13 July 2010

Council

General Medical Council

Regulating doctors
Ensuring good medical practice

To consider

Chief Executive's Report

Issue

1. Progress towards the delivery of the GMC's strategic aims and activities for 2010.

Recommendations

2. To consider the Chief Executive's Report (paragraphs 9-79 and Annexes A-G).

3. To agree that we should retain information about warnings indefinitely; publish both historical and future warnings for only five years; disclose both historical and future warnings to all enquirers for only five years, and to disclose to employers indefinitely (paragraphs 61-67).

Further information

4. If you require further information about this paper, please contact us by email: gmc@gmc-uk.org or tel. 0161 9236602

Background

5. This report brings members up to date on progress towards the delivery of the GMC's strategic aims and activities for 2010.

6. The report is structured around three sections:

a. Section one – sets out the Chief Executive's commentary on our work over the period since the last Council meeting, including important external developments or engagements and the general outlook for the organisation.

b. Section two – provides an exception report on progress against the 2010 Business Plan, highlighting significant developments that are likely to be of particular interest to members, including:

i. Major achievements where we have delivered a significant piece of work or achieved a particularly positive result.

ii. Significant issues or challenges to achieving our objectives.

iii. Significant changes or additions to our activities.

c. Section three – provides a summary of progress against each of the activities in the 2010 Business Plan (Annex A). This is supported by additional information for the period since the last report of 20 May 2010 on:

i. Key operational statistics for Registration (Annex B) and Fitness to Practise (Annex C).

ii. Fitness to Practise actual panel hearing days (Annex D).

iii. Appeals and judicial reviews (Annex E).

iv. Income and expenditure (Annex F).

7. This report looks in detail at operational performance relating to the delivery of our major work programmes. Council has previously agreed that we should broaden our approach to performance management at the GMC by introducing a focus on evaluation, which defines and measures our success in terms of outcomes and impacts, rather than focussing on simply delivering tangible outputs and meeting operational service targets.

8. To achieve this, we agreed to give Council six-monthly updates on progress towards the Business Plan outcomes. A paper on evaluation is at item 7b on the Council agenda for 13 July 2010.

Discussion

Section one – Chief Executive's commentary

Political developments

9. As we come to terms with the era of coalition government, more details are emerging about the new administration and its priorities. Although a great deal of what they are attempting to do in health could have been predicted, the degree of interest in professional regulation at ministerial level is greater than we might have expected and is to be welcomed. There has been active consideration of areas such as language testing of health professionals, the use of data to drive quality, revalidation, and the importance of independent adjudication. Throughout government, and crucial to health policy as well, is a determination to make significant savings.

Emergency budget

10. In the budget, the Chancellor unveiled a £40 billion package of tax rises and spending cuts between now and 2014-15. The details of the spending plans have not yet been revealed but we do not expect the measures to have a significant direct impact on us. However in a variety of ways they are likely to hit healthcare and higher education, affecting those whom we regulate and our other key interest groups. We cannot be immune from the period of austerity which this marks. Among the areas where we shall need to consider are:

a. A two-year pay freeze for public sector workforces from 2011-12, except for those earning £21,000 or less, who will receive an increase of at least £250 in these years. In addition, the Government has commissioned two reports to consider public sector pay and public sector pensions. The first is an independent commission chaired by the Rt Hon John Hutton MP, the former Secretary of State for Work and Pensions, which will undertake a fundamental structural review of public service pension provision. It will report in time for the 2011 Budget and consider the case for short-term savings by September 2010. The second will be led by the commentator, Will Hutton, who will conduct an Independent Review of Fair Pay in the Public Sector. The Review will produce an interim report in autumn 2010, with a final report to the Prime Minister and the Chancellor in March 2011.

b. There will be cuts in most departmental budgets of around 25% over the next four years, although, as mentioned in my previous report, health spending will receive a degree of protection by the commitment to see that health spending rises in real terms during every year of the Parliament. Details of where the reductions will take place across Whitehall will be revealed in the Comprehensive Spending Review in October 2010.

c. Despite the ring-fencing of the Department of Health's budget, the NHS will have to make significant savings to meet increasing demand with minimal growth in resources. The Health Secretary announced on 21 June 2010 that the NHS in England is to make immediate efficiency savings by tackling escalating management costs. National targets which were a key feature of the last administration's performance management of the service have been scrapped – this includes the removal of the guarantee of an appointment with a GP within 48 hours; changes to the four-hour Accident and Emergency target; and 18-week hospital treatment waiting time targets.

d. No specific references were made to healthcare regulation, but business regulation will be reduced with a commitment to reduce regulatory costs by introducing a 'one-in-one-out' system for new regulations. The Department for Business, Innovation and Skills will publish more details in July 2010.

e. There are no further reductions in capital spending beyond the cuts already announced as part of the £6.2 billion of savings in 2010-11.

