WORKING WITH DOCTORS WORKING FOR PATIENTS

Our annual report: 2014

General Medical Council

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A word from our Chair

We are, fundamentally, a patient safety organisation. We are prepared to reach out and engage with the profession, we are not afraid to act where patients are at risk and we seek to understand and respond to those who have an interest in our work – patients, doctors, employers and all those involved in medical education.

I took up the role of Chair on 5 January 2015. For me, in taking on this role, it was critical that I continue with my own clinical practice, seeing emergencies and teaching undergraduates and doctors in training on the wards, so that I remain in touch with the realities of practice and the NHS, using this insight to inform our direction of travel.

The GMC has undergone massive change in recent years and we are committed to a programme of significant further reform to meet clear and present challenges across all four pillars of our work:

- undergraduate and postgraduate education and training
- standards and guidance
- the medical register
- fitness to practise.

Our *Corporate strategy 2014–17* establishes our aspirations to be a more outward-focused and forward-looking organisation.

What we're doing to meet the needs of patients and doctors

We're committed to exploring the idea of a national licensing exam, to reassure the public that all newly licensed doctors practising in the UK are of a comparable standard. If elements of the independent Shape of Training review are implemented, we want to work with the profession to develop postgraduate training so that it can meet the changing demands on doctors and patients.

It's essential that our guidance remains relevant and useful in clinical practice for doctors throughout their careers. We're also committed to finding new ways to support doctors with difficult ethical professional decisions.

Over the past four years we've seen the volume of complaints that we receive about doctors increase almost twofold. We believe that changes to the legislation that governs our role are essential if we are to deliver a series of long-awaited and badly needed reforms, including speeding up our processes to protect the public. There is work for us to do to understand what information about doctors is valued and to consider how our medical register can be improved to reflect this.

It would be naive to think any of the challenges we face can be swiftly resolved but I believe we are travelling in the right direction. This report sets out the achievements we've made that put us in good stead for 2015 and beyond.

Professor Terence Stephenson

A word from our Chief Executive

We continue to focus relentlessly on how we can work with the profession to protect patients and improve standards of medical practice. The past year has demonstrated that overall standards in the UK remain high, but it has also exposed more shocking examples in the Morecambe Bay Investigation* and the Vale of Leven Hospital Inquiry,† which found care of patients that was unacceptable.

Effective regulation can only work in context, and a leading theme running through our work this year has been a major effort to understand the realities of what patients experience and what today's clinical practice involves, as well as the educational environments in which medical students and doctors learn.

And of course the GMC itself is not immune from this changing environment. The number of complaints about doctors has more than doubled in the past four years. The organisation of the health services we deal with in every part of the UK has been in a state of flux, and fundamental questions have been asked about the nature of medical professionalism.

A year of progress

In spite of these challenges 2014, was a year of significant progress as we continued to reform every area of our business to take us towards a different model of regulation for the 21st century.

This will be one which reaches out and recognises our need to engage closely with doctors and the wider healthcare system and which increasingly uses data to identify risks before problems arise.

However, doing the basics remains a priority. We are pleased that we met all the standards of good regulation set by the Professional Standards Authority and were commended by the House of Commons health select committee as 'an effective regulator'.

After a long and persistent campaign we also succeeded in changing UK law, which will allow us to assess doctors from Europe when we have a doubt about their language competency. And, with others, we have secured new European legislation that will allow us to assess knowledge in English on a routine basis.

2014 was also the second full year of processing revalidation recommendations from across the profession. We have commissioned a major independent study that will report in due course, but the early indications are encouraging. Feedback from responsible officers has been almost universally positive and initial surveys show that doctors are more engaged as a result, able to reflect more on their practice and value the process.

The future of healthcare in the UK as elsewhere is rather uncertain but, working with others, we should be able to provide assurance about standards of medical care and importantly contribute to raising those standards.

Niall Dickson

* See www.gov.uk/government/publications/morecambe-bay-investigation-report.

† See www.valeoflevenhospitalinquiry.org.

OUR **ROLE**

“Every patient should receive a high standard of care. We help to achieve this by working closely with doctors, their employers and patients, to make sure that the trust patients have in their doctors is fully justified.”

We are an independent organisation. We help protect patients and improve medical education and practice across the UK by delivering our core functions.

- We set the standards that doctors need to follow, and make sure that they continue to meet these standards throughout their careers.
- We decide which doctors are qualified to work here and we oversee UK medical education and training.
- We take action to prevent a doctor from putting the safety of patients, or the public's confidence in doctors, at risk.

Healthcare is a complex and changing environment that continues to face major pressures. Healthcare organisations and the doctors, nurses and other professionals who work for them are being asked to do more with the same or fewer resources. Medical careers and roles are becoming increasingly complex.

We've changed a lot in the past 157 years and we continue to adapt to make sure we maintain our relevance to doctors and patients. Our *Corporate strategy 2014–17** sets out how we will continue to change to meet an increasingly challenging external environment. This report sets out how we've made great steps in delivering against this strategy in 2014.

Each year we also produce our report, *The state of medical education and practice in the UK*.† It sets out much of what we know about the medical profession and the challenges it faces, drawing on our own data and, where appropriate, data from other sources. Our aim in publishing this information is to promote discussion and debate on issues and trends that require attention or further analysis, to improve standards of medical practice.

* See www.gmc-uk.org/publications/corporate_publications.asp.

† See www.gmc-uk.org/somep.

Some highlights of 2014

- **We introduced more stringent checks on whether doctors have the necessary knowledge of English to treat patients safely.** We can now check the English language skills of doctors who qualified in Europe. We also reviewed and increased the minimum score we accept as evidence of knowledge of English for doctors from the rest of the world.

- **We made changes to the way we deal with less serious complaints about doctors.** Some complaints are more effectively handled when managed by employers and those who work more closely with the doctor. By passing these concerns on to them we can focus on concerns that pose a real threat to patient safety.

- **We continued to press for urgently needed changes in the law so that we can introduce a range of reforms to improve the efficiency and effectiveness of our work.** We worked with others to maintain momentum on the draft *Regulation of Health and Social Care Professionals Bill* ('Law Commissions' Bill'), which will introduce a single, consistent legal framework for us and other health and social care regulators. In the meantime, we've placed the adjudication service for doctors, the Medical Practitioners Tribunal Service (MPTS), on a statutory footing. This gives the GMC the power to appeal decisions made by its panels. And it improves some of the rules for MPTS hearings – making them more effective and helping to reduce unnecessary delays.

- **We continued to roll out revalidation.** Early research indicates that revalidation is having a positive impact on doctors, on the environments in which they work and on patient safety. We've started looking at the longer-term impact of revalidation so we can understand how to build on these benefits and continue to improve our approach.

- **We sought views on what action we should take when we believe a doctor may be putting the safety of patients, or public confidence in doctors, at risk.** Our indicative sanctions guidance consultation introduced new approaches for us to understand the views of the public so we can apply them in our work. Our consultation received more than 500 responses.

- **We used our data and intelligence to improve our understanding of the factors that can affect doctors and their work.** This included further research into the factors that lead to groups of doctors performing differently in examinations and assessment, so that we can understand what interventions might be helpful.

- **We hosted the best-attended International Conference on Medical Regulation.** More than 360 participants from 48 countries attended, to discuss issues such as evaluating risk and reducing harm to patients. Our Chief Executive, Niall Dickson, became Chair of the International Association of Medical Regulatory Authorities (IAMRA) during the conference. We'll use our leadership of IAMRA to promote medical regulation as a means of protecting patients throughout the world.

> “We can now check the English language skills of doctors who qualified in Europe.”

2014 in numbers

"Be more prepared to speak up for patients."

Medical student learning from our engagement event

21% increase in appraisal rates in England between 2010 and 2014

777 calls to our confidential helpline

9,639 concerns about doctors reviewed

21,510 doctors checked and approved to practise

2013

102 visits to check the quality of education and training

1,213 meetings with employers about fitness to practise concerns

66,740 revalidation recommendations processed

98.2% of doctors in training responded to our 2014 national training survey

15,500 doctors we spoke with directly about our standards for good practice

12,000 students and educators that we spoke with directly about our standards for good practice

201 doctors from Europe not granted a licence to practise because they were unable to give us satisfactory evidence of their English language skills

2,763 full investigations launched into doctors' fitness to practise

2014

82% of doctors surveyed said they would change their practice as a result of our engagement sessions

2,300 members of the public we spoke with directly about our standards for good practice

260,000 doctors on the medical register

"I will practise more safely."

Doctor feedback from one of our engagement events

969 doctors' licences withdrawn for not engaging in revalidation

IMPROVING WHAT WE DO

“Instead of waiting for problems to be brought to us, we’ve begun to engage much more with those working on the frontline and to listen to those who are delivering care, to help us understand where there may be risks to patient safety.”

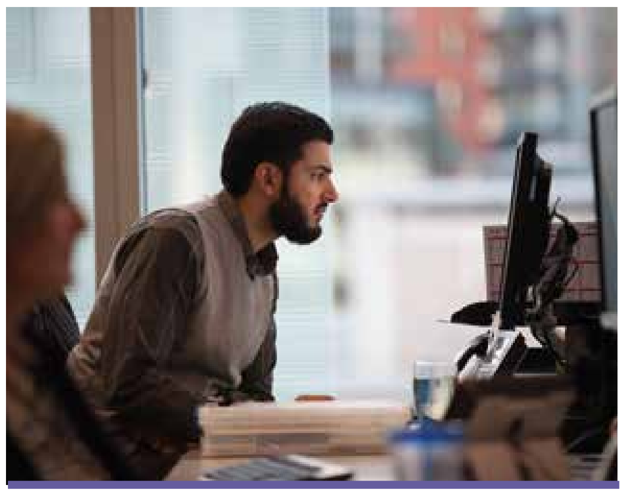
Our new corporate strategy

Over the past few years, we've started to transform the way we work. Instead of waiting for problems to be brought to us, we've begun to engage much more with those working on the frontline and to listen to those who are delivering care, to help us understand where there may be risks to patient safety.

2014 was the first year of our new *Corporate strategy 2014–17*.* It defines our ambition to maintain the quality of our existing functions, but also to continually improve so that we can be as responsive, fair and proactive as possible.

Healthcare is a complex and changing environment. The public today has different expectations and rightly demands that doctors are open and transparent both in their dealings with patients and about their own performance. At the same time, pressures on doctors and other staff are increasing with many being asked to do more with fewer resources.

All of this means that organisations like ours must change too.



* See www.gmc-uk.org/publications/corporate_publications.asp.

Our five strategic aims for 2014–17

To deliver against the ambition of our strategy we are now focusing our work on the following strategic aims.

01 HELPING TO RAISE STANDARDS IN MEDICAL EDUCATION AND PRACTICE

We will develop our standards, our guidance and the way we support particular groups of doctors to help them deal with professional challenges. We will ensure that medical education equips doctors to meet these standards.

02 IMPROVING HOW WE HANDLE CONCERNS ABOUT PATIENT SAFETY

We have seen a significant rise in the number of complaints about doctors. To respond to this, we will continue to press for much-needed reform of the legislative system. We will make sure that concerns about doctors are first addressed locally wherever possible. We will continue to develop new ways to reduce the stress for those involved in our fitness to practise procedures.

03 USING INFORMATION IN SMARTER WAYS

We will use and share information in smarter ways to support high standards of medical practice and to help reduce risks to patients. Putting the information we hold to best use will help to create a more open system and to safeguard the interests of patients.

04 WORKING MORE CLOSELY WITH PATIENTS, DOCTORS AND MEDICAL STUDENTS ON THE FRONTLINE OF CARE

We will have more contact with doctors, medical students and patients so that we have a better understanding of their lives and work. More of them will be aware of our guidance and use it to help them maintain standards of patient care.

05 WORKING BETTER TOGETHER

We recognise there are often barriers to better collaboration within and between organisations – we will work across teams within the GMC to make best use of all available knowledge and skills to help us deliver effective regulation.

Helping to raise standards in medical education and practice

It is not enough for us just to make sure that doctors perform at the minimum standard to avoid an investigation into whether they are safe to treat patients.

We want to help continually improve the standards of medical practice and maintain the confidence of the public in the profession.

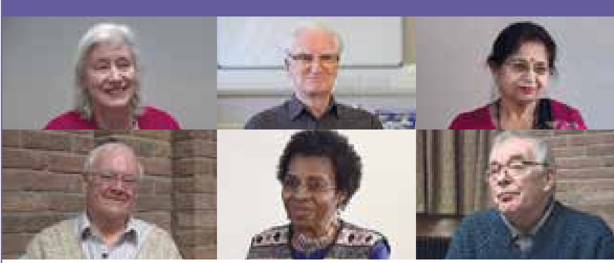
We know we can't do this work alone – it's vital that we work with others, such as medical schools and local groups of doctors and patients, as well as medical royal colleges and professional associations.

Making our guidance relevant and accessible

In 2014, we concluded a review of how we develop and promote our professional standards. The review considered the purpose and intended impact of, and audiences for, our guidance. It also considered how recent and expected future changes may mean that we need to adopt different approaches to developing and promoting the guidance.

The review concluded that our approach to guidance and standards was fit for purpose but that there were ways that we could increase the impact of our guidance and do more to target our promotional efforts. Using this, we have developed a wider range of resources to help doctors apply our guidance to their work. And we continued with our major outreach work through our Regional Liaison Service and devolved offices.

PUTTING PATIENTS AT THE CENTRE OF CARE – BETTER CARE FOR OLDER PEOPLE



Over 65s make up over two thirds of NHS patients in the UK. There are now more people living with complex, and multiple, long-term conditions than ever. Doctors need to be able to respond clearly, effectively and compassionately to their needs.

We worked closely with partner organisations, including the British Geriatrics Society and Age UK, to create a new online resource, Better care for older people.* It gives doctors practical advice on how to put older patients first by using our guidance to handle their clinical, emotional and psychological needs.

Better care for older people includes a series of videos featuring interviews with older patients. Their experiences of dealing with doctors, from feeling that they have been pushed aside because of their age to the importance of seeing the same doctor, helps put our guidance into context and is a strong reminder of the importance of placing the patient at the centre of care.

The resource also contains a mixture of guidance, case studies, scenarios, articles and tips to prepare doctors for caring for the growing number of older patients. Since it was launched, it's been accessed over 10,000 times.

'We know that care of older people is too often not good enough – doctors have a key role in devising and providing treatment, coordinating care and in overseeing the whole process – we hope these learning materials will stimulate discussion and help to support doctors working with older people.' **Niall Dickson, Chief Executive**

* See www.gmc-uk.org/guidance/23756.asp.

We continued to revalidate doctors

Every five years, we ask for formal confirmation that each doctor is following our standards and that their knowledge and skills are up to date. As part of this we work with employers to make sure every doctor has an annual check or appraisal based on *Good medical practice*[*] – our core ethical guidance for doctors. This system of checks is called revalidation and it helps make sure every doctor practising in the UK is competent. We're the first country in the world to introduce such an approach.

