

To consider

Chief Executive's Report and Review of 2009

Issue

1. Report on achievements and outcomes in 2009 and ongoing in 2010.

Recommendation

2. To consider the Chief Executive's report and review of 2009 (paragraphs 4-164 and Annexes A-D).

Further information

3. If you require further information about this paper, please contact us by email: gmc@gmc-uk.org or tel. 0161 923 6602

Background

4. The Chief Executive's regular reports for each Council meeting update members on progress against the key aims in the Business Plan. The first report in each new year reports on achievements and outcomes in the previous year. This report reviews 2009, mapped against the key aims in the 2009 Business Plan, and reports on ongoing work in 2010.

Introduction

5. Most of this report is devoted to an account of the GMC activities in 2009, a year of considerable change within and beyond the organisation. In spite of this and the fact that a new Council had to establish itself, this was a year of major achievements, which reflects a strong organisation with a clear sense of purpose

6. Nevertheless, as we look to 2010 we face a challenging agenda.

7. The environment in which we operate is about change with the era of endlessly increasing resources likely to be replaced by a period of turbulence and austerity in the health system. We know there will be rising demand for services, restricted resources and professionals, including doctors, under more pressure than we have seen for some years.

8. In a system where expectations are higher than ever and where more transparency will be required, the pressure on regulators such as the GMC will also be correspondingly greater. In some situations it may make those at the front line more risk averse and less willing to embrace change, and that too could present its own difficulties.

9. The greatest challenge we face will be the introduction of revalidation. We recognise there is widespread support in principle but there is also fear of the unknown and concern about the details of implementation. We will need to work hard to reassure, to listen, to learn lessons from our consultation and from the pilots. At the same time we need to ensure that every doctor understands what is required, while minimising costs in time and resources.

10. On the one hand revalidation is the largest change in the relationship between the GMC and the profession in more than 150 years; on the other, it is no more than the putting in place of good practice, which is already operating in many parts of the UK. To succeed it will need the combined effort of the entire organisation, single minded commitment, and the ongoing support of our partners. We cannot do this alone. We need employers to embed good local systems of clinical governance and appraisal, we need the visible leadership of the health departments in each of the parts of the UK, and we need clear messages of support from the leadership of the profession, together with their enthusiasm and involvement even when times get tough.

11. Three immediate tasks lie in front of us. First, there is the consultation that is about to get underway. Its purpose is to test the approach through piloting. We will need to be flexible and willing to take on new ideas. Secondly, we have to reach as many doctors as possible to find out their views and ideas and explain what is being planned and how it will affect them. Thirdly, we want to begin a process of engagement with the profession which will set out the benefits of revalidation and the process and timetable for introducing change.

12. We had considerable success last year in introducing the licence to practise and that should give us confidence to take on this work but we should be in no doubt that this is of a different order. Above all, we need to communicate effectively, reassuring doctors that this is about assuring their practice not weeding out under-performers, and that what will be required is no more than should be going on anyway.

13. Reflecting the importance we attach to this work we have created a new directorate of Continued Practice and Revalidation. It will lead the GMC's contribution working with our partners in the profession, patients, employers, and in the four administrations across the UK.

14. Our second major challenge over the next fourteen months will be to move our adjudication function to the Office of the Health Professions Adjudicator (OHPA). Again this is highly significant in that it represents a major logistical challenge with the overriding need to ensure business continuity and the effective running of panels throughout the transition.

15. It is also a move which will redefine the role of the GMC creating a helpful distinction between our key functions as investigator and case presenter, and OHPA's role as adjudicator. Under the current arrangements there is little understanding outside the organisation of the autonomous nature of the panels and the fact that while we propose the sanction we believe is appropriate according to our published guidance, it is a matter for the panel to decide what is actually determined. The separation will make this division of responsibilities much more apparent.

16. We have a loyal and dedicated staff and we must do everything possible to make the move as seamless as possible for them and for all those involved in our procedures. The creation of OHPA will be an opportunity to bring about further improvements, building on the significant reforms in our Fitness to Practice procedures of recent years. We are determined to work closely with the Chair of OHPA and his team to bring this positive change about.

17. The third challenge will be to adjust and develop to our new responsibilities in medical education. As far as PMETB is concerned we are of course much further down the road than with OHPA and it is to the enormous credit of both the team at PMETB and the project team here that we are on track to achieve a successful merger. We have achieved this on a 'lift and shift' principle, minimising change and disruption to ongoing PMETB functions. The challenge now is to take this forward and not just integrate postgraduate regulation but look across the whole spectrum of education and assess the GMC's role. This will mean taking forward the work of the Patel Review, which raises a number of key issues on linkages within the system and our role as regulator. We aim to use this to help shape the road map for the next few years and to start a wider debate about the role of the GMC in regulating medical education and training.

18. In recent years, after extensive consultation and debate, we have produced seminal publications which arguably provide the profession in the UK with some of the best guidance on standards and ethics anywhere in the world. It is certainly adopted and adapted widely elsewhere. In the coming year we will be working on End of Life and other guidance before moving on critically to the next edition of *Good Medical Practice*. In 2010, we will be taking to the road, with the End of Life Care guidance as well as continuing our efforts to ensure that the new edition of *Tomorrow's Doctors* is widely understood and adopted by students and medical schools alike. One of the most significant advances we can make in this area is to continue to find new ways of making our guidance accessible to front line practitioners and others who are directly affected by it.

19. Much of what we are planning this year and over period covered by the Strategic Plan developed by Council is about changing our relationships with those whom we serve and work alongside. Part of this is just about understanding the various groups who have an interest in our activities; in essence this is about making equality and diversity integral to what we do. That will involve a greater awareness and understanding of different groups and identities; understanding what matters to them, continuing to ensure fairness and transparency in everything we do and valuing the important contribution such groups bring to our work.

20. It is also about continuing to make ourselves more responsive – we have made enormous strides in recent years, to the point where our Call Centre was recognised last year in a national award scheme. But there is more we can learn and do, from the tone of our standard communications to how we deal with individuals who for one reason or another may be traumatised when they come into contact with us.

21. Changing and developing these relationships will also mean taking steps to make the register more useful for doctors, employers and patients. Here too we need to know more about those we deal with, to ensure that the register is a resource that provides more useful information, further confidence in the profession and greater protection to the public. Alongside the work on revalidation we will explore additional information that can be included on the register to help achieve that end.

