical topics most frequently covered included decision making and consent, raising concerns, and confidentiality. Our employer liaison advisers also held over 1,200 meetings with responsible officers. In these meetings, they discussed our handbook for effective clinical governance for the medical profession and how it can help strengthen local systems. They also provided fitness to practise advice in relation to just over 2,200 doctors.

Our efforts in this area enable us to work with doctors and other partners to protect and promote patient safety in different ways. In the following pages are some examples of how our liaison advisers have responded to requests from our partners to contribute to their programmes of work.

In **England**, we have done significant work to support doctors at the start of their career.

- We collaborated with NHS England, NHS Improvement, and HEE to design and implement the Midlands Charter. The charter aims to support doctors in training.
- We contributed to the design of NHS England's standardised induction.
- We contributed to HEE's returners induction pilot.
- We participated in NHS Professionals' Doctors Gateway programme. The programme aims to help UK doctors who studied in the EU gain experience to develop a career in the UK.

> "Just the fact that you're reaching out to individual universities to hold sessions for students shows you really care."
> - Student attending an outreach session

> "Great reminder that everyone is responsible for patient safety and that the standard you walk past is the standard you accept."
> - Doctor attending an outreach session

In **Northern Ireland**, we provided educators and doctors in training with advice on ethical scenarios. We also provided information on our fitness to practise work. The work included:

- a session regarding student fitness to practise (FTP), attended by staff from both medical schools in Northern Ireland. The session helped academic staff understand how we make FTP decisions. It was a well-attended event and feedback was very positive.
- a session involving over 100 GPs in training. The session focused on raising and acting on concerns, and on appropriate use of social media. The training was well received, so we will continue to run it in 2022.

In **Scotland**, we engaged with partners to promote our work on equality, diversity, and inclusion.

- We piloted a half-day workshop around the findings from *Fair to refer?* and our commitment to eliminate differentials in FTP referrals and in attainment. The workshop was hosted by the NHS Grampian Health Board. As part of it, participants discussed local case studies and how implementing recommendations could help address issues.
- Following concerns expressed in NHS Scotland North about the expectations on fulfilling the requirements of the Recognition and Approval of Trainers scheme during the pandemic, we ran a session to reassure trainers about our expectations regarding the scheme and how the GMC has sought to support them and trainees during the pandemic.

In **Wales**, we engaged with doctors in training around different topics.

- We ran tailored interactive sessions with GP trainees in the Bridgend GP Training Scheme network. The sessions focused on decision making and consent, remote consultations, addressing unprofessional behaviour, and the use of social media during lockdown. They also sought to clarify some aspects of our FTP work.
- We developed a bespoke induction programme for IMG doctors at Aneurin Bevan University Health Board. The pilot was a great success and had 100% positive feedback. We covered an introduction to the GMC, key guidance topics, professionalism, and common misconceptions about our work. We plan to run two full-day induction workshops for IMG doctors every year.
- We began work to better support specialty and associate staff doctors wishing to apply for a Certificate of Eligibility for Specialist Registration. Work is well underway to embed a supportive framework for those who apply.

> “Thank you so much for an excellent session. The comments were all very good and I am sure the attendees went away feeling they had gained a lot. I sure did!”
>
> - Assistant Medical Director

Welcome to UK Practice

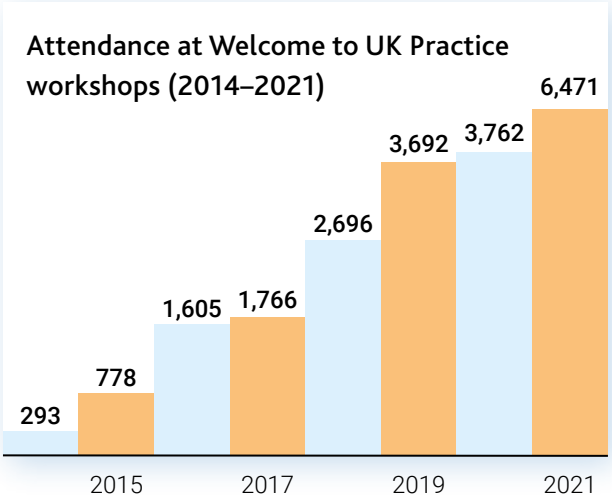


In 2020, we began running online versions of our free Welcome to UK Practice (WtUKP) workshops. As the disruption caused by the pandemic continued into 2021, we expanded this approach.

The workshops are aimed at doctors new to working in the UK. They are designed to help doctors adjust to working in the UK's healthcare systems and are delivered by our regional liaison advisers, national office liaison advisers, and by GMC associates. They cover a range of possible ethical scenarios doctors might encounter. The sessions offer advice on how to tackle them and explain how to get support. They also provide insights into aspects of the different healthcare systems across the four countries of the UK and give participants a chance to meet other internationally qualified doctors starting their career in the UK.

The online workshops received consistently positive feedback and previous evaluations have confirmed they are effective in achieving their aims. Our long-term goal is to establish a hybrid model of engagement, combining digital engagement with traditional face-to-face engagement. We will also work with partners to make the workshops an integral part of induction programmes across the four countries of the UK.

> "I am extremely happy with this warm welcome organised by GMC for the new overseas trained doctors. I greatly applaud this initiative which significantly brings down the anxiety and doubts of 'fitting in' from the minds of these IMGs."
> - Doctor attending WtUKP workshop



> "I was a bit nervous before about joining the NHS; however, after today's workshop I feel at ease now that I know that there will always be help whenever I need it."
> - Doctor attending WtUKP workshop



Equality, diversity, and inclusion: fairer referrals

In February 2021, we committed to targets to tackle long-standing racial inequalities in the medical profession. One of these is to eliminate inequality in fitness to practise referrals based on race or place of primary medical qualification by 2026. So, we are promoting more supportive and inclusive environments to ensure fair treatment. Tackling discrimination and inequality is the right and fair thing to do. It is also vital to helping retain doctors working in the UK and to supporting high-quality patient care. Our research shows more inclusive environments have better patient satisfaction and outcomes.

We cannot achieve this target alone as it relies on wider cultural change. So, we are working closely with other organisations who share our aims. In particular, we are working with employers to make sure referral processes are fair and bias free. We will also work with regulators and partners across the UK's healthcare systems to bring about change.

To meet our target on referrals, we will engage in activities that will vary over time. This is because we need to take into account changes in the working world. Flexibility in how we reach our target means that we can adapt our approach over time. In 2021:

- we met with responsible officers (ROs)* to explore how they are implementing the recommendations from our *Fair to refer?* research and to understand any barriers they are experiencing.
- we updated our employer referral form to help ROs make sure referrals are fair and appropriate. We also engaged in conversations with ROs about the form and the new questions about referrals it asks them to consider. We will review the insights from this work to identify best practice and work to embed it more widely.
- we worked to develop and improve our feedback process for ROs about the cases they referred to us. As part of this, we ran a workshop with them to explore ways of developing, recording, and sharing feedback.
- we contributed data to the *Medical Workforce Race Equality Standard*, led by NHS England. Our support focused on three key areas: revalidation recommendations, postgraduate training, and fitness to practise concerns. We will continue to support this work in future. We will promote its findings as a powerful tool in measuring and driving fairness in medicine.
- we significantly expanded the number of Welcome to UK Practice workshops available, reaching more doctors. The workshops are a valuable way to help doctors new to the UK adapt to working in the UK's healthcare systems.

For more information about our work in this area and to see how it is progressing, see our *Equality, diversity, and inclusion: Targets, progress, and priorities for 2022* report.

* A responsible officer is the senior clinician in an organisation who ensures that doctors continue to practise safely and are properly supported and managed in maintaining professional standards.



Developing a sustainable workforce

Safe, effective, and responsive healthcare rests on the talent, commitment, and diversity of the people providing it. The long-standing shortage of healthcare professionals in the UK poses risks to patient care. It is also a threat to professionals' well-being and progression. Our position allows us to help shape medical education and training in ways that can better support the development of medical students and professionals. We also make sure that entry to the medical register and progression through training is fair and flexible, meeting the needs of both patients and professionals.

In 2019, we agreed with the UK's Department for Health and Social Care that we will also start to regulate physician associates and anaesthesia associates. We welcome this development and, while the legislation to allow this is being developed for approval by the UK's different legislatures, we made significant progress on this agenda in 2021.

Assuring the quality of medical education and training

As part of our role, we regulate all stages of a doctor's undergraduate and postgraduate education and training in the UK. We set standards and expected outcomes and we carry out quality assurance work to make sure standards are maintained.

New schools and programmes

If an institution plans to open a new medical school, or an existing school plans to establish a new programme, we conduct quality assurance to ensure they meet our standards and outcomes.

In 2021:

- we visited five medical schools that were created in England as a result of the 2017 undergraduate expansion programme who had admitted their first students (Anglia Ruskin, Aston, Edge Hill, Kent Medway, and Sunderland).
- in Northern Ireland, Ulster University admitted its first students in August 2021. We quality assure the university's programme in accordance with our new schools process and will continue to do so in the coming years.
- in Scotland, we are quality assuring ScotGem, a graduate entry programme delivered by the Universities of Dundee and St Andrews. The programme plans to graduate its first students in 2022.
- we also visited Brunel University, one of three new schools planning to admit students in 2022. We plan to visit Worcester (Three Counties) University and Chester University, who are expected to do the same.



Proactive quality assurance

Our undergraduate and postgraduate quality assurance processes promote and encourage the local management of concerns about the quality and safety of medical education and training.

In 2021, we completed the rollout of our new proactive quality assurance process. The process covers both undergraduate and postgraduate education and training and is part of our efforts to make our regulation as proportionate as possible. As part of it, every established medical school will need to declare that it meets, or is working to meet, our standards for education and training. Completing the rollout means that all the 35 UK medical schools, plus any future schools, will participate in the process.

Despite the disruption caused by the pandemic, we were also able to continue to monitor the quality of postgraduate training environments, identifying and addressing challenges to the safety of patients and doctors in training where necessary. As part of this, in one case we worked with Health Education England to temporarily suspend training in an A&E department and related acute medical specialties at Weston General Hospital. The University Hospitals Bristol and Weston Trust NHS Foundation Trust has since been taking remedial action to address the situation.

Supporting students and medical schools

We also continued to support medical schools in making decisions about graduating students whose studies had been disrupted as a result of the pandemic. We encouraged the development of enhanced induction for graduates who were also joining a service that faced many challenges in terms of backlogs and the ongoing pandemic. We are aware that the disruption to studies will affect students in later years and we will continue to work with medical schools to ensure that only those students who are safe to practise and who can meet GMC outcomes and standards can graduate as doctors.

Investing in medical education

Flexibility in training

Doctors have long told us that training opportunities were not flexible enough. For example, if a doctor wanted to switch specialties, they had to restart training from the beginning. This could be a frustrating experience. It was also not a constructive use of professional time. In some cases, doctors left the profession entirely rather than repeat years of training.

In 2021, after careful research, we introduced some changes to make training more flexible.

- Doctors who want to change specialty and become GPs can have some of their existing skills recognised so they do not have to repeat during training.
- We facilitated improved training options for doctors who work or train less than full time.
- We introduced further flexibility in curriculum development that we agreed with colleagues and the statutory education bodies to help support doctors' progression during the pandemic. The changes will be ongoing for as long as training continues to be disrupted.



These changes and others will allow doctors to progress and grow their skills more efficiently. Our work in this area will continue into the future as we support the development of a more sustainable workforce.

Credentialling

In 2021, our Council approved our updated credentials framework. Credentialling is a process through which we will recognise a doctor's expertise in a specific area of practice. GMC credentials will provide a proportionate and flexible training solution to address changing patient needs and safety issues. They will be approved where there is a demonstrable need for recognised standards in an area of expert practice not otherwise certified through postgraduate training. They will also provide additional regulation in areas where this can help reduce risks to patient safety. We started introducing credentials in 2019, testing how well our existing postgraduate curricula approval process worked with five early credential adopter areas. These are:

- rural and remote medicine
- liaison psychiatry
- interventional neuroradiology (acute stroke)
- pain medicine
- cosmetic surgery.

The early adopters continued to progress through our approval processes in 2021 and we are now working with them on preparing for full implementation. The updated framework reflects their feedback. It also reflects further policy development and engagement since we started working on the credentialling process. We aim to approve the first GMC credentials in 2022.

Equality, diversity, and inclusion: fairer education and training cultures

In February 2021, we committed to targets to tackle racial inequalities, including in medical education and training.

There is evidence that students from ethnic minorities face barriers in accessing important educational resources. This makes them more vulnerable to feeling less prepared and leads to poorer educational outcomes. These students, and doctors in training from ethnic minorities and/or with primary qualifications obtained outside the UK, also have different experiences of inclusivity than white students and doctors. Negative experiences in training and in the workplace affect well-being and performance and can ultimately affect patient safety. It is right and fair that students receive an equitable footing in their training experience, regardless of background or characteristic. So we want to end differentials in medical education and training based on ethnicity and primary qualification by 2031.

Achieving change in this complex area requires significant collaboration with multiple organisations and partners. There is recognition across the board of the collective need to act throughout healthcare if progress is to be made and, in line with this, we have adapted our ask of training institutions.

Educators must have stronger governance and plans in place for providing inclusive, supportive environments while assuring themselves they are making improvements. Change is needed to policy and process throughout the whole system from entry into medical education, to access to support and learning opportunities, to the design of assessments. This is a challenge reflected in broader education and society and it will require close ongoing attention.

To pursue these objectives in 2021, we provided guidance to medical royal colleges and faculties and required them to submit evidence of work to make sure assessments reflect the diversity of the trainee and patient population and that appropriate support is provided to candidates to both prepare for or recover from a high-stakes examination fail. We also supported medical schools in their work to:

- review curricula and assessment materials to better represent patients' and doctors' diversity
- engage with students on their experiences of racism
- develop reporting tools for concerns relating to inequalities in the education journey
- make sure recruitment and selection processes are fair and represent diversity.

Medical schools provided us with examination outcomes data that will feed into our proactive quality assurance process (see page 34). We also shared updated data with postgraduate training organisations and supported them in analysing it. Training organisations are now required to submit annual action plans demonstrating how they are addressing the attainment gaps in their regions and meeting our standards.

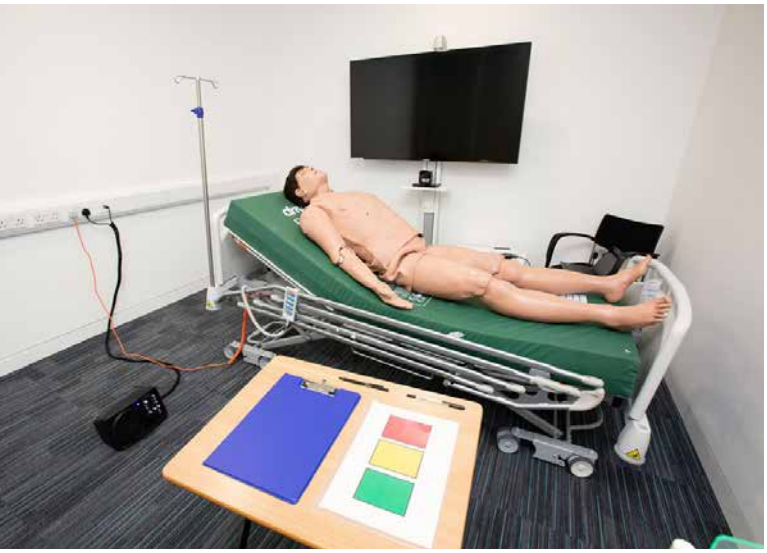
We are committed to building evidence on the interventions that make a real-world difference to trainee outcomes. As part of this, we partnered with Health Education England and the Royal College of Psychiatrists to pilot an examination preparation training course and to formally evaluate its impact on examination outcomes for ethnic minority trainees. This initiative will continue through 2022, with 170 trainees taking part, and will provide essential evidence on which further initiatives can be built.

Systemic changes in medical education and training are complex and require adaptability. We will continue to capture learning from this work and the work of our partners on this agenda. We will also continuously review our approach based on that learning.



Managing entry to the medical register

Our new clinical assessment centre



Around half of all doctors from outside the UK who want to practise medicine in the UK's healthcare systems need to take our Professional and Linguistic Assessments Board (PLAB) test. The test is in two parts, a multi-choice examination (PLAB 1), and a clinical assessment (PLAB 2).

PLAB 2 is taken at a clinical assessment centre (CAC), located in Manchester. The examination allows us to test doctors' clinical competence through a series of scenarios. The practical scenarios reflect real-life situations that doctors may encounter during their work in the UK.

In 2020, our testing capacity for PLAB 2 was severely impacted by the social distancing measures required to combat the pandemic. To overcome this, we developed an additional, temporary assessment centre at our Manchester headquarters. We opened the new temporary CAC in June 2021. The new centre brings our total assessment capacity back to pre-COVID levels. This means we have been able to welcome more doctors from all over the world to sit their exam. In 2021, we examined 8,648 candidates across both our assessment centres. 3,283 of these attended the temporary centre. Overall, 6,043 candidates were successful and have since progressed to apply to join the register. These new doctors come at a time when the medical profession and our healthcare systems need as much support as possible.

Granting temporary emergency registration as part of the response to the pandemic

As part of the national response to the pandemic, in 2020 the UK Government asked us to give temporary emergency registration (TER) to doctors who left the register in recent years. Over 35,000 doctors who had stopped practising were given TER. As of the end of 2021, around 22,000 of them still held their temporary registration. Many of these doctors played a valuable role in delivering patient care. Others were of vital support for the vaccination programme. In 2021, we remained in regular contact with this group to make sure they understood they had been re-registered, and what this meant. Their registration was intended to last for the duration of the emergency, and the UK Government has asked regulators to close it in September 2022.



However, more than 1,100 doctors have since decided to return from TER to full registration. This means they will remain available for work in the future. There is great value in bringing back the talents and contribution of experienced professionals both in regard to patient safety and in terms of the wider healthcare community.

Medical Licensing Assessment

We are pleased to be working in collaboration with medical schools and other partners to introduce a new assessment – the Medical Licensing Assessment (MLA). It is set to launch in 2024.

The assessment will test the core knowledge, skills, and behaviours of doctors wishing to practise in the UK. It will help make sure that the standards we set match patients' needs and that doctors new to the register are well prepared to provide safe care. This will give patients, employers, and fellow doctors greater confidence in doctors new to practice, wherever they trained. It will also provide for better consistency and fairness between candidates. Finally, it will allow us to better monitor and approve the standard for entry to the profession over time.

All medical students who graduate from UK universities from the 2024–25 academic year will be required to pass the new assessment as part of their degree. Doctors from overseas who currently need to take our PLAB test to practise in the UK will also take the MLA instead once it has been introduced.

In 2021, we made significant progress towards the introduction of the new assessment.

- In March, we published *Assuring readiness for practice: a framework for the MLA*. The framework covers the content of the MLA and the requirements for its components.
- In June, our Council approved a proposal by all medical schools and the Medical Schools Council (MSC) for the Applied Knowledge Test (AKT) to be set centrally, overseen by the GMC, and delivered by each school locally to their students.
- We have since been working with schools and the MSC to oversee the design and development of the national AKT for medical schools.
- We have continued to engage extensively with staff in medical schools to help them prepare for the introduction of the MLA.
- We have continued our work to make the MLA a fair, robust, and high-quality assessment and to engage widely to inform our work, including with postgraduate training bodies and students.

> "a landmark moment in the history of medical education in the UK"
>
> - Professor Malcolm Reed, Lead Co-Chair of the Medical Schools Council, commenting on Council's approval of the proposal made by medical schools and the MSC



Post-Brexit registration routes

The Brexit transition period ended on 31 December 2020. As part of this, agreements between the UK and the EU on the mutual recognition of professional qualifications ended. This meant that graduates with EEA nationality wishing to practise as a doctor in the UK would no longer be entitled to automatic recognition of their qualifications in the UK.

To make sure doctors from EEA countries could continue to join the UK medical workforce, the UK Government introduced new legislation on 1 January 2021. This meant we needed to prepare and implement new registration routes based on assessing the qualifications doctors have rather than on routes to registration resting on nationality.

Through an extensive programme of work, we updated our systems, policies, and processes to prepare these for 1 January 2021. We launched communications in advance to give as much notice as possible and developed extensive guidance on how doctors can apply under the new arrangements. This has helped us assure continuity in the intake of new doctors from overseas at a time when our healthcare systems are under significant pressure.

Sharing insights about trends in the medical profession

As part of our role, we collect and share a significant amount of data to help improve patient safety and aid planning. We also carry out or commission analysis and research. This work helps to improve medical training, patient care, and workforce development.

In 2021:

- we released findings from our commissioned research into how employer induction can affect medical practice and patient care. The research revealed a huge difference in the quality of inductions.
- we published research into the impact and value of feedback for trainee doctors. The report highlighted the important link between feedback and well-being.
- we also published findings from research into how working in an FiY1 role affected new doctors' practice. Different from Foundation Year 1 (FY1), interim Foundation Year 1 (FiY1) roles were created to allow final year medical students to be fast-tracked onto the frontline to help respond to the COVID-19 pandemic. The research concluded that FiY1 was a largely valuable experience that eased the transition into practice.
- we shared findings from commissioned research into how service changes impact doctors' training. The findings illustrated how involving trainees in decisions about service changes can lead to better patient care.

If you would like to receive regular updates on our research work, sign up to our Research e-newsletter.



The state of medical education and practice in the UK

In December, we published the 11th edition of our annual report into the state of medical education and practice in the UK. The report uses data and insights from the medical register, surveys, and other sources to provide a comprehensive picture of doctors' experiences, as well as trends in the medical workforce and in medical education.

The 2021 report looked in particular at how the COVID-19 pandemic and the recovery affected doctors' work and training. One of its conclusions was that despite the current pressures on the UK's healthcare systems, now is the time to retain and embed positive changes to ways of working that were a key part of the initial response to COVID-19. Otherwise, the report warns, exhaustion and disillusionment will grow even more rapidly, blunting the effects of initiatives to boost recruitment.

In particular:

- 23% of doctors said they were planning to leave the profession, up from 19% in 2020. 7% of all doctors also said they had taken hard steps towards leaving the profession, up from 4% in 2020.
- over a third of doctors (35%) said they were considering reducing their contracted hours. Some doctors also felt it was not realistic to reduce their hours in the current climate, though they may have wanted to.

The report also made for stark reading in relation to equality, diversity, and inclusion. For example, it outlined that:

- disabled doctors were almost twice as likely as non-disabled doctors to be dissatisfied, at a high risk of burnout, struggling with workload, and taking hard steps towards leaving the profession.
- doctors from ethnic minority backgrounds, particularly Asian/Asian-British doctors, were less likely to agree that they are supported by their immediate colleagues or are part of a supportive team.

We shared the report on our website and through the media, and the web pages containing the report were viewed over 7,000 times in the first week after release. Many of our partners released statements acknowledging the findings and the importance of the report in providing key insights into medical education and practice trends.

Completing the picture: why doctors leave the profession

As part of our research programme, we worked with Health Education England, the Department of Health (Northern Ireland), NHS Education for Scotland, and Health Education and Improvement Wales to understand the reasons why doctors leave the profession and what might encourage them to return. Over 13,000 doctors completed an online survey on this topic. All of them had practised in the UK within the last 15 years but were not practising at the time they responded to the survey.



Key findings from the survey, available in our *Completing the picture* report, include:

- many doctors stopped practising in the UK for personal reasons, such as retirement. However, others left due to negative pressures such as burnout.
- a higher proportion of disabled doctors stopped practising in the UK than those who did not consider themselves as disabled.
- disabled doctors are more likely to report bullying as an important factor in leaving, and LGBTQ+ doctors more commonly indicated mental health issues as key.
- 35% of the respondents wanted to return to practice in the UK, but only 23% thought it likely they would. However, the majority (59%) said they were both unlikely and unwilling to return.
- GPs showed higher levels of burnout and were reported as being less likely to return than other doctors.
- a small pool of countries account for a very large proportion of doctors moving abroad (eg Australia and New Zealand).
- improvements in areas like induction and providing up to date information on how to return could make a big difference in encouraging more doctors to return.

These findings suggest that well-led, supportive, and compassionate workplaces are vital in encouraging doctors and other healthcare professionals to stay in the profession.

> "This has been a useful barometer in our education reform work and will allow us to understand how we help support doctors who wish to return, as well as giving those thinking of leaving the profession the support to stay..."
> - Professor Sheona MacLeod, Deputy Medical Director, Education Reform, HEE

National training survey

Our national training survey helps us to monitor and report on the quality of postgraduate medical education and training. It is the largest annual survey of doctors' training in the UK. In the 2021 survey, we asked some questions about the continued impact of the COVID-19 pandemic on training. Over 63,000 doctors completed the survey. 76% of all trainees in the UK responded, and 32% of trainers. This is higher than in 2020, but still lower than our usual response rates. We believe this was due at least in part to the pressures and the disruption caused by the pandemic.

The survey helps us improve our quality assurance work in relation to education. It also improves the support we provide to trainers, trainees, and training environments across the UK.

For more information and to read the survey findings in detail, see the National Training Survey pages on our website.



Regulating physician associates and anaesthesia associates

In 2019, we agreed with the UK's Department for Health and Social Care (DHSC) that we will also start to regulate physician associates (PAs) and anaesthesia associates (AAs).

PAs and AAs are two of the medical associate professions (MAPs) working in UK healthcare. We are pleased to support the development of these valuable professionals, recognising the important role they play in the medical workforce. Regulation will help to increase the contribution PAs and AAs can make to UK healthcare, while keeping patients safe.

While the legislation that will enable us to bring these two professions under our regulation is being developed, we have made significant progress on several aspects of regulatory design.

Registration

We designed the processes that will bring the following groups of PAs/AAs onto the register:

- existing UK-based practitioners
- future PA/AA qualifiers from UK universities.

We published information about these processes on our website, so that future registrants can familiarise themselves with our expectations ahead of time. We will contact them nearer the start of regulation to let them know what we need from them to support their registration.

We have also begun work on how PAs and AAs will revalidate and are developing registration criteria for overseas-qualified practitioners.

Education

We have established a quality assurance (QA) process for UK PA and AA courses. All 37 current course providers have:

- engaged voluntarily in a baseline QA exercise
- completed a self-assessment against our published standards
- received initial feedback on strengths and areas for improvement.

We also developed high-level education outcomes for these professions. We worked with the Royal College of Physicians, Royal College of Anaesthetists, and others to create PA and AA curricula that are outcome-focused and meet our standards.

Professional standards

In October 2021, we published interim standards for the two associate professions. *Good medical practice for PAs and AAs* provides a framework for decision making to keep patients safe. We also produced accompanying case studies to set the standards in context. These standards will apply from when we begin regulating PAs and AAs until we publish new ethical guidance for all registrants, as part of our overall review of *Good medical practice*.



Fitness to practise

We expect PAs and AAs to be subject to revised fitness to practise processes eventually resulting from broader regulatory reforms that are currently underway. In the meantime, we have been liaising with the Faculty of Physician Associates and the Royal College of Physicians on handling concerns about the conduct of PAs on the voluntary register. We have met with counterparts to understand their approach and the nature of concerns raised and will offer our expertise in the year ahead.

Supporting the case for prescribing

The DHSC has begun work to extend appropriate prescribing responsibilities to PAs and AAs after our regulation begins. We are supportive of this step as it will maximise the contribution these professionals can make to patient care. We therefore contributed to discussions on the subject with relevant partners and offered our support to those working on defining the practical aspects of this important move.

To learn more about our work around PAs and AAs, join our community of interest, which is open to members of the public and those working in healthcare, or visit our online information hub.

Making every interaction matter

Healthcare professionals and members of the public often come to us at a challenging time. We want to make sure they are met with empathy, fairness, and professionalism by all our colleagues. We are also committed to listening to, learning from, and acting on their feedback about our services, and to learning more about the challenges experienced by the profession through research. Below are some examples of our work towards these objectives in 2021.

Supporting patients and others who raise a concern with us

When a patient raises a concern with us, we review the information to see if we need to investigate. If we decide to investigate a concern, our patient liaison team contacts the patient to talk through what is going to happen and to answer any questions. Once we have finished our investigation, we offer another meeting to explain the outcome and any next steps.

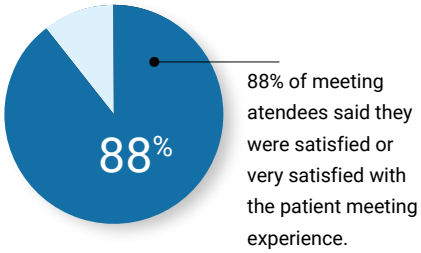
> "I was given time to voice any concerns and questions. I felt listened to and understood. I was given a full, clear explanation regarding the process that would take place."
>
> - Patient attending a patient liaison meeting

Prior to the pandemic, our patient liaison meetings were generally held in our offices in Belfast, Cardiff, Edinburgh, London, and Manchester.

In 2021, the majority of the meetings were held by telephone due to the pandemic. At the end of the year, we also started offering online meetings, which were very positively received.

We held liaison meetings with 337 patients over the course of 2021. Feedback was very positive: 88% of meeting attendees said they were satisfied or very satisfied with the patient meeting experience.

We also improved the information available on our website for patients considering whether to raise a concern with us. Often, concerns are best raised locally first, and we have provided updated guidance on how to do this. We also provided more information on the types of concern we typically investigate and those we do not. We explain that we only investigate when we believe a doctor poses a serious risk to patients or has significantly or repeatedly failed to meet our standards. Since the new web pages were launched in May 2021, they have been viewed over 40,000 times.





Regulatory reform

Regulation exists to protect the public. However, the legislation that currently regulates our work has not kept up with changes to the UK's healthcare system and society. In particular, it prevents us from adapting our processes as quickly as we would like in order to better support those we regulate to deliver great care.

The UK Government has proposed changes to the way that we and other healthcare regulators work. The changes will affect all areas of our work and processes. We welcome the opportunities the legislation will bring. Regulatory reform will help us respond more quickly and effectively. This means:

- dealing with complaints faster and more flexibly, reducing stress for all involved
- implementing more streamlined registration processes which will help the development of a more sustainable workforce
- exercising additional powers over monitoring education and training, allowing us to better support medical professionals through their studies and career.

These reforms will be key in enabling us to achieve the aims of our corporate strategy. We formally established a programme of work to support the changes in January 2021. From March to June last year, the Department of Health and Social Care consulted on high-level changes to healthcare regulators. Further Government consultation will need to take place once the drafting of this complex legislation is complete. Following that, the new legislation will be laid before the UK Parliament. If and when that is approved, we will consult to seek views on the way to put changes in place. We will then begin to introduce these changes. We expect some to happen quickly, while others will need to be phased over several years.

Communication and engagement continue to be a vital part of our work on regulatory reform. We have regularly updated and engaged with our key audiences on this agenda, and we will continue to do so while this programme of change develops.

Fairer regulation

We want to make sure fairness is at the core of our approach. We also want to set an example of the behaviours we expect from others. So, we have committed to reviewing our processes to make sure they are free from bias and as transparent as possible.

In 2021, an employment tribunal ruled that a number of factors led to us making a decision that was racially discriminatory against a doctor, with reference to a case dating back to 2018. We have applied to appeal this ruling, and at the time of going to print with this report the appeal has not yet been held.

In any case, we are determined to make sure that every registrant is treated fairly, both by ourselves and by others.



So, following previous research on the subject, we commissioned a fairness audit from the University of Edinburgh and Fieldfisher. The audit focused on how we make decisions regarding fitness to practise. The auditors found no evidence of bias in the way our decision makers interpreted our guidance. However, we are aware that further work is needed. The targets we set in relation to equality, diversity, and inclusion reflect this acknowledgement.

As part of our ongoing commitments, we are:

- future proofing our approach through regulatory reform: as we reform how we work as a regulator, we want to make sure fairness is central to all the changes we plan to introduce. We are doing this by engaging all our teams in understanding how to meet our equality goals and assessing how new regulatory processes could impact on equality and diversity. We will publish our equality analyses to be transparent with our stakeholders.
- improving our processes: we are systematically reviewing the decision points in our procedures to see if we can strengthen fairness controls. For example, through more or different training of our people, anonymisation of data, group decision making, and other quality assurance arrangements.
- investing in independent assurance: following the fairness audit mentioned above, we have commissioned an external review of how doctors experience our processes and of best practice in auditing for bias. We plan to use the review's findings to develop and put in place routine fairness audits as part of our processes.

Four-country regulation

The Northern Ireland, Scotland, and Wales healthcare systems each have different and specific characteristics and needs to the healthcare system in England. In order to understand and address these needs and better serve patients and doctors in these contexts, we regularly engage with our partners and key interest groups in each of the UK's devolved nations through our UK Advisory Forums.

Forum members include representatives from the relevant Departments of Health, medical leaders, medical education bodies, system and professional regulators, and patient representative organisations.

At twice-yearly meetings in each country, members have the opportunity to raise issues directly with our Chair and Chief Executive. The meetings allow us to discuss our priorities and seek views on policy development in collaboration with members in each country.

In 2021, discussions focused on our equality, diversity, and inclusion targets and on pressures on the medical profession. Members shared their insights on issues and initiatives to support doctors from ethnic minority backgrounds in each country. They also shared their reflections on the impact of the pandemic on the medical profession, highlighting aggression from the public towards healthcare staff and high levels of burnout, and what we can do collectively to support doctors' psychological safety.

Improving the user experience on our online portals

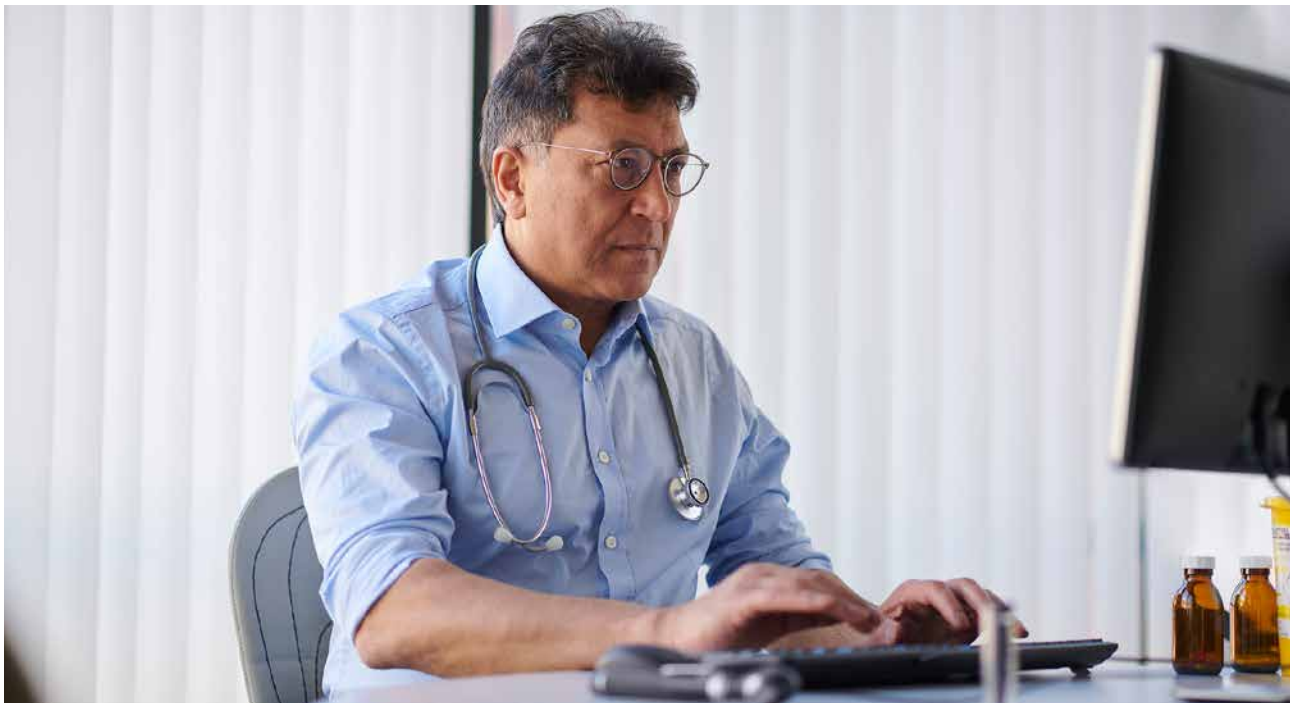
In August 2021, we introduced significant improvements to our secure online portals – GMC Online and GMC Connect.

GMC Online is our portal for doctors. They can use it to manage registration, carry out revalidation, pay fees, apply to take a Professional and Linguistic Assessments Board test, complete our national training surveys, and more.

GMC Connect is the system used to transfer data securely, both into and out of the organisation. The groups we share with include responsible officers, education organisations, legal organisations, and more. The improvements we made to the systems include:

- a better experience accessing GMC Online on a phone or tablet
- a simpler login process
- easier password recovery
- the ability to link accounts for GMC Online and Connect, which means users need only one login for both platforms
- an updated design which is more consistent with the rest of our website.

The changes significantly improve the user experience for doctors and others with accounts and are part of continuing work we are doing to keep up with external developments and increasing demand for our services.





Investing in our people

The majority of our colleagues tell us they find the GMC a great place to work. But we know that not everyone has the same experience. In 2021, our annual people survey showed that the percentage of colleagues who experience or witness bullying, harassment, or discrimination increased. We have zero tolerance for these behaviours and recognise we have more to do to ensure all colleagues are treated with respect and feel safe at work.

Equality, diversity, and inclusion programmes

We want to build a more diverse and inclusive organisation and a broader, more inclusive and diverse workforce where everyone can fulfil their potential through dedicated personal support. In line with this commitment, alongside our other equality, diversity, and inclusion (ED&I) targets, we have set ourselves targets in relation to improving staff representation and career progression for underrepresented ethnic groups in our workforce. By 2026, we want to reduce ethnicity-related differentials in relation to:

- recruitment and selection
- representation across staffing levels
- retention and progression
- employee engagement and inclusivity perceptions
- pay gaps.

To achieve these goals in 2021, we:

- briefed staff responsible for recruitment and selection on the targets we have set and how to achieve them
- embedded inclusivity into the core behaviours expected of all staff and integrated it into everyone's objectives
- expanded our leadership development programmes to cover colleagues of all levels, including those who do not (yet) have direct reports
- launched a talent development programme aimed at colleagues from ethnic groups that are under-represented in our leadership roles
- launched a bespoke training programme focusing on fostering inclusion with around 430 colleagues in leadership positions expected to take the training in 2022
- developed new training on professional behaviours (see page 49), to be completed by all staff by the end of 2022
- launched a new anti-racist allyship programme. As part of the first phase, 50 colleagues across the organisation have taken the training, including our senior management team.

We will review and report on progress against our goals in this area regularly based on human resource data, focus groups, and the results of our annual people survey.

Investors in people

We use Investors in People (IiP)'s We Invest in People framework to assess our processes and policies relating to our people. We have a talented and committed workforce and the IiP standard allows us to look at how we can best engage and inspire our people to achieve our strategy and deliver our business plan.