We introduced revalidation at the end of 2012 and up until the end of 2014 we had processed recommendations for 79,500 doctors. This is in line with our plans, and we are on track to revalidate the majority of licensed doctors by April 2016.

We believe that every doctor treating patients in the UK should have an interest in reflecting on their whole practice, both clinical and ethical, and considering how they can continually improve their work. A doctor's responsible officer[†] can notify us at any time if a doctor is not engaging in the local systems that underpin revalidation, such as appraisal.

When we know that a doctor isn't engaging, we try to work with them – but ultimately, if they continue to refuse to engage, we will withdraw their licence so they can no longer treat patients in the UK. In 2014, we made the decision to withdraw licences from 969 doctors.

We maintained our commitment to deal with revalidation recommendations in a timely way in 2014, despite the volume of recommendations that we received increasing by almost 100% compared with 2013, in line with our planning. It's also important for us that revalidation is fair – 86% of the doctors we surveyed during 2014 who had been revalidated thought they were treated fairly.[‡]

* See www.gmc-uk.org/gmp.
† See www.gmc-uk.org/doctors/revalidation/12385.asp.
‡ See www.gmc-uk.org/about/research/26472.asp.

> “We believe that every doctor treating patients in the UK should have an interest in reflecting on their whole practice, both clinical and ethical, and considering how they can continually improve their work.”

98%
of recommendations processed within five days

969
doctors whose licence to practise has been withdrawn

50,000
doctors revalidated in 2014

79,500
doctors revalidated since it began at the end of 2012

Although revalidation is still relatively new, the emerging evidence suggests that it is having a very positive effect on doctors and the environments they work in.

Revalidation – helping doctors to reflect more on their practice

Appraisal rates have risen since revalidation was introduced. In 2013–14, the appraisal rate in England was 83.8% – up from 63% in 2010–11.[*] In Scotland, the appraisal rate has risen from 87% in 2012–13 to 90% in 2013–14.[†]

A survey we commissioned in 2014 showed that two in five doctors reported that they were now collecting more information about their practice than a year ago. And three in ten were more aware of how to apply the principles of *Good medical practice* to their work.

Revalidation – helping drive improvements in local processes

'Revalidation has gone some way in raising the profile of governance and of clear-cut quality. It's caused us, internally, to think carefully about how we can use the data that we have about every practitioner to effectively benchmark individuals against each other and that is going to become a very increasingly powerful tool for us.'

Medical Director, Revalidation: From compliance to commitment[‡] *(2014), King's Fund*

Revalidation – helping organisations identify concerns about doctors earlier

38% of employers say revalidation has allowed organisations to identify concerns earlier.

81% of doctors said they would be willing to raise concerns about a colleague, if they wished to do so, as part of an appraisal discussion.[§]

While the early evidence is positive, it's important that we also understand the long-term impact of revalidation on patient safety and clinical governance and quality. In 2014, we appointed an academic partner to lead on a major piece of work at Plymouth University Peninsula Schools of Medicine and Dentistry, called Collaboration for the Advancement of Medical Education, Research and Assessment (CAMERA). The study will look at the views of doctors, employers, responsible officers, patients and members of the general public. We expect that some findings will be available from 2015, ahead of the final report in 2017.

* NHS Revalidation Support Team, March 2014.
† Healthcare Improvement Scotland, October 2014.
‡ See www.kingsfund.org.uk/publications/medical-revalidation.
§ *The Early Benefits and Impact of Medical Revalidation* (2014), NHS Revalidation Support Team.

Making sure doctors have the necessary knowledge of English to practise safely

On 25 June 2014, a change in the law gave us new powers to check the English language skills of European doctors who apply for a licence to practise medicine. This helps us to make sure that only doctors who are able to communicate effectively in English are able to treat patients in the UK.

This was a significant milestone in patient safety, and one that we'd been campaigning for since 2010. Up until June 2014, European doctors were allowed to register with a licence to practise medicine in the UK without us having the power to ask them to give evidence of their English language knowledge. This has been a long-standing requirement for doctors trained in the rest of the world.

Since the law changed, we've assessed 1,370 European doctors to see if evidence of their English should be requested. 201 of these doctors were not granted a licence to practise medicine in the UK because they were unable to give us satisfactory evidence.

As part of these changes, our core guidance *Good medical practice* was updated to include a requirement for doctors to have the necessary knowledge of the English language to provide a good standard of practice and care in the UK. We can now take action against a doctor if they don't meet this requirement. Since this new category of impairment came into force, we've opened 34 fitness to practise investigations relating to not having the required knowledge of English, amongst other allegations. In 22 cases the doctor was directed to undergo a language assessment.

On 18 June 2014, we also raised the required scores that we accept in the International English Language Testing System (IELTS) as evidence of knowledge of English.

The Professional and Linguistic Assessments Board (PLAB) test is the main route by which international medical graduates* demonstrate that they have the necessary skills and knowledge to practise medicine in the UK. In 2014, an independent-led review into the PLAB test, led by Professor Ian Cumming OBE, Chief Executive of Health Education England, was completed. We had commissioned the review in 2011 to make sure the current test continues to be objective, fair and fit for purpose.

The review acknowledged a number of improvements that have been made to the test in recent years, such as introducing more real-life scenarios to test candidates' understanding of key ethical principles, and their ability to assimilate and communicate information in a handover situation. While confirming that the test is fit for purpose, the review also made a number of recommendations to improve it. We are taking forward the recommendations as part of our 2015 work plan.

* An international medical graduate is a doctor who qualified outside the European Economic Area or Switzerland.

We really fleshed out our concerns and how far back they went with this GP. The GMC representatives were very patient.”

Feedback from the evaluation into our pilot of meetings with complainants

Improving how we handle concerns about doctors

In recent years, the number of complaints that we receive about doctors has risen significantly.

Between 2010 and 2014, the volume of complaints about a doctor's fitness to practise increased by 96%. Not all complaints about doctors are serious enough to meet our thresholds for full investigation. However, within this same period the volume of complaints that met our threshold for investigation also rose, by 72%.

Other health and social care regulators have also seen increases in the number of complaints about their registrants. Part of the challenge in dealing with concerns efficiently is that the current legislative frameworks for all health and social care regulators are 'expensive, complex and require continuous government intervention to keep them up to date'. This means that, if we want to make a change to our processes, we must follow a lengthy legalistic process that prevents us from being as responsive to changes as we need to be.

In April 2014, the UK government published the draft Law Commissions' Bill. We welcomed this proposal to introduce a single, flexible and consistent framework across all healthcare regulators. This would give us the change in legislation that we need to be able to introduce a range of reforms to improve the efficiency and effectiveness of our work. We were disappointed when the Bill was not included in the Queen's Speech in June 2014, but we continued to work with the UK government, Parliament and health departments across the UK to maintain momentum on the Bill throughout the rest of the year. We will continue to press for this urgently needed reform.

In the meantime, we've continued to seek improvements within the existing legislative framework. In March 2015, changes to the *Medical Act 1983* established the MPTS on a statutory basis and gave the GMC the power to appeal decisions of MPTS panels where we consider a panel decision does not sufficiently protect the public – a power that didn't previously exist. A raft of further changes will be introduced to improve the efficiency and effectiveness of MPTS hearings during 2015, connected with this legislative change.

Improving support for those who make a complaint

We know that patients and others who make a complaint about a doctor can often experience isolation within our process. In 2014, we completed a pilot project of meetings with those whose complaint had been referred for a full investigation.* The meetings were held soon after the start of the investigation process and again after a decision about the case had been reached.

Our aim was to see whether these meetings would help us to improve our relationships with patients and others who make a complaint and make sure that their concerns are fully understood.

It's clear from the feedback that the meetings build rapport with patients and can reduce their feeling of isolation within our process. They also appear to help those who make a complaint understand our investigation process and our broader role and purpose.

We have made some improvements following feedback received in the pilot.

We know that one party involved with an investigation will often be dissatisfied with the overall outcome. We now make it much clearer at the outset that we don't have the power to change a decision through these meetings – but that we can seek to make sure that the people who've complained about a doctor understand why a particular decision has been made. We also tell them what the steps are if they want to challenge our decision or need support from another organisation. We're extending the meetings across the UK in 2015 and beyond.†

At the meeting, the processes were explained very well step by step. As it was face to face, I found it easier to interact with the explanation and they satisfied all my questions.”

Feedback from the evaluation into our pilot of meetings with complainants

* You can read the report *Evaluation of the Pilot of Meetings with Complainants* at www.gmc-uk.org/GMC_Complainants_Meetings___Complainants_Feedback_Final.pdf_57700793.pdf.

† See our Performance and Resources Board paper *Implementing patient meetings across the UK*, available at www.gmc-uk.org/12___Implementing_Patient_Meetings_across_the_UK.pdf_57922079.pdf.

A supportive ear. Someone I could trust to maintain confidentiality.”

Feedback from a doctor using the Doctor Support Service

Supporting doctors involved in our fitness to practise processes

In 2014, we published a report* looking at how we could improve our fitness to practise procedures. This review was commissioned to examine the period between 2005 and 2013 when 28 doctors undergoing fitness to practise investigations committed suicide or died of a suspected suicide.

While the individual circumstances of each case varied, these were tragic outcomes in any event. We will consider the recommendations and seek to give vulnerable doctors additional support building on our work in 2014 into 2015 and beyond.

Feedback from a doctor using the Doctor Support Service

Doctor Support Service

In 2014, we evaluated our Doctor Support Service† pilot.‡ This service offers confidential doctor-to-doctor emotional support to any doctor involved in a fitness to practise case.

The British Medical Association's Doctors for Doctors service was commissioned by us so that there would be an independent source of emotional support. 80 doctors who used the service were included within the evaluation.

The independent evaluation found that this service gives real value to doctors who use it. It lets doctors speak to a fellow doctor who understands the clinical background, while remaining a step away from the environment where the concerns arose. It was also clear from the evaluation that doctors generally found the service easy to access and use, that the support time was the right length, and that they could speak with the same doctor throughout the process.

Given the positive feedback, we will roll the Doctor Support Service out in full in 2015.

* See *Doctors who commit suicide while under GMC fitness to practise investigation*, available at www.gmc-uk.org/Internal_review_into_suicide_in_FTP_processes.pdf_59088696.pdf.

† For information on the *Doctor Support Service*, go to www.gmc-uk.org/doctorsupportservice.

‡ See *Final Report of the Pilot of the Doctor Support Service*, available at www.gmc-uk.org/Report_of_the_pilot_of_the_doctor_support_service_60386786.pdf.

Meetings with doctors

In 2014, we also completed an evaluation* of our pilot of meetings with doctors who are being investigated. The aim of these meetings was to enhance information sharing and reduce the stress doctors can feel by making sure they fully understand our processes and what aspects of their practice we have concerns about.

The independent evaluation found that the meetings improve doctors' understanding of our key concerns. The meetings give an opportunity for constructive and open discussion and it's clear from the feedback that doctors find the meetings genuinely helpful.

The meetings also encourage doctors to share information about the case earlier in the process, and improve the quality of any supporting written evidence. This leads to better informed decisions at the end of the investigation stage of the fitness to practise process. It can also reduce the time needed to investigate the doctor.

The feedback told us that meeting face to face can be very valuable.

Following the success of this pilot we intend to implement the meetings more widely in 2015.†

By attending a meeting you see the human side and they were so nice to us. It gave me confidence, if people like that were making the decision they would find out what actually happened.”

Doctor, quoted in the evaluation into our pilot of meetings with doctors

* You can read *Final Report of the Pilot Meetings with Doctors* at www.gmc-uk.org/Final_report_of_the_pilot_of_meetings_with_doctors_59252788.pdf.

† See our Performance and Resources Board paper *Implementing doctor meetings*, available at www.gmc-uk.org/13___Implementing_doctor_meetings.pdf_58721521.pdf.

Supporting unrepresented doctors

A number of delays at panel hearings arise from doctors who choose to represent themselves and who are unfamiliar with the legal elements of the process. These delays cause unnecessary stress for both complainants and the doctor involved. In 2014, 109 doctors chose to appear unrepresented by a lawyer at fitness to practise hearings – approximately 11% of the total.

In December 2014, the MPTS launched further support for unrepresented doctors.* This includes a pilot independent telephone information service on our hearings process and procedures, provided by supervised postgraduate law students from Manchester law schools. The aim is to make sure doctors are fully prepared for the hearing and that they understand what will be required of them. This should allow unrepresented doctors to be in a better position to present their case effectively and reduce unnecessary delay in proceedings.

Feedback has been positive from doctors, their defence organisations and from the MPTS legal assessors, who engage with unrepresented doctors. We hope that this initiative will help MPTS panels to reach a decision as quickly as possible, minimising stress as far as possible for all parties involved.

Improving our guidance for panels on sanctions

Between August and November 2014, we asked for views on our indicative sanctions guidance.† Our decision makers and fitness to practise panellists use this guidance when they consider how serious a complaint is and what the appropriate action against a doctor should be. The consultation looked at a number of areas where we propose to give clearer guidance to panels about matters that should lead to more serious outcomes, such as erasure from the medical register. It also looked at our approach to warnings and the role of apologies.

Making sure that sanctions are fair, proportionate and reflective of the values of the public is of key importance. To make the subject as accessible as possible so that the views we received would be wide reaching we developed a microsite, Fitness to practise panel decisions in action,‡ to highlight and explain the sanctions-making process. The scenarios take the audience through the facts of a case, any additional information, and factors that might affect their view. They are then asked to make a decision about what should happen from a range of options. The exceptionally high number of responses that we received suggests that this approach of engaging the public has been successful.

1,600 scenarios were completed through the interactive microsite, and we received 567 responses to our written questionnaire. We also used our Regional Liaison Service to work through the questions with groups of doctors and patients so that we could get as many views as possible.
On the whole, our proposals received support from the majority of respondents. We will implement the changes to our indicative sanctions guidance during 2015.

* See www.mpts-uk.org/hearing/7433.asp.

† To read our indicative sanctions guidance consultation, go to www.gmc-uk.org/concerns/fitness_to_practise_consultations.asp.

‡ To view *Fitness to practise panel decisions in action*, go to www.gmc-uk.org/pdia.

Using information in smarter ways

We are just one part of a complex health system and have a role to play in working with others to identify and act on risks to patients. Understanding and sharing data – both within our own organisation and with others – are important enablers to identifying these risks and to planning the right action to take in response.

Sharing information with other regulators

In 2014, we worked with other regulators and organisations to put arrangements in place so we could work better together and share information relevant to our roles. This work reflects the recommendations in the Francis report* of the need for regulators to work more closely together.

We agreed memoranda of understanding with Healthcare Inspectorate Wales, the Regulation and Quality Improvement Authority and the NHS Trust Development Authority and, in early 2015, with Monitor, and Healthcare Improvement Scotland. This builds on the success of our work with the Care Quality Commission, which was launched in August 2013 as part of a joint working framework to help staff in both organisations work more closely, and share information more quickly and efficiently, so as safeguard patients.

