

General Medical Council

Annual Report 2020

Trustees annual report and
accounts for the year ended
31 December 2020

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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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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
- equality, diversity and inclusion
- public protection
- 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

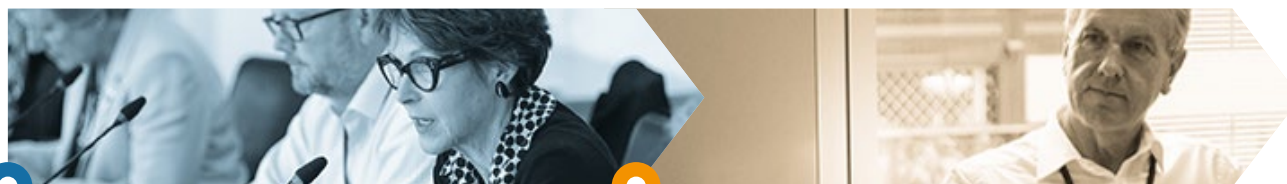
Chief Executive

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.

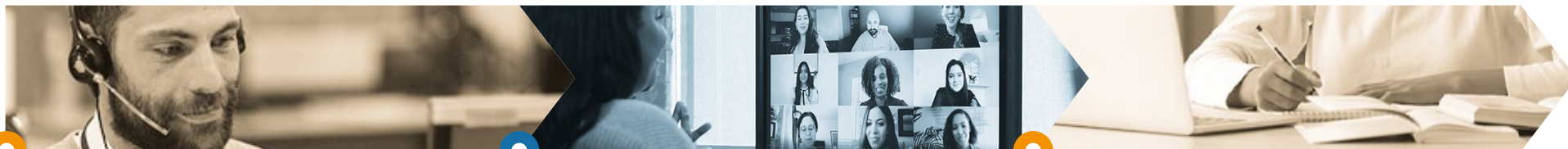
We **temporarily paused requesting information from employers and healthcare professionals in fitness to practice investigations** unless we identified an immediate patient safety concern. We continued to progress investigations where possible, and with the agreement of relevant parties, to minimise 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 register¹

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.

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 register²:

77,679[^]

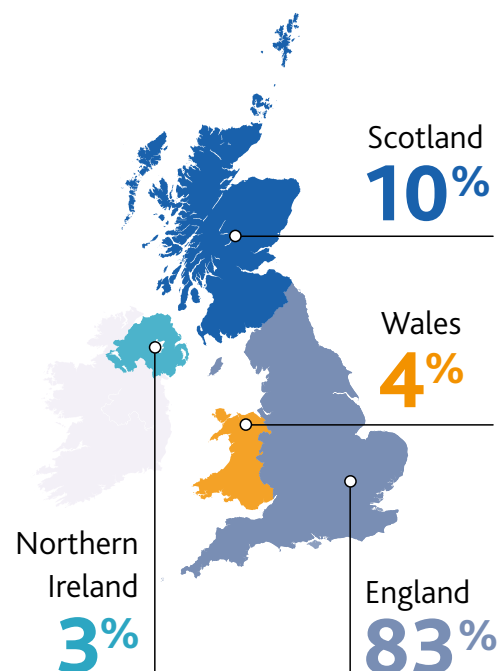


Number of doctors on
specialist register:

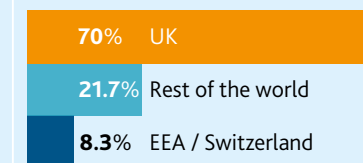
104,412^{2 ^}

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.

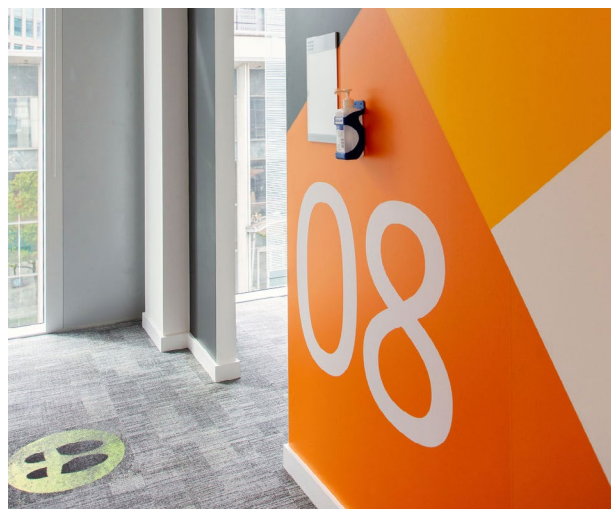
The PLAB day feels very different to how it used to. Most examiners are now remote marking and we are using telephone stations so many of the role-players aren't required to be physically in the room with candidates.

