Annual report 2012

Trustees' annual report and accounts for
the year ended 31 December 2012

General
Medical
Council

Regulating doctors
Ensuring good medical practice

Contents

Statutory purpose

The General Medical Council (GMC) is the independent regulator for doctors in the UK. Our statutory purpose is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine. Our current powers and duties are set out in the *Medical Act 1983* (as amended) and in our statutory rules and regulations.

2 We help to keep patients safe in the UK by making sure that doctors practise medicine safely and effectively. We do this by:

- a setting standards for medical education and training and for medical practice
- b making sure only those doctors who've shown they can meet our standards can practise medicine in the UK and by keeping a publicly searchable register of these doctors
- c making sure doctors continue to meet these standards throughout their careers and helping them to do so
- c taking action when we receive information that a doctor isn't meeting these standards – for example, by removing their right to practise medicine in the UK.

3 As a registered charity (number 1089278 with the Charity Commission for England and Wales, and number SC037750 with the Office of the Scottish Charity Regulator), we have to show that our aims are for public benefit. Our trustees follow the Charity Commission's guidance and confirm that our aims and objectives, as set out in our *Corporate strategy 2010–2013* are for public benefit. The trustees have complied with their duty to have regard to the Charity Commission guidance on public benefit in exercising their powers and duties.

4 Our *Corporate strategy 2010–2013* sets out how we will improve the quality of healthcare and enhance patient safety through effective medical regulation. Four themes across our eight strategic aims reflect the integrated approach we take to delivering our statutory functions, and the importance we place on engaging and working with others.

a **Theme: Protecting the public**

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

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

b **Theme: Helping doctors**

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

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

c **Theme: Working with partners**

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

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

d **Theme: Delivering value for money**

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

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

5 Our trustees regularly monitor and review our success in meeting these strategic aims. The trustees confirm that these aims fully meet the public benefit test and that all the activities described in this report are undertaken in pursuit of these aims. In this report, we set out our activities in 2012 to benefit the public.

Review of 2012

Some highlights of the year

6 This was a milestone year for us. The introduction of revalidation in December 2012 marked the biggest change in how doctors are regulated for more than 150 years. We achieved this change by working with the National Health Service (NHS) and our key partners across the UK over several years towards a shared vision of improving the quality of care provided by doctors and promoting patient safety.

7 We have made raising and acting on concerns easier. We issued guidance and materials to support doctors in raising concerns about patient safety. We also introduced a confidential helpline for doctors to raise concerns, especially when they feel unable to do this at local level.

8 We strengthened our approach to investigating concerns in organisations that train doctors by establishing a new team of experienced medical professionals at the GMC to act quickly to protect patients or doctors in training where there are serious concerns about the quality of education.

9 We took steps to speed up and improve the efficiency of our processes for handling complaints about individual doctors. We started two pilots that make fundamental changes to the way we communicate with doctors and complainants about our fitness to practise work.

10 Our strengthened local presence is helping us to create closer working relationships and forge new connections with all those impacted by our work. Through our newly established employer liaison service and regional liaison service (along with our existing devolved offices in Northern Ireland, Scotland and Wales), we met directly with employers, the profession, students and patients more than ever before. We continue to develop these services ahead of fuller evaluation. We also liaised and collaborated extensively with other professional health and social care regulators.

11 In June 2012, we launched a new tribunal service for doctors. The Medical Practitioners Tribunal Service (MPTS) is an impartial adjudication function – the UK Government agreed we could establish the MPTS after it decided not to set up the Office of the Health Professions Adjudicator in 2010.

12 As well as starting a fundamental review into the way that we quality assure medical education and training, we jointly sponsored the Shape of Training review. This is an independent review of UK postgraduate medical education and training, that considers what changes are required to ensure that doctors meet future patient and service needs.

13 To support doctors, we issued new guidance and materials on the following topics: leadership and management; raising concerns; writing references, child protection; and treating patients with learning disabilities.

14 *Good medical practice* is our core guidance for doctors that defines the principles and values on which good practice is founded. We continued our review and used academic research as well as public consultation to inform the updated edition.

15 Our ongoing efficiency programme, which generated total efficiency gains of £13.5 million by the end of 2012, allowed us to freeze the 2013–14 annual retention fee at the current level and reduce registration fees for new doctors joining the register.

16 Following the UK Government's decision to reduce the size of our Council, we appointed a new, smaller Council, and developed a new governance model that came into effect from 1 January 2013.

Delivery against our business plan for 2012

Protecting the public

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

17 In 2012, we granted 21,222 registration applications, 6,223 certification applications and 579 licence restorations. We responded to 100% of applications within five working days. We undertook significant work with the medical royal colleges and faculties to improve the timeliness of our response to applications for certificates of eligibility for GP and specialist registration. The target we set ourselves was to deliver 95% of decisions within three months of receiving an application. At the beginning of 2012, we were achieving this only 38% of the time, but were meeting the target set by the end of 2012.

18 Our Manchester-based contact centre responded to 195,872 calls and 83,627 emails and letters. Major campaigns throughout the year to support the implementation of revalidation increased call length, which occasionally impacted on our ability to meet our service targets for answering calls, emails and letters. Our commitment to providing excellent customer service was recognised in a national award scheme, the Top 50 Call Centres for Customer Service. Our service was placed top of the public sector group and ninth overall in the call centre category.

19 We received 428 subject access requests made under the *Data Protection Act 1998*, and 856 information requests made under the *Freedom of Information Act 2000*. Despite an increase in the volumes of both types of request received, we were able to meet the targets we set ourselves to deliver timely responses.

20 We reviewed two major policy areas to improve the robustness of our registration framework. Proposals were developed to limit the duration a doctor can spend provisionally registered. These proposals ensure that provisional registration is used exclusively for its legal purpose of obtaining a suitable foundation for practice. Before implementing this policy, we will need to hold a consultation in 2013 and make a change to our rules. As part of our ongoing review of the Professional and Linguistic Assessments Board (PLAB) assessment, we engaged widely across the UK and began research to inform that review.

Registration performance against targets in 2012

To respond to 95% of applications within five working days.	**100%**
To complete 95% of Certificate of Eligibility for Specialist Registration (CESR) and Certificate of Eligibility for GP Registration (CEGPR) applications within three months.	**72%**

Contact centre performance against targets in 2012

To answer 90% of calls within 15 seconds.	**89%**
To see 95% of doctors visiting reception within ten minutes of their arrival.	**97%**
To answer 95% of emails and letters within five working days.	**87%**
To respond to 95% of complaints within ten working days.	**98%**

Information access performance against targets in 2012

To respond to 80% of subject access requests within 40 calendar days.	**86%**
To respond to 87.5% of freedom of information requests within 20 working days.	**91%**

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

Fitness to practise

21 In 2012, we continued to handle increasing numbers of concerns about doctors' fitness to practise. We processed 10,347 concerns in total – an 18% increase on 2011. We opened 16% more stream 1 (more serious) cases and 9% fewer stream 2 (less serious) cases. We have responded to the increase in complaints and serious cases by adding further staff, improving the management of individual cases, and improving the training and support for new and existing members of staff. These measures have ensured that, despite the overall rise in volumes, we are continuing to meet our service targets to maintain the timeliness of our decisions, and an independent audit confirmed that the quality of our decisions remains high.

22 We are taking steps to speed up our processes and make them more efficient. We began a review of our processes in late 2012 using Lean methodology and, in early 2013, we started the first project to implement improvements. We are also researching why we are receiving more complaints from members of the public.

23 We introduced a confidential helpline for doctors to raise concerns about patient safety, especially when they feel unable to do this at local level. We hope the helpline will encourage reporting of concerns and result in issues, not reported in the past, now being raised at the appropriate level.

24 At the end of September 2012, we began to pilot face-to-face meetings, changing how we communicate with doctors and complainants about our fitness to practise processes. These changes are designed to improve our understanding of the case and speed up the process, while making sure that our primary purpose to protect patients is not compromised. We are meeting with the doctor concerened at the end of an investigation into complaints about their fitness to practise and will encourage the sharing of information at an earlier stage in the process. We are also separately meeting with complainants in a regional pilot at the start of an investigation to ensure we fully understand the details of their concerns and to explain how we will investigate them. We will also invite complainants to a meeting after the doctor concerned has accepted our sanction to explain our decision. Initial feedback from these pilots has been positive, and we will evaluate the findings in 2013.

25 We are aware of the stress that our fitness to practise procedures can cause. In 2011, we started providing emotional support for witnesses appearing before a fitness to practise panel hearing. In May 2012, to support doctors, we launched the Doctor Support Service pilot. The British Medical Association (BMA) Doctors for Doctors unit is providing free, independent, confidential, emotional support to any doctor in our fitness to practise procedures. The service has been well received and the pilot will be independently evaluated in 2014.

Fitness to practise performance against targets in 2012

To conclude 90% of fitness to practise cases within 15 months.	**96%**
To conclude or refer 90% of cases at the investigation stage within six months.	**90%**
To conclude or refer 95% of cases at the investigation stage within 12 months.	**95%**
To review 100% of doctors with conditions or undertakings attached to their registration before being returned to unrestricted registration.	**100%**
To start 100% of Investigation Committee hearings within two months of referral.	**100%**

Medical Practitioners Tribunal Service (MPTS)

26 In June 2012, we launched the MPTS. This major change is a key part of our fitness to practise reforms and creates a clear separation between our investigation work and the decisions made about a doctor's fitness to practise. The aim is to improve confidence that decisions made at MPTS hearings are impartial. The MPTS is led by His Honour David Pearl, an independently appointed Chair with significant judicial experience. The MPTS reports to the Council of the GMC and also directly to Parliament. The first report from the Chair of the MPTS to our Council was received on 7 February 2013.

27 One of the MPTS's initial priorities was to make improvements to the way that panellists are trained and their performance is managed to make sure their decisions are consistent and of high quality. A consultation on changes to our rules concluded in August 2012 and we are now improving case management and the way hearings are run. These changes will improve the effectiveness and timeliness of the hearing process. Further, more fundamental change is planned and discussions with the Department of Health are under way for changes to section 60 of the *Medical Act 1983*.

28 Hearing-related workloads have increased considerably in the past year with a 42% increase in referrals to an interim orders panel (IOP). The MPTS has successfully taken forward this far-reaching reform programme against this backdrop of rising workload.

MPTS performance against targets in 2012

To start 90% of panel hearings within nine months of referral.	**92%**
To start 100% of IOP hearings within three weeks of referral.	**100%**

Revalidation

29 Revalidation was introduced for all licensed doctors in December 2012. This marked the biggest change in how doctors are regulated for more than 150 years. Revalidation is the process by which licensed doctors have to show regularly that they are meeting our standards, including keeping their skills and knowledge up to date. Revalidation aims to give patients extra confidence that their doctor is being regularly checked by their employer and the GMC.

