

*To consider*

**Chief Executive's Report**

**Issue**

1. The Chief Executive's regular reports for each Council meeting update members on progress against the key aims in the business plan. The first report each year reflects on achievements and outcomes in the previous year. This report reviews 2008, mapped against the key aims in the 2008 Business Plan.
2. To consider the Chief Executive's review of 2008 (paragraphs 6-95).

**Further information**

3. If you require further information about this paper, please contact us by email: [gmc@gmc-uk.org](mailto:gmc@gmc-uk.org) or tel. 0161 923 6602

## Background

4. In February 2007, the Government published the White Paper, *Trust, Assurance and Safety – the Regulation of Health Professionals in the 21st Century*, outlining a programme of reform for the regulation of all health professionals in the United Kingdom. The White Paper endorsed many of the GMC's proposals for establishing an accountable and fair system of medical regulation, independent of Government – as the dominant provider of healthcare in the UK – and independent of dominance by any single group.

5. In 2008 we continued to implement our programme of reform, building on the foundations laid in 2007.

## Discussion

*Key Aim 1: To operate an independent, accountable and integrated system of medical regulation that commands the confidence and support of our key interests.*

6. The White Paper Implementation Steering Group met five times and provided assurance to Council on the overall status of the implementation programme against Council's agreed target dates and milestones.

7. We completed the transition to the reconstituted Council. We worked closely with the Appointments Commission to secure the appointment of 24 Council members reflective of key interests from the four countries of the UK.

8. We worked with the Department of Health for England to ensure that the required legislation came into effect on 1 January 2009.

9. We developed a governance model to support the reconstituted Council and proposed arrangements for the election of the successor to Sir Graeme, as Chair.

10. We worked closely with the four health departments, and with others, to deliver the White Paper proposals. This included participation in Sir Liam Donaldson's Medical Revalidation Working Group, which led to the publication of the report, *Medical Revalidation: Principles and Next Steps*, in July 2008.

11. Paul Philip chaired the GMC Affiliates sub group of the Tackling Concerns Locally Working Group. We developed proposals for two pilots – in Yorkshire and Humberside, which began on 1 September 2008; and in London, which began on 1 October 2008. The pilots will run for 12 months; and DH(E) have appointed KPMG to evaluate them. KPMG will evaluate the pilots against four criteria;

a. The model supports consistent, effective and robust decision making, which contributes to and enhances both public and professional confidence, whilst being generalisable and enduring over time and location.

b. Data is readily available and accessible, relevant, reliable and verified, comparable, complete and consistent.

c. Good quality cost data exists to allow analysis of the impact of Affiliates within their local 'patch'. These costs can be used as a basis for considering scaling-up of the Affiliates model to support UK wide coverage.

d. Sufficient qualitative data can be gathered to measure the perception and reputation of the Affiliates and the extent to which their role is seen to be key in the interface between local clinical governance frameworks and national health regulation, leading to greater, trust, assurance and safety.

12. Our offices in Northern Ireland, Scotland and Wales continued to work closely with the devolved administrations and with key interests. We participated in a range of events designed to maintain momentum on the White Paper proposals. We attended a wide range of other meetings and events to promote our work, including our plans for licensing and revalidation.

13. We continued to develop a broad evidence base to underpin the Council's approach to regulation. We have established a programme of independent research that has begun to explore questions relating to the nature, quality and delivery of medical regulation, including aspects of equality and diversity.

14. Our research programme has been taken forward, in part, through a partnership arrangement with the Economic and Social Research Council under its Public Services Programme.

15. Baroness Amos of Brondesbury agreed to chair the Equality and Diversity Research Forum. The aim of the Forum is to inform the development of our research agenda and to provide the opportunity for researchers to discuss their projects. The Forum met in September 2008 and will meet again in 2009.

