Annual Report 2011

Trustees' annual report and accounts for
the year ended 31 December 2011

General
Medical
Council

Regulating doctors
Ensuring good medical practice

Contents

Statutory purpose

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

2 We aim to deliver regulation that:

- **a** raises standards and enhances patient safety
- **b** fosters the professionalism of doctors
- **c** is independent, fair, efficient and effective
- **d** encourages early and effective local action
- **e** commands the confidence and support of all our key interest groups.

3 As a registered charity (number 1089278 with the Charity Commission for England and Wales and number SC037750 with the Office of the Scottish Charity Regulator), we have complied with the duty in section 4 of the *Charities Act 2011* to have due regard to the public benefit guidance published by the Charity Commission in determining the activities we undertake. This annual report sets out the details of our work in 2011 that demonstrates public benefit.

Review of 2011

Some highlights of the year

4 During 2011, we laid the foundations for significant reforms that will help us to prepare for the future and move us towards becoming a more proactive regulator.

5 We made very good progress throughout 2011 in developing revalidation and planning for its implementation, and we will focus our efforts in 2012 to make sure it is successfully introduced by the end of the year.

6 We developed and consulted on major reforms to our fitness to practise processes and secured wide support for our proposals. These are designed to increase the speed and cost-effectiveness of our investigations, while ensuring they remain proportionate, modernise and streamline our adjudication procedures, and give our key interest groups greater confidence in the independence of our adjudication panels.

7 Despite the increasing volumes of fitness to practise concerns (2011 saw a year-on-year increase of 23%), we were able to meet six out of seven of our service level targets for the timely handling of fitness to practise activity. We improved the efficiency of case management through enhanced management controls and established a new training regime for staff thereby improving performance across the year.

8 We continued to deliver the priorities set out in our *Education Strategy 2011-2013*, and to realise the benefits of the merger of the Postgraduate Medical Education and Training Board (PMETB) with the GMC. In 2011, we implemented a coordinated approach to quality assurance across undergraduate and postgraduate education. We also created a single set of standards for postgraduate education and training set out in *The Trainee Doctor*. Alongside this practical work, we have sought to develop closer and productive relationships with all those with an interest in medical education.

9 We reviewed our core guidance for doctors, *Good Medical Practice*, and launched a public consultation on an updated version. It is now structured using the four headings (knowledge, skills and performance; safety and quality; communication, partnership and teamwork; and maintaining trust) from the framework for appraisal on which recommendations to revalidate doctors will be based. The more concise, updated edition will be launched in 2012, and we will work to make it as relevant as we can where it matters most – to doctors on the frontline delivering clinical care.

10 We set the foundations for a much stronger local presence by establishing our Employer Liaison Service to work with employers, and by piloting our Regional Liaison Service to work with our key interest groups. The pilots for both of these services suggest they have been very well received and will encourage a closer and more effective dialogue between the GMC and those involved in the local delivery of healthcare. The new teams will also play a vital role in supporting the implementation of revalidation.

11 We worked closely with the Department of Health (England) (DH(E)), our counterparts in the Alliance of UK Health Regulators on Europe (AURE), and the European Commission to underline the need for patient safety to be at the heart of the review of the Directive on the recognition of professional qualifications.

12 In October 2011, our extensive discussions with DH(E) over the language testing of doctors from the European Union (EU) came to fruition when the Secretary of State for Health announced that the Government will amend the *Medical Act 1983* and introduce measures to ensure that all doctors who come from overseas to work in the UK have the necessary language skills needed to practise safely.

13 We remain committed to providing value for money and, during 2011, we delivered efficiency gains of £8.7 million, representing approximately 9% of our budget for the year. As a result, from April 2012 we reduced the annual retention fee paid to us by doctors. We received external assurance that our efficiency programme is robust, and advice on how we can further reduce our costs, which we are taking forward in 2012.

14 We published our first report on the state of the UK's medical profession. *The state of medical education and practice in the UK 2011* received an excellent response, and we used it to engage with our key interest groups, including their senior representatives, at meetings held during the main political party conferences.

15 We have continued our major programme of work not only to ensure that our policies, procedures and ways of doing business are fair and inclusive but also to ensure that we increase awareness and promote the value diversity brings to the organisation. This goes beyond compliance with equality and diversity legislation. We are striving to make sure that equality and diversity issues are considered throughout the development and implementation of core GMC activities.

16 During 2011, following extensive consultation with staff and with the engagement and endorsement of Council, we agreed a new set of organisational values that underpin how we behave towards one another and how we relate to the wider environment. The five GMC values are as follows.

- **a** We protect the public through the work that we do.
- **b** We treat everyone fairly.
- **c** We are honest and strive to be open and transparent.
- **d** We are committed to excellence in everything that we do.
- **e** We are a listening and learning organisation.

17 Alongside these headline achievements, we have also sought to improve the way we communicate with doctors, patients, employers and all those we serve. This has led to changes in our written materials and our website, to make it easier to navigate. We have also engaged extensively with patient and public involvement groups and held two conferences to share our ideas with and hear from our key interest groups.

Delivery against our business plan for 2011

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

18 In 2011, we continued to ensure the accuracy, robustness and accessibility of the medical register. We have improved how we carry out our registration functions, including making improvements to the processes we use to enter doctors onto the Specialist Register or the GP Register, reviewing our primary source verification sample rates and auditing our operational processes.

19 We reviewed a number of areas of our policy framework, as a result of which we harmonised our registration and certification appeal activity; produced revised guidance to the Registrar on dealing with minor offences declared by doctors applying for registration; and aligned the criteria for awarding approved practice setting status with that of a 'designated body' (an organisation, under the revalidation regulations, that employs or contracts with registered doctors).

20 We also started a number of reviews that we will take forward in 2012, including a review of the Professional and Linguistic Assessments Board (PLAB) test and a review of the policy that supports sponsorship and postgraduate qualifications as a mechanism for international medical graduates gaining registration.

21 We collected additional information from doctors to enhance our understanding of their practice. Hard copy questionnaires were used between January and March 2011, and, from April 2011, we moved to online collection via *GMC Online*, our dedicated website for doctors. We confirmed that the demographic profile of respondents broadly reflects the characteristics of the full register of licensed doctors by age, geography and primary medical qualification. We used this information to understand the number of doctors without a prescribed connection to a designated body.

22 We met all our targets to provide a prompt and efficient registration service across 2011. We have seen a move from telephone to email enquiries; calls to the automated service confirming a doctor's registration were down 21% in 2011 compared with 2010, and calls to our contact centre were down 6.4% in 2011 compared with 2010. We will continue to monitor these volumes and keep our resource model under review.

Registration performance against targets in 2011

To respond to **95%** of applications within five working days.	**100%**
To answer **90%** of calls within 15 seconds.	**91%**
To see **95%** of doctors visiting reception within ten minutes of their arrival.	**97%**
To answer **95%** of emails and letters (enquiries) within five working days.	**98%**
To answer **95%** of emails and letters (updates) within five working days.	**97%**
To respond to **95%** of complaints within ten working days.	**97%**

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

Fitness to practise

23 In 2011, we continued to deal firmly and fairly with all fitness to practise concerns raised about individual doctors through our fitness to practise procedures.

24 We held a public consultation on changes to the way we deal with cases at the end of an investigation. The 217 responses we received helped to shape our plans. We plan to meet doctors face to face to talk through the evidence gathered during our investigation and any new evidence they can provide. Following this meeting, we will confirm the outcome we believe is necessary to protect the public and ask the doctor to accept it. To maintain transparency and to ensure public confidence, we plan to publish a summary of the concern and the outcome. We also plan to meet with complainants to explain our processes and make sure we fully understand the nature and scope of their concerns. We will pilot both of these meetings during 2012.

25 We started providing emotional support for witnesses appearing before a fitness to practise panel hearing. This is provided under contract by the organisation *Victim Support*. We will also pilot a service to provide emotional support to the doctors who are involved in our procedures.

26 We reviewed how we deal with cases where we are alleging that a doctor's practice is impaired because of adverse physical or mental health. We are determined to be sensitive, proportionate and fair in our dealings with doctors with health concerns. An expert working group helped us to develop a new website for doctors who may be concerned about their own health or that of a colleague. *Your Health Matters* provides case studies on doctors with a range of health concerns, a testimonial from a doctor who has gone through fitness to practise procedures, and a range of advice on the process. The website was launched in January 2012.

27 In 2011, we consulted on proposals to establish a new Medical Practitioners Tribunal Service (MPTS) to be responsible for the day-to-day operation of adjudication and thereby establish a clear distinction between the investigation and adjudication stages. Many aspects of the resulting reforms require amendments to our rules or to the *Medical Act 1983* and we are working with DH(E) to secure these. The MPTS has been established in shadow form and was launched on 11 June 2012. We also started implementing changes to make hearings simpler, faster and cheaper. We will continue this work in 2012.

