

---

## 6a: Membership of Committees, Boards and Reference Groups: Annex A

### Description of the Proposed Governance Model for the Reconstituted Council

#### Background

1. In the course of 2008, Council, on a number of occasions, considered the key features of a governance model to commend to the reconstituted Council. This paper sets out the key features of that model, which draws closely on the structures that have served the GMC well over the last five years, with some refinements in the light of experience and to reflect changes in legal requirements and external circumstances, as well as a review of governance good practice.
2. The main refinements proposed are:
  - a. The three Boards (reflecting the three-board model proposed in our contribution to the 2007 White Paper *Trust, Assurance and Safety*), which provide cross-functional coherence in our approach to our target populations.
  - b. The acknowledgement of the primary decision-making roles and responsibilities of the Council itself as competent authority, and its ability to delegate authority as appropriate.
  - c. The recognition of the value gained from collaborative working between members and staff, embodied within the Reference Groups.
  - d. Building on our engagement with external interests, both by explicitly including them in all three Boards, a number of Working Groups, and some Reference Groups, and by creating a widely-drawn Reference Community to facilitate engagement with patients and the public, and with doctors.

#### Discussion

3. The commended model has the following components:
  - a. A governing body, which makes all strategic policy decisions – the Council (paragraph 7).
  - b. Three standing Governance Committees as at present – Audit and Risk; Remuneration; and Resources (paragraphs 8-9).

- c. Four Reference Groups of members and staff with remits covering each of our main functions (paragraphs 10-12)
  - d. Two Reference Groups covering those underpinning aspects of our work which feature in key aims eight and nine in the Business Plan 2009: research, and equality and diversity (paragraph 13). In addition to members and staff, these will include external representatives.
  - e. Three Boards with thematic remits – Undergraduate, Postgraduate, and Continued Practice (paragraph 14-19).
4. Working Groups are also an important feature of our overall approach and are briefly discussed in paragraph 20.
5. Members have not discussed the statutory Investigations Committee, the PLA Board, registration panels, or fitness to practise panels, which will continue unaffected and, for the purposes of this description, are not considered part of the governance model. Effective engagement with our interest groups – patients and the public, doctors, the NHS and other healthcare providers, and those involved in the provision of medical education – will be an important feature of the governance model, but is likewise not discussed in this paper.
6. In addition to the ‘core’ components of the GMC’s own governance model, two groups are involved in the implementation of revalidation: the joint GMC / Academy of Medical Royal Colleges Group and the UK Revalidation Programme Board. More details are at Annex B13-14.

### *Council*

7. The Council will exercise oversight of the operations and performance of the GMC, holding the executive to account. It will set the strategic direction for the organisation, consider major strategic and policy issues directly and make decisions on them. It will agree terms of reference for other components of the governance model, and programmes of work for the Boards, and delegate and commission work from the Registrar as appropriate.

### *Governance committees*

8. The Governance Committees are:
- a. Audit and Risk Committee.
  - b. Remuneration Committee.
  - c. Resources Committee.
9. The model assumes that these Governance Committees will continue substantially unchanged. Chairs of these Committees would be appointed by the Committee members and would be eligible, as now, for an additional honorarium. More detail on the purpose of these Committees is at Annex B1-3.

### *Reference Groups covering our main functions*

10. The four main Reference Groups are as follows, one for each of our main statutory functions:

- a. Education and Training
- b. Fitness to Practise
- c. Registration
- d. Standards and Ethics.

11. These groups will provide an effective means of ensuring early and continuing member involvement in developing proposals in all areas of our work, in a relatively informal and flexible way. More detail on their purpose is at Annex B4-7.

12. Reference Groups will be joint groups of members and staff, normally without external membership. They will be chaired by Council members who receive an additional honorarium for doing so. They will have some scheduled face to face meetings but use a range of more 'virtual' working methods, for example e-mail and telephone conference.

### *Reference Groups covering Research and Equality & Diversity*

13. It is also proposed that there will be Reference Groups to cover two other areas of our work which need sustained oversight and joint working between members and staff. It is envisaged that these groups could also include external members representing the GMC's wider interests. More detail on their purpose is at Annex B8-9. These Reference Groups will cover:

- a. Research
- b. Equality and Diversity.

### *Boards*

14. The three Boards will be themed around the main phases of a doctor's career:

- a. Undergraduate
- b. Postgraduate
- c. Continued Practice.

15. It is envisaged that each Board will cover all aspects of the phase for which it is responsible, and thus embed cross-functional working, addressing how our responsibilities impact upon each of our main populations. This is particularly important for doctors who have completed their formal training for whom no such cross-functional grouping currently exists. More detail on the purpose of the Boards is at Annex B10-12.

16. Boards will offer advice to Council, particularly on the practicability of proposed policy, at an early stage; and they will assist in the detailed implementation of policy decisions for their own target groups. They will have clear terms of reference, and decision-making powers as delegated to them by Council.

17. Unlike the Reference Groups covering our statutory functions, Boards will include, besides Council members, members reflecting relevant key interests. Each will be chaired by a Council member who will receive an additional honorarium for doing so. They will have an established pattern of meetings but will also develop working methods that do not depend on formal, face to face, meetings.

18. The Postgraduate Board will need to collaborate closely with PMETB for the remainder of PMETB's separate existence, and it is hoped that some members might serve on both in order to facilitate this.

19. The Continued Practice Board will need to work closely with the UK Revalidation Programme Board, chaired by Sir Michael Pitt, which is to be set up under the recommendations of the report of the CMO (England) on Revalidation.

### *Working Groups*

20. Working Groups, widely varying in size and composition depending on the nature of their responsibilities, have been a successful component of our policy-making process and wider governance model, allowing members with relevant expertise, staff, and (where appropriate) external interest groups to focus on particular issues that need sustained commitment, and contributing effectively to the making of high quality decisions. We believe there is value in building on this. Working Groups, focused on themes of our work or on specific tasks, will therefore continue to be an important part of our working arrangements.