22. The integrity of the register remains paramount which is why we will continue to work to change the legal framework which prevents us from language and competence testing doctors applying to join the register from the European Economic Area. If we are to make a difference in this and other areas where we are concerned about safety and practice, we will have to be more active and sustained in our efforts to bring about change. The work begun last year following the research on prescribing errors is one example of what can be achieved.

23. In the longer term the development and implementation of GMC Affiliates will be crucial in this different environment helping us to reach out to doctors and employers but also acting as a conduit back into the organisation.

24. Improving our performance and demonstrating value for money will also be a major theme this year. We are committed to reviewing the fee structure following the merger of PMETB and must be conscious of the difficult financial environment in which doctors, the health service and higher education will all be working.

25. Paul Philip, Deputy Chief Executive, will chair a new Performance Board which will look to drive business improvement and efficiency throughout the organisation, including the assessment of value provided by activities that may be less easy to measure and where simple operational targets may not be appropriate.

26. Another major piece of in house work will be the review of governance arrangements Council has indicated it wishes to undertake in the coming year. This will build on what has been achieved and ensure members can be effective in all their key responsibilities including strategic decision making, oversight, and as ambassadors for the GMC.

27. All this is a big agenda as we take forward the achievements of 2009.

Discussion

28. A broad theme for 2009 was the further enhancement of our framework for medical regulation, a framework that puts patient safety at its heart, by setting and upholding appropriate professional standards; bringing together all stages of medical education and training; coordinating the necessary arrangements for delivering revalidation as the means of providing assurance that every licensed doctor remains up to date and fit to practise; as well as ensuring the fitness for purpose of the Medical Register and the fitness to practise of those on it.

29. Significant progress and achievements in 2009, including:

a. The successful introduction of a reconstituted Council from 1 January 2009, with parity of lay and medical members all independently appointed.

b. The publication of our Corporate Strategy for 2010-2013 which sets out what we aim to achieve over the next four years to ensure continued high standards of medical regulation in the UK.

- c. The assessment by the Council for Healthcare Regulatory Excellence that we continue to be 'a well-run, effective regulator with strong leadership...responsive to changing circumstances' and commending the GMC for 'its effectiveness in anticipating and shaping change within the profession'.
- d. Ongoing work to continue to use our resources efficiently and effectively, with the estimated benefit to the organisation of these initiatives to be in the range of £30 million to £40 million between 2003 and 2009.
- e. The successful introduction of licences to practise which marked the completion of the first major milestone towards the implementation of revalidation.
- f. The establishment of the UK Revalidation Programme Board and Delivery Boards in each of the four UK countries; agreement of a UK wide high level readiness plan; and the start of a number of projects and pilots across the UK aimed at assessing and testing various components of revalidation.
- g. Further progress towards achieving the merger of the Postgraduate Medical Education and Training Board with the GMC in April 2010, which will make the GMC directly responsible for the regulation of all stages of medical education and training, which remained on track throughout the year.
- h. Producing a range of new and revised guidance, including the revised *Tomorrow's Doctors*; *Medical Students: Professional Behaviour and Fitness to Practise*; *Confidentiality*; and *Pandemic Influenza: Good Medical Practice – Responsibilities of Doctors in a National Pandemic* and further developing *GMPinAction*.
- i. The establishment of the Reference Community, comprising 27 members of the public and 28 doctors, to help inform policy development and decision taking.

30. These achievements and progress made in delivering against the key aims in the Business Plan in 2009, under the effective leadership of former Chief Executive Finlay Scott and Paul Philip, Deputy Chief Executive, provide a strong platform to take forward the programme of work that will give effect to our Corporate Strategy and 2010 Business Plan.

Key Aim 1: To develop, promote and assure the quality of all aspects of basic medical education in the UK up to the point of full registration.

Consult on and publish a fully revised edition of *Tomorrow's Doctors*

31. We published the revised edition of *Tomorrow's Doctors*, following extensive public consultation, which included a conference in London and meetings with key interests and workshops in all four UK countries. The new guidance has been commended by the Council for Healthcare Regulatory Excellence and the Lancet.

Among other things, the new guidance will require medical schools and the NHS to work together to organise 'student assistantships' to help students become more familiar with work in a hospital or community setting and to understand practical tasks such as filling in a prescription form or ordering a blood sample. Medical schools will need to ensure that students are competent to undertake a standardised list of clinical procedures before graduation.

32. Medical schools will be required to implement the revised standards by 2011/12. We have planned workshops across the UK to bring together medical schools, postgraduate deaneries and health service providers to discuss and support the implementation of *Tomorrow's Doctors*. The first workshop was held in Cardiff on 18 December 2009. Further events will take place in Spring 2010 and we will continue to work closely with medical schools and our key interest groups to ensure a smooth transition to the new standards.

Develop and promote basic medical education

33. Jointly with the Medical Schools Council, we published a new version of guidance for medical schools, *Medical students: professional behaviour and fitness to practise* and undertook training seminars to help medical school staff put the guidance into practice. The guidance is intended to promote greater consistency in the way medical schools address fitness to practise problems amongst students, building on the good progress already made.

34. We commissioned a literature review from Peninsula Medical School to inform a research proposal on the relationship between medical schools and placement providers, such as NHS Trusts, where medical students and doctors in training undertake part of their programmes. The researchers will report early in 2010 and suggest further work in this area. This is an important area as we plan the implementation of *Tomorrow's Doctors* 2009, in particular, the requirements in relation to 'student assistantships'.

35. We established the Basic Medical Education Fitness to Practise Working Group to consider fitness to practise issues in undergraduate medical education and foundation year one, with a specific focus on the transition between the two stages. The Group will report later in 2010.

Assess and report on eight medical schools

36. We evaluated and reported on eight medical schools, and published the reports on our website. This concluded the first Quality Assurance of Basic Medical Education (QABME) visiting cycle. The Undergraduate Board is now discussing a range of possible enhancements to the QABME process, drawing on the learning from this first cycle.

Quality Assurance of the Foundation Programme

37. The GMC and PMETB jointly quality assured the delivery of foundation programme training at four deaneries: Northern, Severn, North Western and Oxford.

38. We printed an amended version of *The New Doctor* to update the list of core clinical and procedural skills that F1 doctors must demonstrate before being able to apply for full registration (which will come into effect from August 2010) and to keep the standards for training in the Foundation Programme consistent with PMETB's *Generic standards for training*, and *Tomorrow's Doctors*.

