professional standards authority

General Medical Council

Performance Review

Periodic review 2023/24

General Medical Council

Performance review report 2023/24

Key findings and areas for improvement

Equality, Diversity and Inclusion (EDI)

This year we have introduced a new approach to assessing regulators' performance on EDI. Our Standard covers four high-level outcomes, all of which a regulator must meet. The GMC has performed strongly against all four outcomes. There is evidence of significant activity in relation to nearly all the relevant indicators, and we have identified several areas of good practice, including the GMC's relatively advanced work to address identified areas of disproportionality. But the GMC still has some way to go in assuring stakeholders about the fairness of its processes, particularly in fitness to practise. We encourage the GMC to continue its work to build stronger assurance around the fairness of its processes, and to continue to take action where it identifies evidence of disparities.

Fitness to practise timeliness

The GMC has continued to improve its timeliness for fitness to practise in this review period. Compared with last year, it has reached key decision points faster and has reduced the number of open old cases. The overall time for cases that go to a final hearing remains high and it will be important for the GMC to continue to improve in this area. We will continue to closely monitor its performance, particularly as we saw an increase in some of our measures of timeliness in the final quarter of the review period.

Good Medical Practice 2024

From January 2024, a new version of Good Medical Practice, the GMC's core standards for registrants, came into effect. The updated version includes new duties for registrants, including about creating fair workplace cultures, preventing sexual harassment, and speaking up when misconduct is witnessed. There are additional obligations for registrants in leadership roles. The new guidance emphasises a patient-centred approach to decision-making. It now incorporates or signposts to other pieces of guidance, for example in relation to use of social media, or decision-making and consent. We welcome the increased focus on patient-centred care and fair workplace cultures.

Assessing and recording risk

We reviewed a sample of closed fitness to practise cases. The GMC does not require risk assessments to be separately documented as other regulators we oversee do. It was not always clear how and when risks had been considered. We did not see any cases where we considered the GMC had failed to seek an interim order when one was needed. There is an opportunity for the GMC to improve the controls it has in place, by being clearer about how and when staff are identifying, considering and responding to evidence of risk in cases. We will closely monitor how it considers our feedback and any action it takes as a result.

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About our performance reviews

We have a statutory duty to report annually to Parliament on the performance of the 10 regulators we oversee. We do this by reviewing each regulator's performance against our Standards of Good Regulation and reporting what we find. The judgements we make against each Standard incorporate a range of evidence to form an overall picture of performance. Meeting a Standard means that we are satisfied, from the evidence we have seen, that a regulator is performing well in that area. It does not mean there is no room for improvement. Where we identify areas for improvement, we pay particular attention to them as we continue to monitor the performance of the regulator. Similarly, finding that a regulator has met all of the Standards does not mean perfection. Rather, it signifies good performance in the 18 areas we assess.

Our performance reviews are carried out on a three-year cycle; every three years, we carry out a more intensive 'periodic review' and in the other two years we monitor performance and produce shorter monitoring reports. Find out more about our review process here. We welcome hearing from people and organisations who have experience of the regulators' work. We take this information into account alongside other evidence as we review the performance of each regulator.

This is a periodic review report on the General Medical Council (GMC) and covers 1 October 2023 to 30 September 2024.

About the GMC

The GMC regulates the practice of doctors in the United Kingdom. From December 2024 the GMC is scheduled to also commence regulation of anaesthesia associates (AAs) and physician associates (PAs) in the United Kingdom. It currently has a total of **390,520 doctors** on its register (as at 31 October 2024).

Standards of Good Regulation met 2023/24

General Standards	5 out of 5
Guidance and Standards	2 out of 2
Education and Training	2 out of 2
Registration	4 out of 4
Fitness to Practise	5 out of 5
Total met	**18 out of 18**

Standards met 2022-23

2022/23	18 out of 18
2021/22	18 out of 18
2020/21	18 out of 18

About the GMC's performance for 2023/24

For this review, the General Medical Council met 18 out of 18 of our Standards of Good Regulation. These Standards provide the benchmark against which we review performance. Meeting or not meeting a Standard is not the full story about how a regulator is performing. Our report provides more detail about the General Medical Council's performance this year.

General Standards

1 The regulator provides accurate, fully accessible information about its registrants, regulatory requirements, guidance, processes and decisions.

1.1 The GMC continues to publish information about its role, regulatory requirements, guidance, and activities. It has dedicated sections of its website for different areas of its work. These were recently updated to include reference to the updated Good Medical Practice 2024[1] and changes to how the GMC oversees education and training.

1.2 The GMC website includes a Future Regulation Hub, which gathers together information about the GMC's regulation of Anaesthesia Associates (AAs) and Physician Associates (PAs). The GMC will start regulating AAs and PAs from December 2024, shortly after the end of our review period. The hub includes information for doctors, patients and employers, as well as AAs and PAs, and links to specific guidance about how the GMC will regulate AAs and PAs.

1.3 The GMC's register is on the website and is easy to search. The register information is also searchable by key characteristics. The GMC provides access to its public Council meeting papers for a range of committees and boards across its functions on its website. The GMC has published a range of reports about its activities. It publishes statements about topical issues through the media hub on its website.

1.4 The GMC has implemented the Welsh Language Standards across its functions. It continues to make the information it publishes available in Welsh and other languages and formats so that it is accessible.

Conclusion

The GMC continues to publish a range of information on its website. We have seen that it takes action to keep the information accurate and up to date. We are satisfied that this Standard is met.

2 The regulator is clear about its purpose and ensures that its policies are applied appropriately across all its functions and that relevant learning from one area is applied to others.

[1] See Standard 6.

2.1 The GMC's overarching objective is to protect the public. Although its legal powers are changing to allow it to regulate AAs and PAs, the overarching objective remains the same.

2.2 The GMC continues to publish its plans to deliver its purpose. Its Corporate Strategy 2021-25 is categorised into four themes: enabling professionals to provide safe care; developing a sustainable medical workforce; making every interaction matter; and investing in people to deliver.

2.3 The GMC business plan for 2024 is based on the Corporate Strategy. It sets out the key projects, activities, and milestones under the four priority areas and highlights compassionate regulation as an ongoing strategic focus for the GMC's activities. The GMC reports on progress against its business plan in each annual report.

2.4 We have seen evidence of the GMC applying learning across its functions. It uses feedback from the National Training Survey[2] to inform its oversight of training programmes across the UK. The GMC also has national strategies for its work in each of the four UK nations. It holds regular UK Advisory Forums with stakeholder organisations across the UK. Its reports on the workforce[3] include nation-specific data and highlight issues for the sector to address to ensure doctors can provide safe, effective care to patients.

Conclusion

The GMC is clear about its purpose and continues to focus its activities on public protection. We are satisfied that this Standard is met.

3 The regulator understands the diversity of its registrants and their patients and service users and of others who interact with the regulator and ensures that its processes do not impose inappropriate barriers or otherwise disadvantage people with protected characteristics.

3.1 This year, we have used a new approach to assessing regulators against this Standard.[4] As part of our new approach, we have broken down the Standard into four separate outcomes. For a regulator to meet the Standard, we would need to be assured that the regulator has met all four of the outcomes. Our assessment of the GMC's performance against the four outcomes is set out below.

