

To consider

Chief Operating Officer's report

Issue

1. This report gives an update on the GMC's operational performance.
 - Annex A – Business Plan 2013.
 - Annex B – 2013 Income and Expenditure.
 - Annex C - Performance against service targets and volumes of activity – fitness to practise, registration and revalidation.

Recommendation

- 2 Council is asked to consider the Chief Operating Officer's report.

Significant issues potentially affecting our operational performance

2. Our financial and planning cycle starts on 1 January. The business plan (Annex A) and budget (Annex B) are attached. Council will note the operating budget for 2013 has been set at £96,453,000 with a capital budget of £7,681,000.
3. Our revalidation regulations and formal guidance came into effect on 3 December 2012. We wrote to all licensed doctors during December 2012 and January 2013 to tell them the date of their first revalidation. Between January and March 2013, we expect to revalidate most Responsible Officers and medical leaders.
4. Introduction of the NHS Commissioning Board and other changes to the healthcare structures in England will take effect from 1 April 2013. This is a key consideration in the opening phases of revalidation because approximately 100,000 doctors will move their prescribed connection on that date. We have plans in place to minimise the disruption to us and to doctors. This issue features on our Corporate Risk Register.
5. Niall Dickson wrote to Ian Dalton (Chief Operating Officer of the NHS Commissioning Board) in December 2012 to set out the importance of maintaining continuity and momentum in revalidation, and our dependence on the NHS Commissioning Board in supporting this.
6. The number of enquiries in our fitness to practise procedures increased by 18% between 2011 and 2012 (from 8,779 to 10,357), continuing an upward trend that started in 2009. We have seen a 16% increase in the number of stream 1 cases between 2011 and 2012, which could require us to remove or restrict the doctor's right to practise, and a 9% decrease in the number of stream 2 cases, which are likely to be less serious. January 2013 levels were on par with intakes in January 2012.
7. To accommodate the extra staff we have taken on in fitness to practise, we have acquired space in a third building in Manchester, provisionally on a temporary basis.

Education and Standards

8. The Education and Standards Directorate are providing secretariat support for the independent Shape of Training review. The written evidence gathering phase will close on 8 February 2013. The GMC's response is at item 8 for this meeting. The response rate so far has been very high and the Expert Advisory Group will meet on 14 March to consider the trends that have emerged and plan the next steps including oral evidence sessions.
9. We completed our scheduled visits to education providers in the London region in December 2012 and we are currently compiling the report of our findings. We will hold a workshop to share lessons learned on 7 March 2013.

10. We will shortly publish two independent research reports, the first is a literature review about selection to medical school, the second is a report about the impact of the Working Time Regulations on postgraduate education and training. We will work with partners to take forward the learning from these reports.

Equality and Diversity

11. We are beginning our programme of work to develop the 2014-17 supporting strategy for Equality and Diversity (E&D). This will involve evaluating progress in delivering the current strategy, and consulting internally and externally about our future priorities in this area. Aligned to this, each Directorate will have in place E&D plans for 2013 which sets out the work underway to mainstream E&D into our core activities.

12. We have recently published the report of the 'Being fair' conference which took place in 2012, bringing together a cross-section of our interest groups to explore the fairness issues inherent in our work as a professional regulator. Our programme for this year will enable us to deliver against the commitments made on that occasion.

Fitness to Practise

13. We continue to pilot ways of improving the efficiency of our fitness to practise work. We are at the early stages of engaging with those who complain about doctors at both the beginning and the end of our procedures. We have also commenced a pilot of meeting with doctors at the end of our investigation to better understand the issues and to offer an opportunity to be clear about the information required by our decision makers to make an appropriate decision in a case regarding referral to a public hearing. Both pilots are going well.

14. The Lean review of all our fitness to practise procedures has identified three 13-week projects that we will implement in 2013. The first of these projects (reviewing our triage processes) started at the beginning of January 2013. The outcome of this project will be to make our processes as efficient as possible.

Medical Practitioners Tribunal Service (MPTS)

15. A full report from the Chair of the MPTS is at item 6 for this meeting. In future Chief Operating Officer's reports, we will outline any exceptional operational issues for the MPTS. The key issue facing the service is to introduce new secondary and primary legislation. The former is in hand and we would hope to introduce new operating rules in the Spring. The latter will, by necessity, need to be on a longer time-line.

Registration and Revalidation

16. We held our first 'Welcome to UK practice' (induction) event for 31 delegates on Saturday 19 January 2013. This is the first of three pilot events designed to test how we can better support doctors new to the UK system. The feedback from the

event has been positive, although we will need to complete a full analysis when all three events have taken place.

17. In January 2013, we published guidance for overseas regulators and organisations about revalidation. This advises that doctors who practise permanently outside the UK do not need a licence to practise in the UK.

Resources and Quality Assurance

18. A summary of our budget 2013 is at Annex B. Future Chief Operating Officer's reports will include an income and expenditure report.

19. In 2010, we began a four-year programme to make ongoing efficiency gains across the GMC that are equivalent to 3–5% of our annual budget. So far we have delivered total efficiency gains of around £30 million up to the end of 2012, of which around £24 million are cashable gains. For 2013, we estimate that our programme of efficiency projects will deliver total efficiency gains of £15.5 million.

20. We have taken advantage of a break option on our leases for the St James' Buildings in Manchester to secure more favourable terms on our hearing offices. We reviewed what benefits we could gain by exercising the 2014 lease break and negotiating new lease terms. We have negotiated terms on a new ten-year lease with a break option at five years. Our commitment to the building remains until 2019.