30 The introduction of revalidation was a shared responsibility involving the four health departments, the NHS and other healthcare providers, the medical royal colleges and faculties, and doctors. We completed a major programme during 2012 to ensure that we were ready to deliver revalidation across the UK. This included a complex communications programme to a wide range of key interest groups and doctors.

31 In April 2012, we launched a major campaign to connect doctors with their designated bodies. Designated bodies are the organisations that have a duty to provide the doctors they employ with a regular appraisal and support them with revalidation. We used information from the NHS and the departments of health to understand the connections for the vast majority of doctors. Throughout 2012, we continued to work with a range of organisations to help doctors identify and confirm their designated body using GMC Online – a secure online portal for doctors. By the end of 2012, we understood the connection of over 90% of all licensed doctors.

32 We consulted on the *General Medical Council (Licence to Practise and Revalidation) Regulations* before they came into force in December 2012.

33 We established the information systems and business processes required to receive revalidation recommendations from responsible officers and to make revalidation decisions. We established a responsible officer reference group and worked with several designated bodies during 2012 to test whether our processes and systems were efficient and effective, and compatible with local systems.

34 We published a suite of guidance to support doctors and employers, including: *The Good medical practice framework for appraisal and revalidation; Supporting information for appraisal and revalidation;* and *Making revalidation recommendations: the GMC responsible officer protocol*.

Helping doctors

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

35 In 2012, our regional visit programme, which helps us assure the quality of education and training in a region, focused on London. It included the five medical schools in London, the London Deanery and the new local education and training boards (LETBs). We selected foundation, core surgery, general surgery, anaesthetics, and obstetrics and gynaecology as the specialty areas for review, and we considered undergraduate clinical placements at all local education providers. In addition to the regional review, we continued to visit new medical schools as part of our established process. We also did check visits to Aberdeen School of Medicine and Leeds School of Medicine, and began a series of seven check visits to emergency medicine departments. A check visit is a short-focused visit to explore a specific issue.

36 We established a team of experienced medical professionals at the GMC to act quickly to protect patients or doctors in training where there are serious concerns about the quality of education. This team helps us support deaneries (and, from April 2013 in England, LETBs) in responding to these concerns, and team members visit hospitals and other education providers, observe deanery visits and review action plans. This intervention means we have a direct input into designing solutions and monitoring and, as a result, have better and more timely assurance that serious issues are being addressed appropriately.

37 In response to feedback from our key interest groups, we also created a group of medical and lay associates to improve the quality and timeliness of our decisions about changes to postgraduate education and training. The group reviews proposed changes to curricula and assessment systems for postgraduate medical specialties and sub-specialties, and gives expert advice to the GMC.

38 Our annual survey of doctors in training, the national training survey, is one way in which we assess the quality of doctors' training. We significantly improved the survey in 2012 by halving the number of questions, reducing the time the survey was available for and developing a new flexible tool to speed up reporting. A record 95% of doctors in training took part in the survey.

39 For the first time, we asked doctors in training whether they had any concerns about patient safety at the place where they were working and training. Around 5% said they did have concerns. We liaised with local NHS organisations and alerted them where there appeared to be a substantive issue, and we asked postgraduate deans to investigate every concern and report to us. Around 75% of the reported concerns were already known about locally and being addressed, but the remainder were new. We wrote individually to every doctor in training who raised a concern to tell them what was being done in response.

40 We began a major review of the way we assure the quality of medical education and training. This included commissioning independent research into how other regulators carry out similar responsibilities, and holding a series of workshops and briefings with key interest groups. The review is continuing in 2013, and will be complemented by a review of our education and training standards against which we carry out our quality assurance activities.

41 In February 2012, an independent review of UK postgraduate medical education and training was jointly established by us, the Academy of Medical Royal Colleges, the Conference of Postgraduate Medical Deans of the UK, Health Education England, the Medical Schools Council, NHS Scotland, NHS Wales and the Northern Ireland Department of Health, Social Services and Public Safety. The purpose of the Shape of Training review is to consider how postgraduate medical education needs to change to ensure that doctors emerging from training will be equipped to meet future patient and service needs. The review issued a call for evidence in late 2012, and is expected to deliver a final report, with recommendations, by autumn 2013.

42 We did a review of the challenges faced by disabled medical students and doctors in training at all stages of their education and training. As a result, Council decided not to create a special or restricted category of registration for disabled medical students and doctors in training. Our review recommended specific further actions for us and others, and we are taking forward a programme of work with key interest groups from across the sector.

43 To promote and support doctors who provide medical training, we consulted on and published new arrangements for the recognition of medical trainers. We recognise that the quality of medical practice and the safety of patients are dependent on the quality of medical training received. We are now working with postgraduate deans and medical schools to make sure these changes can be implemented in a phased and pragmatic way.

44 Following extensive consultation with doctors, medical royal colleges, employers, patients and the public, we launched revised guidance on continuing professional development in June 2012. The new guidance provides a framework for doctors when they are considering how to maintain and improve their professional practice, and will help them gather information for their appraisal and revalidation. The guidance tied in with the launch of revalidation in December 2012.

45 We held a public consultation in 2012 on proposals to strengthen the way that we assess equivalence applications to join the Specialist and GP Registers. Proposals were broadly supported by respondents, and Council agreed the framework for a new approach. Further work to develop and implement the policy principles is now being taken forward.

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

46 With the introduction of revalidation at the end of 2012, all licensed doctors now need to regularly reflect on their practice and use supporting information to show they are meeting the principles and values set out in our core guidance *Good medical practice*.

47 We worked throughout 2012 to develop an updated edition of *Good medical practice*. This work was informed by a major public consultation in 2011 and by research we commissioned to understand better both the barriers and the incentives doctors face in delivering good practice.

48 In 2012, we held a further public consultation on eight pieces of explanatory guidance to publish alongside the updated *Good medical practice*. This explanatory guidance gives more detailed advice on specific issues. We published the updated edition of *Good medical practice* and the explanatory guidance in March 2013. The guidance came into effect in April 2013 – at this time we also published, for the first time, a guide for patients on what they can expect from their doctor, and we updated our learning tools to show doctors how the principles of our guidance might work in practice.

49 We launched several pieces of new or updated guidance in 2012 that we had worked on during 2011. These included: *Leadership and management for all doctors*; *Raising and acting on concerns about patient safety*; *Writing references;* and *Protecting children and young people: The responsibilities of all doctors*. We conducted wide-ranging campaigns and produced materials to promote the guidance to key audiences. This included developing an interactive flow chart – the raising concerns decision tool – to illustrate the different routes for raising concerns in an easy-to-access format.

50 Following a consultation in 2011, we developed a revised version of our guidance *Good practice in prescribing and managing medicines and devices*. The revised version, which we launched in early 2013, reflects complex issues about the application of European law to prescribing medicines outside the terms of their licence.

51 In April 2012, we launched a new website offering practical learning tools and advice on the key issues doctors need to consider when treating a patient who has a learning disability. During July and August 2012, we partnered with Mencap to promote the website through their magazine.

52 During 2012, we developed, and have now published, new guidance for our fitness to practise decision makers who are investigating allegations that a doctor has encouraged or assisted a patient to commit suicide. We published this guidance early in 2013, together with brief advice for doctors on how to handle situations where a patient seeks advice on ending their life.

53 We developed our Welcome to UK practice programme for all doctors who are new to practice in the UK, whether they trained in or outside the UK. We identified the need for this programme from the analysis in our 2011 report on the state of medical education and practice in the UK. The programme, including face-to-face events and online content, was piloted in early 2013 with positive feedback from participants.

Working with partners

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

54 During 2012, we continued to engage, consult and communicate extensively with our key interest groups. Some of the ways we have done this include:

- targeted engagement methods – for example, questionnaires, focus groups and in-depth interviews to inform the review of *Good medical practice*
- a major conference on fairness, which brought together a wide range of individuals and organisations
- workshops, seminars and working groups as part of consultations and dissemination of guidance and standards
- online communications, such as greater use of social media.

55 We are meeting doctors directly more than ever before. The employer liaison service and regional liaison service both give us a significantly stronger local presence, closer relationships and a much better exchange of information.

56 During 2012, our employer liaison service became fully operational across the UK with a team of 15 regionally based employer liaison advisers. The employer liaison advisers met regularly with responsible officers, medical directors and their teams across the NHS and independent sector. In these meetings, they raised awareness and understanding of fitness to practise processes and thresholds, and advised on managing concerns about individual doctors, including referring them to the GMC when appropriate. The employer liaison advisers also played a key role in preparing for the start of revalidation, including advising responsible officers on the detail of the revalidation process, participating in responsible officer networks, supporting the scheduling of revalidation dates for doctors, and providing feedback from designated bodies on our operational and policy teams.

57 Following a successful pilot in 2011, we established a regional liaison service in England, further strengthening our local presence and complementing the work of our devolved offices in Northern Ireland, Scotland and Wales. We recruited a full team of eight regional liaison advisers who took part in a comprehensive induction programme, enabling them to begin connecting with a wide range of key interest groups. In engaging at a local level, the regional liaison advisers have focused on:

- promoting a better understanding of revalidation and its roll-out
- engaging with medical students on professionalism
- broadening our understanding of patient and public representation in the NHS.

58 Revalidation was a major achievement in 2012, which could not have been delivered without effective relationships with our partners. It relies on the strength of a range of local systems and engaging the doctors within them. We worked with the departments of health, including the NHS Revalidation Support Team in England, the BMA, patient groups, NHS Confederation and the Independent Healthcare Advisory Services throughout 2012 to implement revalidation.

59 We have continued this work with our partners to manage the ongoing implementation of revalidation, including managing the impact of changes to the NHS structure in England through close cooperation with the NHS Commissioning Board (now NHS England), the NHS Revalidation Support Team and the Department of Health in England.

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

60 We have continued to liaise extensively with other professional health and social care regulatory bodies and collaborated in many areas during 2012. We participated in a number of inter-regulatory groups to discuss areas of common interest, share best practice and share data and intelligence. We also played an active role in the Law Commission's consultation on the regulation of health and social care professionals.

61 Throughout 2012, we continued to develop and progress work programmes arising from themes identified in the Mid Staffordshire NHS Foundation Trust Public Inquiry. These included stronger liaison services described in paragraphs 55–57, the Welcome to UK practice programme described in paragraph 53, and our involvement with the National Quality Board (NQB)and our work with the Care Quality Commission (CQC) described in paragraph 62.

62 We worked with the CQC to build on our memorandum of understanding, developing an operational model that supports increasingly more effective and efficient partnership working. The emphasis is on jointly working to address emerging issues, on systematically sharing information and on coordinating activity where possible. This also supports our commitment to feed into the emerging systems for improving quality, identifying concerns and early warnings with the NHS in England. As part of this work, we and the CQC are members of the NQB, and we are participating in the NQB's first Quality Surveillance Group pilot.

