Business Plan 2004 – 2005

May 2004
General Medical Council

Business Plan 2004 – 2005

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Introduction

1. Following the reconstitution of the Council in July 2003, the incoming Council developed a strategy to drive the work of the GMC for the period 2003-2007. It was adopted at the Council meeting in January 2004 and will be reviewed on an annual basis. The strategy can be found in the next section of this document.

2. The strategy will be underpinned by annual business plans, to consist of objectives and priorities for the following year, together with a budget. This is the first such business plan. Our intention is to adopt the business plan for the year ahead in the November of the preceding year. However as this first plan has been developed later in the planning cycle than will normally be the case, it covers a longer period - to the end of 2005. Later this year we will adopt the budget for 2005 and incorporate it in the plan. At this point we will also review both the plan and the strategy.

3. The plan will be delivered on the GMC’s behalf by the Chief Executive and his staff, who are organised in four directorates: Fitness to Practise; Registration and Education; Policy and Corporate Affairs; and Resources. Together the Chief Executive and Directors have overall responsibility for supporting the work of the Council and its committees in the discharge of the GMC’s statutory functions.

4. This business plan is primarily an internal management document, identifying our aims, objectives, targets and resources. When we review it later this year we will set out how we intend to measure and monitor progress towards the strategy and the business plan. The plan is also part of our external accountability and as such will be distributed externally.

5. At the start of each section in the business plan, we have linked the objectives back to the strategic aims. Under the section ‘Strategic Aims’, we have also shown which paragraphs of the business plan refer to which strategic aims.
Statement of purpose

6. Our purpose is defined by legislation and by the Charities Commission and was agreed by the Council on the adoption of a four year strategy in January 2004. It is:

   To protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine.

7. The Medical Act 1983 defines our functions as

   a. Setting the standards of good medical practice which society and the profession expect of doctors throughout their working lives.

   b. Assuring the quality of undergraduate medical education in the UK and co-ordinating all stages of medical education.

   c. Administering systems for the registration and licensing of doctors to control their entry to, and continuation in, medical practice in the UK.

   d. Dealing firmly and fairly with doctors whose fitness to practise is questioned.

Vision

8. To be recognised as delivering and safeguarding the highest standards of medical ethics, education and practice, in the interests of patients, public and the profession.
Strategic aims 2004-2007

9. In our strategy, a number of key strategic aims were identified. These are shown below, cross-referenced to the paragraphs in the business plan to which they particularly relate. Over the next four years we will strengthen our role as an authoritative and independent voice on issues facing doctors, patients and society. We aim:

a. To uphold the principles of good regulation as set out in the Government’s proposals for Supporting Doctors, Protecting Patients. (Paragraphs 45 – 55 and 128-134).

b. To concentrate our efforts on guaranteeing the quality of doctors: ensuring high standards of professional practice among doctors entering the profession and supporting the continuation of good medical practice throughout their careers. (Paragraphs 45-55, 61-68 and 76-83).

c. To emphasise that the GMC’s role in education, standards and ethics is central to the good practice of medicine. (Paragraphs 76-83 and 111-125).

d. To deal firmly, fairly and in a timely fashion with the minority of doctors who fail to maintain the high standards that we have set. (Paragraphs 87-103).

e. To provide effective and efficient professional regulation so that those who deal with us become advocates for the GMC. This will require us not only to maintain but also enhance our reputation. (Paragraphs 111-125).

f. To take a leading role in the future development of health regulation by engaging proactively with the UK Government, the devolved administrations, institutions in the EU and others on issues affecting regulation in this country. (Paragraphs 111-125 and 128-134).
Achievements in 2003

Reforms of the GMC

10. Following Parliamentary approval for legislation in November 2002, the GMC was able to begin to implement the most fundamental set of reforms in its history. There are three main areas in the reform programme:

b. New Fitness to Practise procedures.
c. New system for the licensure and revalidation of doctors.

Reconstituted Council

11. Until 2003, the Council was made up of 104 members, of whom 25% were lay. The new Council established on 1 July 2003 is made up of 35 members, of whom 40% (14) are lay and 60% (21) are medical. The medical profession elects 19 of the medical members.

New Fitness to Practise procedures

12. By the end of 2003, the redesign of the new fitness to practise procedures was largely complete. A unified process will allow a doctor’s fitness to practise to be considered in the round, bringing together what are currently separate conduct, health and performance procedures.

New licence to practise and revalidation

13. Planning for the introduction of licensure and revalidation has continued. Milestones in 2003 included the publication of a prospectus to all doctors in April 2003.

Equal treatment for international medical graduates

14. Prior to 2003, most international medical graduates were required to demonstrate their capability for practice before being granted limited registration. For historical reasons, graduates from some universities were eligible for full registration on the basis of their overseas primary qualifications alone. The preferential treatment for this group was widely viewed as discriminatory.

Review of Registration

15. A widespread consultation was carried out, on proposed changes to registration arrangements which will see the introduction of a single structure of registration and licensure for all doctors, regardless of where they qualified. The response, from employers, doctors, patient groups and educational establishments was overwhelmingly supportive of the proposed changes.
Professional and Linguistic Assessments Board

16. Important steps were taken to make the PLAB testing process more efficient and deal with the growing number of applicants. These include the opening in London of our first purpose-built testing centre for international doctors, and improved use of the internet to register candidates.

Education

17. Tomorrow’s Doctors, dealing with undergraduate medical education, was reissued following revision and consultation. The New Doctor, for graduates entering medical practice, was thoroughly revised prior to consultation.

Advising on UK legislation

18. During 2003 we were at the forefront of a successful campaign to amend the Health and Social Care Bill, which would have given CHAI wide powers to access records including those of individual patients. The GMC along with the Nursing & Midwifery Council and the Consumer’s Association argued successfully that this gave insufficient weight to patients' right to confidentiality.

International links

19. Within Europe, the GMC, together with other UK health regulators, continued to press for changes to the draft EC directive on the recognition of professional qualifications.

20. Beyond Europe, we have continued to play a leading role in the International Association of Medical Regulatory Authorities. In particular, we have been involved in the development of a pilot project for the electronic exchange of fitness to practise data between international regulators.

Accommodation

21. The successful relocation of posts and services from London to Manchester increased in pace during 2003. An office was opened in Edinburgh.

Service standards

22. Service standards for both Fitness to practice and Registration and Education Directorates have continued to be both met and, in a number of areas, exceeded. Tougher standards were also introduced.

A 7
Environment

23. The Government is looking at extending the scope of regulation to new groups or to different areas. There is a growing debate about the purpose and effectiveness of regulation in a broad sense, and concern is increasingly expressed that regulation does not become over-burdensome and must be targeted at areas of risk, on the basis of good evidence. This has been reflected in a number of ways including in reports of the Better Regulation Task Force. It is important that we contribute to this debate on the future of regulation, in particular in the regulation of medicine and healthcare. We must continue to make a vigorous case to the public why professionally-led regulation in partnership with the public is the model that best meets the needs of patients and the public interest.

New partner organisations

The Healthcare Commission

24. The Healthcare Commission came into operation on 1 April 2004. Its purpose is to promote improvement in the quality of health and healthcare. It aims to do this by ‘becoming an authoritative and trusted source of information and by ensuring that this information is used to drive improvement’. The new organisation will be an important strategic partner for the GMC, as was its predecessor, the Commission for Health Improvement.

Council for the Regulation of Health Care Professionals

25. The National Health Service Reform and Health Care Professionals Act 2002, established a new Council for the Regulation of HealthCare Professionals (CRHP), which, from April 2003, has powers to oversee the work of the regulatory bodies for all health professionals. CRHP is looking to develop best practice and ensuring consistency of approach by regulators. Under powers contained in Section 29 of the 2002 Act, it can refer certain fitness to practise panel decisions to the High Court on the basis that they are unduly lenient or should not have been made.