Strategy and Communication

21. We have done significant work to understand the key issues, implications and provide support for the senior team ahead of the publication of the Francis Report into the Mid Staffordshire NHS Foundation Trust. We have also developed a detailed plan for internal and external communication.

22. The full team of eight regional liaison advisers (in England) completed their induction training in December 2012 and are now actively engaging with groups of doctors, patients and the public. They are playing a key role in supporting our promoting professionalism programme by running workshops with medical staff to promote our standards and engaging with medical students.

Supporting information

If you have any questions about this paper please contact:

Paul Philip, Chief Operating Officer, 020 7189 5124 pphilip@gmc-uk.org.

Annex A

Business Plan 2013

Introduction

1. 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.
2. The activities presented below are underpinned by a detailed operational plan which is overseen by our Performance and Resources Board.
3. The business plan for 2013 was approved by Council at its meeting on 5 December 2012.

Our strategic aims

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

11. To deliver evidence-based policy that demonstrate 'better regulation' principles and promote and support equality and diversity.

Protecting the public

12. 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.

13. Our significant work in 2013 will include:

- a. Delivering high quality registration, certification and licensing services to our published service targets.
- b. Processing revalidation recommendations in a timely way.
- c. Ensuring an effective and efficient registration framework, implementing findings from the Certificate of Eligibility for Specialist Registration (CESR) and Professional and Linguistic Assessment Board (PLAB) reviews.

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

14. Our significant work in 2013 will include:

- a. Introducing revalidation and reviewing its implementation.
- b. Reviewing and developing policy areas relating to regulatory development, including completing the review of the Professional and Linguistic Assessments Board (PLAB) test.
- c. Dealing swiftly and appropriately with concerns raised about fitness to practise, maintaining this service despite rises in the number and complexity of enquiries.
- d. Improving fitness to practice processes, following the 'lean' review and evaluating our pilots of meetings with doctors and complainants designed to reform the handling of cases after an investigation.
- e. The Medical Practitioners Tribunal Service (MPTS) implementing the adjudication reform programme.

Helping doctors

15. 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.

16. Our significant work in 2013 will include:

- a. Further developing quality assurance activities to ensure medical education and training meets our standards, concluding our review of how this is done.
- b. Contributing to the independent Shape of Training review, with the aim of ensuring that postgraduate education and training remains fit for purpose in a rapidly changing environment.
- c. Reviewing our standards and outcomes, including evaluating the impact of Tomorrow's doctors (2009).
- d. Continuing to develop our approach to Continuing Professional Development (CPD), building on the guidance we published in 2012 with the aim of helping doctors across the UK keep their knowledge and skills up to date throughout their working life.

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

17. Our significant work in 2013 will include:

- a. Developing a programme of engagement in the context of the 2012 edition of Good medical practice.
- b. Reviewing guidance to ensure it reflects the changing healthcare environment and needs of doctors.

Working with partners

18. 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.

19. Our significant work in 2013 will include:

- a. Ensuring that our strategic engagement builds and maintains relationships with organisations and individuals who influence our work.
- b. Employer liaison advisers, regional liaison advisers, and devolved offices continuing to develop effective local relationships that foster a better understanding of our role and support intelligence sharing.

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.

20. Our significant work in 2013 will include:

- a. Publishing The state of medical education and practice in the UK: 2013 to help us contribute to broader policy debates and inform our approach to regulation.
- b. Promoting the GMC's interests to all UK Parliaments and Assemblies and other interest groups; developing and strengthening UK, European and international links with those responsible for regulating medical education and training.

Delivering value for money

21. 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.

22. Our significant work in 2013 will include:

- a. Changing our governance framework, decision-making processes and ways of working to ensure effective transition to the reconstituted smaller Council.
- b. Developing our corporate strategy for 2014 -17.
- c. Delivering a continuous improvement plan, including 3-5% efficiency gains.

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

23. Our significant work in 2013 will include:

- a. Launching an equality and diversity strategy for 2014-2017, aligned to our new corporate strategy.

- b. Developing a stronger data analysis and insight capability to better understand the profession and the effectiveness of our activities.

Summary operating budget

2013 budget summary by expenditure

type	£000	%
Direct Staffing Costs	44,136	45.8%
Indirect Staffing Costs	3,556	3.7%
Office Costs	6,375	6.6%
Accommodation Costs	6,623	6.9%
Legal Costs	5,758	6.0%
Professional Fees	6,636	6.9%
Council & Members Costs	473	0.4%
Panel & Assessment Costs	16,234	16.8%
Depreciation	6,162	6.4%
New Initiatives Fund	500	0.5%
Total	96,453	100.0%

2013 budget summary by directorate

	£000	%
Fitness to Practise	31,346	32.5%
MPTS	11,192	11.6%
Strategy and Communication	11,147	11.6%
Education and Standards	5,672	5.9%
Registration and Revalidation	12,144	12.6%
Resources and Quality Assurance	11,667	12.1%
Accommodation	6,623	6.9%
Depreciation	6,162	6.4%
New Initiatives Fund	500	0.5%
Total	96,453	100.0%

Annex B

2013 Income and Expenditure

Revenue budget

1. The overall budget for 2013 was approved by Council on 5 December 2012. Actual income and expenditure is monitored on a monthly basis and compared to budget. Once approved, the annual budget is profiled on a monthly basis to match the expected pattern of activity levels over the year. Actual income and expenditure is monitored on a monthly basis, and variations from budget are investigated.
2. We provide update reports to Council throughout the year. However, due to the timing of the Council meeting on 7 February 2013, it has not been possible to include details of January's income and expenditure with these papers. A verbal update will be given at the meeting, and a full report presented to Council at its next meeting.