We have been accredited against this standard since 2018 at Silver level and we are working to achieve Gold accreditation. In 2021, following a survey and targeted interviews with staff, IiP found that we made significant strides towards Gold across all areas of the standard. Out of the 27 themes assessed, 12 met the Gold standard and 15 achieved the Silver standard. IiP also acknowledged that we improved on all the indicators in the framework since 2018.

Our focus for the next few years will be on continuing to embed our people management policies and procedures across the organisation.

> "There have been improvements in the responses to all indicators compared to the results in 2018, with many themes within each indicator increasing to Advanced (Gold) level...it is clear, from a strategic perspective, that the organisation is operating at Advanced (Gold) level."
> - IiP 2021 report

Professional Behaviours: Championing respect and inclusion

The majority of our colleagues tell us they find the GMC a great place to work. But we know that not everyone has the same experience.

During 2021, we developed mandatory training, Professional Behaviours: championing respect and inclusion. The training underpins our strategy and our equality, diversity, and inclusion objectives. It combines online learning with team discussions and follow-up events and encourages staff to consider their behaviour, the impact they have on others, and our individual responsibility for creating an inclusive and professional environment. It also focuses on what colleagues can do if they feel someone is not behaving appropriately and how to raise a concern. Those who completed the first phase of the training provided very positive feedback:

- 88% agreed or strongly agreed they had reflected critically on their behaviour past and present
- 83% agreed or strongly agreed they are now more likely to change their behaviour where it may be negatively affecting another person
- 72% agreed or strongly agreed they feel more confident to challenge or report unprofessional behaviour in the future.

We expect the training to be completed by all staff by the end of 2022.

Freedom to speak up

The *Freedom to speak up* (FTSU) initiative started in 2016 with the appointment of Freedom to Speak Up Guardians across the NHS. The scheme encourages and supports workers to speak up about events or behaviours that impact negatively on patients or on staff.

At the GMC, we have had a FTSU Guardian since March 2019. We recognised the value of enhancing our existing arrangements for colleagues internally to raise any issue they felt was negatively affecting our work and our culture.

The initiative has proved a valuable addition to our existing arrangements. Between March 2019 and December 2021, 279 issues were raised through this channel. These covered a range of matters, with the main themes including:

- behaviours (how we treat one another)
- consistent application of GMC policies
- perceived fairness of recruitment exercises.

Evidence from the programme shows that an increasing number of colleagues have felt able to take follow-up action themselves after a conversation with the Guardian or one of our supporting FTSU champions. It takes courage for colleagues to speak up and we actively encourage them to do so. We recognise the valuable learning from their experiences, which we can use to continuously improve our policies, management training, and communication.



Corporate social responsibility



Corporate social responsibility

We strive to be a socially responsible organisation. We want to embed sustainability, social impact, and ethics into everything we do. From standalone initiatives to everyday activities, we try to carry out our work in a way that benefits the environment and society.

In 2021, we made progress with this agenda in several ways.

Supporting social mobility and widening participation in medical education

- We designed and implemented a legal apprenticeship scheme with support from the Social Mobility Foundation. We launched the scheme in August 2021, receiving a positive response. The scheme allowed us to recruit four talented law students from the Greater Manchester area who will study towards their degree while they work in our legal team.
- We also took part in a number of events organised by the Social Mobility Foundation. The events were aimed at young people who want to go to medical school. Three of our clinical fellows presented at summer school events for these students, sharing their experiences of applying for medical school and their experiences of training.
- We joined the National Medical Schools Widening Participation Forum and worked with the Medical Schools Council on plans to develop resources to help widen participation in medical education.

Protecting the environment

- We launched the GMC's net zero carbon project. The project is designed to enable us to measure our environmental impact and develop options to become a net-zero-carbon organisation.
- We grew our internal network of GMC environment champions.
- We attended the International Association of Medical Regulatory Authorities conference. As part of this, we gave a joint presentation with Greener NHS.
- We published a blog in support of COP26.

Benchmarking and working with partners to promote CSR

- We strengthened our relationship with Business in the Community (BITC). As part of this, we started using their Responsible Business Tracker to benchmark our CSR work. The tracker allows us to measure our progress compared to other organisations.
- We represented the GMC on the BITC North West Leadership Board. The Board provides guidance and support for responsible business work across the region.

Creating opportunities and developing our CSR programme further

- We began a pilot programme of internships focusing specifically on CSR. Our first CSR intern joined us in May 2021 for 12 weeks. The intern helped us with research into widening participation schemes at UK medical schools.
- We launched our first corporate volunteering pilots. As part of this, some of our staff took part in a virtual reading scheme with a north London academy. They have been reading with Year 9 and 10 pupils from the academy with English as a second or third language for 30 minutes twice a week. We also worked with an academy trust in Manchester on their plans for Special Educational Needs schools in the area.

> "The reading scheme will provide huge benefits, as literacy is so important. For me, being able to contribute to it will be a positive highlight of my work at the GMC. It also reflects well on the organisation, showing it wants to contribute to local communities and society in this way."
>
> - GMC colleague taking part in our corporate volunteering scheme

The steps we have taken so far in relation to our CSR agenda will help us identify where we can do even more in future.



Our structure, governance, and management

Council and other governance groups

Council is our governing body. Its role is to provide strategic direction, hold the executive to account, and take major high-level policy decisions. It comprises 12 members from the 4 countries of the UK, 6 of whom are medical members and 6 of whom are lay members.

We are a registered charity and our Council members are also the trustees of the organisation.

They are all independently appointed by the Privy Council through a process that follows the Professional Standards Authority's guidance for making appointments to healthcare professional regulatory bodies.

The trustees between 1 January 2021 and 31 December 2021 were:

- Mr Steve Burnett
- Dr Vanessa Davies
- Ms Lara Fielden (until August 2021)
- Professor Anthony Harnden
- The Rt Hon Lord Hunt of Kings Heath PC
- Professor Paul Knight
- Professor Dame Carrie MacEwen
- Professor Deepa Mann-Kler
- Dame Clare Marx (until July 2021)
- Professor Suzanne Shale
- Dr Raj Patel
- Miss Alison Wright.

Dame Clare Marx was appointed by the Privy Council as the Chair of the General Medical Council in January 2019, but sadly due to ill health decided to step down at the end of July 2021. Dame Carrie MacEwen took on the role of acting Chair after Dame Clare Marx stepped down and chaired Council from then on.

In August 2021, we were shocked and extremely saddened by the untimely death of Lara Fielden, an outstanding member of Council who joined us in January 2021. Her contribution will be greatly missed.

Council therefore had two vacancies. Recruitment for a permanent Chair commenced in November 2021 and concluded in May 2022, with the appointment of Dame Carrie MacEwen as Chair.

Council members are also asked to declare any conflicts of interests. These are listed in a register of interests published on our website.

All Council members also participated in appraisal reviews in 2021, which included consideration of any learning and development needs and revisiting actual or perceived conflicts of interest to make sure any conflicts identified are manageable.

As a charity, we take into account the seven principles set out in the Charity Governance Code (2020) and can demonstrate how we use these principles to guide our work on an 'apply or explain' basis.

There are two exceptions to the Code, which we explain rather than apply. Firstly, our Council and committees operate without a formally appointed deputy or vice-chair. However, provisions are made in the *Governance handbook*

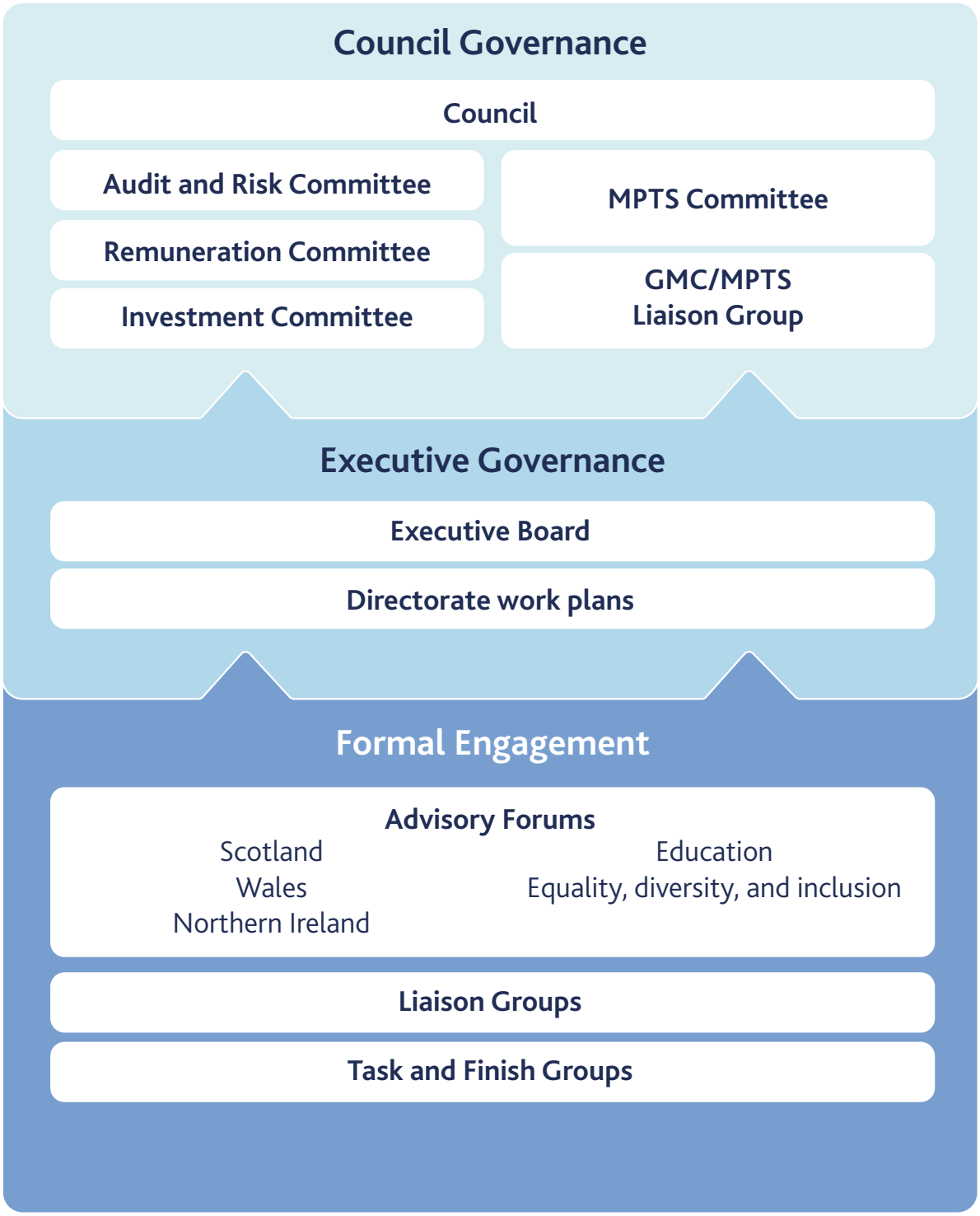
for chairs to nominate a deputy to assist during periods of absence, which was enacted this year. Secondly, as our appointments process is well established and thorough and is overseen by the Professional Standards Authority, a nominations committee is not considered necessary.

The *Governance handbook* is the governing document of the organisation. It was reviewed in 2019 to further incorporate the Charity Governance Code and minor updates are made with Council's approval on an ongoing basis, for example, to the membership of committees.

Our Corporate Governance team is charged with supporting the Council in maintaining high standards of governance, on an 'apply or explain' basis, in line with the good practice set out within the Charity Governance Code. The team also provides training and advice to the organisation on matters of governance. Each committee accounts to the Council through a formal report, and the Council and each committee undertake to review their effectiveness in delivering its statement of purpose, which is reviewed annually.

The diagram on the next page shows the different governance groups that assist Council in discharging its responsibilities. These have all been agreed by Council to help it oversee our work effectively. The roles and activities of these groups are described in the pages that follow.

Council business is conducted in an open and transparent manner and the agenda and papers for each meeting are published on our website.


Council Governance
Council
Audit and Risk Committee
Remuneration Committee
Investment Committee
MPTS Committee
GMC/MPTS Liaison Group
Executive Governance
Executive Board
Directorate work plans
Formal Engagement
Advisory Forums
Scotland
Wales
Northern Ireland
Education
Equality, diversity, and inclusion
Liaison Groups
Task and Finish Groups

Audit and Risk Committee

Paul Knight chaired the Audit and Risk Committee during 2021. Its external co-opted members were Elizabeth Butler (until July 2021), Jon Hayes (from July 2021), and Kenneth Gill.

The Committee plays a key part in our governance, providing Council with independent assurance about:

- the integrity of our financial statements
- the effectiveness of internal control, governance, and risk management systems
- the delivery of internal and external audit services.

The Committee met five times in 2021 and reports to Council twice a year. You can find out more about its role and its work in the Audit and Risk Committee Report section (see page 71) of this report.

Remuneration Committee

Anthony Harnden chaired the Remuneration Committee in 2021. The Committee advises Council on the remuneration, the terms of service, and the expenses policy for Council members, including the Chair. It oversees the recruitment process of the Chair and Council members before their appointment by the Privy Council. It determines the appointment process for the Chief Executive and the Medical Practitioners Tribunal Service (MPTS) Chair and the remuneration, benefits, and terms of service for the Chief Executive, directors, MPTS Chair, and MPTS Committee members. It is also responsible for making sure the assessment and measurement of performance and the assessment of recruitment and succession planning take place within an appropriate framework for the senior management roles within its remit. The Committee reports annually to Council and met three times in 2021.

Investment Committee

Steve Burnett chaired the Investment Committee in 2021. Its external co-opted members during 2021 were Tim Scholefield (until May 2021), David Stewart (until June 2021), Keith MacKay, and Mike Jennings (from November).

The Committee is responsible for implementing and reviewing our investment policy, making sure the management of assets is consistent with the policy, appointing and managing fund managers, and monitoring performance.

It also has responsibility for overseeing the GMC's investment in GMC Services International Limited (GMCSI), including ensuring compliance with the GMC's Investment Policy, scrutinising GMCSI's business plan, and assessing the potential levels of investment risk and return. The Committee reports on investment performance to Council via post-meeting circulars and reports on the performance of the portfolio to Council on an annual basis. It met five times in 2021.

GMC Services International

GMC Services International Limited (GMCSI) was established by Council in 2016 as a wholly owned trading subsidiary of the GMC. The main objective of GMCSI is to introduce new revenue streams and so reduce our reliance on doctors' fees.

Robust and effective governance arrangements are in place to ensure that our interests are protected and that our relationship with GMCSI is managed effectively.

While Council has overall responsibility for GMCSI, the Audit and Risk Committee considers the risks to the GMC from the operation of GMCSI, conducting routine internal audit and spot checks as appropriate.

Andrew McCulloch chaired the GMCSI Board during 2021. The Board comprised (in addition to the Chair) Paul Reynolds, Anthony Harnden, Alison Wright, and Colin Melville.

Board of Pension Trustees

The GMC's defined benefit staff superannuation scheme is managed and administered by a board of trustees in accordance with the scheme's trust deed and rules. The trust makes sure the pension scheme's assets are kept separate from those of the employer.

The scheme's trustees are responsible for the proper running of the scheme, including the collection of contributions, the investment of assets, and payment of the pension benefit commitments made by the employer.

Deirdre Kelly chaired the Board during 2021. Deirdre, Steve Burnett, Raj Patel, and Vanessa Davies are employer-nominated trustees. Danny Dubois, John Foley, Paula Robblee, and Martin Hart are member-nominated trustees.

Medical Practitioners Tribunal Service

The Medical Practitioners Tribunal Service (MPTS) is responsible for overseeing the adjudication of fitness to practise hearings. It is overseen by Dame Caroline Swift as Chair and by Gavin Brown as Executive Manager.

The MPTS Committee and joint GMC/MPTS Liaison Group are a core part of our governance framework.

Dame Caroline Swift chairs the MPTS Committee. The Committee oversees the delivery of the hearing service for doctors and makes sure the service meets its responsibilities under the *Medical Act 1983*. The GMC/MPTS Liaison Group is chaired by the Chair of Council. It oversees the working relationship between the MPTS and the functions of the GMC with which it interacts.

Executive Board

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

The Board meets monthly (except for August) and reports to every meeting of Council through the Chief Executive's report and via a separate annual report.

UK Advisory Forums

In 2013, we established advisory forums in Northern Ireland, Scotland, and Wales. The forums make sure we have effective engagement and consultation with interest groups and that our policies are suited to all parts of the UK. The invited membership differs from country to country and reflects the diverse range of those who have an interest and expertise in the areas under our regulation across the UK. The forums report on their work to the Executive Board twice a year.

Education Advisory Forum

The Education Advisory Forum, which replaced the Education and Training Advisory Board (ETAB) and the Assessment Advisory Board (AAB), began work in February 2019. The forum engages widely and effectively with our key interest groups on education, training, and assessment matters, making sure we are able to best develop and promote a strategic approach to this work across all countries of the UK. Professor Colin Melville, Medical Director and Director of Education and Standards, chairs the forum and the invited membership reflects the diverse range of those who have an interest and expertise in medical education, training, and assessment across the UK. The work of the forum is reported to the Chief Executive and to Council through the Chief Executive's report.

Equality, Diversity and Inclusion Forum

Our Strategic Equality, Diversity and Inclusion Forum helps us make sure that our activities respond to the needs of diverse groups of doctors. The forum comprises organisations representing doctors with shared protected characteristics, and helps us meet our ED&I objectives by providing feedback and advice on our policies and strategies, raising issues and concerns requiring our attention, and generally acting as a sounding board in relation to ED&I issues. In 2021, discussions with the forum covered our new ED&I targets, fairness and transparency, bullying, harassment, and discrimination, our review of *Good medical practice*, and the redesign of our processes as part of our regulatory reform programme.

Member attendance at Council, boards, and committees in 2021*

Member and trustee	Number of meetings attended
Steve Burnett	
Council	8/8
Investment Committee	4/4
Board of Trustees of the GMC's Superannuation Scheme	5/5
UK Advisory Forums – Wales	2/2
Vanessa Davies	
Council	8/8
Remuneration Committee	3/3
Board of Trustees of the GMC's Superannuation Scheme	5/5
Lara Fielden (until August 2021)	
Council	3/4
Investment Committee	2/2
Anthony Harnden	
Council	8/8
Remuneration Committee	3/3
Investment Committee	1/1
GMCSI	3/3
Philip Hunt	
Council	8/8
Audit and Risk Committee	5/5
Remuneration Committee	3/3

* Includes seven Council meetings and one strategic away day. Council member attendance at the Forum meetings is on a voluntary basis on the invitation of the Chair of Council. Attendance data reflects the total number of meetings where attendance was possible.

Member and trustee	Number of meetings attended
Paul Knight	
Council	8/8
Audit and Risk Committee	5/5
GMC Services International	1/1
UK Advisory Forums – Scotland	2/2
Carrie MacEwen	
Council	8/8
Investment Committee	4/4
GMC/MPTS Liaison Group	1/1
UK Advisory Forums – Northern Ireland	1/1
UK Advisory Forums – Scotland	1/1
UK Advisory Forums – Wales	1/1
Deepa Mann-Kler	
Council	8/8
Investment Committee	4/4
Remuneration Committee	3/3
UK Advisory Forums – Northern Ireland	2/2
Clare Marx (until July 2021)	
Council	4/4
GMC/MPTS Liaison Group	1/1
UK Advisory Forums – Northern Ireland	1/1
UK Advisory Forums – Scotland	1/1
UK Advisory Forums – Wales	1/1
Raj Patel	
Council	8/8
Audit and Risk Committee	5/5
Board of Trustees of the GMC's Superannuation Scheme	5/5
Suzanne Shale	
Council	8/8
Audit and Risk Committee	5/5

External co-opted members

External co-opted members sit on the Investment Committee and Audit and Risk Committee respectively.

Investment Committee	
Mr Keith MacKay	5/5
Mr Tim Scholefield	1/2
Mr David Stewart	1/2
Mike Jennings	1/1

Audit and Risk Committee	
Ms Elizabeth Butler	3/3
Mr Kenneth Gill	4/5
Jon Hayes	2/2

GMCSI	
Dr Andrew McCulloch	4/4

Management

At the beginning of 2021, our staff were under the direction of Chief Executive Charlie Massey. He is supported by a team of directors, who, as at 31 December 2021 were:

- Shaun Gallagher, Director of Strategy and Policy
- Una Lane, Director of Registration and Revalidation
- Colin Melville, Medical Director and Director of Education and Standards
- Anthony Omo, General Counsel and Director of Fitness to Practise
- Paul Reynolds, Director of Strategic Communications and Engagement
- Neil Roberts, Director of Resources.

Key management personnel – remuneration policy

The Remuneration Committee is responsible for determining the remuneration, benefits, and terms of service for the Chief Executive, Chair of MPTS, and directors. The Committee sets all aspects of salary or honoraria, the provision of any other benefits, and any other arrangements or contractual terms for this group of staff.

The Committee considers that we should provide remuneration and rewards that will attract and retain the high-calibre staff necessary to enable us to fulfil our statutory remit and deliver our strategic objectives.

In setting the base pay for individual posts, the Committee will take external advice on roles within its remit and align salaries with an appropriate market rate subject to resource considerations.

An annual consolidated pay award is considered with reference to the organisation's level of performance, the financial implications of any award, the award agreed for other GMC employees and wider market trends. An annual variable non-consolidated element is considered, reflecting personal performance with regard to the same considerations applied to any consolidated award. We review the effectiveness of these arrangements on an annual basis.

Staff within the Remuneration Committee's remit will usually be entitled to the benefits package available to all GMC employees on the same terms. The Committee retains the ability to withdraw, adjust, or change any benefits for staff within its remit, subject to any consultation and contractual requirements. The Committee considers any additional benefits in kind (such as relocation payments) on a case-by-case basis.

New external staff appointees within the Committee's remit are automatically enrolled into our defined contribution pension scheme. Where employees have existing agreed pension arrangements, such as membership of our defined benefit scheme, they retain this for the course of their employment, subject to any changes to the rules agreed by trustees and the employer.

The Committee makes sure that the equality and diversity implications of remuneration policy and related decisions are considered appropriately. Specifically, it ensures that:

- any salary differentials are supported by a formal job evaluation or independent external market advice
- any decisions relating to variable pay are supported by an objective assessment of performance
- any adjustment or changes to remuneration arrangements do not discriminate unlawfully
- other decisions relating to terms of service are supported by appropriate advice on any equality and diversity implications.

2021 financial review

The accounts for the year ended 31 December 2021 have been prepared in accordance with the Charities Statement of Recommended Practice (FRS 102).

Our total income and expenditure in 2021

The coronavirus (COVID-19) pandemic continued to have a significant impact on our activities throughout 2021, but we were able to start to work through the backlogs created by the early pandemic lockdowns and we continued to deliver many of our core services to support doctors and patients.

In 2021, we generated unrestricted income of £119.7 million, which was £11.4 million higher than 2020. This was due to the increase in the size of the register and the impact of running more Professional and Linguistic Assessments Board (PLAB) tests in 2021 than 2020, plus the subsequent increase in new applications to the register.

We were able to run additional PLAB tests by investing £1 million in a new temporary clinical assessment centre designed specifically for socially distanced exams, which allowed us to return to pre-pandemic capacity from June.

In addition, the Department of Health and Social Care of the UK Government provided £2.6 million of funding in 2021 to continue implementation work to bring physician associates and anaesthesia associates into regulation by the General Medical Council. This funding is restricted in nature, and so is shown separately in the accounts. It was fully spent in 2021, with £0.9 million used to develop IT systems, which are capital in nature, creating a restricted asset on the balance sheet.

We also generated £4.9 million of gains on our investments in 2021. This was higher than 2020 due to the impact of the early stages of the pandemic on financial markets in 2020.

Our unrestricted charitable expenditure in 2021 was £117.9 million, which was an increase of £11.3 million compared with 2020. In 2020 tribunals and PLAB 2 tests were temporarily postponed and restarted in the second half of the year. Throughout 2021 we were able to run tribunals on a hybrid basis, with some being face to face and some being virtual. We continued to deliver PLAB 2 tests under social distancing measures and successfully ran PLAB 2 tests on a non-socially distanced basis towards the end of 2021. We increased capacity for both tribunals and PLAB tests in 2021, which allowed us to process some of the work delayed during the temporary closures, which increased costs.

We increased our dilapidations provision by £1.9 million to ensure our obligations under our building leases can be met. Our 2021 accounts also include a further £0.1 million provision to meet potential costs arising from legal claims.

Our other core activities continued throughout 2021 with the impact of the pandemic generally influencing our ability to travel, return to the office with new working patterns, and host and attend events.

We set an efficiency target to generate savings of £1.5 million, which we felt was a realistic target considering the challenges the pandemic has brought to our operating environment. We managed to deliver cost savings of £1.9 million by realising savings through implementing virtual tribunals and deferring recruitment to vacant posts.

The charity had no fundraising activities requiring disclosure under S162A of the *Charities Act 2011*.

Reserves policy and going concern

Our level of reserves and our reserves policy are reviewed annually, and any financial implications are addressed as part of the budget-setting process.

Our total reserves are made up of free reserves, reserves backed by fixed assets, and pension reserves.

We hold free reserves:

- to provide working capital to undertake our normal day-to-day business
- to provide funds to deal with any risks that materialise
- to provide funds to respond to new initiatives, opportunities and challenges that present themselves
- to cover the period before any changes to fee levels take full effect.

A significant proportion of our total reserves is represented by fixed assets, which cannot easily be converted into cash without adversely affecting our ability to fulfil our charitable aims and statutory obligations. The value of fixed assets is therefore disregarded for reserves policy purposes.

The value of pension reserves is also disregarded for reserves policy purposes. The defined benefit scheme was closed to future accruals in 2018, and any deficit or surplus in the scheme can be managed over the medium term, so has no immediate impact on free reserves.

There is no standard formula that can be used to calculate the ideal level of free reserves. We follow the Charity Commission's guidance and set a target range based on our cash flow requirements and an assessment of the risks facing the organisation. We aim to hold free reserves at a level that is not excessive but does not put our solvency at risk.

Based on our analysis of cash flows and the risks facing the organisation, our policy has been to maintain free reserves in the range of £25 million to £45 million. However, in 2021 we re-assessed the risks we face, and Council approved increasing our upper threshold to £50 million.

For future years, to ensure that the free reserves policy continues to reflect changes in the size of the organisation, we will link the target range directly to expenditure, expressed in percentage terms, therefore our target range of free reserves will be between 20% and 35% of annual expenditure.

We will also continue to review the purpose and scope of our reserves policy on an annual basis to ensure the thresholds reflect our current risk profile, cash flow requirements and operating environment.

Our policy is to maintain actual free reserves in line with the target level over the medium term. If our actual reserves vary significantly from the

target range set out in the reserves policy, we take action to address the variation as part of the annual budget-setting process to bring actual reserves back into line within a reasonable period.

Our total reserves at the end of 2021 were £99.8 million, made up of free reserves of £45.2 million, plus £18 million of reserves represented by fixed assets, and a pension reserve of £36.6 million.

The spread of the coronavirus (COVID-19) had a significant impact on our activities throughout 2020 and 2021, and in overall terms our net costs were lower than planned. We are planning for our expenditure to be higher than our income in 2022 as we continue our recovery plans. We estimate that our free reserves will reduce to around £40.9 million at the end of 2022, which is consistent with our reserves policy.

Most of our income comes from registration fees paid by doctors. All doctors must be registered with us to practise medicine in the UK, and so our income is relatively certain. Despite the impact of the pandemic, trustees remain of the view that the GMC is a going concern for the foreseeable future, and therefore have prepared the financial statements on a going concern basis.

There are no material uncertainties related to events or conditions that cast significant doubt on our financial stability for the foreseeable future.

Investment policy

Council is responsible for determining and reviewing the overall investment policy, objectives, risk appetite and target returns. It has delegated responsibility for implementing the investment policy, appointing and managing fund managers, and monitoring performance to the Investment Committee, which regularly reports to Council.

Our investment policy separates our funds into four categories:

- those which are required as working capital for the normal day-to-day operation of the business
- those which we may invest under management
- those which we may invest in a trading subsidiary
- any residual cash balance.

We hold a minimum of £15 million as working capital for normal cash flow purposes. This is held in instant access bank accounts and provides sufficient flexibility to avoid temporary borrowing and/or the need to liquidate investments to deal with short-term variations in operational income and expenditure.

We originally invested £50 million under management in June 2019. Our target rate of return on funds invested under management is inflation (CPI) plus 2% over a rolling five-year period. This reflects our relatively low risk appetite. We seek to provide protection against inflation; to generate a modest level of return; and to diversify our funds to reduce the risk of capital and/or revenue loss.

We have adopted a comprehensive ethical approach to investments. We believe that investing in certain companies or sectors would conflict with our charitable aims or may create reputational damage. We do not wish directly to profit from, or provide capital to, activities that are materially inconsistent with our charitable aims and so we specifically exclude investment in companies that derive more than 10% of their revenue from: tobacco, alcohol, gambling, pornography, high-interest-rate lending, cluster munitions and landmines, and the extraction of thermal coal or oil sands. We do not invest in companies that are under investigation for, or have been found guilty of, tax evasion or money laundering in the past three years.

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

We invest only through fund managers who demonstrate the strongest environmental, social, and governance credentials. When appointing fund managers, we take into consideration how they incorporate an assessment of a company's performance on environmental, social, and governance issues in their stock selection.

Our funds under management were valued at £61.6 million at the end of 2021, compared with £57 million at the start of the year. We generated a return of 8.59% in 2021, compared with a target of 7.4%.

We invested £0.6 million as share capital in GMC Services International Limited, a trading subsidiary of the GMC, at the end of 2016. Our investment at the end of 2021 was valued at £0.2 million.

Any residual cash not held as working capital or invested is held in medium-term deposits and/or interest-bearing accounts. We generated interest of £0.08 million on our cash balances, equivalent to an average annual rate of return of 0.20%. Cash held as working capital, and any residual cash, is shown on our balance sheet within current assets.

GMC Services International Limited

The trading subsidiary was incorporated as a private company limited by shares on 16 December 2016. It is a wholly owned subsidiary of the GMC and provides services on a commercial basis, including consultancy, training, and accreditation. One of its main objectives is to introduce new revenue streams and so reduce the GMC's reliance on core financial resources. It will do this by gifting its profits back to the GMC for the purpose of delivering the GMC's charitable aims.

The GMC invested £0.6 million as share capital in GMC Services International Limited (GMCSI). In its early years of operation GMCSI generated net losses but has been able to recently generate modest profits. In 2021, GMCSI generated a net loss of £7,410 and ended the year with net assets of £230,445, so no profits have been gift-aided back to the GMC. GMCSI is projected to generate profits over the medium term.

The accounts presented here are consolidated group accounts to include our trading subsidiary GMCSI. The statement of financial affairs shows the consolidated position for the GMC and GMCSI combined. The balance sheet shows separate columns for the group position (GMC and GMCSI combined) and the parent charity position (GMC). Separate company accounts have been prepared for GMCSI.

Trustees' responsibilities for the financial statements

The trustees are responsible for preparing the trustees' annual report and the financial statements in accordance with applicable law and United Kingdom Generally Accepted Accounting Practice (United Kingdom Accounting Standards). The law, applicable to charities in England, Scotland and Wales, requires the trustees to prepare financial statements for each financial year which give a true and fair view of the state of affairs of the charity and the group, and of the incoming resources and application of resources of the group for that period.

In preparing these financial statements, the trustees are required to:

- select suitable accounting policies and then apply them consistently
- observe the methods and principles in the Charities Statement of Recommended Practice
- make judgements and estimates that are reasonable and prudent
- state whether applicable accounting standards have been followed, subject to any material departures being disclosed and explained in the financial statements
- prepare the financial statements on the going concern basis unless it is inappropriate to presume that the charity will continue in business.

The trustees are responsible for keeping adequate accounting records that are sufficient to show and explain the charity's transactions, and to disclose, with reasonable accuracy at any time, the financial position of the charity, enabling them to make sure that the financial statements comply with the *Charities Act 2011,* the *Charity (Accounts and Reports) Regulations 2008,* the *Charities and Trustee Investment (Scotland) Act 2005,* the *Charities Accounts (Scotland) Regulations 2006* (as amended), the Privy Council Directions issued under the *Medical Act 1983*, and the provisions of the charity's constitution. They are also responsible for safeguarding the assets of the charity and the group and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

Related party transactions

We require that all trustees and senior managers disclose details of any organisations in which they (and their close family members and business partners) hold a position of authority or other material interest and whose business could bring them into financial contact with the GMC. Details of any actual transactions between the GMC and related parties in the year must also be disclosed. We also publish a register of interests on our website.

In 2021, all disclosures were made and there were no issues of concern.

Audit and risk committee report

Our Council's Audit and Risk Committee plays a key role in our governance. The committee provides Council with independent assurance about:

- the integrity of our financial statements
- the effectiveness of internal control, governance, and risk management systems
- the delivery of internal and external audit services.

It also monitors our anti-fraud policies and any risks relating to the *General Data Protection Regulations* and reviews arrangements for raising concerns.

The committee bases its advice and decisions on guidance issued by the Financial Reporting Council, the Charity Commission, the Office of the Scottish Charity Regulator and, where appropriate, independent external advice.

At the beginning of 2021, there were seven members on the committee – five Council members and two co-opted members. The committee welcomed a new co-opted member in July and unfortunately lost one of our Council members in September due to their untimely passing, resulting in four Council members and two co-opted members on the committee at the end of 2021. Co-opted or independent, members enhance the work of the committee by bringing valuable additional skills and experience to the independent scrutiny of finance, risk, and governance. All members of the committee participate in an annual appraisal process.

In 2021, the committee met five times and submitted two formal reports on its work and findings to Council. As well as this, committee members had the opportunity to learn more about and scrutinise specific areas of the business and their risks in five seminar sessions.

The committee bases its annual work programme on risk and our Corporate Opportunities and Risk Register reflects the key strategic risks we manage. The committee's oversight and scrutiny play a valuable role in assuring that risks are being managed and opportunities are enhanced through effective systems of governance, internal control, and risk management arrangements.

Key activities during 2021

In 2020, the committee paused its planned programme of audit work to respond to the emerging risks of the pandemic and focus instead on a series of learning reviews and audit activity to provide assurance over new activities and risks. In 2021, the committee was able to pursue its planned internal audit programme. This has continued to focus on activities which have been adapted to respond to the pandemic, checking progress on our plans for backlog recovery, and completing regular spot checks to assess progress in our work to support the Government's regulatory reform programme.

At each of its meetings, the committee:

- discussed a wide range of strategic risks to provide an important backdrop to its understanding of the challenges and opportunities the GMC was facing
- considered the assurance it had with respect to how the organisation was responding to emerging threats and opportunities
- challenged our Corporate Opportunities and Risk Register
- continued support for risk maturity evolution in line with the principles of effective risk management set out in the ISO 31000:2009 international guidance standard
- scrutinised audit and learning review findings to satisfy itself that the actions being taken were appropriate
- monitored the implementation of recommendations made in previous audit reports to make sure they were being managed effectively by senior management
- reviewed any findings and lessons learnt from work undertaken in relation to significant adverse events.

Other key activities in the year included:

- approving the external audit letter of engagement and scrutinising the Annual report and accounts for 2020
- reviewing the *Head of Internal Audit's annual report and opinion*
- commissioning an independent test of our cyber security control arrangements
- reviewing concerns raised to our Freedom to Speak Up (FTSU) Guardian, as reported in the FTSU 2020 annual report
- holding a seminar to understand how we are addressing the committee's corporate social responsibility agenda
- considering risk and assurance through the lens of organisations that experienced a major event or failing of governance and internal controls.

The committee also commissioned an independent review of our arrangements for compliance with BS 10008 standard on the evidential weight and legal admissibility of electronically stored information (ESI), to which the GMC became fully accredited in 2016. The independent reviewer was again complimentary about our work and the ongoing maintenance of high standards despite the continued disruption caused by the pandemic. The review concluded that our information management system is effective in ensuring the trustworthiness of electronic information.

Risk management in 2021

During 2021, the wider context has continued to be dominated by the pandemic. Our priority has continued to be protecting patients, supporting the medical workforce, and the health and well-being of our colleagues. The organisation has continued to adapt to external circumstances and risks. For example, reflecting COVID-19 contexts in fitness to practise decision making, continuing MPTS hearings remotely, developing interim circuits for PLAB 2 clinical assessments, and continually updating plans to ensure a safe return to offices.

This ability to handle a diverse range of risks, continually scanning the wider external horizon for emerging threats and opportunities, and work with others across the health landscape illustrates the maturity of our risk arrangements and their resilience.

High-level strategic risk discussions at both Council and Audit and Risk committee provide an important backdrop to understanding the context of the GMC's activities and the potential to achieve positive impacts for patients and doctors. As well as reflecting on the potential implications of the ongoing nature of the pandemic and thinking about the opportunities for future plans and recovery activities, some of the key areas of risk and opportunity focus in 2021 have been:

- considering the opportunities to re-shape and improve delivery of our statutory responsibilities through the Government's programme of regulatory reform
- managing preparations for the impact of Brexit
- preparing for the introduction of the Medical Licensing Assessment in 2024
- responding to a range of important public investigations and inquiries, including the Independent Neurology Inquiry in Northern Ireland, the Independent review into West Suffolk Hospital NHS Foundation Trust, and the review into safety of maternity services in England
- developing our approaches to regulatory fairness to eliminate the disproportionate pattern of fitness to practise concerns we receive from employers based on doctors' ethnicity and place of qualification, and eliminating discrimination, disadvantage, and unfairness in undergraduate and postgraduate medical education and training
- maintaining staff safety and welfare in responding to Government guidance for home working and for return to offices.

Risk thinking is inherent in discussions and operations at all levels of the business. We have a mature set of risk management arrangements embedded in day-to-day activities and risk registers are used as a tool for identifying, articulating, monitoring, and managing operational and project risks which help us identify opportunities to improve how the business is managed and our working environment. Our Corporate Opportunities and Risk Register is published regularly on the website through the Chief Executive's report to Council.

Learning from events and issues

Fundamental to good risk management and developing resilience is the ability to appraise situations openly and honestly when something unexpected arises. We have a robust approach to undertaking significant event and learning reviews to identify opportunities to improve.

We carried out a number of these in 2021, including:

- a learning review following an incident when sensitive information was inadvertently shared in response to a Freedom of Information request. In this instance the Information Commissioner was notified in line with the statutory GDPR notification process, but they decided not to investigate or take action and subsequently closed the matter.
- a review following the judgment from an employment tribunal in a case where a doctor brought a claim of race and religious discrimination against the GMC, in relation to the handling of a concern regarding their fitness to practise. The tribunal found that the complaint of direct race discrimination was well founded and succeeded. The complaint of discrimination on the grounds of religion and belief was deemed to be not well founded and was dismissed. As part of the review, we undertook an initial exercise to consider immediate learnings to help improve how we respond to future employment tribunal claims and other non-standard litigation. Separately, recognising the potential for racial inequality to affect our activities, we have established a programme of work focused on making sure that existing systems, controls, and approaches on mitigating bias, monitoring differentials, and promoting fairness across our regulatory functions are effective both for now and the longer term (see page 45). The outcomes from this work will become a blueprint for how we embed stronger fairness control mechanisms in our processes as part of the UK Government's regulatory reform agenda.