Using our information about patient safety concerns

On 8 October 2014, we published our fourth annual report on *The state of medical education and practice in the UK*.† The 2014 report uses our data and the data of other organisations to assess the trends, opportunities and challenges facing medical education and practice across the UK.

As well as being valued for its insights by others working in healthcare, we also use the findings of the report to help shape our policies and research.

In 2014, we focused on the shape of the workforce and patterns of complaints that we receive. We also found that differences in the proportion of doctors being complained about or receiving a sanction or warning are related much more to the nature of the specialties they work within as opposed to the characteristics of the doctors working in them.

* See www.midstaffspublicinquiry.com.

† See www.gmc-uk.org/somep.

For the first time, we also published a qualitative analysis of the issues raised through our liaison services across the UK and from the issues raised when people ask for our advice on good practice. This information can help us to identify potential areas to further support doctors. Of particular concern are the difficulties doctors describe in relation to raising concerns about patient safety. Doctors also told us that they are feeling higher pressures at work than they have experienced in the past.

The results of our national training survey 2014, which over 98% of doctors in training responded to, revealed similar concerns. While overall satisfaction remains high, there is also some evidence that not all patient safety issues are managed appropriately within some organisations. The majority of patient safety concerns raised by doctors in training relate to a lack of staffing and resources. With the increased pressure on the health service to deliver more with less, this reinforces the importance for us to do all we can to identify and act on patient safety concerns.

In 2014, we also compared the national training survey results over the past three years. This was made possible for the first time due to the introduction of our new reporting tool. This richer picture of data gave us more evidence to require postgraduate training organisations to make improvements, as we were able to more easily identify persistent issues.

IDENTIFYING PATIENT SAFETY RISKS ACROSS THE PROFESSION

Some 8% of those who responded to our 2014 national training survey said that they had experiencing bullying, and 14% reported witnessing bullying. In November 2014, we published a report on bullying and undermining,* looking at these issues, which can have a big impact on patient safety.

We also wanted to look at some of the environments where doctors in training had raised particular concerns. So, between September and December 2014, we carried out 12 site visits (six in obstetrics and gynaecology and six in surgery) to see what progress has been made and how we could learn from these experiences to support further progress. In March 2015, we published a thematic review† based on what we learnt from these site visits, which can be used to help support other sites and specialties.

In 2014, we commissioned the Right Honourable Sir Anthony Hooper to review how we deal with doctors who raise concerns in the public interest. These doctors need to be supported – raising concerns is central to protecting patients and providing good medical care. We will take forward the recommendations of the review‡ to develop our current guidance to make sure it fully reflects the needs of whistleblowers.

* See www.gmc-uk.org/NTS_bullying_and_undermining_report_2014_FINAL.pdf_58648010.pdf.

† See www.gmc-uk.org/news/26317.asp.

‡ See www.gmc-uk.org/Hooper_review_final_60267393.pdf.

Using our data and intelligence to help make sure we're a fair organisation

We use our data and intelligence to make sure that, as well as meeting our legal obligations, we're proactive in understanding the factors that can affect different groups. This helps make sure that our policy and operational development is fair and seeks to support different groups.

Our report, *The state of medical education and practice in the UK*, is one way we do this. Our 2014 report identified groups of doctors who are more at risk of:

- being complained about
- being investigated
- receiving a sanction or warning.

A key focus for us is to gain a better understanding of the differences in how some groups of doctors perform in examinations and assessments. This theme will be explored in *The state of medical education and practice in the UK: 2015*, as well as through other work, such as research into possible interventions to support different groups of doctors.

In March 2015, we published two interactive reports on the progress of doctors in training,[*] based on recruitment data showing doctors applying for specialty and GP training programmes, and examination data showing pass rates. The reports illustrate that some groups of doctors in training are less likely to progress than others. We are working with those involved in managing and delivering medical education to investigate the underlying causes, which aren't currently clear from the data alone.

Research we carried out in 2014[†] has been reassuring – it told us that the majority of doctors who responded felt that they would be treated fairly:

- when they are applying for registration to the medical register
- throughout our revalidation processes
- in a fitness to practise investigation.

But a minority of doctors felt they might not be treated fairly. In particular, black and minority ethnic doctors who qualified in the UK and international medical graduates were significantly more likely than white UK graduates to consider that they might not be treated fairly within some of our processes.

We commissioned an independent audit of decisions made during our fitness to practise investigations, undertaken by Plymouth University Peninsula Schools of Medicine and Dentistry, to check they are consistent with our published guidance. The review considered our guidance for decision makers and whether this plays a role in over-representation of doctors in our procedures and whether our use of language reveals any cultural aspects to our approach that may impact on over-representation. The findings from the audit[‡] are positive – showing that our decisions have been made according to our guidance, and the guidance does not reflect a cultural bias.

* See www.gmc-uk.org/about/research/26472.asp.

† See www.gmc-uk.org/education/25495.asp.

‡ See www.gmc-uk.org/about/research/26342.asp.

Working more closely with patients, doctors and medical students in frontline care

Our ability to successfully engage doctors in raising standards relies on us working more closely with others, including patients, educators, employers, medical students, and other healthcare professionals and regulators. By understanding more about the daily challenges that doctors face, we can learn more about what motivates and influences their behaviour and engage them more successfully.

We carried out research to understand how our key audiences experience us as an organisation

Working more closely with others relies on us understanding what they already know of our work and their existing perceptions of us. In 2014, we carried out a survey to better understand how our key audiences perceive us. Our aim is to introduce this survey on a regular basis, and use the findings to help shape our policy, making sure that it takes into account the needs of different interest groups. We also want to make sure that our communications are effective and to increase understanding about our role.

In general, there was a high level of confidence in our regulation of doctors across most audiences. All groups were likely to identify the correct roles and responsibilities that we have. There was general agreement that we help raise standards in medical practice and that we are modernising the way that complaints and concerns about patient safety are dealt with. We published the report in April 2015.[*]

* See www.gmc-uk.org/about/research/26472.asp.

† www.gmc-uk.org/doctors/WelcomeUK.asp.

We sought to understand and help doctors to overcome some of the challenges they face in the workplace

In 2011, our first report on *The state of medical education and practice in the UK* found evidence that doctors new to UK practice needed more support. In 2014, we continued to roll out our Welcome to UK Practice programme,[†] which was developed in 2013. We believe that this support for doctors new to practising in the UK can help improve their understanding of how to apply our standards and the quality of care that patients receive in the UK.

Over 290 doctors attended the 18 evaluative pilot events that we held in 2014. Out of those who gave us feedback, 90% said that they would change their practice as a result of the session.

Our focus in 2014 has been to refine the delivery model further. We want to be able to deliver this service where possible in the environments where doctors are practising. Our Regional Liaison Service[‡] and devolved offices,[§] which allow us to listen to and understand the needs of doctors, patients, medical students and other key interests across the UK, have been key in delivering events in 2014.

Resources designed to support doctors new to UK practice are also available on our website. Our online scenario-based tool[¶] allows doctors to assess their knowledge and application of our core guidance, *Good medical practice*. It contains 16 different case studies that explore ethical challenges in a variety of clinical scenarios. It also provides help on finding further information and advice. In 2014, there were 4,000 visits to the tool.

‡ See www.gmc-uk.org/rls.

§ See www.gmc-uk.org/devolved.

¶ See www.gmc-uk.org/guidance/case_studies.asp.

CASE STUDY

Our clinical fellow, Achyut Valluri, facilitated an event for doctors new to UK practice, on the Scottish islands of Orkney

Realising the challenges that working in remote and rural areas in Scotland can present, we delivered a pilot session of our Welcome to UK Practice programme at the Balfour Hospital in Kirkwall, on Orkney, on 29 October 2014.

The session was well received by attendees. All said that the session had helped them to reflect on their practice and that they felt able to use the ethical and professional guidance and frameworks discussed in their practice.

In the feedback we received, the opportunity to discuss ethical issues with a GMC representative as well as with peers was highlighted as a benefit. Topics highlighted to be of particular use were the safeguarding of children and vulnerable adults, and doctors' use of social media.

'The thing that struck me was how open and honest the doctors who attended the session were in their discussions. It's really reassuring to see this type of relationship developing between doctors and their regulator – and the effort that both are putting in to make sure patients get safe, effective and person-centred care.'

Clinical fellow Achyut Valluri,
event facilitator

We listened to the needs of doctors, patients and medical students and others across the UK

The events run by our Regional Liaison Service and devolved offices give us an opportunity to discuss the work we do and to listen to and understand the needs of those we work with and for. We use the feedback from this engagement to develop our policies and systems.

Our Employer Liaison Service* supports a two-way exchange of information about underperforming doctors, improving patient safety and the quality of referrals. In 2014, it held more than 1,200 meetings with responsible officers. The meetings help them and their teams to understand our fitness to practise thresholds and procedures.

The Employer Liaison Service grew over 2014, to reflect the increasing number of designated bodies in England and to allow us to engage in wider quality activity. Designated bodies are the organisations that give doctors an annual appraisal and help them with revalidation.†

WE DELIVERED NEW EVENTS TO REACH KEY PARTNERS IN NORTHERN IRELAND

In 2014, we worked with the Northern Ireland Medical and Dental Training Agency to develop a one-day professionalism programme. This included delivering a series of interactive sessions, covering a range of our guidance and fitness to practise scenarios, to groups of 25–45 doctors in training from across Northern Ireland. Over 85% said their practice would change as a result of the sessions.

'More likely to report concerning behaviours due to increased awareness of procedures.'

'Has made me more aware of considering my own limitations as part of my daily practice.'

Feeback from doctors in training following the events.

In December 2014, we also hosted our first medical professionalism conference in Northern Ireland with over 100 doctors, patients and senior health and social care representatives. The event was delivered in partnership with our key partners, with a strong line-up of senior representatives working in or with the health and social care sector in Northern Ireland. Through a series of workshops, attendees explored areas of our guidance, including raising and acting on concerns, confidentiality, and communicating with patients.

* See www.gmc-uk.org/els.

† You can find out more about designated bodies on our website at www.gmc-uk.org/doctors/revalidation/12387.asp.

WE WORKED WITH PARTNERS TO DELIVER AN EVENT EXPLORING ADULT SAFEGUARDING ISSUES

Changes to the law that came into effect in April 2015 put adult safeguarding on a similar legal level as child protection. On 20 November 2014, we hosted an event with Camden Borough Council and Care UK to raise awareness of this and how it will affect doctors' work.

During the event, we looked at the definitions of abuse and neglect and considered GPs' responsibilities in relation to the *Care Act 2014*. A case study was used to show some key points, such as the need to work together, and attendees linked their actions to our guidance on confidentiality and raising concerns.

55 GPs, including locums, attended. Feedback was very positive and all doctors said that their practice would change as a result of the session.

Working better together

It's essential that we continue to give clear value for money, especially as demand for our services increases and pressures within the health service continue. This includes finding new ways of doing things by improving our existing approach, and by exploring better ways of working together.

We held an event to promote learning between regulators from around the world

Between 9 and 12 September 2014 we hosted the IAMRA 11th International Conference on Medical Regulation. Over 360 participants from 48 countries attended, to discuss issues such as evaluating risk and reducing harm to patients and to hear from a high calibre of speakers, including Dr Dan Poulter MP, Sir Robert Francis QC and Dr Margaret Mungherera (President of the World Medical Association).

The success of the conference helped to position the IAMRA as a leading voice on regulation and patient safety. Our Chief Executive, Niall Dickson, became Chair of IAMRA during the conference and will now serve a two-year term. We will use our leadership of IAMRA to promote medical regulation as a means of protecting patients throughout the world.

We used our resources as efficiently as possible

We continued our programme to improve our performance and achieved new efficiency gains of £3 million in 2014. These have been generated from a range of initiatives, including the renegotiation of our existing office leases and implementing the second phase of our scheduled home working project. In addition, we also generated ongoing gains of £5.5 million from projects begun in previous years. We've therefore achieved total annual efficiency gains of £8.5 million for 2014.

We continued our work on being a fair employer

In 2014, we continued our work on being a fair employer. Our aim is to treat everyone who works with us with dignity and respect and to work towards being a diverse workforce at all levels of the organisation. This includes taking steps to make sure that our policies, recruitment and selection processes continue to align with our commitment to being fair.

At the end of 2014, we employed 1,020 staff (991 full-time). Our aim is to achieve a diverse workforce at all levels. In terms of ethnicity, we continue to attract a high percentage of applicants for roles from a black and minority ethnic background (27% in 2014). In terms of gender, we have made recent progress in achieving a better balance in our management roles, with the percentage of women in senior roles increasing from 18% in 2011 to 36% in 2014.

We rewarded staff who embodied our core values and went beyond their day-to-day responsibilities

We recognise that doing our job well relies on having the right people for the role. Our annual Valued Awards were held on 16 December 2014 to recognise the achievements and efforts of our staff across the organisation. Over 400 people attended the event in both London and Manchester. The quality and dedication of the people who work for us help to make sure we're a successful organisation.

The nominations and winners highlighted individuals and teams who bring to life our core values of transparency, collaboration, fairness and excellence, and of protecting patients and improving standards of medical practice, through all aspects of their work.

Without Natalie's assistance I do not believe the witness would have found the strength to give her evidence. ”

CASE STUDY

Individual winner for our value of protecting patients

Natalie is a paralegal in our Fitness to Practise directorate whose commitment to our work demonstrates our values. In a case during 2014, Natalie gave a great deal of support to a vulnerable witness who was due to testify at a hearing but was reluctant to do so.

Her nomination for the award noted her natural ability to make conversation and diffuse difficult situations. In supporting the witness, Natalie gave up her weekend to enable the witness to remotely testify, and to lend the necessary emotional support that enabled the witness to tell their story.

'Natalie has acted with the utmost dedication and professionalism. Firstly in Manchester when the witness was ill, and then when she travelled on two separate occasions to facilitate evidence by video link, Natalie worked extremely hard to make sure the GMC's case could proceed. Without Natalie's assistance I do not believe the witness would have found the strength to give her evidence. Always cheerful and willing to help, Natalie is a credit to the GMC.'

Chloe Hudson, GMC Counsel

OUR STATUTORY OBLIGATIONS

“In 2014, we directly engaged on our role across the UK with 15,536 doctors.”

98%

of students surveyed said our engagement sessions helped them to reflect on their practice

96% of key partners said working with us would improve the practice of doctors they work with

In addition to the new developments and innovation we are striving for in our new corporate strategy, we also have to make sure we deliver a consistent, efficient and fair service against our statutory obligations.

We are an independent organisation. We help protect patients and improve medical education and practice across the UK by delivering our core functions.

- We set the standards that doctors need to follow, and make sure that they continue to meet these standards throughout their careers.
- We decide which doctors are qualified to work here and we oversee UK medical education and training.
- We take action to prevent a doctor from putting the safety of patients, or the public's confidence in doctors, at risk.