Postgraduate Medical Education and Training Board

26. Legislation to establish a new Postgraduate Medical Education and Training Board (PMETB) has been approved by Parliament and the organisation will formally assume its statutory functions from October 2004. The PMETB has been set up to bring together responsibility for all postgraduate medical education. It will take over the existing roles of the Specialist Training and the Joint Committee on Postgraduate Training for General Practice.

Public Inquiries

27. A number of high profile public inquiries, including the Shipman Inquiry, will report their findings and recommendations during 2004. The breadth and
impact of any recommendations could be far-reaching, although it is ultimately for Government and Parliament to decide whether any changes to the reformed model of medical regulation, which received approval in 2002, would be justified.

*European issues*

28. On 1 May 2004, a further 10 counties became part of the EU. This enlargement will allow more doctors the right to work in this country. Under current provisions, we are obliged to give automatic recognition for registration purposes to EEA nationals holding EEA qualifications, as long as they reach the minimum requirements for training, as determined by the EU. As the EU expands, so the need for enhanced co-operation between regulatory bodies - particularly in sharing of information about fitness to practise decisions – increases too.

*Handling patient complaints*

29. For some time the GMC has called for better information and signposting for patients wishing to make complaints or raise concerns about their care. More recently we have suggested the development of a single gateway to enable this. This has received support from a number of organisations and individuals, and work to develop the proposal is currently being undertaken by the Healthcare Commission. The Council have firmly in mind that any proposals for a gateway are compatible with arrangements for the NHS complaints procedures in all four countries of the UK.

*Changing professional boundaries*

30. The boundaries between the different healthcare professions are increasingly being blurred, creating new demands on professionals, and on those who regulate them, to work in co-operation with others. For example, the emergence of new healthcare professionals, such as physicians' and surgeons' assistants, is already requiring us (and others) to consider how these new roles fit into the existing regulatory structures.

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1 Cyprus, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovakia and Slovenia.
Planned Achievements for 2004/2005

The implementation of revalidation

31. Revalidation, which we will introduce in 2005, is fundamental to modernising the regulation of doctors. The aims of revalidation are:

   a. To encourage all doctors to reflect meaningfully on their practice, using evidence gathered through audit and in other ways, and thus to improve their practice.

   b. To update what being registered and being qualified means, by shifting the emphasis away from qualifications alone, to being up to date and fit to practice.

   c. To replace the ‘management by exception’ approach that has been in place since 1858, by introducing regular confirmation that no adverse concerns are known and that the doctor is up to date and fit to practise.

Implementation of the fitness to practise reforms

32. The new fitness to practise procedures, which we will introduce later in 2004, will introduce a unified, rationalised, fitness to practise model. This will enable us to deliver our statutory responsibilities in a considerably more streamlined, focused and responsive manner than is possible under current legislation.

Review of Good Medical Practice

33. Our core document, Good Medical Practice, sets out the principles of good practice that we – on behalf of the public and the profession - expect of all doctors. In 2004-2005 we propose to undertake a major review of it to make sure it continues to reflect public and professional expectations.

Securing a further Section 60 Order to implement the review of registration

34. We need further to amend the Medical Act 1983 to enable us to implement the outcomes of the first phase of the review of registration, including the abolition of limited registration and the introduction of a single system of licensure for all doctors. This will be done through a Section 60 Order during 2004-2005.

Completion of the PRHO review and development of procedures for the quality of the PRHO year

35. The GMC’s Education Committee has a statutory duty to determine the patterns of experience which may be recognised as suitable for the general
clinical training necessary for full registration\textsuperscript{2}. In addition to putting in place new arrangements for PRHOs which, in summary, will be ‘outcome-based’ rather than ‘experience-based’, we wish to ensure, through quality-assurance, that we can demonstrate the effectiveness of the new arrangements.

\textit{Completing the move to new premises in Manchester and London}

36. The GMC’s Accommodation Strategy will be fully implemented in 2004, with new premises in London and Manchester.

\textsuperscript{2} Pre-Registration House Officer (‘PRHO’) training
Standards and ethics

Strategic Aims:

The objectives for standards and ethics flow from the following strategic aims:

To uphold the principles of good regulation as set out in the Government’s proposals for *Supporting Doctors, Protecting Patients*. (Paragraph 9a).

To concentrate our efforts on guaranteeing the quality of doctors: ensuring high standards of professional practice among doctors entering the profession and supporting the continuation of good medical practice throughout their careers. (Paragraph 9b).

Key assumptions

37. Amongst audiences with a detailed knowledge of medical regulation the standards guidance given by the GMC is recognised as being of a very high quality. Indeed, *Good Medical Practice* has been recognised as being particularly useful and is now used in a number of countries.

38. The standards set by the GMC reflect the needs and values of society and the advance of medical science. The GMC overarches both to provide guidance that meets the values of society. In 2004-2005, as this area of our work becomes more visible and attracts more public attention, activity will increase considerably and we must take steps to plan for the additional demands which will be made on us.

Required outcomes

39. We aim to continue keeping our published guidance up to date and develop new guidance where appropriate. In 2004-5 we propose to undertake a major review of our core document *Good Medical Practice* in order to ensure our guidance is appropriate for use in fitness to practise and revalidation procedures, as well as reflecting the values of the public and the profession.

40. We also aim to make the standards and ethics work of the Council more visible, in line with the strategy to bring standards and education in to the forefront of our work. This will require some additional resource; the current standards budget represents 2% of total costs and the total amount allocated to standards will probably need to be increased, to a yet unknown amount. The most likely increase will be in staff costs as we extend the work we undertake with partners and other outside bodies and as we generate more enquiries – in line with a higher profile.

41. The additional resource will however help us to achieve recognition for the GMC as an authoritative voice on issues facing doctors, patients and
society. This will involve new policy development, for example, in commenting on Bills before Parliament and working with civil servants and members of the both Houses of Parliament.

42. We must work with patient/public organisations and charities to consider how our guidance can best be used to inform patients and carers about what to expect from doctors. In particular to explore options for promoting and explaining to patients the advice in *Withholding and Withdrawing Life-prolonging Treatments: Good Practice in Decision-making* working with Help the Aged and other charities.

43. Raising the profile of the GMC’s standards work is also likely to result in a substantial increase in the number of written and telephone inquiries to the section about guidance and related issues.

44. In order to achieve these aims we plan to increase the number of staff in the Standards section by one in the first quarter of 2004. A further three staff will be proposed for the 2005 budget (for approval in November 2004).

**Objectives and targets**

**Objective 1: Undertaking routine work of the Section effectively and promptly.**

45. We have established a number of performance indicators for the period to December 2005, namely:

   a. Responding to 85% of written inquiries within 14 days of receipt. Dealing promptly with telephone inquiries.

   b. Preparing and circulating papers for Standards Committee in accordance with service standards (to be defined).

   c. Responding to relevant consultation documents within the timescale indicated by the consulting organisation.

   d. Accepting invitations to speak at conferences, seminars and training events which contribute to our wider objectives.

   e. Preparing FAQs for website and GMC News which explain agreed policy on topics regularly raised in day-to-day inquiries.

**Objective 2: Keeping our published guidance up to date and developing new guidance where appropriate.**

46. We will hold a seminar on the review of management guidance, decide on options for revising, withdrawing or redrafting this guidance and implementing a change by early 2005.
47. We will begin a review of *Good Medical Practice*, including research on professional and public attitudes to the guidance; the impact of the guidance on fitness to practise and revalidation processes; early consultation on what the profession wants from the guidance.


