
7 - Draft Business Plan 2009 – Annex A

Strapline at front of document (above contents page)

Our purpose is to protect, promote and maintain the health and safety of the public.

President's Foreword

1. The GMC enters 2009 with a reconstituted governing body - a Council composed of equal numbers of lay and medical members, and reflective of those who receive and provide healthcare across the UK.
2. Enhancing our own independence and accountability has left us better placed to establish a fair and effective framework for medical regulation that is independent of Government – as the dominant provider of healthcare in the UK – and independent of dominance by any single group.
3. The Council is charged with setting the strategic direction of the organisation, and this Business Plan, in many respects, informs and foreshadows the longer-term Strategic Plan that we plan to consult on and publish in the course of 2009.
4. The Council will take all the key policy decisions, and will be responsible for overseeing the operational performance of the GMC as a whole, ensuring that the organisation delivers to the standards required of it.
5. We look forward to working with our key interest groups across the four countries of the UK to take forward what is a challenging but achievable set of key aims and objectives. Our Business Plan sets out the key components of a regulatory framework that is capable of adapting to meet the needs of a modern society and changing healthcare environment.

Introduction

6. The General Medical Council is the independent regulator for doctors in the UK. Our job is to ensure that patients have confidence in doctors.

7. Our statutory powers and duties are to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine. We aim to secure a regulatory system that:

- a. Is independent, fair, efficient and effective.
- b. Raises standards and enhances patient safety.
- c. Fosters the professionalism of doctors.
- d. Encourages early and effective local action.
- e. Commands the confidence and support of all key interests.

8. We remain committed to a regulatory framework that puts patient safety at its heart. That framework must command the confidence and support of patients and the public; doctors; the NHS and other healthcare providers; and medical schools and medical Royal Colleges.

9. In 2009, the Council is committed to providing regulation *for* the vast majority of good doctors, as well as regulation *of* the minority of doctors whose fitness to practise might be impaired. This is reflected in the ten key aims outlined in this plan.

10. Taken together, our key aims represent more than the sum of their parts and form a challenging and complex programme of work. Integral to this comprehensive programme is the need to set and uphold appropriate professional standards, to bring together all stages of medical education and training, and to coordinate the necessary arrangements for delivering revalidation as the means of providing assurance that every licensed doctor remains up to date and fit to practise. We will introduce licensing as a first step along the road to revalidation.

11. A high priority in 2009 will be taking forward the numerous logistical and policy-related challenges associated with merging the Postgraduate Medical Education and Training Board (PMETB) with the GMC, in order to maximise the immediate opportunities and the long-term benefits. We will also continue our preparations for the separation of our investigation and adjudication functions, once the Office of Health Professions Adjudicator is in place.

12. In 2008 we developed an evaluation framework based on a set of performance indicators designed to ensure public protection is always the focus of our performance. We have built this into this Business Plan in order to provide assurance that we are delivering against the plan.

13. As we develop our existing plans and take on new challenges, we remain as committed as ever to placing patient safety at the centre of what we do, by ensuring the fitness for purpose of the Medical Register and the fitness to practise of those on it.

Priorities for 2009

14. The ten key aims outlined here summarise a challenging and complex programme of work. We recognise that this programme must command the confidence and support of our key interest groups, and to that end we will engage widely and effectively through the components of our governance model. The key aims are:

- a. Key aim one: To develop, promote and assure the quality of all aspects of basic medical education in the UK up to the point of full registration.
- b. Key aim two: To promote and develop postgraduate medical education and training in the UK, through joint work with PMETB as the competent authority, in preparation for the merger of PMETB with the GMC.
- c. Key aim three: To enhance assurance that licensed doctors are up to date and fit to practise by introducing licences to practise and preparing for revalidation.
- d. Key aim four: To encourage and support doctors in the delivery of high quality healthcare by providing accessible, up to date guidance on standards and ethics.
- e. Key aim five: To support high quality healthcare by ensuring a co-ordinated approach to education and training across all phases of a doctor's career.
- f. Key aim six: To safeguard patients by ensuring the integrity and accessibility of the List of Registered Medical Practitioners.
- g. Key aim seven: To enhance patient safety by dealing fairly and effectively with doctors whose fitness to practise may be impaired.
- h. Key aim eight: To ensure that medical regulation is responsive, targeted and evidence-based by enhancing and developing a comprehensive research programme.
- i. Key aim nine: To develop further and implement our strategy for valuing diversity and promoting equality in all aspects of our work.
- j. Key aim ten: To enhance our economy, efficiency and effectiveness.