Beyond 2021

As we begin to recover from the effects of the pandemic operationally, the external environment will remain uncertain as the wider health system begins to address the mounting backlog of elective activity and we enter a challenging economic period. This will present us with further opportunities and threats. Our ambitious Corporate strategy 2021-2025 and the public commitments we have made require us to remain focused but cognisant of the pressures on partners externally and colleagues internally. Active risk management will continue to be key to aiding us in balancing our work and priorities so that we continue to support doctors and patients.

Key opportunities in 2022

Externally, we have the opportunity to:

- continue working on a legislative reform agenda that transforms us (and other regulators) into a progressive, modern, and flexible regulator
- use our influence, data, and insight to generate pace in our partners' understanding and support to address inequalities and unfairness in the medical education and wider health system.

Internally we will build momentum to:

- refresh and evolve ways of working to enhance business recovery, building on learning and progress in responding to the pandemic
- advance ways of working that support a culture of inclusivity and innovation, including delivery of our diverse talent and leadership programmes.

Key challenges in 2022

There will also be challenges for us to navigate as a regulator and employer, including:

- delivering the policy and operational changes for regulatory reform in line with the timeframes set by the UK Government
- maintaining effective collaboration with key partners whose capacity and organisational efforts are focused on responding to the after effects of the pandemic
- balancing the continued pressures and potential impact on the well-being of our colleagues.

We are not underestimating the scale of these challenges. We know that we cannot achieve the positive impacts patients and doctors deserve if we do not continue to listen to them, to medical leaders, and to patient organisations so that we learn about their experiences and expectations for the future. We have to work with compassion and understanding in a time when society's expectations are shifting. We must be sensitive and flexible so that we continue to keep patients safe, support doctors, and earn respect for being an effective, relevant, and compassionate regulator and employer.

Approved by the trustees on 22 June 2022 and signed on their behalf by:



Dame Carrie MacEwen

Independent auditors' report to the trustees of the GMC

Opinion

We have audited the financial statements of the General Medical Council ('the charitable company') and its subsidiary ('the group') for the year ended 31 December 2021 which comprise the Consolidated Statement of Financial Activities, Consolidated Balance Sheet, Consolidated Statement of Cash Flows and notes to the financial statements, including significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and United Kingdom Accounting Standards, including Financial Reporting Standard 102 The Financial Reporting Standard applicable in the UK and Republic of Ireland (United Kingdom Generally Accepted Accounting Practice).

In our opinion the financial statements:

- give a true and fair view of the state of the group's and the charitable company's affairs as at 31 December 2021 and of the group's income and expenditure, for the year then ended;
- have been properly prepared in accordance with United Kingdom Generally Accepted Accounting Practice; and
- have been prepared in accordance with the requirements of the *Companies Act 2006* and the *Charities and Trustee Investment (Scotland) Act 2005* and Regulations 6 and 8 of the *Charities Accounts (Scotland) Regulations 2006* (amended).

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the charitable company in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the trustee's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the charitable company's or the group's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the trustees with respect to going concern are described in the relevant sections of this report.

Other information

The trustees are responsible for the other information contained within the annual report. The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Opinions on other matters prescribed by the Companies Act 2006

In our opinion based on the work undertaken in the course of our audit:

- the information given in the trustees' report, which includes the directors' report and the strategic report prepared for the purposes of company law, for the financial year for which the financial statements are prepared is consistent with the financial statements; and
- the strategic report and the directors' report included within the trustees' report have been prepared in accordance with applicable legal requirements.

Matters on which we are required to report by exception

In light of the knowledge and understanding of the group and charitable company and their environment obtained in the course of the audit, we have not identified material misstatements in the strategic report or the directors' report included within the trustees' report.

We have nothing to report in respect of the following matters in relation to which the *Companies Act 2006* and the *Charities Accounts (Scotland) Regulations 2006* require us to report to you if, in our opinion:

- adequate and proper accounting records have not been kept; or
- the financial statements are not in agreement with the accounting records and returns; or
- certain disclosures of trustees' remuneration specified by law are not made; or
- we have not received all the information and explanations we require for our audit.

Responsibilities of trustees

As explained more fully in the trustees' responsibilities statement set out on page 69, the trustees (who are also the directors of the charitable company for the purposes of company law) are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the trustees determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the trustees are responsible for assessing the charitable company's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the trustees either intend to liquidate the charitable company or to cease operations, or have no realistic alternative but to do so.

Auditor's responsibilities for the audit of the financial statements

We have been appointed as auditor under section 44(1)(c) of the *Charities and Trustee Investment (Scotland) Act 2005* and under the *Companies Act 2006* and report in accordance with the Acts and relevant regulations made or having effect thereunder.

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Details of the extent to which the audit was considered capable of detecting irregularities, including fraud and non-compliance with laws and regulations are set out below.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Extent to which the audit was considered capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We identified and assessed the risks of material misstatement of the financial statements from irregularities, whether due to fraud or error, and discussed these between our audit team members. We then designed and performed audit procedures responsive to those risks, including obtaining audit evidence sufficient and appropriate to provide a basis for our opinion.

We obtained an understanding of the legal and regulatory frameworks within which the charitable company and group operate, focusing on those laws and regulations that have a direct effect on the determination of material amounts and disclosures in the financial statements. The laws and regulations we considered in this context were the *Companies Act 2006, Medical Act 1983* and the *Charities and Trustee Investment (Scotland) Act 2005* together with the Charities SORP (FRS102). We assessed the required compliance with these laws and regulations as part of our audit procedures on the related financial statement items.

In addition, we considered provisions of other laws and regulations that do not have a direct effect on the financial statements but compliance with which might be fundamental to the charitable company's and the group's ability to operate or to avoid a material penalty. We also considered the opportunities and incentives that may exist within the charitable company and the group for fraud. The laws and regulations we considered in this context for the UK operations were, General Data Protection Regulation (GDPR), and employment legislation.

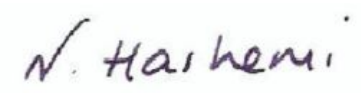
Auditing standards limit the required audit procedures to identify non-compliance with these laws and regulations to enquiry of the trustees and other management and inspection of regulatory and legal correspondence, if any.

We identified the greatest risk of material impact on the financial statements from irregularities, including fraud, to be within the timing of recognition of income, estimates surrounding legal provisions, dilapidations and the override of controls by management. Our audit procedures to respond to these risks included enquiries of management, internal audit, legal counsel and the Audit & Risk Committee about their own identification and assessment of the risks of irregularities, sample testing on the posting of journals, reviewing accounting estimates for biases, reviewing regulatory correspondence with the Charity Commission, performing data analytics on ARF and PLAB income and reading minutes of meetings of those charged with governance.

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations (irregularities) is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it. In addition, as with any audit, there remained a higher risk of non-detection of irregularities, as these may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. We are not responsible for preventing non-compliance and cannot be expected to detect non-compliance with all laws and regulations.

Use of our report

This report is made solely to the charitable company's members, as a body, in accordance with Chapter 3 of Part 16 of the *Companies Act 2006*, and to the charitable company's trustees, as a body, in accordance with Regulation 10 of the *Charities Accounts (Scotland) Regulations 2006*. Our audit work has been undertaken so that we might state to the charitable company's members those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the charitable company and the charitable company's members as a body and the charitable company's trustees as a body, for our audit work, for this report, or for the opinions we have formed.



Naziar Hashemi
Senior Statutory Auditor
For and on behalf of
Crowe U.K. LLP
Statutory Auditor
55 Ludgate Hill
London
EC4M 7JW
1 July 2022

Consolidated statement of financial activities for the year ended 31 December 2021

	Note	Unrestricted funds £'000	Restricted funds £'000	**Total 2021 £'000**	Total 2020 £'000
Income					
From charitable activities					
Registration	2	114,545	-	**114,545**	103,042
Specialist and GP registration	2	4,047	-	**4,047**	4,052
Revalidation	2	107	-	**107**	54
Other trading activities	3	337	-	**337**	193
Commercial trading operations	3	239	-	**239**	316
Investments	3	154	-	**154**	388
Department of Health funding - MAPS*	3	-	2,605	**2,605**	1,577
Other	3	308	-	**308**	242
Total incoming resources		119,737	2,605	**122,342**	109,864
Expenditure					
Raising funds					
Commercial trading operations	4	246	-	**246**	302
Investment management costs	4	249	-	**249**	221
		495	-	**495**	523
Charitable activities					
Fitness to practise	4	46,882	-	**46,882**	42,936
Registration and revalidation	4	29,803	-	**29,803**	25,394
External relationships	4	15,319	-	**15,319**	15,140
Medical Practitioners Tribunal Service	4	14,012	-	**14,012**	11,297
Education	4	9,941	-	**9,941**	10,025
Standards	4	1,920	-	**1,920**	1,760
Department of Health funding - MAPS	4	-	1,749	**1,749**	1,577
		117,877	1,749	**119,626**	108,129
Other expenditure					
Legal provision	11	144	-	**144**	3,744
Dilapidations provision	11	1,882	-	**1,882**	973
		2,026	-	**2,026**	4,717
Total expenditure	4	120,398	1,749	**122,147**	113,369
Operating surplus/(deficit)		(661)	856	**195**	(3,505)
Net gains/(losses) on investments	8	4,879	-	**4,879**	2,476
Net income/(Net loss)		4,218	856	**5,074**	(1,029)
Other recognised gains and losses					
Actuarial (loss)/gain on defined benefit pension scheme	16	30,143	-	**30,143**	(6,971)
Net movement in funds		34,361	856	**35,217**	(8,000)
Total funds brought forward		64,581	-	**64,581**	72,581
Total funds carried forward		98,942	856	**99,798**	64,581

The General Medical Council incorporated a wholly owned trading subsidiary on 16 December 2016 with the purpose of providing services on a commercial basis including consultancy, training and accreditation. The Charity has taken exemption from presenting its unconsolidated profit and loss account. The charity movement in funds for the year is £35,217,000.

* The Department for Health and Social Care (DHSC) provided funding in 2021 to continue implementation work to bring physician associates and anaesthesia associates under regulation with the General Medical Council. Funding was restricted in nature, and was fully spent in the year. A proportion of the funds paid for IT System Development which has created an asset on the balance sheet. The net impact on GMC reserves is £856,000. The balance of the reserves will reduce when the asset is amortised in future periods.

Balance sheet

	Note	2021 Group £'000	2021 Charity £'000	2020 Group £'000	2020 Charity £'000
Fixed assets					
Intangible fixed assets	6	11,702	11,702	10,361	10,361
Tangible fixed assets	7	6,305	6,305	7,519	7,519
Investments	8	61,649	61,879	57,020	57,257
		79,656	**79,886**	74,900	75,137
Current assets					
Debtors and prepayments	9	24,041	24,096	23,349	23,303
Cash and bank balances		46,821	46,502	38,128	37,882
		70,862	**70,598**	61,477	61,185
Liabilities					
Creditors: amounts falling due within one year	10	(80,538)	(80,504)	(71,067)	(71,012)
Net current liabilities		(9,676)	(9,906)	(9,590)	(9,827)
Total assets less current liabilities		**69,980**	**69,980**	65,310	65,310
Provisions for liabilities and charges	11	(6,743)	(6,743)	(4,717)	(4,717)
Net assets excluding pension scheme asset		**63,237**	**63,237**	60,593	60,593
Defined benefit pension scheme asset	16	36,561	36,561	3,988	3,988
Total net assets		**99,798**	**99,798**	64,581	64,581
Unrestricted income funds		62,381	62,381	60,593	60,593
Restricted income funds		856	856	-	-
Pension reserve		36,561	36,561	3,988	3,988
Total funds	12, 13	**99,798**	**99,798**	64,581	64,581

The financial statements were approved by the trustees and authorised for issue on 22 June 2022.
They were signed on behalf of trustees by:



Dame Carrie MacEwen
Chair of Council

Consolidated cash flow statement

	2021		2020	
	£'000	**£'000**	£'000	£'000
Cash flows from operating activities:				
Net cash provided by/(used in) operating activities (note i below)		16,902		14,064
Cash flows from investing activities:				
Dividends, interest and rents from investments	84		180	
Purchase of property, plant, equipment and intangibles	(8,293)		(6,783)	
Net cash used in investing activities		**(8,209)**		(6,603)
Change in cash and cash equivalents (note ii below)		**8,693**		7,461

Note (i)

Cash flow from operating activities	
Net incoming/(outgoing) resources	5,074
Investment income and interest	(154)
Net investment movement	(4,629)
Non-cash items - depreciation and amortisation	8,165
Non-cash items - assets written off	1
Pension scheme contribution	(2,360)
(Increase)/decrease in debtors	(692)
Increase/(decrease) in creditors and provisions	11,497
Net cash provided by/(used in) operating activities	**16,902**

Note (ii)	**Short-term deposits**	**Cash at bank and in hand**	**Total**
Cash and equivalents	**£'000**	**£'000**	**£'000**
Balances at 1 January 2021	-	38,128	**38,128**
Net increase in cash and cash equivalents	-	8,693	**8,693**
Balances at 31 December 2021	-	46,821	**46,821**

Notes to the accounts

General information

We are a statutory body governed by the Medical Act 1983 and are registered with the Charity Commission for England and Wales (1089278), and with the Office of the Scottish Charity Regulator (SC037750).

1. Principal accounting policies

(i) Accounting convention

The financial statements have been prepared to give a 'true and fair' view and have departed from the Charities (Accounts and Reports) Regulations 2008 only to the extent required to provide a 'true and fair' view. This departure has involved following the Charities SORP (FRS 102) first published on 16 July 2014, updated 1 October 2019.

Our financial statements have been prepared on a going concern basis and in accordance with the Charities Statement of Recommended Practice (FRS 102) - effective 1 October 2019, applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland, the Charities Act 2011, the Charities and Trustee Investment (Scotland) Act 2005, the Charities Accounts (Scotland) Regulations 2006 and UK Generally Accepted Practice as it applies from 1 October 2019. The GMC meets the definition of a public benefit entity under FRS 102.

(ii) On 16 December 2016 the GMC incorporated a trading subsidiary, GMC Services International LTD, company number 10530157, which is wholly owned by share capital by the General Medical Council.

(iii) The principal accounting policies adopted in the preparation of the financial statements, which have been applied consistently, are:

Incoming resources

Income is included in the statement of financial activities when all of the following criteria are met:

- Entitlement - control over the rights or other access to the economic benefit has passed to the GMC
- Probability - it is more likely than not that the economic benefits will flow to the GMC
- Measurement - the value can be measured reliably.

The following specific policies apply:

- Annual retention fees relate to services to be provided over a 12-month period. Income is deferred and released to the statement of financial activities on a straight-line basis over the period to which the income relates.
- Registration fees, including provisional registration fees, are recognised when registration is granted.
- Professional and Linguistic Assessments Board (PLAB) fees are recognised when the examinations are sat.
- Income from investments and funds held on deposit is recognised when it is receivable and the amount can be accurately measured.

All income is recognised gross.

Basis for recognising liabilities

Expenditure includes staffing costs, office costs, committee costs, legal costs, accommodation costs, purchase of assets, and financial, actuarial and professional costs.

Resources expended are included in the statement of financial activities on an accruals basis. All liabilities are recognised as soon as there is a legal or constructive obligation committing the charity to expenditure.

Basis for allocation of resources expended

The majority of our resources are expended directly in pursuit of our charitable aims, and are identified as such in the statement of financial activities.

Accommodation costs, governance costs and other support costs are apportioned to charitable activities on the basis of staff head count across the organisation.

Irrecoverable VAT

Any irrecoverable VAT is charged to the statement of financial activities as part of the relevant item of expenditure, or capitalised as part of the cost of the related asset where appropriate.

Taxation

We can take advantage of the exemptions from taxation on income and gains available to charities, so no taxation is payable on the net incoming resources.

Debtors

Trade and other debtors are normally recognised at the settlement amount due after any trade discount offered. Prepayments are normally valued at the amount prepaid net of any trade discounts due.

Creditors and provisions for liabilities

Creditors and provisions are recognised when the charity has a present legal or constructive obligation as a result of a past event. They are recognised when it is probable that a transfer of economic benefit will be required to settle the obligation and a reliable estimate can be made of the amount of the obligation. Creditors and provisions are normally recognised at their settlement amount after allowing for any trade discounts due.

Critical accounting judgements and key sources of estimation uncertainty

The key sources of estimation uncertainty that have a significant effect on the amounts recognised in the financial statements are:

- All unsettled claims for legal costs made against the GMC are reviewed on a case-by-case basis at the year end. Provisions are based on historical experience and a detailed assessment of the specific details of current cases. The final settlement of cases is dependent on a number of factors, so the accuracy of the provision is subject to a significant degree of uncertainty.
- Provisions for property dilapidation costs are made for all leased buildings. They are assessed on a case-by-case basis reflecting the different configurations of leased buildings and the cost to revert to their original state.
- Provisions for holiday pay are based on the actual level of accrued days and salaries of each staff member.

Tangible fixed assets

Tangible fixed assets are stated at cost, net of depreciation and any provision for impairment. Expenditure is only capitalised where the cost of the asset or group of assets acquired exceeds £5,000.

Intangible fixed assets

Intangible fixed assets comprise computer software. They are stated at cost, net of amortisation and any provision for impairment. Expenditure is only capitalised where the cost of the asset or group of assets acquired exceeds £5,000.

Depreciation

Depreciation is provided so as to write off the cost, less estimated residual value, of the assets evenly over their estimated lives.

The estimated useful lives are as follows:

- Leasehold buildings and leasehold improvements - the lesser of five years or the remaining term of the lease.
- Furniture, fixtures, and office fittings - the lesser of five years or the remaining term of the lease.
- Information Technology (IT) equipment - three years.
- Intangible assets: (IT software) - three years.
- Other office equipment - three years for IT-related items and five years for all other items

Depreciation rates are reviewed on a regular basis comparing actual lives of assets with the accounting policy rates.

Licensed IT software

Development costs for implementing new IT systems are capitalised and depreciated over the lesser of 3 years or the useful life of the asset. The first year license costs are capitalised as they are necessary to bring the asset into use, subsequent year license costs are treated as operating expenditure.

Operating leases

Rent payable under operating leases is charged to the statement of financial activities on a straight-line basis over the period of the lease.

Financial instruments

The charity has financial assets and liabilities of a kind that qualify as basic financial instruments. Basic financial instruments are initially recognised at transaction value and subsequently measured at amortised cost. Financial assets held at amortised cost consist of cash and bank balances, short-term deposits (cash flow statement), investments held in cash deposits (note 8) together with trade and other debtors (note 9). Financial liabilities held at amortised cost comprise trade and other creditors, tax and social security creditors and accruals (note 10).

Investments

Our investment policy separates our funds into four categories: those which are required as working capital for the normal day to day operation of the business; those which we invest under management; those which we may decide to invest in a trading subsidiary; and the remaining cash balance which fluctuates during the year.

Funds held as cash for the normal day to day operation of the business are shown on the GMC's balance sheet within current assets, while funds held for the longer term are shown as investments.

Pensions

We have a defined benefit pension scheme for permanent employees. The scheme was closed to new members on 30 June 2013, and for future accrual to existing members on 31 March 2018, and replaced by a defined contribution scheme. The surplus or deficit of the defined benefit scheme is recognised on the balance sheet. Changes in the assets and liabilities of the scheme are disclosed and allocated as follows:

- Charges relating to current or past service costs, and gains and losses on settlements and curtailments, are included within staff costs and charged to the statement of financial activities
- Interest on the net defined benefit asset/liability is shown as a net amount of other finance costs or as an incoming resource alongside investment income and interest. Actuarial gains and losses are recognised immediately in other recognised gains and losses on investments.
- The assets, liabilities and movements in the surplus or deficit of the scheme are calculated by qualified independent actuaries as an update to the latest full actuarial valuation. Details of the defined benefit scheme assets, liabilities and major assumptions are shown in the notes to the accounts.
- Our defined contribution pension scheme was set up on 1 July 2013. Contributions to the scheme are charged to the statement of financial activities in the year in which they are payable to the scheme.
- 1 member of staff who transferred to the GMC on the merger with the Postgraduate Medical Education and Training Board (PMETB), contribute to the NHS multi-employer scheme and contributions to the scheme are charged to the statement of financial activities in the year in which they are payable to the scheme.

Funds and reserves

The majority of our funds are unrestricted, and so can be expended at the trustees' discretion in pursuit of our charitable aims. Restricted funds will be expended in line with the purpose of the funding.

Termination payments

Termination payments are accounted for as soon as the organisation is aware of the obligation to make the payment.

2. Income from charitable activities

	Unrestricted funds	**Total 2021 £'000**	Unrestricted funds	Total 2020 £'000
Registration				
Annual retention fees	99,025	**99,025**	93,428	93,428
Registration fees	4,630	**4,630**	3,916	3,916
Provisional registration fees	416	**416**	25	25
PLAB fees	10,388	**10,388**	5,576	5,576
Other fees	86	**86**	97	97
	114,545	**114,545**	103,042	103,042
Specialist and GP registration				
Certificates of Completion of Training fees	2,949	**2,949**	2,790	2,790
Certificate of Eligibility for Specialist Registration/ Certificate of Eligibility for General Practitioner Registration fees	1,072	**1,072**	1,220	1,220
Other fees	26	**26**	42	42
	4,047	**4,047**	4,052	4,052
Revalidation				
Revalidation annual return	98	**98**	48	48
Revalidation assessment	9	**9**	6	6
	107	**107**	54	54

3. Income from raising funds

	Unrestricted funds	Restricted funds	**Total 2021**	Unrestricted funds	Restricted funds	Total 2020
			£'000			£'000
Activities for raising funds						
Other trading activities*	337	-	**337**	193	-	193
Commercial trading operations†	239	-	**239**	316	-	316
Other‡	308	-	**308**	242	-	242
	884	-	**884**	751	-	751
Investment income						
Other finance income - pension scheme (note 16)	70	-	**70**	208	-	208
Bank interest	84	-	**84**	180	-	180
	154	-	**154**	388	-	388
Department of Health funding						
Funding to cover expenditure on Medical Associate Professionals regulation¶	-	2,605	**2,605**	-	1,577	1,577

* Other trading activities include the reimbursement of costs of visiting overseas medical schools and the reimbursement of costs of staff seconded to external bodies.

† Income from commercial trading operations is derived from GMC Services International Ltd, a wholly owned subsidiary, which provides services on a commercial basis including consultancy, training and accreditation.

‡ Other income includes reimbursement of legal fees from appeals and transaction fees generated through registration status changes.

¶ The Department of Health and Social Care have provided funding for the General Medical Council to start implementation work to bring physician associates and anaesthesia associates under regulation with the General Medical Council. The work is ongoing and legislation is expected to be in place for regulation to start no sooner than 2023.

4. Total expenditure

Charitable activity and support cost allocation

	Direct staffing costs £'000	Direct costs £'000	Allocated costs £'000	Total 2021 £'000	Direct staffing costs £'000	Direct costs £'000	Allocated costs £'000	Total 2020 £'000
Expenditure on:								
Commercial trading operations	216	30	-	**246**	266	36	-	302
Investment management costs	-	249	-	**249**	-	221	-	221
Total expenditure on raising funds	216	279	-	**495**	266	257	-	523
Fitness to practise	21,354	6,774	18,754	**46,882**	20,168	4,597	18,171	42,936
Registration and revalidation	12,077	5,915	11,811	**29,803**	10,491	4,403	10,500	25,394
External relationships*	8,948	602	5,769	**15,319**	8,992	506	5,642	15,140
Medical Practitioners Tribunal Service	4,782	4,972	4,258	**14,012**	4,295	3,054	3,948	11,297
Education	5,841	345	3,755	**9,941**	6,048	151	3,826	10,025
Standards	1,109	13	798	**1,920**	1,002	2	756	1,760
Department of Health funding - MAPS	1,196	553	-	**1,749**	1,185	392	-	1,577
Total charitable expenditure	55,307	19,174	45,145	**119,626**	52,181	13,105	42,843	108,129
Other expenditure - legal provision	-	144	-	**144**	-	3,744	-	3,744
Other expenditure - dilapidation provision	-	1,882	-	**1,882**	-	973	-	973
Total group expenditure	55,523	21,479	45,145	**122,147**	52,447	18,079	42,843	113,369

* External relationships include the work done by our Regional Liaison Service, strategic relationships, our devolved offices, and our European and international development activities.

Support costs allocated to charitable activities

	Management £'000	IT £'000	Human resources £'000	Finance £'000	Procurement £'000	Facilities £'000	Governance £'000	Total 2021 £'000	Management £'000	IT £'000	Human resources £'000	Finance £'000	Procurement £'000	Facilities £'000	Governance £'000	Total 2020 £'000
Fitness to practise	3,249	6,066	2,367	875	161	4,678	1,358	**18,754**	3,237	5,817	2,082	756	154	4,744	1,381	18,171
Registration and revalidation	2,046	3,820	1,490	551	102	2,946	856	**11,811**	1,871	3,361	1,203	437	89	2,741	798	10,500
External relationships*	999	1,866	728	269	50	1,439	418	**5,769**	1,005	1,806	646	235	48	1,473	429	5,642
Medical Practitioners Tribunal Service	738	1,377	537	199	37	1,062	308	**4,258**	703	1,264	452	164	34	1,031	300	3,948
Education	650	1,215	474	175	32	937	272	**3,755**	682	1,225	438	159	32	999	291	3,826
Standards	138	258	101	37	7	199	58	**798**	135	242	87	31	6	198	57	756
Total charitable expenditure	7,820	14,602	5,697	2,106	389	11,261	3,270	**45,145**	7,633	13,715	4,908	1,782	363	11,186	3,256	42,843

Support costs are allocated to charitable activities on the basis of staff head count across the organisation.

Support cost recharges have been made to both the trading subsidiary, GMCSI, and the MAPS project throughout the year on a direct basis therefore are treated separately to the year end allocation.

Group expenditure by type

	Charitable activities 2021	**Expenditure on raising funds 2021**	**Department of Health funding - MAPS 2021**	**Other expenditure 2021**	**Total 2021**	Charitable activities 2020	Expenditure on raising funds 2020	Department of Health funding - MAPS 2020	Other expenditure 2020	Total 2020
	£'000	**£'000**	**£'000**	**£'000**	**£'000**	£'000	£'000	£'000	£'000	£'000
Staffing costs	74,880	216	1,196	-	**76,292**	71,692	266	1,185	-	73,143
Office costs	1,412	24	530	-	**1,966**	1,558	29	392	-	1,979
Council and committee costs	359	-	-	-	**359**	435	1	-	-	436
Panel and assessment costs	13,220	-	-	-	**13,220**	9,296	-	-	-	9,296
Legal costs	4,408	-	-	144	**4,552**	2,627	-	-	3,744	6,371
Accommodation costs	7,016	-	-	1,882	**8,898**	5,876	-	-	973	6,849
Financial, actuarial and professional costs	4,115	255	23	-	**4,393**	3,371	228	-	-	3,599
Purchase of assets - charged to revenue	4,301	-	-	-	**4,301**	3,795	-	-	-	3,795
Assets written off	1	-	-	-	**1**	47	-	-	-	47
Depreciation	3,163	-	-	-	**3,163**	3,070	-	-	-	3,070
Amortisation	5,002	-	-	-	**5,002**	4,784	-	-	-	4,784
	117,877	495	1,749	2,026	**122,147**	106,551	524	1,577	4,717	113,369

Total resources expended includes:

	2021	2020
Operating lease costs: leasehold property and equipment	3,639	3,505
Audit fees	43	43

5. Staff

	2021	2020
	£'000	£'000
Total costs of all staff		
Salaries	**59,022**	56,922
Social security costs	**6,189**	5,874
Superannuation costs - defined contribution scheme	**8,487**	7,928
Redundancy costs	**202**	-
Other staffing costs	**2,392**	2,419
	76,292	73,143

During the year the General Medical Council made termination payments of £40,000 (2020: £0), a further £162,000 was paid after year-end relating to decisions within 2021, giving a total expense for the year of £202,000 (2020: £0).

	2021	2020
Average staff numbers in the year by category		
Fitness to practise	**478**	460
Registration and revalidation	**301**	266
External relationships	**147**	143
Medical Practitioners Tribunal Service	**109**	100
Education	**96**	97
Standards	**20**	19
Governance and Management	**154**	145
Resources	**217**	211
	1,522	1,441
GMC Services International Ltd	**1**	1
	1,523	1,442

The number of staff whose total employee benefits (excluding employer pension contributions) fell into higher salary bands was:

	2021	2020
GMC		
£60,000–£70,000	52	59
£70,001–£80,000	57	42
£80,001–£90,000	28	29
£90,001–£100,000	14	12
£100,001–£110,000	7	7
£110,001–£120,000	11	11
£120,001–£130,000	9	7
£130,001–£140,000	3	5
£140,001–£150,000	4	3
£150,001–£160,000	1	-
£160,001–£170,000	-	-
£170,001–£180,000	-	-
£180,001–£190,000	-	-
£190,001–£200,000	-	1
£200,001–£210,000	6	4
£210.001–£220,000	-	-
£220,001–£230,000	-	1
£230,001–£240,000	-	-
£240,001–£250,000	-	-
£250,001–£260,000	1	1
	193	182
MPTS		
£60,000–£70,000	2	2
£70,001–£80,000	1	1
£80,001–£90,000	2	2
£90,001–£100,000	1	1
£100,001–£110,000	-	1
£110,001–£120,000	1	-
	7	7
Total	200	189

	2021	2020
Number of staff included above for whom retirement benefits are accruing		
GMC defined contribution pension scheme	197	186
NHS defined benefit pension scheme	1	1
Not in scheme	2	2
	200	189

The senior management team includes the Chief Executive and six permanent directors in 2021. The total employee benefits (including employer pension contributions) of the senior management team was £1,705,118 in 2021. The equivalent figure for 2020 was £1,739,919.

Senior management team remuneration

	Basic salary 2021 (bands of £5,000)
	£'000
Charlie Massey	245–250
Paul Reynolds	200–205
Anthony Omo	200–205
Shaun Gallagher	200–205
Una Lane	200–205
Neil Roberts	200–205
Colin Melville	200–205

All GMC staff, including the senior management team, are entitled to pension contributions of 15% of salary into the GMC Group Personal Pension Plan and may exchange contributions for salary.

All GMC staff, including the senior management team, are entitled to buy and sell leave and to the taxable benefit of private medical insurance. These costs and benefits are not included in the table above.

The Chief Executive's salary is 7.67 times the median salary.

There were no related party transactions in the year that require disclosure other than payments made to Trustees as disclosed in notes 17 and 18.

6. Intangible fixed assets

Group and charity

	Computer software and systems development £'000
Cost	
Balance at 1 January 2021	28,410
Additions	6,343
Disposals	(3,804)
Balance at 31 December 2021	**30,949**
Amortisation	
Balance at 1 January 2021	18,049
Amortisation charge for year	5,002
Disposals	(3,804)
Balance at 31 December 2021	**19,247**
Balance at 1 January 2021	10,361
Net book value at 31 December 2021	**11,702**

Intangible assets incorporates all IT software development costs including, but not limited to, the development of our strategic applications, Siebel, Livelink and Agresso, the development of IT security systems, facilities management systems and website. Intangible assets also include the systems to support working from home and mobile applications.

7. Tangible fixed assets

Group and charity

	Buildings	Fixtures, furniture and equipment	IT equipment	Total
	£'000	£'000	£'000	£'000
Cost				
Balance at 1 January 2021	2,188	13,353	9,344	**24,885**
Additions	-	1,180	770	**1,950**
Disposals	-	(1)	(2,042)	**(2,043)**
Balance at 31 December 2021	2,188	14,532	8,072	**24,792**
Depreciation				
Balance at 1 January 2021	1,918	8,157	7,291	**17,366**
Depreciation charge for year	82	1,913	1,168	**3,163**
Disposals	-	-	(2,042)	**(2,042)**
Balance at 31 December 2021	2,000	10,070	6,417	**18,487**
Net book value at 1 January 2021	270	5,196	2,053	**7,519**
Net book value at 31 December 2021	188	4,462	1,655	**6,305**

8. Investments

Managed funds

	Group			Charity			
	Cash & cash equivalents	Listed Investments	Total	Cash & cash equivalents	Listed Investments	Equity Investment in Group Undertakings	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
The valuation at the end of the year consisted of:							
As at 1 January 2021	-	57,020	**57,020**	**-**	57,020	237	**57,257**
Additions	-	11,252	**11,252**	**-**	11,252	-	**11,252**
Disposals	-	(11,502)	**(11,502)**	**-**	(11,502)	-	**(11,502)**
Gain on investments	-	4,879	**4,879**	**-**	4,879	-	**4,879**
(Impairment)/reversal of impairment*	-	-	**-**	**-**	-	(7)	**(7)**
Balance at 31 December 2021	**-**	**61,649**	**61,649**	**-**	**61,649**	**230**	**61,879**

* The General Medical Council incorporated a wholly owned trading subsidiary on 16 December 2016. Having previously been impaired by £363k due to trading losses incurred, an additional £7k impairment at the end of 2021 has been recognised as a result of the loss generated by the company reducing its net assets.

Listed investments are managed by CCLA Investment Management Ltd. Investment management fees of £249,422 were incurred (2020 £221,160).

9. Debtors

	2021		2020	
	Group	**Charity**	Group	Charity
	£'000	**£'000**	£'000	£'000
Amounts falling due within one year				
Registration debtors	**18,810**	**18,810**	17,539	17,539
Prepayments and accrued income	**5,054**	**5,121**	5,325	5,416
Other debtors	**177**	**165**	485	348
	24,041	**24,096**	23,349	23,303

10. Creditors

	2021		2020	
	Group	**Charity**	Group	Charity
	£'000	**£'000**	£'000	£'000
Amounts falling due within one year				
Trade creditors	**877**	**872**	1,129	1,120
Tax and social security	**1,829**	**1,825**	1,774	1,771
Holiday pay	**1,106**	**1,106**	1,763	1,763
Accruals	**9,050**	**9,025**	8,378	8,335
Deferred income	**67,676**	**67,676**	58,023	58,023
	80,538	**80,504**	71,067	71,012

Charity deferred income

Income from annual retention fees is deferred and released to the statement of financial activities on a straight-line basis over a 12 month period from the date of renewal. All deferred income brought forward from the previous year is released to the statement of financial activities in the following year. Professional and Linguistic Assessments Board (PLAB) fees are deferred to the date the examination is sat.

	Annual retention fees	**PLAB fees**	**Specialist and GP registration fees**	**Revalidation assessment fees**	**Total**
	£'000	**£'000**	**£'000**	**£'000**	**£'000**
Deferred income at 1 January 2021	54,927	3,075	21	-	**58,023**
Resources deferred during the year	57,356	10,222	57	41	**67,676**
Amounts released from previous years	(54,927)	(3,075)	(21)	-	**(58,023)**
Deferred income at 31 December 2021	**57,356**	**10,222**	**57**	**41**	**67,676**

11. Provisions

Group and charity

	2021	2020
	£'000	£'000
Dilapidations	**2,855**	973
Legal claims	**3,888**	3,744
	6,743	4,717

Dilapidations - each year we review our property leases and make a provision for dilapidations, where the cost can be reasonably estimated.

Legal claims - Each year we make a provision for potential costs related to ongoing legal cases. In 2020 we increased the provision to reflect potential additional costs that may arise following the outcome of an employment tribunal. The outcome is still outstanding, but may have implications for a wider group of individuals. Further details in relation to the ongoing case cannot be provided in order to avoid prejudicing proceedings.

	Dilapidations	Legal claims	Total
	£'000	**£'000**	**£'000**
Provisions at 1 January 2021	973	3,744	**4,717**
Provisions created during the year	2,855	3,888	**6,743**
Amounts released from previous years	(973)	(3,744)	**(4,717)**
Provisions at 31 December 2021	**2,855**	**3,888**	**6,743**

12. Group fund movements in the year

Group and charity

	Unrestricted funds	Restricted funds	Pension fund	2021 Total
	£'000	£'000	£'000	£'000
At 1 January 2021	60,593	-	3,988	64,581
Net incoming/(outgoing) resources	1,788	856	32,573	35,217
At 31 December 2021	**62,381**	**856**	**36,561**	**99,798**

	Unrestricted funds	Restricted funds	Pension fund	2020 Total
	£'000	£'000	£'000	£'000
At 1 January 2020	63,190	-	9,391	72,581
Net incoming/(outgoing) resources	(2,597)	-	(5,403)	(8,000)
At 31 December 2020	60,593		3,988	64,581

13. Net assets by fund

Group and charity

Fund balances at 31 December 2021 are represented by

	Unrestricted funds	Restricted fixed asset funds	Pension reserve	2021 Total funds
	£'000	£'000	£'000	£'000
Intangible fixed assets	10,846	856	-	11,702
Tangible fixed assets	6,305	-	-	6,305
Investments	61,649	-	-	61,649
Current assets	70,862	-	-	70,862
Current liabilities	(80,538)	-	-	(80,538)
Provisions for liabilities and charges	(6,743)	-	-	(6,743)
Pension scheme asset	-	-	36,561	36,561
Total net assets	**62,381**	**856**	**36,561**	**99,798**

	Unrestricted funds	Restricted fixed asset funds	Pension reserve	2020 Total funds
	£'000	£'000	£'000	£'000
Intangible fixed assets	10,361	-	-	10,361
Tangible fixed assets	7,519	-	-	7,519
Investments	57,020	-	-	57,020
Current assets	61,477	-	-	61,477
Current liabilities	(71,067)	-	-	(71,067)
Provisions for liabilities and charges	(4,717)	-	-	(4,717)
Pension scheme asset	-	-	3,988	3,988
Total net assets	**60,593**	**-**	**3,988**	**64,581**

14. Capital commitments

Capital expenditure contracted but unspent at 31 December 2021 amounted to £63,936. The equivalent figure for 2020 was £93,288.

15. Operating lease commitments

	Land and buildings		Equipment	
	2021	2020	**2021**	2020
Expiry date	**£'000**	£'000	**£'000**	£'000
Within one year	**4,359**	3,649	**97**	145
In years two to five	**7,723**	11,119	**48**	48
After more than five years	**1,974**	2,876	**-**	-
	14,056	17,644	**145**	193

Commitments include our obligations under our buildings and equipment leases. They are calculated up to the first lease break clause or lease end where there is no break clause in the agreeement. Commitments are calculated on a cash basis rather than incorporating rent free benefits.

16. Superannuation schemes

The GMC has three staff pension schemes:

GMC Group Personal Pension Plan

This is a defined contribution pension scheme, which was set up on 1 July 2013. We started auto enrolment on 1 November 2013. At the end of 2021 there were 1,536 members of staff contributing to this scheme. It meets the government's requirements following the introduction of automatic enrolment. Individuals can choose to make additional contributions by deduction from salary to the scheme. Under the terms of FRS102, contributions are accounted for as a defined contribution scheme based on actual contributions paid through the year.

