General Medical Council
Performance Review Meeting
29th March 2004

Introduction

At the Council for the Regulation of Healthcare Professionals (CRHP) meeting in January 2004, it was agreed that in furtherance of the Council's statutory role as set out in Section 26(1) of the National Health Service Reform and Healthcare Professionals Act 2002, annual performance review meetings would take place between CRHP and the Regulatory Bodies:-

- To examine comparative performance
- To identify noteworthy practice
- To identify strategic cross-cutting issues which might benefit from a co-ordinated approach
- To highlight any factors inhibiting the development of professional self-regulation

The performance review meeting for the General Medical Council (GMC) was held on 29th March 2004 and prior to that date, the Council had provided CRHP with extensive documentary evidence of performance. Additional information from the CRHP Scoping Study was also available.

Composition of the GMC

The GMC is the regulatory body for 203,398 registrant including those on the principal register, the overseas list and limited register. The council (from July 2003) comprises: 19 doctors elected by registrants, 2 doctors appointed by universities and Royal Colleges, 14 lay members appointed by the Queen/Privy Council and a President elected from members. The term of office is 4 years. Membership is limited to 8 consecutive years and members are able to stand for re-election or re-appointment after 4 years.

Corporate Governance Arrangements

It was apparent from the documents provided by the GMC, and from discussion, that the Council has good corporate governance arrangements in place.

Diversity

The GMC has an equal opportunities policy, and its Race, Equality and Diversity Committee has a work programme for 2003. Initiatives in this work programme include introducing equality proofing procedures, to help the GMC assess the impact of new procedures or policies on different parts of the community, and avoid direct or indirect discrimination. The GMC will also introduce new arrangements to consider appeals against GMC decisions to refuse registration, which will apply to all doctors.

Education

- The GMC sees its duty as coordinating all stages of medical education and is therefore taking a lead on Continuing Professional Development (CPD), as well as supporting the Postgraduate Medical Education Training Board (PMETB).
- The GMC has recently issued draft guidance on CPD. The guidance will emphasise the responsibility of the doctor to keep up to date and to undertake CPD. It will put the patient at the heart of CPD opportunities for doctors. CPD will help doctors to keep up to date. It will also help doctors to demonstrate that they are up to date for the purpose of revalidation.

European and international issues

- The GMC is taking a leading and facilitative role in the Alliance of UK Health Regulators on Europe (AURE). AURE is lobbying on European issues where they consider that there is a risk to the public in the UK. For instance, AURE has lobbied against health professionals being able to practise in the UK for up to four months per year, every year, without being registered, or has lobbied the European Commission about the need to clarify which qualifications of health professionals from the European Union (EU) accession countries comply with the minimum EU training requirements.
- Currently EU doctors do not have to do a Professional and Linguistic Assessments Board (PLAB) test, unlike overseas doctors, which has led to allegations that overseas doctors are treated less favourably.

Standards

- The GMC is moving away from standards in a formal code to standards in a Question and Answer format.
- The GMC has worked collaboratively with other regulatory bodies on the common Code of standards across health professionals.

Fitness to Practise (FTP)

The GMC is developing and consulting on new FTP mechanisms in which the previously separate performance, conduct and health procedures will be considered in the round. This will avoid problems of referring down one route which forecloses other routes.

Communication and public and patient involvement

The GMC does not have any published documents covering this area. However, it does have a Public Reference Group '...to enable patient and consumer representatives to make an effective contribution to the development of GMC policy and procedures'. The PRG is made up of lay members of the GMC, representatives of umbrella patient and consumer groups and representatives from patients' groups of medical Royal Colleges. The GMC is keen to make the PRG as diverse and representative as possible. In addition, the PRG has set up a sub-group 'to work with the GMC's PR team to draw up a strategy and programme for connecting efficiently and effectively with the public over the next 18 months, reporting to the Patients' Reference Group and, as appropriate, to the reconstituted Council.'

Example of Noteworthy Practice

- The GMC is taking the lead on the design of revalidation procedures. The proposed system is designed to complement existing appraisal and clinical governance systems.
- The *Tomorrow's Doctors* booklet on medical education is used as a template internationally
- The GMC is about to introduce identity checks to combat identity fraud, requiring photographs which will be available digitally to employers.