Key aim one: To develop, promote and assure the quality of all aspects of basic medical education in the UK up to the point of full registration.

15. The GMC is responsible for all aspects of medical regulation as they apply up to the point of a doctor's full registration, including the standards and quality assurance of basic medical education, the initial registration of doctors, and issues relating to student fitness to practise and trainees in difficulty.

16. The Council agrees the bodies that should be entitled to hold qualifying examinations for the purpose of awarding UK primary medical qualifications. In doing so, it must take into account the views of patients and the public; doctors; those involved in the delivery of medical education and training; and the NHS and other providers of healthcare.

17. In 2009 we will:

- a. Develop and promote all aspects of basic medical education in the UK.
- b. Assess and report on eight medical schools.
- c. Carry out quality assurance reviews of four deaneries and their delivery of the Foundation Programme (in conjunction with PMETB) and further develop and strengthen our approach to quality assurance.
- d. Consult on and publish a fully revised edition of *Tomorrow's Doctors*, setting out the standards, knowledge, skills, and behaviours required of medical graduates and the standards required of UK medical schools.

Key aim two: To promote and develop postgraduate medical education and training in the UK, through joint work with PMETB as the competent authority, in preparation for the merger of PMETB with the GMC.

18. In February 2008, in response to the final report of the independent inquiry into Modernising Medical Careers, the Government accepted Sir John Tooke's recommendation that '*PMETB should be assimilated in a regulatory structure within GMC that oversees the continuum of undergraduate and postgraduate medical education and training, continuing professional development, quality assurance and enhancement*'.

19. The merger of PMETB with the GMC will provide an opportunity to build further on the strengths and achievements of both bodies. We already cooperate with PMETB in a number of important areas. In 2009, the two organisations will work increasingly closely to ensure that there is no loss of momentum and that PMETB's programme of work and development continues.

20. In 2009 we will:

- a. Put in place all necessary preparatory work to establish a single continuum for all stages of medical education and training, in order to realise and optimise the benefits envisaged by the merger of PMETB with the GMC.

- b. Co-locate PMETB staff within our London office as soon as is practicable, and make all necessary preparations for all aspects of the physical integration of PMETB within the GMC.
- c. Take forward joint development work in a number of areas including revalidation and certification and quality assurance.

Key aim three: To enhance assurance that licensed doctors are up to date and fit to practise by introducing licences to practise and preparing for revalidation.

21. Revalidation will require doctors to demonstrate periodically that they continue to practise in accordance with the standards set by the GMC and, for those on the Specialist or GP Register, by the relevant Royal College or Faculty. This demonstration will take place in a number of ways, but mainly through an enhanced form of annual appraisal. We have already developed a working framework based on *Good Medical Practice* to support regular appraisal and assessment.

22. We will introduce the Licence to Practise in the autumn of 2009. This will be a landmark change in the way doctors in the UK are regulated to practise medicine. This first step will lead to the introduction of revalidation which will give patients, medical colleagues, employers, commissioners, and others, regular assurance that licensed doctors are up to date and fit to practise.

23. In 2009 we will:

- a. Introduce the Licence to Practise.
- b. Establish the UK Revalidation Programme Board to oversee the implementation of revalidation.
- c. Pilot and deliver the changes needed to support revalidation, working in conjunction with the Department of Health (England) and the devolved administrations.
- d. Develop standards and evaluation method, working with the medical Royal Colleges and the Academy of Medical Royal Colleges.
- e. Develop and consult on guidance showing how revalidation will work.

Key aim four: To encourage and support doctors in the delivery of high quality healthcare by providing accessible, up to date guidance on standards and ethics.

24. In 2008, in collaboration with all our key interest groups, we translated our core guidance *Good Medical Practice* into an effective framework for the assessment and appraisal of doctors. We continue to take steps to embed *Good Medical Practice* into doctors' working practices by developing new and innovative ways of disseminating materials, including interactive case studies delivered online and across the four countries of the UK.

25. In 2008 we published new or updated guidance on Consent (doctors and patients making decisions together); Acting as an Expert Witness; Conflicts of Interest; Personal Beliefs and Medical Practice; Good Practice in Prescribing Medicines; and Reporting Criminal and Regulatory Proceedings within and outside the UK. We also consulted widely on the professional behaviour and fitness to practise of medical students; and on confidentiality; and held a preliminary consultation on the development of our guidance on withholding and withdrawing life-prolonging treatment into broader advice on end of life care.

