GENERAL MEDICAL COUNCIL

COUNCIL

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PROFESSOR PETER RUBIN in the Chair

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Apologies for absence

Apologies were received from Professor Rajan Madhok.

1. Chair's business

THE CHAIR: It is a pleasure to congratulate Ann Robinson on being appointed to the Engagement and Development Board for the Information Standard, which aims to accredit providers of information on health and social care.

There are a couple of things to update you on. I would like to thank those members who have volunteered to come along with me when I go out to speak to doctors about revalidation. The meetings for the autumn, as you will have realised from their location, have been a little opportunistic; that is, Nottingham followed by Nottingham followed by Nottingham! However, we will be getting a little more broadminded after that.

What we are doing for next year is planning a meeting every month around the UK, and I would encourage you to come along. It will send a very positive message from the GMC but it will also be very interesting.

You probably will not have had time yet to look at, let alone read, the CHRE report on the health regulators. It is in your email in-box. The GMC is very warmly referred to in that report, including the statement that "…*all regulators can learn from each other and there is much to learn from the GMC*". I think we can take some pleasure from that. Finlay will be referring to it later and I will be referring to it again on one of the later agenda items.

The only other point to note in the Chair's business is that we had a very positive meeting with Andy Burnham, the Secretary of State for Health for England, about ten days ago. The main purpose of the meeting was to talk through revalidation with him and the need for the NHS to be underpinning the revalidation process. He was very positive, very engaged with this, and was very clear in agreeing with us that revalidation and the processes that lead to it – local appraisal, for example – are not an optional add-on; they are an integral part of the quality agenda. It was helpful to have that high-level political support for the process; so that was very good.

I will be meeting Edwina Hart in Cardiff next Monday for the same reason and then, in August, I will be going to Northern Ireland and to Edinburgh for the same kind of meeting.

2. Minutes of the Council meeting on 7 May 2009

THE CHAIR: Anne Weyman had asked for a change to the minutes to reflect the fact that, when we were discussing OHPA and the size of the Board, the minutes had not accurately recorded that we thought three was too small. Those

minutes have therefore been changed. Anne, I gather that you are now content with the way the minutes have been changed.

*The minutes, as amended, were **approved** as being a correct record*.

3. Chief Executive's report

MR FINLAY SCOTT: May I start with two apologies? We had to reissue my report because in at least one copy one page was missing. We have had to punch a fresh set of holes and put a new paper into your folder. I apologise. Also, you will find on your table an amended Annex C from my May report. On reconsideration, we found that there was a mistake in it that we wanted to correct. What you have labelled as Annex C relates to my report and, again, apologies for the need for that.

I want to say only a couple of things. First, as Peter has referred to, the CHRE report which was published on Monday acknowledges the huge amount of good work that is done by my colleagues, and I would like to take this opportunity of expressing my gratitude to them. I think it is fair to say that we have now had two successive reports, 2008 and 2009, which have held much of what we do to be best practice and worthy of consideration by others; but there is no sense of complacency. The aim is not simply to be good enough for today's conditions but to stay ahead of the game, and to be fit for purpose not just in 2009 but five and ten years from now. As I say, I am very grateful to my colleagues for the huge amount of good work.

The second thing to say is that, after a slow'ish start, we have begun to see real progress in relation to the merger of PMETB with the GMC. I am grateful to Paul Buckley, to Simon and others, who have done an enormous amount to get this far.

The two landmarks were the decision by PMETB to serve notice on their accommodation at Hercules House, which finally is the visible commitment that they are on their way to 350 Euston Road. That, I think, is a real tipping point in the sense of preparation for the merger.

The other major breakthrough was that, despite the discouraging bureaucracy that we encountered, we eventually managed to get approval for the outline business case, as a result of which we are assured of funds to meet the restructuring and relocation costs associated with the merger – again, due to a huge amount of work.

The first meeting of the Joint Co-ordination Group, which is reported elsewhere on the agenda, is a sign of the two organisations working together, not just in terms of the mechanics of the merger but how we can improve regulation of education and training for the benefit of patients and the public.

Those are probably the only points I wanted to pick out. I know that Hamish wants to say something about the Working Group on Standing Orders, which is a

prosaic title if ever I heard one! I do not know whether you want that, Peter, before we do the recommendations?

THE CHAIR: It sounds like it might be the high point of the meeting, Hamish!

DR HAMISH WILSON: I recall the excitement that went through the room when this was mentioned, and Rodney, Stephen and I had to push back all the other members who wanted to volunteer for this task!

Rather than just talk about a review of standing orders and delegated authority, the view we have taken is that we should have a broader approach, looking at a governance handbook for members and indeed for the benefit of staff as well. It is now a broader concept, therefore.

We had our first meeting yesterday and had a look at a very helpful draft, and our thanks go to Ross and to Christine for doing all the hard work on that. We will take a rain check after the second draft, to determine how we move forward. We hope to do that perhaps towards the end of July, because one of the things we want to do is to give the opportunity for engagement and perhaps rekindle some enthusiasm for this. We certainly want to engage chairs of boards, committees and so on, in the specific issues that they will be interested in. However, I am aware of expertise around the table on a number of the issues; for example, around the code of conduct, which will be part of the handbook. We therefore want to give the opportunity to engage with the whole Council before it comes back.

Our original intention had been to take this back to the Council meeting in September but I think, because of the wish to get broader engagement, we are probably now aiming for October. I would rather the work was done fully and properly and to bring it back in October. That is the kind of process and timetable to date.

The only other thing I want to mention is this. A little time ago, when we agreed that we would review the governance arrangements at some appropriate time, perhaps after a year or so of operation, I do not think that we set a process for doing that. I am not suggesting anything formal at this stage but we thought it might be helpful that – as we work through our endeavours in committees, boards, et cetera, over the next few months – people might themselves log up any issues that they feel are relevant to review, which might take place for example in the spring of next year. It is not a formal review process at this stage, but just a wish that people might take the opportunity to log up anything that they think may be relevant to that review.

THE CHAIR: That would be very helpful indeed. With regard to the first point you made, Hamish, while such things as standing orders do not have people sitting on the edge of their seat with enthusiasm, the time when they do get exciting is when we get them wrong – so it is important that we get them right.

I am sure that Council would agree that we would want you to take this at your pace, to make sure that it is all done correctly.

With regard to the review of the governance arrangements, we are committed to doing a review. Two things occur to me, however. One is that we all feel there are too many reference groups, committees and what-have-you, and we inherited this from the previous Council. A positive aspect of all that in the short term has been that it has been a very good opportunity for members to meet each other, for staff to meet members; so it has had a positive outcome. However, we all feel that there are too many.

The other thing that will become apparent to you all as the months go on, I think, is how much work each of these committees and so on do or do not involve; because there are some where the workload will be going up exponentially and others where it may be trickling along at a fairly low level. I think that we have to be honest and frank about that. We may need more members on some groups where the workload will become enormous as the months go by, and we may need to cut back or even close down some others.

It would be really helpful to get your frank views on that, because we do need to make changes but they need to be the right changes. Your frank view on that, therefore – and the plan is to feed the views in to Hamish or Christine.

PROFESSOR TERENCE STEPHENSON: Something for people to reflect on about governance, not really for today, came up in our Fitness to Practise Committee. Whilst here we have a literal transcript, the minutes of the committees really reflect action points and notes. I remember that we discussed this in Graeme’s time and I was quite happy with that.

What came to light, however, was that we had a meeting where some members of the committee expressed views that were then not recorded. For me, that raises three possible issues. One is an analogy with events like MTAS, the weapons of mass destruction and so on, where there is no audit trail of what discussion took place to verify what people said.

The second is that generally, rightly or wrongly, people assume silence to be assent. If there is no record of the discussion, people may conclude that everyone in the room assented.

The third is a very mundane one but it is to do with institutional memory. Three months on, I find it quite hard to remember what I did or did not say, or what other people said.

Whilst I was very comfortable with the idea of rather brief notes when we originally discussed this, I think it is something that we should reflect on about the governance of the organisation; about how, if something was under public scrutiny in three years’ time, we would identify the discussion that took place and what views were held. I do not have an answer.

MR FINLAY SCOTT: I think that Terence makes a good point. At one stage we did have transcripts of almost everything that took place, and members gradually refined the model because it was found that that was an unnecessary expense. It is also true that at one stage we always had the solicitor to the Council present, for the same reason. It was felt that we could not go to the toilet without advice from a lawyer!

What we perhaps failed to do, however, was to see that the style of the note that we produce has to change, to reflect those changes. Perhaps we can take that away and think about it, and perhaps talk with Hamish and his colleagues on the working group; because it is not obvious to me that we have to wait for Hamish's working group to report before we make that kind of change. If you would leave that with us, therefore, we will look at it.

DR HAMISH WILSON: It was indeed one of the issues that we looked at yesterday. We felt that the initial trawl of views needed to be supplemented, perhaps by more clearly defined views against better information about what actually happens. It is one of the issues that we want to come back on before we produce our final report. It is something on which we want to seek members' views and would be one of the issues that we would want to highlight as part of this process.

THE CHAIR: That is helpful, Hamish. You will recall that I had asked Christine to do a fairly quick survey of you all on this very topic, shortly after I became Chair. I think that half of the members responded and half did not; so I agree with Hamish that we need to get high-quality information.

MRS ENID ROWLANDS: I am also mindful that the Remuneration Committee is about to start a fairly big piece of work on the appraisal system for members, and this clearly needs to dovetail quite firmly into the governance work.

I think that Hamish and I probably need to have a conversation, therefore. This is my opportunity to remind those members who have not responded to the views that we sought on the present appraisal system to respond, please. No naming or shaming either!