[2] The National Training Survey asks doctors in training for their views on the training they receive. The GMC publishes results on its website.
[3] The State of Medical Education and Practice 2024.
[4] More information is available in our guidance document.

Outcome 1: The regulator has appropriate governance, structures and processes in place to embed EDI across its regulatory activities

3.2 The GMC holds protected characteristics data relating to senior staff, Council members and associates. It has reported this year on the progress of initiatives to increase the diversity of its pool of expert witnesses and the barristers it instructs. The GMC has specific targets to increase the proportion of staff from ethnic minority backgrounds at all levels, including senior management roles, in its EDI strategy.

3.3 The GMC has strategic EDI objectives within its corporate strategy, as well as four EDI-focused priority programmes addressing: fairer employer referrals; fair training cultures; assuring fairness within the GMC; and inclusivity as an employer. It reports annually to a public Council meeting about progress against the strategy, as well as regular updates about relevant work. We have seen that it has updated the strategy over recent years to take account of, for example, the outcomes of major reviews, and that it identifies priorities for each year based on the progress and impact of its work.

3.4 The GMC has an EDI Steering Group as well as a Strategic EDI Forum and a dedicated EDI team. There is a senior sponsor for the organisation's EDI work. It has used its internal audit to gain assurance about the effectiveness of its governance arrangements and has taken action to implement further recommendations from its EDI team.

3.5 We have seen examples of EIAs carried out by the GMC. It has introduced new templates for the EIA process and is reviewing the impact of this.

Outcome 2: In terms of EDI, the regulator ensures that registrants and students are equipped to provide appropriate care to all patients and service users, and have appropriate EDI knowledge and skills

3.6 The updated version of *Good Medical Practice*[5] requires doctors to treat patients as individuals, to respect their dignity and privacy and to consider reasonable adjustments. There are similar requirements for students and provisionally-registered doctors. The GMC provides additional resources for doctors on how to provide inclusive care for patients who share protected characteristics through its ethical hub.[6]

Good Practice

The GMC provides further guidance and resources for doctors on how to provide inclusive and effective care for patients who share certain protected characteristics (including older patients, and trans and gender diverse patients). It has also published a series of interactive case studies, Good Medical Practice in

[5] See Standard 6.
[6] See Standard 7.

action, to illustrate how the standards apply in a variety of scenarios, including some where specific EDI considerations are relevant.

3.7 GMC guidance is clear about requiring registrants not to discriminate. The new version of Good Medical Practice includes a requirement to challenge discriminatory behaviour when witnessed. Some other guidance documents[7] do not yet reflect this, though the GMC publishes other guidance about how and when to raise concerns. We also understand that the GMC plans to review its guidance documents to align them with the new version of Good Medical Practice.

3.8 The new GMC guidance also contains responsibilities on doctors not to discriminate and on those in leadership positions to report discriminatory behaviour when they witness it.

3.9 The GMC publishes guidance about equality and diversity considerations for training organisations. The guidance sets out the equality and diversity indicators relevant to each of the GMC's requirements, and the types of evidence organisations may be able to collect to demonstrate that they have met them. Training organisations must complete a self-assessment each year, and we have seen evidence of published inspection reports addressing equality considerations. The GMC also publishes guidance for training organisations about how they can support disabled students.

Good Practice

The GMC has a well-established programme of work on fair training cultures, which we consider to be good practice. It collects data on learners' progression, experiences and outcomes, which is analysed by protected characteristic. It has added optional questions to its National Training Survey to support this. The GMC has also carried out analysis of intersectionality and the effects this can have on differential attainment.

The GMC requires training organisations to demonstrate action they are taking to address inequality of opportunity for learning, either through annual action plans or self-assessment against the GMC's standards.

Outcome 3: In terms of EDI, the regulator makes fair decisions across all regulatory functions

[7] Such as guidance for medical students.

3.10 The GMC collects registrants' EDI data and publishes this through its interactive Data Explorer tool as well as through its annual State of Medical Education and Practice reports. The GMC has methods to collect EDI data from people raising fitness to practise concerns.

3.11 The GMC's fitness to practise guidance at all stages of the process makes clear that discriminatory behaviour is serious. The GMC told us it has a range of controls in place to assure it that the guidance is being followed.

3.12 The GMC told us that all staff and associates receive mandatory EDI training, and that there is a range of optional EDI training available. The GMC has carried out work to identify High Impact Regulatory Decisions[8] and the people who make them; it is piloting new learning on fairness for these decision-makers and staff who advise them. We think that this work has the potential to enable the GMC to make targeted interventions to promote fairness in its decision-making; at present it is at a relatively early stage and we have not seen evidence of outcomes. We will continue to monitor this work.

3.13 There is evidence of significant activity by the GMC to look for and address evidence of unfairness in its processes. It has commissioned or undertaken numerous reviews in relation to the fairness of its processes, including in relation to concerns raised with it (such as the Singh/Forde review in response to concerns raised about the outcome of a final fitness to practise hearing). As part of its work on fair training cultures, it has published a detailed analysis on intersectionality and differential attainment.

What we heard from stakeholders

" The current rates of disproportionate referrals are concerning. We urge the GMC to prioritise cultural sensitivity training, including training on Islamophobia, to ensure its procedures are equitable and respectful of diverse backgrounds."

3.14 The GMC has been active in reviewing its processes to look for evidence of unfairness. But it still has some way to go in assuring stakeholders about the fairness of its processes, particularly in fitness to practise. We heard some concerns from stakeholders and we have seen similar concerns expressed publicly. We encourage the GMC to continue its work to build stronger assurance around the fairness of its processes, and to continue to take action where it identifies evidence of disparities.

[8] It identified 42 decision points as HIRDs, which between them amount to about 27,000 decisions a year.

Outcome 4: The regulator engages with and influences others to advance EDI issues and reduce unfair differential outcomes

3.15 The GMC engages with a wide range of stakeholders. Its Strategic EDI Forum meets with doctors from diverse backgrounds to hear their experiences. It has also announced the launch of a new Race Equality Forum, to which representatives can bring themes and challenges to the GMC, so that it can ensure its work responds to the needs of these doctors. It has an Advisory Forum on GMC Procedures and Doctors' Health which includes various stakeholders including Royal Colleges, the Faculty of Occupational Health, the Conference of Postgraduate Medical Deans and NHS providers. It has a Patient Roundtable. It also commissioned research when consulting on the new version of Good Medical Practice; this explored themes such as patients' language and communication skills, the needs of disabled patients and taking account of patients' socioeconomic background.

3.16 The GMC says it works collaboratively with partners to understand issues affecting patients who share protected characteristics and provides supportive materials both for training doctors and for patients, such as its LGBTQ patient guide. We also saw evidence of the GMC engaging with other regulators and organisations, particularly in relation to medical education and training.

Good Practice

The GMC has been working with partners to promote supportive inductions for international medical graduates (IMGs). It collaborated with NHS England, the British Medical Association and the Medical Protection Society to produce *Welcoming and Valuing IMGs*, a set of comprehensive induction standards. It works with employers and educators to support them to implement these standards and to share good practice.

