

General
Medical
Council

Business plan 2012

General
Medical
Council

Regulating doctors
Ensuring good medical practice

Our values

- We **protect the public** through the work that we do.
- We treat everyone **fairly**.
- We are honest and strive to be **open and transparent**.
- We are **committed to excellence** in everything that we do.
- We are a **listening and learning** organisation.

We protect patients by ensuring proper standards in the practice of medicine in the UK.

This year, we will continue our work to become a more proactive regulator by:

- introducing revalidation, to make sure doctors are up to date and fit to practise; and putting in place two new teams to support employers and strengthen our regional liaison
- publishing the new version of our core professional guidance *Good Medical Practice*, and making sure that it is part of doctors' day-to-day practice
- continuing the reforms of our fitness to practise procedures, to deal with cases as effectively and quickly as we can
- further developing the analysis of our data and publishing a second edition of our report on the state of medical education and practice in the UK
- reviewing how we make sure that medical education and training are being delivered to the quality and standards we set
- continuing our first class operational delivery to maintain the register and protect the public.

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Chair's foreword

- 1** Our business plan for 2012 reflects an ambitious work programme that builds on the progress we have made in the past year. We believe it will help improve the quality of healthcare and further protect patients across the UK.
- 2** Our top priority for 2012 is the introduction of revalidation. Revalidation will give patients greater assurance that their doctors are meeting the standards expected of them. We have made significant progress throughout 2011 in developing revalidation and planning for its implementation, and we will focus our efforts in 2012 to make sure it is successfully introduced by the end of the year.
- 3** In 2012, we will have a much stronger local presence. Our employer liaison service will allow us to work closely with responsible officers across the UK to support them to take early and effective action to manage concerns about doctors and help them deliver revalidation. Our new regional liaison team in England, together with our teams in Northern Ireland, Scotland and Wales, will be engaging with our key interest groups to improve our understanding of what is going on locally and help us make better policy decisions.
- 4** These developments will help us achieve our ambition to be more proactive. This also means

that we need to get better at analysing and using our own and others' data, and reflecting our insights back to the profession, the health service and other regulators. In 2011, we published our first report on the state of medical education and practice in the UK. The report drew on data from many sources to provide a picture of the medical profession, and identified some of the ongoing challenges. It has been widely welcomed, and in 2012 we will act on the findings and publish a second report that will further develop and respond to the insights identified.

- 5 We will also strengthen our position as a leader of the medical profession in 2012 by promoting professionalism and supporting a culture where doctors can raise concerns. We will update our

core guidance for doctors, *Good Medical Practice*, and we will develop new approaches to reinforce these standards and embed them in doctors' day-to-day working lives. In particular, we will engage with doctors and their organisations on how best to reinforce professional standards and create a culture where clinicians feel empowered to raise concerns. We will also work with employers and professional organisations to develop an induction programme for all doctors who are new to practice in the UK.

- 6 Building on our public consultations in 2011, we will continue to reform our fitness to practise processes. These changes are designed to increase the speed and cost-effectiveness of our fitness to practise investigations, modernise and

streamline our adjudication procedures, and give our key interest groups greater confidence in the independence of our adjudication function. They will also help us to manage the increasing number and complexity of concerns we are receiving about individual doctors.

7 We will continue to deliver the priorities set out in our *Education Strategy 2011-2013*, and to realise the benefits of the merger of PMETB with the GMC, which gave us responsibility for regulating all stages of medical education and training in the UK. One of our key achievements in 2011 was implementing a single *Quality Improvement Framework* for undergraduate and postgraduate medical education and training. In 2012, we

will undertake a comprehensive review of our approach to assuring the quality of medical education and training in the UK, to make sure that our high standards are being met. We will also contribute to a major review that will look at the future shape of postgraduate medical education and training.