	2013 Revenue Budget £000	Revenue Budget as at 31 January 2013 £000
Annual retention fees	86,600	7,121
Registration fees	4,100	224
PLAB fees	1,200	99
Certification fees	3,000	318
Treasury management	500	41
Sales & other income	200	17
Total Income	95,600	7,820
Direct staffing costs	44,136	3,515
Indirect staffing costs	3,556	242
Office costs	6,375	510
Accommodation costs	6,623	556
Legal costs	5,758	486
Professional fees	6,386	257
Council & member costs	473	38
Panel & assessment costs	16,234	1,113
Bank charges	250	14
Depreciation	6,162	475
New Initiatives Fund	500	38
Total Expenditure	96,453	7,244

Capital programme

3. In addition to our revenue expenditure on day to day operational business, the GMC incurs capital expenditure on major projects and assets that will generate benefits over a number of years. The standard accounting treatment is to spread capital costs over the lifetime of the asset, rather than accounting for the whole cost in the year of acquisition. This is achieved through an annual depreciation charge to the revenue account.

4. Details of the new capital projects planned for 2013 are set out below. The total cost of these projects is £7.7 million, which will be depreciated over future years. The GMC's accounting policy is to spread the cost of IT projects over three years, and all other projects over five years.

5. Capital expenditure is monitored and reported in the same way as revenue expenditure.

	2013 Capital Budget £000	Capital Budget as at 31 January 2013 £000
IS hardware projects	526	12
Business continuity projects	283	12
IS software projects	1,052	26
IS tactical projects	195	19
SAP projects	2,411	248
Facilities projects	1,553	66
Scheduled homeworking project	1,078	0
Registration projects	83	40
New initiatives fund	500	0
	7,681	423

Efficiency programme 2010-2013

6. We have a strong track record of implementing measures to improve our overall economy, efficiency and effectiveness.

7. In 2010 we embarked on a four-year programme aimed at making ongoing efficiency gains across the GMC equivalent to 3-5% of our annual budget. This programme supports our strategic aim to continue to use our resources efficiently and effectively.

8. In broad terms this equates to a total efficiency target of £26 million to £43 million over the four year period 2010-2013.

9. Some efficiency gains are cashable, in that they release cash which can be reinvested in other activities or used to hold down our overall level of expenditure. Non-cashable efficiency gains arise when productivity and/or quality increases within existing expenditure levels. Many efficiency projects generate recurring gains that extend for a number of years.

10. So far we have delivered total efficiency gains of around £30 million up to the end of 2012, of which around £24 million are cashable gains. Significant initiatives over the period include:

- a. Economies of scale following the merger of PMETB.
- b. Relocating our adjudication and certification functions from London to Manchester.
- c. Negotiating a rent review on our premises.
- d. Expanding our in-house legal team to reduce our requirement for external lawyers.
- e. Changing the panel quorum for fitness to practise hearings.
- f. Improving the way our fitness to practise cases are handled so that only the most serious cases are referred to a panel hearing.
- g. Reviewing our travel policies.
- h. Reducing our use of specialist IT contractors by transferring skills in-house.
- i. Making greater use of e-communications rather than paper copy, and making changes to our stationery and postage requirements.
- j. Business improvement projects and contract renegotiations within directorates.

11. For 2013 we estimate that our programme of efficiency projects will deliver total efficiency gains of £15.5 million, comprising new efficiency projects of around £2.0 million, together with ongoing efficiency gains of £13.5 million from previous years. New efficiency projects for 2013 include the introduction of digital recording of fitness to practise hearings in place of transcriptions; bringing more legal work in-house; the continued application of 'lean principles' to our operations and a range of business process improvements within directorates.

12. The success of the efficiency programme has helped us to freeze or reduce the fees doctors pay the GMC over recent years, while also helping to improve the quality and timeliness of our services.

Annex C

Performance against service targets and volumes of activity – fitness to practise, registration and revalidation

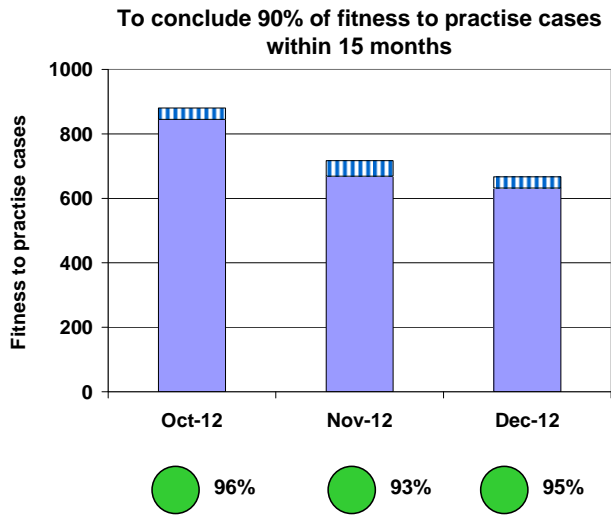
1 These graphs show our performance against our fitness to practise and registration service targets over the past three months, and the volume of activity we have handled. This includes the performance of our contact centre and reception services which support the whole organisation.

2 We also include data on revalidation activity. As revalidation has only recently commenced, the service targets are still in development.