11. In advance of the much bigger cuts announced in the emergency budget, the new administration cancelled 12 projects totalling £2 billion and suspended 12 projects totalling £8.5 billion. Projects have been cancelled where they have not demonstrated value for money, and suspended where more detailed work is needed as part of the Comprehensive Spending Review process. Even though areas including libraries, schools, hospitals, and specific companies will be hit, it could be argued that these pre-budget cuts have greater political than economic significance as they only represent 0.05% of public expenditure.

Queen's Speech

12. The new Government's priorities for healthcare were unveiled in the Queen's Speech on 25 May 2010. A new Health Bill will seek to give health professionals and patients more say over NHS decision-making. Four key elements of the Bill are to establish an independent NHS Board to allocate resources and provide commissioning guidance; to allow GPs to commission services on behalf of their patients; to improve efficiency and outcomes by strengthening the role of the Care Quality Commission and developing Monitor into an economic regulator; and to cut the number of health service quangos. The Queen's Speech also contained a range of measures aimed at reducing the role of the State and reducing bureaucracy and regulation.

Queen's Speech debate – health issues

13. In the Queen's Speech debate the Secretary of State stressed the need for a change from 'a command-and-control, top-down system of running our schools, hospitals, healthcare and social care services to one that is built on standards of delivering quality.' He went on to say that patients require greater information, choice and control and those who deliver healthcare should be able to do so with 'a much greater sense of ownership'. The health reforms will have a significant impact on doctors in all specialties and especially GPs who will face major reorganisation and new responsibilities for commissioning.

Health Select Committee

14. The new Chair of the Health Select Committee is the Rt Hon Stephen Dorrell MP, a former Health Secretary. I met with Stephen Dorrell on 22 June 2010 and discussed a wide range of issues, including language testing and revalidation. Once the members of the Committee are in place, it will be important to engage directly with them and explain our role and ambitions.

Labour's interim shadow health team

15. The members of Labour's interim shadow health team have been announced. The Shadow Health Secretary is the Rt Hon Andy Burnham MP, the former Health Secretary and a prospective Labour leadership candidate.

Meetings with ministers

16. The Chair and I met the new Secretary of State on 21 June 2010 following an exchange of letters. In his letter to Sir Peter, Andrew Lansley indicated his intention to extend the revalidation pilots in England and to proceed to lay the regulations before Parliament to establish the role of Responsible Officer. He also made it clear that the Government believes revalidation must be proportionate and not bureaucratic but that he was committed to the principle and acknowledged that this was something patients expected.

17. The meeting was very positive and we discussed a range of issues including revalidation, where the Secretary of State confirmed his commitment, and language testing where we agreed to work together to find a solution that was acceptable to the European Commission and which provided adequate safeguards for patients.

18. I have also had a productive meeting with Anne Milton MP, the minister responsible for professional regulation. She acknowledged the progress the GMC had made in recent years, and was fully behind revalidation, providing we can make it proportionate. She was also very keen that we were able to ensure that doctors coming to practise in the UK could communicate effectively in English.

Revalidation

19. We report elsewhere in detail on our consultation exercise which was a significant piece of work and which attracted nearly 1000 responses from both individual doctors and organisations. We had always intended that this would help us develop the approach and the model of revalidation and that is what we will now do. Overall, it is clear that most respondents support the principle but many have reservations about the practicalities. Once we have assessed the responses in detail we need to work with partners to adapt the proposals. While we accept there is a great deal more to do, all the indications we have so far suggest that there is a shared commitment to make this work and that is encouraging.

Regulatory change

20. Regulatory change has also been an important early element of the new Government's agenda. Thus far this has included sweeping changes to the financial regulatory system and the abolition of the General Teaching Council for England, which the Government claimed did little to raise teaching standards or professionalism.

21. The arguments used for regulatory reform underline the need for us to continue to demonstrate added value and the importance of being able to demonstrate having a real impact on standards and professionalism.

