To consider

Chief Executive’s Report

Issue

1. Progress towards the delivery of the GMC’s strategic aims and activities for 2011.

Recommendation

2. To consider the Chief Executive’s Report (paragraphs 6-74 and Annexes A-F).

Further information

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

3. This report brings members up to date on progress towards the delivery of the GMC’s strategic aims and activities for 2011.

4. 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 2011 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 2011 Business Plan (Annex A). This is supported by additional information for the period since the last report of 7 April 2011 on:

      i. Key operational statistics for Registration including Professional and Linguistics Assessment Board (PLAB) activity (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, including Q1 forecast (Annex F).

Discussion

Section one – Chief Executive’s introduction

Health reform in England

5. The Government’s decision to launch a period of engagement and reflection around its proposed legislation for the health service in England has provided us with the opportunity to reinforce the key issues that have a direct bearing on the education and regulation of the profession. As a result, the Chair and I, along with other directors, have held meetings with Professor Steve Field (who is heading the work on this) and the leads in his team for education and clinical leadership and advice.
6. The process has been extremely quick and, given the political factors, the outcome – including the likely scope of any changes and their possible consequences – remains far from certain. However, we have emphasised: the importance of renewing the commitment to revalidation within the agreed timetable; securing sound arrangements for good clinical governance, including a stable base for revalidation with Responsible Officers in place throughout the service at the earliest opportunity; and the need for autonomous education champions at a local level who can be responsible to the GMC for ensuring the quality of postgraduate education on the ground.

7. We submitted written evidence to the Committee on the Bill on 21 March 2011, focussing on the abolition of the Office of the Health Professions Adjudicator, our proposals for adjudication, and the potential implications for medical education and revalidation.

8. In spite of the flux within the healthcare system, we have been encouraged by the commitment and seriousness with which the newly appointed Responsible Officers appear to be taking their roles. These are early days but anecdotal evidence suggests that Responsible Officers are concerned to fulfil their statutory duties and, in particular, that they understand how important it is to satisfy themselves that the doctors for whom they are responsible are competent and fit to practise. This is something we will want to build on, working with the revalidation delivery boards in each part of the UK, with Strategic Health Authority (SHA) medical directors and by using our new team of employment liaison advisors, all of whom should be in post by the end of the year.

May elections across the UK

9. The elections in Northern Ireland, Scotland and Wales have brought significant changes both to personnel and to the political complexion of the administrations. However, we have good relations with politicians and officials and are confident that we can work effectively with the new teams. We are drawing on the knowledge and experience of Council members from each part of the UK to discuss the implications of these changes for our work over the next few years. All the indications we have thus far suggest that there is a commitment to support the GMC in delivering its statutory functions, and a genuine welcome for what we are doing to deepen our engagement with local employers and the wider health system throughout the UK.

10. We updated members on the outcomes of these elections on 10 May 2011 and 24 May 2011. In summary, the position in each of the countries is now as follows.

Northern Ireland

11. Peter Robinson MLA and Martin McGuinness MP MLA have been appointed First Minister and deputy First Minister respectively. The mandatory coalition model used in Northern Ireland allocates Executive Ministries on the basis of the number of seats held. The new Health Minister is Edwin Poots MLA Democratic Unionist Party (DUP), although the DUP has announced that he will be replaced by Jim Wells MLA after two years.
12. The Northern Ireland Assembly has legislative competence for medical regulation. Since devolution was restored, legislation in this area has been taken forward on a UK wide basis with legislative consent from the Assembly. We do not expect any change in this.

Scotland

13. With a Scottish National Party (SNP) majority, the First Minister of Scotland, Alex Salmond MSP, is focussing on further devolution of powers to Holyrood through the Scotland Bill. This will allow Scotland to control a third of its budget under a new Scottish-set income tax and borrowing regime. The SNP majority means that a referendum on independence (potentially including an option for ‘fiscal autonomy’ rather than full independence) is highly likely in the lifetime of the administration. The UK Government has indicated that it will not move to block a referendum on Scottish independence.

14. Nicola Sturgeon MSP remains as Deputy First Minister and Health Secretary.

Wales

15. In Wales, Labour has formed a minority Government, with Carwyn Jones AM as First Minister. Lesley Griffiths AM, formerly the Deputy Minister for Science, Innovation and Skills, has been appointed Health Minister.