*Key Aim 2: To deliver effective and responsive regulation by engaging fully with those receiving and providing healthcare across the four countries of the UK.*

16. The Public and Patient Reference Group met four times and contributed to a number of policy initiatives, including development of our plans for revalidation, the reviews of *Tomorrow's Doctors* and our guidance on end of life issues, and insurance and indemnity.

17. We continued to engage with doctors in the four countries on a range of issues. This included our plans to introduce licences to practise in autumn 2009 and progress toward revalidation.

18. In partnership with the King's Fund and the Royal College of Physicians of London, we held road shows for medical students to debate the role and importance of professional values. We organised a student forum to identify areas of our work that interest medical students and to explore approaches to engaging students.

19. With the Medical Schools Council, we held a workshop on student fitness to practise, as part of the consultation and engagement process for guidance on student fitness to practise.

20. We implemented a new relationship management system to support our engagement work; and developed proposals for strengthening how we engage with key interests.
21. We worked towards strengthening the connections between national and workplace regulation through our representation on the six sub groups of the White Paper Tackling Concerns Locally Working Group. The aim of the Working Group is to strengthen local arrangements for identifying poor practice among healthcare workers and taking effective action where poor practice is suspected.
22. I signed a memorandum of understanding with the NHS Scotland Counterfraud Service.
23. We contributed to the development of healthcare professional regulation, within Europe and internationally.
24. The President called on MEPs to recognise the importance of sharing disciplinary information about health professionals to ensure patient safety across Europe at a meeting at the European Parliament in January 2008.
25. We continued to manage the Healthcare Professionals Crossing Borders initiative on behalf of all European regulators. We further raised the profile of the initiative and launched a website to promote it ([www.hpcb.eu](http://www.hpcb.eu)). We attended a meeting in Oslo in May 2008 to discuss implementation of the HPCB's Memorandum of Understanding on Case-by-Case and Proactive Information Sharing. Paul Philip spoke on revalidation at the HPCB's spring conference in June 2008.
26. The EC published a draft Directive on the application of patients' rights in cross-border healthcare on 2 July 2008. The draft Directive raises significant issues for patient safety. We produced a position paper, held meetings with key interests at the European Parliament, hosted a seminar in Edinburgh, responded to the DH(E)'s consultation, and gave oral evidence to a House of Lords Sub Committee on the Directive.
27. Council members and senior GMC staff attended and participated in the 8th Conference of the International Association of Medical Regulatory Authorities in Cape Town. The conference theme was 'Medical professionalism: the building blocks'.
28. We launched initial consultations as part of the reviews of our guidance on involving patients in research and on confidentiality.
29. We launched formal consultations as part of our reviews of our guidance, *Confidentiality: protecting and providing information* and *Tomorrow's doctors*.

30. We promoted Welsh-language versions of some of our guidance, including *Good Medical Practice, 0-18 years: guidance for all doctors*, and *Consent: patients and doctors making decisions together*, at the National Eisteddfod in Cardiff in August 2008. The Deputy Minister for Health and Social Services in Wales welcomed the Welsh-language versions, recognising their importance for the Welsh-speaking public, including children, young people and doctors.

*Key Aim 3: To enhance the role of the Medical Register as the single authoritative source of information on doctors, and as a national resource for patients, employers and the profession.*

31. We prepared for the introduction of licences to practise in autumn 2009, as the first step to implementing revalidation. This included drafting regulations and guidance, on which we are now consulting; developing a revised fees framework to take account of licence to practise; and continuing to plan for compulsory insurance and indemnity.

32. The Registration Committee agreed the data set for the collection of scope of practice information from doctors who wish to hold a licence to practise.

33. We engaged with key interests across all four UK countries to communicate our plans for revalidation and the changes that will take place on the introduction of licence to practise. We wrote to registered doctors who will be affected, to explain the action they need to take, and to some others, including the NHS and other healthcare providers, and patient groups. We participated in events and meetings across the UK to raise awareness of our plans and organised key conferences, seminars and workshops.