22. There has inevitably been some speculation about the future of the Office of the Health Professions Adjudicator, given the Government's need to save money and its commitment to reduce the number of arms length bodies. However, no decision has been made and we will continue to work on the assumption that the current plans will go ahead and with the aim of making sure that there is a smooth transition of our adjudication function to OHPA in April 2011.

Wider regulatory environment

23. We welcomed Professor Sir John Temple's report into the impact of the European Working Time Directive (EWTD) on postgraduate medical education and training, which concludes that high-quality training can be secured but not if trainees have the major role in providing out-of-hours services, are poorly supervised, or have limited access to training. The report makes an important contribution to our understanding of the impact of the EWTD. It clearly highlights a number of problems at the front line and, as the regulator of all stages of medical education and training across the UK, we have a key role, with others, in ensuring that these problems are addressed so that the quality of training is maintained and enhanced.

24. As well as through our meetings with ministers we have been working to find an answer to the issue of the language knowledge of the medical profession, which has continued to receive considerable media attention. We are now a key player in helping to inform the revision of the Directive on the mutual recognition of professional qualifications, which is expected by 2012. The European Commission invited us to convene an informal network of competent authorities for doctors to assist member states with the drafting of national reports on how the Directive is being implemented in different jurisdictions. This should give us an important opportunity to share our concerns with the current recognition regime at an early stage.

25. The first meeting of this group took place on 7 May 2010 in Paris, and I chaired a further meeting in London on 2 July 2010, at which 17 nations from the EU were represented, together with senior officials from the Commission. We discussed a wide range of issues including the automatic recognition of qualifications, temporary mobility, minimum training requirements and continuous professional development, as well as fitness to practise information sharing and patient safety concerns. A further meeting will be held in Berlin in September 2010. The Commission has made it clear how much they value the support we have given in helping them to start their review of the Directive.

26. Following publication in February 2010 of the *Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009*, a public inquiry was announced on 9 June 2010. It will be chaired by Robert Francis QC who headed the original inquiry and he has been asked to report by March 2011. Its remit is to ‘examine the operation of the commissioning, supervisory and regulatory organisations and other agencies, including the culture and systems of those organisations in relation to their monitoring role […] and examine why problems at the Trust were not identified sooner; and appropriate action taken’. The GMC, along with others, has been included on the ‘provisional list’ of bodies whose operations will be within the scope of the inquiry but we are not considered to be among the core organisations and, although these things can change, at this stage our understanding is that we will not be asked to give oral evidence.

Other issues

27. As previously reported we have set up a working group to produce new guidance for doctors working in child protection. The group will hold its first meeting on 7 July 2010 under the chairmanship of Lord Justice Thorpe. Three members of Council, Terence Stephenson, John Jenkins and Ros Levenson are members of the group.

28. As reported elsewhere we have had discussions with the Royal Colleges, representatives of junior doctors and postgraduate deaneries to resolve the question of when professional examinations can be taken in order to count towards a CCT. We have made real progress on this issue and with good will on all sides I very much hope we can not only solve the immediate uncertainty but find a way forward which preserves the integrity of postgraduate programmes while providing flexibility to trainees.

29. I am sure members will wish to congratulate our Chair, Peter Rubin, on the award of his Knighthood for services to medicine in the Queen's Birthday Honours, which were published on 12 June 2010. This is a richly deserved award and is recognition of a highly distinguished career in medicine and research, as well as a great contribution to medical education and regulation. It also reflects well on the GMC and what Peter has achieved in the years he has served this organisation.

30. We also remember Dr Roger Brearley, who sadly passed away recently. Dr Brearley was an elected member of the Council from 1979 to 1984. We have passed on the sympathies of the Council to his family, which includes former GMC Council member and Chair of the Registration Committee, Mr Stephen Brearley.

31. Two fairly high profile judicial reviews have concluded since my last report and are worthy of specific comment. The first was the judicial review by Remedy UK of our decision not to open an investigation in relation to the Chief Medical Officer for England regarding his role in relation to the Medical Training Appointments System (MTAS). The application was dismissed in full and our decision upheld. The second case was a judicial review of a decision to erase a doctor from the register in 1987. The individual in question was a former member of Council. The judicial review was not allowed. We are seeking our legal costs in both cases.