8 We remain committed to continuing to improve the efficiency and effectiveness of our operations. In 2011, we achieved gains of more than £8 million. We will continue to meet our target of 3-5% efficiency gains in 2012, which will help us to deliver our ambitious work programme and to freeze or reduce the fees that doctors pay to us.

9 For the first time, we have set out not only our intentions for the coming year, but also a high level view of what we aim to achieve in 2013 and 2014. We believe that this approach helps to clarify our longer term goals, sets a clear direction for the organisation, and helps us plan both our activities and our use of resources. It also supports our aspiration to communicate more effectively with all of our key interest groups, underlining our desire to be a proactive, outward-facing organisation with a commitment to doing all that we can to protect, promote and maintain the health and safety of the public.

10 Overall, this is an ambitious plan that builds on work started in 2011 and ensures we focus on delivering revalidation in 2012, which will make a significant contribution to protecting, maintaining and promoting the health of the public.

A handwritten signature in white ink that reads "Peter Rubin". The signature is written in a cursive, flowing style.

Professor Sir Peter Rubin
Chair, General Medical Council

Introduction

11 The General Medical Council (GMC) is the independent regulator for doctors in the UK. We protect patients by making sure doctors have the right knowledge, skills and experience to provide safe, high quality care to patients.

We want to be a regulator that:

- a** raises standards and enhances patient safety
- b** fosters the professionalism of doctors
- c** is independent, fair, efficient and effective
- d** encourages early and effective local action where problems occur
- e** has the confidence and support of all our key interest groups.

We put patient safety first.

-
- 12** Our plans for the year ahead follow the four themes in our *Corporate Strategy 2010-2013*. We are taking on a challenging and complex programme of work and we will need the support of partners to deliver it.
- 13** In an ever-changing healthcare environment, new priorities could emerge during 2012 that we have not foreseen and planned for. However, we have allowed enough flexibility in our plans to be able to respond to these. We also have tools and processes in place so that we can assess the relative priority and resourcing implications of new or changing demands.

Our strategic aims

- 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.
- 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.

In 2011, we improved the way we make sure that doctors joining the register have the qualifications and skills to provide safe, high quality care to patients. For example, we streamlined the way we deal with appeals about registration and certification by introducing a single system for both. To start to make the medical register a more useful resource and to help prepare for revalidation, we asked licensed doctors for information such as where they work and in what specialty.

In 2012, we will gather more information about licensed doctors. We will review a number of our policies and processes, including the Professional and Linguistic Assessments Board (PLAB) test, to ensure they continue to protect patients.

In 2013 and 2014, we will continue to improve our registration, certification and licensing processes. For example, we will implement our induction programme, following the pilot in 2012. We will also update the PLAB test with any changes identified in the 2012 review to make sure it continues to provide an objective and reliable assessment of a doctor's knowledge and skills. We will have a better picture of the medical profession from the data we will have collected, and this will help us to work more effectively and give the public greater confidence that licensed doctors are fit to practise.

What will we do in 2012?

1.1 We will operate fair, transparent, effective and cost-efficient registration, certification and licensing processes.

Outcomes:

Doctors wanting to join the register experience an effective and efficient service from the GMC.

Only those doctors who are properly qualified and fit to practise are able to join the register and practise medicine in the UK.

1.2 We will review a range of our registration policies and processes, including the PLAB test, the settings in which doctors new to UK practice can train or work (approved practice settings), the way we assess doctors' English language skills, and how long doctors can retain provisional registration.

Outcome:

Our policies and processes deliver effective protection for patients because only those doctors who are properly qualified and fit to practise are able to join the medical register, and those new to the register can only practise in appropriate settings.

1.3 We will collect additional, up-to-date information from doctors about their practice.

Outcome:

We have better information about doctors, which we can analyse and use to support the implementation of revalidation.

1.4 We will seek to understand how we can improve the information we hold and publish about doctors.

Outcome:

We have a better understanding of the types of information about doctors' practice that is of most interest or use to our key interest groups.