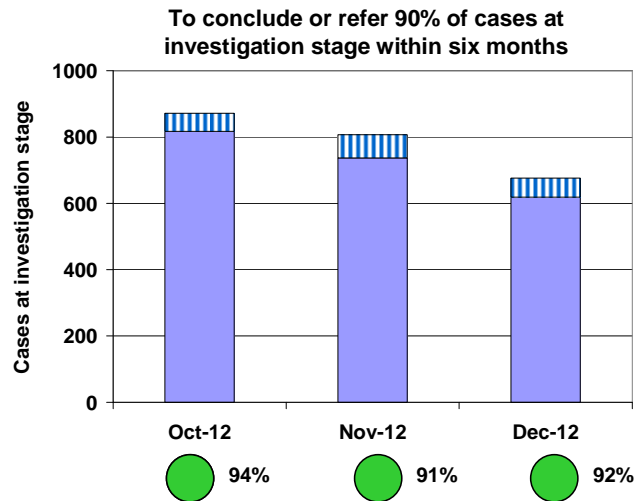
3 For the service targets, we illustrate the volume of activity and the proportion of total activity handled within and outside the target timeframe. The traffic lights show our monthly performance, and indicate whether or not we achieved the target.

Fitness to practise

Service targets



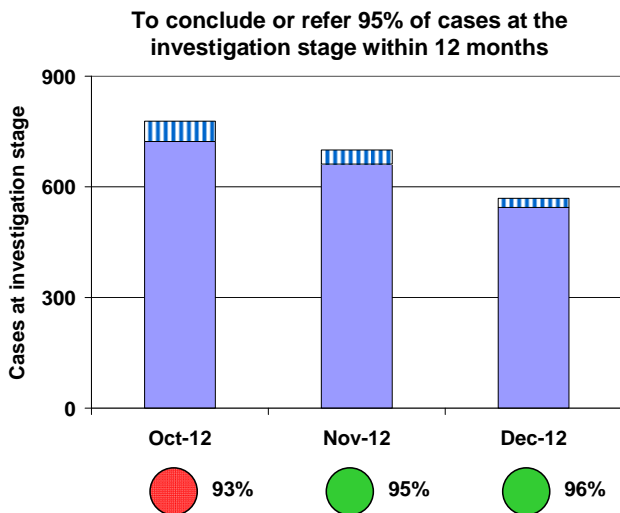
Commentary: Service target achieved.¹



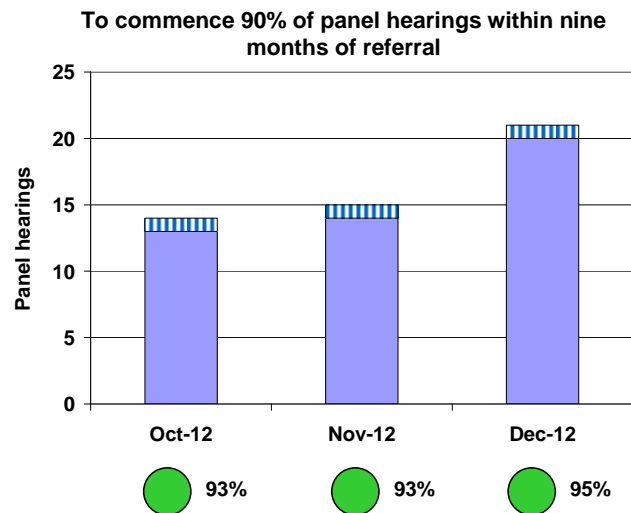
Commentary: Service target achieved.²

¹ This target measures all fitness to practise enquiries received by the GMC that result in a stream 1 investigation, stream 2 investigation or immediate closure and excludes cases that are criminal convictions, statutory inquiries, determinations and restoration applications. Each bar (by month) shows the number of cases that were opened 15 months before.

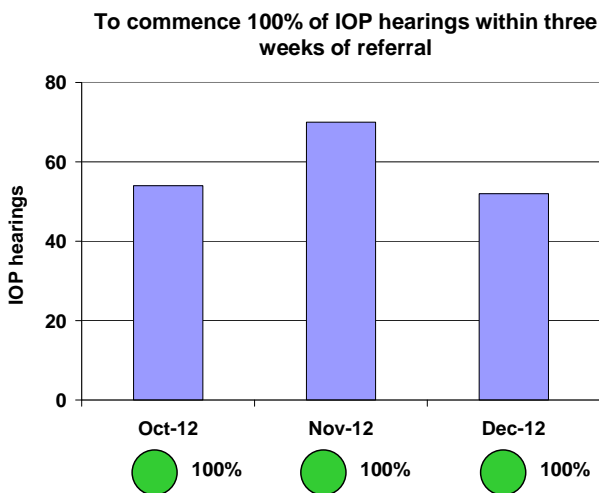
² This target measures all fitness to practise enquiries received by the GMC that result in a stream 1 investigation, stream 2 investigation or immediate closure including cases that require health assessments, performance assessments and those that are considered by the Investigation Committee. It excludes from consideration cases that are criminal convictions, statutory inquiries, determinations and restoration applications. Each bar (by month) shows the number of cases that entered the investigation stage six months before.