16. The devolved administration has been renamed the Welsh Government (no longer the Welsh Assembly Government).

European and International engagement

17. We continue to make progress in our work with the Department of Health (England) about the language skills of doctors from the European Economic Area. We now have the outline of a scheme which we are checking with lawyers and which is due to be reviewed by ministers and our Chair in the next few weeks. This has been a challenging area of policy and if we are able to provide new safeguards it will be a significant achievement.

18. There should also be an opportunity to raise this issue when we provide evidence to the EU Sub Committee on Social Policies and Consumer Protection into the Mobility of Healthcare Professionals on 30 June 2011. It will be concerned about how member states work to ensure fitness to practise for professionals seeking work outside their registered countries and it will examine whether there needs to be a strengthening of language requirements.

19. We attended the fourth meeting of the informal network of European regulators in May in Ljubljana which provided another opportunity to share views on the revision of the Directive and feed into the EU Green Paper on professional qualifications which is expected by the end of June 2011. The Commission is committed to adopting a revised proposal for a Directive before the end of the year.

20. We are also continuing to contribute to the Commission steering group which is looking at the development of European professional cards. The group is expected to publish a working document later this year. Together with several other regulators, we continue to question the added value and cost of a European card.
21. In April, we hosted a visit from six members of the Board of Governors from the Medical Council of India, and three officials from the Ministry of Health and Family Welfare. They were interested in all aspects of our work but especially our education and training responsibilities. The visit was useful although its impact may have been reduced by the fact that the Indian Government has subsequently replaced the entire Board of Governors. We will continue to watch developments in India, and offer whatever support we can, as the Government there seeks to rebuild medical regulation following the problems experienced in 2010.

Consultations

22. Our consultations on changes to fitness to practise and adjudication have progressed well, and the report on our proposed reforms to the investigation stage is being considered by Council at Item 8a of this meeting. The consultation on adjudication, which is linked to a separate consultation for staff on the proposals to move adjudication and certification staff to Manchester, has also generated a good level of interest. Staff have been involved at each stage and there has been positive and constructive engagement with an expanded Staff Forum raising concerns and helping support staff who may be affected. Council will consider the outcome of these two consultations on 19 July 2011.

New appointments

23. The organisation remains extremely busy coping with ongoing business alongside significant reforms in every area. I am pleased to report that we have filled senior vacancies in Education, Continued Practice and Revalidation and in Strategy and Communication. These Assistant Directors will be critical for the delivery of Council’s strategic ambitions in these areas.

Engagements

24. Our programme of roundtables with groups of doctors has been productive and appreciated by those who took part. We have held sessions with students, consultants, SAS doctors and trainees. Feedback from these events will inform future sessions. In addition to the Chair’s ongoing programme of engagements, in the past month I have visited Sheffield Medical School, and addressed a number of gatherings including the Royal College of Anaesthetists diplomates’ ceremony, the World Health Congress in Brussels, a debate run by the Bar Standards Council, the Westminster Health Forum, SHA Medical directors and the CHKS Top Hospitals award ceremony.


25. The Council for Healthcare Regulatory Excellence (CHRE) now has a number of commissions from the Department of Health (England) arising out of the Command Paper Enabling Excellence. They include work on voluntary registers, appointments to Councils, and the proposed CHRE levy. We expect that CHRE will produce an interim report on efficiency and effectiveness of regulators by the end of July 2011 and a final report by November 2011. This review will include consideration of the size and make-up of Councils.
26. We plan to hold a further meeting of the member steering group on the Command Paper as soon as we are clearer about the process and timing CHRE will follow.

27. Last month, we had a helpful initial discussion with the Law Commissioner Frances Patterson QC and her colleagues who have been asked to develop a single simplified legislative framework for healthcare professional regulation.

**Mid Staffordshire NHS Foundation Trust Public Inquiry**

28. The Mid Staffordshire Public Inquiry continues to hear evidence. Thus far it has heard from a range of witnesses, including experts on the NHS and patient safety, patients and their relatives, patient groups, local GPs, overview and scrutiny committees, MPs, Trade Unions, the Coroner, the Royal College of Nursing, current and former staff members and governors of the Trust, the South Staffordshire Primary Care Trust, Strategic Health Authorities, the Healthcare Commission, the Care Quality Commission (CQC), and Monitor.

29. The Inquiry is currently reviewing its witness schedule, following issues with the timetabling of evidence from DH(E), which has meant bringing other witnesses forward. The Inquiry had been due to adjourn from 30 July 2011, however due to unforeseen events the adjournment has been brought forward to 7 July 2011. Hearings will resume on 5 September 2011. DH(E) had been due to commence its evidence in July 2011, however this will now commence in September 2011. The next phase of evidence is expected to include professional and system regulators, health professional bodies, national advisory bodies and organisations which collect data, regulators in other areas, DH(E), the Chief Medical Officer, Chief Nurse and other Government.