39. The Foundation Programme curriculum, developed by the Academy of Medical Royal Colleges Foundation Programme Committee (AFPC), specifies the content for the Foundation Programme and the associated assessment system. The Postgraduate Board ratified a revised curriculum and assessment system, following detailed scrutiny and approval at a joint meeting of a Postgraduate Board sub-committee and a PMETB Curriculum and Assessment Approval Panel. Conditions of approval were set and members of the Postgraduate Board sub-committee and GMC staff will consider whether that the AFPC has met these conditions when a final version is submitted.

Key Aim 2: To promote and develop postgraduate medical education and training in the UK, through joint work with PMETB as the competent authority, in preparation for the merger of PMETB with the GMC.

Put in place all necessary preparatory work to establish a single continuum for all stages of medical education and training, in order to realise and optimise the benefits envisaged by the merger of PMETB with the GMC

40. We worked closely with PMETB through the Joint Co-ordination and Joint Implementation Groups and, jointly with PMETB, with the Department of Health (England), through the, Joint Steering Group and to ensure that the merger remained on track throughout 2009. We continue to make very good progress (papers 5b, 5c and 5d on the agenda) to ensure the merger takes place as planned on 1 April 2010.

41. The General and Specialist Medical Practice (Education, Training and Qualifications) Order 2010 (the 'Section 60 Order') which will merge PMETB with the GMC completed its passage through Parliament on 14 January 2010; and, by the middle of February 2010, supporting rules and regulations will have been made (paper 5d on the agenda).

Make the necessary preparations for all aspects of the physical integration of PMETB within the GMC, including the co-location of PMETB staff within our London office

42. We are on track to co-locate PMETB staff to the London office in March 2010. The fit-out of the accommodation is expected to be completed by the end of February 2010.

43. We have made significant progress on the human resources aspects of the merger programme and issued individual contract offers to PMETB staff at the end of January 2010, building on an earlier communication advising PMETB colleagues on their prospective positions in outline.

Take forward joint development work in a number of areas including revalidation and certification, and quality assurance

44. Business integration activities continue to be taken forward in line with the agreed programme plan and a number of GMC staff have been seconded to, or are spending time with, teams at PMETB to increase knowledge pre-merger.

45. We are developing a benefits realisation plan to support the next phase of the merger programme. This will build on the early plans set out in the Full Business Case, approved by DH(E) in October 2009, and will incorporate recommendations that Council adopts following discussion at the meeting on 31 March 2010 of the final report of Lord Patel's review of the regulation of education and training.

46. We are making good progress on developing an induction programme for PMETB staff. Generic induction sessions have been scheduled for all PMETB staff and a further Joint Open Forum meeting will be held on 1 March 2010.

Key Aim 3: To enhance assurance that licensed doctors are up to date and fit to practise by introducing the licence to practise and preparing for revalidation.

Introduce the licence to practise

47. We successfully introduced the licence to practise on 16 November 2009. This was the first practical step towards the introduction of revalidation.

48. The licensing campaign 'It's time to decide' ran throughout much of 2009 and resulted in 97.3% of all registered doctors providing us with their licensing decision, as well as other information about their practice. All 218,153 doctors who requested a licence (as well as the small number who did not respond) were granted a licence, with 5.6% (12,907) of doctors remaining registered without one.

49. We held briefing events across the UK to help organisations which employ or contract with doctors to understand the new regulatory requirements and to demonstrate how services such as the online register would change on introduction of the licence to practise. We engaged with patient groups and, after consultation with the GMC's Reference Community, published a leaflet aimed at helping patients understand licensing.

Establish the UK Revalidation Programme Board to oversee the implementation of revalidation

50. We continued to make good progress towards implementing revalidation (paper 4b on the agenda).

51. We established the UK Revalidation Programme Board (UKRPB) to provide strategic oversight of the delivery of revalidation and to provide assurance to Council that we are moving toward implementation in a coordinated manner across the four UK countries. The UKRPB, which met five times in 2009, endorsed the Revalidation Project Initiation Document (PID) at its first meeting and monitored progress on the 12 workstreams set out in the PID. In 2010, the UKRPB will continue to oversee implementation and monitor progress on all workstreams to ensure that systems are being established and developed locally to support revalidation.

Pilot and deliver the changes needed to support revalidation, working in conjunction with the Department of Health (England) and the devolved administrations

52. We prepared a UK-wide high level readiness plan that was agreed, and is being monitored, by the UKRPB. The plan sets out the work that is being undertaken to prepare for revalidation.

53. We worked with DH(E) to establish Delivery Boards in each of the four UK countries. The Delivery Boards are responsible for ensuring that changes necessary to support revalidation are delivered locally in each of the four countries.

54. We developed a strategy for project and pilot work to ensure it is coordinated in a coherent way and that learning from each pilot feeds back into the planning process. We also supported a number of projects and pilots across the UK aimed at assessing and testing various components of revalidation, such as appraisal systems and the *Good Medical Practice* Framework.

55. We presented to the UKRPB the final reports from the Buckinghamshire PCT project (examining the type, quantity and quality of supporting information brought to appraisal by GPs), the Revalidation in General Practice in Wales project (examining appraisal and clinical governance systems for GPs in Wales) and the NHS Professionals project (evaluating the locum appraisal system). In the first quarter of 2010, we will present the final reports from the Northern Ireland secondary care and the Mersey Deanery projects, which concluded at the end of 2009.

56. We responded to the DH(E) consultation on the regulations and guidance for the Responsible Officer role.

Develop standards and an evaluation method, working with the Academy of Royal Medical Colleges

57. In November 2009, we received final submissions from the medical Royal Colleges and Faculties on the speciality standards and supporting information. The Continued Practice Board evaluated the submissions against defined evaluation criteria and agreed them as the basis for consultation.

Develop and consult on guidance showing how revalidation will work

58. In June 2009, we published a comprehensive set of frequently asked questions on revalidation covering a wider range of issues, including the timetable for implementation, the information that doctors will need to collect, how revalidation will work in different types of medical practice, and the role of the Responsible Officer.

59. We convened a revalidation communications forum to develop a strategic approach to the communication of revalidation and to coordinate communication activities among UKRPB members.

60. We started planning for the consultation, which will be launched in March 2010 (paper 4a on the agenda). In September 2009, the Continued Practice Board agreed the framework for the consultation and on 9 February 2010 will discuss the draft consultation document.

Credentialing

61. In May 2009, the GMC participated in a joint seminar with PMETB on the credentialing of medical practice, which looked at the way in which regulation might be used to recognise or accredit doctors' competence in discrete areas of specialty practice. DH(E) subsequently invited PMETB to lead exploratory work on the potential for credentialing in UK medical practice. The work had two strands: credentialing within progression through training (led by PMETB) and credentialing as part of revalidation (led by the GMC).