THE CHAIR: It would be really helpful if those who have not responded could respond, because there is a rather evenly distributed range of views at the moment that is not there and it would be helpful to see where the balance lies.

To be clear, Hamish, we are committed to looking at the minutes and the content of the minutes, are we not – to see if the minutes, in the way that Terence is proposing, could be more informative of the balance of the debate, the factors that were taken into account, and why that conclusion was reached?

Members who have views – again, in to Hamish or Christine.

SIR RODNEY BROOKE: Hamish has given an admirable summary of our deliberations yesterday, but it did throw up a number of issues that will excite the interest of Council because of how it addresses the way in which the Council itself behaves and its procedure. There are clearly a number of areas where members of Council have to form a view on genuine issues about how it actually conducts its business.

THE CHAIR: Hamish, when do you imagine that you would be coming back to Council with recommendations? You were saying that early autumn is too soon; so when would you be coming back?

DR HAMISH WILSON: I hope that we will come back with a substantive document in October. Our intention is to look at a second draft and then to take a view about how we raise those substantial issues with all members of Council – between, for example, the beginning of August and getting a final paper to the October meeting.

MR FINLAY SCOTT: I used Hamish as a device for neatly sidestepping whether there were any members' questions on my report. On the basis that I am unlikely to get away with that as a ploy, are there any questions on my report? [*No response*]

THE CHAIR: I am reminded that we need to agree the updated membership of the boards, committees and reference groups, which are in the annex. Is Council content? [***Agreed***]

Communications

4. Improving engagement

THE CHAIR: We all agree that engagement is a very high priority for us. I am grateful to members and staff colleagues who have already put a lot of effort into this. Stephen Whittle will make a few introductory comments and then over to Jackie for more information.

MR STEPHEN WHITTLE: Could I urge you to support the paper, which translates into what I might describe as "GMC-ese" the essence of what we agreed at our communications brainstorm last month.

Thank you to those of you who came and, for those of you who were not there, I will try to summarise very quickly some of the things that we discussed – because we did indeed have a very valuable discussion which picked up on points that Peter has previously emphasised, namely a proactive,

communicating Council which both engages with but, equally importantly, listens to the key interest groups.

One of the things that we were very clear about in the brainstorm was that we needed a better narrative about who we are, why we exist and why we do the things that we do. Obviously that is something that will be dealt with in much greater depth in the corporate strategy away-days, but it is something that I think will prove to be very interesting as a discussion; because it was already clear in the brainstorming group that there are lots of different views around that issue.

The thing that was clear, however, was that we needed some descriptors of ourselves that are progressive and dynamic and which articulate much more clearly our role in ensuring the highest standards of medical practice as well as patient safety.

The corporate strategy clearly needs to clarify corporate priorities, so that communications resources can be appropriately used. Good communication cannot be isolated from organisational aims. They require a context which ensures consistency, which mirrors what the organisation does, but which should not themselves drive principles or policy.

For those of you who were not there, we thought that the top communications priority was revalidation – something which is reflected in the paper. Clearly it is both highly visible and also high risk. There is too the importance of getting a wider understanding of the relationship between standard-setting through education and what is achieved through the various strands, levels and stages of medical education, around the transmission of professional ethics to the way that eventually doctors are assessed, both through revalidation as well as fitness to practise.

The other thing we talked about was the need to ensure that we have a joined-up, coherent Council, without too many silos; and a clear need to have systems in place to check the effectiveness of what we do in our communications work. That may potentially require a bit more focus, and possibly even more resources – but clearly that is a discussion for the strategy, for the away-days, and so on.

The last thing we asked the communications team to do was to give more thought to what it means for members of Council to be ambassadors for Council, and also how they are engaged in drawing up the communications plans for projects around such things as end of life or indeed *Tomorrow's Doctors*. That is what we discussed, and I hope that is helpful.

THE CHAIR: Does anybody who was there, or indeed anybody who was not there, want to either agree, disagree, comment or question Stephen before we move on to Jackie? [*No response*] In that case, Jacky…?

MS JACKIE ROWLEY: I have elected to sit here because I do not have a presentation for Council members on this one. I hope that the Council paper that

I have produced is relatively straightforward. Those may be "famous last words" – we will see!

First of all, I would like to express my thanks to Stephen for that introduction, which saves me a lot of words; secondly, for his expert chairing of the brainstorm, which I certainly found extraordinarily helpful and so did my staff; thirdly, to the Council members who took part and also the other Council members who wrote to me and offered some very supportive thoughts and insights. One of the things I am hugely valuing from this Council is the kind of one-to-one engagement with those who counsel me on how we move forward with communications.

I will make a couple of brief points about the paper itself and then go through the two recommendations, with a pause for discussion if there are comments that members want to make.

In broad terms, Peter as Chair and Council members have all emphasised to me your commitment to enhance communications and engagement as a big priority for the Council and for the GMC moving forward; and that was something that the recent brainstorm certainly confirmed.

I hope that the paper, particularly in the first instance, makes clear that we do have a pretty good communications machine in place. I promise that I will get the Comms report out to you tomorrow for last month, but we continue to do an awful lot of work based on the work that we committed to in the Business Plan last year.

The machine is there and, as I think the brainstorm concluded – or at least I took out of the brainstorm – it is not exactly execution that is the problem with our communications issues; it is more a question of priorities. Those priorities are the things that we are seeking from Council and from this corporate strategy, and we can then underpin that with a new communications strategy.

I welcome the corporate strategy and the corporate communications strategy work, because I think it is an opportunity for members to consider what it is we do, what our priorities are, and to allow us as a communications team to hurry up with getting on with what it is you want us to do with communications. I do sense a sort of "hurry up" feeling coming through to us about getting on with the different engagement ideas that you have. The truth is that we cannot do that in isolation. We need a clear framework for us to communicate with. It is a catastrophe when communicators start to lead the process of policy engagement by pushing out there with communications messages which you are not all engaged in. That is the process that I think this corporate strategy work and the corporate communications strategy work will underpin.

Turning to the first recommendation, it is "*To endorse the current work on engagement and communications as an appropriate starting point for developing the communications strategy to support the new corporate strategy*".

What I have written in the paper up to this point hopefully is an *aide-mémoire* to members about what it is we are already up to. In particular, I have listed

engagement activities because engagement is a huge priority for the Council. Peter has made it especially clear that he has particular concerns around engagement. That list is not exhaustive. One of the things that is not there and which I think should have been there is engagement work that we are doing with different ethnic groups.

Recently, Paul chaired a terrific form with BME doctors, out of which we have developed an action plan and out of which we want to work much more closely with BAPIO, BIDA and others on our engagement work with the BME doctors. I think that is a really important part of our communications – and my apologies for it being missed out from that part of this document.

The key words in this recommendation are "starting point". The work that we are doing now is good and it is strong; most members are content with what we are up to; but there is a feeling that there is more we can do. My sense is that what we need to do now is to prioritise that work and to get on with what it is that you as a Council want to express as the GMC going forward. If Council members are content, therefore, I would like to leave it there with the first recommendation and see if anyone has any comments to make on what is contained in the paper.

MRS ANN ROBINSON: I have just a small point. I think that this is terrific, but one point I want to pull out is this. I am particularly pleased with the fact that we now have the reference community pretty well in place.

This is a question really. Having got them in place – and I do know one or two people who are on that list from the lay side – the important thing is to make sure that we generate enthusiasm, commitment and all the rest of it. They are going to need something there that they can relate to because, even for new Council members, it has taken a little while, not surprisingly, to get to grips with what we are doing. It is really important that we therefore put a bit of effort into making sure that they understand what they are doing, why, and the background to it.

MS JACKIE ROWLEY: I think that is an immensely helpful point, and absolutely underpins this high-level communications work that we need to do at the moment as part of the corporate strategic discussion – which is "What is the purpose of the Council? What do we feel the Council is about? How do we create the communications for those people coming in?" Yes, absolutely. It is a really useful reminder, and thank you for that.

DR SAM EVERINGTON: I was looking at the website issue and two things were going through my mind, the first of which is a sense of whether we have addressed the issue of communication to doctors. Because the big issue to me is not necessarily what we produce but how we get into the mind of the doctors, particularly in the modern climate, where I think most doctors would describe a scenario of being overwhelmed with information being bombarded to them. How we make that happen is therefore a key issue to me.

That is tied in with an experience I had recently, where we had to spend four hours doing online learning in relation to data protection and we had tests at the end of it. It struck me that, if we have to do that, why are we not having to do that on essential things in relation to being a doctor, and things in relation to being the GMC?

That took me on to my next question about the whole issue of e-learning and around revalidation. Should the appraisal website be the GMC website rather than an NHS website? I know that this is taking it a long way, but the underlying theme is whether there is something around developing the GMC website as a much greater learning tool, so that it becomes an instantaneous communication mechanism to all doctors, rather than a random process – which it is at the moment. I am not sure that is quite on the website redesign at the moment, but it is future-gazing in relation to revalidation.

MS JACKIE ROWLEY: I would concur with that. I think that the website is a fantastic asset to us. As you know, we are currently undertaking a total website review. There are lots of things that we can do with it but, yes, increasingly the web world is one in which people engage in order to find out information and in order to learn.

I was talking to Jim McKillop yesterday about engagement with students. One of the interesting questions is how we might use the website and e-learning tools in order to engage with students about the GMC at a very early stage, so that maybe they could undertake modules or whatever. We were kicking around lots of ideas yesterday; there are ideas that we could kick around with you. Yes, I agree that it has to be the next stage.