28 We received 8,781 concerns about doctors' fitness to practise in 2011, compared with 7,153 in 2010 – a year-on-year increase of 23%. This follows a 24% increase in 2010. We commissioned research to investigate this trend, which suggested that factors driving the increase included changing attitudes on the part of doctors and the public towards raising concerns, and improved clinical governance.

29 Overall performance against our service targets was good. Our most challenging fitness to practise target is to conclude or refer 90% of cases at the investigation stage within six months. We took steps to help us respond to the rise in concerns by increasing the number of staff involved in this work and undertaking additional management controls to review cases. As a result, our performance across the year improved.

Fitness to practise performance against targets in 2011

To conclude **90%** of fitness to practise cases within 15 months.	**96%**
To conclude or refer **90%** of cases at the investigation stage within six months.	**87%**
To conclude or refer **95%** of cases at the investigation stage within 12 months.	**95%**
To commence **90%** of panel hearings within nine months of referral.	**93%**
To commence **100%** of Interim Orders Panel hearings within three weeks of referral.	**100%**
To review **100%** of doctors with conditions or undertakings attached to their registration before being returned to unrestricted registration.	**100%**
To commence **100%** of Investigation Committee hearings within two months of referral.	**100%**

Revalidation

30 Revalidation remains our number one priority, and in 2011 we continued our work to develop further policy and guidance to support its introduction from late 2012.

31 We published the *Good Medical Practice Framework* for appraisal and revalidation, and guidance on the supporting information that all doctors will need to bring to appraisal. We also published guidance on developing, administering and implementing colleague and patient feedback, together with draft questionnaires that are free for those employing or contracting with doctors to use.

32 We launched a public consultation on the regulations necessary for the introduction of revalidation. We plan to revoke the Licence to Practise Regulations and create a new set of regulations covering both licensing and revalidation. These will cover our existing powers plus the additional powers we will need to maintain, withdraw, restore or refuse to restore licences in the context of revalidation. The outcome was published in July 2012.

33 We worked with our partners to finalise the text of the positive recommendation that responsible officers will give to the GMC to support the revalidation of their doctors. We began to develop our approach to quality assurance, and defined a number of quality checks that will be applied to the recommendations from responsible officers.

34 To progress local and national plans for implementation, we monitored readiness across three key areas of the programme: the readiness of design elements to support the process of revalidation, the maturity of organisation and user systems to support the implementation of revalidation, and the maturity of the governance systems to deliver joint management of the programme across delivery partners.

35 We revised the 'Blueprint for Revalidation', which we presented to the UK Revalidation Programme Board in January 2012. It sets out in simple terms the key work that needs to be delivered to support the introduction of revalidation and the key milestones that need to be met to support implementation.

36 Readiness assessments were completed or underway in all four countries during 2011. We monitored information about local readiness through a series of dashboards. These are completed by each country with data from a wide range of sources, including from the revalidation self-assessment exercises across the UK.

37 We also began to make the changes needed internally to support the introduction of revalidation.

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

38 Our new *Quality Improvement Framework* setting out our coordinated approach to the quality assurance of medical education and training in the UK was endorsed by Council in February 2011 and we worked throughout the year to implement it. We worked closely with our partners, such as the medical schools, the medical royal colleges and the deaneries, to ensure that implementation was successful.

39 We set up the Quality Scrutiny Group to bring a clear and consistent view across the quality assurance of all stages of education and training, helping to provide scrutiny and identify priorities and themes. Dr David Sales was recruited as Chair of the Group, which meets quarterly.

40 Our quality assurance programme for 2011 was implemented as planned. We carried out integrated regional visits to deaneries in Wales and the West Midlands, and to medical schools in Birmingham, Cardiff and Warwick. We also visited medical schools in Swansea and Keele, and Newcastle Medical School in relation to its Bachelor of Medicine and Bachelor of Surgery (MBBS) degree delivered in Malaysia, as part of the new schools visits process. During the year we worked with deaneries and medical schools to enhance our response to concerns process, clarifying what we think should be reported on and encouraging the deaneries to do so.

41 We continued our discussions with DH(E) about the requirement to quality assure medical education delivered overseas. In discussion with the Medical Schools Council, we amended the guidance for medical schools on the quality assurance of medical education delivered overseas, making it clear that we will seek reimbursement of the full economic costs of undertaking this activity.

42 Key findings from our annual survey of junior doctors in 2011, the national training survey, painted a broadly encouraging picture of current postgraduate medical education with continuing high levels of satisfaction with training and practical experiences. Significant concerns were raised about some aspects of training and we are working with senior doctors, managers and medical educators to bring about improvement and change.

43 We reviewed the arrangements for the approval and recognition of undergraduate and postgraduate trainers. As a result, we developed proposals designed to improve the quality and consistency of medical training across the UK by clarifying roles and responsibilities. We launched a public consultation on these proposals in January 2012.

44 We reviewed our role in continuing professional development and launched a public consultation; as a result, we launched new guidance in June 2012. We also reviewed the 'equivalence routes' to the Specialist and General Practitioner Registers. This included commissioning research to look at the perceptions of the Certificate of Eligibility for Specialist Registration (CESR) or Certificate of Eligibility for GP Registration (CEGPR) routes among the profession, employers and the medical royal colleges. We held a public consultation in spring 2012.

45 After evaluating the case for student registration, Council decided that we should not introduce either mandatory or voluntary registration of medical students, with the issue to be revisited in 2015. We are implementing a programme of enhanced engagement with medical students, including bringing forward the point at which students engage formally with us to make provisional registration more straightforward.

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

46 During 2011, we launched a major public consultation on our core guidance, *Good Medical Practice*. The draft for consultation reflected current issues in medical practice, and emphasised the lead role that doctors are asked to take in making sure a patient's safety, comfort and dignity are always maintained. We used a range of different methods for consulting, including tailored questionnaires, a postcard campaign and an online survey. We also piloted the use of social media to increase our reach to individual doctors; and held meetings with groups that are seldom heard or may have been under-represented in past consultations. We will publish a new version of *Good Medical Practice* in late 2012.

47 We built up our body of evidence about doctors' awareness of our guidance, their views on its value and relevance, and their views on how we promote our guidance and learning materials to professional audiences. A literature review, in the first quarter of 2012, examined the factors in doctors' working environments that actively empower or act as disincentives on doctors to behave in ways consistent with established standards of good practice.

48 We have developed an extensive new online resource offering practical advice for doctors treating patients with learning disabilities. In preparing the website, we worked closely with people who have learning disabilities and with the bodies that represent them, as well as with carers, doctors and experts. We launched the website in April 2012.

49 Following consultation, we have updated a number of key pieces of guidance for launch in 2012. Our updated guidance on prescribing medicines ensures a focus on the medicine-related topics most frequently raised by doctors seeking our advice, as well as issues featured in fitness to practise investigations. *Leadership and management for all doctors* sets out doctors' wider responsibilities in relation to employment issues such as teaching and training, planning, using and managing resources, and participating in service improvement and development. Alongside this, we launched our guidance on *Raising and acting on concerns about patient safety* and *Writing references*.

50 We drafted and consulted on guidance for doctors working in child protection, clarifying their responsibilities when concerns about abuse or neglect arise. We published the guidance in July 2012, supported by learning materials, including 'key points' as quick reminders, and case studies that will enable doctors to explore issues they find challenging.

51 We developed draft guidance for GMC case examiners and the Investigation Committee to help them decide what action to take if a doctor is alleged to have assisted in a suicide. We consulted on the guidance in spring 2012.

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

Revalidation

52 Throughout 2011, we continued to engage extensively with our key interest groups, and to produce materials to help them prepare for the introduction of revalidation from the end of 2012. We hosted or attended a significant number of meetings, workshops and round-table events across England, Northern Ireland, Scotland and Wales; including attending and supporting responsible officer training days, and regularly attending responsible officer network meetings. We hosted regular meetings with the Independent Healthcare Advisory Services (IHAS) and, in October 2011, we launched a revalidation guide for independent sector leaders in England. We also published a guide on preparing for the introduction of revalidation for NHS leaders in England.

53 We hosted an exhibition stand at the NHS Confederation Annual Conference in Manchester from 6 to 8 July 2011; and an *Are you ready?* exhibition stand at the NHS Employers conference in Liverpool on 15 and 16 November 2011. This was delivered in partnership with DH(E), the NHS in England, the Revalidation Support Team and NHS Employers.

54 In December 2011, we began a campaign to engage with individual doctors on revalidation. This involved our Chair writing directly to all licensed doctors describing what they should be doing to prepare for the introduction of revalidation. The campaign will continue throughout 2012.