Conclusions

There are shared problems facing the regulatory bodies, but the capacity exists for regulators to tackle these in a more co-ordinated way. This first performance review cycle has identified a variety of ways in which CRHP can support and facilitate this ongoing process:

- Helping the Department of Health reach a better understanding of the boundaries between employment/management processes and regulatory issues, and of the need to consult with regulators when considering workforce issues
- Benchmarking regulators, for example on the costs of prosecution and lengths of time to prosecute a case (within and possibly beyond health care regulatory sector)
- Ensuring appropriate induction mechanisms for overseas health workers new to the NHS.

council for healthcare regulatory excellence

General Medical Council Performance Review Report 2005

1. Introduction

1. The GMC is the regulatory body for medical practitioners. Its purpose is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine. It has approximately 200,000 registrants (as at the end of 2003). Its Council has 35 Members: 19 doctors elected by doctors on the register, 14 lay members of the public appointed by the Privy Council and 2 academics appointed by educational bodies. Its annual revenue for 2003 was £60.3m. It has 380 members of staff (as of March 2005). More information on the GMC can be found at www.gmc-uk.org or by calling 0845 357 8001.

2. GMC's good practice

Learning and feedback loops

2. Areas of good practice in feeding back learning across the GMC's functions include:

   - consultation is undertaken with the relevant policy committees in developing subject specific guidance. For example, the preparation of the indicative sanctions guidance for fitness to practise took account of the views of the Standards Committee.
   - linking regulatory activities through its guidance to doctors, *Good Medical Practice*. The values and standards described are used to inform the standards for undergraduate medical education and are contained in the standards for entry to full registration for UK graduates. *Good Medical Practice* also provides the blueprint for the structure of the PLAB test set by the Professional and Linguistic Assessments Board, the principal route by which international medical graduates obtain registration. Within the context of the GMC's fitness to practise procedures, *Good Medical Practice* is also the template against which doctors are judged.

3. The GMC's guidance is set out in booklets which are regularly reviewed and updated. The GMC aims to review each booklet at least every five years, but more frequently if the need arises. The GMC also keeps *Tomorrow's*

Doctors, *The New Doctor* and *Continuing Professional Development,* which set out the GMC's educational standards, under review. It may be worth noting that the GMC logs comments on these documents internally, so that it can consider these comments when the documents are revised. The GMC is also reviewing its guidance on the criteria and thresholds used by decision makers at the initial stages of the fitness to practise process and will consult on these later in the year

4. Generally, the GMC aims to review its activities regularly. For instance, the introduction of a smaller Council in 2003 will be followed in 2005 by a post-implementation review of the governance reforms.

Fitness to practise (FTP)

5. The GMC's new fitness to practise procedures replaced all its adjudication committees by generic fitness to practise panels. This establishes a unified process which addresses the overall issue of whether fitness to practise is impaired.

6. The GMC was the first regulator to develop Indicative Sanctions Guidance. At the time of this report, the GMC was reviewing this Guidance and, as it considers that the Guidance is a living document, is committed to reviewing it on a regular basis.

7. The GMC established an auditing group in 2003 to review the consistency of the decisions of the fitness to practise panels. Office staff identify decisions where the determination and/or the reasons for the determination are unclear or where the outcome in relation to the finding or the sanction is unexpected. Those cases are then reviewed by a group of members who report to the Fitness to Practise Committee and ultimately to Council. The results of the audit feed into the training of panellists and legal assessors and feedback is also provided to individuals. Successful appeals, judicial reviews and section 29 referrals also feed into the guidance and training provided.

8. The Rules now provide for all convictions resulting in a custodial sentence (whether immediate or suspended) to be referred directly by the Registrar to a Fitness to Practise Panel for adjudication. There is also a presumption in the Rules that all convictions, cautions and determinations of other regulatory bodies will be treated in the same manner. Fitness to Practise Panels may now rely on overseas convictions and determinations of other regulatory bodies as conclusive evidence of the underlying facts, in the same way as UK convictions are handled under the present arrangements.