62. In October 2009, the Continued Practice Board and the GMC Credentialing Working Group discussed credentialing and in January 2010 we circulated a position paper to key interests for comment to inform PMETB's final report to DH(E).

Key Aim 4: To encourage and support doctors in the delivery of high quality healthcare by providing accessible up to date guidance on standards and ethics.

Update and reissue guidance, focussing on end of life care, confidentiality and research

63. The review of our guidance on end of life care continued throughout 2009, including a public consultation on draft revised guidance and events in all four UK countries to discuss the revised guidance with key interests. We are considering key issues arising from the consultation. Council will be invited to approve the draft guidance for publication on 20 May 2010.

64. We published new guidance for doctors on confidentiality. The guidance is accompanied by seven pieces of supplementary guidance which explain how the principles in the core guidance apply in a range of situations doctors often encounter or find hard to deal with.

65. We reviewed our guidance booklet on research and launched consultations on two new pieces of draft guidance: *Good practice in research* and *Consent to research*. These will be published as 'supplementary guidance', expanding the principles in *Good Medical Practice* and in *Consent: patients and doctors making decisions together*. We are making final amendments to the drafts. We will seek members' views on the draft guidance later in February 2010.

66. We also reviewed our supplementary guidance, *Making and using visual and audio recordings of patients*. Following a public consultation, we are seeking further views from key interests. We will seek members' views on the draft guidance before publication in April 2010.

67. We published new guidance, *Pandemic Influenza: Good Medical Practice – Responsibilities of doctors in a national pandemic*.

Develop further learning materials and new ways of promoting our guidance

68. We launched a poster informing young people of their rights when visiting a doctor. The poster was designed by a group of young people aged 13-15, as part of a project we commissioned run by the National Children's Bureau.

69. We published new case scenarios as part of *GMP in Action*. These include maintaining professional boundaries with patients and former patients, child protection issues, raising concerns about patient safety, and the importance of a confidential sexual health service for young people.

70. We began work to develop learning materials focusing on the care and treatment of patients with learning disabilities.

Engage with key interest groups in the development of guidance

71. As part of the consultation on revised guidance on end of life care, we engaged with a wide range of key interests across the UK, including a conference in London and events in all four UK countries. We commissioned secondary research of structured interviews with 86 people with terminal illnesses and nine carers of people who had died, and worked with BLISS and Mumsnet.com to run a survey about who should decide when to stop treating very young babies.

72. We started work on new guidance to replace the booklet, *Management for Doctors*, including seeking views from doctors, managers and others, as well as key organisations, on the principal problems faced by doctors in the workplace. We are using the responses to this initial scoping exercise to identify the key issues for the new guidance. We will establish a working group to develop new draft guidance for formal consultation between September and December 2010. Professor Dame Joan Higgins has been appointed to chair the Working Group. We will discuss the proposed membership of the working group with the chair on 11 February 2010. We expect the first meeting to take place in Spring 2010.

73. We worked with other regulators, government bodies, charities and professional bodies to draft new guidance on testing patients for serious communicable diseases following injuries to healthcare workers which may have exposed them to infection. We are drafting new guidance which we will discuss with key interests before consulting formally in March 2010.

Set evaluation criteria to measure the effectiveness of our guidance

74. We used the GMC's evaluation framework to identify the areas of work where there are no existing measures through which we can assess whether we are meeting our objectives. We have identified projects that will provide base-line information from which we can track improvements. For example, we have commissioned a survey of doctors to assess the level of awareness and understanding of GMC guidance in the profession. In 2010, we will commission further expert advice on consultation processes to help assess the effectiveness of different approaches to consulting the public and the profession.

Key Aim 5: To support high quality healthcare by ensuring a co-ordinated approach to education and training across all phases of a doctor's career.

Support the review led by Lord Patel

75. In 2008, we invited Lord Patel to lead a review of the regulation of education and training to help inform future work following the merger of PMETB with the GMC. An advisory group of GMC and PMETB members supported the review.

76. In late 2008 and early 2009, Lord Patel took soundings from a range of key interests about the current regulation of education and training and their aspirations for the future to help the review group identify priorities for further exploration.

77. In November 2009 the review group shared its emerging thinking with key interests. Discussion helped shape the draft report of the review, which was published for consultation on 12 January 2010. Its 27 recommendations address the different stages of education and training (undergraduate, postgraduate and continuing practice) and the links between them, as well as the handling of medical graduates from other countries. The recommendations have implications not only for doctors and those involved in their training, but also for patients and for healthcare organisations throughout the UK.

78. Lord Patel will submit his final report to Council on 31 March 2010.

Engage effectively with key interests to ensure a strategic approach across the UK

79. As part of a programme of work to engage with medical students, Council members and staff gave presentations on the role of the GMC at medical schools across the UK throughout 2009. This work continues in 2010.

80. In partnership with the King's Fund, the Royal College of Physicians London, the NHS Institute for Innovation and Improvement, the University of Liverpool and Student BMJ, we hosted road shows for medical students at a number of medical schools to promote and encourage debate about the concept of professionalism, including engaging with professional regulation, the role of the doctor and professional values. Peter Rubin, Jim McKillop and I will support road shows planned for 2010.

Develop the three boards themed around the main phases of a doctor's career

81. We developed work programmes for the three Boards, established as part of the new governance framework to support the reconstituted Council from 1 January 2009. At their meetings in 2009, each Board discussed a range of issues relevant to the phase of a doctor's career for which it is responsible. For the Undergraduate Board this included: establishing, with the Postgraduate Board, a working group to consider issues relating to student fitness to practise; QABME reports; enhancing QABME; and the review of *Tomorrow's Doctors*. For the Postgraduate Board this included: thematic presentations on PMETB's work and policy issues that the GMC will inherit post-merger; QAFP reports; amending the *New Doctor*; the revised Foundation Programme Curriculum; providing good care for patients with learning disabilities; and credentialing. For the Continued Practice Board this included a range of issues relating to revalidation.

Key Aim 6: To safeguard patients by ensuring the integrity and accessibility of the List of Registered Medical Practitioners (LRMP)

Ensure that we provide comprehensive LRMP information in an effective manner

82. In 2009, the Registration Reference Group agreed a programme of work (to be delivered through four projects) to develop the register and a project team has been established to take this forward. On 26 January 2010, the Reference Group considered the timetable for delivery and the outline of an engagement strategy, which will ensure the views of all four key interest groups are taken into account. The Reference Group will oversee the work and report to Council later in 2010 on opportunities for enhancing the register.