THE CHAIR: Perhaps I may pick up Sam's point about communicating to the profession. As you know, I have been doing lots of interviews with the trade press, and so on. If anyone has any ideas as to what more we can do, then we will most definitely listen to those ideas.

In addition, and perhaps equally important, I am focusing on doctors because we have to take doctors with us on the revalidation journey. However, I want every Council member to feel that he or she is actively involved in our communications strategy.

In the same way that I have been doing interviews with magazines, journals and newspapers that would naturally relate to me, you all come from organisations, backgrounds and so on, which may well be interested from the patient perspective or other perspectives in what we are doing. If you feel that there are opportunities for you to be doing interviews with things that we may not know about, please say; because we want to get the message out as widely as we can, and I genuinely want every Council member to be a part of what we are doing. We are therefore very keen to broaden the message as far as we can. If you have any ideas about how to communicate better, Sam, we are really open to it.

MRS ENID ROWLANDS: It did arise during the discussions but I think it is worth emphasising here that the differences which are emerging because of devolution and the devolved health systems cannot be over-emphasised. Whilst there is still some degree of continuity as far as the professions are concerned, we also have a very major job to communicate with the public – and that really is very different in the devolved countries.

What I am urging, therefore, is that there is a high degree of flexibility; that we are not driven, as I think I said in the meeting, by neatness, by having one shape, because it will not work; it will not be effective. Neither will we make best use of our own resources. I am already aware of Consumer Focus, for instance, which has a major exercise in Scotland about patient's views –because we have to look at public services and it has done a particular piece of work there. Similarly in Wales, I have been putting colleagues in Consumer Focus in contact with the GMC and also with the Welsh Assembly government, who are about to commission their own work. It probably does not need to do that; it could actually work through the GMC.

It seems to me that, to be effective, that involvement will have to be quite sophisticated as we move on.

MS ANNE WEYMAN: I wanted to follow up your point, Peter, about Council members' role in communication, which was something we discussed at the working group.

The moment you tell somebody that you are on the GMC they want to ask you all sorts of questions about things, and you have to explain all sorts of things to them. However, if as individuals we are going to go into print or border media, it is really important that it is all co-ordinated through the communications team, and that we have, as part of the communications strategy, clear messages that we are trying to put across. If each of us interprets them for ourselves, we may find that we are giving rather different views to the world. It is a real opportunity to make sure that we are all saying the same thing, and that we feel confident and are supported in doing so.

Obviously some members have lots of experience of the media but others do not, and also it is in a different context that we have that experience. I therefore think that is a really necessary basis.

THE CHAIR: Thank you very much for making that point, Anne. I agree with it totally.

MS SALLY HAWKINS: I want to emphasise one of the things that came up in the group about communications being listening. Just as much as it is communicating to, it is receiving from. Equally, that we need to co-ordinate what we learn; so that if I learn something by talking to someone, somehow the

organisation gets the benefit of that. Again, if we are all going out, we have to find systems for ensuring that the organisation gets the benefit.

MS ROS LEVENSON: I welcome this paper and I am very happy to support the recommendations, but perhaps I could make one or two suggestions.

One is – and I am not sure that it belongs in this paper but it may be for future work – there needs to be a bit more emphasis on new technology and ways of engaging the public. Things I actually know nothing about: things like Facebook. I am almost out of my depth with my own question here! But there are things that people who are about 30 years younger than me could tell us about that would help in terms of other ways to engage.

I think that we need to close the loop and make sure that we are clear as a Council and clear with our stakeholders about what we have done as a result of the engagement, so that the process does not become a stand-alone thing but is seen to be part of our business cycle. We could perhaps emphasise that a little more.

PROFESSOR JIM McKILLOP: One of the other themes at the brainstorming was that we are building a very excellent base but we do perhaps need to change some of the culture of what the communications is about. Perhaps as a Council we need to debate how much more proactive we can be; where should we be being a bit braver, and perhaps taking risks sometimes in our communications?

We will not always get it right but if we are signed up to that as a Council and have some idea as to what degree of risk we are willing to take, I think that we can substantially change our communications culture and strategy.

THE CHAIR: I have to say that my natural instinct is to be a bit riskier. I am very conscious that as a regulator I have to put myself back in the box a lot, but my natural instinct is to be much more confident and to test ideas with people. Rather than saying, "The Medical Act says this, and this is what we do", I would like us to be able to test ideas. What is the point of a regulator? What should a regulator be doing? This kind of thing. I would be up for that. Would members be up for that? [*Several members*: Yes]

MRS ANN ROBINSON: I would like to build on that, Peter. You have heard me say this many times, but I do think that if we are truly going to engage we have to be prepared to engage at an earlier stage, when we are shaping our thoughts. That is quite a brave thing to do, but the benefits of it are enormous. At least we can get the reactions; we understand it; we will manage it better. It is very important that we do that – we find courage from somewhere.

THE CHAIR: Can I be absolutely clear? You are up for this, are you, as a Council?

PROFESSOR TERENCE STEPHENSON: I am up for testing our ideas with the public and doctors, but I would not be up for testing them in the media – but I am sure that is not what you meant. When you engage with the media, you have to have decided what you are going to say before you get there, as I am sure you know.

THE CHAIR: You do, but, if managed properly – and this is something where the Comms team would be crucially important – it can be a way of introducing ideas to start a public debate. The risks are obvious.

It comes back to what Ann and Jim are saying: that if we are to move forward and if we are to take our position as a leading regulator, not just nationally but internationally, we have to be testing some ideas and saying, "We think this is the direction we are going in".

MR STEPHEN WHITTLE: I think that it has been a fantastically helpful discussion, which hopefully will feed in both to the statutory days and also eventually to the elaboration of the communications strategy.

It seems to me that one of the ways in which one takes a risk as a regulator is by providing options. One does not necessarily commit to any position from the outset, but one offers more options for people to engage with in that discussion around the way forward.

THE CHAIR: That is key, is it not? That is very helpful.

DR SAM EVERINGTON: A quick comment on your issue of us as ambassadors. Can I, as a Council member, give permission to Jackie, and anyone else to be requested to do something if they think we are the right person to do it? It is not just a question of asking for volunteers; I am very happy to be told to do something.

THE CHAIR: As some Council members know, I have already made requests of them. Where possible, I want to involve everybody around the country, doing things for the GMC. If you have not yet been asked, it is because there has been nothing where you live or because it has not been in your area of interest. As a number of you know, however, I am doing this.

The support that you will get from the team will be very strong. Even with all the experience I have, I am never allowed out alone! The same will be true with you, I am sure.

MR STEPHEN WHITTLE: There is one other point in response to what Anne Weyman said, which demonstrates the read-across here. Yesterday, the standing orders group did discuss, in the context of the code of conduct, the whole issue both of collective responsibility as well as relationships between members and the Comms team.

MS JACKIE ROWLEY: Perhaps I could pick up on a couple of the points. Enid, one of the interesting things about the devolved countries issues and being sensitive to the differences is that we do have to build up a team that deals with England. At the moment, a third of my team deals with Scotland, Wales and Northern Ireland, which accounts for about 40,000 doctors; but I think that England itself probably needs some interesting separation. It is one of the things that I hope next year, through this process, we may start to address.

Sally, I hope you noticed that the word "listening" has appeared in this document. I did note and listen to that.

Ros, social media – we have already sort of started. I hope you will see in the new Comms report for this month that Vicky has done some fantastic work with the Mums.net media, which is a website. We asked them to carry a couple of questions about end-of-life care. We have an extra 30 responses on neonate care and 600 women talking about our end-of-life guidance through social networking. It is fantastically important. I do not know much about it either. It is the younger members of my team who are much better at it, but I definitely think that you are right – and I will try to address that.

Perhaps I can now deal with recommendation 2, which is about process. The hard work for Council will be the discussion and the drafting of the corporate strategy. Again, these may be famous last words but I rather hope that the Comms document will be a natural follow-on to that. If it is not supporting the work that you do on that, then we are in serious trouble.

The process I am proposing is that, as I understand it, once the discussion days have taken place there will be emerging thoughts, discussions with Council about the corporate strategy in September, and I would propose to bring something back as a draft document on Comms in October. There is no question of Comms pushing the corporate strategy; it is a question of Comms very much supporting what the corporate strategy is about.

As agreed at the brainstorm, I would hope to continue to draw on the advice of all Council members on a one-to-one basis and, in areas connected with this, I really do value your coming to me and giving me your advice on how you think that we should take this forward.

The recommendation is "*To approve the process for the development of a new communications strategy*". I think that it is fairly straightforward, as set out in the document.

THE CHAIR: Are we content with that? [***Agreed***]

Education

5. Outcome of consultation on review of *Tomorrow's Doctors*

THE CHAIR: It is a pleasure to welcome Professor Michael Farthing, Vice-Chancellor of the University of Sussex, to the GMC. Mike is well known to the GMC, having been on the Education Committee. Mike chaired the *Tomorrow's Doctors* Review Group.

Before you came in this morning, Michael, I was talking about the report of the CHRE on health regulators which was published a day or two ago, in which it comments that all regulators can learn from each other and that there is much to learn from how the GMC does things. They particularly pick out the review of *Tomorrow's Doctors*. So this is an opportunity to say "Well done" and thank you on behalf of Council for the vast amount of work that went into this: work by yourself, by Martin, Ben and all the Education team. This was a huge effort and I am delighted that it has been recognised by the CHRE in such a very public way.

PROFESSOR MICHAEL FARTHING: Thank you very much, Peter, and thank you to all the Council for giving me this opportunity today. I will say one or two words in three areas. I want to say a few words about process; give a personal view about content; and then maybe a word about the future.