49. New guidance will be developed on the use of organs and tissue in line with the Human Tissue Act.

50. FAQs will be developed on a range of issues, including prescribing; confidentiality; the role of doctors as expert witnesses; the use and retention of human tissue for research; and child protection.

**Objective 3: Working with other bodies, including patient and professional organisations to ensure consistency, accuracy and helpfulness of our guidance.**

51. We will establish regular meetings and other means of exchanging information and developing joint projects with other health regulators and CRHP. Establish means of obtaining input from patient and professional organisations on ‘gaps’ in our guidance and the effectiveness of guidance in practice, (e.g. dedicated website area, survey).

52. Over the next two years we will be working with the Departments of Constitutional Affairs and Health on issues relating to mental capacity and mental health and with government bodies on electronic health records, data protection and confidentiality issues.

53. This objective will be one of the drivers for additional resource as attending outside meetings is very time demanding.

**Objective 4: Assisting in achieving recognition for the GMC as an authoritative voice on issues facing doctors, patients and society**

54. We will need to respond to government policy proposals and Bills, working with the public affairs team; work with GMC’s Scotland Office to provide briefing on health and standards issues arising from the Scottish Executive and other bodies; and work with the Media Relations team to improve our response to issues raised in national and medical media.

55. This objective will also require us to increase our resources, not only because of the additional work but also because it will increase our profile and increase enquiries made to us.
Registration

**Strategic Aim**

The objectives for registration flow from the following strategic aim.

To concentrate our efforts on Guaranteeing the quality of doctors: ensuring high standards of professional practice among doctors entering the profession and supporting the continuation of good medical practice throughout their careers. (Paragraph 9b).

**Key Assumptions**

56. Levels of applications for registration and restoration (and of applications for other amendment to the registers) will remain broadly consistent with previous years (adjusting for the non-recurring surge in Section 19 applications at the end of 2003).

57. The legislation and subsidiary regulations on which the registration reforms (including licensing, the abolition of limited registration, the revised fees framework, and registration decision and appeals panels) will rely will be in force in good time for the introduction of a new regulatory regime on 1 April 2005, subject to legislation being in place.

**Required outcomes**

58. Historically most registration services have been reliant on paper based administrative systems. In recent years we have invested in new IT systems, which will facilitate the delivery of registration services on line via the GMC’s website. Over the course of 2004 and 2005 we aim to transfer all our current paper based services (including PLAB bookings, registration applications, restorations, change of address, and payment of annual fees) on-line via a secure part of the GMC’s website.

59. During 2004 we will complete the planning work for the registration reforms. We aim to implement the first of the reforms (licensing, the abolition of limited registration, the revised fees framework, and registration decision and appeals panels) in the spring of 2005. Our current working date for implementation is 1 April 2005. The first revalidations will commence later in the spring of 2005.

60. Over the course of 2004 we aim to considerably revise and modernise the rigour of our registration checking procedures. We will do this by introducing identity checks at the point of registration and certificates of good standing for all applications for registration from international medical graduates.
Objectives and targets

Objective 1: Processing applications for registration and handling enquiries about registration in accordance with GMC agreed policies

Objective 2: Improving services for doctors by delivering on-line processes.

61. At present much of our update work (changes of address, payment of annual fees etc) is processed using paper based systems. Our plan is to automate some of these services during 2004 by allowing doctors access to their own electronic registration account so that some of these transactions can be undertaken directly, without the need for a written communication.

Objective 3: Improving the rigour of our registration processes

62. During 2004 we will extend the requirement for a certificate of good standing requirement for all doctors who have worked outside the UK prior to registration or restoration. We currently rely on self-declaration for all applicants but only support this with a certificate of good standing for some groups (currently sought for EEA qualified doctors, doctors applying under S19 and those seeking specialist registration). We believe it would be appropriate to improve the rigour of our registration process by requiring a certificate of good standing from all applicants. This would also bring our procedures into line with best practice internationally.

63. During 2004 we plan to improve our identity checks at the point of registration and the retention of photographic images for our records. While for some groups we have sighted identity documentation this was only sought to verify the doctor’s route to registration (e.g., to make sure they were entitled to the EEA route). Our plans involve the formal identification of all applicants for registration. This will involve the requirement for all doctors to complete formal identification checks (UK medical students are already doing this through the smart card which is issued while they are still studying). For most this will involve a visit to the GMC’s offices so that checks can be undertaken (to passport or similar) and a photograph taken for our records.

Objective 4: Complete the review of the PLAB test and ensure that it is fit for purpose and delivers what is required of it.

64. The PLAB Review Group, as set up by The Registration Committee is expected to produce its report toward the end of 2004.

Objective 5: Setting up of a permanent home for the GMC assessment centre.
65. Following the setting up of a new GMC office in London, the current assessment centre will need to be relocated to a permanent base. This will be at the GMC’s new main London office and will be fully operational by October 2004.

Objective 6: Completion of the introduction of the licence to practise.

66. In the spring of 2005 we will introduce the revised registration framework with the licence to practise. This will involve the abolition of limited registration. During 2004 we will continue development of licensing and revalidation arrangements. We are working to introduce the licence to practise for all doctors from 1 April 2005. In advance of that we will need to collect information (including payment preferences) that will enable us to issue the licence. We expect this process will require much housekeeping on the register (especially for doctors who may have had only limited contact with the GMC over many years). With this in mind we plan to begin a programme of writing to all registered doctors during 2004.

Objective 7: Introduce a revised fee structure.

67. At the same time as the revised registration framework is introduced we will implement a revised fees structure. Planning work will continue during 2004, with formal regulations being approved by Council by mid 2004. The changes in the fees framework will require significant administration. At the very least we will need to collect a revised direct debit authorisation. But we expect that many will also opt to pay their fees by instalment and others will be entitled to a low-income discount. We plan to co-ordinate the administrative arrangements for licensing with those for the revised fees framework.

Objective 8: The successful introduction of Revalidation

68. During 2004 we will complete the planning work for revalidation. In the autumn of 2004 we expect to be in a position to publish formal guidance for doctors about the licensing framework and revalidation. In 2005 we will commence the first revalidations. We expect to issue notices to the first group of doctors due to revalidate in the spring of 2005. The formal notice will give six months notice to deliver the evidence required for revalidation. Thus we expect the first revalidations in the Autumn of 2005.

Service Standards

69. In July 2002 we agreed a set of target standards for our service delivery across our registration and helpline services. These are set out in Table 1. We report on our monthly progress against these service delivery standards to the Registration Committee.
### Table 1: Service delivery standards

<table>
<thead>
<tr>
<th>Service standard</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>We will provide a decision on applications (or communicate the reasons why we are unable to reach a decision) as soon as possible and at the latest within five days of receipt.</td>
<td>To be achieved in 95% of cases.</td>
</tr>
<tr>
<td>Cases requiring a committee decision at a plenary meeting to be presented to a committee meeting within eight weeks of receipt of all the documentation required for the application.</td>
<td>To be achieved in 95% of cases.</td>
</tr>
<tr>
<td>Cases requiring a decision by a postal vote will be made within four weeks of all the documentation required for the application.</td>
<td>To be achieved in 95% of cases.</td>
</tr>
<tr>
<td>Phone calls to our operator assisted help lines to be answered in less than 15 seconds.</td>
<td>To be achieved on 100% of calls.</td>
</tr>
<tr>
<td>Doctors arriving at reception to be seen within 10 minutes.</td>
<td>To be achieved on 100% of cases.</td>
</tr>
<tr>
<td>Letters and emails to be answered within five working days of receipt.</td>
<td>To be achieved in 100% of cases.</td>
</tr>
<tr>
<td>Complaints to be answered within 10 working days of receipt.</td>
<td>To be achieved in 95% of cases.</td>
</tr>
</tbody>
</table>

70. We do not set targets for the volume of registration transactions, because we have no direct influence on the numbers of doctors seeking registration in the UK and therefore on processing levels in a given year. Each year we set forecasts for the levels of registration transactions we expect over the forthcoming year. These cover the main areas of the directorate’s activity, namely:

   a. Processing applications for registration.

   b. Dealing with enquiries by telephone, letter and face-to-face contact.

   c. Delivering the PLAB test for international medical graduates.