63 On 31 August 2012, along with the Nursing & Midwifery Council (NMC), we published a statement on the professional values expected of nurses, midwives and doctors. We developed the joint statement following a report on the human factors affecting care, which was initiated by Sir Bruce Keogh, NHS Medical Director in England. Nurses and doctors share professional values, and these are set out in the NMC's code: *Standards of conduct, performance and ethics for nurses and midwives,* and in our guidance *Good medical practice* and its supporting explanatory guidance.

64 Following our annual accountability hearing in September 2012, the Health Select Committee published a report that described us as 'effective' and applauded the leadership we have provided to the medical profession. The Committee also laid down several challenges it expects us to address in 2013. These include continuing to make sure the patient's voice is heard as we develop the revalidation model, and setting ourselves more ambitious service targets for the time spent in concluding fitness to practise cases.

65 We participated in the main UK party political conferences as well as those in Scotland, Wales and Northern Ireland. At these conferences, we engaged with parliamentarians, key interest groups and members of the public on issues affecting us, patients and the medical profession.

66 We continued to engage in the review of Directive 2005/36/EC on the recognition of professional qualifications. This included securing amendments to the proposal through key Members of the European Parliament and briefing them ahead of debates and votes in the relevant European Parliament committees, both directly and with our counterparts in the Alliance of UK Health Regulators on Europe and the Network of Medical Competent Authorities.

67 Through our engagement with the European Parliament and the European Commission, we have secured key safeguards for patient safety in the draft text on a number of issues, including:

- clear provisions that would allow us to check the language skills of doctors who have qualified in the European Economic Area
- strengthening the alert mechanism about healthcare professionals who have been removed from practice in other jurisdictions, and the duration of medical training.

We continued to lead the Healthcare Professionals Crossing Borders initiative and held a successful meeting in the European Parliament in March 2012 that attracted over 100 delegates to discuss the European Commission proposal.

68 We made considerable progress working with the Department of Health in England toward ensuring that doctors working in the UK can speak English safely. We were pleased to welcome the announcement by Dr Dan Poulter, Health Minister, on 25 February 2013 of his plans to give us new powers to check the language skills of doctors from Europe. To prepare for the introduction of these new powers, we have instructed our legal advisers to begin work on any necessary changes to our regulations and have started work to develop the necessary policy, systems and processes.

69 In the meantime, the Department of Health in England has taken steps to strengthen measures to protect patients by giving responsible officers a mandatory duty to ensure the doctors they take on are able to communicate effectively before taking up a post. We are working with NHS Employers and others to ensure responsible officers are clear about these responsibilities. We have also discussed these duties with officials in Northern Ireland, Scotland and Wales to explore the best way of achieving the same level of assurance for the public in these jurisdictions, while recognising that these are matters for the governments in these countries.

70 We continued to actively participate in the work of the International Association of Medical Regulatory Authorities. As Chair of the Physician Information Exchange Working Group, we secured the adoption of a statement of intent on proactive information sharing by the General Assembly at the tenth international conference on medical regulation held in Ottawa, Canada, in October 2012.

Delivering value for money

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

71 We continued our programme to improve our performance and achieved new efficiency gains of £4.4 million in 2012. Additionally, we have generated ongoing efficiency gains of £9.1 million from major projects started before 2012 that deliver gains over several years. So, since 2010, we have achieved total annualised efficiency gains of £13.5 million. Of this, around £11.4 million is cashable savings, which helped us to freeze the 2013–14 annual retention fee at the current level, and reduce registration fees for new doctors joining the register. You can find further information on this in paragraphs 88–90.

72 Alongside our efficiency programme, we met with regulators of other health professionals through a variety of forums to discuss common issues with our operations to help increase efficiency and effectiveness. We have worked with the NMC to improve our processes, and have shared best practice across the board.

73 We offer a range of employee benefits to help us recruit and retain high-quality staff. Benefits currently available include:

- childcare vouchers
- cycle to work scheme
- employee assistance programme
- flexible working
- health checks
- private medical insurance
- reduced rates at health clubs and gyms
- season ticket loans.

We keep these benefits under review.

74 Following the UK Government's decision to reduce the size of our Council and move to an appointed, rather than elected, Chair, we worked throughout the year to support arrangements for a new Council from 1 January 2013. This included developing a new governance model that would allow Council to focus on strategy, and holding the executive to account. You can find further information on this in paragraphs 133–136.

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

Research and analysis

75 We published our second report on the state of medical education and practice in the UK in September 2012. The report is part of our commitment to share the insights we learn from our own and others' data, and we use it to engage with the profession and the wider health system. It sets out much of what we know about the medical profession and the challenges it faces. For the first time, the report was accompanied by an online data application for readers to further explore the data we provided in the report.

76 We use research as evidence to inform and support our decision making. This includes externally commissioned research, internal literature reviews and secondary research based on the collation and analysis of our own datasets. Highlights from the research programme in 2012 are described in the following paragraphs.

77 Research on the incidence and causes of errors in prescribing in general practice showed that one in 20 prescription items in primary care contains an error, and one in 550 errors is severe. The research recommended that, during GP training, greater prominence be given to therapeutic knowledge and skills and to the attitudes that GPs need for safe prescribing.

78 We have met with relevant organisations such as the Royal College of General Practitioners (RCGP) to ensure that the research findings are translated into actions that help protect patients. As a result of our research, TPP SystmOne, one of the UK's biggest GP software systems providers, has implemented a series of improvements to its software based on the findings of our study.

79 Two studies of how doctors use our standards and ethics guidance, and how the guidance is applied to their work, generated insights that helped us develop an updated edition of *Good medical practice* and informed our work on embedding standards.

80 We published a study in early 2013 of the impact of the Working Time Regulations on medical education and training in the UK. It showed the adverse effect of fatigue and stress on doctors in training and on patient safety. The study highlighted the ongoing challenge – posed by the changing nature and composition of the medical workforce – to ensure that rotas remain compliant with the Regulations, while minimising the effects of fatigue and stress and providing sufficient exposure to educational opportunities. We are using the findings of this study to take forward work on rota design with key partners to address this challenge.

81 A literature review of the effectiveness of methods used by medical schools to select students, which we also published early in 2013, revealed a mixed picture, with stronger evidence existing for some methods (multiple mini interviews and situational judgement tests) than for others (traditional interviews). Evidence for the effectiveness of widening access initiatives was limited. Further research is needed to determine how students selected as part of widening access initiatives can be best supported once they begin studying. We will work with the Medical Schools Council and others to take forward a programme of work to identify good practice in selection and widening access.

82 To inform the development of our policies and processes, we undertook several research studies to learn from the experiences of other bodies, covering a broad spectrum of regulatory interests. Examples include:

- Exploring the approach to continuing professional development by medical regulators or equivalent (professional bodies /government) in jurisdictions outside the UK. This research informed our revised guidance on continuing professional development described in paragraph 44.

- Reviewing best practice in examination and assessment methodology within the context of professional entrance examinations (to inform the PLAB review).

- Reviewing approaches to the quality assurance of education – a study which reaffirmed that the emphasis of quality assurance is shifting to a model which gives greater priority to quality enhancement over accountability; proportionate risk-based targeting over cyclical models; and outcomes-focused standard setting. This research informed our review described in paragraph 40.

Equality and diversity

83 We delivered a programme of activities throughout 2012 to further embed equality and diversity principles in our work, both as a regulator and as an employer.

84 We believe that being seen to be fair and objective in delivering our functions is fundamental to maintaining public confidence in our work. Over 80 senior delegates from across our key interest groups participated in *Being fair: challenges and opportunities*, a half-day conference on 12 September 2012. Participants explored three areas where fairness issues arise that are fundamental to maintaining public confidence in our work:

- dealing with concerns and complaints
- progression in medical education and training
- raising standards through revalidation.

85 We worked with others to ensure that revalidation is fair for all doctors. For example, all the guidance, criteria and principles for revalidation are based on the principles of being fair and transparent. We have made arrangements to support doctors who need to take breaks from practice. We have also developed clear and accessible information to help patients and the public understand how they can give feedback about their doctor.

86 We want a career in medicine to be open to as many people as possible who have the skills to be good doctors. Doctors with health conditions or disabilities can bring unique insights and understanding to patient care, and it is important that they don't face unreasonable barriers. We launched a review looking at their experiences at all stages of their education and training. The working group considered a range of issues, including how reasonable adjustments work in practice and what experiences disabled students and doctors in training had of accessing support. Further information is described in paragraph 42.

87 We are committed to ensuring that our website and the guidance we produce are accessible to everyone. All our publications can be made available in alternative formats or languages. We have had a Welsh language scheme since June 2005 and offer services to the public in Wales in either English or Welsh.

Financial review

88 We continued our programme to improve our performance and achieved new efficiency gains of £4.4 million in 2012. Savings came from a range of initiatives, including:

- relocating our adjudication and certification functions to Manchester, and the reduction of our office space in London
- introducing digital recording in place of written transcripts at adjudication hearings
- further expanding our in-house legal team, reducing our requirement for external lawyers
- reducing the number of panellists sitting on panels
- improving the handling of fitness to practise cases to ensure that we adopt a proportionate approach, so that only the most serious cases are referred to a panel hearing.

89 Additionally, we have generated ongoing efficiency gains of £9.1 million from major projects started before 2012 that deliver gains over several years, including:

- moving to a single adjudication hearing centre in Manchester
- successfully negotiating a rent review on our premises
- increasing the use of e-communications and reducing the use of paper copy.

90 We have therefore achieved total annualised efficiency gains of £13.5 million in 2012. Of this, around £11.4 million is cashable savings, which helped us to freeze the 2013–14 annual retention fee at the current level, and reduce registration fees for new doctors joining the register.

91 In 2012, we generated total income of £97.9 million, and our operational expenditure was £88.4 million.

92 Our income in 2012 was £1.3 million more than budgeted. The introduction of licensing in 2009, and revalidation in 2012, has made accurate forecasting of our income difficult. We took the view that some doctors – for example, those not in clinical practice – might choose to relinquish their licence to practise or to seek voluntary erasure from the medical register. But the number of doctors holding a licence to practise actually increased slightly over the course of 2012, resulting in additional annual retention fee income of £0.8 million compared with that budgeted.

93 Income from new registrations and certification fees was £0.2 million lower than budgeted. There was lower demand for PLAB tests than anticipated, which reduced our income by £0.1 million, but this was offset by a corresponding reduction in the costs of administering the tests.

94 Investment income and other miscellaneous income was £0.8 million more than expected.

95 Our total operational expenditure in 2012 was £1.2 million under budget.

96 Our fitness to practise costs are a significant proportion of our total expenditure. Our expenditure in 2012 was £0.3 million more than budgeted because of a significant increase in the number of complaints being referred to us for investigation. Inevitably, this leads to more cases being referred to an adjudication hearing, and so the costs incurred by the MPTS were £0.2 million more than budgeted.

97 Registration and revalidation costs were £1.0 million under budget. The volume of new registrations, applications for GP and specialist registration, and the demand for PLAB tests were all lower than expected, leading to a reduction in our costs, but this was offset by a reduction in our income. Costs were also lower than budgeted because of staff vacancies during the year, improvements to business processes, and some project work being deferred.

