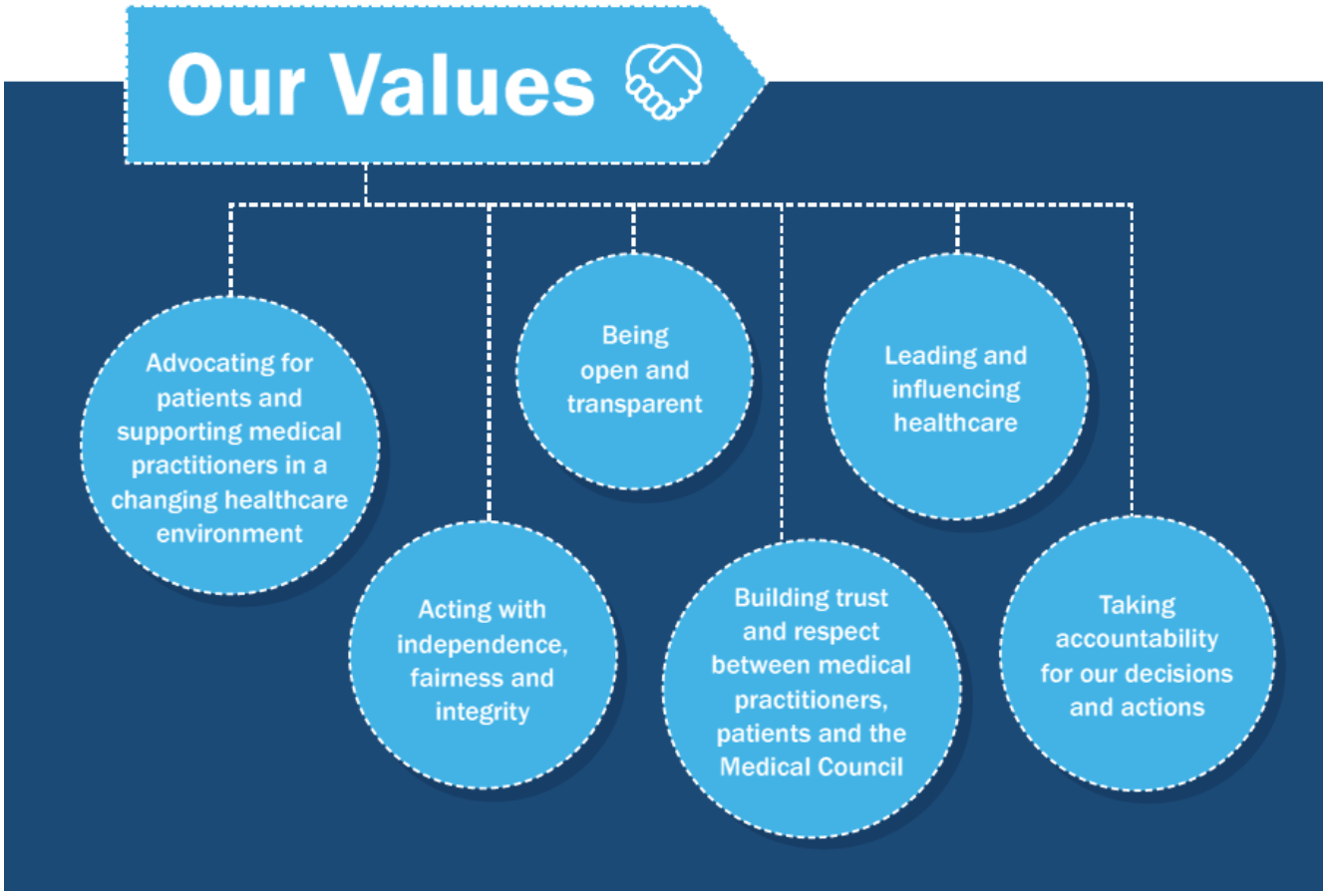
Medical Council

Approved by the Medical Council for submission to the Department of Health

Comhairle na nDochtúirí Leighis
Medical Council

Contents

1. Vision, Mission & Values of the Medical Council



2 Strategic Objectives 2019 – 2023

To deliver the strategy the Council has defined six key strategic objectives and several key actions.

The six key strategic objectives for this term are:

3 Business Objectives 2019 Aligned to the Strategic Objectives

Strategic Objective 1

Ensure medical regulation protects the public and supports registered medical practitioners

We aim to achieve this objective through the following actions:

1.1 Maintain the application of standards that ensure the efficient and effective registration of medical practitioners

1.2 Maintain the application of proportionate and targeted regulatory interventions

1.3 Identify, harness and utilise Medical Council expertise to develop clear positions on key healthcare issues and contribute to health policy development which impacts on patient safety and the medical profession

1.4 Collaborate with Irish and international medical regulators to contribute to and enhance best practice regulatory models and standards

Action	Dependencies	Responsibility	Period	Desired Outcomes	KPIs
Implement changes to the operational processes, procedures and systems to reflect the amendments to the MPA 2007 arising from the Regulated Professions (Health & Social Care) (Amendment) Bill.	The Oireachtas Dept of Health Professional Standards External legal providers ICT & ICT provider	Director of Registration & BPI Director of Regulation	On-going	Improved regulatory management within PPC, FTP, Council and Registration processes for doctors.	System changes in place within six months of legislation being enacted (dependent upon enactment date and proximity to “peak period”).
Apply for WFME recognition as an accreditation agency.	Budget capacity (fee is US$60,000) WFME availability	Director of ETP	Q1	Application documentation prepared and submitted.	Application documentation prepared to desired standard.
			Q2	Confirmation of application accepted.	Application accepted.