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

In 2011, we developed the detailed plans we needed to introduce revalidation by the end of 2012. We dealt with a higher number of concerns about doctors than in previous years, making sure that patients were protected. And we consulted our key interest groups on changes that we believe will further improve how we protect patients (our fitness to practise and adjudication procedures) and people's confidence in our procedures.

In 2012, we will start to introduce revalidation across the UK. Revalidation will improve patient safety and the quality of healthcare by making sure all doctors are keeping up to date and fit to practise. Building on the public consultations we held in 2011, we will also change the way we deal with fitness to practise cases

at the end of an investigation, and modernise and streamline our adjudication procedures. We will show more clearly that these procedures are independent of our work in investigating complaints about doctors by introducing the Medical Practitioners Tribunal Service.

In 2013 and 2014, we will continue to roll revalidation out across the UK, and monitor and review its impact on the wider health sector. We will have established the Medical Practitioners Tribunal Service to run hearings about doctors' fitness to practise, and we expect to be able to appeal against its decisions if we feel they are not the right ones to protect patients. We will also introduce further changes to make our fitness to practise work more proportionate and cost effective.

What will we do in 2012?

2.1 We will start to introduce revalidation.

Outcome:

The first cohort of doctors will begin to demonstrate that they are keeping up to date and fit to practise through revalidation, and our key interest groups have confidence in the system.

2.2 We will deal swiftly and appropriately with concerns raised about the fitness to practise medicine of individual doctors.

Outcome:

We protect patients and are fair to doctors by making timely and sound decisions in response to concerns about doctors. We maintain this even if there are significant increases in the number and complexity of concerns raised with us.

2.3 We will develop and pilot changes to the way we deal with fitness to practise cases after an investigation.

Outcome:

We deal with fitness to practise concerns more proportionately and cost-effectively while continuing to protect the public.

2.4 We will begin to change our adjudication procedures, including establishing the Medical Practitioners Tribunal Service in shadow form.

Outcome:

People are more confident that decisions about doctors' fitness to practise are fair, unbiased and independent of the GMC's work in investigating complaints.



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.

In 2011, we began to deliver the activities set out in our *Education Strategy 2011-2013*. We implemented a new *Quality Improvement Framework* and piloted our approach to examining the quality of all stages of education together in the West Midlands and Wales. We published advice supplementary to our standards for undergraduate education, *Tomorrow's Doctors* (2009), to help medical schools understand what they need to do to meet these. We also published *The Trainee Doctor*, a single set of standards for postgraduate training.

In 2012, we will focus on four areas: setting standards, making sure those standards are being met, listening to and working more closely with partners in education, and contributing to the review of the shape of training. We will also review the way we carry out our quality assurance work.

In 2013 and 2014, we will complete our review of the standards we set for medical education and training, and assess what impact *Tomorrow's Doctors* (2009) has had. We will change the way we assure the quality of medical education and training in response to the findings of our review. We will also develop and publish a strategy for our work over the next three years.

What will we do in 2012?

3.1 We will improve standards of medical education and training by publishing new guidance on continuing professional development and by consulting on proposals to recognise and promote the contribution of doctors involved in training. (Subject to consultation, these proposals will be implemented from 2013.)

Outcome:

We improve patient care by raising the standards expected and achieved at all stages of medical education and training.

3.2 We will ensure that the quality of medical education and training meets our standards, and review our overall approach to quality assurance, including improving further how we respond when serious concerns are raised.

Outcome:

We promote excellence in medical education and training, have robust methods to ensure that standards and outcomes are being met, and intervene quickly when serious concerns emerge.

3.3 We will review how we engage with and support our education partners and take steps to improve our approach.

Outcome:

We work effectively in partnership with all groups involved in medical education and training.

3.4 We will make a significant contribution to the independent review of the shape of postgraduate medical education and training in the UK.