71. We expect that processing levels will be revised significantly in 2005 following the abolition of limited registration and the introduction of revalidation. We have not therefore included figures for 2005 in the forecasts set out below. Formal forecasts for registration transactions in 2005 will be prepared and finalised later in 2004.

Processing applications for registration

72. Over the whole of 2003 we processed 35,100 applications for registration. We expect the level of applications will remain broadly consistent in 2004 with the increase in 2003 caused by the ending of the S19 route (7,000 applications in 2003), being balanced by an increase in the number of doctors applying for limited registration due to the increasing availability of
PLAB 2 places following the opening of our dedicated centre in 2003. Further details of the forecast applications are set out in Table 2. In one area we have forecast a potential increase in applications. We expect that applications from Doctors seeking an initial period of limited registration will rise from 5,000 in 2003 to 9,300 in 2004, following further increases in capacity to meet demand for PLAB 2 places during 2004.

Table 2: Registration activity, 2003 actual and 2004 forecast

<table>
<thead>
<tr>
<th>Transaction type</th>
<th>2003 actual</th>
<th>2004 forecast</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Applications</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full – UK qualified doctors</td>
<td>4,500</td>
<td>4,500</td>
</tr>
<tr>
<td>Full – EEA</td>
<td>2,000</td>
<td>2,000³</td>
</tr>
<tr>
<td>Full – S19</td>
<td>5,500</td>
<td>200³</td>
</tr>
<tr>
<td>Full – Moving from LR</td>
<td>3800</td>
<td>4,200</td>
</tr>
<tr>
<td>Limited – initials</td>
<td>5,000</td>
<td>9,300</td>
</tr>
<tr>
<td>Limited – renewals</td>
<td>4,000</td>
<td>6,100</td>
</tr>
<tr>
<td>Provisional – UK qualified doctors</td>
<td>4,700</td>
<td>4,700</td>
</tr>
<tr>
<td>Provisional – Other</td>
<td>2,000</td>
<td>600</td>
</tr>
<tr>
<td>Specialist – UK trained doctors</td>
<td>2,100</td>
<td>2,100</td>
</tr>
<tr>
<td>Specialist – Non UK trained doctors</td>
<td>1,500</td>
<td>1,700</td>
</tr>
<tr>
<td><strong>Total grants</strong></td>
<td>35,100</td>
<td>35,400</td>
</tr>
</tbody>
</table>

Dealing with enquiries by telephone, letter and face-to-face contact

Details of our actual activity for 2003 and forecasts for 2004 are set out in Table 3. We anticipate that demand for our historical information services will continue to decrease as we make more information available via our website. We have however, forecast an increase in activity overall because we believe that the introduction of licensing and revalidation in 2005 will generate additional demand from currently registered doctors.

Table 3: Helpline activity, 2003 Actual and 2004 Forecast

<table>
<thead>
<tr>
<th>Transaction</th>
<th>2003 actual</th>
<th>2004 forecast</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calls to helpline (excluding automated service callers)</td>
<td>242,000</td>
<td>254,000</td>
</tr>
<tr>
<td>Correspondence (emails and letters) excluding registration applications</td>
<td>57,500</td>
<td>65,000</td>
</tr>
<tr>
<td>Visitors to reception (doctors seeking advice about registration and the PLAB test)</td>
<td>21,000</td>
<td>25,500</td>
</tr>
</tbody>
</table>

³ There is the potential for applications from EEA nationals to rise from 2000 in 2003 following the admission of 10 additional countries to the EEA from mid 2004. However we also expect Department of Health recruitment activity to decline in the corresponding period so at this stage we are predicting no overall change in numbers.

⁴ Note that although the S19 route has closed, doctors who were provisionally registered at the end of December 2003 may continue to take advantage of this route to registration to move from provisional to full registration.
Delivering the PLAB test for international medical graduates

74. Details of our actual activity for 2003 and forecasts for 2004 are set out in Table 4. We anticipate that demand for part 1 of the PLAB test will remain the same as 2003 levels. We have forecast an increase in the number of part 2 places reflecting the number of candidates taking and passing part 1 during 2003.

Table 4: PLAB test activity, 2003 Actual and 2004 Forecast

<table>
<thead>
<tr>
<th>PLAB test</th>
<th>2003 actual</th>
<th>2004 forecast</th>
</tr>
</thead>
<tbody>
<tr>
<td>PLAB Part 1 places</td>
<td>12,680</td>
<td>16,500</td>
</tr>
<tr>
<td>PLAB Part 2 places</td>
<td>7,200</td>
<td>9,900</td>
</tr>
</tbody>
</table>
Education

Strategic Aim

The objectives for education flow from the following strategic aims:

To concentrate our efforts on guaranteeing the quality of doctors; ensuring high standards of professional practice among doctors entering the profession and supporting the continuation of good medical practice throughout their careers. (Paragraph 9b).

To emphasise that the GMC’s role in education, standards and ethics is central to the good practice of medicine. (Paragraph 9c).

Required outcomes

75. There are two main outcomes for us:

   a. The promotion of high standards in medical education.
   b. The co-ordination of all stages of medical education.

Objectives and targets

76. We aim to have completed the following 10 objectives by the end of 2004:

   Objective 1: In conjunction with significant partners, to develop, publish and implement principles of good medical education and training.

   77. Principles have been drafted with members of the Education Committee and will be considered through the GMC-PMETB Reference Group.

   Objective 2: To demonstrate effective procedures for the undergraduate part of the process to quality assure basic medical education.

   78. We will complete the pilot in the three schools that we are currently working with (Aberdeen, Birmingham and Liverpool) by 1 November 2004. By this time we also hope to confirm that the four new schools remain on track to be able to grant a primary medical qualification by the time their first cohort graduates. (The four new Schools are: Brighton/Sussex, Hull/York, Peninsula and UEA). A formal quality assurance cycle with four further established schools will start by 1 September 2004.

   Objective 3: To start the piloting for the general clinical training part of the process to quality assure basic medical education.
79. We will achieve this by publishing the revised *The New Doctor* by 1 November 2004. We will also have developed piloting arrangements, and will demonstrate a clear and effective co-ordination between *The New Doctor* and *Modernising Medical Careers*. We will also demonstrate a clear and effective co-ordination with PLAB.

**Objective 4: To demonstrate clear and effective co-ordination with the PMETB.**

80. This is being achieved, for example through cross-membership of PMETB and the Education Committee and regular meetings of representatives of the two bodies.

**Objective 5: To publish guidance on CPD.**

81. This was achieved in April 2004.

**Objective 6: To put in place arrangements to demonstrate further the effectiveness and cost-effectiveness of our Education systems.**

82. We will commission research into the effectiveness and cost-effectiveness of medical education and training in the United Kingdom. We will also demonstrate that the GMC has contributed to ensuring that medical education and training reflects contemporary society (promoting equality, valuing diversity; learning to practise with others; patient centred practice; work in a constantly changing environment; learner centeredness)

**Objective 7: To complete the quality assurance of four further Medical Schools and to ensure that the new Schools remain on track.**

83. By 1 November 2005 we will have completed the quality assurance for four established schools. The Education Committee will choose these schools during 2004. We will also confirm that the four new schools remain on track to be able to grant a primary medical qualification by the time their first cohort graduates. We will also begin formal visits to four further established schools by 1 September 2005.