83. We provided the LRMP download service to a range of organisations, perhaps most significantly to the NHS enabling their systems to provide users with daily notification of any changes in doctors' registration status.

Develop the register to reflect the introduction of licensing

84. The LRMP was updated successfully to reflect the introduction of the licence to practise on 16 November 2009, including the new status of all doctors on the register.

85. We worked closely with the providers of the Electronic Staff Record (England and Wales), the Scottish Workforce Information Standards System (Scotland) and directly with employers in Northern Ireland in the run up to the introduction of the licence to practise. We provided employers with information about their doctors' licensing status in advance of 16 November 2009 so that this could be uploaded onto their systems. We distributed over 2000 resource packs for employers containing information about the introduction of licensing.

Agree with the profession and the departments of health in the four countries of the UK, additional information about doctors that we should hold and make available

86. As part of the programme of work agreed by the Registration Reference Group to develop the register, we will engage with key interests using a wide range of tools, including focus groups and targeted surveys, to inform development of this programme of work in 2010.

Other Registration-related activity

87. Following consultation in 2008, the scheme for the existing specialists route to the Specialist Register was introduced in March 2009.

88. We successfully introduced the Certificate of Current Professional Status to meet EEA requirements and the changes we committed to in the Edinburgh Agreement of 2005. The new certificate includes additional data to its predecessor, the certificate of good standing, for example date of birth, specialist or GP register entry and nationality. The CCPS, once it is adopted universally, will help a move towards standardised information about doctors within the EEA.

89. We engaged widely to design and put in place processes for delivering temporary registration in an emergency (TR(E)). This included liaising with DH(E), the devolved administrations, collating data for potential registrants, their specialties and geographical locations, and drafting frequently asked questions. Work will continue in 2010 to ensure we remain ready to grant TR(E) to suitable persons should an emergency occur.

90. We formally met the UK Olympic Committee twice in 2009. We agreed the principles for registering visiting doctors and briefed the 2012 IOC Medical Director on our processes. We started to design the procedures and the application form for doctors of visiting Olympic teams to apply for registration and developed the concept of a 'principal' medical officer for each country to help streamline the registration process for their doctors. We are planning to complete "dry runs" of this process and type of registration during the World Athletics Championships in 2010 and 2011.

91. The Contact Centre entered the Top 50 Call Centres for Customer Service competition, which began in 2008 with the aim of creating a benchmark for customer service excellence and transforming the public perception of the contact centre industry. It spans all service sectors and ran between May and July 2009, a challenging period for the GMC due to the traditional summer registration peak. During this period, we were subjected to extensive mystery shopping of our telephone and email enquiry services. We were awarded second place in the Public Sector category and third place overall for best e-mail service. We will use the detailed analysis of our performance to further enhance our services.

Performance against targets

92. Key operational statistics for 2009, compared with 2008, are at Annex A. On average, we exceeded all the targets in 2009, save those for dealing with letters and e-mails. We only narrowly missed these targets (99% on average against a target of 100%) We saw increased numbers of applications for registration from International Medical Graduates in November and December 2009 which meant that in December 2009 we only responded to 89% of applicants against a target of 95%. There is evidence of increased levels of recruitment within the NHS and this may explain the increase in applications. Overall, average performance improved on performance in 2008.

Key Aim 7: To enhance patient safety by dealing fairly and effectively with doctors whose fitness to practise may be impaired.

Deal firmly and fairly with fitness to practise concerns

93. Former Chief Executive, Finlay Scott, gave evidence to the House of Commons Health Select Committee in connection with their inquiry on patient safety. During our evidence, we highlighted our contribution to improving patient safety, including: the revised guidance in *Tomorrow's Doctors* 2009 and patient safety in relation to undergraduate training, Dr Jan Illing's research into the preparedness of new doctors for practice, the research we commissioned to investigate prescribing errors in hospitals and our future research on prescribing errors in primary care, and how revalidation will contribute to patient safety. The Committee published its report in July 2009.

94. We published revised Indicative Sanctions Guidance.

95. We held training events for panellists who sit on Fitness to Practise and the Interim Orders Panels, panel chairs and legal assessors. These included training on the implications of the introduction of licensing for fitness to practise cases.

96. In *Cohen v GMC* [2008] the judge held that at the impairment stage a Panel ought to take account of evidence and/or submissions from both the doctor and the GMC that the doctor's failing is easily remediable; and/or has already been remedied. This factor is closely linked to the risk of repetition of that failing. We revised our guidance to reflect this and provided training for Case Examiners and other staff.

97. We consulted on proposals for improving hearings management and on extending the categories of cases for consensual disposal. The latter also considered our voluntary erasure procedures in cases in which there are fitness to practise issues. Council considered the responses to both consultations in October 2009. The Fitness to Practise Reference Group has agreed draft guidance on consensual disposal and voluntary erasure, which will implement the changes.

98. We introduced amendments to the GMC (Fitness to Practise) Rules 2004, as agreed by Council following consultation, designed to further improve the efficiency and effectiveness of our fitness to practise procedures.

99. The Independent Safeguarding Authority was created by the Safeguarding Vulnerable Groups Act 2006, to help prevent unsuitable individuals from working with children and vulnerable adults. Section 41 of the Act, which came into effect on 12 October 2009, places on the GMC and the other healthcare professional regulators a duty to refer prescribed information to the ISA in certain circumstances, for example, when the registrant has been convicted of particular criminal offences or when the regulator considers that the registrant has harmed or may harm a child or vulnerable adult.

100. We had a number of discussions with the Home Office and the ISA about the framework for referring information to ISA, which remains unclear. A workshop involving ISA, DH(E) and all the healthcare regulators on 15 January 2010 provided further clarification on the legislation. Paul Philip, deputy Chief Executive, has written asking ISA's Chief Executive for a meeting to discuss further the arrangements, including the development of a memorandum of understanding between the two organisations to clarify the exact nature of the duty of referral. In the meantime, an expert panel is being established, the membership of which will include a representative of the GMC, to further develop the guidance, including a referral decision making assistance tool.

101. Details of performance against service targets and open caseloads in 2009, compared with 2008, are at Annex B.

102. Overall, our performance against service targets should be considered to be a significant achievement in the light of the increase in in-coming enquiries (up by around 30% on the 2008 monthly average), an increase in the numbers of referrals from NHS bodies, the attendant upturn in both the volumes of stream 1 investigation work and the numbers of cases, and the increase in the numbers of cases referred to fitness to practise panels and length of hearings.