For over ten years, it has been running *Welcome to UK Practice* workshops, which are free and designed to support doctors new to the UK. They provide practical advice and explore different ethical scenarios that an IMG may encounter. They explain the GMC's key standards and guidance and are designed to equip doctors with knowledge and skills to provide appropriate care in an environment that may be very different from their country of qualification.

3.17 The GMC publishes a significant amount of research and data relevant to EDI. This includes registrant EDI data, data about education and training, and its annual State of Medical Education and Practice report.

Good Practice

The GMC is working towards targets to eliminate disproportionate FTP referrals from employers by 2026, and to eliminate differential attainment in medical education and training by 2031. It reports annually on progress against the specific measures towards which it is working. These show steady progress in

terms of employer referrals and a mixed picture in relation to differential attainment.

From 2025/26, we will expect all regulators to demonstrate the impact of their work to reduce unfair differential outcomes, but we have not yet required them to do so. We consider that the progress already made by the GMC in identifying and working towards these objectives amounts to good practice.

Conclusion

The GMC has performed strongly against all four outcomes in the Standard. There is evidence of significant activity in relation to nearly all the relevant indicators, and we have identified several areas of good practice, including the GMC's relatively advanced work to address identified areas of disproportionality. But the GMC still has some way to go in assuring stakeholders about the fairness of its processes, particularly in fitness to practise. We encourage the GMC to continue its work to build stronger assurance around the fairness of its processes, and to continue to take action where it identifies evidence of disparities. We are satisfied that this Standard is met.

4 The regulator reports on its performance and addresses concerns identified about it and considers the implications for it of findings of public inquiries and other relevant reports about healthcare regulatory issues.

4.1 The GMC reports regularly on its performance. Papers for its public Council meetings routinely include operational key performance indicators and reporting against deliver of the corporate strategy. We have seen evidence of the GMC's Council discussing performance reports. The Audit and Risk Committee also reports to Council, including details of internal audit of GMC functions.

4.2 The GMC publishes a range of reports once a year, including: its Annual Report and Accounts; a joint report on whistleblowing with the other health and care regulators; the report of its Freedom to Speak Up Guardian; progress reports against its EDI targets; and an annual safeguarding report.

4.3 The GMC publishes regular data about the number of corporate complaints and compliments it receives. It continues to hold ISO accreditation for handling customer complaints.

4.4 The GMC is currently engaging with several public inquiries, including the Muckamore Abbey Hospital Inquiry, the Lampard Inquiry, the Thirlwall Inquiry and the Ockenden Maternity Review. It is also working to implement recommendations

from the Infected Blood Inquiry. We will continue to monitor the progress of this important work.

Conclusion

The GMC continues to report on its performance regularly and in appropriate detail. It is engaging with relevant public inquiries. We are satisfied that this Standard is met.

5 The regulator consults and works with all relevant stakeholders across all its functions to identify and manage risks to the public in respect of its registrants.

5.1 The GMC carried out a major public consultation on its proposed rules, standards and guidance for regulating AAs and PAs. The consultation ran from March to May 2024. As part of the new legal powers, it will have to regulate AAs and PAs, the GMC will be able to make rules about registration, fitness to practise, appeals and revisions of decisions, and education and training. The consultation included the rules the GMC proposed to make, as well as supporting materials such as decision-making principles for fitness to practise.

5.2 Some stakeholder groups have expressed concerns about the GMC's approach to regulating AAs and PAs, as well as wider issues about the regulation, role and deployment of AAs and PAs more generally. We understand that there has been a significant volume of responses to the consultation. We responded to it, highlighting some areas where we would like to see changes or further detail to ensure the GMC can make the best use of its new powers to protect the public effectively.[9]

[9] Our consultation response is published on our website.

What we heard from stakeholders

" Discussion was open and frank. Representatives of the GMC generally had a good understanding of the issues. The discussion considered the needs of patients."

"The GMC was proactive in its communications and was equally responsive to any requests […] This was crucial in allowing us to respond to emerging issues or developments."

"The GMC are working with us and other system-level partners to develop consistent, system-wide narrative and communications around the MAPs roles[10] […] Group discussions have helped guide the contents of MAPs guidance, in order to optimise consistency across published documents, and we value the GMC's expertise and input into this work."

5.3 The GMC said it would publish its response to the consultation in December 2024,[11] shortly before it starts to regulate AAs and PAs. We acknowledge that it will take time to properly review and consider consultation responses, particularly given the extent and detail of the consultation and what we understand to be a large number of responses.

5.4 In November 2024, the Department of Health and Social Care announced an independent review of the AA and PA professions. The review is intended to produce a comprehensive picture of these roles. The terms of reference[12] include professional regulation, though the review does not affect the date when the GMC starts to regulate AAs and PAs. The review and next steps are expected to be published in spring 2025.

5.5 The GMC has published statements to explain its approach to bringing AAs and PAs into regulation, as well as engaging directly with relevant organisations. We received generally positive feedback from stakeholder organisations about how the GMC engaged with them. It will be important for the GMC to continue to engage and communicate effectively, including with those who are raising concerns about how it will regulate AAs and PAs. We will continue to monitor this work, and any relevant outcomes from the independent review, as the GMC starts to regulate AAs and PAs.

[10] Medical Associate Professionals, a collective term which includes AAs and PAs.
[11] After the end of the period covered by this report.
[12] Leng review: independent review of physician associate and anaesthesia associate professions terms of reference - GOV.UK

5.6 The GMC worked with relevant stakeholders in other areas of its work. It issued joint statements with other regulators about Martha's Rule[13] and about providing care during shortages of medication.[14]

5.7 The GMC published information on how its guidance applies to doctors taking part in protests or other forms of activism. The information includes case studies to explain how the GMC deals with concerns about the actions of doctors during protests, including when doctors have been found to have broken the law.

Conclusion

The GMC continues to engage with stakeholders. We recognise that concerns have been raised about a range of issues connected to the regulation of AAs and PAs. It will be important for the GMC to communicate clearly about how it has considered these concerns and any associated risks to public protection. We will continue to monitor its work to bring AAs and PAs into regulation, including how it develops and uses its new legal powers. We are satisfied that this Standard is met this year.

Guidance and Standards

6 The regulator maintains up-to-date standards for registrants which are kept under review and prioritise patient and service user centred care and safety.

6.1 The updated version of *Good Medical Practice*, the GMC's core standards for registrants, came into effect on 30 January 2024. As we reported last year, the new version includes new duties for registrants, including about creating fair workplace cultures, preventing sexual harassment, and speaking up when misconduct is witnessed. There are additional obligations for registrants in leadership roles, and in relation to sustainability, recognising that climate change presents a risk to public health. There is more emphasis in the new guidance on strengthening professional boundaries and ensuring a patient-centred approach to decision-making.

6.2 The new version of *Good Medical Practice* incorporates or signposts to other pieces of guidance, for example in relation to use of social media, or decision-making and consent. It was reasonable for the GMC to review how and where different elements of its guidance are published, and we welcome the increased focus on patient-centred care and fair workplace cultures.

[13] https://www.gmc-uk.org/news/news-archive/joint-statement-on-marthas-rule-from-the-gmc-nmc-and-cqc
[14] https://www.gmc-uk.org/news/news-archive/joint-statement-on-meeting-regulatory-standards---an-update

Conclusion

The GMC has implemented an updated version of its standards, which emphasises patient-centred care and safety. This Standard is met.