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!

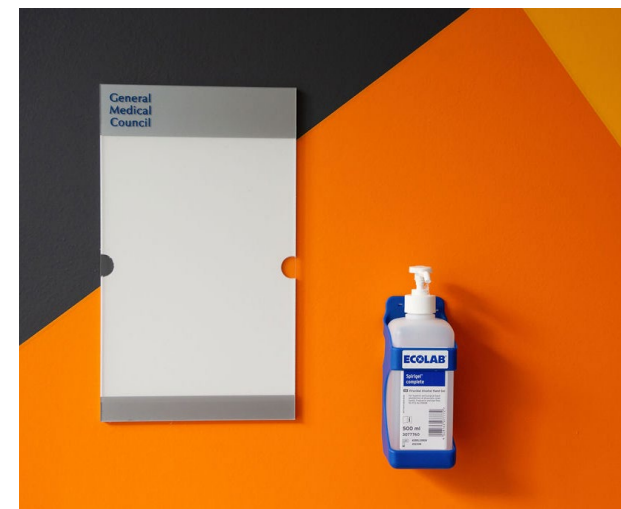
– Feedback from a PLAB 2 candidate



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
process³

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.

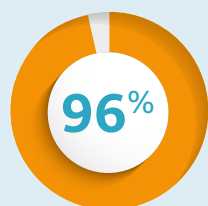
Using provisional enquiries to swiftly assess safety concerns

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.

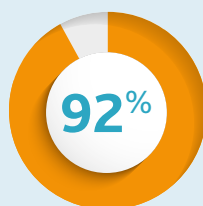
Investigating and acting on concerns

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.



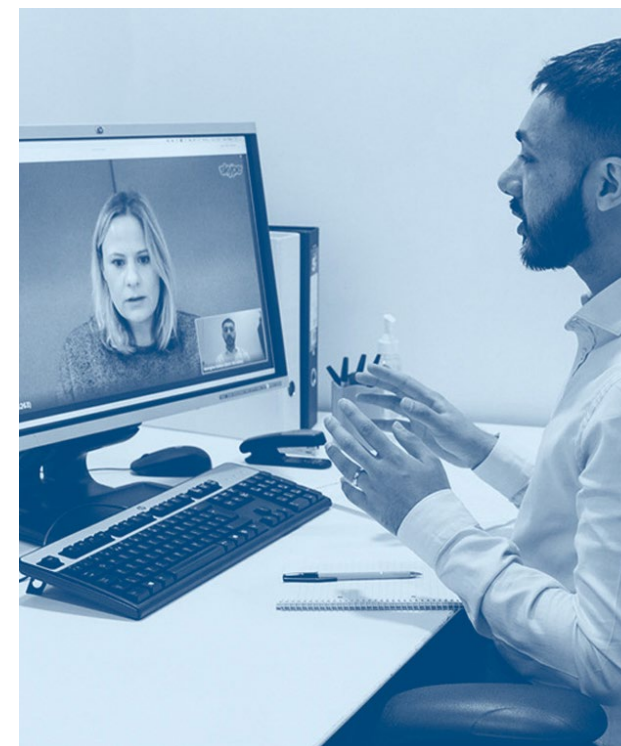
found the meeting
helped them
understand what
action we could take.

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 revalidation⁴ 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 2020⁵. 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-19⁶.

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.

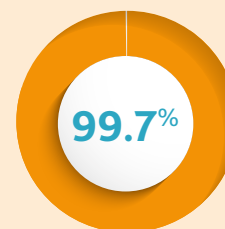
The workshops help doctors adjust to the working culture of the UK healthcare systems and provide practical guidance on ethical scenarios they might encounter. They also give participants a chance to meet other internationally qualified doctors who have also recently started practising in the UK.