Liaison services

55 During 2011, we implemented our plans for closer liaison with employers and with our key interest groups across England through two dedicated new services.

56 Our Employer Liaison Service introduced a more direct relationship with medical directors and responsible officers by helping them to deal with concerns about doctors and providing specific fitness to practise advice, and by supporting responsible officers in relation to revalidation. We appointed a team of 15 regionally based Employer Liaison Advisers (ELAs) covering the whole of the UK.

57 We piloted a Regional Liaison Service in England to build and benefit from better links with our key interest groups. The pilot built on the approach that we believe has worked well for our offices in Scotland, Wales and Northern Ireland. Regional liaison advisers work with groups representing patients and the public, doctors, medical schools and students to make sure that what we do is understood and meets their needs. At the end of 2011, we had three regional liaison advisers in post with plans for further recruitment in 2012.

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

58 We continued to engage and share good practice with organisations with a common interest, including the Council for Healthcare Regulatory Excellence (CHRE) and other professional regulators. This included ongoing collaboration through the healthcare professional regulators' Chief Executives Steering Group, Governance Regulators Group and CHRE's Regulators Forum. We hosted a CHRE seminar on 'Evolution and Devolution' at our Edinburgh office and we presented on 'Regulation and the Workplace' at another CHRE seminar. We worked closely with other regulators to ensure effective exchange of information.

59 In 2011, we gave evidence to the Mid Staffordshire NHS Foundation Trust Public Inquiry. The second phase of the Inquiry looked at the role of the commissioning, supervisory and regulatory organisations and systems, and the attendant culture in relation to their monitoring role at the Trust between January 2005 and March 2009.

60 In giving evidence, we were able to explain our role and responsibilities, including our contribution to improving patient safety and the way medical professionals and the service are regulated. This covered our approach to medical education and in particular quality assurance, visits and surveys, guidance for doctors on raising and acting on concerns, progress towards the implementation of revalidation, fitness to practise reform and our procedures for dealing with doctors whose fitness to practise may be impaired, and how we work with other regulators.

61 We identified a number of themes arising from the Inquiry relevant to our role in improving patient safety and ensuring the system works better together. We are reflecting this in ongoing work programmes, such as embedding professionalism and establishing more effective information sharing and liaison arrangements with the service at local level.

62 We also gave evidence to the House of Commons Health Select Committee for the first of its annual accountability hearings on our work as well as for the Committee's inquiry into *Education, training and workforce planning*. These sessions gave us the opportunity to set out Council's programme of reform, the progress that we are making, and our commitment to improve patient safety and ensure that it underpins everything we do. We also appeared before the House of Lords EU Sub-Committee, which considered the European Commission's Green Paper on the mobility of healthcare professionals across Europe.

63 We continued to engage in the review of the recognition of professional qualifications Directive. This included responding to two European Commission (EC) consultations, both directly and with our counterparts through the AURE. The Network of Medical Competent Authorities, which we lead in collaboration with the French Medical Council and the German Medical Association, met three times in 2011 and issued joint responses to both EC consultations highlighting our patient safety concerns.

64 In our responses, we called for patient safety to be at the centre of any simplified recognition regime for doctors in Europe, including the need for an alert mechanism about healthcare professionals who have been removed from practice in other jurisdictions and clear provisions about language assessment.

65 Following extensive discussions and close working between the GMC and DH(E), the Secretary of State for Health announced in October 2011 that the Government will introduce measures to ensure all doctors who come from overseas to work in the UK must have the necessary language skills needed to practise medicine safely. We strongly welcomed this announcement, which will provide greater protection to UK patients. We are working with the Government to ensure that these additional safeguards are compatible with the proposals put forward in the draft Directive published in December 2011.

66 We participated in the European steering group set up by the EC to consider whether the introduction of a professional card would speed up the recognition process and facilitate the exchange of information between regulators. We expressed our view that a plastic card would create unnecessary bureaucracy and that the introduction of national registers across Europe instead would provide better assurance to employers and patients. The outcome of the group's work fed into the proposal for a European professional card put forward by the EC in the draft recognition Directive.

67 We continued to lead the Healthcare Professionals Crossing Borders (HPCB) initiative and carried out a review of our compliance with the HPCB Memorandum of Understanding (MoU) on case-by-case and proactive sharing of information about fitness to practise. We hosted 19 international visits in 2011, which allowed us to increase collaboration and share best practice in healthcare regulation. We continued to participate in the work of the International Association of Medical Regulatory Authorities (IAMRA), including chairing the Physician Information Exchange Working Group, which aims to ensure effective information exchange between regulators.

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

68 In 2011, we continued with the second year of our three-year programme aimed at making ongoing efficiency gains across the GMC equivalent to 3%–5% of our annual budget. We delivered total annualised efficiency gains of £8.7 million in 2011, representing approximately 9% of our budget for the year. As a result, from April 2012 the annual retention fee paid to us by all doctors was reduced. Further details about our efficiency programme are at paragraphs 80–82.

69 We asked KPMG to review our efficiency plans and help us identify any other potential savings. KPMG concluded that our efficiency programme is on target and had exceeded expectations. They also identified areas where we could build on this work. We are taking a number of initiatives forward in 2012.

70 Our efficiency programme was overseen by the Performance Board, which also reviewed core management information throughout the year and conducted a programme of functional evaluation.

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

Research and analysis

71 In 2011, we conducted and commissioned a range of research, data-gathering and analysis to inform evidence-based policy development and decision making. We are committed to making better use of our extensive data and, in 2011, we commissioned a study to explore how we can do this, both to inform our own decision making and to enable us to provide more relevant and timely information to our key interest groups.

72 For the first time in our 153-year history, we produced a report on the key issues facing medical education and practice, drawing upon our own data as well as evidence from other sources. *The State of Medical Education and Practice in the UK: 2011* represents the start of us fulfilling our commitment to be an authoritative voice, able to identify important trends, challenges and opportunities that will affect the quality of medical education and practice in the UK. We will publish this report every year.

73 We commissioned research to understand a range of topics, including: the impact of implementing the European Working Time Directive, and similar restrictions outside of the EU, on the provision of medical education and training outside the UK; and the increase in fitness to practise referrals from persons acting in a public capacity. Literature reviews helped us better understand how other countries structure their medical specialties and whether any interim recognition occurs prior to formal certification, and how other medical jurisdictions set and quality assure standards for continuing professional development. We conducted focus group research into the use of and access to *Good Medical Practice* by doctors.

Equality and diversity

74 We have continued with our programme of work to mainstream equality and diversity (E&D) in our work as a regulator and employer. Our starting point is to ensure that we comply with equality, diversity and human rights legislation. During 2011, we briefed our boards and committees on the requirements of the *Equality Act 2010* and the implications of the public sector equality duty for their work. We also rolled out a new approach to assessing compliance with the three aims of the duty.

75 We are working with DH(E) and partners to ensure a route to revalidation for all doctors, including those who share characteristics that are protected under the *Equality Act 2010*.

76 We continued to ensure that the relevant E&D issues are considered throughout the development and implementation of core GMC activities across our functions. This included our fitness to practise reforms programme, the review of GMP, the rollout of our education strategy, and the review of our registration and certification appeal panels.

77 There is clear leadership by Council and the Executive on implementing our E&D strategy. The Deputy Chief Executive is the senior sponsor for our work on E&D, supported by a network of champions across the organisation. Each directorate has an action plan that shows where the relevant E&D issues are being taken account of in their business plans. These plans are reviewed regularly by the Senior Management Team.

78 Our policies and practices for recruitment and selection reflect our commitment to the principles of equality and fairness. Treating everyone fairly is one of our organisational values.

79 We continue to make progress in reaching out to and involving people who share the protected characteristics in our consultation and engagement activity. We have developed new relationships with a range of E&D interest groups, including Stonewall, the Gender Identity Research and Education Society, and the Medical Women's Federation. We also continue to run the GMC Black and Minority Ethnic Doctors Forum.

Financial review

80 Our Performance Board, established in 2010, continued to oversee and drive performance improvements across the organisation. In 2011, we achieved total annualised efficiency gains of £8.7 million, which represents approximately 9% of our budget for the year. Around £6.6 million of this figure relates to cashable savings, which have been incorporated into our 2012 budget.

81 Major savings were delivered through projects to improve our efficiency, including: the further expansion of our in-house legal team, reducing our requirement for external lawyers; reducing the number of panellists sitting on panels; and improving the way our fitness to practise cases are handled to ensure we adopt a proportionate approach so that only the most serious cases are referred to a panel hearing.

82 As part of our drive to reduce costs we also relocated our adjudication and certification functions from London to Manchester, reduced our use of specialist IT contractors by transferring skills in-house, made changes to our travel and subsistence policies, negotiated a rent review on our premises, and made greater use of e-communications rather than paper copy.