98 Our strategy and communication costs were £0.9 million under budget because of staff vacancies during the year and several research projects being deferred.

99 Education costs were £0.1 million under budget, mainly because the review of the shape of postgraduate medical training started later than planned.

100 Resources costs were broadly in line with the budget.

101 We vacated the third floor of our offices at 350 Euston Road in London to reduce our overall long-term costs by around £1 million per year. But the work to reconfigure our remaining office space without affecting day-to-day business was complex, which meant that implementing this change cost around £0.2 million more than estimated. Other accommodation costs were £0.2 million over budget, partly due to an increase in the energy price for our Manchester office.

102 Depreciation charges were £0.4 million over budget, reflecting the nature and timing of our capital expenditure during the year.

103 We budgeted £0.5 million to cover the new levy on medical regulators to fund the Professional Standards Authority for Health and Social Care, which replaced the Council for Healthcare Regulatory Excellence. We do not now expect this levy to be introduced until 2014, and so no costs were incurred in 2012. The Professional Standards Authority for Health and Social Care will continue to be funded by the UK Government in the meantime.

104 During 2012, we continued our programme of capital investment to improve our accommodation and IT infrastructure. We spent £4.8 million on major projects, including reconfiguring our office space, introducing a scheduled home-working pilot, and developing our information systems.

105 The pension scheme ended the year with a surplus of £4.2 million, comprising assets of £101.7 million and liabilities of £97.5 million, valued in accordance with the accounting standard *FRS 17: Retirement Benefits*. This is set out in more detail in note 13 to the accounts.

Trustees' responsibilities for the financial statements

106 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).

107 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 ensuring 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

108 Our level of reserves and our reserves policy are reviewed annually, and any financial implications are addressed as part of the budget-setting process. In 2012, the Resources Committee was responsible for determining the reserves policy, and the current policy was approved on 15 November 2012. From 1 January 2013, our governance arrangements changed and the reserves policy will, in future, be considered by the Performance and Resources Board and then approved by Council.

109 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 it taking full effect.

110 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 requirements 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.

111 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.

112 A significant proportion of our total reserves is 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.

113 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 year on 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.

114 Our free reserves on 31 December 2012 were £45.5 million, which is marginally above the target range set by the Resources Committee. Our total reserves at the end of the year were £61.6 million, made up of free reserves, plus £11.9 million of reserves represented by fixed assets, and a pension reserve of £4.2 million valued in accordance with *FRS 17: Retirement Benefits*.

115 On 5 December 2012, we decided to freeze the 2013–14 annual retention fee at the current level, and to reduce registration fees for new doctors joining the register. 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, so we expect our reserves to move back in line with the target range over the medium term.

Investment policy

116 Our investment policy is 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. The investment policy supports the aims of the reserves policy and so is reviewed periodically at the same time as the reserves policy. Our investment policy was reviewed by the Resources Committee on 1 May 2012. From 1 January 2013, our governance arrangements changed and the investment policy will, in future, be considered by the Performance and Resources Board and then approved by Council.

117 Cash required for normal day-to-day working capital is shown on our balance sheet within current assets, whereas cash held for the longer term is shown as investments.

118 In 2012, our investments generated interest of £0.6 million, equivalent to an average annual rate of return of 0.6%. The Resources Committee regularly reviewed investment income, as part of the overall monitoring of our financial performance in 2012.

Audit and Risk Committee's report

119 The Audit and Risk Committee is an important part of our governance structure. Throughout 2012, the Committee was made up of five Council members and two external members. The Committee was reconstituted in January 2013, and now consists of six members of Council and two external members, one of whom will be appointed during 2013.

120 The Committee bases its advice and decisions on guidance issued by the Financial Reporting Council. Its responsibilities include:

- confirming whether the accounting policies used in preparing the annual report and accounts are appropriate
- appointing the external auditors and reviewing their work
- monitoring internal control and risk management
- monitoring internal audit work and the implementation of actions arising from it.

The Committee reports its activities and any significant matters to Council at least twice a year.

121 Following a tender process, the current external auditors were appointed in September 2011 for an initial period of three years. Internal audit is provided separately and the head of the internal audit service has a direct reporting line to the chair of the Committee. The internal auditors undertake an approved programme of internal control reviews, reporting to the Committee on the effectiveness of controls in managing the risks associated with our activities.

122 The Committee met four times in 2012, and among other things:

- monitored the non-audit services provided by the external auditors to make sure the auditors are independent and objective

- approved the external audit letter of engagement, and reviewed how the audit for the year ending 31 December 2012 would be done to ensure that it set out what would be produced, identified key areas of risk, and reflected changes in circumstances since the previous year

- approved the programme of internal audit work for 2013

- oversaw our risk management activities, as outlined in the risk management statement in paragraphs 123–27.

Risk management statement

123 Council has ultimate responsibility for ensuring that the organisation operates an appropriate system of risk management. Council has ensured that there are formal structures and processes in place to identify, evaluate, mitigate and monitor risks effectively; and has delegated responsibility for routine oversight of risk management arrangements to the Audit and Risk Committee.

124 Our approach to risk management is set out in our risk management framework. The Audit and Risk Committee has reviewed and endorsed the framework, and has been assured by the internal auditors that the arrangements in place are sufficient to ensure that risks are identified, mitigated and monitored.

125 A performance report, including emerging risks, was monitored monthly by the Performance Board and the Senior Management Team. Additionally, the Performance Board and the Senior Management Team reviewed the corporate risk register quarterly.

The Audit and Risk Committee and Council each received two reports on risk management arrangements during 2012 – the Committee in September and November, and Council in July and December.

126 Risk management needs to permeate all levels and operational functions of the organisation, and sound risk management needs to be embedded in business planning and project management. To achieve this, we keep three types of risk register to assist in the strategic and operational management of the organisation:

- local risk registers – embedded in the operational plan of each directorate

- project risk registers – maintained for specific projects

- a corporate risk register – summarising critical risks facing the organisation.

The Audit and Risk Committee and Council focus on the corporate risk register.

127 Our risk registers are structured around the eight strategic aims from our *Corporate strategy 2010–2013*. We know there are inherent risks associated with our core functions and we have systems and procedures in place to mitigate these. For example, there is a risk that we register or revalidate an individual who is not properly qualified and/or fit to practise. We mitigate this risk by having registration and revalidation systems and procedures in place that are specifically designed to prevent this.

Structure, governance and management

128 The GMC is registered with the Charity Commission for England and Wales under number 1089278, and with the Office of the Scottish Charity Regulator under number SC037750.

129 The trustees present their report and financial statements for the year ended 31 December 2012. In preparing this report, the trustees have complied with the *Charities Act 2011* and applicable accounting standards. The statements are in the format required by the *Statement of Recommended Practice: Accounting and Reporting by Charities* (revised March 2005).

130 The 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 have established a register of members' interests, which is published on our website.

Organisational structure

Council

131 The trustees between 1 January 2012 and 31 December 2012 were:

Professor Jane Dacre, BSc MD FRCP Lon FRCP Edinburgh Glas FHEA
Dr Suzanne Davison, BSc (Hons) PhD
Dr Sam Everington, OBE MBBS MRCGP Barrister
Ms Sally Hawkins, BA
Dr John Jenkins, CBE MD FRCP FRCPCH FRCPI
Lord Kirkwood of Kirkhope, BSc
Ms Ros Levenson, BA (Hons) CQSW Dip in Applied Social Studies
Professor Malcolm Lewis, FRCGP LLM
Mr Robin MacLeod, MHSM Dip HSM MI Mgt Dip Business Studies
Professor Rajan Madhok, MBBS MSc FRCS FFPH
Dr Johann Malawana, MBBS
Dr Joan Martin, DPhil FCOT MA
Mrs Suzanne McCarthy, BA LLM MSc
Professor Jim McKillop, BSc MB ChB PhD FRCP FRCR
Professor Trudie Roberts, BSc MB ChB PhD FRCP
Mrs Ann Robinson
Mrs Enid Rowlands, BSc CCMI
Professor Sir Peter Rubin, BM BCh MA DM FRCP
Dr Mairi Scott, MB ChB FRCGP FRCPE FHEA
Professor Iqbal Singh, OBE MBBS MRCP FRCP Dip Rehab Med
Professor Terence Stephenson, BSc BM BCh DM FRCP FRCPCH
Ms Anne Weyman, OBE BSc(Soc) FCA Honorary LLD
Mr Stephen Whittle, OBE LLB FRSA
Dr Hamish Wilson, CBE MA PhD FHSM FRCGP

132 The trustees of the GMC, the 24 Council members listed in paragraph 131, were all independently appointed by the Appointments Commission, with an equal number of lay and medical members.

Changes to our governance model from 1 January 2013

133 During 2012, the UK Government made changes to reduce the size of our Council. These changes were designed to simplify our governance arrangements and allow our governing council to focus on strategy and holding the executive to account, and to reduce the cost of regulation. Our Council Chair was also changed to being appointed rather than elected. Following consultation, the UK Government enacted *The General Medical Council (Constitution) (Amendment) Order 2012*.

134 Our Council was reconstituted from 1 January 2013, with 12 members (six doctors and six lay members), including an appointed Chair. The 12 members were appointed by the Privy Council, through a process which followed the Professional Standards Authority's guidance for making appointments to healthcare regulatory bodies.

135 The trustees from 1 January 2013 are:

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

136 We carried out significant work in 2012 to review our governance arrangements and revise the requirements and process for appointing Council members. The new governance model approved by the reconstituted Council in February 2013 builds on the previous model, but with refinements in light of experience. The new model includes changes necessary due to the reduction in size of Council, and takes into account good practice. The governance model from 2013 comprises:

- a smaller Council, reduced from 24 to 12 members
- two governance committees: Audit and Risk, and Remuneration
- a Board of trustees, which oversees the GMC's Staff Superannuation Scheme
- the MPTS Committee, and GMC/MPTS Liaison Group
- advisory forums in Scotland, Wales and Northern Ireland
- two advisory boards: Education and Training, and Revalidation Implementation

- two executive boards to support the work of the Chief Executive and the Chief Operating Officer respectively: Strategy and Policy Board, and Performance and Resources Board, which both report to Council.

Induction and training of new trustees

137 We carried out an induction programme to ensure that our new Council members have the information they need to support them in their role. Since they were appointed in November 2012, members have received briefings relevant to their role and responsibilities, including guidance on trusteeship, and information on our work (for example, our legislative framework) and on equality and diversity. The induction and training process continues in 2013, including:

- visits to the GMC and MPTS offices to see our operations
- one-to-one meetings with the Chair
- meetings with the executive management team
- bespoke induction and training sessions on the work associated with the committees they are part of.

