

The background is a teal color with various medical and scientific motifs. On the left, there are two wireframe heads in profile, one larger than the other. In the center, a hand is shown with fingers spread. Scattered throughout are various icons: pills, a DNA double helix, a microscope, and other medical symbols. The overall aesthetic is clean and professional, representing the medical profession.

General Medical Council

Regulating doctors
Ensuring good medical practice

Business Plan 2011

Our statutory purpose is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine.

We protect UK patients by improving the practice of medicine.

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Chair's foreword

For the GMC, 2010 was a year of considerable progress. We began to deliver our ambitious four-year Corporate Strategy which aims to transform the organisation and its relationships with all those who share our commitment to protect patients and improve standards of medical education and practice.

Revalidation has been, and remains, our number one priority. In 2010, we held a major public consultation on revalidation and agreed a Statement of Intent, signed by the four Health Departments in the UK and the GMC, which sets our agreed priorities and the principles for taking them forward. It commits all the governments and the GMC to work towards rolling out revalidation from the end of 2012. We now move into the implementation phase and must do everything we can to ensure that every doctor understands what is being proposed and that what is delivered is simple, cost-effective and proportionate.

In the past year, we have managed a considerable increase in the number and complexity of fitness to practise enquiries,

as well as an increase in the number of registration applications. In 2011 we will continue to manage these volumes, and introduce further significant changes to our investigation process that should over time reduce both the length of investigations and the number of hearings.

We expanded our standards guidance in 2010 to include advice on treatment and care towards the end of life and the use of research. This coming year, we will launch a major public consultation on *Good Medical Practice*, our core guidance

for doctors, to ensure that it remains up to date and relevant to all doctors regardless of how, or where, they practise. This is a key priority as we seek to ensure that our core guidance remains fit for purpose in a changing healthcare environment.

We will also consult on, and begin to implement, reforms to our adjudication function following the Government's decision to abolish the Office of Health Professions Adjudicator (OHPA).

We are determined to work more closely with front line doctors to ensure we understand the issues

facing doctors in every day practice and that our role in helping to improve standards and protect patients is better understood. The recent work we have undertaken to pilot closer liaison with employers has been a real success and we will build on this in 2011 by creating an employer liaison service across the UK.

In recent years, we have had success in Scotland, Wales and Northern Ireland in developing good relationships with our key interests, influencing decision-makers, and building a better shared understanding of our respective work and priorities.

We aspire to being a more proactive organisation, and will therefore establish regional liaison teams and adopt the good practice developed. This will enable us to engage locally across all four of our functions, building and maintaining relationships at a local level with the whole range of our key interest groups, including doctors, employers, NHS managers and others working at regional level, GP consortia, postgraduate deans, medical schools, local MPs and patient groups.

In 2011, we will start to deliver our new Education Strategy. It sets out

an ambitious agenda reflecting our new responsibilities as the single body responsible for regulating all stages of medical education. The aim must be at all times to promote high standards and ensure that those providing and those benefiting from medical education receive the support they need.

We recognise the increased financial pressure that public services are under, which impacts greatly on doctors. In 2010, we achieved efficiency gains of more than £7 million and our commitment to value for money will be increasingly important in the

coming year. We will continue to bear down on our costs to ensure we can deliver our programmes of work.

Professor Sir Peter Rubin
Chair, GMC



Introduction

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





Our statutory purpose is 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:

- is independent, fair, efficient and effective
- raises standards and enhances patient safety
- fosters the professionalism of doctors
- encourages early and effective local action
- commands the confidence and support of all our key interest groups.

We remain committed to regulation that puts patient safety first. That regulation must 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 the medical Royal Colleges.

Priorities for 2011

The strategic aims in this Business Plan represent a challenging and complex programme of work. We recognise that if we are going to deliver it successfully, we will need to command the confidence of our key partners and engage widely and effectively. The strategic aims are built around the four themes in our *Corporate Strategy 2010-2013* and build on our work in 2010.