Appointment of a new Council member

32. The recruitment campaign for the appointment of a lay member to fill the vacancy on Council (following Sir Rodney Brooke's departure at the end of last year) got underway in June 2010. The campaign is being run by the Appointments Commission, and the post was advertised through a number of publications and circulated to a range of external organisations. We have had a good response to the campaign, which closed on 30 June 2010. The short-listing process is now underway, with interviews scheduled for late July 2010. We expect that an appointment will be made in early August 2010.

Section two – exception report

33. We continue to make good progress towards delivering the activities in our 2010 Business Plan. This section provides an exception report that highlights key achievements and major challenges to delivery since we last met.

Major achievements

The merger of PMETB with the GMC (Business Plan Activity 3.1)

Delivering our PMET responsibilities

34. In the main, the delivery of our new responsibilities for postgraduate medical education and training following the merger of PMETB with the GMC continues to go smoothly although we have had to deal with the results of legal advice PMETB had received in relation to the timing of examinations taken by trainees (see paragraph 71 below).

35. We are making progress towards the high level benefits outlined in the Full Business Case agreed with DH(E). Specifically, proposals to align standards for the Foundation Programme and Specialty Training to produce a single document were discussed and agreed by the Postgraduate Board on 17 June 2010. We shall keep key interests informed of our proposals, although we do not plan to undertake a major three-month consultation as the changes are non-controversial, relatively straight-forward and mark the next stage in the evolution of the standards. This in turn will facilitate the introduction of an integrated quality assurance regime for foundation and specialty training including GPs. Pilots have been taking place to help develop this approach. Work is also on track to develop an integrated IT system to support the collection, management and analysis of information on medical education. We began testing the system in June 2010 ahead of a phased launch from August 2010.

36. We are also identifying further opportunities for continuous improvement in the former PMETB functions. We recently carried out work to map the Specialist and GP certification processes before transferring them to Siebel, which enabled us to share good practice and identify potential improvements and efficiency gains.

37. We are starting to develop an education strategy which will clearly set out our purpose, aims and objectives for the regulation of medical education and training over the medium term. We plan to bring this draft strategy for discussion at the Education Conference on 12 October 2010.

PMETB's Annual Report and Accounts

38. The *General and Specialist Medical Practice (Education, Training and Qualifications) Order 2010* which abolished PMETB required the GMC, as successor body, to prepare the Board's Annual Report and Accounts for the year ending 31 March 2010.

39. Our original understanding was that the GMC would need to give formal approval to the PMETB Annual Report and Accounts and the Letter of Representation. The arrangements for doing this were agreed by Council on 31 March 2010.

40. Subsequent discussions between DH(E) and the National Audit Office (NAO) concluded that the Annual Report and Accounts and the Letter of Representation must be signed by an Accounting Officer. The Accounting Officer framework extends only to the government and its agencies and cannot include the GMC. Consequently, the Department advised us that the most appropriate course of action was for both documents to be signed by a DH(E) Accounting Officer.

41. While the requirement for the GMC to approve the Annual Report and Accounts no longer exists, the requirement for us to prepare them remained. We have completed this work, which has been reviewed by PMETB's external auditors, Baker Tilly and the NAO. No issues of concern were reported.

42. As the Annual Report and Accounts has been prepared by the GMC, DH(E) asked us to provide some form of limited assurance to their Accounting Officer to confirm that, to the best of our knowledge, all transactions have been properly recorded in the accounting records and that all records have been made available to the external auditors. A suitable letter of assurance, to be signed by the Chair of the Resources Committee, was approved by the Resources Committee on 24 May 2010 and endorsed by the Audit and Risk Committee on 14 June 2010.

43. We have taken steps to ensure that we do not bear any costs relating to any known or unknown PMETB liabilities relating to the pre-merger period, even where such liabilities come to light after the point of merger. Provision has been made in the PMETB final accounts for all known liabilities, and funding of £985K has been transferred to us to discharge these liabilities. In addition, we have secured an agreement that any unknown liabilities which subsequently materialise will be funded by DH(E).

Revalidation (Business Plan Activities 2.2, 2.3, 5.1 and 5.2)

44. The public consultation on revalidation closed on 4 June 2010. The overall response has been positive with over 940 completed consultation responses received, which is the highest number for any GMC consultation to date. This reflects our extensive UK-wide engagement programme, which saw us attend over 130 events involving direct contact with over 4,600 people, including one in every six GPs in Northern Ireland.