83 In 2011, our income was £7.8 million higher than budgeted, and expenditure was £6.4 million below budget. Further details are set out in paragraphs 84–99.

84 The introduction of licensing in November 2009 created a degree of volatility to our income projections. Given the constraints on public finances, Council took the view that some doctors, for example those not in clinical practice, might choose to relinquish their licence to practise or seek voluntary erasure from the medical register during the year. Council therefore made a prudent assessment and factored an allowance for income volatility into the 2011 budget. In the event, we saw no reduction in the number of doctors holding a licence to practise, resulting in an additional annual retention fee income of £4.1 million compared with that budgeted.

85 Income from new registrations and certification fees was £0.4 million lower than budgeted. There was higher demand for PLAB tests than budgeted, which generated additional income of around £0.6 million, although this was offset by a corresponding increase in the costs of administering the tests.

86 Our accounts also include £1.4 million of income from the DH(E), to finalise the funding of the one-off transitional costs of the merger with the PMETB in 2010.

87 Other miscellaneous income was £0.6 million more than expected. We also received additional income of £0.3 million relating to investment income underpaid to us in previous years.

88 Our Standards and Fitness to Practise costs represent a significant proportion of our total expenditure. Our costs in 2011 were around £6.7 million lower than originally budgeted, mainly due to a reduction in the number of cases being referred to a fitness to practise hearing. We were also able to reduce costs by handling a greater proportion of legal work in-house and by reducing the number of panellists sitting on hearings.

89 Our Strategy and Communication costs were £0.5 million under budget. Additional expenditure was incurred on an enhanced programme of research and development projects, and savings were generated in other areas, including reduced printing costs as a result of *GMC today* not being issued in hard copy.

90 Continued Practice and Revalidation costs were £0.6 million under budget. Staffing costs were £0.3 million under budget because of delays in filling posts, and printing and distribution costs were £0.3 million under budget partly as a result of making greater use of e-communications rather than using hard copy.

91 Education costs were broadly in line with budget.

92 Registration costs were £0.5 million over budget. Additional demand for PLAB tests increased costs by £0.5 million, although this was offset by additional income generated. Staffing costs were £0.3 million over budget due to increased activity in certification and complex case work, offset by £0.3 million lower panel costs and office costs.

93 Resources costs were £0.2 million over budget, mainly as a result of additional work relating to the Mid Staffordshire NHS Foundation Trust Public Inquiry.

94 Accommodation costs were £0.3 million over budget, relating to a provision made for future dilapidations.

95 Depreciation charges were £0.2 million under budget, reflecting the nature and timing of our capital expenditure during the year.

96 In 2011, we set aside a New Initiatives Fund of £3.5 million to fund new opportunities and initiatives that may present themselves during the year. In July 2011, Council agreed to relocate our Adjudication and Certification functions from London to Manchester. We charged £2.7 million of one-off relocation costs to the New Initiatives Fund, and £1.5 million of relocation costs were capitalised and spread over five years in line with our normal depreciation policy. We estimate that the relocation of work will reduce our ongoing costs by around £2.7 million each year from 2012 onwards. We also charged £0.1 million of consultancy costs to the New Initiatives Fund in 2011, relating to an external review of our efficiency programme, a review of reserves and some external advice on our registration process.

97 On 1 April 2010, the GMC assumed statutory responsibility for regulating all stages of medical education and training. The GMC's accounts for 2011 therefore include a full year of operational income and expenditure compared with only nine months in 2010. The accounts for 2011 also include one-off transitional costs of £1.4 million associated with this change, funded by the DH(E).

98 During 2011, we continued our programme of capital investment to improve our accommodation and IT infrastructure. We spent £5.7 million on major capital projects, which included the reconfiguration of our office space, the capital costs of relocating the adjudication and certification functions from London to Manchester, and the development of our information systems, including the development of electronic communication channels.

99 The pension scheme ended the year with a surplus of £5.1 million, comprising assets of £88.8 million and liabilities of £83.7 million, valued in accordance with Financial Reporting Standard 17 (FRS17). This is explained in more detail in note 13 to the accounts.

Trustees' responsibilities for the financial statements

100 The trustees are responsible for preparing the Trustees' Report and the financial statements in accordance with applicable law and regulations. Charity law requires the trustees to prepare financial statements for each financial year in accordance with UK Generally Accepted Accounting Practice (UK Accounting Standards) and applicable law. Under charity law, the trustees must not approve the financial statements unless they are satisfied that they

give a true and fair view of the state of affairs of the charity and of its net incoming resources for that period. In preparing these financial statements, the trustees have:

a selected suitable accounting policies and applied them consistently

b made judgements and estimates that are reasonable and prudent

c followed applicable accounting standards without any material departures

d prepared the financial statements on the going concern basis

e observed the methods and principles in the Charities SORP.

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

Investment policy

102 Our investment policy is to hold general reserves in low-risk, high liquidity investments that will maintain or enhance their value. The investment policy supports the aims of the reserves policy and, consequently, is reviewed periodically in conjunction with the reserves policy. The GMC's investment policy was reviewed by the Resources Committee on 1 May 2012.

103 General reserves are held as cash on short-term or medium-term deposits. Cash required for normal day-to-day working capital is shown on the GMC's balance sheet within current assets, while cash held for the longer term is shown as investments. The Resources Committee regularly reviews investment income, as part of the overall monitoring of the GMC's financial performance.

104 In 2011, our investments generated interest of £0.5 million, equivalent to an average annual rate of return of 0.5%.

Reserves policy

105 The Resources Committee is responsible for determining the reserves policy. The policy is reviewed annually, and any financial implications are addressed as part of the budget-setting process. The GMC's reserves policy was reviewed by the Resources Committee on 9 February 2012.

106 We hold reserves:

a to fund working capital and manage the normal day-to-day cash flow of the business, given that expenditure is broadly linear while income is concentrated in summer and winter peaks

b to fund risks that may materialise, resulting in an unexpected increase in expenditure and/or a reduction in income

c to provide financial flexibility to respond to new initiatives and opportunities that may present themselves during the year

d to manage the time lag in increasing/decreasing income.

107 There is no standard formula that can be used to calculate the ideal level of reserves. The GMC follows the Charity Commission's guidance and sets a target range of reserves based on our cash flow requirements and an assessment of the

risks facing the organisation. Our aim is to hold reserves at a level that is not excessive, but does not put our solvency at risk.

108 The GMC operates a defined benefit pension scheme. In line with the accounting standard *FRS17: Retirement Benefits*, the value of the pension scheme assets and liabilities is recognised on the balance sheet. While the operation of the defined benefit pension scheme does create a financial risk for the organisation, any deficit or surplus in the scheme can be managed over the medium term, and so has no immediate impact on our cash flow requirements. Any risks associated with changes in the level of pension scheme assets and liabilities are therefore disregarded for reserves policy purposes.

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

110 Based on our analysis of cash flows and the risks facing the organisation, our policy is to maintain free reserves within the range of £25 million–£45 million.

111 The GMC's free reserves as at 31 December 2011 were £34.2 million, which is in the target range set by the Resources Committee. Our total reserves at the end of the year were £53.1 million, made up of free reserves, plus £13.8 million of reserves represented by fixed assets, and a pension reserve of £5.1 million valued in accordance with FRS17.

112 The level of reserves will inevitably fluctuate year on year, reflecting variations in actual levels of income and expenditure compared with budget. Our policy is to maintain actual free reserves in line with the target level over the medium term. If our actual reserves vary significantly from the target range set out in the reserves policy, we will address the variation as part of the annual budget-setting process in order to bring actual reserves back into line.

Audit and Risk Committee's report

113 The Audit and Risk Committee met four times in 2011; all meetings were quorate. The Committee:

- **a** considered the internal auditors' opinions on the adequacy of risk management and internal controls; and monitored the implementation of actions arising from internal audit work
- **b** approved changes to the agreed programme of internal audit work, where necessary
- **c** considered a progress report at each meeting, as a basis for monitoring the delivery of the internal audit service
- **d** reviewed and approved the programme of internal audit work for 2012
- **e** agreed that the 2010 accounts were properly prepared in accordance with the *Charities Act 2011*, the *Charities and Trustee Investment (Scotland) Act 2005*, the *Charities Accounts (Scotland) Regulations 2006*, and applicable accounting standards, and that significant judgements and estimates used in preparing the accounts were appropriate

f monitored the provision of non-audit services by the external auditors, in order to be satisfied in respect of their independence and objectivity

g conducted an assessment of the performance of the external auditors against agreed criteria, covering the knowledge and experience of the audit team, the effectiveness of the audit, and the quality of the audit service

h approved the re-tendering of the external audit contract and the appointment of Crowe Clark Whitehill LLP as the new external auditors

i approved the external audit letter of engagement, and reviewed the external audit strategy to ensure that it set out planned levels of materiality, identified key areas of risk, and reflected changes in circumstances since the previous year.