103. With regard to the target for completing 90% of the investigation process within six months, performance was just below the target in the months where the target was not met.

104. With the agreement of the Resources Committee, our hearing capacity kept pace with the increase in referrals (16 hearing rooms from October 2009). However, because of the increase in referrals and in the average hearing length we expect consistent achievement of the service target to be unlikely before the middle of 2010. In 2009, average hearing room utilisation was 85% (against a target of 80%), compared with 75% in 2008. A detailed breakdown of panel sitting days in 2009, compared with 2008, is at Annex C.

105. We met the Interim Orders Panel service target each month save for in August 2009, when the failure related to an administrative oversight in only one case.

106. We missed the Investigation Committee service target in only two months. In June 2009 the failure related to just one case where there was a complex legal argument. The closure of the Clinical Assessment Centre impacted on the target in September 2009 as many of the Committee's hearings were held there as an overspill from adjudication panel activity. The increase in hearing room capacity in October 2009 brought performance back on track in Q4.

107. The Interim Orders Panel sat for 311 days in 2009 (278 in 2008) and 411 interim orders were in place at the end of December 2009 (405 at the end of December 2008).

108. Since the last report, there has been one new application in the High Court challenging an IOP decision. This is the only outstanding application.

109. Table 1 summarises appeals and judicial reviews as of 21 January 2010. Additional information is at Annex D – in 2009 we had fewer appeals and judicial reviews than 2008.

Table 1:

	Cases carried forward since last report	New cases	Concluded cases	Cases carried forward to 2010
Appeals	21 ¹	0	5	16 ¹
Judicial Reviews	13	3	2	14

110. Of the five appeals which concluded since the last report, three were dismissed (with costs awarded to the GMC in two cases), one was withdrawn and one was allowed (with costs awarded to the doctor and the case remitted back to a panel). Both judicial reviews concluded with the applications for permission refused.

111. There were no new referrals by CHRE to the High Court under Section 29 in 2009.

112. We continue to deal with a range of other litigation, including cases before the Employment Tribunal and the Employment Appeals Tribunal.

Work with healthcare providers on the identification of problems and remedies

113. In 2009, we continued to participate in the working groups established by DH(E) to take forward the work streams flowing from the White Paper, *Trust, Assurance and Safety – the Regulation of Health Professionals in the 21st Century*. These included the Tackling Concerns Locally Working Group and its sub-groups on Affiliates (chaired by Paul Philip and established to advise the GMC on proposals for piloting GMC Affiliates) and Responsible Officers.

Prepare for the Office of the Health Professions Adjudicator

114. In March 2009, DH(E) published the report of the Tackling Concerns Nationally Working Group (which considered the proposals in the White Paper relating to the establishment of OHPA). OHPA became a legal entity on 25 January 2010.

¹ This includes one case in the Court of Appeal.

115. During 2009, we worked closely, initially with the DH(E), and subsequently with OHPA's Chair and his Transition Team, to begin planning for the transfer of our adjudication function to OHPA in April 2011. Much of the early work focused on establishing OHPA's governance arrangements, in particular recruiting members of the Shadow Board and establishing a Transition Team to support the Shadow Board. The Shadow OHPA Board assumed responsibility from DH(E) for delivering the programme of work required in November 2009. Preliminary work has been undertaken on the rules and procedures that OHPA will operate, transitional arrangements, information systems options, location options and the process for transferring staff and Associates to OHPA. We will continue to work closely with OHPA and DH(E) in 2010.

Assess the affiliate pilot studies on GMC affiliates and agree a way forward

116. We conducted two pilots – in West Yorkshire and North London – between September 2008 and October 2009. DH(E) commissioned KPMG to undertake an independent evaluation of the pilots. KPMG's final report, published in November 2009, was very positive about the quality of the pilots and the contribution of Affiliates to local decision-making. The report made it clear that there will be substantial cost implications of rolling out the pilot model nationally and discussed a range of options for delivering some form of national Affiliates scheme. Paper 5a on the agenda considers the options for taking this forward.

Deliver research findings on the over-representation of IMGs

117. The projects commissioned through the Economic and Social Research Council (ESRC) progressed on track throughout 2009. The findings relating to the representation and progression through our fitness to practise procedures of International Medical Graduates and of doctors from the European Union and European Economic Area practising in the UK will be made available to Council members and key interests at events being held on 22 and 23 February 2010.

Key Aim 8: To ensure that medical regulation is responsive, targeted and evidence-based by enhancing and developing a comprehensive research programme.

Assess research findings from the ESRC partnership

118. The 11 projects commissioned in collaboration with the Economic and Social Research Council, under the auspices of their Public Services Programme, progressed on track throughout 2009. They are now drawing to a close, with many undergoing peer review. The programme will complete in April 2010.

119. We have organised a conference event on 22 February 2010 for the researchers to present their findings to Council members. The implications of the projects for the GMC and the potential direction for future research will be discussed.

120. We have planned two further events on 23 February 2010: one to present the findings of the projects with an equality and diversity focus to the Equality and Diversity Research Forum, and the other to discuss the projects at an open session for a wider group of key interests.

Build on our collaborative programme with the ESRC

121. In October 2010, the ESRC will begin to evaluate the success of the Public Services Programme. We have agreed to contribute. In the meantime, the Research Reference Group began, in 2009, to consider the potential for an internal evolution of the projects we commissioned within the Programme and will take this forward once the Programme has completed. They met with the ESRC in July 2009 to discuss the potential for future collaboration. Once our supporting Research Strategy has been agreed and core themes for commissioning new projects identified, we will assess which organisations represent a 'best fit' for research collaboration based on alignment of strategic priorities for the next two to three years.

Appoint a research fellow

122. In July 2009, the Research Reference Group discussed the principle of establishing a Research Fellow in Equality and Diversity. We will assess the scope for the Fellowship when the supporting strategies for Research and Equality and Diversity have been agreed. This will ensure that it is aligned to our strategic priorities and informs policy development and practice accordingly.