26. In 2009 we will:

- a. Update and reissue our advice to doctors on standards and ethics guidance, ensuring it is fit for purpose in a changing healthcare environment, focusing on end of life care, confidentiality and research.
- b. Publish new case studies in the *GMP in Action* format and develop further learning materials.
- c. Develop new ways of promoting the guidance and demonstrating how it applies in practice, through interactive case studies and other learning materials.
- d. Engage widely and effectively with our key interest groups in the development of our guidance.
- e. Set evaluation criteria to measure the effectiveness of our guidance.

Key aim five: To support high quality healthcare by ensuring a co-ordinated approach to education and training across all phases of a doctor's career.

27. The planned merger of PMETB with the GMC will mean that, for the first time, one organisation will be responsible - within an integrated regulatory framework of standards, education, registration and fitness to practise - for all stages of medical education and training, from the point of entry into medical school to retirement, including undergraduate education, postgraduate education and continuing practice.

28. We have already completed much valuable work on the policy issues relevant to particular stages of education and training. The prospect of the creation of a single continuum for medical education and training provides a unique opportunity to take a strategic approach. We have commissioned an independent review, led by Lord Naren Patel, which seeks to maximise the benefits of a single point of contact, and single public profile, for all stages of medical education and training.

29. In 2009 we will:

- a. Support the review led by Lord Patel such that it is able to deliver clear recommendations on what constitutes an appropriate, modern approach to the regulation of education and training.

- b. Engage widely and effectively with all our key interest groups to ensure we are able to best develop and promote a strategic approach to medical education and training across all countries of the UK.
- c. Develop three boards to advise and support Council, themed around the main phases of a doctor's career: undergraduate; postgraduate (leading to the certificate of completion of training); and continued practice. Each Board will cover all aspects of the phase for which it is responsible, and thus embed cross-functional working, addressing how our responsibilities impact upon each of our main target groups.

Key aim six: To safeguard patients by ensuring the integrity and accessibility of the List of Registered Medical Practitioners.

30. We deal with registration applications from doctors from the UK, EU and the rest of the world: our application processes are designed to ensure that only those who are properly qualified and fit to practise gain entry to the medical registers.

31. Through our website, contact centre and electronic interfaces with the NHS we provide accurate, up to date information about the registration status of doctors.

32. In 2009 we will:

- a. Engage with those who rely on the medical registers to ensure that we provide information to them in the most effective manner.
- b. Develop the registers to reflect the introduction of licensing.
- c. Agree, with the profession and the Departments of Health in the four countries of the UK, additional information about doctors that we should hold and make available.

Key aim seven: To enhance patient safety by dealing fairly and effectively with doctors whose fitness to practise may be impaired.

33. We take firm and fair action against doctors who fail to maintain the standards expected of them. This involves the investigation of concerns raised about individual doctors and, where the investigation calls into question the doctor's fitness to practise, the adjudication of cases before a fitness to practise panel. In addition, we undertake active monitoring to ensure that restrictions imposed on a doctor's registration are being met.

34. We monitor and strive to ensure the high quality and continuous improvement of our fitness to practise procedures, case work, and decision making. Work to prepare for the introduction of an independent adjudication function – the proposed Office of Health Professions Adjudicator – is already underway and will continue in 2009.

35. In addition, a new concept known as GMC Affiliates forms part of a proposed new architecture for dealing with concerns about doctors and bridging the regulatory gap between local workplace regulation and national professional regulation. The architecture also comprises Responsible Officers and Regional Medical Regulation Support Teams. In 2008 we initiated two pilots – in London and West Yorkshire – and plan to assess these in 2009.

36. In 2009 we will:

a. Deal firmly and fairly with all fitness to practise concerns raised about individual doctors.

b. Work with healthcare providers on the early identification of problems and on appropriate remedies.

c. Make all necessary preparations for the establishment of the independent Office of Health Professions Adjudicator.

d. Assess the conclusions derived from the two pilot studies on GMC Affiliates and, working with the Departments of Health, agree implementation plans as appropriate.

e. Deliver research findings that help us understand the over-representation of international medical graduates in fitness to practise cases.

Key aim eight: To ensure that medical regulation is responsive, targeted and evidence-based by enhancing and developing a comprehensive research programme.

37. The GMC is committed to evidence-based policy making to inform modern medical regulation. We have developed a programme of research and development focused on examining crucial, long-term questions about the future of medical regulation through high quality, independent findings.

38. Since 2006 we have collaborated with the Economic and Social Research Council (ESRC) in taking forward a unique set of complementary research projects, delivered from academic institutions around the UK and led by researchers drawn from a variety of disciplinary backgrounds. Through this programme, we have sought to investigate a range of issues including factors that lead doctors to under-perform, the problems posed by 'transitions' in medical careers, and the extent of challenges encountered by international medical graduates. We hope the findings of this research programme will inform future medical regulation and lay the foundations for a new generation of research.