9. The Medical Act 1983 requires all international medical graduates applying for registration to satisfy the Registrar of the GMC that they are of good character. In 2004 the GMC enhanced its arrangements for meeting this

requirement by insisting that all such applicants provide evidence of their good character in the form of a certificate of good standing from the overseas regulatory authorities under whose jurisdiction they have previously worked. Equivalent arrangements for doctors from within the EEA have been in place for many years.

10. In all cases where the GMC decides to investigate a complaint it obtains details of the doctor's employers/contracting parties. They are informed of the complaint and steps are taken to identify whether there are wider concerns about the doctor. The aim is to ensure that the GMC has a complete overview of the doctor's practice. The dialogue between GMC and employers/contracting parties also means that information is made available to those responsible for local clinical governance.

11. The GMC collects statistical information on categories of cases.

Stakeholder involvement

12. The GMC's current policy development process would typically involve research conducted by or on behalf of a project working group (usually comprising Council members, experts in the field and other stakeholders), feasibility studies, an equality impact assessment, consultation with internal and external stakeholders, and consideration by the relevant GMC policy committees.

13. The GMC also has a Patient and Public Reference Group (PPRG). The Group comprises six medical and lay members of Council (with a lay Chair) and representatives from a range of public and patient interest groups. The GMC is currently exploring ways of reinforcing the role of the PPRG in policy development, and identifying a range of additional mechanisms for enhancing patient and public involvement in its work.

14. In 1998-9 and 2003 the GMC undertook perception audits to test views about the GMC held by key internal and external stakeholders. The GMC will this year begin to undertake an annual tracking survey. Its purpose will be to test the opinion of the public and the profession on a range of key issues relating to its purpose and strategy, compare these over time and help to inform policy development.

15. The GMC instigated and co-ordinates the Alliance of UK Health Regulators on Europe (AURE) which pursues the regulators' shared concerns on European regulatory issues. The GMC is also an active member of IAMRA (International Association of Medical Regulatory Authorities).

16. The GMC actively collaborates with other organisations, for instance it has established memoranda of understanding (MoU) with some key partner organisations (such as NCAA – now the NCAS), and is in the process of developing MoU with a number of other bodies such as ACPO, CPS and NPSA.

Organisational development

17. The GMC mentioned that the introduction of its new, smaller Council has given it a more strategic approach. The GMC has also established in 2004 a new Strategy and Planning Directorate. The key functions of the Directorate are to provide a strategic approach to the GMC's work and to enhance processes for the co-ordination of management and other information across all of the GMC's functions.

18. The GMC developed its in-house legal services and considered that this has generated considerable savings in fitness to practise spending.

Education and continuing professional development (CPD)

19. The GMC highlighted its system for the Quality Assurance of Basic Medical Education (QABME) to ensure that the standards that it sets for undergraduate and Pre-Registration House Officer (PRHO) medical training are met. This involves annual returns from medical schools complemented by a review of each school twice in every ten year period. The review takes place over an 18-month cycle. The medical school provides information and documentation in response to a questionnaire. A series of visits takes place by members of a dedicated Visiting Team for that school. A final wrap-up visit at the end of year includes the whole Team and leads to the completion of a Report that is considered by the GMC's Undergraduate Board and Education Committee.

20. The GMC also mentioned that its PLAB test is a leading initiative worldwide. The GMC is also developing its role in Continuing Professional Development and published *Continuing Professional Development* in 2004.

Diversity

21. The GMC consulted in 2004 on a Diversity Work Programme. It has a Race Equality and Diversity Committee, which has considered the consultation responses and is ensuring that the GMC is taking into account the issues raised. An Equality Impact Assessment is undertaken for all new policies to ensure that they do not have a negative impact on parts of the community. During 2005 the GMC will be developing advice on diversity issues for

doctors. The GMC also undertakes ethnic monitoring of new applicants for registration. (See also paragraph 24)

3. Areas for possible development

Fitness to practise (FTP)

22. The Fifth Report of the Shipman Inquiry contained 109 recommendations. Just over half of these recommendations focus on the GMC. Of those, the majority are concerned with the GMC's fitness to practise procedures. The GMC considers that many of these recommendations reflect existing GMC policy and practice and will consider the remaining recommendations during the course of the year. The Government has commissioned the Chief Medical Officer for England to carry out a review of the issues arising from the report and we await the forthcoming conclusions of this review.