114 The Committee met once with the internal and external auditors in the absence of management; and reported twice to Council on its activities.

115 The Committee provided oversight of the GMC's risk management activities, as covered under the risk management statement in paragraphs 116–122.

Risk management statement

116 Council has ultimate responsibility for risk management at the GMC. To that extent, it has ensured that there are formal structures and processes in place to facilitate effective risk identification, evaluation, mitigation and monitoring.

117 Council has delegated responsibility for routine oversight of risk management arrangements to the Audit and Risk Committee. It receives regular reports from the Committee, as well as information on the management of risks through reports from the Chief Executive and other governance committees. Council considered the Corporate Risk Register in May and December 2011.

118 The GMC has a formal risk management framework to identify, evaluate, mitigate, monitor and report on risks associated with its strategic aims. The Audit and Risk Committee has reviewed and endorsed the risk management framework, and obtained assurance from the internal auditors that the arrangements in place are sufficient to ensure that risks are identified and systems are established to mitigate them.

119 The identification of risks is an integral part of the annual business planning process, and regular review processes are in place to facilitate the detection of emerging risks.

120 The Corporate Risk Register is monitored regularly by the Senior Management Team.

121 The Audit and Risk Committee receives reports on the risk management arrangements at least twice each year. The Committee considered updates on risk management and the Corporate Risk Register in May and November 2011.

122 The internal auditors conducted a review of the risk management arrangements in December 2011, and provided substantial assurance over their adequacy and effectiveness. The internal audit recommendations for further development of the risk management arrangements have been accepted and scheduled for action.

Structure, governance and management

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

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

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

Organisational structure

Council

126 The trustees between 1 January and 31 December 2011 are listed below. All were still in post at 18 July 2012.

Professor Jane Dacre, BSc MD FRCP Lon FRCP Edinburgh Glas FHEA
Dr Sue Davison, BSc (Hons) PhD
Dr Sam Everington, OBE MBBS MRCGP Barrister
Ms Sally Hawkins
Dr John Jenkins, CBE MD FRCP FRCPCH FRCPI
Lord Kirkwood of Kirkhope, BSc
Ms Ros Levenson, BA (Hons) CQSW Dip Applied Social Studies
Professor Malcolm Lewis, FRCGP LLM
Mr Robin MacLeod, MHSM Dip HSM MI Mgt Dip Business Studies
Professor Rajan Madhok, MBBS MSc FRCS FFPH
Dr Johann Malawana, MBBS
Dr Joan Martin, DPhil FCOT MA
Mrs Suzanne McCarthy, BA LLM MSc
Professor Jim McKillop, BSc MB ChB PhD FRCP FRCR
Professor Trudie Roberts, BSc MB ChB PhD FRCP
Mrs Ann Robinson

Mrs Enid Rowlands, BSc CCMI
Professor Sir Peter Rubin, BM BCh MA DM FRCP
Dr Mairi Scott, MB ChB FRCGP FRCPE FHEA
Professor Iqbal Singh, OBE MBBS MRCP FRCP Dip Rehab Med
Professor Terence Stephenson, BSc BM BCh DM FRCP FRCPCH
Ms Anne Weyman, OBE BSc (Soc) FCA Honorary LLD
Mr Stephen Whittle, OBE LLB FRSA
Dr Hamish Wilson, CBE MA PhD FHSM FRCGP

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

Committees, boards and other groups

128 The revised governance framework, agreed by Council in 2010, was implemented in 2011. Supporting the Council, the governance framework comprises:

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

129 The MPTS has been established in shadow form and was launched on 11 June 2012. The MPTS has responsibility for overseeing the adjudication of fitness to practise cases. The legislative changes that will establish the MPTS in statute are expected in 2013. In the meantime, Council has agreed the governance arrangements for the MPTS, including establishing the MPTS Committee and a joint GMC/MPTS Liaison Group, which were incorporated into our governance handbook prior to the launch in 2012.

130 In 2011, we continued to draw on our Reference Community, composed of 27 members of the public and 27 doctors, as a sounding board to help inform policy development. A review of the use of the Reference Community in 2011 concluded that it continues to be a useful mechanism for getting public and professional perspectives on the development of our policies, processes and publications. We have therefore extended the appointments of current members until the end of 2012. At the same time, we are considering how best to refresh membership of this useful forum and aim to have a new Reference Community in place by the end of 2012.

131 During 2012, the Government has been taking forward its proposed changes to reduce the size of the councils of the GMC and the General Dental Council. These changes include a proposal that the chairs of these councils be appointed rather than elected. Subject to the outcome of the consultation, the Government will legislate to effect the constitutional changes. The GMC has been carrying out work in 2012 to implement the necessary changes, including revised arrangements for the appointment of Council members. This includes a review of the current governance arrangements, in preparation for the reconstituted Council that will take office on 1 January 2013.

Audit and Risk Committee

132 The Chair of the Audit and Risk Committee is Mrs Ann Robinson. The purpose of the Committee is to monitor the integrity of the financial statements, to review the internal control and risk management systems and to monitor and review the internal and external audit services. The Audit and Risk Committee's report can be found at paragraphs 113–115.

Remuneration and Member Issues Committee

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

Resources Committee

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

Undergraduate Board

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

Postgraduate Board

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

Continued Practice, Revalidation and Registration Board

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

Education and Training Committee

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

Standards and Ethics Committee

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

Fitness to Practise Committee

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

Equality and Diversity Committee

141 The Chair of the Equality and Diversity Committee is Professor Iqbal Singh. The purpose of the Committee is to: help embed E&D as central to the development and review of policies and procedures across the GMC; to advise on the action required to fulfil our commitment to valuing diversity and promoting equality, ensuring that outputs link to our priorities and addressing gaps in areas that may not be driven by statutory requirements; and to help ensure that processes and procedures are fair, objective, transparent and free from unlawful discrimination. It is also responsible for advising on how most effectively to embed our E&D commitments across the organisation, with a view to mainstreaming E&D during the 2009–12 Council, and for scrutinising the E&D plans developed by the other GMC committees and boards.

Management

142 In 2011, the GMC's staff were under the direction of Chief Executive Niall Dickson. The directors were:

- **a** Paul Buckley, Director of Education
- **b** Ben Jones, Director of Strategy and Communication (in post from 26 January 2011)
- **c** Una Lane, Director of Continued Practice and Revalidation
- **d** Paul Philip, Deputy Chief Executive and Director of Standards and Fitness to Practise
- **e** Neil Roberts, Director of Registration and Resources.

143 The GMC's principal places of business are Regent's Place, 350 Euston Road, London NW1 3JN and 3 Hardman Street, Manchester M3 3AW. The GMC also has offices in Belfast, Cardiff and Edinburgh and a Hearings Centre, where the MPTS is based, at St James's Buildings, 79 Oxford Street, Manchester M1 6FQ.

Looking forward to 2012

144 Our key activities for 2012 are structured around the eight strategic aims outlined in our *Corporate Strategy 2010-2013*. The *Business Plan 2012* sets out how we will deliver these in the third year of our corporate strategy.

145 Our priorities in 2012 reflect our commitment to being a proactive, outward-facing organisation, and to do all that we can to protect, promote and maintain the health and safety of the public.

146 Our top priority is the successful introduction of revalidation. Revalidation will change the way in which we regulate doctors who practise in the UK, as we will begin checking regularly that they are up to date and fit to practise.

147 We will have a much stronger local presence through our new liaison services. Our new team of ELAs will allow us to work more closely and proactively with medical directors and responsible officers across the UK; and our regional liaison team in England will strengthen our engagement with patients and doctors.

148 In 2012, we will update our core guidance for doctors, *Good Medical Practice*, and develop new approaches to reinforce these standards and embed them in doctors' day-to-day practice.

149 We will continue the reforms of our fitness to practise procedures. These changes are designed to increase the speed and cost-effectiveness of our fitness to practise investigations, modernise and streamline our adjudication procedures, and strengthen confidence in the independence of our adjudication function. In 2012, we will consult on the regulations that will underpin the new MPTS.

150 We will share our data and insights, specifically by publishing our second report on the state of medical education and practice in the UK. It will further develop and respond to the insights highlighted in the 2011 report.

151 We will undertake a comprehensive review of our approach to assuring the quality of all stages of medical education and training in the UK. We will also contribute to a major review looking at the future shape of postgraduate medical education and training.

152 We will work with the Department of Health to develop proposals to deal with concerns about the communication skills of doctors from the European Economic Area (EEA), including changing the *Medical Act 1983* to give us powers to check the language knowledge of EEA-trained doctors.

153 We will also engage with EU institutions to make sure that the proposed new Directive on the recognition of professional qualifications is amended to make clear that regulators are able to check the language knowledge of migrating EEA doctors after recognition of their qualifications but before granting them access to the profession.