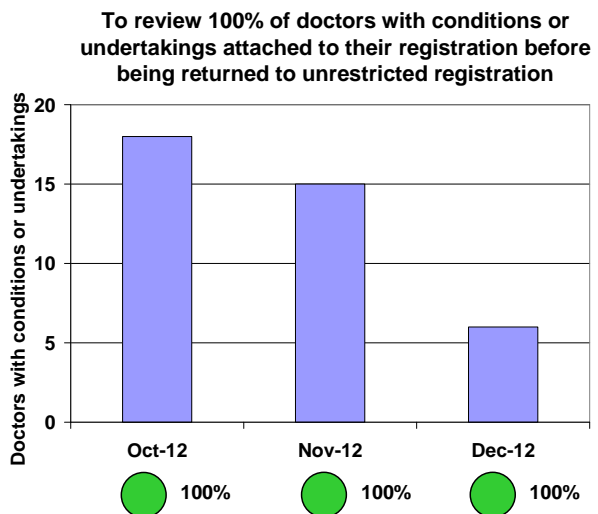
Commentary: We received a large number of enquiries in the corresponding period in 2011. A year later, this impacted on our ability to meet this target.³



Commentary: Service target achieved.⁴



Commentary: Service target achieved.⁵



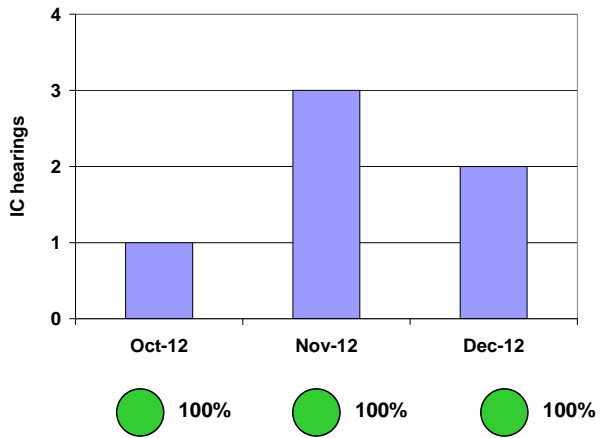
Commentary: Service target achieved.

³ This target measures all fitness to practise enquiries received by the GMC that result in a stream 1 investigation, stream 2 investigation or immediate closure including cases that require Health Assessments, Performance Assessments and those that are considered by the Investigation Committee. It excludes from consideration cases that are criminal convictions, statutory inquiries, determinations and restoration applications. Each bar (by month) shows the number of cases that entered the investigation stage 12 months before.

⁴ This target excludes cases that have concluded prior to a FTP panel hearing within nine months of referral from investigation (i.e. referral cancellations, voluntary erasures etc). Each bar (by month) shows the number of referrals to a Fitness to Practise Panel nine months before.

⁵ Each bar (by month) shows the number of referrals to an Interim Orders Panel three weeks before.

To commence 100% of IC hearings within two months of referral



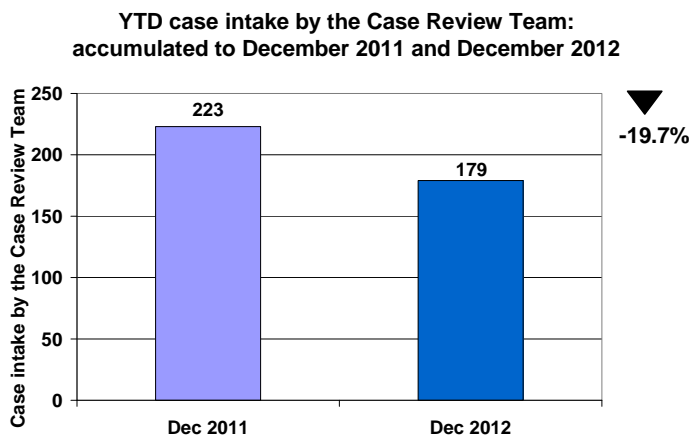
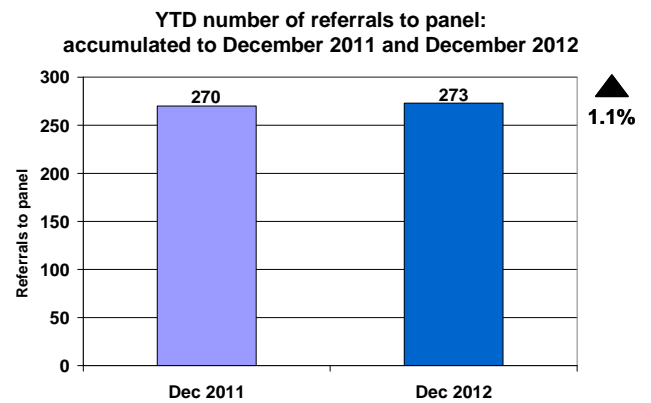
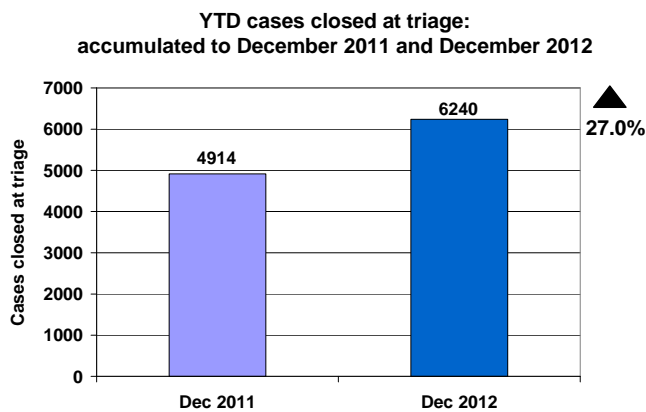
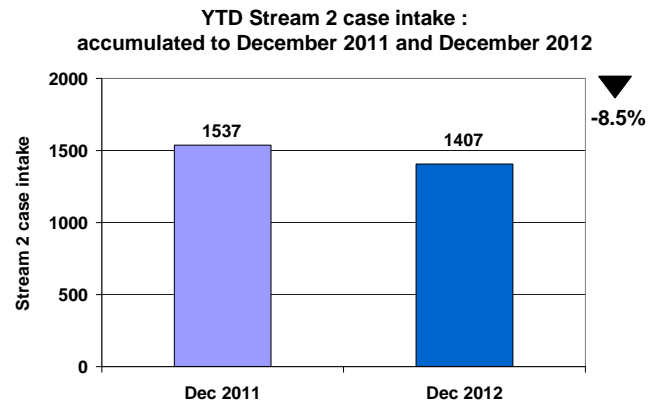
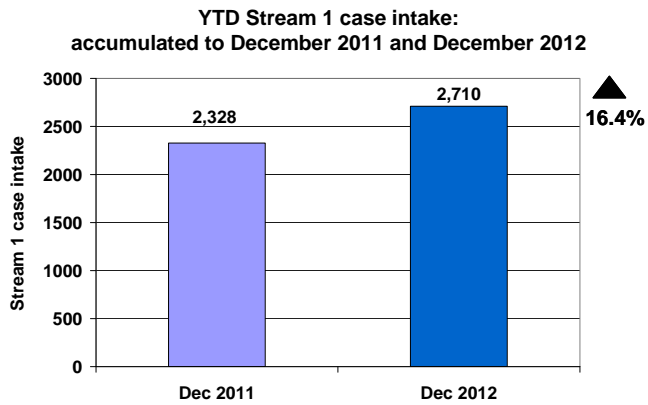
Commentary: Service target achieved.⁶