Action	Dependencies	Responsibility	Period	Desired Outcomes	KPIs
	ETP Staff capacity to meet deadlines Compatibility of schedule of Regional Visits with WFME observation needs		Q4	WFME recognition as an accreditation agency so that graduates of Irish medical schools continue to have their training recognised internationally, especially in the USA (essential from 2023).	WFME observation phase completed.
Work with DoH in preparation for impact of Brexit on Irish regulation.	Department of Health GMC	CEO Director of Regulation Director of Registration and BP	Q2	Minimise disruption of doctors crossing borders post Brexit. Learning outcomes discussion with GMC.	Contingency plan/agreement in place regarding information sharing post-Brexit. Presentation to Council. MOU agreed and activated.
Develop a campaign supporting Doctor wellbeing in partnership with stakeholders.	Support from key sections, funding for campaign, participation from stakeholders	Head of Communications CEO Directors	Q1	A detailed draft campaign plan is prepared.	Council endorsed plan.
			Q2	Campaign launched with supporting materials.	Campaign successfully launched.
			Q4	Wellbeing supports available for doctors are accessible and utilised.	Outcome reported to Council.
Undertake research into doctor wellbeing as it relates to patient safety and support doctors.	Availability of resources/approval of business case Availability of research experts in this specific area of work Recruitment and engagement of research participants	Research Unit INMED	Q2	Increased information that can support programme development and targeted action.	Research proposal with INMED completed with clear actionable items.
			Q4	Consultation with RMPs completed.	Advanced qualitative analysis initiated (data sourced, coded, and draft findings initiated).

Action	Dependencies	Responsibility	Period	Desired Outcomes	KPIs
Management of existing cases for Performance Assessment.	Number of referrals from PPC and FTP. RMP's current employment status RCPC frequency of meetings. Availability of resources.	Performance Assessment	On-going	Timely management of performance assessment cases from receipt to close. Engagement with PGTBs through PCS arrangements for supporting Drs in action planning.	Performance assessment cases are processed from referral to report production within 9-month timeframe (length of time depends on nature of case).
Undertake an analysis of performance assessment referrals to identify a way of better recording and comparing case types, and case outcomes.	Availability of resources	Performance Assessment	On-going	The Section has a database of records and compares case types that may be utilised to inform decision making by the RCPC.	Accessible, historical evidence to inform decision making is available.
Monitoring and managing MPC compliance in professional competence scheme enrolment.	RMPs enrolling on Scheme Quality of data obtained from PGTBs	Prof Comp	Q1 – Q4	Data analysis to determine size and characteristics of non-enrolled group conducted quarterly. Follow up strategies post analysis (including correspondence to non-enrolled RMPs, changes to ARAF etc.). Non-compliant RMPs referred to RCPC/ Council for possible escalation as complaint is kept to a minimum.	Increase the percentage of RMPs who should be enrolled in a Professional Competence Scheme to 99%.
Monitoring and managing MPC compliance in compliance with CPD requirements.	RMPs enrolling on Scheme Quality of data obtained from PGTBs	Professional Competence	Q1	Guidelines to monitor and manage non-compliant RMPs established. Targeted correspondence issued to RMPs who have not recorded any CPD	Approximately 30% reduction in the number of enrolled RMPs who have not recorded MPC activity over the last 3 consecutive years.

Action	Dependencies	Responsibility	Period	Desired Outcomes	KPIs
				credits over the last 3 consecutive years. Monitoring of same RMPs through report provided by PGTB in August 2019.	
Ongoing monitoring of PGTB PCS operations.	PGTBs providing business plans on time for review. PGTBs providing reports on time for review.	Professional Competence	Q3	Business plans from 13 PGTBs reviewed. Feedback on same provided to individual PGTBs. Annual reports from 13 PGTBs reviewed: - Qualitative Reports - Quantitative Reports - Financial Reports Feedback on same provided to individual PGTBs.	Increased number of PGTBs which adhere to the Standards on MPC – bodies operating the Professional Competence Schemes.
Phase two of Safe Start activated.	External stakeholders alerting MCI of changes to available resources detailed on website and in booklet.	Professional Competence Communications	Q2-3	Online and hard copy of Safe Start resource is reviewed and updated quarterly. Safe Start resource distributed to stakeholders. New starters and NCHDs not in training posts have engaged in relevant SS activities detailed in the SS booklet.	Safe Start information is easily accessed by RMPs. PGTBs report uptake of SS activities based on access to CPDSS programme prospectus.
Increase transparency via consistent publication of statistics on sources, nature of complaint,	Professional Standards Communications	Professional Standards	Q4	Increased understanding of Medical Council regulatory process from a	Statistics available for external queries and/or publication.