Our governance model in 2012

138 The governance model in 2012 comprised:

- three corporate governance committees: Audit and Risk, Remuneration and Member Issues, and Resources
- three boards, themed around the main phases of a doctor's career: Undergraduate, Postgraduate, and Continued Practice Revalidation and Registration
- three policy committees, covering our main statutory functions in relation to: Education and Training; Standards and Ethics; and Fitness to Practise
- an additional committee covering Equality and Diversity, which advised Council on the actions required to develop and further enhance our strategy and embed equality and diversity in the work of the GMC.

139 The MPTS was launched on 11 June 2012 with responsibility for overseeing the adjudication of fitness to practise cases. The MPTS is led by the Chair of the MPTS, His Honour David Pearl. The MPTS Committee and a joint GMC/MPTS Liaison Group were established as part of the governance framework in 2012 prior to the launch. The legislative changes that will establish the MPTS in statute are expected in 2014.

140 In 2012, we continued to draw on our Reference Community, composed of 27 members of the public and 27 doctors, as a sounding board to help inform policy development. A review of the use of the Reference Community in 2011 concluded that it continues to be a useful mechanism for getting public and professional perspectives on the development of our policies, processes and publications, and the appointments were extended until the end of 2012. During 2012, we conducted 18 exercises, ranging from support with testing communication materials to policy development workshops.

141 The current appointments have been extended until the end of September 2013. During 2013, we are hoping to refresh membership of this useful forum, and also look for other opportunities to involve the current Reference Community members in other forms of engagement.

Audit and Risk Committee

142 The Chair of the Audit and Risk Committee was Mrs Ann Robinson. The purpose of the Committee is to monitor the integrity of the financial statements, to review the internal control and risk management systems and to monitor and review the internal and external audit services. The Audit and Risk Committee's report can be found at paragraphs 119–122.

143 Mrs Robinson demitted office as Chair on 31 December 2012. The new Chair of the Audit and Risk Committee from 7 February 2013 is Dr Hamish Wilson.

Remuneration and Member Issues Committee

144 The Chair of the Remuneration and Member Issues Committee was Mrs Enid Rowlands. The purpose of the Committee is to advise Council on the remuneration, terms of service and the process for appraisal for Council members, including the Chair; to advise on the provision of induction, training and development for members; and to review and develop Council's capacity and competency to be effective. The Remuneration and Member Issues Committee also determines the appointment process for the Chief Executive and MPTS Chair and the remuneration, benefits, and terms of service for the Chief Executive, Deputy Chief Executive, Chief Operating Officer, Directors, and MPTS Chair and MPTS Committee members.

145 As part of the revised governance arrangements from 2013, the Remuneration and Member issues Committee has amended terms of reference to focus on the remuneration and appointments aspects of its work, and is now known as the Remuneration Committee.

146 Mrs Rowlands demitted office as Chair on 31 December 2012. The new Chair of the Remuneration Committee from 7 February 2013 is Dame Denise Platt.

Resources Committee

147 The Chair of the Resources Committee was Mr Robin MacLeod. The purpose of the Committee was to guide Council on the appropriate human resources, information systems, property and financial strategies, including equality and diversity issues relating to GMC staff and Human Resources policies, such that the GMC can fulfil its statutory functions and remain at all times in sound financial and operational health.

148 As part of the revised governance arrangements from 2013, the Resources Committee ceased to operate on 31 December 2012. Mr MacLeod demitted office as Chair at the same time. The Resources Committee's responsibilities have been assigned to the Performance and Resources Board, the Remuneration Committee, and Council.

Undergraduate Board

149 The Chair of the Undergraduate Board was Professor Jim McKillop. The purpose of the Board was to enhance our ability to protect, promote and maintain the health and safety of the public by coordinating our four regulatory functions as they apply up to the completion of the undergraduate curriculum. This includes the standards and outcomes for undergraduate medical education and their quality assurance, the application of *Good medical practice* and other standards and ethics guidance in the context of undergraduate medical education, the initial registration of doctors, and issues relating to students' fitness to practise.

150 As part of the revised governance arrangements from 2013, the Undergraduate Board ceased to operate on 31 December 2012. Professor McKillop demitted office as Chair at the same time. Under the new governance model, the Undergraduate Board's work will come under the responsibility of the Strategy and Policy Board, informed by the Education and Training Advisory Board.

Postgraduate Board

151 The Chair of the Postgraduate Board was Dr John Jenkins. The purpose of the Board was to enhance our ability to protect, promote and maintain the health and safety of the public by coordinating our four regulatory functions as they apply while a doctor continues in postgraduate medical education. This includes the application of *Good medical practice* and other standards and ethics guidance in the context of postgraduate medical education and research, and all matters to do with fitness to practise, registration and licensing as they relate to postgraduate doctors in training.

152 As part of the revised governance arrangements from 2013, the Postgraduate Board ceased to operate on 31 December 2012. Dr Jenkins demitted office as Chair at the same time. Under the new governance model, the Postgraduate Board's work will come under the responsibility of the Strategy and Policy Board, informed by the Education and Training Advisory Board.

Continued Practice, Revalidation and Registration Board

153 The Chair of the Continued Practice, Revalidation and Registration Board was Professor Malcolm Lewis. The purpose of the Board was to enhance our ability to protect, promote and maintain the health and safety of the public by coordinating our four regulatory functions as they apply to the continued practice of established doctors not in training programmes (whether before or after Certificate of Completion of Training), ensuring that they remain up to date and fit to practise. The Committee also has responsibility for liaising closely with the UK Revalidation Programme Board on the implementation of revalidation for doctors, and for advising Council on maintaining the policy and statutory frameworks governing registration, which doctors can reach by different routes. The Committee also oversaw the Professional and Linguistic Assessments Board.

154 As part of the revised governance arrangements from 2013, the Continued Practice, Revalidation and Registration Board ceased to operate on 31 December 2012. Professor Lewis demitted office as Chair at the same time. Under the new governance model, the Continued Practice, Revalidation and Registration Board's work will come under the responsibility of the Strategy and Policy Board, informed by the Revalidation Implementation Advisory Board. Responsibility for overseeing the work of the Professional and Linguistic Assessments Board has also been assigned to the Strategy and Policy Board

Education and Training Committee

155 The Chair of the Education and Training Committee was Professor Jane Dacre. The purpose of the Committee was to identify and take forward improvements in medical education, in particular by supporting Council in meeting its statutory duties to coordinate all stages of medical education; to identify and suggest ways of addressing any potential for inconsistency (for example, at points where medical students/doctors transfer from one stage to another); and to promote high quality in all aspects of medical education.

156 As part of the revised governance arrangements from 2013, the Education and Training Committee ceased to operate on 31 December 2012. Professor Dacre demitted office as Chair at the same time. Under the new governance model, the Education and Training Committee's work will come under the responsibility of the Strategy and Policy Board, which reports to Council. The Board will be informed by the newly established Education and Training Advisory Board.

Standards and Ethics Committee

157 The Chair of the Standards and Ethics Committee was Ms Ros Levenson. The purpose of the Committee was to support Council in fostering excellence in medical practice by supporting the formulation of guidance for doctors on the principles of good medical practice and ethics, analysing the issues raised, formulating policy proposals for approval by Council, and facilitating the interpretation and application of our policy in response to specific questions as they arose.

158 As part of the revised governance arrangements from 2013, the Standards and Ethics Committee ceased to operate on 31 December 2012. Ms Levenson demitted office as Chair at the same time. Under the new governance model, the Standards and Ethics Committee's work will come under the responsibility of the Strategy and Policy Board, which reports to Council.

Fitness to Practise Committee

159 The Chair of the Fitness to Practise Committee was Dr Joan Martin. The purpose of the Committee was to provide an opportunity for discussing key fitness to practise issues and to ensure that our procedures are fit for purpose, by monitoring and reviewing their operation and their statutory framework and making proposals for modification and improvement as necessary.

160 As part of the revised governance arrangements from 2013, the Fitness to Practise Committee ceased to operate on 31 December 2012. Dr Martin demitted office as Chair at the same time. Under the new governance model, the Fitness to Practise Committee's work will come under the responsibility of the Strategy and Policy Board, which reports to Council.

Equality and Diversity Committee

161 The Chair of the Equality and Diversity Committee was Professor Iqbal Singh. The purpose of the Committee was to help embed equality and diversity as central to the development and review of policies and procedures across the GMC; to advise on the action required to fulfil our commitment to valuing diversity and promoting equality, ensuring that outputs link to our priorities, addressing gaps in areas which may not be driven by statutory requirements; and to help to ensure that processes and procedures are fair, objective, transparent and free from unlawful discrimination. It was also responsible for advising on how most effectively to embed our equality and diversity commitments across the organisation, with a view to mainstreaming equality and diversity during the 2009–2012 Council, and for scrutinising the equality and diversity plans developed by the other GMC committees and boards.

162 As part of the revised governance arrangements from 2013, the Equality and Diversity Committee ceased to operate on 31 December 2012. Professor Singh demitted office as Chair at the same time. The Equality and Diversity Committee's responsibilities have been reassigned in the revised governance model. The Strategy and Policy Board will develop the equality and diversity strategy, and monitor progress at a high level. The Performance and Resources Board will ensure that equality and diversity are integrated into the GMC's core activities and is responsible for considering the equality duty and monitoring actions.

Member attendance at Council, Boards and Committees in 2012

Professor Jane Dacre	Number of meetings attended
Council	4/5
Postgraduate Board	3/4
Resources Committee	2/4
Education and Training Committee (Chair)	3/3
Equality and Diversity Committee	1/3

Dr Suzanne Davison	Number of meetings attended
Council	5/5
Undergraduate Board	0/3
Continued Practice, Registration and Revalidation Board	1/4
Remuneration and Member Issues Committee	3/4

Dr Sam Everington	Number of meetings attended
Council	2/5
Undergraduate Board	2/3
Resources Committee	2/4
Standards and Ethics Committee	1/4

Ms Sally Hawkins	Number of meetings attended
Council	5/5
Undergraduate Board	2/3
Standards and Ethics Committee	4/4
Equality and Diversity Committee	2/3

Dr John Jenkins	Number of meetings attended
Council	5/5
Postgraduate Board (Chair)	4/4
Education and Training Committee	3/3
Standards and Ethics Committee	3/4

Lord Kirkwood of Kirkhope	Number of meetings attended
Council	5/5
Continued Practice, Registration and Revalidation Board	2/4
Resources Committee	3/4
Board of Trustees of the GMC's Superannuation Scheme	5/5

Ms Ros Levenson	Number of meetings attended
Council	5/5
Postgraduate Board	4/4
Remuneration and Member Issues Committee	3/4
Standards and Ethics Committee (Chair)	4/4
Equality and Diversity Committee	2/3

Professor Malcolm Lewis	Number of meetings attended
Council	5/5
Continued Practice, Registration and Revalidation Board (Chair)	4/4
Remuneration and Member Issues Committee	3/4
Education and Training Committee	2/3
UK Revalidation Programme Board	4/5

Mr Robin MacLeod	Number of meetings attended
Council	5/5
Postgraduate Board	4/4
Resources Committee (Chair)	4/4
Fitness to Practise Committee	2/4