154 We will do all of this while continuing our first-class operational delivery to maintain the register and protect the public.

Professional advisers

Bankers	National Westminster Bank Plc Regent Street Branch PO Box 4RY Regent Street London W1A 4RY
Solicitors	The majority of our legal work is carried out by our in-house legal team.
Auditors	Crowe Clark Whitehill LLP St Bride's House 10 Salisbury Square London EC4Y 8EH
Investment adviser to the pension scheme	Walter Scott & Partners Limited One Charlotte Square Edinburgh EH2 4DR
Actuary	Hewitt Bacon & Woodrow Parkside House Ashley Road Epsom Surrey KT18 5BS

Approved by the trustees on 18 July 2012, and signed on their behalf by

Professor Sir Peter Rubin

Independent auditors' report

To the trustees of the General Medical Council

We have audited the financial statements of the General Medical Council for the year ended 31 December 2011, which comprise the statement of financial activities, the balance sheet, the cash flow statement and the related notes numbered 1–15.

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

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

Respective responsibilities of trustees and auditors

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

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

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

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the charity's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the trustees; and the overall presentation of the financial statements.

In addition, we read all the financial and non-financial information in the trustees' annual report to identify material inconsistencies with the audited financial statements. If we become aware of any apparent material misstatements or inconsistencies, we consider the implications for our report.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the state of the charity's affairs as at 31 December 2011 and of its incoming resources and application of resources, for the year then ended
- have been properly prepared in accordance with UK Generally Accepted Accounting Practice

- have been prepared in accordance with the requirements of the *Charities Act 2011*, the *Charities and Trustee Investment (Scotland) Act 2005*, Regulation 8 of the *Charities Accounts (Scotland) Regulations 2006* and the *Medical Act 1983* and the *Privy Council Directions* issued thereunder.

Matters on which we are required to report by exception

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

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

Crowe Clark Whitehill LLP
Statutory Auditors
London

9 August 2012

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

Accounts 2011

Statement of financial activities for the year ended 31 December 2011

	Note	Total 2011 £000	Total 2010 £000
Incoming resources			
From charitable activities			
Registration	2	94,271	91,194
Certification	2	3,576	4,500
Department of Health	2	1,382	4,521
From generated funds			
Sales and other income	3	435	461
Investment income and interest	3	1,966	663
Total incoming resources		**101,630**	**101,339**
Resources expended			
Charitable activities			
Fitness to practise		50,294	53,834
Registration		15,700	12,745
Communications		6,075	4,406
Education		4,714	4,118
Continued practice and revalidation		2,715	2,365
Standards		1,434	1,189
Governance		6,530	8,685
Total resources expended	**4**	**87,462**	**87,342**
Net incoming resources before recognised gains and losses		**14,168**	**13,997**
Other recognised gains and losses on investments			
Actuarial (loss)/gain on defined benefit pension scheme	13	(1,787)	11,692
Net movement in funds		**12,381**	**25,689**
Total funds brought forward		40,672	14,983
Total funds carried forward		**53,053**	**40,672**

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

Balance sheet as at 31 December 2011

	Note	2011 £000	2011 £000	2010 £000	2010 £000
Fixed assets					
Tangible fixed assets	6		13,771		14,731
Investments	7		25,000		25,000
			38,771		**39,731**
Current assets					
Debtors and prepayments	8	18,034		15,878	
Cash and bank balances		428		382	
Short-term deposits		61,547		44,007	
		80,009		**60,267**	
Liabilities					
Creditors: amounts falling due within one year	9	(70,811)		(64,562)	
Net current assets/(liabilities)			9,198		(4,295)
Total assets less current liabilities			**47,969**		**35,436**
Defined benefit pension scheme asset	13		5,084		5,236
Net assets including pension scheme asset			**53,053**		**40,672**
The funds of the charity					
Unrestricted income funds			47,969		35,436
Pension reserve			5,084		5,236
Total charity funds	**10**		**53,053**		**40,672**

The financial statements were approved by the trustees and authorised for issue on 18 July 2012.

They were signed on behalf of the trustees by:

Robin MacLeod, MHSM Dip HSM MI Mgt Dip Business Studies
Chair of the Resources Committee

Cash flow statement for the year ended 31 December 2011

	2011		2010	
	£000	£000	£000	£000
Net cash inflow from operating activities (Note 1 below)		**22,661**		14,697
Returns on investments and servicing of finance				
Interest received	652		252	
Net cash inflow from returns on investments and servicing of finance		652		252
Capital expenditure	(5,727)		(2,963)	
Net cash inflow/(outflow) from investing activities		(5,727)		(2,963)
Net increase/(decrease) in cash and cash equivalents (Note 2 below)		**17,586**		11,986

Note 1

Cash flow from operating activities	2011	2010
	£000	£000
Net incoming resources	14,168	13,997
Investment income and interest	(1,966)	(663)
Non-cash items – depreciation	6,687	6,714
Non-cash items – assets written off	0	0
Pension past service cost and curtailment	(197)	0
Pension scheme current service cost	4,350	5,476
Pension scheme contribution	(4,474)	(4,341)
(Increase) in debtors	(2,156)	(1,949)
Increase/(decrease) in creditors	6,249	(4,537)
	22,661	14,697

Note 2

Cash and equivalents	Short-term deposits	Cash at bank and in hand	Total
	£000	£000	£000
Balances at 1 January 2011	44,007	382	44,389
Net increase in cash and cash equivalents	17,540	46	17,586
Balances at 31 December 2011	**61,547**	**428**	**61,975**

Notes to the accounts

1. Principal accounting policies

Accounting convention

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

Incoming resources

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

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

Basis for recognising liabilities

Expenditure includes staffing costs, office costs, committee costs, legal costs, accommodation costs, purchase of assets, net of capitalisation and depreciation, and financial, actuarial and professional costs.

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

Basis for allocation of resources expended

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

Expenditure relating to shared accommodation costs and other support costs is apportioned to the relevant activity of the charity, either in proportion to area occupied by the relevant departments or on the basis of staff head count across the organisation.

Irrecoverable VAT

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

Taxation

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

Provisions for liabilities

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

Tangible fixed assets

Tangible fixed assets are stated at cost, net of depreciation and any provision for impairment. Expenditure is only capitalised where the cost of the asset or group of assets acquired (where the assets meet the FRS15 definition of 'grouped assets') exceeds £5,000.

Depreciation

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

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

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

Operating leases

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

Finance leases

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

Investments

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

Pensions

The GMC operates a defined benefit pension scheme for permanent employees. The surplus or deficit of the scheme is recognised on the balance sheet. Changes in the assets and liabilities of the scheme are disclosed and allocated as follows:

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

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

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

Details of scheme assets, liabilities and major assumptions are shown in Note 13. 36 members of staff, who transferred on the merger with PMETB, contribute to the NHS multi-employer scheme and contributions to the scheme are charged to the statement of financial activities in the year in which they are payable to the scheme.

Funds and reserves

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

2. Income from charitable activities

	Total 2011 £000	Total 2010 £000
Registration		
Annual retention fees	88,019	83,170
Registration fees	3,422	5,260
Provisional registration fees	763	1,085
PLAB fees	1,858	1,452
Other fees	209	227
	94,271	**91,194**
Certification		
CCT fees	2,945	3,737
CESR/CEGPR fees	631	763
	3,576	**4,500**
Department of Health (England)*		
GAP funding	168	512
Merger funding	1,214	2,996
Completion funding	0	1,013
	1,382	**4,521**

* On 1 April 2010, the GMC assumed statutory responsibility for regulating all stages of medical education and training. Prior to that, postgraduate medical education and training was the responsibility of PMETB, an executive Non-Departmental Public Body sponsored by DH(E). The GMC's accounts for 2010 and 2011 include one-off transitional costs associated with this change, funded by DH(E).

3. Income from generated funds

	2011 £000	2010 £000
Activities for generating funds		
Sales and other income	435	461
Investment income		
Other finance income – pension scheme (Note 13)	1,314	411
Bank interest	652	252
	1,966	**663**

4. Total resources expended

	Direct staffing costs £000	Direct costs £000	Allocated costs £000	Total 2011 £000	Total 2010 £000
Fitness to practise	14,780	23,078	12,436	50,294	53,834
Registration	6,032	2,829	6,839	15,700	12,745
Communications	2,496	1,713	1,866	6,075	4,406
Education	2,391	413	1,910	4,714	4,118
Continued practice & revalidation	1,504	145	1,066	2,715	2,365
Standards	791	110	533	1,434	1,189
Charitable expenditure	**27,994**	**28,288**	**24,650**	**80,932**	**78,657**
Governance	2,343	2,365	1,822	6,530	8,685
Total resources expended	**30,337**	**30,653**	**26,472**	**87,462**	**87,342**

Communications includes our regional liaison service, strategic relationships, our devolved offices, corporate communications and publications. Governance includes the costs of our strategy and planning functions, the Chair and Chief Executive activities, research and development, consultancy and review, and European and international development activities. One-off costs associated with the merger with PMETB are also included within Governance.