**Objective 8: To operationalise piloting arrangements for the quality assurance of the PRHO year by 1 November 2005.**

**Objective 9: By 1 November 2005, we will demonstrate the enhancement of clear and effective co-ordination with the PMETB.**

**Objective 10: We will evaluate our guidance on CPD by 1 March 2005.**
Fitness to Practise

Strategic Aims:

The objectives for Fitness to Practise flow from the following strategic aim:

To deal firmly, fairly and in a timely fashion with the minority of doctors who fail to maintain the high standards that we have set. (Paragraph 9d).

Key assumptions

84. The key assumptions regarding the Fitness to Practise work of the Council are that:

   a. The number of doctors reported to the GMC will remain stable at around 4,000 each year.
   b. The number of cases necessitating hearing by a determining committee will remain broadly similar to last year.
   c. The development of the changing policy model will continue throughout the spring of 2004 and the implementation date of the Fitness to Practise Review will be in October 2004.
   d. We will continue to recruit, develop and retain high quality staff in Manchester and London to support this important aspect of the GMC's work.

85. Although the above represent our key assumptions for the Directorate, we must recognise that external factors may impact upon these and change the short or medium term priorities. The most obvious event, which may impact on the volume of work received, is the pending publication of a number of high profile public inquiries that are due for publication later this year. It is quite possible that, on publication of these reports, we may see a significant increase in our complaints received about doctors.

Required outcomes

86. The Directorate has four required outcomes in the short to medium term. These are:

   a. To build upon earlier successes in relation to delivering a timely resolution of complaints received about doctors;
   b. To continue to develop procedures to ensure the consistency and appropriateness of decisions taken within the Directorate;
c. To plan for and successfully implement the Fitness to Practise Review in October 2004;

d. To continue to develop the staff base as a high quality resource to service the work of the Council;

Delivering a timely resolution in dealing with complaints about doctors

Objective 1: Insofar as is possible, within available resources, to deliver a timely service in keeping with the published service standards.

87. The volume of expressions of concern received about doctors peaked in 2001/2002 at approximately 4,500; the figures for 2003 are approximately 4,000. Since 2002, the Directorate has been engaged in reducing the backlogs of work that had built up in previous years. This has now been dealt with and the amount of open complaints is presently running at between 1,700 and 1,800 at any given time. The case mix remains constant with considerably more allegations regarding clinical care being received than in previous years. During 2003, we took the decision to reduce our concurrent Professional Conduct Committee panels from 6 to 4 each day and to empanel 2 panels each in London and Manchester. This decision appears to have been correct with no consequent build up of cases awaiting hearing.

Objective 2: To develop and agree through the Fitness to Practise Committee (FPC) a new set of service standards for the timeliness of Fitness to Practise work by October 2004.

88. During 2003, the Directorate achieved all of its major service targets for the timeliness of work and agreement was subsequently reached, through the Fitness to Practise Committee, to tighten these targets. New and more challenging targets were introduced late last year and we are now seeing considerable progress towards meeting these and, in so doing we are improving the levels of service, which we provide to complainants and doctors alike. Performance against these is reported to the Fitness to Practise Committee and within the Chief Executive's report to Council.

89. Our intention is to continue to strive towards a more timely resolution of complaints whilst satisfying ourselves as to a doctor's Fitness to Practise medicine, as measured against the standards set out in Good Medical Practise. This will, of course, now be within the context of our new procedures as we move towards implementation of the Fitness to Practise Review. We expect, therefore, that staff effort will be directed towards a smooth implementation of the review whilst at the same time striving to achieve the new service standards that now exist.
Developing procedures to ensure the consistency and appropriateness of decisions taken

Objective 3: Develop a full suite of audit procedures and reports to support the FPC and the Investigation Committee in auditing casework by October 2004.

90. During 2003, the Directorate recruited and established a small case-based audit team and began to audit both compliance with agreed processes and decisions taken within the casework carried out by the Directorate, using a systems audit approach. In order to do this, the Directorate developed standards against which we review compliance. Issues such as the timeliness of our work, completion of fields in our database, the appropriateness of letters sent from the office (e.g. spelling, diplomacy etc.) are reviewed, the results collated and the corrective action communicated to staff. This is fed into the performance review cycle of staff members. The exercise is seen as a learning opportunity and subsequent audits are carried out to ensure improvement in any problem areas is achieved.

91. Likewise, in 2003, we began to sample decisions taken by staff and screeners within the Directorate for compliance with agreed policy intent. As with procedural issues, feedback and re-auditing are occurring routinely.

92. The audit team currently consists of 4 staff. However, we intend to recruit a further 3 caseworkers to bring the staffing establishment to 7 staff. This is necessary if we are to establish the systems audit approach on a much wider basis within the Directorate and to support the establishment of the Investigation Committee on implementation of the Fitness to Practise Review. It is envisaged that the Investigation Committee will receive regular audit reports to satisfy itself that a proper investigative process is being delivered in line with the policy intent of Council. Clearly, any one audit can only flag areas of concern, which would need further consideration by senior staff, or the Committee, in order to identify if a significant problem actually exists. Until the Investigation Committee is established the audit programme will be overseen by the Fitness to Practise Committee.

Objective 4: Continue to develop and support the work of the Fitness to Practise Determination Audit Sub-Group in monitoring and feeding back on the decisions of determining committees.

Objective 5: To develop and implement a quarterly newsletter to all panellists on the work of the Determination Audit Sub-Group by the summer of 2004.

93. Whilst case-based audit is one way of approaching quality and appropriateness of casework based decisions, another must be found in order to provide comfort to the Council in relation to the decisions taken by its casework committees. It was to address this issue that earlier this year, the Fitness to Practise Committee established a Determination Audit Sub-Group to review the decisions of the determining committees of Council. Early
indications are that this is going well and this development, together with the case-based audit of all decisions of the GMC on a routine basis will ensure that compliance with the policy intent of Council, will be achieved.

To plan for and successfully implement the Fitness to Practise Review in October 2004

- **Objective 6:** To deliver the legislative framework for the new Fitness to Practise procedures by September 2004.

- **Objective 7:** To provide appropriate training on the new procedures for all staff, panel members and legal assessors by October 2004.

- **Objective 8:** To develop and deliver the necessary operational changes to support the new Fitness to Practise procedures.

- **Objective 9:** To implement the new Fitness to Practise procedures in October 2004.

94. The development of the new Fitness to Practise model has been ongoing for sometime and we are now fast approaching its implementation in October this year. Recent changes in the policy model have had a major impact on the planning and timetable for implementation. However, October 2004 appears to remain achievable, given the support of the Department of Health and its legal team.

95. During 2003, the Directorate took forward a large-scale exercise in communicating with and training associates who sit on the casework committees of the GMC. We also consulted widely on a new set of Fitness to Practise rules to govern the new procedures. However, due to policy changes, it has become clear that a further short consultation period will be necessary during 2004 in order to properly implement the existing policy model further to changes earlier this year that were taken forward by the Fitness to Practise Committee.