7 The regulator provides guidance to help registrants apply the standards and ensures this guidance is up to date, addresses emerging areas of risk, and prioritises patient and service user centred care and safety.

7.1 The GMC publishes guidance and learning materials to support registrants to meet its standards. It has published resources in the form of fictional case studies to illustrate Good Medical Practice in action.

7.2 It also includes advice on its guidance in its ethical hub. The advice relates to a range of topics including: remote consultations; trans healthcare; learning disabilities; racism in the workplace; and social media use. It also includes a speaking up hub.

7.3 The GMC has said that the ethical hub is designed to reflect emerging risks. It has used data and research to identify areas of care where good practice for patients with protected characteristics could be improved, or which doctors find challenging. The GMC has also published separate learning materials about the use of artificial intelligence and innovative technologies, another area of emerging risks and opportunities. The learning materials explain that changes to Good Medical Practice aim to make clear how registrants' professional responsibilities apply when they are using innovative technologies including artificial intelligence.

Conclusion

The GMC has provided updated guidance to support its new standards. There is evidence of a focus on emerging areas of risk. We are satisfied that this Standard is met.

Education and Training

8 The regulator maintains up-to-date standards for education and training which are kept under review, and prioritise patient and service user centred care and safety.

8.1 The GMC publishes guidance for students. *Achieving good medical practice: guidance for medical students*, produced jointly with the Medical Schools Council (MSC), sets out the expectations for medical students. It has been updated to reflect the new version of *Good Medical Practice*.

Medical Licensing Assessment

8.2 We have reported in previous years on the GMC's work to introduce the Medical Licensing Assessment (MLA). The aim of the MLA is to ensure that doctors seeking registration with a licence to practise medicine in the UK have met a threshold for safe practice that is appropriate to their point of entry to the medical register. The GMC implemented the MLA during this review period, in line with its planned timescale. We discuss the implementation in more detail under Standard 9.[15]

Education and training standards for AAs and PAs

8.3 The GMC has also published guidance for AA and PA students, which will apply once it starts to regulate these roles. It produced *Achieving good medical practice: guidance for physician associate and anaesthesia associate students* jointly with the Physician Associate Schools Council, and *Professional behaviour and fitness to practise*, guidance for course providers. The GMC has previously published information about the generic and shared learning outcomes AAs and PAs must meet to be registered with the GMC by the time they qualify.

8.4 When the GMC starts regulating AAs and PAs, applicants will have to pass an assessment to register with the GMC.[16] The PA registration assessment will be in the same format as the MLA: a knowledge test and an Objective Structured Clinical Examination. The AA registration assessment will consist of a knowledge test and a workplace-based assessment of clinical skills.

8.5 As noted above, the GMC consulted on proposed rules for its regulation of AAs and PAs, including in relation to education and training. We will continue to monitor further updates to the education and training standards for AAs and PAs.

Portfolio pathway

8.6 The GMC has made changes to one of the routes for applying for specialist or GP registration. This follows legal changes in November 2023, which allow more flexibility in how the GMC assesses an applicant's training and experience. This portfolio pathway is for doctors who have specialty experience but have not completed the main approved UK training route for specialist registration.[17]

8.7 The GMC does not intend to change the standard necessary for specialist or GP registration, but to make the portfolio assessment less bureaucratic. The evidence required is set by the GMC in consultation with royal colleges; to apply by the

[15] We considered the work to introduce the MLA relevant to Standard 8 because it was about how the GMC keeps its standards for training up to date; now that the MLA has come into use, it is part of how the GMC ensures that trainees meet its requirements for registration, and so more relevant to Standard 9.
[16] PAs who have already passed the examination to join the Faculty of Physician Associates' voluntary register will be able to provide evidence of this.
[17] The Certificate of Completion of Training, or CCT.

portfolio pathway, the doctor applies to the GMC which then arranges for their portfolio to be assessed.[18]

Conclusion

The GMC maintains standards for education and training. It has been updating its standards and guidance to reflect updates to *Good Medical Practice* and the introduction of statutory regulation for AAs and PAs. This Standard is met.

9 The regulator has a proportionate and transparent mechanism for assuring itself that the educational providers and programmes it oversees are delivering students and trainees that meet the regulator's requirements for registration, and takes action where its assurance activities identify concerns either about training or wider patient safety concerns.

9.1 The GMC publishes information about its processes for the approval and quality assurance of education programmes in the UK. It publishes quality assurance reports and information about where it has taken action to address concerns, for example through enhanced monitoring of training providers.

9.2 This year the GMC approved a new medical school, at Sunderland University.

MLA implementation

9.3 As noted above, the GMC has now implemented the MLA, an assessment framework with two components: an applied knowledge test (AKT) and a clinical and professional skills assessment (CPSA). From the 2024/25 academic year, all medical students graduating from UK universities need to pass the MLA as part of their degree before they can join the medical register with provisional registration. International medical graduates who want to join the UK medical register will continue to take the PLAB[19] test, which is now compliant with the MLA requirements.

9.4 The GMC has been overseeing MSC and medical schools' development of a national AKT as part of the MLA. The GMC has reviewed whether the medical schools' AKT, their local delivery of it, and each assessment provider's CPSA comply with the GMC requirements for the MLA. It has published compliance reports on its website.

[18] There is detailed guidance on the GMC website.
[19] Professional and Linguistic Assessments Board.

9.5 In summer 2024, the first medical School AKT examinations took place in the schools who hold written finals in the penultimate year of study. There was a connectivity issue during the first sitting which resulted in a short pause at all schools sitting the paper. This triggered contingency arrangements: the MSC's rapid response team, which will be convened as necessary for all medical school AKTs, resolved the issue so that the test could be completed. We understand that subsequent tests have run without disruption.

9.6 As well as engaging with the GMC directly, we sought feedback from stakeholders involved with the MLA. The feedback we received was mixed. Some stakeholders were very positive about the GMC's engagement and transparency. Others felt that parts of the process could have been clearer, or raised queries about specific elements of the transition.

9.7 We shared stakeholders' feedback with the GMC and we will expect it to continue to reflect on areas for development as the MLA transitions from a discrete project to part of business as usual. Given the scale of the project to introduce a new assessment across all UK medical schools, some initial minor technical issues and other room for improvement might reasonably be expected. We have not seen evidence of serious problems in the delivery of the MLA. We will continue to monitor the GMC's work on the MLA.

Quality assurance of AA and PA training programmes

9.8 When the GMC starts regulating AAs and PAs, it will have responsibility for assuring the quality of their education and training. It has been engaging with training providers for some time, including voluntary quality assurance checks. All current AA and PA course providers have completed a voluntary self-assessment, which the GMC has used to carry out a gap analysis and provide feedback. When AAs and PAs come into regulation, these training courses will be subject to the same quality assurance process as medical schools.

Conclusion

The GMC continues to have processes in place for education quality assurance. It has introduced the MLA as planned. There was a minor technical issue during the first examination, which was promptly resolved, and some mixed feedback from stakeholders, which we have shared with the GMC. We are satisfied that the Standard is met.