In this section, we explain how we've achieved this during 2014.

82% of doctors surveyed said they would change their practice as a result of our engagement sessions

Making sure our role and standards are understood

Our standards define what makes a good doctor by setting out the professional values, knowledge, skills and behaviours required of all doctors working in the UK. The core professional standards expected of all doctors are set out in our guidance, *Good medical practice*.

This guidance covers the fundamental aspects of a doctor's role, including working in partnership with patients and treating them with respect. We also provide detailed guidance on ethical principles that most doctors will use every day.

We want to do everything we can to make sure our guidance is widely known, understood, and applied by doctors in their day-to-day lives. Serious or persistent failure to follow our guidance will put a doctor's registration at risk. Our Regional Liaison Service and devolved offices in Northern Ireland, Scotland and Wales played a key part in 2014 in raising awareness and understanding of our standards.

In 2014, we directly engaged on our role across the UK with:

- 15,536 doctors
- 2,271 patients and members of the public
- 12,258 students and educators.

98%

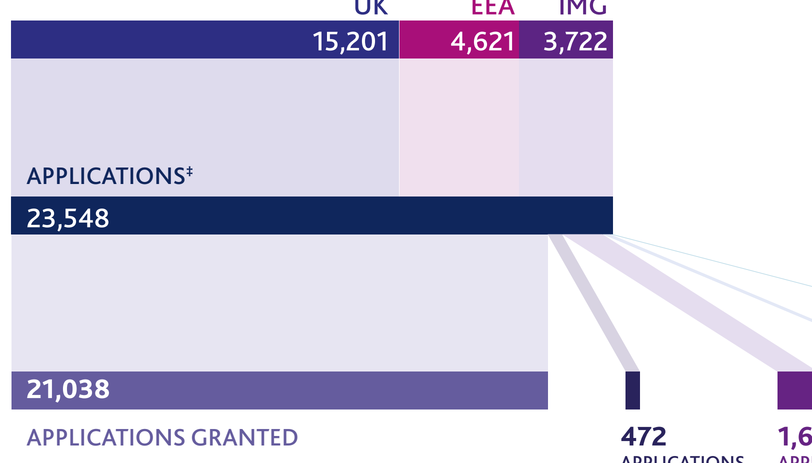
of CESR and CEGPR applications were completed within three months

Registering doctors who are safe and fit to practise

We check each doctor's identity and qualifications before they're allowed to practise in the UK. We maintain a list of all the doctors that meet our requirements – this is called the medical register.

In 2014, we processed 23,548 applications for registration with a licence to practise. Of these, 15,201 applications were from doctors who qualified in the UK, 4,621 in the European Economic Area (EEA) or Switzerland,* and 3,722 from the rest of the world, also known as international medical graduates (IMGs). We approved 21,510 doctors to practise.

2014 outcomes of applications for registration



We also maintain a Specialist Register and a GP Register. These list the doctors who have completed further specialty training and who meet the criteria to work as a GP in the NHS or to be appointed in a substantive consultant role in the NHS. In 2014, we granted over 9,000 applications (including new applications and restorations) for entry onto the Specialist Register or the GP Register.†

95%

of applications were responded to within five working days

* For simplicity we will refer to this group as European doctors for the remainder of the report.

† Certificate of Eligibility for Specialist Registration (CESR) or a Certificate of Eligibility for GP Registration (CEGPR) are equivalence routes for doctors to gain this type of registration where they are not eligible for a Certificate of Completion of Training. Further detail on these processes is available on our website at: www.gmc-uk.org/doctors/SpecApps.asp.

‡ Four applications didn't specify the primary medical qualification.

§ Includes applications that were withdrawn by the doctor, closed or not eligible.

Taking action where concerns are raised

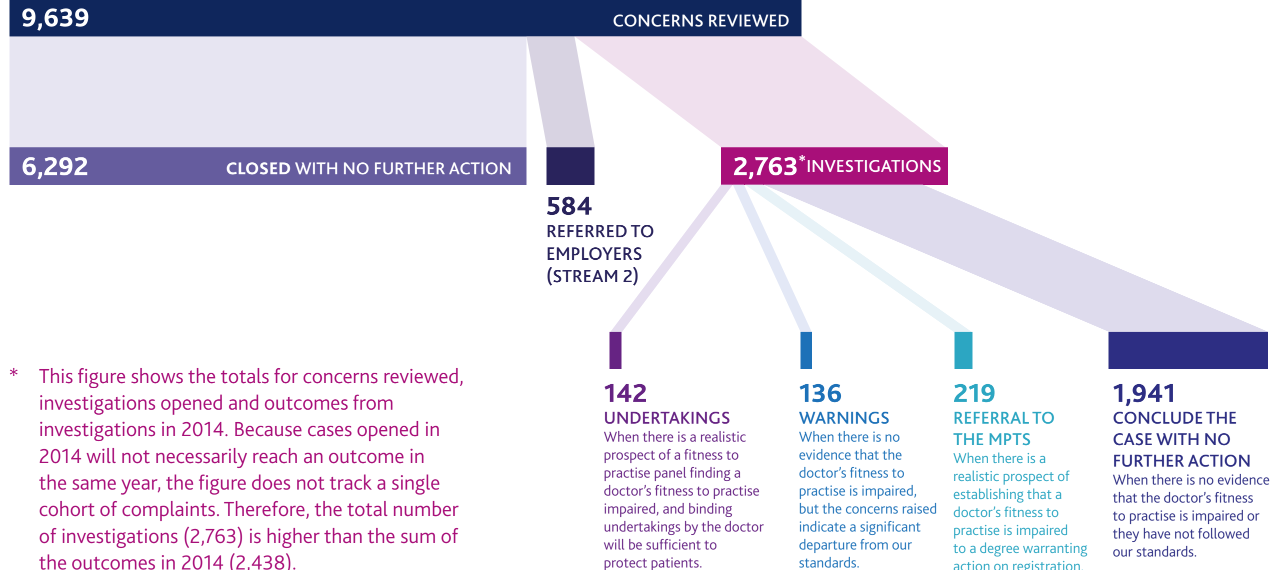
When a serious concern is raised about a doctor's behaviour, health or performance, we investigate to see if the doctor is putting the safety of patients, or the public's confidence in doctors, at risk.

In 2014, we reviewed a total of 9,639 concerns about doctors. Of these, we opened investigations into 2,763 potentially serious concerns.

- We achieved our service target of concluding 90% of fitness to practise cases within 12 months, achieving 91%.
- We achieved 88% against our service target of concluding or referring 90% of cases at the investigation stage within six months.
- We achieved 94% against our service target of concluding or referring 95% of cases at the investigation stage within 12 months.
- We met our service target of reviewing 100% of doctors with conditions or undertakings attached to their registration before being returned to unrestricted registration.

We narrowly missed two of our service targets in progressing cases. This was largely a result of an increase during the year of more serious investigations. In response, we have increased our investigation teams to enable us to deal with our cases as quickly as we possibly can. Page 18 gives more information about our work to make more fundamental improvements to how we handle concerns about doctors.

2014 outcomes of investigating concerns



* This figure shows the totals for concerns reviewed, investigations opened and outcomes from investigations in 2014. Because cases opened in 2014 will not necessarily reach an outcome in the same year, the figure does not track a single cohort of complaints. Therefore, the total number of investigations (2,763) is higher than the sum of the outcomes in 2014 (2,438).

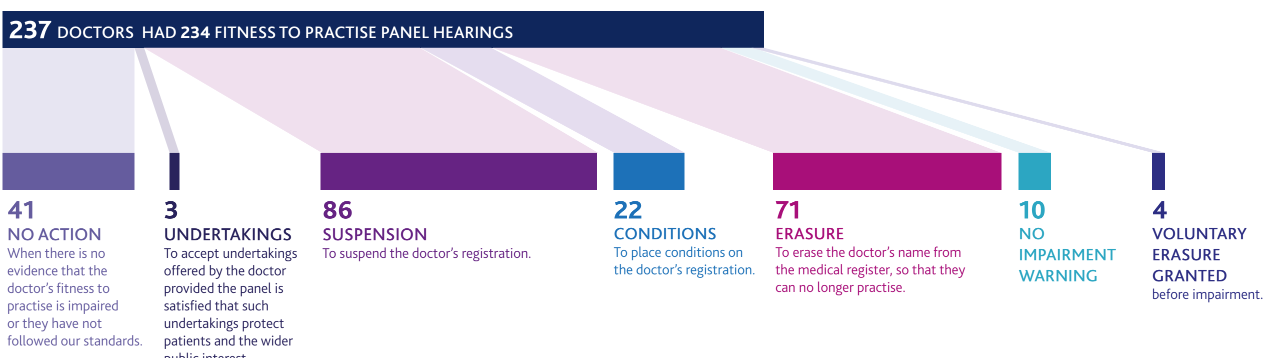
Independent adjudication of cases

The MPTS is the adjudication service for UK doctors. It operates separately from the rest of the GMC's fitness to practise work, so that all decisions are independent. In 2015, this independence will be strengthened with the MPTS becoming a statutory body. Page 18 gives more information about this important change.

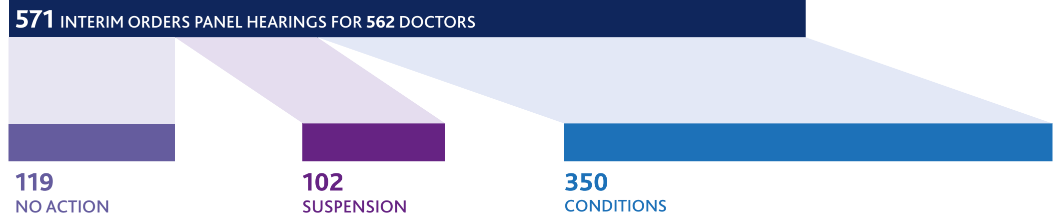
When action is needed to protect patients or to maintain public confidence in doctors, an MPTS panel can suspend a doctor's right to work, or restrict his or her practice – for example, by requiring them to work under supervision, or undergo further training. In the most serious cases the MPTS panel can remove a doctor's name from the medical register.

- The MPTS met its service target of starting 90% of fitness to practise panel hearings within nine months of referral, achieving 98%.
- The MPTS met its service target of starting 100% of interim orders panel hearings within three weeks of referral.*

2014 outcomes from MPTS fitness to practise panels



2014 outcomes from MPTS interim orders panels



The outcomes are given by individual doctors for fitness to practise panel hearings, and by panel hearings for interim orders panel hearings. This is because a fitness to practise panel hearing can cover more than one doctor (and therefore there may be more than one outcome).

* The exact figure was 99.7%. Two out of a total of 571 interim orders panel hearings missed the target.

Ensuring high-quality education and training for doctors

We set the educational standards for all UK doctors through undergraduate and postgraduate education and training. We promote high standards and make sure that medical education and training reflect the needs of patients, medical students and doctors in training, and the healthcare systems across the UK. We also visit medical schools and training environments to check that our standards for education are being met.

HOW DOES OUR QUALITY ASSURANCE WORK MAKE A DIFFERENCE?

Enhanced monitoring is the process by which we support deaneries, local education and training boards and medical schools to manage concerns about quality and safety in medical education and training.

Although the concern remains locally managed, we require frequent updates and can provide support on activity such as visits where appropriate. One example of a concern that was managed to resolution via this process is Basildon University Hospital.

In October 2009, Health Education East of England (HEEoE) found that doctors in training at Basildon University Hospital were experiencing problems with poor access to education, rota issues, and unprofessional staff behaviour.

The specialties affected were emergency medicine, obstetrics and gynaecology, and trauma and orthopaedic surgery. HEEoE contacted us to ask for our support to address these issues.

HEEoE kept us informed of progress through scheduled reporting (the dean's reports). We also attended risk summits led by the Care Quality Commission (CQC), and supported HEEoE on their visit to the emergency medicine department in July 2013.

HEEoE visited the trust in June 2014 and found considerable improvement across all training grades and specialties with exemplary practice in 13 specific areas. This improvement was reinforced by our 2014 national training survey results.

As a result of this improvement we decided to remove the trust from our enhanced monitoring process. We receive updates as normal from the dean's reports.

98% of all complaints* received were responded to within 10 working days

Responding to enquiries

Our Contact Centre is often the first contact point with our organisation for the public, employers, doctors and other regulators, with our organisation. We aim to provide excellent levels of service to the high volume of people who contact us. In 2014, our Contact Centre answered over 185,000 telephone calls and nearly 90,000 pieces of correspondence.

- We achieved 73% against our target of answering 90% of calls within 15 seconds.
- We achieved 88% against our service target of answering 95% of emails and letters within five working days.
- We achieved 97% against our target of seeing doctors within ten minutes of their arrival for an appointment.
- We achieved 98% against our target of responding to complaints within ten working days.†

Staff changes and the changing nature of the types of enquiry we're receiving meant that during 2014 we weren't able to answer all calls as quickly as we would have liked.

Over the past three years, the average duration of calls has significantly increased. This reflects the more complex nature of the types of question that we are now receiving. We've reviewed our resource levels in the Contact Centre and were able to meet our service targets from September until the end of the year. The same team that answer calls to our Contact Centre also respond to written enquiries.

The challenges we had in providing our phone service meant that we weren't able to respond to written enquiries as quickly as we would have liked. We were able to meet our service targets from July.

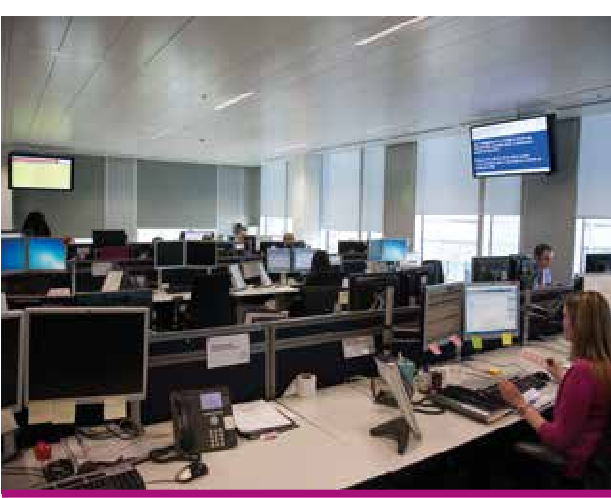
* Complaints received by our Registration and Revalidation directorate.

† Figure relates to complaints received by our Registration and Revalidation directorate.

Information requests

We received 536 subject access requests under the *Data Protection Act 1998*. This was an increase of 8.7% from 2013. The number of information requests that we received under the *Freedom of Information Act 2000* in 2014 was 801. This was a 6.4% decrease from 2013.

- We achieved 83% against our target to respond to subject access requests within 40 calendar days.
- We achieved 87.7% against our target to respond to 87.5% of freedom of information requests within 20 working days.



87.7%

of all requests on freedom of information were responded to within 20 working days

2014 FINANCIAL REVIEW

“We continued our programme to improve our performance and achieved new efficiency gains of £3 million in 2014.”