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.

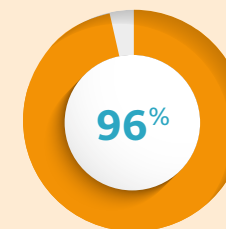
Our Outreach teams engaged with over **13,500 doctors** ✓ and over **7,500 medical students** ✓ across the UK in 2020.



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 results⁸. 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.

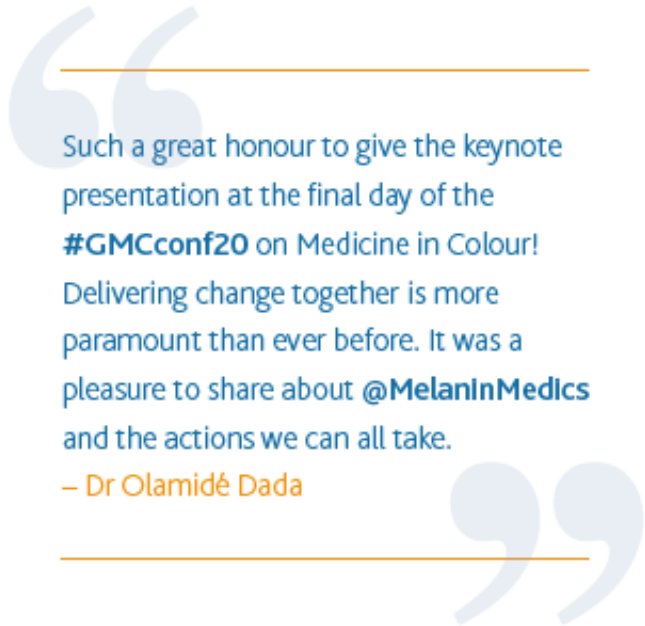
It's crucial to continue the important conversation about what more we can all do to tackle existing inequalities.

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.

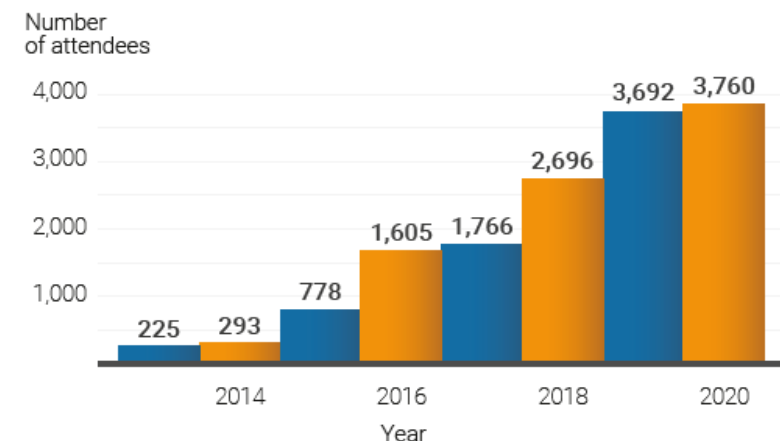
Interactive, interesting and engaging.
Useful interpretation of GMC guidelines.

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.

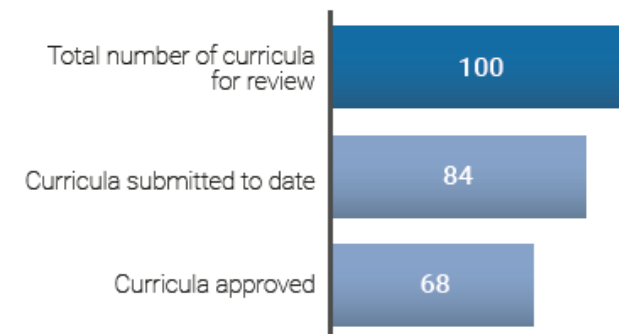
This is important progress against one of a series of commitments we set out in our report, [Adapting for the future: a plan for improving the flexibility of UK postgraduate medical training](#). Key to this development was our work with the Academy of Medical Royal Colleges (AoMRC) to review its arrangements 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.

