10 September 2009

Council

General Medical Council

Regulating doctors
Ensuring good medical practice

5a

To consider

Evaluating the GMC's Performance

Issue

1. Developing and piloting the evaluation framework to ensure accountability in the discharge of our statutory functions. This paper outlines the results of the pilots agreed by Council and sets out how we plan to embed evaluation in our corporate planning and reporting for 2010, including in the development of the corporate strategy.

Recommendations

2.

   a. To endorse the results of the evaluation pilots (paragraphs 12-39 and Annex A).

   b. To agree the principles and next steps for the implementation of the evaluation framework (paragraphs 40-42).

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

4. This paper relates to Key Aim 10 of the 2009 Business Plan – to enhance our economy, efficiency and effectiveness – but is relevant to all areas of our work.

5. Council has identified the need to move beyond measures of operational outputs, to focus on the outcomes and impacts of our work as they relate to our statutory purpose – to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine.

6. External assessment supports this approach. In December 2008, KPMG's Internal Audit Report on our performance management arrangements stated that *'the Council or executive were not felt to be held to account for higher level outcomes of the organisation as success was measured largely through service targets at an operational level and not at a strategic, cross-functional level'.*

7. CHRE have commended our work to enhance performance management information, including the development of the evaluation framework, and have indicated their intention to follow up on this in their next review.

Evaluation framework

8. In 2008, Council established the Evaluation Framework Review Group. EFRG reviewed accepted good practice in organisational performance evaluation and developed an evaluation framework to guide future performance assessment.

9. In the absence of a single or obvious measure of how regulation contributes to healthcare quality and patient safety, EFRG concluded that performance evaluation required a range of perspectives and that the framework should comprise a hierarchy of four criteria, in order of importance:

a. The extent to which we achieve our statutory purpose – to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine.

b. The extent to which we command the confidence and support of our key interest groups – patients and the public, doctors, the NHS and other healthcare providers, and medical schools and medical Royal Colleges.

c. The extent to which we adhere to accepted principles of better regulation – proportionality, accountability, consistency, transparency and targeting.

d. The extent to which we deliver economy and efficiency, and make best use of the resources available to deliver our objectives.

10. The evaluation framework was endorsed by Council in March 2009 and members expressed a desire to make it an operational reality as soon as practicable. As a next step, Council agreed to pilot the framework by using it to evaluate four priorities in the 2009 Business Plan.

11. As part of this work, we identified the need to align more closely our corporate strategy (as Council's statement of where we want to be), our annual Business Plan (as our stated means of getting there) and our evaluation framework (as the means for both Council and staff to assess how well we are doing).

Discussion

Piloting the evaluation framework

12. We have applied the evaluation framework to four important work programmes in the 2009 Business Plan:

a. Merger of PMETB with the GMC (Key Aim Two).

b. Introducing the licence to practise (Key Aim Three).

c. Guidance on standards and ethics (Key Aim Four).

d. GMC Affiliates pilot studies (Key Aim Seven).

13. For each of those, we identified the desired outcomes and outlined the measures to assess whether the outcomes had been achieved.

14. We completed an interim evaluation of our performance based on available information and assigned a rating to each outcome:

a. Green when we are on track to achieve the outcome.

b. Amber when we are facing some challenges to achieving the outcome but action is planned or in place to address the challenges.

c. Red when we are facing significant challenges and we are unlikely to achieve the outcome.

Results of the evaluation pilots

15. The results of the four evaluation pilots are summarised below, with further detail at Annex A.

Pilot 1 – merger of PMETB with the GMC

16. The merger of PMETB with the GMC aims to create a more coherent approach to the regulation of all stages of medical education and training, as envisaged in the final report of the Independent Inquiry into Modernising Medical Careers. The merger also presents an opportunity to realise more far reaching improvements, through the implementation of recommendations emerging from the review led by Lord Naren Patel.

17. We are on track to achieve the two most immediately critical outcomes for the merger:

a. To create a single competent authority for the regulation of medical education and training.

b. To deliver the physical and administrative co-location of staff and functions.

18. Legislation to enable the formal transfer of PMETB's functions to the GMC has been published for consultation and is on track for introduction by 5 April 2010. Concerns remain about the timetable for subordinate legislation, including rules and regulations, but we are working closely with the Department of Health (England), through the Joint Steering Group, to identify and mitigate the risks associated with the tight legislative timetable.

19. The Department of Health (England) has approved the outline business case authorising expenditure for co-location, organisational integration and gap funding.

20. Workstreams are in place to ensure that other important outcomes relating to maintaining business continuity, and integrating staff and back office systems and functions, are achieved.

21. Aside from the tight legislative timetable, challenges (as is the case with many mergers) include ensuring that key interests are made aware of the new arrangements and that staff are kept appropriately informed and involved. We have said that Phase Two of the project will require optimal engagement with staff from both organisations as well as increased levels of internal and external communications.

Pilot 2 – introducing the licence to practise

22. The introduction of the licence to practise is the next tangible step towards the introduction of revalidation. We have asked all doctors on the medical register to indicate whether they wish to take a licence and to provide us with information on their practice. This represents a major change in the nature of our relationship with doctors which we will build on through our work on revalidation.