96. Council agreed, in January this year that any Fitness to Practise issue reported to the GMC should be disclosed to a doctor’s employer at the beginning of the new Investigation Stage. This will mean that many more cases will be disclosed to employers than has been the position in the past. It also means that we will need to gain consent from the patient and identify doctors, and their primary place of work, in a far greater percentage of cases than is the position currently. This decision is likely to have resource implications.

97. It has always been the intention within the new procedures to investigate expressions of concern about doctors in more detail before deciding the most appropriate way in which to deal with them. During 2003, we recruited individuals to fulfil the new role of Case Examiners within the new process. Case Examiners will be the primary decision makers when deciding
the most appropriate method of disposal of a case at the Investigation Stage, further to a full investigation of a complaint where appropriate. This will have resource consequences and will be fundamentally different to that which we do now.

98. Over the summer period of 2004, staff will be engaged in training and communicating the new process in preparation for implementation in October. The Investigation Committee will need to be established in late summer and will need to meet in (shadow) plenary session to agree an initial mode of working. Likewise, further communication with and training of panellists and legal assessors will be scheduled. Following consultation, a new set of draft rules will be brought forward to Council in July 2004 for ratification before being sent to the Department of Health for agreement.

99. This particular work programme is fundamental to the Directorate’s success in the coming years and will be the main priority during 2004/5 in terms of its implementation and on-going work to ensure that the perceived benefits of the new arrangements are delivered.

Continue to develop the staff base to deliver a high quality resource to service the work of the Council

Objective 10: To administer recruitment programmes to ensure appropriate levels of suitably experienced and qualified staff are available to the operational sections of the Directorate as required.

100. During 2003, the Directorate took forward large-scale recruitment programmes to enable the movement of a significant amount of work from London to Manchester. Likewise, a number of new functions were developed successfully within the Directorate to support the Fitness to Practise work of the Council. These included the establishment of an In-House Legal Team, an Audit Team and the Committee Development team, the latter being responsible for communication with and the training and development of associates who populate our Fitness to Practise committees.

Objective 11: To support the training and development of individuals throughout the Directorate - sourcing and arranging activities to assist in the development of the skills and competencies required within their roles and in-line with business objectives.

101. Significant training and development was undertaken to ensure the development of these teams during past year. However, both the audit team and the legal team will need further expansion if the Directorate is to provide a full supporting function to Council on the implementation of the Fitness to Practise Review.

102. In particular, the legal team will need to expand to support the higher volume of investigative work at the beginning of our new process, to support
our Case Examiners and investigation teams and to ensure that appropriate and timely legal advice is on hand to assist the making of decisions at the Investigation Stage. A new investigation manual is being developed that will set out the process to be followed. Also, as highlighted above, the audit team will need to expand if it is to fully support the Investigation Committee. It is also likely that further recruitment of investigation staff will be necessary to deal with the larger number of cases that will be live at the Investigation Stage whilst further information is sought.

**Objective 12: To oversee the administration of the GMC's performance assessment and performance related pay procedures throughout the Directorate - providing support to line managers and staff members as required.**

103. Given the expected on-going recruitment, at this critical time of change, we will need, more than ever, to ensure that appropriate support and training is provided to ensure that the key principles of our new Fitness to Practise model are communicated to and understood by all staff and associates to equip them to perform to high levels during and beyond the change period.
Communications (Media and public relations, public affairs)

**Strategic Aim**

The objectives for Communications flow from the following strategic aims:

- To emphasise that the GMC’s role in education, standards and ethics is central to the good practice of medicine. (Paragraph 9c).

- To provide effective and efficient professional regulation so that those who deal with us become advocates for the GMC. This will require us not only to maintain but also enhance our reputation. (Paragraph 9e).

- To take a leading role in the future development of health regulation by engaging proactively with the UK Government, the devolved administrations, institutions in the EU and others on issues affecting regulation in this country. (Paragraph 9f).

**Key assumptions**

104. The legislative framework within which the GMC operates will remain unchanged save for the reforms instigated by the Council, specifically in fitness to practise and registration.

105. We are working to change the perceptions of the GMC in line with our strategic objectives and to reflect the reforms taking place in 2004 and 2005.

106. The GMC is a high profile organisation at the top of the public agenda and consequently will continue to operate within a difficult environment through the lifetime of this plan. In part this reflects the result of the reports of three major public inquiries; in part the continuing interest in our fitness to practise activities; and in part to the lead times taken in changing public perceptions.

107. There will be a continuing development of the role of the devolved legislatures and the increasing EU influence in medical regulation.

**Required outcomes**

108. To succeed in our strategic objectives we must strengthen our role as an authoritative and independent voice on issues facing doctors, patients and society over the next four years and emphasise that the GMC’s role in education, standards and ethics is central to the good practice of medicine.
Objectives and targets for media and public relations

109. Our target audiences will be clinical governance managers within the NHS; doctors’ employers; patients and patient organisations; doctors and their representatives; political audiences; health correspondents and health commentators in the national trade and local media; staff, members and associates; stakeholders such as the Healthcare Commission, NCAA and other healthcare regulators; medical schools.

110. Our key messages will be:

   a. The GMC’s purpose is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine.

   b. The GMC regulates the medical profession in partnership with other regulatory bodies, local systems and the public. Protecting patients and the public interest underlies everything we do.

   c. The GMC is implementing the biggest reform of medical regulation since 1858. Key elements of this reform programme are the introduction of a licence to practise with revalidation and the streamlining of the complaints procedure.

   d. The GMC is pleased contribute to public debate on the issue of medical regulation and will continue to work with partners from government and the health sector to enhance the reforms programme and further improve medical regulation within the UK.

   e. The integrity of the Medical Register depends upon the high standards set by the GMC in medical education and ethical guidance.

   **Objective 1: We will need to communicate the reforms programme to key target audiences, particularly within the NHS.**

111. We will implement a comprehensive communications programme targeted at clinical governance managers within the NHS and managers within the private sector explaining our reform programme, particularly focusing on ftp reforms and revalidation. The project will comprise a coordinated and branded programme of road shows, electronic communications and media relations activity.

112. Working closely with the Clinical Governance Support Unit and the Clinical Governance Association, set up an e-bulletin and special website pages for the clinical governance community, attend key exhibitions and conferences around the country with branded exhibition stands and materials, identify speaking slots/fringe events on the reforms, place editorial or adverts in key publications, establish an effective measurement system for the campaign.
Objective 2: We will communicate the new licence to practise and revalidation to the general public in time for their launch in 2005.

113. We will implement a communications programme, working with the PRG and through PALs to tell the general public about the new licence to practise and revalidation.

114. The project will focus on media relations activity including placing interviews with GMC spokespeople in prominent national media. Involve the PRG more closely with the work of the GMC and review its purpose and composition.

Objective 3: We will communicate the GMC’s response to key Inquiries and handle reactive media interest in an effective manner.

115. We will implement effective media protocols and publicise them on the online press office. Ensure that spokespeople are media trained, Q&A briefs are up to date, InsidelInfo, the members’ website and the online press office are up to date. Ensure that crisis management procedures are understood by senior management and are in place. Organise a briefing programme for key stakeholders on medical regulation issues and the GMC’s role. Initiate public discussion on professionally led regulation through a joint event with a think-tank. Identify and exploit media opportunities for getting across our key messages.

Objective 4: Review and revise all communications tools

116. Working with an external consultancy, we will set up a review programme to audit our audiences and our existing communications channels and make recommendations for revisions to our corporate identity and our strapline.

117. We will introduce a revised corporate identity including a new GMC logo to work with the existing “General Medical Council” logo and introduce a new strapline. Map all audiences and identify the best channel of communication for reaching them. Review all channels of communication and draw up recommendations and guidelines for introducing new channels and revising existing ones as appropriate. Introduce the revised corporate identity across all of our materials and website.
Objectives and targets for Public Affairs

Objective 5: To communicate GMC key messages to politicians and other stakeholders through a range of activities.