Reviewing updated postgraduate 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 work⁹.

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 positive⁹.

Our Strategic Relationships Unit held **over 300** meetings with stakeholders and regulatory partners across the UK.

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.

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.



Dame Clare Marx highlights key research findings at the Parliamentary reception

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 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.

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.

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.

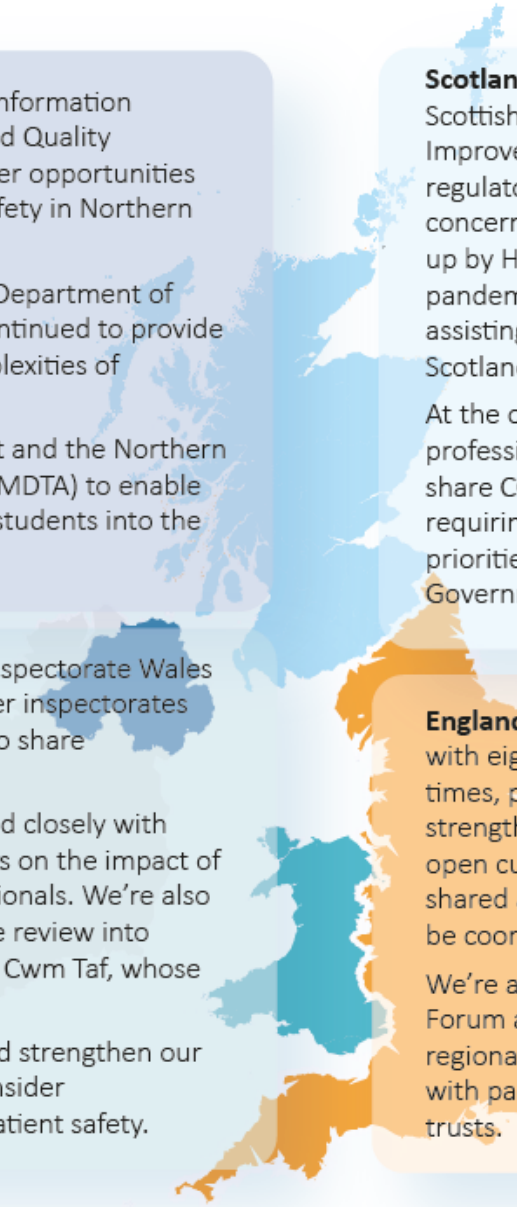
In response to demand from maternity services in the East of England, we piloted a virtual preliminary session to support providers with crucial culture changes. 95% of attendees rated the session as 'good' or 'very good' and 93% would recommend it to their colleagues.

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.

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.

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.

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 us¹⁰.

Overall, confidence in GMC regulation remains high for most groups:

73% for medical students
70% for responsible officers
77% for educators
92% for stakeholders¹⁰.

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.

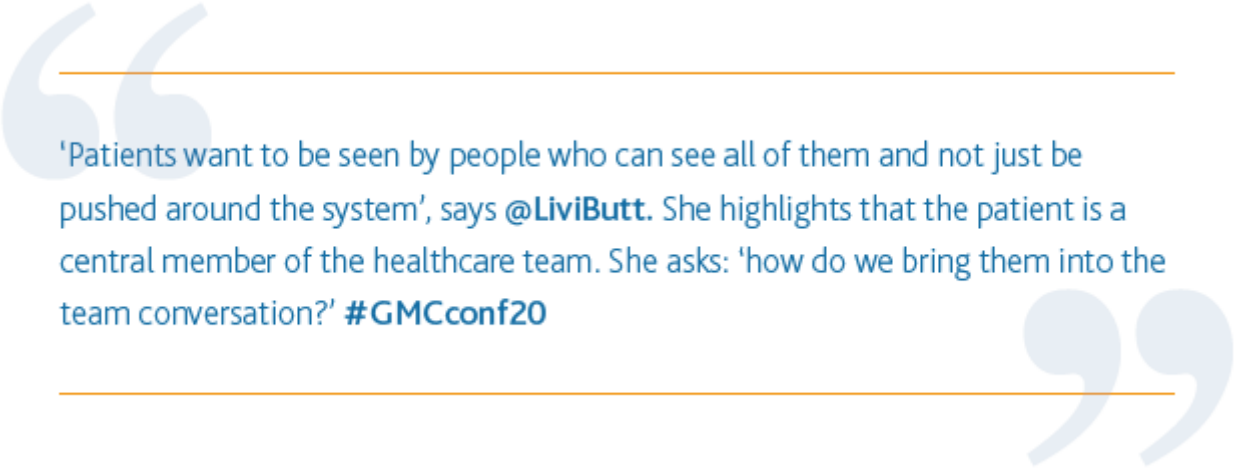
Involving patients and the public in our work