23. We are performing well against the principal outcomes for the introduction of licences:

a. To ensure that all doctors who require a licence to practise have one on 16 November 2009 when the licence is introduced.

b. To achieve high levels of response from doctors during the campaign.

c. To ensure that doctors are aware of the implications of holding, or not holding, a licence.

24. Of the 87% of doctors who have responded so far, around 95% have opted for a licence. This meets the projection at the start of the project, and verification of the data received gives us confidence that all doctors who need a licence will have requested one.

25. Our communications have received positive feedback with only a small number of complaints. Response rates have exceeded expectations at every stage and we are forecasting a final response rate of 95%.

26. The number of enquiries received, as a proportion of the total number of doctors contacted, is low. Although there may be other possible explanations, this suggests that doctors understand what the introduction of licences means for them.

Pilot 3 – guidance on standards and ethics

27. We support doctors to deliver high quality healthcare by providing guidance on standards of professional conduct and medical ethics. We undertake regular reviews of our guidance to ensure that it is up to date and fit for purpose.

28. We have evaluated specific aspects of our work, including our processes for consulting, drafting and disseminating our guidance. We are performing well against the two most critical outcomes for effective guidance:

a. To follow best practice consultation in the development of guidance.

b. To ensure that doctors and other key interest groups consider our guidance to be fit for purpose.

29. The consultation procedures in place to develop guidance follow best practice methods, in line with our protocol.

30. External assessment is positive. In the Performance Review for 2008/09, CHRE concluded that *'standards continue to be an area of excellence for the GMC'*.

31. *GMP in Action*, an online scenario-based tool to help bring the principles of our guidance to life, has been well received by patients and the public, and by doctors. We continue to develop proposals to embed *Good Medical Practice* within medical education and training, registration, and ensuring that doctors remain up to date and fit to practise.

32. Challenges include doing more to target diverse groups and communities in the dissemination of our guidance, which we plan to address in the implementation of our guidance on confidentiality.

33. We have some information about the level of penetration our guidance has within the profession. Proxy measures (for example, the number of times *Good Medical Practice* is accessed via our website) suggest there is an appetite for consulting and using the guidance.

34. The full extent to which doctors are familiar with our guidance, and the influence it has on their actions and behaviours, remains unclear. Embedding our guidance in doctors' professional development and practice is an area of priority that is reflected both in the emerging corporate strategy and the Standards and Ethics work programme.

35. We plan to evaluate the effectiveness of different means of promoting and embedding our guidance in doctors' practice. In 2010 we propose to commission surveys about the current awareness of GMC guidance and attitudes towards its relevance and helpfulness. This will provide the baseline from which to assess the effectiveness of different approaches to implementing the guidance.

Pilot 4 – GMC Affiliates pilot studies

36. The two pilot studies on GMC Affiliates form part of a proposed new architecture for healthcare regulation designed to bridge the gap between workplace regulation and national regulation. One aim is to encourage early and effective action locally in order to enhance patient safety and strengthen public confidence.

37. We are on track to achieve the most immediately critical outcomes for the pilots:

a. To establish an independent evidence base demonstrating whether the Affiliates model improves the effectiveness with which concerns are addressed.

b. To establish an independent evidence base demonstrating whether the Affiliates model leads to greater transparency about the ways in which concerns are managed at a local level.

c. To strengthen relationships with those managing concerns locally.

38. Initial findings from the mid-term evaluation of the pilots indicate that Affiliates are perceived to contribute to a more effective resolution of concerns about doctors, and to provide independent input to local procedures. The Affiliates model is seen by many as being useful, and it has helped to develop relationships with Medical Directors. The full evaluation report in November 2009 will provide an opportunity to further test and substantiate those findings.

39. Challenges include ongoing concerns about the cost of the model and the practicality of scaling up. More generally, we need to demonstrate that findings from the pilots are utilised in future policy development, particularly around issues relating to fitness to practise and revalidation.

Recommendation: To endorse the results of the evaluation pilots.

Principles

40. The evaluation pilots have been useful in demonstrating the practical application of our evaluation framework. The exercise has shown that evaluation needs to be:

a. Flexible in approach, utilising a range of methods and measures.

b. Implemented at the planning stage, before work is underway.

c. Aligned with, and built on, existing management information where possible.

Next steps

41. We need to align our work on evaluation to the development of the corporate strategy, and to the 2010 Business Plan and Budget. Important next steps will be to:

a. Identify a small number of high level performance indicators, drawn from the corporate strategy aims, that we will measure and report to Council at least annually.

b. Identify key outcomes and measures associated with all objectives in the 2010 Business Plan, that we will monitor and report to Council quarterly.

42. We expect formal performance evaluation to be augmented at each Council meeting through the review of Business Plan objectives in the Chief Executive's report. By using complementary methods of assessing progress against the Business Plan we can have confidence that we are achieving the higher-level, cross-functional outcomes outlined in the corporate strategy.

Recommendation: To agree the principles and next steps for the implementation of the evaluation framework.

Resource implications

43. None.

Equality

44. Effectively incorporating equality and diversity considerations is a key outcome for all of our work. We will use the evaluation framework to evaluate our performance in this area.