23. The GMC has an internal process for the internal audit of decision-making at the initial stages of its fitness to practise process. A sub-group of the GMC's Fitness to Practise Committee, established in May 2004, approves a programme of audit carried out by an audit team composed of GMC staff, receives reports of the audit activity, reviews case files where the audit team believes there may be significant errors in the decision-making process, and may refer any cases where they think an unsustainable decision was made to the President (who can in turn ask the Case Examiners to re-open the case and re-consider it). However, the GMC may wish to consider commissioning an external audit of decision-making at the initial stages of the fitness to practise process for quality assurance.

Diversity

24. Although the GMC undertakes ethnic monitoring of new applicants for registration, it does not systematically monitor the ethnic diversity of every doctor on the register. The GMC is commissioning research on the outcomes of its fitness to practice cases which will look, in particular, at the apparent over-representation of overseas qualified doctors at various stages of its fitness to practise procedures. The GMC may wish to consider how it might enhance its current monitoring processes.

Complaints scheme

25. A number of regulators have published on their website their complaints scheme detailing how to make complaints against the regulator itself (as opposed to complaints against registrants), and their example may be of interest to the GMC.

4. Challenges for the future/planned changes

Considering the recommendations of the Fifth Report of the Shipman Inquiry

26. The Neale, Ayling and Shipman Inquiries have all reported in the period covered by the 2004/2005 performance review. Just over half of the 109 recommendations of the Fifth Report of the Shipman Inquiry focus on the GMC, and the subsequent review by the Chief Medical Officer and the review of Non-Medical Professional Regulation (the Foster review), have possible implications for the GMC and generally for all the regulators.

Public perception

27. The GMC's regulatory activities cover education, registration, professional standards and fitness to practise. The GMC highlighted that since 2000 the organisation has undertaken wide-ranging reforms affecting each of these business areas and transforming the GMC's governance arrangements. However, the GMC feels that public perception has not always reflected the changes it has made, and that the media, inevitably, still focus on the small number of doctors who are found unfit to practise.

council for healthcare regulatory excellence

Annex 3

General Medical Council Performance Review Report 2005-06

1. This report is specific to the General Medical Council (GMC). Common themes and general issues arising from the performance review 2005-06 are addressed in the overall covering paper.

Introduction

2. The GMC is the regulatory body for medical practitioners. Its purpose is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine. It has about 210,000 registrants (as at December 2004). Its Council has 35 Members: 19 doctors elected by doctors on the register, 14 lay members of the public appointed by the NHS Appointments Commission and 2 doctors appointed by educational bodies. Its annual income for 2004 was £66.76m (as at December 2004). It has 380 members of staff (as of March 2005). More information on the GMC can be found at www.gmc-uk.org or by calling 0845 357 8001. The response of the GMC to performance review questionnaire of this year can be found on www.chre.org.uk.

Noteworthy practice 2005-06

3. There are two key aspects to highlight in relation to GMC's good practice this year: the development of its partnerships, in particular with patients and the public, and the adoption of a risk-based approach to regulation.

4. The GMC has enhanced the mechanisms it employs in seeking the views of the public and patients on its standards and policies. For instance, a citizens' jury considered the issue of children's rights when receiving medical care, and the information from this exercise will be taken into account in developing the guidance on the treatment and care of children. Following the successful piloting of its tracking survey last year to ask the public and registrants their views on a range of subjects, the GMC has decided to undertake a tracking survey every year.

5. The GMC has also sought to strengthen its links with employers (a general term which includes contractors of services and agencies). It has established an employers' reference group for employers to strengthen the links between national regulation by the GMC and local regulation by

employers. This group will, among other things, develop a complaints handling protocol.