30. We have recently provided additional information to the Inquiry covering developments since our provisional statements in August and September 2010, and I subsequently met with the Inquiry’s Solicitors on 16 May 2011 to provide a further witness statement.

31. We are grateful to our member oversight group (Dr Hamish Wilson, Dr John Jenkins, Mr Stephen Whittle, chaired by Professor Sir Peter Rubin) for their input in steering our contribution to the Inquiry. The group is due to meet on 7 June 2011 to discuss any further developments relating to the Inquiry.

32. It is likely that I will be called to give evidence in the second half of June 2011. The Inquiry has also indicated that it will wish to hear evidence from Professor Stuart Macpherson, former Chair of PMETB, and Paul Streets, former Chief Executive of PMETB.

33. The GMC continues to receive brief mentions at the Inquiry and a number of themes relevant to our work have emerged. Much of the recent evidence has focussed on the role of the systems regulators and other agencies responsible for monitoring the Trust; their awareness of, and response to, issues at the Trust between January 2005 and March 2009 (the period being investigated by the Inquiry), and why these were not identified and acted on sooner.
Health Select Committee - Report on revalidation and evidence session

34. On 29 March 2011, the Government responded to the Health Select Committee’s report *Revalidation of Doctors*, stating that it ‘will work with the GMC and other delivery partners to design and properly test a proportionate and streamlined system for revalidation during 2011-12. The intention is to undergo a final assessment of readiness in late 2012, to ensure that revalidation meets the needs of the profession, employers, patients and the public and can be implemented in a way that is effective, cost-effective and affordable’.

35. We produced a detailed formal response to the report and the steps we are taking to ensure that revalidation can be delivered on time, and in a way that is both practical and proportionate. Our response was published on the Committee’s website on 12 May 2011.

36. We have begun to receive responses to our letters sent from Sir Keith Pearson and Professor Sir Peter Rubin to the Chairs of the four Delivery Boards asking for details on how they will ensure that organisations are ready to support revalidation, and how they will assess and test that readiness. An update on the responses received is included as part of the Revalidation Programme Update Report at item 6 for this meeting.

37. The Health Select Committee will be taking further evidence from us on 14 June 2011 as part of its function of holding public bodies to account. Professor Malcolm Lewis, Paul Philip and I will give oral evidence on behalf of the GMC. This session has been organised as a result of the recommendation in the Committee’s report on revalidation that the GMC be made accountable to Parliament via the Health Select Committee. It is expected that this session will be the first of what will become regular hearings to scrutinise the regulators.

**Vetting and Barring Scheme**

38. As I noted in my last report, we have welcomed the Government’s plan to narrow the scope of the scheme and to replace the duty on professional regulators bodies to refer information to the Independent Safeguarding Authority (ISA) with a power to refer information. However, we remain of the view that aspects of the current law are not clear and we have again written with the General Social Care Council (GSCC) on behalf of the health and social care regulators to the minister responsible to reiterate our concerns. We have also submitted written evidence to the Public Bills Committee on the Protection of Freedoms Bill.

39. Together with the GSCC, we met with DH(E), the Home Office, the Department for Education and their lawyers on 16 May 2011 to discuss our concerns. It was clear from the meeting that there is no intention to amend the legislation beyond what is proposed, but the Government did agree to issue formal guidance to reflect the current arrangements we have in place for referring cases with ISA. While this does not have the force of statute, it will provide important clarity on how the law is intended to be interpreted.
In my last report, I noted that Swansea University College of Medicine had decided to defer the delivery of Year 3 of its Graduate Entry Programme and to transfer students currently in Year 2 to Cardiff Medical School to complete their training. This decision was taken in light of significant concerns expressed by the GMC.

This was a significant and unusual move and when we met the affected students at Swansea we promised that we would reflect on what had happened. Following this, the Undergraduate Board agreed a proposal to hold an independent review so that we could learn any lessons. This does not in any way call into question our approach in this case, but should give us an opportunity to reflect, and it will contribute to the comprehensive review of quality assurance which we are committed to launching next year. A paper on quality assurance is on the agenda for this meeting at item 5.

The review will be undertaken by an experienced QABME lead visitor who was not involved in the Swansea process. It will consider: the adequacy of the quality assurance standards set out in *Tomorrow's Doctors 2009*; the process undertaken, including timetabling of quality assurance activities and the reporting and communication throughout; and the governance of the process.