Strategic aims

1. To continue to register only those doctors that are properly qualified and fit to practise and to increase the usefulness of the medical register.
2. To give all our key interest groups confidence that doctors are fit to practise.
3. To provide an integrated approach to the regulation of medical education and training through all stages of a doctor's career.
4. To provide doctors with relevant, up-to-date guidance on professional standards and ethics.
5. To develop more effective relationships with delivery partners in order to achieve an integrated approach to medical regulation in the UK.
6. To help shape the local, UK, European and international regulatory environment through effective engagement with decision-makers, other regulators and key interest groups.
7. To continue to use our resources efficiently and effectively.
8. To deliver evidence-based policies that demonstrate 'better regulation' principles, and promote and support equality and diversity.





Protecting the public

Providing assurance to the public by giving people more confidence that doctors are fit to practise; and providing them with greater access to information about their doctor's practice, and an understanding of the role of the regulator.



Strategic aim 1: *To continue to register only those doctors that are properly qualified and fit to practise and to increase the utility of the medical register.*

What did we do in 2010?

In 2010, our focus was on continuing to meet our service delivery targets for registration while managing a significant increase in the number of applications received. Following the introduction of the licence to practise in November 2009, we also identified more information we wanted about doctors and developed a plan for collecting it to enable us to establish a better understanding of licensed doctors' medical practice.

What will we do in 2011?

In 2011, we will continue to deliver against our registration service targets, and we will build on our work this year by implementing a rolling programme of information collection from all licensed doctors, asking them about the nature of their practice. This will enhance the value of the register and inform our policy development, particularly in the areas of revalidation and education.

1.1 We will operate robust, fair, transparent and effective registration, certification, and licensing processes.

Outcomes:

- Only those doctors who are properly qualified and fit to practise gain entry to the medical register.
- Service level performance targets for registration and certification activities are met or exceeded.

1.2 We will continue to review a range of registration policies and processes, including fitness to practise at the point of registration; registration and certification appeals; the PLAB test; Approved Practice Settings; and language assessments and orientation.

Outcome:

- We continue to have registration processes that are efficient, effective and fit for purpose.

1.3 We will implement processes for the regular collection of data from licensed doctors on the nature of their practice.

Outcome:

- We have an enhanced understanding of licensed doctors' practice, which will enable us to plan for the introduction of revalidation and to make a contribution to workforce planning that others need to undertake.





Strategic aim 2: *To give all our key interest groups confidence that doctors are fit to practise.*

What did we do in 2010?

In 2010, we dealt with a considerable increase in the number and complexity of fitness to practise inquiries, including a rise in the proportion of inquiries referred to us by public bodies. This resulted in an increase in the number and length of fitness to practise hearings. We reviewed our fitness to practise procedures to see if we could move to a more proportionate and cost-effective model while continuing to deliver effective public protection. We also developed the policy and guidance that will underpin

revalidation, informed by a major UK-wide public consultation.

What will we do in 2011?

In 2011, we will take forward work to deliver more proportionate and cost-effective fitness to practise procedures, and we will consult on our proposed changes. This will include changes to our adjudication process to enhance its independence, efficiency and effectiveness, following the Government's decision to leave the adjudication function within the GMC. Our work on revalidation will move from policy development to the implementation phase, as we develop the detailed plans and processes needed to enable its delivery, incorporating learning from the pilots taking place across the UK.

2.1 We will deal firmly and fairly with all fitness to practise concerns raised about individual doctors.

Outcome:

- Service level performance targets for fitness to practise activities are met or exceeded.

2.2 We will consult on a programme of reforms for our fitness to practise procedures.

Outcome:

- We have developed a model and begun to implement arrangements for our fitness to practise procedures that deliver a more effective and proportionate system that ensures patient and public protection.