34. We established the UK Revalidation Programme Board, which will meet for the first time on 10 February 2009. The Board includes representatives from the four UK administrations, the Academy of Medical Royal Colleges, the BMA, patient organisations, and the NHS and other healthcare providers. Sir Michael Pitt has been appointed as Chair.

35. We continued to develop patient and colleague questionnaires. The results of the first phase of a pilot study, undertaken by Professor John Campbell at Peninsula Medical School, were published in the BMJ's *Quality and Safety in Healthcare* in June 2008.

36. We have commissioned the research team to undertake further, more in-depth, testing of the questionnaires across organisations and in different clinical settings.

37. We worked with the Academy of Medical Royal Colleges to develop process models for recertification. We sought the views of NHS and other healthcare providers on the models to help to shape piloting work later in 2009 and 2010.

38. We embarked on a number of revalidation projects with organisations across the UK. The aim is to gain a better understanding of how key components will work at a local level.

39. The Revalidation in General Practice in Wales project, which we are leading with the Postgraduate Deanery in Wales, is looking at the readiness of appraisal and clinical governance systems in local health boards to support revalidation through the development of a self-assessment tool for employing organisations.
40. We are working with NHS Professionals (Doctors), Buckinghamshire Primary Care Trust and 10 secondary care trusts in Merseyside on the types of evidence and supporting information that doctors in different settings bring to appraisal.
41. We cooperated with DH(E) on legislation to restore the 'existing specialists' route to the specialist register, for those who were consultants in the NHS before 1 January 1997. We launched a formal consultation on how the scheme would operate.
42. We implemented a new service to support the download of the List of Registered Medical Practitioners. This includes an interface with DH(E)'s electronic staff records. The service provides an initial copy of the LRMP, with daily updates.
43. Following advice from leading counsel, Council agreed to end age exemption from the annual retention fee as it was deemed unlawful under age discrimination legislation. We wrote to all affected doctors to explain the decision and the action they needed to take.
44. Key registration statistics for 2008 are at Annex A.
45. New registrations totalled some 18,500, compared with some 22,500 in 2007. The number of UK graduate applications granted rose by 9% (1,000), as a result of the increased output from the new UK medical schools.
46. EEA applications granted dropped by about 12% (350). This was attributed to the general fluctuation in demand.
47. We granted 2,800 applications for registration from international medical graduates in 2008, compared with 7,700 in 2007. However, these figures are not directly comparable. In October 2007 we introduced the new registration framework, which removed the requirements for IMG doctors to apply for the renewal of their limited registration (approximately 1,500 grants in 2007) and to move from limited to full registration (approximately 2,800 grants in 2007). Therefore, comparing like for like figures would highlight a drop in IMG application grants of 18% (600) between 2007 and 2008. We believe that this drop is linked to the change in visa requirements for overseas doctors, changes in the application process for specialist training and increased competition from UK graduates.
48. The fall in registration applications led to a corresponding reduction in calls to the Contact Centre and in visitors to our reception.
49. Registration Directorate continued the rolling programme of continuous improvement. This includes reviewing and improving business policy and procedures, recruitment processes, staff training and communications with key interests.

*Key Aim 4: To support the delivery of high quality care to patients by setting rigorous standards for doctors and co-ordinating all stages of medical education.*