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

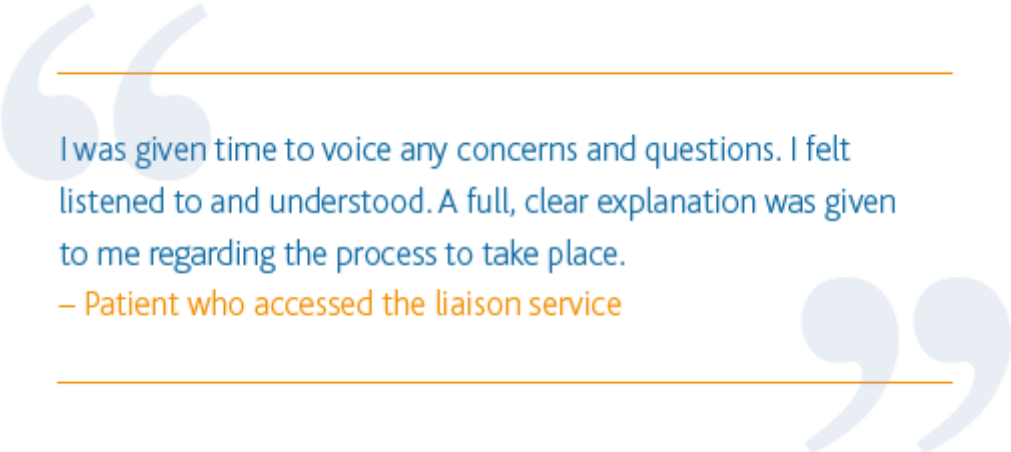
As well as involving patients in our work, we're keen to learn more from them about their interactions with us and use this information to make improvements to the services we offer. Our new Strategic Relationships Unit regularly consults with patient representative organisations on our policies and 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.



Facebook reach:
2.4m unique users
↑ 1.2m from 2019



Twitter impressions:
2.4m
↑ 564.1k from 2019



LinkedIn reach:
624k unique users
↑ 45k from 2019

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.

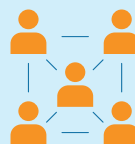
85% of UK parliamentarians expressed confidence in the way we regulate doctors.

The majority of members of the devolved legislatures believe we are focusing on the right issues as a regulator¹¹.

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 2018¹¹.



Three quarters of UKAF members agreed the topics discussed at meetings were relevant and timely¹².



Over 1,000 people responded to our consultation about our upcoming regulation of medical associate professionals.