NHS Multi-Employer Scheme

We have 1 member of staff who contribute to the NHS multi-employer scheme, which is a defined benefit scheme. The staff member transferred to the GMC on the merger with PMETB. The scheme operates as a pooled arrangement, with contributions paid at a centrally agreed rate. The trustees are unable to confirm the GMC's share of the underlying assets and liabilities of the NHS scheme and so, under the terms of FRS102, contributions are accounted for as if the scheme were a defined contribution scheme based on actual contributions paid through the year.

GMC Staff Superannuation Scheme

This is a funded scheme of the defined benefit type, providing retirement benefits based on final salary. The top-up arrangement is an unfunded scheme.

This scheme was closed to new members on 30 June 2013, and replaced by the GMC Group Personal Pension Plan. The scheme was closed to future accruals for existing members on 31 March 2018 therefore at the end of 2018 there were no members of staff contributing to this scheme.

The FRS 102 valuation has been based on a full assessment of the liabilities for the Scheme as at 31 December 2018. The present values of the defined benefit obligation, the related current service cost and any past service costs were measured using the projected unit credit method. There is an ongoing full assessment of the pension liabilities which is set to conclude late 2022. The output of this will form the basis of the 2022 FRS102 valuation.

Actuarial gains and losses have been recognised in the period in which they occur (but outside the profit and loss account) through the Other Comprehensive Income (OCI).

The GMC recognises surplus in accordance with the requirements of FRS 102 Section 18. The trustees of the Scheme do not have the unilateral right to commence wind-up of the Scheme. Thus, the GMC assumes that the Scheme continues in existence until the last benefit payments are made to members, at which point any residual assets are returned to the GMC in line with the rules of the Scheme.

The GMC made a two top-up payments to the scheme of £2.3m in total during 2021 and will contribute a top up payment to the scheme of £1.3m each year between 2022 and 2025.

Responsibility for investing pension scheme assets rests with pension trustees. The Pensions Act 1995 requires trustees to draw up a Statement of Investment Principles, setting out the scheme's investment strategy. Pension trustees are required to consult the employer (GMC) when drawing up the strategy, but do not require the employer's formal agreement. Following consultation with the GMC, in 2014 the pension trustees adopted a fiduciary management approach to the investment of the scheme's assets

The principal assumptions used by the independent qualified actuaries to calculate the liabilities under FRS102 are set out below.

Main financial assumptions

	31 December 2021	31 December 2020
	%pa	%pa
Retail Prices Index inflation	3.1	2.7
Consumer Price Index inflation	2.7	2.3
Rate of general long-term increase in salaries	3.7	3.3
Pension increases (excess over guaranteed minimum pension)	2.7	2.3
Discount rate for scheme liabilities	1.9	1.4

Mortality assumptions

The mortality assumptions are based on standard mortality tables which allow for expected future mortality improvements. The assumptions are that a member currently aged 65 will live on average for a further 22.7 years (2020 22.6 years) if they are male and for a further 24.5 years if they are female (2020 24.4).

For a member who retires in 2041 at age 65 the assumptions are that they will live on average for a further 23.3 years after retirement if they are male and for a further 25.4 years after retirement if they are female.

Scheme asset allocation

	31 December 2021		31 December 2020	
	£'000	**%**	£'000	%
Delegated consulting services	**327,665**	**99%**	305,166	99%
Other	**1,891**	**1%**	1,103	1%
Total	**329,556**	**100%**	306,269	100%

The Delegated Consulting Service (DCS) is a fiduciary management solution that invests in a wide range of underlying assets in order to meet the Scheme's specific investment objectives. The underlying asset allocation changes over time, based on the views of the fiduciary manager within the overall bounds set by the trustees. Under this approach the majority of scheme assets are invested in pooled funds. The managers of the pooled funds are required to have in place a policy on social, environmental and ethical considerations.

None of the Scheme assets are invested in the Company's financial instruments or in property occupied by, or other assets used by, the GMC.

Reconciliation of funded status to balance sheet

	31 December 2021	31 December 2020
	£'000	£'000
Fair value of assets	**329,556**	306,269
Present value of funded defined benefit obligations	**(291,864)**	(301,086)
Funded status	**37,692**	5,183
Present value of unfunded defined benefit obligation	**(1,131)**	(1,195)
Asset/(liability) recognised on the balance sheet	**36,561**	3,988

Amounts recognised in income statement

	31 December 2021	31 December 2020
	£'000	£'000
Financing cost:		
Interest on net defined benefit liability/(asset)	**(70)**	(208)
Pension expense recognised in profit and loss	**(70)**	(208)

Amounts recognised in Other Comprehensive Income (OCI)

	31 December 2021	31 December 2020
	£'000	£'000
Asset gains/(losses) arising during the year	**19,325**	43,589
Liability gains/(losses) arising during the year	**10,818**	(50,560)
Actuarial gain/(loss) on defined benefit pension Scheme	**30,143**	(6,971)

Changes to the present value of the defined benefit obligation during the year

	31 December 2021	31 December 2020
	£'000	£'000
Opening defined benefit obligation (DBO)	**302,281**	248,752
Interest expense on DBO	**4,213**	4,955
Actuarial (gains)/losses on liabilities	**(10,818)**	50,560
Net benefits paid out	**(2,681)**	(1,986)
Past service cost	-	-
Closing defined benefit obligation	**292,995**	302,281

Changes to the fair value of Scheme assets during the year

	31 December 2021	31 December 2020
	£'000	£'000
Opening fair value of Scheme assets	**306,269**	258,143
Interest income on Scheme assets	**4,283**	5,163
Gain/(loss) on Scheme assets	**19,325**	43,589
Contributions made by the company	**2,360**	1,360
Net benefits paid out	**(2,681)**	(1,986)
Closing fair value of Scheme assets	**329,556**	306,269

Actual return on Scheme assets

	31 December 2021	31 December 2020
	£'000	£'000
Interest income on Scheme assets	**4,283**	5,163
Gain/(loss) on Scheme assets	**19,325**	43,589
Actual return on Scheme assets	**23,608**	48,752

17. Honoraria

	2021	2020
Trustees		
Dame Clare Marx (Chair)*	64,167	110,000
Professor Dame Carrie MacEwen (Acting Chair)†	41,055	-
Mr Steve Burnett	18,000	18,000
Dr Vanessa Davies‡	18,000	-
Lady Christine Eames¶	-	18,000
Professor Anthony Harnden	18,000	18,000
Lord Philip Hunt	18,000	18,000
Professor Deirdre Kelly¶	-	18,000
Professor Paul Knight	18,000	18,000
Ms Lara Fielden§	12,000	-
Dame Suzi Leather¶	-	18,000
Professor Deepa Mann-Kler‡	18,000	-
Dr Rajesh Patel‖	18,000	16,500
Dame Denise Platt¶	-	18,000
Dr Suzanne Shale‡	18,000	-
Miss Amerdeep Somal¶	-	13,500
Miss Alison Wright‖	18,000	16,500

* Demitted as Council Member and Chair 31 July 2021.

† Appointed as Council Member in January 2021 and Acting Chair from 1 August 2021.

‡ Appointed as a Council Member in 2021.

¶ Demitted as a Council Member in 2020.

§ Appointed as a Council Member January 2021, deceased August 2021.

‖ Appointed as a Council Member in 2020.

Honoraria payments are permitted by the governing document of the General Medical Council, The Medical Act 1983, paragraph 17, schedule 1.

Medical Practitioners Tribunal Service Committee members	2021	2020
Dame Caroline Swift	93,286	92,937
Mrs Joy Hamilton	3,720	3,720
Professor Jacky Hayden	7,440	7,440
Gill Edelman (Gillian Gordon)*	564	-
Dr Tushar Vince*	564	-
Dr Patricia Moultrie†	3,156	3,720
Mrs Judith Worthington†	3,156	3,720

* Appointed as MPTS Committee member 2021.

† Demitted as MPTS Committee member 2021.

Audit and Risk Committee co-opted members	2021	2020
Ms Elizabeth Butler*	1,473	1,550
Jon Hayes†	930	-
Mr Kenneth Gill	2,945	2,170

* Demitted as ARC co-opted member 2021.

† Appointed as ARC co-opted member 2021.

Investment Committee co-opted members	2021	2020
Mr Keith Mackay	2,170	2,170
Mr Tim Scholefield*	620	1,860
Mr David Stewart*	-	-
Michael Jennings†	620	-

* Demitted as IC co-opted member 2021.

† Appointed as IC co-opted member 2021.

GMC Services International Ltd	2021	2020
Dr Andrew McCulloch	-	155

18. Travel and subsistence expenses claimed in 2021

	2021	2020
Trustees		
Dame Clare Marx (Chair)*	**-**	445
Professor Dame Carrie MacEwen (Acting Chair)†	**236**	-
Mr Steve Burnett	**732**	489
Dr Vanessa Davies‡	**706**	-
Lady Christine Eames¶	**-**	1,704
Professor Anthony Harnden	**184**	84
Lord Philip Hunt	**-**	50
Professor Deirdre Kelly¶	**-**	420
Professor Paul Knight	**1,689**	659
Ms Lara Fielden§	**-**	-
Dame Suzi Leather¶	**-**	425
Professor Deepa Mann-Kler‡ **	**2,878**	-
Dr Rajesh Patel‖	**942**	175
Dame Denise Platt¶	**-**	113
Dr Suzanne Shale‡	**-**	-
Miss Amerdeep Somal¶	**-**	1,380
Miss Alison Wright ‖	**-**	194

* Demitted as Council Member and Chair 31 July 2021.

† Appointed as Council Member in January 2021 and Acting Chair from 1 August 2021.

‡ Appointed as a Council Member in 2021.

¶ Demitted as a Council Member in 2020.

§ Appointed as a Council Member January 2021, deceased August 2021.

‖ Appointed as a Council Member in 2020.

** Professor Mann-Kler is our Council representative based in Northern Ireland and as such incurs higher travel and subsistence expenses to carry out her responsibilities as a Council Member.

Medical Practitioners Tribunal Service Committee members	**2021**	2020
Dame Caroline Swift	**463**	30
Mrs Joy Hamilton	**-**	217
Professor Jacky Hayden	**302**	316
Gill Edelman (Gillian Gordon)*	**167**	-
Dr Tushar Vince*	**-**	-
Dr Patricia Moultrie†	**-**	250
Mrs Judith Worthington†	**-**	207

* Appointed as MPTS Committee member 2021.

† Demitted as MPTS Committee member 2021.

Audit and Risk Committee co-opted members	**2021**	2020
Ms Elizabeth Butler*	-	21
Jon Hayes†	241	-
Mr Kenneth Gill	-	101

* Demitted as ARC co-opted member 2021.

† Appointed as ARC co-opted member 2021.

Investment Committee co-opted members	**2021**	2020
Mr Keith Mackay	74	-
Mr Tim Scholefield*	-	-
Mr David Stewart*	-	-
Michael Jennings†	26	-

* Demitted as IC co-opted member 2021.

† Appointed as IC co-opted member 2021.

GMC Services International Ltd	**2021**	2020
Dr Andrew McCulloch	-	-

	2021	2020
Senior management team		
Charlie Massey (Chief Executive)	**1,118**	1,071
Paul Buckley – Director of Strategy and Policy*	**-**	1,196
Shaun Gallagher – Director of Strategy and Policy†	**1,355**	-
Una Lane – Director of Registration and Revalidation	**971**	1,088
Colin Melville – Director of Education and Standards	**392**	3,314
Anthony Omo – Director of Fitness to Practise	**-**	3,579
Paul Reynolds – Director of Strategic Communications and Engagement	**156**	2,313
Neil Roberts – Director of Resources and Quality Assurance	**2,164**	5,071

* Paul Buckley left his role as Director of Strategy and Policy on 31 December 2020.

† Shaun Gallagher was appointed as Director of Strategy and Policy on 01 December 2020.

Variations in expenses reflect that the trustees, committee members and the Senior Management Team live in different parts of the UK and are required to travel around the UK on GMC business, including to our offices in London, Manchester, Edinburgh, Belfast and Cardiff, and occasionally outside the UK.

Adjustments are also made for those with disabilities, which may mean that additional expenses are incurred for travel and accommodation according to specific needs.

Reference and administrative information

We are independent of UK government and the medical profession and accountable to Parliament. Our powers are given to us by Parliament through the *Medical Act 1983*.

We are registered with the Charity Commission for England and Wales (1089278), and with the Office of the Scottish Charity Regulator (SC037750). We are not currently required to be registered separately with the Northern Ireland Charity Commission.

Our principal places of business are 3 Hardman Street, Manchester M3 3AW and Regent's Place, 350 Euston Road, London NW1 3JN. We also have offices in Belfast, Cardiff and Edinburgh; a centre for hearings, where the MPTS is based, at St James's Buildings, 79 Oxford Street, Manchester M1 6FQ; and a Clinical Assessment Centre, in 3 Hardman Square, Manchester M3 3EB.

Our trustees have a duty to act impartially and objectively, and to take steps to avoid any conflict of interest arising as a result of their membership of, or association with, other organisations or individuals. As trustees, members have a duty to avoid putting themselves in a position where their personal interests conflict with their duty to act in the interests of the charity, unless authorised to do so. To make this fully transparent, we publish a register of members' interests on our website.

Day-to-day management of the organisation is delegated to the Chief Executive, Charlie Massey. You can read more about our governance and management arrangements from page 54.

We work with the Professional Standards Authority (PSA), an independent body, which is accountable to Parliament and scrutinises and oversees our work, together with other health and social care professional regulatory bodies in the UK.

Information requests

In 2021, we received 402 subject access requests under the General Data Protection Regulation (GDPR). This was a decrease of 15% from 2020. The number of information requests we received under the Freedom of Information Act 2000 (FOI) in 2021 was 841. This was a 32.6% increase from 2020.

We achieved 77.2% against our target of responding to 80% of subject access requests within the statutory timeframe. We achieved 83.1% against our target of responding to 90% of FOI requests within 20 working days.

Paying for goods and services

We paid 98% of valid and undisputed invoices within 30 days and did not pay any interest to suppliers due to late payment in excess of 30 days.

Professional advisers

Bankers	Royal Bank of Scotland 250 Bishopsgate London EC2M 4AA
Solicitors	The majority of our legal work is carried out by our in-house legal team.
Auditors	Crowe U.K. LLP 2nd Floor, 55 Ludgate Hill London EC4M 7JW
Actuary and pension scheme adviser	Aon Parkside House, Ashley Road Epsom Surrey KT18 5BS

Email: gmc@gmc-uk.org

Website: gmc-uk.org

Telephone: 0161 923 6602

Textphone: **please dial the prefix 18001** then **0161 923 6602** to use the Text Relay service

To ask for this publication in another format or language, please call us on **0161 923 6602** or email us at **publications@gmc-uk.org**.

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Published July 2022

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The GMC is a charity registered in England and Wales (1089278) and Scotland (SC037750).

Code: GMC/AR2021/0722.

GENERAL MEDICAL COUNCIL

England & Wales - Charity number 1089278

Accounts

General Medical Council

Annual Report 2020

Trustees annual report and accounts for the year ended 31 December 2020

General Medical Council

Annual Report 2020

Trustees annual report and accounts for the year ended 31 December 2020

Presented to Parliament pursuant to section 52A of the Medical Act 1983 as amended by The Health Care and Associated Professions (Miscellaneous Amendments) Order 2008 (SI No.1774).

General Medical Council

Annual Report 2020

Trustees annual report and accounts for the year ended

31 December 2020









Annual report 2020

General
Medical
Council

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About this report

Our trustees present this report and financial statements for the year ending 31 December 2020.

They confirm they have taken into account the Charity Commission's public benefit guidance when reviewing our aims and objectives; and have had regard to this guidance when exercising any powers or duties; or when making a decision to which the guidance is relevant. The trustees are satisfied that at all times we have operated for public benefit; and that the activities as described in this report and accounts fully meet the public benefit requirements and support our charitable purpose.

About us

We are the UK's independent regulator of doctors. Our role is to:

- protect the health, safety and wellbeing of patients and the public
- promote and maintain professional standards for doctors
- oversee UK medical education and training
- take action when the safety of patients, or the public's confidence in doctors, are at risk.

How we keep patients safe

Keeping patients safe and protecting public confidence in doctors are at the core of all our work.

- We manage the UK medical register – We check every doctor's identity and qualifications before they are able to join the register. And we check with medical schools or previous employers to find out if they have any concerns about a doctor's ability to practise safely.
- We set the standards for doctors – Our standards define what makes a good doctor by setting out the professional values, knowledge, skills and behaviours required of all doctors working in the UK. When we develop our standards and our guidance, we consult with a wide range of people, including patients, the public, doctors, employers and educators.
- We oversee all stages of medical education and training – We make sure doctors get the education and training they need to deliver high-quality care throughout their careers, setting out what outcomes are needed for graduates and approving curricula for postgraduate education. We set educational standards across the UK and monitor training environments to enable safe and effective learning.
- We help to maintain and improve standards through revalidation – It's important that every licensed doctor in the UK keeps their knowledge and skills up to date. Revalidation makes sure this happens and is a fundamental part of clinical governance for doctors. It gives patients and the public assurance that doctors in the UK are part of a governed system, which checks their fitness to practise on a regular basis and supports their continuous improvement and development. It also supports the identification and management of concerns at an early stage.
- We investigate and act on concerns that put patients, or public confidence in doctors, at risk – When we receive a concern, we assess whether it meets our threshold for investigation. If it does, we investigate. At the end of the investigation, we decide what action we need to take. This can include taking no action, issuing advice or a warning to the doctor, or agreeing with the doctor that they will restrict their practice, retrain or work under supervision. In some situations, we refer the case to the Medical Practitioners Tribunal Service (MPTS) for a hearing.

The MPTS produces a separate report to Parliament. You can read the latest report on their website.

Our performance review

Every year, the Professional Standards Authority assesses our performance as a regulator across our four core functions: education and training, registration, guidance and standards, and fitness to practise.

Its latest annual assessment confirmed that we successfully met all 18 of its Standards of Good Regulation in 2019/20. This means that we're performing to a high standard as a regulator. And it reflects the commitment we make in all our work to standards, such as:

- transparency
- public protection
- equality, diversity and inclusion
- timeliness.



Foreword from the Chair and Chief Executive





The coronavirus (COVID-19) pandemic has been a timely reminder of the value of the National Health Service in our society. Healthcare professionals have shown remarkable fortitude, acting with compassion and professionalism to deliver care to those who need it.

The healthcare workers who have died over the course of the pandemic are a great loss. Throughout their careers, these clinicians had a huge impact on thousands of patients. We offer grateful thanks for their work and the commitment they held until the end of their lives.

2020 was the year that long-standing health inequalities were exposed. The disproportionate impact of the coronavirus on older people, on those with disabilities, and on both patients and healthcare workers from ethnic minority backgrounds has been a reminder of existing societal disparities.

Equality, diversity and inclusion are fundamental to our mission to be fair and effective, both as a regulator and an employer.

Evidence shows that doctors joining the UK medical workforce from other countries and those from ethnic minority backgrounds still suffer discrimination and disadvantage. We are determined to tackle the issues these doctors face, such as differential attainment and disproportionate fitness to practise referrals from employers. From 2021, we have adopted clear key performance indicators to drive the changes we want to see.

Responding to the pandemic has been a major focus of our work in the past year. Early in 2020, we gave temporary registration to over 30,000 past practitioners and registered around 5,000 final-year students early to increase the supply of available doctors. Some of our colleagues have also joined the effort, returning to the frontline as ITU nurses and vaccinators.

To provide practical support for doctors at this challenging time, we created a new coronavirus online guidance hub, which was accessed over 87,000 times in 2020. It features information on themes including remote consultations, consent, working safely, and health and wellbeing.

To support the response to the pandemic, we deferred revalidation for over 60,000 doctors, enabling them to fully focus on frontline delivery.

We also paused fitness to practise investigations where there was no immediate patient safety risk, and published guidance to reassure doctors that we would take the unprecedented context into account where it was appropriate.

It was important for us to adapt quickly to support trainee progression. We worked with statutory education bodies, faculties, and medical royal colleges to allow more flexible approaches to assessing that trainees had the necessary skills, knowledge and experience to progress.

This saw us approving derogations to 77 curricula and changes to 108 exams in 2020. We also approved around 550 additional training locations, including the Nightingale hospitals, for trainees who were redeployed there, and developed new guidance for postgraduate exams, alongside medical royal colleges, faculties and trainees.

Despite the global disruption, many internationally qualified doctors continued to seek registration to work in the UK. To enable us to continue to run our Professional and Linguistic Assessments Board (PLAB) tests, we redesigned our processes and buildings in line with social distancing rules. As at January 2021, the UK was the only country in the world that had continued to run its clinical exams.

We have continued with our ambition to shift the emphasis of our work, from stepping in when things have gone wrong, to supporting all doctors in delivering the highest standards of care.

So that those new to the service from overseas can understand some of the differences they may encounter when they join the health service, we've continued to develop our free *Welcome to UK practice* induction training. In 2020, we made this service virtual and continued to see high levels of interest, with 3,760 attendees across the year.

Enhancing the delivery of safe, high-quality care, and environments where doctors can thrive remained a core priority in 2020. We continued to strengthen our collaboration with fellow regulators on crucial issues like maternity, working with the Care Quality Commission and the Nursing and Midwifery Council to develop a shared data platform to allow us to spot trends early and identify actions to resolve issues more quickly.

As a patient safety body, it's also vital that we have open channels of communication with patients and their families. From 2018 to 2020, our Patient Liaison Service (PLS) supported over 1,200 patients, relatives and members of the public who had raised concerns about a doctor. Over 90% of the people surveyed about their PLS experience found the service helpful.

Despite the difficulties, we have continued to progress cases through our disciplinary processes where patient safety issues have been a priority.

To strengthen our local connections, we launched our new Outreach service. This brings together the work of our employer, regional and national liaison advisers across the UK. During 2020, colleagues engaged with over 23,000 doctors, medical students and other key interest groups across the four nations.

The insights from these engagements have been critical in the formation of our corporate strategy for 2021–2025.

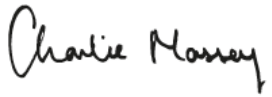
The fast-moving landscape in which we work demands that we remain responsive, effective and timely. We're confident that our strategy is robust and flexible enough to allow us to navigate the challenges ahead, and to seize the opportunities that will emerge as our healthcare systems across the UK recover from the pandemic.

In this extremely challenging year, we and the whole senior team are incredibly grateful to the GMC staff for their enormous effort. They committed to going the extra mile to enable change, thereby supporting doctors and protecting patients.



Dame Clare Marx

Chair



Charlie Massey

Chief Executive

Responding to the coronavirus pandemic

2020, a year like no other, presented the biggest challenge the UK's healthcare systems have ever faced.

Here, we describe the steps we took to support the UK-wide response to the outbreak of COVID-19, up until December 2020, as well as the significant and prolonged impacts it's had on our operations.

From responding to the immediate impacts of the pandemic, to working through the recovery of our projects and operations, our principal objective has always remained the same – to keep patients safe and support doctors.



Jan

28 January – Upon seeing an escalation of COVID-19 cases in China, our incident management team met and activated our pandemic response plan, in the preparedness phase.

Mar

3 – 11 March – As the situation developed, we issued joint statements with other healthcare regulators, and the UK's chief medical officers and the four statutory education bodies, outlining our approach to regulation considering the context of the pandemic.

11 March – The World Health Organization declared the COVID-19 outbreak a global pandemic.

16 March – Following the UK Government's 'stay at home' announcement, we issued guidance to our staff on working remotely. On the morning of 17 March, around 1,300 colleagues successfully logged on from home.

18 – 25 March – To ease the pressure on the UK's healthcare systems and the medical workforce, we deferred revalidation for one year for more than 60,000 doctors who were due to revalidate between March 2020 and March 2021. See page 16 for more information.



Mar

18 – 25 March – Following government advice on social distancing, we **cancelled all PLAB 2 tests** between 18 March and 29 June. See page 12 for more about this and what we've done since to maximise the number of doctors who can take the test.

We **temporarily paused our quality assurance visits to medical schools** and our enhanced monitoring processes. We also extended the approval of doctors who are recognised trainers for 12 months.

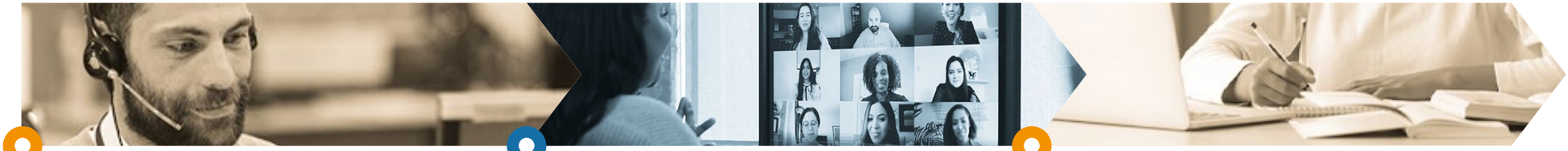
We **temporarily paused requesting information from employers and healthcare professionals in fitness to practice investigations** unless we identified an immediate patient safety concern. We continued to progress investigations where possible, and with the agreement of relevant parties, to minimise delays.

26 March – In response to the UK Government's Secretary of State for Health and Social Care activating section 18A of the Medical Act, we started **granting temporary emergency registration to doctors** who had left the register or had relinquished their licence in previous years. By 24 June, we had **restored 34,837 doctors** to a licence or registration with a licence. See page 10 for more information.

Apr

2 April – We **published our coronavirus online guidance hub,** a source of information and guidance specifically developed to support doctors involved in the response to the pandemic. By the end of 2020, it had been accessed **over 87,000 times.** See page 17 for more information.

7 – 9 April – We invited final year medical students to apply for provisional registration at an earlier point in the year than usual, so they could provide further support to our health services. We worked with the Medical Schools Council and medical schools to ensure learning outcomes were met. Between April and June 2020, we **awarded provisional registration to 6,868 UK graduates.** Of these, 4,662 graduates filled foundation interim year 1 (FiY1) posts by July – 72% of which were in areas where there were confirmed or suspected cases of COVID-19.



Apr

21 April – We worked with UK statutory education bodies, medical royal colleges and faculties to approve changes to curricula to enable as many trainees as possible to progress to the next stage of training, while ensuring patient safety would not be compromised. See more information on this on page 13.

Jun

11 June – We began conducting quality assurance visits to medical schools and enhanced monitoring activities fully online.

15 June – We tailored our Barometer survey to find out more about doctors' day-to-day experiences during the pandemic. Over 3,600 doctors responded to the survey, an independent research project that we commission annually. We presented the findings in *The state of medical education and practice in the UK 2020*.

We worked with suppliers to restart PLAB 1 tests where they had stopped, in compliance with public health guidance in the host countries. Measures depended on local circumstances: unfortunately, in some locations PLAB 1 tests had to be cancelled, in line with the host country's public health advice.

Jul

1 July – We developed a new policy supporting solutions to allow trainees to sit over 100 different exams safely. We also supported the Royal College of General Practitioners in developing an entirely new exam, which was approved and up and running in July.

13 July – After careful consideration and with agreement from responsible officers, we decided to resume existing investigations, where possible. We progressed these investigations in discussion with affected doctors, employers, complainants and medical defence and support organisations.



Jul

16 July – We **issued a shorter and more targeted version of our national training survey**, usually released in March. This enabled us to capture vital insights into training practice and training environments, while keeping the pressure on trainees and trainers to a minimum. See page 29 for more information.

22 July – Our Outreach teams began **delivering an interactive online version of *Welcome to UK practice*,** which doctors from anywhere in the world could join. See page 18 for more about this.

Aug

13 August – Following work to make our Clinical Assessment Centre safe, we were able to **resume PLAB 2 exams for doctors whose tests had been postponed.** See page 12 to read more about the adaptations we made and our plans to maximise the number of PLAB places in future.

Sep

14 September – We **issued guidance for fitness to practise decision makers** describing how to take into account the extraordinary circumstances of the pandemic when investigating concerns about a doctor.







Nov

11 November – We issued a new joint statement with all four chief medical officers and the National Medical Director of NHS England to support doctors. The statement acknowledged the challenging circumstances in which healthcare professionals were practising and outlined our commitment to take into account factors relevant to the environment should a concern be raised with us.

17 November – We hosted an education summit with key stakeholders across the four countries to reflect on lessons learnt during the pandemic. Together, we explored how best to seize the opportunity to embed longer-term changes in medical education and training. See page 46 to read more about the reforms we're scoping in 2021.

18 November – We announced we would extend the changes we introduced in April and July to continue to maximise the number of trainees who could progress during the pandemic. See page 13 for more on this.

25 November – In a time of immense pressure, we published wellbeing resources for doctors working in challenging circumstances. We also published our *Wellbeing plan* to promote and support good health and wellbeing among colleagues.

27 November – Our annual *The state of medical education and practice in the UK report* put a spotlight on the diverse impacts the spring peak of the pandemic had on the profession and patient care. Issues emerging from the report, including inequalities in experiences related to ethnicity, led us to reinforce our call for action to improve healthcare environments, cultures and leadership. See page 28 for more information on the report and its findings.

Dec

30 November – 2 December – We held our first online conference, *Delivering change together*, bringing together people from across the UK's healthcare systems to discuss issues facing the medical profession and the UK's healthcare systems, at a particularly challenging time.

7 December – We helped promote the national UK-REACH study into COVID-19 outcomes in people of different ethnicities working in health and social care.

8 December – Our Chair, Dame Clare Marx, sent a message of support and thanks to all doctors, acknowledging their dedication, professionalism and compassion throughout an incredibly challenging year.

All data is correct as at 31 December 2020 unless otherwise specified. The arrows next to each figure show how it compares with 2019.

The medical register[1]

17,227 ⌄
doctors joined the medical register for the first time.



7,460	UK
2,081	EEA / Switzerland
7,686	Rest of the world

4,755 ⌄
doctors joined the specialist register.

2,970 ⌄
doctors joined the GP register.

Managing the medical register

Granting temporary emergency registration

For the first time since September 1940, we used our emergency powers to grant temporary emergency registration to doctors. 80 years after it was needed during World War II, in March 2020, our health services were once more faced with a monumental crisis.

We restored 34,837 doctors to a licence or registration with a licence. This only included doctors with a UK address who had left the register or given up their licence to practise in the previous three years, and who didn't have any outstanding complaints, sanctions or conditions on their registration.

In October, we surveyed 26,439 doctors who held temporary emergency registration, to understand if they were using their registration. Over 20% of the doctors who responded said they would consider returning to the profession permanently. As at 30 December 2020, 25,344 of these doctors were still on the medical register.

We'll work with the profession and partners to embed learnings from this initiative, so we can continue to support the profession to deliver good patient care.

1 These figures include doctors with temporary emergency registration.

Managing the medical register

The medical register

Number of doctors on register:
335,694^

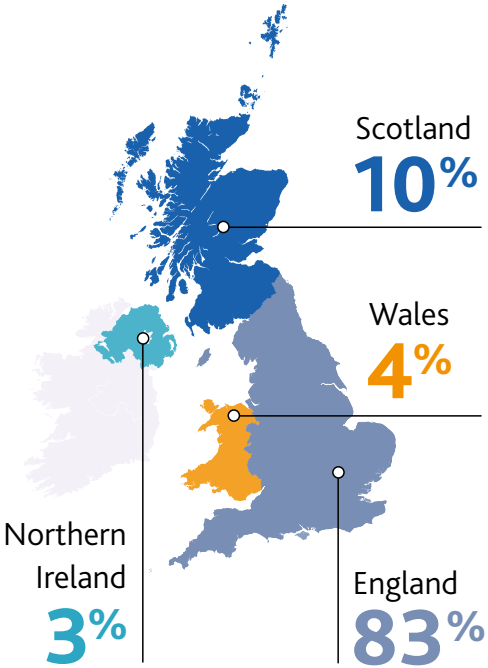
Number of doctors with a licence:
297,618^
(89% of the register)

Number of doctors on GP register[2]:
77,679^

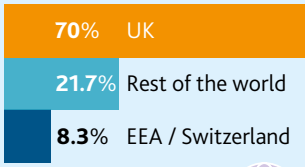
Number of doctors on specialist register:
104,412[2]^

Here's some more information about this diverse group of doctors who we granted temporary emergency registration.

Geographical distribution



Primary medical qualification gained



Role

Around a third **GPs**

Around a third **specialists**

2 Some doctors may be on both the GP and the specialist registers.

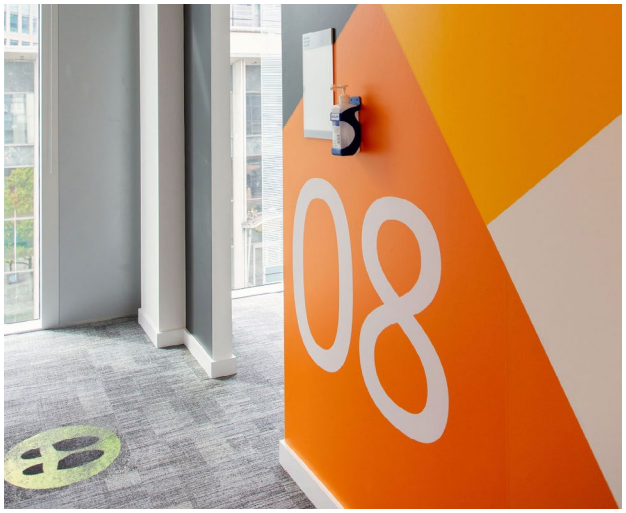
Adapting and expanding our Clinical Assessment Centre

6,331 doctors took **PLAB 1**.

3,640 doctors took **PLAB 2**.

The PLAB day feels very different to how it used to. Most examiners are now remote marking and we are using telephone stations so many of the role-players aren't required to be physically in the room with candidates. Arrival times are spread out with only small groups arriving at a time.
– Alex Harding, Administrator and Technical Operator

I think the exam was very well organised and it went off much smoother than I thought it would. I didn't feel like we were disadvantaged in any way, compared to the candidates who took their exam before COVID-19. Thank you!
– Feedback from a PLAB 2 candidate



With the onset of the pandemic, we had to close our Clinical Assessment Centre, where internationally qualified doctors take the PLAB 2 exam as part of their registration application process.

The centre remained closed from March to August 2020, during which time we were able to develop measures to allow socially distanced PLAB 2 exams.

We were delighted to be able to reopen the centre and restart exams in August, initially with a capacity of 16 doctors per day. This increased to 32 doctors in October.



This still only represents less than half of the 72 places per day we were able to offer prior to the pandemic. So we decided to build an additional, temporary PLAB 2 circuit on the second floor of our Manchester office, where we have sufficient space to comply with social distancing and all other safeguards. With the additional capacity, we're now able to test around 11,000 candidates per year.

Addressing the impact of the pandemic on medical education and training

We worked closely with undergraduate and postgraduate deans, trusts, boards, colleges, trainee representatives and statutory education bodies across the UK to ensure robust quality assurance of medical education and training throughout the pandemic.

Easing pressure on doctors in training

We introduced several changes to support trainee progression and minimise disruption, including:

- approving around 550 additional training locations – including all the Nightingale hospitals – to allow trainees who were redeployed to different sites and/or specialties to count the experience gained towards their training progression
- adapting our approvals process to allow medical royal colleges and faculties to change curricula more quickly, so that assessments could be adapted to new working conditions, while making sure the same competencies are required to attain a certificate of completion of training
- working with medical royal colleges, faculties and trainees to develop new guidance for postgraduate exams during the pandemic, which has enabled over 100 exams to run safely, while upholding standards.

Together with partners across the system, we're now exploring how best to retain some of the changes we've introduced, including increased flexibility.

Quality assuring medical schools and identifying risks in education and training environments

In March 2020, we had to pause face-to-face quality assurance visits and enhanced monitoring in response to pandemic restrictions.

We used our monitoring systems and held meetings with medical schools and postgraduate training organisations to identify any risks in different education and training environments. We then monitored how these risks were being managed locally. From June 2020, we were able to restart quality assurance visits virtually. Where necessary, we also conducted on-site visits to maintain patient safety.



We carried out **86** quality assurance visits and found:

7 areas of **good practice**

17 areas where our standards were met, but where we **identified improvements** that could be made

5 areas that **required improvement**

4 issues were **escalated** to our enhanced monitoring process[3]

6 **enhanced monitoring** issues were resolved in 2020

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

Investigating and acting on concerns

8,468 ⌄
concerns were raised with us.

- **6,318** ^
  were raised by a member of the public.
- **707**
  were related to the pandemic.
- **1,117** ⌄
  met our statutory threshold for investigation. Of these:
  - **276** were referred to a tribunal
  - **52** agreed undertakings
  - **59** were issued with a warning
  - **641** concluded with no action.
- **415** ⌄
  were considered under provisional enquiry. Of these:
  - **318** were closed
  - **1** was referred
  - **74** were progressed to investigation
  - **22** are still in progress.

In 2020, we progressed open cases where we could, but we knew that some employers and doctors wouldn't be able to assist with our investigations at such a critical time. This meant that some cases progressed more slowly, or not at all for a time.

From the start of July, after careful consideration and in agreement with responsible officers, we started to progress existing fitness to practise cases again, where it was possible.

A flexible and proportionate approach

Our priority, as always, remains patient safety. But we've recognised the importance of taking a flexible and proportionate approach to fitness to practise cases in challenging circumstances.

To help our decision makers apply this principle consistently and fairly, we issued new guidance on the specific issues that may have a bearing on doctors' practice during the pandemic, such as access to suitable personal protective equipment (PPE) and the disproportionate burden of disease and mortality carried by doctors from black and minority ethnic backgrounds. Doctors have a duty to provide the best and safest care to patients possible under the circumstances at the time, so we continue to assess each concern on a case-by-case basis.

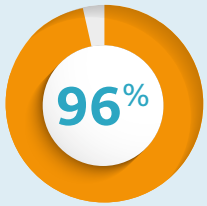
Using provisional enquiries to swiftly assess safety concerns

We've reviewed most of the concerns we've received about patient care during the pandemic using our provisional enquiry process. This has helped us consider at the earliest stage whether a doctor poses a risk to patients, opening full investigations only where necessary. To support this, we also published new overarching provisional enquiries guidance.

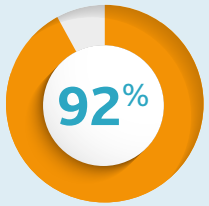
Investigating and acting on concerns

465
calls were made to our confidential helpline.

Our Patient Liaison Service supported **340** patients, relatives, and members of the public who raised concerns about a doctor.



felt that staff showed empathy for their situation.

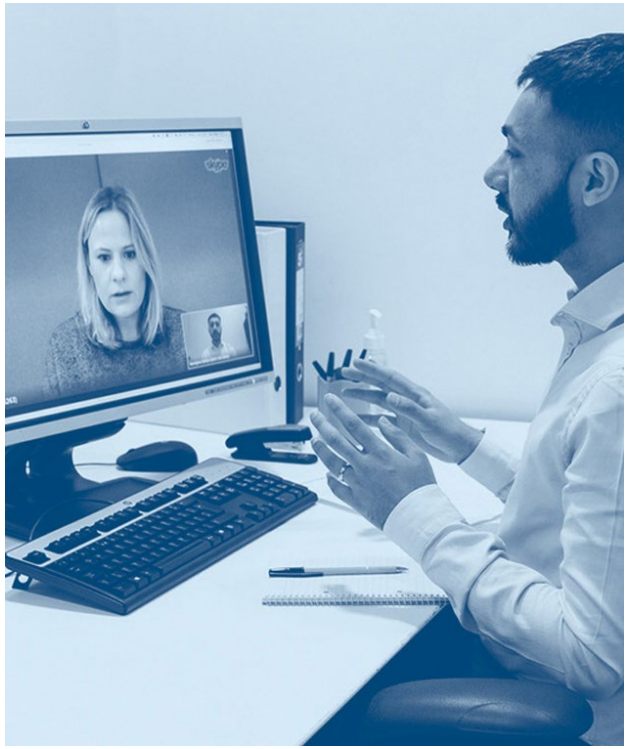


found the meeting helped them understand what action we could take.