Professor Rajan Madhok	Number of meetings attended
Council	2/5
Postgraduate Board	2/4
Continued Practice, Registration and Revalidation Board	4/4
Resources Committee	3/4
UK Revalidation Programme Board	3/5

Dr Johann Malawana	Number of meetings attended
Council	4/5
Postgraduate Board	3/4
Resources Committee	1/4
Standards and Ethics Committee	1/4
Board of Trustees of the GMC's Superannuation Scheme	1/5

Dr Joan Martin	Number of meetings attended
Council	4/5
Undergraduate Board	2/3
Resources Committee	4/4
Fitness to Practise Committee (Chair)	4/4
Board of Trustees of the GMC's Superannuation Scheme	4/5

Mrs Suzanne McCarthy	Number of meetings attended
Council	4/5
Continued Practice, Registration and Revalidation Board	2/4
Audit and Risk Committee	3/4
Fitness to Practise Committee	3/4
Education and Training Committee	3/3

Professor Jim McKillop	Number of meetings attended
Council	5/5
Undergraduate Board (Chair)	3/3
Audit and Risk Committee	3/4
Remuneration and Member Issues Committee	4/4
Education and Training Committee	2/3
Standards and Ethics Committee	3/4

Professor Trudie Roberts	Number of meetings attended
Council	3/5
Undergraduate Board	0/3
Continued Practice, Registration and Revalidation Board	3/4
Audit and Risk Committee	1/4
Fitness to Practise Committee	2/4

Mrs Ann Robinson	Number of meetings attended
Council	5/5
Continued Practice, Registration and Revalidation Board	1/4
Audit and Risk Committee (Chair)	4/4
Standards and Ethics Committee	2/4

Mrs Enid Rowlands	Number of meetings attended
Council	4/5
Postgraduate Board	3/4
Remuneration and Member Issues Committee (Chair)	4/4

Professor Sir Peter Rubin	Number of meetings attended
Council (Chair)	5/5

Dr Mairi Scott	Number of meetings attended
Council	4/5
Undergraduate Board	2/3
Continued Practice, Registration and Revalidation Board	3/4

Professor Iqbal Singh	Number of meetings attended
Council	5/5
Undergraduate Board	2/3
Fitness to Practise Committee	1/4
Equality and Diversity Committee (Chair)	3/3

Professor Terence Stephenson	Number of meetings attended
Council	3/5
Postgraduate Board	2/4
Fitness to Practise Committee	2/4

Ms Anne Weyman	Number of meetings attended
Council	5/5
Continued Practice, Registration and Revalidation Board	3/4
Resources Committee	3/4
Fitness to Practise Committee	3/4
Education and Training Committee	2/3
UK Revalidation Programme Board	4/5

Mr Stephen Whittle	Number of meetings attended
Council	4/5
Undergraduate Board	2/3
Audit and Risk Committee	3/4
Education and Training Committee	3/3
Standards and Ethics Committee	3/4

Dr Hamish Wilson	Number of meetings attended
Council	5/5
Postgraduate Board	4/4
Resources Committee	4/4
Fitness to Practise Committee	4/4
Education and Training Committee	2/3
Board of Trustees of the GMC's Superannuation Scheme	5/5

Management

163 In 2012, the GMC's staff were under the direction of Chief Executive Niall Dickson. On 5 November 2012, organisational changes were made to establish a new role of Chief Operating Officer and realign the Directorates within the GMC.

164 Before 5 November 2012, the directors were:

- Paul Buckley, Director of Education
- Ben Jones, Director of Strategy and Communication
- Una Lane, Director of Continued Practice and Revalidation
- Paul Philip, Deputy Chief Executive and Director of Standards and Fitness to Practise
- Neil Roberts, Director of Registration and Resources.

165 After 5 November 2012, the directors and their responsibilities changed as follows:

- Paul Philip, Chief Operating Officer and Deputy Chief Executive; Paul Philip also continued to act as Director of Fitness to Practise until 31 May 2013
- Paul Buckley, Director of Education and Standards
- Ben Jones, Director of Strategy and Communication
- Una Lane, Director of Registration and Revalidation
- Anthony Omo, Director of Fitness to Practise (in post from 1 June 2013)
- Neil Roberts, Director of Resources and Quality Assurance.

166 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.

Looking forward to 2013

Our top priority for 2013 – revalidation

167 In 2013, our biggest challenge is to deliver the first year of revalidation. We introduced revalidation at the end of 2012, and in 2013 we expect to revalidate nearly 30,000 doctors.

Defining good practice

168 In 2013, we will achieve the following:

- Publish a new version of *Good medical practice*, which reflects changes in medical practice and new demands on healthcare. We've produced this with the input of doctors, patients and other key partners to make sure it reflects everyone's needs and interests.
- Create a guide to *Good medical practice* aimed specifically at patients to help them understand what they should expect from their doctor.
- Publish more detailed guidance on a range of issues, including prescribing and managing medicines and devices, and doctors' use of social media.

Acting if doctors aren't meeting our standards

169 In 2013, we will achieve the following:

- Continue to provide expert advice and support to employers dealing with doctors in difficulty.
- Continue to pilot ways to reduce the stress of being involved in a fitness to practise case, including meeting with doctors and patients during an investigation to increase the speed and accuracy of our decision making.
- Continue to help doctors raise concerns about patients' safety through our confidential helpline, online tool and national survey of doctors in training.
- Review all of our fitness to practise processes to find ways we can improve our efficiency.
- Implement the UK Government's announced support for new checks to help us ensure that all doctors who treat patients in the UK can speak proficient English and to prevent those who can't from treating patients.
- Keep supporting the MPTS, which we set up in 2012 to increase confidence in the independence of decisions made about doctors' fitness to practise at hearings.
- Share the insight our data on medical practice gives us about where there may be problems or where particular groups of doctors may need more support to deliver safe, high-quality care.

Meeting future needs and changing demands of doctors

170 In 2013, we will achieve the following:

- Contribute to the independent review of postgraduate medical training to make sure that UK doctors have the right knowledge and skills to meet patient needs in the years to come.
- Continue to make sure that the quality of medical education and training in the UK meets the standards that we set and complete our review of the way that we do this to make sure it's as effective as possible.
- Use our annual survey of doctors in training to assess how satisfied they are with the education and support they receive and act on the findings.
- Use our data and that of others to identify risks and trends and take action ourselves or recommend changes to others based on this evidence.
- Work closely with patients, doctors, employers and others, respond to changing needs and continue to find ways to improve standards of medical practice and protect patients more effectively.
- Launch a major programme of events on the future of medical professionalism.

Helping doctors to meet our standards

171 In 2013, we will achieve the following:

- Work to support the Statement of Common Purpose that we share with other key partners in responding to the Francis Report.
- Use our liaison teams across the UK to meet doctors, patients, educators and employers to listen to their views, promote our guidance and discuss how it can help doctors in front-line practice.
- Publish new resources that bring our guidance to life.
- Pilot a new programme of induction training to help doctors new to UK practice to understand the standards expected of them.
- Work more closely with medical students to debate what medical professionalism means to them and to discuss the standards that will be expected of them as doctors.

172 Our activities for 2013 represent the final year of our *Corporate strategy 2010–2013*. We will work with our Council to define a new corporate strategy to steer all aspects of our work during 2014–2017.

Professional advisers

Bankers	National Westminster Bank Plc Regent Street Branch PO Box 4RY Regent Street London W1A 4RY
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 22 May 2013, and signed on their behalf by

Professor Sir Peter Rubin

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 2012, which comprise the statement of financial activities, the balance sheet, the cash flow statement and the related notes numbered 1–15.

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 obtaining evidence about the amounts and disclosures in the financial statements sufficient 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; and the overall presentation of the financial statements.

In addition, we read all the financial and non-financial information in the trustees' annual report to identify material inconsistencies with the audited financial statements. 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 2012 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) requires 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

22 May 2013
Crowe Clark Whitehill LLP is eligible to act as an auditor in terms of section 1212 of the *Companies Act 2006*.

Accounts 2012

Statement of financial activities for the year ended 31 December 2012

	Note	Total 2012 £000	Total 2011 £000
Incoming resources			
From charitable activities			
Registration	2	93,452	94,271
Certification	2	3,089	3,576
Department of Health	2	0	1,382
From generated funds			
Sales and other income	3	377	435
Investment income and interest	3	1,057	1,966
Total incoming resources		**97,975**	**101,630**
Resources expended			
Charitable activities			
Fitness to Practise		41,296	50,294
MPTS		8,150	0
Registration and Revalidation		18,069	18,415
Standards		1,729	1,434
Education		5,035	4,714
Communications		4,135	2,577
External Relationships		3,948	3,306
Governance		6,060	6,722
Total resources expended	**4**	**88,422**	**87,462**
Net incoming resources before recognised gains and losses		**9,553**	**14,168**
Other recognised gains and losses on investments			
Actuarial (loss)/gain on defined benefit pension scheme	13	(958)	(1,787)
Net movement in funds		**8,595**	**12,381**
Total funds brought forward		53,053	40,672
Total funds carried forward		**61,648**	**53,053**

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 2012

	Note	2012 £000	2012 £000	2011 £000	2011 £000
Fixed assets					
Tangible fixed assets	6		11,936		13,771
Investments	7		60,000		60,000
			71,936		**73,771**
Current assets					
Debtors and prepayments	8	18,328		18,034	
Cash and bank balances		238		428	
Short-term deposits		30,232		26,547	
		48,798		**45,009**	
Liabilities					
Creditors: amounts falling due within one year	9	(63,293)		(70,811)	
Net current assets/(liabilities)			(14,495)		(25,802)
Total assets less current liabilities			**57,441**		**47,969**
Defined benefit pension scheme asset	13		4,207		5,084
Net assets including pension scheme asset			**61,648**		**53,053**
The funds of the charity					
Unrestricted income funds			57,441		47,969
Pension reserve			4,207		5,084
Total charity funds	**10**		**61,648**		**53,053**

The financial statements were approved by the trustees and authorised for issue on 22 May 2013.