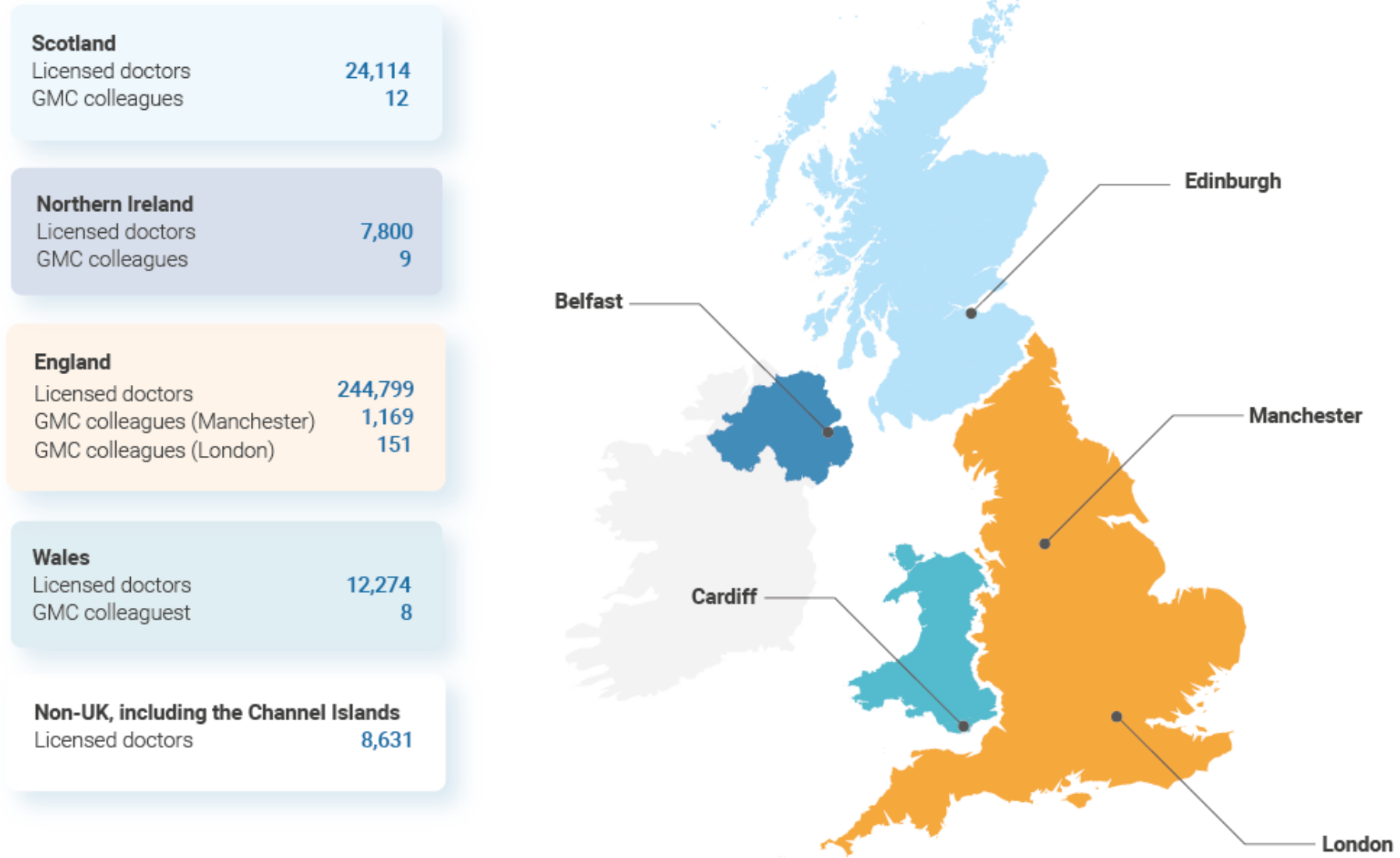
Throughout 2020, Outreach teams engaged with **over 23,000** doctors, medical students and other key interest groups across the UK

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.



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 Outreach teams engaged with
over 7,500 medical students,
over 13,500 doctors and around
2,000 key interest groups, including
patient groups.

Over 18,700 in England

Over 830 in Northern Ireland

Over 980 in Wales

Over 2,750 in Scotland

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 professionals¹³. 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 caused 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 work¹⁴. 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.