Registration

10 The regulator maintains and publishes an accurate register of those who meet its requirements including any restrictions on their practice.

10.1 The appearance of the GMC's public register remains unchanged, and the search facility is easy to use.

10.2 We carried out a check on a sample of cases where there had been a final fitness to practise hearing during the review period. We had no concerns about the information displayed on the GMC's register and found that the published information was accurate.

Register entries for AAs and PAs

10.3 When the GMC starts regulating AAs and PAs, its public register will include three different professions. It has explained how it will update the presentation of its register to help people use it. People will be able to search by profession. Each registrant's entry will clearly state the profession for which they are registered. The GMC will distinguish AAs and PAs on the register from doctors by giving them a registration number prefixed with a letter A.

Alemi review

10.4 In February 2024, the Government announced an independent review into the case of Zholia Alemi, who fraudulently gained GMC registration in 1995 and practised for some years in the NHS. The review will look at how regulators and employers took action when concerns arose, and what they have done to prevent similar cases from happening in future. We will continue to monitor this work and any response from the GMC.

Conclusion

The GMC continues to publish its register, and to consider the information that should be included. We found no errors in our check of the register and are satisfied this Standard is met.

11 The process for registration, including appeals, operates proportionately, fairly and efficiently, with decisions clearly explained.

11.1 The GMC met this Standard last year. This year it received a similar volume of new registration applications overall,[20] and the time taken to deal with them remains stable. The number of registration appeals remains relatively small. We have not seen evidence of concerns about the GMC's registration process.

Digital identity checks

11.2 We reported last year that the GMC had launched its digital identity check system. It intended to make the process of registration more efficient and less expensive for applicants by providing an alternative to in-person identity checks. It also sought to provide a solution to a backlog of doctors who were registered during the pandemic and had been unable to attend in-person checks.

11.3 There were around 30,000 doctors affected by this backlog. Although other steps had been taken to check their identities, it is important for the GMC to be assured that only people who have met all its requirements are on its register. So it was appropriate for the GMC to take steps to clear the backlog. By 4 December 2024, as a result of the introduction of digital identity checks, the number of doctors with an outstanding identity check had reduced to 1,526, of whom fewer than 950 hold a licence to practise. The GMC continues to mitigate the risks associated with incomplete identity checks by committing to considering alternatives such as bringing forward revalidation for the small proportion of doctors with registration who have not completed the relevant checks.

Conclusion

We do not have concerns about the time the GMC takes to process applications for registration. The introduction of digital identity checks has helped it make significant progress in clearing the backlog of doctors with outstanding identity checks. This Standard is met.

12 Risk of harm to the public and of damage to public confidence in the profession related to non-registrants using a protected title or undertaking a protected act is managed in a proportionate and risk-based manner.

12.1 The GMC's process for managing protection of title cases is unchanged since last year. Its website continues to provide information about its protection and misuse of title function, including detail on how to raise a complaint.

12.2 From December 2024, the GMC will begin regulation of AAs and PAs. These will become legally protected titles from December 2026. We described at Standard

[20] There was an increase in applications from UK graduates, offset by a reduction in applications from international graduates.

10 above the measures the GMC is taking to make its register clear about the registration status of different professionals.

Conclusion

The GMC has proportionate processes in place to manage risk of harm to the public of misuse of its protected title. We are satisfied that this Standard is met.

13 The regulator has proportionate requirements to satisfy itself that registrants continue to be fit to practise.

13.1 The GMC has not made significant changes to its revalidation requirements for doctors during this review period. Its published performance data shows that it continues to meet its KPI for making decisions on revalidation recommendations within five working days. It publishes guidance about continuing professional development, including examples to support reflective practice.

13.2 The GMC has published updated versions of its revalidation guidance to include AAs and PAs. This includes clinical governance guidance for employers, as well as guidance for registrants on the supporting information they should collect and reflect on. Like doctors, AAs and PAs will be required to participate in annual appraisals and reflect on a range of information, including feedback from patients and colleagues.

13.3 The GMC is developing the revalidation model for AAs and PAs. As noted above, it consulted on proposed rules and guidance for its regulation of AAs and PAs, but revalidation rules were not included in this initial consultation.

Conclusion

The GMC continues to have requirements in place to assure itself about registrants' continuing fitness to practice. It has published updates to its revalidation guidance to reflect AAs and PAs coming into regulation. This Standard is met.

Fitness to practise

14 The regulator enables anyone to raise a concern about a registrant.

14.1 Since the last review period, the volume of fitness to practise referrals received by the GMC has increased. Most referrals come from members of the public. On the face of it, this does not suggest that people have been unable to raise concerns about registrants with the GMC.

14.2 The GMC has measures in place to provide additional support to members of the public wishing to make referrals, such as the Independent Support Service.[21] This service is for complainants, patients, witnesses, and their families involved in a fitness to practise case and provides emotional support to individuals, including signposting to specialist support agencies and where necessary, referrals to statutory safeguarding agencies.

14.3 Last year the GMC introduced updated third-party investigation guidance.[22] Where it receives a referral about a matter where a third-party investigation is in progress, the GMC may wait until the third-party investigation has completed before opening an enquiry.[23] The GMC would close such cases without a formal decision about whether they amount to an allegation about a registrant's fitness to practise (known as a Rule 4 decision). This makes it easier to reopen them if new information is received at the conclusion of the third-party investigation. Cases may also be closed without a Rule 4 decision where there is no other investigation in progress, but the GMC is unable after reasonable efforts to obtain information it needs to make a decision.

14.4 As discussed under Standard 15 below, we reviewed a sample of GMC fitness to practise cases, as part of which we identified some concerns about decisions to close cases without a Rule 4 decision. We asked the GMC for some more information about its handling of cases closed without a Rule 4 decision. Its data showed that closure without a Rule 4 decision accounted for 12% of all triage decisions in 2023. A quarter of those cases had subsequently had a Rule 4 decision at the point the GMC updated us.

14.5 The GMC also shared information about how it monitors cases closed without a Rule 4 decision. It said that cases closed because of a third-party investigation are reviewed monthly to consider whether there is anything further the GMC should do to manage associated risks. It provided evidence of ongoing monitoring of cases closed in this way. It also explained that it is completing a post-implementation review of the process. We will continue to monitor the impact of this process and any outcomes from the GMC's review.

Conclusion

The GMC is receiving more concerns, which suggests that people are able raise concerns. We have also reviewed the way in which the GMC is monitoring cases closed due to ongoing third-party investigations. We are satisfied that this Standard is met.