They were signed on behalf of the trustees by:

Professor Sir Peter Rubin
Chair of Council

Cash flow statement for the year ended 31 December 2012

	2012 £000	2012 £000	2011 £000	2011 £000
Net cash inflow from operating activities (Note 1 below)		**7,733**		22,661
Returns on investments and servicing of finance				
Interest received	581		652	
Net cash inflow from returns on investments and servicing of finance		**581**		652
Capital expenditure	(4,819)		(5,727)	
Net cash inflow/(outflow) from investing activities		**(4,819)**		(5,727)
Net increase/(decrease) in cash and cash equivalents (Note 2 below)		**3,495**		17,586

Note 1

Cash flow from operating activities	2012 £000	2011 £000
Net incoming resources	9,553	14,168
Investment income and interest	(1,057)	(1,966)
Non-cash items - depreciation	6,363	6,687
Non-cash items – assets written off	293	0
Pension past service cost and curtailment	49	(197)
Pension scheme current service cost	4,873	4,350
Pension scheme contribution	(4,529)	(4,474)
(Increase) in debtors	(294)	(2,156)
Increase/(decrease) in creditors	(7,518)	6,249
	7,733	22,661

Note 2

Cash and equivalents	Short-term deposits £000	Cash at bank and in hand £000	Total £000
Balances at 1 January 2012	26,547	428	26,975
Net increase in cash and cash equivalents	3,685	(190)	3,495
Balances at 31 December 2012	**30,232**	**238**	**30,470**

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 *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 the GMC is 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. All deferred income brought forward from the previous year is automatically released to the Statement of Financial Activities in the following year.
- Registration fees, including provisional registration fees, are recognised when registration is granted.
- 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 the charitable aims. Other resources are expended on governance of the charity and are identified as such in the Statement of Financial Activities.

Expenditure relating to shared 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

The GMC is able to 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 the GMC's 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 remaining term of the lease
IT equipment and software	Three years
Other office equipment	Three to five years

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-term or medium-term deposits. Cash required for normal day-to-day working capital is shown on the GMC's balance sheet within current assets, while cash held for the longer term is shown as investments.

Pensions

The GMC operates a defined benefit pension scheme for permanent employees. 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 scheme assets, liabilities and major assumptions are shown in Note 13.

Twenty-seven members of staff, who transferred on the merger with the Postgraduate Medical Education and Training Board (PMETB), contribute to the NHS multi-employer scheme and contributions to the scheme are charged to the Statement of Financial Activities in the year in which they are payable to the scheme.

Funds and reserves

All of the GMC's funds are unrestricted, and can be expended at the trustees' discretion, in furtherance of the objectives of the charity.

2. Income from charitable activities

	Total 2012 £000	Total 2011 £000
Registration		
Annual retention fees	88,090	88,019
Registration fees	3,255	3,422
Provisional registration fees	718	763
PLAB fees	1,232	1,858
Other fees	157	209
	93,452	**94,271**
Certification		
CCT fees	2,413	2,945
CESR/CEGPR fees	676	631
	3,089	**3,576**
Department of Health (England)*		
GAP funding	0	168
Merger funding	0	1,214
	0	**1,382**

* On 1 April 2010, the GMC assumed statutory responsibility for regulating all stages of medical education and training. Before that, postgraduate medical education and training was the responsibility of PMETB, an executive non-departmental public body sponsored by the Department of Health in England. The GMC's accounts for 2011 include one-off transitional costs associated with this change, funded by the Department of Health in England.

3. Income from generated funds

	2012 £000	2011 £000
Activities for generating funds		
Sales and other income	377	435
Investment income		
Other finance income – pension scheme	476	1,314
Bank interest	581	652
	1,057	**1,966**

4. Total resources expended

	Direct staffing costs £000	Direct costs £000	Allocated costs £000	Total 2012 £000	Total 2011 £000
Fitness to practise	15,257	16,466	9,573	41,296	50,294
MPTS*	1,332	5,127	1,691	8,150	0
Registration and revalidation	7,915	2,983	7,171	18,069	18,415
Communications	1,343	2,014	778	4,135	2,577
Education	2,738	674	1,623	5,035	4,714
External relationships†	1,892	737	1,319	3,948	3,306
Standards	856	433	440	1,729	1,434
Charitable activities	31,333	28,434	22,595	82,362	80,740
Governance‡	2,129	2,172	1,759	6,060	6,722
Total resources expended	**33,462**	**30,606**	**24,354**	**88,422**	**87,462**

* In June 2012, we launched a new tribunal service for doctors. The Medical Practitioners Tribunal Service (MPTS) is an impartial adjudication function, and its creation was agreed by the UK Government after its decision not to proceed with the setting up of the Office of the Health Professions Adjudicator in 2010. Before the creation of the MPTS, adjudication costs were included within Fitness to Practise.

† External relationships includes the work undertaken 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 and Chief Executive costs, research and development, consultancy and review, and equality and diversity.

Support costs allocated to charitable activities

	Management £000	IT £000	HR £000	Finance £000	Procure-ment £000	Facilities/ accomm £000	Total 2012 £000	Total 2011 £000
Fitness to practise	98	3,102	1,292	693	140	4,248	9,573	12,436
MPTS	17	549	228	122	25	750	1,691	0
Registration and revalidation	74	2,323	968	519	105	3,182	7,171	7,905
Communications	8	252	105	56	12	345	778	874
Education	17	526	219	117	24	720	1,623	1,910
External relationships	14	427	178	95	19	586	1,319	1,052
Standards	5	142	59	33	6	195	440	533
Charitable activities	233	7,321	3,049	1,635	331	10,026	22,595	24,710
Governance	18	570	237	142	26	766	1,759	1,762
Total	**251**	**7,891**	**3,286**	**1,777**	**357**	**10,792**	**24,354**	**26,472**

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

4. Total resources expended (continued)

	2012 £000	2011 £000
Staffing costs	39,656	36,800
Office costs	6,741	5,210
Council and committee costs	584	589
Panel and assessment costs	15,184	15,045
Legal costs	6,472	8,321
Accommodation costs	5,823	7,495
Financial, actuarial and professional costs	5,004	4,185
Purchase of assets – charged to revenue	2,302	3,130
Assets written off	293	0
Depreciation	6,363	6,687
	88,422	**87,462**

Total resources expended include:

Operating lease costs: leasehold property	3,685	2,526
Audit fees	37	36
Finance lease costs: office equipment	0	4

5. Staff

Total costs of all staff:	2012 £000	2011 £000
Salaries	30,241	27,617
Social security costs	2,325	2,128
Superannuation costs	4,981	4,240
Redundancy costs	228	1,060
Other staffing costs	1,881	1,755
	39,656	**36,800**

Average staff numbers (full-time equivalents) in the year by category:	2012	2011
Fitness to practise	259	244
MPTS	28	0
Registration and revalidation	183	168
Standards	13	11
Education	45	39
Communications	18	15
External relations	30	21
Governance	48	43
Resources	112	113
	736	**654**

The number of staff whose taxable emoluments (excluding redundancy payments) fell into higher salary bands was:	2012	2011
GMC		
£60,000–£70,000	18	23
£70,001–£80,000	24	18
£80,001–£90,000	11	3
£ 90,001–£100,000	6	8
£100,001–£110,000	9	7
£110,001–£120,000	1	0
£120,001–£130,000	1	1
£140,001–£150,000	0	1
£150,001–£160,000	1	1
£170,001–£180,000	3	2
£180,000–£190,000	1	1
£220,001–£230,000	1	1
MPTS		
£60,000–£70,000	1	0
£70,001–£80,000	1	0
£90,001–£100,000	1	0

5. Staff (continued)

Number of staff included on page 58 for whom retirement benefits are accruing:	2012 £000	2011 £000
GMC defined benefit pension scheme	74	63
Defined contribution scheme*	3	2
Not in scheme	2	1
	79	**66**

* These staff transferred to the GMC on the merger with PMETB, and contribute to the NHS multi-employer scheme. Contributions to the scheme are charged to the Statement of Financial Activities in the year in which they are payable to the scheme.

6. Fixed assets

	Buildings £000	Fixtures, furniture and equipment £000	IT equipment and software £000	Total £000
Cost				
Balance at 1 January 2012	12,649	9,681	28,154	50,484
Additions	331	277	4,211	4,819
Disposals	(921)	(39)	(18,221)	(19,181)
Balance at 31 December 2012	**12,059**	**9,919**	**14,144**	**36,122**
Depreciation				
Balance at 1 January 2012	9,217	3,007	24,489	36,713
Depreciation charge for year	1,367	1,120	3,876	6,363
Disposals	(652)	(27)	(18,211)	(18,890)
Balance at 31 December 2012	**9,932**	**4,100**	**10,154**	**24,186**
Net book value at 1 January 2012	3,432	6,674	3,665	13,771
Net book value at 31 December 2012	**2,127**	**5,819**	**3,990**	**11,936**

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

Asset disposals include £18.9 million of historical assets that had reached the end of their useful life and been disposed of in prior years. These assets were fully depreciated, and so their removal from our accounting records has no financial impact. In addition, we disposed of £0.3 million of assets before the end of their useful life and these costs have been charged to the Statement of Financial Activities in 2012.

7. Investments

	2012 £000	2011 £000
Cash deposits	60,000	60,000

8. Debtors

	2012 £000	2011 £000
Amounts falling due within one year		
Registration debtors	14,591	14,942
Prepayments and accrued income	2,356	2,335
Other debtors	1,381	757
	18,328	**18,034**

9. Creditors

	2012 £000	2011 £000
Amounts falling due within one year		
Trade creditors	679	1,548
Other creditors including tax and social security	1,894	1,317
Accruals and deferred income*	60,720	67,946
	63,293	**70,811**

* 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. The annual retention fee reduced from £420 in 2011/12 to £390 in 2012/13, which reduced the level of deferred income in 2012.

10. Fund movements in the year

	Unrestricted fund £000	Pension fund £000	2012 Total £000	2011 Total £000
At 1 January	47,969	5,084	53,053	40,672
Net incoming/(outgoing) resources	9,472	(877)	8,595	12,381
At 31 December	**57,441**	**4,207**	**61,648**	**53,053**

11. Capital commitments

Capital expenditure contracted by unspent at 31 December 2012 amounted to £184,488. The equivalent figure for 2011 was £134,568.

12. Operating lease commitments

	2012 £000	2011 £000
Committed amounts payable for the next year are:		
Leases of land and buildings expiring:		
Within one year	110	219
In years two to five	999	688
After more than five years	2,576	1,619
	3,685	**2,526**

13. Superannuation scheme

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

In addition to the GMC scheme we have 27 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 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.

The valuation used for FRS 17 disclosures has been based on a full assessment of the liabilities of the scheme as at 31 December 2009. 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 (STRGL).

Regular contributions to the scheme in 2013 are estimated to be £5,879,000.

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 2012 % p.a.	31 December 2011 % p.a.	31 December 2010 % p.a.
RPI inflation	3.3	3.4	3.8
CPI inflation	2.8	2.7	3.3
Rate of general long-term increase in salaries	5.3	5.4	5.8
Pension increases (excess over guaranteed minimum pension)	2.8	2.7	3.3
Discount rate for scheme liabilities	4.6	4.7	5.3

Mortality assumptions

The mortality assumptions are based on standard mortality tables, which allow for future mortality improvements. The assumptions are that a member currently aged 65 will live on average for a further 23 years if they are male and for a further 24 years if they are female.

For a member who retires in 2032 at age 65 the assumptions are that they will live on average for a further 24 years after retirement if they are male and for a further 26 years after retirement if they are female.