We continued our programme to improve our performance and achieved new efficiency gains of £3 million in 2014. These have been generated from a range of initiatives, including the renegotiation of our existing office leases and implementing the second phase of our scheduled home working project.

We also generated ongoing gains of £5.5 million from projects begun in previous years. We therefore achieved total annualised efficiency gains of £8.5 million in 2014.

Our total income and expenditure for 2014

In 2014, we generated a total income of £97 million, and our operational expenditure was £101 million. Our income in 2014 increased by £1.6 million compared with 2013, largely due to natural growth in the number of new doctors joining the register. Our expenditure in 2014 increased by £9.3 million compared with 2013, largely as a result of a significant increase in activity levels in fitness to practise. There were also increases in education, registration and revalidation.

Each year we set a business plan and budget based on our strategic aims and a forecast of likely work volumes. Our actual performance against our strategic aims is set out earlier in this report, and our financial performance against budget is summarised below.

Our income in 2014 was around £0.3 million more than budgeted. The introduction of licensing in 2009, and revalidation in 2012, has made accurate forecasting of our income difficult. The number of registered doctors increased over the year, and the timing of doctors joining and leaving the medical register during the course of the year differed from our budget assumptions.

Our total operational expenditure in 2014 was £2.8 million more than budgeted.

Fitness to practise costs are a significant proportion of our total expenditure. Expenditure in 2014 was £2.7 million more than budgeted, due to an increase in activity. This in turn led to an increase in adjudication hearings, so the costs incurred by the MPTS were £0.9 million more than budgeted.

Education and standards costs were £0.1 million over budget, due to increased activity levels.

Our strategy and communication costs were £1.2 million under budget because of staff vacancies during the year and project work being deferred.

Resources costs were £0.2 million more than budgeted, due to increased demand for information systems and HR support across the organisation.

Depreciation charges were £0.1 million more than budgeted, reflecting the nature and timing of our capital expenditure during the year.

Our registration and revalidation costs and accommodation costs were broadly in line with budget.

During 2014, we spent £7.8 million on major projects to improve our accommodation and information systems infrastructure.

Following a strong return on assets, the GMC's defined benefit pension scheme ended the year with a surplus of £17.1 million. This comprised assets of £152 million and liabilities of £134.9 million, valued in accordance with the accounting standard FRS 17: Retirement Benefits. This is set out in more detail in note 14 of the accounts. The defined benefit pension scheme was closed to new joiners and a new defined contribution scheme was introduced on 1 July 2013.

Trustees' responsibilities for the financial statements

The trustees are responsible for preparing the trustees' report and the financial statements in accordance with applicable law and regulations. Charity law requires that the trustees prepare financial statements for each financial year in accordance with *UK Generally Accepted Accounting Practice (UK Accounting Standards)* and applicable law.

Under charity law, the trustees must not approve the financial statements unless they are satisfied that they give a true and fair view of the state of affairs of the charity and of its net incoming resources for that period. In preparing these financial statements, the trustees have:

- selected suitable accounting policies and applied them consistently
- made judgements and estimates that are reasonable and prudent
- followed applicable accounting standards without any material departures
- prepared the financial statements on the going concern basis
- observed the methods and principles in the *Statement of Recommended Practice: Accounting and Reporting by Charities* (revised March 2005).

The trustees are responsible for keeping adequate accounting records that are sufficient to show and explain the charity's transactions and disclose, with reasonable accuracy at any time, the financial position of the charity. The trustees are also responsible for making sure that the financial statements comply with the *Charities Act 2011*, the *Charity (Accounts and Reports) Regulations 2008*, the provisions of the trust deed, the *Charities and Trustee Investment (Scotland) Act 2005*, the *Charities Accounts (Scotland) Regulations 2006* and the Privy Council Directions issued under the *Medical Act 1983*. The trustees are responsible for safeguarding the assets of the charity and for taking reasonable steps to prevent and detect fraud and other irregularities.

Reserves policy

Our level of reserves and our reserves policy are reviewed annually, and any financial implications are addressed as part of the budget-setting process.

We hold reserves:

- to fund working capital and manage the normal day-to-day cash flow of the business because our expenditure is broadly linear whereas income is concentrated in summer and winter peaks
- to provide funds to address the risks we have identified that may result in an unexpected increase in expenditure and/or a reduction in income
- to provide funds to respond to new initiatives and opportunities that come up during the year
- to fund the period between a decision to increase income and its taking full effect.

There is no standard formula that can be used to calculate the ideal level of reserves. We follow the Charity Commission's guidance and set a target range of reserves based on our cash flow needs and an assessment of the risks facing the organisation. We aim to hold reserves at a level that is not excessive, but does not put our solvency at risk.

We operate a defined benefit pension scheme. In line with the accounting standard FRS 17: Retirement Benefits, the value of the pension scheme assets and liabilities is recognised on the balance sheet. While the operation of the defined benefit pension scheme does create a financial risk for the organisation, any deficit or surplus in the scheme can be managed over the medium term, and so has no immediate impact on our cash flow requirements. Any risks associated with changes in the level of pension scheme assets and liabilities are therefore disregarded for reserves policy purposes. We also operate a defined contribution pension scheme. This does not create a financial risk for the organisation and so is also disregarded for reserves policy purposes.

A significant proportion of our total reserves are represented by fixed assets, which cannot easily be converted into cash at short notice without adversely affecting our ability to fulfil our charitable aims. The value of fixed assets is therefore disregarded for reserves policy purposes.

Based on our analysis of cash flows and the risks facing the organisation, our policy is to maintain free reserves in the range of £25 million–£45 million. However, we recognise that the level of reserves will inevitably fluctuate each year, reflecting variations in actual levels of income and expenditure compared with the budget. Our policy is to maintain actual free reserves in line with the target level over the medium term. If our actual reserves vary significantly from the target range set out in the reserves policy, we will address the variation as part of the annual budget-setting process to bring actual reserves back into line.

Our free reserves at the end of 2013 stood at £42.3 million. While this was within the target range, we recognised the challenging financial circumstances facing doctors and took the decision to freeze registration fees and the annual retention fee in 2014.

As a result of the fee freeze and the increase in our costs in 2014, our free reserves on 31 December 2014 reduced to £36.9 million. Total reserves at the end of the year were £68.2 million, made up of free reserves, plus £14.2 million of reserves represented by fixed assets, and a pension reserve of £17.1 million valued in accordance with FRS 17: Retirement Benefits.

On 10 December 2014, we decided to increase the 2015–16 registration fees and annual retention fee, recognising the additional cost pressures we face. Also, a proportion of doctors facing revalidation – for example, those not in clinical practice – might choose to relinquish their licence to practise or seek voluntary erasure from the register, which would impact on our future income. We estimate that our free reserves at the end of 2015 will reduce to around £31.9 million.

Investment policy

During 2014, our investment policy was to hold general reserves in cash or near cash equivalents to minimise risk in terms of both loss of capital and volatility of investment returns. We have reviewed the policy and agreed a new one, which we will implement in 2015 to improve yield while maintaining an appropriate degree of security and liquidity.

Our 2014 accounts show cash needed for normal day-to-day working capital on our balance sheet within current assets, and cash held for the longer term is shown as investments.

In 2014, our investments generated interest of £0.6 million, equivalent to an average annual rate of return of 0.7%. Our Performance and Resources Board regularly reviewed investment income, as part of the overall monitoring of our financial performance in 2014.

Audit and Risk Committee's report

The Audit and Risk Committee continues to be a key part of our governance structure. It is responsible for ensuring the integrity of our financial statements, reviewing the systems of internal control, governance and risk management, and monitoring and reviewing both the internal and external audit services. The committee bases its advice and decisions on guidance issued by the Financial Reporting Council.

The committee consists of six Council members, and two external members who bring additional relevant experience and knowledge of finance, governance and risk to its work.

In 2014, the committee held five meetings and formally reported to Council on two occasions. Key activities included:

- approving the external audit letter of engagement and reviewing the outcome of the external auditor's work
- participating in the procurement tender exercise to appoint a new internal audit provider for three years beginning in January 2015 and ratifying the Chief Executive's final decision
- agreeing and overseeing a full programme of internal audit reviews
- overseeing the implementation of a refreshed risk management framework
- supporting the development of a risk assurance map aligned to the corporate risk register
- reviewing and approving a risk-based three-year audit programme for 2015–17
- overseeing the refinement of the co-sourcing audit delivery model to enhance the strategic leadership of audit and risk assurance.

Risk management statement

Our approach to risk management is set out in our risk management framework, which we refreshed during 2014. It includes a number of improvements, such as improved clarity on the respective responsibilities of Council, the Audit and Risk Committee, the Performance and Resources Board and senior management, and a strengthened risk escalation process. The framework has been supported by guidance and training for staff across the organisation.

Both Council and the Audit and Risk Committee have discussed risks regularly throughout the year. In addition, a report is prepared for senior management of emerging and changing risks so that they can consider the sufficiency of existing controls and any further remedial action. This is monitored by the Performance and Resources Board, which and makes sure that we continue to take a robust approach to identifying and managing strategic risks across the organisation.

At local level, risks are captured and monitored through individual directorate business plans and specific delivery plans for key organisational projects.

During 2014, we also refreshed the structure of our Corporate Risk Register – the central record of organisational risks that potentially threaten the achievement of our strategic aims and core functions, and the work we are doing to minimise and monitor them. And we developed an assurance map for the risks identified.

At the core of our risk management approach is understanding and responding to the risk to patient safety. We have robust systems and procedures in place to mitigate the risk of failure in the delivery of our statutory functions – which are core to promoting good practice and protecting patients. We continually seek to identify and respond to emerging risks, and the introduction of processes to check the English proficiency of EEA registrants during 2014 has helped us further reduce the risk to patients.

The most significant risks are often where we do not have full control of the actions that need to be taken. During 2014 we have identified such areas as:

- emerging European legislation and its implications for regulating doctors
- ours and others' roles in sharing of information across the broader health service
- changes to legislative frameworks in the UK.

During 2015, we will continue to monitor these risks and work with partners to mitigate any potential impact arising from them.

We are constantly alert to the risks incumbent in the sensitivity of information and data that we use on a daily basis and in making sure that Council discharges its accountabilities in an effective manner. However, we continue to be vigilant and regularly monitor our action plans to mitigate all potential threats.

ABOUT US

STRUCTURE, GOVERNANCE AND MANAGEMENT

We work with the Professional Standards Authority, an independent body, which is accountable to Parliament and scrutinises and oversees our work, together with other health and care professional regulatory bodies in the UK.”

We are independent of government and the medical profession and accountable to Parliament. Our powers are given to us by Parliament through the *Medical Act 1983*.

We work with the Professional Standards Authority, an independent body, which is accountable to Parliament and scrutinises and oversees our work, together with other health and care professional regulatory bodies in the UK.

We are registered with the Charity Commission for England and Wales (1089278), and with the Office of the Scottish Charity Regulator (SC037750).

Council is our governing body. It comprises 12 members, six of whom are medical members and six of whom are lay members. Our Council members are also the trustees of the organisation.

The trustees are responsible for making sure that we fulfil our charitable purpose of protecting, promoting and maintaining the health and safety of the community by ensuring proper standards in the practice of medicine. Our core regulatory functions all support this purpose.

The trustees present this report and financial statements for the year ending 31 December 2014. In preparing this report, the trustees have complied with the *Charities Act 2011*, Charity Commission guidance on public benefit in exercising their powers and duties, and applicable accounting standards. The statements are in the format required by the *Accounting and Reporting by Charities: Statement of Recommended Practice* (revised 2005). The trustees also considered and confirmed that the aims and objectives, as set out in our *Corporate strategy 2014–17*, are for public benefit and support our charitable purpose.

Our trustees have a duty to act impartially and objectively, and take steps to avoid any conflict of interest arising as a result of their membership of, or association with, other organisations or individuals. As trustees, members have a duty to avoid putting themselves in a position where their personal interests conflict with their duty to act in the interests of the charity, unless authorised to do so. To make this fully transparent, we publish a register of members' interests on our website.*

* See: www.gmc-uk.org/about/council/register.asp.

Council

The trustees between 1 January 2014 and 31 December 2014 were:

- Dr Shree Datta, MBBS BSc (Hons) MRCOG LLM
- Lady Christine Eames, OBE LLB MPhil
- Professor Michael Farthing, MD DSc(Med) FRCP FMedSci
- Rt. Hon. Baroness Hayman, GBE MA PC
- Rt. Hon. Professor The Lord Kakkar, BSc (Hons) MBBS (Hons) Phd FRCS PC
- Professor Deirdre Kelly, MD FRCP FRCPI FRCPCH
- Dame Suzi Leather, DBE MBE MA BA BPhil CQSW LLD (Hons) FRCOG (Hons) FRSH (Hons) DL
- Professor Jim McKillop, BSc MB ChB PhD FRCP FRCR
- Dame Denise Platt, DBE CBE BSc Econ
- Mrs Enid Rowlands, BSc CCMI
- Professor Sir Peter Rubin, BM BCh MA DM FRCP
- Dr Hamish Wilson, CBE MA PhD FHSM FRCGP (Hons)

The trustees were all independently appointed by our Privy Council, through a process that followed the Professional Standards Authority's guidance for making appointments to healthcare regulatory bodies.

The Chair, Professor Sir Peter Rubin, and Dr Hamish Wilson demitted office at the end of 2014. An appointments campaign took place during 2014 to fill the vacancies, under the same independent process used for existing Council members.

Professor Terence Stephenson was appointed Chair of Council, and Mr Julian Lee was appointed as a Council member. Both were appointed for a four-year term with effect from 1 January 2015.

We carried out an induction programme to make sure that our new Chair and Council member have the information they need to support them in their roles. Since they were appointed in 2014, they have received briefings and information relevant to their roles and responsibilities, including guidance on trusteeship, and information on our work (for example, our legislative framework and on the public sector Equality Duty).

In 2014, we reviewed our governance arrangements, facilitated by the internal audit service. We also asked external consultants with expertise in board effectiveness to review the effectiveness of our Council.

The governance review reported a positive view of the new arrangements that had come into effect in 2013. It found that our governance structure has clarity, there is a clear line of accountability between Council and the Executive, and that the structure and working arrangements are appropriately documented.