Supporting patients and doctors involved in fitness to practise investigations

During the pandemic, our Patient and Doctor Liaison team continued to offer meetings to both complainants and doctors involved in the fitness to practise process. As soon as the severity of the pandemic became apparent, the team moved all their meetings to either telephone or video calls, so they could maintain support for people who needed it.

> Following the decision to pause a number of investigations in order to relieve pressure on doctors and health care providers, Patient Liaison Officers also began offering meetings to inform patients of the reasons we had paused some investigations and also what they could expect from the investigation when we were in a position to proceed.
> – Laura Berryman, Patient and Doctor Liaison Manager



Introducing flexibility around revalidation dates

In March 2020, we wrote to all responsible officers (ROs) to explain that we were changing revalidation[4] dates for doctors who were due to revalidate between 17 March and the end of September 2020. Deferring revalidation dates enabled doctors to focus on providing the best possible patient care during the pandemic.

Our employer liaison advisers (ELAs) continued to support ROs who were grappling with new and difficult challenges, by shifting to online meetings. This key line of communication crucially helped us understand how the profession was coping during the pandemic. In response to the feedback we received, we decided to also move revalidation submission dates back one year for doctors whose dates fell between October 2020 to March 2021.

So, all in all, any doctors whose revalidation submission date fell between 17 March 2020 to 16 March 2021 had their revalidation submission date moved back by one year.

However, ROs also told us that they would like more flexibility to make recommendations to revalidate doctors where they were ready to do so.

Therefore, we put all doctors whose dates were moved under notice from 8 June 2020[5]. This meant that ROs could make a recommendation to revalidate any doctor whose date had changed, from that date up until their new revalidation date.

ELAs have also supported ROs with emerging concerns, appraisals, and concerns about changing national guidance. The ELAs also continued to work with trusts and boards to address local concerns.

4 Revalidation is the process by which doctors demonstrate they remain up to date and fit to practise. By law, every doctor working in the UK is required to revalidate once every five years. Recommendations for revalidation are usually submitted to the GMC by a doctor's responsible officer, most often a senior doctor – such as a medical director – in an organisation employing doctors.

5 They'll appear on the 'Under notice doctors' section on GMC Connect.

We received **32,661** revalidation recommendations.

We made **99%** of revalidation recommendations within 5 working days.

30,837 doctors were revalidated.

We approved **1,730** doctors' deferrals.

We approved **19** recommendations of non-engagement.

95 licences were withdrawn.

Employer Liaison Advisers supported over **600** responsible officers.

Providing guidance and advice to doctors through a new online resource hub

Our Standards team answered over **756** ethical enquiries.

280 of which were related to COVID-19[6].

From when it was first published in April to the end of 2020, **over 87,000 people,** had accessed our new coronavirus online guidance hub.

> Early in the pandemic, the most common themes were concerns regarding personal protective equipment (PPE) allocation, the health risk to doctors, and working outside of competence. In the following months, we received a significant number of enquiries relating to remote consultations, specifically the practicalities as well as concerns around how to obtain sufficient consent from patients.[7]
> – Chloe Harrison, Standards Enquiries Officer

The pandemic posed unique challenges to doctors working in the UK's healthcare systems. It was essential to provide clear, targeted guidance to support medical professionals in challenging situations.

So we developed a coronavirus online guidance hub, a bespoke online resource providing guidance specifically with regard to working in the context of the pandemic. The hub includes information on remote consultations, consent, working safely, and health and wellbeing.

The UK Government's Department of Health and Social Care identified our hub as an example of good practice in a letter to all trust chief executives in England.

In developing the resource, we used insights from our ethical enquiry service, and from discussions between our Outreach teams and the profession. This helped us to identify the key themes that doctors needed guidance and support for. We also consulted with our Strategic equality, diversity and inclusion advisory forum and the Black and Minority Ethnic (BME) Doctors Forum.

We've since continued to update the content on the hub to reflect dynamic developments throughout the pandemic.

6 A large proportion of ethical enquiries came from doctors, but we also received some from the public, professional organisations and other sources.
7 See page 22 for more about our recent work on our *Remote prescribing guidance, Good practice in prescribing and managing medicines and devices.*

Supporting doctors to apply our ethical guidance

Kelly Tully, Senior Regional Liaison Adviser, joined our Outreach teams in the midst of the pandemic.

'It became apparent early on that our team would need to adjust our approach to the role to meet the changes lockdown and the pandemic would bring.

Prior to the pandemic, we would be on the road visiting a variety of organisations, including hospital trusts and boards. As part of our role, we would deliver interactive sessions that promote our standards and raise awareness about how doctors can apply them in practice.

Our biggest challenge in 2020 was that we didn't have the existing infrastructure in place to easily switch from face-to-face to virtual offerings. So we set up a virtual delivery project to increase our capabilities in virtual engagement.

We focused on upskilling and supporting outreach advisers to feel well equipped and confident to engage with and deliver sessions to stakeholders virtually, by making better use of the resources at our disposal.

Our advisers adapted extremely well to the difficult circumstances they faced and I am pleased to say that evaluations of sessions continue to be glowing, showing that, despite the challenges we faced, we continued to provide a professional service of high-quality guidance sessions for trainees.'

Welcome to UK practice

In response to pandemic restrictions, we also began running online versions of our free *Welcome to UK practice* workshops for doctors new to working in the UK.

The workshops help doctors adjust to the working culture of the UK healthcare systems and provide practical guidance on ethical scenarios they might encounter. They also give participants a chance to meet other internationally qualified doctors who have also recently started practising in the UK.

Our virtual delivery will continue as we adapt to the changing external landscape. Our long-term goal is to reach an established hybrid model of engagement, whereby virtual engagement complements our traditional face-to-face approach. See page 24 for more on how we've expanded these workshops.

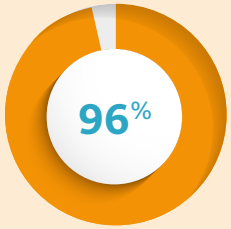
Our Outreach teams engaged with over **13,500 doctors** and over **7,500 medical students** across the UK in 2020.



Over 3,700 doctors attended our virtual *Welcome to UK practice* workshops.



99.7% of doctors said that the session improved their knowledge of our role and standards.



96% said they would change their practice as a result.

Using insight to support the profession and sharing data to inform important workforce discussions

Between January and March 2020, around 13,000 doctors responded to our *Completing the picture* survey. The survey focused on the causes behind why doctors had decided to stop practising medicine in the UK and the barriers preventing them from returning to practice. The findings provided us and our partners with fresh insights into key issues affecting the maintenance and development of the medical workforce.

Ordinarily, we would follow a set process of analysing the results and writing a storylined report before formally publishing the results[8]. However, the onset of the pandemic made the sharing of insights and information more urgent.

So we adapted our processes and shared early emerging findings with partners in March, to help inform important discussions about the workforce in the context of the pandemic. We then shared different relevant parts of the data with various stakeholders throughout 2020. We were careful to caveat that these were emerging findings that still required further analysis.

Stakeholders welcomed this early essential insight, which shed some light on the risks and issues affecting doctors' practice in a timely way.

As well, we shared data, research and case studies that explored doctors' experiences throughout the first peak of the pandemic in *The state of medical education and practice in the UK*. See page 28 for more on this.

We adapted our processes and shared early emerging findings with partners in March, to help inform important discussions about the workforce in the context of COVID-19.



8 For more information about our data and insight work, see page 30.

Progressing our 2018-20 strategy



2020 was the last year covered by our 2018–20 corporate strategy. The strategy set out our ambition for change, shifting the emphasis of our work from acting when things have gone wrong, to supporting all doctors in delivering the highest standards of care. Our work in 2020 continued to be shaped by this strategy and its four main aims.

- Supporting doctors in maintaining good practice
- Strengthening collaboration with our regulatory partners across the health services
- Strengthening our relationship with the public and the profession
- Meeting the changing needs of the health services across the four countries of the UK

As evidenced in the previous section, the pandemic had a significant impact on our operations. It also slowed our strategic progress too.

Still, there's a great deal we've achieved since we outlined our priorities in 2018.

Here, we look at how far we've come, and how we intend to carry this work through to the next few years, on the strength of *Our strategy 2021–25*.

Supporting doctors in delivering good medical practice



Over
760 people
– including patient groups, doctors, health service employers, and healthcare and legal experts – helped shape our revised *Decision making and consent* guidance.

The updated *Decision making and consent* guidance was viewed **just under 152,000 times** on our website in 2020.

Our online ethical hub was viewed **over 211,000 times** in 2020.

3,760 doctors
attended *Welcome to UK practice* workshops in 2020 – the highest number yet, despite the disruption caused by the pandemic.

Throughout 2020, national liaison advisers engaged with
13,550 doctors
including at training sessions and events.

From 2018 to 2020, an increasing proportion of doctors felt we had supported them in their jobs: **one out of three doctors said they felt supported by us** to deliver high-quality care.

Developing relevant and informed guidance with and for doctors

Even before 2020, healthcare was constantly changing. That's why we routinely review our guidance. When we do this, we hold extensive consultations with the public, the profession and our partners to make sure our guidance for doctors remains relevant, credible and consistent with patients' and doctors' experiences. The feedback we receive is crucial in shaping our resources for doctors and patients.

Decision making and consent

Over 760 people – including patient groups, doctors, health service employers and healthcare and legal experts – helped shape our revised *Decision making and consent* guidance. Published in September 2020, it highlights the importance of doctors and patients making decisions about treatment and care together.

Following its release, the guidance was viewed just under 152,000 times on our website in 2020. Alongside this, there were over 15,000 views of a short summary video we produced to help doctors quickly familiarise themselves with the seven principles of decision making and consent. These numbers indicate a high level of engagement with this important information, which is perhaps unsurprising given its relevance to the rollout of the COVID-19 vaccine.

Remote consultations and prescribing

In recent years, there has been a rapid increase in the use of remote consultations and prescribing. We recognised the importance of keeping pace with this growth in 2019 by co-producing high-level principles and issuing a joint statement. In 2020, we used responses to our call for evidence to update our guidance, *Good practice in prescribing and managing medicines and devices*, so it reflected doctors', patients' and regulatory partners' day-to-day experiences.

Feedback from a patient roundtable, held in 2019, also helped us to shape and inform safety tips for patients accessing healthcare online. The tips, which we co-produced with the General Pharmaceutical Council and other regulators, launched in March 2020.

> Clear and focused, including great summary of the key areas of adult patients capacity to make decisions. The guidance and tool links provide solid foundation to build the art of the consultation **#DecidingTogether**
> – Dr Roya Vaziri

> The MHRA was delighted to be involved in **@gmcuk's** initiative to update guidance for doctors on remote prescribing, and support efforts to keep patients safe.
> – The MHRA

Addressing inequalities and helping to create inclusive healthcare

Not all doctors' and medical students' experiences are equal – we've seen that in the extensive evidence we've gathered in recent years. And events of 2020 both highlighted and exacerbated the inequalities that persist in medicine and across society.

Our research has been crucial in helping us and others understand more about who is adversely affected by unfairness and injustice. And it is clear that it's now high time to act.

Promoting inclusive healthcare environments

Our *Fair to refer?* research highlighted that some black and minority ethnic doctors feel they are in 'outsider' groups within organisations, meaning they don't have adequate support and are more likely to be referred to us by their employer.

As part of our efforts to address this, we have supported work on race equality in the NHS. In particular, we contributed data and ideas to improve induction as part of our work on the *NHS Workforce Race Equality Standard*. The standard sets out requirements for all NHS commissioners and NHS healthcare providers, including independent organisations.

It's crucial to continue the important conversation about what more we can all do to tackle existing inequalities.

At our first-ever virtual GMC conference, in 2020, Dr Olamidé Dada, Founder and Chief Executive of Melanin Medics, gave a powerful talk about her hopes for African and Caribbean medical professionals to be able to thrive without racism and discrimination.

Along with the doctors and medical students who have reached out to us, we believe it's vital for diversity to be represented in medical education and training curricula. We've been working with the Medical Schools Council to support guidance on inclusive learning environments. And we're committed to our work with UK medical schools and postgraduate training providers to make sure all doctors are able to meet all patient and population needs.

Equality, diversity and inclusion are an integral part of our work as a regulator, and as an employer. That's why we've embedded our commitments right across our new strategy. There are more details about this from page 52.

> Such a great honour to give the keynote presentation at the final day of the **#GMCconf20** on Medicine in Colour! Delivering change together is more paramount than ever before. It was a pleasure to share about **@MelaninMedics** and the actions we can all take.
> – Dr Olamidé Dada

Providing practical support for doctors to give the best possible patient care

Our Outreach teams hold free workshops across the UK, designed to help doctors tackle some of the ethical issues they face on a day-to-day basis. In 2020, our regional and national liaison advisers provided training for and engaged at events with over:

- 11,840 doctors in England
- 530 doctors in Northern Ireland
- 940 doctors in Scotland
- 240 doctors in Wales.

Covering a range of topics, the workshops help to equip doctors with the tools and support to give the highest standard of patient care. Our advisers routinely receive positive feedback on the quality and impact of the workshops.

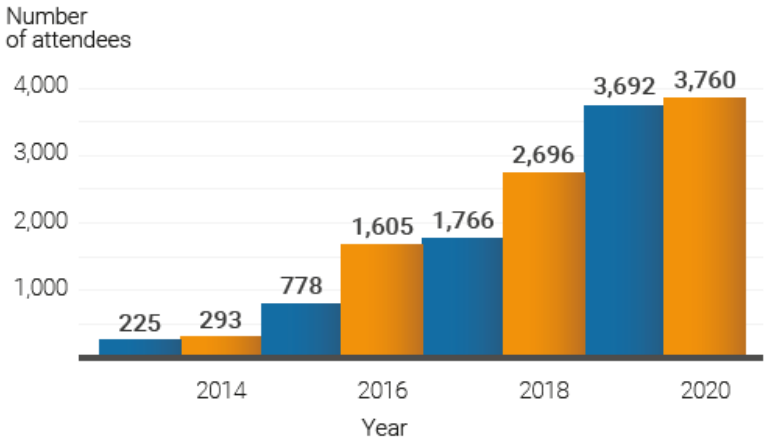
> Interactive, interesting and engaging.
> Useful interpretation of GMC guidelines.

> Very useful in terms of updated guidelines.
> Useful pointers regarding remote consultations.

Over the first two years of our 2018-2020 strategy, attendance at our *Welcome to UK practice* workshops almost doubled, to 3,692 doctors in 2019. These workshops give internationally qualified doctors practical guidance on different ethical scenarios. Further progress in 2020 was slowed down by the impact of the pandemic, as we had to pause face-to-face delivery in March.

To continue to offer this service in 2020, we designed, developed and tested an online version of the workshop, which we were able to roll out as a pilot in July. The new online workshop, delivered by national and regional liaison advisers and GMC associates, has consistently received positive feedback. It's also seen high attendance levels, with over 3,760 attendees since it started in July 2020.

Attendance at Welcome to UK practice workshops (2013–2020)



The ethical hub on our website also gives doctors and medical students quick and easy access to our ethical guidance. The collection of learning resources, viewed over 211,000 times in 2020, includes case studies, decision tools, flow charts and videos. They are all designed to support doctors with common ethical scenarios, such as adult safeguarding, trans healthcare and remote consultations.

Doctors are working under immense pressure and we're committed to doing what we can to provide timely and effective support, so all patients receive consistent, high-quality care.

Making switching specialties simpler for doctors

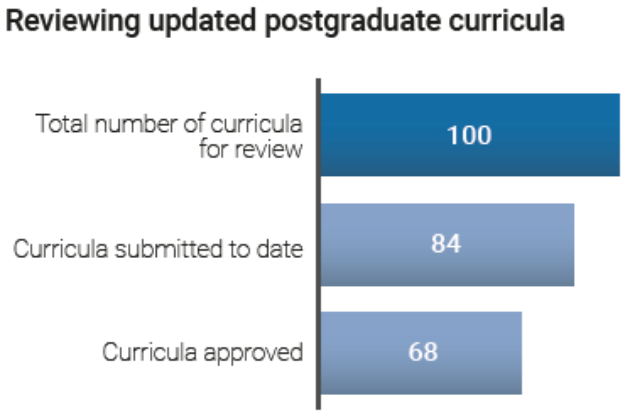
Doctors in training can now move between specialties, without losing recognition for the work they've already completed. This will enhance the flexibility of training, making it easier for doctors to broaden their experience of different specialties and to develop their careers in ways that are tailored to their own strengths, preferences and circumstances. All while making sure patients continue to receive high-quality and safe care.

This is important progress against one of a series of commitments we set out in our report, *Adapting for the future: a plan for improving the flexibility of UK postgraduate medical training*. Key to this development was our work with the Academy of Medical Royal Colleges (AoMRC) to review its arrangements to support trainees who wished to transfer to another specialty. This complex piece of collaborative work resulted in the AoMRC publishing *Guidance for flexibility in postgraduate training and changing specialties* in June 2020.

This is only one part of our wider educational reforms. For example, we have also:

- restated our commitment to less than full-time training
- updated our policy for doctors wishing to receive a Certificate of Completion of Training through the Certificate of Eligibility for Specialist Registration combined programme
- issued comprehensive guidance on support for trainees with health and disability issues.

In response to *Excellence by design: standards for the development and design of postgraduate medical curricula*, which we designed to make training more flexible, medical royal colleges and faculties have been updating their curricula.



As at June 2021, 84 out of 100 curricula had been updated. We've approved 68 and we're reviewing a further 32.

This marks an important first step to boost the flexibility of postgraduate training. We continue to work with partners to build on this much-needed progress.

Working together to develop the Medical Licensing Assessment

Doctors join our healthcare system with a great variety of experience, whether that's gained through medical training in the UK or overseas. Patients benefit from these diverse experiences, but we need to be sure that all doctors start work in the UK with the essential knowledge, skills and behaviours needed for safe practice.

That's why we're introducing the Medical Licensing Assessment (MLA). It will make sure that students in UK medical schools, as well as international medical graduates seeking registration with a licence to practise medicine in the UK, have met a common threshold for safe practice that is appropriate to their point of entry to the medical register.

The impact of the pandemic limited both our and our stakeholders' capacity for engagement to inform the MLA's development in 2020. As a result, we decided to reschedule the MLA's implementation by one year. This means that the MLA will apply in the academic year 2024-25 for students in UK medical schools, and in early 2024 for international medical graduates.

Between February and July 2020, the MLA team, supported by independent assessment experts, ran a pilot involving volunteer medical schools and our PLAB team to develop the quality assurance processes for the clinical and professional skills assessment (CPSA). Details about what we learnt can be found in the pilot's report on our website. Following the pilot, we published a revised set of CPSA requirements, which can also be found on our website.

Partners welcomed the joint statement we published with the MSC in July. The statement announced a commitment from medical schools to embed the MLA in their medical degrees. It included the proposal that medical schools work together to develop a university-led assessment for students in the UK, which we would regulate. The formal proposal is to be submitted for GMC Council's consideration and approval in 2021.

Throughout 2020, we provided updates to students and their representatives, focusing on how these developments will affect them. In December 2020, 68 medical school colleagues from across 29 schools attended our virtual information and Q&A sessions. As development work continues, we'll continue to engage with and update medical schools, postgraduate trainers, patients, student organisations and students, to give them an opportunity to contribute their insight and expertise to the MLA programme.

Strengthening collaboration with our regulatory partners across the health services





71% of stakeholders agree we have a collaborative approach to our work[9].

Over **50 parliamentarians** and a variety of UK-wide health organisations attended a parliamentary reception on the findings of the 2020 edition of *The state of medical education and practice in the UK*.

Over 38,000 trainees and trainers completed our National training survey. And **over 3,600** doctors completed the Barometer survey.

Since we launched the Emerging Concerns Protocol with eight other regulators in 2018, the protocol has been effectively triggered **nine times.**





Most stakeholders **(88%)** feel their working relationship with us is positive[9].

Our Strategic Relationships Unit held **over 300** meetings with stakeholders and regulatory partners across the UK.

9 Figures taken from the GMC perception survey 2020.

Sharing insights into doctors' and medical students' experiences

Our 2020 edition of *The state of medical education and practice in the UK* highlighted the effects of the spring peak of the pandemic on doctors, health services and patient care across the UK. The report provides detailed analysis of key findings from the National training survey and the Barometer survey. It also includes case studies, which delve deeper into individual doctors' experiences.

The report was welcomed by partners in the UK's healthcare systems, including medical royal colleges, health education boards and the NHS Confederation. Dr David Chung, Chair of the Equity, Diversity and Inclusion Committee at the Royal College of Emergency Medicine (RCEM) commented:

> The GMC report reveals that the experience of our ethnic minority colleagues is sadly not the same as their white peers.
>
> The survey itself is the first step in acknowledging this reality but now we must ensure this work is continued, that we listen to the concerns raised and act with purpose to remedy this situation.
>
> At the start of our journey, the EDI Committee of RCEM hopes to work constructively with the GMC and build on this important work to move on from what we had hoped was in our past, but is still clearly in our present.

Key findings from the 2020 edition of *The state of medical education and practice in the UK*

- Four out of five (81%) doctors experienced significant changes to their work and over two fifths (42%) were redeployed.
- Around a third (32%) of doctors also indicated that the initial phase of the pandemic had a negative impact on their mental health and wellbeing.
- The medical workforce continues to grow, with a record rise in the number of licensed doctors between 2019 and 2020 (5%). From 2012 to 2020, the number of licensed doctors grew by more than 14%.
- The number of international medical graduates (IMGs) joining the UK medical workforce has continued to increase. Between July 2019 and June 2020, over 10,000 new IMGs joined the register – more than UK and EEA graduates combined.
- Around a third (36%) of doctors said they were considering reducing their clinical hours, a decrease from nearly half (46%) in 2019.

The UK medical workforce is increasingly ethnically diverse. More than half (54%) of the doctors joining the register in 2020 identified themselves as black and minority ethnic.

Amplifying doctors' and medical students' voices

Surveys provide us with vital insight into doctors' day-to-day experiences, forming an evidence base from which we can act.

National training survey

Every year, we survey trainees and trainers to get their views on training and the environments where they work.

Our teams use National training survey findings to monitor the quality of training across each training environment in the UK – and to work with postgraduate deans, medical royal colleges and employers to identify good practice, tackle concerns and help to develop supportive and inclusive training environments.

Because of the pandemic, we postponed the 2020 survey from its original launch date in March. We also added new questions to help us understand the impact of the pandemic on training, wellbeing, inclusivity and support, alongside our usual questions on workload, burnout, and patient safety.

The survey results are published in an online reporting tool with filters to explore the data by region, country, specialty, programme, or trust/board – all benchmarked against the UK average.

Survey of specialty and associate specialists (SAS) and locally employed (LE) doctors

There are more than 45,000 SAS and LE doctors on the medical register and this number is increasing.

In 2020, we published findings from the first survey for SAS and LE doctors, and we've since been working with others to explore how we can address some of the issues raised.

The Barometer survey

We first commissioned IFF Research to carry out the Barometer survey in 2019. It's designed to provide a baseline for the annual tracking of doctors' experiences in the workplace, adaptations they make to cope with pressure, and their career intentions.

While the 2020 survey retained this aim, we refined some questions, so we could find out about doctors' experiences during the pandemic.

Each year, we present analysis of findings from the Barometer survey and the National training survey in *The state of medical education and practice in the UK*. In 2020, we also included interim findings from Newcastle University's research. The research, which we supported, looked into the experiences of 2020 medical graduates, beginning with those who had started in foundation interim posts.

Completing the picture

Our *Completing the picture* survey ran between 21 January and 10 March 2020, before the spring peak of the pandemic. It was conducted in partnership with Health Education England, the Department of Health (Northern Ireland), NHS Education for Scotland and Health Education and Improvement Wales (HEIW).

We surveyed 13,158 doctors who had previously practised in the UK, but who weren't doing so at the point of completing the survey. We asked them a series of questions about why they had decided to stop practising or leave the UK to practise elsewhere.

Sharing our data and our insights with the UK's healthcare system

We are strongly committed to sharing our data and the insights we derive from it with partners in the UK's healthcare systems. In 2020, initiatives included:

- hosting a reception to share 2019 findings from *The state of medical education and practice in the UK*, which was attended by over 50 Parliamentarians and a variety of UK-wide health organisations, including patient groups
- launching a new e-newsletter, featuring articles about our research and information on how it helps to inform our work with patients and doctors
- creating new data products tailored to each of the four countries.

Complementing these initiatives, our Strategic Relationships Unit (SRU) strengthens our information sharing with regulatory partners and strategic stakeholders across the UK. In 2020, they held over 300 meetings with stakeholders and regulatory partners.

We also routinely share insight with our partners through other channels, such as our UK Advisory Forums and via our European and International team.

2020 saw important discussions around issues, such as the impact of the pandemic on registration, revalidation, and education and training.



Dame Clare Marx highlights key research findings at the Parliamentary reception

Anyone can access the data we hold – via GMC Data Explorer – and use it to discover new insights into and reveal emerging trends in the healthcare workforce. In 2020, over 10,300 people accessed this interactive resource.

Delivering change together

Since we published a suite of reports as part of the *Supporting a profession under pressure* programme, we've been working closely with partners to deliver the recommendations. Of the 15 recommendations set out solely for us in the reports, we've delivered over half and we're making good progress with the remaining seven. Some key developments include:

- four trusts piloting the standardised induction for international doctors that we developed with NHS England and NHS Improvement (NHSE/I)
- 729 doctors attending reflective practice sessions delivered by our Outreach teams
- over 80 people across multiple medical schools attending our *Caring for doctors Caring for patients* events, where we promoted the report's findings and discussed how schools could take forward changes locally
- employer liaison advisers carrying out regular 'fairness conversations' with responsible officers regarding fair decision making and delivering unconscious bias training to multiple organisations.

Our teams across the UK routinely raise awareness of the programme's recommendations in our interactions with doctors, medical leaders and employers.

The pandemic has given a new dimension to this work, bringing with it not only challenges, but also opportunities for greater flexibility and innovation within the UK's healthcare systems.

Delivering change together across the UK



In Northern Ireland, together with the Department of Health (Northern Ireland)'s Improving Junior Doctors and Dentist Working Lives Group, our focus is on recommendations relating to the wellbeing of doctors in training. We have also welcomed engagement with the Northern Ireland Medical Leaders Forum and the Health and Social Care Leadership Centre on these important issues.

In Scotland, we have jointly established a medical workforce wellbeing stakeholder group along with the British Medical Association (BMA) and Scottish colleges. The group will support a shared programme of work to improve and support the wellbeing of doctors in Scotland. We also sit on the Government's Mental Health Network Oversight Group, representing the professional regulators.

In Wales, our productive relationship with Health Education and Improvement in Wales (HEIW) has enabled us to support initiatives that align closely with our priorities, such as compassionate leadership, improved inductions, and support for doctors' wellbeing. In 2020, we met with the Head of Workforce Data and Analytics at HEIW to brief them on how our data can support their implementation plans for the Wales Workforce Strategy. We're also working closely with the medical royal colleges, Healthcare Inspectorate Wales (HIW), and HEIW on triangulating the data we all hold to form a picture of the current and future workforce.

In England, organisations including NHS England and Improvement, the CQC, NHS Employers, the BMA and the Patients Association, provided helpful insight and suggested priorities for action including: improving clinical leadership behaviours and supporting multidisciplinary teamworking; better access to induction, support and ongoing development; alignment of regulatory frameworks; a more consistent approach to compassionate leadership; and workloads.

Working together to improve medical education and training on eating disorders

In December 2017, the Parliamentary and Health Service Ombudsman (PHSO) identified problems in the care and treatment of people with eating disorders. The PHSO report, *Ignoring the alarms: How NHS eating disorder services are failing patients*, was published following their investigations into the deaths of Averil Hart and two anonymised cases.

Since the report was published, we've reviewed the quality of education and training on eating disorders, and we've identified good practice as well as gaps. Our focus in 2020 was on improving training resources on eating disorders. Early on, we agreed with UK Foundation Programme and eLearning for Healthcare leads to develop new bespoke e-learning resources for foundation doctors and doctors in specialty training.

We worked with Beat, the UK's eating disorders charity, and others on the development of a new training package for medical students and foundation doctors.

In autumn 2020, we worked with NHSE/I solicitors to contribute to the inquest into the death of Averil Hart. During the inquest, we described our ongoing work to improve care for people with eating disorders through improved education and training.

As a member of the delivery group, we continue to meet regularly with other stakeholders to measure much-needed progress against the PHSO's recommendations.

> Delighted to announce that we've created an education package on **#EatingDisorders** for medical schools and foundation training programmes, in collaboration with **@NHS_HealthEdEng** & **@rcpsychEDFac** and supported by **@gmcuk**
> – Beat

Working together to understand repeated areas of concern across maternity care

Throughout 2020, we worked closely with the CQC and the NMC to join up our response to recurring and persistent issues in maternity services in England. The main aim of this work was to collectively improve insight, so we could better support doctors and healthcare providers, as well as align our regulatory approach and interventions. Together, we made progress in 2020 by:

- triangulating our data and results of historic investigations, to create a shared list of areas of concern
- hosting a joint roundtable in November 2020 with multiple key organisations to confirm consensus on underlying issues and identify improvements
- agreeing to develop further insight around maternity services.

We're also in the process of developing a shared data platform with the NMC and the CQC to pool the information we hold for the purpose of joint risk analysis. We'll review this shared data platform tool to see if this approach is useful for creating maternity insight too.

The collaboration group also discussed the professional behaviours and patient safety work, which our Outreach teams, together with the NMC, are taking forward linked to maternity services.

In response to demand from maternity services in the East of England, we piloted a virtual preliminary session to support providers with crucial culture changes. 95% of attendees rated the session as 'good' or 'very good' and 93% would recommend it to their colleagues.

Sessions are now underway with Basildon (Mid and South Essex NHS Foundation Trust) and planning discussions are taking place with the Queen Elizabeth Hospital Kings Lynn NHS Trust. We plan to widen the reach of these sessions and build on them with face-to-face workshops when pandemic restrictions make this possible.

Working with partners to address risks to patient safety earlier

We have a vital responsibility, along with regulatory partners across the UK, to share our unique insight and intelligence and work together to help prevent patient safety issues. The direction of travel over the past few years has been towards fostering more effective communication, collaboration and coordination, so we can identify and tackle risks at an earlier stage.

Our Patient Safety Intelligence Forum provides an internal platform to share escalated, emerging and ongoing risks to patient safety and medical practice. The initiatives on the next page complement our internal mechanisms for sharing information across the GMC.

Northern Ireland. We agreed to review our information sharing arrangements with the Regulation and Quality Improvement Authority (RQIA) and to consider opportunities for more collaboration to enhance patient safety in Northern Ireland.

Throughout 2020, we regularly updated the Department of Health (Northern Ireland) on changes and continued to provide advice to doctors as they navigated the complexities of changed ways of working.

We also supported Queen's University Belfast and the Northern Ireland Medical & Dental Training Agency (NIMDTA) to enable the earlier deployment of final year medical students into the Health and Social Care service.

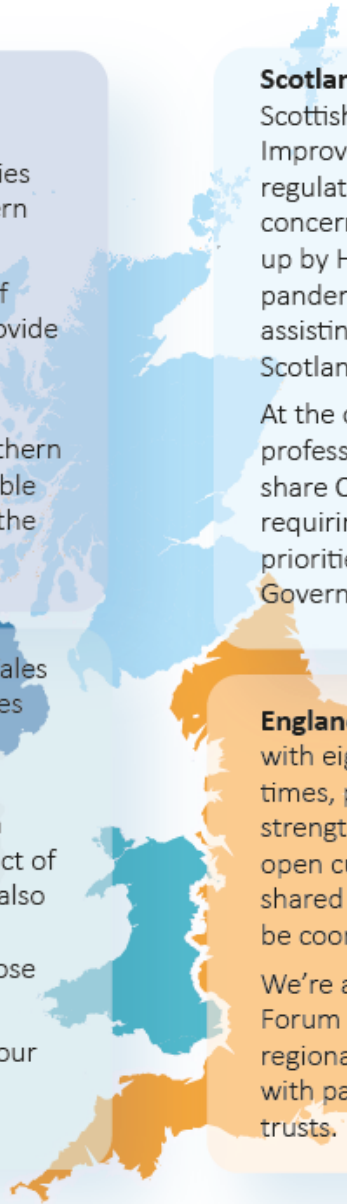
Scotland. We've been working with partners, including the Scottish Government, NHS Education for Scotland, Healthcare Improvement Scotland (HIS) and other professional and system regulators to secure the implementation of an emerging concerns protocol for Scotland. A working group has been set up by HIS, and although work was paused due to the pandemic, the group has reconvened, and we have been assisting HIS with the initial draft of the proposed protocol for Scotland.

At the outset the pandemic, we set up a weekly call with other professional regulators in Scotland. These calls enabled us to share COVID-19 experiences and to identify collective concerns requiring escalation. We continue to meet to discuss shared priorities, and in doing so provide assurance to Scottish Government on regulatory alignment.

Wales. In Wales, we attend the Healthcare Inspectorate Wales (HIW) biannual summit, which brings together inspectorates and patient safety organisations specifically to share intelligence about providers.

Since the start of the pandemic, we've worked closely with HIW and other healthcare regulatory partners on the impact of the pandemic on services and health professionals. We're also working closely with them on the Wales-wide review into maternity services, and specifically regarding Cwm Taf, whose services remain in special measures.

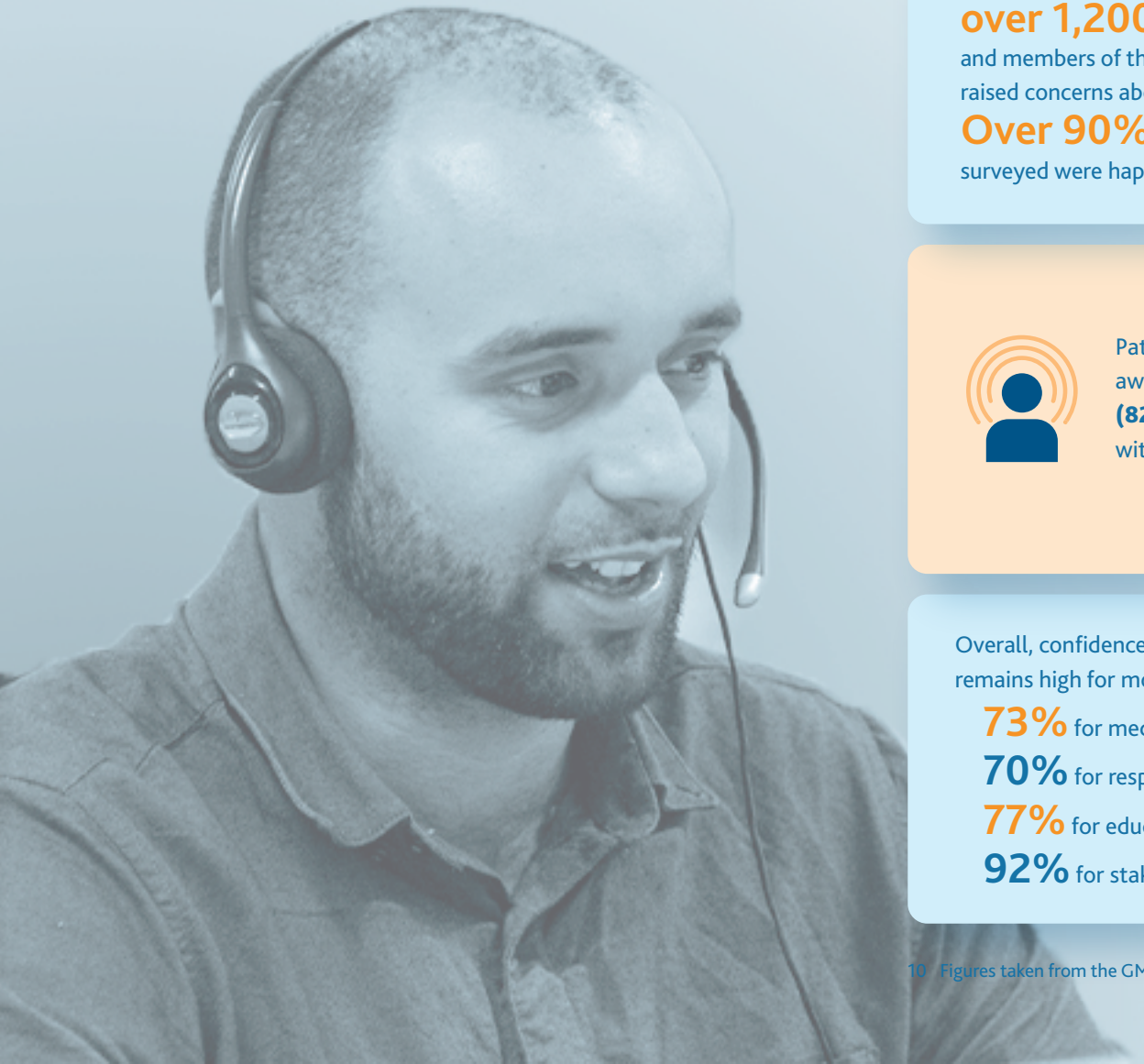
In October, we liaised with HIW to update and strengthen our information sharing arrangements and to consider opportunities for collaboration to enhance patient safety.



England. Since we launched the Emerging Concerns Protocol with eight other regulators in 2018, it's been triggered nine times, preventing serious patient safety issues. The protocol strengthens our existing arrangements and encourages an open culture, where concerns about risks to patients can be shared at an early stage, and where any necessary actions can be coordinated among relevant organisations.

We're also members of the Health and Social Care Regulators' Forum and Joint Strategic Oversight Groups – at a national and regional level. These forums enable us to align our approach with partners, to share insight and learning, and support trusts.

Strengthening our relationship with the public and the profession



From 2018 to 2020, our Patient Liaison Service supported **over 1,200** patients, relatives and members of the public who had raised concerns about a doctor. **Over 90%** of those we surveyed were happy with the service.

Our contact centre advisers answered **178,823** calls and responded to **116,205** emails and letters in 2020.

Patients have a higher awareness of us now **(82%)** compared with 2018 **(74%)**[10].

The number of doctors who are confident in GMC regulation has increased by **around a third** from 2018 to 2020. And in 2020, **85%** of responsible officers felt supported by us[10].

Overall, confidence in GMC regulation remains high for most groups:

- **73%** for medical students
- **70%** for responsible officers
- **77%** for educators
- **92%** for stakeholders[10].