First, it has taken quite a while. It is well over two years that we were working on this. By and large it was an extremely enjoyable and educative process for us. I think that our meetings were stimulating, challenging, and the work that we did in between – and we did a lot of work in between – was also great fun.

I should stress at this point that I am here today representing the team. It was very much a team effort. I was the chair but I was not the most skilled or experienced person on the panel by any means. We had some extremely forceful, intelligent, driving individuals. One of the things that I did do was to harness this force and drive it into the document that you have before you today.

We worked as a team; we devolved responsibility. I hope people felt that they really did have a voice and that they can see their work in the final product. For me that was a very important part of the process.

In terms of the consultation, we had the formal period of consultation. I tried to drive the whole process as a consultative process throughout. We constantly had people coming in and out of the room, communicating with us, writing to us, doing visits to various organisations, throughout the whole of the early stages of the review. When it came to delivering this draft for consultation, therefore, I think that there were very few surprises in there to anybody. For me, that was a very good learning point. One sees it in other areas where new documents

arise; they appear out of the ether; apparently they are written in 30 days and they come out for formal consultation for another 30 days. You just wonder who has been involved in the preparation of that document. The GMC did do it differently on this occasion and I think that it has paid off, particularly in view of the largely positive feedback that we had during the consultation process.

In terms of content, the overarching statement, although short, is very important. It does begin to set out what we wanted it to do – the distinctiveness around the medical profession and around what doctors do. It is very easy to say, “Everybody is part of a team”. We are of course part of the team. The document clearly states that and states that medical students need to understand what it means; but doctors have a distinctive role in the team. I think that statement tries to draw it out, particularly with words like “leadership” and “analysis of complex and uncertain situations”.

By and large, I think that the three domains we chose to use as a framework for outcomes are right. We have flagged up one or two important areas and, for me, the most important was clinical contact. My own personal view is that we have pushed responsibility and decision-making too far to the right and we need to begin to pull that back. This document does pull it back into the undergraduate medical curriculum.

When I spoke to our own local trust in Brighton about the implications that this might have for them, the chief executive looked at me in some surprise and said, “But, Michael, these are our doctors. These are our doctors of the future. Why would I not want them to get this experience and to be better prepared for Foundation?” I think that one of the tricks that we have to play is to make sure that where medical students train is not too far away from where they subsequently do Foundation; so that the NHS organisations do feel that sense of ownership around our students and their doctors of the future.

Finally, a few words about the future. I gave a lecture to our medical students at the end of last week. I had to inspire the whole of the fourth year who had just completed some research projects and to tell them how important it was that there might still be a role for the clinician/scientist. I decided to give them a lecture not just on that, because I thought it might be a bit dry, but I modified a lecture that I gave in Ireland a few months ago where I effectively write out the medical profession from the health service’s agenda over the next 30 years ago and make a case that you do not need doctors in 30 years’ time. Of course I do not believe that, but I do it in that way in order to stimulate the profession to think about what it is that it will contribute to health care in the future, because so much of what doctors have done traditionally is now being taken over to some extent by other members of the team.

What came out for me at the end of that – and the last thing I want to do is to influence the next edition of *Tomorrow’s Doctors* – and the thing that I think will make the medical profession distinctive is what is encapsulated in the scholar/scientist section. It is about the fundamental understanding of disease processes; it is about the science that underpins health care; and it is through that that a large amount – not all but a large amount – of the innovation will come. That will not just be working with biomedical scientists; it will be working

with engineers, designers, physicists and biophysicists, to create the world for the future. I think that is where the medical profession will find its distinctiveness in the future, and we lose that at our peril.

It has been a great pleasure to do this. It has been quite a worry over the last few years because, at the end of the day, one had to deliver a document that would not only be acceptable to ourselves, to the profession, but also to our patients and the community as a whole. I think that we have delivered something and I think that it is different.

Finally, I would like to thank all the members of the team, who did work as a team and who brought a lot of very interesting issues to the table, the majority of which are incorporated in one way or another in this document.

THE CHAIR: Thank you very much, Michael. Over to you, Martin.

MR MARTIN HART: A very few words to take members forward from when we discussed this in seminar mode in May. I would emphasise the point Michael made about the consultation and the acceptability of the draft.

The vast majority of respondents believe that the new draft will promote high standards in medical education, which I think is really what we are about. What is very important is that we have had very favourable responses not just from the Medical Schools Council, who are clearly a very important constituency in delivering this, but also from employers. As you may have sensed from our discussion last time, employers are vital if we are to deliver this.

A subset of the Review Group and the Undergraduate Board met and made a few changes. Perhaps the most significant one is to put the *Outcomes* before the *Standards for delivery* and, importantly, to have a new foreword at the beginning, to place the outcomes in more context and also to address some valid criticisms that the draft consultation was a rather dry document.

We have looked quite closely at the list of practical procedures in Appendix 1 and have reduced it, but have hopefully put greater emphasis on diagnostic skills, interpretation skills, and working in multidisciplinary teams.

We have also made very clear the commitment and the agreements we want medical schools to achieve with local employers and issues about financial resources, to make sure that they do properly support undergraduate medical education.

We are proposing that the new standards should apply from 2011-12 rather than 2010-11. This is quite a big agenda for medical schools to step up to. That is not to say that we will not be engaging in a programme of quality assurance before that time. Indeed, we are starting almost as soon as we have got the ink dry on this – thinking about how we implement the new *Tomorrow's Doctors*, share it with and work with medical schools.

The last thing I would say – and it is almost a cliché – is that this is not the end of a journey; this is very much a stage on a road. We have a lot of work to do to implement this, particularly to work with employers. We have to, and are very keen to, look again at our quality assurance process, not just in the context of undergraduates and *Tomorrow's Doctors* but also looking at the implications for the continuum and the merger with PMETB.

As you will see in the penultimate paragraph of Annex 1, paragraph 99, there are a whole series of policy initiatives that we want to take forward and we will be developing these over the next few months. Clearly they will provide a lot of the basis for our Business Plan for 2010.

THE CHAIR: At the risk of stating the obvious, this document is of huge importance. It is of huge importance because it shapes the doctors of tomorrow in this country; it is also of huge importance because it is widely used internationally, either directly or indirectly. It is one of the documents by which we as an organisation will be judged and known.

Are there any comments or questions?

DR SAM EVERINGTON: I suppose that my question is particularly in relation to the medical schools implementing this. How will we know whether they have done it or not?

Tied in with that, one of the big issues to me has been the inequality in terms of the education – and I would say this as a GP, wouldn't I? – between actual general practice and the acute sector, and how we are going to test that in this process.

DR JIM McKILLOP: Can I first say that I am really grateful for what the team has done in responding to the consultation work. There were a lot of responses and I think that they have very much been fed into this final draft.

One of the points that Martin made was the importance of engaging with the employers. That is not just around the outcomes; it is around making sure that the opportunities are there for the students to have the experience in clinical areas that we wish them to have. Michael has had a response from his local trust, but I feel that is not what we will see across the country.

I think that there is a large piece of work for us to do, to work with the Departments of Health around the country and indeed individual health authorities, to make sure that we can actually deliver what we are asking, and indeed to make sure that schools are being judged against that.

MR MARTIN HART: Clearly the quality assurance process will be the main way in which we address the delivery of it with medical schools. However, I guess what we are very keen to be different this time is to make sure that the QA

process has the involvement of all of our stakeholder groups and really does get under the skin of it.

The QABME process has been very successful, and I say that knowing that quite a few people around this table have been involved in it. However, we recognise that there are areas where it could be improved. We have not really engaged with employers in the process. The real challenge now, therefore – and I do not underestimate the challenge – is to improve and strengthen the QA process.

The general practice point chimes very strongly with me. One of the things we emphasise in *Tomorrow's Doctors* is the whole issue of careers advice and knowledge of the NHS. A lot of medical students still do not realise that probably one in two of them will need to become GPs to meet the service needs. There is a lot to be done about education in that role.

It is a bit about the Foundation programme as well, which is also being looked at and which I think was created as a way to deliver acute needs. I think that we also have a role in lobbying to make changes to the Foundation programme.

PROFESSOR JANE DACRE: This is clearly an excellent start, but I think that engagement with our NHS colleagues in its delivery, not just the employers, is crucial. I can see a time coming when the already scant resources across the patch will be even less and, frequently, the first thing that is lopped off the bottom is medical education.

We need to be very careful that this does not just become an aspirational document which people cannot achieve. We need to make sure that we lobby to raise the crucial importance of continuing to have education linked within the NHS.

THE CHAIR: I absolutely agree with that. In the meeting with the Secretary of State for Health for England last week we raised the importance of not just education in general but the importance of final-year clinical placements, where medical students do more than has been the norm of late.

The medical director of Medical Education England – and I realise that I am talking England at the moment – agreed that this was an important issue and, in the presence of the secretary of state, undertook to take this matter forward; but it was with regard to engaging with employers in England.

We will of course be having the same engagement in all countries in the UK. The reason I mention it, however, is because we are on the case. We understand that this needs to be done. The timing is everything in terms of making these points.

PROFESSOR IQBAL SINGH: There is a great challenge that we may face in relation to monitoring in relation to quality assurance standards, for doctors who

in the future may be trained overseas but still have degrees from UK universities, with the expansion of satellite UK medical schools.

This is a challenge for us in terms of the resources we may have and in terms of the ability that may be there – but it is something that we need to be aware of.

THE CHAIR: We are indeed aware of it. The Education Committee had been aware of it and established some ground rules to cover just these eventualities, which I am sure Martin will be happy to share with you outside of the meeting. We are very aware of the resource implications.