Action	Dependencies	Responsibility	Period	Desired Outcomes	KPIs
section 60 and breakdown of public/ private inquiries, to ensure transparency in our processes and heighten awareness of role of Council.				disciplinary point of view. Fulfilment of Medical Council key values.	
Support the doctors with professional practice or health issues via the: Health Committee Monitoring committee Performance Assessment.	Health Committee Monitoring Committee RCPC	Professional Standards	Q4	Continued efficient and regular support for practitioners with identified relevant health and practice issues to facilitate the doctors return to practice.	Committee reports identify supports provided via these programmes and data to show improved outcomes is included.
Prepare and distribute medical workforce intelligence reports utilising registration and survey data.	Department of Health (all relevant Departments) Maccraith Group HSE via NDTP	Research Unit	Q1		
			Q1 – Q2	Medical workforce issues identified, and collaborative action agreed.	2017 and 2018 medical workforce reports published.
			Q4	Collaboration with key stakeholders to define solutions to address medical workforce planning challenges (recruitment and retention).	Agreed medical workforce planning solution/s identified.
			On-going	Collaboration with Patient Safety office to inform and support patient safety monitoring and developments.	Relevant data collected and reported by the Medical Council.
Review and agree both the oversight and Performance Delivery agreements with the Department.	Department of Health		Q3	KPIs in the performance delivery agreement reflect the Council's new strategy.	Performance Delivery Agreement updated.

Strategic Objective 2

Ensure consistency in application of quality assured standards across the continuum of education, training and lifelong learning

We aim to achieve this objective through the following actions:

2.1 Continued development of a proportionate, evidence-led, regulatory model to quality assure medical education, training and lifelong learning

2.2 Ensure all education, training and lifelong learning interventions are evidence-based

2.3 Ensure professional identity formation process, from lay person to skilled professional, is embedded in education, training and lifelong learning

2.4 Guide the development of outcome-based education, training and lifelong learning programmes appropriate to the student or registered medical practitioner's career stage

2.5 Undertake or commission targeted medical education research that addresses strategically important themes that advance medical education, training and lifelong learning quality in Ireland

2.6 Provide leadership to students and registered medical practitioners on their professional conduct and ethical responsibilities

2.7 Support and advocate for the physical and mental well-being of students and registered medical practitioners

Action	Dependencies	Responsibility	Period	Desired Outcomes	KPIs
Focus attention of CPD activities on areas of poor performance identified through complaints and national research and systems investigations e.g. Communication including Open	Resources	PGTBs HSE Employers Doctors	Ongoing	An increased percentage of doctors engaged in developing communication skills.	Stakeholders advised of the Medical Council's focus on communication skills enhancement.

Action	Dependencies	Responsibility	Period	Desired Outcomes	KPIs
Disclosure as part of formal CPD, education and training programmes.					
Research and consultation to develop CPD Accreditation Model.	Ability to link with and obtain meaningful collaboration from relevant stakeholders to draft the proposal. Availability of resources/approval of business case. Link with independent review (above) Director Education and training RCPC Council PTGBs	Professional Competence & Research	Q3	Research on international accreditation models and guidelines completed.	Leading best practise CPD accreditation model framework concepts identified.
			Q4	Draft proposal on CPD Accreditation Model prepared and stakeholder's consultation completed. Proposal must: • define set of accreditation principles and rules for delivery of RMP-centred CPD • principles must be diverse, relevant, practice based and encourage reflection and action • Safeguard against commercial manipulation of CPD.	Draft CPD accreditation model that meets key principles.
Access tests of competence tools for RMPs not in clinical practise, returning to clinical practise and at-risk RMPs to enhance the performance assessment process.	Collaboration with relevant external stakeholders.	Performance Assessment	Q4	Appraisal model which includes tests of competence to assess RMPs' competence relevant to their area of practice. Draft Service Level Agreement (SLA) that facilitates tests of competence agreed with PGTBs.	Test of competence models available to support the PA process.