45. We have started to analyse the consultation responses. Preliminary analysis shows broad support for our proposals, but it is clear that individual doctors want clarity about how revalidation will apply to their particular circumstances and assurances over the costs and complexity of revalidation.

46. As members are aware, the Secretary of State for Health has written to our Chair, Professor Sir Peter Rubin, about our proposals for the implementation of revalidation. He welcomed our consultation on revalidation and underlined his support for the principle of revalidation by stating that this is what patients would expect. He also announced his intention to extend the pathfinder pilots at the 10 sites in England for a further 12 months to allow more time to understand the 'costs, benefits and practicalities' of the implementation of revalidation, while at the same time committing the Government to 'lay regulations on Responsible Officers before Parliament shortly'.

47. We welcomed the Government's intention to 'press ahead immediately with the introduction of Responsible Officers' (the regulations were debated in the Northern Ireland Assembly on 22 June 2010) and their commitment to 'the introduction of regular checks for doctors'. Clearly we are keen to ensure that the momentum towards implementing revalidation is maintained, and we will continue to discuss how we will achieve this with the Government and other delivery partners as required. Sir Peter and I met with Andrew Lansley on 21 June 2010, and I also met with the Parliamentary Under Secretary of State for Public Health, Anne Milton MP, on 23 June 2010. These were both positive and productive meetings.

2014 International Association of Medical Regulatory Authorities Conference (Business Plan Activity 6.3)

48. We have submitted a bid to the International Association of Medical Regulatory Authorities (IAMRA) Management Committee to host the 11th International Conference on Medical Regulation, in September 2014.

49. The outcome will be publicly announced at the September 2010 IAMRA Conference in Philadelphia. If we are successful, we will consider how best to approach the detailed planning phase based on our observation at the 2010 Conference and following discussions with the IAMRA Management Committee.

Significant issues or challenges

Managing high volumes of activity in Registration and Fitness to Practise (Business Plan Activities 1.1 and 2.1)

Increase in the number of Stream 1 cases, and the volume and length of panel hearings

50. As outlined in my last report, we continue to deal with a high number of fitness to practise cases. This is affecting our ability to meet our service targets in 2010, most notably in relation to the following targets:

a. Commencing 90% of panel hearings within nine months of referral – our performance was 56% in April 2010 and fell to 38% in May 2010, reflecting the increase during 2009 in average hearing length and referrals to hearings. As we list Fitness to Practise Panel Hearings nine months in advance we were able to forecast this reduction in performance and have previously reported this issue to Council. Steps have already been taken to increase our hearing capacity as well as initiating two projects aimed at reducing the length of hearings. As a result, performance is forecast to improve from June 2010 onwards, with the service target being achieved by October 2010 and then sustained for the rest of the year. Specifically, we expect our nine-month hearing performance to be around 52% in June, 68% in July, 82% in August, 79% in September and 94% in October 2010.

b. Concluding or referring 90% of cases at the investigation stage within six months – our performance was below target in both April 2010 (84%) and May 2010 (87%), reflecting the increase in Stream 1 cases. Pressure on this target is likely to continue over the coming months, and in May 2010 we experienced the highest number of new Stream 1 cases over the last 12 months. As a temporary measure we have recruited six additional investigations staff.

c. We remain concerned about the large number of serious cases being drawn to our attention – this is a pattern which is also being experienced by other regulators. As well as taking short term measures, we are working with OHPA and others to explore whether there are further changes we can make to our fitness to practice procedures.

Increase in registration activities

51. As outlined in my last report, we continue to see an increase in the number of applications for registration granted – there has been a rise of more than 25% in the year to date compared with the same period in 2009. Despite this, in April and May 2010 we managed to respond to 100% of applications within five working days.

52. We cannot be certain why applications are rising but it is likely that NHS recruitment and the perceived buoyancy of the UK labour market are playing a part. We have introduced a questionnaire for doctors sitting Part 1 of the PLAB test to help us understand their reasons for seeking registration in the UK. A recent survey of EEA and IMG applicants highlighted that only 36% of them had a job offer at the point of application.

53. Further detail on our key operational statistics for Registration and Fitness to Practise can be found at Annexes B-E.

Performance Board

54. Our internal Performance Board, chaired by Paul Philip, met for the third time on 10 June 2010. The Board is driving our efficiency programme and has started to develop a cross-GMC programme of savings and continuous improvements which should deliver efficiency gains of 3-5% over each of the next four years. The Board is also helping to embed our focus on evaluation, including through the development of a benchmarking programme. This is discussed at item 7b on the Council agenda for 13 July 2010.