**Legislative developments**

The public sector Equality Duty, contained in section 149 of the Equality Act 2010, came into force on 5 April 2011. The GMC is now listed in Schedule 19 of the Act as a ‘public authority’, and is therefore is subject to the Equality Duty. The Government has recently issued new guidance for public bodies which includes a duty to show ‘due regard’ to the aims of the Equality Duty. Having due regard means consciously considering the aims of the Equality Duty as part of the process of decision making and planning. We are monitoring these developments.

**Other regulatory and political developments**

The Overarching Implementation Steering Group in Scotland has been stood down. The group was originally put in place to oversee implementation in Scotland of the UK White Paper, *Trust, Assurance & Safety* - as a result of the 2011 Command Paper, the governance arrangements for regulatory reform in Scotland are now being reviewed.

On 29 March 2011, the Care Quality Commission (CQC) published its second annual report to Parliament on the state of health care and adult social care in England. The report covers the period April 2009 to March 2010 and the findings refer mainly to CQC evidence from regulation, assessment and review activities. The report also draws upon patient surveys. One section of the report states that: 80% of inpatients ‘always’ had confidence and trust in their doctors and 17% ‘sometimes’ did; 82% of outpatients ‘definitely’ had confidence and trust in their doctors.
46. In the Government’s *Plan for Growth*, published alongside the Budget 2011, it announced that HM Treasury and the Department for Business, Innovation and Skills (BIS) would publish an Enforcement White Paper in May 2011, considering how outcome-focused enforcement can help ensure that regulations are meeting their intended aims. As of writing, this White Paper was still awaited, but the renewed emphasis on outcomes-focused regulation is an important part of the context within which we operate.

47. David Sissling is the new Chief Executive of the NHS in Wales. I have written to him seeking an early meeting with him in his new role.

48. In March 2011, CHRE published its second annual audit of early fitness to practise decisions by the health professional regulatory bodies that it oversees. This audit reviewed a selection of cases that each regulatory body had closed without referral to a final stage fitness to practise hearing. The 100 cases reviewed at the GMC showed that we have a robust initial-stages casework system leading to good decisions that were properly recorded and communicated.

### 2011 income and expenditure and quarter one forecast

49. More detail on our income and expenditure for the year to April 2011 is at Annex F. In summary, income continues above budget, driven by several factors including: a lower than budgeted number of doctors moving to registration without a licence to practise; a higher number of applications for registration than budgeted; and higher income from PLAB tests. Expenditure remains below budget, owing largely to a number of unfilled vacancies, and savings in office, accommodation and legal costs.

### Section two – exception report

50. We continue to make good progress towards delivering the activities in our 2011 Business Plan. This section provides an exception report that highlights key achievements and challenges to delivery since we last met.

#### Major achievements

*Developing our guidance (Business Plan Activities 4.1 and 4.4)*

51. As I mentioned in my last report, in February we began our wide-ranging conversation to inform the review of *Good Medical Practice* with the launch of an initial public consultation on the scope and structure of the guidance. This consultation closed on 13 April 2011. The consultation was promoted widely with our key interest groups through a call to participate targeted at organisations and individuals familiar with *Good Medical Practice*, as well as promotion in our GMC e-bulletin sent to approximately 170,000 doctors.

52. We received 230 responses from registered users and a further 1,867 responses from doctors responding to the GMC e-bulletin. This questionnaire used identical questions, but did not require registration on the site. The responses to the consultation have now been analysed and considered by the *Good Medical Practice* Review Working Group. The findings will inform the broad scope of the review and in particular the structure of guidance, the key issues and themes.
53. On 6 April 2011, we launched a public consultation on draft guidance, *Good practice in prescribing and managing medicines and devices*, which sets out the principles that doctors must follow when prescribing medicines. This draft updates the current guidance, *Good practice in prescribing medicines* (2008), with a focus on the medicines-related topics most frequently raised by doctors contacting the GMC for advice, as well as issues featured in fitness to practise investigations. The draft includes guidance on internet/remote prescribing, prescribing off-label and unlicensed medicines, doctors prescribing for themselves and family members, and prescribing in sports medicine. The launch of the consultation was accompanied by a press release and targeted email communications to encourage participation from prescribing-related colleagues and organisations across the UK. The consultation will run until 3 June 2011.