39. In 2009 we will:

a. Assess the implications of the research findings emerging from our collaborative partnership with the European Social Research Council.

- b. Consolidate and build on our collaborative programme with the ESRC by setting out, as part of our longer-term strategic plan, a further programme of priority issues and areas for further research and development.
- c. Appoint a Research Fellow to address a range of equality and diversity-related questions that will help us ensure that medical regulation is fair, objective, transparent and free from unlawful discrimination.

Key aim nine: To develop further and implement our strategy for valuing diversity and promoting equality in all aspects of our work.

40. Equality and diversity is integral to all aspects of our work, both in our role as employer of staff and in the way in which we carry out our statutory functions. Equality and diversity training is mandatory for all our staff, and we are committed to ensuring that our processes and procedures are fair, objective, transparent and free from unlawful discrimination. We are also committed to a programme of Equality Impact Assessment of our policies.

41. In accordance with our statutory responsibilities, we produce an annual Equality Scheme. The Scheme sets out how we promote, through our functions and policies, equality in the areas of race, disability, gender, age, sexual orientation and religion and belief.

42. In 2009 we will:

- a. Produce a comprehensive equality and diversity strategy that provides appropriate profile, impact and consistency to equality and diversity across the GMC, bringing together our internal policies and practices with our external engagement in a coherent way.
- b. Ensure that our equality and diversity strategy supports us in delivering independent, accountable regulation that promotes fairness and equality and values diversity.
- c. Deliver Equality Impact Assessments, ensuring that they are undertaken at a sufficiently early stage in the policy development process.
- d. Deliver our Equality Scheme Action Plan.
- e. Engage with key interests through our Equality and Diversity Research Forum.

Key aim ten: To enhance our economy, efficiency and effectiveness.

43. Enhancing the economy, efficiency and effectiveness of all the work we do is of central importance. We recognise that this needs to be balanced against the progress we seek to make through the challenging work programme set out in this Business Plan, and work we foresee in the current Council's term of office.

44. We define economy as reducing the costs of acquisitions of the various resources we need; efficiency as increasing output from the same input resources; and effectiveness as the extent to which the outcomes match the aims and objectives of the organisation.

45. In 2009 we will:

- a. Reduce the cost of legal services by £1.2m through the continued development of our in house legal team.
- b. Achieve a £750k saving in the procurement of goods and services through supply chain management and competitive tendering.
- c. Complete the third phase of the Strategic Applications Project, introducing state of the art finance, procurement and human resource management systems.
- d. Implement a pay and reward system based on a competence and performance standards framework.
- e. Enhance the functionality and accessibility of the GMC website.
- f. Move our staff in Manchester to suitable long term accommodation, improving both their working environment and ability to work collaboratively.

Commanding confidence and support

46. In developing and delivering our Business Plan for 2009, we recognise the need to command the confidence and support of our key interest groups by engaging widely, effectively and systematically.

47. Engagement with our key interests, in all four countries of the UK, is essential. It informs our policy making and helps us convey what we do, how we do it, and how we evaluate our success. We have identified four key interests as patients and the public; doctors; the NHS and other healthcare providers; and medical schools and medical Royal Colleges.