Outcome:

The review defines a future structure of postgraduate medical education and training that will produce doctors equipped to meet future patient and service needs.

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

In 2011, we began a review of our core guidance for doctors, *Good Medical Practice*. We drafted and consulted on updated guidance on good practice in prescribing medicines and for doctors working as managers or leaders. We also developed and consulted on new guidance for doctors involved in child protection.

In 2012, our main priority will be to work with our key interest groups to develop and implement an updated version of *Good Medical Practice*, which clearly sets out the values and principles that underpin good practice. We will use the guidance to encourage medical professionalism and reinforce the core standards of behaviour that we expect from doctors.

We will also commission research to find ways to embed these standards more firmly in doctors' day-to-day working lives, and develop and pilot an induction programme to support doctors new to UK practice.

In 2013 and 2014, we will continue to make sure that our guidance is up to date. For example, we expect to publish revised guidance both on treating children and young people and on issues relating to patient consent. We will also develop new guidance, where appropriate, to help doctors respond to complex ethical problems in their professional lives, and we will continue to support doctors to apply our guidance in their daily practice.

What will we do in 2012?

4.1 We will launch an updated edition of *Good Medical Practice*, including a version for patients. This will be supported by updated supplementary guidance and learning materials.

Outcome:

Good Medical Practice sets out the standards that doctors, employers, educators and the public think doctors in the UK should meet.

4.2 We will research how doctors use our guidance, and develop new approaches to embedding our standards in doctors' lives, including better supporting doctors who raise concerns.

Outcome:

The principles and values of our guidance are more consistently used by doctors in their day-to-day practice, and doctors are better supported to raise concerns about colleagues.

4.3 We will pilot an induction programme for all doctors who are new to practice in the UK.

Outcome:

Doctors who are entering UK practice for the first time understand the standards expected of them and are familiar with our guidance.

4.4 We will work with doctors to improve their understanding of how to meet the needs of different patient groups – for example, older patients and disabled patients.

Outcome:

Patients from different groups in society receive better care from their doctors.

4.5 We will consider whether we should develop new guidance for people making decisions about the fitness to practise of doctors who may have helped someone to commit suicide.

Outcome:

People know what factors they should take into account when considering fitness to practise concerns that suggest a doctor may have assisted a person to commit suicide.



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.

In 2011, we built strong relationships with a wide range of key interest groups. One of the ways we did this was through piloting a team of regional liaison advisers to work with partners locally. This helped us to raise awareness about revalidation and what doctors, employers and others need to do to support its introduction. We also recruited and trained a network of employer liaison advisers across the UK who will work with employers to prepare for revalidation and advise them on concerns about doctors.

In 2012, we will work even more closely with our partners to deliver revalidation. Employer liaison advisers will start work helping responsible officers to prepare, and will encourage early intervention when concerns about doctors have been identified. We will

further encourage the latter by sharing information more effectively with other regulators. Regional liaison advisers will work closely with employers, patients and other key interest groups to give us a stronger local presence. We will use the insight this local presence gives us to make sure our policies reflect and are responsive to local needs.

In 2013 and 2014, our employer liaison advisers will continue to work closely with responsible officers to help them meet their responsibilities for the quality of medical practice in their organisations after revalidation has been introduced. We will assess the impact of our new liaison arrangements and closer collaboration with other regulators, and will identify how we can strengthen our approach.

What will we do in 2012?

5.1 We will continue to build strong relationships with our partners, and work closely with responsible officers and other key interest groups to help deliver revalidation.

Outcome:

Revalidation is introduced successfully as responsible officers, doctors, employers and other delivery partners understand what they need to do to support it.

5.2 Employer liaison advisers will work with responsible officers throughout the UK to help implement revalidation locally and manage concerns about doctors earlier and better.

Outcome:

Responsible officers are supported in fulfilling their role, and in taking early and effective action to address concerns about doctors.