118. We will position the GMC as an authoritative voice in the political arena by identifying issues that will impact on GMC and ensure effective management and response, promote GMC initiatives to a public affairs audience e.g. publication of guidance on confidentiality and deliver a programme of events for our target audiences.

119. This will include working with a think-tank in coordinating an event with policymakers and other stakeholders highlighting the value of professionally led regulation and producing a paper for circulation arising from that event.

Objective 6: To manage the public affairs activity necessary in anticipation of the Shipman and other Inquiries and contribute to the overall organisational strategy.

120. This will require timely briefings to key audiences and a public affairs dimension represented in all relevant strategies.

Objective 7: To co-ordinate the GMC’s activity in Wales and establish an office in Wales.

121. We will meet with key Assembly Members (AM’s) and other stakeholders and contribute to the planning of the Welsh Branch Conference.

122. By early 2005 we will have established a permanent presence for the GMC in Wales and respond to the requirements of the Welsh Language Board.

Objective 8: Continue to convene and develop the Alliance of UK Health Regulators on Europe (AURE)

123. This will require is to continue co-ordinating activity on the draft directive for the mutual recognition of professional qualifications, the Directive on Services and accession issues.

124. Four meetings of AURE will be held and briefings issued throughout 2004 as the Directive progresses. To achieve priority aims and objectives at each legislative stage.

125. In addition we will co-ordinate AURE activity, in liaison with DH, in planning for the UK Presidency of the EU. A working Group of AURE membership, CRHP and NHSU will be convened to plan for UK Presidency and a paper produced and submitted to DH for approval and ongoing strategy managed.
## Strategy and Planning

### Strategic Aims

The objectives for Strategy and Planning flow from the following strategic aims:

- To uphold the principles of good regulation as set out in the Government’s proposals for *Supporting Doctors, Protecting Patients* (Paragraph 9a).
- To take a leading role in the future development of health regulation by engaging proactively with the UK Government, the devolved administrations, institutions in the EU and others on issues affecting regulation in this country. (Paragraph 9f).

### Key assumptions

126. The key assumption is that the importance of strategic management and planning will continue to be recognised and supported.

127. There will be a continued public interest in the way medicine is regulated, and Council will want to ensure that the value of professionally-led regulation in partnership with the public continues to be vigorously promoted in this debate.

### Required Outcomes

128. Through establishing effective strategic and business planning, to assist the Council in delivery its purpose.

129. To support the Council in responding strategically to the many challenges and opportunities currently facing us.

### Objectives and targets

#### Strategic planning

**Objective 1: To set up a robust planning cycle, which enables integration of the GMC’s strategic planning and business planning.**

130. Following the adoption in January 2004 by Council of the strategy, to co-ordinate the production of the GMC’s Business plan to the end of 2005, ensuring it fits with the strategy. We will start a review of the strategy in September 2004 which we will report to Council.

131. We will embed a GMC planning cycle, in which the discipline of annual business planning linked to broader strategic planning helps to support the work of the organisation.
Objective 2: Put in place a process to ensure improved co-ordination of management and other information, to support forward planning.

132. We will develop and implement a more effective monthly reporting system to enable the evaluation of key information about organisational functioning and external development by the Chief Executive and Directors. These will for the basis of the Chief Executive’s regular reports to Council.

Public Inquiries

Objective 3: Coordination of our input into the various public inquiries so that submissions are made as necessary and requests for information are actioned immediately and comprehensively.

Objective 4: Prepare for the publication of the Shipman and other various public inquiry reports and develop any implementation plan / responses as required

133. At the time of the preparation of this plan, the timing of the publication of the Shipman / Neale / Kerr / Haslam and Ayling Inquires reports remains uncertain.

Strategic Issues

Objective 5: To support the Directorates by undertaking strategic policy work. This will include the co-ordination of cross-directorate activity including research projects, quality assurance, legislation, strategic relationships and other issues.

134. We will complete the first phase of the registration review. This will involve working with the DH on the preparation of draft legislation for publication in summer 2004.

135. We will take forward the second phase of the registration review covering specialist licensure. Develop proposals, and secure agreement from Council, on the basis for consultation by the end of 2004.

Objective 6: To co-ordinate strategic policy input on international issues.

136. This will include monitoring and responding to new legislation and other initiatives from within the EU (e.g. Directive on Services, Directive on the recognition of professional qualifications, the implications of EU enlargement, and information exchange), and supporting our work within IAMRA.
Secretariat

137. The Secretariat will continue to manage Council and Committee business so that strategic aims and objectives can be met. We will provide developmental and administrative services to members and staff and monitor the progress of work through Council and its Committees. This will include the review of the existing committee structure and working practices. We will also ensure that both the Patients Reference Group and the Race Equality and Diversity Committee discuss our key policies and procedures.

138. We will also ensure that the GMC complies with relevant legislation, regulatory guidance and where possible best practice. Key compliance areas will be charity law and recommended practice, diversity legislation, data protection and freedom of information.

Electronic Document and Records Management

139. We will work with others to define and develop an electronic document and records management (EDRM) system fit for our needs. The system will provide records management tools to ensure that we are able to comply with best practice standards. The system will also ensure that we are able to meet the requirements of legislation including the Data Protection and Freedom of Information Acts.
Resources

140. The Resources Directorate covers the following functions: Information Systems; Procurement; Facilities Management; Finance and Human Resources.

Key Assumptions

141. Following completion of the relocation programme in 2004, 2005 will not see any further major changes beyond the identified developments to Fitness to Practice and Registration and Education processes.

142. The Overall financial position of the GMC will be such as to continue to fund the Directorate and its planned development.

143. The plan assumes that there will be no changes to UK legislation that would fundamentally impact the operations of the GMC.

Objectives and targets

Facilities

Objective 1: to implement the GMC’s Accommodation Strategy and thereby effect the successful transition of GMC personnel to new facilities in London, Manchester and Edinburgh

144. In Manchester the GMC will open a new office at the St James’s Building in 2004. This building will house some 200 staff, a Hearing suite and the Registration Call Centre. The new building will be fitted out by the end of April 2004, the transfer of all staff completed by the end of May 2004, with costs within the budget agreed by the Resources Committee in November 2003.

145. In London the GMC will open a new office at 350 Regents Place, this building will house some 150 staff, a hearing suite and the PLAB centre. The new building will be fitted out by July 2004 and the transfer of all staff completed by the middle of October 2004.

Objective 2: The introduction of improved service delivery processes through facilities management systems, SLAs and process mapping and improvement

146. To Implement a facilities management System by March 2005. To have implemented SLA for the following by the end of 2004: Post room; Reprographics; Maintenance and Help Desk teams; cleaning; catering; M&E; security services.

147. We intend to use a knowledge mapping as the basis for process improvement within Facilities with all processes mapped by September 2004.
Objective 3: to ensure that the GMC’s Health and Safety Systems are fit for purpose

148. We plan to review all current Health and Safety guidelines by October 2004.

Human Resources

Objective 4: to recruit, induct, retain, develop and motivate a high quality responsive and flexible workforce.

149. HR will work to ensure that the GMC has the right skills and staffing numbers to ensure continued operational effectiveness during (1) the transition into the new Manchester Office (2) the development of more effective working practices and (3) in anticipation of changing business needs. We plan to ensure that both locations are fully staffed by December 2004.