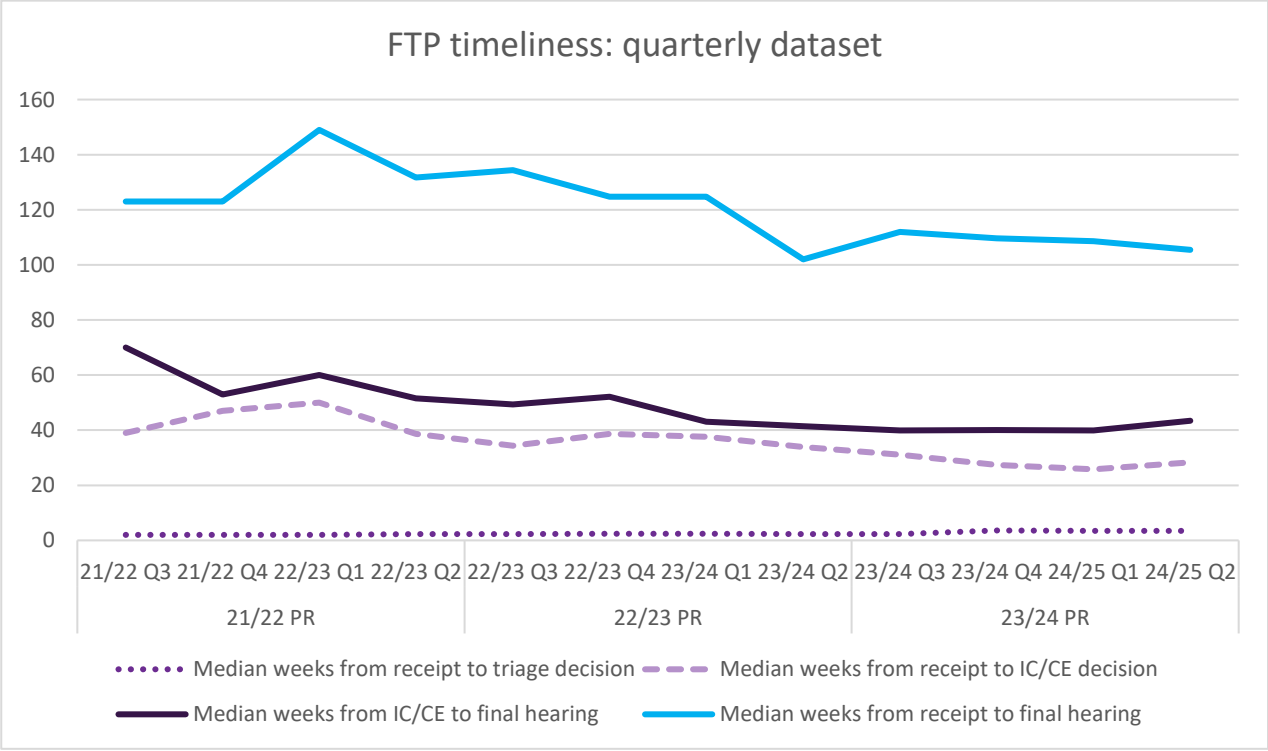
[21] Run for the GMC by the charity Victim Support.
[22] That is, an investigation by another organisation, such as the police or an employer.
[23] Unless an interim order is required.

15 The regulator's process for examining and investigating cases is fair, proportionate, deals with cases as quickly as is consistent with a fair resolution of the case and ensures that appropriate evidence is available to support decision-makers to reach a fair decision that protects the public at each stage of the process.

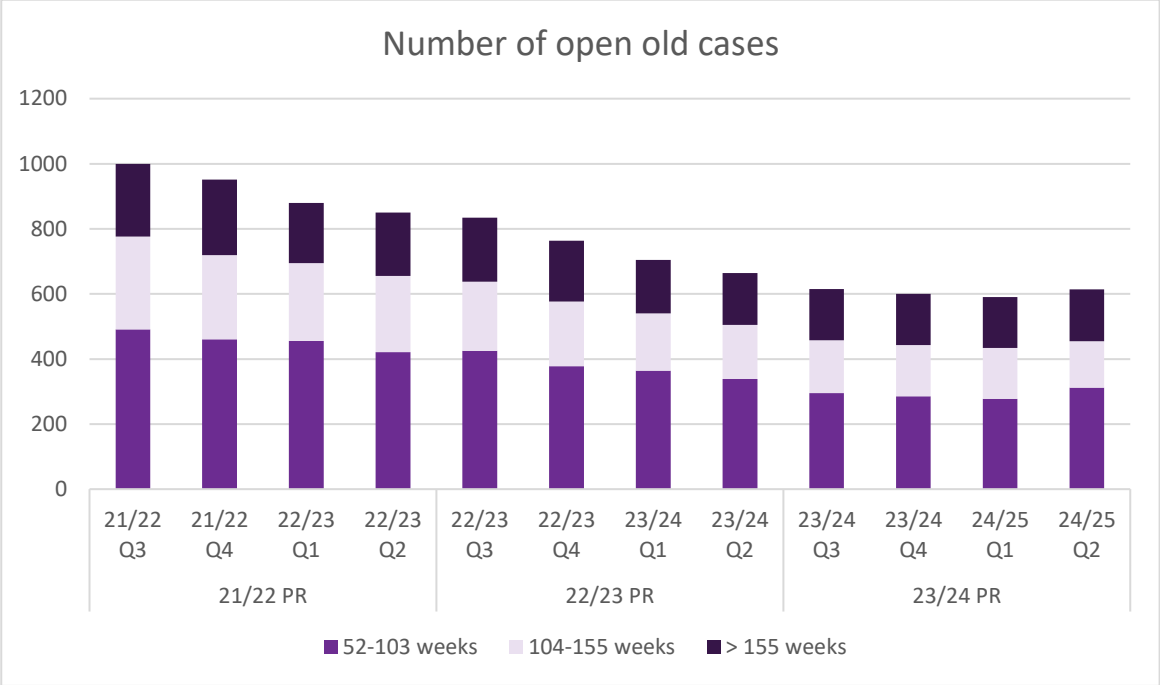
15.1 The GMC met this Standard last year. We said that we expected it to continue to improve its timeliness in fitness to practise.

FTP timeliness

15.2 Our quarterly dataset captures the time it takes for FTP cases to reach key decision points. The chart below illustrates that the GMC has, on average, reached decisions faster this year than last year.



15.3 We also collect regular data on the number of open old cases, that is, cases more than a year old. The chart below shows that the GMC had fewer old cases open at the end of this review period than at its beginning, despite a slight increase in old cases in the most recent quarter.



15.4 The GMC has continued to improve its timeliness for fitness to practise in this review period. The overall time for cases that go to a final hearing remains high and it will be important for the GMC to continue to improve in this area. The data for the final quarter of this review period shows an increase in some of our timeliness measures, but it is too early to say whether this is a change in the overall trend of improving timeliness over recent years. We will continue to monitor this closely.

Audit of FTP cases

15.5 We reviewed a sample of fitness to practise cases closed at the early stages of the GMC's process, to help us understand how fairly and effectively this is working to protect the public. We looked at cases closed at the following points:

- Triage: our sample included cases closed with a Rule 4 decision and cases closed without one.
- Provisional enquiry: the GMC's Rules allow it to carry out limited enquiries to assist its triage decision.
- Case examiner: cases that pass triage must be referred to a pair of case examiners to decide whether there is a real prospect of a hearing finding that the registrant's fitness to practise is impaired.

15.6 We also looked at a sample of cases the GMC had considered under Rule 12, which allows it to reconsider decisions to close cases where there has been a material error, or new information becomes available which might have affected the decision. In addition, our audit included cases to inform our consideration of the GMC's handling of allegations about sexual misconduct (see below).