6. Further engagement of stakeholders and enhancement of its evidence-based approach to policy-making can be seen in the review of *Good Medical Practice*, where the GMC used meetings open to the public and doctors to explore specific issues and commissioned qualitative research on 'what makes a good doctor'. Evidence-based policy making is also apparent in initiatives to develop a risk-based approach to regulation.

7. The GMC has decided to adopt a risk-based approach to the regulation of doctors, particularly in terms of revalidation: where there is a low regulatory risk, the level of scrutiny and intervention by the GMC should be similarly low. Risks can be divided into two aspects: the context in which the doctor works, and personal indicators of impairment. Where the risk is higher and the potential for harm to patients is greater, a correspondingly greater level of scrutiny is required. A key element of this approach will be the collection of information on doctors' scope of practice. The GMC are commissioning a feasibility study into research of key early indicators of serious impairment to fitness to practise.

8. The GMC introduced in October 2005 an on-line doctor search facility which helps the accessibility and transparency of information on registrants as it links registration information with current fitness to practise status, showing any current restrictions on practice.

Notable developments since last year

9. Notable developments relate to the strengthening of the GMC's policies and processes.

10. The GMC is reviewing some of its policies in relation to the education and training of prospective registrants. It has recently completed a consultation on strategic options for undergraduate medical education. It is moving from an experience-based period of training to one based on outcomes, as the Foundation Programme beds down, by taking forward proposals for PRHO training which is now incorporated in the Foundation Programme. The GMC is also working in partnership with the Postgraduate Medical Education and Training Board (PMETB) on developing co-ordinated methods of quality assurance for Foundation Programme training.

11. Although its proposals for the revalidation of doctors are on hold pending the Government response to recent Inquiries and the report of the Chief Medical Officer for England, Sir Liam Donaldson, the GMC is taking forward work on revalidation. It is, for instance, carrying forward work to define and assess the attributes of 'approved environments', where regulatory scrutiny would be 'light' touch, and research on the use of questionnaires and other tools to support the revalidation of doctors working outside such environments. It has also commissioned the

Academy of Royal Medical Colleges to review the criteria, standards and evidence documents published by medical Royal Colleges and Faculties.

12. In addition to the on-line doctor search, other notable developments in registration include the replacement of the separate system of limited registration for international graduates by a single registration structure for all doctors, and the introduction of a new requirement for all applicants for registration to satisfy the GMC that their fitness to practise is not impaired. The GMC has launched a review of its specialist register and plans to introduce a new GP register from 1 April 2006.

13. The GMC intends to report publicly on the delivery of high level objectives in its business plan.

14. Following last year's report, the GMC Fitness to Practise Committee agreed to the introduction of an independent element to their audit of decision-making at the initial stages of the FTP process. The GMC is currently exploring how best this could be done. As part of its plans to develop a risk-based approach to regulation, and in the context of issuing licences to practise, the GMC plans to collect a range of information about doctors' scope of practice, and this will provide the GMC with an opportunity to collect ethnicity data on licensed doctors. Finally the GMC will develop a new, centrally co-ordinated corporate complaints process to deal with complaints about the organisation (as opposed to complaints against registrants).

Areas for possible development

15. The GMC recognises that its processes for handling complaints against the organisation would benefit from further development. Progress has been made, but further work is needed to realise a fully effective system.

Challenges for the future/planned changes

16. The common challenges identified in the covering paper apply to the GMC, in particular the outcomes of the Chief Medical Officer's review of clinical performance and medical regulation.

17. The GMC has changed the way in which it deals with complaints against doctors. The GMC categorises complaints into two categories, stream 1 complaints where it is clear to the GMC that it will need to investigate, and stream 2 complaints, which the GMC considers could justify action if part of a wider pattern of concern about a doctor but would not do so by themselves.

18. The GMC continues to investigate all stream 1 complaints but from October 2005 refers all stream 2 cases where the doctor works within the NHS directly to local NHS procedures for consideration. It also continues to investigate Stream 2 cases where the concerns relate to a doctor's

private practice or where the doctor is a peripatetic locum. It has developed appropriate systems to ensure that cases referred to local procedures are returned to the GMC where there is further information that calls into question a doctor's fitness to practise and that the GMC receives written confirmation that there is no such evidence where the case has been concluded locally. A challenge for next year will be to review current practice and ensure that the system is working to its optimum.