What Iqbal is talking about basically is a UK medical school establishing a wholly-owned medical school in another part of the world, but giving a UK primary medical qualification which is therefore registrable with the GMC. There are a number of initiatives of this type underway.

The Education Committee were engaged with this for probably a couple of years and processes have been established which take account of resource implications.

PROFESSOR TRUDIE ROBERTS: First of all, I think that this document is great. I really like it. I like the way it reads, particularly in its final version.

I think that people should not underestimate how influential *Tomorrow's Doctors* has been as a document. It really is internationally recognised and, in places that I go to, referred to a lot. People use it as a basis for what they do in their own institutions often. It is also very influential with other regulators, taking it as an example for their own education committees.

I really am concerned about the commitment of employers, as they like to call themselves. I think that we are now going into unprecedented financial difficulties within the public sector, which we have not known before. HEFCE has announced that it is cutting £160 million from universities' budgets over the next five years. There will be no more investment in the NHS. A lot of new consultants and a lot of new managers have never known a time like this before. They have come into the NHS since 2000, when a lot of it has been growth.

I think that it will be very difficult and we have to make sure they understand the commitment to training the doctors, because they are part of training their own future employees. Too often they stand back and criticise the outcome, when they have actually been part of that process. They need to understand that as a partnership. I am glad that the GMC is on the case, but I think that it will be very difficult in the future.

DR JOHN JENKINS: This is just to tie in with what Trudie has said. In a sense there is a three-legged stool that we are dependent on to deliver this. We have talked about the Departments of Health; we have talked about the local delivery

in trusts; but of course the medical schools themselves are absolutely critical to this.

The feedback I get from my colleagues in the medical school where I work is that they are up for this, but they are not sure that at the moment the resources are available to them to deliver it, because of the emphasis which is sometimes seen in medical schools to be in a different direction from that of education. That is a challenge that we will also need to address with the medical schools – indeed, with the universities – and one that we should not underestimate.

THE CHAIR: We understand these issues very well and I can assure the Council that we will be very vigilant in this matter. It is an area where the GMC has to behave with great determination, because it is the future that we are talking about here and the quality of doctors in the future.

SIR RODNEY BROOKE: As a lay member, I deeply appreciate the amount of work that has gone into this document and, in so far as I can judge, it seems to me absolutely admirable.

I want to make two points. One is echoing the points made by Jane and Trudie. I would very much hope that the Care Quality Commission would believe that its remit extended to looking at the facilities for education in the health service. I realise your organisation wants to be outcome-focused, which is perfectly proper; but unless you get the inputs right in terms of education at this stage, your outcomes in five or ten years' time will be deeply unsatisfactory. I very much hope that in your interaction with the CQC you might try to get that point across.

Secondly, I want to draw attention to the last point Martin made with regard to paragraph 99. I very much welcome the commitment to further work on this and, in particular, looking at the ways in which guidance could be given on adjustments that might make a medical career more possible for disabled people. I look forward very much to seeing the outcome of that programme of work. Perhaps I should also declare an interest as Chair of the QAA, Chairman.

THE CHAIR: With regard to the Care Quality Commission, I have a meeting with the chair and chief executive some time in the middle of August and I will be exploring these issues with them.

PROFESSOR TERENCE STEPHENSON: I echo the views about the Care Quality Commission. When you meet them, you may want to think about what they could take out; because at the moment trusts are visited by 53 separate regulatory bodies, and the Care Quality Commission alone has a book <u>this</u> thick, which are the criteria that a trust must already meet. The databases that all of those 53 regulators ask for are all different.

If we just go and say, “We want you now to look at education” – which I would be entirely supportive of and which people have been pushing for for some time – I suspect the reaction of the trust will be, “We’re already being audited on everything. We can’t do more”.

We have to think about helping them decide what they could drop. There are some very unnecessary and unhelpful things in what they regulate that are not measurable. For instance, one of the things they regulate is that a hospital should recognise when patients are ill and treat them quickly!

THE CHAIR: Thank you, Terence. Can I turn to recommendation 2a, which is to agree the publication of the revised text of *Tomorrow’s Doctors*? Is Council content to agree? [***Agreed***]

Recommendation 2b was to authorise me to finalise any changes. We are agreeing on where the hurdles are but, in terms of the text, I think that you are agreeing the text without changes.

Then to agree that the medical schools should incorporate the changes by 2011-12, which was thought to be as soon as was practical, because changing a curriculum is not an overnight matter. Is the Council content with that? [***Agreed***]

Once again, Michael, Martin, Ben and the team, thank you so much.

MR STEPHEN WHITTLE: May I make a communications point? This is obviously a public document, and it is a public document of enormous importance. We have just passed it but we are not going to launch it until September.

One of the things we talked about yesterday was whether or not it is possible in the future to find a way forward so that, when something like this happens, which is entirely consistent with transparency and accountability, we do not find ourselves in the situation of having a public document now which we will want to launch with great fanfare and support at a later stage – so that we do not get caught between these two stools.

MS JACKIE ROWLEY: It is a very important point and it is an issue for us. Of course, openness and transparency are absolutely essential in what the Council does and we need to be accountable for all of our decisions; but it is also quite difficult for the Communications department to do an enormous amount of work – as in fact we did on the launch of the end-of-life guidance – and then find that the journalists who read the document immediately wanted to write about it. That makes life very difficult for us.

There are practical points here. Once this document has been agreed, we then have to print it and to get it ready for our launch and publication. We cannot do it instantly. If the working group is engaging with this, it is immensely helpful and I would hugely value it from a communications perspective.

MS ANNE WEYMAN: I wanted to ask about the programme of work that has been identified in the list in paragraph 99 and whether at some point we will get a report back about those issues. I know that some of these issues came up during the discussions and they are really very important.

PROFESSOR JIM McKILLOP: There are a number of them which we see as being of higher priority than others, but at the next couple of board meetings we will be trying to refine the order in which we take them. There are some that are very urgent to do, in order to make sure that *Tomorrow's Doctors* gets implemented; some of them are perhaps rather longer-term pieces of work. But, yes, we will be looking at the work programme over the next couple of years.

Licensing and Registration

6a. Licences to practise: consultation report and approval of Draft guidance for doctors

MR RICHARD MARCHANT: You have already heard quite a lot from Ben this morning about the licence to practise and our plans for implementation, so I think that what I need to say can probably be quite brief. It is also true to say that you have already had something of a taster of this consultation back in May, when we reported to you the initial conclusions of the feedback on the consultation.

Our more detailed analysis of the consultation responses, if anything, tended very much to bear out what we said to you last time, namely that there is broad support for our proposals in relation to the way we are hoping to introduce licensing. There is certainly a strong desire for more information on practical arrangement about licensing and, above all, an appetite for much more information about revalidation rather than simply licensing.

The responses we have received to the consultation have been hugely helpful in helping to refine, shape and improve all of our communications messages and to try to improve the guidance for doctors that we have prepared on the back of this consultation. I hope you will see that we have made quite a lot of changes to the original draft, as you will see in the documents that are before you today.

What it has also helped us to do is to inform and refine the revalidation frequently asked questions document that we published last month, and already that is receiving quite good feedback.

With that brief preamble, the paper itself asks you to do three things: to note and consider the report; to endorse the conclusions on the way forward; and to approve the draft guidance that we have prepared around licensing.

THE CHAIR: Taking these one at a time, looking at the report which is at Annex A, are there any comments or questions for Richard on that?
[*No response*]

Moving on to 2b, which is to endorse our conclusions in respect of the report, paragraphs 12 to 15, is there anything? [*No response*]

You are having a smooth run here, Richard! Then 2c, to approve the licence to practise guidance, which is on Annex B, paragraphs 16 to 19 – are we content formally as a Council to approve this? [***Agreed***]

[*After a short break*]:

6b. Fees framework

MR STEVE DOWNS: This is a short paper, the purpose of which is to set the fee levels that will apply from 1 April 2010 for those activities that are currently provided by PMETB.

In the medium term, we recognise that there is a need for a full review in terms of setting a comprehensive fees framework that addresses not only the merger of GMC with PMETB but also a whole host of other challenges which the GMC will face, including things like transferring adjudication to OHPA, licensing, revalidation, and so forth. To develop that comprehensive fees framework will take some time, in terms of developing a framework, considering the financial issues and then consulting with interested parties. Our Resources Committee therefore considered the issue and agreed that we would need some kind of interim arrangements that would apply from 1 April onwards.

What the paper proposes is that we retain the current PMETB structure in the short term and, rather than increase the fees from 1 April 2010, we will leave them at the current levels. That is very much a kind of positive statement in terms of the benefits that trainees can expect following the merger of PMETB with GMC.

We can afford to fix the fees at the current levels and not increase them because we expect to get about half a million pounds of initial economies of scale as a result of the merger. That again points to this being very much a good news story that does not cause us financial problems in the short term, and gives us some time to develop this longer-term fees framework. I will leave it there and take any questions.

THE CHAIR: What we are being asked to do this morning is simply to endorse what you have heard from Steve: that we stay where we are with regard to PMETB fees. That is pretty straightforward, I think, unless anyone tells me it is not. It is to give us time to think through the much more complicated issue of fees for the future. Robin, are you content with this?

MR ROBIN MACLEOD: Absolutely. We discussed it at length and I think it makes eminent sense to say let us at least stay where we are at the moment. It would be madness to increase the fee, only to reduce it if we could – or indeed to reduce it at this stage and then to have to increase it. We thought that we would take the commonsense approach, find out what the position is going to be and then take a decision at that stage, rather than to have some interim arrangement that we would have to change.