150. We plan to ensure the successful operation of the performance management system for 2004 and 2005, and ensuring 95% of reviews are complete by the end of each year. All managers and staff are to be trained within six months of joining the GMC. We will introduce an appropriately structured element of 360-degree feedback into the process (Heads of section by end of 2004 all staff by the end of 2005)

151. We aim to complete a comprehensive review of GMC pay, benefits and conditions of employment in line with serviced and operational requirements with any changes to be fully effective from April 2005 on pay, by the end of 2005 on conditions.

152. We plan to ensure a full corporate induction training package is implemented for all staff in their first six months, commencing in June 2004.

153. We will develop an appropriate top managers programme to cover 50% of all section heads in 2004 and all section heads by the end of 2005

154. We will be responsible for the full implementation in 2004 and 2005 of the HR action plan reported to and agreed by REDC.

155. Ensure the development of strong HR services at both main GMC locations and maximise the contribution of the function to the GMC

156. We will ensure the establishment of a Manchester based HR team by June 2004, implement the upgrade of PS 2000, August 2004 and complete a comprehensive review of service needs and specifications by April 2005

Information Systems (IS)

157. The Strategic Aim of IS in the GMC is to have a suite of complimentary and integrated IT systems, extended where appropriate to share information with the broader health community, that will enable the creation and
maintenance of high integrity management information. The information will be available to all GMC constituents through appropriate filters.

**Objective 5:** We will create a new, more resilient and more efficient network infrastructure, leveraging the opportunity created by the two new facilities in Manchester and London. There will be duplication of some aspects of the systems infrastructure to create a higher level of resilience for the key application systems – specifically IRS and FPD.

158. We aim to have a fully commissioned network infrastructure by end of October 2004.

**Objective 6:** To introduce an integrated suite of applications that fully support the core functions of each directorate whilst enabling information to be easily shared and managed.

159. We aim to provide a single set of process-based requirements to potential solution providers by the end of June 2004. We will also select one or more (complementary) solution providers by the end of July 2004.

160. We will develop a phased implementation programme ensuring that each phase is appropriately sized to enable the GMC to retain control of timescales and cost. The programme is likely to run over a two-year period and the plan will be in place by the end of 2004.

161. The standard architecture will be defined by the end of April 2004. The strategic applications programme will be based on the standard architecture and there will therefore be a phased migration to the new architecture as the strategic application programme proceeds through 2004 and 2005. Tactical migrations to the new architecture will be made on a business case basis through 2004.

**Objective 7:** To create an IS Organisation whose primary capabilities are project management, service management and analytical skills.

162. Complete review of options for production of an IS organisation by end of 2004 and migrate through 2005 if required.

163. The GMC’s Internet and intranet have provided an appropriate level of capability to date. Their content is substantial and valuable. However, business requirements are now evolving which will demand more capability particularly in terms of content management and interactive applications.

**Business Objective 8:** To continue to develop the GMC’s Internet and Intranet portals to reflect the wider evolution of the GMC and the environment in which it exists.
164. We aim to review Internet and intranet requirements and produce a development plan by the end of September 2004.

Procurement

165. Procurement will contribute to the achievement of the business plan through the purchasing of goods and services, of the right specification, delivered at the right time, on the best available commercial terms, and at the lowest total cost of ownership. In doing so we will treat our external suppliers in a fair and even-handed manner, ensuring that all dealings adhere to the highest ethical standards.

**Objective 9: Improve the procurement process by the introduction of a Purchasing System that integrates with the existing Sun Systems Finance module. At a minimum, the selected system should be able to facilitate online order approval, order status tracking, automated invoice matching and year-end accrual routines.**

166. We will establish requirements for the Purchasing System by May 2004, and to ensure that the system is operational by August 2004.

167. At present the Procurement Policies and Procedures are fragmented in several different locations on the Company Intranet. They also need revalidating and amending to reflect best practice and the creation of a dedicated in – house Procurement resource

**Objective 10: Review, revise and consolidate the existing policies and procedures to be reviewed and revised for relevance and appropriateness. Of particular importance are the bid thresholds, which dictate whether a process of informal bids or formal tendering activity is followed.**

168. Revised policies and procedures will be subject to initial review and approval by internal audit by June 2004. The resultant documents will be posted under a procurement link on the GMC intranet.

**Objective 11: We will undertake to systematically review the areas identified. The methodology will encompass the end-to-end procurement cycle for each commodity area including, where applicable, policy and entitlement issues.**

169. The first three areas for review will be complete by July 2004. The overall savings in the costs of goods and services of £350k will be achieved by the end of 2004. We will also maintain oversight of all procurement associated with the relocation of work and ensure that costs remain within overall budget.
Objective 12: To develop a procurement capability within the GMC through education, training and where appropriate delegation to staff within the Directorates.

170. Introduce basic procurement training for appropriate staff by September 2004. We will also introduce a devolved procurement organisation so that nominated staff can carry out basic procurement activities by November 2004.

Finance

171. The Finance function, which plays a key role in ensuring that the office can function properly and efficiently, continues to develop in response to the growing need for up to date information for management decisions and meeting the expanding array of statutory requirements.

Objective 13: To provide the basic finance support necessary for the day to day operation of the GMC

172. We will provide the Directors and the Resources Committee with the necessary financial information to enable them to make appropriate business decisions based on most up to date financial and other information available.

173. Through Audit ensure that all financial transactions are regular, necessary and proper and to undertake regular sample checks, monitoring and reconciling to demonstrate to our auditors that all financial transactions are taking place in a properly controlled environment.

174. The finance function will continue to improve its internal processes, reducing processing costs and lead times and increasing the availability of timely and accurate information.

Objective 14: To introduce Process Improvements to the finance systems and services

175. By November 2004 we will develop and implement a new PC based system that will enable the budget holders to interrogate the accounting system for further details of expenditure charged to their budget.

176. We will conduct a review of the main finance processes including the rolling forecast process and introduce revisions as necessary by July 2004.

177. In order for the GMC to maximise its use of finance data it is necessary for the Finance function to be both appropriately staffed and integrated with the Directorates. Integration will enable closer links between those whose actions drive the costs and revenues of the GMC and the finance function who record and analyse the outcomes.

Objective 15: To Staff the Finance function with appropriately trained personnel and to integrate the activities of finance with the Directorates.
178. We plan to integrate the Finance function with the Directorates by placement of Management Accountant staff into each Directorate who will assist with budgeting, forecasting and variance analysis by July 2004.

Business Continuity Planning (BCP)

179. All Organisations need to have contingency plans in place to deal with external events that disrupt the normal course of work. The GMC is developing a business continuity plan that will enable a structured response to the loss of some or all of its facilities, staff or systems as a consequence for example of a natural disaster, or terrorist action.

**Objective 16:** To provide the GMC with the ability to continue part or all of its operations following the loss of some or all of its facilities, staff or systems.

180. To create a Business Continuity Plan by June 2004, and to familiarise all staff with its content and have a planned cycle of simulated trial and improvement review in place by September 2004.

Quality Assurance

181. The GMC will introduce a Quality Assurance System designed to promote the effectiveness of its core processes of Registration and Fitness to Practice. The approach will be: to determine the required outcomes for each process; to eliminate as far as possible waste and variation from the processes; through audit and analysis continually improve the performance of each process.

**Objective 17:** The introduction of a Quality Assurance System.

182. We plan to present an outline of the GMC’s approach to Quality Assurance to the Resources Committee for approval in April 2004. We will gain agreement that the business processes and associated outputs that will be subject to Quality Assurance by July 2004. We will also ensure that by November 2004, there is the necessary organisation structure to sustain the QA system by November 2004. Our audit and process improvement will commence by April 2005.
### General Medical Council - Budgeted Income and Expenditure Account-Year

#### Annex A

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