15.7 Overall, we found high levels of compliance with the GMC's processes and decision-making guidance. In nearly all the cases where the GMC had made a

formal decision, we were assured that the decision was reasonable and protected the public. Where we gave the GMC feedback about individual cases, it shared more information with us, including about other action it was already taking to manage relevant risks.

15.8 We had concerns about four cases the GMC had closed without a Rule 4 decision. We considered that the GMC did not yet have enough information to be assured that it was appropriate to close these cases without further enquiries. All four of these cases were in our sexual misconduct sample and we were not assured that the decision to close these cases reflected the seriousness of the allegations. The GMC provided further information about action it had taken in these cases:

- In two cases, this included following up with the police under its third-party investigation process.
- In one case, the GMC said it was considering further action based on our feedback, and it was already engaging with the registrant's Responsible Officer in relation to local concerns.

15.9 As noted above, the GMC's position is that closing cases without a Rule 4 decision means that they can be progressed once further information becomes available. We also note the steps it has taken in relation to the cases we raised, and the measures it has in place to monitor cases closed in this way.

15.10 In all the Rule 12 cases we reviewed in our audit, decision-makers applied the relevant test reasonably. This reflected that Rule 12 is a specific and relatively narrow decision about whether there is evidence of a material flaw or new information relevant to a previous decision.

15.11 The GMC provided data about its handling of Rule 12 cases. The data showed that most Rule 12 requests were closed at Rule 12(2).[24] The average time taken to make Rule 12(2) decisions in the period covered by the data was around six weeks. We considered this was a reasonable timescale for a process to review an initial decision.

Handling of allegations about sexual misconduct

15.12 As part of our review of the GMC this year, we wanted to understand more about its handling of FTP referrals about sexual misconduct. As noted at Standard 6, the GMC updated *Good Medical Practice* so that it addresses sexual harassment in the medical profession more clearly. We have also seen relevant information through other areas of our work, such as our reviews of final FTP decisions and information people share with us about their experiences of raising concerns with regulators.

[24] The Rule 12 process has two decision points: the first at Rule 12(2), a decision whether to undertake a review; then, if a review is undertaken, its outcome at Rule 12(8).

15.13 For our audit, the GMC provided a list of cases where one or more of the recorded allegation types might indicate a referral about sexual misconduct.[25] It was acknowledged that this would result in a number of false positives within the sample. The GMC said that it uses a combination of search methods when it needs to be able to identify cases about sexual misconduct more specifically.[26] We recognise the difficulty of reliably identifying on receipt whether a referral might be about sexual misconduct, as there may be limited information available at that point. We consider that this might be an area for further reflection with regulators more generally.

15.14 In the cases in our audit sample, where the GMC had made a decision on cases including allegations of sexual misconduct, we were satisfied the outcomes were reasonable and sufficient for public protection. As noted above, we were less assured about four cases closed without a Rule 4 decision, though we agreed that the GMC did not have information to take those cases forward.

15.15 We also looked at the data the GMC had shared with us, though we acknowledge its limitations. This indicated that cases including a potential sexual misconduct allegation were, on average, more likely to be referred to the case examiners than cases not including such allegations. This is consistent with the GMC's guidance that such allegations are serious.

15.16 We also engaged with a stakeholder group to understand more about people's experiences of raising concerns with the GMC about sexual misconduct.[27] We are particularly grateful to two people who shared detailed feedback about their own experiences. The feedback highlighted themes including concerns about inconsistency in the advice given to complainants, and a perception that there was a lack of specific expertise in dealing with cases of this type.

15.17 We shared this anonymised, thematic feedback with the GMC. The GMC provided further information about the programme of work it began some years ago to embed learning from cases about sexual misconduct. The GMC has been working with stakeholder groups including people with specialist experience and/or lived experience of sexual misconduct and harassment to produce documentation for survivors of sexual misconduct explaining its fitness to practise processes. It has also worked with a specialist training provider to deliver targeted training for its staff who handle sexual misconduct and harassment concerns. It plans further work to build on this training.

15.18 The GMC has also produced further guidance for Responsible Officers and employers about the handling of concerns about sexual misconduct. The guidance emphasises the seriousness of this conduct and Responsible Officers' obligations

[25] This included alleged conduct both within a doctor's clinical practice and in their private life.
[26] It has also introduced a new specific allegation type on its system for sexual harassment, in line with the updated *Good Medical Practice*.
[27] We spoke with a group that campaigns against sexism and sexual harassment in the healthcare workforce. It includes doctors who have made referrals to the GMC about sexual misconduct by colleagues.

under the updated version of Good Medical Practice, as well as signposting to other sources of advice and guidance.

Conclusion

The GMC has continued to improve its fitness to practise timeliness. It will be important for it to continue to improve, particularly as the end-to-end time remains high. We audited a sample of GMC cases and found high levels of compliance with the relevant processes. We obtained more information about the GMC's use of Rule 12 and its handling of cases including allegations of sexual misconduct. Where we shared feedback with the GMC about themes or individual cases it has provided further information about work undertaken or in progress to address the issues raised. We will continue to monitor the progress of its work to embed learning about handling cases of sexual misconduct. The Standard is met.

16 The regulator ensures that all decisions are made in accordance with its processes, are proportionate, consistent and fair, take account of the statutory objectives, the regulator's standards and the relevant case law and prioritise patient and service user safety.

Audit findings

16.1 As explained above, our audit found that GMC decisions against its formal decision points were reasonable and sufficient to protect the public. We had concerns about four cases closed without a Rule 4 decision, and the GMC shared more information about how it monitors cases closed in this way.

Reviews of final fitness to practise decisions

16.2 During this review period we have lodged appeals against two final decisions of the Medical Practitioners Tribunal Service (MPTS)[28] on the grounds that they were insufficient for public protection. We also joined the GMC's appeal against the outcome of another case, about sexual misconduct towards colleagues. This appeal was allowed both on the grounds put forward by the GMC and our additional grounds.

16.3 We have also shared learning points with the MPTS from our reviews of final fitness to practise hearings. We identified fewer learning points this year than last year. The MPTS said its Quality Assurance Group had discussed and noted the learning points we raised.

[28] The MPTS is the GMC's hearings service.

16.4 We have been monitoring the effect of changes to the GMC's charging guidance, which was updated to include reference to charging sexual motivation in cases of sexual harassment. We did not see a pattern of learning points about this issue this year. We will continue to monitor it.

Court judgments

16.5 We reported last year that an Employment Appeal Tribunal (EAT) upheld the GMC's appeal against a decision that it had discriminated against a doctor on the grounds of his race. The doctor appealed the EAT's decision, but in July 2024 the Court of Appeal dismissed his appeal. The case is to be heard by a new Employment Tribunal.

16.6 We also noted last year the outcome of a judicial review which overturned a decision to grant a doctor voluntary erasure from the register. At a hearing during this review period, the doctor was erased from the register for deficient professional performance.