50. On 28 February 2008, the Secretary of State for Health announced that the Postgraduate Medical Education and Training Board would be merged with the GMC. The target is to achieve the transfer of functions not later than April 2010.
51. We have worked closely with PMETB on preparation for the merger. We jointly commissioned Towers Perrin to undertake a scoping study to provide a solid factual basis for taking forward the mechanics of the merger. We established oversight arrangements to support the merger process and to provide assurance to each governing body that risks are managed, plans developed and resources are in place.
52. We invited Lord Naren Patel to review the medium and long-term options for developing the new regulatory framework for medical education. The review is in the early stages. Lord Patel will consult widely and, following an interim report, will make final recommendations early in 2010.
53. We completed the translation of *Good Medical Practice* into a framework for appraisal and assessment in support of revalidation. The proposal is that the framework should be incorporated as a module in NHS and other appraisal systems.
54. We published revised guidance, *Consent: patients and doctors making decisions together*, and revised supplementary guidance on conflicts of interest, prescribing and doctors' duty to report criminal and regulatory proceedings to the GMC.
55. We published new supplementary guidance, *Personal beliefs and medical practice*; and *Acting as an expert witness*.
56. Jointly with DH(E), we published interim guidance on reporting knife wounds. Revised guidance on confidentiality, which we will publish in 2009, will include advice on reporting knife and gunshot wounds.
57. We developed guidance on how *Good Medical Practice* will apply during a pandemic. This will be published in January 2009.
58. Together with 11 medical schools, we developed guidance on encouraging individuals with disabilities into medicine. The project was match-funded by the Department for Innovation, Universities and Skills under their Gateways to the Professions Scheme. We published the guidance, *Advising medical schools: encouraging disabled students*, in March 2008.
59. In partnership with the Medical Schools Council, we developed revised guidance on student fitness to practise to be published in 2009.
60. We evaluated and reported on eight medical schools.

61. We conducted quality assurance reviews of two deaneries and their delivery of the Foundation Programme. We will publish reports in January 2009.
62. We developed and published guidance for medical schools to ensure effective regulation and quality assurance of UK medical education delivered outside the UK.
63. Two additional UK primary medical qualifications were recognised under the Medical Act 1983 – from Hull York Medical School and from Brighton and Sussex Medical School.

*Key Aim 5: To enhance patient safety by improving further the procedures for dealing with doctors whose fitness to practise may be impaired.*

64. We introduced the civil standard of proof for fitness to practise panel hearings starting on or after 31 May 2008. Implementation included extensive training for panellists, legal assessors and staff.
65. We launched a new interactive web zone on our website, *Good Medical Practice in Action*, to bring our core guidance, *Good Medical Practice*, to life. *Good Medical Practice in Action* invites users to be the doctor in a series of ethical case studies, set in both primary and secondary care, to highlight important issues addressed in *Good Medical Practice*.
66. We developed and published a new information centre on the website to help those who have a concern about a doctor to navigate the complaints system. The new site, *Patient's Help*, includes contact details for local help and advice across the UK, case studies and an online complaint form.
67. We continued to work with healthcare providers on the early identification of problems and on appropriate remedies. We took forward this work through participation in the White Paper Tackling Concerns Locally Working Group and its six sub groups.
68. We reviewed and consulted on our Indicative Sanctions Guidance. We will publish revised guidance in 2009.
69. We published a new section on our website dedicated to witnesses giving evidence at hearings before fitness to practise panels. This includes information about our fitness to practise procedures and the help available.
70. On 1 November 2008, we launched a pilot project, involving Victim Support and Action Against Medical Accidents, to improve support for vulnerable witnesses at fitness to practise panel hearings. The pilot will run for 12 months.
71. We continued to improve performance against the fitness to practise service targets. Details are at Annex B, which includes information on caseloads and outcomes.

72. The Interim Orders Panel sat for 278 days in 2008, compared with 232 in 2007 (an increase of 20%). 388 interim orders were in place at the end of December 2008, compared with 360 at the end of December 2007.

73. Two applications in the High Court against a decision of the Interim Orders Panel remain outstanding.

74. A detailed breakdown of panel hearing days is at Annex C. Panels sat for 2,138 days, compared with 2,249 days in 2007, reflecting a reduction in referrals by case examiners. This appears to be a temporary phenomenon and examiner referrals have increased to a level that will make the continued achievement of service targets particularly challenging in 2009.