Other research

123. We published the reports of projects commissioned as part of our wider research programme:

- a. Warwick University's report, *Non UK qualified doctors and Good Medical Practice: The experience of working within a different professional framework*.
- b. The report of RAND Europe's study, *International Comparison of 10 Medical Regulatory Systems: Egypt, Germany, Greece, India, Italy, Nigeria, Pakistan, Poland, South Africa and Spain*.
- c. Manchester University's report, *An in depth investigation into causes of prescribing errors by foundation trainees in relation to their medical education – EQUIP Study*. In order to understand the levels of errors across all areas of medical practice, we commissioned a complementary project to investigate the prevalence and causes of prescribing errors in general practice which will complete in February 2011.

Key Aim 9: To develop further and implement our strategy for valuing diversity and promoting equality in all aspects of our work.

Produce a comprehensive equality and diversity strategy that provides appropriate profile, impact and consistency to equality and diversity across the GMC, bringing together our internal policies and practices with our external engagement in a coherent way

124. In early 2009, Shapiro Consulting Ltd conducted an independent review of our policies, practices and attitudes to equality and diversity and how this compares with experience of good practice in other organisations. Achievements in 2009 against the work programme established to take forward the outputs included: developing an equality and diversity rationale setting out our strategic imperative for equality and diversity; creating an equality and diversity champions network, with defined roles and responsibilities, to share good practice and build ownership of this agenda across the GMC; and joining the six leading employer-led diversity networks in order to access external good practice and benchmark the GMC's approach with other leading UK organisations.

125. In his 2007 Annual Report, the Chief Medical Officer for England recommended the establishment of an annual roundtable discussion for ethnic minority doctors. The purpose of the roundtable is to discuss concerns of these doctors to ensure that action is taken to tackle any underlying factors not being tackled elsewhere. We are members of the Roundtable Group, and contributed to the work of the Group, which held its first meeting in February 2009, with further meetings in June and November 2009. At the meeting in November 2009 we presented to the Group on ongoing work in the light of the merger of PMETB with the GMC in relation to the routes to General Practice and Specialist Registration established under Articles 11 and 14 of the 2003 PMETB Order and on research commissioned through ESRC

Ensure that our equality and diversity strategy supports us in delivering independent, accountable regulation that promotes fairness and quality and values diversity

126. The Equality and Diversity Reference Group met on four occasions in 2009. Discussion included: our equality and diversity work programme, joint working on equality and diversity between the GMC and PMETB, the Equality Scheme, workforce data, revalidation, and the Corporate Strategy.

127. We responded to the Government Equalities Office's consultation, 'Equality Bill – Making it Work'. In 2010 we will prepare for the proposed legislative changes. The majority of the Bill's provisions are expected to come into force in autumn 2010 and the remainder in 2011.

128. During 2009, we continued to network and share good practice on equality and diversity issues with other influential organisations in the healthcare sector. This included the healthcare regulators' Equality and Diversity Forum. We also continued to facilitate the Diversity Partners forum (a collaborative and best practice sharing group comprising the GMC, DH(E), the BMA and NHS Employers).

129. In November 2009, we attended the first meeting of the Inspectors and Regulators Forum (hosted by the Ministry of Justice and the Equality and Human Rights Commission) to explore best practice in embedding the human rights agenda across key functions and operations.

130. Equality and diversity was identified as an area of joint working in the context of the merger of PMETB with the GMC. In 2009 we consolidated the two organisations' Equality Schemes. Pre-merger, we will continue joint work with PMETB on equality impact assessments, reasonable adjustments, collection and monitoring of diversity data and on external engagement with key stakeholders.

Deliver Equality Impact Assessments, ensuring that they are undertaken at a sufficiently early stage in the policy development process

131. We delivered 18 equality impact assessments in 2009 and aim to undertake around 25 in 2010.

132. Following the findings of the Shapiro report, work began to simplify and reposition the equality impact assessment process to ensure it becomes further embedded in our 'business as usual' activities. The Equality and Diversity Reference Group will discuss proposals on 11 February 2010.

Deliver our Equality Scheme Action Plan

133. We published an interim version of our Equality Scheme, subsequently updated following the Shapiro recommendations. We will conduct a major review of our Equality Scheme in 2010, as required by legislation.

Engage with key interests through our Equality and Diversity Research Forum

134. The Forum, chaired by Baroness Amos of Brondesbury, met for the second time on 4 June 2009: members were updated on the progress of the ESRC projects and the findings of the Rand Europe and Warwick University studies.

135. Jane Dacre was subsequently appointed as the Forum's Chair, following Baroness Amos's resignation. The Forum next meets on 23 February 2010.

Key Aim 10: To enhance our economy, efficiency and effectiveness.

136. We are working on the production of the final accounts for 2009. The surplus for the year is likely to be around £8 million, an increase on the £7.1million previously reported to Council. There are, however, a number of year-end accounting entries still to be processed, including the final position on the pension fund and a further provision for tax and national insurance costs arising from our ongoing dispute with HMRC.

137. The external auditors will undertake their fieldwork in February and March 2010. The draft accounts for 2009, together with the disclosure notes, will be considered by the Resources Committee on 20 April 2010, and the Audit and Risk Committee on 6 May 2010. Council will be invited to approve the Annual Report and Accounts on 20 May 2010.

138. In January 2010, the 'Performance Board' was established, chaired by Paul Philip, deputy Chief Executive. It is responsible for overseeing the performance of all parts of the organisation, including monitoring progress against service delivery targets, efficiency and effectiveness, delivery of the Business Plan and overall quality assurance across the organisation. Its first meeting will be held during the week of 24 February 2010.

Develop the in house legal team to reduce the cost of legal services by £1.2 million

139. The In-House Legal Team increased incrementally throughout 2009. It is now sufficiently resourced to handle around 90% of fitness to practise cases and other litigation, as well as providing legal advice across the GMC's operational areas. The increased transfer of work in-house has facilitated a reduction in the legal budget this year of £3 million.

Save £750,000 in the procurement of goods and services

140. The provisional final total recorded in the 2009 Savings Log is some £1,004,600. The actual final total will not be known until the end of February 2010 when we have the figures from Q4's efforts in relation to rail and stationery savings.

141. Since the beginning of January 2009 we have been required to conduct procurement activity under the EC Procurement Regulations. We advertised 19 tenders on the myTenders.co.uk website, of which seven were published in the EU Journal. We advertised 12 domestically. This activity included tenders for services in relation to the relocation of the Manchester accommodation, fitting out Regent's Place to co-locate PMETB staff, telephony infrastructure, and print services, including the production of *GMCtoday*.

Complete the third phase of the Strategic Applications Project

142. We successfully implemented SAP Phase 3 on 16 November 2009, with the introduction of the new Agresso system to support finance, billing, payroll, HR and procurement, and revisions to the existing Siebel system to support the introduction of the licence to practise.