13. Superannuation scheme (continued)

Expected return on assets

	Long-term rate of return expected at 31 Dec 2012 % p.a.	Value at 31 Dec 2012 £000	Long-term rate of return expected at 31 Dec 2011 % p.a.	Value at 31 Dec 2011 £000	Long-term rate of return expected at 31 Dec 2010 % p.a.	Value at 31 Dec 2010 £000
Equities	5.95	58,855	6.05	51,538	7.45	52,390
Fixed Interest Gilts	2.70	13,123	2.80	12,752	4.20	10,099
Index-Linked Gilts	2.70	12,728	2.80	12,669	4.20	10,274
Property	4.95	15,926	5.05	11,298	6.95	7,108
Other	1.00	1,049	1.80	522	1.45	113
Combined	**4.92**	**101,681**	**4.97**	**88,779**	**6.57**	**79,984**

The GMC employs a building block approach in determining the long-term rate of return on pension plan assets. Historical markets are studied and assets with higher volatility are assumed to generate higher returns consistent with widely accepted capital market principles. The assumed long-term rate of return on each asset class is set out within this note. The overall expected rate of return on assets is then derived by aggregating the expected return for each asset class over the actual asset allocation for the Scheme at 31 December 2012.

Reconciliation of funded status to balance sheet

	Value at 31 December 2012 £000	Value at 31 December 2011 £000	Value at 31 December 2010 £000
Fair value of scheme assets	101,681	88,779	79,984
Present value of funded defined benefit obligations	(96,884)	(83,111)	(74,188)
	4,797	5,668	5,796
Present value of unfunded defined benefit obligations	(590)	(584)	(560)
Asset/(liability) recognised on the balance sheet	**4,207**	**5,084**	**5,236**

13. Superannuation scheme (continued)

Analysis of profit and loss charge

	Year ending 31 December 2012 £000	Year ending 31 December 2011 £000
Current service cost	5,975	5,180
Past service cost	49	398
Interest cost	4,059	4,085
Expected return on scheme assets	(4,533)	(5,399)
Curtailment cost	0	(595)
Settlement cost	0	0
Expense recognised in profit and loss	**5,550**	**3,669**

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

	Year ending 31 December 2012 £000	Year ending 31 December 2011 £000
Opening defined benefit obligation	83,695	74,748
Current service cost	5,975	5,180
Interest cost	4,059	4,085
Actuarial (gains)/losses on scheme liabilities	4,251	771
Net benefits paid out	(555)	(892)
Past service cost	49	398
Net increase in liabilities from disposals/acquisitions	0	0
Curtailments	0	(595)
Settlements	0	0
Closing defined benefit obligation	**97,474**	**83,695**

Changes to the fair value of scheme assets during the year

	Year ending 31 December 2012 £000	Year ending 31 December 2011 £000
Opening fair value of scheme assets	88,779	79,984
Expected return on scheme assets	4,533	5,399
Actuarial gains/(losses) on scheme assets	3,293	(1,016)
Contributions by the employer	5,631	5,304
Net benefits paid out	(555)	(892)
Net increase in assets from disposals/acquisitions	0	0
Settlements	0	0
Closing fair value of scheme assets	**101,681**	**88,779**

13. Superannuation scheme (continued)

Actual return on scheme assets

	Year ending 31 December 2012 £000	Year ending 31 December 2011 £000
Expected return on scheme assets	4,533	5,399
Actuarial gain/(loss) on scheme assets	3,293	(1,016)
Actual return on scheme assets	**7,826**	**4,383**

Analysis of amounts recognised in the STRGL

	Year ending 31 December 2012 £000	Year ending 31 December 2011 £000
Total actuarial gains/(losses)	(958)	(1,787)
Cumulative amount of gains/(losses) recognised in the STRGL	(7,186)	(6,228)

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

	31 Dec 2012 £000	31 Dec 2011 £000	31 Dec 2010 £000	31 Dec 2009 £000	31 Dec 2008 £000
Fair value of scheme assets	101,681	88,779	79,984	67,541	53,903
Defined benefit obligation	(97,474)	(83,695)	(74,748)	(73,273)	(49,620)
Surplus/(deficit) in scheme	**4,207**	**5,084**	**5,236**	**(5,732)**	**4,283**

History of experience gains and losses

	Year ending 31 Dec 2012 £000	Year ending 31 Dec 2011 £000	Year ending 31 Dec 2010 £000	Year ending 31 Dec 2009 £000	Year ending 31 Dec 2008 £000
Experience gains/(losses) on scheme assets	3,293	(1,016)	3,972	6,569	(5,020)
Experience gains/(losses) on scheme liabilities*	(635)	113	2,896	(405)	(630)

* 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.

14. Honoraria

Trustees	2012 £	2011 £
Professor Jane Dacre, BSc MD FRCP Lon FRCP Edinburgh Glas FHEA	15,225	15,050
Dr Suzanne Davison, BSc (Hons) PhD	12,000	11,825
Dr Sam Everington, OBE MBBS MRCGP Barrister	12,000	11,825
Ms Sally Hawkins, BA	12,000	11,825
Dr John Jenkins, CBE MD FRCP FRCPCH FRCPI	15,225	15,050
Lord Kirkwood of Kirkhope, BSc	15,225	15,050
Ms Ros Levenson, BA (Hons) CQSW Dip in Applied Social Studies	15,225	15,050
Professor Malcolm Lewis, FRCGP LLM	15,225	15,050
Mr Robin MacLeod, MHSM Dip HSM MI Mgt Dip Business Studies	15,225	15,050
Professor Rajan Madhok, MBBS MSc FRCS FFPH‡	12,000	11,825
Dr Johann Malawana, MBBS	12,000	11,825
Dr Joan Martin, DPhil FCOT MA	15,225	15,050
Mrs Suzanne McCarthy, BA LLM MSc	12,000	11,825
Professor Jim McKillop, BSc MB ChB PhD FRCP FRCR	15,225	15,050
Professor Trudie Roberts, BSc MB ChB PhD FRCP†	12,000	11,825
Mrs Ann Robinson	15,225	15,050
Mrs Enid Rowlands, BSc CCMI	15,225	15,050
Professor Sir Peter Rubin, BM BCh MA DM FRCP†	95,433	95,433
Dr Mairi Scott, MB ChB FRCGP FRCPE FHEA*, †	12,000	12,179
Professor Iqbal Singh, OBE MBBS MRCP FRCP Dip Rehab Med	15,225	15,050
Professor Terence Stephenson, BSc BM BCh DM FRCP FRCPCH	12,000	11,825
Ms Anne Weyman, OBE BSc(Soc) Honorary LLD	12,000	11,825
Mr Stephen Whittle, OBE LLB FRSA	12,000	11,825
Dr Hamish Wilson, CBE MA PhD FHSM FRCGP	12,000	11,825

* Dr Mairi Scott ceased acting as Chair of the Registration Reference Group on 17 February 2012
† paid to employer during 2012
‡ paid to employer until 30 June 2012

Travel and subsistence expenses of £122,199 were paid to the 24 members in 2012. The equivalent figure for 2011 was £128,091.

Medical Practitioners Tribunal Service Committee members	2012 £	2011 £
His Honour David Pearl*	0	0
Dr Tim Howard, MBBS (Lond) LRCP MRCS DObstRCOG MRCGP	4,960	0
Ms Alison White, MBA FCMA	4,960	0

* 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.

15. Travel and subsistence expenses claimed in 2012

Trustees	2012 £	2011 £
Professor Jane Dacre, BSc MD FRCP Lon FRCP Edinburgh Glas FHEA	399	160
Dr Suzanne Davison, BSc (Hons) PhD	2,396	3,858
Dr Sam Everington, OBE MBBS MRCGP Barrister	0	231
Ms Sally Hawkins, BA	232	174
Dr John Jenkins, CBE MD FRCP FRCPCH FRCPI	26,002	29,417
Lord Kirkwood of Kirkhope, BSc	1,348	485
Ms Ros Levenson, BA (Hons) CQSW Dip in Applied Social Studies	609	787
Professor Malcolm Lewis, FRCGP LLM	13,173	11,719
Mr Robin MacLeod, MHSM Dip HSM MI Mgt Dip Business Studies	6,204	4,819
Professor Rajan Madhok, MBBS MSc FRCS FFPH	3,583	4,335
Dr Johann Malawana, MBBS	129	0
Dr Joan Martin, DPhil FCOT MA	22,024	17,558
Mrs Suzanne McCarthy, BA LLM MSc	0	86
Professor Jim McKillop, BSc MB ChB PhD FRCP FRCR	12,540	15,255
Professor Trudie Roberts, BSc MB ChB PhD FRCP	3,375	5,100
Mrs Ann Robinson	214	261
Mrs Enid Rowlands, BSc CCMI	1,032	2,778
Professor Sir Peter Rubin, BM BCh MA DM FRCP	9,906	8,610
Dr Mairi Scott, MB ChB FRCGP FRCPE FHEA	4,265	4,752
Professor Iqbal Singh, OBE MBBS MRCP FRCP Dip Rehab Med	7,908	9,090
Professor Terence Stephenson, BSc BM BCh DM FRCP FRCPCH	129	508
Ms Anne Weyman, OBE BSc(Soc) Honorary LLD	189	292
Mr Stephen Whittle, OBE LLB FRSA	185	265
Dr Hamish Wilson, CBE MA PhD FHSM FRCGP	6,357	7,551

15. Travel and subsistence expenses claimed in 2012 (continued)

Medical Practitioners Tribunal Service Committee Members	2012 £	2011 £
His Honour David Pearl	396	0
Dr Tim Howard, MBBS (Lond) LRCP MRCS DObstRCOG MRCGP	3,161	0
Ms Alison White, MBA FCMA	1,123	0

Senior Management Team	2012 £	2011 £
Niall Dickson – Chief Executive	18,119	17,949
Paul Philip – Chief Operating Officer	8,550	9,168
Paul Buckley – Director of Education and Standards	5,047	3,007
Ben Jones – Director of Strategy and Communication	6,211	8,027
Neil Roberts – Director of Resources and Quality Assurance	16,666	17,336
Una Lane – Director of Registration and Revalidation	6,669	4,596

Variations in expenses incurred by individuals reflect their different roles and responsibilities. For example, some trustees had responsibility for chairing boards, committees and working groups.

Variations in expenses also reflect that trustees and members of 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. In most cases travel costs include outbound and return journeys.

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

Acronyms

BMA	British Medical Association
CCT	Certificate of Completion of Training
CEGPR	Certificate of Eligibility for GP Registration
CESR	Certificate of Eligibility for Specialist Registration
CQC	Care Quality Commission
FRS	Financial Reporting Standards
GMC	General Medical Council
IOP	Interim Orders Panel
LETB	Local Education and Training Board
MPTS	Medical Practitioners Tribunal Service
NHS	National Health Service
NMC	Nursing & Midwifery Council
NQB	National Quality Board
PLAB	Professional and Linguistic Assessments Board
PMETB	Postgraduate Medical Education and Training Board
RCGP	Royal College of General Practitioners
SORP	Statement of Recommended Practice
STRGL	Statement of Recognised Gains and Losses

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