19. The GMC has planned a considerable programme of work, on which it has undertaken to report publicly. A particular challenge will be its demonstration of progress in key areas.

20. Key to the GMC's development of its risk-based approach is the availability of information on doctors' scope of practice. Consequently, CHRE fully supports the GMC's need for a section 60 order to enable it to collect this information.

Annex 3

GMC Performance Review Report 2006/2007

council for healthcare regulatory excellence

1. *This report is specific to the General Medical Council (GMC). Common themes and general issues arising from the performance review 2006/2007 are addressed in the overall covering paper.*
2. As with all regulators, the GMC performance review was set against the background of discussions arising from the UK-wide reviews of the regulation of healthcare professionals. This is particularly the case for the GMC, for which this year has been dominated by engaging in work and debate on the report by the Chief Medical Officer (CMO) (see covering paper).

Introduction

3. The GMC is the regulatory body for medical practitioners. Its purpose is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine. It has about 240,000 registrants (as at December 2006). Its Council has 35 Members: 19 doctors elected by doctors on the register, 14 lay members of the public appointed by the Appointments Commission and 2 doctors appointed by educational bodies. Its annual income for 2006 was £63.73m and it has 380 members of staff (as of March 2005). More information on the GMC can be found at www.gmc-uk.org or by calling 0845 357 8001. The response of the GMC to performance review questionnaire of this year can be found on www.chre.org.uk.

Noteworthy practice 2006/2007

4. There are three areas of noteworthy practice to highlight for the reporting year: continued partnerships with stakeholders, in particular patients and the public, increased research activity and the production of new guidance.
5. Building on the successes highlighted in last year's performance review, the GMC has further improved its patient and public involvement (PPI) processes. The GMC's Patient and Public Reference Group (PPRG) has been expanded through the recruitment of seven members of the public, while an external readers panel has been established to ensure that the GMC's communications are accessible and easily understandable. In addition to its existing online facility for professionals and adult patients to comment on draft guidance, the GMC is hosting a website aimed at children and young people to invite their views on the broad issues raised in the guidance on doctors' roles and responsibilities vis-a-vis children and young people.
6. The GMC continues to take an evidence-based approach to policy and 2006 has seen the formation of a new research partnership with the Economic and Social Research Council (ESRC). A number of projects are planned,

and these are expected to begin in 2007 and run until 2009. The GMC continues to produce its own research and has launched a scoping study to look at how its processes for engaging with the profession could be enhanced, a report from which is expected this year.

7. In reviewing its core guidance, *Good Medical Practice (GMP)*, the GMC produced four pieces of supplementary guidance: *Conflicts of Interest*, *Maintaining Boundaries*, *Raising Concerns about Patient Safety* and *Reporting Criminal and Regulatory Proceedings*, while further supplementary guidance (*Acting as an Expert Witness* and *Writing Reports*) is being developed. The GMC has developed a protocol to make the production of supplementary guidance more open and inclusive, by means of greater use of electronic communication and a consultation period of eight weeks. The GMC has produced other guidance for its registrants[1], its staff and its stakeholders.

Notable developments since last year

8. The GMC's continued partnerships with employers and the devolved nations, and the GMC's initiatives on diversity have been notable in the reporting year.

9. The GMC continues to engage with employers and a key project of its Employers' Reference Group, formed in early 2006, involves the mapping of complaints processes to ensure that both the GMC and the employer are aware of their roles and responsibilities. In response to the differing needs of the devolved nations, the GMC has established an office in Belfast, in addition to those previously established in Edinburgh and Cardiff, and developed memoranda of understanding (MoUs) with bodies specific to the devolved regions. Working through its offices in Scotland, Wales and Northern Ireland, the GMC encountered strong interest amongst local clinicians and patients' groups in its guidance on *Withholding and Withdrawing Life-Prolonging Treatments*. A number of local organisations became involved in developing and delivering a three-month programme of workshops and talks which were spread across the four countries.