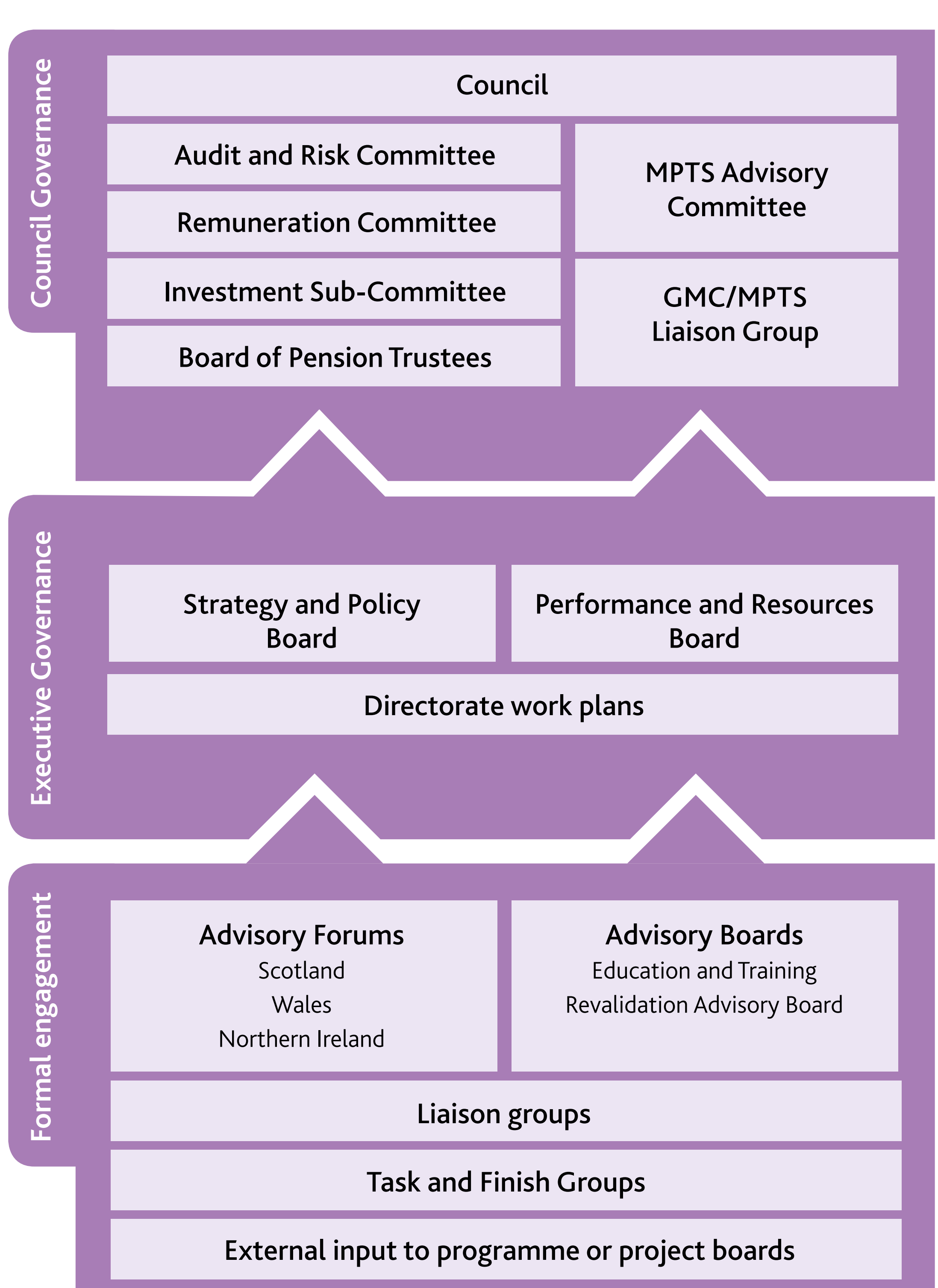
The Council effectiveness review was completed at the end of 2014. Our Council is taking this work forward in 2015, including consideration of how it can maximise its impact and effectiveness mapped against the six themes in the *Good Governance Standard for Public Services*,* adapted to be relevant to the context in which we operate.

Council members participated in appraisal reviews in 2014. We reviewed the competency framework that underpins the member appraisal system. The revised competency framework was agreed by Council in June 2014 and implemented to inform the 2014 appraisal process.

The diagram on the next page shows the different governance groups that assist Council in discharging their responsibilities. These have all been agreed by Council to help them oversee our work effectively.

In September 2014, Council agreed to establish an investment sub-committee, which will take forward work on in 2015. This sub-committee will be responsible for implementing our investment policy, appointing and managing fund managers, monitoring performance, and reporting to Council.

* See www.cipfa.org/-/media/Files/Publications/Reports/governance_standard.pdf.


Council Governance
Council
Audit and Risk Committee
Remuneration Committee
Investment Sub-Committee
Board of Pension Trustees
MPTS Advisory Committee
GMC/MPTS Liaison Group
Executive Governance
Strategy and Policy Board
Performance and Resources Board
Directorate work plans
Formal engagement
Advisory Forums
Scotland
Wales
Northern Ireland
Advisory Boards
Education and Training
Revalidation Advisory Board
Liaison groups
Task and Finish Groups
External input to programme or project boards

Audit and Risk Committee

In 2014, the Audit and Risk Committee was chaired by Dr Hamish Wilson. Its purpose is to monitor the integrity of the financial statements, to review the internal control, governance, and risk management systems, and to monitor and review the internal and external audit services. It has two external, co-opted members, Mr John Morley and Ms Elizabeth Butler. The Audit and Risk Committee's report can be found on page 45–47. From 1 January 2015, the Audit and Risk Committee has been chaired by Professor Jim McKillop.

Remuneration Committee

The Remuneration Committee is chaired by Dame Denise Platt. It advises Council on the remuneration, the terms of service and the expenses policy for Council members, including the Chair. It also determines the appointment process for the Chief Executive and MPTS Chair and the remuneration, benefits, and terms of service for the Chief Executive, Chief Operating Officer/Deputy Chief Executive, directors, and MPTS Chair and MPTS Advisory Committee members. Dr Shree Datta became a member of the Committee from 1 January 2015.

Board of Pension Trustees

Our Staff Superannuation Scheme is managed and administered by a Board of Trustees and chaired by Lord Kirkwood of Kirkhope, in accordance with the Scheme's Trust Deed and Rules.

Medical Practitioners Tribunal Service

The MPTS has responsibility for overseeing the adjudication of fitness to practise hearings, and is led by the Chair of the MPTS, His Honour David Pearl.

The MPTS Advisory Committee and joint GMC/MPTS Liaison Group continue as part of the governance framework. The role of the MPTS Advisory Committee is to give advice to His Honour David Pearl. The GMC/MPTS Liaison Group, which was chaired in 2014 by Professor Sir Peter Rubin, Chair of Council, oversees the working relationship between the MPTS and the functions of the GMC with which it interacts. Since January 2015, the GMC/MPTS Liaison Group has been chaired by Professor Terence Stephenson, Chair of Council.

In March 2015, changes to the *Medical Act 1983* established the MPTS on a statutory basis. They gave us the power to appeal decisions of MPTS panels when it considers a panel decision does not sufficiently protect the public, a power that didn't previously exist. The rule changes to establish the MPTS as a statutory committee, accountable directly to Parliament, are expected to come into force by the end of 2015.

Strategy and Policy Board

Our Strategy and Policy Board is an executive Board, and is chaired by our Chief Executive, Niall Dickson. It includes members of the Senior Management Team. The board is an advisory forum for Niall Dickson, which gives advice and recommendations on areas including:

- supporting Council in strategy development
- policy development priorities and significant changes to existing policy, including information and research to support strategy and policy development
- linkages between policy development and legislation
- external engagement in the organisation's strategy and policy development.

In 2014, the board was also responsible for overseeing the work of the Professional and Linguistic Assessments Board. The board reports its work through the Chief Executive's reports and an annual report to Council.

Performance and Resources Board

The Performance and Resources Board is an executive board and, since October 2014, has been chaired by Susan Goldsmith, our Chief Operating Officer. Between January and October 2014, the board was chaired on a rotating basis by each director as part of the transitional arrangements in place pending the appointment of Susan Goldsmith. The board includes members of the Senior Management Team.

The board is an advisory forum for the Chief Operating Officer, and gives advice and recommendations to the Chief Executive on areas including:

- business and operational planning
- performance management and reporting
- resource management
- risk management and related controls
- quality assurance, efficiency and continuous improvement
- making sure that equality and diversity are integrated into our core activities, including monitoring action plans and compliance with the equality duty.

The board also oversees the advisory Management Committee, which monitors and reviews our Staff Defined Contribution Pension Scheme. The board reports its work through the Chief Operating Officer's reports and an annual report to Council. From January to October 2014, the board reported its work through the Chief Executive's report to Council.

UK advisory forums

We have established advisory forums in Scotland, Wales and Northern Ireland, which were chaired in 2014 by Professor Sir Peter Rubin, as Chair of Council. The forums support Council's role in making sure that we have effective engagement with interest groups, and that our policies are suited to the context in all parts of the UK. From January 2015, the forums have been chaired by Professor Terence Stephenson, Chair of Council.

The forums are in addition to our existing arrangements for engagement and are intended to give a structured setting for us to engage on medium- and long-term priorities, and to share and discuss any early-stage views on policy development.

Education and Training Advisory Board

The Education and Training Advisory Board is chaired by Professor John Connell. It gives us advice on the delivery of undergraduate and postgraduate medical education and training, and career progression.

The board's advice is crucial in developing our policy and in making sure that Council is fully briefed before major decisions are made. The board's invited membership reflects the range of those who have a key interest in medical education and training across the UK. The board's work is reported to the Strategy and Policy Board.

Revalidation Implementation Advisory Board

The Revalidation Implementation Advisory Board is chaired by Sir Keith Pearson. It gives us advice about how effectively revalidation has been operating since it was introduced in December 2012.

The board gives insight from a range of perspectives about how the system is working on the ground, and how different groups, including doctors, responsible officers, patients, the public and employers, are experiencing revalidation. It is an important part of how we monitor implementation, as well as issues relating to the evaluation of revalidation and whether revalidation it is being delivered as envisaged. The board's work is reported to the Strategy and Policy Board.

Member attendance at Council, Boards and Committees in 2014

Member and trustee	Number of meetings attended
Dr Shree Datta	
Council	7/7
Audit and Risk Committee	5/5
UK Advisory Forum – Wales	1/2
Lady Christine Eames	
Council	7/7
Audit and Risk Committee	5/5
UK Advisory Forum – Northern Ireland*	2/2
UK Advisory Forum – Scotland	1/2
Professor Michael Farthing	
Council	7/7
Audit and Risk Committee	5/5
Baroness Helene Hayman	
Council	7/7
Remuneration Committee	1/2
Professor The Lord Ajay Kakkar	
Council	5/7
Remuneration Committee	2/2
Professor Deirdre Kelly	
Council	4/7
Audit and Risk Committee	3/5
Dame Suzi Leather	
Council	6/7
Audit and Risk Committee	5/5
UK Advisory Forum – Scotland	1/2

* Council member attendance at the forum meetings is on a voluntary basis on the invitation of the Chair of Council.

Member and trustee	Number of meetings attended
Professor Jim McKillop	
Council	7/7
Remuneration Committee	2/2
Board of Trustees of the GMC's Staff Superannuation Scheme	5/5
UK Advisory Forum – Scotland*	2/2
Dame Denise Platt	
Council	6/7
Remuneration Committee	2/2
UK Advisory Forum – Wales*	1/2
Mrs Enid Rowlands	
Council	6/7
Remuneration Committee	2/2
Board of Trustees of the GMC's Staff Superannuation Scheme	5/5
UK Advisory Forum – Wales*	2/2
Professor Sir Peter Rubin	
Council	7/7
GMC/MPTS Liaison Group	2/2
UK Advisory Forum – Northern Ireland	1/2
UK Advisory Forum – Scotland	2/2
UK Advisory Forum – Wales	1/2
Dr Hamish Wilson	
Council	7/7
Audit and Risk Committee	5/5
Board of Trustees of the GMC's Staff Superannuation Scheme	5/5
UK Advisory Forum – Scotland*	2/2

* Council member attendance at the forum meetings is on a voluntary basis on the invitation of the Chair of Council.

Management

In 2014, our staff were under the direction of Chief Executive Niall Dickson. On 6 October 2014, Susan Goldsmith took up the post of Chief Operating Officer and Deputy Chief Executive. These roles were previously held by Paul Philip, who left the GMC on 31 January 2014.

On 31 December 2014, the directors were:

- Paul Buckley,
  Director of Strategy and Communication
- Judith Hulf,
  Interim Director of Education and Standards
- Una Lane,
  Director of Registration and Revalidation
- Anthony Omo,
  Director of Fitness to Practise
- Neil Roberts,
  Director of Resources and Quality Assurance.

In January 2014, the previous Director of Strategy and Communication, Ben Jones, left the GMC and Paul Buckley was appointed. Paul Buckley's previous role was Director of Education and Standards, and Judith Hulf took up this post on an interim basis from 1 January to 31 December 2014. On 1 January 2015, Vicky Osgood took up the role of Director of Education and Standards on a substantive basis and Judith Hulf returned to her role as Senior Medical Adviser and Responsible Officer.

Our principal places of business are Regent's Place, 350 Euston Road, London NW1 3JN and 3 Hardman Street, Manchester M3 3AW. We also have offices in Belfast, Cardiff and Edinburgh and a centre for hearings, where the MPTS is based, at St James's Buildings, 79 Oxford Street, Manchester M1 6FQ.

Professional advisers

Bankers	The Royal Bank of Scotland 3rd Floor 280 Bishopsgate London EC2M 4RB
Solicitors	The majority of our legal work is carried out by our in-house legal team.
Auditors	Crowe Clark Whitehill LLP St Bride's House 10 Salisbury Square London EC4Y 8EH
Actuary and pension scheme adviser	Aon Hewitt Parkside House Ashley Road Epsom Surrey KT18 5BS

Approved by the trustees on 2 June 2015, and signed on their behalf by:

Professor Terence Stephenson

Independent auditors' report to the trustees of the General Medical Council

We have audited the financial statements of the General Medical Council (GMC) for the year ended 31 December 2014, which comprise the statement of financial activities, the balance sheet, the cash flow statement and the related notes numbered 1–16.

The financial reporting framework that has been applied in their preparation is applicable law and *UK Accounting Standards (UK Generally Accepted Accounting Practice)*.

This report is made solely to the charity's trustees, as a body, in accordance with section 154 of the *Charities Act 2011* and section 44(1c) of the *Charities and Trustee Investment (Scotland) Act 2005*. Our audit work has been undertaken so that we might state to the charity's trustees those matters we are required to state to them in an auditors' report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone, other than the charity and the charity's trustees as a body, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of trustees and auditors

As explained more fully in the statement of trustees' responsibilities, the trustees are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view.

We have been appointed as auditors under section 144 of the *Charities Act 2011* and section 44(1c) of the *Charities and Trustee Investment (Scotland) Act 2005*, and we report in accordance with those Acts.

Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and *International Standards on Auditing (UK and Ireland*). Those standards require us to comply with the *Auditing Practices Board's Ethical Standards for Auditors*.

Scope of the audit of the financial statements

An audit involves gathering enough evidence about the amounts and disclosures in the financial statements to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of:

- whether the accounting policies are appropriate to the charity's circumstances and have been consistently applied and adequately disclosed
- the reasonableness of significant accounting estimates made by the trustees
- the overall presentation of the financial statements.