2.3 We will consider whether we can make further improvements to our processes for dealing with doctors with ill health, to ensure they are proportionate and we are supporting them.

Outcome:

- We have the right balance between protecting patients and the public, and supporting doctors suffering from illness.

2.4 We will consult on fundamental reform of our adjudication function.

Outcome:

- We have enhanced the independence, efficiency and effectiveness of our adjudication function.

2.5 We will develop further policy and guidance and consult on the necessary legislative rules and regulations to support the introduction of revalidation.

Outcome:

- We have a revalidation model that commands the confidence and support of our key interest groups and is ready for implementation.

2.6 We will develop plans and manage the governance arrangements for the revalidation programme, in order to progress local and national plans for implementation.

Outcome:

- There are appropriate and effective plans and governance arrangements in place to support the implementation of revalidation.

Helping doctors

Providing doctors with first-class guidance
at all stages of their medical careers,
thereby enhancing their professionalism
for the benefit of patients.





Strategic aim 3: To provide an integrated approach to the regulation of medical education and training through all stages of a doctor's career.

What did we do in 2010?

In 2010, we assumed statutory responsibility for regulating all stages of medical education and training. Our operational activity was maintained throughout the transitional period and work to deliver the early benefits of the merger, such as a single point of contact for those raising concerns about medical education, was achieved. We delivered major programmes covering the implementation of *Tomorrow's Doctors 2009*, quality assurance, and the Patel review.

What will we do in 2011?

In 2011, we will focus on starting to deliver the activities set out in our *Education Strategy 2011-2013*. Its purpose is to demonstrate, by 2013, significant and visible progress towards a coherent and proportionate system for regulating all stages of medical education and training. Our work falls into four areas: setting and assuring standards and valuing education and training; promoting effective selection, transition and progression; defining outcomes for education and training; and working with partners and promoting feedback and learning. We will take forward a programme of work to consider the recommendations for the GMC in Professor John Collin's report, *Foundation for Excellence*, working closely with key interest groups.

3.1 We will develop and implement the Quality Improvement Framework for medical education and training in the UK, building on the existing quality assurance processes, to ensure that standards are maintained by those responsible for the delivery of medical education and training.

Outcome:

- The standards we set provide a framework for excellence that helps to improve and enhance the quality of medical education and training.

3.2 We will develop a framework for the approval of undergraduate and postgraduate trainers.

Outcome:

- Key interest groups consider that the framework will promote and enhance the value of training for

individual doctors and organisations that employ doctors in training.

3.3 We will continue our programme of quality assurance, and pilot a programme of integrated visits in two areas of the UK, looking at all stages of education delivery (including medical schools and postgraduate deaneries) within a geographical location.

Outcomes:

- Our quality assurance activities continue to provide assurance that standards and outcomes are being met.
- There is a more proportionate, consistent, transparent and effective approach to quality assurance activities across the continuum of medical education and training.

3.4 We will complete a review of Continuing Professional Development (CPD), and the 'equivalence routes' to the Specialist and GP Registers.

Outcome:

- There is clarity on the GMC's role in CPD; and the routes for entry to the Specialist and GP Registers command the confidence and support of our key interest groups.

3.5 We will evaluate the case for establishing student registration.

Outcome:

- We have thoroughly considered and consulted widely on the arguments for and against student registration, and come to a view that commands broad support from our key interests.



Strategic aim 4: *To provide doctors with relevant up-to-date guidance on professional standards and ethics.*

What did we do in 2010?

In 2010, we published guidance to help doctors provide good care and respond to the complex ethical problems they may face in their professional lives, including on end of life care and research. We also launched a review of guidance for doctors involved in child protection and issued a wide range of online learning materials for doctors on how the principles of our guidance apply in practice.

What will we do in 2011?

In 2011, our primary focus will be a review of our core guidance, *Good Medical Practice*, to ensure it remains fit for purpose in a changing social and healthcare environment. Our 2010 survey of 1,000 doctors found that the vast majority of doctors consider our guidance to be helpful, but they identified areas where we can do more to improve its practical impact. We will take this work forward in 2011.