⁶ Each bar (by month) shows the number of referrals to an Investigation Committee two months prior.

Fitness to practise

Case intake

4 These graphs show our accumulated case intake levels to the end of December 2012, compared with the accumulated levels to the end of December 2011, and indicate the percentage change.

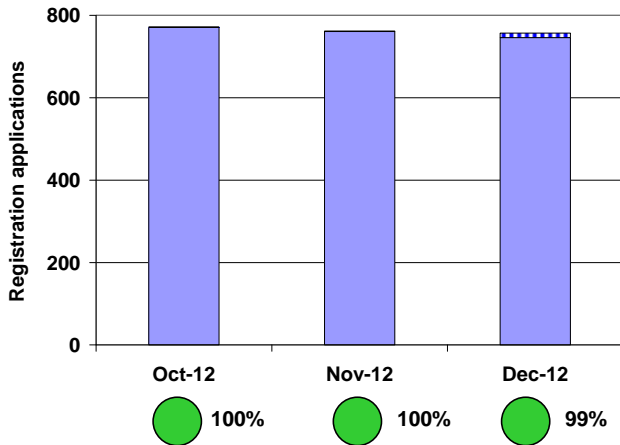


Registration, PLAB and certification

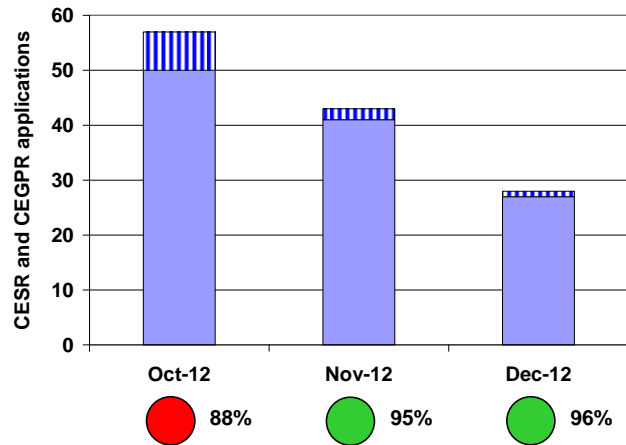
Service targets



To respond to 95% of applications within five working days



To complete 95% of CESR and CEGPR applications within 3 months

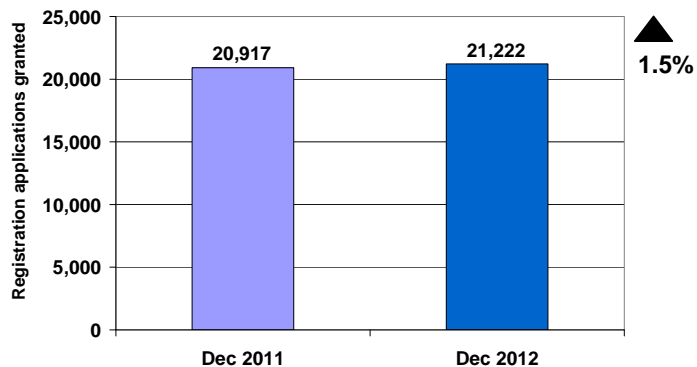


Commentary: We have a statutory requirement to issue a decision within three months of receiving a completed Certificate of Eligibility for Specialist Registration (CESR) or Certificate of Eligibility for the General Practice Register (CEGPR) application. The process of issuing a decision is split between the GMC and the Royal Colleges and Faculties. We continue to work closely with the mRCs on the recruitment and training of evaluators. This has begun to address the issue of delays in turnaround times. We believe it should also improve the quality of the evaluations. There have been significant improvements in the last six months and we met the target in November for the first time in 2012.