In addition, we read all the financial and non-financial information in the trustees' annual report and any other surrounding information to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies, we consider the implications for our report.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the state of the charity's affairs as at 31 December 2014 and of its incoming resources and application of resources, for the year then ended
- have been properly prepared in accordance with *UK Generally Accepted Accounting Practice*
- have been prepared in accordance with the requirements of the *Charities Act 2011*, the *Charities and Trustee Investment (Scotland) Act 2005*, Regulation 8 of the *Charities Accounts (Scotland) Regulations 2006* and the *Medical Act 1983* and the Privy Council Directions issued thereunder.

Matters on which we are required to report by exception

We have nothing to report in respect of the following matters where the *Charities Act 2011* or the *Charities Accounts (Scotland) Regulations 2006* (as amended) require us to report to you if, in our opinion:

- the information given in the trustees' annual report is inconsistent in any material respect with the financial statements
- sufficient accounting records have not been kept
- the financial statements are not in agreement with the accounting records and returns
- we have not received all the information and explanations we require for our audit.

Crowe Clark Whitehill LLP
Statutory Auditors
London

Crowe Clark Whitehill LLP is eligible to act as an auditor in terms of section 1212 of the *Companies Act 2006*.

ACCOUNTS **2014**

Statement of financial activities for the year ended 31 December 2014

	Note	Total 2014 £000	Total 2013 £000
Incoming resources			
From charitable activities			
Registration	2	90,735	90,651
Certification	2	3,270	3,022
From generated funds			
Sales and other income	3	732	462
Investment income and interest	3	2,317	1,302
Total incoming resources		**97,054**	**95,437**
Resources expended			
Charitable activities			
Fitness to practise		45,658	40,912
MPTS		13,767	12,538
Registration and revalidation		18,809	18,028
Education		6,732	5,610
Standards		1,249	1,270
Communications		2,542	2,862
External relationships		5,153	4,678
Governance		7,114	5,815
Total resources expended	**4**	**101,024**	**91,713**
Net (outgoing)/incoming resources before recognised gains and losses		**(3,970)**	**3,724**
Other recognised gains and losses on investments			
Actuarial gain/(loss) on defined benefit pension scheme	14	7,308	(485)
Net movement in funds		**3,338**	**3,239**
Total funds brought forward		64,887	61,648
Total funds carried forward		**68,225**	**64,887**

The results above are derived from continuing activities. All gains and losses recognised in the year are included in the statement of financial activities above.

Balance sheet as at 31 December 2014

		2014		2013	
	Note	£000	£000	£000	£000
Fixed assets					
Tangible fixed assets	6		14,217		13,257
Investments	7		60,000		60,000
			74,217		**73,257**
Current assets					
Debtors and prepayments	8	18,019		17,934	
Cash and bank balances		91		103	
Short-term deposits		25,242		28,750	
		43,352		**46,787**	
Liabilities					
Creditors: amounts falling due within one year	9	(65,476)		(63,567)	
Net current liabilities			**(22,124)**		**(16,780)**
Total assets less current liabilities			**52,093**		**56,477**
Provisions for liabilities and charges	10		(991)		(912)
Net assets excluding pension scheme asset			**51,102**		**55,565**
Defined benefit pension scheme asset	14		17,123		9,322
Net assets including pension scheme asset			**68,225**		**64,887**
The funds of the charity					
Unrestricted income funds			51,102		55,565
Pension reserve			17,123		9,322
Total charity funds	**11**		**68,225**		**64,887**

The financial statements were approved by the trustees and authorised for issue on 2 June 2015.
They were signed on behalf of trustees by:

Professor Terence Stephenson
Chair of Council

Cash flow statement for the year ended 31 December 2014

	2014		2013	
	£000	£000	£000	£000
Net cash inflow from operating activities (note 1 below)		3,641		4,657
Returns on investments and servicing of finance:				
Interest received	643		794	
Net cash inflow from returns on investments and servicing of finance		**643**		**794**
Capital expenditure	(7,804)		(7,068)	
Net cash inflow/(outflow) from investing activities		**(7,804)**		**(7,068)**
Net increase/(decrease) in cash and cash equivalents (note 2 below)		**(3,520)**		**(1,617)**

Note 1	**2014**	**2013**
Cash flow from operating activities	**£000**	**£000**
Net incoming resources	(3,970)	3,724
Investment income and interest	(2,317)	(1,302)
Non-cash items – depreciation	6,834	5,645
Non-cash items – assets written off	10	102
Pension past service cost and curtailment	36	10
Pension scheme current service cost	8,565	7,425
Pension scheme contribution	(7,420)	(12,527)
(Increase)/decrease in debtors	(85)	394
Increase/(decrease) in creditors	1,988	1,186
	3,641	**4,657**

Note 2	**Short-term deposits**	**Cash at bank and in hand**	**Total**
Cash and equivalents	**£000**	**£000**	**£000**
Balances at 1 January 2014	28,750	103	28,853
Net increase/(decrease) in cash and cash equivalents	(3,508)	(12)	(3,520)
Balances at 31 December 2014	**25,242**	**91**	**25,333**

Notes to the accounts

1. Principal accounting policies

Accounting convention
The financial statements have been prepared on a going concern basis and under the historical cost convention as modified by the inclusion of investments at market value in accordance with the *Charities and Trustee Investment (Scotland) Act 2005* and the *Charities Accounts (Scotland) Regulations 2006*, the *Statement of Recommended Practice: Accounting and Reporting by Charities (SORP 2005)*, applicable accounting standards in the UK, and the *Charities Act 2011*. The principal accounting policies adopted in the preparation of the financial statements, which have been applied consistently, are detailed below.

Incoming resources
Income is included in the statement of financial activities when we are legally entitled to the income and the amount can be quantified with reasonable accuracy. The following specific policies apply to certain categories of income.

- Annual retention fees relate to services to be provided over a 12-month period. Income is deferred and released to the statement of financial activities on a straight-line basis over the period to which the income relates.
- Registration fees, including provisional registration fees, are recognised when registration is granted.
- Professional and Linguistic Assessments Board (PLAB) fees are recognised when the examinations are sat.
- All income is recognised gross.

Basis for recognising liabilities
Expenditure includes staffing costs, office costs, committee costs, legal costs, accommodation costs, purchase of assets, and financial, actuarial and professional costs.

Resources expended are included in the statement of financial activities on an accruals basis. All liabilities are recognised as soon as there is a legal or constructive obligation committing the charity to expenditure.

Basis for allocation of resources expended
The majority of resources are expended directly in pursuit and support of our charitable aims. Other resources expended on the governance of the charity are identified as such in the statement of financial activities.

Expenditure relating to accommodation costs and other support costs is apportioned to the relevant activity of the charity on the basis of staff head count across the organisation.

Irrecoverable VAT
Any irrecoverable VAT is charged to the statement of financial activities as part of the relevant item of expenditure, or capitalised as part of the cost of the related asset, where appropriate.

Taxation

We can take advantage of the exemptions from taxation on income and gains available to charities and accordingly no taxation is payable on the net incoming resources.

Provisions for liabilities

Provisions are recognised when the charity has a present legal or constructive obligation as a result of a past event. They are recognised when it is probable that a transfer of economic benefit will be required to settle the obligation and a reliable estimate can be made of the amount of the obligation.

Tangible fixed assets

Tangible fixed assets are stated at cost, net of depreciation and any provision for impairment. Expenditure is only capitalised where the cost of the asset or group of assets acquired (where the assets meet the FRS 15 definition of grouped assets) exceeds £5,000.

Depreciation

Depreciation is provided so as to write off the cost, less estimated residual value of the assets, evenly over their estimated lives. In the case of leased assets, the cost is written off over the period of the lease. The period of the lease is determined as the period up to the first break clause, unless our intention is not to exercise the break.

The estimated useful lives are as follows:

Asset	Estimated useful life
Leasehold buildings and leasehold improvements	Period of lease or useful economic life of assets
Furniture, fixtures, and office fittings	The lesser of five years or the remaining term of the lease
IT equipment and software	Three years
Other office equipment	Three years for IT-related equipment and five years for all other equipment

Depreciation rates are reviewed on a regular basis comparing actual lives of assets with the accounting policy rates.

Operating leases

Rent payable under operating leases is charged to the statement of financial activities on a straight-line basis over the period of the lease.

Finance leases

Rental payments under finance leases are apportioned between the finance charge and the reduction of the outstanding obligation. The finance charge is charged to the statement of financial activities over the period of the lease.

Investments

General reserves are held as cash on short- or medium-term deposits. Cash needed for normal day-to-day working capital is shown on the balance sheet within current assets, while cash held for the longer term is shown as investments.

Pensions

We have three staff pension schemes:

GMC Group Personal Pension Plan

This is a defined contribution pension scheme, which was set up on 1 July 2013. Under the terms of FRS 17, contributions are accounted for as a defined contribution scheme based on actual contributions paid through the year.

NHS Multi-Employer Scheme

A number of staff who transferred to the GMC on the merger with the Postgraduate Medical Education Training Board (PMETB) contribute to the NHS multi-employer scheme, which is a defined benefit scheme.

The scheme operates as a pooled arrangement, with contributions paid at a centrally agreed rate. As a consequence, no share of the underlying assets and liabilities can be directly attributed to the GMC. In these circumstances, under the terms of FRS 17, contributions are accounted for as if the scheme were a defined contribution scheme based on actual contributions paid through the year.

GMC Staff Superannuation Scheme

This is a defined benefit pension scheme, which was closed to new members on 30 June 2013, and replaced by the GMC Group Personal Pension Plan.

Under the terms of FRS 17, the surplus or deficit of the scheme is recognised on the balance sheet. Changes in the assets and liabilities of the scheme are disclosed and allocated as follows:

- Charges relating to current or past service costs, and gains and losses on settlements and curtailments, are included within staff costs and charged to the statement of financial activities.

- The interest cost and the expected return on assets are shown as a net amount of other finance costs or as an incoming resource alongside investment income and interest. Actuarial gains and losses are recognised immediately in other recognised gains and losses on investments.

The assets, liabilities and movements in the surplus or deficit of the scheme are calculated by qualified independent actuaries as an update to the latest full actuarial valuation.

Details of the defined benefit scheme assets, liabilities and major assumptions are shown in note 14.

Funds and reserves

All of our funds are unrestricted, and can be expended at the trustees' discretion, in pursuit of our charitable aims.

2. Income from charitable activities

	Total 2014 £000	Total 2013 £000
Registration		
Annual retention fees	85,455	85,401
Registration fees	3,291	3,218
Provisional registration fees	697	709
PLAB fees	1,157	1,191
Other fees	135	132
	90,735	**90,651**
Certification		
Certificates of Completion of Training fees	2,507	2,357
Certificate of Eligibility for Specialist Registration/Certificate of Eligibility for General Practitioner Registration fees	763	665
	3,270	**3,022**

3. Income from generated funds

	2014		2013	
	£000	£000	£000	£000
Activities for generating funds				
Sales and other income		732		462
Investment income				
Other finance income – pension scheme (note 14)				
Interest cost	(5,279)		(4,636)	
Expected return on assets	6,953	1,674	5,144	508
Bank interest		643		794
		2,317		**1,302**

4. Total resources expended

	Direct staffing costs £000	Direct costs £000	Allocated costs £000	Total 2014 £000	Total 2013 £000
Fitness to practise	19,301	13,404	12,953	45,658	40,912
MPTS	3,114	8,284	2,369	13,767	12,538
Registration and revalidation	8,674	2,790	7,345	18,809	18,028
Education	3,899	763	2,070	6,732	5,610
Standards	754	93	402	1,249	1,270
Communications	1,260	712	570	2,542	2,862
External relationships*	2,687	997	1,469	5,153	4,678
Charitable activities	**39,689**	**27,043**	**27,178**	**93,910**	**85,898**
Governance†	3,780	1,631	1,703	7,114	5,815
Total expenditure	**43,469**	**28,674**	**28,881**	**101,024**	**91,713**

* External relationships include the work done by our Regional Liaison Service, strategic relationships, our devolved offices, and our European and international development activities.

† Governance includes the costs of our strategy and planning functions, the Chair, Council, Chief Executive and Chief Operating Officer costs, research and development, consultancy and review, and equality and diversity.

	Support costs allocated to charitable activities							
	Management	IT	Human resources	Finance	Procurement	Facilities	Total 2014	Total 2013
Fitness to practise	184	4,451	2,054	1,193	160	4,911	12,953	10,668
MPTS	33	815	376	217	29	899	2,369	2,325
Registration and revalidation	104	2,523	1,165	678	91	2,784	7,345	6,846
Communications	9	196	91	52	7	215	570	744
Education	29	711	328	191	26	785	2,070	1,695
External relationships	21	505	233	135	18	557	1,469	1,507
Standards	6	138	64	37	5	152	402	333
Charitable activities	**386**	**9,339**	**4,311**	**2,503**	**336**	**10,303**	**27,178**	**24,118**
Governance	27	587	271	164	22	632	1,703	1,440
Total	**413**	**9,926**	**4,582**	**2,667**	**358**	**10,935**	**28,881**	**25,558**

Support costs are managed within our Resources and Quality Assurance directorate, and then allocated to charitable activities and governance cost on the basis of staff head count across the organisation.

4. Total resources expended (continued)

	2014 £000	2013 £000
Staffing costs	54,389	45,574
Office costs	4,302	5,826
Council and committee costs	512	397
Panel and assessment costs	15,950	14,364
Legal costs	6,106	6,930
Accommodation costs	6,493	6,345
Financial, actuarial and professional costs	4,346	4,645
Purchase of assets – charged to revenue	2,083	1,885
Assets written off	9	102
Depreciation	6,834	5,645
	101,024	**91,713**

Total resources expended include:

	2014 £000	2013 £000
Operating lease costs: leasehold property and equipment	3,467	3,224
Audit fees	40	38

5. Staff

	2014	2013
	£000	£000
Total costs of all staff		
Salaries	39,483	34,626
Social security costs	3,090	2,648
Superannuation costs	7,901	6,113
Redundancy costs	192	115
Other staffing costs	3,723	2,072
	54,389	**45,574**

	2014	2013
Average staff numbers (full time equivalents) in the year by category		
Fitness to practise	345	295
MPTS	71	62
Registration and revalidation	200	197
Standards	11	11
Education	61	50
Communications	19	20
External relations	41	45
Governance	55	41
Resources	142	133
	945	**854**

5. Staff (continued)

The number of staff whose taxable emoluments (excluding redundancy payments) fell into higher salary bands was:

	2014	2013
GMC		
£60,000–£70,000	27	22
£70,001–£80,000	30	25
£80,001–£90,000	17	9
£90,001–£100,000	6	6
£100,001–£110,000	5	7
£110,001–£120,000	5	6
£120,001–£130,000	2	1
£130,001–£140,000	1	1
£140,001–£150,000	1	0
£170,001–£180,000	1	1
£180,001–£190,000	4	3
£190,001–£200,000	0	1
£220,001–£230,000	0	1
£230,001–£240,000	1	0
MPTS		
£70,001–£80,000	1	1
£90,001–£100,000	1	1
£100,001–£110,000	0	1
£110,001–£120,000	1	0

	2014	2013
Number of staff included above for whom retirement benefits are accruing		
GMC defined benefit pension scheme	94	82
GMC defined contribution pension scheme	3	0
NHS defined benefit pension scheme	3	2
Not in scheme	3	2
	103	**86**

6. Fixed assets

	Buildings	Fixtures, furniture and equipment	IT equipment and software	Total
	£000	£000	£000	£000
Cost				
Balance at 1 January 2014	11,683	11,930	17,791	41,404
Additions	0	1,077	6,727	7,804
Disposals	(88)	(111)	(1,270)	(1,469)
Balance at 31 December 2014	**11,595**	**12,896**	**23,248**	**47,739**
Depreciation				
Balance at 1 January 2014	9,629	5,311	13,207	28,147
Depreciation charge for year	1,067	1,241	4,526	6,834
Disposals	(88)	(111)	(1,260)	(1,459)
Balance at 31 December 2014	**10,608**	**6,441**	**16,473**	**33,522**
Net book value at 1 January 2014	2,054	6,619	4,584	13,257
Net book value at 31 December 2014	987	6,455	6,775	14,217

All fixed assets are owned by the GMC, except for buildings and building improvements which are all leasehold.