4.1 We will launch a major public consultation to inform the review of our core guidance, *Good Medical Practice*.

Outcome:

- There are high levels of engagement with the profession, the public and all our key interests in our consultation, and the feedback received informs our approach. The consultation should be leading edge and wide ranging.

4.2 We will continue to improve the way we develop and implement our guidance, informed by qualitative research into how doctors use guidance, and reviews of the *GMP in Action* format and our consultation processes.

Outcomes:

- The findings of our research and reviews inform our approach to consulting on *Good Medical Practice* and the future format of *GMP in Action*.
- There is evidence that doctors read, understand and use our guidance as part of their day-to-day practice.

4.3 We will publish new learning materials to support doctors in applying the principles of *Good Medical Practice* to patients with learning disabilities.

Outcome:

- Doctors consider that our guidance is published in formats that help them to understand how the principles apply to their day-to-day practice.



4.4 We will publish revised guidance on good practice in prescribing, and management, and continue to develop new guidance for doctors involved in child protection.

Outcome:

- Doctors and other key interest groups consider our guidance to be relevant and fit for purpose.



A high-angle photograph of a circular meeting room. The room features a light-colored wooden floor and a curved wooden desk that forms a circle. Several laptops are open on the desks, each with a microphone. In the center of the room, there is a large, circular, illuminated floor graphic with a colorful, abstract pattern of dots. The room is well-lit, and the overall atmosphere is professional and collaborative.

Working with partners

Working in partnership with key interest groups across the UK, Europe and internationally, particularly the NHS and other healthcare providers, to develop appropriate, more effective relationships that will enhance patient safety.



Strategic aim 5: *To develop more effective relationships with delivery partners in order to achieve an integrated approach to medical regulation in the UK.*

What did we do in 2010?

In 2010, we worked closely with our key interests across the UK to progress the readiness for revalidation. We also worked with medical directors through the 2010 'Affiliates' pilots to test the role of closer liaison with employers.

What will we do in 2011?

In 2011, we will continue to work closely with our key interests to develop and refine our proposals and prepare for implementation of revalidation. We will establish employer and regional liaison across the UK. This will include a network of employer liaison advisers who will work with medical directors to support the effective management of concerns about doctors, and a regional liaison team in England, which will develop closer and more effective relationships with all our key interest groups.

5.1 We will work with our interest groups to help them prepare for the introduction of revalidation.

Outcome

- There is greater understanding of the benefits revalidation can bring and what doctors and employers need to do to support the implementation of revalidation.

5.2 We will roll out an employer liaison service across the UK.

Outcome

- We have strengthened our relationships with medical directors and increased understanding of the thresholds for referrals to the GMC.

5.3 We will implement a regional liaison programme to work with our key interest groups across England.

Outcome:

- We have established more effective relationships with our key interest groups in England.



Strategic aim 6: *To help shape the local, UK, European and international regulatory environment through effective engagement with decision-makers, other regulators and key interest groups.*



What did we do in 2010?

In 2010, we developed a strategy for our European and international work. We worked closely with the Department of Health and the

European Commission to raise the profile of patient safety, particularly where it was affected by the mutual recognition of professional qualifications and language competence of doctors from the European Economic Area. We co-led an informal European network of medical regulators; continued to convene the Alliance of UK Health Regulators on Europe (AURE) and Healthcare Professionals Crossing Borders (HPCB) network, and actively participated in the work of the International Association of Medical Regulatory Authorities (IAMRA).

What will we do in 2011?

In 2011, we will seek to influence the European Commission's proposal for a directive on patients' rights in cross-border healthcare and the forthcoming review of the directive on the mutual recognition of professional qualifications to ensure our concerns about language and competence checks and sharing fitness to practise information are addressed. We will continue to lead and participate in events and initiatives which support a more joined-up approach to healthcare regulation internationally, working with AURE, HPCB and IAMRA.