54. On 18 April 2011, we launched new guidance *Making and using visual and audio recordings of patients*. This came into effect on 9 May 2011 and replaces the previous version issued in 2002. The guidance provides detailed advice on how the principles in other GMC guidance, *Consent: patients and doctors making decisions together* and *Confidentiality*, apply in the context of making recordings of patients. The new guidance was sent via targeted email distribution to a wide range of doctors, patients and other colleagues who had been involved in the guidance review or have an interest in this area. Its launch was announced and further promoted by a press release.

*Roll out of employer liaison and changes to fitness to practise procedures (Business Plan Activity 2.2 and 5.2)*

55. We recently advertised for Employment Liaison Advisors (ELAs) and have now made offers to 11 regionally-based candidates for the roles. The appointees will join two current members carrying out ELA roles to make up a team of 13 covering England and Scotland. The new staff will be joining us in groups at the beginning of July, August, and September 2011. We will shortly be launching the recruitment for the ELAs for Wales and Northern Ireland and for the support staff of the service. The Employer Liaison Service will help us to strengthen our relationships with medical directors and other employing doctors. The ELAs will undergo a significant training programme and we expect to have the service up and running by the end of the year.

56. Our consultation on the reform of fitness to practise procedures proposing changes to the way we deal with cases at the end of an investigation closed on 11 April 2011. We received a total of 217 responses from across our key interest groups. The consultation was promoted widely including a series of round-tables with patients in England, Northern Ireland, Scotland and Wales; webinars with patient and doctor groups; engagement with the Black and Minority Ethnic Doctors Forum and sick doctors groups; and a reception for MPs in House of Commons. A report on outcomes of the consultation is included at item 8a on the agenda for this meeting.
Improvements to appeal systems (Business Plan Activity 1.2)

57. Following the merger of PMETB with the GMC, the decision was taken to proceed initially with broadly the existing separate appeals processes for registration and certification appeals. This flexibility was designed to allow for an evaluation of each appeal process with a view to introducing a harmonised approach during 2011. A review has been completed, and the Continued Practice, Revalidation and Registration Board endorsed a move to a single system approach on 4 May 2011.

58. The single system approach will see all registration and certification appeals managed by a single Appeals Office, and more effective case management, including overview by a single Head of Registration and Certification Appeals Services to improve internal efficiency. The new approach will also see panellists for both appeal types drawn from the same pool with all current panellists to be given training; and for a trial period of 12 months, both registration and certification appeals will use legally qualified chairs, which removes the need for legal assessors to be in attendance.

59. The new approach will be fully effective from later this year with current plans for appeals harmonisation to begin in the next few months when panellists have been trained and administrative arrangements are in place. These changes to appeals and delivery arrangements are within existing law. Further improvements to the system may be possible and it is proposed that a further review will be undertaken once the two systems have been operating satisfactorily together for 18 months.

National Training Surveys 2011

60. The 2011 National Training Surveys were launched across the UK at the start of May. Promotional materials including leaflets and posters have been sent to over 300 local education providers across the UK. In addition, marketing materials including a presentation, web button and a news item are now online and have been distributed via email to colleagues at deaneries and foundation schools. Over the course of May, 85,000 invitations to trainees and trainers will be distributed via email inviting them to respond by 22 July 2011. A press release will be issued at the beginning of June when all invitations have been sent.

61. We have worked closely with the Deaneries since the start of the year to improve the quality of the data we receive from them. This has included ensuring we collect complete and accurate information on who we should be surveying. We have also undertaken improvements to make the survey delivery system more effective and enhancements to deliver a more robust reporting system.

62. We are also simultaneously undertaking a project to review the overall surveys and ensure they are fit for purpose. The review will initially focus on defining and agreeing the purpose of the surveys, which will then inform a redevelopment of the survey outputs, question sets, data collection processes and the underlying IT system which delivers them. We are engaging with each of the Deaneries, Royal Colleges and other key stakeholder groups to ensure that we identify their needs. The review and redevelopment of the surveys will be completed in time for delivery of the 2012 surveys.
Quality assurance of medical education and training (Business Plan Activity 3.3)

63. Following agreement at Council on 8 December 2010, we have been progressing plans for the establishment of a Quality Scrutiny Group (QSG) to support our work in quality assuranceing all stages of medical education and training. I am pleased to announce that recruitment for membership of the QSG has now concluded, with Dr David Sales appointed as the Chair and six medical, six lay and three student/trainee members also appointed. Following a training session in the summer, we expect the group to commence their scrutiny activity in September 2011.