Implement a competence and performance based pay-and-reward system

143. This project was linked to SAP Phase 3 and we made good progress towards developing our pay and reward systems in 2009. We conducted a staff survey to inform developments and Mercer, our pay consultants, undertook a review of existing arrangements. We launched a virtual learning centre and an online learning management system which, with Agresso, provide the infrastructure to underpin changes to our pay and reward systems. We have started work on detailed job specific competence frameworks and produced training plans for each section across the GMC.

144. The Resources Committee received a report on pay in November 2009 and a series of staff seminars on developing our pay arrangements took place in December 2009. Further similar events are planned for 2010 to provide staff with an opportunity to comment.

Enhance the functionality and accessibility of the GMC website

145. We completed a major project to renew the GMC's website and to migrate it to a content management system. The new website, launched in November 2009, has improved navigation as well as improved usability and accessibility features. Initial feedback about the site has been very positive and visitor numbers continue to grow. We will conduct a formal user survey in 2010.

146. We produced two new sets of scenarios for *GMP in Action* which was short listed in the Internet Product of the Year category at the UK IT Industry Awards. We also produced two microsites: a virtual hearing room to familiarise doctors, witnesses and others on the layout of a hearing room and those involved in a hearing, the other to support the licensing campaign.

Relocate our Manchester staff to modern, long-term, accommodation

147. The project to relocate the GMC's Manchester operations (save those related to Adjudication) from St James's Buildings proceeded on schedule throughout 2009. Staff were successfully relocated in January 2010.

148. The Clinical Assessment Centre was also relocated to the new Manchester accommodation. We have appointed a manager and two technicians, and dry runs of the PLAB Part 2 and Fitness to Practise test of competence will take place in February 2010, prior to the new Centre opening in March 2010.

Other efficiency and effectiveness

149. Given the economic climate, we undertook a structured review of our supplier base to ascertain our potential exposure to business failure and to identify mitigating action to minimise the risk should such a failure occur. We reported the outcome to the Resources Committee.

150. Following a security review and feedback from users, we implemented a new, secure, more user-friendly log in process for *MyGMC*.

151. The British Standards Institute carried out our annual ISO27001 Information Security audit in October and November 2009. We were successful and our certification was validated for another year. The auditor provided very positive feedback, noting in particular the high levels of information security awareness throughout the GMC, our effective clear desk and clear screen policy and our excellent Information Security Management System.

152. We continued to look to improve the efficiency and effectiveness of our registration and fitness to practise processes and procedures. In relation to registration, we completed 37 continuous improvement projects in 2009. These included improvements to our online applications process, reducing the number of errors on applications for registration from International Medical Graduates, and improving the death notification process. 34 active projects have been carried over into 2010, including further reducing errors on applications for all types of registration. In relation to fitness to practise, continuous improvement activity included increasing productivity of the investigation teams and improving the support for vulnerable witnesses giving evidence at fitness to practise hearings. We have identified 57 potential projects for 2010, including projects to increase the number of consensual disposal cases and, in close liaison with OHPA, to improve hearings management.

153. We launched a new virtual learning centre, *Management Direct*, to assist staff studying for the Diploma in Management and for the new Introduction to Management Certificate Programme.

154. We were selected as one of the inaugural recipients of investment in management and leadership recognition awards from the Chartered Management Institute for our commitment to the pursuit of management excellence.

155. We contributed to each of CHRE's five good practice seminars, the purpose of which was to consider and share learning between the healthcare regulatory bodies on areas of good practice identified in CHRE's Performance Review Report 2008/09. Our self assessment for the 2009/10 Performance Review was submitted to CHRE in December 2009, and we await CHRE's report.

Commanding confidence and support

European and international work

156. We established the European and International Working Group. The Group discussed European and international priorities which Council will consider as part of the development of the supporting European and International Strategy on 31 March 2010.

157. We engaged with the European institutions, DH(E), members of both houses of the UK parliament, and the devolved administrations on including a legal duty on competent authorities to share fitness to practise information in the draft EC directive on the application of patients' rights in cross-border healthcare. The European Parliament adopted the GMC-tabled amendment in April 2009. In 2010 we will continue to monitor progress and engage with UK and EU decision-makers.

158. We continued to lead the Secretariat for the Healthcare Professionals Crossing Borders initiative on behalf of all European regulators. We established a HPCB steering group, which met on three occasions in 2009, and launched a survey on the implementation of the Portugal Agreement. The survey outcomes will inform the future HPCB work programme.

159. In 2012, the European Commission will review Directive 2005/36/EC on the recognition of professional qualifications. In advance of this review, we engaged with the European institutions. This included Paul Philip giving evidence regarding the Directive at a European Parliament public hearing. During his evidence, he called on the Commission to rebalance freedom of movement with better safeguards for patients and effective medical regulation.

160. We responded to European Commission consultations on the European Workforce for Health, a harmonised methodology for classifying and reporting consumer complaints and enquiries, and the legal framework for the fundamental right to protection of personal data.

Reference Community

161. We established the Reference Community, comprising 27 members of the public and 28 doctors drawn from a range of backgrounds, to help inform policy development and decision taking. We sought the views of members of the Reference Community on a wide range of issues, including new scenarios for *GMP in Action 3*; the initial recommendations arising from Lord Patel's review; and the consultation on extending the categories of cases appropriate for consensual disposal.

162. The Reference Community's 2010 work programme includes the consultation on revalidation, enhancing the process for the quality assurance of basic medical education, developing the List of Registered Medical Practitioners, implementing our ethical guidance for doctors, and telemedicine.

Governance

163. The reconstituted Council took office on 1 January 2009, with parity of lay and medical members, all independently appointed. The current governance model and membership of the Boards, Committees and Reference Groups were agreed by Council at its first meeting on 27 January 2009. A review of the Standing Orders and Schedule of Authority was subsequently undertaken, and a new Governance Handbook agreed in October 2009. Council also reviewed and agreed a revised member appraisal system in December 2009. A review of the governance arrangements will be undertaken in 2010.

164. We have had discussions with the Appointments Commission on the process and timetable for the appointment of a new lay Council member to fill the vacancy following Sir Rodney Brooke's resignation in November 2009. The final preparations are being made to the specification and information pack for candidates and we expect that the vacancy will be advertised by early March 2010.

Recommendation: To consider the Chief Executive's report and review of 2009.

Resource implications

165. None.

Equality

166. None.