6.1 We will engage with key decision-makers and healthcare regulators to influence the legislative and policy debate on patient safety and healthcare regulation in the UK, Europe and internationally, particularly in relation to the upcoming revision of the directive on the mutual recognition of professional qualifications.

Outcome:

- We have raised the profile of key concerns that impact on our regulatory functions with key decision-makers, with a view to influencing policy and legislation.

6.2 We will support a more joined-up approach to healthcare professional regulation through our leadership of the HPCB initiative, and our

participation in the AURE and the IAMRA.

Outcomes:

- There is increased collaboration and co-operation at UK, European and international levels in healthcare regulation.
- We have raised the profile of the benefits of more comprehensive and consistent data sharing on healthcare professionals between competent authorities, including promoting the further implementation of the Portugal Agreement and the adoption of the *Memorandum of Understanding on Case by Case and Proactive Information Sharing*.

6.3 We will play a leading role in participating in initiatives to share and promote best practice, including with the Council for Healthcare Regulatory Excellence, and between regulatory bodies and other organisations.

Outcome:

- We have continued to promote high standards in healthcare regulation and greater consistency in their application across regulators.





Delivering value for money

Using our resources efficiently and effectively, and ensuring the organisation is well governed, with a clear purpose and evidence-based policies that demonstrate 'better regulation' principles.



Strategic aim 7: *To continue to use our resources efficiently and effectively.*

What did we do in 2010?

In 2010, we established the Performance Board to develop and oversee an organisation-wide efficiency programme that aims to deliver year-on-year gains of 3-5% from 2010-2013. We achieved more than £7 million of annualised efficiency gains in 2010, representing 8% of our total expenditure, primarily through changes to our fitness to practise procedures and procurement arrangements.

What will we do in 2011?

In 2011, we will continue our efficiency drive in order to further improve

the efficiency of our operations. The Performance Board will continue to oversee our efficiency programme and will identify further efficiency improvements of between 3-5% of our expenditure.

7.1 We will continue to analyse and improve the efficiency and effectiveness of our business processes and support functions, by ensuring scrutiny of all our functions through the work of the Performance Board, undertaking benchmarking, and receiving independent advice that could help us go beyond the 3-5% annualised improvements to achieve further reductions in our costs.

Outcomes:

- Improvements in the efficiency of our work of between 3% and 5%.

- Demonstrable improvements in one or more of the quality, cost and timeliness of the services we provide.

Strategic aim 8: *To deliver evidence-based policies that demonstrate 'better regulation' principles, and promote and support equality and diversity.*

What did we do in 2010?

In 2010, we developed a strategy for research. We engaged extensively with staff and our key interests to disseminate the findings from our collaborative research programme with the Economic and Social Research Council. We also developed an equality and diversity strategy

which sets out how we will embed this area in our work both as a regulator and as an employer. This included a commitment to be a non-discriminatory regulator, ensuring that our systems and guidance are free from bias and transparent to all of our interest groups.

What will we do in 2011?

In 2011, we will begin to deliver both our research and our equality and diversity strategies. Our research and analysis activities will have a particular focus on developing the evidence base around revalidation, education and fitness to practise, to enable us to focus our resources in the right areas. Our equality and diversity activities will continue to focus on delivering on our commitment to being a fair regulator and an inclusive organisation.

8.1 We will implement a programme of research, data-gathering and analysis that is aligned with our *Research Strategy*.

Outcome:

- We have a stronger evidence base for our regulatory functions, which informs our policy development and service delivery.

8.2 We will produce and launch a report that sets out our understanding of the key issues facing medicine and implications for the regulation of doctors and quality of healthcare.

Outcome:

- We establish ourselves as an authoritative voice on the challenges facing healthcare in the UK, and we use our knowledge

and understanding of regulation to contribute to broader policy debates in healthcare.