Action	Dependencies	Responsibility	Period	Desired Outcomes	KPIs
				Remediation programmes available to Drs relevant to their area of practise.	
Research exploring postgraduate clinical training in Ireland from the perspectives of both trainees and trainers. This will aim to seek solutions to challenges noted in education and training site visits and WFIR, including quality of the clinical learning environment and access to protected training time.	Recruitment and engagement of research participants. Engagement with the Department for Health, Maccraith, NDTP on encouraging participant recruitment and addressing issues identified.	Research Unit	Q2	Trainer survey developed and administered with ARAF to Irish trainers.	Survey administered.
			Q2	YTC survey revised and administered with ARAF to Irish trainees.	Survey administered.
			Q4	Data analysis of both datasets undertaken and triangulated Reports drafted for publication.	Reports produced.
Complete Phase 1 of the development of an interactive database to support education and training-related accreditation and inspection activities.	Capita ETP Staff Capacity ICT Manager Capacity	Director of ETP	Q1	Technical review of project scope.	System defined, changes, if any identified and appropriateness of budget confirmed.
			Q2	Agreed changes implemented.	Draft database is ready for review.
			Q4	Database is fit for purpose and user-friendly for internal and external stakeholders' use.	UAT completed and Go live.
Conduct a full review of the ETPD 2015-2020 Strategy and Roadmap considering progress to date and current priorities, to ensure all objectives for delivery 2020-2023 are SMART.	ETC availability Staff capacity Ability to outsource projects (niche area)	Director of ETP Director of PCS and Research	Q2	Progress update delivered to ETC, review of Roadmap conducted, and revised roadmap and timelines drafted.	New roadmap defined with clear timelines.
			Q3	Consultation process or event, if required, completed.	Revised roadmap in place.
			Q4	Council has an achievable and effective roadmap to continue delivery of the ETPD strategy 2015-2020.	SMART objectives for remainder of term, approved by Council.

Action	Dependencies	Responsibility	Period	Desired Outcomes	KPIs
Re-open enhanced Specialty Recognition process.			Q1	Process re-opened by end Q1 New application forms and information accurately reflect NDTP and Dept of Health feedback. Process fees are more activity-based.	Process re-opened. Application form questions reflect NDTP and DoH requirements. Fee structure approved by SGC.
			Q4	The revised process applies best practice to speciality recognition, reflects Medical Council strategy and policy, ensures compliance with domestic and EU legislation, achieves input from Dept of Health and NDTP at crucial decision-making and is more cost effective.	Medical Council works collaboratively with HSE NDTP and Department of Health when making decisions on applications for recognition of a new specialty.
Complete project to review entire suite of education and training standards.	HCI engaged to deliver project Stakeholder feedback ETC and Council approval Staff capacity	Director of ETP	Q1	Standards Framework developed.	Framework endorsed by ETC and Council.
			Q2	Consultation process completed.	Irish Medical Schools, Council, Forum PGTBS, Intern Network Executive, HSE NDTP & DoH consulted
			Q4	A set of outcomes-based standards across the continuum of MET, compatible with international standards, including NCFMEA and WFME requirements, yet relevant to the Irish context.	New standards approved by Council.
	EWG	Director of ETP	Q1	Draft revised guidance developed.	Council endorse draft amendments for consultation.

Action	Dependencies	Responsibility	Period	Desired Outcomes	KPIs
Review current guidance on termination of pregnancy in response to new legislation.	Council Legal Advisors Several internal functions (e.g. legal, ETP Directorate, Communications, Research) Director of Regulation			Consultation process completed.	
			Q2	Ethical guidance developed and published.	New guidance approved by Council and published.
Conduct two regional inspection visits.	Hospital Group and individual hospitals. Availability of Assessors and Council members.	Director of ETP	Q2		7 hospitals in RCSI Hospitals, Dublin North East Group visited. Report approved by Council.
			Q4	All clinical training sites within both hospital groups have been visited by the Medical Council by year end.	All 5 hospitals in University of Limerick Hospitals Group visited.
Conduct two medical school visits.	Medical schools and associated clinical training sites Availability of Assessors and Council members	Director of ETP	Q1	RCSI medical school visited.	RCSI medical school assessment completed and actions identified. Report approved by Council.
			Q4	UL medical school visited.	UL medical school assessment completed, and improvement actions identified.
Analyse annual returns from 6 medical schools, 13 postgraduate training bodies and two hospital groups and follow up any issues arising from same.	Medical schools Postgraduate training bodies Clinical Training Sites Hospital Groups ETC ETP Staff capacity	Director of ETP	Q2	All Annual returns received from medical schools and postgraduate training bodies are analysed and presented to ETC.	Analysis report presented to ETC. Medical Council is assured that programmes accredited by the Medical Council are continuing to meet our Standards or identified failures to do so are followed up.
			Q4	All Annual returns received from Saolta University Healthcare Group and South/Southwest Hospital	Analysis report presented to ETC. Medical Council is assured that sites visited by the Medical Council are continuing to meet our Standards or