5.3 Regional liaison advisers in England will work with key interest groups to increase our understanding of what is happening locally, and we will continue to engage effectively with our key interest groups in Northern Ireland, Scotland and Wales.

Outcome:

Our policies, the way we work and the decisions we make protect patients more effectively and meet the needs of our partners across the UK.

5.4 We will continue to collaborate closely with other health professional and systems regulators in the UK and throughout the world, in particular by sharing our data and the insights its analysis gives us.

Outcome:

Concerns about patient safety are identified and dealt with promptly and effectively.

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.

In 2011, we worked closely with the Department of Health in England and the European Commission to influence the review of the European directive that sets out which professional qualifications we need to recognise when a European doctor applies to join the register (the directive on the recognition of professional qualifications). We also contributed to a range of other initiatives to help develop policy and legislation that impact on patient safety and healthcare regulation. For example, we gave evidence to the Mid Staffordshire NHS Foundation Trust Public Inquiry, the House of Lords Inquiry into the mobility of healthcare professionals, and the Health Select

Committee's annual accountability hearing to assess our performance. We continued to play an active role in networks of healthcare regulators across the UK and throughout the world, and worked with the four UK governments to inform their policy development.

In 2012, a key priority will be to influence the revised proposal for the directive on the recognition of professional qualifications so that it reflects our concerns about doctors' language skills and competence and about the sharing of fitness to practise information between different countries and regulators. We will continue to collaborate with

regulators in the UK and overseas, including our work with the International Association of Medical Regulatory Authorities, to support a more consistent approach to healthcare regulation, to share best practice and learn from each other. We will also review and adapt the way we engage with doctors, patients and the public to help them understand our work and our role.

In 2013 and 2014, we will continue to influence UK and European legislation and policy, and to collaborate effectively with other regulators, doctors and the public to make sure that patients are protected and their safety is not compromised by freedom of movement. We expect that issues relating to doctors' language skills, competence and professional qualifications, and to the sharing of fitness to practise

information, will continue to be a focus as the directive on the recognition of professional qualifications is adopted and implemented in the UK. We will also share our experiences of implementing revalidation with other regulators.

What will we do in 2012?

6.1 We will engage with key decision makers to influence the debate on patient safety and healthcare regulation in the UK and throughout the world, particularly in relation to the revision of the directive on the recognition of professional qualifications.

Outcome:

We have raised the profile of developments that impact on patient safety, and influenced UK, European and international policy and legislation.

6.2 We will cooperate with healthcare regulators and other organisations in the UK and throughout the world on policy and operational issues, and participate in initiatives to share and promote good practice.

Outcome:

We have helped to identify and promote more consistent, efficient and cost-effective approaches to healthcare regulation.