Around two thirds of doctors **(65%)** find our guidance, advice and learning sessions helpful and relevant.

10 Figures taken from the GMC perception survey 2020.

Involving patients and the public in our work

Involving patients and the public in developing our guidance and policies can help improve healthcare outcomes and experiences for everyone. It's something we've done increasingly in recent years. Between 2018 and 2020, over 1,100 patients and members of the public have been involved in our consultations, including on *Decision making and consent* guidance and *Patient feedback for revalidation*. We're committed to building on this important development, particularly so we can represent the diverse needs of all patients.

In 2020, we invited representatives from Stonewall and from GLADD (The Association of LGBT Doctors and Dentists) to feed into our new lesbian, gay, bi and trans patient information.

As part of our 2020 conference, Olivia Butterworth, Head of Public Participation for NHSE/I, joined our panel discussion 'Where do we go from here? The post-pandemic future of healthcare'.

At the event, we also hosted four roundtables with patients and public representatives from across the UK, inviting their valuable input into some priority work areas, including our better signposting work, remote prescribing and our new corporate strategy. It was a great opportunity for us to increase awareness around the associate professions that we'll begin regulating soon. Dame Clare Marx, Chair of Council, and Una Lane, our Patient Champion, attended the roundtables.

> 'Patients want to be seen by people who can see all of them and not just be pushed around the system', says **@LiviButt.** She highlights that the patient is a central member of the healthcare team. She asks: 'how do we bring them into the team conversation?' **#GMCconf20**

As well as involving patients in our work, we're keen to learn more from them about their interactions with us and use this information to make improvements to the services we offer. Our new Strategic Relationships Unit regularly consults with patient representative organisations on our policies and initiatives.

Supporting people who raise a concern about a doctor

Raising a concern can be a daunting experience. We always strive to give everyone the help they need and the compassion they deserve during what can be a very difficult time.

Our Patient Liaison Service

Our Patient Liaison Service (PLS) gives dedicated, personal support to patients, their relatives, or members of the public who have raised a concern about a doctor's fitness to practise. From 2018 to 2020, the PLS team supported over 1,200 patients, relatives, and members of the public who had raised concerns about a doctor. In 2020, this was mostly virtual (see page 15). Each year, over 90% of the people surveyed about their PLS experience found the service helpful.

> I was given time to voice any concerns and questions. I felt listened to and understood. A full, clear explanation was given to me regarding the process to take place.
> – Patient who accessed the liaison service

Using feedback to improve our support

We use feedback to continue to strengthen our processes and improve clarity about what people can expect from us. It's led to us:

- continuing to provide a telephone service for people who are unable to provide their concerns to us in writing – we took 465 calls through this service in 2020
- publishing *Our charter for patients, relatives and carers*, which sets out what they can expect when they raise a concern with us.

And, crucially, we're now reviewing and acting on the feedback we've had since publishing the charter, including the length of time an investigation can take, the experience of giving evidence at an MPTS hearing, and how frequently we provide information to patients during an investigation.

Supporting doctors who raise a concern

Our speaking up hub provides advice to doctors who want to raise a concern. It complements the work our liaison advisers do with the Freedom to Speak Up Guardians based across England.

We put in place safeguards for doctors who raise public interest concerns including requiring an organisation to disclose when a referred doctor has raised a concern and if the concern has been investigated. When making a referral, responsible officers must also provide a statement of truth, confirming the information provided is fair and accurate. This is just one of the mechanisms we put in place to safeguard whistleblowers.

In 2020, our report *Supporting vulnerable doctors – Changes to better support doctors under investigation* showed the important impact of changes we've made to our investigation processes and the support we offer. While positive, our focus on supporting vulnerable doctors is a long-term approach and not just connected to a one-off programme of work.

It's important that everyone who interacts with us – through our processes or our communications – is met with empathy and efficiency. 'Making every interaction matter', as we say in our new strategy for 2021–2025, will be of key importance in continuing to strengthen our relationship with the public and the profession.

Engaging with people in a way that meets their needs

Our Contact Centre is the first point of contact for many of the people who interact with us. In 2020, they answered 178,823 calls and responded to 116,205 emails and letters.

The team's commitment to providing excellent customer service has been recognised in their achievement of ServiceMark accreditation from the Institute of Customer Service. In April 2020, despite the impact of the pandemic, 85% of the people surveyed were happy with the quality of the service provided by our advisers in response to customer surveys – against an external industry benchmark of 76.9%.

Since 2019, we've also piloted Live Chat, which gives members of the public and doctors more options to contact us via our website, in a way that suits them. It's particularly beneficial to those people who may find it difficult to contact us using the phone. From March to December 2020, 84% of people who accessed Live Chat were satisfied with the service.

As well, we introduced Facebook Messenger as a channel for doctors and members of the public to speak with the Contact Centre. On this channel alone, we had 6,877 people contact us, sending 107,520 messages. Alongside this, in November 2020, we launched an Instagram account for UK medical students, where we shared posts about wellbeing, ethical guidance and provisional registration.

Digital transformation

Our Digital Transformation 2020 programme has been transforming the way we communicate, engage and interact with our customers online – making sure we provide a better experience for the public and for doctors across our digital channels.

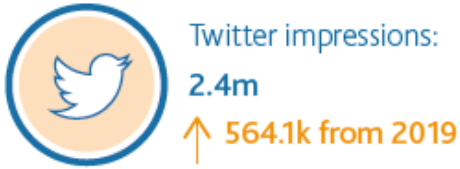
As part of this work, we launched a refreshed GMC website in 2018. Since then, monthly views of our ethical guidance pages have increased from 153,953 in May 2018 to 265,578 in January 2020. This is a positive sign that our guidance – designed to help doctors provide high-quality patient care – is reaching more people.

Accessibility is central to our communications. We also offer many of our communication products in a variety of accessible formats, including easy read, large print and other languages.

Social media

With the onset of the pandemic, social media has become even more crucial as a communications tool. It helps us to quickly share important information and to connect with people on a more personal level.







Some of our key work on social media in 2020 included:

- raising awareness of our updated *Decision making and consent* guidance
- sharing regular updates about PLAB and registration pathways for IMGs, including updates on booking periods, cancelled exams, hosting socially distanced exams, alternative registration pathways, and Q&As
- Professor Colin Melville, Director of Education and Standards, and Greta McLachlan, Clinical Fellow, holding a Twitter chat to share some tips for new doctors in July.

Throughout the pandemic, we also used our e-bulletins to send several supportive messages to doctors, medical students, trainers and trainees.

Making sure everyone can easily access information and interact with us, whether that's digitally, over the phone, or face to face, is at the core of our new strategic aim, 'Making every interaction matter'.

Meeting the changing needs of the health services across the four countries of the UK



Our employer liaison advisers held **over 1,470** meetings across the UK in 2020.

85% of UK parliamentarians expressed confidence in the way we regulate doctors.

The majority of members of the devolved legislatures believe we are focusing on the right issues as a regulator[11].

73% of stakeholders agreed that our approach to regulation anticipates and responds to the needs of individual parts of the UK. An increase from **55%** in 2018[11].

Three quarters of UKAF members agreed the topics discussed at meetings were relevant and timely[12].

Over 1,000 people responded to our consultation about our upcoming regulation of medical associate professionals.

Throughout 2020, Outreach teams engaged with **over 23,000** doctors, medical students and other key interest groups across the UK

11 2020 perceptions survey, IFF research.

12 2019 UKAF survey data.

Our UK presence

We have five offices across the UK and a number of colleagues who are based remotely.

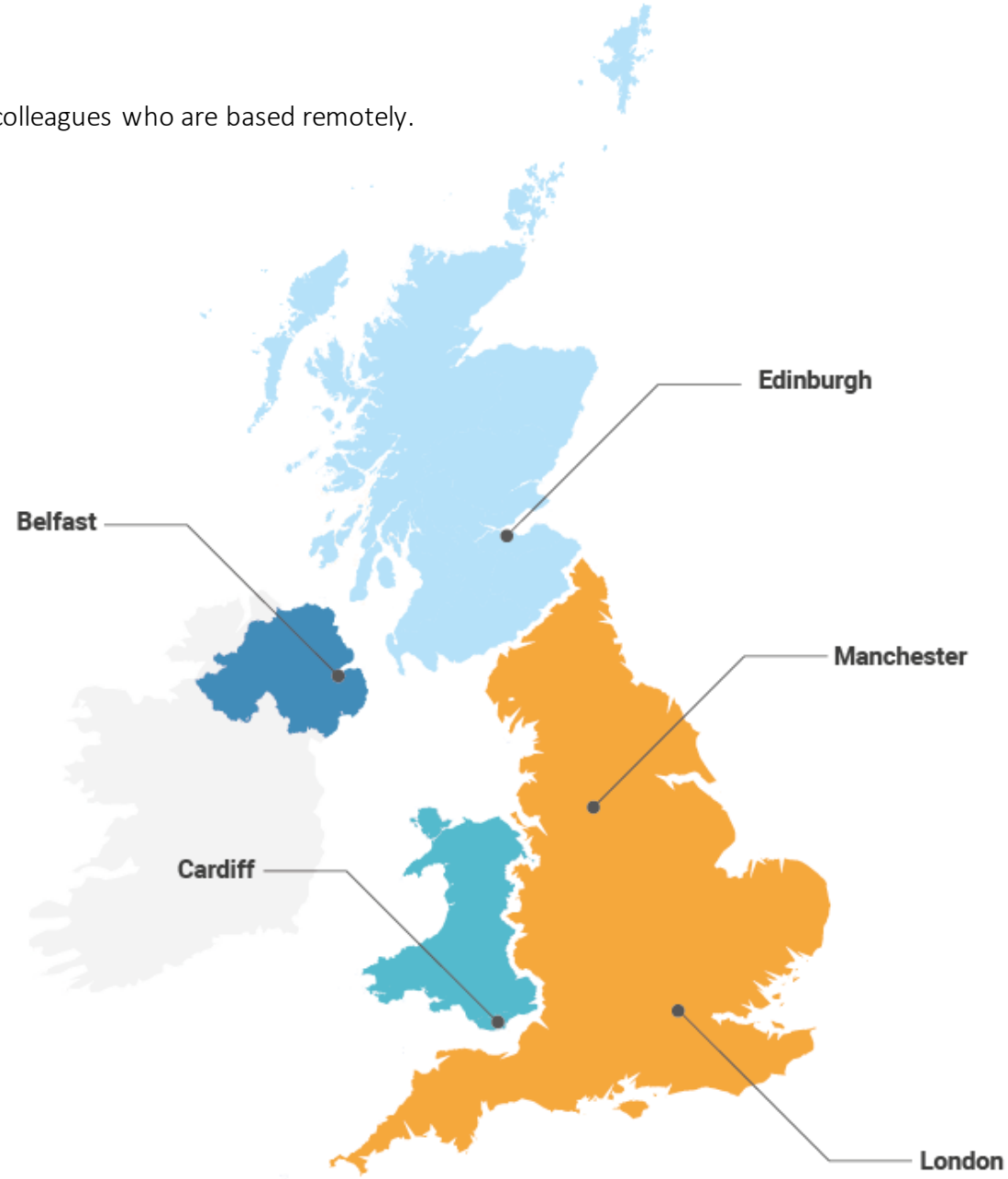
Scotland
Licensed doctors 24,114
GMC colleagues 12

Northern Ireland
Licensed doctors 7,800
GMC colleagues 9

England
Licensed doctors 244,799
GMC colleagues (Manchester) 1,169
GMC colleagues (London) 151

Wales
Licensed doctors 12,274
GMC colleaguest 8

Non-UK, including the Channel Islands
Licensed doctors 8,631



GMC colleagues in England support medical professionals and the public across the four countries of the UK.

Strengthening our local connections across the UK

Our new Outreach services launched at the start of 2020, bringing together the work of our employer, regional and national liaison advisers across the four countries of the UK.

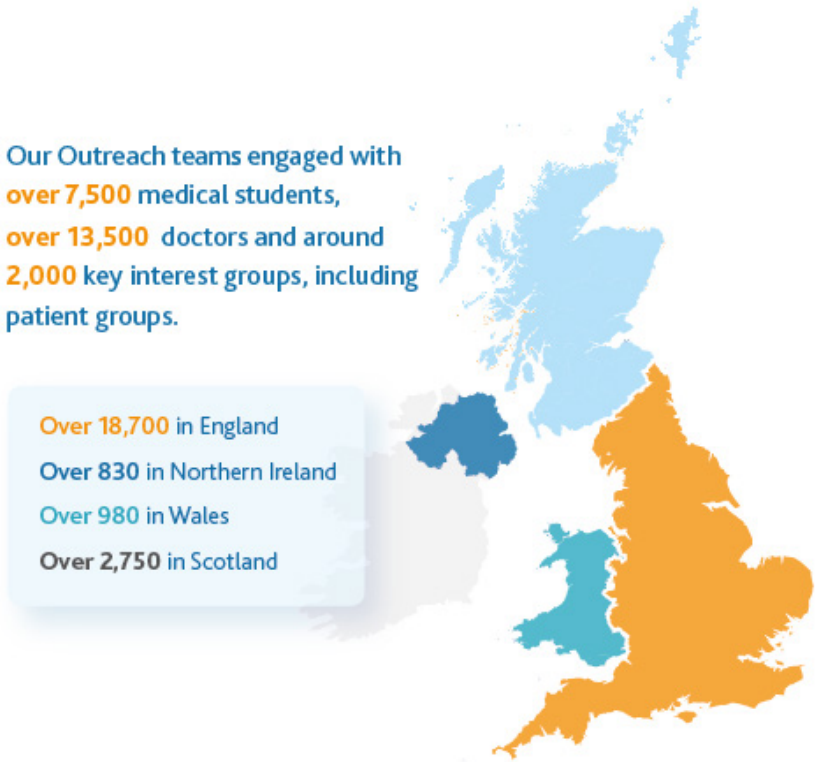
Outreach advisers are an integral part of our organisation, and play a valuable role in supporting the UK's healthcare systems, working with doctors, healthcare providers, educators and other regulators to:

- improve understanding of our role
- learn about the environments in which doctors practise, helping to identify and address risks to patients and doctors before harm occurs
- help responsible officers to address concerns about doctors and support management with concerns at a local level
- support the continuous development of local clinical governance systems, making sure that revalidation continues
- promote and support excellence in medical education, training and practice.

Crucially, they're also helping us to take forward the recommendations from our *Supporting a profession under pressure* programme. Read more about this important work from page 31.

Due to the pandemic, the team had to quickly adapt the plan for the year to move to virtual engagement, so as to continue to support healthcare professionals in a time of great pressure. As part of recovery planning last year, Outreach regional and national liaison advisers contacted over 70 of our key stakeholders across the four countries to ensure their needs were at the core of building our virtual engagement offer.

Throughout 2020, Outreach regional and national liaison advisers engaged with over 23,000 doctors, medical students and other key interest groups, including patient groups. This was lower than our usual reach for a few reasons, including the capacity of the system to engage virtually and doctors' ability to attend training.



Our employer liaison advisers in the four countries of the UK support employers from organisations including the NHS, the independent sector, and mental health organisations. They were able to quickly adapt to virtual support for responsible officers who were under immense pressure. The service completed over 1,470 meetings with responsible officers – 96% of what was planned – in 2020.

Managing the impact of the UK's withdrawal from the European Union (EU)

Over 23,000 EEA-qualified doctors were on the medical register in 2020. They are a vital part of the UK medical workforce. As such, it's been important for us to seek to influence the negotiations between the UK and the EU to make sure the future relationship allowed us to continue to register EEA-qualified doctors in a timely and streamlined way.

On 1 January 2021, the UK Government put in place new legislation to allow us, and other healthcare regulators, to continue to recognise EEA qualifications for a limited period. This legislation means that we can assure continuity in the flow of EEA-qualified doctors to the UK for up to two years.

In August 2020, we contributed to the UK Government's call for evidence to gather insights on the recognition of professional qualifications and regulation of professions. This will help inform future plans for recognising international qualifications after the end of the initial two-year period.

Importantly, the UK's exit from the EU provides an opportunity to review the recognition and regulation of professions more widely. This is why, in our response to the call for evidence, we called for the creation of a new bespoke framework – one that respects the particularity of the healthcare sector and its focus on patient safety, and allows it to diverge, if necessary, from the frameworks of other non-health and safety critical professions.

More generally, we also worked with UK Government officials and our international medical regulatory counterparts to make sure that patient safety is recognised and protected in any future trade agreements signed between the UK and other countries.

Introducing GMC-regulated credentials

Following the launch of the framework for GMC-regulated credentials for doctors in 2019, we have begun a phased implementation. This started with five early adopter credentials in priority areas being taken through our processes for approving postgraduate curricula: liaison psychiatry, interventional neuroradiology (acute stroke), pain medicine, cosmetic surgery, and rural and remote medicine.

While testing how well our approval processes work for credentials, we continued to develop and engage on policy for how doctors will be awarded credentials and maintain recognition on the List of Registered Medical Practitioners. We also continued to explore how we will identify and prioritise areas of practice for future credentials.

Our credentialing framework is intended to improve patient safety by enabling doctors to train in a specific area of practice outside of specialty training where there is a patient safety need or a significant service requirement. It's designed to help the profession adapt to the future needs of patients and to maintain consistent standards across the UK, and will help to make training more flexible.

By the end of 2020, all five early adopters had submitted purpose statements for the first stage of approval, while two had submitted full curricula. We expect most of these to be approved by summer 2021. During this time, we listened to stakeholders for each early adopter as it progressed through each stage of approval. We also heard feedback on developing policy, which we have begun to evaluate.

In 2021, we'll consider what we have learnt from the early adopter phase and will develop a revised framework. We will then hold a review point with further engagement, reporting on our findings, before beginning full implementation and accepting further submissions for approval.

Preparing to regulate physician associates and anaesthesia associates

There are currently around 2,000 physician associates (PAs) and 180 anaesthesia associates (AAs) practising in the UK and we expect numbers to grow steadily over the next few years. Working as part of the clinical team, these medical associate professionals have huge potential to strengthen the UK clinical workforce, improve patient care, and alleviate pressure on doctors.

The Department of Health and Social Care (DHSC) announced, in July 2019, that we would be given responsibility for regulating these medical associate professionals[13]. Since then, in May 2020, the DHSC approved our business case and agreed that all set-up costs would be met by the UK Government. This enables us to uphold our commitment to not use any money that we receive from regulating doctors for the implementation of AA and PA regulation.

[13] Physician associates (PAs) work across a range of specialties in the NHS, in both hospitals and general practice, taking histories, examining, diagnosing, managing and treating patients. Anaesthesia associates (AAs) support the delivery of general anaesthesia and critical care. They perform pre- and post-operative assessments and interventions under the supervision of a consultant anaesthetist.

Before we can begin regulating PAs and AAs, the UK Government needs to introduce legislation. In the meantime, we've continued to work with our key partners across the UK to develop our approach to regulation, and our policies and procedures. Throughout 2020, representatives from across the UK regularly attended and contributed to our External Engagement Group on the subject.

We also ran a survey designed to discover more about the reflections and experiences of working as, or with, a PA or an AA, to help us develop relevant professional standards. 1,147 people responded to the survey, which launched in June 2020. We followed this up with a series of focus groups in December 2020.

Colin Melville, Director of Education and Standards, wrote to vice-chancellors of medical schools to share our quality assurance approach and interim standards in July 2020.

In September 2020, we published a new web guide for PAs and AAs to help them prepare for regulation. The web pages provide details on what regulation will look like, the registration and transition arrangements and some FAQs on registration. Alongside this, we regularly share developments with PAs and AAs, and invite them to share their views via a dedicated e-bulletin.

Reforming education in an evolving world

As the pandemic continues, the health service and patient care are under increasing pressure. The whole system has acted to address this, where possible, and enable innovative solutions to workforce demands.

Alongside these measures, there are real opportunities to bring meaningful changes to medical education and training. In the short term, it is important to balance service needs without losing sight of training. In the longer term, we need to work across the system to manage the pipeline of trainees and ensure they are able to build knowledge and skills to meet the standards we require. The pandemic has presented an opportunity to think differently about how training is organised, how doctors are assessed, and how we manage the balance between service and training.

In November 2020, we brought stakeholders from across the UK together to identify principles that can be used across the system to underpin decisions about the structure and quality of education and training. While there are many lessons to learn from the way students, doctors, trainers and trainees have adapted in this crisis, we agreed four key areas where changes implemented during the pandemic could be embedded into education and training.

- Progression through medical education and training – building on changes made to curricula and assessments to develop a more authentic means of assessment that evaluate applied knowledge and skills.

- **Generalism in serving patients and managing the service** – enhancing the value of general and professional learning and skills in education and training. The pandemic saw widespread redeployment and clinical teams working together in new ways, relying on general, specialty and professional skills to meet the challenges cause by COVID-19.
- **Preparing medical students for practice** – improving the transition for medical students into the Foundation Programme by learning from and formalising the new FiY1, introduced to increase the capacity of the workforce in spring 2020.
- **Doctors as leaders** – developing medical leaders is critical to better managing and shaping the service. There is an opportunity to integrate leadership into education, training and lifelong learning.

We are scoping these four areas for development in 2021. Through this work, and by moving towards more adaptive and flexible medical education and training, we hope to futureproof the workforce against the serious challenges posed by changing healthcare environments, increased multi-morbidity, future emergencies, and workforce pressures.

Our new corporate strategy

Our strategy 2021–25 builds on the ambitions of our previous strategy (2018–20), with everything we've achieved over the past three years laying the foundations for this next stage of work[14]. Crucially, it embeds everything we've learnt from listening to those we work with and for.

Working towards four key priorities

Over the next five years, all our work will be shaped by four strategic themes to achieve our new, ten-year vision:

> We will be an effective, relevant and compassionate regulator – for patients, the public and professionals – and employer.
>
> We will foster a culture of equality, diversity and inclusion in everything we do as a regulator and an employer.



[14] See from page 20 for more about our progress over the past three years.

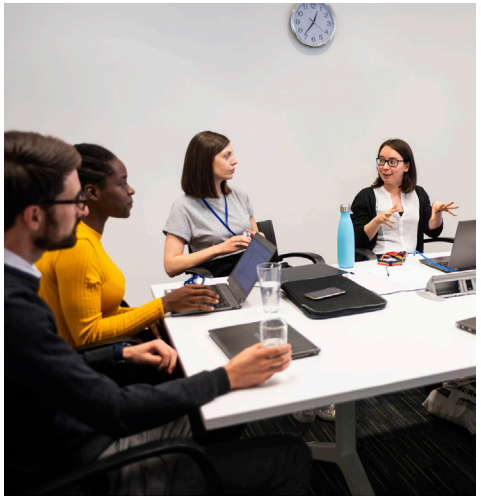
Working together

We've developed our strategy both with and for patients, partners, medical professionals and colleagues.

Although we had to adapt our external engagement plans because of the pandemic while we developed the strategy, we were very much committed to hearing and representing the views of those we work with.

- We held discussions with our UK Advisory forums, Responsible Officer Reference group, Royal Colleges Policy and Public Affairs Group, Doctors in Training roundtable, and equality, diversity and inclusion (ED&I) steering group.
- We also shared drafts with key partners and invited their feedback.

Ongoing collaboration will be key to recovering from the pandemic and delivering wider health system goals.



Our Strategy team collected input from colleagues at all levels, through staff focus groups, surveys and discussions.

A flexible strategy

We agreed the four themes of our strategy just before the pandemic forced the UK into lockdown, in March 2020. Since then, strategy, policy and analyst colleagues have worked together to 'stress test' the strategy against different scenarios and time frames in light of the impact on clinical practice, the UK workforce, societal attitudes and our operations. Broadly, this work confirmed that – with some minor refinements – the strategy was robust and sufficiently flexible to enable us to address the impact of the pandemic appropriately.

We will continue to assess the relevance of our priorities and be flexible enough to make sure that we can adapt and deliver as we all navigate an increasingly complex and uncertain world.

And throughout the life cycle of our strategy, we'll assess our progress and share this through our annual reports and via updates to Council at the end of 2022 and at the end of 2024.

Investing in our people

With more than 1,300 colleagues across the UK, our people are every bit as important as our performance and our progress. And in a year of challenging circumstances, they committed to going the extra mile to continue supporting doctors and keeping patients safe. Here are some of the ways we were there for them, so they could be there for patients and doctors.

Health, wellbeing and flexibility

Since publishing *Caring for doctors Caring for patients* in 2019, we've talked a lot about the importance of connected, compassionate environments for doctors' health and wellbeing. The same can also be said for our colleagues, and we're dedicated to delivering just that.

The pandemic had a significant impact on all our daily lives, including our physical and mental health. We made it our priority to make sure colleagues had the help and support they needed, from flexible working, to access to trained mental health first aiders.

Our new *Wellbeing plan*, which was supported by our wellbeing champions, included sharing supportive resources and promoting an employer support advice line. We also updated our HR policies to provide additional flexibility for colleagues with additional responsibilities and pressures brought about by the pandemic. We continue to update these policies as the situation develops.

A place for everyone

Every one of our colleagues is unique and we continue to make decisions and develop initiatives that are for the benefit of everyone.

The events of 2020 brought to the fore longstanding issues around inequality, which we all need to play our part in tackling. Education, raising awareness and building our own knowledge and understanding are vital to us tackling these issues. See page 52 for more about our commitments to promoting equality, diversity and inclusion.

Our staff networks are an incredibly powerful support to colleagues who share protected characteristics, and they help to enrich the working lives of everyone at the GMC. The networks routinely hold events and share news, all with the important aims of educating, supporting and empowering individuals. Throughout 2020, we encouraged colleagues to read resources recommended by our staff networks, and to have open discussions about what more we can do as individuals and as an organisation.

In March 2020, we also rolled out updated mandatory training on *Treating people fairly* for all colleagues.

Training and development

Effective leadership can positively influence colleagues, teams and the whole organisation, so it's important for us to invest in leaders. In 2020, more than 200 colleagues had successfully completed our leadership programme and 80 were part way through.

Building an understanding of doctors' and patients' experiences is crucial to keeping our work relevant and compassionate. Our 'Brown bag lunches' are just one of the ways we make this possible. Over 1,000 colleagues attended these talks, including Dr Paul Bowie's discussion about human factors and Dr Pearl Hettiaratchy's reflections on her career, including adjusting to a new life in the UK and confronting discrimination.

Throughout 2020, 75 colleagues also took part in development or cover secondments, which gave them opportunities to learn new skills and knowledge. We also continued to encourage colleagues to share feedback with one another and have open discussions with their manager to help their personal development.

Freedom to speak up

We're committed to encouraging a culture where people feel safe to speak up – both those who work for us and those who work with us. Since March 2019, Lindsey Mallors has acted as our Freedom to Speak Up Guardian, alongside 15 cross-organisational Freedom to Speak Up Champions. Collectively, they provide a safe space and a route for colleagues to raise concerns.

Just over 80% of the concerns raised with the Freedom to Speak Up team were resolved in 2020. And work has continued into 2021 to resolve the few remaining issues. In some cases, the issues raised led to wider and sustained changes in the way we work. For example, reflecting on what we learnt in 2019, we initiated pulse surveys for colleagues throughout the year to assess organisational morale and pick up on potential issues early.

Throughout October 2020, which is Speak Up Month, we made a special effort to raise awareness of speaking up. As part of this, we welcomed Dr Chris Turner, a consultant in emergency medicine and founder of Civility Saves Lives, to talk to us about the impacts that rudeness can have in healthcare settings.

Next steps

We care about our colleagues. That's why you'll see a strong focus on us supporting and upskilling them, as well as creating a caring and inclusive culture in our *Our strategy 2021–25*. The improvements we continue to make are setting us on course to achieve the Gold standard for Investors in People in 2021.

Equality, diversity and inclusion

Equality, diversity and inclusion (ED&I) are integral to us being a fair and effective regulator and employer.

Work we have commissioned in recent years has guided us to workstreams of change. For example:

- the *Fair to Refer?* report examined factors in reducing disproportionality in referral to fitness to practise and made recommendations
- both the SAS and LE doctors' survey and the National training survey highlighted the differences in experiences and opportunity of doctors from the black and minority ethnic communities who work in the health service
- in her report *How doctors in senior leadership roles establish and maintain a positive patient-centred culture* Dr Suzanne Shale spoke of the importance of positive examples of leadership in setting cultures and tackling poor behaviours.

Over 2020, we have developed clear commitments to accelerate progress and deliver meaningful outcomes for the people we work with and for, in line with our ED&I strategy. Integral to this will be our work with the UK's healthcare systems in creating inclusive workplaces, where everyone feels valued and respected, and has equal access to opportunity.

Tackling inequalities and creating more inclusive environments

The events of 2020 and the overwhelming impact of the pandemic have reminded us of the persistence of inequalities, in relation to education, health, age, disability, race and other protected characteristics.

As the regulator of medical professionals in the UK, we will play our part in tackling inequality, both within the UK's healthcare systems and within our own workplace.

In June 2020, Dame Clare Marx, our Chair of Council, wrote to the profession addressing healthcare and race inequalities and other forms of discrimination, and outlining our commitment to positive change.

Among other things, it's our priority to address two measurable issues and eliminate:

- discrimination, disadvantage and unfairness in undergraduate and postgraduate medical education and training
- disproportionate fitness to practise referrals from employers, in relation to ethnicity and primary medical qualification.

To do this, we recognise we will need to promote the use of our insights and data to key participants in the health systems.

Our key performance indicators will help us to drive the changes we want to see across both our employment and our regulatory activities. These will be delivered as part of our new strategy from 2021. Read more about the measures we're putting in place and how they will be governed on our website.

Embedding equality and diversity in all our work

During 2020, we continued to work closely with our external stakeholders, responding both sensitively and effectively to the issues they raised with us. For example:

- working with our BME Doctors Forum members to provide specific support to doctors stranded in the UK as a result of PLAB cancellations
- creating a dedicated online ethical hub with guidance on some of the equality issues raised
- contributing to the development of the 2020 Medical Workforce Race Equality Standard, an important initiative led by NHS England to measure and drive fairness in medicine
- supporting efforts to promote diversity in medical teaching and learning, working with the MSC on guidance to help students learn how to treat patients from different backgrounds
- submitting a response to the Women and Equalities Committee inquiry on impacts of the pandemic on people with protected characteristics under the Equality Act 2010, and our actions to support diverse groups during the pandemic
- rolling out a new mandatory e-learning programme on *Treating People Fairly*, designed to help colleagues understand their responsibilities and how they should act and behave to ensure everyone is treated fairly
- continuing work with our Strategic ED&I Advisory Forum on guidance and support towards our strategic aims, in particular on the bullying, harassment and discrimination of diverse groups of doctors
- introducing an Inclusivity index in our annual staff survey, which will be refined over time as a baseline measurement of organisational inclusivity.

Reflecting on how we can continue to improve equality, diversity and inclusion

External auditors, Campbell Tickell, conducted an independent review of the overall effectiveness of our ED&I practices and protocols in 2020. The review covered our role as a regulator, our infrastructure, our accountability and our ownership of ED&I, as well as our compliance with legislation and standards across the UK.

It confirmed that we are compliant with legislative and regulatory requirements. It particularly acknowledged the effort and commitment we have invested in focusing on improvements over the past few years.

The auditors made several recommendations to strengthen our approach in relation to the governance and compliance of our ED&I work, which we will be taking forward in 2021.

Corporate social responsibility

From standalone initiatives, to everyday activities and decisions, we strive to carry out our work in a way that benefits society as a whole and the environment. In 2020, this saw us:

- working with the Social Mobility Foundation and the Social Mobility Business Partnership to create a professional apprenticeship scheme and work experience opportunities for students
- developing an Environmental Management System to help us accelerate our green office practices and become more sustainable
- identifying more ways we can ensure the goods and services we procure are done so responsibly, with the environment and society in mind
- supporting colleagues who were involved in the NHS Volunteer Responders scheme, as well as other volunteering initiatives
- strengthening our relationship with Business in the Community, a collective of hundreds of organisations, which are all dedicated to social and ethical responsibilities
- joining the North West Leadership Board – Jane Durkin, Assistant Director for Corporate Social Responsibility, is working with other board members to influence local debate and action to help communities across the region.

While 2020 was very much dominated by the pandemic, we couldn't lose sight of other important issues, like climate change and social inequality. The examples highlighted above are part of a wider scheme of work, driven by our Corporate Social Responsibility Working Group, which continues to identify where we can do more.

> The main reason I chose to do an apprenticeship was because of the chance to learn and develop new skills, while also having a real job and gaining a formal qualification at the same time. Hearing about the level of support the GMC offered and the opportunities for career progression, I chose to apply here for my apprenticeship – and was successful! I enjoy communicating and generally building positive working relationships with the other Investigation Officers.
> – Ahmed Qasim

Our structure, governance and management

Council and other governance groups

Council is our governing body. Its role is to provide strategic direction, hold the executive to account and take major high-level policy decisions. It comprises 12 members from the four countries of the UK, six of whom are medical members and six of whom are lay members.

We are a registered charity and our Council members are also the trustees of the organisation.

They are all independently appointed by the Privy Council, through a process that follows the Professional Standards Authority's guidance for making appointments to healthcare professional regulatory bodies.

The trustees between 1 January 2020 and 31 December 2020 were:

- Mr Steven Burnett, FIA
- Lady Christine Eames, OBE LLB MPhil
- Professor Anthony Harnden MB ChB MSc FRCGP FRCPCH
- The Rt Hon Lord Hunt of Kings Heath PC OBE
- Professor Deirdre Kelly, CBE MD FRCP FRCPI FRCPCH DL
- Professor Paul Knight OBE, MBChB, FRCP (Edinburgh, Glasgow, London) FRCPI
- Dame Suzi Leather, DBE MBE MA BA BPhil CQSW LLD (Hon) FRCOG (Hon) FRSH (Hon) DL
- Dame Clare Marx DBE DL FRCS
- Dr Raj Patel, (appointed 1 February 2020) MBE, MBChB FRCGP
- Dame Denise Platt, DBE BSc Econ
- Miss Amerdeep Somal LLB
- Miss Alison Wright (appointed 1 February 2020) MBChB FRCOG

Dame Clare Marx was appointed by the Privy Council as the new Chair of the General Medical Council in January 2019. All Council members participated in appraisal reviews in 2020, which included consideration of any learning and development needs, and revisiting actual or perceived conflicts of interest to make sure any conflicts identified are manageable. In 2020, all members also undertook a 360 appraisal process.

Council members are also asked to declare any conflicts of interests. The register of interests, which contains the declared interests of Council members, is published on our website[15].

As a charity, we take into account the seven principles set out in the Charity Governance Code (2020) and can demonstrate how we use these principles to guide our work on an 'apply or explain' basis.

There are two exceptions to the Code, which we explain rather than apply. Firstly, our Council and committees operate without a formally appointed vice- or deputy chair. However, provisions are made in the Governance Handbook for chairs to nominate a deputy to assist during periods of absence. Secondly, as our appointments process is well established and thorough and is overseen by the Professional Standards Authority, a nominations committee is not considered necessary.

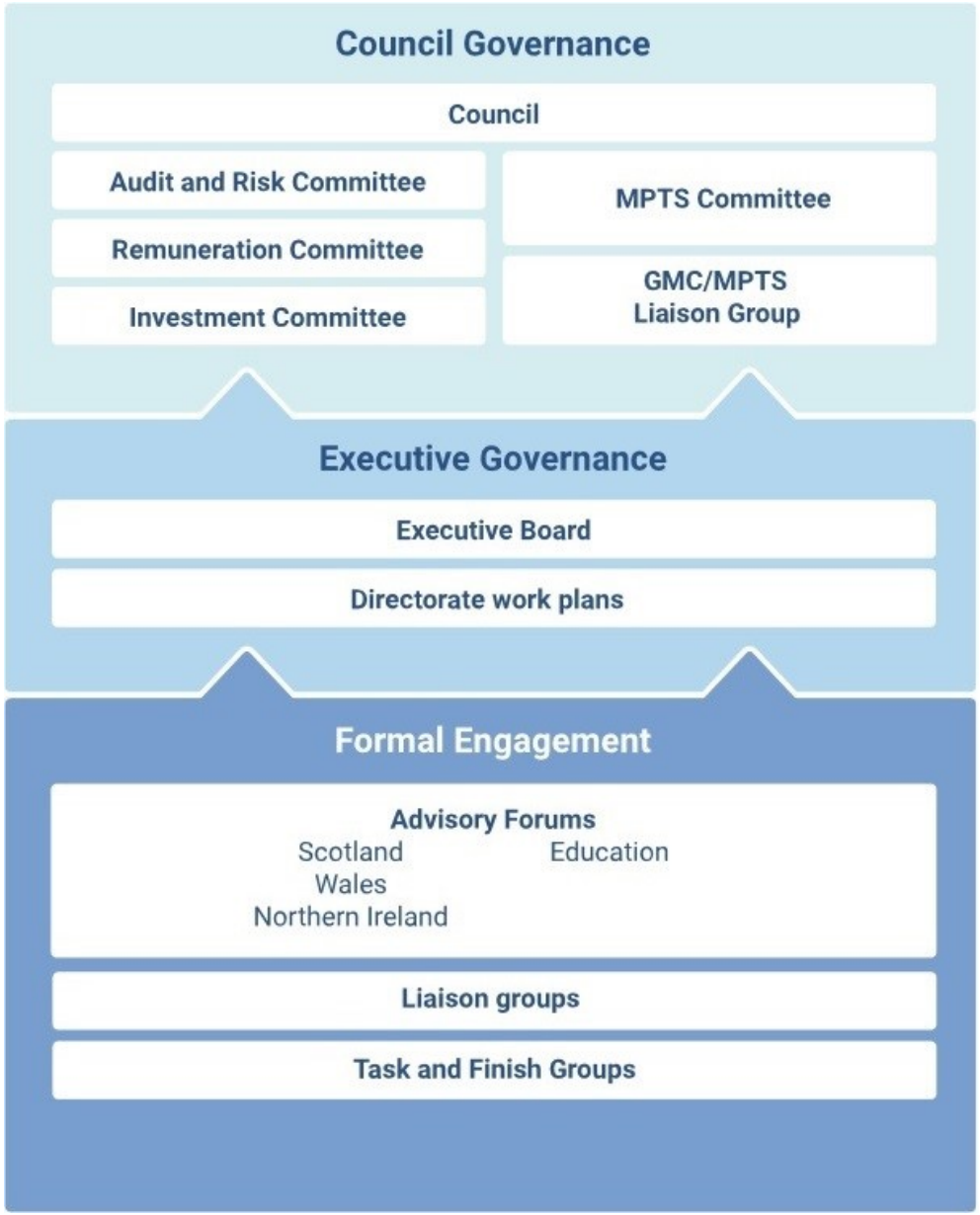
The Governance Handbook is the governing document of the organisation. It was reviewed in early 2019 to further incorporate the Charity Governance Code and minor updates are made with Council's approval on an ongoing basis, for example to the membership of committees.

The Corporate Governance team is charged with supporting the Council in maintaining high standards of governance, on an 'apply or explain' basis, in line with the good practice set out within the Charity Governance Code. The team also provides training and advice to the organisation on matters of governance. Each committee accounts to the Council through a formal report, and the Council and each committee undertakes to review its effectiveness in delivering its statement of purpose, which is reviewed annually.