Action	Dependencies	Responsibility	Period	Desired Outcomes	KPIs
				Group are analysed and presented to ETC. Follow up with relevant bodies if any issues arise from analysis.	identified failures to do so are followed up.
Re-accredit six postgraduate training programmes.	Individual postgraduate training bodies Availability of Specialist Training Assessor Panel members Availability of Council member to chair each Specialist Training Assessor Team (STAT) Stenographer ETP Staff capacity	Director of ETP	Q4	Half of all postgraduate training programmes due to be re-accredited have been reviewed by a STAT.	Six programmes are reaccredited.
Convene first-time accreditation reviews for all postgraduate training programmes under the umbrella bodies of RCSI.	RCSI Availability of Specialist Training Assessor Panel members. Availability of Council member to chair each Specialist Training Assessor Team (STAT). Stenographer. ETP Staff capacity	Director of ETP	Q4	The following RCSI Programmes have undergone an accreditation review: Cardiothoracic Surgery, Neurosurgery, Oral & Maxillofacial Surgery, Paediatric Surgery, Plastic, Reconstructive & Aesthetic Surgery, Otolaryngology, and Urology.	All RCSI programmes are accredited.
Review applications for recognition of new specialties, as and when received.	Postgraduate training bodies	Director of ETP	Ongoing	All applications for recognition of a new specialty are managed in a timely manner and outcomes are in keeping with	All initial applications are reviewed, and decision made on whether/not

Action	Dependencies	Responsibility	Period	Desired Outcomes	KPIs
	HSE NDTP Department of Health Availability of Specialist Training Assessor Panel members Availability of Council member to chair each Specialist Training Assessor Team (STAT) Stenographer ETP Staff capacity			Council policy on specialty recognition.	to proceed within 3 months of receipt. All applications which progress to Stage One completed within 4 months of receipt of complete application. All applications which progress to Stage Two completed within 6 months of progression to this stage.
Inspect four Anatomy Departments.	Availability of College department staff Inspector of Anatomy Availability of non-medical Council member(s) ETP Staff capacity	Director of ETP	Q2	The following inspected: NUI Galway Anatomy Department, UCD Anatomy Department and Mater Hospital satellite site.	Assessment complete and improvement actions identified.
			Q4	RCSI Anatomy Department and York street satellite site inspected. TCD Anatomy Department inspected.	Assessment complete and improvement actions identified.
Analyse anatomical returns from 6 Anatomy Departments.	Anatomy Departments Inspector of Anatomy ETP Staff capacity	Director of ETP	Q2	Anatomical returns are analysed by IOA/staff and presented to ETC.	Anatomical returns are in order, in accordance with Council policy.

Strategic Objective 3

Learn from experience to enhance the delivery of an efficient and proportionate model of regulation

We aim to achieve this objective through the following actions:

3.1 Proactively identify and deliver improvements in regulatory activities

3.2 Analyse and use relevant information (internally and externally) in a targeted way, to better inform decisions

3.3 Collaborate with stakeholders to encourage sharing of information, experiences and joint learning

3.4 Be a learning organisation committed to continually improving what we do

Action	Dependencies	Responsibility	Period	Desired Outcomes	KPIs
Independent review of PCS model to determine whether it is fit for purpose.	Availability of resources/approval of business case. Ability to link with and obtain meaningful collaboration from relevant stakeholders. Ability to select suitable auditor in a relatively short period of time.	Professional Competence	Q1	Resources approved.	Funding obtained.
			Q2	TORs for independent review developed. External auditor selected through tendering process. 3 -4 PGTBs selected and notified for audit.	RCPC endorses ToRs.
			Q3	Audit of 3 – 4 PGTBs conducted to determine whether the current PCS model is fit for purpose with regards to: Management of MPC compliance; Facilitation of RMPs' meaningful MPC.	Audit report identifying improvements.
			Q4	Agreed Action plan to respond to recommendations and consultation with stakeholders concluded.	Action plan agreed by RCPC and endorsed by Council.

Action	Dependencies	Responsibility	Period	Desired Outcomes	KPIs
	Head of Procurement. Director of Regulation.				
Implement Registration and Continuing Practice Committee (RCPC) process changes relating to nonstandard registration cases.	RCPC	Director of Registration & BPI	Q1	Review of process and changes identified.	Consensus on changes required.
			Q2	Changes implemented to provide a streamlined process of determining non-standard registration applications.	Non-standard applications determined within 20 weeks of first decision not to register.
Implement changes to Review hearings including 1. Streamlined procedures 2. Expansion and training of the review panel.	RCPC	Director of Registration & BPI	Q2	Larger review panel appointed and in place by 30 April.	Review hearings offered within 8 weeks of request (subject to applicant doctor availability).
			Q2	Decisions reviewed to quality assure decisions, with report to RCPC.	Periodic reporting of comparative review timeframes.
Implement changes to Professional Indemnity (PI) through annual retention.	PI providers External legal advisers Professional Standards ICT & ICT provider	Director of Registration & BPI	Q4	System and procedural changes implemented for annual retention period. Reduced administrative burden relating to PI for doctors, when completing retention. Reduced cost of administering the PI requirements.	PI component of retention is reported indicating timeframes and achievements.
Review and amendment of complaint/inquiry procedures and correspondence to reflect complaint process feedback, best practice, legislative development,	Professional Standards Communications ICT & ICT provider	Director of Regulation	Q3	All departmental correspondence is in line with emerging legislation. Improved complaint efficiency in the workings of the FTPC and PPC. Correspondence is sensitive to the desired strategy of the Council - i.e. support of medical practitioners and transparency in procedures.	New correspondence/procedural documents in place by Q3, and procedural documents publicly available to registrants and patients in advance of making a complaint.