6.3 We will increase the quality and extent of our interactions with patients and the public.

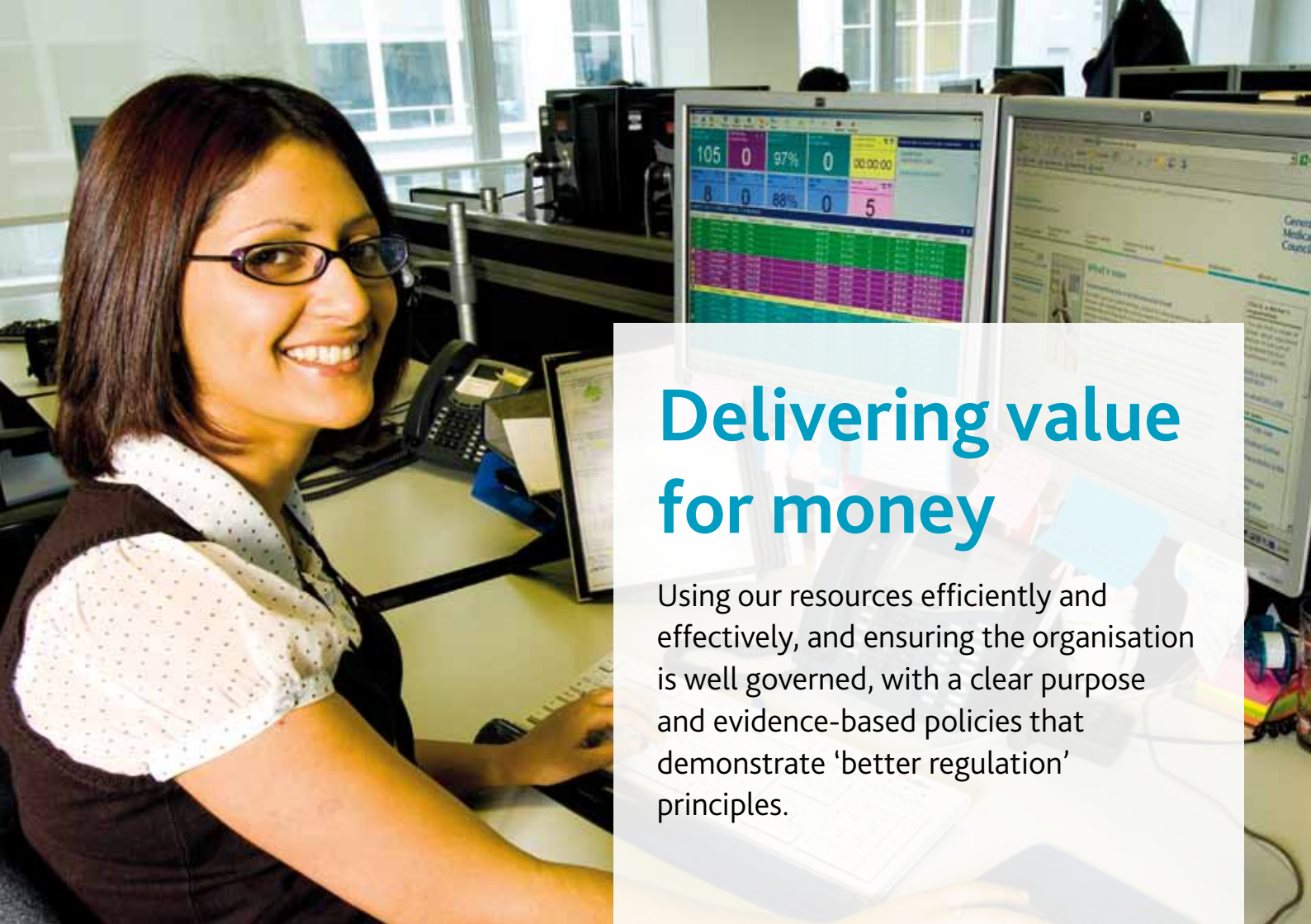
Outcome:

Patients and the public find it easier to interact with us, helping them to understand our role in protecting patients and enabling us to deliver more effective regulation.

6.4 We will review how we interact with doctors, including exploring opportunities for greater e-engagement.

Outcome:

We have a better understanding of doctors' preferences for engaging with us, which helps us to deliver our services in the most effective way.



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.

In 2011, we saved more than £8 million from making our processes more efficient, representing about 8.8% of our budget for the year, and we also delivered a range of projects to improve our services. This helped us to freeze or reduce the fees doctors pay us. We compared our practices with those of other organisations to ensure that we are as effective and efficient as possible, and we received independent advice on how we can further reduce our costs.

In 2012, we will continue to scrutinise the efficiency and effectiveness of all of our functions and to deliver further efficiency savings of between 3% and 5%. We expect to save a significant amount of time and money through modernising our adjudication procedures, and by seeking to use 'lean principles' in our major work programmes. We will also ensure the good governance

of the organisation by putting the necessary arrangements in place to support the appointment of the reconstituted Council from the start of 2013.