The diagram on **the next page** shows the different governance groups that assist Council in discharging its responsibilities. These have all been agreed by Council to help it oversee our work effectively. The roles and activities of these groups are described in the pages that follow.

Council business is conducted in an open and transparent manner and the agenda and papers for each meeting are published on our website[16].

[15] See www.gmc-uk.org/about/how-we-work/governance/council/council-member-register-of-interests.
[16] See www.gmc-uk.org/about/how-we-work/governance/council.



Audit and Risk Committee

Deirdre Kelly chaired the Audit and Risk Committee during 2020.

Its external co-opted members were Elizabeth Butler and Kenneth Gill.

The Committee plays a key part in our governance, providing Council with independent assurance about:

- the integrity of our financial statements
- the effectiveness of internal control, governance and risk management systems
- the delivery of internal and external audit services.

The Committee met five times in 2020 and reports to Council twice a year. You can find more about the Audit and Risk Committee's role in its report from page 73.

Remuneration Committee

Denise Platt chaired the Remuneration Committee in 2020.

The Committee advises Council on the remuneration, the terms of service and the expenses policy for Council members, including the Chair. It also determines the appointment process for the Chief Executive and MPTS Chair and the remuneration, benefits, and terms of service for the Chief Executive, Chief Operating Officer/Deputy Chief Executive, directors, and MPTS Chair and MPTS Committee members.

It is also responsible for making sure the assessment and measurement of performance and the assessment of recruitment and succession planning take place within an appropriate framework for the senior management roles within its remit. The Committee met twice in 2020 and reports annually to Council.

Investment Committee

Suzi Leather chaired the Investment Committee in 2020.

Its external co-opted members during 2020 were Tim Scholefield, Keith MacKay and David Stewart.

The Committee is responsible for implementing and reviewing our investment policy, making sure the management of assets is consistent with the policy, appointing and managing fund managers and monitoring performance.

The Committee also has responsibility for overseeing the GMC's investment in GMC Services International Limited (GMCSI), including ensuring compliance with the GMC's Investment Policy, and scrutinising GMCSI's business plan, assessing the potential levels of investment risk and return.

The Committee met five times in 2020 and reports on investment performance to Council via post-meeting circulars, and reports on the performance of the portfolio to Council on an annual basis.

GMC Services International

On 16 December 2016, Council agreed to the establishment of GMC Services International Limited (GMCSI) as a wholly owned trading subsidiary of the GMC. The main objective of GMCSI is to introduce new revenue streams and so reduce our reliance on doctors' fees.

Robust and effective governance arrangements are in place to ensure that our interests are protected and that our relationship with GMCSI is managed effectively.

While Council has overall responsibility for GMCSI, the Audit and Risk Committee considers the risks to the GMC from the operation of GMCSI, conducting routine internal audit and spot checks as appropriate.

Andrew McCulloch chaired the GMCSI Board during 2020. The Board comprised (in addition to the Chair) Paul Buckley, Steve Burnett (until May) Paul Knight, Alison Wright and Paul Reynolds. Paul Buckley retired from his position as Managing Director on 31 December 2020. He has been replaced as Managing Director by Paul Reynolds, and Colin Melville joined the board.

Board of Pension Trustees

The GMC's defined benefit staff superannuation scheme is managed and administered by a board of trustees in accordance with the scheme's trust deed and rules. The trust makes sure the pension scheme's assets are kept separate from those of the employer.

The scheme's trustees are responsible for the proper running of the scheme, including the collection of contributions, the investment of assets and payment of the pension benefit commitments made by the employer.

Jim McKillop chaired the Board during 2020. Steven Burnett, Deirdre Kelly and Amerdeep Somal (until October) are employer nominated trustees. Danny Dubois, John Foley, Anthony Egerton and Finlay Scott are member nominated trustees.

Medical Practitioners Tribunal Service

The Medical Practitioners Tribunal Service (MPTS) is responsible for overseeing the adjudication of fitness to practise hearings. Dame Caroline Swift, as Chair, and Gavin Brown, as Executive Manager, oversee the MPTS.

The MPTS Committee and joint GMC/MPTS Liaison Group are a core part of our governance framework.

Dame Caroline Swift chairs the MPTS Committee. The committee oversees the delivery of the hearing service for doctors, and makes sure the service meets its responsibilities under the *Medical Act 1983*. The GMC/MPTS Liaison Group is chaired by the Chair of Council. It oversees the working relationship between the MPTS and the functions of the GMC with which it interacts.

Executive Board

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

The Board meets monthly (except for August) and reports to every meeting of Council through the Chief Executive's report and also via a separate annual report.

UK Advisory Forums

In 2013, we established advisory forums in Northern Ireland, Scotland and Wales.

The forums make sure we have effective engagement and consultation with interest groups and that our policies are suited to all parts of the UK. The invited membership differs from country to country and reflects the diverse range of those who have an interest and expertise in the areas under our regulation in each of the four nations.

They are an addition to our existing arrangements for engagement and are intended to give a structured setting for us to engage on medium- and long-term priorities, and to share and discuss any early-stage views on policy development. They report on their work to the Executive Board twice a year.

Education Advisory Forum

The Education Advisory Forum, which replaced the Education and Training Advisory Board (ETAB) and the Assessment Advisory Board (AAB), began work in February 2019. The forum engages widely and effectively with our key interest groups on education, training and assessment matters, making sure we are able to best develop and promote a strategic approach to this work across all countries of the UK. Professor Colin Melville, Medical Director and Director of Education and Standards chairs the Forum and the invited membership reflects the diverse range of those who have an interest and expertise in medical education, training and assessment across the UK. The work of the forum is reported to the Chief Executive and to Council through the Chief Executive's report.

Member attendance at Council, boards and committees in 2020[17]

Member and trustee	Number of meetings attended
Mr Steven Burnett	
Council	8/8
Investment Committee	4/4
Board of Trustees of the GMC's Superannuation Scheme	4/5
UK Advisory Forums – Wales	1/1
GMCSI	1/1
Lady Christine Eames	
Council	8/8
Audit and Risk Committee	5/5
Remuneration Committee	2/2
UK Advisory Forums – Northern Ireland	1/1
Professor Anthony Harnden	
Council	7/8
Remuneration Committee	2/2
Investment Committee	3/5
Lord Philip Hunt	
Council	8/8
Audit and Risk Committee	4/5

[17] Includes seven Council meetings and one strategic away day. Council member attendance at the forum meetings is on a voluntary basis on the invitation of the Chair of Council.

Member and trustee	Number of meetings attended
Professor Deirdre Kelly	
Council	7/8
Board of Trustees of the GMC's Superannuation Scheme	4/5
Audit and Risk Committee	5/5
Professor Paul Knight	
Council	7/8
Audit and Risk Committee	5/5
UK Advisory Forums – Scotland	1/1
GMCSI	4/4
Dame Suzi Leather	
Council	7/8
Investment Committee	5/5
Dame Clare Marx[18]	
Council	8/8
GMC/MPTS Liaison Group	2/2
UK Advisory Forums – Scotland	1/1
UK Advisory Forums – Northern Ireland	1/1
UK Advisory Forums – Wales	1/1
Dr Raj Patel	
Council	7/8
Audit and Risk Committee	3/4

[18] As an ex-officio member of the sub-committees, each year Dame Clare Marx attends one meeting of each sub-committee.

Member and trustee	Number of meetings attended
Dame Denise Platt	
Council	8/8
Investment Committee	4/5
Remuneration Committee	2/2
Miss Amerdeep Somal	
Council	5/8
Audit and Risk Committee	2/4
Board of Trustees of the GMC's Superannuation Scheme	2/4
Miss Alison Wright	
Council	8/8
GMCSI	1/3

External co-opted members

External co-opted members sit on the Investment Committee and Audit and Risk Committee respectively[19].

Investment Committee	
Mr Keith MacKay	5/5
Mr Tim Scholefield	5/5
Mr David Stewart	4/5

Audit and Risk Committee	
Ms Elizabeth Butler	5/5
Mr Kenneth Gill	5/5
GMCSI	
Dr Andrew McCulloch	4/4

[19] Attendance data reflects the total number of meetings where attendance was possible.

Management

At the beginning of 2020, our staff were under the direction of Chief Executive Charlie Massey. He is supported by a team of directors, who, as at 31 December 2020 were:

- Mr Paul Buckley, Director of Strategy and Policy
- Ms Una Lane, Director of Registration and Revalidation
- Professor Colin Melville, Medical Director and Director of Education and Standards
- Mr Anthony Omo, General Counsel and Director of Fitness to Practise
- Mr Paul Reynolds, Director of Strategic Communications and Engagement
- Mr Neil Roberts, Director of Resources.

Mr Paul Buckley retired on 31 December 2020. Mr Shaun Gallagher joined the organisation on 1 December 2020 to fill the vacancy.

Key management personnel – remuneration policy

The Remuneration Committee is responsible for determining the remuneration, benefits, and terms of service for the Chief Executive, Chair of MPTS and directors. The Committee sets all aspects of salary or honoraria, the provision of any other benefits, and any other arrangements or contractual terms for this group of staff.

The Committee considers that we should provide remuneration and rewards that will attract and retain the high-calibre staff necessary to enable us to fulfil our statutory remit and deliver our strategic objectives.

In setting the base pay for individual posts, the Committee will take external advice on roles within its remit and align salaries with an appropriate market rate subject to resource considerations.

An annual consolidated pay award is considered with reference to the organisation's level of performance, the financial implications of any award, the award agreed for other GMC employees and wider market trends. An annual variable non-consolidated element is considered, reflecting personal performance, with regard to the same considerations applied to any consolidated award. We review the effectiveness of these arrangements on an annual basis.

Staff within the Remuneration Committee's remit will usually be entitled to the benefits package available to all GMC employees on the same terms. The Committee retains the ability to withdraw, adjust or change any benefits for staff within its remit, subject to any consultation and contractual requirements. The Committee considers any additional benefits in kind (such as relocation payments) on a case-by-case basis.

New external staff appointees within the Committee's remit are automatically enrolled into our defined contribution pension scheme. Where employees have existing agreed pension arrangements, such as membership of our defined benefit scheme, they retain this for the course of their employment, subject to any changes to the rules agreed by trustees and the employer.

The Committee makes sure that the equality and diversity implications of remuneration policy and related decisions are considered appropriately. Specifically:

- any salary differentials are supported by a formal job evaluation or independent external market advice
- any decisions relating to variable pay are supported by an objective assessment of performance
- any adjustment or changes to remuneration arrangements do not discriminate unlawfully
- other decisions relating to terms of service are supported by appropriate advice on any equality and diversity implications.

2020 financial review

The accounts for the year ended 31 December 2020 have been prepared in accordance with the *Charities Statement of Recommended Practice (FRS 102)*.

Our total income and expenditure in 2020

The coronavirus (COVID-19) pandemic had a significant impact on our activities throughout 2020, but we continued to deliver many of our core services to support doctors and patients.

In 2020, we generated unrestricted income of £108.3 million, which was £1.7 million lower than 2019. This was due to the impact of the spread of coronavirus, which resulted in the temporary closure of our Clinical Assessment Centre, and subsequent reopening with reduced capacity to allow social distancing measures to be put in place. This reduced our income from PLAB test fees, with a subsequent impact on income from new registrations.

In addition, the Department of Health and Social Care (DHSC) provided £1.6 million of funding in 2020 to start implementation work to bring physician associates and anaesthesia associates under regulation with the General Medical Council. The DHSC funding is restricted in nature, and so is shown separately in the accounts. The funding was fully spent in 2020.

We also generated £2.5 million of gains on our investments in 2020. This was lower than 2019, in part due to the impact of the pandemic on financial markets and in part because of particularly strong investment performance in 2019.

Our total operational expenditure in 2020 was £109.6 million, which was a reduction of £4.8 million compared with 2019. Despite the impact of the pandemic, our contact centre remained open throughout 2020 and we continued processing applications for registration and running online courses for doctors new to UK practice. We also made changes to our regulatory activities so doctors could spend more time on clinical care, such as deferring revalidation dates and postponing our national training survey. However, tribunals were temporarily postponed, and then restarted with reduced capacity due to social distancing, which reduced our costs in 2020. PLAB running costs were also lower, and there were reductions in office costs, travel, and events.

Our 2020 accounts also include a provision of £3.7 million to meet potential costs arising from legal claims.

We set an efficiency target to generate savings of £2.0 million (2% of directorate budgets), which we felt was a realistic target that wouldn't impact on quality standards. Our ability to generate savings was constrained as we concentrated our efforts on handling the impact of the pandemic, but we still managed to deliver cost savings of £1.5 million by rationalising our accommodation requirements and deferring recruitment to vacant posts.

The charity had no fundraising activities requiring disclosure under S162A of the Charities Act 2011.

Reserves policy and going concern

Our level of reserves and our reserves policy are reviewed annually, and any financial implications are addressed as part of the budget-setting process.

Our total reserves are made up of free reserves, reserves backed by fixed assets, and pension reserves.

We hold free reserves:

- to provide working capital to undertake our normal day-to-day business
- to provide funds to deal with any risks that materialise
- to provide funds to respond to new initiatives, opportunities and challenges that present themselves
- to cover the time period before any changes to fee levels take full effect.

A significant proportion of our total reserves is represented by fixed assets, which cannot easily be converted into cash at short notice without adversely affecting our ability to fulfil our charitable aims and statutory obligations. The value of fixed assets is therefore disregarded for reserves policy purposes.

The value of pension reserves is also disregarded for reserves policy purposes. The defined benefit scheme was closed to future accruals in 2018, and any deficit or surplus in the scheme can be managed over the medium term, so has no immediate impact on free reserves in the short term.

There is no standard formula that can be used to calculate the ideal level of free reserves. We follow the Charity Commission's guidance and set a target range based on our cash flow requirements and an assessment of the risks facing the organisation. We aim to hold free reserves at a level that is not excessive, but does not put our solvency at risk.

Based on our analysis of cash flows and the risks facing the organisation, our policy is to maintain free reserves in the range of £25 million to £45 million. However, we recognise that the level of reserves will inevitably fluctuate year on year, reflecting variations in actual levels of income and expenditure compared with the budget. Our policy is to maintain actual free reserves in line with the target level over the medium term. If our actual reserves vary significantly from the target range set out in the reserves policy, we take action to address the variation as part of the annual budget-setting process to bring actual reserves back into line within a reasonable period.

Our total reserves at the end of 2020 were £64.6 million, made up of free reserves of £42.7 million, plus £17.9 million of reserves represented by fixed assets, and a pension reserve of £4.0 million.

The spread of the coronavirus (COVID-19) had a significant impact on our activities throughout 2020, and in overall terms our net costs were lower than planned. While the pandemic continues to constrain our activities in the early part of 2021, we are planning for our expenditure to be higher than our income in 2021 as we put in place recovery plans to return our operational activities to full capacity. We estimate that our free reserves will reduce to around £41.4 million at the end of 2021, which is consistent with our reserves policy. We will be reviewing our reserves policy later in 2021, prior to setting the 2022 budget.

The majority of our income comes from registration fees paid by doctors. All doctors must be registered with us to practise medicine in the UK, and so our income is relatively certain. Despite the impact of the pandemic, trustees remain of the view that the GMC is a going concern for the foreseeable future, and therefore have prepared the financial statements on a going concern basis.

There are no material uncertainties related to events or conditions that cast significant doubt on our financial stability for the foreseeable future.

Investment policy

Council is responsible for determining and reviewing the overall investment policy, objectives, risk appetite and target returns. Council has delegated to the Investment Sub-Committee responsibility for implementing the investment policy, appointing and managing fund managers, monitoring performance and reporting to Council.

Our investment policy separates our funds into four categories:

- those which are required as working capital for the normal day-to-day operation of the business
- those which we may invest under management
- those which we may invest in a trading subsidiary
- any residual cash balance.

We hold a minimum of £15 million as working capital for normal cash flow purposes. This is held in instant access bank accounts and provides sufficient flexibility to avoid temporary borrowing and/or the need to liquidate investments to deal with short-term variations in operational income and expenditure.

We originally invested £50 million under management in June 2019. Our target rate of return on funds invested under management is inflation (CPI) plus 2% over a rolling five-year period. This reflects our cautious approach to risk. We seek to provide protection against inflation; to generate a modest level of return; and to diversify our funds to reduce the risk of capital and/or revenue loss.

We have adopted a comprehensive ethical approach to investments. We believe that investing in certain companies or sectors would conflict with our charitable aims, or may create reputational damage. We do not wish directly to profit from, or provide capital to, activities that are materially inconsistent with our charitable aims and so we specifically exclude investment in companies that derive more than 10% of their revenue from: tobacco, alcohol, gambling, pornography, high-interest rate lending, cluster munitions and landmines, and the extraction of thermal coal or oil sands. We do not invest in companies that are under investigation for, or have been found guilty of, tax evasion or money laundering in the past three years.

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

We invest only through fund managers who demonstrate the strongest environmental, social and governance (ESG) credentials. When appointing fund managers, we take into consideration how they incorporate an assessment of a company's performance on ESG issues in their stock selection.

Our funds under management were valued at £57 million at the end of 2020, compared with £54.8 million at the start of the year. We generated a return of 4.55% in 2020 compared with a target of 2.65%.

We invested £0.6 million as share capital in GMC Services International Limited, a trading subsidiary of the GMC, at the end of 2016. Our investment at the end of 2020 was valued at £0.2 million.

Any residual cash not held as working capital or invested is held in medium-term deposits and/or interest-bearing accounts. We generated interest of £0.2 million on our cash balances, equivalent to an average annual rate of return of 0.47%. Cash held as working capital, and any residual cash, is shown on our balance sheet within current assets.

GMC Services International Limited

The trading subsidiary was incorporated as a private company limited by shares on 16 December 2016. It is a wholly owned subsidiary of the GMC and provides services on a commercial basis, including consultancy, training and accreditation. One of its main objectives is to introduce new revenue streams and so reduce the GMC's reliance on core financial resources. It will do this by gifting its profits back to the GMC for the purpose of delivering the GMC's charitable aims.

The GMC invested £0.6 million as share capital in GMCSI. In its early years of operation GMCSI generated net losses, but has been able to generate modest profits in the past two years. In 2020, GMCSI generated a net profit of £13,614 and ended the year with net assets of £237,854 and so no profits have been gift-aided back to the GMC. GMCSI is projected to generate further profits over the medium term.

The accounts presented here are consolidated group accounts to include our trading subsidiary GMCSI. The statement of financial affairs shows the consolidated position for the GMC and GMCSI combined. The balance sheet shows separate columns for the group position (GMC and GMCSI combined) and the parent charity position (GMC). Separate company accounts have been prepared for GMCSI.

Trustees' responsibilities for the financial statements

The trustees are responsible for preparing the trustees' annual report and the financial statements in accordance with applicable law and United Kingdom Generally Accepted Accounting Practice (United Kingdom Accounting Standards). The law applicable to charities in England, Scotland and Wales requires the trustees to prepare financial statements for each financial year which give a true and fair view of the state of affairs of the charity and the group and of the incoming resources and application of resources of the group for that period.

In preparing these financial statements, the trustees are required to:

- select suitable accounting policies and then apply them consistently
- observe the methods and principles in the *Charities SORP*
- make judgements and estimates that are reasonable and prudent
- state whether applicable accounting standards have been followed, subject to any material departures being disclosed and explained in the financial statements
- prepare the financial statements on the going concern basis unless it is inappropriate to presume that the charity will continue in business.

The trustees are responsible for keeping adequate accounting records that are sufficient to show and explain the charity's transactions and disclose, with reasonable accuracy at any time, the financial position of the charity and enable them to ensure that the financial statements comply with the *Charities Act 2011*, the *Charity (Accounts and Reports) Regulations 2008*, the *Charities and Trustee Investment (Scotland) Act 2005*, the *Charities Accounts (Scotland) Regulations 2006* (as amended), the Privy Council Directions issued under the *Medical Act 1983* and the provisions of the charity's constitution. They are also responsible for safeguarding the assets of the charity and the group and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

Related party transactions

We require that all trustees and senior managers disclose details of any organisations in which they (and their close family members and business partners) hold a position of authority or other material interest and whose business could bring them into financial contact with the GMC. Details of any actual transactions between the GMC and related parties in the year must also be disclosed. We also publish a register of interests on our website.

In 2020, all disclosures were made and there were no issues of concern.

Audit and Risk Committee report 2020

The Audit and Risk Committee plays a key role in our governance. The Committee provides Council with independent assurance about:

- the integrity of our financial statements
- the effectiveness of internal control, governance and risk management systems
- the delivery of internal and external audit services.

It also monitors our anti-fraud policies and any risks relating to the General Data Protection Regulations, and reviews arrangements for raising concerns.

The Committee bases its advice and decisions on guidance issued by the Financial Reporting Council, the Charity Commission, the Office of the Scottish Charity Regulator and, where appropriate, independent external advice.

At the beginning of 2020, there were seven members on the Committee – five Council members and two co-opted members. The Committee welcomed a new Council member in February and another Council member stood down in May. Co-opted, or independent, members enhance the work of the Committee by bringing valuable additional skills and experience to the independent scrutiny of on finance, risk and governance. All members of the Committee participate in an annual appraisal process.

In 2020, the Committee met five times and submitted two formal reports on its work and findings to Council. As well as this, Committee members had the opportunity to learn more about, and scrutinise, specific areas of the business and their risks, in three seminar sessions.

The Committee bases its annual work programme on risk and our Corporate Opportunities and Risk Register reflects the key strategic risks we manage. The Committee's oversight and scrutiny play a valuable role in assuring that risks are being managed and opportunities are enhanced through effective systems of governance, internal control and risk management arrangements.

Key activities during 2020

2020 was an unusual year and the risks we faced changed with the onset of the pandemic. In March, the Committee paused its planned internal audit programme. It felt able to do this given the assurance it had from previous years on the strength of the internal systems of governance and control, as well as the embedded risk management arrangements.

The remaining internal audit programme was refocused on a series of learning reviews, providing scrutiny, support and assurance of the adaptations we made in our operations and ways of working. It also monitored and considered new risks emerging in the external environment.

At each of its meetings, the Committee:

- discussed a wide range of strategic risks to provide an important backdrop to its understanding of the challenges and opportunities the GMC was facing from the pandemic
- considered the assurance it had with respect to how the organisation was responding to emerging threats and opportunities
- challenged the corporate opportunities and risk register
- continued support for risk maturity evolution in line with the principles of effective risk management set out in the international guidance standard (ISO 31000:2009)
- scrutinised audit and learning review findings to satisfy itself that the actions being taken were appropriate
- monitored the implementation of recommendations made in previous audit reports to make sure they were being managed effectively by senior management
- reviewed any findings and lessons learnt from work undertaken in relation to significant adverse events.

Other key activities in the year included:

- approving the external audit letter of engagement and scrutinising the Annual Report and Accounts 2019, including the outcome of the external auditor's work on the financial statements and annual report – given the economic implications of the pandemic, this included a focus on whether, and an assurance that, the GMC could continue its activities beyond 2020
- reviewing the Head of Internal Audit annual report and opinion
- commissioning an independent test of the GMC's cyber security control arrangements

- reviewing concerns raised to the Freedom to Speak Up Guardian as reported in the latter's 2019 Annual Report
- holding a seminar to understand the holistic picture of local, central and independent quality controls and assurance, to inform its decision on internal audit focus for 2021.

Each year, the Committee also commissions an independent review of the GMC's arrangements for compliance with BS 10008 – the Evidential weight and legal admissibility of electronically stored information (ESI) Specification to which the GMC became fully accredited in 2016. The independent reviewer was complimentary about our work, concluding that the information management system at the GMC is effective in ensuring the trustworthiness of electronic information. They were also impressed with the organisation's response to the pandemic and its ability to maintain standards during a challenging period.

Risk management

To achieve more influence beyond the immediate remit of doctors, we must also work with others to maximise our impact and manage risks and their implications on others sensitively.

During 2020, we continued to use opportunities to contribute to external debate on supporting the UK Government's response to the pandemic and working with partners to support safe working environments for all healthcare professionals, including doctors.

Risk thinking is also inherent in our discussions and operations at all levels of the business. We have a mature set of risk management arrangements embedded in our day-to-day activities and use risk registers as a tool for identifying, articulating, monitoring and managing operational and project risks. We also have robust governance arrangements with risks and opportunities escalated to the Executive Board for action when needed.

Our corporate opportunities and risk register is published regularly on our website through the Chief Executive's report to Council.

Managing risks in 2020

While responding to the pandemic raised some significant challenges, it also brought opportunities to review how we manage our operations and ways of working, both as a regulator and as an employer.

Our priority focus throughout 2020 has been to protect patients, support the medical workforce, and promote the health and wellbeing of our own colleagues. For more information about the initiatives involved with this, see page 20 onwards.

Managing non-pandemic risks and opportunities

Alongside our work in response to managing the pandemic, we continued to progress other priorities, including:

- driving work forward on our *Supporting a profession under pressure* programme as part of our commitment to becoming a proactive regulator (see page 31)
- managing preparations for the impact of Brexit (see page 44)
- preparing for the introduction of the Medical Licensing Assessment (see page 26)
- responding to a range of important public investigations and inquiries, such as the Independent Neurology Inquiry in Northern Ireland, the Shrewsbury and Telford investigation on maternity care and the Inquiry into the death of Elizabeth Dixon.

During 2020, we also carried out an internal review of the case of Teodora Crisovan. Crisovan is a Romanian national who used fraudulent documentation to gain registration and a licence to practise in the UK. She came to our attention through a telephone call to our helpline expressing concerns about her being a qualified doctor. We responded promptly, protecting patient safety with an interim order, notifying the Police of criminal action and, shortly afterwards, removing her from the register of licensed medical practitioners.

Crisovan was registered under a provision in the *Medical Act 1983* that covers the registration of nationals from any one of the 29 countries in the EEA. We have long expressed our concerns with the significant risks of this route to registration, as the provision allowed EEA nationals with recognised medical qualifications an automatic entitlement to GMC registration.

Since 1 January 2021, the GMC is no longer prevented by EEA legislation from carrying out primary source verification checks on medical qualifications awarded to EEA nationals. All EEA applicants now need to meet the same requirement as international medical graduates and have their medical qualifications independently verified before they apply for registration. We are also able to require EEA doctors to provide evidence of their English language skills upfront before they apply for registration.

Our internal review of the case provided further opportunities to identify areas of our procedures that could be further strengthened beyond the changes brought about by leaving the EU.

- We'll provide refresher fraud awareness training on a more regular basis going forward, to help colleagues keep abreast of the complex and sophisticated techniques being used.
- We're checking the medical qualifications at source of a random sample of doctors who were granted registration without an ID check. Once we've completed checks on this sample and analysed the results, a risk-based decision will be made as to whether we should proceed to check a further sample.

Beyond 2020

For the foreseeable future, there remains an unprecedented and turbulent external landscape. The continuing uncertainty creates a dynamic environment with both significant challenges and rich opportunities. In December 2020, we published our ambitious new Corporate strategy 2021–2025 and the pandemic provides a backdrop against which to push our agenda forward in 2021 and beyond. Active risk management of both opportunities and threats will be key to supporting us in making lasting progress.

Key opportunities

Externally, we have the opportunity to:

- continue working on a legislative reform agenda that transforms us (and other regulators) into a progressive, modern and flexible regulator
- generate more pace through our collaboration and influence with key partners to create supportive and more inclusive working environments for healthcare professionals
- influence and reshape medical education content, training pathways, delivery and assessment.

Internally we will be seeking to:

- refresh and evolve ways of working to enhance business recovery, building on the learning and progress in responding to the pandemic
- advance ways of working that support a culture of inclusivity and innovation
- reshape our working environment.

Key challenges

There will also be challenges for us to navigate as a regulator and employer, including:

- developing the capacity to deliver policy and operational change at speed and scale to grasp the opportunity legislative reform provides
- responding to increasing numbers of complex public inquiries simultaneously
- maintaining effective collaboration with key partners whose capacity and organisational efforts are focused on responding to the pandemic
- sustaining operational momentum as we deal with workload pressures arising from the pandemic
- balancing the continued pressures and potential impact on the wellbeing of our colleagues.

Our approach around protecting patients through listening, learning and remaining flexible is more critical than ever before. We are confident about what we want to achieve and the direction of travel our strategy describes. But we are not complacent about the size of the challenge. Much of what we do requires us to work sensitively and compassionately with others if we are to influence and bring about real change for patients and doctors. That change is to happen in conjunction with broader, seismic shifts in societal, family and working lives and values. We must reflect on this, and like others listen, learn and adapt if we are to continue keeping patients safe, being a respected regulator and a valued employer.

Approved by the trustees on 9 June 2021 and signed on their behalf by:



Dame Clare Marx

Chair of Council

Independent auditors' report to the trustees of the General Medical Council

We have audited the financial statements of the General Medical Council ('the charitable company') and its subsidiary ('the group') for the year ended 31 December 2020 which comprise the Consolidated Statement of Financial Activities, Consolidated Balance Sheet, Consolidated Statement of Cash Flows and notes to the financial statements, including significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and United Kingdom Accounting Standards, including Financial Reporting Standard 102 The Financial Reporting Standard applicable in the UK and Republic of Ireland (United Kingdom Generally Accepted Accounting Practice).

In our opinion the financial statements:

- give a true and fair view of the state of the group's and the charitable company's affairs as at 31 December 2020 and of the group's incoming resources and application of resources, including its income and expenditure for the year then ended;
- have been properly prepared in accordance with United Kingdom Generally Accepted Accounting Practice; and
- have been prepared in accordance with the requirements of the Companies Act 2006, the Charities and Trustee Investment (Scotland) Act 2005 and Regulations 6 and 8 of the Charities Accounts (Scotland) Regulations 2006 (amended).

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the charitable company in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the trustee's use of the going concern basis of accounting in the preparation of the financial statements is appropriate. Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the charitable company's or the group's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue. Our responsibilities and the responsibilities of the trustees with respect to going concern are described in the relevant sections of this report.

Other information

The trustees are responsible for the other information contained within the annual report. The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Opinions on other matters prescribed by the Companies Act 2006

In our opinion based on the work undertaken in the course of our audit:

- the information given in the trustees' report, which includes the directors' report and the strategic report prepared for the purposes of company law, for the financial year for which the financial statements are prepared is consistent with the financial statements; and
- the strategic report and the directors' report included within the trustees' report have been prepared in accordance with applicable legal requirements.

Matters on which we are required to report by exception

In light of the knowledge and understanding of the group and charitable company and their environment obtained in the course of the audit, we have not identified material misstatements in the strategic report or the directors' report included within the trustees' report.

We have nothing to report in respect of the following matters in relation to which the Companies Act 2006 and the Charities Accounts (Scotland) Regulations 2006 requires us to report to you if, in our opinion:

- adequate and proper accounting records have not been kept; or
- the financial statements are not in agreement with the accounting records and returns; or
- certain disclosures of trustees' remuneration specified by law are not made; or
- we have not received all the information and explanations we require for our audit.

Responsibilities of trustees

As explained more fully in the trustees' responsibilities statement set out on page 71, the trustees (who are also the directors of the charitable company for the purposes of company law) are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such

internal control as the trustees determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the trustees are responsible for assessing the charitable company's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the trustees either intend to liquidate the charitable company or to cease operations, or have no realistic alternative but to do so.

Auditor's responsibilities for the audit of the financial statements

We have been appointed as auditor under section 44(1)(c) of the Charities and Trustee Investment (Scotland) Act 2005 and under the Companies Act 2006 and report in accordance with the Acts and relevant regulations made or having effect thereunder.

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Details of the extent to which the audit was considered capable of detecting irregularities, including fraud and non-compliance with laws and regulations are set out below.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Extent to which the audit was considered capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We identified and assessed the risks of material misstatement of the financial statements from irregularities, whether due to fraud or error, and discussed these between our audit team members. We then designed and performed audit procedures responsive to those risks, including obtaining audit evidence sufficient and appropriate to provide a basis for our opinion.

We obtained an understanding of the legal and regulatory frameworks within which the charitable company and group operates, focusing on those laws and regulations that have a direct effect on the determination of material amounts and disclosures in the financial statements. The laws and regulations we considered in this context were the Companies Act 2006, Medical Act 1983 and The Charities and Trustee Investment (Scotland) Act 2005 together with the Charities SORP (FRS102). We assessed the required compliance with these laws and regulations as part of our audit procedures on the related financial statement items.

In addition, we considered provisions of other laws and regulations that do not have a direct effect on the financial statements but compliance with which might be fundamental to the charitable company's and the group's ability to operate or to avoid a material penalty. We also considered the opportunities and

incentives that may exist within the charitable company and the group for fraud. The laws and regulations we considered in this context for the UK operations were, General Data Protection Regulation (GDPR), and employment legislation.

Auditing standards limit the required audit procedures to identify non-compliance with these laws and regulations to enquiry of the Trustees and other management and inspection of regulatory and legal correspondence, if any.

We identified the greatest risk of material impact on the financial statements from irregularities, including fraud, to be within the timing of recognition of income, estimates surrounding legal provisions and the override of controls by management. Our audit procedures to respond to these risks included enquiries of management, internal audit, legal counsel and the Audit & Risk Committee about their own identification and assessment of the risks of irregularities, sample testing on the posting of journals, reviewing accounting estimates for biases, reviewing regulatory correspondence with the Charity Commission, performing data analytics on ARF and PLAB income and reading minutes of meetings of those charged with governance.

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations (irregularities) is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it. In addition, as with any audit, there remained a higher risk of non-detection of irregularities, as these may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. We are not responsible for preventing non-compliance and cannot be expected to detect non-compliance with all laws and regulations.

Use of our report

This report is made solely to the charitable company's members, as a body, in accordance with Chapter 3 of part 16 of the Companies Act 2006, and to the charitable company's trustees, as a body, in accordance with Regulation 10 of the Charities Accounts (Scotland) Regulations 2006. Our audit work has been undertaken so that we might state to the charitable company's members and trustees those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the charitable company, the charitable company's members as a body and the charitable company's trustees as a body, for our audit work, for this report, or for the opinions we have formed.

N. Hashemi

Naziar Hashemi
Senior Statutory Auditor
For and on behalf of
Crowe U.K. LLP
Statutory Auditor
2nd Floor, 55 Ludgate Hill
London
EC4M 7JW
Date: 2nd July 2021

Accounts 2020

Consolidated statement of financial activities for the year ended 31 December 2020

Income	Note	Unrestricted funds	Restricted funds	Total 2020 £'000	Total 2019 £'000
From charitable activities					
Registration	2	103,042	-	**103,042**	**103,258**
Specialist and GP registration	2	4,052	-	**4,052**	**3,828**
Revalidation	2	54	-	**54**	**173**
Other trading activities	3	193	-	**193**	**264**
Commercial trading operations	3	316	-	**316**	**494**
Investments	3	388	-	**388**	**1,394**
Department of Health funding - MAPS *	3	-	1,577	**1,577**	**220**
Other	3	242	-	**242**	**400**
Total incoming resources		108,287	1,577	**109,864**	**110,031**
Expenditure					
Raising funds					
Commercial trading operations	5	302	-	**302**	**473**
Investment management costs	5	221	-	**221**	**142**
		523	-	**523**	**615**
Charitable activities					
Fitness to practise		43,349	-	**43,349**	**43,748**
Registration and revalidation		25,632	-	**25,632**	**28,127**
External relationships		15,269	-	**15,269**	**16,435**
Medical Practitioners Tribunal Service		11,387	-	**11,387**	**12,971**
Education		10,112	-	**10,112**	**10,392**
Standards		1,776	-	**1,776**	**1,880**
Department of Health funding - MAPS		-	1,577	**1,577**	**220**
Other expenditure					
Legal provision		3,744	-	**3,744**	**170**
Total expenditure	5	111,792	1,577	**113,369**	**114,558**
Net gains/(losses) on investments	9	2,476	-	**2,476**	**4,328**
(Net Loss)/Net income		(1,029)	-	**(1,029)**	**(199)**
Other recognised gains and losses					
Actuarial (loss)/gain on defined benefit pension scheme	16	(6,971)	-	**(6,971)**	**(24,826)**
Net movement in funds		(8,000)	-	**(8,000)**	**(25,025)**
Total funds brought forward		72,581	-	**72,581**	**97,606**
Total funds carried forward		64,581	-	**64,581**	**72,581**

The General Medical Council incorporated a wholly owned trading subsidiary on 16 December 2016 with the purpose of providing services on a commercial basis including consultancy, training and accreditation. The Charity has taken exemption from presenting its unconsolidated profit and loss account. The charity movement in funds for the year is £7,943,000.

* The Department for Health and Social Care (DHSC) provided funding in 2020 to start implementation work to bring medical associate professionals (MAPs) under regulation with the General Medical Council. Funding was restricted in nature, and was fully spent in the year so the net impact on GMC reserves is nil. All GMC reserves at the year-end are unrestricted.

Balance sheet

		2020		2019	
		Group	**Charity**	Group	Charity
Fixed assets	**Note**	**£'000**	**£'000**	£'000	£'000
Intangible fixed assets	7	10,361	10,361	9,744	9,744
Tangible fixed assets	8	7,519	7,519	9,254	9,254
Investments	9	57,020	57,257	65,049	65,273
		74,900	**75,137**	**84,047**	**84,271**
Current assets					
Debtors and prepayments	10	23,349	23,303	21,149	21,045
Cash and bank balances		38,128	37,882	30,667	30,350
		61,477	**61,185**	**51,816**	**51,395**
Liabilities					
Creditors: amounts falling due within one year	11	(71,067)	(71,012)	(71,394)	(71,197)
Net current liabilities		(9,590)	(9,827)	(19,578)	(19,802)
Total assets less current liabilities		**65,310**	**65,310**	**64,469**	**64,469**
Provisions for liabilities and charges	12	(4,717)	(4,717)	(1,279)	(1,279)
Net assets excluding pension scheme asset		**60,593**	**60,593**	**63,190**	**63,190**
Defined benefit pension scheme asset	16	3,988	3,988	9,391	9,391
Total net assets		**64,581**	**64,581**	**72,581**	**72,581**
Unrestricted income funds		60,593	60,593	63,190	63,190
Pension reserve		3,988	3,988	9,391	9,391
Total Funds	13	**64,581**	**64,581**	**72,581**	**72,581**

The financial statements were approved by the trustees and authorised for issue on 9 June 2021. They were signed on behalf of trustees by:



Dame Clare Marx
Chair of Council

Consolidated cash flow statement

	2020		2019	
Cash flows from operating activities:	**£'000**	**£'000**	£'000	£'000
Net cash provided by/(used in) operating activities (note i below)		14,064		1,335
Cash flows from investing activities:				
Dividends, interest and rents from investments	180		443	
Purchase of property, plant, equipment and intangibles	(6,783)		(12,074)	
Net cash used in investing activities		**(6,603)**		**(11,631)**
Change in cash and cash equivalents		**7,461**		**(10,296)**

Note (i)

Cash flow from operating activities	
Net (outgoing)/incoming resources	(1,029)
Investment income and interest	(388)
Net investment movement	8,029
Non-cash items – depreciation and amortisation	7,854
Non-cash items – assets written off	47
Pension past service cost and curtailment	-
Pension scheme current service cost	-
Pension scheme contribution	(1,360)
(Increase)/decrease in debtors	(2,200)
Increase/(decrease) in creditors and provisions	3,111
Net cash provided by/(used in) operating activities	**14,064**

Note (ii)	**Short-term deposits**	**Cash at bank and in hand**	**Total**
Cash and equivalents	**£'000**	**£'000**	**£'000**
Balances at 1 January 2020	-	30,667	**30,667**
Net increase in cash and cash equivalents	-	7,461	**7,461**
Balances at 31 December 2020	-	38,128	**38,128**

Notes to the accounts

General information

The legal form and registered office of the GMC is disclosed in the Reference and administrative information section of this report.