THE CHAIR: Are we content? [***Agreed***]

Governance and Legislation

7a. Merger of PMETB with the GMC: consultation on legislation

MR RICHARD MARCHANT: This paper deals with the Department of Health consultation on the draft legislation for bringing PMETB's statutory functions into the GMC.

We have worked very closely and carefully both with the Department of Health lawyers and our colleagues at PMETB to try to ensure that those functions are transferred, as far as possible, as they currently operate and to try to avoid opening up what are potentially wide-ranging and complicating policy issues. The reason for doing that is quite simply because the timeline for merging the two organisations does not give us the luxury at this stage of opening up those more searching policy questions, and that the opportunity for exploring those issues is really through the Patel review that has recently started and will be continuing over the next few months.

What that means is that the current section 60 Order is, I hope, relatively uncontroversial, relatively straightforward, but that the opportunity to explore the more challenging issues is something that will come further down the line. There was mention earlier today about the ambassadorial role of members. It would be quite helpful, if people have the opportunity to be talking around these issues, to convey that message: that this section 60 Order is a straightforward, functional process. The big policy issues are the game to play slightly further down the line.

We have an event coming up on 14 July at RIBA, which is a section 60 Order briefing event, where that is very much the message we want to be telling. A lot of our key interest groups will be attending, and if members would like to attend that event then please let us know and we will ensure that that happens. All of which goes to explain why the proposed terms of the response to this consultation document are unusually benign. The recommendation is really to ask you to endorse a relatively benign response along those lines.

THE CHAIR: Are we content or are there questions or points that people have for Richard?

DR JOHN JENKINS: I certainly would like to support Richard on this, speaking both as a Council member and as a Board member. It is very important that our hands are not tied, and one of the specific questions is in relation to the transfer across of the structures that exist within PMETB.

It is very important that we do take the line that we are taking in this draft response: that we should not be tied by, for example, the need to have two statutory committees and that we should import the functions of PMETB in the way that will most effectively allow those functions to exist within the new domain. I think that it is very important that we try to secure that outcome.

THE CHAIR: Are people content? [***Agreed***]

7b. Joint Co-ordination Group: progress report

MR SIMON HIGDON: This is another short paper, I think. I know that progress on the merger was touched on earlier this morning, so I will not detain you on this.

The paper in front of you is the means by which the Joint Co-ordination Group (JCG) provides a statement of assurance to Council that the objectives flowing from the merger are on track. As you know, the JCG met in early June, around the same time that we were able to report to Council two significant and very positive developments. One was the publication of the consultation of the section 60 Order that you have just been discussing; the second was the approval by the Department of Health England of our business case for securing the necessary funding, including for co-locating PMETB staff in this building in early 2010. Indeed, PMETB have now given notice on their lease at Hercules House.

On that basis, following a review by the JCG of all the agreed work streams that we have set out, the paper invites you to endorse the assurance provided that the work is on track.

Perhaps I may also point out that we did hold a very successful open forum here at the end of May for all PMETB staff and all relevant GMC staff. This represented the start of what we are called "phase 2", the implementation phase of the merger, which is now well underway. We held a phase 2 kick-off workshop with colleagues from PMETB a few weeks ago and we are putting in place the detailed plans for taking that forward, including bringing in a dedicated project manager to help us track and monitor progress.

In summary, phase 2 of the project is underway and I think that we are making good progress, but we recognise that there is much to do.

DR MAIRI SCOTT: This is an additional point and it is for Council to consider, I think. The merger is going very well; I accept that a lot of work has been done on it, and the papers are very helpful; but I still think – and I have said this before – that we have the need to understand something about the history of PMETB, something about its philosophy and approach to regulation of training, and also its procedures, which are different to our own in the GMC.

Yesterday, at the Patel group, we spent quite a lot of time trying to get to grips with the complexities of PMETB, the way it works, and the quality assurance aspects, which are different and have their own additional benefits within it.

The other thing we need to be aware of is not just the extended range of stakeholders but also some of the high stakes of the stakeholders of the work that PMETB has done in the past, and perhaps an understanding that Council needs to have of the difficult times we have gone through with that and the importance of not ever getting into these kinds of situations again in the future.

We have time to do that at the moment, prior to the merger; but I think that Council needs, for its own benefit, needs to spend a little time learning about and understanding these areas.

THE CHAIR: That is very helpful indeed, Mairi. Would that be supported, by and large, around the table? [*Several members*: Yes] Because there are one or two of us around the table who could write a book, could we not?

Could I therefore suggest that, over the course of the next two or three Council meetings, we find time for a seminar when we will give you the full story? It is important for all sorts of reasons. It is so often the case, is it not, that unless you understand the historical context you do not see why things are the way they are. We will do that.

MR FINLAY SCOTT: I think that Mairi's is an excellent suggestion, not least because the history will help to inform what we do, as it were, in the second phase – which is the subject of Naran's review.

I want briefly to say something about Annex A to the group's report. It is at page A1. The third item listed at 1c is about credentialing. I want in particular to pick up the reference toward the end of the paragraph to speciality or SAS doctors.

We have continued to discuss with a number of representatives the intention that has been formed, through the work that Malcolm will be leading, to look at the credentialing of SAS doctors. For those who are not completely familiar with the population, there are about 20,000 specialty doctors who deliver huge amounts of service within the NHS. Currently, their knowledge and skills are not credentialed in the say that, say, consultants on the specialist register are credentialed.

We have been exploring the practicability of taking this forward. I have to say that, in general – not universally but in general – there is huge enthusiasm for this. I just wanted to log that point up.

PROFESSOR IGBAL SINGH: It is exactly the point I was going to raise. I think that this should be the way forward. We say that we do not do things that are just within our remit; we work with others to change, and this is one of the areas where Finlay has been taking a lead – so thank you very much. I think the message does seem to be getting through in terms of the approach to credentialing, which is the way forward.

The other point I was going to raise was in relation to paragraph 15. I am sure that we recognise the need in terms of HR issues for the support, guidance and mentoring that is available to staff who are going through very difficult times. It is important that these support mechanisms are there. It is our responsibility as much as that of the PMETB over a period of time that the availability of these support mechanisms is being communicated to the staff.

THE CHAIR: Simon, do you want to pick up the HR issue and update Council on the approaches we have taken to that?

MR SIMON HIGDON: In essence, part of the reason we held the event on 18 May was to set out the key milestones in terms of HR issues, so that all PMETB staff and indeed GMC staff were clear about what was going to happen and at which stage.

The first stage was to set out at a very high level some work on organisational design; that is to say, where we anticipate GMC functions to fit within the existing GMC structure. Clearly it is still at a very high level and we will be taking that forward. That is the first of a number of steps that have been set out to staff.

Separately, Andrew Bratt and the HR team here have done quite a lot of work on training and development, offering up a wide range of training opportunities to PMETB staff. The take-up has been surprisingly high. We did not expect it to be as high as it was; so that is a really positive message.

Colleagues at PMETB are putting in place things such as career development advice for staff; financial advice for staff; advice around specialties, like pensions, et cetera. There is quite a lot going on in this area, therefore, and we will continue to handle that as sensitively as we can.

THE CHAIR: We are very clear, and I am personally very clear, that people are our most important resource and we must treat everybody well. I feel a personal obligation to the staff at PMETB, for obvious reasons. We are very proactive in the area, therefore, and will continue to be so.

DR MALCOLM LEWIS: Just to come back very briefly to credentialing, it is contained within the papers for the seminar this afternoon, towards the end of the revalidation seminar. There are some important statements within that as to what perceive credentialing to be, and how it might add value for different groups.

I think that we need to be clear in Council in terms of what we mean and understand by credentialing, to ensure that it can deliver something that is of value, and that it meets the need of people out there who are in a way clamouring for it – but that it does not overstate what we can achieve. We therefore need to do quite a bit of work around it, and maybe we can talk about that this afternoon.

ARCHY KIRKWOOD: This is a process question really. Steve was talking about financial advice. I think I know the answer to this question, but who is in control and overseeing the merging, if at all, of the pension schemes? Can there be some assurance that the existing scheme, as is within the GMC, will not be in any way diminished financially by the merger?

Who is looking at that? Can we have some reassurance – as well as financial advice, which is absolutely right and proper – that everybody is treated fairly if the merger involves pension amalgamation?

MR NEIL ROBERTS: The situation at present is that PMETB staff are members of the NHS pension scheme. PMETB are exploring whether or not they can remain members of the NHS pension scheme post the merger. If the answer is yes to that, then that is likely to be the preferred solution. If the answer is no, then we will need to look at how PMETB colleagues will join the GMC scheme and on what terms, and we have yet to complete that analysis. The signs are positive, however, that they will be allowed to stay in the PMETB scheme.

DR JOHANN MALAWANA: I would like to reiterate what Malcolm said about the credentialing issue. I would like to make sure that one of the other things we are aware of is that, whilst we do not overstate things, we are very aware of the decisions we will make regarding credentialing and the potential impact it could have on other groups, and that we do not create problems for ourselves in the future with regard to giving a mechanism to create even greater numbers of SAS doctors who are not able to progress in their training. I just want to make sure that that point is registered.

I have heard a lot of sympathy around the room and from different members saying that, but I want to make sure that it is reiterated again on the credentialing issue.

THE CHAIR: I realise that for a number of people around the table credentialing may be a slightly abstract concept. I suggest that this afternoon we begin to pick it up – and, John, I am sure that you will want to say a few words at that stage –

to convey the kinds of issues that are raised by using the term “credentialing”. This is something to which we will have to keep returning, but the first thing is to make sure that people understand what it means, or what different people think it means – because it means different things to different people.