7. Investments

	2014	2013
	£000	£000
The valuation at the end of the year consisted of:		
Cash deposits	**60,000**	60,000

8. Debtors

	2014	2013
	£000	£000
Amounts falling due within one year		
Registration debtors	15,390	14,910
Prepayments and accrued income	2,107	2,680
Other debtors	522	344
	18,019	**17,934**

9. Creditors

Amounts falling due within one year

	2014	2013
	£000	£000
Trade creditors	720	742
Other creditors including tax and social security	1,039	893
Accruals	14,132	12,641
Deferred income	49,585	49,291
	65,476	**63,567**

Income from annual retention fees is deferred and released to the statement of financial activities on a straight-line basis over the period to which the income relates. All deferred income brought forward from the previous year is automatically released to the statement of financial activities in the following year.

	Annual retention fee	PLAB	Certification	Total
	£000	£000	£000	£000
Deferred income at 1 Jan 2014	48,845	248	198	49,291
Resources deferred during the year	49,083	345	157	49,585
Amounts released from previous years	(48,845)	(248)	(198)	(49,291)
Deferred income at 31 Dec 2014	**49,083**	**345**	**157**	**49,585**

10. Provisions

	2014 £000	2013 £000
Dilapidations	511	424
Legal claims	480	488
	991	**912**

11. Fund movements in the year

	Unrestricted funds £000	Pension fund £000	2014 total £000	2013 total £000
At 1 January 2014	55,565	9,322	64,887	61,648
Net incoming/(outgoing) resources	(4,463)	7,801	3,338	3,239
At 31 December 2014	**51,102**	**17,123**	**68,225**	**64,887**

12. Capital commitments

Capital expenditure contracted but unspent at 31 December 2014 amounted to £274,852.
The equivalent figure for 2013 was £292,720.

13. Operating lease commitments

At 31 December 2014, we had annual commitments under non-cancellable operating leases as follows.

	Land and buildings		Equipment	
	2014 £000	2013 £000	2014 £000	2013 £000
Expiry date				
Within one year	51	102	0	0
In years two to five	91	47	171	236
After more than five years	3,154	2,839	0	0
	3,296	**2,988**	**171**	**236**

14. Superannuation schemes

The GMC has three staff pension schemes:

GMC Group Personal Pension Plan
This is a defined contribution pension scheme, which was set up on 1 July 2013. We started auto-enrolment on 1 November 2013. At the end of 2014 there were 290 members of staff contributing to this scheme. It meets the government's requirements following the introduction of automatic enrolment. Individuals can choose to make additional contributions by deduction from salary to the scheme. Under the terms of FRS 17, contributions are accounted for as a defined contribution scheme based on actual contributions paid through the year.

NHS Multi-Employer Scheme
We have 17 members of staff who contribute to the NHS multi-employer scheme, which is a defined benefit scheme. These staff transferred to the GMC on the merger with PMETB. The scheme operates as a pooled arrangement, with contributions paid at a centrally agreed rate. As a consequence, no share of the underlying assets and liabilities can be directly attributed to us. In these circumstances, under the terms of FRS 17, contributions are accounted for as if the scheme were a defined contribution scheme based on actual contributions paid through the year.

GMC Staff Superannuation Scheme
This is a funded scheme of the defined benefit type, providing retirement benefits based on final salary. The top-up arrangement is an unfunded scheme.

This scheme was closed to new members on 30 June 2013, and replaced by the GMC Group Personal Pension Plan. At the end of 2014, there were 697 members of staff contributing to this scheme.

The FRS 17 valuation has been based on a full assessment of the liabilities of the scheme as at 31 December 2012. The present values of the defined benefit obligation, the related current service cost and any past service costs were measured using the projected unit credit method.

Actuarial gains and losses have been recognised in the period in which they occur (but outside the profit and loss account) through the statement of recognised gains and losses.

Regular contributions to the scheme in 2015 are estimated to be £7,300,000.

The principal assumptions used by the independent qualified actuaries to calculate the liabilities under FRS 17 are set out below.

Main financial assumptions

	31 December 2014	31 December 2013	31 December 2012
	% pa	% pa	% pa
Retail Prices Index inflation	3.3	3.7	3.3
Consumer Price Index inflation	2.4	3.1	2.8
Rate of general long-term increase in salaries	4.8	5.2	5.3
Pension increases (excess over guaranteed minimum pension)	2.4	3.1	2.8
Discount rate for scheme liabilities	3.6	4.4	4.6

14. Superannuation schemes (continued)

Mortality assumptions

The mortality assumptions are based on standard mortality tables which allow for expected future mortality improvements. The assumptions are that a member currently aged 65 will live on average for a further 23.6 years if they are male and for a further 25.6 years if they are female.

For a member who retires in 2034 at age 65 the assumptions are that they will live on average for a further 24.9 years after retirement if they are male and for a further 26.9 years after retirement if they are female.

Expected return on assets

	Value at 31 Dec 2014	Long-term rate of return expected at 31 Dec 2013	Value at 31 Dec 2013	Long-term rate of return expected at 31 Dec 2012	Value at 31 Dec 2012
	£000	% pa	£000	% pa	£000
Equities	0	6.75	70,650	5.95	58,855
Fixed interest gilts	0	3.60	12,351	2.70	13,123
Index-linked gilts	0	3.60	12,800	2.70	12,728
Property	0	5.75	17,256	4.95	15,926
Delegated consulting service	149,029	0	0	0	0
Other	3,032	0.90	12,434	1.00	1,049
Combined	**152,061**	**5.40**	**125,491**	**4.92**	**101,681**

Responsibility for investing pension scheme assets rests with pension trustees. The *Pensions Act 1995* requires trustees to draw up a Statement of Investment Principles, setting out the scheme's investment strategy. Pension trustees are required to consult the employer (GMC) when drawing up the strategy, but do not require the employer's formal agreement. Following consultation with the GMC, in 2014 the pension trustees adopted a fiduciary management approach to the investment of the scheme's assets.

The fiduciary management approach (shown as 'delegated consulting service' in the table above) invests in a wide range of underlying assets in order to meet the scheme's specific investment objectives. The underlying asset allocation changes over time, based on the views of the fiduciary manager within the overall bounds set by the trustees. Under this approach the majority of scheme assets are invested in pooled funds. The managers of the pooled funds are required to have a policy in place on social, environmental and ethical considerations. Whilst the pension trustees do not have direct control over these policies, the ethical issues are kept under review by pension trustees in consultation with their investment adviser and investment manager.

14. Superannuation schemes (continued)

Reconciliation of funded status to balance sheet

	Value at 31 December 2014	Value at 31 December 2013	Value at 31 December 2012
	£000	£000	£000
Fair value of scheme assets	152,061	125,491	101,681
Present value of funded defined benefit obligations	(134,255)	(115,489)	(96,884)
Funded status	17,806	10,002	4,797
Present value of unfunded defined benefit obligations	(683)	(680)	(590)
Asset/(liability) recognised on the balance sheet	**17,123**	**9,322**	**4,207**

Analysis of profit and loss charge

	Year ending 31 December 2014	Year ending 31 December 2013
	£000	£000
Current service cost	8,565	7,425
Past service cost	36	10
Interest cost	5,279	4,636
Expected return on scheme assets	(6,953)	(5,144)
Expense recognised in profit and loss	**6,927**	**6,927**

Changes to the present value of the defined benefit obligations during the year

	Year ending 31 December 2014	Year ending 31 December 2013
	£000	£000
Opening defined benefit obligation	116,169	97,474
Current service cost	8,565	7,425
Interest cost	5,279	4,636
Actuarial (gains)/losses on scheme liabilities	5,715	7,308
Net benefits paid out	(826)	(684)
Past service cost	36	10
Closing defined benefit obligation	**134,938**	**116,169**

14. Superannuation schemes (continued)

Changes to the fair value of scheme assets during the year

	Year ending 31 December 2014 £000	Year ending 31 December 2013 £000
Opening fair value of scheme assets	125,491	101,681
Expected return on scheme assets	6,953	5,144
Actuarial gains/(losses) on scheme assets	13,023	6,823
Contributions by the employer	7,420	12,527
Net benefits paid out	(826)	(684)
Closing fair value of scheme assets	**152,061**	**125,491**

Actual return on scheme assets

	Year ending 31 December 2014 £000	Year ending 31 December 2013 £000
Expected return on scheme assets	6,953	5,144
Actuarial gain/(loss) on scheme assets	13,023	6,823
Actual return on scheme assets	**19,976**	**11,967**

Analysis of amounts recognised in the statement of recognised gains and losses

	Year ending 31 December 2014 £000	Year ending 31 December 2013 £000
Total actuarial gains/(losses)	7,308	(485)
Cumulative amount of gains/(losses) recognised in the statement of recognised gains and losses	(363)	(7,671)

14. Superannuation schemes (continued)

History of asset values, defined benefit obligation and surplus/deficit in scheme

	Year ending 31 Dec 2014	Year ending 31 Dec 2013	Year ending 31 Dec 2012	Year ending 31 Dec 2011	Year ending 31 Dec 2010
	£000	£000	£000	£000	£000
Fair value of scheme assets	152,061	125,491	101,681	88,779	79,984
Defined benefit obligation	(134,938)	(116,169)	(97,474)	(83,695)	(74,748)
Surplus/(deficit) in scheme	**17,123**	**9,322**	**4,207**	**5,084**	**5,236**

History of experience gains and losses

	Year ending 31 Dec 2014	Year ending 31 Dec 2013	Year ending 31 Dec 2012	Year ending 31 Dec 2011	Year ending 31 Dec 2010
	£000	**£000**	**£000**	**£000**	**£000**
Experience gains/(losses) on scheme assets	13,023	6,823	3,293	(1,016)	3,972
Experience gains/(losses) on scheme liabilities*	(933)	3,941	(635)	113	2,896

* This item consists of gains/(losses) in respect of liability experience only, and excludes any change in liabilities in respect of changes to the actuarial assumptions used.

15. Honoraria

Trustees	2014 £	2013 £
Professor Sir Peter Rubin (Chair)*	110,000	110,000
Dr Shree Datta	18,000	18,000
Lady Christine Eames	18,000	18,000
Professor Michael Farthing	18,000	18,000
Baroness Helene Hayman	18,000	18,000
Professor The Lord Ajay Kakkar	18,000	18,000
Professor Deirdre Kelly	18,000	18,000
Dame Suzi Leather	18,000	18,000
Professor Jim McKillop	18,000	18,000
Dame Denise Platt	18,000	18,000
Mrs Enid Rowlands	18,000	18,000
Dr Hamish Wilson	18,000	18,000

* Honorarium paid to employer.

MPTS Advisory Committee members	2014 £	2013 £
His Honour David Pearl*	0	0
Mr Richard Davies	3,720	596
Dr Tim Howard	3,720	6,835
Dr Patricia Moultrie	3,720	596
Mrs Judith Worthington	3,720	596
Ms Alison White†	0	1,078

* His Honour David Pearl is the Chair of the MPTS and is paid as an employee. His remuneration is included in note 5 of these accounts.

† Ms Alison White demitted office on 22 February 2013.

Audit and Risk Committee co-opted members	2014 £	2013 £
Ms Elizabeth Butler	2,480	930
Mr John Morley	1,550	1,085

16. Travel and subsistence expenses claimed in 2014

	2014	2013
Trustees	**£**	**£**
Professor Sir Peter Rubin (Chair)	8,890	10,375
Dr Shree Datta	563	530
Lady Christine Eames	5,014	5,692
Professor Michael Farthing	122	720
Baroness Helene Hayman	165	280
Professor The Lord Ajay Kakkar	0	0
Professor Deirdre Kelly	996	2,337
Dame Suzi Leather	3,115	3,265
Professor Jim McKillop	4,330	5,272
Dame Denise Platt	466	436
Mrs Enid Rowlands	1,992	988
Dr Hamish Wilson	5,852	6,535
Total	**31,505**	**36,430**

MPTS Advisory Committee members		
His Honour David Pearl	1,754	960
Mr Richard Davies	563	301
Dr Tim Howard	1,944	3,201
Dr Patricia Moultrie	1,027	630
Mrs Judith Worthington	858	371
Ms Alison White	0	24

Audit and Risk Committee co-opted members		
Ms Elizabeth Butler	347	41
Mr John Morley	6	0

Senior Management Team	2014 £	2013 £
Niall Dickson – Chief Executive	12,200	25,055
Susan Goldsmith – Chief Operating Officer and Deputy Chief Executive*	2,963	0
Paul Philip – Chief Operating Officer and Deputy Chief Executive*	151	6,936
Paul Buckley – Director of Strategy and Communication	6,418	5,533
Judith Hulf – Director of Education and Standards	2,257	0
Neil Roberts – Director of Resources and Quality Assurance	8,624	9,895
Una Lane – Director of Registration and Revalidation	5,617	9,191
Anthony Omo – Director of Fitness to Practise	13,365	4,339

* Susan Goldsmith took up the post of Chief Operating Officer (COO) and Deputy Chief Executive on 6 October 2014. This role was previously held by Paul Philip, until he left the GMC on 31 January 2014.

Variations in expenses reflect that trustees, committee members and the Senior Management Team live in different parts of the UK and are required to travel around the UK on GMC business, including to our offices in London, Manchester, Edinburgh, Belfast and Cardiff, and occasionally outside the UK.

Adjustments are also made for those with disabilities, which may mean that additional expenses are incurred for travel and accommodation according to specific needs.

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General
Medical
Council