Action	Dependencies	Responsibility	Period	Desired Outcomes	KPIs
and proposed Council strategy.					
Assessing and determining first-time applications for registration.	Council & committees	Director of Registration & BPI	Q4	First-time applications on hand at year end are in line with year on year trends (*Dependent upon number of applications received*).	Open Applications On-Hand at Year end < 500 cases (Monthly trend data to reflect on track in comparison to previous three years).
Determination of specialist applications assessment of training & experience.	CEO & Directors Council & committees	Director of Registration & BPI	Q4	Compliance by both the Council and PGTBs regarding the SLA for assessment of training & experience.	PGTBs complete 95% of assessments within the specified 10 weeks.
Conduct of annual retention of registration.	CEO & Directors Council & committees	Director of Registration & BPI	Q3	Annual retention process conducted in a timely manner.	Annual Retention Fees Paid, Registration Updated and Removals Affected by 19th August 2019.
Conduct the annual intake of interns to the Register.	CEO & Directors Council & committees	Director of Registration & BPI	Q4	All new interns are registered in a timely manner to take up their first post on second Monday of July (HSE specified date).	95% of annual Intern Intake registered by 15th July. (Reflects need for last minute changes/delays in offering of posts by HSE).
Manage matters arising from BREXIT and conduct ongoing liaison with GMC on BREXIT matters.	CEO & Directors GMC DoH	Director of Registration & BPI	Q2	All UK qualified applicants for registration are not adversely affected by BREXIT related changes. The Council and the Executive are kept informed as to matters of concern and resolution of issues, as required.	Application information is updated as soon as final BREXIT arrangements are ratified and BREXIT occurs. Information updates included in Reports to Council and through meetings of the CEO and Directors.

Action	Dependencies	Responsibility	Period	Desired Outcomes	KPIs
Management of complaints before PPC.	Complainant Practitioners External agencies	Professional Standards	Q4	Timely and effective resolutions of complaints.	Reduced average timeline from receipt of complaint to NPF/referral.
Review and update PPC/FTPC procedures and correspondence to ensure the system is managed optimally within the parameters of the legislation.	Number and complexity of complaints received.	Professional Standards	Q3	Improved operation of complaints procedure to include improved feedback from parties involved and reduction in timeline for completion of complaint.	Improvements in complaint management.
Management of inquiry calendar.	Professional Standards Kingram House capacity External legal panels	Professional Standards	Q4	Active management of inquiries. Active management of call overs to assist in case management and progression.	45 inquiries completed by year end. 7 call overs completed by year end. Timeline for complaint completion reduced in annual statistics.

Action	Dependencies	Responsibility	Period	Desired Outcomes	KPIs
Training of all relevant committees and Council.	Professional Standards External Counsel Corporate Governance	Professional Standards and Corporate Governance	Q3	All new and existing committee members trained in relevant legislation and policy related to their role.	Health Committee – 1 training day. Monitoring Committee – 1 training day. Preliminary Proceedings Committee – 1-2 training days. Fitness to Practise Committee –1- 2 training days. All relevant committees and Council receive training.
Defend appeals, judicial reviews or action commenced against the Council, arising from Parts 6,7,8,9 or 10 of the Medical Practitioners Act 2007.	Professional Standards External legal panels	Professional Standards	Q4	Efficient systems resulting in a reduction of legal challenge, and in the case of legal challenge cost-effective handling of same.	Increase in successful court outcomes.

Strategic Objective 4

Improve the understanding of the role of the Medical Council

We aim to achieve this objective through the following actions:

4.1 Promote an open and transparent organisational ethos

4.2 Establish meaningful two-way communication channels and engagement opportunities with stakeholders

4.3 Outline and share the Medical Council's methodologies, operations and processes to key stakeholders

4.4 Publish and promote relevant Medical Council activities

Action	Dependencies	Responsibility	Period	Desired Outcomes	KPIs
Devise and implement a stakeholder engagement strategy on role of Council.	Cross organisation and Council.	Head of Communications Directors	Q3	Draft engagement strategy prepared for review. Engagement Strategy complete.	A draft strategy that delivers on the strategic objectives of the Council. Approved communication plan.
Respond to media queries in a timely and accurate way.	Access to correct information in a timely fashion.	Communications	Q4	Respond to media queries in a timely manner.	Consistent and timely response to media queries.
Host regional seminars to meet with Registered Medical Practitioners.	Support and advice from front line teams. CEO Directors	Head of Communications	Q4	Expanded knowledge of the MC function is increased. To make all relevant stakeholders aware of the Health committee and its remit.	Minimum of three seminars are conducted.