In 2013 and 2014, we will look for ways to achieve further efficiency gains. This will be key to freezing or further reducing the fees doctors pay to the GMC in the medium term, while ensuring that we continue to deliver a service that effectively protects patients.

What will we do in 2012?

7.1 We will continue to analyse and improve the efficiency and effectiveness of our business processes.

Outcome:

We are able to freeze or reduce the fees doctors pay the GMC in the medium term and we have improved the quality and timeliness, and reduced the cost, of our services.

7.2 We will support the arrangements for appointing a reconstituted Council, and develop a revised governance framework.

Outcome:

We have a smaller, more board-like Council in place from 1 January 2013.

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

In 2011, we delivered a wide range of research and analysis projects, many of which provided evidence to inform our approach to revalidation, education and fitness to practise, and we published the first annual report on the state of medical education and practice in the UK. We also worked towards delivering the priorities set out in our *Equality and Diversity Strategy 2010-2013*. This included publishing our *Single Equality Scheme 2011-2014*, and working with teams across the GMC to ensure we are compliant with the new public sector equality duty, and to develop and implement action plans that show how we are embedding equality and diversity in our work.

In 2012, we will improve the way we collect and analyse our data so that we can deliver a more proactive and risk-based approach to regulation, and to feed our learning back to the profession, the health service and other regulators. Our equality and diversity work will focus on four areas: remaining compliant with equality and diversity and human rights legislation; embedding equality and diversity in our core activities; identifying the key measures against which to track and evaluate our progress; and ensuring that we include doctors, patients and members of the public from equality and diversity groups when developing and implementing our policies.

In 2013 and 2014, we will review and refresh both our research and our equality and diversity strategies so that they are fit for purpose for 2014 and beyond. We will continue to ensure that our policies and procedures are evidence based and fair and take into account the needs of diverse interest groups and communities.

What will we do in 2012?

- 8.1** We will deliver a programme of research, data collection and analysis that is aligned with our research strategy.

Outcome:

We have improved the use of our data and evidence, and commissioned and acted on appropriate external research.

- 8.2** We will act on the findings of our first report on the state of medical education and practice in the UK, and publish a second report that builds on these insights.

Outcome:

We provide an authoritative analysis of some of the challenges facing medical education and

practice in the UK, which contributes to broader policy debates and informs our approach to regulation.

- 8.3** We will deliver the priorities identified in our *Equality and Diversity Strategy 2010-2013* and supporting action plans.

Outcomes:

We can show where we have considered equality and diversity in our core activities, and are confident that our plans, processes and procedures are fair, inclusive and accessible.

We are recognised as a good practice organisation with regard to equality and diversity.

Managing the performance and capability of the organisation

- 14** In 2012, we will measure our progress against the activities and outcomes set out in this business plan. We will give the GMC's Council regular reports on our performance, and we will also highlight the risks facing us and how we are managing them. Additionally, we have a number of service targets on which we will report to Council throughout the year and in our published annual report.
- 15** Our internal Performance Board will continue to scrutinise our performance. We will receive independent scrutiny through the Council for Healthcare Regulatory Excellence's annual performance review, the Health Select Committee's annual accountability hearing, our annual report and accounts, which are laid before Parliament, and our audit programme.
- 16** To deliver the challenging programme set out in this business plan, we will need to rely on the skills and experience of our staff. We will continue to offer staff a wide range of learning and development opportunities, and to fulfil our commitment to valuing diversity and promoting equality.

During 2011, we developed and rolled out a set of organisational values that underpin how we behave towards one another internally and how we relate to our external contacts.

- a We **protect the public** through the work that we do.
- b We treat everyone **fairly**.
- c We are honest and strive to be **open and transparent**.
- d We are **committed to excellence** in everything that we do.
- e We are a **listening and learning** organisation.