Independent Safeguarding Authority (Business Plan Activity 2.1)

55. On 15 June 2010, the Home Secretary, the Rt Hon Theresa May MP, announced a review of the Vetting and Barring Scheme with the intention of reducing the scope of the Scheme. To allow the review to take place, the Government has paused the vetting component of the Scheme, which was due to commence from 26 July 2010. The review will be led by the Home Office and supported by DH(E) and the Department for Education. We expect the Terms of Reference for the review to be released shortly.

56. Following the announcement, I wrote to the Home Secretary expressing our support for the review and outlining the need for clarity around the broadly drafted terms of the referral duty. My letter also called for the scope of the review to be widened to include the barring element of the Scheme.

57. The Independent Safeguarding Authority (ISA), which is responsible for barring decisions under the Scheme, will continue to operate while the review takes place, and our duty to make referrals to ISA remains in force.

58. As a result of the way in which the legislation is drafted there is a degree of uncertainty about which cases should be referred, and we sought legal advice which indicated a wider duty than that suggested by ISA. However, we are now working with officials at ISA to agree a practical approach to the referral duty. While we expect the resulting guidance to provide a sensible way forward, we remain concerned about the broad terms of the legislation, which is entirely unhelpful for healthcare regulators attempting to put the Scheme into operation.

59. In early June 2010, we completed a project aimed at identifying and referring doctors who have committed a serious criminal offence prescribed by the Safeguarding Vulnerable Groups Act 2006. The project resulted in a number of referrals to ISA.

60. We continue to work with the Expert Group set up by DH(E) to provide guidance for healthcare regulators on referrals, and will feed in any developments from our discussions with ISA about the legislation. We met with the Scottish Government in May 2010 to discuss the Scottish Protection of Vulnerable Groups Scheme. The Scottish Government provided clarity around a number of key issues including referral trigger points, thresholds and implementation issues. We will continue to engage with officials in the lead up to implementation of the Scottish Scheme.

Publication and disclosure of warnings (Business Plan Activity 2.1)

61. As agreed by Council on 20 May 2010, following discussion about the review of our policy on the publication and disclosure of warnings after five years, we have now taken substantive legal advice on the issue.

62. This advice has clarified that:

a. There are no absolutes in terms of the law and, as previously discussed, it is a matter of balancing the public right to access against the doctor's right to privacy and fairness.

b. Our approach to publishing and disclosing information about doctors must be proportionate and what is proportionate will differ from case to case. Indefinite retention by the GMC of information about warnings is likely to be proportionate. However, it will be difficult to justify indefinite publication and disclosure of warnings, given that they are not a sanction on registration and are intended to be a response to matters that fall beneath the threshold of impaired fitness to practise.

63. In the past, the GMC took the view that it was not practical to treat as confidential information that had been placed in the public domain, as this information would continue to be widely available by means of an internet search. Counsel acknowledged this but has advised that continued publication on our website gives a particular weight and significance to the information.

64. Based on this advice, we do not propose that warnings are disclosed indefinitely. Counsel has confirmed that there is no special significance to the current five years in terms of proportionality. However, for those who have received a warning, a legitimate expectation has developed that they would only be published and disclosed for five years. In view of this we propose to cease publication of these warnings when they reach their five year anniversary and it would seem sensible to retain the five year time limit in relation to warnings going forward.

65. Counsel also advised that it is not necessary or proportionate to have an identical policy for disclosure of information to all types of enquirers and that continued disclosure after five years to employers, who have a special interest in a doctor's fitness to practise history, is likely to be proportionate and desirable.

66. As a result of this advice we propose to:

a. Retain information about warnings indefinitely.

b. Publish both historical and future warnings for only five years.

c. Disclose both historical and future warnings to all enquirers for only five years and to disclose to employers indefinitely.

67. We will make amendments to the secondary legislation which limits retention of warnings to five years and bring this back to Council for approval.

> **Recommendation:** To agree that we should retain information about warnings indefinitely; publish both historical and future warnings for only five years; disclose both historical and future warnings to all enquirers for only five years, and to disclose to employers indefinitely.