Action	Dependencies	Responsibility	Period	Desired Outcomes	KPIs
Engage with key stakeholders on understanding of complaints process and importance of locally addressing patient issues in the first instance.	Professional Standards President of Medical Council Chairs of PPC and FTPC	Director of Regulation	Q4	Improved engagement with health stakeholders, public and profession and a better understanding of the Medical Council complaint remit and process.	Meetings with HSE, registrant indemnifiers, GP representatives and patient safety groups by Q4 on Medical Council complaints process and importance of local complaints process being utilised in the first instance. Increased reporting from key healthcare stakeholders on important issues of fitness to practise. Reduction in NPF complaints not meeting seriousness threshold which could have been addressed locally.

Strategic Objective 5

Review and recommend changes to legislation regulating the medical profession

We aim to achieve this objective through the following actions:

5.1 Review the current legislation regulating medical practitioners to inform and recommend changes

5.2 Examine international health professions regulatory practice and legislation to inform and recommend changes in the regulation of medical practitioners

5.3 Make recommendations on how to improve regulation of registered medical practitioners

Action	Dependencies	Responsibility	Period	Desired Outcomes	KPIs
Review the Act to identify areas requiring amendment that will improve efficiency of the governance and functions of Council.	Cross organisation collaboration. Political appetite Challenges in delivering a medical regulatory governance model under the existing Act are identified.	Organisation wide (lead CEO) Strategy and Governance Committee Streamlining group	Q2	Policy changes in the Act and field of health care regulation are identified.	Production of a document identifying policy and legislative changes in conjunction with the health and social regulatory care Forum.
			Q3	Workshop to agree policy document completed.	Executive management team MT recommendations to be made to Council.
			Q4	Document defining policy changes in the Act (Phase One) & presented to board.	Policy document drafted and submitted to DoH for review and consideration.

Strategic Objective 6

Develop the Medical Council as an engaged, effective and empowered organisation

We aim to achieve this objective through the following actions:

6.1 Develop, align and support a skilled and knowledgeable team required to deliver on the Council's strategic objectives

6.2 Create a culture that encourages collaboration and shared learning within the Medical Council

6.3 Provide a working environment and infrastructure that will support the strategic direction of the Council

6.4 Continuously review and align the governance structures to the strategic priorities of the organisation

Action	Dependencies	Responsibility	Period	Desired Outcomes	KPIs
Design and develop an organisation that ensures the Medical Council has the right number of roles at the appropriate grades and expertise to deliver on the Council's strategic remit. Recruit/develop staff to facilitate the above.	Dept. of Health CEO and Directors	Head of HR	Q1	Complete strategic workforce planning workshops PMDS objectives agreed and linked to the Business Plan.	SWFP completed. Skills audit compete. The organisation reviewed and redesigned (if necessary). PMDS training and recruitment plan in place.
			Q2	Organisation Design completed.	Clear vision on organisation structure to deliver strategy.
			Q3	New Workforce plan completed and submitted to Dept of Health.	Workforce plan approved by Dept of Health.
			Q4	An organisation that is fit for purpose.	Engaged and effective workforce.

				PMDS completed for all employees and reviewed twice a year. Recruitment on track.	Staff retention increased by 3%. 5% reduction in short term absenteeism. PMDS completed and development for all staff.
Improve cross department communication and engagement.	CEO Directors Heads of Departments	Head of HR	Q1 – Q4	Have more cross departmental goals and objectives leading to collaborative environment where objectives, learning and experience are shared. Effective organisation wide communication and objectives.	Three all staff communication sessions completed. Six lunch and learn meetings conducted. Cross department staff induction sessions conducted.
Provide a working environment and infrastructure that will support the strategic direction of the Council.	CEO Directors ICT	Head of HR CEO Directors	Q1 – Q4	A working environment that enables employees to meet the goals of the organisation while fulfilling their own potential and maintaining a health work life balance.	Strategic training plan developed and reviewed quarterly. Wellbeing group strategy and objectives reviewed quarterly. Employee engagement meeting quarterly. Dignity and respect at work training ongoing.
			Q3	Remote working policy in place.	Effective remote working in place.
Review and implement significant repair and replacement plan of essential plant items. Review reconfiguration opportunities for improved utilisation of Kingram House space.	Dependent on PAG decision re direction of Property Strategy.	Head of Procurement and Facilities	Q2	Plan for significant building repairs/replacement in place with essential plant implemented prioritised.	Repairs/replacement of essential plant implemented.
			Q4	Efficient and effective building leading to compliance with H&S and building regulations and reduction in building system failures that lead to downtime / loss of operations.	Closures resulting from building failures are minimised.
Solutions investigated to inform direction of Property	CEO, Director, PAG, Finance, ICT, Corporate	Head of Procurement and Facilities	Q4	Decision on strategic direction of property acquisition/ rental supporting spatial requirements	Council endorse property acquisition group capacity solutions.