75. Average hearing room utilisation was 75%, compared with 74% in 2007.

76. A summary of appeals and judicial reviews in 2008 is at Table 1.

**Table 1:**

	Cases carried forward from 2007	New cases in 2008	Concluded cases in 2008	Cases carried forward to 2009
Appeals	42	31	45	28
Judicial Reviews	25	11	27	9

77. 26 of the appeals carried forward to 2009 remain outstanding. Additional information regarding the outstanding appeals and judicial reviews is at Annex D.

78. There were two referrals by CHRE to the High Court under Section 2. However, CHRE reviewed one decision to appeal and withdrew it. The other remains outstanding.

*Key Aim 6: To enhance the economy, efficiency and effectiveness of the GMC.*

79. We successfully implemented Release 2.2 of the Strategic Applications Project to provide new functions for Fitness to Practise, Registration and Finance.

80. We worked towards the implementation of SAP phase 3, to implement a new Finance, HR and procurement system. This will support developments such as licensing and the merger of PMETB with the GMC. Implementation will take place in the second half of 2009.

81. We worked towards delivering a reviewed and updated pay and reward system, to be implemented in 2009.

82. The British Standards Institute completed an audit against the international standard ISO27001 within Registrations Directorate and Strategy and Planning Unit. On the auditor's recommendation, the Institute extended the scope of our certification from Fitness to Practise to include Registrations and Strategy and Planning. This demonstrated that we have audited policies, procedures and systems in place that ensure the confidentiality, integrity and availability of information we use.

83. We reviewed our internal quality assurance arrangements, with a view to developing a more integrated and consistent assurance framework across directorates.

84. We introduced an online feedback form for users of our website. This enabled us to learn more about our audience, who uses which sections of the website, what users like and dislike about it and suggestions they have for improvements. We postponed further work until 2009, following a decision first to migrate the current intranet to a new web content management system.

85. We relocated our UK Applications Team from London to Manchester. This brought all applications activity within one building, allowing a consistent and streamlined approach to our application processes.

86. CHRE published their performance reviews of the nine healthcare professional regulators in August 2008. The review of the GMC was extremely positive and cited many areas as best practice, including the work of the Evaluation Framework Review Group, with particular reference to ensuring that patient safety is the focus of our work.

87. We reviewed our accommodation needs and chose new offices in Manchester, following a rigorous assessment process. We will move to the new premises in 2009.

88. We are working on the production of the final accounts for 2008. The external auditors will undertake their fieldwork in February 2009. The Resources Committee will consider the draft accounts for 2008, together with the disclosure notes, on 21 April 2009.

89. The actual deficit for the year is likely to be broadly in line with the planned deficit of £5.6 million originally approved by Council. There are, however, a number of year-end accounting entries still to be processed including the final position on the pension fund and a potential provision for the associates tax and national insurance costs, which is subject to discussions with HMRC.

90. The provisional total in the Savings Log is some £1.3 million. The final year end figure will be reported to the Resources Committee.

## *Equality and diversity*

91. We commissioned Shapiro Consulting to undertake an independent review of the current status of our policies, practices and attitudes to equality and diversity and how this compares with experience of good practice in other organisations. The review will inform the development of our diversity strategy in 2009.

92. We completed phase 2 of the ethnicity census of registered doctors in September 2008. We now hold current ethnicity data for approximately 165,000 doctors, about two thirds of those on the register.

93. Council agreed to collect disability data from doctors to support our work to eliminate discrimination and promote equality. In 2009, we will develop plans for the collection of disability data in 2010.

94. In partnership with the Progressive Muslim Forum UK, we held a seminar in October 2008 to discuss issues affecting black and minority ethnic doctors, and to raise the profile of our work to promote equality and diversity, in particular our research partnership with the ESRC.

## *Evaluation framework*

95. The Evaluation Framework Review Group developed a comprehensive framework to assist the reconstituted Council to hold itself and the executive to account for the discharge of the GMC's statutory functions. Early in 2009, the Council will be invited to consider how best to operationalise the framework.

**Recommendation:** To consider the Chief Executive's report.

## **Resource implications**

96. None.

## **Equality implications**

97. None.