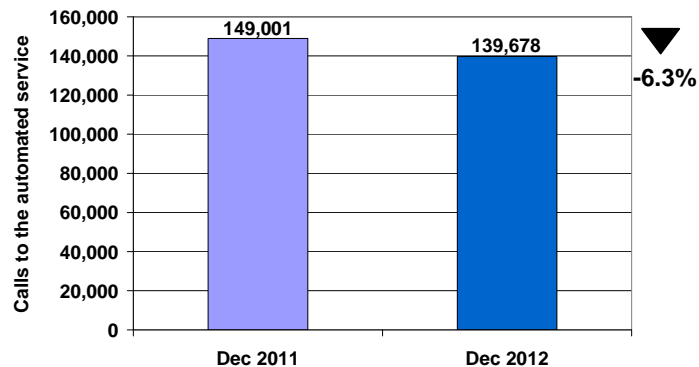
Registration, PLAB and certification

Activity levels

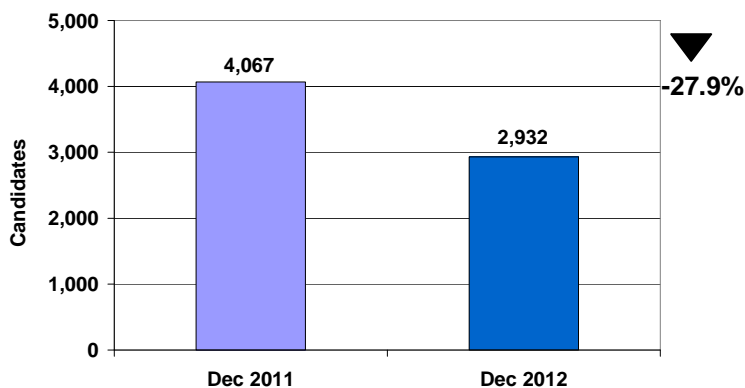
Registration applications granted (excl. specialist registrations, incl. restorations): accumulated to December 2011 and December 2012



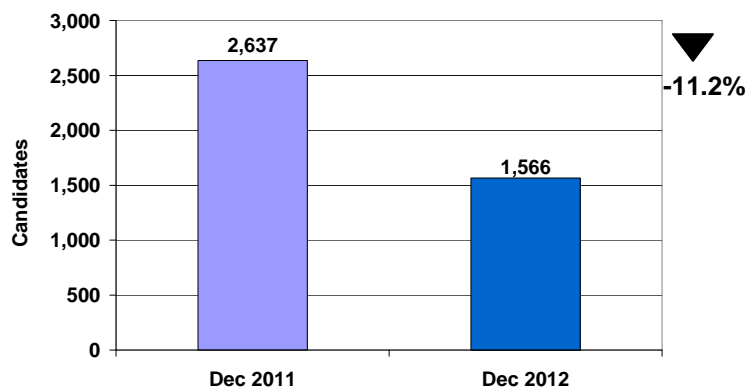
Calls to the automated service confirming a doctor's registration status: accumulated to December 2011 and December 2012



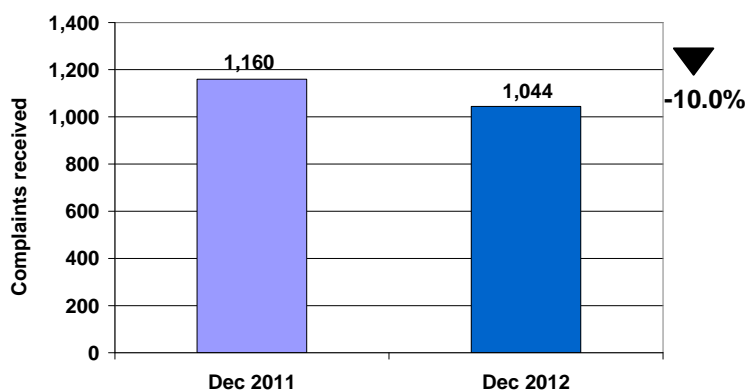
Candidates taking Part 1 of the PLAB test: accumulated to December 2011 and December 2012



Candidates taking Part 2 of the PLAB test: accumulated to December 2011 and December 2012



Complaints received by Registration: accumulated to December 2011 and December 2012

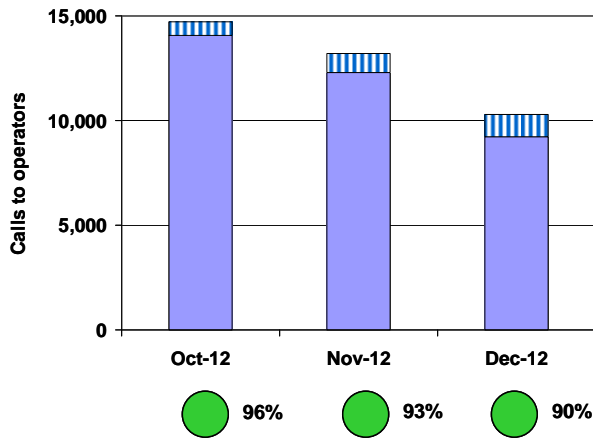


Contact centre and reception services

Service targets

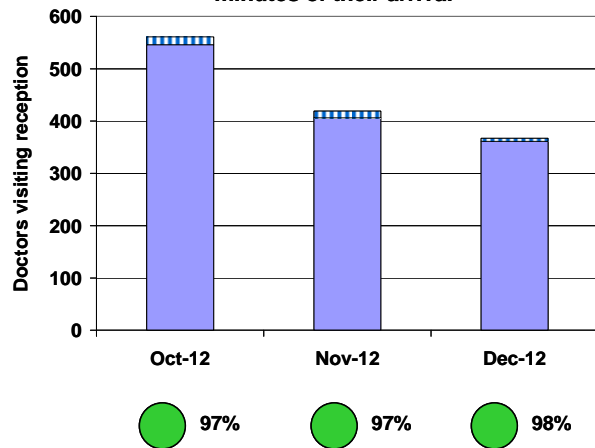


To answer 90% of calls within 15 seconds



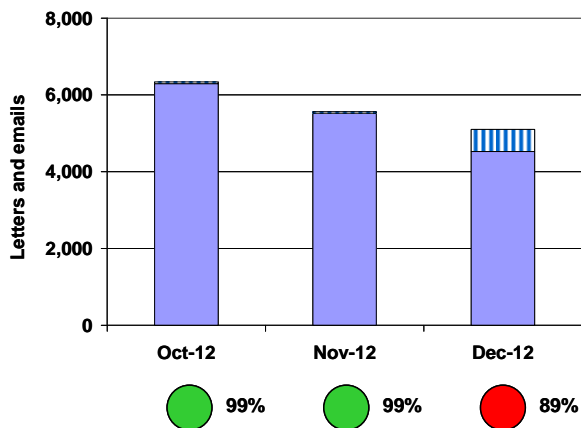
Commentary: Service target achieved.⁷

To see 95% of doctors visiting reception within 10 minutes of their arrival



Commentary: Service target achieved.