Strategy to address Kingram House capacity issues.	Governance, external experts/ contractors	CEO		and operational needs of the organisation.	
Implement 2-year Energy Awareness Programme.	PAG – outcome of Property Strategy decision will inform and support positive variances in Energy Management metrics.	Head of Procurement and Facilities	Q1	Realistic energy baseline and plan in place.	Understanding of savings required and program to achieve.
			Q4	Energy Programme supports financial and environmental savings. Annual SEAI metrics improved with revised baseline enabling reduction in reported consumption.	Establish savings target of 3% on revised baseline.
Complete and embed the organisation's move to the Cloud including: Migration of LAN Services to the Cloud Migration of External Services to the Cloud.	ICT Security Advisor Capita pTools Communications	Head of ICT	Q2	Maximum efficiency and functionality of IT systems supporting the core business of the Org.	< 5 Security Incidents Disaster Recovery plan developed and implemented.
Implement Application Programming Interface (API).	Registration Capita Corporate Governance	Head of ICT	Q2	Technical specification completed and implemented.	API interface in place.
			Q4	Defined List of trusted providers agreed. Provision of service to customer base.	20% uptake of service provided.
Implement and support remote access and e-working solution.	HR Management team	Head of ICT	Q3	Increased efficiency, ease of access and availability of network resources.	75% of services available remotely. Decrease in staff leaving citing commuting & access to remote access services. 25 users (>50%) availing of remote access.
Review, design and implement IT infrastructure for Council, and meetings.	Decision from PAG. Property acquired.	Head of ICT	Q4	Draft Plan for implementation.	Plan in place for approval.

	Corporate Governance Facilities				
ICT Strategic Project Support of Key Projects.	Finance Procurement Directors AFRC	Head of ICT	Q1	Phase 1 - Produce technical specification of requirements for replacement of Integra 2.	Technical specification complete Sign off from AFRC.
			Q4	Phase 2 – Procure Replacement.	Procurement complete.
Income model review (Move towards activity-based hybrid).	All Core functions Registration primarily Communications	Head of Finance	Q1	Review commenced.	
			Q2	Review completed.	Report of recommendations from review
			Q3	A more equitable fee model where regulatory work is cost neutral where possible.	Proposal drafted for Council decision.
Upgrade of Evolve case management system.	ICT and ICT provider	Director of Regulation	Q3	Security on the Evolve system is GDPR compliant and documents password protected. Comprehensive status reports for each individual case officer. 3rd party contact details and legal reference on files for letter generation with most documentation.	Reduction in any potential data breaches leading to GDPR compliance. Increase in accessible complaint information for Annual Report.
Review and implement revised Contract Management processes.	External contractor, Director and Leadership teams	Head of Procurement & Facilities	Q1	Review of Contract Management processes conducted.	Recommendations to improve Contract Management processes identified.
			Q2	Recommendations incorporated into existing tools.	Updated guide to the contract management process.
			Q3	All relevant Staff trained in the new process.	All relevant staff trained.
			Q4	Revised Contract Management processes fully operational.	Cost effectiveness of Contract Management reported to AFRC.

Implement requirements under PEPPOL.	Finance, ICT, OGP and DPER	Head of Procurement & Facilities	Q1	PEPPOL requirements researched and scoped.	Implementation Plan prepared.
Recruit external Committee members.	All directorates External PAS PGTB / Medical Schools	Governance Committee Chairs and Secretariat	Q1	Committee members identified, recruited and trained.	All members appointment and trained.
			Q2	Committee representatives appointed and active.	Meeting attendance and engagement is monitored by Chairs and secretariat.
			Q4	Committees deliver on planned activities in line with Council strategic objectives.	Business Plan actions relevant to the committee have been achieved.
Streamlining of Council meetings and documentation to identify delegation efficiencies.	Coordination and engagement	Strategy and Governance Committee All Directorates Streamlining Group	Q1	Streamlining group reconvened by January and TORs agreed.	Terms of reference agreed.
			Q3	Streamlining recommendations are presented to Council for consideration.	Agreement on recommendations.
			Q4	Improved and consistent Documentation presented to Council.	Standardised templates revised.
Ongoing support, coaching, leadership, guidance and development of Case Officers.	Availability of training/ professional development opportunities that would augment Case Officer knowledge/ experience.	Performance Assessment	Q1	Refresh training undertaken by Case Officers in: - Report writing - Review of International best practice in assessment and incorporating learnings from same; - Liaison with other regulatory authorities in other jurisdictions (e.g. GMC) to share and obtain knowledge.	3 Case Officers confidently utilising skills and knowledge obtained through refresh training. Case officers are confidently managing performance assessment cases with minimal supervision from the performance manager 80% of time.

Medical Council
Kingram House
Kingram Place
Dublin 2
D02 XY88

www.medicalcouncil.ie

Comhairle na nDochtúirí Leighis
Medical Council