One of the great things we can do at the GMC is to be clear about what we mean by credentialing, because that will be the benchmark – “This is what credentialing is”. We will pick that up initially this afternoon, but I am sure that we will need to keep coming back to it, because it is a very complex and challenging area.

I am reminded that Council needs to endorse this. [***Agreed***]

Fitness to Practise

8. Fitness to Practise Rules: outcome of consultation and approval of draft Amendment Order and Rules

MS ANNA ROWLAND: I came and spoke to you in February to let you know about our proposals at that time to consult on a package of rule changes to our Fitness to Practise Rules. These are specifically rule changes that do not require any sort of section 60 Order in relation to primary legislation.

We have now done that consultation. We sent the consultation paper out to a wide range of stakeholders and consulted it on our e-consultation website. We also held some meetings with the medical defence organisations. We had about 50 responses, which, bearing in mind that it is quite a technical document, we thought was quite encouraging. We have now analysed those responses. I ought to add that two members of Council, Joan Martin and Iqbal Singh, have been through the responses in detail to check that the summary we have attached is a fair reflection of those responses.

In general, it is fair to say that the responses were very supportive about the proposals as a whole. In relation to those who had comments on individual issues, I think that they were generally supportive about the thrust of the changes.

Having said that, there were a few issues that drew comments from a wide range of people. It was clearly the same issues that tended to cause concerns, and so I thought that I would run through what those are, what people said, and what our response to that has been.

We had a proposal to amend our rules in relation to specialist advisers, to say that we could remove the requirement to have regard to the specialty to which the allegations relate in appointing an adviser. Our reasoning was that sometimes a doctor is in a fairly obscure subspecialty and, in practice, we have interpreted this rule quite strictly and it has been quite difficult to find somebody at times. Having said that, a lot of respondents had concerns about this and, in discussions with the defence organisations, they pointed out that the wording of

the rule is not as restrictive as perhaps the way we have interpreted it, and that it just requires us to have regard to the specialty. On balance, we have taken that on board and we are not proposing to proceed with that change and I think that we are comfortable that there is probably some flexibility in the wording of the rule for those odd occasions where this causes us problems.

THE CHAIR: Does anyone have any concerns or observations on this issue, or are you content? [*No response*]

MS ANNA ROWLAND: The second issue was the introduction of a power for vexatious complaints. The comments were probably threefold: the importance of the criteria – because the rule itself just contains the power – and the importance of talking to interested groups as we develop that. We are about to start work to develop that and we will be talking to groups as we develop it.

The second point was that we had said in the consultation that we expected this to be used rarely. People made the comment, I think quite rightly, that that ought not to be a criterion. I think that what we what we were trying to say was that in our experience we would expect it to be used rarely, but actually we ought to develop objective criteria and however many cases that produces is a matter of practice after that. I think that is a good point, therefore.

The third point, on the same issue, was that the medical defence unions were keen that, where we do screen something out as vexatious, we notify the doctor. We were not proposing to change the rules but, as a matter of operational practice, we were proposing to do that.

THE CHAIR: I think it was right not to prejudge how many vexatious complaints we were going to receive. Are members content with that change in wording?

MS SALLY HAWKINS: I am not not content but I do think that there are equality issues connected to this. It did disappoint me that at the end we just have this reference to "there is an impact assessment". I think that it would be good to have some of this set out here – the kinds of risks associated with determining that a person has a vexatious complaint and, for example, how you will deal with mental health issues, and some of these things that could be attached such as communication issues.

Whilst I am not saying we should not be going ahead, I think that we do have to set out the risks very clearly and how we intend to address those risks.

MS ANNA ROWLAND: I think that it is in the development of the criteria that that becomes particularly key, and so we will be very careful about looking back at our assessment and checking that it is still appropriate.

THE CHAIR: Anna, could I ask that you run the criteria by Sally and by your group as well, to make sure that they are happy?

PROFESSOR IQBAL SINGH: I think that what Sally has said is right: that we need to identify the risk and, simultaneously, we need to have clear criteria. I was going to suggest that we should be aware that the health service ombudsman has developed work on this, and it may be useful to look at that as well.

MS ROS LEVENSON: Could I also raise the question about vexatious complainants? I support what has been recommended but I have a question about the duration of the decision to designate that somebody is a vexatious complainant, because it could be that somebody is experiencing particular mental health issues that might lead to a spate of complaints and to that designation being applied. However, that may then resolve and no longer apply to that person's situation. I wondered if there was a process of review or a finite period associated with the category.

MS ANNA ROWLAND: Certainly in terms of the power, we have referred to the complaint rather than to the complainant; so it would be categorised as a vexatious complaint rather than attaching to a person.

Having said that, one of the scenarios we envisaged was that such a volume from a single source might in itself lead to concerns about vexatiousness. It is a good point but I think that it is probably at the point at which we develop the criteria that we will really need to dig into that; so I will make a note of your concern about and we will think about it as we are developing the criteria.

The next issue that drew some comment was about the proposed changes to Rule 28, which is when we cancel a hearing. At the moment it is an on/off switch, so we either have the hearing or we cancel it. The proposed changes were to say that when we cancel a hearing we could refer it back to the case examiners. There were three options, namely to consider a warning; to consider agreeing undertakings; or to reconsider the allegations to which it relates.

There were comments about the third of those: about how appropriate it was, if you are talking about a rule that is related to cancellation of hearings, to reinvestigate and almost go through the process again. I think that we do have other procedures in place, for instance if we get new information in relation to an allegation. Again, we thought that was a fair point and we have amended the draft order so that it contains the first two – the warning and the undertakings – but it would not allow us to reconsider the allegations.

The next issue was Rule 12. We thought that Rule 12 would probably draw some comments. They were mainly from the medical defence organisations. They were probably twofold. There was some concern around the scope of the power, but when we discussed this with them in detail it was clear that there was a confusion about what we call the "two-stage test". There is a decision about

whether to review and then there is the decision relating to the review itself. What we have done in response to those concerns is to clarify those two stages and made it clear what criteria appear at each stage. We have fed that back to them and they seem content.

The other issue was their concern that the two-year time limit for reviewing cases was too long. This is an area which we have not been able to agree. Our view is that the current Rule 12 does not have any time limit and so, by introducing a two-year time limit, it is about being fairer in terms of certainty. The defence organisations preferred a 12-month limit. Our concern about that, however, is that we would often get these cases, because someone has perhaps been going through some other process – for instance, the court process – where some new piece of information emerges as a result, we therefore get this application and that 12 months is actually very tight. We thought that two years was probably fair and appropriate, and we have told the defence organisations that that was our proposal. Bearing in mind how many of their views we have taken on board, they did seem to accept that we would not necessarily agree on everything.

THE CHAIR: It seems to me to be one of these things that, after it has been in operation for three or four years, we could look at again to see whether two years is right or not. Are you happy with two years at the moment? [***Agreed***]

MS ANNA ROWLAND: The final issue about which people raised concerns was our plan to change the provisions around service. Our plan was to allow for service on the solicitor as well as the doctor, and also to allow service by email.

The comments made related to concerns about certainty. Solicitors had concerns that sometimes someone may instruct them, then not instruct them and then instruct them again, and that there might be some confusion. We have therefore agreed that we will develop a Notice of Acting process, so that in a sense there is agreement that they are on the record before we do that. And, in relation to email, that we will have prior agreement about the address for service, whether email or otherwise; so that if it is emailed, they are certain that they will check their emails regularly, et cetera, and that there is no confusion. We have fed that back and people seem comfortable with it.

THE CHAIR: Are people okay with that one? [***Agreed***]

MS ANNA ROWLAND: Those were the individual issues. In terms of what happens now, we have a draft Amendment Order which the Department of Health has agreed. Subject to your approval, this would now go forward to the Privy Council, and they have confirmed that they ought to be able to sign it off by the beginning of August.

THE CHAIR: We have been asked to confirm three recommendations. One is that we have considered the responses – which we have just done, I think. The

second and the substantive one is to approve the Amendment Order required to bring the rule changes into force. Can I have Council's formal approval of that? [***Agreed***]

Regarding the third recommendation, can you clarify for me, Anna, is this to authorise me to make any changes that may unexpectedly occur subsequent to this meeting, in terms of interaction with the Privy Council or others, or was 2c there only in the event of Council members asking for a change?

MS ANNA ROWLAND: Primarily the latter.

THE CHAIR: So 2c is redundant?

MS ANNA ROWLAND: Yes.

ARCHY KIRKWOOD: I think that these changes are all extremely worthwhile and I congratulate the people who have been doing that. However, I would like to think that this is not the end of the story. I know the answer to this question, but I would not like to think that this was it for a while. We have to keep the pressure up and to find ways, particularly dealing with the dreaded lawyers, to get some control over how they manage the time in the hearings.

I guess that will take time, because it will also involve Privy Council Orders in Council. If we are backing this – and I think this is substantial progress – I hope that we can encourage our professionals and the colleagues who are dealing with this particular area to keep the pressure up and to keep looking for ways of refining the process, in order to try to constrain costs in future the best way they can.

THE CHAIR: I am sure that we would all support that.

PROFESSOR TERENCE STEPHENSON: Could I also thank Anna and John for bringing this so rapidly to this point? I have just one small correction at Annex B, paragraph 18. It should say "*the Royal College of Paediatrics*" and not "*Paediatricians*". We are the only college that represents a discipline rather than a group of doctors.

THE CHAIR: Thank you, President! We will note that.