Support costs allocated to charitable activities

	Management £000	IT £000	HR £000	Finance £000	Procure-ment £000	Facilities/ accomm £000	Total 2011 £000	Total 2010 £000
Fitness to practise	168	4,095	1,419	531	153	6,070	12,436	9,487
Registration	93	2,252	779	292	84	3,339	6,839	5,496
Communications	25	614	213	80	23	911	1,866	979
Education	26	629	218	81	24	932	1,910	1,506
Continued practice and revalidation	14	351	122	46	13	520	1,066	791
Standards	7	175	61	23	7	260	533	414
Charitable expenditure	**333**	**8,116**	**2,812**	**1,053**	**304**	**12,032**	**24,650**	**18,673**
Governance	25	600	208	78	22	889	1,822	1,167
Total	**358**	**8,716**	**3,020**	**1,131**	**326**	**12,921**	**26,472**	**19,840**

Support costs are managed within our Resources directorate, and then allocated to charitable activities. Accommodation costs are allocated on the basis of floor area occupied. Management, IT, human resources (HR), finance, procurement and accommodation costs are allocated on a head-count basis.

4. Total resources expended (continued)

	2011 £000	2010 £000
Staffing costs	36,800	33,544
Office costs	5,210	6,951
Council and committee costs	589	608
Panel and assessment costs	15,045	13,189
Legal costs	8,321	12,030
Accommodation costs	7,495	6,426
Financial, actuarial and professional costs	4,185	4,129
Purchase of assets – charged to revenue	3,130	3,751
Depreciation	6,687	6,714
	87,462	87,342

Total resources expended include:

Operating lease costs: leasehold property	2,526	3,160
Provision for future dilapidations *	350	0
Audit fees	36	24
Finance lease costs: office equipment	4	160

* All GMC property is leasehold. A provision of £350,000 has been recognised for a potential liability for dilapidations at the next lease break. The level of provision is reviewed annually.

5. Staff

Total costs of all staff:	2011 £000	2010 £000
Salaries	27,617	24,713
Social security costs	2,128	1,902
Superannuation costs	4,240	5,309
Redundancy costs	1,060	82
Other staffing costs	1,755	1,538
	36,800	**33,544**

Average staff numbers (full-time equivalents) in the year by category:	2011	2010
Fitness to practise	244	223
Registration	145	138
Communications	30	31
Education	39	33
Continued practice and revalidation	23	21
Standards	11	11
Governance	49	40
Resources	113	108
	654	**605**

The number of staff whose taxable emoluments (excluding redundancy payments) fell into higher salary bands was:	2011	2010
£ 60,000–£70,000	23	18
£ 70,001–£80,000	18	12
£ 80,001–£90,000	3	4
£ 90,001–£100,000	8	6
£100,001–£110,000	7	6
£110,001–£120,000	0	2
£120,001–£130,000	1	0
£130,001–£140,000	0	0
£140,001–£150,000	1	2
£150,001–£160,000	1	0
£160,001–£170,000	0	2
£170,001–£180,000	2	1
£180,000–£190,000	1	0
£210,001–£220,000	0	1
£220,001–£230,000	1	0

5. Staff (continued)

Number of staff included on page 42 for whom retirement benefits are accruing:	2011 £000	2010 £000
Defined benefit scheme	63	52
Defined contribution scheme*	3	2

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

6. Fixed assets

	Buildings £000	Fixtures, furniture and equipment £000	IT equipment and software £000	Total £000
Cost				
Balance at 1 January 2011	12,593	6,827	25,337	44,757
Additions	56	2,854	2,817	5,727
Balance at 31 December 2011	**12,649**	**9,681**	**28,154**	**50,484**
Depreciation				
Balance at 1 January 2011	8,941	2,520	18,565	30,026
Depreciation charge for the year	276	487	5,924	6,687
Balance at 31 December 2011	**9,217**	**3,007**	**24,489**	**36,713**
Net book value at 1 January 2011	3,652	4,307	6,772	14,731
Net book value at 31 December 2011	**3,432**	**6,674**	**3,665**	**13,771**

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

7. Investments

	2011 £000	2010 £000
Cash deposits	25,000	25,000

8. Debtors

	2011 £000	2010 £000
Amounts falling due within one year		
Registration debtors	14,942	13,551
Prepayments and accrued income	2,335	2,045
Other debtors	757	282
	18,034	**15,878**

9. Creditors

	2011 £000	2010 £000
Amounts falling due within one year		
Trade creditors	1,548	1,689
Other creditors, including tax and social security	1,317	684
Accruals and deferred income	67,946	62,189
	70,811	**64,562**

10. Fund movements in the year

	Unrestricted fund £000	Pension fund £000	2011 Total £000	2010 Total £000
At 1 January 2011	35,436	5,236	40,672	14,983
Net incoming/(outgoing) resources	12,533	(152)	12,381	25,689
At 31 December 2011	**47,969**	**5,084**	**53,053**	**40,672**

11. Capital commitments

Capital expenditure contracted but unspent at 31 December 2011 amounted to £134,568. The equivalent figure for 2010 was £195,187.

12. Operating lease commitments

	2011 £000	2010 £000
Committed amounts payable for the next year are leases of land and buildings expiring:		
Within one year	219	252
In years two to five	688	557
After more than five years	1,619	2,351
	2,526	**3,160**

13. Superannuation scheme

The GMC Staff Superannuation Scheme is a funded scheme of the defined benefit type, providing retirement benefits based on final salary. The 'top up' arrangement is an unfunded scheme. Regular employer contributions to the scheme in 2011 were £4,474,000.

In addition to the GMC scheme, we have 36 members of staff who contribute to the NHS multi-employer scheme, which is a defined benefit scheme. These staff were transferred to the GMC on the merger with PMETB. The scheme operates as a pooled arrangement, with contributions paid at a centrally agreed rate. As a consequence, no share of the underlying assets and liabilities can be directly attributed to the GMC. Under the terms of FRS17, in these circumstances contributions are accounted for as if the scheme were a defined contribution scheme based on actual contributions paid through the year.

The valuation of the GMC Superannuation Scheme used for FRS17 disclosures has been based on a full assessment of the liabilities of the scheme as at 31 December 2009. The present values of the defined benefit obligation, the related current service cost and any past service costs were measured using the projected unit credit method.

Actuarial gains and losses have been recognised in the period in which they occur (but outside the profit and loss account) through the Statement of Recognised Gains and Losses (STRGL).

The principal assumptions used by the independent qualified actuaries to calculate the liabilities under FRS17 are set out below.

Main financial assumptions

	31 December 2011 % p.a.	31 December 2010 % p.a.	31 December 2009 % p.a.
RPI inflation	3.4	3.8	3.9
CPI inflation	2.7	3.3	n/a
Rate of general long-term increase in salaries	5.4	5.8	5.9
Pension increases (excess over GMP only)	2.7	3.3	3.9
Discount rate for scheme liabilities	4.7	5.3	5.7

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

For a member who retires in 2031 at age 65, the assumptions are that they will live on average for a further 24 years after retirement if they are male and for a further 26 years after retirement if they are female.

13. Superannuation scheme (continued)

Expected return on assets

	Long-term rate of return expected at 31 Dec 2011 % p.a.	Value at 31 Dec 2011 £000	Long-term rate of return expected at 31 Dec 2010 % p.a.	Value at 31 Dec 2010 £000	Long-term rate of return expected at 31 Dec 2009 % p.a.	Value at 31 Dec 2009 £000
Equities	6.05	51,538	7.45	52,390	7.75	48,521
Fixed interest gilts	2.80	12,752	4.20	10,099	4.50	9,195
Index-linked gilts	2.80	12,669	4.20	10,274	4.25	9,429
Property	5.05	11,298	6.95	7,108	n/a	n/a
Other	1.80	522	1.45	113	0.70	396
Combined	**4.97#**	**88,779**	**6.57#**	**79,984**	**6.78#**	**67,541**

The overall expected rate of return on scheme assets is a weighted average of the individual expected rates of return on each asset class.

The GMCl employs a building block approach in determining the long-term rate of return on pension plan assets. Historical markets are studied and assets with higher volatility are assumed to generate higher returns consistent with widely accepted capital market principles. The assumed long-term rate of return on each asset class is set out within this note. The overall expected rate of return on assets is then derived by aggregating the expected return for each asset class over the actual asset allocation for the scheme at 31 December 2011.