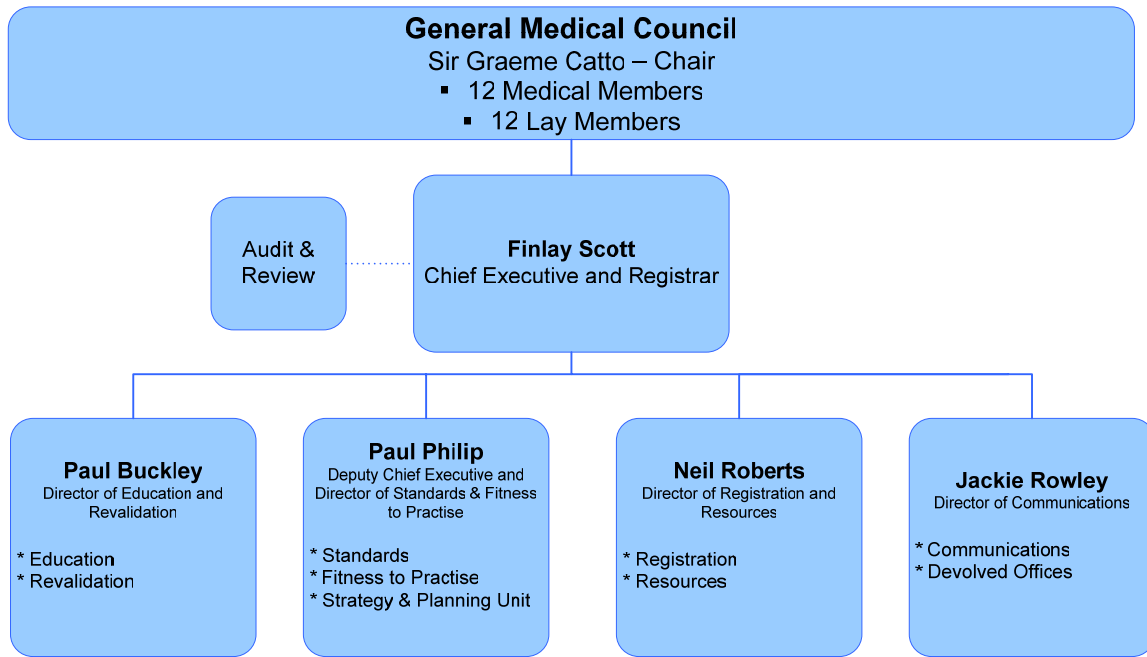
48. Beyond the UK, we will continue to engage with EU institutions and regulators in other countries. In 2009 we remain committed to implementing our European and International Action Plan, influencing regulation in Europe through our leadership of the Healthcare Professionals Crossing Borders initiative, and beyond Europe through our participation in the International Association of Medical Regulatory Authorities.

49. Engagement is not a standalone or add-on activity and does not merely seek endorsement of policy development already undertaken. We use a range of mechanisms to engage key interests in our work, including written and e-consultation, focus groups, roundtable discussions, and invitations to participate in working groups and expert panels. During 2009, we propose to expand our use of finite-life working groups to enhance provision for the participation of external parties

within our work, whilst at the same time enhancing the quality of our interactions with individuals and organisations through improved relationship management.

50. The Council will ensure that the GMC has appropriate mechanisms for engagement as part of its ongoing commitment to achieving good governance and demonstrating best practice in the discharge of its responsibilities.

Organisational Chart

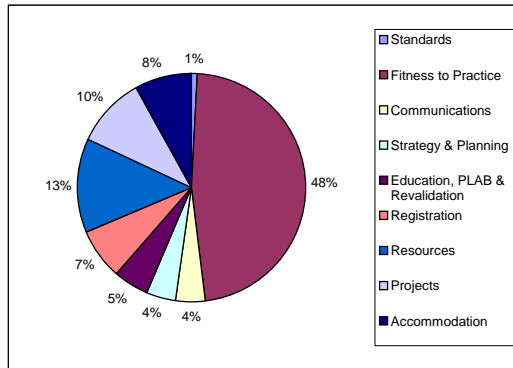


Financial Information

Business Plan and Budget 2009

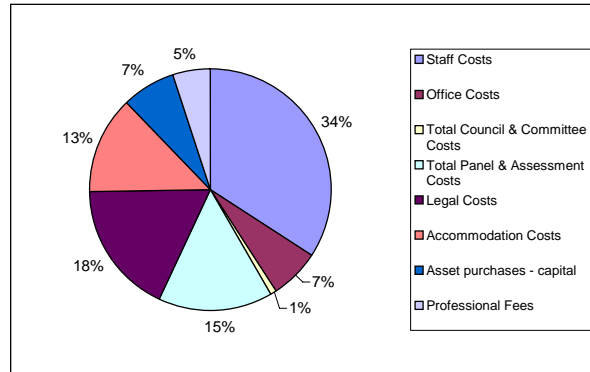
2009 Budget Summary by Directorate

	Total £000	%
Standards	707	1%
Fitness to Practice	41,440	48%
Communications	3,627	4%
Strategy & Planning	4,033	5%
Education, PLAB & Revalidation	4,398	5%
Registration	6,425	8%
Resources	9,261	11%
Projects	6,496	8%
Accommodation	6,956	8%
Total	£83,343	100%



2009 Budget Summary by Expenditure Type

	Total £000	%
Staff Costs	29,652	36%
Office Costs	5,877	7%
Total Council & Committee Costs	741	1%
Total Panel & Assessment Costs	13,482	16%
Legal Costs	15,434	19%
Premises costs	7,659	9%
Asset purchases - capital	5,755	7%
Professional Fees	4,743	6%
Total	83,343	100%



Note all figures are net of capitalisation and depreciation.

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