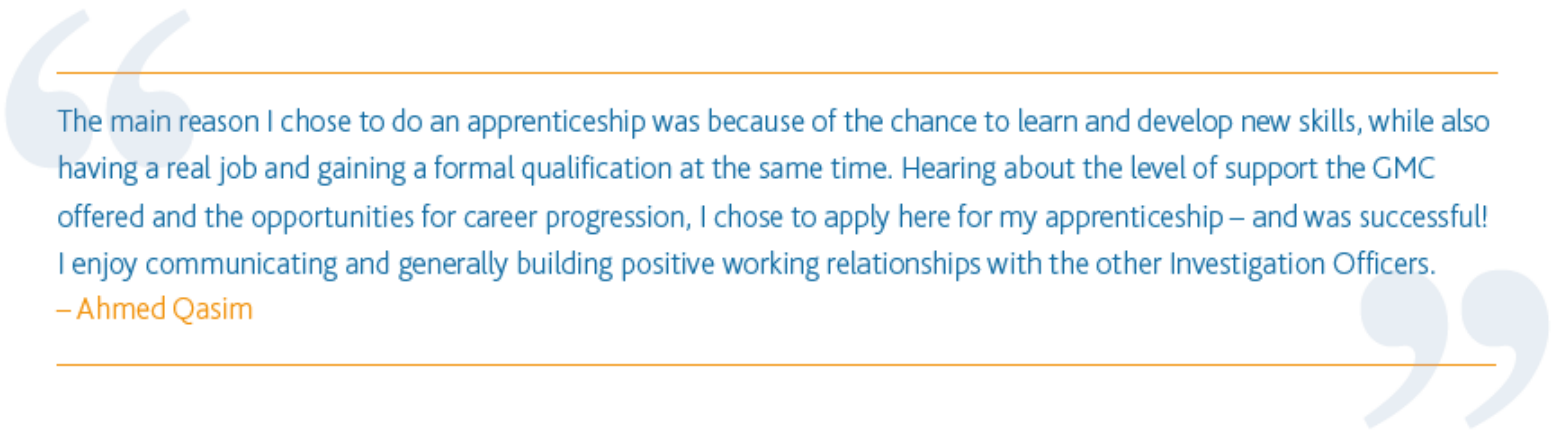
The auditors made several recommendations to strengthen our approach in relation to the governance and compliance of our ED&I work, which we will be taking forward in 2021.

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 website¹⁵.

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.

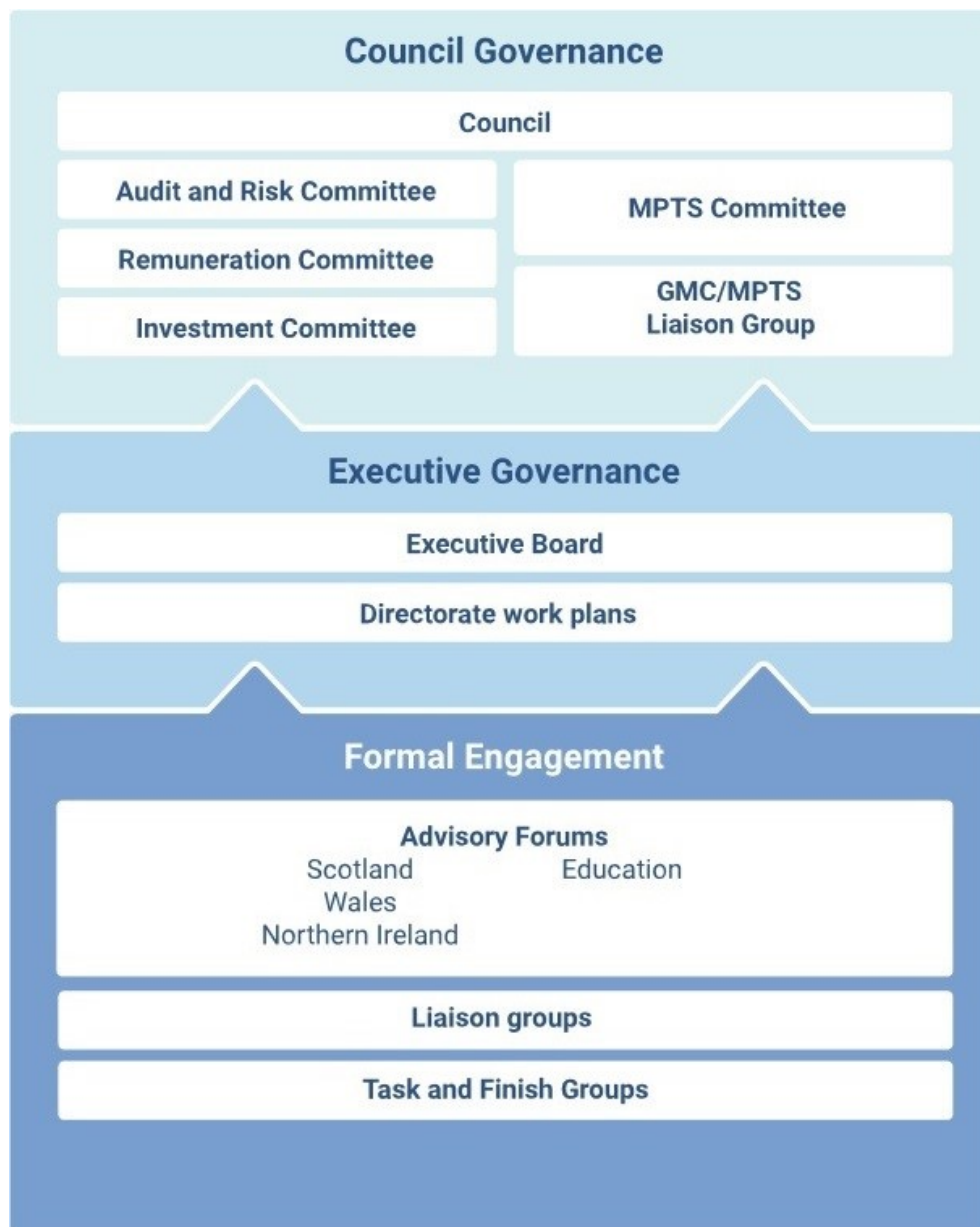
The Corporate Governance team is charged with supporting the Council in maintaining high standards of governance, on an 'apply or explain' basis, in line with the good practice set out within the Charity Governance Code. The team also provides training and advice to the organisation on matters of governance. 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 website¹⁶.