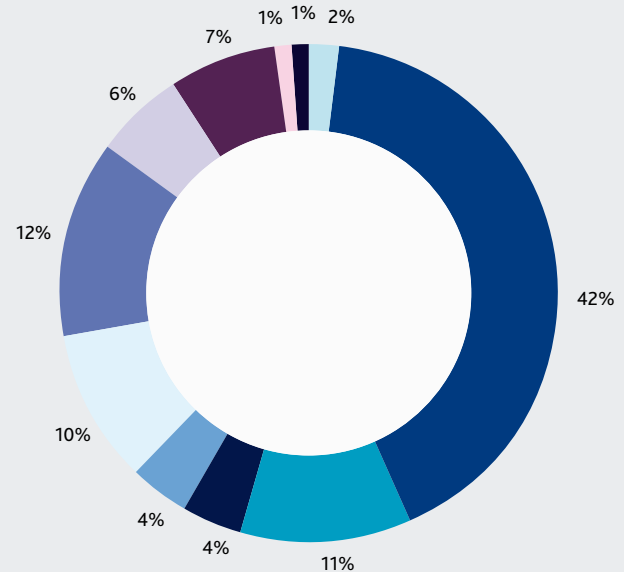
17 As part of our commitment to openness and transparency, we will continue to build on our effective networks for communicating and engaging with key interest groups about matters that affect them, including consulting them about policy and operational developments and sharing information with them. We will further strengthen relationships with other professional and systems regulators across the UK and with all of the partners with whom we need to collaborate to assure proper standards in the practice of medicine.

18 We will also make sure we have the technology and infrastructure needed to provide high quality, cost-effective services to our key interest groups.

Summary operating budget

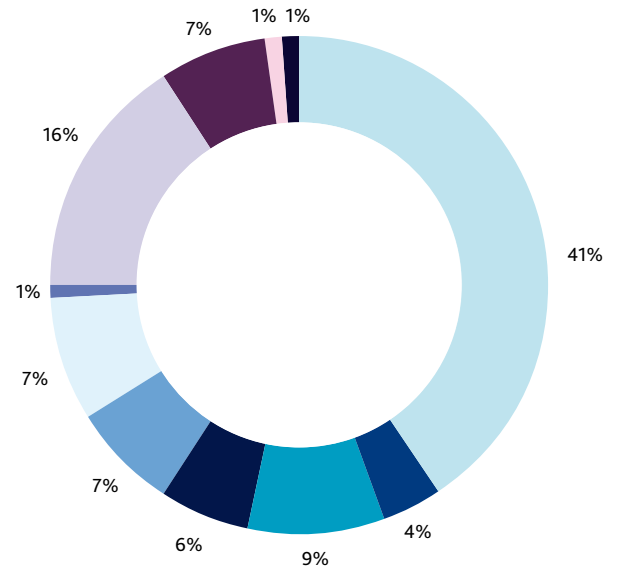
2012 budget summary by directorate (£000s)

Standards	1,390	2%	■
Fitness to Practise	37,635	42%	■
Strategy and Communication	9,620	11%	■
Continued Practice and Revalidation	3,963	4%	■
Education	3,534	4%	■
Registration	9,373	10%	■
Resources	11,228	12%	■
Accommodation	5,375	6%	■
Depreciation	6,010	7%	■
New initiatives fund	1,000	1%	■
Proposed CHRE levy	500	1%	■
Total	89,628	100%	



2012 budget summary by expenditure type (£000s)

Direct staffing costs	36,488	41%	■
Indirect staffing costs	3,442	4%	■
Office costs	8,275	9%	■
Accommodation costs	5,375	6%	■
Legal costs	6,560	7%	■
Professional fees	6,882	7%	■
Council and members costs	630	1%	■
Panel and assessment costs	14,466	16%	■
Depreciation	6,010	7%	■
New initiatives fund	1,000	1%	■
Proposed CHRE levy	500	1%	■
Total	89,628	100%	



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General
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Regulating doctors
Ensuring good medical practice