1. Principal accounting policies

(i) Accounting convention

The financial statements have been prepared to give a 'true and fair' view and have departed from the Charities (Accounts and Reports) Regulations 2008 only to the extent required to provide a 'true and fair' view. This departure has involved following the Charities SORP (FRS 102) published on 16 July 2014 rather than the Accounting and Reporting by Charities: Statement of Recommended Practice effective from 1 April 2005, which has since been withdrawn.

Our financial statements have been prepared on a going concern basis and in accordance with the Charities Statement of Recommended Practice (FRS 102), applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland, the Charities Act 2011, the Charities and Trustee Investment (Scotland) Act 2005, the Charities Accounts (Scotland) Regulations 2006 and UK Generally Accepted Practice as it applies from 1 January 2015. The GMC meets the definition of a public benefit entity under FRS 102.

At the time of approval of these financial statements, the coronavirus (COVID-19) continues to develop and has been designated a global pandemic by the World Health Organisation. The majority of our income comes from registration fees paid by doctors. All doctors must be registered with us to practise medicine in the UK, and so our income is relatively certain. Despite the current circumstances, trustees remain of the view that the GMC is a going concern for the foreseeable future, and there are no material uncertainties about the charity's ability to continue as a going concern.

(ii) On 16 December 2016 the GMC incorporated a trading subsidiary, GMC Services International LTD, company number 10530157, which is wholly owned by share capital by the General Medical Council.

(iii) The principal accounting policies adopted in the preparation of the financial statements, which have been applied consistently, are detailed below.

Incoming resources

Income is included in the statement of financial activities when all of the following criteria are met.

- Entitlement – control over the rights or other access to the economic benefit has passed to the GMC
- Probability – it is more likely than not that the economic benefits will flow to the GMC
- Measurement - the value can be measured reliably.

The following specific policies apply.

- Annual retention fees relate to services to be provided over a 12-month period. Income is deferred and released to the statement of financial activities on a straight-line basis over the period to which the income relates.
- Registration fees, including provisional registration fees, are recognised when registration is granted.
- Professional and Linguistic Assessments Board (PLAB) fees are recognised when the examinations are sat.

- Income from investments and funds held on deposit is recognised when it is receivable and the amount can be accurately measured.

All income is recognised gross.

Basis for recognising liabilities

Expenditure includes staffing costs, office costs, committee costs, legal costs, accommodation costs, purchase of assets, and financial, actuarial and professional costs.
Resources expended are included in the statement of financial activities on an accruals basis. All liabilities are recognised as soon as there is a legal or constructive obligation committing the charity to expenditure.

Basis for allocation of resources expended

The majority of our resources are expended directly in pursuit of our charitable aims, and are identified as such in the statement of financial activities.
Accommodation costs, governance costs and other support costs are apportioned to charitable activities on the basis of staff head count across the organisation.

Irrecoverable VAT

Any irrecoverable VAT is charged to the statement of financial activities as part of the relevant item of expenditure, or capitalised as part of the cost of the related asset where appropriate.

Taxation

We can take advantage of the exemptions from taxation on income and gains available to charities, so no taxation is payable on the net incoming resources.

Debtors

Trade and other debtors are normally recognised at the settlement amount due after any trade discount offered. Prepayments are normally valued at the amount prepaid net of any trade discounts due.

Creditors and provisions for liabilities

Creditors and provisions are recognised when the charity has a present legal or constructive obligation as a result of a past event. They are recognised when it is probable that a transfer of economic benefit will be required to settle the obligation and a reliable estimate can be made of the amount of the obligation.
Creditors and provisions are normally recognised at their settlement amount after allowing for any trade discounts due.

Critical accounting judgements and key sources of estimation uncertainty

The key sources of estimation uncertainty that have a significant effect on the amounts recognised in the financial statements are:

- All unsettled claims for legal costs made against the GMC are reviewed on a case-by-case basis at the year end. Provisions are based on historical experience and a detailed assessment of the specific details of current cases. The final settlement of cases is dependent on a number of factors, so the accuracy of the provision is subject to a significant degree of uncertainty.
- Provisions for property dilapidation costs are assessed on a case-by-case basis, close to the lease end date when a reasonable estimate of costs can be made.
- Provisions for holiday pay are based on the actual level of accrued days and salaries of each staff member.

Tangible fixed assets

Tangible fixed assets are stated at cost, net of depreciation and any provision for impairment. Expenditure is only capitalised where the cost of the asset or group of assets acquired exceeds £5,000.

Intangible fixed assets

Intangible fixed assets comprise computer software. They are stated at cost, net of amortisation and any provision for impairment. Expenditure is only capitalised where the cost of the asset or group of assets acquired exceeds £5,000.

Depreciation

Depreciation is provided so as to write off the cost, less estimated residual value, of the assets evenly over their estimated lives. In the case of leased assets, the cost is written off over the period of the lease. The period of the lease is determined as the period up to the first break clause, unless our intention is not to exercise the break.

The estimated useful lives are as follows:

- Leasehold buildings and leasehold improvements – the period of the lease or the useful economic life of the asset.
- Furniture, fixtures, and office fittings - the lesser of five years or the remaining term of the lease.
- Information Technology (IT) equipment - three years.
- Intangible assets: (IT software) - three years.
- Other office equipment - three years for IT-related items and five years for all other items.

Depreciation rates are reviewed on a regular basis comparing actual lives of assets with the accounting policy rates.

Operating leases

Rent payable under operating leases is charged to the statement of financial activities on a straight-line basis over the period of the lease.

Financial instruments

The charity has financial assets and liabilities of a kind that qualify as basic financial instruments. Basic financial instruments are initially recognised at transaction value and subsequently measured at amortised cost. Financial assets held at amortised cost consist of cash and bank balances, short-term deposits, investments held in cash deposits together with trade and other debtors. Financial liabilities held at amortised cost comprise trade and other creditors, tax and social security creditors and accruals.

Investments

Our investment policy separates our funds into four categories: those which are required as working capital for the normal day to day operation of the business; those which we invest under management; those which we may decide to invest in a trading subsidiary; and the remaining cash balance which fluctuates during the year. Funds held as cash for the normal day to day operation of the business is shown on the GMC's balance sheet within current assets, while funds held for the longer term is shown as investments.

Pensions

We have a defined benefit pension scheme for permanent employees. The scheme was closed to new members on 30 June 2013, and for future accrual to existing members on 31 March 2018, and replaced by a defined contribution scheme. The surplus or deficit of the defined benefit scheme is recognised on the balance sheet. Changes in the assets and liabilities of the scheme are disclosed and allocated as follows.

- Charges relating to current or past service costs, and gains and losses on settlements and curtailments, are included within staff costs and charged to the statement of financial activities.
- Interest on the net defined benefit asset/liability is shown as a net amount of other finance costs or as an incoming resource alongside investment income and interest. Actuarial gains and losses are recognised immediately in other recognised gains and losses on investment.
- The assets, liabilities and movements in the surplus or deficit of the scheme are calculated by qualified independent actuaries as an update to the latest full actuarial valuation. Details of the defined benefit scheme assets, liabilities and major assumptions are shown in the notes to the accounts.
- Our defined contribution pension scheme was set up on 1 July 2013. Contributions to the scheme are charged to the statement of financial activities in the year in which they are payable to the scheme.
- A small number of staff who transferred to the GMC on the merger with the Postgraduate Medical Education and Training Board (PMETB), contribute to the NHS multi-employer scheme and contributions to the scheme are charged to the statement of financial activities in the year in which they are payable to the scheme.

Funds and reserves

The majority of our funds are unrestricted, and so can be expended at the trustees' discretion in pursuit of our charitable aims.

Termination payments

Termination payments are accounted for as soon as the organisation is aware of the obligation to make the payment.

2. Income from charitable activities

	Unrestricted funds	**Total 2020 £'000**	Unrestricted funds	**Total 2019 £'000**
Registration				
Annual retention fees	93,428	**93,428**	88,179	**88,179**
Registration fees	3,916	**3,916**	4,198	**4,198**
Provisional registration fees	25	**25**	418	**418**
PLAB Fees	5,576	**5,576**	10,357	**10,357**
Other fees	97	**97**	106	**106**
	103,042	**103,042**	103,258	**103,258**
Specialist and GP registration				
Certificates of Completion of Training fees	2,790	**2,790**	2,680	**2,680**
Certificate of Eligibility for Specialist Registration/Certificate of Eligibility for General Practitioner Registration fees	1,220	**1,220**	1,104	**1,104**
Other fees	42	**42**	44	**44**
	4,052	**4,052**	3,828	**3,828**
Revalidation				
Revalidation annual return	48	**48**	116	**116**
Revalidation assessment	6	**6**	57	**57**
	54	**54**	173	**173**

3. Income from raising funds

	Unrestricted funds	Restricted funds	**Total 2020 £'000**	Unrestricted funds	Restricted funds	**Total 2019 £'000**
Activities for raising funds						
Other trading activities*	193	-	**193**	264	-	**264**
Commercial trading operations **	316	-	**316**	494	-	**494**
Other***	242	-	**242**	400	-	**400**
	751	-	**751**	1,158	-	**1,158**
Investment income						
Other finance income – pension scheme (note 16)	208	-	**208**	951	-	**951**
Bank interest	180	-	**180**	443	-	**443**
	388	-	**388**	1,394	-	**1,394**
Department of Health funding						
Funding to cover expenditure on Medical Associate Professionals regulation ****	-	1,577	**1,577**	-	220	**220**

* Other trading activities include the reimbursement of costs of visiting overseas medical schools and the reimbursement of costs of staff seconded to external bodies.

** Income from commercial trading operations is derived from GMC Services International Ltd, a wholly owned subsidiary, which provides services on a commercial basis including consultancy, training & accreditation.

*** Other income includes reimbursement of legal fees from appeals and transaction fees generated through registration status changes.

**** The Department of Health and Social Care have provided funding for the General Medical Council to start implementation work to bring physician associates and anaesthesia associates under regulation with the General Medical Council. The work is ongoing and legislation is expected to be in place for regulation to start in 2022.

4. Financial instruments

	Total 2020 £'000	Total 2019 £'000
Financial assets measured at amortised cost	**57,124**	58,121
Financial liabilities measured at amortised cost	**11,361**	14,008
Financial instruments held at fair value	**57,020**	54,765

The entity's income, expense, gains and losses in respect of financial instruments are summarised below:

Total interest income for financial assets held at amortised cost	**180**	443

5. Total expenditure

	Direct Staffing costs £'000	**Direct Costs £'000**	**Allocated Costs £'000**	**Total 2020 £'000**	Direct Staffing costs £'000	Direct Costs £'000	Allocated Costs £'000	Total 2019 £'000
Expenditure on:								
Commercial trading operations	266	36	-	**302**	397	76	-	473
Investment management costs	-	221	-	**221**	-	142	-	142
Total expenditure on raising funds	266	257	-	**523**	397	218	-	615
Fitness to practise	20,168	4,597	18,584	**43,349**	18,704	7,145	17,899	43,748
Registration and revalidation	10,491	4,403	10,738	**25,632**	9,683	7,688	10,756	28,127
External relationships*	8,992	506	5,771	**15,269**	9,137	881	6,417	16,435
Medical Practitioners Tribunal Service	4,295	3,054	4,038	**11,387**	3,911	5,164	3,896	12,971
Education	6,048	151	3,913	**10,112**	5,949	414	4,029	10,392
Standards	1,002	2	772	**1,776**	1,069	10	801	1,880
Department of Health funding - MAPs	1,185	392	-	**1,577**	175	45	-	220
Total charitable expenditure	52,181	13,105	43,816	**109,102**	48,628	21,347	43,798	113,773
Other expenditure - legal provision	-	3,744	-	**3,744**	-	170	-	170
Total group expenditure	52,447	17,106	43,816	**113,369**	49,025	21,735	43,798	114,558

Notes

*External relationships include the work done by our Outreach services, Strategic Relationships Unit, devolved offices, and European and international development activities.

	Support costs allocated to charitable activities							
	Management	IT	Human Resources	Finance	Procurement	Facilities	Governance	Total 2020
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Fitness to practise	4,041	5,817	1,691	756	154	4,744	1,381	**18,584**
Registration and revalidation	2,335	3,361	977	437	89	2,741	798	**10,738**
External relationships*	1,255	1,806	525	235	48	1,473	429	**5,771**
Medical Practitioners Tribunal Service	878	1,264	367	164	34	1,031	300	**4,038**
Education	851	1,225	356	159	32	999	291	**3,913**
Standards	168	242	70	31	6	198	57	**772**
Total charitable expenditure	9,528	13,715	3,986	1,782	363	11,186	3,256	**43,816**

	Support costs allocated to charitable activities							
	Management	IT	Human Resources	Finance	Procurement	Facilities	Governance	Total 2019
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Fitness to practise	3,469	5,252	2,172	644	184	4,616	1,562	**17,899**
Registration and revalidation	2,084	3,156	1,305	387	111	2,774	939	**10,756**
External relationships*	1,243	1,883	779	231	66	1,655	560	**6,417**
Medical Practitioners Tribunal Service	755	1,143	473	140	40	1,005	340	**3,896**
Education	781	1,182	489	145	41	1,039	352	**4,029**
Standards	155	235	97	29	8	207	70	**801**
Total charitable expenditure	8,487	12,851	5,315	1,576	450	11,296	3,823	**43,798**

Notes

Support costs are allocated to charitable activities on the basis of staff head count across the organisation.

Support cost recharges have been made to both the trading subsidiary, GMCSI, and the MAPs project throughout the year on a direct basis therefore are treated separately to the year end allocation.

Group expenditure by type

	Charitable activities 2020 £'000	Expenditure on raising funds 2020 £'000	Department of Health funding - MAPs 2020 £'000	Other expenditure 2020 £'000	Total 2020 £'000	Charitable activities 2019 £'000	Expenditure on raising funds 2019 £'000	Department of Health funding - MAPs 2019 £'000	Other expenditure 2019 £'000	Total 2019 £'000
Staffing costs	71,692	266	1,185	-	73,143	68,494	397	175	-	69,066
Office costs	1,558	29	392	-	1,979	2,422	68	45	-	2,535
Council and committee costs	435	1	-	-	436	401	1	-	-	402
Panel and assessment costs	9,296	-	-	-	9,296	16,227	-	-	-	16,227
Legal costs	2,627	-	-	3,744	6,371	3,975	-	-	170	4,145
Accommodation costs	6,849	-	-	-	6,849	7,267	-	-	-	7,267
Financial, actuarial and professional costs	3,371	228	-	-	3,599	3,952	149	-	-	4,101
Purchase of assets – charged to revenue	3,795	-	-	-	3,795	3,374	-	-	-	3,374
Assets written off	47	-	-	-	47	26	-	-	-	26
Depreciation	3,070	-	-	-	3,070	2,337	-	-	-	2,337
Amortisation	4,784	-	-	-	4,784	5,078	-	-	-	5,078
	107,524	524	1,577	3,744	113,369	113,553	615	220	170	114,558

Total resources expended include:

	2020	2019
Operating lease costs: leasehold property and equipment	3,505	3,873
Audit fees	43	42

6. Staff

	2020 £'000	2019 £'000
Total costs of all staff		
Salaries	**56,922**	52,297
Social security costs	**5,874**	5,438
Superannuation costs defined benefit scheme	-	-
Superannuation costs defined contribution scheme	**7,928**	7,256
Redundancy costs	-	85
Other staffing costs	**2,419**	3,990
	73,143	69,066

During the year, the General Medical Council made no termination payments (2019: £85,000), and £0 was outstanding at year-end (2019: £0).

Average staff numbers in the year by category	**2020**	2019
Fitness to practise	**460**	417
Registration and revalidation	**266**	251
External relationships	**143**	149
Medical Practitioners Tribunal Service	**100**	91
Education	**97**	94
Standards	**19**	19
Governance & Management	**145**	135
Resources	**211**	197
	1,441	1,353
GMC Services International Ltd	**1**	2
	1,442	1,355

The number of staff whose total employee benefits (excluding employer pension contributions) fell into higher salary bands was:

GMC	**2020**	2019
£60,000-£70,000	57	57
£70,001-£80,000	42	29
£80,001-£90,000	29	29
£90,001-£100,000	12	7
£100,001-£110,000	7	7
£110,001-£120,000	11	10
£120,001-£130,000	7	6
£130,001-£140,000	5	4
£140,001-£150,000	3	2
£150,001-£160,000	-	-
£160,001-£170,000	-	-
£170,001-£180,000	-	-
£180,001-£190,000	-	1
£190,001-£200,000	1	2
£200,001-£210,000	4	3
£210.001-£220,000	-	-
£220,001-£230,000	1	-
£230,001-£240,000	-	-
£240,001-£250,000	-	1
£250,001-£260,000	1	-
£260,001-£270,000	-	-
£270,001-£280,000	-	-
£280,001-£290,000	-	-
£290,001-£300,000	-	1
	180	159

* This includes contractual payments relating to the end of employment.

MPTS	2020	2019
£60,000-£70,000	2	3
£70,001-£80,000	1	1
£80,001-£90,000	2	1
£90,001-£100,000	1	2
£100,001-£110,000	1	-
	7	7
Total	187	166

Number of staff included above for whom retirement benefits are accruing	2020	2019
GMC defined benefit pension scheme	-	-
GMC defined contribution pension scheme	184	163
NHS defined benefit pension scheme	1	1
Not in scheme	2	2
	187	166

The senior management team includes the Chief Executive and six permanent directors in 2020. The Chief Operating Officer left on 13 September 2019 and the role has been removed from the SMT structure. The total employee benefits (including employer pension contributions) of the senior management team was £1,721,836 in 2020. The equivalent figure for 2019 was £1,948,556.

There were no related party transactions in the year that require disclosure other than payments made to Trustees as disclosed in notes 17 and 18.

From November 2018 the Remuneration Committee allowed the senior management team the flexibility to exchange employer pension contributions for salary. A similar arrangement is available to all staff. The change is cost neutral to the GMC as any increase in employers NI liability is paid by the employee as a deduction from salary.

7. Intangible fixed assets

Group and charity

	Computer software and systems development £'000
Cost	
Balance at 1 Jan 2020	**27,430**
Additions	**5,401**
Disposals	**(4,421)**
Balance at 31 December 2020	**28,410**
Amortisation	
Balance at 1 January 2020	**17,686**
Amortisation charge for year	**4,784**
Disposals	**(4,421)**
Balance at 31 December 2020	**18,049**
Net book value at 1 January 2020	**9,744**
Net book value at 31 December 2020	**10,361**

Intangible assets incorporates all IT software development costs including, but not limited to, the development of our strategic applications, Siebel, Livelink and Agresso, the development of IT security systems, facilities management systems and website. Intangible assets also include the systems to support working from home and mobile applications.

8. Tangible fixed assets

Group and charity

	Buildings £'000	Fixtures, furniture and equipment £'000	IT equipment £'000	Total £'000
Cost				
Balance at 1 Jan 2020	2,272	13,214	8,473	**23,959**
Additions*	(84)	534	932	**1,382**
Disposals	-	(395)	(61)	**(456)**
Balance at 31 December 2020	2,188	13,353	9,344	**24,885**
Depreciation				
Balance at 1 January 2020	1,836	6,664	6,205	**14,705**
Depreciation charge for year	82	1,841	1,147	**3,070**
Disposals	-	(348)	(61)	**(409)**
Balance at 31 December 2020	1,918	8,157	7,291	**17,366**
Net book value at 1 January 2020	436	6,550	2,268	**9,254**
Net book value at 31 December 2020	270	5,196	2,053	**7,519**

*Buildings additions includes the reversal of an accrual related to a 2019 project.

9. Investments

Managed funds	Group			Charity			
The valuation at the end of the year consisted of:	Cash & cash equivalents £'000	Listed Investments £'000	Total £'000	Cash & cash equivalents £'000	Listed Investments £'000	Equity Investment in Group Undertakings £'000	Total £'000
As at 1st January 2020	10,284	54,765	**65,049**	10,284	54,765	224	**65,273**
Additions	-	6,993	**6,993**	-	6,993	-	**6,993**
Disposals	(10,284)	(7,214)	**(17,498)**	(10,284)	(7,214)	-	**(17,498)**
Gain on investments	-	2,476	**2,476**	-	2,476	-	**2,476**
Reversal of impairment*	-	-	-	-	-	13	**13**
As at 31 December 2020	**-**	**57,020**	**57,020**	**-**	**57,020**	**237**	**57,257**

* The General Medical Council incorporated a wholly owned trading subsidiary on 16 December 2016. Having previously been impaired by £376k due to trading losses incurred, a reversal of the impairment of £13k at the end of 2020 has been recognised as a result of the profit generated by the company increasing its net assets.

Listed investments are managed by CCLA Investment Management Ltd. Investment management fees of £221,160 were incurred (2019 £142,373).

10. Debtors

	2020		2019	
	Group	**Charity**	Group	Charity
	£'000	**£'000**	£'000	£'000
Amounts falling due within one year				
Registration debtors	**17,539**	**17,539**	15,952	15,952
Prepayments and accrued income	**5,325**	**5,416**	4,835	4,835
Other debtors	**485**	**348**	362	258
	23,349	**23,303**	21,149	21,045

11. Creditors

	2020		2019	
	Group	**Charity**	Group	Charity
	£'000	**£'000**	£'000	£'000
Amounts falling due within one year				
Trade creditors	**1,129**	**1,120**	1,379	1,374
Tax and social security	**1,774**	**1,771**	1,601	1,580
Holiday pay	**1,763**	**1,763**	922	922
Accruals	**8,378**	**8,335**	11,707	11,552
Deferred income	**58,023**	**58,023**	55,785	55,769
	71,067	**71,012**	71,394	71,197

Charity deferred income

Income from annual retention fees is deferred and released to the statement of financial activities on a straight-line basis over the period to which the income relates. All deferred income brought forward from the previous year is automatically released to the statement of financial activities in the following year.

Trading subsidiary deferred income

Income from sponsorship contracts and deposits for hiring the Clinical Assessment Centre is deferred and matched to the relevant time period.

	Annual retention fees £'000	PLAB fees £'000	Specialist and GP registration fees £'000	Revalidation assessment fees £'000	Clinical Assessment Centre hire deposit £'000	Total £'000
Deferred income at 1 Jan 2020	51,864	3,819	21	65	16	**55,785**
Resources deferred during the year	54,927	3,075	21	-	-	**58,023**
Amounts released from previous years	(51,864)	(3,819)	(21)	(65)	(16)	**(55,785)**
Deferred income at 31 Dec 2020	**54,927**	**3,075**	**21**	**-**	**-**	**58,023**

12. Provisions

Group and charity

	2020	2019
	£'000	£'000
Dilapidations	**973**	1,109
Legal claims	**3,744**	170
	4,717	1,279

Dilapidations – Each year we review our property leases and make a provision for dilapidations, where the cost can be reasonably estimated.

Legal claims – Each year we make a provision for potential costs related to ongoing legal cases. In 2020 we increased the provision to reflect potential additional costs that may arise following the outcome of an employment tribunal. The outcome is still outstanding, but may have implications for a wider group of individuals.

	Dilapidations £'000	Legal Claims £'000	Total £'000
Provisions at 1 Jan 2020	1,109	170	**1,279**
Provisions created during the year	973	3,744	**4,717**
Amounts released from previous years	(1,109)	(170)	**(1,279)**
Provisions at 31 Dec 2020	**973**	**3,744**	**4,717**

13. Group fund movements in the year

Group and charity

	Unrestricted funds	Restricted funds	Pension fund	2020 Total
	£'000	£'000	£'000	£'000
At 1 January 2020	63,190	-	9,391	72,581
Net outgoing resources	(2,597)	-	(5,403)	(8,000)
At 31 December 2020	**60,593**	**-**	**3,988**	**64,581**

	Unrestricted funds	Restricted funds	Pension fund	2019 Total
	£'000	£'000	£'000	£'000
At 1 January 2019	66,299	-	31,307	97,606
Net outgoing resources	(3,109)	-	(21,916)	(25,025)
At 31 December 2019	63,190	-	9,391	72,581

14. Capital commitments

Capital expenditure contracted but unspent at 31 December 2020 amounted to £93,288. The equivalent figure for 2019 was £63,518.

15. Operating lease commitments

	Land and buildings		Equipment	
	2020	2019	**2020**	2019
Expiry date	**£'000**	£'000	**£'000**	£'000
Within one year	**3,649**	**3,598**	**145**	**97**
In years two to five	**11,119**	**14,211**	**48**	**48**
After more than five years	**2,876**	**3,673**	**-**	**-**
	17,644	**21,482**	**193**	**145**

Lease commitments are prepared on the cash basis and assumption lease break options are triggered.

16. Superannuation schemes

The GMC has three staff pension schemes.

GMC Group Personal Pension Plan

This is a defined contribution pension scheme, which was set up on 1 July 2013. We started auto enrolment on 1 November 2013. At the end of 2020 there were 1,461 members of staff contributing to this scheme. It meets the government's requirements following the introduction of automatic enrolment. Individuals can choose to make additional contributions by deduction from salary to the scheme. Under the terms of FRS102, contributions are accounted for as a defined contribution scheme based on actual contributions paid through the year.

NHS Multi-Employer Scheme

We have 2 members of staff who contribute to the NHS multi-employer scheme, which is a defined benefit scheme. These staff transferred to the GMC on the merger with PMETB. The scheme operates as a pooled arrangement, with contributions paid at a centrally agreed rate. The trustees are unable to confirm the GMC's share of the underlying assets and liabilities of the NHS scheme and so, under the terms of FRS102, contributions are accounted for as if the scheme were a defined contribution scheme based on actual contributions paid through the year.

GMC Staff Superannuation Scheme

This is a funded scheme of the defined benefit type, providing retirement benefits based on final salary. The top-up arrangement is an unfunded scheme. This scheme was closed to new members on 30 June 2013, and replaced by the GMC Group Personal Pension Plan. The scheme was closed to future accruals for existing members on 31 March 2018 therefore at the end of 2018 there were no members of staff contributing to this scheme.

The FRS 102 valuation has been based on a full assessment of the liabilities for the Scheme as at 31 December 2018. The present values of the defined benefit obligation, the related current service cost and any past service costs were measured using the projected unit credit method.

Actuarial gains and losses have been recognised in the period in which they occur (but outside the profit and loss account) through the Other Comprehensive Income (OCI).

The GMC recognises surplus in accordance with the requirements of FRS 102 Section 18. The trustees of the Scheme do not have the unilateral right to commence wind-up of the Scheme. Thus, the GMC assumes that the Scheme continues in existence until the last benefit payments are made to members, at which point any residual assets are returned to the GMC in line with the rules of the Scheme.

The GMC made a top-up payment to the scheme of £1.3m in 2020 and will contribute a top up payment to the scheme of £1.3m each year between 2021 and 2025.

Responsibility for investing pension scheme assets rests with pension trustees. The Pensions Act 1995 requires trustees to draw up a Statement of Investment Principles, setting out the scheme's investment strategy. Pension trustees are required to consult the employer (GMC) when drawing up the strategy, but do not require the employer's formal agreement. Following consultation with the GMC, in 2014 the pension trustees adopted a fiduciary management approach to the investment of the scheme's assets

The principal assumptions used by the independent qualified actuaries to calculate the liabilities under FRS102 are set out from here.

Main financial assumptions

	31 December 2020 %pa	31 December 2019 %pa
Retail Prices Index inflation	2.7	3.1
Consumer Price Index inflation	2.3	2.2
Rate of general long-term increase in salaries	3.3	3.2
Pension increases (excess over guaranteed minimum pension)	2.3	2.2
Discount rate for scheme liabilities	1.4	2

Mortality assumptions

The mortality assumptions are based on standard mortality tables which allow for expected future mortality improvements. The assumptions are that a member currently aged 65 will live on average for a further 22.6 years (2019 22.6 years) if they are male and for a further 24.4 years if they are female (2019 24.4 years). For a member who retires in 2040 at age 65, the assumptions are that they will live on average for a further 23.2 years after retirement if they are male and for a further 25.4 years after retirement if they are female.

Scheme asset allocation

	31 December 2020		31 December 2019	
	£'000	**%**	£'000	%
Delegated consulting services	**305,166**	**99**	256,418	99
Other	**1,103**	**1**	1,725	1
Total	**306,269**	**100**	258,143	100

The Delegated Consulting Service (DCS) is a fiduciary management solution that invests in a wide range of underlying assets in order to meet the Scheme's specific investment objectives. The underlying asset allocation changes over time, based on the views of the fiduciary manager within the overall bounds set by the trustees. Under this approach the majority of scheme assets are invested in pooled funds. The managers of the pooled funds are required to have in place a policy on social, environmental and ethical considerations.

None of the Scheme assets are invested in the Company's financial instruments or in property occupied by, or other assets used by, the GMC.

Reconciliation of funded status to balance sheet

	31 December 2020	31 December 2019
	£'000	£'000
Fair value of assets	**306,269**	258,143
Present value of funded defined benefit obligations	**(301,086)**	(247,603)
Funded status	**5,183**	10,540
Present value of unfunded defined benefit obligation	**(1,195)**	(1,149)
Asset/(liability) recognised on the balance sheet	**3,988**	9,391

Amounts recognised in income statement

	Year ending	Year ending
	31 December 2020	31 December 2019
	£'000	£'000
Operating cost:		
Current service cost	**-**	-
Past service cost	**-**	-
Financing cost:		
Interest on net defined benefit liability/(asset)	**(208)**	(951)
Pension expense recognised in profit and loss	**(208)**	(951)

Amounts recognised in Other Comprehensive Income (OCI)

	Year ending	Year ending
	31 December 2020	31 December 2019
	£'000	£'000
Asset gains/(losses) arising during the year	**43,589**	21,588
Liability gains/(losses) arising during the year	**(50,560)**	(46,414)
Actuarial gain/(loss) on defined benefit pension scheme	**(6,971)**	(24,826)

Changes to the present value of the defined benefit obligation during the year

	Year ending 31 December 2020 £'000	Year ending 31 December 2019 £'000
Opening defined benefit obligation (DBO)	**248,752**	198,895
Current service cost	**-**	-
Interest expense on DBO	**4,955**	5,735
Actuarial (gains)/losses on liabilities	**50,560**	46,414
Net benefits paid out	**(1,986)**	(2,292)
Past service cost	**-**	-
Closing defined benefit obligation	**302,281**	248,752

Changes to the fair value of Scheme assets during the year

	Year ending 31 December 2020 £'000	Year ending 31 December 2019 £'000
Opening fair value of Scheme assets	**258,143**	230,202
Interest income on Scheme assets	**5,163**	6,686
Gain/(loss) on Scheme assets	**43,589**	21,588
Contributions by the Company	**1,360**	1,959
Net benefits paid out	**(1,986)**	(2,292)
Closing fair value of Scheme assets	**306,269**	258,143

Actual return on Scheme assets

	Year ending 31 December 2020 £'000	Year ending 31 December 2019 £'000
Interest income on Scheme assets	**5,163**	6,686
Gain/(loss) on Scheme assets	**43,589**	21,588
Actual return on Scheme assets	**48,752**	28,274

17. Honoraria

Trustees	2020	2019
Dame Clare Marx (Chair)	110,000	110,000
Mr Steve Burnett	18,000	18,000
Dr Shree Datta *	-	16,500
Lady Christine Eames **	18,000	18,000
Dr Anthony Harnden	18,000	18,000
Lord Philip Hunt	18,000	18,000
Professor Deirdre Kelly **	18,000	18,000
Professor Paul Knight	18,000	18,000
Dame Suzi Leather **	18,000	18,000
Dr Michael Marsh *	-	4,500
Dr Rajesh Patel ***	16,500	-
Dame Denise Platt **	18,000	18,000
Miss Amerdeep Somal **	13,500	18,000
Miss Alison Wright ***	16,500	-

* Demitted as a Council Member in 2019

** Demitted as a Council Member in 2020

*** Appointed as a Council Member in 2020

Honoraria payments are permitted by the governing document of the General Medical Council, The Medical Act 1983, paragraph 17, schedule 1.

Medical Practitioners Tribunal Service committee members	2020	2019
Dame Caroline Swift	92,937	94,255
Mrs Joy Hamilton	3,720	3,720
Professor Jacky Hayden	7,440	6,200
Dr Patricia Moultrie	3,720	3,720
Mrs Judith Worthington	3,720	3,720

Audit and Risk Committee co-opted members	2020	2019
Ms Elizabeth Butler	1,550	2,985
Mr Kenneth Gill	2,170	2,465
Mr John Morley*	-	1,085

* Demitted as co-opted member of the Audit and Risk Committee on 18 July 2019.

Investment Committee co-opted members	2020	2019
Mr Keith Mackay	2,170	1,240
Mr Tim Scholefield	1,860	1,550
Mr David Stewart	-	620

GMCSI	2020	2019
Dr Andrew McCulloch	155	930

18. Travel and subsistence expenses claimed in 2020

Trustees	2020	2019
Dame Clare Marx (Chair)	445	6,008
Mr Steve Burnett	489	2,670
Dr Shree Datta *	-	461
Lady Christine Eames **	1,704	6,157
Dr Anthony Harnden	84	1,904
Lord Philip Hunt	50	1,095
Professor Deirdre Kelly **	420	3,639
Professor Paul Knight	659	3,777
Dame Suzi Leather **	425	2,659
Dr Michael Marsh *	-	165
Dr Rajesh Patel ***	175	-
Dame Denise Platt **	113	2,485
Miss Amerdeep Somal **	1,380	6,131
Miss Alison Wright ***	194	-
Total	**6,138**	**37,151**

* Demitted as a Council Member in 2019

** Demitted as a Council Member in 2020

*** Appointed as a Council Member in 2020

Medical Practitioners Tribunal Service committee members	2020	2019
Dame Caroline Swift	30	1,910
Mrs Joy Hamilton	217	329
Professor Jacky Hayden	316	341
Dr Patricia Moultrie	250	543
Mrs Judith Worthington	207	754

Audit and Risk Committee co-opted members	2020	2019
Ms Elizabeth Butler	21	512
Mr Kenneth Gill	101	777
Mr John Morley*	-	595

*Demitted as co-opted member of the Audit and Risk Committee on 18 July 2019

Investment Committee co-opted members	2020	2019
Mr Keith Mackay	-	77
Mr Tim Scholefield	-	-
Mr David Stewart	-	64

GMCSI	2020	2019
Dr Andrew McCulloch	-	195

Senior management team	2020	2019
Charlie Massey (Chief Executive)	1,071	9,884
Susan Goldsmith – Chief Operating Officer and Deputy Chief Executive *	-	19,760
Paul Buckley - Director of Strategy and Policy **	1,196	6,742
Shaun Gallagher - Director of Strategy and Policy ***	-	-
Una Lane – Director of Registration and Revalidation	1,088	13,318
Colin Melville - Director of Education and Standards	3,314	18,270
Anthony Omo – Director of Fitness to Practise	3,579	9,744
Paul Reynolds-Director of Strategic Communications and Engagement	2,313	26,354
Neil Roberts – Director of Resources and Quality Assurance	5,071	14,161

* Susan Goldsmith left her role as Chief Operating Officer and Deputy Chief Executive on 13 September 2019.

** Paul Buckley left his role as Director of Strategy and Policy on 31 December 2020.

*** Shaun Gallagher was appointed as Director of Strategy and Policy on 01 December 2020.

Variations in expenses reflect that the trustees, committee members and the Senior Management Team live in different parts of the UK and are required to travel around the UK on GMC business, including to our offices in London, Manchester, Edinburgh, Belfast and Cardiff, and occasionally outside the UK.

Adjustments are also made for those with disabilities, which may mean that additional expenses are incurred for travel and accommodation according to specific needs.

Reference and administrative information

We are independent of the four governments of the UK and the medical profession. Our powers are given to us by the UK Parliament through the *Medical Act 1983* and we are accountable to Parliament.

We are registered with the Charity Commission for England and Wales (1089278), and with the Office of the Scottish Charity Regulator (SC037750). We are not currently required to be registered separately with the Northern Ireland Charity Commission.

Our principal places of business are 3 Hardman Street, Manchester M3 3AW and Regent's Place, 350 Euston Road, London NW1 3JN. We also have offices in Belfast, Cardiff and Edinburgh; a centre for hearings, where the MPTS is based, at St James's Buildings, 79 Oxford Street, Manchester M1 6FQ; and a Clinical Assessment Centre, in 3 Hardman Square, Manchester M3 3EB.

Our trustees have a duty to act impartially and objectively, and to take steps to avoid any conflict of interest arising as a result of their membership of, or association with, other organisations or individuals. As trustees, members have a duty to avoid putting themselves in a position where their personal interests conflict with their duty to act in the interests of the charity, unless authorised to do so. To make this fully transparent, we publish a register of members' interests on our website.

Day-to-day management of the organisation is delegated to the Chief Executive, Charlie Massey. You can read more about our governance and management arrangements from page 56.

We work with the Professional Standards Authority (PSA), an independent body, which is accountable to Parliament and scrutinises and oversees our work, together with other health and social care professional regulatory bodies in the UK.

Information requests

In 2020, we received 473 subject access requests under the *General Data Protection Regulation* (GDPR). This was an increase of 0.4% from 2019. The number of information requests we received under the *Freedom of Information Act 2000* (FOI) in 2020 was 634. This was an 1.3% increase from 2019. These numbers both increased, despite a reduction in request intake during March and April at the time of the first national lockdown.

Staff availability and adjustments to working practices due to the pandemic had an impact on our ability to meet our targets in this area in 2020. We achieved 73.1% against our target of responding to 80% of subject access requests within the statutory time frame. We achieved 81% against our 90% target of responding to FOI requests within 20 working days.

Paying for goods and services

We paid 97% of valid and undisputed invoices within 30 days and did not pay any interest to suppliers due to late payment in excess of 30 days.

Professional advisers

Bankers	Royal Bank of Scotland 250 Bishopsgate London EC2M 4AA
Solicitors	The majority of our legal work is carried out by our in-house legal team.
Auditors	Crowe U.K. LLP 2nd Floor, 55 Ludgate Hill London EC4M 7JW
Actuary and pension scheme adviser	Aon Parkside House, Ashley Road Epsom Surrey KT18 5BS

General Medical Council

Annual Report 2020

Trustees annual report and accounts for the year ended 31 December 2020

Presented to Parliament pursuant to section 52A of the Medical Act 1983 as amended by The Health Care and Associated Professions (Miscellaneous Amendments) Order 2008 (SI No.1774).

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The GMC is a charity registered in England and Wales (1089278) and Scotland (SC037750).

Code: GMC/AR2020/0721

General Medical Council