8.3 We will deliver on the themes and objectives identified in our *Equality and Diversity Strategy*.

Outcomes:

- We can demonstrate where we have considered equality and diversity in developing and implementing our core activities.
- We are confident that our plans, processes and procedures are fair, inclusive and accessible.
- We are recognised as a good practice organisation with regards to equality and diversity.



Governance and performance management

In 2009, Council agreed an evaluation model to measure how our work contributes to delivering our statutory purpose to protect, promote and maintain the health and safety of the public.












During the past year we also put in place a Performance Board to measure the performance of the organisation, using our evaluation framework to measure the work carried out in each of our functions, and our performance against our *Business Plan 2010*. The Performance Board has also been responsible for monitoring the delivery of our efficiency savings programme.

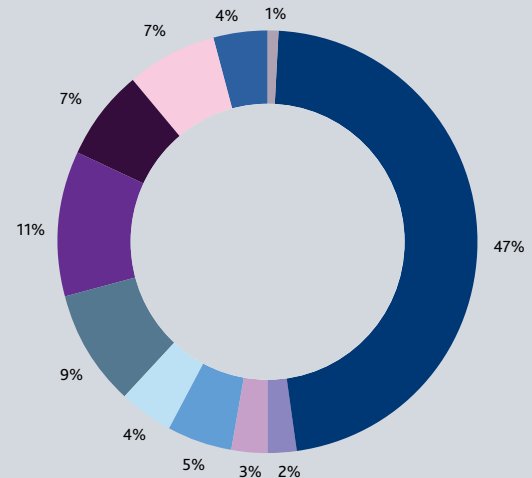
In 2011, we will continue to measure progress against the outcomes set out in this Business Plan. Council will receive regular reports on our performance. We will also highlight the risks facing us and how these risks are managed. We will seek the views of our key interest groups in all areas of our work.

In addition, we will set a number of service targets that are reported to Council throughout the year and in our published annual report, which is presented to Parliament.











Summary operating budget

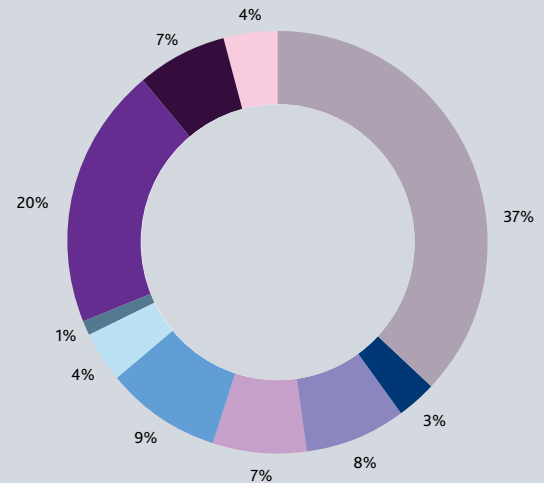
2011 Budget summary by directorate (000s)

Standards	992	1%	
Fitness to Practise	44,510	47%	
Continued Practice and Revalidation	2,150	2%	
Education	2,783	3%	
Strategy and Planning	4,443	5%	
Communications	3,552	4%	
Registration	8,194	9%	
Resources	10,299	11%	
Accommodation	6,441	7%	
Depreciation	6,920	7%	
New initiatives fund	3,527	4%	
Total	93,811	100%	



2011 Budget summary by expenditure type (000s)

Direct staffing costs	35,106	37%	
Indirect staffing costs	3,274	3%	
Office costs	7,410	8%	
Accommodation	6,441	7%	
Legal costs	8,340	9%	
Professional fees	3,338	4%	
Council and member costs	580	1%	
Panel and assessment costs	18,875	20%	
Depreciation	6,920	7%	
New initiatives fund	3,527	4%	
Total	93,811	100%	



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