Office of Health Professions Adjudicator (Business Plan Activity 2.4

68. With the full Board of the Office of the Health Professions Adjudicator in place, the level of activity around the future transfer of our adjudication function to OHPA has intensified. The Joint Co-ordination Group (JCG), which provides assurance to Council and OHPA's Programme Board that the programme is on schedule, held its first meeting on 24 June 2010. The JCG complements the work of the Joint Implementation Group, which has more of an operational focus to its work.

69. Work is progressing across the different workstreams (communications, accommodation, rules development, finance, IS and HR), although at this stage, the key issue facing the programme is whether funding for the transition will be made available by DH(E). A more detailed update is provided at item 6b on the Council agenda for 13 July 2010.

70. In addition to the joint working outlined above, we have also set up a workstream tasked with preparing the GMC for operations after adjudication has transferred to OHPA. We commissioned a change consultancy firm (WCL) to complete a future-state analysis of how the GMC-OHPA relationship will function. By comparing the current and future operational models, we will be able to develop a clear plan of what needs to be put in place to ensure that we are ready for business as usual once OHPA goes live on 1 April 2011.

Issues relating to the regulation of medical education and training (Business Plan Activity 3.1)

Examinations taken outside approved postgraduate training

71. As mentioned above and outlined in my last report, a number of organisations expressed concern about our communications on 9 April 2010 outlining the legal position, based on advice PMETB had received, on the recognition of postgraduate exams for the award of a Certificate of Completion of Training (CCT), which made clear that the exams leading to a CCT must be taken during a period of recognised training.

72. Although this reflected the approach taken by PMETB, it prompted concern from representatives of trainees and some medical Royal Colleges who argued that the current position was unfair on doctors who have taken the exams outside a period of approved training.

73. In response, we sought our own legal advice from senior Counsel and subsequently held a constructive meeting with key interest groups on 17 June 2010 to discuss the position and the way forward. Those attending the meeting agreed that the legal advice to the GMC makes it clear that the Medical Act allows the GMC to be flexible over the timing of exams. Consequently, we will allow all trainees already in approved CCT training programmes, subject to successful completion of them, to obtain a CCT even if they passed one or more of their examinations before entering the programme. We will apply the same flexibility to those already selected to enter CCT training programmes up to and including 31 October 2011.

74. Given the flexibility that is now apparent, we will draw up proposals for discussion on the timing of examinations for future trainees. It is clear that there is scope for flexibility to benefit doctors not currently in or about to enter approved training. A further meeting of key interests will be held in late summer or early autumn to discuss those proposals, and we will issue further guidance by October 2010.

Significant changes or additions to our activities

75. At the meeting on 20 May 2010, Council agreed to amend the description of Business Plan Activity 7.2 (against which we report) to accurately reflect developments in our work since the 2010 Business Plan was published. We have also taken the opportunity to update the wording of Activity 2.2 which relates to the development of revalidation policy and guidance, to ensure it accurately reflects the focus of this work.

76. These changes do not have significant implications for our work programme and simply reflect policy developments agreed by Council since the start of the year. The amended description is as follows:

a. 2.2: We will develop policy and guidance to support the introduction of revalidation.

b. 7.2: We will engage with key interest groups on our fee structure following the merger of PMETB with the GMC.

Governance Review

77. The first meeting of the Governance Review Working Group took place on 23 June 2010. The Group had a useful discussion of a number of overarching principles and issues for its work programme over the next few months. That programme is now underway and members will be kept informed and will be consulted throughout.

78. The Group thought it would be helpful to re-articulate some of the key principles about the role and working style of Council (in addition to the description set out in the Governance Handbook) to provide a framework for discussing the other parts of the governance framework. A draft statement is attached at Annex G, and comments from members would be welcome.

Section three – progress against the 2010 Business Plan

79. The remainder of this report provides an overview of progress to date against each activity in the 2010 Business Plan, at Annex A. This is supported by additional information, at Annexes B-F, on our operational performance and volumes of activity for Registration and Fitness to Practise in April and May 2010, as well as our current financial position.

Recommendation: To consider the Chief Executive's Report.

Resource implications

80. There are no significant changes to planned activity or expenditure in the 2010 Business Plan or Budget.

Equality

81. Equality and diversity is integral to our work as a regulator and an employer. Members have approved the principles for the supporting Equality and Diversity Strategy, and we are now in the process of agreeing with each business area how we will continue to integrate equality and diversity into our Business Plan activities. This work will inform the further development of the Strategy.