10. The GMC is now subject to equality legislation. It has published its *Equality Scheme*, developed after involving a range of organisations and consulting with members of the public. As a result of a new section 60 order (see paragraph 17), it will be able to gain more full ethnicity information by collecting practice information. The Chief Medical Officer (CMO) is currently preparing a report on racism in medicine and the GMC will study its implications for its work.

11. In the light of the White Paper, the election that would have been held in 2007 for the GMC Council will not take place. The terms of office of the

[1] Other new guidance for registrants being developed includes guidance for doctors on their role and responsibilities in relation to children and young people and an updated version of *Seeking patients' consent: the ethical considerations (1998)*. Guidance produced internally includes a review of the mechanisms for determining acceptable overseas Primary Medical Qualifications (PMQ) for the purpose of registration (in force since October 2006) and guidance for streaming cases. There is now also guidance for employers on supervising a doctor with restricted registration. The GMC reviewed its educational standards, *Tomorrow's Doctors*, with a view to producing a new edition in 2008.

current membership of the Council have been extended by the Government so that the current Council can oversee the transition to the new, appointed, Council in 2008, as described by the White Paper.

12. In order to measure and report on their performance, the GMC has developed 'Key Performance Indicators' across their activities. These are monitored through the Chief Executive's report and the GMC's report to the Charity Commission and will be available publicly. Most of the GMC's targets were achieved last year.

Areas for possible development

13. The handling of complaints against the organisation was highlighted in the last performance review as an area that would benefit from further development. The GMC has begun work on an integrated approach to complaints handling on an organisation-wide basis. Further work will be required in this area. As an interim measure a 'customer services manager' mailbox has been established to help improve the current processes pending the outcome of this work.

14. The feedback points identified by CHRE through its section 29 function were raised with the GMC during the performance review meeting. The GMC has always welcomed the feedback points process and there have been considerable and on-going improvements in the giving of reasons in determinations. CHRE notes that the quality of outcomes from the FTP cases has improved. This is evidenced by no GMC cases referred to the High Court by CHRE in the reporting year. The GMC has increased its capacity to hear cases. Finally, the GMC will continue to work with CHRE on its feedback points.

Challenges for the future/planned changes

15. The GMC faces the common challenges identified in the covering paper, notably the implementation of the recommendations of the white paper *Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century*[2]. Many recommendations of the white paper focus specifically on the GMC. This will result in a considerable programme of work, and implementing these significant changes will be the GMC's key challenge for next year (see covering paper). Although recommendations for doctors are specific to the GMC, the GMC aims to work closely with the other healthcare regulators.

16. Specifically, the GMC will face considerable challenges in the implementation of revalidation. The role of affiliates will be crucial to the new system. They should be able to command the confidence of patients and the public and it will be important that affiliates are appointed against clear criteria, have the confidence of patients and all stakeholders, and work within a clear framework of accountability.

17. The other challenges faced by the GMC relate to the implementation of a new section 60 order, approved by parliament in 2006 and scheduled to be

[2] http://www.dh.gov.uk/assetRoot/04/14/31/43/04143143.pdf. For more information, see covering paper.

implemented in 2007. This legislation will, among other things: allow the GMC to use practice information to gain fuller ethnicity data; abolish the system of limited registration for international medical graduates, replacing it with a single registration structure for all doctors; and introduce a requirement that all applicants satisfy the GMC of their fitness to practise.

18. The GMC's key projects for the coming year[3] are:

    - implementing the government's plans for the future of medical regulation;
    - abolishing limited registration;
    - reviewing the fitness for purpose of the specialist register, a project extended in the light of the White Paper to the role and content of the register generally;
    - publishing new guidance on standards and ethics;
    - developing and consulting on proposals for the consensual disposal of certain categories of fitness to practise (FTP) case at the investigation stage of its procedures.

---

[3] Key projects were identified by regulatory bodies in response to the performance review questionnaire. For more information, see the responses to the common template on projects on www.chre.org.uk