Review of the Professional and Linguistic Assessments Board (PLAB) Test

64. I am pleased to announce that Ian Cumming, Chief Executive of NHS West Midlands, has been appointed as the independent Chair of the working group that will take forward the review of the PLAB test. We will discuss proposals for external membership of the working group with the Chair in the near future and hope that the working group will be able to hold its first meeting in July 2011, if not before. Professor Jane Dacre and Dr Sue Davison will also be members of the Group.

Equality and Diversity (Business Plan Activity 8.3)

65. On 5 April 2011, we published our Equality and Diversity Scheme 2011-2014 on our website. Our Scheme, which was informed by a public consultation, is a living document developed in line with our strategic and business plans. It demonstrates our ongoing commitment to equality and diversity and illustrates the work that we are undertaking to uphold, not just the letter, but also the spirit of equality legislation.

2011 Efficiency Programme (Business Plan Activity 7.1)

66. Improving both our efficiency and our effectiveness is one of our key priorities. We have an annual target of 3–5% productivity improvements. We hope to exceed our target in 2011 with £9 million of potential gains identified.

67. There is evidence that having an external view can help, and so we have asked KPMG to work with us to see if there are ways we can do even better. They will be reviewing our efficiency programme to make sure it is robust, and seeking to identify further opportunities for improvement.

Significant issues or challenges

Professional and Linguistic Assessments Board (PLAB) Part 1 exam - March 2011

68. The PLAB Part 1 exam in March 2011 generated a significant number of complaints from candidates following release of the results. Of the candidates that sat the exam, 412 (21.9%) passed. While this is a low pass rate, it is not quite the lowest that we have seen. Some candidates complained that the format of the exam had changed without notification and that the pass mark was set too high in relation to the average mark. A report from the PLA Board on the March 2011 exam will be considered by the Continued Practice, Revalidation and Registration Board when it next meets on 7 July 2011.
Pass rates for PLAB exams vary depending on the cohort of candidates. The March exam was the last exam that could be taken under the old requirements for the provision of alternative evidence of knowledge of English (changes were implemented from 1 February 2011). Of the failed candidates, 541 had supplied alternative evidence of their English language proficiency which would no longer meet our requirements, and 181 had an International English Language Testing System (IELTS) score which no longer fulfills our criteria. All candidates in this position had received advance notification about this and are aware that they cannot book a further PLAB 1 exam again until they have updated their evidence.

Further detail on our PLAB activity including activity levels and pass rates can be found at Annex B.

Performance against Fitness to Practise service targets (Business Plan Activity 2.1).

Over the past three months, our performance has been fully in line with target across five of our seven service targets. The service target for commencing 100% of Interim Orders Panels hearings within three weeks of referral was just missed in February 2011 because of a single case which fell outside the target. Performance against the target to conclude or refer 90% of cases at investigation stage within six months continues below target owing primarily to the continuing high numbers of Stream 1 cases. These have increased by 20.8% compared to the first quarter of 2010. We have identified additional staffing resources to help deal with the increase in caseload and this should result in improved performance as they become fully operational.

Significant changes or additions to our activities

There have been no significant changes or additions to our activities since the last report.

Section three – progress against the 2011 Business Plan

The remainder of this report provides an overview of progress to date against each activity in the 2011 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 February, March and April 2011, as well as our current financial position including our quarter one forecast.

Recommendation: To consider the Chief Executive’s Report.

Resource implications

There are no significant changes to planned activity or expenditure in the 2011 Business Plan or Budget.

Equality

We are monitoring developments with the Equality Act 2010. A programme of briefings is being rolled out to meet the requirement for people throughout public bodies to be aware of the Equality Duty. We are also required to demonstrate how the Duty is being applied in our work, and work is under way to address this.
76. We continue to identify and take forward the equality and diversity considerations of our activities as a regulator and employer. Recent examples include:

a. Work to ensure that appropriate diversity information is held for each Associate to further enhance the equality and diversity monitoring within the GMC Associate pool.

b. Targeting people with protected characteristics\(^1\) in our engagement plans for the review of *Good Medical Practice* and the *Good Management Practice: guidance for all doctors*.

c. Reviewing the equality analysis of our proposals to modernise and reposition adjudication; and producing an equality analysis for our revalidation activities which will complement the one being developed by DH(E).

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\(^1\) The Equality Act 2010 specifies nine groups of individuals who have ‘protected characteristics’ which are covered by this legislation: age, disability, race, sex, gender reassignment, marriage and civil partnership, pregnancy and maternity, religion and belief, sexual orientation.