Conclusion

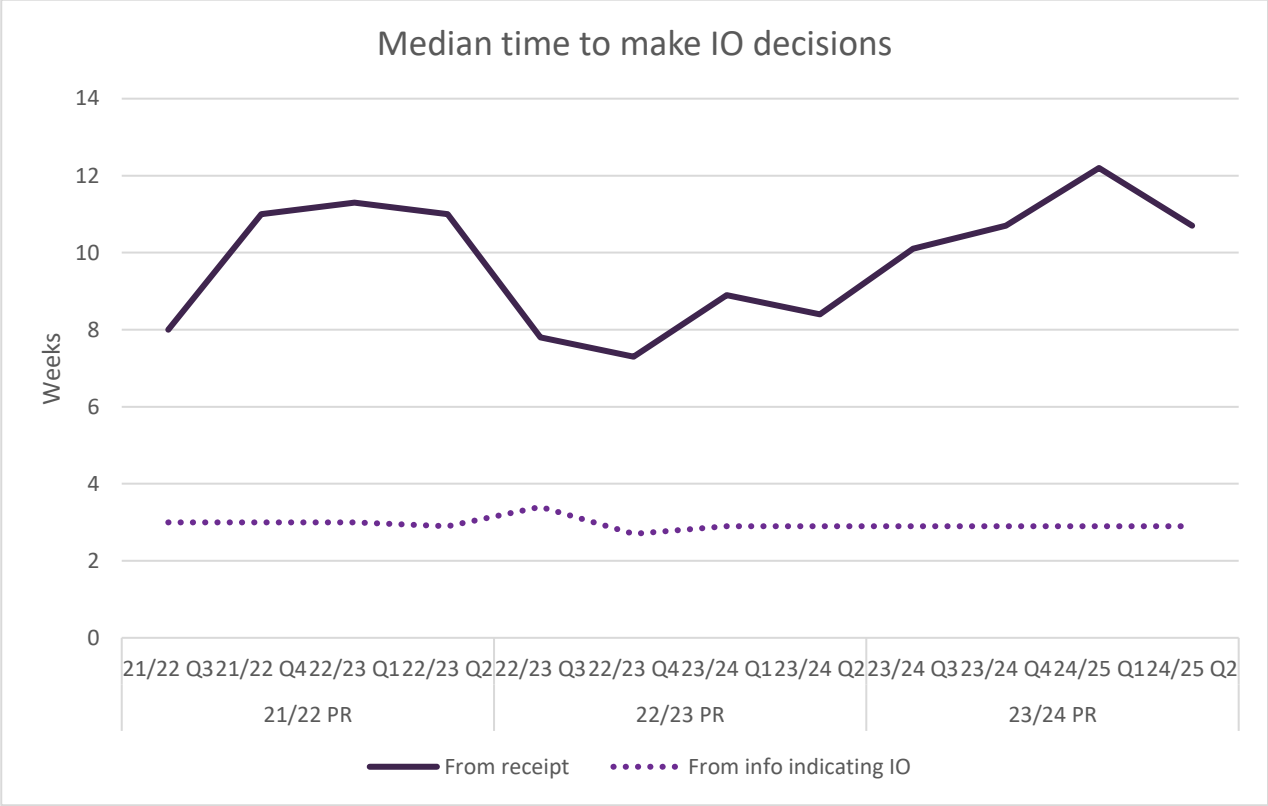
We have not seen significant concerns about the GMC's decision-making in fitness to practise. There have been small numbers of appeals and learning points from our reviews of final fitness to practise hearings. The Standard is met.

17 The regulator identifies and prioritises all cases which suggest a serious risk to the safety of patients or service users and seeks interim orders where appropriate.

Interim order timeliness

17.1 The chart below shows the time the GMC has taken to make decisions about interim orders. The time it takes to make interim order decisions once it has identified the need for one remains stable and low. The average time from receipt to interim order decision has increased slightly during this review period. However, the GMC remains at the faster end of the regulators we oversee, according to this measure.[29] We are not concerned about how long it is taking the GMC, on average, to make interim order decisions.

[29] Different regulators' data may not be directly comparable, due to differences in processes, operating context and powers.



Audit findings

17.2 We considered the GMC's management of risk in FTP cases in our audit. The GMC does not require risk assessments to be separately documented as other regulators we oversee do. It was often not clear from our initial file reviews how or when the GMC had considered the risks arising from information received. The GMC provided further information, including: notes of relevant FTP history; additional records of consideration of possible interim orders; notes of staff discussions about case progression. This provided some further assurance that there was regular consideration of risk, though there remained gaps in the evidence.

17.3 We did not see in our audit any cases where we considered the GMC had failed to seek an interim order when one was needed. We saw cases where the GMC appropriately sought interim orders.

17.4 We were not assured about how risk had been taken into account in decisions to close potentially serious cases without a Rule 4 decision. A clearer record of how and when the risks on a case were considered would have helped the GMC demonstrate that all relevant risks were being promptly considered. The GMC said it was confident that risks were being actively considered throughout the life of a case, but acknowledged that this was not easy to evidence from the records. It said it would reflect on our feedback and consider whether there were proportionate improvements it could make to recording.

17.5 In our view, improved recording of risk assessments could add significantly to the assurance the GMC can provide itself and us about how it is identifying and

managing the risks arising from FTP cases. Limited record-keeping could also increase the risk of human error, for example when cases are transferred between stages or case holders. There is an opportunity for the GMC to improve the controls it has in place, by being clearer about how and when staff are identifying, considering and responding to evidence of risk in cases. We will closely monitor how it considers our feedback and any action it takes as a result.

Conclusion

We do not have concerns about how long it takes the GMC to make interim order decisions. Our audit found room for improvement in how the GMC records consideration of risk arising from information it receives, but we did not find evidence that it had failed to take action when this was necessary. This Standard is met. We will closely monitor how it considers our feedback any action it takes as a result.

18 All parties to a complaint are supported to participate effectively in the process.

18.1 The GMC continues to provide support to people involved in the fitness to practise process, both complainants and registrants. As mentioned at Standard 14, it offers an Independent Support Service to help people who are involved in fitness to practise referrals. We received a small number of concerns this year about the customer service provided by the GMC.

18.2 We looked in our audit at how the GMC supported people to participate in the process. The correspondence we saw was generally empathetic and appropriate in tone. We saw that referrers and registrants were routinely signposted to sources of further support. We identified examples of good practice and shared these with the GMC, for example:

- In a case where concerns had been raised about the registrant's health, the GMC contacted them regularly to explain the process and signpost to sources of support; the case had to be transferred between staff, and this was managed well.
- In a case where the referrer was deaf, the GMC offered extra provision to ensure the process was accessible, and its communication was empathetic and clear.

18.3 As noted in Standard 15, the GMC has been working with stakeholder organisations to develop the support it offers to people making referrals about sexual misconduct. It is also providing targeted training for its staff who deal with sensitive cases. The training has been developed in collaboration with charities who support victims of sexual misconduct.

18.4 We did not see in our audit any cases where we had concerns about how the GMC communicated with people making referrals about sexual misconduct. Our sample was relatively small, and we acknowledge that cases of this nature are

likely to be especially difficult for those affected. It is appropriate for the GMC to work with relevant stakeholders to support continuous improvement in this area.

Conclusion

The GMC continues to offer support to people involved in its fitness to practise process. In our audit, we found that the GMC was communicating appropriately and empathetically with people. We agree it is appropriate for the GMC to work with relevant stakeholders to support continuous improvement in this area. This Standard is met.

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