MS ANNA ROWLANDS: There is just one further point. I have just had some legal advice. It is to check that Council is happy for us now to go ahead and make the rules. I think we need formal approval for that.

THE CHAIR: That is different to 2b, is it?

MS ANNA ROWLANDS: Apparently.

THE CHAIR: Council is asked to confirm that you can go ahead and make the rules. There is much nodding of heads. [***Agreed***]

Thank you, Anna, and all who have been involved in this. Yet again, it is a substantial piece of work that has been brought to us in a very timely way.

Revalidation

9. Revalidation: progress report

MS CLAIRE HERBERT: The progress report on revalidation follows a similar format to previous reports. It again follows the 12 work strands that are set out in the Revalidation Project Initiation Document that you endorsed in January of this year. There will of course be the revalidation seminar this afternoon, when Mr Keith Pearson, the new Chair of the Revalidation Programme Board, will join you in a broader discussion about revalidation; but perhaps I can highlight a number of developments that have taken place since the last Council meeting.

Keith Pearson chaired his first meeting of the Programme Board on 10 June and, at that meeting, the Board endorsed a high-level revalidation readiness plan. This is at Annex B of your paper. It sets out when the first systems are likely to be ready to support revalidation. This is distinct from a timetable for the roll-out of revalidation, which will be developed separately.

You will see from the rather complex-looking timetable that the first systems are projected to be ready by the second quarter of 2011. I should say that the information to develop this plan has been drawn from a number of organisations, namely the four Departments of Health, ourselves, and the Academy of Medical Royal Colleges.

You will see, looking down the 12 work streams and the various organisations that have a day-to-day responsibility for putting those systems in place, that it does make for a rather complex and challenging programme of work and a certain level of risk in ensuring that the programme is put together and delivered in a timely and effective fashion. I think that those are some of the issues you will be discussing more fully this afternoon during the seminar.

The Programme Board agreed that this was an appropriate timetable from which to move forward and monitor progress towards readiness, and that is what the Board will be focusing on at its meetings throughout the rest of this year and throughout 2010.

The Board also endorsed some rather high-level criteria for assessing the readiness of systems for revalidation. These are set out in paragraph 11 of the paper. Essentially, they conform to the components of the revalidation model as we have it. There is some further work to be done to develop the criteria more fully, and one of the recommendations in the paper is for the Continued Practice Board to take that work forward.

At Annex A we have set out a number of other developments that have taken place or are taking place across each of the work streams; in particular, the work around the introduction of the licence to practise, about which you have heard a lot already. As you know, in 2008 we developed the framework for appraisal based on *Good Medical Practice* and, throughout this year and into next year, there will be a number of pilot and project activities relating to that, to embed that framework in local systems of appraisal.

The final point I would make is with regard to our work with, in particular, the Academy of Medical Royal Colleges around developing policy with regard to multi-source feedback and recertification. That likewise will be taken forward in more detail by the Continued Practice Board.

THE CHAIR: Are there any questions for Claire about the progress report before we go on to the recommendations?

MS ANNE WEYMAN: Having now been to two meetings of the Programme Board, I think that the second meeting showed much more engagement from the various parties, and evidence of how they were taking things forward in the programme and their interest in engaging effectively with the process – which I think was not there so much before that. I think that was therefore quite encouraging.

THE CHAIR: It is very heartening to hear that.

PROFESSOR TERENCE STEPHENSON: In case – because the agenda is going on apace – I am not back in time for the seminar ---

THE CHAIR: May I interject here? We cannot start the seminar until two. I do apologise for that. The reason is that Keith Pearson cannot be here until 1.30 at the earliest. There will therefore be quite a lengthy break. We have brought lunch forward to one o'clock, but I realise that there will be a gap.

PROFESSOR TERENCE STEPHENSON: My concern is that what I am hearing from doctors more generally is a concern that revalidation is running away with itself and becoming a hugely bureaucratic organ. I do not think that generally, and indeed I am in the process of writing something for our members, people are against the principle of revalidation. I think that people have bought into it.

However, just to name a few: there is the GMC Revalidation Programme Board; the Academy of Medical Royal College's Revalidation Development Group; the joint AoMRC-GMC Steering Group; the Department of Health Revalidation Support Team, with its 142-page draft appraisal document; the UK Revalidation Programme Board; four Delivery Boards for the four nations, and a network of Responsible Officers, covering only 70% of the employed doctors in the United Kingdom.

I think there is a sense that this could just run away and, whilst no one is in any doubt about the need for it, is there any one person – and I guess that is us! – who has a handle on this, to stop it becoming something that becomes a self-generating, huge machine and a hammer to crack a nut? In the sense that there may be 2% of people that we are trying to identify and this will be a huge amount of work. When people have raised it with me, I have said that I would raise it at the GMC – so I am undertaking to do that really.

MR FINLAY SCOTT: I am sure that this will be discussed further this afternoon but my own take on it is this. The revalidation model is designed specifically to avoid being burdensome. It builds on systems that are not being created for the purpose of revalidation but are being created for the purpose of supporting the delivery of high-quality health care and the support of doctors. Principally, those are clinical governance and appraisal for doctors. Compared to where we were ten years ago, I think that is a much simpler, much lower-cost model than we were originally running with.

My own experience – and Johann was kind enough to chair a breakfast session at the BMA Annual Representative Meeting in Liverpool last week – is that when you engage with doctors and can explain the model, they understand that it is not in itself creating a massive burden that will distract them from delivering health care. However, I do not think that we have yet sold that story and it is one of the points that Peter has been making. We need to be more effective in our engagement and communication around that.

I think that is quite separate from a different question, which is what is it going to take to put the model in place? That is where it looks like a hydra with many heads. We have endless organs. We have tried to resolve some of the issues by creating structures that were previously lacking. The key structures now are Keith Pearson's UK Revalidation Programme Board and then, within each of the four countries, the Delivery Boards, whose responsibility it will be to ensure that effective appraisal systems and effective clinical governance are available to support.

The third element, which is the one that I think we have yet to work our way through, is how does the Council become assured that the local systems on which it is depending for the delivery of revalidation are actually doing the job they are there to do? That requires engagement with the Care Quality Commission and equivalent bodies in the other countries.

I think that we can genuinely reassure doctors about the comparative simplicity of the model, which should not be burdensome so far as individual doctors are concerned, but it remains a complex and challenging task to deliver the local systems and to get them to work in a way that meets this Council's needs.

THE CHAIR: Does that answer your question, Terence, or do you want to come back on that?

PROFESSOR TERENCE STEPHENSON: I think that is kind of my point. It goes back to what Peter was saying earlier: that this is ripe for a very active communications strategy, but *now*, before we lose the profession.

There are those things that you and I know – that it is not intended to be burdensome – but the urban myth out there is already that you will be sitting exams, it will be hugely burdensome, and everyone will be filling in umpteen forms. I heard a presentation by someone who I respect quite a lot, who was being quite satirical about this. There is therefore an onus on us to get a really simple, informed message out there quickly.

THE CHAIR: I completely agree. We do not yet have a grip on the communications aspect of this and we have not yet got the message across that we own it. It is us, actually. Others are doing things on our behalf but we own it, and we will ultimately say yes or no. We will say yes or no to the local appraisal systems; we will say yes or no to the royal college standards. It is us. That message is not out there yet, and there are too many people going off, sometimes making less-than-helpful observations. We are very aware and are actively working on this.

In a few weeks' time, I am having a couple of meetings at the Department of Health here in London to clarify some aspects of this; to clarify an agreement on ownership, who sends the messages out and so on, because there are too many messages coming out from too many sources.

We absolutely agree, Terence. However, some of the committees you mentioned are actually necessary, because the local systems have to be developed; the medical royal colleges have to develop the standards that we will look at and approve or not approve, as the case may be. This sort of work has to be going on.

Malcolm, may I ask you to comment? Your Board will have an increasing workload in this matter.

DR MALCOLM LEWIS: It will do, in this and in other areas. We mentioned credentialing earlier, and you have seen from some of the papers that, for example, we have yet to nominate our external representatives to come to the Continued Practice Board.

This is because we are beginning to feel that there will be work streams in subsets of the Board and revalidation will be one of these. We are also keen not to invent another committee that relates directly to bits of work within revalidation but to take an overview of what is happening, and perhaps to link with both Council on the one hand – at the top end, if you like – but also to link with Keith Pearson's Board, and I am looking forward to the seminar this afternoon.

I take Terence's point but I think that it is more about misinformation and myths growing in the urban setting, as he put it. I do not think it is universal and there may be an element of cynicism that grows with it. At meetings at which I have spoken, including at the BMA and the SAS doctors at the BMA, the response seems to have been fairly positive and there does not seem to be that much fear, even from doctors who may not be quite as well catered for in terms of appraisal and CPD within their organisations. Yet they understand that the GMC is taking not a minimalist approach to this but a structured approach, which should allow the NHS to deliver what it is meant to be delivering in any event – but against standards set by the various colleges. I think that the logic of it is therefore quite appealing to the profession – when the profession gets to hear it.

THE CHAIR: That is the key thing. Claire, what you are asking of us in this paper is to consider the progress report, which we have done. Then we are asked to agree that the Continued Practice Board develop standards on clinical governance and appraisal for use by the Delivery Boards. Claire, do you want to enlarge on that or are you happy for me to put that to Council now to approve?

MS CLAIRE HERBERT: I am happy with that.

THE CHAIR: Are we content? [***Agreed***] Then to endorse the UK-wide readiness plan – which is an impressive plan, multi-coloured! I am sure that we are happy to endorse it. [***Agreed***]

The Chair brought the meeting to a close at 12.10 p.m.