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 2020¹⁷

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 Marx¹⁸	
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 respectively¹⁹.

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
<i>GMCSI</i>	
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:

A handwritten signature in black ink, reading 'Clare Marx' with a small flourish at the end.

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.

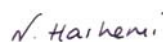
Auditing standards limit the required audit procedures to identify non-compliance with these laws and regulations to enquiry of the Trustees and other management and inspection of regulatory and legal correspondence, if any.

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.



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

	Note	2020		2019	
		Group £'000	Charity £'000	Group £'000	Charity £'000
Fixed assets					
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
	£'000	£'000	£'000
Cash flows from operating activities:			
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)	(199)
Investment income and interest	(388)	(1,394)
Net investment movement	8,029	(4,291)
Non-cash items – depreciation and amortisation	7,854	7,415
Non-cash items – assets written off	47	26
Pension past service cost and curtailment	-	-
Pension scheme current service cost	-	-
Pension scheme contribution	(1,360)	(1,959)
(Increase)/decrease in debtors	(2,200)	(1,853)
Increase/(decrease) in creditors and provisions	3,111	3,590
Net cash provided by/(used in) operating activities	14,064	1,335

Note (ii)

Cash and equivalents

	Short-term deposits	Cash at bank and in hand	Total
	£'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
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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							Total 2020 £'000
	Management	IT	Human Resources	Finance	Procurement	Facilities	Governance	
	£'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							Total 2019 £'000
	Management	IT	Human Resources	Finance	Procurement	Facilities	Governance	
	£'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	Expenditure on raising funds	Department of Health funding - MAPs	Other expenditure	Total	Charitable activities	Expenditure on raising funds	Department of Health funding - MAPs	Other expenditure	Total
	2020	2020	2020	2020	2020	2019	2019	2019	2019	2019
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'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			
	Cash & cash equivalents £'000	Listed Investments £'000	Total £'000	Cash & cash equivalents £'000	Listed Investments £'000	Equity Investment in Group Undertakings £'000	Total £'000
The valuation at the end of the year consisted of:							
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 £'000	Charity £'000	Group £'000	Charity £'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 £'000	Charity £'000	Group £'000	Charity £'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 £'000	2019 £'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 £'000	Restricted funds £'000	Pension fund £'000	2020 Total £'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 £'000	Restricted funds £'000	Pension fund £'000	2019 Total £'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	
Expiry date	2020 £'000	2019 £'000	2020 £'000	2019 £'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	31 December 2019
	%pa	%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 31 December 2020	Year ending 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 31 December 2020	Year ending 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 2 nd 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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General
Medical
Council