Reconciliation of funded status to balance sheet

	Value at 31 December 2011 £000	Value at 31 December 2010 £000	Value at 31 December 2009 £000
Fair value of scheme assets	88,779	79,984	67,541
Present value of funded defined benefit obligations	(83,111)	(74,188)	(72,397)
	5,668	5,796	(4,856)
Present value of unfunded defined benefit obligations	(584)	(560)	(876)
Asset/(liability) recognised on the balance sheet	**5,084**	**5,236**	**(5,732)**

13. Superannuation scheme (continued)

Analysis of profit and loss charge

	Year ending 31 December 2011 £000	Year ending 31 December 2010 £000
Current service cost	5,180	5,476
Past service cost	398	0
Interest cost	4,085	4,292
Expected return on scheme assets	(5,399)	(4,703)
Curtailment cost	(595)	0
Settlement cost	0	0
Expense recognised in profit and loss	**3,669**	**5,065**

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

	Year ending 31 December 2011 £000	Year ending 31 December 2010 £000
Opening defined benefit obligation	74,748	73,273
Current service cost	5,180	5,476
Interest cost	4,085	4,292
Contributions by scheme participants	0	620
Actuarial gains/(losses) on scheme liabilities*	771	(7,720)
Net benefits paid out	(892)	(1,193)
Past service cost	398	0
Net increase in liabilities from disposals/acquisitions	0	0
Curtailments	(595)	0
Settlements	0	0
Closing defined benefit obligation	**83,695**	**74,748**

* Includes changes to the actuarial assumptions

13. Superannuation scheme (continued)

Changes to the fair value of scheme assets during the year

	Year ending 31 December 2011 £000	Year ending 31 December 2010 £000
Opening fair value of scheme assets	79,984	67,541
Expected return on scheme assets	5,399	4,703
Actuarial gains/(losses) on scheme assets	(1,016)	3,972
Contributions by the employer	5,304	4,341
Contributions by scheme participants	0	620
Net benefits paid out	(892)	(1,193)
Net increase in assets from disposals/acquisitions	0	0
Settlements	0	0
Closing fair value of scheme assets	**88,779**	**79,984**

Actual return on scheme assets

	Year ending 31 December 2011 £000	Year ending 31 December 2010 £000
Expected return on scheme assets	5,399	4,703
Actuarial gain/(loss) on scheme assets	(1,016)	3,972
Actual return on scheme assets	**4,383**	**8,675**

Analysis of amounts recognised in the STRGL

	Year ending 31 December 2011 £000	Year ending 31 December 2010 £000
Total actuarial gains/(losses)	(1,787)	11,692
Cumulative amount of gains/(losses) recognised in the STRGL	(6,228)	(4,441)

13. Superannuation scheme (continued)

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

	31 Dec 2011 £000	31 Dec 2010 £000	31 Dec 2009 £000	31 Dec 2008 £000	31 Dec 2007 £000
Fair value of scheme assets	88,779	79,984	67,541	53,903	51,058
Defined benefit obligation	(83,695)	(74,748)	(73,273)	(49,620)	(50,651)
Surplus/(deficit) in scheme	**5,084**	**5,236**	**(5,732)**	**4,283**	**407**

History of experience gains and losses

	Year ending 31 Dec 2011 £000	Year ending 31 Dec 2010 £000	Year ending 31 Dec 2009 £000	Year ending 31 Dec 2008 £000	Year ending 31 Dec 2007 £000
Experience gains/(losses) on scheme assets	(1,016)	3,972	6,569	(5,020)	919
Experience gains/(losses) on scheme liabilities #	113	2,896	(405)	(630)	3,842

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

14. Trustees

Name	Attendance allowance and honoraria 2011 £	Attendance allowance and honoraria 2010 £
Professor Jane Dacre, BSc MD FRCP Lon FRCP Edinburgh Glas FHEA	15,050	15,050
Dr Sue Davison, BSc (Hons) PhD [1]	11,825	3,942
Dr Sam Everington, OBE MBBS MRCGP Barrister	11,825	11,825
Ms Sally Hawkins	11,825	11,825
Dr John Jenkins, CBE MD FRCP FRCPCH FRCPI	15,050	15,050
Lord Kirkwood of Kirkhope, BSc	15,050	15,050
Ms Ros Levenson, BA (Hons) CQSW Dip Applied Social Studies	15,050	15,050
Professor Malcolm Lewis, FRCGP LLM	15,050	15,050
Mr Robin MacLeod, MHSM Dip HSM MI Mgt Dip Business Studies	15,050	15,050
Professor Rajan Madhok, MBBS MSc FRCS FFPH	11,825[4]	11,825
Dr Johann Malawana, MBBS	11,825	11,825
Dr Joan Martin, D.Phil FCOT MA	15,050	15,050
Mrs Suzanne McCarthy, BA LLM MSc	11,825	11,825
Professor Jim McKillop, BSc MB ChB PhD FRCP FRCR	15,050	15,050
Professor Trudie Roberts, BSc MB ChB PhD FRCP [2]	11,825[4]	14,916
Mrs Ann Robinson	15,050	15,050
Mrs Enid Rowlands, BSc CCMI	15,050	15,050
Professor Sir Peter Rubin, BM BCh MA DM FRCP	95,433[4]	93,445
Dr Mairi Scott, MB ChB FRCGP FRCPE FHEA [3]	12,179[4]	15,050
Professor Iqbal Singh, OBE MBBS MRCP FRCP Dip Rehab Med	15,050	15,050
Professor Terence Stephenson, BSc BM BCh DM FRCP FRCPCH	11,825	11,825
Ms Anne Weyman, OBE BSc(Soc) FCA Honorary LLD	11,825	11,825
Mr Stephen Whittle, OBE LLB FRSA	11,825	11,825
Dr Hamish Wilson, CBE MA PhD FHSM FRCGP	11,825	11,825

[1] Dr Sue Davison became a trustee on 1 September 2010

[2] Professor Trudie Roberts ceased acting as Chair of the Research Reference Group on 8 December 2010

[3] Dr Mairi Scott ceased acting as Chair of the Registration Reference Group on 17 February 2012

[4] paid to employer

Travel and subsistence expenses of £128,091 were paid to the 24 members in 2011. The equivalent figure for 2010 was £130,989 paid to 24 members.

15. Travel and subsistence expenses claimed in 2011

	Expenses claimed 2011 £
Trustees	
Professor Jane Dacre, BSc MD FRCP Lon FRCP Edinburgh Glas FHEA	160
Dr Sue Davison, BSc (Hons) PhD	3,858
Dr Sam Everington, OBE MBBS MRCGP Barrister	231
Ms Sally Hawkins	174
Dr John Jenkins, CBE MD FRCP FRCPCH FRCPI	29,417
Lord Kirkwood of Kirkhope, BSc	485
Ms Ros Levenson, BA (Hons) CQSW Dip Applied Social Studies	787
Professor Malcolm Lewis, FRCGP LLM	11,719
Mr Robin MacLeod, MHSM Dip HSM MI Mgt Dip Business Studies	4,819
Professor Rajan Madhok, MBBS MSc FRCS FFPH	4,335
Dr Johann Malawana, MBBS	0
Dr Joan Martin, D.Phil FCOT MA	17,558
Mrs Suzanne McCarthy, BA LLM MSc	86
Professor Jim McKillop, BSc MB ChB PhD FRCP FRCR	15,255
Professor Trudie Roberts, BSc MB ChB PhD FRCP	5,100
Mrs Ann Robinson	261
Mrs Enid Rowlands, BSc CCMI	2,778
Professor Sir Peter Rubin, BM BCh MA DM FRCP	8,610
Dr Mairi Scott, MB ChB FRCGP FRCPE FHEA	4,752
Professor Iqbal Singh, OBE MBBS MRCP FRCP Dip Rehab Med	9,090
Professor Terence Stephenson, BSc BM BCh DM FRCP FRCPCH	508
Ms Anne Weyman, OBE BSc(Soc) FCA Honorary LLD	292
Mr Stephen Whittle, OBE LLB FRSA	265
Dr Hamish Wilson, CBE MA PhD FHSM FRCGP	7,551
Senior management team	
Niall Dickson – Chief Executive	17,949
Paul Philip – Deputy Chief Executive and Director of Standards and Fitness to Practise	9,168
Paul Buckley – Director of Education	3,007
Ben Jones – Director of Strategy and Communication	8,027
Neil Roberts – Director of Registration and Resources	17,336
Una Lane – Director of Continued Practice and Revalidation	4,596

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

Variations in expenses also reflect that trustees and members of the senior management team live in different parts of the UK and are required to travel around the UK for GMC business, including to our offices in London, Manchester, Edinburgh, Belfast and Cardiff, and occasionally outside the UK. In most cases, travel costs include outbound and return journeys.

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

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