To answer 95% of emails and letters within five working days



Commentary: Our contact centre handles emails, letters and calls. In December, call length increased by over 50% due to the introduction of revalidation. This impacted on our ability to respond to emails within the target. The average response time for emails and letters was four days.⁸

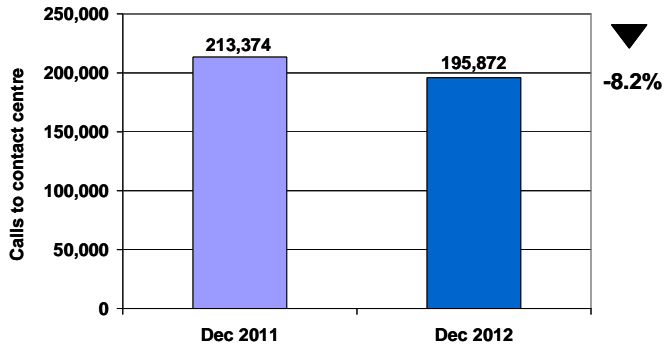
⁷ Excludes lost calls. This is consistent with the industry standard.

⁸ Only providing a substantive response is counted as having met the target.

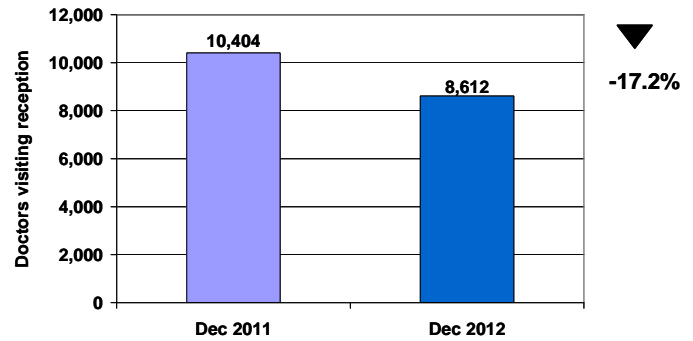
Contact centre and reception services

Activity levels

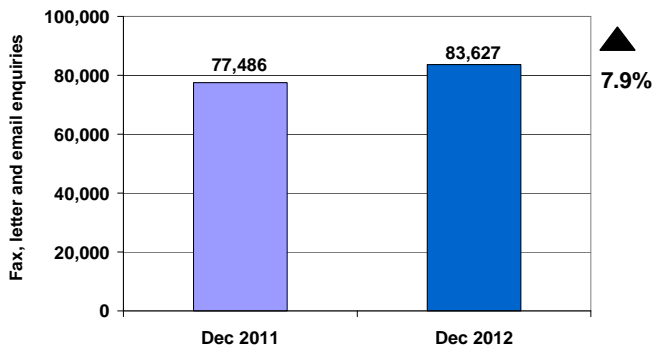
Calls to the contact centre: accumulated to December 2011 and December 2012



Doctors visiting reception: accumulated to December 2011 and December 2012

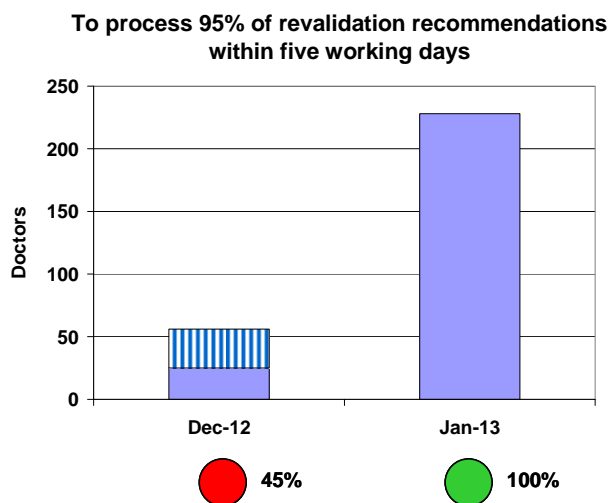


Fax, letter and email enquiries (excl. applications for registration): accumulated to December 2011 and December 2012



Revalidation

Service target



Commentary: We missed the service target in December. This was the first month that revalidation went live. We invested significant time working closely with those submitting recommendations to ensure they were comfortable with the process, had full access to the systems required and were confident in the recommendation they were submitting. We worked to agree with partners that we would process the initial doctors who revalidated in a particular order. The January figures are provided as at 29 January 2013.

Engagement with designated bodies and connection by doctors

- 5 The number of designated bodies without a Responsible Officer (RO) has been decreasing.

	Designated bodies with an RO	Designated bodies without an RO
July 2012	674	72
January 2013	811	29

- 6 The number of doctors with no designated body (DB) has been decreasing.

	Doctors with no DB
July 2012	45,078
January 2013	22,563